Improving community wellbeing, resilience and safety through collaborative efforts

Safe Communities Foundation New Zealand

Safe Community Model Effectiveness
Selected Evidence Summary paper

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Selected Evidence Summary Paper

Overview

What is a Safe Community?

Aotearoa New Zealand has a well-established local, regional and national Safe Community network that supports wellbeing, placemaking, resilience and community safety initiatives. There are no other national organisations, networks or coalition models that offer a comparable structure and reach.

The Safe Communities concepts embody the values and philosophies of whanaungatanga (relationships) manaakitanga (respect, care, and support) and tino rangatiratanga (self-determination and autonomy). It is seen as a mechanism for bringing together agencies and groups that usually work in isolation or in silos to develop a collective 'lens' and generate a collective 'weight' to the process of identifying and responding to pressing community issues. A setting where conventional thinking can be challenged, where new and innovative ideas are developed and where there is a balance between strategic and tactical thinking/planning.

Safe Communities can best be described as a Network of Networks. Across Aotearoa New Zealand participation at a local level engages key government agencies including ACC, Police, Fire Service, CDEM, local authorities (Mayors, elected members, staff), DHBs, MSD; NGO sector including specialist health and social services; Iwi/ Māori organisations; Local specialised services including Regional Sports Trusts, REAP, Community Funding organisations; Local networks including Family Violence Prevention, alcohol-harm reduction, older people's support, youth sector, rural sector, workplace safety, road safety, business, town centre, community and neighbourhood groups. Communities commit to achieving and maintaining the criteria for accreditation (the Safe Communities model), with most Safe Communities hosted and/or funded by their local Council and several are collectives between two or more Councils.

Since SCFNZ was established in 2004, there has been exponential growth of Safe Communities, with just over 3.3 million (68%) New Zealanders living in an accredited Safe Community. 26 cities and districts are currently engaged in the network and participation is open and accessible to any and every community within Aotearoa New Zealand.

SCFNZ is currently funded by Ministry of Health and Te Hiringa Hauora/Health Promotion Agency, with previously funding coming from Accident Compensation Corporation and Ministry of Justice. SCFNZ has both the capacity and capability to provide ongoing services to the Safe Communities movement. www.safecommunities.org.nz

Supporting Discussion Document: *Role, Benefits and Costs of Safe Community Coordination*

SCFNZ Information: SCFNZ Strategy, SCFNZ Strategic Outcomes Framework, SCFNZ Operating Framework

Understanding the benefits of collaboration

SCFNZ has identified several pieces of evidence both locally and globally that confirm the positive impact and benefits of coalitions in reducing injuries within Safe Communities in NZ, US, China and Scandinavia.

Report #1

In December 2015, Social Policy Evaluation and Research Unit, MSD, published a report*: Effective community-level change: What makes community-level initiatives effective and how can central government best support them?*

The Report notes:
The purpose of the project was to inform the Ministry about what works in community-level initiatives, and how central government can best support effective community-level initiatives. For the purposes of this project, community-level initiatives are defined as those that:

1. do not provide services to individual clients;
2. have a significant community engagement component; and
3. are aimed at addressing community-level issues and outcomes such as social connectedness, tino rangatiratanga/self-determination, incidence of family violence, and crime rates.

Key principles:

- Community self-determination: the ability to have a voice, to participate and to exercise control over one's destiny
- A focus on the strengths and assets of communities and the importance of their knowledge base
- A holistic and ecological approach, recognising the interconnectedness and complexity of factors and outcomes at various levels: individual, family, community, society
- A focus on **process** and **relationships** as well as **tangible outcomes**.

Success factors:

- A shared vision, owned by the community
- Community readiness
- Intentionality and a focus on outcomes
- Long-term and adaptable funding arrangements
- A focus on community capacity-building
- Skilled leadership and facilitation
- Processes for addressing power imbalances
- A focus on relationships
- Appropriate scale
- Continuous learning and adaptation.

Barriers to success (excerpted)

- Adverse funding and accountability arrangements
- A central-government culture that is not well-aligned to working with communities
- Lack of focus on addressing 'upstream' factors
- Loss of funding

Achieving Injury Reductions

The following evidence provides examples of how Safe Community systems have achieved injury reductions and return on investment for the activities.

Report #2

Prior to making application for reaccreditation, Safer Napier commissioned an independent review of their Safe Communities programme:

Safer Napier Overall Conclusion

"Overall, from the information obtained it can be concluded that the Safer Napier programme contains a portfolio of projects designed to reach a wide range of target groups on which they have a moderate to high impact and delivers reasonable value for money. Crime prevention and road safety projects appear to have most impact and alcohol-related harm the least, although there is insufficient outcome information to be very definitive in this regard. The evolution of the portfolio across time points to the increasing maturity of the programme that delivers a range of outcomes including increased awareness but perhaps more saliently, crime reduction, a safer physical environment and positive behaviour change." Katoa Ltd, April 2015.

Report #3

Dale Hanson, Dr PHD, MPHTM, MBBS et al, Working From the Inside Out: A Case Study of Mackay Safe Community, Health Education & Behavior, 2015, Vol. 42(1S) 35 S–45S

Dr Hanson and colleagues have undertaken a series of evaluations of the Mackay Safe Community utilising an ecological model. A social network analysis conducted in 2000 and 2004 indicated that the network doubled its cohesiveness, thereby strengthening its ability to collaborate for mutual benefit.

The research identified two forms of connected relationships:

1. *Bonding relationships*: increasing the density and strength of relationships within groups strengthened the ability of the coalition to collaborate for mutual benefit.
2. *Bridging and linking relationships*: these boundary-crossing relationships connected subgroups within the community (bridging relationships) and connected the community to external agencies (linking relationships). These relationships proved to be a critical conduit for the sharing of resources.

These boundary-spanning relationships accessed an estimated 6.5 full-time equivalents of human resources and US$750,000 in 2004 that it used to deliver a suite of injury control and safety promotion activities, associated with a 33% reduction in injury deaths over the period 2002 to 2010.

Report #4

The 'WHO Safe Communities' model for the prevention of injury in whole populations (Review).
Spinks A, Turner C, Nixon J, McClure RJ; The Cochrane Collaboration and published in The Cochrane Library, 2008, Issue 3

The Manifesto for Safe Communities states that 'All human beings have an equal right to health and safety'. The Safe Communities concept was introduced to the world during the First World Conference on Accident and Injury Prevention held in Stockholm, Sweden in September 1989. It arose as the celebrated response to a successful community approach to the problem of injury which had been implemented as a pilot project in the Swedish municipality of Falkoping in 1974 (WHO 1999). This

project demonstrated a 23% decrease in total population injury rates, following an intervention which focussed on specific injury related issues identified within the local community (Schelp 1987).

Authors' conclusions, Implications for practice
There is some evidence that the Safe Communities model does reduce injuries in whole populations, and further implementation of these programmes is supported.

Report #5

Injuries and Safe Communities Accreditation: Is there a link? Sergey Sinelnikova, Lee S. Friedman, Emily A. Chavez, National Safety Council, Department of Research and Safety Management Solutions, 1121 Spring Lake Drive, Itasca, IL 60143, United States University of Illinois at Chicago, School of Public Health, Environmental and Occupational Health Sciences Division, Chicago, IL 60612, United States, Accident Analysis and Prevention 91 (2016) 84–90

This study explored the temporal relationship between Safe Community accreditation and injury trends in three Safe Community sites from the state of Illinois—Arlington Heights, Itasca, and New Lenox. Hospitalization data, including patient demographics, exposure information, injury outcomes, and economic variables, were obtained from a statewide hospital discharge database for a 12-year period (1999–2011). Joinpoint regression models were fitted to identify any periods of significant change, examine the direction of the injury trend, and to estimate monthly percent changes in injury counts and rates. Poisson random-intercept regression measured the average total change since the official Safe Community accreditation for the three communities combined and compared them to three matched control sites. In joinpoint regression, one of the Safe Community sites showed a 10-year increase in hospitalization cases and rates followed by a two-year decline, and the trend reversal occurred while the community was pursuing the Safe Community accreditation. Injury hospitalizations decreased after accreditation compared to the pre-accreditation period when Safe Community sites were compared to their control counterparts using Poisson modeling. Our findings suggest that the Safe Community model may be a promising approach to reduce injuries. Further research is warranted to replicate these findings in other communities.

Report #6

The Harstad Injury Prevention Study. A Decade of Community-based Traffic Injury Prevention with emphasis on Children. Postal Dissemination of Local Injury Data can be Effective. Harstad Hospital and Institute for Community Health University of Tromsø, Norway, Børge Ytterstad M.D., Ph.D. International Journal of Circumpolar Health 62:1 2003

The Harstad Safe Community initiated interventions in 1988 that combined the efforts of an injury prevention group, health services, and public and private organisations, including educational institutions, road planners and builders, national laws mandating safety equipment and a media campaign.

Objectives. To evaluate the outcome of a community-based program for reducing traffic injury rates with special focus on children and to assess the impact of a Traffic Injury Report (TIR) in terms of awareness and attitudes about safety issues.

Results. From the first two years (mean rate 116.1/10 000 person years), to last two years, a significant 59% [confidence interval (CI): 42% to 71%] reduction of traffic injury rates was observed for Harstad children. Overall rates for all ages decreased 37% [CI: 47% to 24%] in Harstad and increased by 3% [CI:-4% to 10%] in Trondheim (reference city). Significantly higher scores were found in Harstad compared

to Trondheim concerning the awareness of, and positive attitudes towards, safety issues (e.g. alcohol and driving, speeding and children's safety in traffic). 56.0 % of respondents in Harstad reported having acquired information, or good advice, about traffic safety from the reports.

Conclusions. Traffic injuries in children can be prevented by community- based interventions. Distributing written information may enhance the program's sustainability.

Other Influences that Impact on Achieving Goals

Safe Community governance groups acknowledge that no single agency or organisation can possibly claim to be solely responsible for achieving a result like "A safe community". They recognise that, through the adoption of the Safe Community model, it takes the many contributions of a range of government and community partners to achieve population wellbeing.

In addition to measuring how well the Safe Communities are achieving the goal of reducing injury, other benefits include attracting additional support and resources locally to support national programmes and the uptake of injury preventative behaviours. Adoption of the Results-Based Accountability (RBA) framework is one way to demonstrate this and measurable outcomes. They can be achieved by aligning (`line of sight') the performance measures of individual programmes (increase in skills & knowledge and/or behaviour/circumstance change) with population indicators (reduction in injuries).

The following reports are a sample that demonstrate that Safe Community systems measures the changes in the target population's knowledge, attitudes, beliefs, or behaviours associated with the specified outcome.

Behaviour Changes

This report is an example of a programmes that resulted in behaviour change to reduce the risk of falls in a Safe Community.

Report #7

The KAP Evaluation of Intervention on Fall-Induced Injuries among Elders in a Safe Community in Shanghai, China, Ling-ling Zhang, Koustuv Dalal, Ming-min Yin, De-guo Yuan, Johanna Yvonne Andrews, Shumei Wang, PLoS ONE 7(3): e32848. doi:10.1371/journal.pone.0032848

Methodology/Principal Findings: Five neighborhood areas in a Safe Community were purposively selected. All individuals aged 60 years or over in five neighbourhoods were prospective participants. From randomly selected prospective households with elders, 2,889 (pre intervention) and 3,021 (post intervention) elderly people were included in the study. Knowledge, Attitude and Practice Model (KAP) questionnaires were used at the pre- and post-intervention phase for fall-induced injury prevention in the community. Descriptive statistics and chi-square tests were used. After the intervention, knowledge about the prevention of fall-induced injuries increased, as did attitudes, beliefs and good behaviors for fall prevention. Behavior modification was most notable with many behavior items changing significantly (p value, 0.0001).

Conclusions/ Significance: The integrated program for reducing fall-related injuries in the community was effective in improving fall prevention among the elderly, but the intervention still needs further improvement.

Aligning Local Resources to National Programmes

The following NZ based example explains the contribution to a national programme in a Safe Community system.

Report #8

Safer Waimakariri

In February 2016, Safer Waimakariri undertook an exercise to calculate the added value of partner contributions in cash and kind to the delivery of specific programmes. The analysis demonstrated that for programmes delivered in Suicide Prevention (below) there was a real dollar return of 135% or in other words: for every $1.00 of Ministry of Health funding, it was matched by a contribution of $1.35 from partners. Falls Prevention demonstrated a return of approximately 90% or $0.90 for every $1.00 from MOH. Rural programmes achieved $0.74 for every $1.00, and child safety $0.84 for every $1.00 in 'added value'.

SUICIDE PREVENTION Value Breakdown over 1 year of delivery

Partners: *CDHB (including School Based Mental Health), Depression Support Network, Local Schools, Pegasus PHO, Neighbourhood Support, Hope Community Trust, Oxford Community Trust, Grey Power, Com Care Trust, Presbyterian Support, Whanau Champion Ngai Tahu Farms, North Canterbury Sport and Recreation Trust, Waimakariri Youth Council, Victim support, Male Survivors of Sexual Abuse, Rural Canterbury Primary Health Organisation, NZ Police, R13 Trust, Wellbeing North Canterbury, Enabling Youth, 298 Youth Health, Local GP, Family Planning, Waimakariri Access Group and community members. Road Safety Co-ordinator, Safe Community Facilitator, Rural Support Trust, Wisdom Counsellor.*

Activities include:

1. Establishment and facilitation of Wai Life Suicide Prevention Steering Group
2. Review, re-establishment and support for Waimakariri Bereaved by Suicide group and waves programme
3. Facilitation of local QPR Suicide Prevention training initiatives
4. Workshops on wellbeing, depression & how to address signs of potential suicide. (e.g. Depressions Awareness workshop at Rangiora Library, Oxford Youth Forum, Good Bad and Ugly Parenting Teens seminar) approx. 3 days each
5. Facilitation of Community-Led initiatives to support connection and wellbeing in rural communities. (E.g. Funky Farmworkers' Food and Farm Strong)
6. Facilitating links to assist with the establishment of the Oxford 'Got Your Back' initiative; aimed at ensuring that community members have someone they can turn to in a crisis.
7. Development of locally relevant on-line resources
8. Engagement in regional fora to establish practitioner links
9. Local research and associated links (e.g. in relation to contagion, or accessing local stakeholder evidence)

Activity	**# of Partners**	**Residents reached**	**Coordinator Hours** (per year)	**Coordinator cost:** (rent, IT, etc)	**Project costs**	**Partner hours**	**Cost in kind** (averaged $30 per volunteer hr)	**Total Health Promotion value**	**Total investment from MOH**
1	42	Whole of population promotion; but with targeted groups, project dependent	114	$ 4,446	$ 200	1680	$ 37,800		
2	Over whole suicide portfolio		140	$ 5,460	$ 500	34	$ 1,020		
3			48	$ 1,872	$ 920	38	$ 1,140		
4			56	$ 2,184	$ 900	160	$ 4,800		
5			80	$ 3,120	$ 750	128	$ 3,840		
6			80	$ 3,120	$ 750	12	$ 360		
7			64	$ 2,496	$ 1,190	2	$ 24		
8			96	$ 3,744	$ 200				
9			40	$ 1,560	$ 100				
TOTAL	**42**	**60,000**	**718**	**$ 28,032**	**$ 4,160**	**358**	**$48,984**	**$75,732**	**$32, 192**