DEVELOPMENT FRAMEWORK FOR BEYOND THE SAFE CITY STRATEGY

2014-2017

February 2014

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CITY OF MELBOURNE

DEVELOPMENT FRAMEWORK FOR BEYOND THE SAFE CITY STRATEGY 2014-17

1. Introduction

Over the last two decades, we have built a strong foundation on which we respond to community safety issues. This is evidenced by our success in achieving and maintaining accreditation as an international safe community since the year 2000. In 2013, the City of Melbourne was also ranked the world's most liveable city for the third time in a row against a range of criteria by the Economist Intelligence Unit Survey.

The *Strategy for a Safer City* and the *Policy for the 24 Hour City* are being merged to form a single strategic plan titled *Beyond the Safe City Strategy 2014-17.* The integration will ensure that issues associated with the 24 hour city are sustainable and firmly embedded in the core business of Council. This includes the way we build in safety and accessibility into the design and management of our public spaces, local services, community programs and events.

The Strategy will be unique and progressive in its approach. Safety issues will be approached in an integrated and sustainable way. The focus of this Strategy will be to address the underlying causes of safety issues, not just the management of impact of issues.

The City of Melbourne is a relatively safe city in comparison to other capital cities in Australia and around the world (*refer to Appendix One - Local safety profile*).

The Strategy will build on existing infrastructure and programs already in place that have helped us achieve and maintain our internationally recognised status.

This Development Framework will help inform the development of the Beyond the Safe City Strategy 2014-17.

2. Vision

Melbourne is a place where people feel safe, connected and able to participate in city life at any time of the day or night.

3. Principles

Our approach to community safety planning is based on eight principles. Each principle is applied in the development and implementation of actions outlined under the priority action areas.

3.1 Integrated solutions

We need to take a broad view of the causes of and solutions to crime, violence and other antisocial behaviour, injury and drug and alcohol issues in the 24 hour city context. It is widely recognised by criminologists that reducing the incidence of crime[1] and injury[2] in a community requires a focus on the natural and built environment as well as on cultural, social and economic factors that impact on safety and wellbeing.

[1] Geason, S., & Wilson, P.R. (1989) *Designing out crime: Crime prevention through environmental design.* Australian Institute of Criminology.
[2] Dannenberg. A. L., Frumkin, H., & Jackson, R.J (2011) *Making Healthy Places: Designing and building for health, well-being and sustainability.* Island Press.

3.2 Partnerships

Developing proactive partnerships and ensuring coordination of our efforts is critical to the creation of a safer community. A community building approach that emphasises the importance of social capital (social justice, trust, participation, sharing common values) is crucial when working towards local solutions.

We place high value on opportunities for members of the community to provide input into the development and evaluation of our community safety strategies and programs. We will use existing consultative arrangements and develop new ones to ensure all groups in the community are represented in both the planning and the implementation of our safety strategy.

3.3 Evidence based approach

Our approach to improving the safety of the municipality emphasises the social, economic and environmental impacts on health and wellbeing. A strong evidence and research base enables us to understand our population and ensure our approach is as effective as possible.

3.4 Community capacity building

Fostering a strong sense of community connectedness, where all members of the community are equally valued and respected, is the key to creating a healthier and safer community. The strategy aims to ensure that all members of the community, especially those from disadvantaged and vulnerable groups, feel safe and welcome and are able to participate in city life.

In addition to our capital city/central activity district role, we also service and support a number of affluent and highly disadvantaged communities who reside in suburbs. Responding to community safety across all settings and for all populations is critical to the success of the plan.

We will work within the context of Council's Neighbourhood Development model to help build strong, inclusive and resilient communities. We will work with neighbourhoods and communities to plan and develop local solutions and build their capacity to respond to ongoing safety and security issues occurring within their local area.

3.5 Harm minimisation

Harm minimisation focuses on reducing the adverse social, economic and health consequences of drug and alcohol use for the individual and the broader community. It is consistent with the Australian and Victorian Government's policies on drugs and alcohol. It encompasses three main approaches: supply control (law enforcement), demand reduction and harm reduction.

3.6 Prevention

We will use prevention strategies to tackle the risk factors that cause crime, violence and injury. This approach is more cost effective and leads to greater social benefits for the community[3]. The three levels of prevention we will apply include: (i) primary prevention, directed at changing conditions in the physical and social environment at large; (ii) secondary prevention, directed at early identification and intervention in the

[3] Institute for the Prevention of Crime (2008) *Making Cities Safer: International Strategies and Practices.* Number 1 www.prevention-crime.ca. University of Ottawa.

lives of individuals or groups; and (iii) tertiary prevention, directed at prevention of. reoffending.

3.7 Safer by Design

The proper design and effective use of the built environment can lead to a reduction in the fear and incidence of crime and an improvement of the quality of life. Applying crime prevention through environmental design (also referred to as CPTED) principles to the way we plan, design, and manage our built environment will increase community usage, improve perceptions of public places; achieve connection and integration of streets and public places, and reduce opportunities for crime and anti social behaviour.

3.8 Gendered response

We will ensure gender equity in the way we plan, design and manage the safety of our city. Applying a gender analysis will help us to understand the different safety needs, capacities and experiences of women and men in the municipality.

Our Approach

Beyond the Safe City Strategy 2014-17 contains our long term guiding principles and priority action areas. The strategy will also help achieve a number of goals within the Council Plan 2013-17. Refer to Diagram One.

In collaboration with our key partners, we will develop an annual action plan which will highlight activities that will be carried out over a 12 month period to respond to both ongoing and emerging issues that fall within the priority action areas.

An annual public report will also be prepared highlighting key achievements and outcomes of the Strategy.

4. Priority (prevention) action areas

Since the development of the foundational *Strategy for a Safer City* in 1996, the City of Melbourne has focused its community safety efforts on improving perceptions of safety and minimising crime, violence, intentional and unintentional injury, and drug and alcohol related harm. All of these issues impact on individuals and communities who reside, work, study and visit our city by day and night.

We propose to respond to these issues by focusing on the following key prevention action areas:

4.1 Support a prosperous and creative 24 hour city

Melbourne is a capital city municipality with a diverse range of communities and places. Over the past decade the city has also attracted a diverse and vibrant mix of residents, visitors and business using the city 24 hours a day, seven days a week. This has underpinned economic and cultural development and has seen the city develop into an internationally recognised location in which to live, work, visit and socialise.

Melbourne's vibrant night time economy is a major contributor to its status as a world leading cultural city. However, as the city stays awake longer, there is a need to make policy and operational decisions to manage the competing demands of the groups who visit the city, as well as those who live and work there.

Beyond the Safe City Strategy 2014-17 integrates the innovation first developed through Melbourne's Policy for the 24 Hour City. In recent years City of Melbourne's plans and programs have been developed with the intention of balancing growth, creative and economic prosperity while managing community safety and wellbeing across our municipality, including a specific focus on our central city late at night. This Strategy further develops our vision for a 24 hour city that acknowledges and addresses the varying needs of city users.

The intention is to set out a positive vision for our late night economy that balances activation with regulation and thereby promoting a safe, vibrant and inclusive city that extends from the day into the night. City of Melbourne will enhance its commitment to advocate for improved governance, policy and service area provision to ensure a holistic approach is taken to addressing the issues associated with the 24 hour city.

4.2 Change the cultural and social norms that support crime and violence

Cultural and social norms are highly influential in shaping individual behaviour, including the use of violence. Norms can protect against violence, but they can also support and encourage the use of it. For instance, cultural acceptance of violence as a normal method of resolving conflict, is a risk factor for all types of interpersonal violence. Social tolerance of violent behaviour is likely learned in childhood, through the use of corporal punishment or witnessing violence in the family, in the media or in other settings. Interventions that challenge cultural and social norms supportive of violence can help reduce and prevent violent behaviour and other associated crime[4].

4.3 Improve the safety of the built environment

The design of our built environment affects all those who live, work and visit the municipality. Designed well, the built environment enhances the development and wellbeing of individuals, and supports healthier and happier communities. By engaging residents and city users in the planning and design of our built environment, we can create places and spaces in our city centre and neighbourhoods that are engaging, fun, safe and accessible.

Reducing the opportunity to commit crime through the design of built environments is an important aspect of building safer communities. This approach focuses on the 'situation' as opposed to the individual, by making it more difficult, more risky and less profitable to commit crime.

Much can be done to prevent crime and make it harder for crimes to be committed, through environmental design and practical measures such as improving the physical environment (e.g. better street lighting, less litter and graffiti) and applying Crime Prevention Through Environmental Design (CPTED) principles (i.e. natural access control, natural surveillance, territorial reinforcement and maintenance), and CCTV.

Transportation can also play a part in improving safety in our urban setting. City of Melbourne's *Road Safety Plan* and *Transport Strategy* aim to improve safety by reducing the number of people killed or seriously injured on our roads, improve the attractiveness of public transport, and the safety and accessibility of walking and cycling.

[4] World Health Organization (2010) *Violence prevention the evidence: Series of briefings on violence prevention – Briefing 6.* WHO Press.

4.4 Minimise the harm caused by drugs and alcohol

The harmful use of alcohol and other drugs (that is, any use that impacts negatively on the health, social and emotional wellbeing of users themselves and others) is a significant public health problem for our community and incurs significant economic costs.

Reduction of harmful alcohol and other drug use must include broad strategies to address the underlying social factors which predispose towards or protect against, harmful use, and strategies specifically targeting harmful use itself.

Strategies should aim to prevent or minimise the uptake of harmful use, provide safe care for those who are intoxicated, provide treatment for those who are dependent, support those whose harmful alcohol and other drug use has left them disabled or cognitively impaired, and support those whose lives are affected by others' harmful alcohol and other drug use.

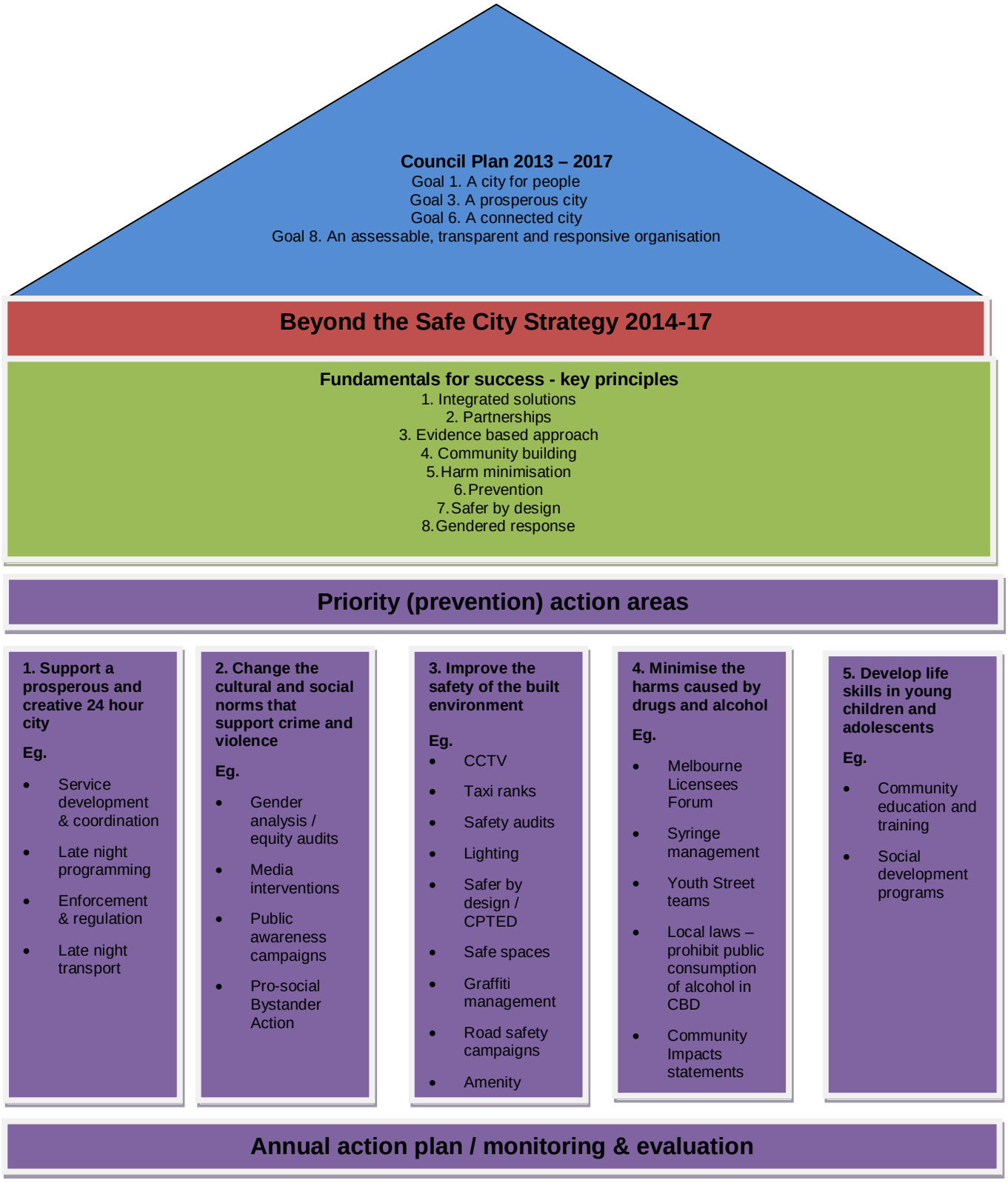
4.5 Develop life skills for young children and adolescents

Factors such as poor social competence, low academic achievement, impulsiveness, truancy and poverty increase individuals' risk of violence[5]. Developing children's life skills can help protect them from crime and violence, both in childhood and later in life. Interventions for developing life skills can help young people to avoid crime and violence, by improving their social and emotional competencies, teaching them how to deal effectively and non-violently with conflict and helping them to find training pathways and employment.

Evidence shows preschool enrichment programs (which aim to increase children's school preparedness and chances of academic success by providing them with early academic and social skills) and social development programs (which seek to provide children with social and emotional skills to solve problems, empathize and deal with conflict) can reduce aggressive behaviour and violent crime in childhood and later in life[6].

[5] World Health Organization (2010) *Violence prevention the evidence: Series of briefings on violence prevention – Briefing 2.* WHO Press.
[6] World Health Organization (2010) *Violence prevention the evidence: Series of briefings on violence prevention –Briefing 2.* WHO Press.

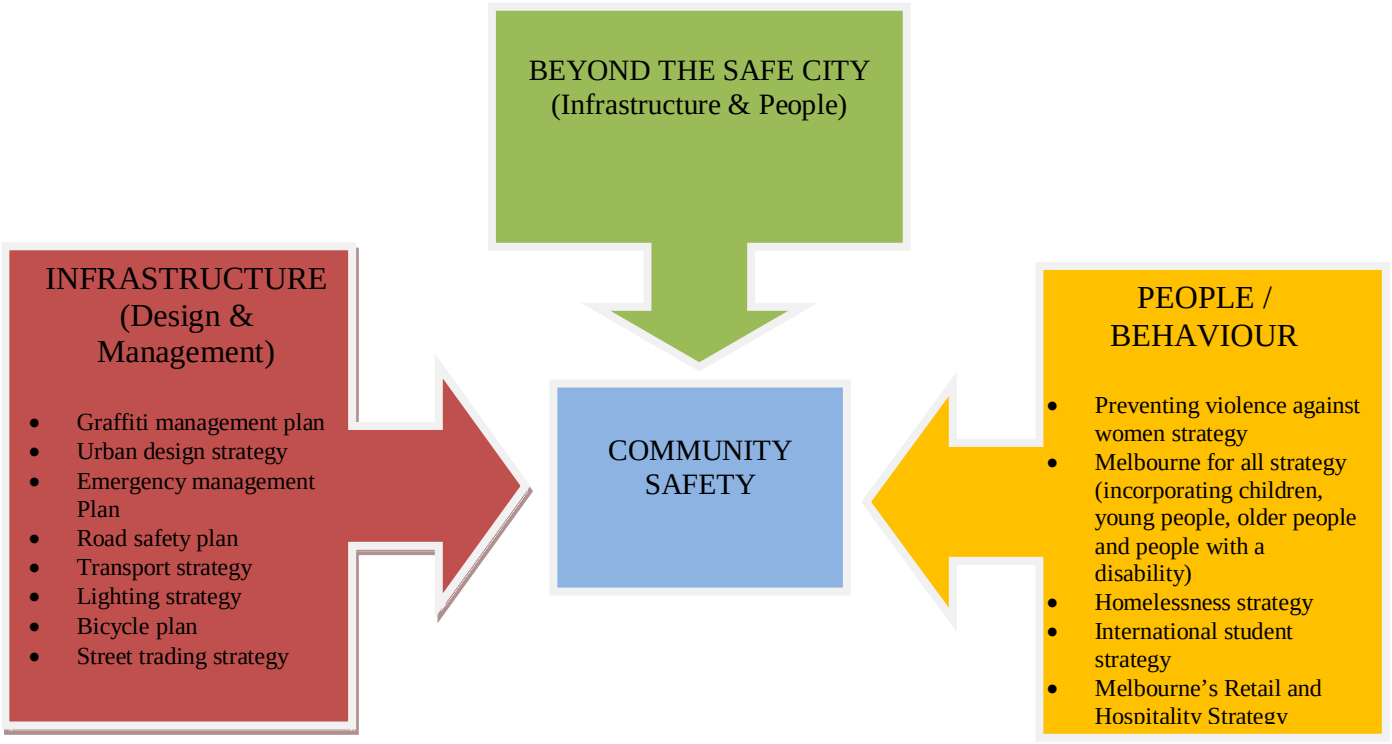
Diagram One. Link between Council Plan and Beyond the Safe City Strategy



5. Other City of Melbourne strategies contributing to community safety

There is a number of other City of Melbourne strategies which contribute to community safety (*refer to Diagram Two*). The Beyond the Safe City Strategy aims to compliment Council's existing strategies and programs.

Diagram Two. City of Melbourne strategies contributing to community safety



6. Monitoring performance and evaluating impacts

A key focus for the new Strategy is to develop a comprehensive research and data knowledge bank. This will assist Council and our partners to identify priority issues, understand why they are occurring, how best to address them and monitor the impact of our intervention.

Local crime, perceptions of safety, injury, drug and alcohol data will be regularly collated, analysed and where possible shared. We will adopt a longitudinal data analysis approach to help monitor trends and determine the level of impact of each intervention.

We will conduct small and large scale research with the use of both qualitative (e.g. video ethnography, in-depth interviews, workshops) and quantitative methods (e.g. surveys) to ensure we gain the views and understanding of the issues from a wide variety of sources.

Impacts of the strategy will be monitored and evaluated on a regular basis. Our framework will take into account Melbourne's role as a municipality, state capital city and as one of Australia's major international cultural, sporting and entertainment hubs.

As many societal issues cannot be addressed by local government alone, we will continue to establish and maintain a number of formal and informal committees and

partnerships with relevant stakeholders including federal and state government, police, service providers, academic institutions, community groups and residents.

7. Opportunity for community and stakeholder input

A number of opportunities are being made available for community and stakeholders to contribute to the Strategy, these include:

- Perceptions of Safety survey (1400 respondents – residents, businesses and city users)
- Drugs and Alcohol Roundtables (October and December 2013) with drug and alcohol experts and agencies
- Consultation with special interest groups and consultative committees (October 2013 to March 2014)
- Consultation with Councillors to develop key themes/action areas
- Beyond the Safe City Social Innovation Forum (5 and 6 March 2014) – strategic thinkers, social entrepreneurs, residents, businesses, planners, developers, key experts and others will come together to develop creative and innovative responses to local safety issues

8. Join the conversation

Visit Participate Melbourne to provide input into the Development Framework for the Beyond the Safe City Strategy 2014-17.

participate.melbourne.vic.gov.au/beyond-the-safe-city

APPENDIX ONE.

Local research and data

Reported crime statistics

According to Victoria Police reported crime statistics, the *overall* rate (per 100,000 population) of reported crime for the Melbourne local government area has increased by 3.5 per cent from 26,712 in 2010/2011 to 27,643 in 2011/2012.

The rate of *crimes against the persons* decreased by 2 per cent from 3,471 in 2010/2011 to 3,409 in 2011/2012. High volume crime in this category for 2011/12 included Assaults 2,707.

The rate of *crimes against property* increased by 2 per cent from 17,258 in 2010/2011 to 17,557 in 2011/2012. High volume crime in this category for 2011/12 included Theft (other) 5,702 Deception 3,142, Theft (shop steal) 1,938, Theft from motor vehicle 1,785 and Property damage 1,666.

The rate of *drug offences* increased by 2 per cent from 1,481 in 2010/2011 to 1,509 in 2011/2012. High volume crime in this category for 2011/12 included Drug possession / use) 1,281.

The rate of *other crime* increased by 15 per cent from 4,503 in 2010/2011 to 5,168 in 2011/2012. High volume crime in this category for 2011/12 included Behaviour in public (1,481).

Family incident data

According to the Victoria Police family incident reporting data, the number of family incidents for the Melbourne local government area has increased over time. This trend is consistent with all other local government areas in Victoria and is attributed to Victoria Police's improved capacity to respond to family violence incidents through the introduction of the *Code of Practice for the Investigation of Family Violence* in August 2004, and legislative change brought about by the *Family Violence Protection Act* 2008.

Table One. Family incident reports for Melbourne local government area

Family Incident Reports	2007/08	2008/09	2009/10	2010/11	2011/12
Melbourne LGA	408	492	676	673	841
Victoria (State)	31,660	33,891	35, 687	40,839	50,382

Perceptions of safety profile

According to the recent iteration of the Perceptions of Safety survey conducted by Colmar Brunton on behalf of the City of Melbourne in early 2013, the majority of residents and traders (87 per cent) and city users (81 per cent) feel safe in the central city area.

After a decline in the proportion of residents and traders indicating they feel safe (always or more often than they feel unsafe) from 92 per cent in 2006 to 84 per cent in 2009, in 2013 the proportion feeling safe has stabilised at 87 per cent.

The majority of residents and traders base their perception of safety on factors they have experienced themselves (82 per cent in 2013 compared to 75 per cent in 2009). Other factors that form perceptions of safety have remained consistent with about a

third (34 per cent) indicating their perceptions were based on incidents they had witnessed and about a quarter (27 per cent) on incidents they had heard or read in the media. One in five (19 per cent) indicated their perception was based on information they had heard from family and friends.

Among residents and traders, factors most commonly cited as contributing to their feeling of *safety* was activity and people on the street (49 per cent) followed by police presence (40 per cent) and abundant lighting (22 per cent).

For city users, they were significantly more likely to mention activity and people on the street (68 per cent), police presence (24 per cent, abundant lighting (22 per cent), clean streets and buildings (11 per cent) and broad open streets (11 per cent) as contributing to their feeling of safety.

For residents and traders, factors contributing to feeling *unsafe* in the central city area were public drunkenness (39 per cent), groups of people hanging around (28 per cent) inadequate street lighting (18 per cent) and anti- social behaviour (18 per cent).

For city users, they were more likely to mention public drunkenness (48 per cent) threatening and aggressive behaviour (29 per cent) groups of people hanging around (22per cent) and evidence of drug use (20 per cent).

The highest proportion of respondents perceived they were most at risk of *accidental injury* when using bike lanes (18 per cent never or rarely feel safe) and shared paths (14 per cent never or rarely feel safe). The issues associated with bike lanes and shared paths were drivers endangering cyclists, cyclists endangering pedestrians, cyclist disobeying road rules, there being too much traffic and drivers not giving way.

Injury profile

Every three years and as part of the review of the Strategy for a Safer City, the City of Melbourne commissions Monash University Injury Research Institute to prepare a City of Melbourne Injury Profile. The latest profile was prepared in June 2013.

The injury profile only captures injury data relating to residents of the City of Melbourne. Injuries incurred by visitors to the City of Melbourne are not included and therefore is a limitation to the data given that we have a large daily visiting population of approximately 788,000 people.

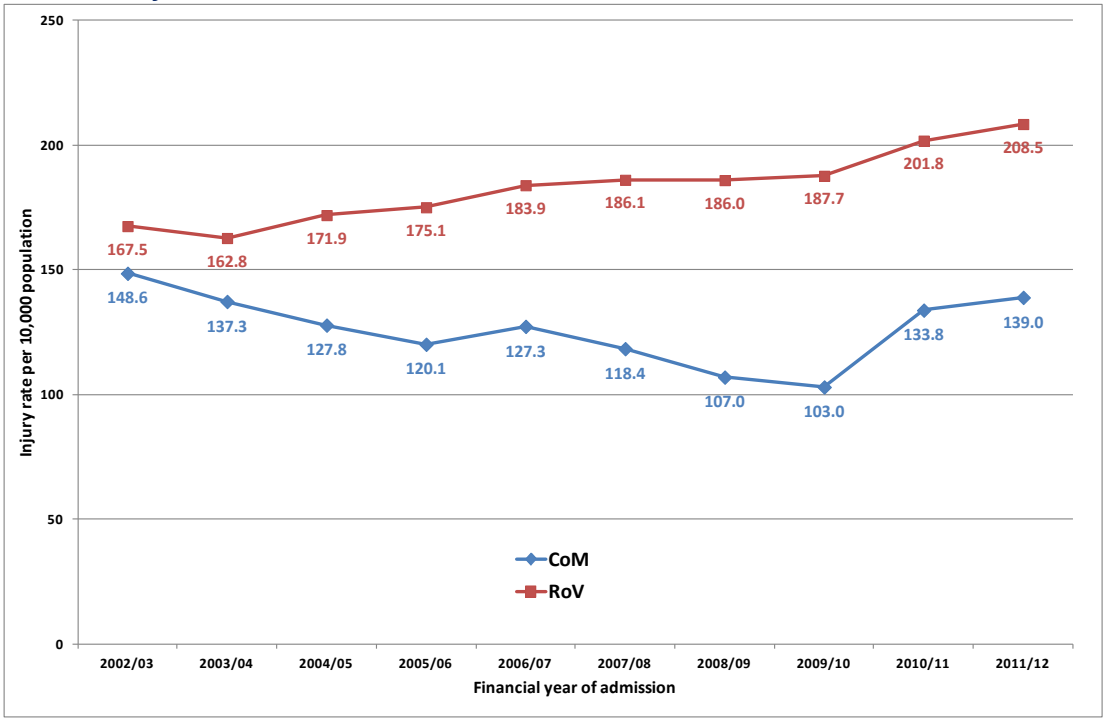
The profile highlighted that there were an annual average of 1,485 injury hospital admissions and 3,924 injury Emergency Department (ED) presentations among City of Melbourne (CoM) residents over the three-year study period (2009/10-2011/12).

A summary of the data follows:

Hospital Admissions - Trends

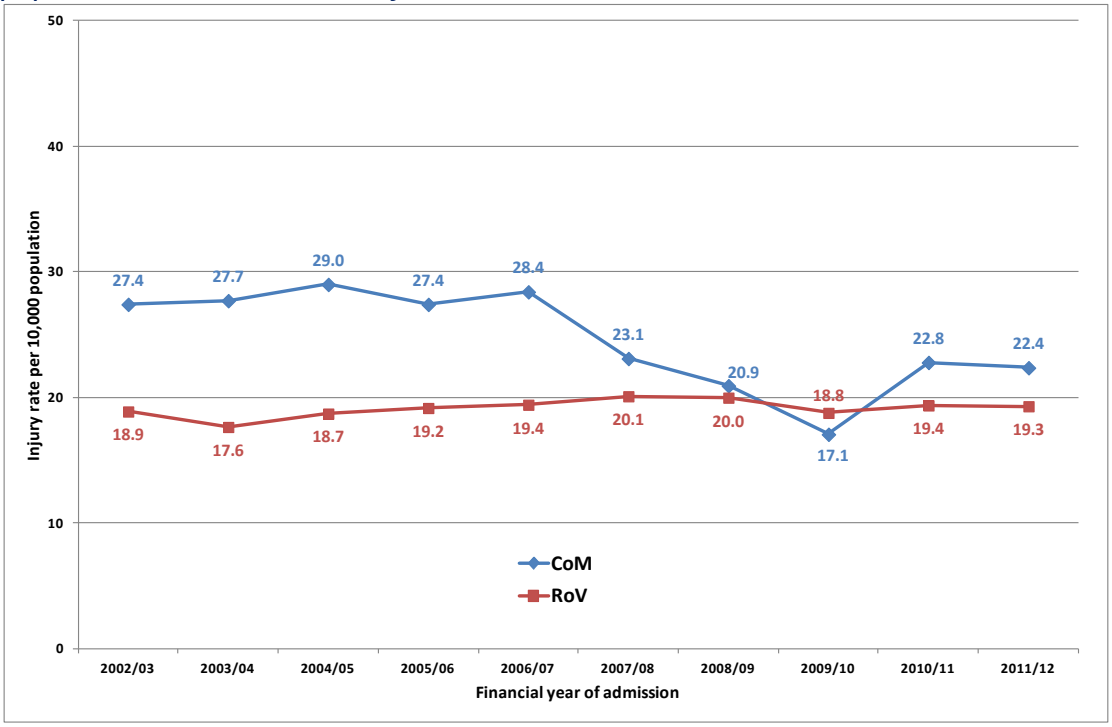
Over the ten-year period, 2002/03 to 2011/12, there was a non-significant 13 per cent decrease in the unintentional injury admission rate among City of Melbourne (CoM) residents compared to a significant 28 per cent increase among residents of the Rest of Victoria (RoV) [Figure 1].

Figure 1: Hospital admission rates for unintentional injury per 10,000 population, Victoria, July 2002 to June 2012



Over the same period, there was a significant 33 per cent decrease in the intentional injury admission rate among CoM residents compared to no change among residents of the RoV [Figure 2].

Figure 2: Trend in hospital admission rates for intentional injuries per 10,000 population, CoM and RoV, July 2002 to June 2012



Profile of **unintentional** injury hospital admissions among CoM residents (n=3,674):

- The 20-29 year age group accounted for the greatest proportion of unintentional injury hospital admissions (25 per cent).
- Males were over-represented (27 per cent).
- Falls were the major injury cause (40 per cent) followed by transport (15 per cent).
- Fractures were the most common injury type (36 per cent) [Table 5] and the upper extremity (30 per cent) was the body region most commonly injured.
- The road/street/highway is the most commonly specified location of injury (27 per cent of cases with specified location) followed by the home (25 per cent of cases with specified location).
- Most (63 per cent) unintentional injury hospital admissions required less than a two-day stay in hospital. Twelve per cent had a length of stay of 8 days or more.
- Residents of postcode 3000 accounted for the highest proportion of unintentional injury hospital admissions (23 per cent).

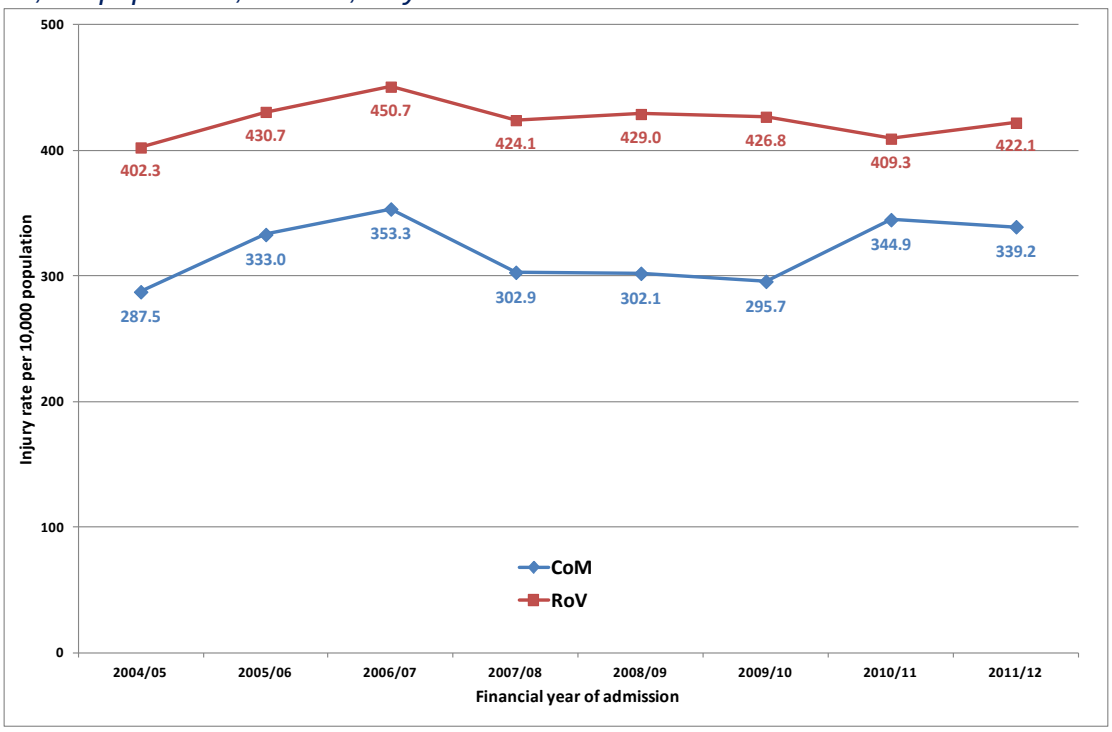
Profile of **intentional** injury hospital admissions among CoM residents (n=608):

- Among intentional injury hospitalisations, 53 per cent were assault and 47 per cent were self-harm.
- The 20-29 year age group accounted for the greatest proportion of intentional self-harm injury hospital admissions (42 per cent) and assault injury hospital admissions (36 per cent).
- Males were over-represented in assault injury hospital admissions (82.5 per cent) while females accounted for a larger proportion of intentional self-harm injury hospital admissions (59 per cent).
- Poisoning by pharmaceuticals was the main cause of self-harm injury (71 per cent of intentional self-harm injury hospital admissions) followed by cutting/piercing by a sharp object (17 per cent). Bodily force was the main cause of assault injury (59 per cent of intentional assault injury hospital admissions), followed by cutting/piercing by a sharp object (15 per cent) or a blunt object (14 per cent).
- The home is the most commonly specified location of self-harm injury (61per cent of cases with specified location). The home is also the most commonly specified location of assault injury (28 per cent of cases with specified location) followed closely by the road/street/highway (27 per cent of cases with specified location).
- Seventy-two per cent of both self-harm and assault injury hospital admissions required less than a two-day stay in hospital.
- Residents of postcode 3000 accounted for the highest proportion of self-harm (24 per cent) and assault injury admissions (30.5 per cent).

Emergency Department Presentations (non-admissions)

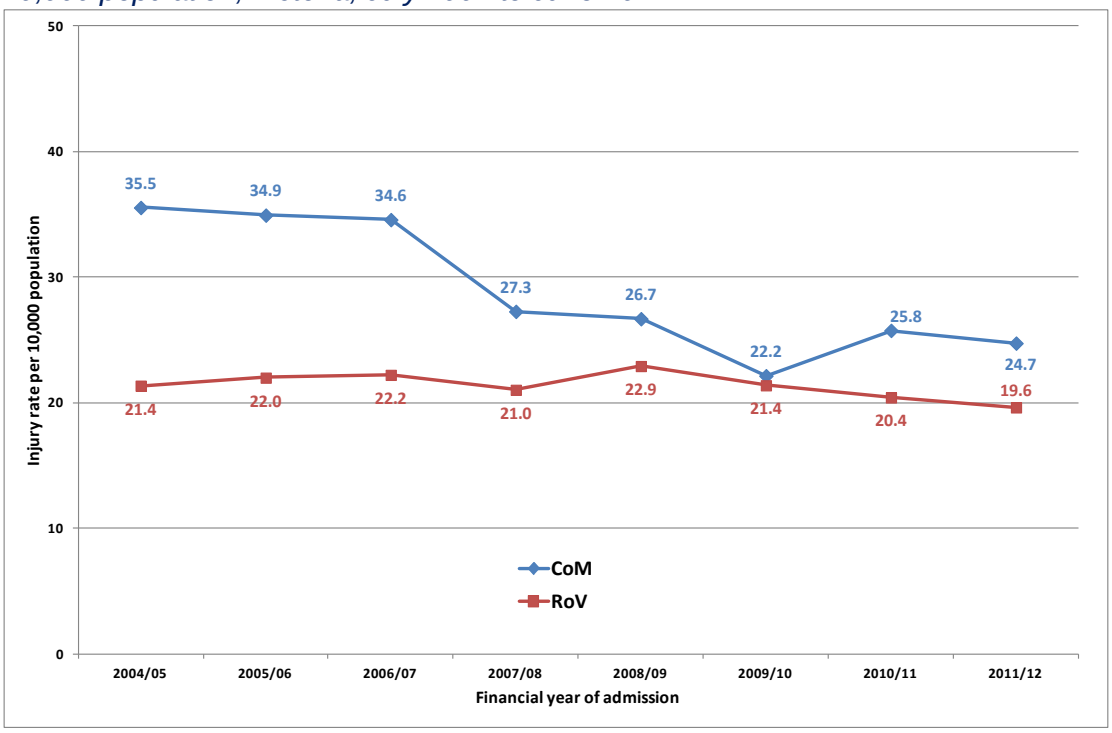
Over the eight-year period, 2004/05 to 2011/12, there was a non-significant 8per cent decrease in the unintentional injury ED presentations rate among CoM residents compared to a smaller non-significant 1 per cent decrease among residents of the RoV [Figure 3].

Figure 3: ED presentation (non-admissions only) rates for unintentional injury per 10,000 population, Victoria, July 2004 to June 2012



Over the same period, there was a significant 41 per cent decrease in the intentional injury ED presentations rate among CoM residents compared to no change among residents of the RoV [Figure 4].

Figure 4: ED presentation (non-admissions only) rates for intentional injury per 10,000 population, Victoria, July 2004 to June 2012



Over the study period, 2009/10 to 2011/12:

- There were 11,771 injury ED presentations, an average of 3,924 per year.
- Most (81 per cent) injury ED presentations were unintentional and 6per cent were intentional.
- Residents of postcode 3000 accounted for the highest proportion of injury ED presentations (23 per cent).

Profile of **unintentional** injury ED presentations among CoM residents (n=9,563):

- The 20-29 year age group accounted for the greatest proportion of unintentional ED presentations (38 per cent).
- Males were over-represented (59 per cent).
- Falls were the major injury cause (33.5 per cent), followed by hitting, striking, crushing incidents (19 per cent) and cutting/piercing (11 per cent).
- Dislocation, sprain and strain injuries were the most common injury type (23 per cent) [Table 21] and the upper extremity was the body region most commonly injured (35 per cent).
- The home is the most commonly specified location of unintentional injury ED presentations (32.5 per cent).
- Residents of postcode 3000 accounted for the greatest proportion of unintentional injury ED presentations (23 per cent).

Profile of **intentional** injury ED presentations among CoM residents (n=709):

- Most intentional injury ED presentations were for assault (72 per cent) and 28per cent were for self-harm.
- The 20-29 year age group accounted for the greatest proportion of intentional self-harm injury ED presentations (51 per cent) and assault injury ED presentations (38 per cent).
- Males were over-represented in the assault injury hospitalisation category (80 per cent) while females accounted for a larger proportion of self-harm injury ED presentations (57 per cent).
- Poisoning by medications was the main cause of self-harm injury ED presentations (42 per cent of intentional self-harm injury ED presentations) followed by cutting/piercing by a sharp object (26 per cent). Being struck by or colliding with another person was the main cause of assault injury (66.5per cent of intentional assault injury ED presentations), followed by being struck by an object (12.5 per cent).
- The home is the most commonly specified location of self-harm injury ED presentations (59 per cent). For assaults, the road/street/highway is the most commonly specified location of injury (25 per cent).
- Residents of postcode 3000 accounted for the highest proportion of self-harm injury ED presentations (25 per cent) and assault injury admissions (29 per cent).

Homelessness profile

Primary homelessness

Data from the 2008-2012 City of Melbourne Street Counts indicate that at least 100 homeless people sleep rough in and around the City of Melbourne. This group of people is predominantly single, male, and Australian born. On average, 40 per cent of those recorded in StreetCount have been homeless for more than five years and many for more than ten years. This suggests the presence of a group of at least 30 to 50 long-term homeless single men who sleep in and around the inner city.
In the 2012 StreetCount, a total of 101 people were recorded as sleeping rough.

Furthermore:

- 86% were male and 14 per cent were female.
- 24% of those sleeping rough were aged 41 – 60; 45% were aged 26 - 40 years old; 11% were aged 18-25; 2 per cent were under 18 years old; 3 per cent were aged over 60 years of age. The age of the remaining 15 per cent was unable to be estimated by observation during the Street Count, or not provided to interviewers by participants
- 88 per cent were alone; 6 per cent in a couple; no children were observed.
- 7 per cent of rough sleepers self-identified as Aboriginal or Torres Strait Islanders compared to 3 per cent in 2011; 12 per cent in 2010 and 10 per cent in 2009.

Table two. Population by housing type

Homelessness type	People on the street	People staying with family and friends	People living in rooming or boarding houses	People in SAAP accommodation
Total	**101**	**118**	**872**	**211**