in the hands of each state and territory. To date only Queensland and Victoria have enacted provisions that address all pools. Both states introduced regulation for large pools and lesser requirements for existing pools with time to comply. In both countries, local councils or authorities are the bodies responsible for practical implementation of the code and any laws through the building approval and inspection processes.

The general approach under building codes is to stipulate performance requirements and the form of words is: ‘barriers to restrict access to young children to the pool and the immediate pool area’. What constitutes such barriers can be clarified by reference to standards or guidelines issued by relevant government departments. In New Zealand such barriers are restricted children under 6, in Australia it is children under 5.

How well are these requirements working?
The Injury Prevention Research Unit was recently commissioned by the New Zealand Water Safety Council to undertake a survey to check on the current state of compliance and enforcement of the pool fencing requirements. A postal survey was responded to by 60 out of 74 territorial authorities and follow up interviews were conducted with 12. Around half (46%) of the pools identified by the authorities were known to comply, 18% were known NOT to comply, and the status of the rest (36%) was unknown. Few authorities had procedures for locating and inspecting pools, apart from the building permit process. Two thirds did not have reinspection programs to ensure on going compliance.

In New Zealand, according to the New Zealand Water Safety Council figures, pool drowning deaths of children under 5 averaged eight per year before the Swimming Pools Act was introduced and four per year in the period since its introduction.

The Australian State of Queensland was the first jurisdiction to require fencing of all pools; existing pools were subject to lower requirements and an extended period within which to comply. There was a substantial fall in the number of child drownings in pools around the time existing pools were required to be fenced. In absolute terms the number of deaths fell from around 13 per year before the legislation (1991) to one in the first year after full compliance was required. Initially this was regarded as evidence of both compliance and effectiveness but subsequent increases in the number of deaths (to around five per year) has resulted in some rethinking. The debate over the introduction of fencing regulations was acrimonious and inescapable and undoubtedly had an educative effect which has reduced over time. The degree of compliance with the legislation is being investigated.

IAN SCOTT
KidSafe Australia, 10th Floor, 123 Queen Street, Melbourne, Victoria 3000, Australia
fax: + 61 3 670 7616
email: ian.scott@geeg.pegase.com.au

DAVID CHALMERS
Injury Prevention Research Unit, University of Otago, Dunedin, New Zealand
email: dchalmers@gandalf.otago.ac.nz

FURTHER READING

LETTERS TO THE EDITOR

THINK FIRST program

EDITOR,—In your June 1997 issue, a notice was published announcing the expansion of the THINK FIRST program to Mexico and Russia (p 83). You included an editorial comment citing a 1995 study which questioned the efficacy of the THINK FIRST high school program,1 and implied that the expansion was ill advised in light of that report.

It is important to note that the paper you cited as being critical of THINK FIRST was actually initiated through our own Foundation. Our Board of Directors realized, early on, that it was important to evaluate this program objectively in order to make modifications that would improve the THINK FIRST underwent dramatic changes, based in large part on the information gleaned from this and other studies.2

Most significant was our shift in emphasis from the high school students to elementary grade children. In 1996, we premiered the THINK FIRST FOR Kids program which is directed towards first, second, and third graders. The program is delivered over six weeks and encompasses basic anatomy, as well as prevention strategies in five distinct areas including: vehicular safety, water safety, sports and recreation safety, bicycle safety, and violence (weapons avoidance and conflict resolution). The program improves national media presentation using animated videos, classroom posters, color and black and white comics, an extensive curriculum manual for teachers with reproducible worksheets, and an online THINK FIRST web site (www.thinkfirst.org). Extensive reinforcement activities throughout the community are also included.

In response to the findings of the efficacy studies on the teen program, we developed new videos, modified the existing presentation, moved toward a more intimate classroom format, rather than large assemblies, and included innovative year long reinforcement activities. Efficacy studies are currently underway to gauge the effects of these modifications, as well as to evaluate the new THINK FIRST FOR Kids program.

Few, if any, programs associated with injuries and deaths have a self scrutinizing and concerned with efficacy as THINK FIRST. This no doubt reflects the fact that the foundation was created by organized organizations, and impacts influential surgeons on its board of directors. With our collective scientific backgrounds, we feel compelled to continue to prove that what we are doing works.

It seems likely fair that the THINK FIRST Foundation should be lauded for its commitment to efficacy and its willingness to modify its approach, rather than be derided on the basis of a single paper published in your journal in the past. Our mission is to prevent injuries and, thus, save lives, and we will continue to pursue that goal undaunted.

JEFFREY M. LOBOSKY
Medical Director, THINK FIRST Foundation, American Association of Neurological Surgeons, 22 South Washington Street, Park Ridge, IL 60068-4287, USA