Auckland Regional Community Action Project on Alcohol Evaluation Report

Final Report

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Executive Summary

Project Background

- The Auckland Regional Community Action Project (ARCAP) is aimed at reducing alcohol-related harm for young people in the Auckland region. It began in 2001
- The Regional Alcohol Project (RAP) group is comprised of the Auckland Regional Public Health Service (ARPHS), Alcohol Healthwatch (AHW), Safe Waitakere Alcohol Project (SWAP) and Hapai Te Hauora Tapui. Their activities are funded by the Ministry of Health (MoH). The intention of the project was to increase collaborative links between these MoH funded agencies and with other key stakeholders in the region
- Formative, process and impact evaluation has been provided to the project from July 2002 to June 2005 by the Centre for Social and Health Outcomes Research and Evaluation (SHORE) and Te Ropu Whariki from Massey University
- ARCAP was developed in response to increasing trends in youth drinking and related harm, the need to optimise limited resources and a requirement for the evaluation of alcohol-related public health service provision in the Auckland region
- Auckland survey data had shown increases in the quantities of alcohol young people were drinking, the frequency of drinking and reports of alcohol-related harms from young drinkers
- These increases had occurred in a liberalised environment where the availability and promotion of alcohol had increased substantially
- While public health alcohol providers had worked together on an ad hoc basis there was no joint strategic plan for the utilisation of evidence-based approaches to reduce alcohol-related harm in the region
- At the start of the project alcohol issues were not designated as a high priority for new funding by the MoH. The only possible resources for enhancing alcohol-related public health activities came from a dedicated evaluation budget. This was used for the development of this evaluated regional community action project in order to encourage the use of evidence-based environmental strategies by the RAP providers
- The MoH-funded providers were brought together in 2001 to share information about current activities and further develop a collaborative and strategic evidence-based approach to preventing alcohol related harm
- Five objectives were developed by RAP, the funders and the evaluation team. These were to:
  1. Reduce social supply to under 18s
  2. Reduce access to off licence purchases by under 18s
  3. Reduce on-licensed premise intoxication of under 25s
  4. Reduce drinking and intoxication in public places
  5. Challenge the marketing of alcohol to young people in a way that contributes to changing the existing social norms of alcohol use

Evaluation Design

- The evaluation is a single case study design and a combination of qualitative and quantitative methods have been used to collect data
- The evaluation includes formative, process and impact components. The aim of the evaluation is to assist with the development and implementation of evidence-based strategies; document and analyse project processes and progress; and determine the impact of these strategies on five specific objectives and the overall objective of reducing alcohol-related harm for young people in the Auckland region
- Recommendations were made in each evaluation report. A number of these have been implemented including the appointment of a project coordinator and development of Terms of Reference. However, others have not, largely due to lack of commitment to the project on the part of managers and workers, changing staff, competing priorities and lack of continuity in the coordinator position.
- In March 2003 the providers were contracted to direct 70% of their work towards the five objectives

Formative Evaluation Input (for 2004-5 reporting period)

- The formative evaluator had a positive relationship with the RAP group and a productive working relationship with the project coordinator (during the period in which she was employed) and they worked together with RAP members to improve RAP planning processes
- The formative evaluator gave information and advice to individual providers regarding general planning and evaluation issues as well as specific strategies
- The formative evaluator was also involved with pre and post planning for all three of the pseudo patrons surveys. In 2004 detailed assistance was given to RAP members for the development of best practice guidelines for monitoring off-licence premises but this initiative was not pursued by the group
- Formative evaluation input was given to the exit survey project. The formative evaluator worked with RAP members and other SHORE researchers on survey design and safety issues. Assistance was given with the dissemination of exit survey findings and with planning follow up activities
- Research advice and input were provided for submissions from individual RAP providers regarding Auckland City's Alcohol Strategy and for a RAP submission to the LLA in support of a District Licensing Inspector (DLI) from Auckland City
- Feedback was provided for the preparation of the RAP presentation at the Working Together Conference in March 2005

Progress Towards the Five Objectives

- The RAP group has worked collaboratively on Objectives Two (to reduce access to off-licence purchases by under 18s) and Three (to reduce on-licensed premise intoxication of under 25s)
- In the current reporting period this involved follow-up activities to the 2004 pseudo patrons survey and planning and dissemination of the exit survey findings
- Three pseudo patrons surveys have been undertaken by SHORE and Whariki on behalf of the RAP group

- The surveys involve 18-year-old "pseudo patrons" visiting approximately 250 randomly selected off-licence premises in the Auckland region. The pseudo patrons attempt to purchase alcohol without age verification from bottle stores, supermarkets and grocery stores. Each premise is visited twice, once by a male and once by a female. Data collection took place over three successive weekends
- The RAP group has undertaken a range of follow-up activities including media launches, development of a newsletter for licensees and workshops with stakeholders and dissemination of data to Liquor Liaison Groups (LLGs)
- One exit breathalyser survey was conducted by SHORE and Whariki on behalf of RAP in 2004 (results launched in June 2005). The survey investigated breath alcohol levels and assessed intoxication of people under the age of 25 years exiting on-licence premises (nightclubs, taverns and rural hotels) in the Auckland Region
- The RAP group organised a media launch of the results and there are plans for further follow-up activities
- RAP providers have worked, individually, together (but not specifically as RAP) and with external stakeholders on other activities aimed at reducing social supply, reducing drinking and intoxication in public places and influencing or challenging the marketing or promotion of alcohol
- External stakeholders have also conducted both regional and local enforcement operations including Controlled Purchase Operations (CPOs) and operations targeting drink drive and intoxication at on-license premises

RAP Coordination, Planning and Evaluation

- Over the last three years this project has only had a dedicated coordinator for an eight month period. The positive impact of the coordinator was acknowledged. A number of barriers to effective RAP coordination were also identified. There is a lack of agreement amongst the RAP managers about the future coordination of RAP. Some participants thought that more work needs to be done to ensure there are solid supports in place for a new coordinator
- There has been a high turnover of managers since the beginning of RAP with only one of the original RAP managers remaining. Management meetings have not been held on a regular basis and the varying levels of manager involvement in RAP has created challenges for the project
- Although strategic and action plans have been developed by RAP many of the initiatives have not been implemented. There was a lack of support from RAP providers for a common planning template
- Some participants expressed concern that the evaluation findings would not be considered when decisions were made about the future of RAP. The value of formative evaluation assistance was mentioned by some RAP members. The importance of internalising evaluation components into ongoing RAP activities was also mentioned
- The potential of initial connections made between the Responsible Auckland Region Project (RARP) (a project aiming to reduce alcohol-related crime and other harms) and RAP was acknowledged. Some felt that greater clarity about the purpose of RAP and an increase in dedicated resources would enhance the ability of the group to work with external agencies

- Some RAP members did not support the use of RAP funds for a local community action project, the Waiuku project, as this is not a regional project

Impact Evaluation Data

- There is evidence that the activities of the RAP group (and the response to these by external stakeholders) has led to some improvement in age verification practices
- There is evidence of a sustained improvement in age verification in two of seven territorial authority areas
- There is evidence of a sustained improvement in age verification in one type of premise, that is, supermarkets
- There is evidence that the pseudo patrons surveys and their media coverage have influenced police policy and practice
- There is evidence that RAP providers are now placing a stronger emphasis on environmental strategies (as opposed to educational initiatives) since the beginning of the project
- There is evidence of structural supports for collaboration between the four public health providers in the Auckland region
- There is evidence of some regional collaborative work by the four providers (however, this does not at this stage comprise the bulk of their activities)
- Routinely collected statistics on alcohol related harm were analysed to provide contextual information on trends in the time frame that included the ARCAP project (1996 – 2004). They were not expected to show evidence of impact of the ARCAP project given its timeframe

Conclusion

- There is evidence in this report to suggest that the ARCAP project has resulted in some changes in provider activities aimed at alcohol harm reduction, specifically in collaborative activity in relation to the objective of reducing off-licence purchases by those under 18 years and, to a lesser extent, to the objective of reducing intoxication on licensed premises
- This collaborative activity resulted in some positive changes to the alcohol environment including some improvement in age verification policies and practices
- There is also evidence of some structural change within the health sector, including revision of contractual arrangements with the funding agency, provision of a coordinator's salary and development of some tools for collaboration
- The responses of external stakeholders, such as the police and licensing sector, to the collaborative activities and structural change show some impacts on their practices, for example in CPO activity
- Given the difficulties inherent in: reorienting existing health sector resource, encouraging more evidence-based collaborative practice, and the competing demands of individual organisations' profiles and organisational cultures, these impacts are encouraging signs

Recommendations

The following recommendations are made on the understanding that the MoH will have support from each RAP provider manager to work collaboratively on regional evidence-based strategies to reduce alcohol-related harm. Without the combined support of RAP managers it is unlikely that the recommendations below can be achieved.

- A new RAP coordinator be appointed as soon as possible
- Key regional priorities and an effective infrastructure for RAP are reviewed and implemented by RAP managers and the new coordinator
- RAP providers continue to develop, implement and review a Regional Public Health Alcohol strategy as a major focus of their work on which their individual alcohol service plans and activities are based
- RAP providers continue to move towards working collaboratively with other initiatives such as RARP and Community Action on Youth and Drugs (CAYAD) at a regional level using evidence-based approaches that are aligned with RAP strategic and action plans
- An agreed planning template is used by RAP providers to align individual provider strategies and activities with RAP regional planning
- RAP providers continue to direct 70% of their activities at the five RAP objectives with RAP planning processes determining priority objectives for specific time periods and collective resource allocation in terms of staff time and shared resources
- RAP continues to use tools such as pseudo patron and exit surveys initiatives to raise awareness and inform activities
- The project would benefit from further formative evaluation support and collection of impact evaluation data, particularly given the gradual progress to date, and discontinuity due to considerable staff changes and the limited RAP coordination role during this period

1. Introduction

This is the final evaluation report for the Auckland Regional Community Action Project (ARCAP). Previous evaluation reports have covered the period from the 1st of July 2002 to 31st August 2004 (Casswell, Huckle et al. 2003; Greenaway, Conway et al. 2005). This report documents the formative, process and impact evaluation findings.

1.1 Project background

The development of ARCAP has been described in earlier reports (Casswell, Huckle et al. 2003). However it is useful to give a brief overview of the context in which the project arose and key events that have occurred over the course of the project.

Several important background factors set the context for the development of this project. These can be summarised as the need to:

- Address the increase in youth drinking and alcohol-related harm through evidence-based strategies focusing on the increased access to alcohol that had occurred through the 1990s
- Optimise the very limited public health resources available in the region through reorientation and collaboration of service providers
- Evaluate alcohol public health service activities (with monies already earmarked for evaluation by the Ministry of Health (MoH)

Alcohol Environment

The impetus for this and other initiatives to reduce youth alcohol-related harm came from growing concerns with the heavy drinking patterns and alcohol–related harms associated with young people's drinking (Habgood, Casswell et al. 2001). The availability, access and promotion of alcohol had substantially increased over the past decade in a progressively liberal social climate (Conway and Casswell 2003). Major changes included the lowering of the purchase age from 20 to 18 in December 1999, as well as the introduction of beer sales in supermarkets and increased licensing hours to include sales on Sundays. There was also considerable concern that police and licensing personnel were not given any additional resources to monitor and enforce the new minimum purchase age.

In response to the emerging alcohol issues and research evidence and clear need to reduce alcohol-related harm for young people, the MoH developed a National Alcohol Strategy (Ministry of Health 2001). This was complemented by a more specific 'Alcohol Toolkit' (Ministry of Health 2001), for alcohol public health service providers. Both the Strategy and Toolkit emphasised environmental and policy action approaches and collaboration between health promoters.

At this time, the MoH was also promoting a 'joined up' philosophy to encourage collaborative intersectoral initiatives between health providers and other sectors. The Toolkit was designed to reorient providers to a more evidence-based and environmentally focused approach and this was followed later by more specific service specifications detailed in their Public Health Service Handbook (Ministry of Health 2004).

In Auckland, the MoH Public Health portfolio manager (alcohol) was aware of the current alcohol research data indicating that alcohol-related harm was trending in the wrong direction, particularly affecting young people in the Auckland region (Casswell and Bhatta 2001; Habgood, Casswell et al. 2001; Everitt and Jones 2002). However alcohol and drug issues were not high MoH priorities at the time and were not receiving new resources other than monies that had already been earmarked for evaluation. There were also greater Government accountability requirements for funding of services to be outcomes-focused.[1] In light of these considerations the MoH manager decided that the best way to effectively address the trends in youth drinking and related harm and to optimise the limited resources available in Auckland was to adopt a more coordinated outcome-focused approach using evidence-based strategies.

In the Auckland region funding for public health activities in relation to alcohol had been spread across four different agencies. These agencies are Alcohol Healthwatch (AHW), a non-governmental organisation; Auckland Regional Public Health Service (ARPHS), the regional public health provider which is part of the Auckland District Health Board (ADHB); Safe Waitakere Alcohol Project (SWAP), an alcohol harm reduction project based at Waitakere City Council (WCC); and Hapai te Hauora Tapui, a Maori public health provider.

Prior to the development of ARCAP these agencies had been operating with a broad MoH service description within which they determined their own work directions and priorities. Collaboration between these providers occurred on an ad hoc basis, usually based around one-off events. There was no joint *strategic* planning for evidence-based regional alcohol harm reduction initiatives. Furthermore, there was no strategic planning (at a regional level) between health, police and councils aimed at reducing alcohol-related harm in the Auckland region.

Evidence from both international studies and New Zealand research had demonstrated the effectiveness of evaluated community action approaches for reducing alcohol-related harm for young people (Holder 2002). Previous community action projects in New Zealand had successfully focussed on encouraging intersectoral collaboration between agencies with licensing responsibilities in order to promote systemic change (Stewart, Casswell et al. 1997). At both the international and national level there is a growing demand for public health programmes to be based on evidence of effectiveness. In the alcohol field this has led international and national researchers to synthesise the available evidence about effective strategies and mechanisms to reduce alcohol-related harm (Hill and Casswell 1999; Babor, Caetano et al. 2003; Loxley, Toumbourou et al. 2004; Casswell and Maxwell 2005). Support for utilising evidence–based community action approaches was strengthened through a visit in 2001 from an eminent international expert Harold Holder, the Alcohol Advisory Council visiting research fellow based at SHORE. He gave a series of seminars featuring the Community Trials project findings (Holder, Saltz et al. 1997) on the effectiveness of community action strategies to reduce alcohol-related harm. The MoH manager had initial discussions with SHORE researchers and Harold Holder

[1] A review of the State sector in New Zealand highlighted the need for more integrated service delivery across multiple agencies, less fragmentation of the State sector and a shift from an "outputs" to an "outcomes" focus (Ministerial Advisory Group 2001).

about the possibility of undertaking a similar but smaller scale project, working with existing alcohol service providers in Auckland to most effectively focus their current resources.

The only actual funding available was some earmarked alcohol evaluation monies as per MoH policy to regularly evaluate its public health programme areas. This was a dedicated budget that could only be used for evaluation purposes and was normally used to evaluate the performance of individual providers. However most of the service specifications and activities undertaken by the four Auckland alcohol service providers were very broad. They were framed in terms of outputs rather than outcomes, with many based around promoting educational events and developing information resources rather than environmental change. It was thought that it would be fairly difficult to demonstrate effectiveness through undertaking individual service evaluations when these services focused on relatively ineffective strategies.

The MoH decided that the most appropriate option would be to encourage the four organisations funded specifically for alcohol harm reduction work to undertake planning as a group to work on specific objectives and collaborative initiatives that could be evaluated. Planning would be evidence-based, informed by current research data, successful elements of community action in previous New Zealand and international projects and would also build on effective activities already underway in the region. The evaluation would include a formative component to encourage the use of evidence-based strategies and maximise the effect of available resources.

The RAP group, evaluators and funders developed five objectives in order to reduce alcohol-related harm for young people in the Auckland region. These are to:

1. Reduce social supply to under 18s
2. Reduce access to off-licence purchases by under 18s
3. Reduce on-licensed premise intoxication of under 25s
4. Reduce drinking and intoxication in public places
5. Influence/challenge social norms (marketing and promotion of alcohol).

From March 2003, providers were required to direct about 70% of their work towards the five objectives as per the MoH Public Health Service Handbook 2003/2004 (Ministry of Health 2004). A focus on these five objectives is also a national requirement for the alcohol health promotion and protection sector.

To date the RAP group has undertaken the following collaborative activities:

- Planning and follow-up activities in relation to three pseudo patrons surveys (2002, 2003 and 2004)
- Planning and follow-up activities in relation to one exit breathalyser survey (2004/2005)
- In 2002 the RAP media group developed a radio advertisement regarding social supply issues for Maori and Pacific parents and caregivers which was played in 2003. Promotional work was also undertaken at community festivals along with a survey on social supply issues
- The Waiuku community action project is funded under the RAP umbrella but is based with AHW who, along with a health promoter from ARPHS, have supported the project. It began in late 2003 and is focused on developing local responses to the five objectives.

1.2 Report structure

This report provides an overview of the evaluation design and an outline of the formative evaluation activities undertaken since the last progress report. This is followed by a report on the progress that has been made towards the five objectives. This section outlines collaborative activities undertaken by the RAP group, individual RAP provider activities and includes information about the efforts of external stakeholders such as the Police and District Licensing Inspectors (DLIs). In Section 4, a number of process issues are canvassed and discussed. These include the coordination of RAP, management issues, planning and decision-making processes, responses to the evaluation, collaboration in the alcohol sector and the future of RAP. The impact evaluation findings are reported in Section 5. The report ends with a number of recommendations, based on the evaluation findings about the future of RAP.

1.3 Evaluation design

The evaluation is a single case study design with measures of aspects of the case, ARCAP, made at several points in time over the course of the project. A case study design is a detailed, in-depth description and analysis of a subject, event or project drawing on multiple sources of evidence. The evaluation uses a combination of qualitative and quantitative methods. Data collected was fed into the formative evaluation (to inform future developments). It has also informed the impact evaluation in order to make judgements about whether changes have occurred and can be linked to the ARCAP project.

For the purposes of the evaluation the acronym 'ARCAP' (Auckland Regional Community Action Project) refers to collaborative initiatives involving key stakeholders working on alcohol-related issues in the Auckland region (such as police and licensing inspectors as well as the RAP group), and the acronym 'RAP' (Regional Alcohol Project) refers to just the MoH funded project group (alcohol public health personnel).

The primary aim of the impact evaluation is to determine the impact of an evidence-based community action project on five specific objectives, with the overall objective being a reduction in alcohol-related harm for young people across the Auckland region. An intermediate aim was to assess the influence of a community action project on the reorientation, deployment and collaborative use of existing public health and related sector resources.

Contextual data on alcohol-related statistics has been analysed and provided for background information. It was not anticipated that these data would reflect the impact of ARCAP over this short time period.

Key informant interviews were conducted over the months of April, May and June 2005. A purposive sample was used for selecting the key informants. Face-to-face interviews with the managers of the organisations involved with RAP and with key informants who had some involvement with RAP were conducted in late April and

May. Telephone interviews with police and licensing personnel from across the Auckland region were conducted in late May and June 2005.

Interviews with RAP members were primarily concerned with the progress and the future of the RAP project, whereas interviews with external stakeholders had a more general focus on the wider alcohol environment. These data, after thematic analysis assisted by Nvivo (qualitative data analysis software), are included in this report.

The service schedules and progress reports from each of the RAP providers were analysed. Information was also drawn from other project documentation such as meeting minutes.

1.4 Previous findings and recommendations

In the second progress report a number of recommendations were made. These are outlined below with a brief commentary on progress made to date:

1. **The designated RAP coordination role should continue and be extended to include wider ARCAP stakeholders**
   The RAP coordinator went on maternity leave in September 2004 and resigned in January 2005. To date a new RAP coordinator has not been appointed although funding for this position has been maintained.
2. **Plans for collaborative RAP projects are developed prior to and incorporated in the development of provider service plans**
   The RAP group has been involved in collaborative activities related to the exit breathalyser survey but not engaged in any other RAP-specific collaborative planning in relation to new activities since the last progress report.
3. **RAP providers use a common planning template to ensure that linkages between RAP activities and service plans are clearly identified**
   No further progress has been made on the further development or use of a common planning template.
4. **RAP managers address time allocation issues so that health promotion and health protection staff prioritise RAP collaborative activities**
   Alcohol Healthwatch continued to take a major role in RAP activities and coordinated RAP meetings after the coordinator went on maternity leave. SWAP did not have a worker for a considerable part of this period but, until their worker left in late 2004, they played a significant role in RAP planning. Their new worker appointed in April 2005 has been a regular participant in the exit breathalyser survey meetings. ARPHS was less involved during the initial part of this period; however they have hosted recent exit breathalyser survey meetings and have taken a more active role during 2005. There have been staff changes at Hapai (who have a small (0.3) contractual role and they have had little involvement with RAP during this period.

5. **Establish working groups or work through the Liquor Liaison Groups (LLGs) (as appropriate) to further involve key stakeholders in the development of activities from the Action Plan such as follow up strategies to the pseudo patrons survey**
   Individual RAP providers have worked with LLGs on activities that are congruent with some of the RAP objectives but these are seen, by the providers, as separate from "RAP".

6. **Clarify and disseminate information about the role of the regional project to external stakeholders**
   No progress has been made in relation to this recommendation.

7. **Continue to identify opportunities to work with key stakeholders on structural changes to improve policies and practices in line with the project objectives**
   The RAP group supported stakeholders in their efforts to include conditions of licenses aimed at reducing access to off-licence purchases for under-18s.

8. **RAP develop project plans for either data collection or other activities with opportunities for media coverage which directly relate to the five objectives so that the group can quickly apply for non-sustainable or ongoing funding when opportunities arise**
   The RAP action plan was successfully used as the basis for applying to the ADHB for non-sustainable funding in 2004, however due to staff changes this funding was not utilised.

2. Formative Evaluation Input

In contrast to some tensions indicated in previous reports there has been a generally positive and productive working relationship between the RAP group and the evaluator over this reporting period. Most of the final six months, particularly during 2005 was spent working with the group on exit breathalyser survey planning issues.

2.1 Relationship with RAP coordinator

The role of the RAP coordinator, Carmen Collie, helped provide a clear direction for the project between February and September 04 and the dynamic of working alongside the coordinator with the RAP group was a very constructive one. As well as attending all RAP meetings where possible, the formative evaluator met often with the coordinator and maintained regular email and phone contact. This involved:

- Provision of input and feedback on different documents (for example the Terms of Reference) that Carmen prepared for RAP
- Input into RAP action planning
- A presentation (at Carmen's request) and referenced handout on evidence-based strategies, based on the project objective and given to the RAP group at a planning day in May 2004.

Joint meetings were organised with Carmen and the AHW, ARPHS and Hapai project managers to discuss current proposed service plans and the activities that would roll out of these to meet the five project objectives. The evaluator also met with the SWAP coordinator to provide feedback on their service plan. As there were a variety of planning formats and it was not always clear how activities in these plans related to the five objectives, examples of objective-based planning templates along with some exemplars were provided to the coordinator. Assistance was provided with drawing up a potential standardized template based on the five project objectives. This was used by one of the RAP providers but others felt they had already spent considerable time on their plans and were loath to use different formats. It was notable that few regional collaborative activities were included in these service plans. This highlighted the need to have the RAP planning finished well ahead of the individual provider service plan development so that overall RAP strategies and activities could be incorporated into the service plans in a strategic and cohesive way. This RAP planning had not occurred in time due to lack of alignment with provider planning dates and the providers giving priority to individual provider plans ahead of regional planning.

2.2 General assistance provided

Specific research and resource material has been provided (often by request) to SWAP, AHW, ARPHS, Hapai and the Waiuku CAP project. This has included information on successful community action activities in the Midlands project[2], sports club initiatives, alcohol accords and their evaluation, alcohol and water safety data

[2] A community action project based in Hawera and Ngaruawahia which encourages the use of environmental strategies to reduce alcohol-related harm for young people. It has been funded by the MoH since 2000 and is evaluated by SHORE and Whariki.

and programmes, alcohol bans, potential parenting initiatives related to social supply, demerit systems for non-compliant licensees and relevant media items.

The formative evaluator and others in the ARCAP evaluation team met with the project coordinator of a local community action project (in Waiuku) when he started to provide him with some direction on planning and evaluation issues. There has been some additional ongoing advice from time to time although this is not technically part of SHORE's ARCAP role. Following a request from AHW (the fundholder for the Waiuku project), an outline of basic evaluation assistance that SHORE could provide independently was provided but this additional evaluation offer was not formally taken up by the fundholder.

The evaluator also had meetings with the SWAP coordinator (to discuss SWAP strategies particularly in relation to the Waitakere City Council (WCC) alcohol policy and strategy development underway) and with Denny Flavell of ARPHS (to discuss evaluation and more effective use of the Pubright cards). Written feedback was provided on the Pubright card.

2.3 Pseudo patrons survey and follow-up activities

The formative evaluator participated in pre and post planning groups for the latest Auckland pseudo patrons survey and urged that follow-up activities be planned regionally with the wider stakeholders. She summarised a number of strategies that could be implemented as collaborative and supportive activities to ensure reduced sales to minors without verification of ID. These helped inform the subsequent plan of follow-up activities that were drawn up by the coordinator to be discussed with wider stakeholders and prioritised for action by RAP group members.

Following the development of smaller working groups committed to implementing selected strategies, there was specific participation and input into a working group focused on addressing barriers and incentives to licensee compliance with age verification practices, including a stocktake on the perspectives of staff members from different premise types. Assistance to this group included:

- Discussion and feedback on the design of themes for informal discussions with licensing trust staff
- Information sought on ID verification practices from the National Association of Retail Grocers and Supermarkets of New Zealand (NARGON). This was unsuccessful despite numerous phone calls and emails
- Information sought from three experienced licensing inspectors and a health protection officer of long-standing. As a result of the information received and other evidence-based literature which supported more ‘stick than carrot’ approaches, the evaluator expressed concern about a need for a change in the working group’s approach with an emphasis on enforcement rather than educative activities
- Feedback on a proposal by a working group member to develop local District Licensing Agencies (DLA) ‘best practice’ guidelines for assessment and screening of licensee applications. Further discussion with the wider RAP group and re-consideration of whether this was the most effective strategy was urged

- Information on mystery shopper[3] strategies was provided for a potential re-development of the DLA guidelines initiative. This was not however picked up by the RAP group and the funding for this initiative subsequently lapsed

Members of RAP participated in a Regional LLG meeting to ascertain what support the statutory stakeholders such as police and licensing inspectors required from RAP to help them improve monitoring and enforcement of licensed premises. Evidence from the pseudo patrons surveys was also presented by a SHORE researcher at a Liquor Licensing Authority hearing. This was in response to a request by the Waitakere police who required evidence to back their case for designation of all off-licence premises in Waitakere city as “supervised” (which means an underage person can only enter the premise if accompanied by a parent or legal guardian) rather than non-designated, open entry.

2.4 Exit breathalyser survey

An initial RAP working group meeting to discuss design and safety issues as well as possible follow-up activities was organised by the SHORE exit breathalyser survey project manager in April 2004. Comprehensive research information on the utility of this type of strategy and protocols relating to safety issues were provided by the evaluation team. Following suggestions by RAP group members, presentations were made to LLG meetings by the exit breathalyser survey manager with a request for input and comment on how it would be conducted and followed-up. As its implementation was delayed no other exit breathalyser survey meetings occurred until October 2004 when the formative evaluator called a meeting to discuss design and resource issues, dissemination of findings and follow-up with key stakeholders. Safety issues were discussed again and the RAP group made the suggestion that the exit breathalyser survey team visiting selected premises comprise three rather than the two people allocated. This meant further resources would be required and RAP undertook to provide the additional monies to ensure the survey could go ahead as planned.

Several meetings followed on specific planning around the launch in 2005. A summary presentation of main findings was provided by the exit breathalyser survey manager to a RAP group meeting in March 2005. Additional information and analysis was requested by RAP group members. This was incorporated into the draft report circulated to the RAP group. A further refined summary of key messages from the survey and their implications was provided by the formative evaluator to the RAP group. In addition, Maori wardens were briefed on the survey findings. Assistance was also provided with the media release for the launch of the survey. The launch of the survey findings was presented by the formative evaluator at the North/West Host Responsibility and Safer Environments Expo organised by ARPHS and AHW. A short follow-up form was provided as a hand out to participants to indicate that there would be follow-up activity and to potentially enlist support for involvement in initiatives such as improving host responsibility practices, increasing compliance with

[3] Mystery shoppers are used by market research companies to assess the degree to which customer service staff members are following store policies and so forth. Mystery shoppers are also being used by some licensed premises to test staff compliance with SoLA and premise policies regarding age verification

the Sale of Liquor Act (SoLA) intoxication provisions and the development of Council strategies to address relevant licensing and planning issues with regard to intoxication. Feedback was also given on a more extensive licensee survey drafted by one of the RAP partners in preparation for further work with licensees from on-licence premises.

2.5 Submissions

The evaluator worked with RAP providers and the RAP group in taking a proactive stance advocating for public health policies to support the RAP objectives within the Auckland region. The two areas addressed were:

- Auckland City Council Alcohol Strategy – Research evidence on policies relating to density, licensing hours, liquor bans and so forth was supplied and although RAP decided not to make a joint submission, there was some discussion between AHW and SWAP as well as SHORE and all three made individual submissions. This has contributed to the Council picking up some of the suggestions made regarding licensing hours (currently calling for further consultation) and an alcohol-free youth event under-writing fund
- Liquor Licensing Authority hearing – RAP was approached by an Auckland DLI to made a submission to oppose a supermarket application to vary the Auckland DLA requirement of Under-25 age verification as a licensing condition. This required collaboration with a key stakeholder, the Auckland DLA. There was substantial work by AHW staff members who were supported by SHORE in preparing a professional case. A member of AHW and the formative evaluator (on behalf of RAP) appeared as expert witnesses in relation to the evidence-based research component of the submission. Although this application was not successful, due to the tight legal constraints under which the LLA operates, the chair of the LLA commented on the quality of the presentations from those involved with RAP

2.6 Conference presentations

Two conference presentations on the ARCAP were prepared and delivered in February 2005, one from the RAP group at an ALAC Working Together conference in Auckland and the other by the SHORE evaluators at the Kettil Bruun Society Community Action on Alcohol Symposium in Mandurah, Western Australia. Their respective presentations reflected the different perspectives from the RAP group members "Working Together is Easy, Yeah Right" and "More burden or more value: Reorienting health promotion services – the challenges of implementing evidence-based approaches in a community action on alcohol setting"

Most of one RAP meeting was devoted to preparing what the ALAC conference paper would cover. This was a useful cathartic process with people identifying some of the difficulties and challenges in the project in a very constructive mode.

3. Progress Towards the Five Objectives

The overarching objective for RAP is to reduce alcohol-related harm for young people through collaborative community action initiatives. There are five objectives for the RAP group. These are to:

1. Reduce social supply to under 18s
2. Reduce access to off-licence purchases by under 18s
3. Reduce on-licence premise intoxication of under 25s
4. Reduce drinking and intoxication in public places
5. Influence and challenge existing social norms (marketing and promotion of alcohol)

This section outlines the RAP groups' regional collaborative activities directed towards meeting these five objectives. It also includes information about the response of external stakeholders to RAP activities. Information is drawn from interviews with RAP members and key informants, provider reports, service descriptions, meeting minutes and other project documentation.

3.1 Reduce social supply to under 18s

The RAP group have not undertaken any collaborative activities in relation to this objective in the last nine months.

Individual RAP Provider Activities

Individual RAP providers have undertaken some initiatives in relation to this objective. As part of the Waiuku community action project run by AHW a public forum was organised in early 2005, with Celia Lashlie (ex-prison manager, author and researcher) as a guest speaker. The forum attracted approximately 260 people with a smaller group staying to discuss parenting issues. The aim of the forum was to instigate a parent support group to address social supply issues. However, follow up meetings have not been well attended despite being well-advertised and promoted.

One of the rationales for establishing the Waiuku project was to feed information about what works at a local level into the regional project. This has only happened on an informal basis to date. One person commented that:

> *I think if we sat down formally and said ok, what are we going to do with this objective* [social supply] *now, then certainly you think we could kind of bring that* [insights from Waiuku] *there and, to learn and to see whether there is any way that could inform and help us develop some alternative strategies* [RAP Member, 2005].

AHW was involved in the distribution of the North Shore Parent Pack information to all North Shore intermediate school principals in 2005. At the national level AHW has advocated for amendments to SoLA to reduce opportunities for social supply (Alcohol Healthwatch 2004).

Some initial work had been done in Waitakere by the previous SWAP coordinator to investigate social supply issues. Licensees had raised concerns about social supply with the coordinator and he was exploring possible strategies that included reconvening the Youth Access to Alcohol (YATA) group. However, he left this position at the end of November 2004 and a new coordinator was not appointed until April 2005. This initiative has been followed up in conjunction with the CAYAD coordinator a separate MoH funded community action project on youth and drugs and there are plans to run the "Think before you buy under 18s drink" and the "Think consequences" campaigns in Waitakere.

External Stakeholders

Very few of the external stakeholders reported specific initiatives in their local areas aimed at targeting social supply. One person reported that local licensees have complained about parents buying alcohol for their children. Another noted that this is an issue that some licensees find difficult to deal with as they are not sure when it is appropriate for them to intervene.

Over the course of the three year project there is no evidence of collaborative activities in the alcohol sector to address social supply issues at a regional level.

3.2 Reduce access to off-licence purchases by under 18s

The RAP group has undertaken collaborative activities in relation to this objective. As reported previously three pseudo patrons surveys have been conducted by SHORE and Whariki on behalf of the RAP group. The 2004 survey results and some of the follow up activities undertaken by the RAP group have been reported previously (Greenaway, Conway et al. 2005). The following section describes the follow–up activities undertaken by RAP after August 2004 and responses from key stakeholders to the pseudo patrons surveys.

3.2.1 Pseudo Patrons Survey

Background

The first pseudo patrons survey was conducted in 2002 and has been repeated in 2003 and 2004 (Huckle, Broughton et al. 2004)[4]. The survey involves 18-year-old "pseudo patrons" visiting approximately 250 randomly selected off-licence premises in the Auckland region. The pseudo patrons attempt to purchase alcohol without age verification from bottle stores, supermarkets and grocery stores. Each premise is visited twice, once by a male and once by a female. Data collection took place over three successive weekends.

In 2002, the total proportion of successful purchases made without ID was 61%. In 2003, there was a significant decrease to 46%. However, this reduction was not maintained and in 2004 there was a significant increase (between 2003 and 2004) in the total proportion of sales made without ID to 56% (Huckle, Broughton et al. 2004). No pseudo patrons survey was undertaken in 2005 as the absence of a coordinator meant that the RAP group had not engaged in strategic planning. Only non-

[4] A full report on the 2004 Pseudo-Patron survey is available on the SHORE website: http://www.shore.ac.nz/projects/pseudopatrons.htm

sustainable funding was available for conducting the surveys and these monies needed to be applied for each year.

Follow-up RAP activities

The launch of the pseudo patrons survey in 2004 was followed by the development of the "Off-the-Shelf" newsletter by members of the RAP group, which was sent to all licensees across the Auckland region. It was also translated into Korean and Mandarin, the first language of many staff in smaller retail outlets selling alcohol.

One key informant thought the development of the newsletter was an example of a successful RAP activity:

> *I think the newsletter that ARPHS and Alcohol Health Watch worked on seemed to me like* [...] *we saw a gap, we filled it, it's a new and quite exciting idea and the translation into a range of languages etc, I thought great it will happen. There was some energy [...]. So I think that was a great success because it was, we outlined it early on, carried it through, it happened and I believe there was going to be follow-on and they'll do it again. It was very exciting* [RAP Member, 2005].

However, other follow-up strategies were not implemented:

> *I think the group did some good solid planning at the beginning of the year that informed what we would do post-pseudo patrons. Then we had another meeting that fine-tuned that a little. I think we had some really good ideas and we had a lot of work to come out of that as follow on from the launch of the information. Some of it went ahead and then it got into a real pickle* [RAP Member, 2005].

The management of the funds to undertake the follow up activities became a problem for RAP. In mid-2004 the RAP project coordinator had successfully applied to a special ARPHS non-sustainable funding pool for additional monies to resource some of the pseudo patrons survey follow-up strategies that had been identified in the RAP action plan. The money was allocated to RAP to work on the following activities:

- undertake a stock-take of identification and age-verification practices for off-licences in Waitakere
- identification of motivators, barriers and solutions for youth accessing alcohol
- development of District Licensing Inspector best-practice guidelines/check list for monitoring off-licence premises

These activities also linked with the strategic plan that was being developed for the Responsible Auckland Region Project (at this stage it was known as the Auckland Regional Crime Prevention and Safety Promotion Initiative (ARCPSPI)).[5]

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[5] This project is a strategic partnership between the four largest local authorities in the Auckland region (Manukau, Auckland, North Shore and Waitakere), and the three Auckland policing districts (Auckland City, Counties Manukau, and North Shore/Waitakere/Rodney). It is focused on reducing alcohol-related crimes and other social harms across the Auckland Region by enhancing enforcement, minimising alcohol-related harm for at-risk populations, minimising alcohol-related harm in high-risk environments and supporting safer communities.

The funds needed to be spent within a short-time period which required quick decision-making. In the middle of this process the RAP coordinator went on maternity leave and the SWAP coordinator took on the leadership of this project, as Waitakere City Council was the fund holder, via a contract with ARPHS. Despite the potential benefits of these projects some RAP members were unhappy at the speed of project development and subsequent changes made to the original proposal. The SWAP coordinator also resigned in the middle of this process. In the absence of a project coordinator the RAP group was unable to reach consensus on an agreed project and WCC cancelled the contract. None of the RAP providers were willing to manage the funds under these circumstances so the opportunity to pursue the identified projects was lost.

The inability of RAP to utilise available resources and in particular to move these projects forward was a source of frustration for some RAP members:

> *Yeah, I think one of my frustrations with the RAP group was* […] *this constant discussion about not having any money, or* […] *lacking a resource. This non-sustainable funding money through regional public health became available and* […] *it was very last minute when the notification or the calls for tenders came in, or proposals and the RAP strategic plan was submitted. And that was the basis under which that decision was made, that we'd identified a number of projects or areas, that we were wanting to work in and that as I understood that was signed off, that strategic plan. When we had that money and were looking at where it could actually be spent there was hesitation I guess or some RAP members wanted to go back and re-litigate the actual purpose of that money. […] I think what we* […] *underestimated was the value in having a RAP coordinator doing so many of those follow up things and being an important communication link within the group itself* [RAP Member, 2005].

Some initial focus groups with licensed premise staff were conducted in Waitakere to identify barriers to effective age verification practices. As far as the evaluation team is aware these data are still held at Waitakere and may be analysed by the new SWAP leader.

The RAP group organised a workshop at the regional LLG meeting in November 2004, to gain more information on the resource issues for external stakeholders. Unfortunately the coordinator of RCPSPI had just conducted a similar workshop in September 2004 with the same stakeholders examining similar issues and there was a subsequent limited response from this group.

In response to a request from an Auckland City DLI, RAP made an objection to an application by General Distributors Ltd to vary the license condition for a Foodtown premise located in downtown Auckland. The Auckland DLA had placed a condition on all new and renewed off-licence and supermarket licenses that staff members were required to request ID from all customers who appeared to be aged 25 or younger. The objection was led by AHW with support from the SHORE and Whariki evaluation team. Evidence of poor age verification practices from the pseudo patrons surveys was presented to the LLA along with information about alcohol-related harm

(Liquor Licensing Authority 2004). The application made by the DLI was unsuccessful.

Taisia Huckle, a researcher from SHORE presented evidence about the pseudo patrons survey results in another hearing before the LLA in November 2004 (Liquor Licensing Authority 2005). The Police wanted to change the designation of off-licence premises from “undesignated” to “supervised” in Waitakere. Evidence from the pseudo patrons survey was presented to support the police claim that age verification practices were inadequate in the Auckland region. Whilst the Authority commended the intent behind the designation they did not think it was a reasonable condition. They noted that evidence was needed about the poor performance of individual licensed premises.

An article covering the first two pseudo patrons surveys and the follow up activities by the RAP group has been published in an academic journal (Huckle, Conway et al. 2005). Another paper about the use of pseudo patron surveys as a community action tool was presented at a conference in Perth in March 2005 by a member of the evaluation team.

As reported previously there was less media coverage of the pseudo patrons surveys in 2004 compared to 2002 and 2003. However, the results of the pseudo patrons surveys were reported in two articles about Auckland City’s new Alcohol Strategy in February 2005 (See Appendix One for analysis of newsprint items).

Individual RAP Provider Activities

AHW have continued to coordinate the LLGs in each area of the Auckland region and they have also convened regional LLG meetings. Their role has provided an important link between the RAP group and external stakeholders. Again at the national level AHW have advocated for amendments to SoLA including the return of the purchase age to 20 years (Alcohol Healthwatch 2004).

AHW have organised host responsibility training for off-licence premises in Rodney and on-license premises in Manukau. They also wrote a letter to support the efforts of the police to change the designation of off-licence premises in Waitakere.

The SWAP coordinator is planning to run pseudo patrons surveys in Waitakere and to use the data gathered to target enforcement activities such as CPOs.

ARPHS staff members have continued to report on licensed premises as part of their regulatory responsibilities under SoLA. Staff members are involved in the planning of enforcement activities with external agencies. New signage about the illegality of sales to minors has been produced for use in licensed premises.

External Stakeholder Follow-up Activities to the Pseudo Patrons Survey

Some stakeholders reported that the pseudo patrons survey results are a useful key performance indicator for regulatory agencies in the Auckland region. One person stated that the pseudo patrons survey results helped to inform decision-making about the monitoring and enforcement of off-licence premises in his area. He noted that one of the reasons the latest CPO targeted grocery outlets was because of the poor performance of this type of premise in the pseudo patrons surveys. He believed that

this type of targeting would not have occurred prior to survey implementation. Another person supported the development of other measures, like the pseudo patrons survey, to provide a benchmark for the performance of licensing agencies.

One key informant reported that one of the follow up strategies to the survey in their area has been to change the designation of licensed premises when they come up for renewal. The designation is changed to from "undesignated" to "supervised". Some licensees have objected to the designation change but when this is the case the DLI opposes the license and the LLA makes the final decision. The key informant reported that the LLA had supported his stance.

Other external stakeholders continue to feel frustrated that they were not told which premises had sold alcohol to pseudo patrons. Some felt that this limited the utility of the pseudo patrons surveys. One key informant stated that the pseudo patrons surveys are a good idea but the "*data provided is hopeless*" and that it is important for DLAs to know which premises sold to minors. He said that he would do it himself if he could get the funding. Indeed, a local Liquor Licensing Group is planning to run a pseudo patrons survey in the next few months in one area of Auckland region. The survey results will be used to target approximately six premises for enforcement action with a CPO. One key informant commented that they had carried out a number of educational initiatives in this area and now it is time for enforcement.

A few stakeholders did not report any follow up activities in relation to the 2004 results.

Controlled Purchase Operations (CPOs)

When RAP began in 2002, CPOs were not conducted on a regular basis in the Auckland region. In 2002, CPOs were conducted in three areas of the Auckland region. To the best of the evaluators' knowledge no CPOs were conducted in 2003 anywhere in the Auckland region. Due to a loophole in the SoLA that needed to be resolved by an amendment to protect minors from prosecution whilst undertaking police CPOs, the police were unable to conduct CPOs between August 2003 and April 2004.

After the 1st of April 2004, CPOs were conducted in North Shore, Waitakere, Rodney, Auckland City, Counties Manukau and Franklin District. CPOs have not been conducted in Papakura in either 2004 or 2005 to date. Respondents from all areas of the Auckland region reported that CPOs are planned for either 2005 and/or 2006 and indicated that these operations would become a routine part of police liquor licensing work.

CPOs were conducted at off-licence premises in one area as part of a wider regional enforcement initiative (Operation Manhattan). However, one key informant mentioned that one of the downsides to this approach was that there was no targeting of problem premises. They said the operation gave the police an overview of the current situation but the LLA prefers CPOs to be intelligence driven. Premises will be identified through information supplied by youth and community services constables and from daily disorder reports.

Other Activities

At the beginning of the interviews with police and DLIs each participant was asked about their concerns about young people and alcohol use in their area. Over half responded that they were concerned about young people's ability to access alcohol.

In one area of the Auckland region a new system for dealing with fake IDs has been introduced. A fraudulent ID noting form has been distributed to licensed premises (as they have expressed concern about this issue). The licensee collects a fake ID, records it and then when they have gathered about 10 they post these back to the police. The envelopes and forms are supplied by the police so this system does not cost the licensees anything. The fake IDs are then sent to the relevant agencies (internal affairs for passports or Land Transport for driver's licenses. As part of introducing the system to licensees the police are recording which premises they have dealt with. When they explain the system to licensees they also take ALAC's host responsibility guidelines and they explain the various provisions. If the Team Policing Unit (TPU) visit the premise and find intoxicated patrons or minors then the police know the premise is only paying lip service to that advice. The Fake ID system is also being introduced to off-licence premises at the request of a large supermarket chain.

Over the course of the RAP project the RAP group has worked collaboratively on a number of follow-up activities arising from the pseudo patrons surveys. External stakeholders have also taken a number of actions such as visiting premises and targeting enforcement activities.

There were no funds available to undertake a pseudo patrons survey in 2005. The evaluation team did raise this issue at a RAP meeting in late May 2005, but the group felt unable to make decisions about future RAP projects. There was also some uncertainty about the degree to which external stakeholders supported pseudo patrons surveys.

3.3 Reduce on-licensed premise intoxication by under 25s

The RAP group has undertaken collaborative activity in relation to this objective. The RAP group was involved with SHORE in the design, piloting and analysis of an exit breathalyser survey in 2004. RAP also organised the launch of the results in 2005. The majority of key informant interviews were conducted prior to the launch of the exit breathalyser survey so only formative and process evaluation data is presented below.

3.3.1 Exit Breathalyser Survey

Background

The idea of an exit breathalyser survey (of patrons exiting on-license premises) was first mooted in early RAP planning in 2003. SHORE researchers suggested that it was a very useful way of collecting local data to inform effective activities to reduce on-licence premise intoxication. International studies have reported that individuals involved in incidents leading to alcohol related harm are likely to have used licensed premises prior to incidents occurring. Such studies recommend that prevention efforts be focused on licensed premises, especially those which continue to serve patrons who are obviously intoxicated (Stockwell, Lang et al. 1993). Addressing on-premise

intoxication has been demonstrated as an effective strategy to reduce alcohol-related crime (Wallin, Norstrom et al. 2003).

The Auckland Region Last Drink Survey Annual Report 2002 had reported that 16% of alleged offenders who named a licensed premise were assessed as having an extreme intoxication level, 8 or higher (on a scale of 1 to 10).) It has also been reported in New Zealand that 17 percent of assaults in or around hotels result in hospitalisation involved people under 20. This illustrates a link between harm, licensed premises and young people (Langley, Chalmers et al. 1996).

There are several offences under the Sale of Liquor Act 1989 (SoLA) regarding intoxicated patrons; however there are currently no formal processes in place to monitor intoxication of on-licence premises to ensure compliance with the SoLA. An exit breathalyser survey was therefore viewed as potentially very useful in both providing data on the current levels of intoxication in the Auckland region and for assisting in assessing the effectiveness of host responsibility compliance efforts across the city.

There was a well-established survey design, with several exit breathalyser surveys using similar methodology having been conducted previously in Fremantle, Sydney and Perth (Stockwell, Somerford et al. 1992; Krass and Flaherty 1994; Lang, Stockwell et al. 1998).

Initially there was considerable resistance from some RAP group members to the concept of undertaking an exit breathalyser survey. This included concern about the safety of interviewers conducting the survey. There were no other funding proposals put forward by RAP members for regional RAP activities in 2004, and the exit breathalyser survey funding bid put forward by SHORE was successful.[6] MoH end-of-year 'unspent monies' were provided for an exit breathalyser survey to take breath samples from patrons exiting on license premises in order to inform and stimulate stakeholder action.

The exit breathalyser survey issue was fraught for some time, given the original conflict regarding safety issues. It was successfully mediated by the newly appointed coordinator and the SHORE exit breathalyser survey project manager who consulted extensively with stakeholders on design and safety issues. RAP safety concerns were addressed with the extensive safety protocol and the RAP group also supported the survey operation by providing additional funding from unspent RAP monies, to ensure each data collection team had a supervisor tasked with maintaining the safety of the team.

The RAP group also met regularly during 2005 to discuss how the exit breathalyser survey findings would be best utilised as per the 2004 RAP strategic plan. Ideas discussed were to organise a launch (at the North/West Host Responsibility and Safer Environments Expo), give presentations of findings to key groups, provide a newsletter for licensed premises, collaborate more closely with other groups including Liquor Liaison groups, ALAC, the RARP, Hospitality industry trainers and explore

[6] The survey design and methodology was approved by the Massey University Human Ethics Committee.

setting up cross-sector working groups to improve monitoring, enforcement and host responsibility practices including a focus on door staff training.

Summary of Methodology and Findings

The Auckland regional exit breathalyser survey was conducted by SHORE and Whariki after consultation with RAP members. It investigated breath alcohol levels and assessed intoxication of people under the age of 25 years exiting on-licence premises (nightclubs, taverns and rural hotels) in the Auckland Region.[7] The selected premise types included those premises commonly referred to as bars and pubs.

Of the 250 premises selected, 111 were open and were eligible; that is, had people aged under 25 years of age exiting the premise. Of the 319 visits to premises, 171 (54%) were eligible visits where patrons who were under the age of 25 were seen inside or exiting the premise. Of the 171 eligible visits, 64% returned valid breath test readings (BTR). Three hundred and fifty BTR were obtained from 403 eligible potential participants, a response rate of 87%. Nine people were excluded from the survey as they were too intoxicated to give consent.

Data collection took place over four successive weekends in 2004 between 10pm and 4am. Two hundred and fifty on licence premises were randomly selected to be visited by the data collection teams. These consisted of: 1) a male field worker who took the breath sample; 2) a female field worker who approached those exiting the premise and conducted a short interview; and 3) a supervisor who maintained the safety of the field workers at all times (following the safety protocol developed for the survey that was based on NDARC interviewer guidelines (Day, Topp et al. 2002) and further developed by consultation with two Health Protection Officers in New Zealand).

Teams stood outside the selected premise and approached the first person or group who exited who appeared to be under the age of 25. Participants were eligible to participate if they were under the age of 25 and had consumed an alcoholic or non-alcoholic drink inside the selected premise. Participants were invited to have a free breath test and to participate in a short interview about alcohol. Both a male and a female breath test reading (BTR) and interview were obtained from each premise where possible.

Overall, results from this survey indicated

- Nearly half of the breath test readings (BTR) for those aged under 25 years in the Auckland region (42%) were over the legal limit for driving (for people aged 20 years and over; 400mcg/l).

- Fourteen percent of the BTR were 600 mcg/l or above. Of these, 12% were between 601mcg/l and 800mcg/l. This is the equivalent to more than six drinks for an average man and more than four drinks for an average woman.[8]

[7] The full report can be found here: http://www.shore.ac.nz/projects/projects_1.html

[8] This calculation is an estimate based on the average weight of a man and woman in New Zealand (Male 80.4; Female 69.7) Ministry of Health (1999). Key Results of the 1997 National Nutrition Survey - NZ Food: NZ People. Wellington. and does not take into account actual body weight of participants. A drink is 15mls of absolute alcohol.

- Two percent of the BTR taken were over 800mcg/l; this is the equivalent of more than eight drinks for an average man and more than five drinks for an average woman.

- The average BTR for men for the Auckland region was significantly higher than the average BTR for women (these averages include BTR readings of zero).

- Over 40% of participants reported that they were moderately intoxicated and approximately 8% reported that they were extremely intoxicated.

- Approximately 34% of participants were rated by data collection field workers to be moderately intoxicated; approximately 8% of participants were rated as extremely intoxicated.

- Fifty percent of premises visited in the Auckland region had at least one patron who showed visible signs of intoxication.

- The average number of drinks that participants had consumed at the premise they were leaving was four. The total average that participants reported consuming over the night was around nine.

- Thirty seven percent of participants reported that they would usually drink more alcohol than they had consumed at the time of data collection.

- Half of the participants who had a BTR of over 400mcg/l were moving on to another licensed premise, 13% of people with a BTR of over 600mcg/l reported they were going to do the same.

- Average BTRs significantly increased over the night.

Media

The aim of the media launch by the RAP group, as with the pseudo patrons media campaigns, was to increase advocacy for improved monitoring, enforcement and host responsibility practices for on-licences as required by the Sale of Liquor Act. A media kit and media release were prepared but there was a fairly low-key approach taken to engaging the media, possibly because the findings were somewhat complex to interpret in simple messages and sound-bites. There was a corresponding low level of coverage; four newspaper articles (in June) including two national and two local items. The RAP spokesperson (from AHW) did four radio interviews. There was no television coverage of the exit breathalyser survey findings

As noted above the survey was launched shortly before the end of the evaluation. Some limited planning has been undertaken in relation to potential follow-up activities such as a newsletter for on-licenses similar to the earlier off-licence newsletter produced following the pseudo patrons surveys. However it is unclear at this stage which of the proposed activities will be implemented and in the absence of a coordinator, there has been no concerted plan of activities drawn up nor tasks assigned or agreed to.

Information about the exit breathalyser survey was presented at the Auckland regional LLG in late June by AHW and at the National Alcohol Health Promotion Workforce Development training run by SHORE and Whariki in Wellington.

Individual RAP Provider activities

ARPHS has continued to report on new applications and renewals of on and club licenses in the Auckland region. Staff members have also been involved in regional enforcement operations such as Operation Manhattan.

ARPHS have distributed 100,000 Pubright cards to a range of organisations in the Auckland region including Maori Wardens, Taxi companies, DLAs, Police and other RAP providers. The aim of the Pubright cards is to raise awareness amongst Maori and other communities about host responsibility services that licensed premises are required to provide under the SoLA; encourage the public to take a community watch/action approach to host responsibility services and to increase opportunities for the public to take affirmative action by completing the cards and sending them to ARPHS. It is not clear how many of the Pubright cards have been completed and returned to ARPHS to report on host responsibility practices at licensed premises.

One RAP member thought that the RAP group could have done more to support the Pubright card initiative:

> *I think there was a lost opportunity with the Pubright cards that Auckland Regional Public Health Service developed with the Maori wardens and then the training that occurred with that, that* [Hapai] *also participated in. Now that was a Maori driven kaupapa in terms of... it was for a particular group of people. It had a kaupapa Maori approach to it you know. Yet, it seemed to the periphery somehow of the RAP project, but really it should have been central to it* [RAP Member, 2005].

A health promoter at ARPHS has been involved in the development of the GR8 sports club initiative which is aimed at improving host responsibility practices at sports clubs. The SWAP coordinator has also been involved in discussions about implementing an accreditation programme for sports clubs in Waitakere. Currently ALAC and ACC are planning to implement a national accreditation programme in early 2006.

A number of external stakeholders and RAP providers were involved with the organisation of the North/West Host Responsibility and Safer Environments Expo, with AHW as the lead coordinating agency. This was an initiative that arose from the LLGs in Waitakere, North Shore and Rodney and was organised outside of the RAP group despite the involvement of three RAP providers. As a result there was limited opportunity for the formative evaluator to have input into the planning of this event and insufficient discussion of how the Expo might have been built upon and also aligned with the RAP strategic plan.

The Waiuku project coordinator has worked with police and the Franklin District Council to increase the enforcement of drink driving. This has resulted in an increased focus on the host responsibility practices of licensed premises in Waiuku. The project

coordinator has worked with licensees to develop a designated driver campaign. There have been reports that the drink drive statistics in Franklin have improved as a result of these activities but these claims are made without any supporting data.

AHW have continued to coordinate LLGs across the Auckland region. Members of the ARPHS health promotion/protection team also attend these meetings.

External Stakeholder Activities

External stakeholders have continued their routine monitoring activities across the Auckland region. The 101 form system, developed by Counties Manukau police, for monitoring and enforcing intoxication at licensed premises is also being used in other areas of the Auckland region.[9] Three stakeholders thought that one downside of the 101 system is that the LLA is now less willing to accept evidence of intoxication from a single police officer or DLI.

In Counties Manukau, the police, DLIs and ARPHS are developing a standard check list for the monitoring of licensed premises. It is hoped that the same checklist will be used by all agencies across the Auckland region.

Another regional enforcement operation was conducted in December 2004 (Operation Manhattan) which involved police visiting on-license premises to check compliance with the Sale of Liquor Act. Police also targeted drink driving using CBT checkpoints. As noted above, CPOs were conducted as part of this operation in Counties Manukau. There was some comment that the targeting of licensed premises could be improved for future regional enforcement operations of this type. One key informant thought that the Team Policing Unit had lower tolerance for intoxication compared to local police officers. Another person believed that ordinary constables needed more training on SoLA so that they could identify breaches when participating in large operations.

A designated driver scheme has been developed through the North Shore, Rodney and Waitakere LLGs and Road Safety. The scheme targets under 25 year old patrons at on-licensed premises. The aim is to both improve host responsibility practices and to encourage young people to plan their night out effectively. Licensed premises participated on a voluntary basis and a range of resources (coasters, posters and T-shirts) were produced with the "think before you drink" message.

ALAC have developed working draft guidelines for the monitoring and enforcement of intoxication at licensed premises. These were distributed to agencies interested in trialling them in early May 2005.

A number of external stakeholders mentioned the North/West Expo as an example of local activities to reduce intoxication at licensed premises. In one area the DLI had been involved in the delivery of health seminars for licensees which focused on effective age verification practices and general information on SoLA.

[9] See Greenaway, S., K. Conway, et al. (2005). Auckland Regional Community Action Project on Alcohol, Evaluation Report: Progress Report Two September 2003-August 2004. Auckland, Centre for Social and Health Outcomes Research and Evaluation and Te Ropu Whariki**:** 1-52.

One external stakeholder thought that host responsibility practices at sports clubs needed to be improved. In particular, he believed that there needs to be more training for committee members.

3.4 Reduce drinking and intoxication in public places

The RAP group has not undertaken any collaborative activities in relation to this objective.

Individual RAP Provider Activities

In 2004 the SWAP coordinator and other members of the Safe Waitakere team worked with a range of stakeholders to address problems associated with Guy Fawkes celebrations in Langholm. In the previous year there had been a riot involving excessive alcohol consumption by young people and adults. They also worked with local business owners to address concerns about drinking in the Glen Eden and Titirangi town centres.

AHW have provided general advice to councils about Alcohol Strategies which includes information about the management of drinking in public spaces.

External Stakeholder Activities

Some key informants expressed concern about the impact of the Smokefree Environments Act amendment that banned smoking in licensed premises. They reported that the number of people drinking outside licensed premises has increased as a result.

Liquor bans are currently operating in a number of areas of the Auckland region including Auckland City, Waitakere City, Manukau City, Rodney District and Franklin District. North Shore City has also introduced a bylaw allowing temporary liquor bans to be implemented.

3.5 Challenge the marketing of alcohol to young people in a way that contributes to changing the existing social norms of alcohol use

The RAP group has not undertaken any collaborative activities in relation to this objective.

Individual RAP Provider Activities

AHW produced a briefing paper on alcohol marketing which updated an earlier policy paper on alcohol advertising. They have also been actively involved in the Group Against Liquor Advertising (GALA). The activities of this group have led to an agreement from the Ministerial Committee on Drug Policy to review the regulatory regime for alcohol advertising. AHW have made a number of complaints to the Advertising Standards Authority (ASA).

The SWAP coordinator has done some initial work on Waitakere City Council's internal policies about host responsibility and sponsorship of events.

External Stakeholder Activities

No external stakeholders mentioned activities in relation to this objective.

3.6 Other RAP activities

The RAP group was consulted in relation to the Draft Waitakere Alcohol Strategy in early 2005. The RAP group also presented a paper about the RAP project entitled "Working Together is Easy—Yeah right" at the Working Together Conference in March 2005.

4. RAP Coordination, Planning and Evaluation

4.1 Project coordination

While funding was sought from the outset there was no resource available for a coordinator at the start of this project and this was acknowledged as a major flaw in the structural support needed to sort out key establishment issues such as project processes, planning, priorities and communications. The dynamics of this project became increasingly difficult without formal coordination. In an effort to keep the project focused and moving the MoH manager and formative evaluator took on this responsibility with accompanying resentment expressed from some about their level of input (Casswell, Huckle et al. 2003). When an experienced alcohol health promotion project coordinator was employed, project cohesion and function improved but there were still unresolved issues for a number of RAP members with regard to the purpose and structure of the project and the required focus on the five objectives (Greenaway, Conway et al. 2005).

The coordinator went on maternity leave in September 2004 and in January 2005 decided not to continue as project coordinator. No replacement coordinator was appointed and AHW staff acted as de facto coordinators from September 2004 to May 2005, despite the coordination resources remaining with ARPHS. If AHW had not taken on this task, collaborative activity may not have continued, for example the exit breathalyser survey launch by the RAP group. From May 2005 an ARPHS staff member organised RAP meetings. This meant that RAP continued to meet on a regular basis. Funding has been in place for a coordinator since late 2003 however over the three year project RAP has had a designated coordinator for only an eight month period.

The coordination role

A number of key informants commented that the experience and skills that the project coordinator brought to the RAP group were valuable as the following comment indicates:

> ***How do you think the* [project coordinator] *contributed to RAP?***
> *Absolutely fantastically. I think that it was difficult for her to come up with the terms of reference, which she did and then she developed a strategic plan with the kaimahi and developed an action plan. Every time I read it I think as an organisation, yes we can go with this and we can build our planning around this* [RAP Member, 2005].

One respondent recognised the value of the coordinator and felt that the job should be expanded to full time.

> *That the coordinator was great for driving the group, she was the central point of contact for the group; if anyone wanted to find out who this RAP groups was and what we were doing, and I think that that coordination capacity should be built up to full time, if they are to continue with a top down model of having to work together and needing a dedicated resource there.* [RAP Member, 2005].

Coordination role in relation to external collaboration

An external stakeholder commented that a single point of contact for the RAP group was valuable:

> *The work that I was focused on at that stage was police and TAs. So the background that I had suggested that they were two parts of a triangle and that the missing part was health, so liaising with Carmen was a good way of getting engagement with the various public health agencies that RAP was the umbrella organisation for. So it was one avenue with multiple outcomes, if you like […] the position was important in that it provided a single step into those agencies and a single voice.* [External Stakeholder, 2005].

Limits or barriers for effective coordination

There were a range of views expressed about the coordination of the RAP group by key informants.[10] A number of key informants thought that the coordinator position could have received more support from the RAP provider managers. Some felt that the coordinator would benefit from backing from a single lead agency rather than being located in the agency which held the funding for that position:

> *[T]here is a huge difference between being a fund holder and if you like a project leader. And I think one of the fundamental problems with RAP and I've seen it with other regional coordinated projects is that to make it really work well, it has to have more than just a fund-holder sort of sponsoring a coordinator, who just hangs in the ether. I think you have to have a lead agency that supports that person. Albeit, reporting to, working to, you know a steering group or whatever* [RAP Member, 2005].

Although, there was some consensus on the need for a lead agency, there was considerable lack of agreement about which agency should provide this service. This was a major tension in the RAP group particularly at the management level.

Resistance to collaboration

The resistance to collaboration between RAP members continued to be expressed in this round of interviews:

> *I think it is an artificial construct, RAP, and it is not working because it is not an organic network, it is being forced from top down to achieve goals that would be better achieved through other means* [RAP Member, 2005].

According to this person, the MoH could have given clear directives about what was wanted to each of the provider organisations rather than fund a coordinator position. This person thought that coordination was only necessary because of previous decisions made by the MoH to fund four different providers (rather than one) to undertake alcohol health promotion work in the Auckland region.

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[10] The interviews with RAP provider managers were conducted shortly before and after the Ministry of Health sent a letter informing the managers of decisions made about how RAP funds were to be spent and which provider would manage the RAP co-ordinators' position.

Another person thought the diversity of the individual providers created difficulties for collaboration because they differ in size, level of dedication to alcohol issues, funding, structures and strategic direction.

Group Dynamics

One manager was more closely involved in RAP and has attended the majority of meeting whereas other managers have not had such a "hands on" role. This created difficulties for some as this person was able to make decisions on behalf of their organisation whereas none of the other RAP participants could. Furthermore, one person thought that other RAP members would be less likely to challenge a manager's viewpoint or offer an alternative perspective. As a result some felt that RAP meetings were dominated by one individual's viewpoint.

In one respondent's view, the personal style of one of the RAP members significantly limited the ability of the RAP group to move forward. This was also thought to have affected the coordinator's decision not to continue in the role:

> *I just have huge accolades for the previous coordinator. I said to her that I was quite saddened to hear that she was not wanting to continue that role. I understand it was about the dynamics. I think that's an issue that us as managers, SHORE, and the Ministry need to look at and say well what is the issue and address that, because I think we've lost someone who was really good* [RAP Member, 2005].

Future of the Coordination Role

At the time of the key informant interviews three of the four RAP provider managers wanted the resources for RAP coordination to remain with ARPHS. The other manager felt that coordination should be done by their organisation. The difference in views amongst managers about the future of RAP coordination and which agency should be responsible for managing it had, not surprisingly, created tension at the time the interviews were undertaken.

4.2 Management issues

Concern over the power dynamics and difficulties with decision-making arising from the involvement of workers, managers and the funder at RAP meetings led to the development of separate managers' meetings as recommended in the first evaluation report. Several management meetings have occurred. However, not all RAP provider managers have attended every meeting. One person thought the management meetings were not very productive because not enough time was allocated to resolve contentious issues. Also one meeting was held shortly before the departure of the project coordinator and another before the departure of the MoH portfolio manager which meant that key people were not available to follow up on outstanding issues.

Some RAP members felt that the provider managers need to be more closely involved in RAP:

> *I think the managers do need a greater role. It's up to them to manage RAP, to set some goals, and for staff to actually follow through with some stuff, rather*

than everything being put down on to the whole group for consensus and everybody involved in everything. [RAP Member, 2005].

Another issue facing RAP is the high turnover of many of the personnel that have been involved in the project. Only one of the current RAP provider managers was involved at project inception. The MoH portfolio manager, a key driver for RAP, left her position in early 2005.

4.3 Planning and decision-making processes

Shortly before her departure in September 2004 the RAP coordinator facilitated the development of RAP strategic and action plans. As noted above, some RAP members thought these plans provided a solid basis for future joint RAP planning.

However, in the absence of a coordinator many of the strategies identified in the RAP action plan have not been implemented. For example, with reference to the exit breathalyser survey one person commented:

> *We've got this really good information but how are we actually going to follow up with some meaningful interventions that we can achieve […] and giving information, sharing information with people is one strategy, but you can't just leave it there* [RAP Member, 2005].

The need to involve external stakeholders in RAP planning processes was mentioned by some key informants. In particular, aligning RAP activities with the priorities of regulatory agencies was seen as something that would enhance the effectiveness of RAP.

One key informant thought that a lot of work had gone into the development of the five objectives and that they provided a solid basis for the future work of the RAP group.

Over the three-year project the MoH had an ongoing focus on refining provider contracts to be more specific and consistent. However, despite this some felt that there had been a lack of clear direction and inconsistent messages from the MoH about what each provider should be doing:

> *I mean really I think it's the Ministry that needs to be clear about what it is purchasing and what it actually wants to do.* [RAP Member, 2005].

However, other RAP members supported the MoH portfolio manager's efforts to get RAP providers to work together on evidence-based objectives and were quite clear about what the focus of RAP should be:

> *My feeling is that you know personally I believe in the value of working together. I would personally do it anyway […]. So to me, in some ways, if it's an accountability mechanism where the Ministry demonstrates that it is spending X amount of money in the Auckland area and it expects people to do it that way, it doesn't personally worry me, I think it's fine. But I'd say that there are organisations within RAP that perceived it as an imposition. I'd*

> *also say that there are some organisations within RAP that don't have the clearest strategic vision of their role within the group* [RAP Member, 2005].

One person thought that the involvement of university researchers (the evaluation team) enabled the group to undertake collaborative activities:

> *Well it gave RAP credibility, by being aligned with a university and a research centre. That was the main one. Also because there was funding to do projects, as well, which was fairly important. So it gave people something to focus on to actually do, as opposed to looking at project plans and schedules and going, what shall we do next* [RAP Member, 2005].

One person thought that RAP processes were not Maori-friendly even though a number of Maori workers have been or are involved. This comment was made in relation to the ways in which decisions were made about which projects the RAP group decided to work on. This person felt that, for example, the Pubright card project was an opportunity for RAP to support a project that was developed with a Maori kaupapa and engaged with Maori stakeholders.

One RAP manager did not see any point in their organisation focusing on the five objectives. Another manager did not want to be involved in what they saw as a frustrating process.

One key informant commented that even though the RAP objectives were supposed to comprise 70% of the core business for each provider's alcohol component, it never felt that that amount of the resource had been allocated.

4.4 Responses to the evaluation

One person thought that the second progress report did not accurately reflect the views of RAP members and presented an overly positive picture of RAP. Another person thought that apart from the recommendation for a planning template the report was fair.

The value of the formative evaluation input was mentioned by some RAP members and they found the input about evidence-based strategies constructive.

Some felt that evaluation components needed to be incorporated into ongoing RAP activities. In particular one key informant thought that it was important for all RAP providers to critically reflect upon what role they play in reducing alcohol-related harm in the Auckland region and whether or not their efforts were effective.

Some key informants were concerned that there is no process in place to enable the evaluation findings to be considered when decisions are made about the future of RAP:

> *From a RAP perspective I think it would be really useful and one of the things that we talked about with the Ministry was that we really need to sit down with the evaluation, we really need to sit down with our own feedback and respond*

to that. We need to actually focus on the learning around it and I haven't seen any commitment, from anyone to do that [RAP Member, 2005].

4.5 Alcohol sector collaboration in the Auckland region

An external stakeholder thought the RAP model was a good way of enhancing collaboration between public health providers and other agencies in the alcohol sector.

I think RAP as an umbrella vehicle for a range of public health agencies is quite a good idea, because otherwise looking at it from the point of view of police and local authorities there is a perception of chaos, well who are these tiny little players, you know they all have quite discreet areas of interest. So to have an umbrella body means that they suddenly have a critical mass and a shared focus [External Stakeholder, 2005].

One RAP member saw the linkages developed between RAP and the regional crime prevention project (now RARP) in mid 2004 as illustrating a good link with external stakeholders:

It was the most, well profitable, yes the fact that the outcome of them having the same plans as us, we were all moving in the same direction [RAP Member, 2005].

The coordinators of each project had been in close contact and made an effort to ensure that the plans for each project were complementary. Unfortunately both coordinators had left their positions by the end of 2004 and in their absence strategic linkages between these external agencies were not pursued. AHW has made some links with the new RARP coordinator but it is unclear whether RAP as a group has shared in this information.

Resource Issues for Collaboration

Barriers to collaboration because of perceived limited resource were voiced from both RAP members and external collaborators:

I think it's one of those areas, where we keep going around in circles in terms of engaging with external stakeholders and you know if we ask them or encourage them to do stuff on off-licences and they can't do stuff on on-licences and so you know, apparently they know about the exit survey, so we're obviously going to end up drawing them away from off-licences because of, we might want them to put their focus on on-licences and so it's a constant battle, actually. And I think it's that resourcing issue across the region that is a significant barrier [RAP Member, 2005].

An external stakeholder commented that the effectiveness of the coordination position would have been enhanced by additional resources:

The financial costs and opportunity costs of encouraging multi-sector partnerships are large and when your time is consumed by administration, bureaucracy, you know, multi-sector management, you need to be able to

almost recoup that time with money to increase the reach of your interventions [External Stakeholder, 2005].

A number of people thought that the internal difficulties with RAP reduced the extent to which RAP interacted with external stakeholders:

> [I]*f there was a failure in RAP* […] *I think it was that we were maybe too inward looking and I don't think we built great relationships outside with the key stakeholders.* […] *I think we wanted to get our own ducks in a row before we actually started talking with others. The fact was that we could never get them in a row. So we didn't venture out and work with others much* [RAP Member, 2005].

External stakeholders (police and licensing personnel) were asked if they had had any involvement with RAP. Some mentioned that they had been consulted about the exit breathalyser survey. Others were aware of RAP but reported that they had had no direct involvement. Key informants reported that a regional focus on reducing alcohol-related harm amongst DLAs and the police is lacking in the Auckland region.[11] It appears that DLIs and police deal with individual agencies in their specific areas. Others confused RAP with another regional project addressing alcohol-related harm (Responsible Auckland Regional Project-RARP).

4.6 Future of RAP

RAP members were asked for their opinions about how they would like to see RAP operating in the future. One informant emphasised the need for good support to be in place before a new project coordinator was employed:

> *[Before a project* [coordinator] *was re-employed* […] *maybe some structural stuff* [needs to] *be done to support it a little more, that's something around the stuff I was saying about MoH getting it right at their level. Looking at all the diverse structures of the providers and trying to make a way that they can work together, more effectively that's going to work for each of the organisations involved. There's a lot of work to be done around that. That's about the managers of each of the provider organisations stepping up and really having some good quality input there* [RAP Member, 2005].

Other key informants expressed opinions about the future of RAP. One external stakeholder though it was important that RAP had resources (that is funding to undertake projects) in order to match the contributions from other agencies (such as police and TAs). This would enable RAP to be involved with external partners in projects aimed at reducing alcohol-related harm in the region. For example one key informant made the following suggestion for the future of RAP:

> *Use it in an evidence-based way to focus on the most opportune realistic and achievable way of reducing the burden of harm and then that means lining up with what police and TAs are doing, which by default means a focus on compliance. That means that we're doing all those things that health wants to do anyway, like reduce supply and minimise inappropriate demand and yes*

[11] The interviews were conducted at the same time that RARP was being resurrected.

get everybody moving in the same direction. […] *But you know stop all this waffling around with other bits and pieces of money and put some money into actually make this a viable thing and if that means employ a coordinator, well yes, employ two, but give it the opportunity actually to have some traction and to be able to come to the party with other powerful agencies who in the past have been very wary of health, because health is perceived to have a really soft and fuzzy agenda that doesn't fit with the more clear business drivers of the other two sectors* [External Stakeholder, 2005].

One person who had been involved with RAP thought that the project needed a higher profile across the Auckland region in order to establish good working relationships with external stakeholders:

Then the external stakeholders once they know what RAP actually is, then they can utilise it, they can say look we need funding for this, or would it be useful if you could run this project, because we don't have funding […] if they see RAP as a resource to use, to go and do projects through RAP, then it will actually be useful to them [RAP Member, 2005].

4.7 Discussion

This project has attempted to pursue an ambitious programme of work largely by re-focusing existing resources, albeit with some additional ongoing resources for provider organisations and one-off funds for evidence-based initiatives such as the pseudo patrons and exit breathalyser surveys. It is also important to acknowledge that the challenges faced by RAP are common to many collaborative endeavours. As Huxham notes:

[T]he output from collaborative arrangements often appears to be negligible or the rate of output to be extremely slow. Even where successful outcomes are reported, stories of pain and hard grind are often integral to the success achieved (2003:403).

The overall goal from the funder's perspective was to optimise the effectiveness of existing MoH-funded alcohol harm prevention services in the Auckland region. The project developed had two key aims:

1. To reorient the overall approach of the four alcohol health promotion providers towards more strategic and collaborative approaches i.e. from working as individual service operators, largely on educational activities, events and resources to working collaboratively on regional evidence-based initiatives focusing on environmental strategies
2. To develop a collaborative plan of action based on agreed evidence-based objectives.

There were inevitable tensions and resistance to the changes that this project strived to create. The process of organisational change is always challenging and the changes required in organisational culture, focus and operation in undertaking this project understandably stretched providers, particularly those with a more educational rather than environmental focus. Furthermore resistance could be expected to the re-

orientation of services to a more evidence-based and collaborative regional strategic approach when, in the past, they were used to operating within fairly broad service descriptions within which they determined their own work directions and priorities.

Not all the services were then or are even now convinced of the benefits in re-focusing most of their efforts as a collaborative entity and also on the objectives identified. This is compounded by the very different mix of organisations involved and varied backgrounds, experiences and skills of staff. There were evident differences at the start around reaching a shared understanding of the purpose of the project and the community action approach. There were also concerns that are still evident about the feasibility of achieving some of the selected objectives to reduce alcohol-related harm.

Managers play a critical role in a multi-agency collaborative project in ensuring buy-in and commitment to the success of any project. Their support in aligning work-plans, allocating and directing resources (people and material) for collaborative activities, and maintaining communication at the managerial inter-agency level was identified early on as essential to project development and success. Notably there has been a change in managers at nearly all the providers over the project duration and substantive staff turnover at most of these as well.

Concerns about the scope of the project, the resources available to it and the 'extra work' involved in addressing the RAP objectives, as identified in earlier reports, have continued amongst the RAP group providers. This has led to a lack of full engagement with the project and has meant the five objectives have largely not been achieved apart from the objective of reducing access to off-licence purchases by those under 18.

The importance of a dedicated coordination (or "strategic brokerage") role for collaborative community action projects has been identified by a number of researchers (Casswell 1999; Conway, Tunks et al. 2000; Huxham and Vangen 2000; Laverack 2001; Moore and Holder 2003; Craig and Courtney 2004; Greenaway and Witten 2005). The coordination or project management role is a vital one for community action projects as it provides the direction and drive required to keep them on track (Casswell 1999; Moore and Holder 2003). It is particularly important for new projects with new approaches to have people in these roles who are familiar with the issues and have planning and organisational skills (Conway, Tunks et al. 2000). Whilst an experienced and skilled coordinator is an essential asset, they require good levels of resource and support in order to be effective (Huxham and Vangen 2000).

The need for a project coordinator was identified at the outset of the project and some of the difficulties with project establishment would have been dealt with more effectively if this dedicated role had been in place. There was certainly a perceptible shift in more collaborative planning activity by both RAP and its key stakeholders following the appointment of a coordinator in February 2004. Improved relationships, project direction and collaborative planning occurred during the time that the coordinator was employed. There was clarification of the project purpose, respective roles within the project and attention to maintaining a balance with process as well as tasks. The coordinator's role made a significant difference in facilitating group cohesion, providing a much tighter focus on the project objectives, collaborative

activities and aligning individual service plans and activities with more evidence-based strategies. This represented a move away from some of the less effective and previously prevalent personal health/health education approaches.

The new spirit of active co-operation continued after the coordinator left with a collaborative focus on the exit breathalyser survey. However this did not extend to other activities and the absence of a coordination role left a definite coordination and communication gap once again with some opportunities falling by the wayside, including the innovative initiatives that had successfully attracted ARPHS monies. Since the coordinator's departure there has been a slow-down in overall project momentum with no further work on the initial Action Plan developed by the RAP group other than in relation to the exit breathalyser survey. There is no longer a pivotal point for collaborative activity such as with the exit breathalyser survey or pseudo patrons surveys and it is questionable whether the project will retain any cohesion or collaborative direction without a coordinator in place and full management support from all of the providers.

5. Impact Evaluation

The primary aim of the impact evaluation was to determine the impact of an evidence-based community action project on five specific objectives with the overall goal being a reduction in alcohol-related harm for young people across the Auckland region. Intermediate impacts such as those on the reorientation, deployment and collaborative use of existing health and related sector resources were also assessed using the data collected as part of the process evaluation.

5.1 Five objectives

The RAP group has engaged in collaborative activities in relation to Objectives Two and Three. However as collaborative activity in relation to Objective Three was launched in June 2005 (shortly before the completion of the evaluation), impact data is only available in relation to objective two (reduce access to off-licence purchases by under 18s).

There is evidence that the activities of the RAP group (and the response to these by external stakeholders) has led to some improvement in age verification practices.

- Pseudo patrons surveys have been conducted in 2002, 2003 and 2004 and the RAP group has undertaken follow up activities after each of these with activities in 2002 generating the most media coverage. Activities have included the launch or release of the survey results, publication of a newsletter (available in both Korean and Mandarin), media advocacy for increased monitoring and enforcement of licensed premises and the use of survey findings in submissions to the LLA. Letters reporting individual and overall results were sent to the licensee of every premise visited in each pseudo patrons survey.

There is evidence of an impact on age verification practices in off-licences at a regional level.

- In 2002 61% of purchase attempts by pseudo patrons resulted in a successful purchase. In 2003, the proportion of successful purchase attempts was 46%, a significant decrease from 2002. Of the visits made to selected off-licences in 2004 the total proportion of successful purchases without ID was 56%. This was a significant increase from 2003.

There is evidence of a sustained improvement in age verification in two of seven territorial authority areas.

- The percentage of sales made without ID in the Auckland areas were as follows (2002; 2003; 2004):
    - Rodney (67%; 42%; 69%)
    - Auckland City (57%; 53%; 65%)
    - **Manukau City (77%; 52%; 54%)**
    - Franklin (65%; 57%; 48%)
    - **Papakura (91%; 25%; 44%)**

- Waitakere City (40%; 36%; 39%)
- North Shore City (39%; 30%; 37%)

A decreasing trend in sales made without ID was found in both Manukau City and Papakura District over all years.

Between 2003 and 2004 a significant increase in the proportion of sales made without ID was found for Rodney District.

There is evidence of a sustained improvement in age verification practices in one type of premise, supermarkets.

- The percentage of sales made without ID for bottle shops, supermarkets and grocery outlets were as follows (2002; 2003; 2004):
    - Bottle shops (59%; 43%; 61%)
    - Supermarkets (53%; 28%; 21%)
    - Grocery outlets (80%; 71%; 71%)
- Between 2003 and 2004 a significant increase in the proportion of sales made without ID was found for bottle shops.
- A decreasing trend in sales made without ID was found for supermarkets over all years (Huckle, Broughton et al. 2004).

In Auckland, larger retailers have instituted their own monitoring systems. For example, at least one supermarket chain conducts internal "sting" operations to monitor whether staff are routinely asking all customers under the age of 25 for identification (2004).

There is evidence that the pseudo patrons surveys and their media coverage have influenced police policy and practice.

- In some areas of the Auckland region, the police have used the pseudo patrons survey results to justify the use of CPOs in their area. Police also used the findings to focus their enforcement activity on particular premises, such as grocery outlets. Regular enforcement is particularly important because it has been shown to reduce the sale of alcohol to young people (Wagenaar, Toomey et al. 2005).

Over the course of the project (July 2002 to June 2005) there has been an increase in the number of CPOs conducted in the Auckland region. Whilst a number of factors have led to or supported increased enforcement activity (amendment to the SoLA, production of guidelines for conducting CPOs (ALAC 2004)) the pseudo patrons surveys provided evidence of poor age verification practices and placed this issue on national and regional agendas:

> *CPOs and pseudo patron surveys to date have provided a clear picture of an 'across the board' problem with compliance in New Zealand. It is now known*

that numerous convenience stores, taverns, bottle stores and major supermarkets have sold, and do sell to minors (ALAC 2004).

5.2 Re-orientation and collaboration of public health alcohol providers

An intermediate aim of the evaluation was to assess the influence of a community action project on the reorientation, deployment and collaborative use of existing health and related sector resources.

There is evidence that RAP providers have placed a stronger emphasis on environmental strategies (as opposed to educational initiatives) since the beginning of the project.

- Analysis of service schedules, provider reports, interviews with key informants and the process documentation of activities undertaken do indicate some general shifts with reorientation of organisational workloads to focus on evidence-based activities such as media advocacy and more support for environmental strategies such as working with Councils on their alcohol policies
- Some provider resources have been directed toward a specific focus on Objective Two and Objective Three as opposed to providers working on a multitude of different projects (but some still were)
- It is important to note that AHW already had a strong focus on environmental strategies prior to ARCAP due to their role coordinating the dissemination of Last Drink Survey data and LLGs across the region.
- ARPHS is placing more emphasis on regulatory health promotion activities with a regional focus rather than working on small locality-based projects
- SWAP has a clear focus on supporting regulatory activities and on the implementation of the Waitakere Alcohol Strategy
- Hapai has had only a small amount of direct resource allocated to RAP but did acknowledge they needed to move from working mainly with alcohol and drug treatment providers and schools to contributing more to collaborative RAP initiatives such as the pseudo patrons survey

There is evidence of structural support for collaboration between the four public health providers in the Auckland region.

- As a result of RAP the four providers contracted to provide public health services to reduce alcohol-related harm share a common set of objectives and are required, as part of their contracts, to meet regularly to develop, implement and review a regional alcohol strategy for Auckland that is consistent with five specific objectives. There is also a designated resource (salary and overheads) for a coordination position to support collaborative activities

There is evidence of some regional collaborative work by the four providers. However, this does not at this stage comprise the bulk of their activities.

5.3 Changes within the Ministry of Health

There is evidence of the allocation of additional resources from the MoH to address alcohol-related harm issues in the Auckland region. In total, an extra $185 000 of ongoing funding has been allocated to further RAP objectives since the beginning of the project. In addition to new ongoing funding one-off money has been accessed to fund three pseudo-patron surveys and follow-up activities along with one exit breathalyser survey.

There is now a requirement for 70% of provider activities to be focused on the five objectives. The MoH is also working on aligning the contractual and planning cycles of the RAP providers and developing a common RAP planning template.

5.4 Alcohol-related harm in the Auckland region

5.4.1 Methodology

Time trend analyses were carried out on routinely collected alcohol-related harms and offences data for the Auckland region 1996-2004. This was done in order to provide contextual information of trends in some alcohol-related harms and offences in the Auckland region in a time frame that included the duration of the ARCAP community action project evaluation. Data analysed were: prosecutions for driving with excess alcohol; alcohol involved vehicle crashes (all and fatal); and prosecutions for disorder offences. These were carried out separately for those aged 14-15, 16-17, 18-19, 20-24 and 25 and over.

Prosecutions for driving with excess alcohol

Prosecuted cases for driving with excess alcohol were obtained from the Research and Evaluation Unit of the Ministry of Justice. Data excluded cases where the offender was prosecuted for driving under the influence of drugs. These data are collected via a national computer system that records all prosecutions in court. If a prosecution was initiated by Police, it is in the data. If there is proof that a person has been driving while over the legal limit, they will be prosecuted. The legal breath alcohol limit for driving in New Zealand is 400mcg/l for people aged 20 years and over and in 1993 a limit of 150mcg/l was introduced for people under 20 years. In May 1999 drivers were required to produce their driver licence at the request of an officer. This meant that drivers under 20 years old, who had a lower legal limit, were more effectively identified and the testing equipment was more likely to be correctly set to the level of their legal limit.

Alcohol-involved crashes

Alcohol involved vehicle crashes (all and fatal) where the driver had been drinking were obtained from the Land Transport Safety Authority of New Zealand. In the case of non-fatal crashes a breath test is obtained to determine the involvement of alcohol in the crash. In some cases drivers who are likely to be over the legal limit leave the scene of the crash and cannot be breath tested; they are not included in this data. There is therefore likely to be some under estimation of non-fatal alcohol involved crashes. In the case of fatal crashes a blood test is obtained at autopsy.

Disorder offences

Apprehensions resulting in prosecutions for disorder offences came from the New Zealand Police; this data represents offences and it is possible that one or more offences may have been committed by one person, or multiple persons may have been apprehended for one offence. Disorder behaviours are an indicator of alcohol-related offending. While not all of the disorder offences will be alcohol-related, in New Zealand people committing disorder offences may be more likely to have been drinking when the offence was committed (Lash, 2002). Police do not have a formal definition for 'disorder'; rather it is a label for a group of offences, each with their own definitions appearing in criminal legislation (personal communication; New Zealand Police 18.05.05). Disorder offences broadly include; obstructing/hindering/resisting, inciting/encouraging offences; behaviour offences; language offences; miscellaneous disorder offences; and disorderly assembly offences. These categories of disorder have remained stable over time. Please note data are for Auckland Police District only.

Alcohol-related hospitalisation data

Data was obtained from the New Zealand Health Information Service (NZHIS). It included all alcohol-related publicly funded hospital discharges (where a patient had been admitted to hospital and subsequently discharged).

Discharge data is reported in financial years. A value of “1990” is the period from 1 June 1990 to 31 May 1991.

In 2000 a change in data reporting practices occurred for some areas of the country. Patients who had spent three or more hours in an Emergency Department (ED) were included in the discharge data where previously they had been excluded.

Population data

Population data for the Auckland region (Rodney, Waitakere, North Shore, Auckland City, Manukau, Franklin and Papakura) was obtained from Statistics New Zealand. Data from 1996 to 2004 was available.

5.4.2 Analysis

The model used for this data tried to capture any linear trends to between 1996 and 2004 in the Auckland region (Rodney, Waitakere, North Shore, Auckland City, Manukau, Franklin and Papakura). There were five responses of interest: 1) the number of all alcohol involved crashes; 2) the number of all alcohol involved fatal crashes; 3) the number of prosecutions for disorder offences; 4) the number of prosecutions with excess alcohol; and 5) the number of alcohol-related hospitalisations. These count data were analysed using Poisson regression with an identity link function and the model allowed for over dispersion. The explanatory variables were adjusted by a factor equal to the yearly population divided by 100,000 so that the effective response was number of events per 100,000 of the population i.e. the model, as represented to computer software, is

$count_i \sim Poisson(\lambda_i)$ and

$\lambda_i = \beta_0 \times p_i + \beta_1 \times (year_i - year_0) \times p_{i,}$

where $p_i = population_i / 100000$ and i = 0,…,n

However the interpretation of interest, the population rate per 100,000, is

$\lambda_i / p_i = \beta_0 + \beta_1 \times (year_i - year_0)$

and the interpretation of the coefficients is now:

β_0 is the population rate per 100,000 at $year_0$ and

β_1 is the slope or yearly increase in the population rate per 100,000

Standard errors were calculated for the number of alcohol-related hospitalisations in each specific year. A similar modelling process was used but with year splitting up into 8 binary variables, year0 – year7, where year0 = 1 $\times p_{i,}$ if year = 1996, else 0. The scale values from the trend models were used as fixed scale values in these models.

The data were analysed using SAS 8.02 (SAS Institute, 2001) and graphs drawn in R 2.0.1 (CRAN, 2005). Significance is declared for any test with a p-value of less than 0.05.

5.4.3 Results

Tables 1 to 5 list the parameter estimates and the trend p-value for each age group and the over dispersion parameter. The baseline is at 1996 and shows the rate per 100,000. For the age group 14-15 there were no fatal crashes so this group was not analysed for this response.

The 'slope estimate' shows if the trend is negative or positive i.e. -7.1015 is a downward sloping trend; the larger the slope estimate the larger the rate in trend. The 'slope p-value' shows if the trend is significant - a p-value 0.05 or less is significant.

Table 1: All crashes involving alcohol

	Baseline		Slope			Scale
Age group	Estimate	Std Error	Estimate	Std Error	p-value	
14-15	11.0328	4.4903	-0.925	0.7796	0.2471	1.1649
16-17	84.353	10.0806	-7.1015	1.8102	<.0001	1.1069
18-19	142.0894	22.5948	-9.4065	4.1528	0.0235	1.8761
20-24	127.4533	14.5322	-10.8586	2.565	<.0001	2.1388
25+	47.4838	4.2577	-3.8092	0.7753	<.0001	2.9083

There were decreasing trends in rates of alcohol involved crashes for all age groups, except those aged 14-15 years (Table 1).

Table 2: Fatal crashes involving alcohol

	Baseline		Slope			Scale
Age group	Estimate	Std Error	Estimate	Std Error	p-value	
16-17	4.0753	0.9539	0.177	0.2362	0.4536	0.4257
18-19	4.3657	1.0432	-0.2376	0.1853	0.1998	0.4071
20-24	6.0761	1.2603	-0.5062	0.2073	0.0146	0.8328
25+	1.3442	0.2749	-0.0587	0.0528	0.2661	1.0944

The 20-24 year old age group had a significant negative trend for fatal crashes. There were no other significant trends among the other age groups. There were no fatal crashes in the 14-15 year old age group

Table 3: Prosecutions for driving with excess alcohol

	Baseline		Slope			Scale
Age group	Estimate	Std Error	Estimate	Std Error	p-value	
14-15	6.0574	3.6215	1.6671	0.8722	0.056	1.0177
16-17	535.5285	17.1722	-1.3436	3.4897	0.7002	0.6977
18-19	1551.611	126.0028	5.1915	25.4883	0.8386	2.9834
20-24	1336.7	89.8344	-58.2422	16.9551	0.0006	3.9819
25+	768.3466	39.0062	-36.1197	7.5332	<.0001	6.3974

The 20-24 and 25 plus year old age groups both had significant negative trends in prosecutions for driving with excess alcohol. The greatest decrease in rates was in the 20-24 year old age group, followed by those aged 25 years and over. There were no other significant trends between 1996 and 2004 for any other age group.

Table 4: Disorder offences[13]

	Baseline		Slope			Scale
Age group	Estimate	Std Error	Estimate	Std Error	p-value	
14-15	118.1785	27.8119	4.8296	5.8965	0.4128	2.2328
16-17	792.4029	125.1781	-3.5819	25.9651	0.8903	3.9454
18-19	1553.445	123.8337	-27.7249	24.8287	0.2641	2.8704
20-24	1345.408	69.3359	-61.9337	13.2897	<.0001	2.9707
25+	228.155	15.8064	-1.1963	3.2284	0.711	4.5769

The 20-24 year old age group showed a significant negative trend in the rate of disorder offences. The decrease was over two times higher than for any other age group. There were no other significant trends among the other age groups.

Table 5: Alcohol-related hospitalisations

	Baseline		Slope			Scale
Age Group	Estimate	Std Error	Estimate	Std Error	p-value	
14-15	66.8078	20.1597	20.5473	5.6014	0.0002	1.8172
16-17	66.6064	18.1707	17.2023	5.0101	0.0006	1.7869
18-19	41.7236	17.918	32.1971	5.5978	<.0001	1.9009
20-24	49.8367	15.5967	21.313	4.5666	<.0001	2.7201
25+	237.5308	11.4916	13.5018	2.8403	<.0001	2.9405

[13] Please note data is for the Auckland Police District, not the Auckland region.

All age groups show a significant increasing trend in alcohol-related hospitalisations from 1996 to 2004. The rate of increase is largest for the 18-19 year old age group and lowest for those aged 25 and older.

5.4.4 Summary

The data analysed here provides contextual information of trends in some alcohol-related harms and offences in the Auckland region in a time frame (1996 – 2004) that included the duration of the ARCAP community action project evaluation. Please note this analysis measures overall trends and does not attempt to measure differences in trends after particular points in time where changes have occurred such as, the lowering of the minimum purchase age, or for example the time at which ARCAP began. This analysis was not carried out given the short time frame of the ARCAP project to date. Please also note that this analysis cannot directly assess the effects of other external factors that are associated with drinking behaviour, which may influence harm and offending, such as the real price of alcohol or economic effects in the Auckland region during the period assessed.

The trends in drink driving generally showed declines for alcohol-related crashes and prosecutions for driving with excess alcohol in the Auckland region. The rates of decline for prosecutions for driving with excess alcohol were greater among the older age groups 20-24 and 25+ age groups compared to the younger age groups below 20 years of age.

These trends are likely to be linked to initiatives including: introduction and enforcement of compulsory breath testing (CBT) legislation in New Zealand; lowering the legal alcohol level for driving for those under 20 years (Land Transport Safety Authority, 2004); advertising campaigns to deter people from drinking and driving. The effect of CBT on lowering drink driving offences and related crashes has previously been found in New Zealand (Guria et al., 2003). Nationally there was also a Police safety campaign (SRSP) introduced in 1995/1996 that is likely to have contributed to the reduction in alcohol-related crashes (Guria et al., 2003).

In the Auckland region there has also been specific work on drink driving which is likely to have had an impact including: enforcement, host responsibility education, recidivist rehabilitation, youth action, and legislative advocacy (by a number of partners including Police, Local Authority Road Safety Coordinators, Students Against Drunk Driving, ALAC, ARC/ARTA, ARPHS, AHW and ACC).

Trends in disorder offences showed little change between 1996 and 2004, however a decrease was found for the 20-24 year olds. These results contrast with national data where significant increases in rates of disorder behaviour have been found among all age groups (14-15, 16-17, 18-19, 20-24 and 25+) with the highest rates of increases found among those under 20 years of age (Huckle et al in press).

Factors such as enforcement and liquor bans (from 2002) may have worked to keep disorder offences reasonably constant (and relatively lower than national standards) in the Auckland Police District. RAP's collaborative initiative to reduce access to alcohol to those under 18 years of age may have potentially contributed to the status of disorder offences in Auckland from 2002. However the positive result of reduced

access to alcohol by under 18s (documented by the pseudo patrons surveys) was found only between 2002 and 2003 and this would not affect the overall trends in the data for those under the age of 18 years.

Increases in rates of alcohol-related hospitalisations for all age groups were found for the Auckland region, and the largest increase in trend was for those aged 18-19 years. As with the disorder offences, RAP's collaborative initiative to reduce access to alcohol for under 18s could have potentially impacted on alcohol-related hospitalizations; however the positive impact of this initiative was not sustained long enough to be able to affect trends in the data.

As mentioned in the methodology section in 2000 a change in data reporting practices occurred for some areas of the country regarding hospitalisations. Patients who had spent three or more hours in an Emergency Department were included in the discharge data where previously they had been excluded. It is possible to partially separate this effect by excluding same day patients from the data. This has not been done in this analysis as previous analysis on national data (controlling for the change in reporting practice) has shown that it does not affect the overall trends in the data.

In the Auckland region between 1996 and 2004 there have been a number of initiatives to reduce alcohol-related harm and offending (including national initiatives). More recently, in the Auckland region, there has been concern from health, Police and other relevant stakeholders about youth drinking and a range of interventions have been implemented from the community to the policy level (liquor bans and so forth). It appears that in some areas, including drink driving and disorder offences, some impact has been made to reduce harm/offending.

The activities of RAP are likely to have contributed generally to this environment however, due to the lack of sustained effort placed on collaborative initiatives (most of the objectives were not worked on collaboratively at a regional level); it is unlikely that RAP has contributed significantly to changing these aspects of alcohol-related harm in the Auckland region.

6. Conclusion

There is evidence in this report to suggest that the ARCAP project has resulted in some changes in provider activities aimed at alcohol harm reduction, specifically in collaborative activity in relation to the objective of reducing off license purchases by those under 18 years and, to a lesser extent, to the objective of reducing intoxication on licensed premises.

This collaborative activity resulted in some positive changes to the alcohol environment including some improvement in age verification policies and practices.

There is also evidence of some structural change within the health sector, including revision of contractual arrangements with the funding agency, provision of a coordinator's salary and development of some tools for collaboration.

The responses of external stakeholders such as the police and licensing sector to the collaborative activities and structural change show some impacts on their practices, for example in CPO activity.

Given the difficulties inherent in reorienting existing health sector resource, encouraging more evidence-based collaborative practice and the competing demands of individual organisations' profiles and organisational cultures, these impacts are encouraging signs.

7. Recommendations

Preamble

Now that the reorientation to more evidence-based environmental strategies is occurring, it could be expected that there will be a greater focus on working collaboratively both within RAP and with the external regulatory stakeholders such as police, licensing inspectors and relevant City Council staff, who were identified as the original "community of interest" for this project. Currently there is a very favourable climate in terms of proactive alcohol policy and supportive national initiatives with police prioritising alcohol and the advent of their Alcolink project, a new alcohol Toolkit for local City Councils produced by Local Government New Zealand and ALAC, as well as the present bill to amend the Sale of Liquor Act before the Law and Order Select Committee. It is imperative that this project capitalises on its work so far to further strengthen its intersectoral work with these stakeholders on regional initiatives.

The following recommendations are made on the understanding that the MoH will have support from each RAP provider manager to work collaboratively on regional evidence-based strategies to reduce alcohol-related harm. Without the combined support of RAP managers it is unlikely that the recommendations below can be achieved.

- A new RAP coordinator be appointed as soon as possible
- Key regional priorities and an effective infrastructure for RAP are reviewed and implemented by RAP managers and the new coordinator
- RAP providers continue to develop, implement and review a Regional Public Health Alcohol strategy as a major focus of their work on which their individual alcohol service plans and activities are based
- RAP providers continue to move towards working collaboratively with other initiatives such as RARP and Community Action on Youth and Drugs (CAYAD) at a regional level using evidence-based approaches that are aligned with RAP strategic and action plans
- An agreed planning template is used by RAP providers to align individual provider strategies and activities with RAP regional planning
- RAP providers continue to direct 70% of their activities at the five RAP objectives with RAP planning processes determining priority objectives for specific time periods and collective resource allocation in terms of staff time and shared resources
- RAP continues to use tools such as pseudo patron and exit surveys initiatives to raise awareness and inform activities
- The project would benefit from further formative evaluation support and collection of impact evaluation data, particularly given the gradual progress to date, and discontinuity due to considerable staff changes and the limited RAP coordination role during this period

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Appendix One: Analysis of Print Media Items

Methods

Print news items relating to young people and alcohol issues were collected from all local papers in the Auckland region and from national papers where news items specifically related to the Auckland region. From September 2003 newsprint items have been collected by a press clipping bureau relating to; 1) the pseudo patrons survey; 2) ID practices or enforcement of the minimum purchase age in Auckland; and 3) all other alcohol-related issues for people under the age of 25 years in Auckland.

Measures

A composite measure was derived based on Treno and Holder (1997), for all media items. The measure comprised:

- Number of articles per month
- Total area (sq cm) per month
- Articles with photo/picture
- Front page articles

This measure has been used previously in international research to examine media advocacy in the newsprint media (Holder, Saltz et al. 1997; Treno and Holder 1997). Previous analysis of this composite measure has found that it is capable of capturing different dimensions of coverage, and is likely to be more valid than the exclusive use of any one measure (Treno and Holder 1997). For example, a count of print news items does not take into account the size of the item, nor does it take into account the increased likelihood that people will read items if they are on the front page of a newspaper or have a picture attached.

Analysis

A monthly score was derived by summing the four variables, number of articles per month, total area, articles with a picture and front page articles.

Results

Figure 1 shows print news items relating to the pseudo patrons survey compared with all other newsprint items regarding age identification and/or enforcement of the purchase age in the Auckland region. The arrows depict months when the RAP group was involved in collaborative media advocacy regarding the pseudo patrons project(s).

The graphs show clear periods where the collaborative activities of RAP generated media coverage. There was also coverage of the pseudo patrons survey even when RAP was not actively engaging in media activities. For example in February 2005, results from the pseudo patrons survey were used as evidence of poor age verification practices in two articles reporting on the Alcohol Strategy for Auckland City. The RAP group was also mentioned in two articles about Foodtown's objection to having a requirement to request ID from anyone under the age of 25 as a condition of their license in January 2005.

Figure 2 shows all print items relating to the pseudo patrons survey, identification or enforcement of the minimum purchase age issues and all other items relating to young people and alcohol use in the Auckland region. In November 2004, there were a number of articles about alcohol-related harm and discussion about whether or not the purchase age should be returned to 20 years. In June 2005 there were fourteen items concerning the private member's bill to lower the purchase age for alcohol and four articles on the exit breathalyser survey.

Figure 1

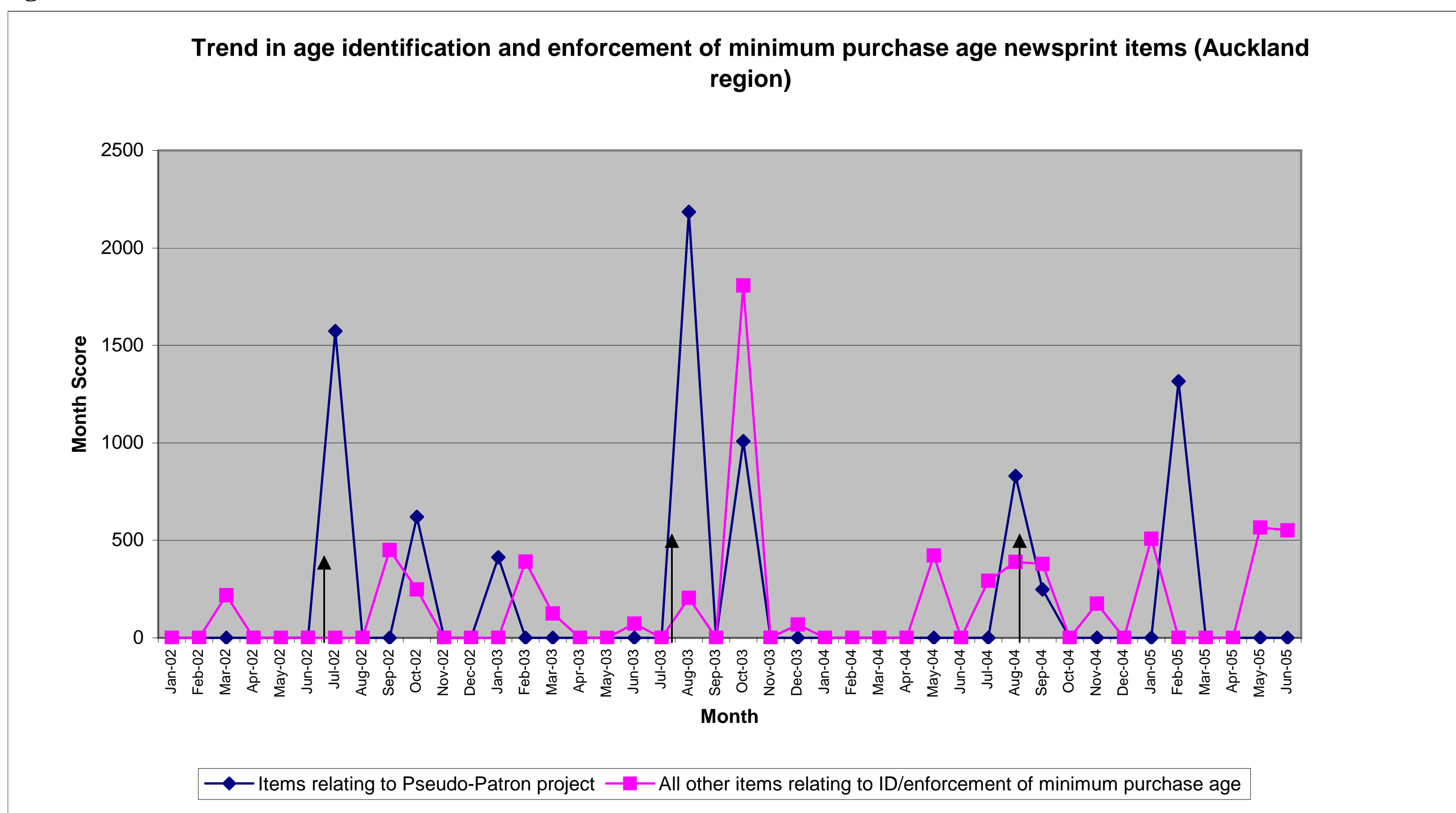

Figure 2