

**EVALUATION
OF THE
HOST RESPONSIBILITY PROGRAMME
IN
DUNEDIN CITY, 1990 - 1998:
A RETROSPECTIVE CASE STUDY**

KATE CLIFFORD MORGAINE

A dissertation submitted for the degree of

Master of Public Health

of the University of Otago, Dunedin

New Zealand

31 May 1999

ABSTRACT

**EVALUATION OF THE HOST RESPONSIBILITY PROGRAMME IN
DUNEDIN CITY, 1990 - 1998: A RETROSPECTIVE CASE STUDY**

Alcohol use is significantly implicated in many issues, such as motor vehicle crashes, intentional and unintentional injuries, and long term disease. Alcohol related harm was estimated in 1996, to cost New Zealand between \$1.5 billion and \$2.4 billion including injury, disease, lost production, lost working efficiency and excessive unemployment, even in the face of falling consumption. (ALAC 1998)

A commitment to reducing alcohol related harm has been evident in the Sale of Liquor Act 1989 and successive Governments' policies. An important objective remains "To improve health by reducing *alcohol* related harm" (Ministry of Health 1997). Thus the effort to identify and implement effective strategies was renewed. The key findings after reviewing published literature were that a successful prevention programme in licensed premises should have a comprehensive approach which includes management training, patron awareness, serving staff training, written responsible beverage service policies, purposeful community involvement, enforcement by police, skilful media advocacy, and a process to ensure institutionalisation of the programme.

Responsible beverage service was introduced to New Zealand as Host Responsibility in 1990 by the Alcohol Advisory Council (ALAC). Host Responsibility consists of five strategies aimed at altering the drinking environment to reduce alcohol related harm. They are to provide low and non-alcoholic alternatives and appropriate food, serve alcohol responsibly, be able to identify and responsibly deal with under-aged and intoxicated people, and arrange safe transport options. (ALAC, 1992)

This dissertation describes the approach undertaken in Dunedin implementing the Host Responsibility programme, evaluates the success of the programme and the elements that contribute to its success. Although the whole programme was evaluated, six benchmark projects were identified. Process and impact health promotion evaluation demonstrated that they were successful in meeting their objectives. Organisational analysis illustrated the factors which made the project

successful and explained the enthusiastic adoption and development of the Host Responsibility concept in Dunedin.

The Dunedin programme was developed in a parallel timeframe to many of the programmes documented in the research literature. Nonetheless, it addressed many of the elements necessary for a successful programme. Purposeful involvement of the community of interest (in particular, members of the hospitality industry), training for management and staff of licensed premises, a requirement for written host responsibility policies in licensed premises, projects which involved and targeted both the industry and the public, and a commitment to institutionalising the Partnership Agencies relationship with a formal Partnership Protocol, are reflected in the Benchmark projects evaluated. Areas where the programme could improve were also identified. Increasing the public profile and patron awareness of projects, improving media advocacy, increasing police enforcement practices and building in more formal evaluation would strengthen and enhance an already successful programme.

The Partnership Agencies programme is characterised by a willingness to work with the industry, a variety of agencies and communities of interest, and to innovate while institutionalising that which has been successful, including creating a working environment where cross organisational co-operation and innovation were the expected norm. While outcome evaluation was not possible, it is plausible to conclude from other measures that the Dunedin Host Responsibility Programme has been successful in reducing alcohol related harm in Dunedin.

PREFACE

This dissertation has provided a fitting finale to my work in the alcohol health promotion field. I began it as a Health Promotion Adviser working in the field, moved on to become the Manager of the Health Promotion Unit within the Otago Public Health Service and finally evaluated part of the alcohol health promotion programme - the Dunedin Host Responsibility Programme.

I wish to thank my supervisors, Rob McGee and Robin Gauld, who offered timely advice and support, much of which was via email as I sat across the other side of the world.

I thank HealthCare Otago and the Otago Public Health Service who supported my MPH study as well as allowing me free and open access to all documentation within their public health files. I wish to thank the other Partnership Agencies, the District Licensing Agency, Dunedin City Council and Dunedin Police for allowing me access to their files and information.

In particular, I wish to thank my health promotion colleagues and the current fieldworkers in the Dunedin Host Responsibility Programme, who offered advice, support and enthusiasm, as well as rushing around digging up information and references for me which I had left behind.

I wish to thank the Stakeholders for their time, openness and honesty.

I wish also to acknowledge the assistance I received from HealthCare Otago, the District Licensing Agency and the Preventive and Social Medicine Department to attend the International Health Promotion Conference in Wales in 1998 at which I presented the research from this paper.

Finally, I wish to express my thanks to my family. My partner was an academic sounding board as well as the mainstay at home and with the family, while I binge studied between working weeks. My children tolerated an absent parent and understood the need for me to finish my 'school work'.

CONTENTS

Abstract	iii
Preface	v
List of Tables	viii
1 Introduction	1
1.1 Background	1
1.2 Host Responsibility	3
1.3 Rationale	3
1.4 Researcher Role	4
2 Alcohol and Health Promotion	5
2.1 Health Promotion and Harm Reduction	5
2.2 Interventions to Reduce Alcohol Related Harm	8
2.3 Responsible Serving Practice	12
2.4 Responsible Serving Practice in New Zealand	18
2.5 Summary	21
3 The Dunedin Host Responsibility Programme	23
3.1 The National Context	23
3.2 Dunedin Demographics	27
3.3 The Public Health Service History	28
3.4 The Dunedin Police History	28
3.5 The District Licensing Agency and Dunedin City Council History	28
3.6 The Dunedin Partnership Process	29
3.7 The Dunedin Partnership Projects	31
3.8 Benchmark Projects	32
4 Framework for Evaluation	36
4.1 Health Promotion	37
4.2 Responsible Beverage Service	38
4.3 Organisational Analysis	39
5 Method	43
5.1 Project Evaluation	43
5.2 Stakeholder Analysis	44
5.3 Document Analysis	45
5.4 Attributes of Innovation	46
5.5 Summary	46
6 Results	47
6.1 Project Evaluation	47
6.2 Stakeholder Analysis	54
6.3 Document Analysis	60
6.4 Factors Contributing to Success	65
6.5 Summary	68

7	Discussion	69
7.1	Evaluation of the Dunedin Host Responsibility Programme	69
7.2	Results of the Dunedin Host Responsibility Programme	70
7.3	Contributing Factors to the Success of the Dunedin Host Responsibility Programme	75
7.4	Summary	79
8	Conclusion	80
8.1	Dunedin Host Responsibility Programme	80
8.2	Evaluation Method	82
8.3	Recommendations for Future Action	82
8.4	Summary	83
	Bibliography	85
	Appendices	91
1	Dunedin Host Responsibility Project Profiles	91
2	Evaluation Summary Schedules	93
3	Interview Schedule	95

LIST OF TABLES

TABLE	TITLE	PAGE
1	Percentage of fatal motor vehicle crashes where alcohol is the leading contributory factor	1
2	Age standardised rates for cirrhosis of the liver per 100,000	2
3	Examples of Partnership Agencies' Projects by Ottawa Charter Strategy	32
4	Innovation Attributes (Meyer et al, 1997)	42
5	Innovation Attributes of Dunedin Host Responsibility Partnership Agencies	76

1 INTRODUCTION

1.1 Background

Alcohol related problems deplete the human and financial resources of many nations. They reduce life expectancy, lower productivity, require substantial expenditure by health and other services, and ravage family and community life.(Farrell, 1985) Alcohol related problems are experienced by the individual drinker and by the community in the physical, psychological, social and economic spheres.(Edwards et al, 1994) Alcohol related harm was estimated in 1996 to cost New Zealand between \$1.5 billion and \$2.4 billion including lost production, lost working efficiency and excessive unemployment, even in the face of falling consumption. (ALAC 1998)

Alcohol is significantly implicated in many issues such as deliberate self harm and completed suicides. In Canada, it is implicated in 30% of suicides and 60% of homicides. Two areas where alcohol is indisputably involved causally, are motor vehicle crashes and cirrhosis of the liver. Table 1 and Table 2 illustrate the level of involvement in these two adverse health outcomes, respectively. (Edwards et al, 1994)

Table 1: Percentage of fatal motor vehicle crashes where alcohol is the leading contributory factor

Country	% of fatal accidents
Canada	37
USA	50
France	40
Germany	19
United Kingdom	800 (people not %)

In New Zealand in 1990 the percentage of fatal motor vehicle crashes where alcohol was a contributory factor was 42%. In 1997 that percentage had dropped to 27% and shows a marked improvement in the last seven years.(ALAC, 1998) Cirrhosis of the liver provides us with a long term picture of the effect of alcohol consumption. In all countries, illustrated rates for males were more than for females and in some cases double that of females. (Edwards et al, 1994)

Table 2: Age standardised rates for cirrhosis of the liver per 100,000

	Eire	N.Z.	Neth.	U.K.	Austral.	Canada	U.S.A.	Japan	France
Male	3.1	5.2	6.3	6.9	11.7	12.7	15.2	17.7	23.3
Female	2.7	2.4	3.9	5.3	4.2	5.8	8	9.1	10.6
Total	2.9	3.7	5.1	6.1	8.1	9.3	11.6	13.4	17

Alcohol related harm has been identified by the Ministry of Health, and its predecessors in the last two decades, as a major public health issue. The 1993-1994 Public Health Commission policy paper on alcohol, while developed amidst controversy, contains objectives, targets and research relating to alcohol and was accepted by the Ministry of Health. The 1996-97 review of the Strategic Direction for Public Health confirmed alcohol as a health issue in New Zealand and an important objective remains:

"To improve health by reducing *alcohol* related harm"

Related objectives also confirmed were:

- To reduce death rates, injury and disability from *road traffic crashes*; and
- To reduce the adverse health effects of *violence*, including family violence.

It is intended that "*Strengthening Public Health Action: the Strategic Direction to improve, promote and protect public health ... will ... set the public health policy development agenda for the next three to five years*" (Ministry of Health, 1997) Similarly the Sale of Liquor Act 1989, which came into force in April 1990 had as its object:

'... to establish a reasonable system of control over the sale and supply of liquor to the public with the aim of contributing to the reduction of liquor abuse, so far as that can be achieved by legislative means.'

The New Zealand Police's Strategic Plan in 1993 recognised the role that alcohol played in crime, disorder and community safety by introducing 'Alcohol the Aggravator' as a slogan to summarise their more proactive approach to reducing alcohol related harm.(New Zealand Police, 1993)

1.2 Host Responsibility

This dissertation presents a retrospective case study evaluating the effectiveness of the Host Responsibility programme in Dunedin City 1990 - mid 1998.

Host Responsibility, as a stand alone concept, was introduced to New Zealand in 1990 by the Alcohol Advisory Council (ALAC), a Quasi Non-Governmental Organisation (QUANGO) with responsibility for reducing alcohol related harm through providing advice, developing programmes and supporting services in the alcohol health field. Host Responsibility consists of five strategies aimed at altering the drinking environment and thereby reducing alcohol related harm. They are to: provide and actively promote low and non-alcoholic alternatives; provide and actively promote appropriate food; serve alcohol responsibly; be able to identify and responsibly deal with under-aged and intoxicated people; and to arrange safe transport options. (ALAC, 1992) In Dunedin, *Host Responsibility* is the term used to cover all prevention activity undertaken by the Partnership Agencies of the Public Health Service, the Dunedin District Licensing Agency of the Dunedin City Council and the Dunedin Police regarding the sale and supply of alcohol. Although aimed primarily at licensed premises it is not restricted to them.

1.3 Rationale

Considerable time, effort and money has been committed to Host Responsibility by Public Health Services, Police and District Licensing Agencies throughout New Zealand. Each of these agencies share essentially the same goals as outlined in the Sale of Liquor Act 1989 and their programmes and projects succeed or not to a greater or lesser degree. By examining a fully functional programme and analysing the components, we will be able to assess its effectiveness and illustrate the factors which contribute to its success or which need to be developed. This process will also allow other districts and programmes to apply particular aspects to their own areas and so build on that success.

1.4 Researcher Role

I worked directly in the development and implementation of the Dunedin programme from February 1992 to February 1993 and again from March to November 1996. From March 1993 until August 1997, I was the manager of the Public Health Service field workers. From August 1997, I was no longer a manager or field worker in the Public Health Service and from June 1998, I was no longer employed by the Public Health Service. My role as researcher was helped by this distance which allowed me to stand back to observe and analyse the processes. This distance in turn helped minimise what bias I might bring to the evaluation. My personal involvement and hence contacts with stakeholders ensured easy access to information and ready permission and co-operation for interviewing and access to organisational documents. Local field workers and their managers were eager to have their programme evaluated.

2 ALCOHOL AND HEALTH PROMOTION

This literature review will set the context for the Dunedin Partnership Agencies programme. It commences by canvassing broad health promotion models, then focuses more specifically on a review of international alcohol intervention programmes, and programmes equivalent to host responsibility. Finally it reviews the national literature on host responsibility in New Zealand. The Dunedin programme will be described in Chapter 3.

2.1 Health Promotion and Harm Reduction

Health promotion, as it is practised in New Zealand in the 1990s, is an eclectic mix from different traditions that have been present for many decades. Aspects come from many different theoretical and practical strands such as: health belief and behaviour models, community development, social action, social marketing, organisational change, education, public health, the principles of The Treaty of Waitangi, harm reduction or minimisation, and population strategies. (Nutbeam & Harris, 1998) It has been, however, somewhat overlaid by the Ottawa Charter for Health Promotion 1986 (World Health Organisation) strategies and has now in a sense become underpinned and informed by it. The Ottawa Charter is a World Health Organisation document with over 200 countries as signatories to it, which lays out the basis for prevention work. In particular, health promotion programmes are informed by three actions - enabling, mediating, and advocating; by five strategies - building healthy public policy, creating supportive social and physical environments, strengthening community action, developing personal skills and reorienting the health service; and by the focus on population groups rather than on individuals with particular problems. The health reforms in New Zealand in the early 1990s, required public health services to address the Ottawa Charter strategies as part of their contracting process,ⁱ illustrating the powerful role the Ottawa Charter for Health Promotion has had in framing a more holistic approach, addressing policy and environmental factors, both social and physical, as well as community, personal and professional action.

ⁱ Many of the contracting documents (1991 - 1995) between the Public Health Commission, the Southern Regional Health Authority (now the Health Funding Agency) and the Public Health Service of HealthCare Otago were written using Ottawa Charter strategies as frameworks for developing contracts and work programmes.

Within the alcohol and drug fields, harm minimisation and harm reduction are two strategies for prevention which are in current use. Although minimisation and reduction are used by some interchangeably, there is considerable debate within the field as to their exact meanings and the consequent impact that meaning has on policy and practice. The idea of harm minimisation or reduction is not new but the parameters have become more defined. A World Health Organisation Expert Committee defined the harm minimisation approach as one where "... attention is directed to the careful scrutiny of all prevention and treatment strategies in terms of their intended and unintended effects on the level of consumption." (Wodak and Saunders, 1995) In 1994, the Australian National Campaign Against Drug Abuse saw harm minimisation as its central plank. It considered that a "...harm minimisation policy focuses on the specific harms that can be caused by the use of particular drugs, by particular people, in particular circumstances ... [and that it] ...is based on a recognition that there is a continuum of harm associated with the use of alcohol and other drugs." They argued, therefore, that no one approach would be appropriate and that the responsibility for addressing harm minimisation is shared between many different agencies who contribute to such strategies as demand reduction, supply control, controlled use, safer drug use, and abstinence.(Homel et al, 1994)

Single (1995b) defines harm reduction as "...a policy or programme directed towards decreasing adverse health, social, and economic adverse [sic] consequences of drug use even though the user continues to use psychoactive drugs at the present time". Harm reduction, therefore, is not necessarily proportional to consumption. This is widely known as the prevention paradox. (Rose, 1991) While "...it is true that the heaviest drinkers are more likely to experience alcohol-related problems than those that drink less often and in smaller amounts, it is nevertheless also true that eradicating the problems experienced by this small proportion of heavier drinkers will not eradicate most of the problems. This is because the bulk of the problems are contributed by the much greater numbers of more moderate drinkers. This may be particularly true of the consequences of drinking such as driving related injury, accidents at work and hospital admissions for alcohol related conditions."(Casswell, 1991) Roche et al (1997) argue that harm reduction as a policy sits at odds with use reduction while harm minimisation includes within it the possibility of use reduction if minimising

harm is the goal. They consider an exclusive focus on harm reduction to overlook causal and contributory factors and that "...in principle [it] is inconsistent with control policies." Single(1995b) goes on to state that a limited definition of harm reduction would make it clear that harm reduction was not the only goal to be pursued. The United States of America Government's policy is for use reduction, while the United Kingdom Government's policy combines both harm reduction and use reduction. Caulkins and Reuter (1997) argue that harm reduction is closely related to maximising societal welfare, which is an implicit if not explicit government responsibility in the Western World and that this makes harm reduction especially attractive to governments.

In New Zealand, the Sale of Liquor Act 1989's objective includes both the control of the sale and supply of alcohol, and harm reduction. The agencies involved with implementing this Act, through their national plans, emphasise the importance of reducing alcohol related harm. There is very little public documentation which explicitly addresses use reduction other than for young people. As the recent review of the Sale of Liquor Act 1989 showed there is considerable debate about the age of access to alcohol with most parties apart from public health professionals agreeing to lowering the age of access to alcohol to 18 years of age. This has yet to become law.

Erickson (1995) argues that harm reduction's meaning has changed much over the years and that initially it was associated with a more traditional public health approach. It has now come full circle in one sense, to be realigned with public health approaches having been "... modified to emphasise the social, environmental and cultural dimensions which promote personal and community health." In this context the Ottawa Charter for Health Promotion has acted as a pivotal framework to facilitate the twin aims of harm reduction and use reduction. Its focus on policy and environment works in tandem with harm reduction while community action and personal skills development provides support for use reduction.

2.2 Interventions to Reduce Alcohol Related Harm

The World Health Organisation has commissioned two reviews of the effectiveness of interventions undertaken with the aim of preventing alcohol related problems. The first was completed by Susan Farrell in 1985 and the second was published in 1994 as Alcohol Policy and the Public Good (G. Edwards ed.). Edwards et al (1994) acknowledged and built on the work first completed by Farrell and assembled a cast of prominent researchers in the prevention of alcohol problems. Both works provide a comprehensive and critical analysis of the research available over the prior two decades. It is my intention in this section to summarise these two works and supplement them with effectiveness research published since 1994.

Edwards et al (1994) and Farrell (1985) canvas the effectiveness of the interventions carried out at both the political and community level. They are for the most part looking for hard, quantitative data and where this is not available conclude that either the intervention was not effective, or that the intervention has potential but that quantitative research is necessary to demonstrate it. This somewhat limits the scope of what they can assess as being effective and in some part denies the efficacy of other, qualitatively evaluated, interventions. It also makes little allowance for the way in which interventions occur in communities, particularly when the community is involved in the development of the intervention, nor for the expense of high quality research which frequently communities cannot afford, even when desiring that their intervention be evaluated.

Retail price has been thought to influence alcohol consumption and been part of the rationale governments have used to increase taxation on alcoholic beverages. 'Happy hours' where licensed premises offer alcohol at reduced rates for a certain period of time effectively increase consumption of both light and heavy drinkers. However, when prices are increased for alcohol, heavy drinkers are more likely to have their consumption affected than light drinkers.(Edwards et al, 1994) Consequently, interventions which minimise reduced price alcohol should reduce the likelihood of increased consumption of both light and heavy drinkers. Bearing in mind the prevention paradox, increasing the price of alcohol while affecting

heavy drinkers is unlikely to shift the majority of light and moderate drinkers towards less consumption and so may not be a particularly effective consumption prevention mechanism.

In many countries, including New Zealand, there have been sudden and drastic reductions in the amount of alcohol available. For the most part this has been as a result of striking workers, either at the manufacturing or distribution stages. Many studies were undertaken when these strikes occurred. In almost all cases, alcohol consumption dropped dramatically as did alcohol related problems. In Finland following a five week strike overall consumption was down by one third, arrests for public drunkenness reduced by 50%, arrests for drinking and driving down by 10 - 15%, and arrests for assault and battery down by 25%. (Edwards et al, 1994) Similarly in New Zealand alcohol related problems were also significantly reduced.(Farrell, 1985) In the USSR, however, "... there was a sudden increase in deaths associated with drinking illegally produced alcohol, a black market emerged, and a shortage developed in the supply of sugar for household use because of its diversion to illegal alcohol production." (Edwards et al, 1994) Where sudden change in alcohol retail availability occurs, the relationship between consumption and related problems appears to be directly related. A sudden decrease in alcohol availability equates to a decrease in alcohol related problems, while a sudden increase in alcohol availability equates to an increase in alcohol related problems. (Edwards et al, 1994) It would appear from this information that levels of consumption are the best indicator of alcohol related problems. However, it should be remembered that these data refer to a sudden change in alcohol availability. For the most part, alcohol availability is affected by less dramatic occurrences. Nonetheless a ...

large number of studies have been undertaken which examine the basic premise that restrictions on alcohol availability can have significant effects on alcohol consumption, and on associated problems. Those studies which address the availability of alcohol have usually found that when alcohol is less available, less convenient to purchase, or less accessible, consumption and alcohol related problems are lower. (Edwards et al, 1994)

Prohibition was undertaken in a number of countries in the early 20th century. While there is little debate that some of the direct indicators of alcohol related ill-health were much improved other problems arose, such as black markets and their consequences. Many prohibition regulations were eliminated due to lack of popular support and compliance. Apart from some Islamic countries most governments today are unlikely to consider a total alcohol ban. (Edwards et al, 1994) Not infrequently alcohol is referred to by field workers in a similar manner to tobacco and suggestions made that similar measures for prevention could be used in the alcohol field as those in the tobacco field. However, the government and community reluctance to ban alcohol outlined above is worth bearing in mind when considering interventions which might reduce alcohol use or harm, as it shifts the parameters those interventions must work within.

A prominent form of government control of the amount of alcohol available, has been through the agency of retail monopolies. This has reduced the ability of demand to stimulate supply. Lifting the monopolies has usually lead to an increase of outlets, hours of sale and lower prices as a consequence of increased competitiveness. (Edwards et al, 1994) The idea of state run monopolies along with rationing of alcohol would sit uneasily with the political ideologies of Western world governments today. In both cases it is likely that these forms of control would affect the heavy drinker the most. Several studies have addressed the issue of the density of alcohol retail outlets. Early studies seemed to indicate that outlet density had no relationship to alcohol consumption. Studies since have indicated that there is a relationship between outlet density and consumption and in particular beer consumption. (Edwards et al, 1994) In Iceland, where beer had been unavailable, lifting the restriction had an immediate impact on consumption. "Surveys taken before and after the change in beer availability found that beer was added to the total consumption of alcohol for men, but substituted for wine or spirits for women... [In addition the] ... increase in beer consumption was sufficient to raise the total alcohol sales by one-quarter in 1989, and by one-fifth in 1990, compared with total alcohol sales in 1988." (Edwards et al, 1994) In the case of restricted hours of sale or of one day where no sales can take place, most studies have shown decreased consumption of alcohol. In most of the studies summarised previously there has been an implicit link between levels of consumption and alcohol related problems. However, in both Sweden and

Norway, studies regarding the closure of alcohol retail outlets for one day a week did not reduce the total level of alcohol consumption but did reduce the rate of acute alcohol related problems. (Edwards et al, 1994) Single (1995a) points out that several recent studies in the United States of America, Australia and Canada "...have consistently found that the number of heavy drinking occasions is a stronger predictor of drinking problems than level of consumption."

A hotly debated issue in New Zealand in the alcohol field is the minimum legal drinking age, with public health workers consistently opposed to lowering the minimum age, while the police and industry consistently support lowering the minimum age. Edwards et al (1994) reviewed numerous studies (26 cited) regarding the lowering of the minimum drinking age to 18 years. In summary they considered that these "... studies have generally found that a lowered age limit produced greater alcohol-involved traffic crashes for the age groups affected by the change, while increased age limits reduced such crashes. Interestingly, few studies found that the higher minimum age always produced an immediate reduction in general alcohol consumption among the age groups affected by the law. However, recent research has found lower alcohol consumption in the long term (into the early 20s) among young people in North America in areas where the legal age has been raised by at least one year." (Edwards et al, 1994) Other interventions such as designated driver programmes were found to have no controlled evaluation trials available and so were scantily reviewed.

One popular area of intervention in almost any primary prevention or health promotion field is that of education and in particular, education of young people. Edwards et al (1994) state that "... the popular and often well resourced intervention of school-based education and moderation mass media campaigns, was not found to be effective." Similarly, in a report from a recent conference, Casswell stated that although "... educational campaigns are a popular prevention approach, there is little research evidence for any direct effects on alcohol consumption...[and that] educational campaigns cannot be relied upon as a primary strategy to reduce alcohol-related harm." (Montonen, 1997) Education strategies, in order to have any chance of effectiveness, need to be entwined with other strategies, especially those which more directly impact on the drinkers environment. (Edwards et al, 1994) The value conceded to educational and

moderation mass media campaigns is that of raising alcohol issues in the social and political context so that they may be taken into account in making policy decisions.

Alcohol Policy and the Public Good reviewed an almost exhaustive range of alcohol prevention interventions and found that there was strong evidential underpinning for a public health approach to alcohol related problems. In summary, they found that there were several interventions which have proven to be effective, such as taxation, a variety of environmental measures which make physical access to alcohol less easy and drink driving campaigns if they are high profile and highly enforced; some interventions which show less promise, such as school education as a lead programme or teaching the public to count to 'safe drinking limits' unless mitigated by describing it as lower risk; and some such as community action programmes where they consider there to be no hard evidence but a potential to affect alcohol related problems. (Edwards et al, 1994) In an invited background paper Casswell (1991) stated there was a consensus agreement that "... a significant impact on alcohol-related problems is more likely to be achieved when there is consistency of approach at all levels, including not only policies which affect broad population groups but also those implemented at community, business and school level and those designed to influence the individual more directly." The research surveyed in Alcohol Policy and the Public Good outlines the shift in approach to harm reduction rather than use reduction and provides strong support for that shift while placing the overall environmental and policy approaches firmly in the public health, and consequently health promotion, field. (Addiction: 90 1995, Various Authors)

2.3 Responsible Serving Practice

Known variously around the world as server intervention or patron care, responsible beverage service(RBS) has a number of manifestations in different cultures and communities. It is most commonly practised in the USA, Canada, Australia and New Zealand. In the UK and Europe there is less focus on this aspect of interventions. It was on the basis of much of the early work reviewed here, that ALAC developed host responsibility for the New Zealand context in 1990. Edwards et al (1994) included a review of responsible beverage service.

Some of the research showed mixed results or results which, because of the particular social settings, were not readily generalisable to other settings. However, most studies showed that it was effective in changing server practice and in one US state which mandated server training "... produced a statistically significant reduction in alcohol-involved traffic crashes when at least 50% of servers had completed training." (Edwards et al, 1994) This, coupled with server liability in the United States which was established from litigation following two major suits in 1983 and 1984, has suggested that responsible beverage service can make a difference to alcohol consumption and related problems. Writing in 1993 Gilksman et al stated that in "... the past 10 years, hospitality organisations, government agencies and even the alcohol producers have endorsed and/or developed server intervention programmes." Although many programmes began as specifically server intervention programmes, they have over time expanded to include a "...broad range of strategies designed to reduce the harm associated with drinking in licensed environments." (Krass & Flaherty, 1994) Australian, Canadian and New Zealand research has shown that alcohol consumption on licensed premises is strongly associated with high levels of intake and a range of alcohol related problems. "These data are persuasive that efforts to prevent acute alcohol-related problems should explore the potential within the licensed drinking settings for the reduction of harm and, in particular, strategies which will reduce levels of patron intoxication." (Gilksman et al, 1993)

2.3.1 North America

North America was the birth place of responsible beverage service and, until the 1990s, the only place where published evaluations of responsible beverage service came from. As such almost all responsible beverage service programmes rely on the findings of those programmes to build their own programmes and all later published information refers to those key documents in summary form. The key findings were that a comprehensive approach incorporating house policy redevelopment, and manager and server training is able to reduce the likelihood of a patron being served to intoxication without reducing the overall alcohol sales.(Saltz) In other studies it was found that trained servers were less likely to serve to intoxication, although it was more likely that they would avoid harmful practices than use confrontational strategies, particularly if servers were unsure of management support. In most cases server intervention alone made no impact on

patron intoxication, rather it needed to be combined with other strategies such as management training or enforcement activities. In one programme which focussed on the control of sale and supply of alcohol at sports stadiums with seven basketball associations, server intervention in its broadest sense led to decreased beer consumption, increased food and non-alcoholic beverage consumption, and increased attendances at games.(Gilksman et al, 1993; Carvolth, 1991)

The Community Prevention Trial was a five year (1991 - 1996) comprehensive intervention programme developed by the Prevention Research Center, Berkeley, in the United States of America.ⁱⁱ It focussed on three experimental communities of around 100,000 population each with three similar control sites. "The goal of the project was to reduce alcohol-involved accidental injuries and death by instituting a comprehensive program of community-based environmental prevention activities and policy changes." (Holder et al, 1997b) The Project had five phases which were: baseline measurement; community mobilisation and initial implementation; comprehensive implementation; reinforcement of comprehensive implementation including booster activities; and institutionalisation and outcome assessment. Institutionalisation was defined as "... the process by which prevention activities ... are established within existing local structures to be continued after outside funding and technical support have ended."(Holder et al, 1997b)

The five components were chosen as the most likely to affect the contributing factors and alcohol related problems identified, and for their ability to interact with and enhance each other's effect.

Working with existing coalitions to mobilise community action through implementing prevention activities and raising public awareness was the first component. In this project 'community' meant all those living in the target community, including professionals and institutions. All three experimental communities were successful in mobilising community action and in establishing the role of policy through key decision makers. One of the communities did not conform to the protocol and, in particular, the aspect which required a wide

ⁱⁱAn entire supplement journal of *Addiction* was dedicated to publishing the outcomes of this trial. **Addiction (1997) 92 (Supplement 2).**

ranging spectrum of community representation, yet they still succeeded in achieving their aims. They, therefore, "...provide some doubt about assumptions that broad coalitions representing a wide and diverse set of organisations and interests are essential organising elements to community prevention." (Treno & Holder, 1997)

Reducing the number of drink driving events by increasing both the actual and perceived risk of detection if driving while intoxicated was the second component. During the course of the Project, alcohol involved traffic crashes were reduced as a result of the drink driving component. It provided "... the first published demonstration of a full causal model for the development of deterrence through the enforcement and news coverage of DUI [driving under the influence] deterrence."(Voas et al, 1997)

Establishing responsible beverage service was the third component. The hospitality associations sponsored the server intervention training, while the programme itself emphasised the managers role and had as secondary targets such organisations as the hospitality associations and alcohol wholesalers. Interestingly, licensed premise managers were more likely to believe that servers could prevent intoxication than the public. In the experimental sites there was an increase in refusal of service, however, the numbers were too small to detect any statistical significance. The key lessons extracted from this component were that: hospitality industry involvement in the project from an early stage is crucial to success; voluntary responsible beverage service training is not effective in establishing RBS in the community; and both serving staff and the public must know that there is effective enforcement in place as an incentive to act responsibly.(Saltz & Stanghetta, 1997)

All Councils in the experimental sites adopted regulations relating to reducing the density of alcohol outlets and alcohol use in public which met the objective of the fourth component.(Reynolds et al, 1997)

The fifth component aimed to reduce under age drinking by restricting the sale and supply of alcohol to minors. Training similar to RBS training was provided for retail clerks and assistance to managers in developing consistent policies regarding

sales to minors. While there was a decrease in sales to minors there was no evidence that the training had any effect, however, this may have been due to the relatively small number of trained outlets in individual communities.(Holder & Reynolds, 1997).

Media advocacy was a tool used throughout the Community Project. (Holder & Treno, 1997) It entailed the strategic use of the news media to advance particular social or public policy initiatives. As news coverage shapes public and political concerns and action, media advocacy was aimed at reframing the public debate around alcohol issues. It proved to be most effective as a reinforcer of specific environmental effects as well as being relatively cheap to implement and institutionalise. The crucial role of media advocacy should not be underestimated. "Without skillful media work it is very difficult (perhaps impossible) to create policy-driven structural changes within a community." (Holder & Reynolds, 1997)

The Community Prevention Trial project was successful across all its pre-determined indicators demonstrating that an environmentally directed approach to prevention, using policies as the form of intervention can reduce alcohol problems at the local level. (Holder et al, 1997a)

2.3.2 Australia

Closer to home where the culture, particularly the drinking culture, resembles New Zealand's culture, Australia has been actively pursuing its own version of responsible beverage service. Many of the programmes reviewed were community driven and as such had a variety of approaches. In the Northern Territory several different programmes operate in tandem but with a particular community as a focus for each. The Living with Alcohol programme used a variety of strategies such as community action projects, educational campaigns and server intervention training. They found that traffic accidents decreased, and the consumption of low alcohol beer increased within an overall decline in alcohol consumption. (Crundall, 1994) In Melbourne, a designated driver programme was established with three suburban nightclubs which enabled a pre-selected designated driver with two or more passengers to obtain free non-alcoholic drinks. The outcome evaluation found that the programme did encourage patrons to select

their designated driver before commencing drinking and resulted in significant decreases in self reported alcohol consumption. There is some evidence also that links the programme to a reduction in drink-drive risk taking behaviour.(Boots, 1994) Krass and Flaherty (1994) found that in the server intervention programme implemented in Waverley, Sydney, server behaviour and management practices changed to slow service down and a noticeable increase in the promotion of food and low alcohol beer was observed. However, there was no corresponding reduction in levels of patron intoxication. This finding should give us pause. It reflects the range of outcomes found in earlier US and Canadian research but is at odds with other research which found that server intervention could have an impact on patron intoxication. It is interesting to note that the Waverley intervention was confined to server and management training programme only. Several of the programmes reviewed previously have pointed out the importance of a more comprehensive programme than server intervention training alone. A more successful programme was the deliberate development of a low risk drinking environment in a club setting. The programme was developed in close consultation between the Western Australian Health Promotion Foundation, the Alcohol Advisory Council of Western Australia and the management and staff of the Fly By Night Musicians Club. Five strategies were agreed to: responsible server training, standard drink serves for beer and spirits, attractively priced alternatives, a house policy developed and displayed, and alcohol awareness sponsored music events. During the programme timeframe the patronage of the club doubled as did the alcohol consumption, however, there was no increase in alcohol related problems. (Slinger & Stockwell, 1994)

"The limited data available concerning the social ecology of drinking situations and alcohol related harm point strongly to the licensed drinking environment as a major cause for concern and an important focus for prevention efforts." (Stockwell et al, 1991) In 1992 Homel et al reported on the possible links between aspects of the public drinking environment and the occurrence of violence. They found several factors which contributed to the occurrence of violence. The most critical element they found which contributed to violence was the social atmosphere. In the violent premises studied, substantial food was not available especially later in the night, whereas the non violent premises studied operated substantial restaurants. They also found that " Violent occasions [were]

characterised by ... groups of male strangers, low comfort, high boredom, high drunkenness, as well as aggressive and unreasonable bouncers and floorstaff. ... [However, in] a well-managed club or pub employing skilled doormen and floorstaff who can detect problem situations before they get out of hand, or who have good communication skills and can defuse aggression before it leads to violence, there may rarely be any connection between levels of intoxication and violence."(Hommel et al, 1992)

2.4 Responsible Service Practice in New Zealand

When responsible service practice was introduced to New Zealand in the 1990s by ALAC it came with a new name - Host Responsibility. It incorporated many of the same strategies reviewed previously. However, it was more broadly focussed in that it included private hosts as well as those of licensed premises. At a similar time the Sale of Liquor Act 1989 came into force (April 1, 1990). For the purposes of this dissertation the literature review of host responsibility in New Zealand will focus on the published research on the implementation and effectiveness of host responsibility in licensed premises.

In 1990, ALAC funded the Alcohol Research Unit at Auckland University to develop a two year project which would facilitate public health input into the implementation of the Sale of Liquor Act 1989. As part of that process, formative evaluation was undertaken for the duration of the project. In all this amounted to four evaluation reports. The Alcohol Research Unit chose to work directly with health promotion workers, most of whom were employed by the then Area Health Boards. This group of workers collaborated and established a number of objectives for the project which would raise and maintain the visibility of health concerns with District Licensing Agencies (DLA) and Medical Officers of Health, each of whom had assumed specific licensing responsibilities under the Sale of Liquor Act 1989. These objectives included establishing input into: DLA committee membership; licensing meetings between the Local Authority, MOH, police and Ministry of Transport; and setting objectives with DLAs which would include public health issues. They also included working with the local MOH to establish an MOH checklist for licensing applications. The responses to these approaches varied considerably around New Zealand. In some areas the public

health approach was very welcome, in others the reception was somewhat more hostile. (Stewart et al, 1990)

For the second and subsequent Formative Evaluative Reports health promotion workers reported against the objectives they had agreed at the beginning of the project. The Second Report, covering the period August - December 1990, (Stewart et al, 1991a) notes that many of the health promotion workers had been introduced to host responsibility and server intervention through a training programme offered by ALAC and presented by Jim Mosher who was from the Responsible Beverage Service programme in California. In many areas of the country, health promoters reported positively against the objectives. The third report, covering the period January - June 1991, (Stewart et al, 1991b) again showed a wide range of responses with areas such as Christchurch, Wellington, Nelson, Auckland and Gisborne reporting very favourably on the progress made. The fourth and final report, covering the period July 1991 - March 1992, (Stewart & Casswell, 1992) concluded that the project had led to an enhanced public health input into the Sale of Liquor Act 1989. These reports provide an interesting insight into the early history of host responsibility in New Zealand. Several of the areas which reported very positive starts to host responsibility input into licensed premises have not carried that on consistently over the last 8 years.

Concurrent with host responsibility fieldwork by health promoters, was a national television advertising campaign for host responsibility. An evaluation of the campaign in November 1992 found that host responsibility had gained wide acceptance in the 12 months since it was first promoted and that the national campaign made a useful contribution to the local work. It was not, however, particularly attractive to Maori or rural people. (Wyllie & Panapa, 1992)

In 1993 the Wellington Regional Public Health Service evaluated their Sale of Liquor Project. (Roseveare & Withers) The project had a two fold approach. First, all licensed premises were assessed for their degree of host responsibility practice as part of the liquor licensing process and a recommendation to the Liquor Licensing Authority that host responsibility be part of licensing strategies made. Second, 65 priority licensed premises were selected via police reports and offered a host responsibility visit, assistance with training and other host responsibility

resources. The evaluation found that there was a 43% reduction in total recorded alleged alcohol impaired driving offences and a significant reduction of 59% in offences from priority identified premises. A focus group of licensees involved in the programme identified a confusion of roles between health promotion advisers, health protection officers and Council inspectors and considered that those offering host responsibility advice should have industry experience. They also considered the Alleged Alcohol Offences data to be biased, as they felt intoxicated people lied. However, the police felt that although licensees complained, they none-the-less took note and maintained their internal enforcement. Overall, the evaluation found that the programme had been successful in achieving its objectives relating to drink driving reduction and host responsibility uptake.

In 1993 the Alcohol and Public Health Research Unit undertook a survey of stakeholder perceptions to "...provide feedback and suggestions for the national host responsibility campaign from a range of respondents with various involvement in the field." The groups included national level host responsibility players, Maori community workers, community health promotion workers, licensing inspectors and on-licensed premise managers. In general the campaign was reviewed favourably with suggestions that Maori and rural people should be included more. The programme themes should be broadened from drink driving to moderate drinking and non-violence. Concern was also expressed to encourage police enforcement action. Overall the stakeholders' felt that the "...campaign aimed at licensed premises should receive more emphasis than that aimed at private hosts because licensed premises are associated with a greater level of alcohol-related problems and there are significantly more incentives for licensees to adopt host responsibility practices, especially since the recent introduction of compulsory breath testing." (Abel et al, 1993)

In 1996 the Department of Justice undertook a comprehensive review of the Sale of Liquor Act 1989. In preparation the Alcohol and Public Health Research Unit undertook a survey of local perspectives on the Act. Most interviewees felt that the legislation could contribute to the reduction of liquor abuse and were more concerned with particular parts of the Act which they perceived to be unfair or unworkable. They considered the law to have as much a symbolic value as a pragmatic one, in that it set accepted norms of behaviour and premise

management. In locations where statutory officers worked closely together respondents reported a more united approach to enforcement and a more proactive approach to initiatives directed at the reduction of alcohol related harm. In areas without close working relationships there was dissension about appropriate activities and approaches with criticism of other officers and agencies. The presence in a location of an active public health officer/adviser tended to contribute towards a higher priority given to food and other host responsibility strategies; resource sharing; liaison committees including licensees; and productive co-operation between statutory agencies.

At first glance having a proactive approach to liquor licensing, and working towards reducing alcohol related harm, appears to come down to personalities - simply the luck of having a good person in the job. At second glance it is structural. It is about creating the policy, positions and the job descriptions to cover the tasks and responsibilities under the Sale of Liquor Act. (Hill & Stewart, 1996)

2.5 Summary

There is strong evidential underpinning for a public health approach to alcohol related problems. Several interventions which have proven to be effective, such as taxation, a variety of environmental measures which make physical access to alcohol less easy and drink driving campaigns if they are high profile and highly enforced; some interventions have shown less promise, such as education alone; and some such as community action programmes demonstrate an as yet unproven potential to affect alcohol related problems. (Edwards et al, 1994) The shift in approach to harm reduction rather than use reduction is strongly supported by the research summary and places the overall environmental and policy approaches firmly in the public health field. Complementing this research is the evidence demonstrating that responsible beverage service accompanied by community mobilisation, enforcement of legislation, policy action by local decisionmakers, media advocacy, involvement of the hospitality industry and institutionalisation of practices reduces alcohol related harm. In the New Zealand context, the Sale of Liquor Act 1989's objective required a commitment to reducing alcohol related harm while the host responsibility concept introduced by ALAC offered a framework for implementing harm reduction strategies. This review has set the

context within which the Dunedin Host Responsibility Programme was developed and implemented.

3 THE DUNEDIN HOST RESPONSIBILITY PROGRAMME

3.1 The National Context

The Dunedin programme was developed in the context of a national movement from individual education to population strategies epitomised by host responsibility. The Alcohol Advisory Council (ALAC) was a government agency responsible for oversight of the alcohol treatment and prevention fields. In the prevention dimension of its work it had been involved in supporting health promotion and education workers in their prevention work and in offering training to those workers. It was also provided advice to the Government regarding alcohol issues. Much of this had been related to reducing injury and death from alcohol related motor vehicle crashes. In the late 1980s concern with drink/driving had grown for the Government, health professionals and the general public. It was evident from research that education, either in the classroom or via media campaigns was not effective in reducing alcohol related motor vehicle crashes. ALAC began exploring health promotion programmes in other countries which targeted the sale and supply of alcohol. This was in keeping with the Ottawa Charter which shifted the focus from individual education and campaigns to creating an environment supportive of health, and the public policies which would establish that environment. From that exploration of international programmes outlined in Chapter Two, the concept of *Host Responsibility* was developed. (Stakeholder Interview ALAC) While implementation of host responsibility has changed in the last seven years, the underlying principles and key factors have not.

The concept of host responsibility focuses on the places in our communities where we serve alcohol. It is about creating drinking environments that are welcoming and comfortable and where alcohol is served responsibly. Host responsibility applies in commercial, workplace and private settings. The five basic components of host responsibility are simple and straightforward but the key to success is good planning. A responsible host:

- provides and actively promotes low and non-alcoholic alternatives
- provides and actively promotes appropriate food

- serves alcohol responsibly
- is able to identify and responsibly deal with under-aged and intoxicated people
- arranges safe transport options.(ALAC, 1992)

While developed within the framework of the Ottawa Charter, host responsibility also fits within the framework of harm minimisation rather than harm reduction. Reducing harm related to alcohol is certainly one of the aims, as is reducing consumption so that intoxication does not occur or acting so that young people do not have access to alcohol, thus shifting it into the broader harm minimisation field.

To support the host responsibility campaign, ALAC worked with health promotion workers around the country, providing training, resources and support as well as initiating the two year programme the Alcohol and Public Health Research Centre undertook with health promotion workers establishing public health input into the Sale of Liquor Act. They also implemented several national advertising campaigns aimed at raising awareness of the host responsibility concepts in the general public.

Concurrent with the development of host responsibility, the Government passed into law the Sale of Liquor Act 1989 (effective April 1, 1990), following a lengthy review of both the Sale of Liquor Act 1962 and the issues surrounding alcohol in New Zealand. This review was known as the Laker Report. The new Act changed the legislative requirements for the sale and supply of alcohol substantially. Under the 1962 Act there were a limited number of licences which could be held in the country. They became a tradeable commodity. Following the introduction of the 1989 Act, the number of licences were not restricted in such a way but rather by the suitability of the applicant and premise as well as by the market. Other dramatic changes included the lifting of specific hours of retailing to allow for conditions which suited both the premises and the local area. During the Parliamentary debate it was recorded that one aim in lifting the restrictions was to encourage smaller sized but more licensed premises for the public to choose from. This was seen as a deliberate shift from the large 'swill barn' type premises where patrons were encouraged to drink copious quantities of alcohol in a time restricted

fashion, to more intimate premises where other entertainment was also part of the time spent there.

Other key changes which supported host responsibility were: the requirement that licensed premises must provide food while open; the requirement that licensed premises not serve under age patrons, nor serve patrons to intoxication; the requirement that the Medical Officer of Health provide a report; and the establishment of the District Licensing Agency within the local Council to conduct and administer the licensing process for that locality. All applications for on or club licences were to be accompanied by reports from the Licensing Inspector(s) from the local Council, from the Police and the Medical Officer of Health. Some of these were similar to reports required under the 1962 Act, however, the Medical Officer of Health report was a new requirement. Part of the aim of including a Medical Officer of Health report was to include a local input. (Hood, 1996) It was unclear though, what such a report should contain. Across the country the Medical Officer of Health report has evolved to become, to a greater or lesser extent, a report focusing on the implementation of host responsibility in licensed premises. This is in some part due to the two year Alcohol and Public Health Research Unit's programme with health promotion workers outlined in Chapter Two. In the years since the introduction of the 1989 Act until mid 1998, case law, through the central Liquor Licensing Authority, has developed which has established the parameters of various responsibilities of both the statutory agencies and the licensees. At the time of this dissertation the Sale of Liquor Act 1989 is being reviewed again. This is a substantial review, having commenced in 1996. It is yet to go before Parliament (March 1999).

Other national organisations also contributed to the context in which the Dunedin programme was developed and implemented. During the time of the programme the Police and the Department of Transport were amalgamated. The Ministry of Transport Traffic Officers who had a specialist interest in alcohol related motor vehicle crashes were assimilated into the Police force. The Ministry of Transport became a policy body for the Government and the Land Transport Safety Authority was formed. The Ministry of Transport, the Police (national) and the Land Transport Safety Authority developed and aired road safety advertising campaigns. Many were aimed at reducing alcohol related motor vehicle injury and

death. Two such slogans from the advertising were "If you drink and drive you're a bloody idiot" and "Rural people die on rural roads." Many of these campaigns were used by local health promotion workers as booster activities for their own programmes which mimicked the slogans and adapted the material for the locality. (Personal communications: health promotion workers, 1992 - 1998)

Prior to amalgamation with the Traffic Officers, the Police (at an anecdotal level) were well aware that whenever the Traffic Officers carried out 'drink driving blitzes' much other crime reduced as well. (Personal communications: Dunedin & Christchurch Police) In 1993 the Police acknowledged alcohol as a major contributor, not only to motor vehicle crashes but to almost all other crime and disorder, within their Strategic Plan 1993 - 1998. They summarised their approach with the slogan 'Alcohol the Aggravator' and publicised it with national media advertising. The Police Strategic Plan also saw a move towards partnership working with local agencies and the community, and a focus on prevention. Following the very successful introduction of Compulsory Breath Testing in New Zealand, the Police actively pursued alcohol impaired drivers with new technology and alcohol checkpoints. In 1996 the Police (national headquarters) in conjunction with ALAC developed a training programme for licensed premise staff and management to assist them to recognise patrons who were becoming intoxicated. This programme was called "How to Recognise the Seven Drunks". It was sent to each district where the police officer responsible for licensing was to use it. Its implementation depended on the skill of the police officer and the relationship they had with either the licensed premises or the local health promotion workers.

In the early 1990s the national breweries began to promote either patron care or host responsibility and the Hospitality Industry Training Board offered training in host responsibility. The Hotel Association of New Zealand also supported the concept of host responsibility although they were somewhat sceptical about the role of the statutory agencies whom they considered for the most part to be inclined toward litigation and obstructing legitimate business. The impact of the Sale of Liquor Act 1989 also affected the Hotel Association in that a large and growing number of licensees were not hotel owners or managers. The Hotel

Association became the Hospitality Association to reflect its changing membership.

The national context outlined above is one in which all local host responsibility programmes in New Zealand were developed and implemented. Locally, other groups contributed to the Dunedin programme. The Alcohol Issues Council, a local group of concerned citizens, had been in existence since the mid 1980s. It acted as a support group to the local alcohol health promotion worker and lobbied local and national government regarding alcohol. Like many community groups it wound up in the face of taxation law changes in 1992/93. (Otago Public Health Service Programme Files) The other community organisation which contributed to the programme particularly in its early stages was the Dunedin and Community Road Safety Council. As a group of local citizens, they contributed to various campaign projects which were particularly aimed at reducing drink driving. Midway through the Dunedin Programme the Dunedin City Council appointed a road safety worker whose brief overlapped the Host Responsibility programme. This added another dimension to the team.

3.2 Dunedin Demographics

Dunedin City is located on the coast in the south of the South Island and is the main city of the province of Otago. Its population of 118,143 is spread over a large and varied geographic area incorporating inner city and suburban dwellings, rural settlements and farms, and areas of outstanding natural and wildlife habitat. Tertiary education is one of the main industries in the city with three campuses located in the central city. This contributes to a higher proportion of young people under 25 than many other cities in New Zealand. The Maori population in Dunedin at approximately 8% is considerably less than the New Zealand average. (New Zealand Census, 1996) In 1990 at the introduction of the Sale of Liquor Act 1989, the number of on, club and off licences in Dunedin stood at 103 while at 30 June 1998 the number of current on, club and off licences was 380. (Programme Files: Dunedin District Licensing Agency)

3.3 The Public Health Service History

The health system has been in almost constant reform since the late 1980s. The Public Health Service changed from being a branch of the now defunct Department of Health to being a service of HealthCare Otago. Throughout these processes the Public Health Service's overall role and focus has remained the same, that is, to promote and protect the public health. Before the Sale of Liquor Act 1989 and the launch of host responsibility by ALAC, the Public Health Service had been involved in alcohol health promotion and education. This had included input into policy making, such as a submission to the Laker Report, education in schools, assisting teachers and local SADD (Students Against Drunk Driving) chapters, and raising awareness of drink driving issues with media campaigns. The health promotion worker often worked in conjunction with the local Police Youth Education Service and with the Community Advisory Service of the Dunedin City Council on alcohol education programmes for young people. (Stakeholder Interview: Otago Public Health Service; & Otago Public Health Service Programme Files)

3.4 The Dunedin Police History

Prior to the Sale of Liquor Act 1989 the Dunedin Police were, for the most part, enforcement driven with regard to alcohol. They were regularly involved in 'raids' on various licensed premises where they arrested underage patrons or other patrons who were disturbing the peace. The Youth Education Service of the Police were involved in education programmes in schools often in conjunction with the health promotion worker. The Traffic Officers, who were not yet assimilated into the police force, conducted periodical drink drive blitzes often related to holiday or festive times and undertook road safety education in schools. (Stakeholder Interview: Dunedin Police)

3.5 The District Licensing Agency and Dunedin City Council History

Under the 1962 Act the Dunedin City Council provided inspections of licensed premises, although these were somewhat different to the inspections carried out under the 1989 Act. The Community Advisory Service were involved in alcohol

education of young people often in conjunction with the health promotion worker. The Dunedin District Licensing Agency came into existence as a result of the Sale of Liquor Act 1989. The Environmental Health Officers incorporated the new Licensing Inspector role into their job description and a co-ordinator of the District Licensing Agency was appointed. (Stakeholder Interview: Dunedin City Council & District Licensing Agency)

3.6 The Dunedin Partnership Process

Although various sectors within each of the organisations which were to form the Dunedin Partnership had worked together on alcohol related issues, this had primarily been on an ad hoc basis. No ongoing and developing relationship existed. With the advent of the Sale of Liquor Act 1989, legislative requirements meant that each organisation had a new statutory responsibility. The Public Health Service participated in the Alcohol and Public Health Research Unit's two year project to facilitate public health input into the Sale of Liquor Act 1989 procedures. The Dunedin Police appointed a Sergeant with particular responsibility for liquor licensing and the Dunedin City Council appointed a co-ordinator for the District Licensing Agency. Each of these players viewed the Sale of Liquor Act 1989 as enabling legislation and held the Act's objective as their primary goal. The impact of the Sale of Liquor Act 1989 on the licensing process meant that in Dunedin, there was a steady flow of new premises being licensed and of existing premises changing hands.

Required statutory input into licensing offered an opportunity to initiate relationships with each other. These were rather tentative at first, with all participants concerned that their perspectives and responsibilities be understood. (Stakeholder Interviews: All Dunedin) National documentation (Stewart et al, 1990,1991a,1991b, & Stewart & Casswell, 1992) suggests that initial relationships were somewhat difficult, however, local documents (Otago Public Health Service Programme Files) suggest that the relationship between the three statutory agencies had already begun to address tasks jointly as early as 1991. It is fair to say that at this stage and for several years into the partnership the Police and the District Licensing Agency viewed the Public Health Service's role as that

of an Enforcement Agency and to some extent not an equal partner.ⁱⁱⁱ However, the health promotion workers of the Public Health Service viewed the Sale of Liquor Act 1989 requirement for a Medical Officer of Health report (the inspection for which they undertook with the authority delegated by the Medical Officer of Health) as an entrée into the sale and supply of alcohol, which allowed them credibility and the opportunity to develop the prevention messages they wished to share. It is clear that in the early stages of the Partnership they viewed the Police and District Licensing Agency as much in need of prevention training as the licensed premises. (Stakeholder Interviews: Otago Public Health Service & Stewart et al, 1990, 1991a, 1991b) The Partnership Agencies met on a regular basis in a 'Strategy Meeting'. These meetings initially focused on licensing-specific issues but each Agency's focus on prevention as required by the Sale of Liquor Act 1989 shifted the focus of the group to a series of projects which were united in their goal of reduction of alcohol related harm. These formal meetings are no longer required as the Partnership Agencies now work as a fully functioning team who are in contact every day and meet for task specific reasons.

Together in 1991 the Partnership Agencies set up a Liquor Liaison Committee. This Committee included each of the agencies as well as local Hotel Association (HANZ) and Sports Club Association representatives, brewery representatives, the Injury Prevention Unit of the Otago Medical School and a variety of individual licensees. The focus of these meetings was to discuss licensing issues in particular for on and club licensed premises. The Partnership Agencies used these meetings to raise key issues with the industry as did the industry with the Agencies. Concurrently meetings of all licensees were called by the Partnership Agencies to discuss aspects of licensing and to provide general information and education about Host Responsibility.

The Dunedin Programme has a multi-level partnership approach. The Partnership Agencies, and particularly the key workers of those Agencies, form the core partnership. However, there is a wider partnership which includes industry representatives, such as the local HANZ branch or the local brewery, voluntary

ⁱⁱⁱ This nomenclature is present in both Stakeholder Interviews - Dunedin Police and Dunedin City Council and District Licensing Agency as well as the presentations given by the Police and District Licensing Agency to Conferences.

organisations such as the Otago Rugby Football Union, community groups such as the local Road Safety Council and professionally related organisations such as the Injury Prevention Unit of the Otago Medical School. Each of these members of the wider partnership brings their particular perspective and expertise to specific and appropriate projects.

The Partnership Agencies' philosophy is neatly summed up by the National Police statement on partnerships from Policing 2000. "Partnerships are strategic alliances between two or more parties who share the same vision and who are committed to working together to achieve agreed goals." Partnership is not just about liaising but working proactively together on issues, initiatives and enforcement. The key element the Partnership Agencies saw in their partnership was an acceptance of the mutual goal to reduce alcohol related harm. The bases for achieving that goal were regular and open communication, taking time to build the relationship and trust, blurring the boundaries of responsibility, developing joint projects and actively sharing resources. (Partnership Agencies Presentation, 1996) Developing joint projects has proved the main catalyst for achieving a working partnership, credibility with the industry and a reduction in alcohol related harm.

3.7 The Dunedin Partnership Projects^{iv}

All the Partnership Projects were developed under the umbrella of reducing alcohol related harm from a population prevention perspective. The primary target was the drinking environment which led to working with licensed premises' owners, managers and staff. The secondary target was the drinking public which led to working with particular groups of the population. Projects range across the spectrum of the Ottawa Charter strategies. Some were developed in response to issues raised by the community, while others were initiated by the Partnership Agencies as part of the overall programme. Table 3 illustrates the Ottawa Charter strategies with a selection of the projects undertaken.

^{iv}Information regarding projects was taken from Public Health Service and District Licensing Agency Programme Files and from Stakeholder Interviews.

Table 3: Examples of Partnership Agencies' Projects by Ottawa Charter Strategy

OTTAWA CHARTER STRATEGY	PROJECT ILLUSTRATION
Building healthy public policy	<ul style="list-style-type: none"> • Sale of Liquor Policy written by Partnership Agencies and adopted by the Dunedin City Council. Included a requirement for on and club licensing applications to include Host Responsibility. • The Dunedin City Alcohol Charter setting Host Responsibility policy and practice in place launched and publicly signed by all major agencies, the local brewery, HANZ, Sports Club Association(SCANZ) and a representative of future generations. • Partnership Agencies made a substantial submission to the Review of the Sale of Liquor Act 1989
Creating supportive environments	<ul style="list-style-type: none"> • The University Union Meal Deal project was designed to address the confusion regarding young people of 18 and 19 years old being on licensed premises and accessing alcohol. • The Sammy's Project, The Carisbrook Project and several others were specifically aimed at the drinking environment.
Strengthening community action	<ul style="list-style-type: none"> • The Youth Alcohol Issues Group was initiated and assisted by the Partnership Agencies. They focused particularly on issues for young people.
Developing personal skills	<ul style="list-style-type: none"> • Host responsibility training was provided for licensed premises • The Door Staff project and PSST... were educational projects.
Reorienting the health service	<ul style="list-style-type: none"> • The Partnership Agencies Chief Executives and Commander signed the Partnership Protocol which sets out the approach the Agencies will take to reducing alcohol related harm and to their work together.

3.8 Benchmark Projects

The Benchmark Projects were chosen for this case study because they met three criteria. First that they had some kind of written evaluation process; second, that they occurred at different times over the eight years; and third that they were representative of the diversity of approach the Dunedin Partnership Agencies

took. The choice of these projects as benchmark projects was confirmed during the Stakeholder Analysis as these particular projects were spontaneously commented on by all those interviewed to a greater or lesser extent.

Sammy's (1993 - 1995): The Sammy's project was the first major joint project undertaken by the Partnership Agencies. Sammy's was the local 'in' night club of the time, where the main live music and bands came to in Dunedin. The project provided a licensed entertainment venue where 16 - 19 year olds could participate as non-drinking patrons. A subsidiary objective was to demystify the licensed drinking environment for young people with the aim of reducing intoxication in the future. Project development was in conjunction with the management of Sammy's. It involved intensive host responsibility and intervention training for staff and management. Strong management support for staff interventions and intensive monitoring and support from the Partnership Agencies were principal elements.

The Atmosphere of Licensed Premises (1994 - 1995): Both the Partnership Agencies and the local industry were concerned about what they described as the 'atmosphere' of some licensed premises in Dunedin. The Partnership Agencies were interested in reducing incidences of intoxication, sales to underage patrons, violence and unintentional injury, while the industry was concerned with maintaining patronage through safer drinking environments, enhancing profits and reducing their premises' implication in alcohol related harm. A research project was undertaken to determine what the 'atmosphere' was in licensed premises. Pairs of male/female observers visited a wide range of licensed premises across the City assessing the premises against a set of criteria, ranging from service, intoxication, and entertainment available, through to overcrowding and the condition of toilets. These criteria were derived from those identified by Homel et al (1992) in their study of violence in licensed premises. Results for particular premises were fed back directly to those premises. The Partnership Agencies received aggregated results. This was to protect premises from possible enforcement action and thus ensure the greatest participation from premises. One outcome of the project was that it provided impetus for concurrent projects and identified new areas of work. These new projects were initially referred to as being part of or under the umbrella of the Atmosphere Project but have come to exist separately from it.

PSST... (1997): Originally commissioned by the Public Health Service from the Theatre in Health Education Trust (THeTa) two years earlier, PSST ... was an educational theatre production aimed at senior school students addressing issues of alcohol and violence at parties. The Partnership Agencies recommissioned the programme for the senior schools in Dunedin as part of the overall commitment to reducing alcohol related harm. Educating young people was seen as part of preparing them for the changed drinking environment the Agencies hoped to have created.

Doorstaff Project (1996 - ongoing): This project was initiated following public complaints about overly confrontational bouncers and age identification as an issue from the Atmosphere Project. Consultation with both door staff and licensed premises managers identified particular issues which were addressed in training developed for door staff and management. The objective was to improve the practice of doorstaff and thereby reduce their involvement in violent incidents.

Events Management - Carisbrook (1996 - ongoing): Provincial and international rugby is a major entertainment event in Dunedin. The Otago public's reputation as supporters is well known. Consumption of alcohol at such events is also well known. The Partnership Agencies, together with the Otago Rugby Football Union, the sponsoring brewery Speights, HANZ, alcohol and food retailers, security staff and the voluntary organisations involved such as Rotary, developed a project approach which aimed to reduce alcohol related incidents and harm. Strong communication channels were established between all stakeholders which facilitated the identification of problems. Solutions were developed which primarily focused on the environment created at matches and on the management of access to alcohol at the grounds. This particular project was nominated as New Zealand's only entry for the sixth annual Herman Goldstein Award for Excellence in Problem Oriented Policing (1998) at the Ninth Annual International Policing Conference in the USA.

Events Management - New Year's Eve (December 1996): The street party with Dave Dobbyn as lead act for New Year's Eve went against national 'alcohol free' trends. Significant but unobtrusive management controls learned from the

Sammy's project and from the Carisbrook project were put in place with the aim of reducing alcohol related incidents. Approximately 4,000 people attended the street party (from ticket sales) and another 4,000 were in the surrounding central city area.

A comprehensive list of Partnership Projects can be found in Appendix 1.

4. FRAMEWORK FOR EVALUATION

Any discussion with health promotion workers across New Zealand or internationally will reveal that they consider health promotion programmes and projects notoriously difficult to evaluate. (Personal communications) For the most part they are developed with little thought given to the possibility of future evaluation, so that while general country-wide or age group data may be available, base line data of the programme's target population is frequently not. In addition, community based programmes are often ecological in their initiation, growth and conclusion. In some instances there are clear time demarcations such as a New Year Street Party while in others the programme continues for several years with constant briefing and debriefing. It is in this climate the Dunedin Partnership Agencies developed and continue to develop their programmes and projects.

To analyse the success of the projects, an equally ecological approach which was multi-faceted and would produce a robust evaluation framework was required. While specific projects had initial evaluation conducted, I was interested in understanding not only the success or otherwise of those projects but the elements and processes that contributed to that success. It was clear that quantitative research methods would not be able to give the information required nor was it possible to apply them retrospectively to this particular programme.

In choosing which evaluation model to use, cognisance needed to be given to the purpose of the evaluation. Walker, discussing drug education evaluation, contends that many models have been designed to answer management questions as much as effectiveness questions. Evaluation needs to be concerned with whole programmes. "In itself the measurement of variables and effects provides only limited and partial understanding. In evaluating programmes we have, necessarily, to take into account a wide range of concerns." He argues that one of the unacknowledged strengths of case study methods is their capacity to move between levels of a programme; to look at both the policy decisions and the practical fieldwork. Writing in 1991, Milio considered that understanding healthy public policy required a new generation of policy studies. The purpose would be to understand the process of policy development and identify general principles which contribute to developing healthful policies. The kinds of data considered

necessary to accomplish this would be information on the social context, the organisations and key stakeholders, and the strategies they deploy. To achieve this is beyond the scope of traditional 'gold standard' quantitative research. Therefore a variety of evaluation techniques were reviewed, most particularly those relating to health promotion and to organisational research, with the aim of establishing an acceptable framework for evaluating this programme.

4.1 Health Promotion

There are several models for health promotion evaluation. Green and Kreuter (1991) developed both a methodology for planning health education and promotion programmes and for evaluating them. The PRECEDE/PROCEED model is a seminal work for health promotion planning and evaluation. It is limited by its underlying presumption that programmes begin with a clean slate and are time limited. It was developed for the American health education and promotion field. While it is able to be adapted to New Zealand circumstances, unless a programme was planned using its methods it is difficult to apply it to evaluating the programme. Notwithstanding this criticism, most health promotion planning and evaluation documents acknowledge the influence of Green and Kreuter on their models.

Most health promotion evaluation models have between three and four stages. The names of these stages vary although the content is the same. The first stage is carried out during the development of the programme. Its purpose is to understand the process as it is happening and to provide feedback to the programme workers which will enable them to adjust the programme as necessary at the time. This is usually called formative evaluation. The second stage overlaps somewhat with formative evaluation and is more often carried out at the end of a programme. Its purpose is to determine if the programme was implemented as planned and what the programme's target population thought of the programme. This is most commonly called process evaluation. The third stage is most commonly called impact evaluation. Its purpose is to understand the immediate impact of the programme such as whether the target population changed behaviour. These often represent intermediate steps which are used as a proxy for the final stage of evaluation known as outcome evaluation. Outcome evaluation is most concerned

with the effectiveness of the programme and asks the question was alcohol related harm reduced?

In the Australasian context there are various models of evaluation in use. The Alcohol and Public Health Research Unit at Auckland University published a series of documents outlining health promotion evaluation techniques. Hawe et al (1995) developed a fieldworkers guide to evaluation of health promotion. It provides comprehensive guidance for undertaking health promotion evaluation, particularly as applied to specific programmes. They contend that health promotion programmes need both quantitative and qualitative research to measure the effects and interpret the meaning respectively. They too consider that measuring outcomes and health status to be difficult and suggest using an indirect impact evaluation measure as a proxy, such as condom sales for changed sexual health practices. The questions used for the process and impact evaluation format applied to the six benchmark projects were based on the information Hawe et al (1995) and can be found in Appendix 2.

While Hawe et al (1995) advocated using qualitative research methods and included some techniques in detail, the analysis was still firmly embedded in the quantitative research methodology and did not assist in moving between the different levels of the programme nor with determining the reasons for success. On this basis other organisational evaluation methodologies were reviewed.

4.2 Responsible Beverage Service

The key findings from the Literature Review are that a successful Responsible Beverage Service programme needs:

- a comprehensive approach which includes
 - a) management training, patron awareness as well as serving staff training
 - b) written policies within licensed premises reinforcing their responsible beverage service
 - c) community involvement; and
 - d) relying neither on litigation or education alone
- an emphasis on problem prevention rather than intervention

- to enlist the support and compliance of the hospitality industry as part of the programme development and delivery; and
- warnings of and active enforcement by the police of the licensing laws.

There is little evidence that self regulatory approaches alone by licensed premises are effective. (Stockwell, 1997)

The Community Prevention Trials Project builds on these criteria by establishing the need for successful programmes to expand their comprehensiveness beyond responsible beverage service. It strongly reinforces the need for active enforcement by the police of the licensing laws for success. It adds other criteria for success:

- skilful media advocacy; and
- a process to ensure the programme is institutionalised after the initiators have withdrawn.

It also raised the question as to the level of community participation necessary for an effective programme asking the question "...can special purpose taskforces do their job without the existence of a broad, widely representative coalition?" (Treno & Holder, 1997)

4.3 Organisational Analysis

Patton (1990) considers that qualitative research's purpose is to illuminate the structures and processes of human organisation. Patterns and themes will emerge from the data and can be either indigenous, that is brought up by the participants or applied by the analyst to the data. Understanding the structures and processes of a health promotion programme require both process and impact evaluation and an understanding of how the relationships develop throughout the process. Each of the benchmark projects and the Dunedin programme as a whole had a series of networking events occur which impacted on programme development. A systematic observation of a range of activities should result in data from which an evaluation can be made.(Thomas, 1998) Qualitative methods of research allow for flexibility and uncover the structures and processes. The three major techniques are interviews, ethnography (participant observation) and document analysis. (Cassell & Symon, 1994) Ethnography was not applicable in this retrospective

study, however, interviews and document analysis were. Applying them in a systematic way required a little more exploration of the field.

A case study is a detailed investigation of a programme over time with an analysis of context and processes. It is particularly useful when evaluating new processes or those not understood. Understanding what occurs in one programme can reveal processes which can plausibly be generalised. Knowing the processes and context of the programme can help specify what conditions need to be present for it to reoccur. (Hartley, 1994) Community based projects can provide concrete local data which can be translated into policies and programmes. (Giesbrecht & Ferris, 1993) In this way, the generalisation is about theoretical propositions rather than target populations.

Stakeholder analysis uses the technique of interviews with key stakeholders to address the research questions. It can be applied at a simple and robust level. It is not a purely qualitative method in that what is quantitative should be counted. This sits neatly with the main health promotion evaluation methods outlined above. It is underpinned by the assumption that stakeholders do experience the 'same' phenomenon differently. Stakeholders can be either individuals, groupings or organisations depending on the level of investigation. Data gathered from the interviews are coded into themes and analysed against whether they reflect personal opinion, shared or not shared by others; opinion grounded in verifiable evidence; or whether for all practical purposes it is factual, objective and non-controversial. (Burgoyne, 1994)

Analysis of company documents provides further information. When taken over time it provides another dimension to the programme. The information provided may be fragmentary and should never be taken at face value. Clusters of meanings can be taken from the documents but it is important that they be representative of the overall documentation. (Forster, 1994)

To ensure validity and reliability of qualitative data a further technique is applied. "Methodological triangulation involves 'within-method' triangulation, that is the same method is used on different occasions. and 'between-method' triangulation when different methods are used in relation to the same object of study."

(Mikkelsen, 1995) Complementing standard health promotion evaluation methods with stakeholder analysis and document analysis will enable triangulation of data to provide a plausible answer to the research questions.

The diffusion of innovation theory was developed three decades ago to explain why some new projects were implemented successfully and others were not. Over time the attributes considered important for successful uptake of innovation have been identified. The most commonly used were identified by Rogers (1995). In 1997, Meyer et al applied those attributes of innovation to three programmes initiated with the Cancer Information Service (USA). Meyer et al based their evaluation on Rogers' work and aimed to refine the theory by applying it to a new organisational form. The innovation characteristics or attributes they identified are in Table 4.

One other factor which Meyer et al considered important to innovations being adopted and implemented was the role of the manager or managers. How managers respond to innovation will directly influence its adoption. "Managers who validate organizational members' perception of innovation, perhaps incorporating feedback to modify innovations midstream, are ... cultivating the climate of innovativeness within their organization. ... Creating a supportive atmosphere for innovation is especially important in new organizational forms where innovation is a central goal." (Meyer et al, 1997)

These criteria, questions and attributes will be used to inform the evaluation of the Dunedin Host Responsibility Programme.

Table 4: Innovation Attributes (Meyer et al, 1997)

ATTRIBUTE	DEFINITION	DESCRIPTION
Relative Advantage	The degree to which an innovation is perceived as being better than the idea that precedes it.	Economic advantage equates with profitability. Effectiveness may be seen as the degree to which an innovation is communicated as being relatively more capable of achieving an ideal end-state. The question to be asked is: Do the organisational members perceive the innovation to be 'a better way of doing things?'
Compatibility	The degree to which an innovation is perceived as consistent with existing values, past experiences and the needs of the adopters.	A degree of consistency is always important as organisational change brings uncertainty with it.
Complexity	The degree to which an innovation is perceived as relatively difficult to understand and use.	The more components an innovation has the more uncertainty it involves. Minimising uncertainty is crucial for successful innovation.
Trialability	The degree to which an innovation may be experimented with on a limited basis.	Piloting and pre-testing as methods of experimentation contribute to this attribute.
Observability	The degree to which the effects of an innovation are visible.	If it is possible to see the impact of the innovation on the target audience then it is more likely to be viewed favourably.
Adaptability	The degree to which an innovation can be modified to local needs.	The more easily adaptable an intervention is the more likely it will be undertaken.
Riskiness	The degree to which an innovation is perceived as risky.	The greater the uncertainty of outcome the greater the perceived risk.
Acceptance	The degree to which the innovation is accepted.	A high degree of acceptance would indicate a high probability that an intervention would be implemented.

5 METHOD

Standard health promotion evaluation methods were applied to the Benchmark Projects. This was supplemented by stakeholder analysis and document analysis to allow triangulation to take place.

5.1 Project Evaluation

Six Benchmark Projects were identified. The use of Outcome Evaluation was considered for each of these projects. That is, was there a specific measure of alcohol related harm that was easily accessible? The most obvious measures were a change in consumption of alcohol in Dunedin or a change in alcohol related incidents (related to the projects) involving the police. In both these cases the data were very difficult to access. Although permission was given by the police to access their information, it was stored as original incident sheets and no analysis of any kind had been carried out on it. Consequently accessing this data was beyond the scope of this dissertation. Secondary outcome measures might be the number of licences opposed, cancelled or suspended compared with a previous baseline or other districts, or similarly the number of managers' certificates opposed, cancelled or suspended. While accessing this data was possible, the information it could provide was full of problems. If the Dunedin rate was higher than other districts did that indicate that the Dunedin licensed premise situation was worse than other districts or that the Partnership Agencies were more interventionist than others? If the Dunedin rate was lower than other areas did that indicate that there were fewer problems (and even if there were how did this information plausibly connect to the programmes?) or that the other districts were more interventionist? The conclusion reached was that for the purposes of this dissertation there were no straightforward outcome measures of the success of the programme.

Each of the Benchmark Projects had been evaluated by the Partnership Agencies. The written appraisals included process and impact evaluations. From a synthesis of the health promotion evaluation literature (Hawe et al 1995), a set of criteria was developed for process and impact evaluation. (Appendix 2) Each Benchmark Project was assessed using the criteria that included assessing the degree to which the

project was implemented, the participation of the target audience, an analysis of what worked or did not work for the component parts, an assessment of whether the objectives were met, what key impacts had occurred, including any unexpected ones, and an assessment of the extent to which the changes could plausibly be attributed to the project. In three of the projects (Sammy's, PSST, and Atmosphere) the impact evaluations were thorough. In two projects (Carisbrook and Doorstaff) the impact evaluation was in depth for the areas covered but acknowledged that areas of the projects were not implemented. In the remaining project (New Year 1996) the evaluation while written, was in the nature of a debriefing and as such more truncated.

5.2 Stakeholder Analysis

Stakeholders were selected for their organisation's role in the overall programme. The three national stakeholders were chosen for their role in the development and implementation of the Host Responsibility concept in New Zealand, their representativeness of particular groups, and their ability to assess the programme in relation to others. The national stakeholders chosen were ALAC, who were instrumental in bringing the host responsibility concept to New Zealand, the National Police Headquarters, and the Hospitality Association of New Zealand (HANZ). On a local level, the core agencies of the Dunedin Partnership were identified as stakeholders. All current and previous employees were interviewed except one short term public health worker. The local workers were instrumental in providing the evaluation reports of the Benchmark Projects and the documents used in the analysis. The interview, which lasted approximately one hour, explored the organisation's history of involvement in host responsibility, their assessment of the Partnership Agencies success and the reasons for that success. The interview schedule is in Appendix 3. The interviews were transcribed and analysed for key themes that were grouped into core areas. Interviewees were not guaranteed absolute confidentiality, as the field is small enough that most workers in it could make a reasonable guess at the identity of the interviewee. However, to minimise the possibility no direct references to individuals are made, rather information is referred to in the following manner - 'Stakeholder Interviews - Dunedin City Council and District Licensing Agency' or 'Stakeholder Interviews - National Host Responsibility'.

My personal connections with almost all of the stakeholders assisted me in obtaining full and frank material. While local representatives were eager to hear what others had said or my opinion of what I had found, they were more than willing to accept my explanation that I preferred not to discuss that with them as I didn't want to influence or lead their answers. All interviewees accepted my request for openness and frankness and my reassurance that as I was no longer involved in the programme I was interested in the truth and had no feelings to hurt. The local stakeholders reassured me that they were very interested in a truthful analysis of the programme. Similarly the national stakeholders had very little invested personally in the Dunedin Partnership programme and were also interested in a truthful analysis.

5.3 Document Analysis

The third step in the evaluation process was document analysis. Documents were selected to complement the Project Evaluation and the Stakeholder Analysis. The criteria used for selection was that it covered a reasonable time frame; and represented the Partnership Agencies approach to host responsibility; or included industry opinion.

The documents that met these criteria were the Partnership Protocol signed by the three Agencies' Chief Executives; the Public Health Service contract with the Health Funding Agency; Dunedin Police Action Plan 1993 - 1998; the Project Profiles 1995 and 1998; presentation notes about the Partnership written in 1994, 1995 and 1997; the Dunedin Licensees Survey 1997; Dunedin DLA Sale of Liquor Policy; Conference Outcomes from the Management of Alcohol at Sporting Events and Outdoor Concerts held by the Partnership Agencies in Dunedin 1997; and a selection of the Partnership Agencies Newsletter to licensees between 1992 and 1998. The Dunedin section of the Formative Evaluations carried out by the Alcohol Research Unit (Stewart et al 1990, 1991a, 1991b, Stewart & Casswell, 1992) is also included in the document analysis.

5.4 Attributes of Innovation

The attributes of innovation framework refined by Meyer et al (1997) were applied to the stakeholder interviews and document analysis. The Dunedin Partnership Agencies were then given a rating of low, medium or high against each attribute.

5.5 Summary

Once each of these processes was completed the results were synthesised with the criteria for successful programmes identified from the literature review, which were used as a proxy for outcome evaluation, so that the two key questions of this dissertation could be answered.

Was this programme successful in meeting its objectives?

(and if so)

What are the factors that make it successful?

The results are described in Chapter 6.

6. RESULTS

6.1 Project Evaluation

6.1.1. The Sammy's Project^v:

- Process Evaluation:

This project was implemented thoroughly with intensive management and staff training, and monitoring and debriefing meetings by and with the Partnership Agencies. Sixteen to nineteen year olds certainly frequented the club. In general they were satisfied.

"We certainly got a lot of praise from the younger members of the community for our ability to let them into the venue."

Those that expressed dissatisfaction focused on the bands that performed or in some cases that did not perform in Dunedin. While on the premises they did not have access to alcohol. This was strictly monitored, however, it was clear that they had had access to alcohol before they arrived.

- Impact Evaluation:

The immediate results were a change in management and staff practice; a change in drinking patterns as minors did not access alcohol; and a change in the drinking and general behaviour of the legal patrons. The programme implemented seemed to have a positive influence on the behaviour of all patrons regardless of age.

"We have experienced a huge reduction in intoxication, violence and vandalism on and around our premises since the trial began."

The perceived potential problems of access to alcohol by minors and friction between age groups never eventuated. This is likely to be due to the management and staff approach within the premises. The change in drinking patterns however only occurred within Sammy's nightclub. Patrons accessed alcohol prior to visiting Sammy's. This highlighted the importance of addressing access to alcohol across the City. Unexpected results included first, the very good co-operation between the Partnership Agencies, industry groups, Sammy's management and the public. Management and staff were particularly pleased with the new skills they

^v The process and impact summary evaluation was conducted on the formal report of The Sammy's Project. Public Health Services and District Licensing Agency files. The quotes were taken from the report and are all attributable to the management of Sammy's Nightclub.

had learned. Second, the project drew the attention of legislators to issues of age restrictions and licensed premises designations as allowing minors onto the Sammy's premises with its particular licensing designations was illegal. Finally, Sammy's was the first major project the Partnership Agencies undertook together. The lessons learned about conducting joint project work, the roles and skills of each Agency, and the management techniques within licensed premises were new and well taken. The Project concluded when Sammy's management decided to close the nightclub and reopen as a pool hall. They advised that bands of quality were hard to draw to Dunedin and concluded that without the Project they would have had to close much earlier.

If not for the ability to accept patrons from sixteen up, we would have taken this step almost two years ago. The trial allowed us to increase our base of available customers and try entertainment that would have previously been financially unviable.

Other economic factors may have come into play as well. Several new bars and nightclubs opened in Dunedin in the mid 1990s. Many had live music or dance party DJs. It may be that Sammy's was unable to compete in that market. During the week long Dunedin Youth Festival (1996) the Sammy's Project process was applied to four other venues including a popular nightclub/bar. Similar results occurred within premises and with patrons gaining access to alcohol prior to their arrival at the venues.

An ability to undertake such initiatives in appropriately managed premises would be an important step forward in creating safer environments for young people. However, without controlling access to alcohol either in other on- or club-licensed premises or through off-licensed premises the effect of a reduction in intoxication, violence and vandalism would be lost.

6.1.2. The Atmosphere Project^{vi}:

- Process Evaluation:

As a joint research project the Atmosphere Project was fully implemented. Ninety percent of the target group of all on-licensed premises were observed and a 90% response rate was gained from licensed premises managers to the questionnaire. A

^{vi} The process and impact summary evaluation was conducted on the formal reports of The Atmosphere Project. Public Health Service and District Licensing Agency files.

random selection of 600 members of the general public were also interviewed. The feedback to premises from the observer teams was a particularly successful component. However, the observer component was also the most difficult with the need to identify evaluation criteria and train observer teams proving to be time consuming.

- Impact Evaluation

The immediate results, which were directly attributable to the project, were that 50% of licensed premises managers reported changing their behaviour or their premises as a result of the feedback from the observer teams. In addition specific issues were identified for the Partnership Agencies which became the focus of future projects. One such issue became the Door Staff project evaluated below. An unexpected and surprising result from the general public survey was that one of the most significant reasons for not visiting a licensed premises was the amount of smoking occurring and the lack of smoke-free areas. It would be a useful contribution to outcome evaluation if this research project was repeated in the future.

6.1.3. PSST ...^{vii}

- Process Evaluation

The PSST ... theatre programme including the follow up workshop sessions was performed at ten of the eleven secondary schools in Dunedin. Approximately 2,700 Year 11 - 13 students participated in the programme. The performance was adjudged very realistic, humorous and well targeted with 99% of students stating they had witnessed similar scenes in real life. They considered the workshop to be valuable, particularly the peer education style of the actors who ran the workshops. A majority of the students acclaimed it the best alcohol education programme they had ever participated in. Teachers found the resource package useful or very useful but would have appreciated a chance to preview the programme. This is an interesting comment given that a preview performance was offered to all schools with a specific invitation to parents. In almost all schools

^{vii} The process and impact summary evaluation was conducted on the formal reports of the PSST... programme (Public Health Service and District Licensing Agency files) and on 'PSST' *There's a New Alcohol Education Programme*, S. Kent, MEd Research Report (unpublished).

this offer was not taken up. A different approach to parents and teachers may be necessary to ensure that they have previewed the programme.

- Impact Evaluation

In follow up evaluation students stated that they were more aware of the dangers of alcohol consumption and considered that they should drink in moderation. They reported that as a result of the programme they had changed their own drinking patterns and developed safety networks amongst groups of friends to ensure they avoid dangerous situations. The report states 'many' had changed their behaviour. It was impossible from the evaluation done to tell how widespread this change was. It should also be remembered that almost all the students attending the performances were well under the legal age for alcohol consumption and should have found it difficult to access alcohol in general. Clearly this was not the case. An unexpected result was that schools, which had not had their own ongoing alcohol education programme, were motivated to develop them.

The longer term impact of this education programme has not been evaluated. Education on its own is unlikely to have an ongoing impact. However, the Partnership Agencies intended that the education of young people was part of preparing them, once they were legal age patrons, for the changes the overall Host Responsibility programme was bringing to on-licensed premises.

6.1.4. Doorstaff^{viii}:

- Process Evaluation

The Doorstaff Project was centred around liaison with licensed premises' management and door staff; education programmes for both groups; and facilitating improved communication between management and doorstaff so that roles and responsibilities were better understood. Improved liaison and understanding between door staff and the Licensing Sergeant was a subsidiary objective. Participants in the programme found it to be very helpful (92%), while 96% found the content and process to be useful. Suggestions were made by participants about the future content of the programme and these were taken into

^{viii} The process and impact summary evaluation was conducted on the evaluation surveys of both managers and doorstaff after one year of the programme and on the education session evaluations undertaken by the Hospitality Lecturer at the Otago Polytechnic. Public Health Service and District Licensing Agency files.

account in planning the 1998 programme. The suggestions were of a very practical nature including undertaking site pre-evaluation, developing reporting and observer skills and practising identification checks.

- Impact Evaluation

Managers consider that more door staff are dealing with conflict situations in non-physical ways. This appears to be borne out as both police and staff report less violent incidents, although the police record data as outlined in Chapter 5 was not possible to analyse. Managers considered that doorstaff were both more friendly and customer oriented as well as better equipped to work with patrons without force. Their understanding of the role doorstaff could play for the licensed premises also expanded to include an almost public relations or customer service role which would assist the staff inside the premises.

" Happy, smiling, pleasant door staff create the right atmosphere for patrons to enjoy their evening..."

"... they must set the tone as well as carry out their duties..."

Door staff considered that they had fewer problems dealing with patrons at the door, although were less likely to attribute it to their own behaviour than their managers were. They considered that the programme had helped managers appreciate the role and responsibility of door staff and that management policy and instructions to doorstaff were considered to be more consistent. This had contributed to a higher level of trust between managers and doorstaff. Doorstaff too, saw themselves as creating the first impression for patrons and setting standards.

"We can create and maintain a safe and enjoyable environment and put customers at their ease."

Both managers and doorstaff considered the programme had improved communication and relationships with the regulatory agencies with 68% of doorstaff reporting that the police had come to appreciate them as "well educated members of the hospitality industry." Two percent, however, disagreed believing the police still regard doorstaff as problem creators who they were reluctant to use as witnesses. In keeping with Homel et al's (1992) research into violence around licensed premises, doorstaff and managers consider that "...a significant

component of their [doorstaff's] role is to defuse situations before they become serious."

As the only programme aimed at doorstaff the changes reported can with some certainty be attributed to this programme. One objective which has not been actively addressed was creating a credible public profile for doorstaff. This is one aspect which could be focused on in the future.

6.1.5. Events Management - Carisbrook^{ix}:

- Process Evaluation

The liaison meetings and communication between the Partnership Agencies, the Otago Rugby Football Union and other stakeholders were implemented well with all participants reporting an atmosphere of mutual respect and openness of communication. The crowd management process of identifying problems and solutions was also successfully implemented, with participants reporting that the atmosphere of trust built up in the liaison meetings created the opportunity to safely raise issues knowing that an unbiased account would be given. The food and alcohol vendors particularly noted that they could raise problems they had, that previously would have been treated as non compliance with the law, and have advice and assistance with those problems. Similarly the security teams, which were a mixture of professional security staff and public volunteers from service organisations such as Rotary, felt that there was improved communication and co-operation possible with the police. The only criticism of this process was that on occasions there was a delay between problem identification and solution implementation. The Partnership Agencies considered that the briefing and debriefing process in place around each major sporting event improved their effectiveness.

- Impact Evaluation

All the participants were extremely pleased with the impact of the programme and several commented that there could be better things waiting to happen. The Police reported that crowd control and behaviour had improved and that there were less

^{ix} The process and impact summary evaluation was conducted on the briefing and debriefing file notes for each of the events, the meeting minutes of the Liaison Meetings and a formal evaluation questionnaire completed by all participants. Public Health Service and District Licensing Agency files.

alcohol related incidents and less violence. The St John's First Aid service also reported a reduced number of alcohol related injuries to treat. One Partnership Agency worker stated that they no longer sat beside the radio or opened the next day's newspaper petrified of what they might see or hear reported therein. All parties considered that a substantial improvement in communication and co-operation had occurred. Given the incidents at the Carisbrook ground prior to the programmes introduction and the ongoing problems at other sporting grounds in New Zealand, the changes in crowd behaviour can be strongly attributed to the programme. The benefits of the programme extended beyond alcohol related incidents to an improvement in the general atmosphere and safety of the ground with just under 50% of the crowd being women. This in turn has provided a substantial marketing and economic boost to the City. This programme has been extremely successful in its process and its impact.

6.1.6. Events Management - New Year's Eve Party December 31, 1996^x:

- Process Evaluation

The lessons learned at Sammy's Nightclub about patron control and from the Carisbrook project were applied to the New Year's Eve Street Party. The event was well attended with 4,000 tickets sold and there were no patron complaints. Management and staff from the licensed premises who ran the Street Party were also, for the most part, satisfied with its implementation. They considered access to the event and patron control to have worked reasonably well and the recommendations were more about the minors they had to turn away than what happened during the event. The only concern with the implementation centred around the end of the event which they considered was too abrupt and could be improved by 'softening' the end through changes in music and closing the bar slightly earlier than the end of the music. There was also some concern that the abrupt end put enormous strain on public transport and that some alternatives needed to be arranged in the future.

^x The process and impact summary evaluation was conducted on the briefing and debriefing file notes for the event. Public Health Service, District Licensing Agency and Police files.

- **Impact Evaluation**

One change in behaviour specifically commented on by the licensees was that patrons did not try to enter the Street Party area with extra alcohol. In marked contrast to other 'alcohol free' New Year's Eve parties around the country where 60 or 70 alcohol related arrests were made at several venues, there were no arrests at all at the Dunedin Street Party. The Police attributed this directly to the host responsibility policies and practices in place at the Street Party. At the same event for New Year's one year later one arrest (not alcohol related) was made. Both the licensees and the Partnership Agencies considered that the Street venue which was able to be well controlled, also contributed to the success of the event. If the event was moved to a different central city venue with more possible entrances and exits then management practices would be more difficult to enforce.

It is clear that each of these benchmark projects were successful in achieving their objectives and that the immediate impact was a reduction in alcohol related harm.

6.2 Stakeholder Analysis

All stakeholders concluded that overall the Dunedin Host Responsibility Programme was a successful programme. Project evaluation confirmed their perceptions. Four themes, somewhat inter-related, emerged from the stakeholder analysis. They collected around the nature of the partnership, the approach the partnership took, the consistency of culture created by the partnership, the involvement of the community of interest and the relationships the Partnership Agencies established with other organisations.

6.2.1. The Nature of the Partnership

Both local and national stakeholders perceive that initially, approximately the first two years, the key element in the successful launch of the programme was the personalities of the people involved. In particular, they were committed to working together even through the difficulties they encountered with each other's approach. However, from about 1993 there is a divergence of opinions between the local and national stakeholders. The national stakeholders continue to attribute success to the personalities of the local players and in particular to one worker within the District Licensing Agency. They qualify this somewhat by

acknowledging that “there must be more to it” and that this particular worker is the key contact they have with the programme. Programme staffing in the three Partnership Agencies has changed considerably over the seven years. Within the Otago Public Health Service and the Police, fieldworkers have changed several times. In the Dunedin City Council, the manager of licensing inspectors has changed, as have the Mayor and several Councillors. The only fieldworker to remain constant has been the District Licensing Agency fieldworker. This could account for the national stakeholders perception that this fieldworker is the key element. The local stakeholders, including the District Licensing Agency, while acknowledging the contribution personalities have made to the programme, understand the nature of the partnership and its success to include several other dimensions.

Understanding each others roles in any given situation and the relationship between each Agency was considered an important component. Each of the Partnership Agencies considered the Sammy’s Project to be the crucial project where they came to understand their roles in the overall programme and their relationship to each other, as well as learning lessons about managing their relationships with the industry and the management of licensed premises for a safer drinking environment. The key roles which were established were that of enforcement primarily carried out by the police; organisational and administrative management primarily carried out by the District Licensing Agency and Dunedin City Council; and the promotion of Host Responsibility concepts and practices primarily by the Otago Public Health Service. Since 1995, attributing each of these roles to a particular Agency has softened and it is not uncommon for the boundaries to be blurred. So that the Otago Public Health Service may be involved directly with premises about enforcement, while the District Licensing Agency and Dunedin City Council might promote Host Responsibility concepts and the Police may suggest organisational or managerial tactics to licensed premises managers in the pursuit of safer drinking environments. Interestingly, the national stakeholders (Police) consider the Sammy’s Project to be a failed project; an interesting attempt but a failure. This is predicated on the fact that the nightclub closed rather than on whether alcohol was available to young people or whether there was less violence around the premises.

What has allowed this blurring of boundaries over time has been another component of the successful partnership, that of structural support. Both fieldworkers and managers involved locally have commented on this facet. The fieldworkers identify the support they have received over time from their managers which allowed them to work in ways new to organisations well known for their bureaucracy, including pooling financial resources. The blurred boundaries have also allowed the fieldworkers to speak publicly on each other's behalf. Managers' commented on the their commitment to the programme, which ensured that they put in place structures and processes that encouraged co-operation between fieldworkers and created a culture within the organisations that ensured that staff new to the programme were selected (among other things) on their ability to work across boundaries in a multi-disciplinary way. This succession planning in appointing new staff also ensured that the Agencies were able to maintain a consistency of message and approach with the alcohol industry. The nature of support includes senior executive commitment and internal policy, and is reflected in various documents discussed in the next section.

The nature of the Partnership Agencies relationship has changed over the course of the programme. Initially the Agencies were three separate organisations with quite separate agendas which saw the usefulness of working together to achieve their own ends. Each local stakeholder did report a level of frustration at times with the other Partnership Agencies' approach, particularly in the first two to three years. Initially, the Police and District Licensing Agency considered that the Otago Public Health Service was not a fully functional member while the Otago Public Health Service considered that they were not being taken seriously as they were not strongly enforcement oriented and could not contribute the same level of finance. Throughout this period though, a commitment by all parties to working together remained and a working partnership emerged despite the differences. As particular projects were carried out, the fieldworkers began to appreciate the differences and similarities in their work. The key to this appreciation was the success of the Sammy's Project. Joint ownership of the programme and projects became a reality. While each fieldworker remains part of their own organisation they view their work- and team-mates for the Host Responsibility Programme as each other rather than their colleagues in their own organisation.

6.2.2. The Approach of the Partnership Agencies

Having the same goal and vision featured in all responses to the question of what made this programme successful. The national stakeholders saw that the Partnership Agencies consistently presented themselves as having the same goals and from their experience of meeting with and observing the programme over time concluded that this was so. The local stakeholders considered they had moved from organisations with their own agendas to undertaking a true partnership where they did indeed share the same goal and visions. This view, which they all held, underpinned all their work. They perceived that this sharing allowed them to undertake innovation and risks in their projects, and solve problems that arose by accessing the different skills that each Agency brought to the partnership. In contrast to other geographical areas, which they perceived to be successful at particular projects at particular points in time, national stakeholders perceived that the Dunedin programme undertook many projects at many levels in a consistent fashion over the seven years. In addition, they noted the problem solving approach the Partnership Agencies used was particularly successful with licensed premises and with reducing alcohol related incidents. The Police in Dunedin noted that they no longer used 'Team Policing' methods to address enforcement issues in licensed premises. Prior to the Host Responsibility programme commencing, Dunedin had two Team Policing Units who would enter licensed premises with the express aim of detecting underage or intoxicated patrons as well as using their presence as a preventive mechanism for alcohol related incidents. The decision to reduce the two Units to one was a combination of the impact of the programme and funding restraints they underwent. However, the Police attribute the closure of the Team Policing Unit completely, entirely to the Host Responsibility programme in Dunedin. They no longer have to deal with as many alcohol related incidents and consider that the Partnership Agencies approach in creating a safer drinking environment meant they no longer needed that kind of enforcement technique.

The administrative and organisational skills of the District Licensing Agency were acknowledged by local and national stakeholders. The contribution well documented and organised information makes to a successful programme allowing ease of review was considered very important.

6.2.3. Consistency

Creating a consistency of message and approach was considered essential by the Partnership Agencies to their success with licensed premises. Ensuring that the approach remained consistent between Agencies and over time was considered paramount to developing and maintaining a good working relationship with the licensed premises as well as with the Liquor Licensing Authority. The process of providing supportive projects combined with education and information was considered to lay the ground work for the problem solving methods the Partnership Agencies engaged with offending licensed premises. These methods involved discussions and offers of support to change practices. The Partnership Agencies considered that this solution-seeking process gave them credibility with the licensed premises, the alcohol industry representatives and with the Liquor Licensing Authority. So that when the Partnership Agencies did object to a licence or to conditions thereof, their credibility with the Liquor Licensing Authority was such that it was likely their objection would be upheld. This perception is reflected by the alcohol industry stakeholders who consider the Dunedin Partnership Agencies to be fair and understanding of the issues licensed premises face.

6.2.4. Community Involvement

As we saw in Chapter 2, definitions of community vary between cultures. In this programme the community most involved with the Partnership Agencies was, for the most part, the alcohol industry community. This will be referred to as the community of interest.

The community of interest involvement in developing, implementing and evaluating the various projects within the Host Responsibility Programme was considered an important factor in the success of the projects by all stakeholders. Each project had different community of interest participants. The Sammy's Project team included the management of the nightclub while the Atmosphere Project had representatives of HANZ and the local licensed premises. The industry stakeholders consider the Atmosphere Project to be the key project which secured their commitment to the ongoing Host Responsibility programme. They consider that it demonstrated that the Partnership Agencies understood the business licensed premises were in and that they (the Partnership Agencies) were

willing to work with the licensed premises to achieve the legislative and organisational goals. The Carisbrook Project had perhaps the most diverse community of interest involvement and comes closest to community action. Alongside the Partnership Agencies and the Otago Rugby Football Union (in itself a community based organisation) were the emergency services, security companies, voluntary organisations such as Rotary and St John's as well as the alcohol and food vendors. The ownership that the community of interest participants took of the project ensured its success.

The more general definition of community involves the residents and visitors of Dunedin who constitute either those members of the public which consume alcohol on licensed premises or those who are affected by other's alcohol consumption. All stakeholders considered that the success of the programme and individual projects did impact on the general community. Safer drinking environments serve the drinking public by exposing them to less intoxication and alcohol related violence on premises, and serve the more general public by reducing their exposure to intoxicated patrons once on the street or in motor vehicles. The safety of venues such as Carisbrook or Dunedin on New Year's Eve contributes both to the general public's enjoyment of the entertainment as well as to Dunedin City's reputation and economy as a visitor destination.

Other factors considered to contribute to the success of the programme by the stakeholders included:

- ◆ the contribution ALAC made to initiating and developing the Host Responsibility concepts and to raising its profile nationally via media campaigns. This was considered to make it easier for the concepts to be raised in Dunedin as Host Responsibility was at least a familiar term. In addition the support and training they offered to health promotion fieldworkers was also mentioned (Stakeholder Interviews: Otago Public Health Service);
- ◆ the size and geography of Dunedin was also mentioned as possibly assisting with ease of managing the issues (Stakeholder Interviews: Dunedin City Council);
- ◆ and finally a general comment that society had changed and Dunedin had reaped the benefit of this change. (Stakeholder Interviews: HANZ) This begs the question of why Dunedin has benefited when other areas both smaller and larger than Dunedin have not.

Criticism of the approach the Partnership Agencies has undertaken came primarily from outside the District and indeed from outside the national stakeholders' group as well. Locally the Sammy's Project engendered some concern that underage patrons would access alcohol, however, as the project did prevent this occurring opposition faded away. Outside Dunedin, the most criticism came from other health promotion workers and researchers opposed to prevention agencies working closely with the alcohol industry. The concern being that prevention work and the ability to criticise the industry would be compromised. This criticism raises a separate debate around how best to achieve change - from within or without? It is not possible to undertake this debate here. However, it is clear that the Partnership Agencies consider the best way for them to achieve change includes working with the alcohol industry.

Overall, the stakeholders consider the Dunedin Host Responsibility Programme to be successful.

6.3 Document Analysis

The document analysis revealed that the Partnership Agencies considered structural support to be their strongest reason for success. They also gave some insight into how the Dunedin public viewed alcohol issues in 1993 and how the Dunedin Licensees viewed the Partnership Agencies in 1997. Finally they gave some insight into how the Partnership Agencies presented themselves publicly over the time of this programme.

6.3.1 Structural Support

Contractual obligations provided the crown agencies with structural support for their approach and work at an internal level and at a national level. The Otago Public Health Service had a formal contractual relationship with the then Southern Regional Health Authority (now Health Funding Agency) which included the goal of reducing alcohol related harm and the requirement to develop strategies underpinned by the Ottawa Charter for Health Promotion which would achieve that goal. The Dunedin Police had a similar requirement to develop action plans at a local level which would implement the national policy and strategies.

Within the Crown agencies these requirements provided the fieldworkers with an element of security and stability in the face of the government reforms. The Otago Public Health Service recognised the role it had and increased its staffing to a full time position in alcohol harm prevention. Financial support for projects was confirmed by the contractual obligations. The Dunedin Police appointed a Sergeant specifically for the alcohol and licensing work. Similarly, financial support for projects was also forthcoming. The District Licensing Agency received Council and management support for the extended role with financial support for projects. Dunedin City Council Environmental Health Officers all undertook alcohol licensing work as part of their role.

The Partnership Protocol was a document developed by the Partnership Agencies' fieldworkers arising from their concern that the programme might become personality based and needed to be institutionalised so that it would carry on regardless of any change in personnel. The Protocol outlined the approach the Partnership Agencies should take and the benefits expected from it. It considered that each of the organisations was a community organisation which existed for the benefit and protection of the community at large. By sharing and pooling resources, the Partnership Agencies expected to achieve greater efficiency, consistency and ability to address joint issues. The approach included joint exploration of practical solutions, developing joint initiatives to achieve shared goals and the maintenance of close working relationships with different parts of the alcohol industry both locally and nationally. The Partnership Protocol was signed by the Chief Executives of the Dunedin City Council and HealthCare Otago and by the District Commander of the Dunedin Police at a public signing which was open to and reported in the media.

The Dunedin City Council approved the Sale of Liquor Act Policy which outlines the District Licensing Agency's expectations of applicants for licenses and incorporates the Partnership Agencies approach to licensing. This provided substantial structural support for the District Licensing Agency fieldworker and by association for the Otago Public Health Service and Dunedin Police fieldworkers.

6.3.2 Public Attitudes to Alcohol

The Partnership Agencies commissioned a survey of the Dunedin public's attitude to alcohol in 1993. (Kersey, 1993) Four hundred households were surveyed with an 84% response rate. The belief that there are harmful consequences of alcohol consumption was widespread and was particularly focused on other people. When asked about their experiences regarding alcohol related incidents from other people, most had experienced some unwanted consequence in a public place over their lifetime and more than 50% had experienced it in the last year. When asked who they might complain to 28% indicated they would notify the police, 20% would notify the manager, 14% the Liquor Licensing Authority, 7% the Dunedin City Council, and 29% did not know who they could complain to. Those who indicated the Liquor Licensing Authority may well have thought they would be notifying the local Licensing Agency rather than the central Authority. At the time of the survey the Sammy's Project had been in place almost a year. Eighty percent had heard of the project. Forty three percent could describe it correctly while a further 18% could describe it partially correctly. Fifty five percent approved of the project while only 7% disapproved. Eighty one percent wanted some community involvement, including 53% who wanted a lot, in the local liquor licensing process.

6.3.3 Licensee Attitudes to the Partnership Agencies

In 1997 the Partnership Agencies undertook a survey of Licensees to obtain feedback on the current projects and on the perceptions the Licensees had of the Agencies. An overwhelming majority considered that the Partnership Agencies understood the impact they had on licensees and licensed premises and offered both fairness and consistency. They were also satisfied with the accessibility of the Partnership Agencies. Overall the projects were rated highly as contributing to safer drinking environments, reducing alcohol related harm and "... keeping our kids safer." However, most respondents considered that the projects helped other licensees rather than themselves.

6.3.4 Presenting Themselves Over Time

The four *Public Health Input into the Implementation of the Sale of Liquor Act Formative Evaluation Reports* (Stewart et al 1990, 1991a, 1991b, Stewart & Casswell, 1992) included information from Dunedin although this was sparse. The first report

stated that there was little initial interest in prevention issues from the city secretary or other senior staff, although the city secretary did indicate he was willing for dialogue to take place. The Dunedin MOH, however, "encountered considerable opposition from the Dunedin City Council over his intention to take health and social implications into account." The second report recorded only three Dunedin elements. The first, a letter to the DLA regarding making information available to the public on how to object to a licensing application; second, that the health promoter had regular input into training offered by the Otago Polytechnic for hospitality management and third, that there was some initiative toward gathering information on where people were drinking but no action had been taken. Dunedin's contribution to the third report was again not particularly encouraging although there were some indication of collaboration between the various agencies. The report includes the comment that the Dunedin City Council's draft annual plan makes no reference to alcohol or its liquor licensing activities and that a submission from the public health service received no reply. The report notes that a number of areas had established multidisciplinary liquor liaison committees but does not include Dunedin in that group. From other documentation it is clear that Dunedin did have a Liquor Liaison Committee in 1991. However, the report did note that Dunedin held a seminar for all agencies involved in April 1991, which addressed several of the issues regarding the interface between the agencies; and that a joint summer host responsibility campaign was being planned. The fourth report noted that the Dunedin City Council had adopted an alcohol policy and that the summer host responsibility campaign Homesafe 91 had been a collaboration between the Public Health Service, the Dunedin City Council, the Ministry of Health, and the Hotel Association of New Zealand. It also noted that the health promoter had worked with Dominion Breweries (DB) on a host responsibility policy document for their publicans. It would appear from these reports that Dunedin had a rocky start. This is not borne out when this is put beside the stakeholder analysis and other documents from the Dunedin Partnership Agencies.

Over the Programme timespan the Partnership Agencies have made public presentations about the programme at a variety of conferences and in the media. It is possible to chart the internal changes of the partnership by looking at these presentations. Each of the conference presentations was for a specific audience.

The first in 1994 was to the Australasian Liquor Licensing Authorities' conference. The second in 1995 was the Police conference and the third was to an ALAC conference in 1997. In 1996 the Partnership Protocol was signed in public by the Chief Executives of the Dunedin City Council and HealthCare Otago and by the District Commander of Police.

The 1994 presentation emphasised the importance of communication and co-operation but maintained that each organisation, while actively liaising, took responsibility for its own area. They outlined some of the problems they had had with licensed premises and some of the solutions and failures. They were candid about their failure to depict their actions well in the media which portrayed the errant licensed premises as the victim. They emphasised the need for adequate judicial backing when they, as enforcement agencies, took prosecutions.

In 1995 the agencies were again described as enforcement agencies although they were now describing themselves as problem solvers. This was also how the police at a national level were describing their proactive projects. The presentation while acknowledging the role of the Otago Public Health Service in working proactively together presented the Partnership as being primarily the Police and District Licensing Agency. It also emphasised the role that licensees and interest groups had to play in the projects.

The Partnership Protocol was developed in 1995 and signed in 1996. The agencies were still being referred to as Enforcement Agencies but it was clear that there was much more of an equal partnership in place. The document demonstrated more interaction between the agencies and joint actions replaced liaison about issues. It also emphasised a close working relationship with the alcohol industry.

The ALAC conference was more focused on prevention and public health action. The presentation to the Conference emphasised blurred boundaries, joint ownership of issues, consistency, shared responsibility and shared resources. A much more equal partnership was demonstrated and media coverage of the reduction of alcohol related harm had improved substantially. The role of the alcohol industry and various communities of interest was also emphasised. The Partnership Agencies no longer referred to themselves as Enforcement Agencies

and overt references to the Ottawa Charter for Health Promotion were being made by all partners.

The change in presentation of the partnership is mirrored somewhat in the stakeholder analysis, although when directly asked about these unequal nature of the partnership local stakeholders denied that this was the case and proffered the explanation that each of these presentations was tailored for its audience.

6.4 Factors Contributing to Success

To understand the contributing factors which made the Dunedin programme successful we turn to the innovation attributes identified by Meyer et al (1997).

6.4.1 Relative Advantage

The Partnership Agencies field workers and their immediate managers clearly saw host responsibility as an idea which was better than that which preceded it. They considered it offered economic advantage through sharing resources and skills as well as being more effective in achieving a reduction in alcohol related harm. (Stakeholder Interviews: Partnership Agencies - all fieldworkers and managers)

6.4.2 Compatibility

The Public Health Service considered host responsibility to be completely consistent with their existing values as well as a way of accessing a target audience (licensees and staff) which had previously proved inaccessible. Both the District Licensing Agency and the Police had a new legislative role and hence legitimacy in engaging in reducing alcohol related harm. Host responsibility offered a method for all the Partnership Agencies to meet their new statutory requirements and shared goals. The Sammy's Project taught the Partnership Agencies how to be a working team with all their individual and organisational differences and identified elements of licensed premises management which would lead to safer drinking environments. In addition, the Atmosphere Project was particularly successful in building relationships between the Partnership Agencies and the hospitality industry. The industry believed that the Partnership Agencies understood the licensees' business and were prepared to work with the

licensees to achieve Agency goals. (Stakeholder Interviews: HANZ & Partnership Agencies)

6.4.3 Complexity

Although host responsibility was a new multi-faceted concept for New Zealand, ALAC spent considerable time and effort minimising its complexity. They clearly identified five key steps, some of which were based in legislation and others which addressed politicians' and the public's demand for action on drink/driving problems. Included in their process was national advertising, supporting documentation aimed variously at fieldworkers, the hospitality industry and the general public, and support via materials and training for host responsibility fieldworkers. In Dunedin, the Partnership Agencies workers similarly aimed to make the host responsibility concept straightforward by concentrating on issues that were the least controversial such as safe transport home or identifying underage patrons. This allowed them to build credibility with licensees so that they could move onto more complex things. (Stakeholder Interviews: ALAC & Partnership Agencies)

6.4.4 Trialability

While the host responsibility concept was not designed as a trial, each of the projects within the Dunedin programme was always considered a 'trial'. The Sammy's Project was explicitly a trial. The other projects were always open to review, briefing and debriefing, and change. (Stakeholder Interviews: Partnership Agencies; Document Analysis)

6.4.5 Observability

Health promotion workers in particular are used to having long lead times when observing outcome successes in any programme. Therefore part of any programme includes observing action which may act as a proxy for success. In the Dunedin programme we have seen that host responsibility policies were in place in licensed premises across Dunedin, that the various communities of interest were engaging in the overall programme and that the Benchmark Projects were successful in meeting their objectives. In addition, the Partnership Agencies workers were able to demonstrate their successes to the executive level management of each of their organisations and so continue to be resourced and supported by the Agencies.

6.4.6 Adaptability

While ALAC set out the five strands of host responsibility nationally and supported it with national media campaigns and health promotion worker meetings, how it was introduced to each region was the responsibility of the workers in that region. This allowed for major diversification. Although the key messages remained the same, each intervention strategy was completely open to being adapted to the audience. The Dunedin projects were developed for the region in concert with the communities of interest.

6.4.7 Riskiness

In the initial stages, the Dunedin Host Responsibility Programme certainly took risks. The Sammy's Project allowed underage young people into a licensed premises which, legally speaking, was inaccessible to them. This certainly caused the executive level management in the Dunedin City Council concern, although the fieldworkers were convinced they could succeed. (Stakeholder Interviews: Partnership Agencies) The perception of riskiness seems to be dependent on the position in the organisation. After several years of successful innovative projects, proposals for new projects by the Partnership Agencies fieldworker team are deemed to be worth trying as the team is seen as successfully innovative while minimising the risk to the Partnership Agencies. (Stakeholder Interviews: Partnership Agencies Management)

6.4.8 Acceptance

The Partnership Agencies fieldworkers embraced host responsibility enthusiastically and incorporated it fully into their programme and approach. The immediate managers were also accepting of the approach and encouraged new projects which could meet the overall aim. (Stakeholder Interviews: Partnership Agencies - Managers and fieldworkers) The Partnership Protocol signed at the Chief Executive level five years into the programme and after some negotiation indicated that the Dunedin Host Responsibility Programme was accepted at all levels in the Partnership Agencies. The hospitality industry's response to the Atmosphere Project and subsequent projects indicated their acceptance of the overall host responsibility concept if not the full range of the Partnership Agencies aims.

6.5 Summary

Project evaluation indicated that the various projects were successful in meeting their objectives. Stakeholders identified that lessons learned from earlier projects were applied to subsequent projects which supported growing relationships within the Partnership Agencies and with the larger community of interest. The view of the Partnership Agencies stakeholders on their working relationship as a partnership which amalgamated different strengths and skills, was not always represented in their public presentations of the Host Responsibility Programme. This changed over time until by the end of the evaluation period, a strong team with a track record of successful projects within a cohesive programme had emerged.

7 DISCUSSION

In this dissertation a retrospective evaluative case study was undertaken. There were certainly constraints on the techniques available. Nonetheless evaluation was possible and the questions posed in Chapter 5 were able to be answered. They were:

Was this programme successful in meeting its objectives?

(and if so)

What are the factors that make it successful?

7.1 Evaluation of the Dunedin Host Responsibility Programme

The Dunedin Host Responsibility Programme was not established with comprehensive evaluation in mind. Developing an evaluation process which could be applied retrospectively required an approach which incorporated several techniques. The methods used were a mixture of well established health promotion evaluation techniques and of qualitative organisational research.

The lack of easily accessible base line data was a considerable handicap to the application of standard health promotion evaluation techniques. Similarly, the lack of evaluation planning during the initial planning stages of the projects hampered the evaluation. The quality of the evaluation reports for each of the Benchmark Projects available from the Partnership Agencies was variable. Some had been comprehensively evaluated while others were a series of briefings and debriefings. The process and impact evaluation techniques were reasonably straightforwardly applied and imposed a structure on the evaluation information. This revealed that immediate and short term changes had occurred as a result of the projects. It is also plausible that these could act as a proxy for outcome evaluation although this is not satisfactory in the long term. The need to establish base line data is urgent, as is the need to plan and invest in evaluation at the beginning of each project.

The stakeholder evaluation added a useful dimension to the overall evaluation as it revealed more of the process of success and the elements which could be applied to future projects. It also demonstrated how the separate projects interacted and provided building blocks for the overall programme. Stakeholder

analysis may have been more revealing if a more formal question structure was in place, particularly one which addressed the attributes of innovation more directly. During the stakeholder interviews it was clear that the participants, particularly those in Dunedin working together on a daily basis, were reluctant to criticise each other for fear of damaging their working relationships. It is hard to judge precisely, the effect I had as a researcher who was well known (having been a colleague and manager). Reflecting on the interview transcripts, I consider that my involvement in the programme over the years and my relationship with the stakeholders actually assisted the genuineness of reply. By itself the document analysis would not have revealed the whole picture, however, it did confirm the findings, particularly those of the stakeholder analysis.

7.2 Results of the Dunedin Host Responsibility Programme

We have seen that successful health promotion programmes in the alcohol field need to be environmental in their approach. That is, they need to address the context of the drinking environment and direct their efforts at the various levels of influence in the community on which they are focused. The Dunedin Host Responsibility Programme focused primarily but not exclusively on the drinking environment of licensed premises.

Of the various programmes reviewed, the Community Trials Project (Holder et al 1997b) seems to most closely resemble the Dunedin Host Responsibility Programme. The researchers claim that major economic, social and cultural factors cannot be directly impacted by prevention factors, yet much of their project was directly aimed at altering such social factors as the level of acceptable drinking as is the Dunedin project. Using the criteria for successful responsible beverage service established in Chapter Four (pp 38-39) it is possible to assess the success of the programme.

7.2.1 Management Training

The Partnership Agencies met regularly with licensees to discuss the Agencies expectations of licensees and their premises and viewed this as management training. Specific training was also provided for managers within the Doorstaff project and in other educative projects not evaluated within this paper. Although

not compulsory, there was good attendance at meetings and training events including support from HANZ for the educative approach of the Partnership Agencies. Towards the end of the period being evaluated, the regular meetings between the Partnership Agencies and licensees dropped off and were replaced with more contact with the local representative of HANZ. How this will affect the training of managers in the medium to long term is yet to be seen.

7.2.2 Serving Staff Training

While there is no mandatory training for all serving staff, those who wished to be managers were required by law to obtain a Manager's Certificate. In the Dunedin setting this was primarily obtained through the Otago Polytechnic. The Partnership Agencies had input into the course and Host Responsibility was a major constituent of the training. In addition, the same Polytechnic department was commissioned to develop and offer the training for doorstaff as part of the Doorstaff Project. There was varied take up of these two programmes. Host Responsibility practice certainly varies between licensed premises as was shown in the Atmosphere project. Within New Zealand, it is unlikely that legislation for the compulsory training of all serving staff in Host Responsibility practice will eventuate. The best that can be achieved would be to ensure that the training available is made attractive through being recognised by the New Zealand Qualifications Authority.

7.2.3 Patron Awareness

Raising patron awareness in this programme has been reliant on the nationally led projects such as the Host Responsibility television advertisements by ALAC or by the cross country attention to and police action about drinking and driving. Local advertisements via the newspaper and radio stations have 'coat-tailed' on the national efforts. Other than the work with schools (Alcohol Awareness education week and PSST...) little has been actively pursued by the Partnership Agencies. Through their work with licensed premises the expectation of raising patron awareness has been placed, by the Partnership Agencies, with the licensees. This has obvious drawbacks in that there is no way of monitoring what action is occurring in licensed premises and allows the Partnership Agencies to abdicate their role in ensuring that patrons know what is expected of them.

7.2.4 Written Policies

Very early in the Host Responsibility programme licensed premises were required to have a written Host Responsibility policy which formed part of their licensing application. This continues to be a primary expectation and is supported through inspections by the Otago Public Health Service as part of completing the Licensing Report from the Medical Officer of Health as required by the Sale of Liquor Act 1989, and by licensing inspections from the Dunedin City Council. This acts as an informal and one to one education process with licensees.

7.2.5 Community Involvement

Involving the community of interest in particular projects has been a primary goal of the Partnership Agencies and one in which they have been successful. In each of the projects reviewed and in several others, the licensees, HANZ, radio station DJs or student representatives have been involved. The Sale of Liquor Act 1989 restricts who can make submissions regarding applications for licences and in this regard the general community is prevented from being fully involved. However, the general community has also been less involved in the ongoing programme. Public information about the projects has dropped off resulting in a low profile. Much documentation about community involvement stresses the need for the whole community to be active in a project for it to succeed. The Community Trials Intervention Project (Treno & Holder, 1997) predicated their project on this. However, they found that in the experimental community which did not have broad community involvement but rather had representatives of the community of interest, much as the Dunedin Host Responsibility programme does, the project was still successful in achieving policy changes and positive outcomes in reducing alcohol related harm. It is clear from the project evaluation results that the Dunedin programme was also successful, adding weight to the argument that community of interest involvement is enough for success. Extending the community of involvement definition to include patrons or potential patrons and those closely affected by the activity surrounding licensed premises is likely to strengthen the Dunedin programme rather than weaken it. However, full community representation does not appear to be necessary to achieve a reduction in alcohol related harm.

7.2.6 Litigation versus Education

The Dunedin programme relies heavily on education and health promotion action to prevent alcohol related harm. It has, however, challenged licensed premises operations successfully through the Liquor Licensing Authority. Indeed, the Partnership Agencies are proud of their reputation with the Liquor Licensing Authority as a body of agencies which exhaust the educative and negotiating processes before using litigation, via the Liquor Licensing Authority, as a last resort. The Partnership Agencies consider that they have had less support from the local judiciary whom they portray as uninterested in alcohol related crime and not supporting the use of litigation in these instances. The Dunedin programme is in danger of relying almost too heavily on education and health promotion action following the reported difficulties of gaining convictions from the local judiciary.

7.2.7 Problem Prevention and Relationships with the Hospitality Industry

The projects evaluated and the stakeholder and document analysis demonstrate the Partnership Agencies commitment to problem prevention as well as problem solving across their environment. This process has actively involved the hospitality industry in planning, implementing and evaluating the projects. While the literature review emphasises the necessity of this approach to achieve a reduction of alcohol related harm, other prevention workers in New Zealand have criticised this approach. Stakeholders, in both local and national settings, indicated that they had received negative feedback from their prevention colleagues. The crux of the criticism seemed to be that working with the industry reduced the workers ability to challenge industry behaviour and to maintain an independent position regarding alcohol related harm prevention. It is clear that the Dunedin Partnership Agencies rejected that criticism and continued to develop their working relationship with the industry. They do not deny that there are differences of goals and approaches but remain advocates of change from within.

7.2.8 Enforcement

Police enforcement of Sale of Liquor Act 1989 has changed during the course of the Dunedin programme. The national emphasis on enforcement of drink driving has remained in Dunedin and the Partnership Agencies have successfully challenged licences and conditions of licences with the Liquor Licensing Authority. The Dunedin Police disbanded their Team Policing Unit as a result of

the success of the Host Responsibility programme. However, there is a danger that as little enforcement occurs and licensees are left to self-police their premises, standards of compliance will diminish. The Partnership Agencies must remain active in enforcement. “...it’s like a well weeded garden, you know, the weeds,... there’s only a few weeds j-u-s-t poking their heads through ...” (Stakeholder Interviews: Dunedin Police).

7.2.9 Media Advocacy

A successful media advocacy approach does much to enhance public perceptions and assists in shifting public and decision makers opinions. The Partnership Agencies have not been particularly focused on media advocacy as defined by the Community Trials Prevention Project. This led to the Partnership Agencies being portrayed negatively when they were taking action against licensed premises which were non compliant with the Sale of Liquor Act 1989. They have been working closely with radio stations, and in particular with announcers, to minimise the portrayal of intoxication as a desired state and alcohol related harm as acceptable. While they have been successful in achieving behavioural change with radio DJs, they have not focused on media reports nor have they actively pursued media coverage and advocacy of the prevention of alcohol related harm.

7.2.10 Institutionalisation

Where the Partnership Agencies have been particularly successful is in institutionalising the Host Responsibility programme in Dunedin. The Partnership Protocol formally instated the process in each of the Agencies parent organisations. The formal signing of the Dunedin City Alcohol Charter included industry, agency and public representation; contractual obligations have embedded the approach in crown agencies while the Sale of Liquor Act 1989 Policy has embedded the approach in the Dunedin City Council. Establishing the training programmes in the local education institutions and succession planning in each of the organisations has ensured ongoing action regardless of individual staff changes. Finally, having strong involvement of the industry and related groups has established an expectation of ongoing projects and programmes.

7.2.11 Summary

It is clear from the project evaluations and the applied criteria established from the review of other community intervention trials, that the Dunedin Host Responsibility Programme has been successful in achieving its intermediate goals. Given that the projects and overall programme closely resembled the successful factors of the Community Trials Prevention Project it is plausible to assume that the Dunedin programme was also likely to be successful in its longer term goals. The question remains though, what were the contributing factors to the success of the programme?

7.3 Contributing Factors to the Success of the Dunedin Host Responsibility Programme

Across New Zealand there are Territorial Local Authorities with District Licensing Agencies, Police Districts with Licensing Sergeants, and Public Health Services with Medical Officers of Health and Health Promotion Advisers, who all work under the same statutory requirements, who have similar contracts with their funding agencies, and who share the same goal of reducing alcohol related harm. Yet the national stakeholders interviewed all considered the Dunedin Host Responsibility Programme to be one of the most successful. Adopting and implementing innovation requires certain attributes (Meyer et al, 1997). We have seen in Chapter 6 that the Partnership Agencies displayed several of those attributes. The Partnership Agencies were both adopters of innovation and innovators in their own right. In the first instance, they adopted the innovation of Host Responsibility from the national body (ALAC) and second, they developed many new projects and relationships to achieve their aims. Using the already identified innovation attributes the following table rates the Partnership Agencies against each attribute.

Table 5: Innovation Attributes of Dunedin Host Responsibility Partnership Agencies

ATTRIBUTE	DEFINITION	RATING	COMMENT
Relative Advantage	The degree to which an innovation is perceived as being better than the idea that precedes it.	HIGH	This has remained a characteristic as each project is seen to be building on and improving on its predecessor.
Compatibility	The degree to which an innovation is perceived as consistent with existing values, past experiences and the needs of the adopters.	HIGH	Values, experience and needs have converged over the course of the project both for Partnership Agency workers and the hospitality industry.
Complexity	The degree to which an innovation is perceived as relatively difficult to understand and use.	MEDIUM	At a Partnership Agency worker level host responsibility was not viewed as highly complex but its implications were less readily understood at executive level management and by the hospitality industry.
Trialability	The degree to which an innovation may be experimented with on a limited basis.	HIGH	The Partnership Agencies experimented with each project while maintaining the core of host responsibility.
Observability	The degree to which the effects on an innovation are visible.	MEDIUM	The overall outcome of reducing alcohol related harm is not easily visible, however, impact results of many of the projects and the programme are visible thereby offering reinforcement to the Partnership Agencies workers.
Adaptability	The degree to which an innovation can be modified to local needs.	HIGH	The Partnership Agencies viewed the implementation of host responsibility as able to be adapted fully to their needs and the needs of their community of interest.
Riskiness	The degree to which an innovation is perceived as risky.	MEDIUM	The Partnership Agencies workers viewed the risk to be small, however, their executive level managers were not as convinced. Success over time has offered extra support to innovation.
Acceptance	The degree to which the innovation is accepted.	HIGH	Stakeholders at all levels of the Partnership Agencies and other organisations involved, including the hospitality industry, have a high degree of acceptance of host responsibility and the various projects.

The display of these attributes has been consistent over time. National stakeholders commented on the consistency of approach and action that the Dunedin programme displayed and compared that favourably with other programmes around the country they had seen. The latter were more likely to have

some projects which were successful but which were not consistent across the region nor across time. (Stakeholder Interviews: National Police, ALAC, HANZ) It would be interesting to apply the Innovation Attributes Rating to other host responsibility programmes in other regions on a more systematic basis to provide a comparative assessment of what makes the Dunedin Host Responsibility Programme successful.

The relationship between the key stakeholders is clearly important. It has had ebbs and flows over the course of the programme. In the first two years the local stakeholders were testing the waters. Tentative approaches were made and projects which were very task and legislatively oriented undertaken. As the organisations experienced working together, they learned each other's strengths and weaknesses. They report on this learning particularly emphasising the Sammy's Project. The Alcohol and Public Health Research Unit's four Formative Evaluation documents indicate a somewhat rocky start to the relationship. Yet by 1991 the Partnership Agencies were working on joint projects, even amid some animosity between them as work boundaries were challenged. The formal presentations the Partnership Agencies made about their project have altered over time. While it may be true that they were tailored for their particular audience, it is also true that they reflect the general internal perceptions that the partnership was not an equal one.

The Partnership Protocol begun in 1995 and signed in 1996 indicated a change in how the Partnership Agencies described themselves and their relationship with each other. The partnership was clearly regarded as more equal and the boundaries were considered to be quite blurred. What this meant in practice was that consensus decision making was a key partnership process which was applied to both project development and implementation, and to expenditure of the financial resources each partner brought to the programme. Since 1996 blurred boundaries has also come to mean each partner trusting each other, to the extent that any one of the partners could speak on behalf of the others, either to licensees or publicly on any of the issues which might have previously been designated health or police or local authority business. This is a considerable achievement.

Each of the stakeholders interviewed addressed the issue of personalities determining the success of the programme. While the local stakeholders acknowledge that in the first two years, personalities and the commitment of the workforce drove the programme, they equally emphasise the contribution made by the organisations they were part of, in allowing and encouraging inter-agency work and by formalising the process in organisational structures. This is at odds with the national stakeholders who consider the programme to be almost totally reliant on personalities. Meyer et al (1997) emphasise the importance of managers within organisations supporting innovation both implicitly and explicitly. In addition they also comment on the importance managers have in framing the context for innovation. All the Partnership Agencies workers commented on the support they received from their managers. The managers also indicated their commitment to creating a context which encouraged cross boundary co-operation and innovation with action such as succession planning. (Stakeholder Interviews: Partnership Agencies Managers) Similarly the Partnership Agencies workers, as managers of the Host Responsibility programme, framed the projects in such a way as to demonstrate to the licensees that implementing and supporting the programme would increase their profitability as well as show their commitment to the community. Meyer et al (1997) comment that failure of innovation "...may dampen the innovation environment." However, the opposite is also true. Success in innovation may well invigorate the innovation environment and certainly seems to have in this programme context. As the Dunedin Host Responsibility Programme demonstrated success over time, executive level management became more supportive and trusted the Host Responsibility team to deliver on innovation even when there was risk to the organisations.

The synergy of each of the projects and the underlying policy objectives should not be overlooked. While the Host Responsibility programme and individual projects were not designed with deliberate synergy in mind at the start of the programme, they have evolved out of and built on each other. Each successful innovation invigorated the next. The goal of reducing alcohol related harm remained to underpin the action taken by the Partnership Agencies.

7.4 Summary

In contrast to many other alcohol related harm reduction programmes and projects, the Dunedin programme places itself firmly within the health promotion tradition established and developed by the Ottawa Charter for Health Promotion, 1986 and the Jakarta Declaration, 1997. Internationally, other programmes do not use the health promotion language promoted by these agreements but describe similar approaches by calling for environmental approaches which address both individual practices and policies which reinforce particular behaviours. The Dunedin programme has addressed most of the five strategies of the Ottawa Charter. Its only failing in this regard is that it does not address the health service and the kind of changes it could make. It is clear that the programme also addresses the twin aims of harm reduction and use reduction.

8 SUMMARY AND RECOMMENDATIONS

8.1 Dunedin Host Responsibility Programme

Alcohol related problems and their cost to New Zealand society are undisputed. A commitment to reducing alcohol related harm has been evident in successive Governments' policies and encapsulated in the Sale of Liquor Act 1989. Host Responsibility has become a key mechanism for implementing that policy, both at a national level (ALAC, Police Headquarters) and at a local level.

In this dissertation a broad range of programmes aimed at reducing alcohol related harm have been reviewed. The key findings were that a successful host responsibility programme should have a comprehensive approach which includes management training, patron awareness, serving staff training, written Host Responsibility policies in licensed premises, purposeful community involvement, enforcement by police, skilful media advocacy, and a process to ensure institutionalisation of the programme.

The Dunedin Host Responsibility programme was developed in an ecological way with each project building on the previous but all with the same objective of reducing alcohol related harm. The projects covered the range of issues which we have seen need to be addressed for a programme to be successful. The Benchmark Projects' evaluations indicate that the programme has been successful in meeting its objectives. Combining this success with the Dunedin programme's coverage of the elements considered necessary, it is plausible to assume a long term outcome of reducing alcohol related harm. However, there are some areas it could develop to improve and build on its success.

While it is clear that the projects aimed at reducing access to alcohol for young people were successful in their own right, it was also clear that outside those projects young people had no trouble gaining access to alcohol. Access to alcohol through off license or club premises negates the positive impacts made in on licensed premises. The Doorstaff project was successful in meeting many of its objectives. However, the public profile of door staff received little attention and is an area where future effort could be focused. PSST... proved very successful and

although parents and teachers did not take up the preview offer, further efforts should be made in this regard.

The Dunedin Programme has been successful in working with the media on specific projects but has spent little time on media advocacy. The Community Prevention Trials Project showed that media advocacy was a powerful tool for mobilising community action, raising the profile of projects and engendering community support for the overall goals of the project. This in turn impacts on the policy makers who perceive a change in attitude in the community they represent. Effort should be spent in the Dunedin Host Responsibility programme developing a media advocacy strategy to complement current projects.

Process and impact evaluation of the Benchmark Projects for this dissertation was straightforward. Validating the plausible assumption of success would require a retrospective study of data held. The Dunedin Police gave permission for access to all incident information relating to alcohol. It proved beyond the scope of this dissertation to analyse that data as it was in the raw form of incident sheets. Analysing and reporting on this data over the last decade would provide valuable outcome information for the Dunedin Host Responsibility programme. Similarly, other baseline data such as licence applications, objections, action with licensees and revocation of licences would also provide valuable outcome information. Future projects should be planned with the evaluation process built into the plan. Repeating the research of the Atmosphere Project at five yearly intervals would provide useful information about the sustainability and spread of the impact of the Host Responsibility programme.

Community involvement and 'ownership' of prevention projects is viewed as essential by most health promotion and community action groups. Yet it appears, both from the Community Prevention Trials Project and the Dunedin Host Responsibility programme, that whole community involvement is not necessary for success. It is clear, however, that community of interest involvement, such as the hospitality industry or sporting groups in the case of Carisbrook, are crucial for success.

8.2 Evaluation Method

Using well established health promotion techniques of process and impact evaluation in this case study has proved useful in assessing the impact of the projects. Stakeholder analysis has provided some understanding of the features that contributed to that success. The document analysis confirmed the findings of the stakeholder analysis. In future case studies where the stakeholders were less forthcoming, document analysis may well be able to contribute more. Being able to use outcome evaluation would have strengthened the argument that the Dunedin Host Responsibility programme was a successful programme.

Applying the diffusion of innovation framework to the programme illustrated the commitment to innovation the Partnership Agencies, both workers and managers had. The project success described previously, invigorated the innovation process within the Partnership Agencies which allowed the synergies possible from the projects to be recognised and implemented.

8.3 Recommendations for Future Action

8.3.1 Evaluation

- Establish current baseline data as part of future project planning processes.
- Ensure future projects include an evaluation plan at the beginning.
- Repeat the Atmosphere Project research at five yearly intervals.
- Complete formal evaluation reports for each project. As a minimum these should include process and impact evaluation.

8.3.2 Dunedin Host Responsibility Programme

- Use the criteria for successful responsible beverage service programmes identified in Chapter 2 (pp38/39) to inform planning for all future projects.
- Maintain good practice already established.
- Develop a specific media advocacy approach.
- Increase enforcement action to complement and support the programme.
- Develop specific project(s) to:
 - reduce young people's access to alcohol outside on-licensed premises
 - improve the public profile of door staff

- improve patron awareness of host responsibility, their rights and responsibilities
- improve the attendance at PSST... previews by parents and teachers.
- The Partnership Agencies may wish to consider:
 - how to increase the input from the general public into the programme; and
 - how to address the fifth Ottawa Charter strategy of reorienting the health services within the context of the Host Responsibility programme, including whether it is feasible.

8.3.3 Research

- Apply the Diffusion of Innovation theoretical framework systematically to a selection of Host Responsibility programmes across New Zealand. The aim would be to understand what characteristics contributed to the successful uptake of the programme over time.
- Conduct a retrospective analysis of the raw data held by the Dunedin Police relating to incidents involving alcohol.
- Similarly conduct an analysis of applications for licences. This would include applications, action taken by the Partnership Agencies regarding particular licensed premises and any revocation of licence.

8.4 Summary

The Dunedin Host Responsibility Programme was developed in a parallel timeframe and demonstrates many of the same characteristics of the Community Trials Project. Many of the outcomes of the Community Trials Project are not possible to measure in the Dunedin programme. Nevertheless, having implemented similar components, it is plausible to infer Dunedin programme success from the successful components of the Community Trials Project. Success was due to many factors including the willingness of the Partnership Agencies workers to innovate and to develop a climate of trust where relationships were institutionalised, so that all new workers came into a context where co-operation and innovation were the expected norm. Implementing the recommendations made above will strengthen and sustain the programme and make it possible for the programme to evaluate its longer term outcomes. The lessons learned from the

literature review and from the Dunedin programme can be applied in other settings where adaptations can be made to fit the local circumstances. In this way the host responsibility programme introduced by ALAC can be strengthened across New Zealand.

BIBLIOGRAPHY

Abel, S., Wyllie, A., Panapa, A., & Casswell, S., **Stakeholders' Perceptions of Host Responsibility: A Summary**, Alcohol and Public Health Research Unit, University of Auckland, 1993

Alcohol Advisory Council of New Zealand (ALAC) *Alcohol Effects Fact Pack*, ALAC website, 31 December 1998

Alcohol Advisory Council of New Zealand, **Alcohol Fact Pack**, Wellington, 1996

Alcohol Advisory Council of New Zealand, **Discussion Document on Sale of Liquor Act 1989: Stage Two: Proposals for improving the effectiveness of the Sale of Liquor Act 1989**, March 1995

Alcohol Advisory Council of New Zealand, **Effectiveness Review: Sale of Liquor Act 1989: Stage One: Report of Key Stakeholders Survey**, January 1995

Alcohol Advisory Council of New Zealand, **National Guidelines for Host Responsibility**, 1992

Badura, B., & Kickbusch, I., Health Promotion Research: Towards a New Social Epidemiology, WHO, European Series No 37, 1991

Boots, K., *The Designated Driver Program: An Outcome Evaluation* in **Health Promotion Journal of Australia 4:1 (1994): 26-29**

Burgoyne, J. G., *Stakeholder Analysis* in Cassell, C., & Symon, G(eds) Qualitative Methods in Organizational Research: A Practical Guide, Sage Publications London, 1994 pp 187 - 207

Carvolth, R., *Does Responsible Hospitality Work? A synopsis of Research Findings*, Paper requested by the National Workshop for Research into the Licensed Drinking Environment, Melbourne, 23 - 24 May 1991

Cassell, C., & Symon, G(eds) Qualitative Methods in Organizational Research: A Practical Guide, Sage Publications London, 1994

Cassell, C., & Symon, G., *Qualitative Research in Work Contexts* in Cassell, C., & Symon, G(eds) Qualitative Methods in Organizational Research: A Practical Guide, Sage Publications London, 1994, pp 1 - 13

Casswell, S., *Invited Background Paper for the WHO Expert Meeting on Alcohol Policies and Programmes* Tokyo, Japan, 2 - 8 April 1991

Casswell, S., Stewart, L., **Control of Drinking on Licensed Premises in New Zealand**, Alcohol Research Unit, University of Auckland, 1986

Caulkins, J., & Reuter, P., *Setting Goals for Drug Policy: harm reduction or use reduction* in **Addiction 92:9 (1997): 1143 - 1150**

Crundall, I., *Living with Alcohol in the Northern Territory* in **Health Promotion Journal of Australia** **4:1 (1994): 52-5**

Dearing, D. W., & Meyer, G., *An Exploratory Tool for Predicting Adoption Decisions* in **Science Communications** **16:1 (1994): 43-57**

Dunedin District Licensing Agency **Sale of Liquor Policy**, 1995

Dunedin District Licensing Agency, *Programme Files*, Dunedin City Council, 1990 - 1998, unpublished.

Dunedin Partnership Agencies, **Dunedin's Approach to the Practical Enforcement of the Sale of Liquor Act 1989**, Paper to the 24th Australasian Conference of Liquor Licensing Authorities, 1994, unpublished

Dunedin Partnership Agencies, **Dunedin Licensees Survey**, 1997, unpublished

Dunedin Partnership Agencies, **Effectiveness Review: Sale of Liquor Act 1989 Submission**, 1995, unpublished.

Dunedin Partnership Agencies, **Management of Alcohol at Sporting Events and Outdoor Concerts: Conference Outcomes**, 1997, unpublished

Dunedin Partnership Agencies, **Partnership Protocol**, 1996, unpublished

Dunedin Partnership Agencies, **The Dunedin Partnership: An Allied Approach to the Sale of Liquor Act 1989**, Paper to the New Zealand Police District Commanders Conference, 1995, unpublished

Dunedin Police, **Action Plan: 1993 - 1998**, unpublished

Edwards, G., & Holder, H. D., (eds) *Alcohol Policy and the Public Good*, Oxford University Press, Oxford, 1994

Erickson, P., *Harm Reduction: what it is and is not*, in **Drug and Alcohol Review** **14 (1995): 283-285**

Farrell, S., *Review of National Policy Measures To Prevent Alcohol Related Problems.*, World Health Organisation - Division of Mental Health, 1985

Forster, N., *The Analysis of Company Documentation* in Cassell, C., & Symon, G(eds) *Qualitative Methods in Organizational Research: A Practical Guide*, Sage Publications London, 1994 pp 147 - 166

Giesbrecht, N., & Ferris, J., *Community-based Research Initiatives in Prevention* in **Addiction** (1993) **88 (Supplement): S83 - S93**

Gilksman, L., MacKenzie, D., Single, E., Brunet, S., Moffatt, K., *The Role of Alcohol Providers in Prevention: An Evaluation of a Server Intervention Programme* in **Addiction** **88 (1993): 1195 - 1203**

Green, L. W. & Kreuter, M. W., Health Promotion Planning: An Educational and Environmental Approach, (2nd edition) Mayfield Publishing, Mountain View Ca., 1991

Grube, J., *Preventing Sales of Alcohol to Minors: Results from a Community Trial* in **Addiction 92 (Supplement 2) (1997): S251 - 260**

Hartley, J., *Case Studies in Organisational Research*, in Cassell, C., & Symon, G(eds) Qualitative Methods in Organizational Research: A Practical Guide, Sage Publications London, 1994 pp 208 - 229

Hawe, P., Degeling, D., Hall, J., Evaluating Health Promotion: A Field Workers Guide, McLennan and Petty, Sydney, 1995

Hill, L., & Stewart, L., **The Sale of Liquor Act 1989: Local Perspectives**, Alcohol and Public Health Research Unit, University of Auckland, 1996

Holder, H., & Reynolds, R., *Application of Local Policy to Prevent Alcohol Problems: Experiences from a Community Trial* in **Addiction 92 (Supplement 2) (1997): S255 - 292**

Holder, H., & Treno, A., *Media Advocacy in Community Prevention: News as a Means to Advance Policy Change* in **Addiction 92 (Supplement 2) (1997) : S189 - 199**

Holder, H., Saltz, R., Grube, J., Treno, A., Reynolds, R., Voas, R., & Gruenewald, P., *Summing Up: Lessons from a Comprehensive Community Prevention Trial* in **Addiction 92 (Supplement 2) (1997): S292 - 301**

Holder, H., Saltz, R., Grube, J., Voas, R., Gruenewald, P., & Treno, A., *A Community Prevention Trial to Reduce Alcohol-Involved Accidental Injury and Death: Overview* in **Addiction 92 (Supplement 2) (1997): S155-S171**

Homel, P., Miller, L., & MacAvoy, M., *Where's the Harm? Harm Minimisation in Practice*, in **Health Promotion Journal of Australia 4:1 (1994):4-4**

Homel, R., Tomsen, S., & Thommeny, J., *Public Drinking and Violence: Not Just an Alcohol Problem* in **Journal of Drug Issues Summer 1992:679-697**

Hood, D., **The Role of the Medical Officer of Health in Liquor Licensing in New Zealand** Dissertation for MPH, unpublished, 1996

Hutt, M., & Howden-Chapman, P., Old Wine in New Bottles, Public Health Monograph, Institute of Policy Studies, Wellington, 1998

Jeffrey, E., Martin, M., & Wilson, J., **Breath Alcohol Levels of Hotel Patrons in North Dunedin**, Trainee Intern Health Care Evaluation Project, 1994

Jeffs, B. W., & Saunders, W. M., *Minimising Alcohol Related Offences by Enforcement of the Existing Licensing Legislation* in **British Journal of Addiction 78 (1983): 67 - 77**

- Kearsley, G. W., **Dunedin Attitudes to Alcohol Survey**, unpublished, 1993
- Keenan, A., **The Atmosphere of Licensed Premises Project: Stage One**, Dunedin Partnership Agencies in association with HANZ, 1995, unpublished
- Krass, I., & Flaherty, B., *The Impact of Responsible Service Training on Patron and Server Behaviour: A Trial in Waverley (Sydney)* in **Health Promotion Journal of Australia 4:2 (1994): 51 - 58**
- Meyer, M., Johnson, J. D., & Ethington, C., *Contrasting Attributes of Preventive Health Innovations* in **Journal of Communications 47:2 Spring 1997: 112 - 131**
- Mikkelsen, B., Methods for Development Work and Research: A Guide for Practitioners, Sage Publications, London, 1995
- Milio, N., *Making Healthy Public Policy: Developing the science by learning the art.*, in Badura, B., & Kickbusch, I., Health Promotion Research: Towards a New Social Epidemiology, WHO, European Series No 37, 1991., pp7 - 28
- Ministry of Health, **Strengthening Public Health Action: the Strategic Direction to Improve, Promote and Protect the Public Health.**, Wellington, New Zealand, 1997
- Montonen, M., *Report on Educational Approaches Seminar re: Casswell, S., presentation on Public Discourse on Alcohol* in **Addiction 92: (Supplement 1) (1997): S123 - 125**
- New Zealand Police, **Strategic Plan 1993 - 1998**, Wellington
- Nutbeam, D. **Health Promotion Glossary**, WHO, 1997
- Nutbeam, D., & Harris, E., Theory in a Nutshell: A Practitioner's Guide to commonly used theories and models in Health Promotion, National Centre for Health Promotion, Sydney, 1998
- Patton, M. Quinn, Qualitative Research and Evaluation Methods (2nd ed.), Sage Publications, London, 1990
- Public Health Commission, **1993-1994 Alcohol Policy: Advice to the Minister of Health**, Wellington
- Public Health Service, *Contract documents (1991 - 1995) Public Health Commission, Southern Regional Health Authority (Health Funding Agency) and the Public Health Service of HealthCare Otago*. 1991 - 1997, unpublished.
- Public Health Service, *Programme Files*, HealthCare Otago, 1990 - 1998, unpublished
- Reynolds, R., Holder, H., & Gruenewald, P., *Community Prevention and Alcohol Retail Access* in **Addiction 92 (Supplement 2) (1997): S 261 - 272**
- Roche, A. M., Evans, K., Stanton, W. R., *Harm Reduction: Roads Less Travelled to the Holy Grail*, in **Addiction 92:9 (1997): 1207-1212**

Rose, G., *Strategy of Prevention: lessons from cardiovascular disease* in **British Medical Journal** **282**, (1991): 1847 - 1851

Roseveare, C., & Withers, M., **Evaluation of the Wellington Regional Public Health Service Sale of Liquor Project 1991 -1993: Report to the Public Health Commission** Wellington Regional Public Health Service, April 1994

Saltz, R., & Stanghetta, P., *A Community-wide Responsible Beverage Service Program in Three Communities: Early Findings* in **Addiction** **92** (Supplement 2) (1997): S237 - 249

Saltz, R., - Research reference lost. Early work regarding server intervention on an armed forces base, USA - ?late 1980s

Single, E., *A Harm Reduction Approach for Alcohol: Between the Lines of Alcohol Policy and the Public Good* in **Addiction** **90** (1995): 195 - 98

Single, E., *Defining harm Reduction* in **Drug and Alcohol Review** **14** (1995): 287-290

Single, E., **Promoting Host Responsibility by Health Promotion Workers in New Zealand**, Presentation, 1992

Slinger, S., & Stockwell, T., *Implementing Harm Reduction Strategies on Licensed Premises* in **Health Promotion Journal of Australia** **4:1** (1994):49-51

Stewart, L., & Casswell, S., **From a Public Health Perspective: Control of Drinking on Licensed Premises in New Zealand**, Alcohol and Public Health Research Unit, Auckland University, January 1986

Stewart, L., & Harré, M., **Evaluation of an Electronic Bulletin Board Service for Alcohol Health Promotion Workers: First Process Evaluation Report**. Alcohol and Public Health Research Unit, May 1994

Stewart, L., Casswell, S., Duignan, P., **Public Health Input into the Implementation of the Sale of Liquor Act: Second Formative Evaluation Report**, Alcohol and Public Health Research Unit, Auckland University, August 1991

Stewart, L., Casswell, S., Duignan, P., **Public Health Input into the Implementation of the Sale of Liquor Act: Third Formative Evaluation Report**, Alcohol and Public Health Research Unit, Auckland University, August 1991

Stewart, L., Casswell, S., **Public Health Input into the Implementation of the Sale of Liquor Act: Fourth Formative Evaluation Report**, Alcohol and Public Health Research Unit, Auckland University, April 1992

Stewart, L., Duignan, P., Casswell, S., **Public Health Input into the Implementation of the Sale of Liquor Act: First Formative Evaluation Report**, Alcohol Research Unit, Auckland University, 1990

Stockwell, T., *Liquor Outlets and Prevention Policy: The Need for Light in Dark Corners* in **Addiction 92:8 (1997): 925 - 930**

Stockwell, T., Somerford, P., & Lang, E., *The Measurement of Harmful Outcomes Following Drinking on Licensed Premises* in **Drug and Alcohol Review 10 (1991): 99-106**

The Sale of Liquor Act, 1989, New Zealand Act of Parliament

Thomas, Prof. D., (Director, Health Research Methods Advisory Centre, Auckland University) **Qualitative Evaluation of Health Programmes and Services**, Presentation to Preventive and Social Medicine Department, Otago Medical School, Semester 1, 1998

Treno, A., & Holder, H., *Community Mobilisation: Evaluation of an Environmental Approach to Local Action* in **Addiction 92 (Supplement 2) (1997): S173 - S187**

Various authors, *Alcohol Policy and the Public Good: An International Debate - 11 Commentaries on the Policy Implications* in **Addiction 90 (1995): 181 - 203**

Voas, R., *Drink Driving Prevention in the Community: Program Planning and Implementation*, in **Addiction 92 (Supplement 2) (1997): S201 - 219**

Voas, R., Holder, H., & Gruenewald, P., *The Effect of Drinking and Driving Interventions on Alcohol-Involved Traffic Crashes within a Comprehensive Community Trial* in **Addiction 92 (Supplement 2) (1997): S221 - 236**

Walker, R., *Evaluating Drug Education Programmes* in Colquhoun D. & Kellehear A., eds., Health Research in Practice: Political, Ethical and methodological issues Chapman & Hall, 1993, pp138 - 151

Wodak, A., Saunders, B., *Harm Reduction Means What I Choose It To Mean*, in **Drug and Alcohol Review 14 (1995): 269 -271**

World Health Organisation, *The Ottawa Charter for Health Promotion 1986*

Wyllie, A., & Panapa, A., **Evaluation of the Host Responsibility Campaign November 1992** Alcohol and Public Health Research Unit, University of Auckland, 1993

APPENDIX ONE: DUNEDIN HOST RESPONSIBILITY PROJECT PROFILES

Atmosphere of Licensed Premises Project:

See Benchmark project description - Chapter 3.

CAAP (Community Alcohol Action Project) Lifesaver:

Working with Dunedin Licensed Clubs to improve the drinking environment and reduce alcohol related road crashes. Aim to improve host responsibility practices within the clubs. Initiated 1996, not a Partnership Agencies project initially.

Carisbrook Project:

See Benchmark project description - Chapter 3.

Central City Safety Project:

Identify perception and actual level of central city safety, particularly evenings and weekends and related to alcohol issues. 1996/97.

Door Staff Project:

See Benchmark project description - Chapter 3.

Liquor Liaison Committee:

Open to all interested parties and membership consists of representatives of the Partnership Agencies, the industry, interest groups, community groups and the general public. Met quarterly. Initiated 1991-1997.

Managers Handbook:

Development and distribution of an 'owners' manual for all licensed premises, managers and staff. 1996/97.

New Year's Street Party:

See Benchmark project description - Chapter 3.

North Dunedin Project:

Working with the community and licensed premises in the North Dunedin area to reduce alcohol related harm amongst the student population. Includes a Campus Alcohol Policy and a North Dunedin Accord setting out basic principles and parameters relating to alcohol and behavioural issues. Initiated 1997.

Otago/Southland Regional Enforcement Agencies Liaison Group:

Group consists of representatives of District Licensing Agencies, Police, Public Health and health promotion from the various districts south of the Waitaki River. Objective is to have a consistent approach to licensing and enforcement issues across the region. Initiated 1994.

Partnership Protocol:

Formalisation of existing working relationship. Aim to institutionalise the working relationship and preserve the integrity of the partnership method of operation. 1996.

Photographic Identification:

Following concerns in the past with the ease of forgery of PubCard, the project was suspended. This project reintroduces the PubCard, in co-operation with HANZ, and addresses the quality of the card and the integrity of the verification process. Initiated 1997/8.

PSST...!:

See Benchmark project description - Chapter 3. Will be revised and repeated 1998/99.

Sammy's Project:

See Benchmark project description - Chapter 3.

School Formal Functions:

Promotion/undertaking of pre and post school formal functions with adequate adult supervision and food and non alcoholic drink available.

University Union Meal Deal Project:

Formal scheme to allow 18 & 19 year old students to consume alcohol as part of a meal for a 2 hour period at University Union functions. Initiated 1994.

YAMS - Youth Alcohol Media Strategy:

Use of advertising campaign to raise alcohol issue awareness in young people coupled with working with the various media to adopt responsible coverage and advertising standards relating to alcohol. Inclusion of the alcohol and hospitality industry in the strategy.

Young People's Entertainment Venues:

Repeat aspects of the Sammy's Project at various licensed venues on a short term basis. 1996/97.

Youth Alcohol Issues Group:

Working with young people on projects they are particularly interested in developing. Example - producing a peer education video about alcohol issues. 1992 - 1996.

There are also ongoing projects such as newsletters to licensees, regular meetings with HANZ and the sports club equivalent SCANZ, community consultation and judiciary consultation.

**APPENDIX TWO
PROCESS EVALUATION SUMMARY**

Actual dates of programme: Evaluation dates: 1) 2) 3) To what extent was the programme implemented? Was each objective achieved? Yes/No (See Impact Evaluation for details)		Was the target audience reached? Yes/No If yes, what proportion? Were they satisfied? If no, why not? If not reached, why not?	
Component Parts	Why this component worked well	Why this component didn't work well	What could have been done differently to make it work better.

General Summary:

IMPACT EVALUATION SUMMARY

Evaluation Timeframe:

Were the objectives met and to what extent?
What were the key results? What changes in knowledge, attitude, behaviour, environment or policy did we see?
Did it occur evenly across the target groups?
To what extent could the changes be attributed to this programme? Any other significant influences?
Were there any significant unexpected results?
Conclusions and recommendations:
Implications for future programmes:

**APPENDIX THREE
INTERVIEW SCHEDULE**

The interviews were conducted with stakeholders at national and local level. The interviews were semi structured and somewhat informal in nature. Although they were similar in nature, some questions asked were more specific to national bodies and others to local bodies.

Initial question	Probe if necessary
<ul style="list-style-type: none"> • Can you tell me about the history of Host Responsibility and your role/the Partnership Agencies role in it? 	<ul style="list-style-type: none"> • Where did it (host responsibility) come from? • How did it emerge? • How did it spread? • What role did you or your organisation have in it? • Who else was involved? • When did happen? • How did that come about? • How did you envisage it being implemented? • What do you recall of the Partnership Agencies role and approach?
<ul style="list-style-type: none"> • How do you view the Dunedin Partnership relationship and working - over time and now? 	<ul style="list-style-type: none"> • How did the relationship develop? • What were the key elements? • What role did you or your organisation have? • What structural/organisational aspects helped or hindered? • Who was involved? • Do you view the Dunedin Host Responsibility programme as successful or unsuccessful or somewhere in between? • What makes it so? • What are the key elements that contribute to that? • What are the strengths and weaknesses of the partnership and programme? • Are there any significant milestones you have noted in the partnership and programme? • What makes these significant?
<ul style="list-style-type: none"> • Are there any other aspects of the programme or partnership you would like to comment on? 	