"IMPLEMENTING AND SUSTAINING ALCOHOL MANAGEMENT PRACTICES IN THE SPORTS SETTING"

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A thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy in Behavioural Science

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STATEMENT OF ORIGINALITY

I hereby certify that the work embodied in the thesis is my own work, conducted under normal supervision. The thesis contains no material which has been accepted, or is being examined, for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made. I give consent to the final version of my thesis being made available worldwide when deposited in the University's Digital Repository, subject to the provisions of the Copyright Act 1968 and any approved embargo.

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THESIS BY PUBLICATION

I hereby certify that this thesis is in the form of a series of papers. I have included as part of the thesis a written declaration from each co-author, endorsed in writing by the Faculty Assistant Dean (Research Training), attesting to my contribution to any jointly authored papers. The University of Newcastle Thesis by Publication Guidelines are included in Appendix 1

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LIST OF PUBLICATIONS INCLUDED AS PART OF THE THESIS

This thesis consists of seven Chapters, five of which are published papers, with summary details listed below. There is some overlap in content between the papers, particularly in the introduction/background and methods sections, as these papers have been written as stand-alone publications. The papers included in the body of the thesis make reference to appendices, which were not included in the published versions.

Table i Outline of Thesis Chapters and associated publications.

Chapter	Chapter title	Research papers
Two	Effectiveness of strategies in sustaining the implementation public health programs	Wolfenden L, Chai LK, Jones J, **McFadyen T**, Hodder R, Kingsland M, Milat AJ, Nathan N, Wiggers J, Yoong SL. What happens once a program has been implemented? A call for research investigating strategies to enhance public health program sustainability. Aust NZJ Public Health. 2019 Feb 1;43(3).
Three	The Feasibility and Acceptability of a Web-Based Alcohol Management Intervention in Community Sports Clubs: A Cross-Sectional Study	**McFadyen T**, Wolfenden L, Wiggers J, Tindall J, Yoong SL, Lecathelinais C, Gillham K, Sherker S, Rowland B, McLaren N, Kingsland M. The feasibility and acceptability of a web-based alcohol management intervention in community sports clubs: a cross-sectional study. JMIR research protocols. 2017;6(6):e123.
Four	Alcohol management practices in community sporting clubs: validation of on-line self-reporting	**McFadyen T**, Tindall J, Wiggers J, Kingsland M, Sherker S, Gillham K, Rowland B, Heaton R, Lecathelinais C, Wolfenden L. Alcohol management practices in community sporting clubs: Validation of an online self-report tool. Drug and alcohol review. 2018 Jul;37(5):580-7.

Chapter	Chapter title	Research papers
Five	A randomised controlled trial of a web-based program to sustain best-practice alcohol management practices by community sports clubs – Study protocol	**McFadyen T**, Wolfenden L, Kingsland M, Tindall J, Rowland B, Sherker S, Gillham K, Heaton R, Clinton-McHarg T, Lecathelinais C, Brooke D. Randomised controlled trial of a web-based programme in sustaining best practice alcohol management practices at community sports clubs: a study protocol. BMJ open. 2018 Jan 1;8(1):e017796.
Six	Sustaining the implementation of alcohol management practices by community sports clubs: A randomised controlled trial	**McFadyen T**, Wolfenden L, Kingsland M, Tindall J, Sherker S, Heaton R, Gillham K, Clinton-McHarg T, Lecathelinais C, Rowland B, Wiggers J. Sustaining the implementation of alcohol management practices by community sports clubs: a randomised control trial. BMC Public Health. 2019 Dec 1;19(1):1660.

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I once read an interesting analogy of the PhD process which has stuck with me over the years. The author likened undertaking a PhD to guiding a newborn through infancy. You have no idea what you are in for, until you are in the thick of it. A lot of joy and heartache comes with the process and once it is done there is a small part of you that will long for the feeling you had at the start of the journey and to do it all over again. My experience was more joy then heartache thanks to the people listed below. I do not, however, have the longing to do it all again, I am looking forward to what the next stage of my career entails.

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CONFLICT OF INTEREST STATEMENT

Tameka-rae McFadyen reports no conflict of interest.

OTHER PAPERS PUBLISHED DURING CANDIDATURE

PAPERS RELATED TO SPORTS CLUBS

1 **McFadyen T,** Chai LK, Wyse R, Kingsland M, Yoong SL, Clinton-McHarg T, Bauman A, Wiggers J, Rissel C, Williams CM, Wolfenden L. Strategies to improve the implementation of policies, practices or programmes in sporting organisations targeting poor diet, physical inactivity, obesity, risky alcohol use or tobacco use: a systematic review. BMJ open. 2018 Sep 1;8(9):e019151.

2 Ooi JY, Wiggers JH, Kingsland M, Lecathelinais C, Tindall J, **McFadyen T**, Rowland BC, Sherker S, Murphy A, Heaton R, Wolfenden L. Exposure to fast-food and sweetened-drink marketing at community sports clubs in Australia. marketing. 2019 Dec;1(5.6):5-6.

PAPERS RELATED TO IMPLEMENTATION

1 Wolfenden L, Reilly K, Kingsland M, Grady A, Williams CM, Nathan N, Sutherland R, Wiggers J, Jones J, Hodder R, Finch M, **McFadyen T**. Identifying opportunities to develop the science of implementation for community-based non-communicable disease prevention: A review of implementation trials. Preventive medicine. 2018 Nov 20.

2 Wolfenden L, Jones J, Finch M, Wyse RJ, Yoong SL, Steele EJ, Williams AJ, Wiggers J, **Small T**, Seward K, Williams CM. "Strategies to improve the implementation of healthy eating, physical activity and obesity prevention policies, practices or programmes within childcare services – Protocol" The Cochrane Library (2015) Issue 7.

3 Wolfenden L, Jones J, Finch M, Wyse RJ, Yoong SL, Steele EJ, Williams AJ, Wiggers J, **Small T,** Seward K, Williams CM. "Strategies to improve the implementation of healthy eating, physical activity and obesity prevention policies, practices or programmes within childcare services" Cochrane Database of Systematic Reviews (2016), Issue 10. Art. No.: CD011779.

4 Dray J, Bowman J, Campbell E, Freund M, Wolfenden L, Hodder R, McElwaine K, Tremain D, **Small T**, Bartlem K, Bailey J, Wiggers J. Systematic review of the effect of school-based, resilience-focussed interventions on child and adolescent mental health. Journal of the Canadian Academy of Child and Adolescent Psychiatry (2016).

5 Williams, C. M., Nathan, N., Delaney, T., Yoong, S. L., Wiggers, J., Preece, S., Lubans, N., Sutherland, R., Pinfold, J., Smith, K., **Small, T.**, Reilly, K. L., Butler, B., Wyse, R, J., Wolfenden, L. CAFÉ: a multicomponent audit and feedback intervention to improve implementation of healthy food policy in primary school canteens: protocol of a randomised controlled trial. BMJ open (2015), 5(6), e006969.

PAPERS RELATED TO ALCOHOL

1 Gilligan C, Wolfenden L, Foxcroft DR, Kingsland M, Williams AJ, Hodder RK, **Small T**, Sherker S, Rae J, Tindall J, Stockings E, Wiggers J. Family-based prevention programs for alcohol use in young people. – Protocol Cochrane Database of Systematic Reviews (2016), Issue 7. Art. No.: CD012287.

2 Gilligan C, Wolfenden L, Foxcroft DR, Williams AJ, Kingsland M, Hodder RK, Stockings E, **McFadyen T**, Tindall J, Sherker S, Rae J. Family-based prevention programmes for alcohol use in young people. Cochrane database of systematic reviews. 2019(3).

CONFERENCE PRESENTATIONS GIVEN DURING CANDIDATURE AND RELEVANT TO THIS THESIS

During the candidature, the candidate presented the contents of this thesis at eight conferences, six of which were international conferences. The details of these presentations are provided below.

2017 – ASBHM/APS Conference. “Can sports clubs sustain the implementation of responsible alcohol management practices?” (oral) and “The feasibility and acceptability of a web-based program to support the implementation of alcohol management practices in community sports clubs.” (oral)

2017 - World Congress on Public Health. “Can sports clubs sustain the implementation of responsible alcohol management practices?” (oral) and “The feasibility and acceptability of a web-based program to support the implementation of alcohol management practices in community sports clubs.” (oral)

2017 - Global Implementation Conference. “The feasibility and acceptability of a web-based program to support the implementation of alcohol management practices in community sports clubs.” (poster)

2016 - International Congress of Behavioural Medicine. “Can sports clubs sustain the implementation of responsible alcohol management practices?” (oral) and “The feasibility and acceptability of a web-based program to support the implementation of alcohol management practices in community sports clubs.” (poster)

2016 - European Public Health Conference. “Can sports clubs sustain the implementation of responsible alcohol management practices.” (oral) and “The feasibility and acceptability of a web-based program to support the implementation of alcohol management practices in community sports clubs.” (poster)

2016 - Australasian Implementation Conference. “The feasibility and acceptability of a web-based program to support the implementation of alcohol management practices in community sports clubs.” (oral)

2015 - Population Health Congress. “Population health improvement through sports clubs: issues, opportunities and effective interventions.” (oral) and “Alcohol consumption and sport: a cross-sectional study of alcohol management practices associated with at-risk alcohol consumption at community football clubs.” (poster)

2014 - Global eHealth Research and Innovation Cluster Showcase. “A randomised controlled trial of a web-based intervention in sustaining best practice alcohol management practices at community sports clubs.” (poster)

THESIS ABSTRACT

BACKGROUND

People involved with organised sport have been found to consume alcohol at greater levels compared to the general population. Previous studies have found sports clubs to be a promising setting for the implementation of interventions to reduce such excessive consumption. Unfortunately, existing implementation and sustainability research suggests that once primary intervention support is withdrawn, implementation of such interventions attenuates, resulting in a loss of the intended benefit of such interventions.

AIMS

This thesis aimed:

1 To review the effectiveness of implementation strategies in sustaining improvements in public health program sustainability (Chapter 2).

2 To assess community sports clubs' perceptions regarding the usefulness, ease of use and intentions to use a web-based program to support the sustainability of club implementation of alcohol management policies (Chapter 3).

3 To assess the validity of web-based self-report of alcohol-management practices in community football clubs (Chapter 4).

4 To assess the effectiveness of a web-based program in supporting community sports clubs to sustain the implementation of alcohol management practices (Chapter 5, 6).

METHODS

Aim 1 was addressed through a review of published and grey literature. Aims 2 and 3 were addressed through a series of studies undertaken with community football clubs in urban and regional areas of New South Wales, Australia. These studies involved: a cross-sectional survey of 73 community football club administrators (Aim 3); a cross-sectional survey and an observation audit of 78 community football clubs (Aim 4). Aim 4 was addressed through a randomised

control trial undertaken with 188 community football clubs in Australia, in regional areas of the state of New South Wales (NSW) and throughout metropolitan and regional areas of the state of Victoria.

KEY FINDINGS

- There was no evidence of effective strategies to support the sustainable implementation of interventions targeting health risk behaviours in community settings.
- The use of the web to support sports clubs in implementing alcohol harm reduction policies and practices was found to be both feasible and acceptable.
- Sports clubs would use a web-based program to support the implementation alcohol harm reduction policies and practices if one was provided.
- The web was found to be a valid method of measuring self-reported implementation of some but not all alcohol management practices in community sporting clubs.
- A web-based program was able to support community sports clubs to sustain their implementation of alcohol management practices, and at an equivalent level as face-to-face support.

CONCLUSION

This thesis provides the first evidence of the effectiveness of strategies to support the sustained implementation of evidence-based alcohol harm reduction practices by community sports clubs. It further provides robust evidence of the ability of web-based strategies to support community sports clubs to sustain their implementation of such practices. In doing so, the thesis demonstrates a potential method for ensuring that the intended benefits of public health interventions more generally can be sustained over time. Further research is required to confirm and to test the generalisability of these findings, to determine the cost effectiveness of web-based sustainability support strategies, and to identify opportunities for further enhancing the sustainability of public health program implementation.

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LIST OF ABBREVIATIONS AND GLOSSARY

AFL	Australian Football League
ARIA	Accessibility/Remoteness Index of Australia score
ASGC	Australian Standard Geographical Classification
AUDIT	Alcohol Use Disorders Identification Test
BIA	Budget Impact Analysis
CATI	Computer Assisted Telephone Interview
CBA	Cost Benefit Analysis
CCA	Cost Consequence Analysis
CEA	Cost Effectiveness Analysis
DALY	Disability-Adjusted Life Year
HREC	Human Research Ethics Committee
ICER	Incremental Cost-Effectiveness Ratio
NSW	New South Wales
MI	Multiple Imputation
OR	Odds ratio
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-analyses
RCT	Randomised controlled trial
RSA	Responsible service of alcohol
SES	Socio-economic status

Club Member

A person affiliated with a sports club either as a paid financial member (player or non-player) or as a known supporter/fan of the club.

Football Sports Codes

Including Association football (Soccer), Rugby League, Rugby Union, Australian Rules football and Gaelic Football.

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CHAPTER 1

Thesis Introduction

CHAPTER OVERVIEW

This introductory chapter involves three sections. *Section 1* describes the burden of disease associated with alcohol-related harm; guidelines to reduce risky alcohol consumption and associated alcohol-related harms; the current prevalence of alcohol consumption in relation to such guidelines; and the alcohol consumption behaviours of individuals involved in sports clubs.

Section 2 describes evidence regarding the effectiveness of interventions in reducing risky alcohol consumption and alcohol-related harms in the sports club setting. Evidence regarding strategies to improve the routine implementation of effective interventions in sports settings is then summarised.

Section 3 explores evidence and frameworks regarding strategies for ensuring that the implementation of effective health promotion programs is sustained over time. The potential of web-based methods of providing support for the sustained implementation of effective programs is then explored.

The chapter concludes with the aims of the thesis.

SECTION 1
ALCOHOL CONSUMPTION AND ALCOHOL-RELATED HARM

1.1 BURDEN OF ALCOHOL-RELATED HARM

Global perspective

In 2016, alcohol use was the seventh leading risk factor for premature mortality,[1] with approximately three million deaths worldwide attributed to harmful alcohol use.[2] The most common causes of Alcohol-related mortality were cardiovascular diseases, unintentional injuries and digestive diseases.[1] Furthermore, in 2016, 132.6 million disability adjusted life years (DALYs) worldwide were attributed to harmful alcohol use,[2] most commonly related to mental health conditions, non-communicable diseases and unintentional injuries. Among 15–49-year-olds, alcohol consumption was the leading risk factor for risk-attributable disease burden.[1]

The burden of Alcohol-related harm globally is greater among males relative to females. Worldwide, 7.6% of deaths and 7.4% of DALYs among males are attributable to alcohol compared to 4% of deaths and 2.3% of DALYs among females.[2] Alcohol misuse is the leading risk factor for death in males aged 15–59, mainly due to injuries, cardiovascular diseases and diabetes, and gastrointestinal diseases. For women, the leading causes of Alcohol-related deaths are cardiovascular diseases and diabetes, gastrointestinal diseases and cancer.[2]

The harmful effects of alcohol misuse are not isolated to the consumer. There is also substantial harm to others, such as family members, friends, co-workers and strangers.[3] For instance, a survey conducted in New Zealand found that the prevalence of alcohol-related harm to others was higher than the prevalence of harm to the individual consuming the alcohol (18% versus 12%).[4] This higher prevalence of harm from other peoples' consumption was particularly true for women and young people.[4] Alcohol-related harm to others included: intentional and unintentional injury; neglect of care for children; prenatal conditions including fetal alcohol syndrome and preterm birth; psychological stress/trauma related to family separation or dysfunction, financial stress, unemployment and absenteeism, and associated social stigma.[3]

Globally, the economic costs of Alcohol-related harm are significant. A 2009 review of studies of alcohol-attributed social costs found that the average cost per person or selected high-income countries (France, United States of America (US), Scotland and Canada) was US$725.[5] The total weighted annual average of alcohol-attributed cost (direct health care, direct laws and other direct costs and indirect costs) for those countries was reported as $179,859 million international dollars.[5] Indirect costs, due to productivity loss, was the greatest contributor to alcohol-attributable costs, accounting for 72.1% ($129,659 million international dollars). This was followed by direct health-care costs (12.8%; $23,090 million international dollars), other direct costs (11.6%; $20,848 million international dollars) (e.g. property damage and loss, direct administrative costs, and social work services; and indirect costs), and law-enforcement costs (3·5%; $6,262 million international dollars).[5]

Australian perspective

In Australia, alcohol use was responsible for 5,039 deaths and 207,777 DALYs in 2011.[6] The number of deaths for males was 3,077, compared to 1,962 for females.[6] Injuries were the largest contributor (34%) to the disease burden caused by alcohol use, followed by alcohol dependence (32%) and cancers (17%).[6] The number of DALYs was almost three times higher for males at 151,149 compared to 56,628 for females.[6] The 2016 Australian National Drug Strategy Household Survey found that 17.4% of recent drinkers aged 14 or older put themselves or others at risk of harm while under the influence of alcohol, and that more than 22% reported having been a victim of an alcohol-related incident within the last year.[7] Males were more likely to experience verbal (20%; females 17.2%) or physical abuse (8.1%; females 6.5%) and females were more likely to experience fear (13.5%; males 9.3%) from people under the influence of alcohol.[7]

In 2010, the total annual cost of alcohol abuse in Australia was estimated to be in excess of $14 billion.[8] This estimate included costs that were both tangible (labour, health care, road accidents, crime) and intangible (loss of life, pain and suffering).[8]. The majority of costs (42.1%) were due to loss of productivity.[8] Additionally, a report on Alcohol-related absenteeism found that alcohol was attributed to approximately 7.5 million days of lost work in 2013, at a cost of over $2 billion in lost workplace productivity.[9]

1.2 GUIDELINES TO REDUCE HARM FROM ALCOHOL CONSUMPTION

Global perspective

Risk of alcohol-related harm is associated with the volume of alcohol consumed[3] and with alcohol consumption patterns, particularly consumption of a high volume of alcohol on a single occasion.[10,11] Based on this evidence, the World Health Organisation (WHO) has called on governments across the world to develop and implement alcohol consumption guidelines to reduce the risk of alcohol-related harms.[2] In response, many countries, including Canada, the US and the United Kingdom (UK), have developed alcohol consumption guidelines to address one or both types of risk. The Canadian alcohol consumption guidelines

recommend that men should limit alcohol intake to 15 drinks per week and women to 10 drinks per week and that men should consume no more than four drinks and women no more than three drinks on one occasion.[12] The US guidelines recommend men should consume no more than two drinks per day, and women no more than one.[13] The UK guidelines recommend that men and women consume no more than 14 units of alcohol per week, and that these be spread across three or more days.[14] The UK guidelines also advise people to limit the amount of alcohol consumed in one drinking occasion, however, a limit is not specified.[14]

Australian perspective

The National Health and Medical Research Council (NHMRC) in Australia released the latest national alcohol consumption guidelines in 2009.[15] These guidelines have been reviewed and a new draft version was released in early 2020.[16] This thesis was undertaken in the context of the 2009 guidelines, which involved four guidelines that addressed both the short-term and long-term effects of alcohol consumption. The guidelines were: 1) For healthy men and women, drinking no more than two standard drinks on any day reduces the lifetime risk of harm from alcohol-related disease or injury; 2) For healthy men and women, drinking no more than four standard drinks on a single occasion reduces the risk of alcohol-related injury arising from that occasion; 3) A: For children under 15 years of age, not drinking alcohol is especially important, B: For young people aged 15–17 years, the safest option is to delay the initiation of drinking for as long as possible; 4) A: For women who are pregnant or planning a pregnancy, not drinking is the safest option, B: For women who are breastfeeding, not drinking is the safest option.

1.3 ALCOHOL CONSUMPTION: VOLUME AND RISK OF HARM

Global perspective

Since 2010, the WHO Organisation has reported a stabilisation in the global consumption of alcohol. Total global annual per capita consumption of alcohol

was reported as 6.4 litres of pure alcohol in 2010 and 6.4 litres in 2016 (equal to 13.9 grams of alcohol per day).[2] Table 1.1 shows recorded per capita consumption of alcohol for selected countries for 2010, 2013 and 2016.[17] As indicated in Table 1.1, all of the included upper middle and high income countries recorded per capita rates of alcohol consumption that were higher than the global average. This compared to a number of lower middle and low income countries that reported rates that were lower than the global average, with the exception of Moldova and Nigeria.

Table 1.1: Recorded annual per capita consumption of alcohol for selected countries

COUNTRY	RECORDED ANNUAL PER CAPITA (15+ YEARS) CONSUMPTION OF ALCOHOL (IN LITRES OF PURE ALCOHOL)		
	2010	***2013***	***2016***
Upper middle – high income countries			
Australia	10.52	9.9	9.7
New Zealand	9.6	9.2	9.2
Canada	8.4	8.2	8.2
United Kingdom	10.22	9.6	9.8
Ireland	11.6	10.6	11.5
United States of America	8.6	8.8	ł
Lower middle – low income countries			
Papua New Guinea	0.8	0.8	ł
El Salvador	2.3	2.4	2.7
Moldova	7.6	9.6	9.3
Nigeria	10.31	9.6	ł
India	2.7	3.0	3.0
Global average	6.4	5.2	6.4

łData not available. Data from the World Health Organisation Global Health Observatory Data Repository – Global Information System on Alcohol and Health - Levels of Consumption.[17]

Table 1.2 depicts the 2016 prevalence of heavy episodic drinking (60 grams or more of alcohol on a single drinking occasion at least monthly) among alcohol consumers for this same selection of countries.[18] As shown, for all countries, there is a higher prevalence of heavy episodic drinking among males compared to

females. The prevalence of heavy episodic drinking among individuals from both the upper middle-high income and lower middle-low income groups of countries were similar, ranging from 32% in Canada and 34% in El Salvador to 55% in Nigeria and 60% in Papua New Guinea.

Table 1.2: Prevalence of heavy episodic drinking in the past 30 days for selected countries (2016)

COUNTRY	HEAVY EPISODIC DRINKING (15years+DRINKERS ONLY) PAST 30 DAYS (%)		
	Female	*Male*	*Both sexes*
Upper middle – high income countries			
Australia	26.4	60.7	45.3
New Zealand	24.4	58.0	42.9
Canada	15.5	45.0	32.9
United Kingdom	22.0	55.1	40.6
Ireland	27.6	62.2	46.5
United States of America	18.3	50	36.4
Lower middle – low income countries			
Papua New Guinea	34.0	70.2	60.7
El Salvador	15.5	45.4	34.8
Moldova	21.3	56.0	40.9
Nigeria	31.8	67.7	55.0
India	21.4	55.1	44.4

Data from the World Health Organisation Global Health Observatory Data Repository – Global Data Information Systems on Alcohol and Health - Patterns of Consumption.[18]

Australian perspective

The 2016 National Drug Strategy Household Survey completed by 23,772 Australians found that one in five (equivalent to 4.4 million people) people aged 14 years and over consumed alcohol at levels that exceeded the lifetime risk guidelines (2 standard drinks per day).[7] A greater proportion of males (24%) reported consuming alcohol at such levels than did females (9.5%).[7]

A quarter of respondents reported exceeding the national guidelines for single occasion risky drinking (consuming five or more standard drinks on a single

occasion) in the past month.[7] Males were more likely to consume alcohol exceeding the single occasion risk guidelines (45%) than females (27%), and males did so more frequently, with 19% reporting weekly single occasion risky levels of alcohol consumption, compared to 7% of females.[7]

1.4 RISKY ALCOHOL CONSUMPTION AND ALCOHOL-RELATED HARM AMONG SPORTS PEOPLE AND FANS

Global perspective

Higher proportions of individuals involved with organised sports, particularly contact team sports, are reported to consume alcohol at risky levels compared to individuals not involved in sport.[19,20] A systematic review by Kwan and colleagues that included 17 longitudinal studies of adolescents and young adults involved in community/non-elite organised sport from the United States and Norway, found a positive association between sports participation and greater alcohol use for 14 of the included studies.[21] In a further systematic review including both cross-sectional and longitudinal studies, Sonderlund and colleagues[19] assessed associations between participation in sports, alcohol use and Alcohol-related harm. The included studies were from the United States (n=9 studies) and Australia (n=2 studies) and involved middle/high school students, college/university students and current/former athletes, at both the professional (elite) and non-professional (non-elite or community) sporting level. Ten of 11 included studies found higher rates of alcohol use, aggression and violence amongst sporting populations compared to non-sporting populations, with odds ratios ranging from 1.15 to 1.70.

Additional studies not included in these reviews have reported similar findings. A study conducted with American college students found that binge drinking (≥6 drinks at least weekly) was more common among students involved in athletics (60%) than students partially involved with athletics (55%) and students with no involvement in athletics (43%).[22] A further study conducted in New Zealand reported higher levels of harmful alcohol consumption among non-elite sports participants (51%) than non-sports participants (31%).[23] Further, a study in

Ireland found that people who played Gaelic football and hurling had higher levels of alcohol consumption (32%) compared to a national representative sample of men of a similar age (15%).[24]

Australian perspective

A 2006 commentary on the relationship between alcohol and sport in the Australian context stated that "alcohol is synonymous with sporting events… just like a half time hot dog…".[25] This notion is supported by Australian studies reporting a link between alcohol consumption and sports engagement at both the professional and non-professional, community club level. For example, a cross-sectional survey of 582 professional/elite level Australian Football League (AFL) players found that long-term harm attributed to risky alcohol use (5 or more drinks on an average day) was higher among players during the end-of-season period (54%) and vacation period (41%), compared to age-matched Australian men (15%).[26] Risky drinking for short-term harm (7 or more drinks on any one day on a monthly basis) was also high during the end-of-season period (57%) and vacation period (48%).[26] Furthermore, it was found that throughout the entire year, a higher proportion of AFL players (ranging from 51% during the season to 88% at end-of-season) undertook risky alcohol consumption at least once a month compared to age-matched Australian men (44%).[26] A further study of sports club members (males and females) from cricket and AFL community level sporting clubs in Australia reported a 30% prevalence of game day alcohol consumption that placed members at risk of short-term harm (>5 standard drinks per drinking occasion), a prevalence markedly higher than that reported for the general population (10%).[27]

A study conducted with 72 community football clubs and 1428 club members in the state of New South Wales, Australia, found particular club characteristics were associated with greater odds of a club member or player consuming alcohol at risky levels.[28] The study found that being involved with Rugby Union (OR:2.64) or Rugby League (OR:1.95) clubs and being a part of a smaller club (less than 150 players) (OR:1.45) significantly increased the odds of players and members

consuming alcohol at risky levels compared to those in other football codes and larger clubs.[28]

SECTION 2
ALCOHOL HARM REDUCTION INTERVENTIONS IN THE SPORTS SETTING

1.2.1 SPORTING VENUES AS A SETTING TO REDUCE RISKY ALCOHOL CONSUMPTION AND ALCOHOL-RELATED HARM

Community sports clubs, defined as ''non-profit and voluntary organisations that have a primary mandate to provide recreational and competitive sport services to their members",[29] have a number of characteristics that make them an attractive setting to address risky alcohol consumption and associated Alcohol-related harm among players and fans. First, worldwide, sports clubs provide access to a large number of community members (players, spectators or officials) at risk of alcohol-related harm. For instance, in England between 2015 and 2016, 15.83 million people 16 years or over (36.1%) engaged in sport at least once a week[30] and, in Australia between 2013 and 2014, approximately 5.2 million Australians aged 15 years and over (28%) were involved with organized sport.[31] Second, community sports clubs in Australia and many other jurisdictions sell alcohol and, as such, are required to adhere to liquor licensing laws regarding the responsible sale of alcohol.[32-34] Third, community sports clubs have been found to be amenable to receiving support to improve their alcohol management practices.[35,36] Fourth, a settings-based approach to health promotion has been shown to be effective in modifying risky alcohol consumption in licensed venues more broadly (e.g. hotels, bars, pubs).[37,38]

1.2.2 INTERVENTIONS TO REDUCE RISKY ALCOHOL CONSUMPTION AND ALCOHOL-RELATED HARM IN THE SPORTS SETTING

Community sports clubs have been shown to be a setting where excessive alcohol consumption can be reduced.[39,40] For example, a cluster randomised controlled trial (RCT) conducted with community football clubs in Australia found that an alcohol management intervention was effective in reducing excessive alcohol

consumption and risk of Alcohol-related harm among football club participants (players, spectators, coaches, committee members and club administration).[41] The intervention involved strategies known to be effective in reducing risky alcohol use in the community more broadly, including restrictions on: alcohol availability, pricing,[42,43] alcohol promotions,[26,44] drinking games[45] and alcohol-related sponsorship.[46] Forty-three clubs were randomised to the intervention group and 45 to the control group (N=1411 participants and N=1143 participants respectively). Post-intervention, a significantly lower proportion of intervention club members reported: risky alcohol consumption at the club (5 or more drinks at least once a month) (Intervention: 19%; Control: 24%; OR: 0.63 (95% CI 0.40 to 1.00); p=0.05); and risk of alcohol-related harm (total Alcohol Use Disorders Identification Test (AUDIT) score ≥8) (Intervention: 38%; Control: 45%; OR: 0.58 (95% CI 0.38 to 0.87); p<0.01).[41] Similarly, a cluster controlled trial of a multi-faceted intervention to reduce alcohol misuse and related harm in Gaelic Athletic Association amateur sporting clubs (N=39) in Ireland found a significantly lower median number of alcohol-related harms reported by players of intervention clubs compared to players of control clubs post-intervention (incident rate ratio: 0.56 (0.37,0.84), P=0.005).[47] Such positive findings are supported by a number of non-controlled trials in community sports clubs in Australia.[27,48]

1.2.3 IMPLEMENTATION OF ALCOHOL HARM REDUCTION INTERVENTIONS IN COMMUNITY SPORTS CLUBS

Without implementation into routine practice, the public health benefits of effective alcohol harm reduction interventions cannot be attained. A systematic review of interventions to support the implementation of programs targeting preventable disease risk factors in community sports settings found an improvement in at least one measure of implementation at follow-up for all included studies.[49] To be eligible, studies needed to have: compared one or more implementation strategies that aimed to improve policy, practice or programme implementation in the sports setting, focussed on one or more chronic disease risk factors (diet, physical activity, obesity, alcohol or tobacco), and had a parallel control group. Three studies met the inclusion criteria. One of the included

studies, an RCT conducted by Kingsland and colleagues, evaluated a multi-strategy intervention designed to support the implementation of Alcohol-related harm reduction practices in community football clubs.[50] The effectiveness of the intervention was measured against a control group of clubs that received no implementation support. The implementation intervention strategies included project officer support, implementation cost recovery, recognition though an accreditation framework, accreditation merchandise, printed resources and newsletter, online training, observational audit and feedback of practice implementation and support from overarching peak sports organisations. At follow-up, there was a significantly greater proportion (88.2%) of intervention clubs implementing at least 80% of the specified alcohol management practices compared to control clubs (65%).[50]

The other two studies included in the review evaluated the effectiveness of interventions in enhancing the implementation of healthy eating practices and policies at sports clubs. One of the studies evaluated the effect of an implementation intervention on the availability, promotion and purchase of fruit, vegetables and non-sugar-sweetened beverages in community sports clubs.[51] The effectiveness of the intervention was measured against a control group that received printed information unrelated to the topic of healthy eating (e.g. illicit drug use). The second study, which was conducted by Naylor and colleagues,[52] evaluated the effectiveness of a capacity-building intervention on the provision of healthy food (reducing access to energy-dense, nutrient poor foods and increasing availability of vegetables and fruit), healthy vending machine products and the implementation of food policies in community sports facilities. The comparison group received no implementation support. The two studies employed implementation strategies similar to those used in the Kingsland et al study,[50] such as program implementation support (face to face or over the phone), educational material and training, small incentives and audit and feedback. Both studies reported significant increases in practice and policy implementation by the intervention sites compared to the control sites at follow-up.[51,52]

SECTION 3
SUSTAINING PUBLIC HEALTH INTERVENTIONS WITHIN THE COMMUNITY SPORTS SETTING: CURRENT EVIDENCE AND FRAMEWORKS

1.3.1 IMPLEMENTATION SUSTAINABILITY

While strategies that are effective in implementing proven health behaviour interventions into routine practice have been identified,[49,53] including those targeting alcohol management practices in sports clubs, the sustained implementation of such interventions is needed to ensure their public health benefits are ongoing. 'Sustainability' of intervention delivery has been variously defined in the literature, and is inherent in the concepts of 'maintenance', 'continuation', 'institutionalization', 'routinization', and 'durability'.[54-56] For the purpose of this thesis, the term sustainability is defined as: the continued use of program components and activities for the continued achievement of desirable program and population health outcomes.

Despite the need for the ongoing delivery of proven interventions to maximise public health benefit, systematic reviews have found that the implementation of public health programs is not always sustained in the long-term.[57-59] A review by Scheirer and colleagues (2005), examined the extent to which mental health, community health, sexual health, nutrition, preventative health, oral health and substance use programs were sustained, and the factors that influenced the sustainability of program implementation.[57] The 19 included studies assessed program sustainability after initial program funding had expired. Just four of the 19 studies (21%) reported the sustainability of at least one program component at 80% or more intervention sites, one to three years after program funding had ceased.[57]

A further review by Wiltsey Stirman and colleagues,[58] reviewed the long-term implementation of programs in the medical, mental health and public health/health promotion literature. The studies included in the review were required to report either sustainability outcomes (defined as 'the continuation of

some or all components of a program or the desired recipient-level outcomes that occurred after initial efforts to implement, fund, or study a new practice were complete') or factors influencing the sustained implementation of such programs. Of the 56 included studies, 19 (34%) reported lower levels of program implementation, 17 (30%) reported an increase in implementation and three (6%) reported no change in level of program implementation. The remaining 17 (30%) studies reported varied changes in implementation across individual intervention or program components.

A more recent review conducted by Herlitz and colleagues,[59] examined the sustainability of public health interventions in the school setting. The review identified 24 studies relating to 18 interventions. The interventions addressed a range of public health topics, including nutrition, physical activity, over-weight/obesity, tobacco, alcohol/drug use, sexual health, mental health, and bullying. The majority (n=17, 71%) of included studies took place in the U.S., with the remainder conducted in Europe (n=5, 21%), the UK (n=1, 4%) and Canada (n=1, 4%). The follow up time-points at which sustainability outcomes were measured varied considerably, with five studies involving follow up more than five years after the initial evaluation period, 10 studies with follow up between two to five years post evaluation, and 9 studies with follow up less than two years post initial evaluation. No included studies reported that implementation of the intervention was sustained in its entirety. However, 23 of 24 studies reported sustainability of some intervention components (<20%–80%) in some schools (5%–91%).[59] No studies included in the above reviews focussed on strategies to support the sustainability of program implementation in sporting clubs.

1.3.2 FACTORS RELATED TO THE SUSTAINABILITY OF PUBLIC HEALTH INTERVENTIONS

The above-mentioned systematic reviews conducted across community and health care settings identified a number of factors associated with the sustainability of health program implementation. The review by Scheirer and colleagues[57] found that sustained program implementation was more likely if: programs are modifiable at the user level (12 studies); programs fit with the

adopting organisation's mission and operational procedures (12 studies); there is a program champion (13 studies); there is perceived program benefits for staff, key stakeholders and/or clients (12 studies); there is support (in-kind, political or other funding) from external organisations (12 studies); there is a variety of funding options (9 studies); low-cost resources are used such as volunteers (five studies); and there is ongoing feedback (four studies). In the review by Wiltsey Stirman and colleagues,[58] program sustainability was similarly found to be influenced by: the fit, adaptability, and effectiveness of the program; organizational context; capacity (both internal and external); and organisational processes (monitoring of fidelity, ongoing evaluation; and changes within the organisation to integrate the intervention). Finally, Herlitz and colleagues[59] identified the following common facilitators of program sustainability: internal (commitment from executive members and staff) and external (parents and community members) program support; program adaptability and integration; funding and resource support; upskilling/training staff and increasing staff confidence in program delivery; external resources (school networks, community organisations and funding agencies); perceived program benefit; and policy climate.

1.3.3 FRAMEWORKS FOR ENHANCING THE SUSTAINABILITY OF PUBLIC HEALTH INTERVENTIONS

Many of the factors associated with sustained public health program implementation identified in the reviews described above are consistent with those hypothesised to be associated with sustainability in theoretical frameworks.[60-63] One of these, The Sustainability Framework,[63] is particularly well suited for application in the field of public health as it addresses the unique challenges pertaining to applied research in this field, such as complex organisation structures, policy and stakeholder influence and program application and adaptation within real world settings.[63] The framework was developed from the findings of a mix-method developmental study in which Schell and colleagues undertook both literature reviews and expert-informed concept mapping. The findings resulted in the identification of nine domains of factors

considered to be important to sustainability of program implementation (Table 1.3). Further, the findings of the research supported the development of reliable tools to determine the capacity of a program to be sustained in a real-world setting.[62]

Table 1.3 The Sustainability Framework domains and definitions[63]

Domain	Definition
Environmental Support	Having a supportive internal and external climate for your program
Funding Stability	Establishing a consistent financial base for your program
Partnerships	Cultivating connections between your program and its stakeholders
Organizational Capacity	Having the internal support and resources needed to effectively manage your program
Program Evaluation	Assessing your program to inform planning and document results
Program Adaptation	Taking actions that adapt your program to ensure its ongoing effectiveness
Communications	Strategic communication with stakeholders and the public about your program
Strategic Planning	Using processes that guide your program's directions, goals, and strategies
Public Health Impacts	Impacts on health attitudes, perceptions and behaviours within the program area

1.3.4 USING WEB-BASED PROGRAMS TO SUPPORT THE SUSTAINED IMPLEMENTATION OF PUBLIC HEALTH INTERVENTIONS

The internet/world-wide-web (hereafter referred to as 'web-based') is suggested to provide a promising method to support initial and sustained implementation of effective public health interventions. In particular, this mode of intervention delivery has the potential to address the factors that are suggested to be associated with sustained implementation of programs such as ease of program modification and adaptation, provision of ongoing feedback, low cost and effective stakeholder communication.[64,65] Additionally, with internet coverage almost universal in high income countries such as Australia,[66] web-based programs

provide access to a diversity of population groups over large geographic areas. The content of web-based programs is also able to be adapted and updated at marginal cost per user, a factor which is suggested to be important for ongoing program adherence by users.[64,65,67]

Web-based programs have been shown to be efficacious in increasing the implementation of evidence-based interventions and processes in clinical settings.[68,69] For instance, a review conducted by Roshanov and colleagues[68] found that over half (n=25) of 48 identified RCTs of Computerized Clinical Decision Support Systems (CCDSS) used by health care practitioners were effective in improving chronic care management within the clinical setting. Similarly, a review by Hemens et al,[69] found that 63% (n=37) of included trials showed improvements in drug therapy management through CCDSS interventions, compared to usual care without CCDSS.

Similar, but more limited evidence, supports the efficacy of web or computer-based strategies in increasing intervention or program implementation in community settings, such as early childhood education centres. In this setting, a single-blind, parallel-group RCT of a web-based menu planning program was identified that aimed to improve compliance with Australian dietary guidelines by 54 childcare services. The study found that the web-based program was able to increase the proportion of services that provided servings of fruit (P<.001), vegetables (P=.03), dairy (P=.03), and meat (P=.003), and reduced their servings of discretionary foods (P=.02) compared to no intervention control services.[70] Furthermore, the childcare service staff reported the program to be highly acceptable (90%) in supporting their planning of food menus.

While the available evidence suggests the effectiveness of web-based programs in supporting intervention implementation, particularly in clinical settings, no evidence has been reported about the feasibility, acceptability or efficacy of web-based interventions in supporting either the implementation or sustainability of implementation of health promotion programs in the sports clubs setting.

1.4 SUMMARY AND THESIS AIMS

The harm caused by risky alcohol consumption is widespread, affecting not only the alcohol consumer but also those close by and society at large. People involved in organised sport are more likely to consume alcohol at levels that place them at greater risk of harm, particularly short term harms, than the general population. Sports clubs have been proven to be an effective setting to reduce risky alcohol consumption and related harm risks among sports club members. Sports clubs have also been shown to be able to improve their implementation of alcohol harm reduction practices. However, no evidence has been reported about the feasibility, acceptability and effectiveness of strategies, including web-based strategies for ensuring the sustained implementation of such practices by sports clubs.

Given these evidence gaps, the aims of this thesis are:

1 To review the effectiveness of implementation strategies in sustaining improvements in public health program sustainability (Chapter 2).

2 To assess community sports clubs' perceptions about the usefulness, ease of use and intentions to use a web-based program to support the sustainability of club implementation of alcohol management policies (Chapter 3).

3 To assess the validity of web-based self-report of alcohol-management practices in community football clubs (Chapter 4).

4 To assess the effectiveness of a web-based program in supporting community sports clubs to sustain the implementation of alcohol management practices (Chapter 5, 6).

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CHAPTER 2

Effectiveness of strategies in sustaining the implementation public health programs

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Wolfenden L, Chai LK, Jones J, McFadyen T, Hodder R, Kingsland M, Milat AJ, Nathan N, Wiggers J, Yoong SL. What happens once a program has been implemented? A call for research investigating strategies to enhance public health program sustainability. Aust NZJ Public Health. 2019 Feb 1;43(3).

2.1 INTRODUCTION

Substantial investments have been made by governments internationally in the provision of public health programs and services. There is now broad acceptance of the need to improve the potential benefits of such investment through enhanced implementation of evidence-based programs at-scale.[1] The prevailing emphasis on implementation as a vehicle for public health improvement is illustrated by the establishment of national funding schemes for implementation and dissemination research, and the proliferation of speciality implementation science training opportunities to support the development and application of the science of implementation in health services. As a consequence of such developments, there has been considerable growth in implementation-related research. Public health indexed publications in Medline with 'implementation' in the title have increased from 917 in the year 2007 to 2,858 in the year 2017,[2] and the leading speciality journal Implementation Science has seen a sevenfold increase in submissions over the same period.[3]

Much of the focus of implementation research has been on identifying factors associated with, or strategies that can improve, the initial uptake or implementation of evidence-based interventions. Although such research is warranted as achieving sufficient implementation of interventions to improve health represents a considerable challenge, unless implementation of public health programs is maintained longer-term the value of investment in initial implementation is open to question.[4] The prospects of sustained implementation, even following substantial investment in initial implementation, are by no means guaranteed. 'Initiative decay' or the 'improvement evaporation effect' whereby the gains of improvement interventions are not sustained is common. Of the 17 studies identified in a systematic review of the sustainability of American and Canadian health-related programs (which were primarily community-based), just four reported achieving program sustainability of at least one intervention component in at least 80% of intervention sites.[5] Similar findings have been reported in a review of 125 studies on sustainability of program effects in the fields of public health and medicine.[2]

Broadly, sustainability is considered as the continued use of program components and activities for the continued achievement of desirable program and population health outcomes.[6] Much of the research examining program sustainability has examined factors that are associated with program sustainability following withdrawal of program funding or an initial implementation phase.[2] Such research has typically been non-experimental and focused on characteristics of the program (or intervention), organisational capacity, or broader contextual factors as correlates of sustained implementation fidelity.[2] Research suggests that establishment of systems, processes and structures within organisations adopting new health programs, and building of organisational readiness and capacity that occur as part of initial implementation efforts may facilitate sustained program implementation.[7] While this research has provided important formative work for the field, to maximise the benefits of investments in population-wide program implementation, policy makers and practitioners are primarily interested in whether planned investments are sufficient to maintain long-term program implementation or whether ongoing investment is required to achieve this outcome. The most robust research to address such questions are intervention trials where strategies to improve the sustainability of implementation outcomes are compared to alternate strategies or usual care control groups.

2.2 METHODS AND RESULTS

We recently sought to assess the effectiveness of implementation strategies in sustaining improvements in implementation of non-communicable disease prevention policies or practices in community settings. We examined all trials included in a series of systematic reviews funded by The Australian Prevention Partnership Centre.[4,8-10] The reviews included trials (randomised and non-randomised) with a parallel control group that examined the impact of an implementation strategy on the fidelity of implementation of a policy or practice by a school, childcare centre, workplace or sporting venue. Studies of policies or practices that targeted diet, physical activity, obesity, tobacco or alcohol use were eligible.[4,8-10] Consistent with definitions used in previous reviews, sustained implementation was defined as sustaining a statistically significant intervention

effect on a measure of implementation fidelity achieved post-intervention for at least three months thereafter. Therefore, to be included in the study, trials were required to have assessed the impact of implementation strategies on policy or practice implementation at three time-points (pre-intervention, post intervention and at least three months after) and to have reported statistically significant effects on at least one implementation outcome at the first post-intervention assessment period.

Of the 108 full texts examined, we did not find any trials that met our inclusion criteria. That is, not a single trial identified across four comprehensive reviews[4,8-10] reported a significant effect on at least one implementation outcome post-intervention and further assessed if such effects were maintained at a longer-term follow up. We also re-analysed data collected as part of a bibliographic study of all 1,648 manuscripts published in 10 leading public health journals in 2013 and failed to identify any trials assessing the sustainability of program implementation.[11]

2.3 DISCUSSION

While concerning, the findings are perhaps unsurprising. Previous systematic reviews on the issue have consistently commented on the nascent state of sustainability research in the field of implementation, and limited use of experimental research designs.[2,6]

The lack of such research is likely a reflection of the considerable challenges in undertaking sustainability trials. Improvements in the initial implementation of evidence-based public health programs are difficult to achieve and, in many cases, initial implementation efforts are ineffective, leaving nothing to 'sustain'.[2] Further, measures of program implementation, and its maintenance, often occur at the organisational level necessitating the participation of large numbers of organisations (e.g. schools, outpatient clinics, sporting clubs) in trials to enable quantitative methods of analysis – trials of a scale beyond the capacity of most research groups. Assessing sustainability also requires extended periods of program follow-up, typically measured in years.[6] Given such challenges with

assessment of sustainability, trialists may need to consider measuring variables known to predict sustainment (i.e. relevant partnerships, organisational capacity) in the earlier stages of program planning. While not directly assessing causality, program planners may need to consider the use of a range of study designs including well-designed, non-experimental prospective designs in the evaluation of program sustainability.

While public health history is littered with examples of effective public health programs that were discontinued when external funds to support implementation have ceased or following attempts to transfer responsibility for ongoing program delivery,[6] a number of case studies in Australia and elsewhere have demonstrated that sustained implementation of public health programs is possible.[6,7,12] Developing an understanding of the success factors for such cases is important. However, rigorous development and testing of strategies that are effective in enhancing program sustainability is urgently needed if the ongoing implementation of beneficial programs is to become the norm, not the exception.

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CHAPTER 3

The feasibility and acceptability of a web-based alcohol management intervention in community sports clubs: a cross-sectional study

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McFadyen T, Wolfenden L, Wiggers J, Tindall J, Yoong SL, Lecathelinais C, Gillham K, Sherker S, Rowland B, McLaren N, Kingsland M. The feasibility and acceptability of a web-based alcohol management intervention in community sports clubs: a cross-sectional study. JMIR research protocols. 2017;6(6):e123.

ABSTRACT

BACKGROUND

The implementation of comprehensive alcohol management strategies can reduce excessive alcohol use and reduce the risk of alcohol-related harm at sporting venues. Supporting sports venues to implement alcohol management strategies via the Web may represent an effective and efficient means of reducing harm caused by alcohol in this setting. However, the feasibility and acceptability of such an approach is unknown.

OBJECTIVE

This study aimed to identify (1) the current access to and use of the Web and electronic devices by sports clubs; (2) the perceived usefulness, ease of use, and intention to use a Web-based program to support implementation of alcohol management policies in sports clubs; (3) the factors associated with intention to use such a Web-based support program; and (4) the specific features of such a program that sports clubs would find useful.

METHODS

A cross-sectional survey was conducted with club administrators of community football clubs in the state of New South Wales, Australia. Perceived usefulness, ease of use and intention to use a hypothetical Web-based alcohol management support program was assessed using the validated Technology Acceptance Model (TAM) instrument. Associations between intention to use a Web-based program and club characteristics as well as perceived ease of use and usefulness was tested using Fisher's exact test and represented using relative risk (RR) for high intention to use the program.

RESULTS

Of the 73 football clubs that were approached to participate in the study, 63 consented to participate and 46 were eligible and completed the survey. All participants reported having access to the Web and 98% reported current use of electronic devices (eg, computers, iPads/tablets, smartphones, laptops, televisions, and smartboards). Mean scores (out of a possible 7) for the TAM constructs were high for intention to use (mean 6.25, SD 0.87), perceived ease of use (mean 6.00, SD 0.99), and perceived usefulness (mean 6.17, SD 0.85). Intention to use the Web-based alcohol management program was significantly associated with perceived ease of use (*P*=.02, RR 1.4, CI 1.0-2.9), perceived usefulness (*P*=.03, RR 1.5, CI 1.0-6.8) and club size (*P*=.02, RR 0.8, CI 0.5-0.9). The most useful features of such a program included the perceived ability to complete program requirements within users' own time, complete program accreditation assessment and monitoring online, develop tailored action plans, and receive email reminders and prompts to complete action.

CONCLUSIONS

A Web-based alcohol management approach to support sports clubs in the implementation of recommended alcohol management policies appears both feasible and acceptable. Future research should aim to determine if such intended use leads to actual use and club implementation of alcohol management policies.

3.1 INTRODUCTION

Worldwide, approximately 3.3 million deaths and over 200 diseases and injuries are attributable to excessive alcohol consumption.[1] High levels of alcohol consumption and alcohol-related harm have been reported among players and supporters of community level, non-elite sports clubs.[2,3]. For instance, in New Zealand non-elite sportspeople have reported higher levels of harmful alcohol consumption (51%) than non-sports people (31%),[4] and non-elite Gaelic football and hurling players in Ireland have reported higher levels of alcohol consumption

(32%) compared to a national representative sample of men of a similar age (15%).[3] Similarly, reported levels of alcohol consumption of non-elite football players in Australia are between 4 and 9 times the recommended level of alcohol per drinking session.[2,5]

In many nations, non-elite community sports clubs provide opportunities for organized sports participation for children and adults. A number of characteristics of such community sports clubs make them an attractive setting to address risky alcohol use and alcohol-related harm among players and supporters. First, sports clubs provide access to large numbers of players, spectators, and officials.[6] For instance, in England between 2015 and 2016, 15.83 million people 16 years or over (36.1%) engaged in sport at least once a week[7] and, in Australia, between 2013 and 2014, approximately 5.2 million Australians aged 15 years and over (28%) were involved with organized sport and physical activity.[8] Second, despite community sports clubs being required to adhere to liquor licensing laws regarding responsible service of alcohol[9-11] to reduce the risk of excessive alcohol consumption and alcohol-related harm,[12] such adherence is poor.[13,14] For example, a study conducted in 87 community football clubs in New South Wales (NSW), Australia, found 32% did not have all bar staff trained in the Responsible Service of Alcohol (RSA), 38% conducted high-risk drink promotions, and 35% allowed bar staff to consume alcohol while on duty.[14] Third, research has found that community sports clubs are amenable to support to improve alcohol management to reduce alcohol use and harm occurring at these venues.[15,16]

Studies have demonstrated that implementing comprehensive alcohol management policies (eg, responsible service of alcohol and inhibiting alcoholic drink promotions) in licensed venues can reduce harmful alcohol use in such premises.[17,18] Similarly, evidence suggests that the implementation of comprehensive alcohol management policies by sporting clubs can reduce excessive alcohol consumption by members in these venues and their risk of alcohol-related harm.[19] For example, in a randomised controlled trial (RCT) of an alcohol management accreditation program in community football clubs in

Australia, clubs received face-to-face and telephone-based support to implement a suite of policies to reduce the risk of excessive alcohol use.[14] Post-intervention, a significantly greater proportion of intervention clubs (88%) implemented alcohol management policies compared to control clubs (65%), and a significantly lower proportion of club members from intervention group clubs engaged in risky alcohol consumption at the club compared to control clubs.[14]

The ability to modify the policies of service delivery organizations is suggested to be enhanced by the use of a variety of evidence-based implementation change strategies such as audit and feedback, consensus processes, training and resource provision.[20] In an RCT of an alcohol management accreditation program in community football clubs in Australia, a number of such strategies were provided on a face-to-face and telephone basis to support the implementation of alcohol management policies. The delivery of implementation support in this manner can represent a logistical and resourcing challenge when a large number of sites (eg, sports clubs, hospitals, schools) are involved and when such sites are geographically dispersed or remote.[21] Computer or Web-based delivery of policy change strategies have become increasingly common and have been shown to be efficacious in improving implementation of evidence-based policies in some settings, such as primarily health care services.[22] For example, in health care settings, Web-based delivery of training, audit, and feedback strategies have been reported to be effective in modifying the provision therapeutic interventions by clinicians.[23]

Web-based programs can be delivered at relatively low cost to large numbers of sports clubs and may represent a potential means of overcoming the logistical challenges of scaling up evidence-based alcohol management policies in this setting. Internet coverage is almost universal in high income countries such as Australia,[24] extending into rural and remote geographic locations, enabling the provision of Web-based support to clubs located in these areas. Furthermore Web-based programs provide consistent, standardized delivery of content, can tailor content to specific needs of users, and have the functionality to incorporate evidence-based techniques to support implementation (eg, performance

monitoring and feedback, action planning and goal setting, and social comparison).[25-29] While Web-based programs have been used to support implementation or support quality improvement initiatives in other settings, such as hospitals, general health care,[22,30] and schools[31-33] we are not aware of evaluations of such initiatives in the sporting club environment.

Despite the potential of Web-based programs, the benefits of such programs are often encumbered by low user engagement and uptake.[30,34] Given this risk of non-utilization, assessment of the feasibility and acceptability of Web-based technologies to end-users has been recommended before significant investments in the development of Web-based programs are initiated.[35,36] The Technology Acceptance Model (TAM) is a validated, widely used, and recommended tool to pre-assess factors associated with end-user intention to use a Web-based program (perceived ease of use and perceived usefulness)[36,37] and to assess the potential use and impact of Web-based technologies. Given the lack of empirical studies examining the use of Web-based programs by sports clubs and club administrators generally and of the potential of such programs to support club implementation of alcohol management policies specifically, a study was undertaken to assess the following:

1 Current access to and use of the Web and electronic devices by community sports club administrators.
2 Administrator perceptions regarding the usefulness and ease of use of a hypothetical Web-based support program to support club implementation of alcohol management policies and their intention to use such a program.
3 Factors associated with intention to use a Web-based alcohol management support program.
4 Specific features of such a program that sports club administrators would find useful.

3.2 METHODS

3.2.1 DESIGN AND SETTING

A cross-sectional survey of club administrator representatives from community football clubs was conducted in the state of NSW, Australia. Clubs were based in major city, regional, and rural communities.

3.2.2 PARTICIPANT ELIGIBILITY AND RECRUITMENT

Football Clubs

Participating clubs were community level, nonelite football clubs across the 4 major Australian football codes: Rugby League, Rugby Union, Soccer/Association football, and Australian Football League. Eligible clubs had players over the legal drinking age (18 years of age and over), were a non-elite community sports club (defined as clubs not involved with a major national or state level league or competition), had over 40 members, and held a current liquor license enabling sale of alcohol at the sports club and were currently participating in an existing alcohol management program delivered on a face-to-face basis (Good Sports).[38] Additionally, clubs had participated in an RCT conducted between 2009 and 2012, which evaluated the effectiveness of a face-to-face alcohol management program to support clubs to implement alcohol management policies.[14] A full description of the intervention has been published;[14] in short, the intervention included hard copy resources, club committee engagement, and face-to-face monitoring and feedback for each intervention club.

Football Club Administrators

A senior club administrator (eg, president, vice president, or secretary) of eligible clubs was identified from club records and sent a study information letter and invited to participate in the study on behalf of the club.

3.2.3 DATA COLLECTION PROCEDURES

An expert advisory group with representation from community sports clubs (senior club administrators), health promotion practitioners, implementation and behavioral scientists, and experts in organizational change informed the development of a computer-assisted telephone interview (CATI) survey, based on previously implemented surveys in sports clubs and other community settings.[14,39] The CATI was piloted on a subsample of community football club administrator representatives to ensure survey language and length was appropriate. Surveys were conducted by trained interviewers in the Australian winter football season (June-August) of 2015. The average length of the survey was 40 minutes.

3.2.4 MEASURES

Football Club and Club Administrator Characteristics

Club administrators were asked to report the club's home ground postcode, football code (Rugby League, Rugby Union, Soccer/Association football, or Australia Football League), the number of senior (18 years of age and over) and junior (under 18 years of age) teams registered with the club, their current role within the club, the time (in years) they had been in that role, their age, and their gender.

Football Clubs' Current Use of the Web and Electronic Devices

Club administrators were asked to report whether they had access to the Internet and whether they used electronic devices (eg computers, iPads/tablets, smartphones, laptops, televisions, and smartboards) to complete specific club-related tasks (at any location), including membership and player registration, game scheduling, managing club finances/book-keeping, communicating with members, committee administration tasks, administration fundraising, and other events.

Perceived Usefulness, Ease of Use, and Intention to Use a Web-Based Alcohol Management Program

The TAM is a validated instrument for prospectively assessing end-user intention to use Web-based programs.[36,37] TAM consists of 3 primary constructs (behavioral intention, perceived ease of use, and perceived usefulness) for which a meta-analysis of 88 studies has reported high internal consistency among each construct (Cronbach alpha score of >0.8).[40] Derived from the theory of reasoned action, TAM postulates that behavioural intention is linked to actual behaviour.[36,41] A systematic review of the TAM literature supports this, with a positive correlation of association between behavioral intention and actual use of technology found for 90% of included studies.[35]

A total of 11 items from TAM were adapted for relevance to the sports club setting. A hypothetical Web-based program was described to club administrators via the CATI to determine clubs' perceived usefulness, ease of use, and intention to use the program to support club implementation of recommended alcohol-management policies. The program was described to club administrators as able to monitor their progress of alcohol policy implementation, provide tailored feedback on their level of implementation, send prompts and reminders for required tasks, and provide unrestricted access to information and resources. Similar adaptation of the TAM has been employed in other community settings.[39] Club administrators were asked to rate on a 7-point scale (1=strongly disagree, 4= neither agree nor disagree, and 7=strongly agree) the perceived usefulness of a Web-based alcohol management program (4 items), the perceived ease of use of such a program (4 items), and their intention to use such a program (3 items). (see Appendix 2 for modified TAM questionnaire, including a description of the hypothetical Web-based program)

Specific Features of an Alcohol Management Web-Based Program that Sports Club Administrators Would Find Useful

A total of 10 questions were used to assess the perceived usefulness of specific Web-based program features to support club implementation of an alcohol management program. Responses were recorded on a 7-point scale (1=strongly

disagree and 7=strongly agree). Assessed program features were ability to complete program requirements in users' own time, ability to complete program accreditation assessment and monitoring online, development of tailored action plans, email reminders and prompts to complete action items, access to support tools and resources, access to training and educational videos or interactive activities, program support via email or live chat, ability to communicate with club members (email), ability to communicate with other sports clubs in the program, and program-related peer comparison.

3.2.6 STATISTICAL ANALYSIS

Statistical analyses were conducted in SAS version 9.3 statistical software (SAS Institute Inc). Clubs were grouped by football code (Rugby League, Rugby Union, Soccer/Association football, and Australian Rules Football), and classified according to geographical location (major city or inner regional/outer regional) using the Australian Standard Geographical Classification (ASGC) based on the Accessibility/Remoteness Index of Australia score (ARIA) and size (small [≤10 teams] or large [>10 teams]). All statistical tests were 2-tailed with an alpha of 0.05.

For aim 1, simple descriptive statistics were used to describe sports club administrators' access to and use of the Web and electronic devices to undertake club tasks. For aim 2, similar to other TAM studies,[39,42] the mean score and standard deviation for each TAM construct was calculated. The internal consistency of each TAM construct was assessed using Cronbach alpha. For aim 3, again similar to other TAM studies,[39,42] the 3 TAM constructs were dichotomized into a score of 1 (strongly disagree) to 5.9 (slightly agree) or 6 (agree) to 7 (strongly agree). By choosing this cut-point, the results allow for a clinically meaningful interpretation, as the median score of the constructs were used. Additionally, this dichotomized score differentiates between those who disagree or only slightly agree to those who have full to strong agreement with the items examined within the TAM constructs. Fisher's exact test was used to test the significance of association between club administrator intention to use the Web-

based program (1.0-5.9 [low intention] vs 6.0-7.0 [high intention]), club geographic location, size, administrator age (≤50 years vs >50 years), use of electronic device for club tasks (≥1 device vs no devices), access to the Internet when undertaking club tasks (yes vs no), perceived ease of use of the Web-based support program (construct mean score dichotomized: 1.0-5.9 [low perceived ease of use] vs 6.0-7.0 [high perceived ease of use]), and perceived usefulness of the Web-based support program (construct mean score dichotomized: 1.0-5.9 [low perceived usefulness] vs 6.0-7.0 [high perceived usefulness]). For aim 4, descriptive statistics were used to summarize the features of a Web-based support program that sports clubs' administrators agreed or strongly agreed that they would find useful to support implementation of recommended alcohol management policies.

3.2.7 ETHICS APPROVAL

Ethics approval was obtained from The University of Newcastle, Human Research Ethics Committee (H-2008-0432).

3.3 RESULTS

3.3.1 FOOTBALL CLUB AND CLUB ADMINISTRATOR CHARACTERISTICS

A total of 73 community sporting clubs were approached to participate in the study, of which 63 consented to participate (86%). Of these 63, 17 were ineligible and 46 completed the survey (73% of eligible). Of the participating clubs, the largest proportion were Rugby League clubs (15/46, 33%) and Rugby Union clubs (14/46, 30%), the majority of clubs (38/43, 88%) were located in major cities, and just over half the sample (24/46, 53%) was classified as large clubs. Most club administrator representatives held the role of club president (15/46, 33%) or secretary (14/46, 30%) and were male (39/46, 85%), with a mean age of 48 years and a mean number of 4.3 years in that position (see Table 3.1).

Table 3.1: Football club and club administrator representative characteristics (N=46)

Characteristics	Number
Football club characteristic	
Football code	
Australian League Football, n (%)	6 (13)
Rugby League, n (%)	15 (33)
Soccer/Association football, n (%)	11 (24)
Rugby Union, n (%)	14 (30)
Geographical region[a]	
Major city, n (%)	38 (88)
Inner/outer regional, n (%)	5 (12)
Club size	
Small (≤10 teams), n (%)	21 (47)
Large (>10 teams) n (%)	24 (53)
Club administrator characteristics	
Club role	
President, n (%)	15 (33)
Vice President, n (%)	4 (9)
Secretary, n (%)	14 (30)
Treasurer, n (%)	4 (9)
Coach, n (%)	1 (2)
Committee member, n (%)	2 (4)
Time in club role, years, mean (SD)	4.3 (3.2)
Age, years, mean (SD)	49 (9.64)
Gender, male, n (%)	39 (85)

[a]N=43

3.3.2 FOOTBALL CLUB'S CURRENT USE OF AND ACCESS TO THE WEB AND ELECTRONIC DEVICES

Most (98%) football club administrators reported current use of electronic devices for club-related tasks and all reported having access to the Web when undertaking these tasks. The proportion of clubs that reported undertaking specific tasks using electronic devices is reported in Table 3.2.

Table 3.2: Proportion of clubs reporting the use of the electronic devices to undertake specific club-related tasks (N=46)

CLUB-RELATED TASK	n	%
Membership and player registrations	45	98
Game scheduling	38	83
Managing club finances/bookkeeping	44	96
Communicating with members	45	98
Committee administration tasks	45	98
Administration fundraising and other events	44	96

3.3.3 PERCEIVED USEFULNESS, EASE OF USE, AND INTENTION TO USE A WEB-BASED ALCOHOL MANAGEMENT IMPLEMENTATION PROGRAM

Table 3.3 presents the mean score and standard deviation for each individual TAM question and overall for each of the 3 TAM constructs. Internal consistency for each construct was high, with a Cronbach alpha score of >0.9 for each of the 3 TAM constructs. For all 11 items within the TAM domains club administrators had high scores, with a mean score of 5.83 or greater (max 7) for all items. The perceived usefulness of a Web-based program to help sports clubs implement recommended alcohol management policies was high; with an overall mean construct score of 6.17 (SD 0.85). Similarly, the perceived ease of use (construct mean 6.00, SD 0.99) and intention to use such a Web-based support program were high (construct mean 6.25, SD 0.87). A total of 89% of clubs reported a high behavioral intention to use a Web-based alcohol management program.

3.3.4 CLUB AND ADMINISTRATOR CHARACTERISTICS AND PERCEPTIONS ASSOCIATED WITH PERCEIVED INTENTION TO USE A WEB

Table 3.4 presents the results of tests of association between club and administrator characteristics and perceived ease of use, perceived usefulness, and perceived intention to use a Web-based program to support implementation of alcohol management policies. The characteristics that were found to be positively associated with high intention to use a Web-based alcohol management program were perceived ease of use (*P*=.02) and perceived usefulness of the program (*P*=.03). Club size was found to be positively significantly associated with high intention to use such a program (*P*=.02).

Table 3.3: Football clubs perceived usefulness, ease of and intention to use a Web-based program to support implementation of recommended alcohol management policies

TAM[a] ITEMS AND CONSTRUCTS	Mean	SD
Perceived usefulness		
I would find Good Sports online useful in helping my club implement Good Sports policies.	6.30	0.70
Using Good Sports online would improve my clubs PERFORMANCE in implementing Good Sports policies.	6.20	0.96
Using Good Sports online would improve my clubs PRODUCTIVITY in implementing Good Sports policies.	6.07	1.04
Using Good Sports online would help enhance the EFFECTIVENESS of my club in implementing Good Sports policies.	6.11	0.97
Overall usefulness of Good Sports online[b]	6.17	0.85
Perceived ease of use		
My interaction with Good Sports online would need to be clear and understandable.	6.33	0.97
Interacting with Good Sports online is not likely to require a lot of my mental effort.	5.83	1.32
I would find Good Sports online easy to get it to do what I want it to do.	5.89	1.16
I would find Good Sports online easy to use.	5.96	1.09
Overall perceived ease of Good Sports online[b]	6.00	0.99
Perceived intention of use		
Assuming I had access to Good Sports online, I INTEND to use it	6.24	0.92
Given that I had access to Good Sports online, I PREDICT that I would use it.	6.24	0.90
If Good Sports online was currently available, I would PLAN to use it in the next 12 months.	6.28	0.91
Overall intention to use Good Sports online[b]	6.25	0.87

[a]TAM: Technology Acceptance Model

[b]Cronback alpha score of 0.9 for each TAM construct: usefulness, perceived ease of use, and intention to use a Web-based program

Table 3.4: Associations between club and administrator characteristics and perceptions and intention to use a Web-based alcohol management program

Characteristics and perceptions	Intention to use[a] Score of 1.0-5.9 N=5 n (%)	Score of 6.0-7.0 N=41 n (%)	Relative risk for high intention of use	Fisher's exact p value
Geographical region[b]				.48
Major city	4 (11)	34 (89)	1.1 (0.8-4.4)	
Inner/outer regional	1 (20)	4 (80)	-	
Club size				.02
Small	5 (24)	16 (76)	0.8 (0.5-0.9)	
Large	0 (0)	24 (100)	-	
Club administrator age				.65
50 years or less	2 (8)	23 (92)	1.1 (0.8-1.5)	
Over 50 years	3 (14)	18 (86)	-	
Current use of electronic devices for club tasks				1.00
1 or more devices	5 (11)	40 (99)	0.9 (0.7-30.8)	
No devices	0 (0)	1 (100)	-	
Access to internet when undertaking club tasks				1.00
Yes	5 (11)	40 (89)	-	
No	0 (0)	0 (0)	-	
Perceived ease of use[a]				.02
1.0-5.9	4 (31)	9 (69)	-	
6.0-7.0	1 (3)	32 (97)	1.4 (1.0-2.9)	
Perceived usefulness[a]				.03
1.0-5.9	3 (37)	5 (63)	-	
6.0-7.0	2 (5)	36 (95)	1.5 (1.0-6.8)	

[a]Score of 1.0-5.9 indicates response to statements of strongly disagree to slightly agree, and score of 6.0-7.0 indicates response to statements of agree and strongly agree.
[b]Clubs categorized using the Australian Standard Geographical Classification (ASGC), which classifies remoteness based on sports clubs postcodes matching the Accessibility/Remoteness Index of Australia (ARIA) score.

3.3.5 SPECIFIC FEATURES OF AN ALCOHOL MANAGEMENT WEB-BASED PROGRAM THAT SPORTS CLUB ADMINISTRATORS REPORTED WOULD BE USEFUL

Overall, there was a high level of agreement regarding the usefulness of each of the proposed program features. All club administrators agreed or strongly agreed

that the ability to complete program requirements within their own time would be a useful feature. Greater than 90% of club administrators agreed or strongly agreed that it would be useful for the program to enable completion of program accreditation assessment and monitoring online (96%), develop tailored action plans (96%), send email reminders and prompts to complete actions (96%), provide access to support tools and resources (96%), include program support (email or live chat) (94%), and provide program-related peer comparison (91%). A high level of support was evident for access to videos or interactive activities for training and education (83%), an ability to communicate with club members by email (78%), and an ability to communicate with other sports clubs in the program (70%).

3.4 DISCUSSION

3.4.1 PRINCIPAL FINDINGS

This is the first study to assess the feasibility and acceptability of a Web-based program to support the implementation of alcohol management policies by community sports clubs. There was universal access to the Web and use of electronic devices when undertaking club-related tasks among clubs. The vast majority (89%) of club administrators reported high behavioural intention to use a Web-based program to support their club's implementation of recommended alcohol management policies. Furthermore, both perceived usefulness of a Web-based alcohol management program and its perceived ease of use were positively associated with intended use. The findings suggest that there is considerable potential for a Web-based program to support sports clubs in the implementation of recommended alcohol management policies and in doing so to make a contribution to reducing alcohol-related harm in this setting and the community at large.

The study findings are comparable to similar studies conducted in other settings. For example, high intention to use Web-based programs to support implementation of health-related programs have been reported in childcare

services,[39] health care centers,[43] and other community settings.[42] Furthermore, significant associations between perceived ease of use or perceived usefulness of Web-based programs with their intended use has been consistently reported across settings. [37,39,43] To ensure a high level of perceived ease of use and usefulness, such findings underscore the importance of program features designed to address barriers to engagement (eg, assimilation and personalization reduction)[27,44] and the importance of formative research with end-users to ensure the development of useful programs that meet their needs.

In this study, larger clubs had a significantly higher level of intended program use (100%) compared to smaller clubs (76%). This may be due to greater complexity of managing alcohol use in larger clubs, requiring greater workforce, resources, and infrastructure to manage. Potentially, the use of Web-based programs to coordinate the implementation of alcohol management policies in these settings may be perceived as of greater benefit. Similarly, as in licensed venues, sports clubs experience a high number of alcohol-related incidents,[45,46] Web-based support to reduce such alcohol-related harm may be more salient among administrators of larger clubs. Nonetheless, the findings suggest that Web-based support may be less effective in supporting improvements in alcohol management in smaller clubs. Future research to identify alternate and adjunctive models of support for such clubs appears warranted.

3.4.2 STRENGTHS AND LIMITATIONS

The results of this study should be considered with respect to its strengths and limitations. The strengths of this study include the application of a validated tool[40] to assess intended use of a hypothetical Web-based program, strong internal consistency across TAM constructs, and complete data for all participants. On the other hand, while club administrators are those most likely to be coordinating and overseeing the introduction of a Web-based program to support the implementation of recommended alcohol management policy, it is possible that they may not be representative of all individuals involved with clubs that may at times use such a program, such as volunteers and other staff. Clubs in this study

were randomized into either the intervention or control arm of a face-to-face alcohol management trial between 2009 and 2012,[14] thus some of the clubs would have received intensive intervention support throughout this time. Therefore, it should be noted that previous intervention clubs within this group may be more likely to find it feasible and acceptable to use a Web-based program to support alcohol policy implementation. In addition, findings from this study may not be able to be generalized to groups outside of the study sample, such as other sporting codes or other community organizations. Finally, although there is empirical evidence[35] to show that intended use of a program is linked to actual use, actual rates of use of a Web-based program to support the implementation of recommended alcohol management policies among participants in this setting has not been reported.

3.4.3 CONCLUSION

Further studies are required to determine if sports clubs will actually use such a program if it existed and to show whether such a program has the intended effect of supporting clubs to implement recommended alcohol management policies.

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CHAPTER 4

Alcohol management practices in community sporting clubs: Validation of an on-line self-report tool

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ABSTRACT

INTRODUCTION AND AIMS

Those involved in organised sport have a high risk of excessive alcohol consumption and alcohol related harm, the implementation of alcohol management practices have been proven to reduce these risks. Measuring alcohol management practice implementation by sporting clubs is impeded by a lack of valid tools. The aim of this study was to determine the validity of online self-report of alcohol-management practices by community football clubs via comparison with observational methods.

DESIGN AND METHODS

A cross sectional study was undertaken with a sample of community football clubs within Australia. The implementation of 12 alcohol management practices was collected via 1) an online survey, and 2) observational audit at a clubs home ground. The prevalence of implementation of alcohol management practices for both data collection methods was calculated as was percent agreement and Kappa/Prevalence Adjusted and Bias Adjusted Kappa (PABAK) statistics.

RESULTS

Data were collected from 58 football clubs. For both assessment methods, implementation prevalence was greater than 80% for 6 of the 12 alcohol management practices. Seventy five percent (n=9) of practices had at least 70% agreement between the online and observation methods of assessment. KAPPA/PABAK scores ranged from -0.08 (poor agreement) to 0.97 (almost perfect agreement).

DISCUSSION AND CONCLUSIONS

The online survey provided valid measure of assessing some but not all alcohol management practices in community sporting clubs. The validity of the measure

may be improved by enhancements to the manner in which the self-report data are collected.

4.1 INTRODUCTION

Excessive alcohol consumption is responsible for 5.9% of deaths and 5.1% of the burden of disease globally.[1] High levels of risky alcohol consumption and alcohol-related harm occur among players and spectators of organised sport, in particular, team and contact sports.[2-7] It has been reported that non-elite football players consume between four and nine times the recommended level of alcohol[8] per drinking session[3] within Australia. These findings are similar among individuals involved in football in other countries.[4-7] In the USA, up to three times the number of alcohol-related arrests are reported to occur on college football game days compared to equivalent non-game days and public holidays.[2]

With approximately 270 million people involved in football (or soccer) alone worldwide[9], and large proportions of people in individual countries (28% to 36%) involved in some form of organised sport[10,11], sporting clubs represent an opportune setting to reduce excessive alcohol consumption and risk of alcohol-related harm in the community.[12] In licensed venues generally, the adoption of alcohol management practices such as pricing of alcohol products, hours of sale and a variety of responsible service of alcohol practices have been found to reduce risky consumption of alcohol and alcohol-related harm among venue patrons[13,14]. Similarly, in the sports club setting, interventions that improve alcohol management practices[15] have been shown to be effective in reducing excessive alcohol consumption by players and club members.[16]

While there is evidence to support the use of alcohol management practices to reduce excessive alcohol consumption and related harm, little is known of the prevalence of such practices being implemented in community sporting club settings. To provide robust prevalence estimates, tools that measure the implementation of alcohol management practices by sports clubs must be valid.[17] While observation represents the 'gold standard' for assessing the

implementation of recommended practices in community and organisational settings generally[18-20], such approaches are expensive and present considerable logistical challenges when applied at a population level.

Self-report measurement of sporting club implementation of alcohol management practices using surveys provides an alternative and potentially more convenient, less expensive and more feasible means of collecting such information, particularly at the population level. The validity of self-report measurement of recommended health promotion practices in community and organisational settings generally has been shown to vary according to the type of practice being measured. For instance, Wiggers et al.[21] found high levels of agreement (90–100%) between licensee/hotel manager self-report and observations of the implementation of alcohol management practice by licensed premises for 63% of measured practices. Similarly, in measuring the health promoting characteristics in child-care services, Dodds et al.[22] reported high agreement (80–100%) between self-reported (written survey) and observed implementation of half of measured healthy eating and physical activity policies and practices. Nathan et al.[23] in their validation of an instrument assessing obesity prevention characteristics of schools, also found moderate to almost perfect agreement between primary school teacher self-report and observation of nutrition and physical activity promoting practices for approximately 70% (27/39) of measured practices.

The collection of self-report data via online surveys holds particular promise as a means of measuring sport club implementation of alcohol management practices, relative to pen and paper or telephone surveys. Compared with such methods, online surveys may be less expensive to conduct, can be tailored for individual use and can be easily distributed to many individuals at the same time.[24,25] Online surveys also have the capacity to be designed to reduce participant burden in the completion of the survey.[26,27] Data collected by online surveys have been found to be of equal quality of data collected by more traditional methods (e.g. pen and paper surveys).[28] Despite the potential benefits of using online surveys to assess the implementation of alcohol management practice in sports clubs, no previous

studies have reported the validity of such an approach in the sports club setting. To address this evidence gap, a study was undertaken to determine the validity of online self-report of alcohol-management practices by community football clubs via comparison with observational methods.

4.2 METHODS

4.2.1 STUDY DESIGN AND SETTING

A cross-sectional study was undertaken in community football clubs in the Australian states of Victoria and New South Wales.

4.2.2 PARTICIPANT ELIGIBILITY AND RECRUITMENT

Participating sports clubs were football clubs recruited and randomised to the intervention group in a trial of an online alcohol management intervention (Trial ID: ACTRN12614000746639). Sports clubs were eligible to participate if they: were non-elite, community-level; were one of the four major Australian football codes (Australian Football League, rugby league, rugby union or soccer club); were participating in and held the highest level of accreditation (Level 3) with an established alcohol harm reduction program[29]; held a current valid liquor licence; currently sold alcohol; had at least one senior (over 18 s) team; had access to the internet; and had completed the required online survey and had an observational visit within the same sporting season and within 20 weeks of one another.

4.2.3 DATA COLLECTION PROCEDURES

Self-report data

An online survey was developed to collect club characteristics data (football club code, club location and team numbers) and club implementation of alcohol management practices. Previously implemented community-based surveys[15,16] and an expert advisory group with representation from community sports clubs, health promotion practitioners, implementation and behavioural scientists and

experts in organisational change informed the development of the survey. The online survey collected data on the implementation of 12 alcohol management practices outlined in Table 4.1. These practices were selected on the basis that there was evidence that they may (alone or in combination with other practices) be associated with reducing excessive alcohol consumption and related harms and that they were observable. Definitions for each practice were included in the questionnaire. The online survey was pilot-tested with four club representatives, not included in the study, before administration. Participating clubs received an email with instructions on how to log in and complete the online survey.

Observational data

Observation of the 12 alcohol management practices (Table 4.1) was conducted using a study specific alcohol management practice observation tool. The tool was developed by the expert advisory group and pilot tested by research staff with four clubs to establish its utility and acceptability. Observational site visits were undertaken by independent data collection staff who were all required to attend a full-day training session, which included testing their reporting accuracy via a hypothetical observation scenario. Data collection staff included individuals from a range of ages and education backgrounds and levels.

Observational data were collected on average 3–4 months prior to online self-report data. Observations were conducted at each participating club's home ground during their most senior team game. The observation period was conducted for a minimum of three hours by a two-person data collection team. Observational data were recorded using handheld touchscreen tablets. Clubs were unaware of the exact date or time of the observation. Data collection staff arrived 30 min prior to the start of the home game and selected an observation location based on pre-specified criteria (central location close to the main alcohol service area). Data collection was completed covertly for nine of the 12 practices. For three of the practices (availability of low and nonalcoholic drinks options; price of low and non-alcoholic drinks; and availability of free water), observers were instructed that they may make contact with the bar staff and, if required, ask

for copies of drinks menus/price lists. Definitions and descriptions for certain practices (e.g. definition and description of drunk or intoxicated persons' and required licensing signs) were included in the data collection tool for observer clarity and ensuring standardised responses. The two observers were required to complete all observation questions independently. Immediately upon completion of the observation period, observers conducted a consensus assessment for each practice. If agreement could not be reached between observers regarding the assessment, they returned to the club to verify the observation. The auditing of observer agreement of responses for each practice ranged from 87% to 100%.

Table 4.1: Alcohol management practices

PRACTICE
People under 18 years of age do not serve alcohol[30]
At least one low-alcoholic drink option available[13,31,32]
Licensing signs visible at all points of alcohol sale[32,33]
Drunk/intoxicated people not allowed to enter club[30,33,34]
Drunk/intoxicated people not served alcohol[30,33,34]
At least four non-alcoholic options available for purchase[13,31,32]
Free water provided when alcohol is sold[31]
No drink promotions that encourage excessive consumption undertaken at the club (happy hour, all you can drink functions, alcohol-only awards and prizes, cheap drinks, drinking games, drinking vouchers/cards)[13,34-38]
Drunk/intoxicated people not permitted to remain on club premises[30]
Substantial food provided when alcohol sold[36]
Non-alcohol and low-alcoholic drinks 10% cheaper than full strength alcoholic drinks[13,14,39]
Staff do not consume alcohol whilst on duty[33,34]

4.3 MEASURES

4.3.1 CLUB CHARACTERISTICS

Data were collected regarding the following club characteristics: club postcode, football code (rugby league, rugby union, Australian Football League or soccer), and the number of senior (18 years of age and over) and junior (under 18 years of age) teams registered with the club (Table 4.2).

4.3.2 ALCOHOL MANAGEMENT PRACTICES

The 12 alcohol management practices addressed in the data collection tools are described in Table 4.1. (See Appendix 3 for alcohol management practice items, responses and dichotomised groups for both online and observational surveys)

4.4 ANALYSIS

Data analyses were conducted using SAS Version 9.3.

4.4.1 DESCRIPTIVE STATISTICS

The postcode of the home ground was used to categorise the club location as either 'major city' or 'inner/ outer regional' using the Accessibility/Remoteness Index of Australia [39], and the socio-economic status of the club (most disadvantage or least disadvantage) using the Socio-Economic Indexes for Areas [40]. The reported number of registered players for the 2015 season was used to categorise clubs size as either 'small' (≤160 players) or 'large' (>160 players).

4.4.2 CLUB ALCOHOL MANAGEMENT PRACTICES

All categorical alcohol management practice variables were dichotomised into two categories: 'yes' or 'no'. This allowed for a valid comparison between the two data collection methods for the 1-day observation. Methods for dichotomising practice items are outline in Appendix 3. Descriptive statistics with 95%

confidence limits were used to describe the prevalence of alcohol management practices for both the online self-report and observation methods. McNemar's test was used to assess whether the prevalence of each practice differed between the two data collection methods.

4.2.3 VALIDITY

Two measures of agreement were calculated to describe the validity of the online survey via comparison with the onsite observations. First, percent agreement between club self-report and observational data was calculated for each practice. As used in other studies, percent agreement levels of 80% or greater were considered evidence for 'strong' agreement.[41] While percent agreement is commonly reported and easily interpreted, it does not correct for the probability of chance agreement.[41] Therefore, agreement was also assessed using the Kappa statistic, which does correct for chance agreement.[42] Although the Kappa statistic is widely used for measuring agreement of conditions, the statistic can be affected by the high and low prevalence of response and any bias between the observers.[43] The Prevalence Adjusted and Bias Adjusted Kappa (PABAK) was also used, as it corrects for the variation of prevalence across the conditions and any potential bias among observers and is recommended for use when high or low prevalence estimates are reported.[43] PABAK was reported for those practices that had a positive agreement score of less than 25% or 75% or greater. Benchmarks suggested by Landis and Koch[44] were used to classify agreement: <0.00 = poor, 0.00–0.20 = slight, 0.21–0.40 = fair, 0.41–0.60 = moderate, 0.61–0.80 = substantial and 0.81–1.0 = almost perfect.

4.2.4 ETHICS APPROVAL

The study was approved by the University of Newcastle Human Research Ethics Committee (H-2013-0429) and conforms to the principles embodied in the Declaration of Helsinki.

4.3 RESULTS

4.3.1 SAMPLE

One hundred and eighty-eight of the 268 clubs approached to participate in the randomised trial were deemed eligible and consented to do so, 92 of these were randomised to the intervention group. Of these, 58 (63%) participated in both the online survey and observation within 20 weeks of one another and were included in final analysis of this study.

Table 4.2: Characteristics of participating football clubs (N=58)

Football club characteristic	n (%)
Football code	
Australian League Football	45 (78)
Rugby League	3 (5)
Soccer/Association football	8 (14)
Rugby Union	2 (3)
Geographical region	
Major city	28 (48)
Inner/outer regional	30 (52)
Disadvantage classification*	
Most disadvantage	27 (47)
Least disadvantage	30 (53)
Club size	
Small (≤160 players)	29 (50)
Large (>160 players)	29 (50)

[8]Differing denominator due to club postcode not classified by SEIFA

4.3.2 PREVALENCE OF ALCOHOL MANAGEMENT PRACTICES

Table 4.3 presents the prevalence of alcohol management practice implementation for both self-report and observation assessment methods. There was no significant difference between the two assessment methods in the prevalence of seven of the 12 practices. However, there was a significant

difference for five of 12 practices with a higher prevalence reported via observation for three of the practices (drunk/intoxicated people not permitted to enter the club or remain on the premises and substantial food is available) and via self-report for the remaining two (liquor signage displayed and one low-alcoholic drink option).

Table 4.3: Prevalence of alcohol management practice implementation by measurement method

ALCOHOL PRACTICE	WEB-BASED SELF-REPORT (N=58)		OBSERVATION (N=58)		P VALUE
	%	95%CI	%	95%CI	
People under 18 years don't service alcohol	100	100-100	98	94.82-100.00	0.32
At least one low-alcoholic drink option is available	98	94.82-100	91	83.94-98.82	0.05
Liquor licence & stat liquor licensing signage displayed at all points of sale	100	100-100	72	60.56-84.27	<0.001
Drunk/intoxicated people not permitted to enter the club	78	66.53-88.65	98	94.82-100.00	0.00
Drunk/intoxicated people not served alcohol at club	83	72.74-92.78	93	86.38-99.82	0.11
At least four non-alcoholic drink options are available	85	74.88-94.09	91	83.94-98.82	0.29
Free water available	91	83.94-98.82	81	70.64-91.43	0.08
No drink promotions that encourage excessive consumption	86	77.06-95.35	78	66.53-88.65	0.23
Drunk/intoxicated people not permitted to remain on the premises	66	52.91-78.12	86	77.06-95.35	0.01
Substantial food is available	38	25.06-50.80	100	100-100	<0.001
Non-alcoholic drinks and low-alcoholic beer are at least 10% cheaper compared to full strength beer	85	74.88-94.09	88	79.29-96.57	0.62
Bar staff don't consume alcohol whilst on duty	81	70.64-91.43	74	62.52-85.75	0.39

4.3.3 VALIDITY

Agreement between club responses from the self-report online survey and the club observations are presented in Table 4.4.

4.3.4 PERCENT AGREEMENT

As indicated in Table 4.4, percent agreement for the 12 alcohol management practices ranged from 38% to 98%. Eleven (92%) practices had a level of agreement greater than 60%. Two (17%) of the practices had strong percent agreement with greater than 80% ('People under 18 years don't serve alcohol' at 98% and 'At least one low-alcoholic drink option is available' at 93%). The lowest level of agreement was for the availability of substantial food (38%).

4.3.5 Kappa/PABAK

Table 4.4 also shows two practices had poor agreement (<0.00), four had slight agreement (0.00–0.20) (based on Kappa), four had moderate agreement (0.41–0.60), and two had almost perfect agreement (0.81–1.0) (based on PABAK). The highest level of agreement was reported for people under 18 years not serving alcohol and the availability of at least one low-alcoholic drink option. The lowest agreement was for bar staff not consuming alcohol while on duty and non-alcoholic/low-alcoholic drinks being at least 10% cheaper compared to full strength. For two of the 12 items the lower confidence interval was higher than 0.41 indicating that, with statistical certainty, they are at or above a moderate strength of agreement.

Table 4.4: Validity of survey practices

ALCOHOL PRACTICE	WEB-BASED SELF-REPORT (N=58) % (n)	OBSERVATION (N=58) % (n)	% AGREEMENT % (n)	Kappa[a] [95% CI]	PABAK[b] [95% CI]	VALIDITY ASSESSMENT
People under 18 years don't service alcohol	100 (58)	98 (57)	98 (57)	0.66 [0.04 to 1.00]	0.97 [0.90-1.00]	Almost perfect
At least one low-alcoholic drink option is available	98 (57)	91 (53)	93 (54)	0.31 [−0.16 to 0.79]	0.86 [0.73-1.00]	Almost perfect
Liquor licence & stat liquor licensing signage displayed at all points of sale	100 (58)	72 (42)	72 (42)	0.08 [-0.07-0.23]	-	Slight
Drunk/intoxicated people not permitted to enter the club	78 (45)	98 (57)	76 (44)	−0.03 [−0.09 to 0.03]	0.52 [0.29-0.74]	Moderate
Drunk/intoxicated people not served alcohol at club	83 (48)	93 (54)	76 (44)	−0.11 [−0.19 to −0.03]	0.52 [0.29-0.74]	Moderate
At least four non-alcoholic drink options are available	85 (49)	91 (53)	76 (44)	−0.12 [−0.20 to −0.05]	0.52 [0.29-0.74]	Moderate
Free water available	91 (53)	81 (47)	79 (46)	0.15 [−0.14 to 0.44]	0.59 [0.37-0.80]	Moderate
No drink promotions that encourage excessive consumption	86 (50)	78 (45)	71 (41)	0.02 [-0.23-0.28]	-	Slight

Drunk/intoxicated people not permitted to remain on the premises	66 (38)	86 (50)	62 (36)	0.02 [-0.20-0.24]	-	Slight
Substantial food is available	38 (22)	100 (58)	38 (22)	0.02 [-0.02-0.06]	-	Slight
Non-alcoholic drinks and low-alcoholic beer are at least 10% cheaper compared to full strength beer	85 (49)	88 (51)	72 (42)	-0.16 [-0.24-0.08]	-	Poor
Bar staff don't consume alcohol whilst on duty	81 (47)	74 (43)	62 (36)	-0.08 [-0.31-0.15]	-	Poor

[a]Prevalence Adjusted and Bias Adjusted Kappa (PABAK) is reported where positive agreement ≥75% or ≤ 25%. [b]Based on Kappa score unless PABAK is reported. CI, confidence interval.

4.4 DISCUSSION

This is the first study to assess the validity of an online self-report survey to measure the implementation of alcohol management practices by community sports clubs, using direct observation as the gold standard. The findings suggest that club representatives can accurately report the presence of some but not all alcohol management practices using an online survey. Based on these findings, online self-report may provide a means of measuring the prevalence of implementation of such practices, particularly, where on-site observation is not feasible as is the case of population studies and studies conducted in diverse rural and remote locations. The potential exists for the validity of the measures to be improved by enhancements to the manner in which self-reported data are collected online. To improve validity, enhancements to the online survey and collection method may include: the addition of an instructional videos at the beginning of the survey, a review of the definitions for specific questions, having easy to find contact details for content or technical support, having the ability to upload documents as evidence, allowing multiple people to complete the survey.

Similar to comparable studies in other settings, the study reported variability in the validity of items. For example, a study looking at the validation of a survey tool to assess nutrition and physical activity practices in the child-care setting found an agreement rate of 80% or more for just 51% of survey items.[22] Additionally, Wiggers et al.[21] reported over 80% corroboration between self-report and observation for licensed premises for 87% of health promotion initiatives. In such studies, greater validity was reported for items assessing the presence of stable, often environmental characteristics, such as the presence or absence of equipment, fixed signage or practices linked to policy, rather than behavioural practices or practices that were more intermittent (e.g. health promotion information distribution, educator led activities and peer modelling practices). A high level of agreement between survey and observation data was not found in this study for a number of practices such as the availability of substantial food, and beverage pricing. Potentially, such practices may have changed between the period of observation and completion of the survey. Alternatively, in the case of

beverage pricing, it may have been difficult for survey participants to accurately calculate the percentage price difference between alcoholic and non-alcoholic drinks.

A number of other factors related to the study may have contributed to low levels of agreement between measures for some policies or practices. Although the use of objective observation is seen as the gold standard data collection method, the observation of practice implementation for this study occurred only once throughout the sporting club season. The findings of this study therefore only relate to a single point in time. The extent to which the findings are generalisable across the sporting season is unknown. The use of repeated observations across the sporting season may provide a more robust approach for determining the validity of online self-report.

The study had a number of strengths. The observation process was strengthened by the pre-testing of research staff observation competence using hypothetical observation scenarios, which allowed any likely inaccuracies in recording of practices being resolved prior to the study observation period. Additionally, the use of two research staff during the observation period allowed a more thorough assessment of each club's alcohol management practices. The study provides novel information regarding the validity of the brief online survey to assess evidence-based alcohol management practices in community sporting clubs. The findings suggest that the web-based self-report survey may provide a valid means of assessing club implementation of some but not all alcohol management practices. Furthermore, may be particularly useful for population level monitoring of alcohol management practices of community sports clubs to ensure that they are consistent with recommendations for the reduction of alcohol-related harm. Future research should aim to enhance the validity of the measurement tool items and to replicate this study in other sporting codes to determine the generalisability of the findings to be determined.

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CHAPTER 5

Randomised controlled trial of a web-based programme in sustaining best practice alcohol management practices at community sports clubs: a study protocol

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ABSTRACT

INTRODUCTION

Community-based interventions have been found to effectively increase the implementation of alcohol management practices and reduce excessive alcohol use and alcohol-related harm at sports clubs. However, once implementation support ceases there may be a reduction in such intervention effects. Thus, ongoing contribution to improving the health of the community is diminished; sustaining practice implementation is a key determinant to address this. One possible solution to the strategic and logistical challenges of sustainability involves the use of the web. The primary aim of this study is to assess the effectiveness of a web-based programme in sustaining the implementation of alcohol management practices by community football clubs. The secondary aim is to assess the effectiveness of the programme in preventing excessive alcohol consumption and alcohol-related harm among members of community football clubs.

METHODS AND ANALYSIS

The study will employ a repeat randomised controlled trial design and be conducted in regional and metropolitan areas within two states of Australia. Community level football clubs who are currently accredited with an existing alcohol management programme ('Good Sports') and implementing at least 10 of the 13 core alcohol management practices (eg, not serving alcohol to <18-year-olds) required by the programme will be recruited and randomised to either a web-based sustainability programme or a 'minimal contact' programme. The primary outcome measures are the proportion of football clubs implementing ≥10 of the 13 required alcohol management practices and the mean number of those practices being implemented at 3-year follow-up. Secondary outcomes include: the proportion of club members who report risky drinking at their club, the Alcohol Use Disorder Identification Test (AUDIT) score and mean AUDIT score of

club members. Outcome data will be collected via observation at the club during a 1-day visit to a home game, conducted by trained research assistants at baseline and follow-up.

ETHICS AND DISSEMINATION

The study was approved by The University of Newcastle Human Research Ethics Committee (reference: H-2013-0429). Study findings will be disseminated widely through peer-reviewed publications and conference presentations. (See Appendix 4 for ethics approval)

Trial registration number ACTRN12614000746639; Preresults.

5.1 INTRODUCTION

Excessive use of alcohol is responsible for more than 3 million deaths and over 200 varieties of disease and injuries worldwide each year.[1] One population group that has been identified as consuming excessive amounts of alcohol are those involved with organized sport (both players and supporters), including those at the non-elite/community level.[2–7] Young men, particularly those involved in contact team sports, have been reported to have a high prevalence of excessive alcohol consumption.[3,5,8] Additionally, when compared with people not associated with sport, a greater prevalence of alcohol-related harm has been reported among players and spectators of a range of sports, again, particularly male dominated, team and contact sports.[7,9–11] Alcohol-related harm refers to both the immediate and long-term negative consequences associated with excessive alcohol consumption, such as injury, assaults, accidents and at home abuse, as well as chronic health conditions and some cases of suicide.[1]

Community sports clubs have been cited as an opportune setting to address excessive alcohol use and alcohol-related harm among sportspeople and fans.[12] Evidence from a 2½ year multi-strategic randomised controlled trial of an alcohol management programme (the 'Good Sport' programme) conducted in community sports clubs in Australia found a significant increase in the implementation of

alcohol management practices in intervention clubs (38%) compared with control clubs (25%).[13] The trial also found a significant post-intervention difference in the proportion of intervention club members who engaged in risky alcohol consumption at the club (19%) and in the proportion of members at risk of alcohol-related harm (38%), compared with control club members (risky drinking: 24%; risk of alcohol-related harm: 45%).[14] The intervention included multiple strategies to support clubs in implementing alcohol management practices, including face-to-face and telephone-based support from a dedicated project officer.

The sustainability of improved practice implementation after initial intervention is a key determinant of whether effective programmes can make an ongoing contribution to improving the health of the community.[15,16] However, sustained implementation of effective health promotion programmes is a common challenge across numerous community settings.[15] A review of 17 studies of a variety of community-based health-related programmes in the USA and Canada found that only 29% (n=5) achieved sustainability of implementation of at least one programme component postintervention.[17] No studies conducted within the sports club setting have reported on the sustainability of alcohol management practices. Given the suggested challenges of sustaining programme implementation, particularly when programmes are implemented at scale across large populations and geographic areas, effective and efficient mechanisms for achieving sustained programme implementation and benefit are required.[18] This is most likely true for the community sport setting specifically and by service provider organisations more generally.

One possible solution to the strategic and logistical challenges of programme sustainability in sports and other settings involves the use of web-based programmes to sustain the implementation of programme elements. Web-based programmes have the potential to be delivered at relatively low cost to large numbers of sites across large geographic areas. While web-based programmes have been used to support both implementation and quality improvement initiatives in other settings, such as hospitals, general healthcare[19,20] and

schools,[21–23] there has not been any reports of rigorous evaluations of their effectiveness in maintaining sporting clubs' adherence to alcohol management practices. Given this, a study will be conducted with the primary aim of assessing the effectiveness of a web-based programme in sustaining the implementation of best practice alcohol management practices by community football clubs. The secondary aim is to assess the effectiveness of the programme in preventing excessive alcohol consumption and alcohol-related harm among members of community football clubs.

5.2 METHODS

5.2.1 STUDY DESIGN AND RESEARCH SETTING

The study will employ a repeat cross-sectional randomised controlled trial design (see figure 5.1). Clubs will either be randomised into a 'web-based sustainability program' or an 'ethical minimal contact' control group. The research will occur in Australia, in regional areas of the state of New South Wales (NSW) and throughout metropolitan and regional areas of the state of Victoria.

5.2.2 PARTICIPANT AND RESEARCH ELIGIBILITY

Football Clubs

Non-elite, community-level clubs that currently hold the highest level of accreditation in an alcohol harm-reduction programme ('Good Sports')[24] will be recruited to participate in the trial. Sporting clubs interested in becoming involved in the Good Sports programme, a free nationwide programme, register their details and are required to implement alcohol management practices of increasing comprehensiveness across three levels of accreditation. Level 3 is the highest level of accreditation with the programme. There are currently approximately 2600 level 3 Good Sports clubs in Australia. All clubs participating in this trial will have been involved with the Good Sports programme for a minimum of 5 years to progress to the highest level (level 3) of accreditation.

Football clubs will be eligible to participate in the study if they: have held the highest level of accreditation (level 3) within the Good Sports programme for a minimum of 12 months; adhere to the alcohol management practices required of level 3 Good Sports clubs; are a non-elite community-level football club; are an Australian Football League, Rugby League, Rugby Union or Soccer club; hold a current valid liquor licence; currently sell alcohol; have at least one senior (over 18s) team; and report having access to the internet. The football codes that are eligible to participate in this study are among the most popular organised sports in Australia[25] and people involved with these sports as players or spectators have been identified as particularly at risk of alcohol-related harm relative to other sporting codes.

Football Club Members

Club members will be eligible to participate in the study if they are: current members/affiliates of a participating club (including players, committee members, regular spectators/fans and coaches), at least 18 years of age and speak English.

5.2.3 RECRUITMENT PROCEDURES

Football Clubs

A list of level 3 Good Sports football clubs within the study areas will be generated by the research team from programme records. A club representative (eg, club president, vice president or secretary) from eligible clubs will be sent a study information sheet inviting the club to participate in the study (See Appendix 5 for club representative study information sheet). Two weeks after sending the letter, club representatives will be contacted via telephone to screen the club for eligibility based on the above criteria and assess interest in study participation. If club representatives do not recall receiving the study information sheet, contact details will be confirmed and an additional information sheet will be sent to them either via email or postal mail. Follow-up phone calls will occur until club representatives are able to make informed decisions about their club's

participation in the study. It is envisaged that some clubs may require this decision to be taken to the club management committee. If club representatives are not able to be contacted, alternative contacts will be sought via programme databases, relevant football code association websites and other publicly available forums. Consenting clubs will be asked to complete and sign a consent form and return it to the research team (See Appendix 6 for club consent form). All recruitment procedures will be managed by a dedicated member of the research team.

Football Club Members

At baseline and follow-up a separate independent sample of club members (players, committee members, regular spectators/fans and coaches) will be recruited at club grounds during a senior home game using a pilot-tested, standardised recruitment protocol which will detail specified locations for recruitment within the club grounds (ie, club bar or canteen). A random number sequence will be generated by a computer program and integrated into the data collection tool (See Appendix 7 for Club member data collection protocol). The random number sequence will dictate the order in which members at the grounds are to be approached by the research assistants. These randomly selected members will then be screened for eligibility, and those who are eligible will be provided with a study information sheet and invited to participate in the study (See Appendix 8 for club member study information sheet). Eligible and consenting club members will be asked to provide their contact details to the research staff. This recruitment process will continue until a maximum of 20 members' contact details are collected at each club/game. The 20 club members who agreed to provide contact details will receive a phone call from the research team formally inviting them to participate in the study. This process will occur until five members from each participating club have been enrolled into the study. For recruitment of both clubs and members, strategies previously found to maximise research participation will be used, including pre-notification of the study and opportunity to participate, direct telephone contact with participants to invite participation, multiple contact attempts, access to research staff for

further clarification regarding participation and the use of dedicated, specifically trained research staff to undertake the recruitment process. Such recruitment strategies have been previously used successfully by the research team.[26–28]

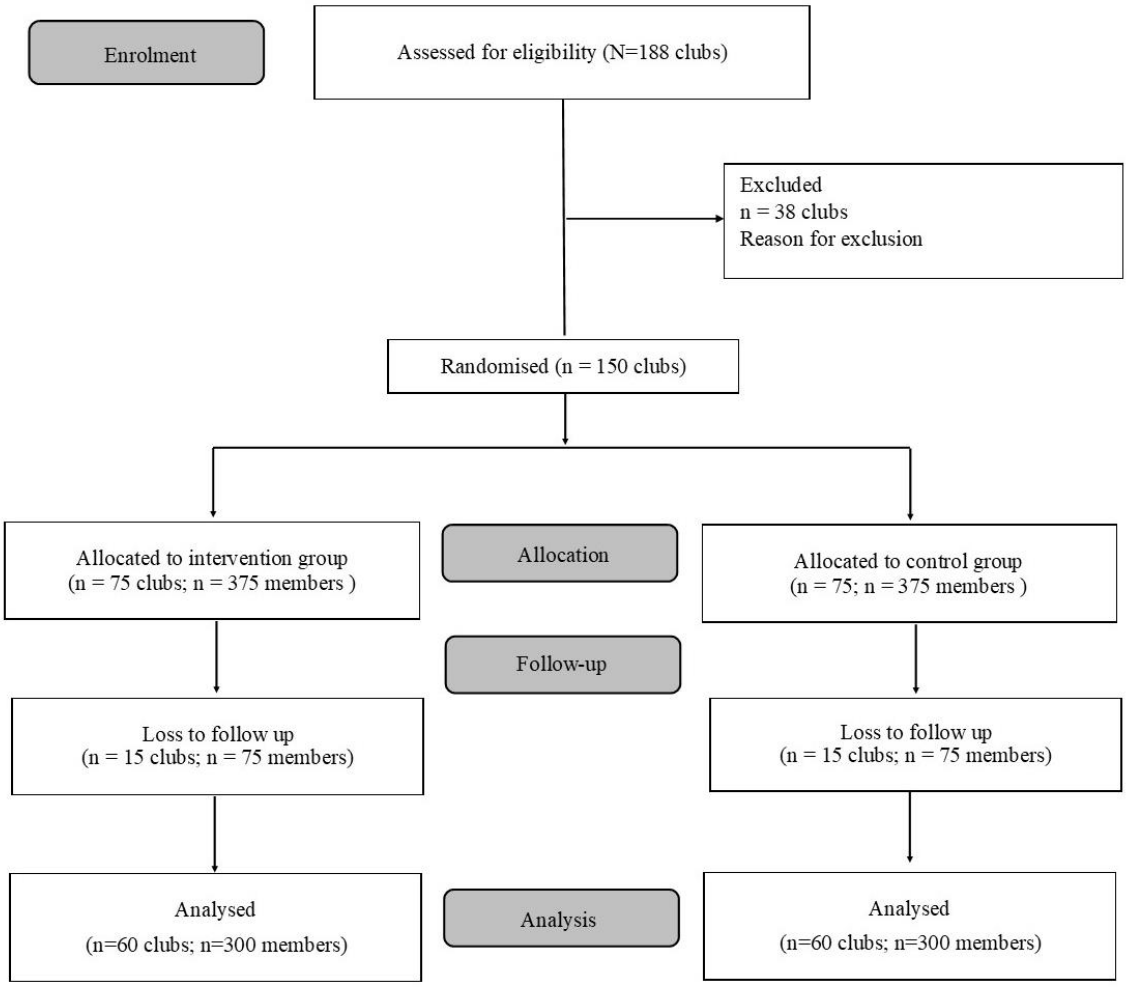

Figure 5.1 Consort flow chart estimating the possible progress of participants through the trial from enrolment to final analysis.

5.2.4 RANDOM ALLOCATION OF SPORTS CLUBS

Clubs will be randomly allocated (after baseline data collection) in a 1:1 ratio to either the intervention or control group by a statistician independent to the research team using a computerised random number function. The randomisation procedure will be stratified by sports code. Research conducted by the research team[14] and others[29] has previously demonstrated an association

between this factor and secondary outcomes related to excessive alcohol consumption and alcohol-related harm. Additionally, due to operational differences between football clubs, the randomisation procedure will also be stratified by state (NSW or Victoria).

5.2.5 BLINDING

Research assistants conducting the field observations for the outcome measures will be blind to group allocation and not be involved in any other aspect of the trial. Effectiveness of research personnel blinding will be tested by asking research assistants to nominate group allocation of clubs following collection of post-intervention data. Additionally, the analysis of primary trial outcomes will be undertaken by a statistician who will be blind to study group allocation through use of and dummy variable for allocation. Due to the difficulty in blinding clubs to group allocation, this will be an open trial with club representatives being told of the treatment status of their club following pre-test data collection.

5.3 INTERVENTION

5.3.1 ALCOHOL MANAGEMENT PRACTICES

Intervention clubs will be supported to maintain the implementation of the alcohol management practices outlined in Table 5.1 via a web-based programme. Each intervention club will be assigned a unique identifier so the research team can track their progress through, and engagement with the programme. The alcohol management practices are consistent with legislation and guidelines regarding the sale and supply of alcohol in licensed premises[30–32] and have been found to be associated with lower levels of alcohol consumption in licensed premises, broadly,[33 34] and community sports clubs, specifically.[35–37]

Table 5.1 Alcohol management practices

Practice
Substantial food provided when alcohol sold.[56]
Non-alcoholic drinks 10% cheaper than full-strength alcoholic drinks.[32–34]
Drunk/intoxicated people not allowed to enter club.[35 36 57]
Low-alcoholic drinks 10% cheaper than full-strength alcoholic drinks.[32 53 58–60]
Four non-alcoholic options available for purchase.[32 53 61]
People under 18 years of age do not serve alcohol.[57]
Drunk/intoxicated people not served alcohol.[35 36 57]
Drunk/intoxicated people not permitted to remain on club premises.[57]
Free water provided when alcohol sold.[53]
Staff do not consume alcohol while on duty.[35 36]
One low-alcoholic drink option available.[32 53 61]
Licensing signs visible at all bars.[35 61]
No drink promotions undertaken at the club (happy hour, all-you-can drink functions, alcohol-only awards and prizes, cheap drinks, drinking games, drinking vouchers/cards).[32 35 36 56 62 63]

5.3.2 WEB-BASED SUSTAINABILITY PROGRAMME

A web-based approach was selected given the capacity for web-based support to be: (1) efficiently delivered to a large number of sports clubs located in a wide geographic area; (2) maintained and updated centrally at relatively low cost; (3) tailored to the needs of individual clubs. Such computer-based interventions have been used to improve and sustain the health-promoting practices of organisations generally.[38] Preliminary unpublished data (2014) collected by the research team suggest that a web-based intervention will be acceptable to sports club representatives as they reported a high level of use of computers and web-based programmes (n=202), 81% reported that club representative tasks were mainly undertaken on computer-based programmes, 62% reported using a web-based programme for the majority of club tasks and 99% indicated that they had a website or social media page.

An expert advisory group consisting of community sports club representatives, health promotion practitioners and experts in community organisational change

and reducing alcohol-related harm associated with licensed premises will develop the programme based on theory[39,40] and evidence.[13] The advisory group will continue to meet via the telephone and face-to-face and undertake programme testing to develop the web-based programme. The web-based programme will only be available to those clubs allocated to the intervention group of the trial, this is not a publicly available web site. It can only be accessed by a personalised login number.

Conceptual model and strategies

A frequently identified limitation of sustainability research has been the lack of conceptual models to guide intervention development.[18,41] To address this, the web-based sustainability programme will be developed based on the Sustainability Framework,[39] which identifies the following domains as being important in sustaining the delivery of programme practices:

- Environmental: having a supportive internal and external climate.
- Organisational capacity: having internal support and resources needed to effectively manage the programme.
- Programme adaptation: taking actions that adapt the programme to ensure its ongoing effectiveness.
- Communications: having strategic communication with stakeholders and the public about the programme.
- Strategic planning: using processes that guide the programme's directions, goals and strategies.
- Programme evaluation: assessing the programme to inform planning and document results.
- Partnership: having connections between the programme and its stakeholders.
- Funding stability: having a consistent financial base for the programme.

Additionally, as the programme will be web based, the Persuasive Systems Design framework[40] will be used to ensure programme usability. This framework

recognizes the importance of the following elements that are relevant to the proposed programme:

- Reduction: system reduces complex behaviour into simple tasks.
- Tunnelling: using the system to guide users through a process or experience provides opportunities to persuade along the way.
- Tailoring: information tailored to the potential needs, interests, personality, usage context or other factors relevant to a user group.
- Personalisation: personalised content.
- Self-monitoring: keeps track of one's own performance or status, supports the user in achieving goals.
- Simulation: provides simulations, links between cause and effect.
- Praise: make users more open to persuasion.
- Rewards: reward targeted behaviour.
- Reminders: remind users of the targeted behaviour.
- Suggestion: offering fitting suggestion for persuasion.

The use of such frameworks in the design of practice change initiatives, particularly those operating at multiple levels of complex systems, has been suggested to be important in facilitating effective practice change.[42]

The programme will include the following functions:

1 Annual online assessment. At the start of each year (sporting season), the club president or a nominated representative from each intervention club (eg, club secretary) will complete an online monitoring assessment. The monitoring assessment will require the club representative to complete a series of questions regarding their club's alcohol management practices (box). The completion of the monitoring report will highlight any practices that clubs are not undertaking. The responses to the annual assessment will be sent to each club committee. (See Appendix 9 for web imagines of the annual online assessment)

2 Action plan. An action plan, individualised for each club, will be generated from the identified incomplete alcohol management practices from the monitoring report. It will contain specific information about such practices, such as why the practice is important, if it is required by legislation and steps to effectively implement the practice. (See Appendix 10 for web images of the online action plan)

3 Tools and resources. From the action plan, clubs will be guided to practise specific tools and resources to support clubs in implementing identified incomplete alcohol management practices. All intervention clubs will have access to all tools and resources via the online intervention programme. (See Appendix 11 for all other website content including tools and resources)

Programme implementation strategies

The programme will be designed to include implementation strategies that address common impediments to organisations sustaining new initiatives or innovations and impediments that are particularly relevant to the volunteer community sport club setting such as high staff turnover, limited resources, lack of time and competing demands.[43–45] Table 5.2 outlines the programme implementation strategies mapped against the domains of the Sustainability Framework and the Persuasive Systems Design framework.

Programme delivery

Programme delivery will occur over three successive Australian winter sporting seasons (April to September 2015–2017). Participating intervention clubs will receive contact from a member of the programme team a maximum of four times via telephone and a maximum of four times via email during each intervention season. Programme implementation completion will occur at the end of the 3-year intervention period with clubs having completed three rounds of annual online assessments and action planning.

Programme quality assurance

User acceptance testing will be undertaken with a sample of representatives from community sporting clubs. Web-based programme testing will occur, with feedback being integrated into the final version of the programme. Ongoing quality assurance checks will be undertaken as clubs engage with the web-based programme. Research staff will perform annual checks on all links to external sites within the intervention site to ensure they remain current, and club logins will be monitored to ensure no barriers to intervention access, such as site blocking or browser issues.

Table 5.2 Intervention implementation strategies and conceptual frameworks

Intervention strategy	Description	The Sustainability Framework construct [49]	Persuasive Systems Design Framework construct [50]
Club champion	• Club champions will hold a role on the club executive (president, vice president, treasure, secretary) • Club champions will be the club representative who will primarily engage with the web-based program on behalf of the club to complete the annual online assessment and action plan.	Environmental support Organisational capacity	
Executive support	• The clubs alcohol management policy will be reaffirmed each year at the club's committee meetings by all executive members, • Results from the club's annual online assessment and action plan will be automatically emailed to all club executive members.	Environmental support, Organisational capacity, Strategic planning	
Targeting interactive intervention	• A tailored action plan will be automatically developed based on responses from the annual online assessment, • All required actions will have links to appropriate list of options/strategies and resources,	Program Adaptation	Tunnelling, Tailoring/personalisation, Self-monitoring

	• Clubs will be able to adjust the suggested completion dates for generated action items (with limits), • Clubs will be able to track their own progress by updating the status of action items (not started / in progress / complete).		
Tailored feedback	• Clubs will receive tailored feedback based on their responses to the annual online assessment and completion of agreed actions. The feedback will occur on the screen of the web-based program immediately after completing the annual online assessment. Email feedback will also be sent in regards to the annual online assessment responses and action plan items generated.	Program Adaptation	Tunnelling, Tailoring/personalisation
Training and support	• An instructional video will be available via the web-based program for club representatives to use, • For any user problems email help options will be available.	Organisational capacity	Ease of use/accessibility
Tools and resources	• Printable instructional materials, sample policies and planning templates will be available via the web-based program	Organisational capacity	Tailoring/personalisation
Systems and prompts	• Email reminders will be automatically sent to: prompt annual online assessment completion and when action plan items due dates are approaching or are overdue.	Environmental	Reminders and prompts, Tailoring/personalisation
Communication and marketing	• An independent nominee (a community stakeholder) will be sent a letter from the program informing them of the club's progress.	Communication, Partnership	Praise, rewards and recognition
Recognition and reward	• Automatic notification and praise via emails will be sent to club champions and club executives when the annual online assessment and action plan is complete. • 'Good News' stories of clubs progressing through the program will be position on the login screen.		Praise, rewards and recognition

5.4 CONTROL GROUP CLUBS

Control group clubs will not have access to the web-based programme or any of the intervention programme resources. Control group clubs will receive minimal programme support throughout the intervention period. This will entail one phone contact occasion initiated by the research team during the 3-year intervention period. Additionally, the research team will provide reactive support, on an as-needs basis in instances where a club seeks support about an alcohol-related incident or concern. The research team will assess each support request to ensure group contamination does not occur and record any additional contact made with clubs.

5.5 MEASURES

5.5.1 PRIMARY OUTCOMES

1 The proportion of clubs implementing ≥10 of the 13 required alcohol management practices (Table 5.1) at follow-up.
2 The mean number of alcohol management practices being implemented at follow-up. Such implementation is consistent with research[46,47] that recognises that the implementation of multiple strategies targeting different aspects of alcohol management (availability, promotion and alcohol service) is more successful in harm minimisation than the implementation of individual strategies.[32,48]

5.5.2 SECONDARY OUTCOMES

1 The proportion of clubs implementing each of the 13 alcohol management practices.
2 The proportion of club members who report drinking alcohol at risky levels at sporting clubs. This outcome is measured by the graduated frequency index,[49] with risky drinking defined as five or more standard drinks of alcohol on one drinking occasion[50] at least once a month at the club.

3 The proportion of club members at risk of alcohol-related harm, as measured by a total Alcohol Use Disorder Identification Test (AUDIT) score of ≥8.51.
4 The mean AUDIT score of club members.

5.5.3 PROCESS DATA

Process data measures will be collected for each intervention club and will include: total time to complete annual report and action plan online, number of logins to complete annual report and action plan, number of tools and resources accessed/downloaded and average number of action items generated.

5.5.4 CLUB CHARACTERISTICS

The following data will be collected on participating sports clubs: number of senior (18 years of age and over) and junior (under 18 years of age) teams and members registered with the club, football code and postcode of sporting club.

5.6 DATA COLLECTION PROCEDURES

5.6.1 PRIMARY OUTCOME

Baseline and follow-up data for the primary trial outcome will be collected by covert field observation of club practices by trained research assistants. Direct observation represents the gold standard when measuring complex environments and organisational behaviours.[52] Observations will occur during a home game at a participating club ground. Participating clubs will not be aware of the exact day that the observation will occur. Given that many clubs have multiple teams, the observation will occur during the most senior game. Observation staff will be trained by the research team and will be required to complete examples of alcohol practice observation scenarios to a satisfactory level. Observers will assess each of the alcohol management practices outlined in Table 5.1 during the field observation. Protocols and methods for such observations have been developed and successfully implemented by the research team during more than

200 observations of sports clubs, hotels and nightclubs as part of previous trials,[53,54] and pilot testing will be conducted with four clubs prior to commencement of data collection to refine the tool.

5.6.2 SECONDARY OUTCOME

Secondary data collection will occur via a Computer Assisted Telephone Interview with club members recruited from the field observations at baseline (2015) and follow-up (2017).

5.6.3 PROCESS DATA

Measures outlined above will be collected via reports generated through the web-based software and Google Analytics. The research team will run reports at the end of the intervention period.

5.6.4 CLUB CHARACTERISTIC DATA

The operational characteristics of clubs, demographics and attitudes of sports club representatives will be collected during a telephone survey with the club representative.

5.6.5 DATA MANAGEMENT

Data management will primarily be the responsibility of a statistician, independent of the research team and trial activities. Management of trial data will be in accordance with a data management protocol, which will be developed for approval by the Project Advisory Group. As a requirement of ethics approval, all data collected for the trial will be securely stored, accessible only to primary researchers and statisticians through the allocation of access rights. Confidential participant data including contact details (eg, phone numbers) will be stored in a secure data set that is not linked to survey response data sets. An independent statistician will be the only person with access to confidential participant data.

5.7 SAMPLE SIZE AND POWER CALCULATIONS

Assuming at follow-up that 70% of clubs in the control group have maintained ≥10 of the 13 required alcohol management practices (box) (ie, the prevalence of adequate practice implementation in the control group falls from 100% at baseline to 70% at follow-up), a sample size of 60 clubs per group will be sufficient to detect an absolute difference of 20% between groups at follow-up (which assumes that the prevalence of clubs in the intervention group that maintain 80% of required practices falls from 100% at baseline to 90% at follow-up) with 80% power and alpha of 0.05.

5.8 STATISTICAL ANALYSIS

5.8.1 PRIMARY OUTCOME

The primary trial outcomes will be assessed by examining group differences at follow-up in the (1) prevalence of clubs maintaining ≥10 of the 13 required alcohol management and (2) the mean number of practices being implemented by clubs. Analysis will be performed in SAS V9.3 statistical software and under an intention-to-treat approach. Dichotomous primary outcomes will be assessed using logistic regression models. Continuous primary outcomes will be assessed using linear regression models. All models will be controlled for baseline outcome values. Sensitivity analysis will be performed to test a range of assumptions for missing data at follow-up as recommended by White et al.[55] Statistical tests will use an alpha of 0.05.

5.9 RESEARCH TRIAL COORDINATION

The trial will be overseen by a Project Advisory Group, which is chaired by one of the chief investigators of the Australia Research Council grant. The group includes representatives from The University of Newcastle, Hunter New England Population Health, the Alcohol and Drug Foundation and Deakin University. A

project team has also been formed to coordinate the implementation of the trial in accordance with the trial protocol. This team consists of staff members of The University of Newcastle, Hunter New England Population Health and the Alcohol and Drug Foundation. Data management is the responsibility of a Hunter New England Population Health statistician, otherwise independent of the research team and trial activities. Management of trial data is in accordance with a data management protocol, developed and approved by the Project Advisory Group.

5.10 Trial discontinuation or modification

There are no predetermined criteria for discontinuing or modifying the trial. While unintended adverse events to trial participants, researchers or other community members are not anticipated, any such events will be forwarded to The University of Newcastle Human Research Ethics Committee (HREC) in accordance with the conditions of ethics approval. Should the research team or HREC consider it appropriate, the trial protocol or procedures may be modified to prevent such harm. Any protocol modification will be communicated through modification of the trial registration listed in the Australian New Zealand Clinical Trials Registry and through publications disseminating trial results.

5.11 DISCUSSION

There is an absence of research evidence with regards to how to sustain alcohol management practices in the sporting club setting. This will be the first randomized controlled trial to measure the effectiveness of a web-based programme in sustaining such practices, in not just the community football club setting but any community setting. The study has a strong design that incorporates computerised random allocation, blinding of data collection personnel and observational data collection methods. In addition, the intervention is based on a strong theoretical framework and research evidence from the sports and other settings. This study will provide clubs in regional and remote geographical locations, who previously had restricted face-to-face

programme support, extensive access to web-based support for the implementation of alcohol management practices. The use of such web-based support may be applicable to other community settings which have wide geographical spread of sites, such as schools and childcare centres. The findings from this study will provide a basis for further research in the field and provide potentially important findings on programme sustainability for both policymakers and those providing health promotion programmes to community sporting groups and community organisations more broadly.

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CHAPTER 6

Sustaining the implementation of alcohol management practices by community sports clubs: a randomised control trial

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ABSTRACT

BACKGROUND

Risky alcohol consumption is responsible for a variety of chronic and acute harms. Individuals involved in organised sport have been identified as one population group who consume risky amounts of alcohol both at the elite and the non-elite level. 'Good Sports', an alcohol management intervention focused on the community sports setting has been successful in addressing risky alcohol use and alcohol-related harm amongst players and sports fans. Sustaining such implementation effects is a common challenge across a variety of community settings. The primary aim of this trial was to assess the effectiveness of a web-based program in sustaining the implementation of best-practice alcohol management practices by community football clubs, relative to usual program care (i.e. control clubs).

METHODS

Non-elite, community football clubs in the Australian states of New South Wales and Victoria, that were participating in an alcohol management program (Good Sports) were recruited for the study. Consenting clubs were randomised into intervention (N = 92) or control (N = 96) groups. A web-based sustainability intervention was delivered to intervention clubs over three consecutive Australian winter sports seasons (April–September 2015–2017). The intervention was designed to support continued (sustained) implementation of alcohol management practices at clubs consistent with the program. Control group clubs received usual support from the national Good Sports Program. Primary outcome data was collected through observational audits of club venues and grounds.

RESULTS

A total of 92 intervention clubs (574 members) and 96 control clubs (612 members) were included in the final analysis. At follow-up, sustained implementation of alcohol management practices was high in both groups and there was no significant difference between intervention or control clubs at follow-up for both the proportion of clubs implementing 10 or more practices (OR 0.53, 95%CI 0.04–7.2; p = 0.63) or for the mean number of practices being implemented (mean difference 0.10, 95%CI -0.23-0.42; p = 0.55). There were also no significant differences between groups on measures of alcohol consumption by club members.

CONCLUSIONS

The findings suggest that sustained implementation of alcohol management practices was high, and similar, between clubs receiving web-based implementation support or usual program support. Trial registration: Australian New Zealand Clinical Trials Registry ACTRN12614000746639. Prospectively registered 14/7/2014.

6.1 INTRODUCTION

Each year there are more than three million deaths and over 200 varieties of disease and injuries worldwide attributable to harmful alcohol use.[1] Individuals involved in organised sport have been identified as one population group who consume risky amounts of alcohol both at the elite and the non-elite level.[2-7] It is well reported that young males and those involved in contact team sports have high levels of risky alcohol consumption.[3,5,8] Additionally, higher levels of alcohol-related harm have been reported among players and spectators of male-dominated, team and contact sports, compared to those not associated with sport.[7,9-11] The community sports setting has been well cited as an opportune setting to effectively implement alcohol management programs which address risky alcohol use and alcohol-related harm amongst players and sports fans.[12] For

example, a randomised controlled trial conducted in community sports clubs in Australia found a significant increase in the implementation of alcohol management practices (e.g. the provision of low-alcohol drink options, sale of substantial food when alcohol is sold and safe transport policies) as part of an alcohol harm reduction program ('Good Sports') in intervention clubs (38%) compared to control clubs (25%).[13] The trial also resulted in a significant decrease in the proportion of intervention club members who engaged in risky alcohol consumption at the club (19%) and were at risk of alcohol-related harm (38%) compared to control club members (risky drinking: 24%; risk of alcohol-related harm: 45%) post-intervention.[14] In Australia, sports clubs are not permitted to sell alcohol without a state or territory specific liquor licence or permit. Liquor licensing requirements differ between each state and territory within Australia, however there are some similarities, including legal drinking age, sale of alcohol to under 18 s and alcohol labelling.[15] To ensure an ongoing contribution to the health of the community, it is important that the implementation of effective interventions are sustained.[16,17] Achieving sustained implementation effects of health promotion programs has been found to be a challenge across a variety of community settings.[18,19] For example, a review of community-based health-related programs in the United States and Canada (N = 17) found that only 29% (n = 5) achieved sustainability of implementation of at least one program component post-intervention for more than 80% of their sites.[19] To date, no studies conducted within the sports club setting have reported data outlining the sustainability of improvements in alcohol management practices. Effective and efficient mechanisms to support sustained program implementation need to be identified, with particular consideration given to the challenges of implementation at scale, across large populations and geographic areas.[20] In the absence of clear guidance from empirical studies on sustainability interventions in this setting,[21] the use of theoretical frameworks can provide a useful guide for development of such interventions. For example, The Sustainability Framework,[22,23] suggests that intervention sustainability can be facilitated through the use of strategies to improve strategic planning, environmental support, organisational capacity, communication, partnership and program

adaptation. The use of web-based programs to support ongoing implementation of program elements is one possible solution to the logistical challenges of program sustainability in sports and other settings. The potential exists for web-based programs to be delivered to large numbers of sporting clubs across large geographic areas at relatively low cost. While the use of web-based programs to support implementation or quality improvement initiatives have been well cited in other settings such as hospitals, general health care,[24,25] and schools,[26-28] there is limited evidence assessing the effectiveness of these programs in supporting sports clubs to maintain adherence to alcohol management practices. The primary aim of this trial was therefore to assess the effectiveness of a web-based program in sustaining the implementation of best-practice alcohol management practices by community football clubs (i.e. intervention clubs), relative to their usual care (i.e. control clubs). A secondary aim of the trial was to assess the impact of the program on alcohol consumption among members of community football clubs.

6.2 METHODS

6.2.1 DESIGN AND SETTING

A randomised controlled trial was conducted with community football clubs within regional areas of New South Wales (NSW), Australia and throughout metropolitan and regional areas of the state of Victoria, Australia. Clubs were either randomised into a 'web-based sustainability program' (i.e. intervention) or a 'minimal contact control' (i.e. control) group.

6.2.2 PARTICIPANT ELIGIBILITY

Football clubs

Non-elite, community-level football clubs that were participating in an alcohol harm-reduction program (Good Sports) were recruited to participate in the trial. Good Sports is a preventative health program in which clubs progress through

three levels of alcohol management accreditation.[29] Football clubs were eligible to participate in the study if they; 1) had held the highest level of accreditation (Level 3) within the Good Sports program for a minimum of 12 months; 2) self-reported the implementing of at least 80% of the alcohol management practices required of Level 3 Good Sports clubs; 3) were a nonelite, community-level football club; 4) were an Australian Football League, Rugby League, Rugby Union or Soccer club; 5) had a current valid liquor licence; 6) sold alcohol; 7) had at least one senior (over 18's) team; and 8) had access to the internet.

Football club members

Current club members or affiliates (including players, committee members, spectators and coaches) of participating sporting clubs, who spoke English and were at least 18 years old, were eligible to participate in data collection for the secondary outcome.

6.2.3 RECRUITMENT PROCEDURES

Football clubs

A list of Level 3 football clubs and executive committee members for each club was generated using Good Sports program records. Study information and participation sheets were sent via postal mail to a club executive member, (e.g. club president, vice president or secretary) of each club (See Appendix 5 for club representative study information sheet). Club representatives were contacted via telephone 2 weeks after the information was sent, to screen the club for eligibility and assess interest in study participation. Contact details were confirmed and new information sheets were sent via email or postal mail where necessary. Follow-up phone calls continued until club representatives were able to make a decision about their club's participation in the study, which would often involve a discussion with the club management committee. If club representatives were unable to be contacted, alternative contacts were sought using program databases, relevant football code association websites and other publicly available forums. Consenting clubs were asked to complete and sign a consent

form and return it to the research team (See Appendix 6 for club consent form). A dedicated member of the research team managed all recruitment procedures.

Football club members

For the purpose of participating in data collection for the secondary outcome, club members were recruited at club grounds during a senior home game using a pilot-tested, standardised recruitment protocol that detailed specified locations (e.g. club bar or main alcohol service area) for recruitment. A different cohort of club members were recruited at baseline and follow-up. A computer program generated a random number sequence and integrated it into the data collection tool (See Appendix 7 for club member data collection protocol). The random number sequence identified the order in which members who walked past recruiters at the grounds were to be approached by the research staff. Research staff would assess eligibility, provide the study information sheet and invite members to participate (See Appendix 8 for club member study information sheet). Research staff collected contact details for eligible and consenting club members and continued until up to 20 club members were collected. Consenting club members were contacted in a random order via a phone call from the research team, formally inviting them to participate in the study. Phone calls continued until at least five members from each participating club completed the study survey.

Random allocation and blinding

After baseline data collection, clubs were randomly allocated to either the intervention or control group by an independent statistician using a computerised random number function in a 1:1 ratio. Stratification by sports code was undertaken as part of the randomisation procedure, as was previously done by the research team[14] and others,[30] to account for the demonstrated association between sports code and outcomes pertaining to risky alcohol consumption and alcohol-related harm. Stratification by state (NSW or Victoria) was also undertaken due to operational differences between football clubs in these jurisdictions. Research assistants who collected trial outcome data via field

observations were blinded to the allocation of clubs to intervention or control groups. The effectiveness of this blinding was tested by asking research assistants to guess the group allocation of clubs following post intervention data collection. Research assistants correctly guessed group allocation for 47% of intervention clubs and 52% of comparison clubs. This was an open trial with club representatives informed of the treatment status of their club following pre-test data collection due to the difficulty in blinding clubs to their allocated group.

6.3 ALCOHOL MANAGEMENT PRACTICES

Intervention clubs were supported to maintain the implementation of the alcohol management practices previously targeted by the club's involvement in the Good Sports Program (Table 6.1). These alcohol management practices are consistent with legislation and guidelines regarding the sale and supply of alcohol in licensed premises[31-34] and have been found to be associated with lower levels of alcohol consumption in licensed premises, broadly,[35,36] and community sports clubs, specifically.[37,38]

Table 6.1 Alcohol management practices

Practice
Substantial food provided when alcohol sold.
Non-alcoholic drinks 10% cheaper than full-strength alcoholic drinks.
Drunk/intoxicated people not allowed to enter club.
Low-alcoholic drinks 10% cheaper than full-strength alcoholic drinks.
Four non-alcoholic options available for purchase.
People under 18 years of age do not serve alcohol.
Drunk/intoxicated people not served alcohol.
Drunk/intoxicated people not permitted to remain on club premises.
Free water provided when alcohol sold.
Staff do not consume alcohol while on duty.
One low-alcoholic drink option available.
Licensing signs visible at all bars.
No drink promotions undertaken at the club (happy hour, all-you-can-drink functions, alcohol-only awards and prizes, cheap drinks, drinking games, drinking vouchers/cards).

6.4 WEB-BASED SUSTAINABILITY INTERVENTION

A web-based sustainability intervention was delivered to intervention clubs over three consecutive Australian winter sports seasons (April–September 2015–2017). An expert advisory group consisting of community sports club representatives, health promotion practitioners, and experts in community organisational change and reducing alcohol-related harm associated with licensed premises, developed the program based on implementation and behaviour change theory[23,39] and evidence.[13] A web-based intervention was selected due to the efficiency it presented in: delivering the program to the large number of sports clubs located across the geographic spread of the two states; the low-cost of maintaining and updating the program centrally; and the flexibility in tailoring the intervention to clubs individual needs. Such computer-based interventions have been used to improve and sustain the health promoting practices of organisations.[40] The intervention was designed based on theoretical frameworks for sustainability (The sustainability framework[22,23]) and behaviour change (The Persuasive Design framework[39]). The intervention strategies are outlined in Table 6.2 and are mapped against the key domains from these conceptual frameworks. A full description of the intervention can be found in the published protocol paper.[41] Each year intervention clubs were supported to undertake an online assessment of club alcohol management practices and online action planning based on identified practice needs. Sports clubs would first engage with the web-based program via an email invitation which was sent to the club champion at the start of each sporting season within the intervention period. The email included a link to log onto the program directly and the club champion could update their details, and those of the club executive. They would then be prompted to complete the club's online assessment. The online assessment generated a club specific action plan. Clubs were required to complete the items on the action plan each sporting season. The club champion had the ability to save and exit the assessment and action plan as needed. These could then be updated and completed at a time which suited the club champion. Each year, the results from the club online assessment and action plan would be sent to all executive

club members. The club champion also had access to a tools and resources tab and frequently asked questions tab to support their progression and completion of the program steps. Intervention clubs were required to complete a new online assessment and action plan each year, regardless of whether they had completed them the previous year or not, and had a maximum of 3 years of web-based intervention access (see Appendices 9-11 for web-based intervention content). A member from the program team contacted intervention clubs up to four times via telephone to prompt and support annual assessment and action plan completion. Clubs also received email prompts for task completion, confirmation emails when they completed the annual assessment and action plans and up to five e-newsletters.

Table 6.2 Intervention implementation strategies and conceptual frameworks

INTERVENTION STRATEGY	DESCRIPTION	THE SUSTAINABILITY FRAMEWORK CONSTRUCT[49]	PERSUASIVE SYSTEMS DESIGN FRAMEWORK CONSTRUCT[50]
Club champion	• Club champions will hold a role on the club executive (president, vice president, treasure, secretary) • Club champions will be the club representative who will primarily engage with the web-based program on behalf of the club to complete the annual online assessment and action plan.	Environmental support Organisational capacity	
Executive support	• The clubs alcohol management policy will be reaffirmed each year at the club's committee meetings by all executive members • Results from the club's annual online assessment and action plan will be automatically emailed to all club executive members	Environmental support Organisational capacity Strategic Planning	
Targeting interactive intervention	• A tailored action plan will be automatically developed based on responses from the annual online assessment • All required actions will have links to appropriate list of options/strategies and resources • Clubs will be able to adjust the suggested completion dates for generated action items (with limits) • Clubs will be able to track their own progress by updating the status of action items (not started / in progress / complete)	Program Adaptation	

INTERVENTION STRATEGY	DESCRIPTION	THE SUSTAINABILITY FRAMEWORK CONSTRUCT[49]	PERSUASIVE SYSTEMS DESIGN FRAMEWORK CONSTRUCT[50]
Tailored Feedback	• Clubs will receive tailored feedback based on their responses to the annual online assessment and completion of agreed actions. The feedback will occur on the screen of the web-based program immediately after completing the annual online assessment. Email feedback will also be sent in regards to the annual online assessment responses and action plan items generated.	Program Adaptation	Tunnelling, Tailoring / personalisation
Training and Support	• An instructional video will be available via the web-based program for club representatives to use • For any user problems email help options will be available	Organisational capacity	Ease of use / accessibility
Tools and Resources	• Printable instructional materials, sample policies and planning templates will be available via the web-based program	Organisational capacity	Tailoring / personalisation
Systems and prompts	• Email reminders will be automatically sent to: prompt annual online assessment completion and when action plan items due dates are approaching or are overdue.	Environmental	Reminders and prompts, Tailoring / personalisation
Communication and market	• An independent nominee (a community stakeholder) will be sent a letter from the program informing them of the club's progress.	Communication Partnership	Praise, rewards and recognition
Recognition and reward	• Automatic notification and praise via emails will be sent to club champions and club executives when the annual online assessment and action plan is complete. • 'Good News' stories of clubs progressing through the program will be position on the login screen		Praise, rewards and recognition

6.5 CONTROL GROUP CLUBS

Control group clubs did not have access to the web-based program or any of the web-based resources. Control clubs received usual support provided to clubs accredited as Level 3 clubs with the Australian Drug Foundation's Good Sports program[29] which consisted of one phone contact initiated during the 2016 sporting season of the intervention period. Reactive support was provided on an as-needs basis in instances where a club made contact for further support about an alcohol-related incident or concern.

6.6 DATA COLLECTION PROCEDURES

6.6.1 CLUB AND CLUB MEMBER CHARACTERISTIC DATA

The operational characteristics of clubs and demographics of sports club members were collected during a telephone survey using items used in previous trials in this setting conducted by the research team.

6.6.2 IMPLEMENTATION OF ALCOHOL MANAGEMENT PRACTICES

Club implementation of alcohol management practices was collected via gold standard field observation[42] at baseline (April – August 2015) and follow-up (May – July 2017) by trained research assistants. Research assistants undertook 1-day training sessions facilitated by the research team and were required to successfully complete simulated scenarios of alcohol observation practice prior to undertaking the field observations (See Appendix 12 for research assistant training manual). The scenarios were a combination of images of potential sports club settings and interactions with members of the research team playing the role of club staff. At the completion of the scenarios, the research team conducted a group consensus process where all research assistants went through their responses, and any discrepancies were discussed, and correct responses were identified. The field observations occurred at a participating clubs home ground during a senior game. Clubs were not informed of the exact date of the observation

visit. Two research assistants undertook the observation at each club, conducting their observations of alcohol management practices independently and comparing complete observation reports at the end of the visit. Upon completion of the observation visit any discrepancies were discussed. If consensus was needed to be reached, research assistants were instructed to check objective observation evidence for alcohol management practices, such as, visible licensing signs at the bar or identifying drunk/intoxicated person who was allowed to remain on club premises. If consensus could not be reached due to the objective evidence being no longer available to observe (ie dunk/intoxicated person had left the premises after the game), research assistants were instructed to record the practice outcome in accordance with the item being observed. Protocols and methods for such observations have been successfully implemented by the research team during more than 200 observations of sports club, hotels and night-clubs as part of previous trials.[43,44] Pilot testing was conducted with four clubs prior to commencement of baseline data collection to refine the tool (See Appendix 13 for data collection tool for observation visit).

6.6.3 RISKY CONSUMPTION AND ALCOHOL RELATED HARM

Alcohol consumption at the club was collected via a Computer Assisted Telephone Interview (CATI) with a repeat cross-sectional sample of club members recruited from the field observations at baseline (2015) and follow-up (2017). (See Appendix 14 for club member CATI survey script)

6.6.4 INTERVENTION USE

Intervention club use and engagement with the intervention website was collected via reports generated through a web-based software system.

6.7 MEASURES

6.7.1 CLUB AND CLUB MEMBER CHARACTERISTICS

Club representatives provided data on; number of senior (18 years of age and over) and junior (under 18 years of age) teams and members registered with the club, football code and postcode of the club. Club members provided information on their role/association with the club, age, gender, education and income.

6.7.2 CLUB IMPLEMENTATION OF ALCOHOL MANAGEMENT PRACTICE

The primary outcomes of the trial were:

1 The proportion of clubs maintaining the implementation of ≥10 of the 13 required alcohol management practices (Table 6.1). The target of more than 10 practices was selected as it represents approximately 80% or more of intervention practices, a benchmark suggested as more appropriate for assessing implementation fidelity, and which has been applied in other implementation studies.[45,46] Perfect implementation is considered unrealistic in real world implementation contexts.[47]
2 The mean number of alcohol management practices implemented at follow up, assessed through direct observation at sporting clubs during game days. The proportion of clubs implementing each of the 13 individual alcohol management practices were included as secondary implementation outcomes. This outcome was not prospectively registered but was included in the published protocol submitted prior to follow up data collection.

6.7.3 RISKY CONSUMPTION AND ALCOHOL RELATED HARM

Secondary outcomes also included:

1 The proportion of club members who reported drinking alcohol at risky levels at sporting clubs as measured by the graduated frequency index [48]. Risky drinking was defined as five or more standard drinks of alcohol on one

drinking occasion at least once a month at the club. Five or more drinks were chosen as the cut off as National Health and Medical Research Council Australian Drinking guidelines for the reduction of harm from alcohol consumed on a single occasion recommend drinking no more than four standard drinks on a single drinking occasion.[49]

2 The proportion of club members who reported being at-risk of alcohol-related harm, as measured by a total Alcohol Use Disorder Identification Test (AUDIT) score of ≥8;[50] and,

3 Mean AUDIT score of club members. This outcome was not prospectively registered but was included in the published protocol submitted prior to follow up data collection.

6.7.4 INTERVENTION USE

Measures used to describe club intervention engagement include the proportion of intervention group clubs that; logged into the intervention site per season; completed the annual assessment per season and completed or partially completed the club specific action plan per season.

6.7.5 SAMPLE SIZE CALCULATIONS

Assuming at follow-up that 70% of clubs in the control group maintained 80% of the required alcohol management practices (Table 6.1); that is, the prevalence of adequate practice implementation in the control group would fall from 100% at baseline to 70% at follow-up, a sample size of 60 clubs per group was calculated to be sufficient to detect an absolute difference of 20% between groups at follow-up, with 80% power and alpha of 0.05, as well as detecting a difference of 51.6% of a standard deviation in the mean number of practices required.

6.8 STATISTICAL ANALYSIS

Analyses were performed under an intention to treat approach using the statistical software SAS v9.3. The primary trial outcomes were assessed by

examining between group differences at follow-up in the: 1) prevalence of clubs maintaining ≥10 of the 13 required alcohol management practices and 2) the mean number of practices being implemented by clubs. Individual practice implementation outcomes were also assessed for between group differences in prevalence at follow-up. For dichotomous outcomes, the difference between the groups was assessed using multiple logistic regression models. For continuous outcomes, differences between groups were assessed using multiple linear regression models. The analyses of each primary and secondary trial outcome controlled for baseline outcome values. Outcome analysis was first performed using complete case analysis, using all available data without imputation. Analyses were also performed using multiple imputation methods, imputing data for any individual practice that was missing for clubs at baseline or follow-up (e.g. practices that assessors did not record) or, imputing all practice data for clubs missing or ineligible at follow-up. Additionally, and for exploratory reasons we completed a per-protocol analyses on the primary outcomes where the effects of the intervention were compared among intervention clubs that received a full intervention dose (i.e. generated and completed an action plan for all three intervention years) compared with those that did not. The per-protocol analyses was not pre-registered. Statistical tests were two tailed and with an alpha of 0.05. Mixed effect logistic regression models were used on dichotomous member level outcomes to measure the difference between group risky alcohol consumption and related harm. A linear mixed effect regression model was be used to assess difference between the continuous member level outcome. Multiple imputation was also performed on member level outcomes of alcohol consumption. If a club had no follow-up data or insufficient (under 5) member data, then artificial members were generated, and multiple imputation was then performed on the member level outcomes through the multiple imputation procedure (MI) in SAS. Exploratory per-protocol analyses was also undertaken on member level outcomes to describe differences in measures among members of the intervention group of clubs that had received a full dose of the intervention with those that had not. This analysis was not pre-specified.

6.9 RESULTS

6.9.1 CLUB RECRUITMENT AND CHARACTERISTICS

Two hundred and sixty-seven clubs were identified and contacted within the study area. Of those, 230 were eligible and 188 consented and provided baseline data (Fig. 6.1). The primary reason for ineligibility was that clubs were no longer selling alcohol. Consenting clubs did not differ from non-consenting clubs in terms of football code [$\chi 2 = 6.71$; (df) = 4; $p = 0.15$] and geographical location [$\chi 2 = 1.10$; $df = 1$; $p = 0.29$]. Consenting clubs were randomised into intervention (N = 92) or control (N = 96) groups. There was minimal variance between groups in baseline characteristics of clubs and club members as outlined in Table 6.3. The majority of clubs in both groups were from the Australian Rules football code, located in major cities and classified as small clubs. Follow-up data collection was completed on 178 clubs (83 intervention; 95 control). Five clubs were found to be no longer eligible to participate in the trial as they were not selling alcohol and five withdrew from the study. Of the 10 clubs that did not complete follow-up data collection, 4 were soccer clubs (3 intervention, 1 control), 3 were rugby league clubs (all intervention) and 3 were AFL clubs (all intervention), and, 5 of the 10 were from a major city (4 intervention, 1 control), and 5 of the 10 were classified as small clubs (all intervention). Where data was imputed, there were 92 intervention clubs and 96 control clubs (Table 6.3).

6.9.2 CLUB MEMBER RECRUITMENT AND CHARACTERISTICS

During the baseline observation period, 4613 people were randomly selected and approached at the sports club ground, of which 2360 provided their contact details. Of those members that provided contact details: 71 were further assessed during the survey to be ineligible (i.e. they were not a current member or supporter of the club); 136 declined to participate in the survey; 708 were uncontactable and 439 were not contacted as the number of completions per club had already been reached. The remaining 1006 members completed the baseline

survey (Fig. 6.1). At baseline club members from both intervention and control clubs were a mean age of 47 years and the majority identified as non-playing member or supporters and were male as outlined in Table 6.3. Where data was imputed, there were 574 members from intervention clubs and 612 members from control clubs.

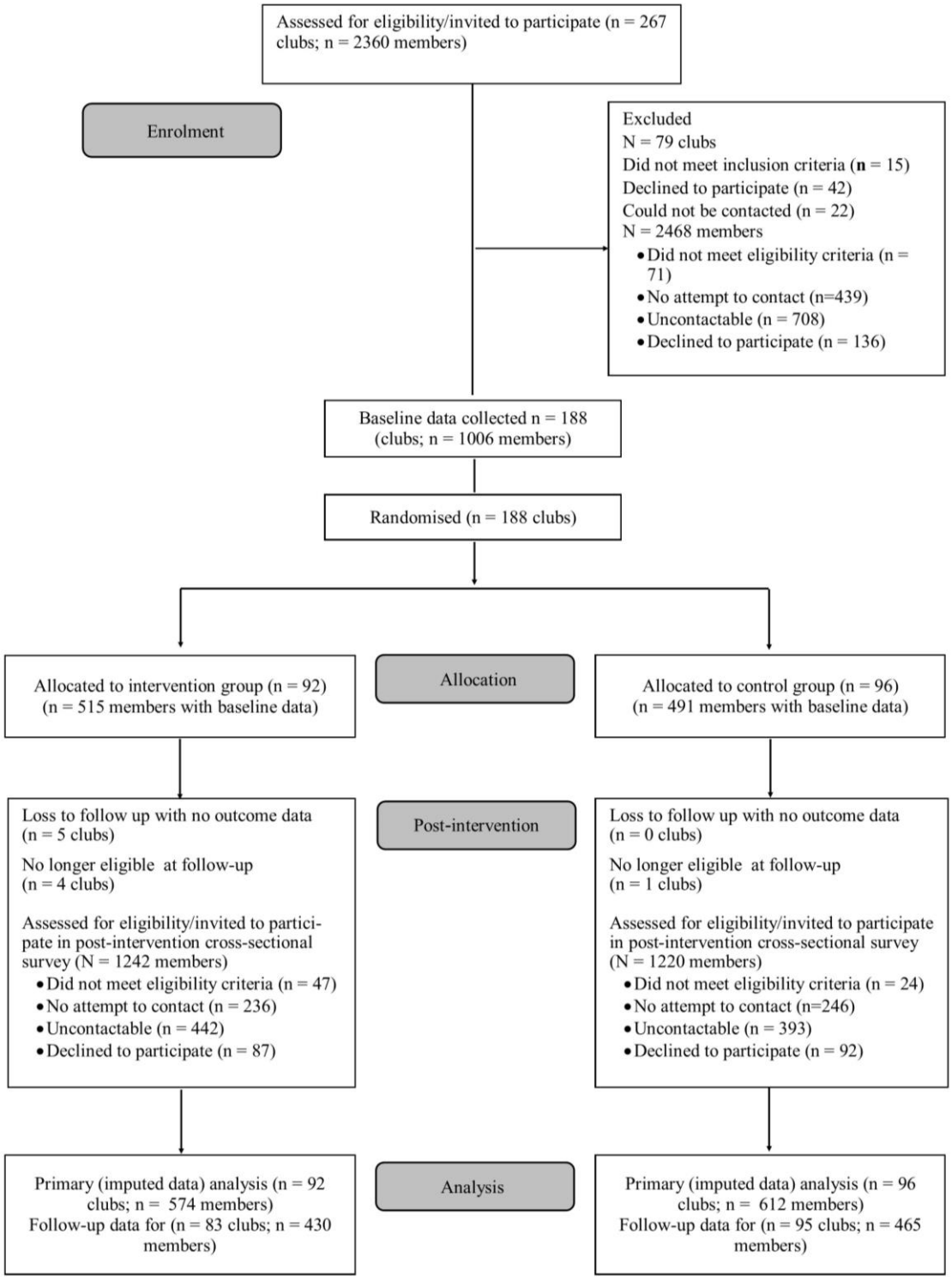

Figure 6.1 Participant flow according to CONSORT reporting requirements for randomised trials

Table 6.3 Baseline characteristics

Characteristics	Intervention	Control
Clubs	N=92	N=96
Football code		
Australian Rules	70%	68%
Rugby League	10%	6%
Rugby Union	4%	6%
Soccer/association football	16%	20%
Geographical region		
Major city	64%	51%
Inner/outer regional	36%	49%
Club size		
Small (≤ 160 players)	56%	55%
Large (>160 players)	44%	45%
Club members who participated in baseline survey	N=515	N=491
Club role/association		
Player	17%	17%
Non playing member (supporter)	57%	61%
Club committee member	23%	21%
Coach/Umpire/referee	10%	9%
Other	22%	20%
Age of members		
Mean (SD)	47 (14.01)	47 (14.33)
Gender		
Male	71%	70%
Education		
University level	27%	29%
Income		
More than AU$52 000	59%	60%

6.9.3 CLUB IMPLEMENTATION OF ALCOHOL MANAGEMENT PRACTICES

The primary outcomes for the trial are outlined in Table 6.4. For multiple imputation analysis there was no significant difference between intervention or control clubs at follow-up for both the proportion of clubs implementing 10 or more practices (OR 0.53, 95%CI 0.04–7.2; p = 0.63) or for the mean number of practices being implemented (mean difference 0.10, 95%CI -0.23- 0.42; p = 0.55). There was also no difference found for complete case analysis at follow-up (p=0.39 and p=0.63 respectively). Among intervention clubs there were no

significant differences identified between those clubs which received a full intervention dose (N=6) and those which did not, in the proportion of clubs implementing 10 or more practices (OR 0.47, 95%CI 0.07-∞; p = 1) or for the mean number of practices being implemented (mean difference 0.73, 95%CI-0.36-1.83; p = 0.19) as part of the per-protocol analyses.

Table 6.4 Club implementation of alcohol management practice

	Intervention		**Control**		**Complete cases N=178**		**Multiple imputation N=188**	
Measures	*Baseline N=92*	*Follow-up N=83*	*Baseline N=96*	*Follow-up N=95*	*OR [95%CI]*	*p-value*	*OR [95%CI]*	*p-value*
10 or more practices *% (n)*	89.1% (82)	95.2% (79)	86.5% (83)	91.6% (87)	1.73 [0.50,6.03]	0.39	0.53 (0.04,7.20)	0.63
					Mean difference [95%CI]	*p-value*	*Mean difference [95%CI]*	*p-value*
Mean number of practices *Mean (SD)*	11.2 (1.54)	11.6 (1.37)	11.2 (1.59)	11.4 (1.30)	0.09 [-0.29,0.47]	0.63	0.10 (-0.23,0.42)	0.55

6.9.4 IMPLEMENTATION OF INDIVIDUAL ALCOHOL MANAGEMENT PRACTICES

Table 6.5 reports the individual practices implemented at baseline and follow-up by trial groups. There were no significant differences between groups in the implementation of any of the targeted individual practices at follow-up. However, two practices (low-alcoholic drinks 10% cheaper than full strength alcoholic drinks and free water provided when alcohol sold) were approaching significance (p = 0.06).

Table 6.5 Individual practice implementation

	Intervention		Control			
	Baseline	Follow-up	Baseline	Follow-up		
	N = 92	N = 83	N = 96	N = 95		
Practice	%(n)	%(n)	%(n)	%(n)	**OR [95%CI]**	**p-value**
One low-alcohol drink option available	84 (78)	81 (77)	77 (74)	77 (64)	0.54 [0.24,1.24]	0.15
Four non-alcoholic options available	93 (85)	95 (90)	95% (91)	92 (77)	0.75 [0.22,2.60]	0.65
Low-alcoholic drinks 10% cheaper than full strength alcoholic drinks	89 (70)*	91 (59)*	92 (71)*	83 (65)*	8.02 [0.92,69.55]	0.06
Non-alcoholic drinks 10% cheaper than full strength alcoholic drinks	98 (83)*	100 (81)*	100 (92)	100 (92)*	-	-
Substantial food is provided when alcohol sold	100 (92)	100 (80)*	99 (95)	99 (87)*	0.92 [0.05,∞]	1.00
Drunk/intoxicated people not permitted to remain on club premises	87 (80)	94(78)	88 (84)	98 (93)	0.33 [0.06,1.73]	0.19
Drunk/intoxicated people not allowed to enter club	98 (90)	98 (81)	96 (92)	100 (95)	0.36 [0-3,08]	0.44
Drunk/intoxicated people not served alcohol	90 (83)	95 (79)	92 (88)	100 (95)	0.17 [0.00,1.00]	0.10
Bar servers do not consume alcohol while on duty	75 (69)	95 (78)	86 (83)	93 (88)	1.78 [0.49,6.48]	0.38

6.9.5 RISKY CONSUMPTION AND ALCOHOL RELATED HARM

For both complete case and multiple imputation analytical approaches, there were no significant differences between groups on measures of alcohol consumption by members (Table 6.6). The odds of members from intervention clubs, relative to control clubs, drinking at risky levels at follow-up, ranged from 0.65–0.71, an effect which approached significance. There were no significant differences between members (N=34) of intervention clubs that received a full dose of the intervention (N=6) compared to those clubs which did not for any of the member outcomes (Graduated Frequency Index p = 0.20 and 0.37 respectively and Alcohol AUDIT p = 0.88 and 0.86 respectively).

Table 6.6 Risky alcohol consumption and related harm

	Intervention club members		Control club members		Complete Cases [N=1901]		Multiple Imputations [N=2192]	
	Baseline (N=515)	*Follow-up* (N=430)	*Baseline* (N= 491)	*Follow-up* (N=465)	**OR [95% CI]**	**p-value**	**OR [95% CI]**	**p-value**
Graduated frequency Index								
Risky drinking at the club at least once a month within the last 3 months (5 or more drinks)					0.65		0.71	
% (n)	28 (147)	20 (87)	22 (107)	21 (98)	[0.41,1.02]	0.06	[0.45,1.10]	0.13
Risky drinking at the club on at least one occasion in the last 3 months (5 or more drinks)					0.93		0.98	
% (n)	47 (243)	38 (164)	43 (212)	36 (166)	[0.63,1.37]	0.72	[0.67,1.44]	0.92
Alcohol AUDIT								
Risk of alcohol related harm (score >= 8)					1.07		1.12	
% (n)	31 (160)	32 (138)	28 (139)	28 (128)	[0.71,1.61]	0.73	[0.75,1.67]	0.57
Mean AUDIT score	6.22 (4.38)	6.18 (4.20)	5.69 (3.78)	5.73 (4.06)	-0.09	0.81	-0.04	0.91
Mean (SD)					[-0.84,0.65]		[-0.75,0.67]	

6.9.6 INTERVENTION ENGAGEMENT

During the first year of the intervention (2015), 91 (99%) intervention clubs had logged into the web-based program (Table 6.7). Of those, 78 (85%) completed the annual online assessment. Eight (10%) clubs completed their action plan which was generated from the completed online assessment, and 21 clubs (27%) partially completed their action plan.

In 2016, 81 (88%) intervention clubs logged into the web-based program. Of those, 72 (88%) completed the annual online assessment. Fifty-four (75%) completed their action plan and 11 clubs (15%) partially completed their action plan.

In the final year of intervention (2017) 74 (80%) intervention clubs logged into the web-based program. Of those, 60 (81%) completed the annual online assessment. One club complied with 100% of practices and therefore did not generate an action plan. Of the remaining clubs, 44 (73%) completed their action plan, with 1 (6%) partially completing their action plan.

Table 6.7 Intervention club (N=92) engagement with web-based program over the 3 year intervention period

Intervention year	Logged into web program % (n)	Completed annual assessment % (n)	Completed action plan % (n)	Partially completed action plan % (n)
2015 (N=92)	99 (91)	85 (78)	10 (8)	27 (21)
2016 (N=92)	88 (81)	88 (72)	75 (54)	15 (11)
2017 (N=87)	80 (74)	81 (60)	73 (44)	1 (6)

6.10 DISCUSSION

This large randomised controlled trial is the first to test the impact of a web-based intervention to support the sustained implementation of best-practice alcohol

management practices by community sporting clubs. The trial found that practice implementation was sustained over time in both intervention and comparison groups. While there was the suggestion (p = 0.06) that risky consumption of alcohol use may have been reduced among members of the intervention, relative to control clubs, there was no significant effect on measures of alcohol intake. The findings provide important information for policy makers and practitioners interested in supporting sustained improvement in alcohol managements in community sporting clubs. Within both the intervention and control groups there was no attenuation in the implementation of the individual alcohol practices targeted by the intervention. More than 90% of clubs in both groups were meeting more than 10 alcohol practices at follow up. The findings suggest that the implementation support received by intervention or control clubs is sufficient to sustain practice implementation. These conclusions are surprising, as evidence from systematic reviews indicate that sustained implementation is uncommon across a variety of health and community settings[18,19] Further, in sporting clubs in particular, significant decay in implementation was expected given the volunteer and transient nature of sporting club officials, the lack of clear governance structures within these organisation and their considerable resource constraints.[51-53] While it is unclear whether and by how much implementation would have eroded had clubs in the control group received no implementation support (rather than usual support provide by the Good Sports program), the findings suggest that once clubs attain high levels of practice implementation, the web-based or usual model of implementation support to maintain such practices is sufficient. The requirement of clubs to progress slowly through each level of the program, taking up to 5 years to reach level three, and the requirement for ongoing accreditation may have been important determinants in the sustained implementation in both groups.

There was a non-significant difference in risky drinking between members of intervention, relative to control clubs at follow-up. The effect size reported on the outcome, however, is similar to that reported in an earlier efficacy trial of the Good Sport program[14] where clubs that had no previous exposure to the program were

recruited. There was no difference between groups for other alcohol related harm outcomes where overall mean AUDIT score and risk of alcohol related harm was low at baseline and found to be sustained at follow-up for both groups.

The current study should be considered within the context of its strengths and limitations. Strengths of the study include the randomised controlled design, blinding of outcome assessors, objective collection methods of outcome measures and large sample size. While study attrition was low overall, more intervention than control clubs were lost to follow-up or were ineligible (Intervention clubs n = 9; control clubs n = 1). One limitation of the study includes the decline in intervention engagement over the 3-year period. There was a 19% drop in clubs logging into the web portal across the 3 years, and a 4% drop in completed annual assessments. This may have reduced the opportunity for an intervention effect. Strategies to increase sustained engagement of clubs with web-based interventions may improve the effects of future trials.

6.11 CONCLUSIONS

The study found high rates of sustained program implementation in both the web-based intervention and usual care comparison group. Such findings suggest that once implementation is achieved, high levels of implementation are sustained following either usual or web-based support. Given these findings, further research regarding the economic and financial benefits of providing sustainability support by the web is considered to be warranted to aid policy and practice decision-making.

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CHAPTER 7

Thesis findings and implications for future research

7.1 INTRODUCTION

This chapter provides an overview of the key findings of the studies undertaken to address the thesis aims and concludes with a consideration of the implications of the study findings for research.

The aims of the thesis were:

1. To review the effectiveness of implementation strategies in sustaining improvements in public health program sustainability (Chapter 2).
2. To assess community sports clubs' perceptions regarding the usefulness, ease of use and intentions to use a web-based program to support the sustainability of club implementation of alcohol management policies (Chapter 3).
3. To assess the validity of web-based self-report of alcohol management practices in community football clubs (Chapter 4).
4. To assess the effectiveness of a web-based program in supporting community sports clubs to sustain the implementation of alcohol management practices (Chapter 5, 6).

CHAPTER 1: THESIS INTRODUCTION

Chapter 1 involved a summary of reported evidence regarding three key themes: 1) the burden of alcohol consumption and alcohol-related harm and the associations with the sports club setting; 2) interventions to reduce such harms in sports club settings and to improve the routine implementation of effective interventions by such settings; and 3) evidence regarding the sustainability of alcohol harm reduction programs in the sports club setting.

Section 1 of Chapter 1 outlined the harms caused by alcohol misuse to both the user and to others, and the burden associated with such misuse. The research evidence demonstrated that worldwide there is a higher prevalence of risky alcohol consumption among males, and individuals who participate in sport, compared to the general population.

Section 2 of Chapter 1 identified that rigorous evaluations of the effectiveness of alcohol management interventions have found that such interventions were effective in reducing excessive alcohol consumption and related harms in the sports club setting.

Section 2 further identified that systematic review evidence supported the effectiveness of interventions in improving the implementation in sports club settings of policies and practices aimed at reducing chronic disease risk behaviours (nutrition and excessive alcohol consumption).

The third and final section of Chapter 1 identified, through a summary of systematic review evidence, the challenges to sustained implementation of effective interventions and programs over time, and the need for strategies to ensure such sustained implementation if the intended benefits of effective interventions are to be achieved. Limited evidence regarding the sustainability of implementation of public health interventions in community settings was identified, with no such evidence from trials conducted in the sports club setting.

The chapter concluded with a summary of evidence regarding the potential of web-based strategies to support the sustained implementation of interventions generally, and in sports club settings in particular. An absence of evidence was identified regarding whether such a web-based approach would be acceptable or feasible in the sports clubs setting. As well as, whether it would be effective in supporting the sustained implementation of health promotion practices generally, and alcohol harm reduction practices specifically, by sports clubs.

CHAPTER 2: EFFECTIVENESS OF STRATEGIES IN SUSTAINING THE IMPLEMENTATION OF PUBLIC HEALTH PROGRAMS

The aim of Chapter 2 was to assess the effectiveness of implementation strategies in sustaining improved implementation of non-communicable disease prevention policies or practices in community settings. The Chapter synthesised the findings of four separate published reviews of the sustainability of public health interventions (N=108 studies). The synthesis found no significant effects on the

sustainability of intervention implementation for any outcomes. Further, no studies were identified that included long-term follow-up (at least three months post intervention) in either community settings generally, or in the community sports club setting specifically. A number of case studies have however suggested that sustained implementation of public health programs is able to be achieved. It was concluded that further rigorous research is required to identify the factors for such success, and to assess the effectiveness of strategies for achieving such an outcome.

CHAPTER 3: THE FEASIBILITY AND ACCEPTABILITY OF A WEB-BASED ALCOHOL MANAGEMENT INTERVENTION IN COMMUNITY SPORTS CLUBS: A CROSS-SECTIONAL STUDY

Chapter 3 assessed the feasibility and acceptability of the potential for a web-based strategy to support sports clubs to implement alcohol harm reduction policies and practices. The study was conducted with sports clubs participating in an existing evidence-based alcohol harm reduction program in Australia (Good Sports). Support for the implementation of the program by sports clubs at the time was provided on a face-to-face basis. A more efficient mechanism for providing such support was needed given the large number of clubs implementing the program (>7,000 clubs).

One potential option for addressing this need was the provision of support for program implementation through the use of the web. No studies that reported the feasibility and acceptability of such an approach in the sports club setting were identified in the literature. To address this evidence gap, a study was undertaken to identify: 1) the current access to and use of the web and electronic devices by sports clubs; 2) the perceived usefulness, ease of use, and intention to use a web-based program to support the ongoing implementation of alcohol management policies by sports clubs; 3) the factors associated with intention to use such a web-based support program; and 4) the specific features of such a program that sports clubs would find useful.

A cross-sectional survey was undertaken with club administrators of community football clubs in the state of New South Wales, Australia. Perceived usefulness, ease of use and intention to use a hypothetical web-based alcohol management support program was assessed using the validated Technology Acceptance Model (TAM) instrument. Of the 73 football clubs that were approached to participate in the study, 46 were eligible and completed the survey. All participants reported having access to the web and 98% reported current use of electronic devices (e.g. computers, iPads/tablets, smartphones). Mean scores (out of seven) for the TAM constructs exceeded six for intention to use, perceived ease of use, and perceived usefulness. Intention to use a web-based alcohol management program was significantly associated with perceived ease of use and perceived usefulness. Although club administrators found a web-based solution to be both feasible and acceptable, the extent to which such intention translated into actual use was unknown. It was also unknown whether such a program was effective in supporting the sustained implementation of an alcohol management program by sports clubs.

CHAPTER 4: ALCOHOL MANAGEMENT PRACTICES IN COMMUNITY SPORTING CLUBS: VALIDATION OF ONLINE SELF-REPORTING

To monitor and evaluate program implementation accurately it is important to have valid and reliable tools to do so. A review of the literature identified limited evidence regarding validated measures of the implementation of alcohol management programs or practices in community settings generally, with none identified in the sports club setting. To address this evidence gap, a study was undertaken (Chapter 4) to determine the validity of web-based self-report of the implementation of alcohol management practices by community football clubs. The study employed a cross-sectional design and was conducted with community football clubs in the states of Victoria and New South Wales, Australia. Implementation of alcohol management practices was collected via an online survey completed by a club representative and validated by observational data collected by independent research assistants. The online survey involved 12

items, including the sale and availability of alcoholic and non-alcoholic beverages, provision of substantial food, restrictions on drink promotions and games, and drunk or intoxicated people not-permitted service or entry to clubs. Percent agreement and Kappa statistics were used to assess agreement between the self-report and observational measures. Data were collected for 58 football clubs. Nine of the 12 survey items had more than 70% agreement. Of the 12 items, six were assessed as having moderate or almost perfect validity assessment, four with slight agreement, with two items being assessed to have a poor validity assessment. The findings of the study suggested that club representatives were able to accurately report the occurrence of some alcohol management practices using an online survey and that further research is required to improve and confirm the validity of web-based self-report of alcohol management practice implementation.

CHAPTER 5: A RANDOMISED CONTROLLED TRIAL OF A WEB-BASED PROGRAM TO SUSTAIN BEST-PRACTICE ALCOHOL MANAGEMENT PRACTICES BY COMMUNITY SPORTS CLUBS – STUDY PROTOCOL

Community based programs have been reported to be effective in increasing the implementation of alcohol management practices and reduce excessive alcohol use and related harms at sports clubs. However, once implementation support ceases, there is a risk that practice implementation may reduce, constraining the intended public health benefits of the program. To address this risk, Chapter 5 described the design of a trial that aimed to determine the effectiveness of a web-based intervention to support sports clubs to sustain their implementation of alcohol management practices over time.

The proposed study involved a randomised controlled trial design to be conducted in regional and metropolitan areas in two states of Australia (New South Wales and Victoria). Community level football clubs that were accredited with an existing alcohol management program (Good Sports) and were implementing at least 10 of the program's 13 core alcohol management practices were recruited and randomised to either a web-based sustainability program or

a minimal contact program (a one off face-to-face visit or telephone call during the trial period). The web-based sustainability intervention was to be delivered to intervention group clubs over three consecutive Australian winter sports seasons.

The proposed primary outcome measures were the proportion of football clubs implementing ≥10 of the 13 required alcohol management practices and the mean number of those practices being implemented at three-year follow-up. Secondary outcomes included: the proportion of club members who reported risky drinking of alcohol at their club, and the proportion of club members who reported being at risk of alcohol-related harm (measured as total AUDIT score ≥8) and mean total AUDIT score of club members. Outcome data were proposed to be collected via observation at the club during a one-day visit to a home game, conducted by trained research assistants at baseline and follow-up.

CHAPTER 6: SUSTAINING THE IMPLEMENTATION OF ALCOHOL MANAGEMENT PRACTICES BY COMMUNITY SPORTS CLUBS: A RANDOMISED CONTROLLED TRIAL

Chapter 6 reported the conduct and outcomes of the trial described in Chapter 5. The trial was conducted between April 2015 and September 2017. A total of 92 intervention clubs (574 members) and 96 control clubs (612 members) were included in the final trial analysis. At follow-up, sustained implementation of alcohol management practices was high in both groups and there was no significant difference between intervention or control clubs for both the proportion of clubs implementing 10 or more practices, or for the mean number of practices being implemented. There were also no significant differences between groups on the secondary measures regarding alcohol consumption by club members or alcohol-related harm. The findings concluded that there was no difference in the web-based program sustaining club implementation of alcohol management practices compared to the provision of minimal contact (face-to-face visit or telephone) sustainability support. Analysis of the trial process measures suggested a decline in the use of the web-based sustainability support program

over time, from 99% in year one to 80% in year three. Although completion of the program requirements was high amongst those that used the web-based program, the decline in usage suggests a potential risk to the longer-term benefits of the program.

The findings of the trial suggested that sustained implementation of alcohol management practices was both high and similar between clubs receiving web-based implementation support or usual (face-to-face or telephone based) program support. Such a finding suggests that further research is required to determine whether a web-based model of providing support for program implementation by sports clubs is more cost effective than face-to-face delivery of such support.

7.2 IMPLICATIONS FOR FUTURE RESEARCH

The results of the studies described in Chapters 3, 4, 5 and 6 suggested that the novel use of the web as a means of providing structured and evidence-based support to help community sports clubs sustain their implementation of alcohol management practices was feasible, acceptable and effective. Two key areas of further research flow from these findings.

First, the positive findings suggest that there is considerable potential for the web-based approach to be adopted as the primary method of supporting the sustained implementation of alcohol management programs by sports clubs, and of public health programs in community settings more generally. Such a suggestion is supported by the argued advantages of web-based delivery of programs, including lower cost, greater access to people in remote locations, consistency and fidelity of support delivery, and as an enabler of enhancing program delivery at-scale.[1, 2] The first of these suggested advantages, lower cost, is of particular importance to policy and decision makers as a key determinant of whether a sustainability strategy is to be supported by government is feasible in terms of economic benefit and cost in the context of available resources. Given this, further rigorous research is required to compare the relative economic and financial

merits of web-based and face-to-face methods of providing support to ensure the sustained implementation of effective public health programs.

Second, as described in Chapter 3, and as reported in the literature, program user acceptability and utilisation are key determinants of whether a web-based program is likely to achieve its intended benefits.[3] The findings of the randomised controlled trial described in Chapter 6 found that, despite the positive findings of no difference in sustained implementation of alcohol management practices between groups, the actual engagement of sports clubs with the web-based program diminished over time. Given this finding, and the potential risk to the sustained implementation of public health programs, further research is warranted to: identify the determinants of ongoing web-program usage; and identify possible strategies to mitigate the risk of such usage diminishing over time.

The following sections elaborate on each of these two areas of suggested further research.

7.2.1 HEALTH ECONOMIC AND FINANCIAL ANALYSIS OF WEB-BASED PROVISION OF SUPPORT TO SUSTAIN THE IMPLEMENTATION OF PUBLIC HEALTH PROGRAMS

Studies of web-based public health interventions often cite reduced cost as one of the benefits of this mode of intervention delivery. However, there is limited evidence regarding the economic and financial evaluation of web-based interventions compared to traditional face-to-face methods of public health program delivery.

A recent 2017 Cochrane review[4] of the effectiveness of digital interventions in reducing harmful alcohol consumption identified 57 eligible studies. Of those studies, only four[5-8] conducted economic evaluations. All four studies involved randomised controlled trials with varying lengths of follow-up (3 months, n=1; 6 months, n=2 and 24 months, n=1) and control group designs (reduced support or

contact, n=2; no support, n=1 and delayed support, n=1). Three studies performed cost-effectiveness analysis[5,7,8] and the remaining study conducted both cost-effectiveness and cost-utility analyses.[6] Cost-effectiveness was measured by an incremental cost-effectiveness ratio, using Quality Adjusted Life Years as the measure of benefit for three studies. The three studies found that the intervention was more cost-effective compared to the control. The fourth study found that there was no difference between intervention and control in cost-utility. The authors reported that sample size limitations of the included studies precluded any definitive conclusions regarding the cost-effectiveness of digital interventions in reducing alcohol-related harm. Further, reviews that have synthesised the cost-effectiveness of digital or web-based interventions in the health-care setting more broadly have come to similar conclusions regarding the limitations of included studies, such as inconsistent reporting of results and variability in economic measures.[9-12]

Each of the above reviews or included studies focused on economic analysis of interventions that aimed to change individuals' health risk behaviours. None of the included studies assessed either the economic or financial merit of interventions that aimed to address improvement in the implementation of care or service delivery practices of health care or other service providers generally, or such interventions in the sports club setting specifically.

A recent editorial by Eisman and colleagues (2020) regarding the conduct of economic evaluations in implementation science generally stated that less than 10% of such studies reported the cost of implementation interventions, with even less reporting economic evaluation of the interventions.[13] This suggested gap in the economic analysis of implementation interventions was confirmed in a recent review regarding the economic evaluation of public health implementation interventions.[14] The review included 14 studies from the USA (n=9), Australia (n=2), Netherlands (n=1), Japan (n=1) and Spain (n=1). The studies addressed the effectiveness of a variety of strategies that sought to improve the implementation of practices and programs targeting cancer screening, physical activity, nutrition, alcohol-related harms and immunisation. The majority (n=12) of studies involved

general population samples, with the remaining two studies being conducted in either school (n=1) or health care (n=1) settings. No studies were conducted in a sports setting and no studies involved web-based interventions. Cost-effectiveness analysis was undertaken in 12 of the 14 included studies, one study involved a cost-benefit analysis and the final study involved both a cost-effectiveness and cost-utility analysis. The implementation interventions for nine of the 14 studies were found to be cost-effective or to have a positive cost-benefit.

Eisman and colleagues also highlighted the importance of identifying not just the cost effectiveness/benefit/consequences of implementation strategies, but also the cost of such strategies to determine the financial impact of such interventions on an organisation's budget, and to determine the possible cost of an intervention being scaled up.[13] The importance of assessing the financial cost of implementation interventions has also been emphasised by Hoomans and colleagues[15], given the organisational and system complexity of implementation interventions, the impact of such complexity on implementation costs involving human resource, goods and services and infrastructure (e.g. IT systems), and opportunity costs for both the service provider and clients.

A variety of types or methods of economic evaluation are available, each comparing the cost of an intervention to its outcomes in different ways. Through such comparison, each method provides different types of information regarding intervention 'value for money'. [15-18] The primary points of difference between the methods lie in the different ways the outcomes of interventions are described (e.g. effectiveness, benefits, consequences), and/or in the use of single metrics that summarise the comparison of the costs and outcomes of an intervention. Cost-effectiveness (CEA) evaluations, for example, are a common method of economic analysis, which provide a comparison of the effectiveness (change in a specified clinical, health or health system outcome measure, e.g. at-risk alcohol consumption) of different interventions compared to the cost of those interventions. A single summary metric is calculated to report the outcome of the comparative analysis: an incremental cost-effectiveness ratio (ICER).[15] Through the use of such a single economic outcome measure, CEA enables a direct

economic comparison of the 'value for money' of different interventions in both a single study, and across studies. Although widely used, this type of analysis has limitations, and when considered in the context of implementation research, such limitations are suggested to centre on the complexity of implementation interventions potentially targeting multiple behaviours, across multiple levels (e.g. patient, provider, systems) and using potentially multiple and different intervention strategies for each level. In these circumstances, multiple cost-effectiveness analyses would be required to fully describe the economic benefit of the intervention. [13, 15]

A second commonly used economic analytical approach is cost-benefit analysis (CBA). CBA differs from CEA through its use of a common monetary measure (e.g. dollar) of both the costs and of the benefits of intervention alternatives to help decision makers decide which intervention provides the greatest 'value for money'. A single summary metric is used to report the economic outcome of the comparative analysis: a cost-benefit ratio. A particular benefit of the use of a single measure of both costs and benefits with regard to implementation intervention research is its provision of a means of directly comparing the costs and the benefits of implementation interventions in a single intervention study, and across such studies. A limitation of CBA arises from potential inconsistencies in the monetising of different health outcomes , as well as an inability to address benefits not related to health outcomes that are also important to policy and practice decision making (e.g. health system benefits, crime, environmental impacts).[13, 15]

Unlike cost-effective analysis or cost-benefit analysis, cost-consequence analysis (CCA) does not report a single summary metric (e.g. economic ratio), nor a single measure of intervention benefit, thus making the method more applicable to complex public health implementation interventions.[15, 19] A CCA reports the costs and importantly, multiple types of benefits (consequences) (e.g. clinical, health, health system, and stakeholder outcomes) of alternate intervention approaches as collected in a trial, without an attempt to aggregate such consequences into a single metric. In doing so, CCA provides a diversity of information that is

commonly required by policy and practice decision-makers in the selection of interventions to be implemented into routine practice.[15, 19] The reporting of an intervention's outcomes as measured in a trial, however, limits the ability of decision-makers to compare an intervention's 'value for money' to the 'value for money' of other intervention options reported in other studies.

A different form of economic analysis that does not seek to determine intervention 'value for money' through comparison of costs and outcomes but to determine intervention financial affordability is budget impact analysis (BIA).[17, 20] BIA can be used to determine whether an individual intervention is affordable within an existing budget, or to indicate what amount of budget is required for an intervention to be afforded in the future. BIA addresses a limitation of comparative 'value for money' economic analytical approaches (e.g. CEA, CBA, CCA) where such analyses may indicate a positive result for an intervention (e.g. greater intervention monetary benefit than cost) but the intervention is not feasible to be implemented into routine practice in terms of its affordability within the available or foreseeable budgets of an organisation.[17, 20] A key limitation of BIA however is its focus on a single financial parameter, cost, and hence provides no consideration of the benefits of an intervention, regardless of its affordability, a key determinant of decision-making.

The above brief description of types of key economic and financial analyses relevant to public health and implementation research demonstrates a need to determine which approach or approaches are appropriate for assessing the economic merits of the intervention evaluated in Chapter 6. The outcomes of that trial included both individual-level health risk factor outcomes, as well as organisational-level implementation outcomes. Each of the types of economic and financial analysis described above (CEA, CCA, CBA, BIA) have the potential to be applicable to an economic evaluation of that intervention, with each providing different information regarding the economic merits of web-based implementation support relative to conventional face-to-face methods. Information from such analyses could involve overall estimates of the

comparative 'value for money' of the web-based intervention relative to the conventional face-to-face-based method (CEA), an indication of costs relative to each of the types of outcomes (CCA), and information upon which an assessment of intervention financial feasibility could be based (BIA). Such a comprehensive economic evaluation of a web-based public health implementation intervention, from either the perspective of a service provider or implementation support provider has not previously been reported in any setting. The conduct of such an evaluation is considered an important opportunity for providing additional key evidence to aid decision-making regarding whether the web-based intervention described in Chapter 6 should be implemented into routine practice among sports clubs, and for advancing scientific knowledge regarding economic evaluations of public health implementation interventions generally.

7.2.2 UNDERSTANDING THE BARRIERS AND FACILITATORS TO THE USE OF WEB-BASED PROGRAMS

To ensure that public health programs, web-based and otherwise, achieve their desired outcomes, adequate intervention exposure amongst the population of interest has been argued to be a fundamental requirement.[3, 21, 22] Understanding of and responding to barriers to web-based intervention use, and the promotion of facilitators to such use has similarly been argued to be essential to maximising the likelihood of achieving intended intervention benefit. [3, 23]

Prevalence of web-based intervention/program use

Studies that have sought to synthesise the literature regarding the level of use of web-based interventions have reported limitations in the ability to do so due to variability in data collection methods and in the types and definitions of measures used (e.g. intervention 'use', 'engagement' or 'adherence').[3, 21-26] For example, engagement with web-based behaviour change interventions has been defined in number of ways, as either the extent of usage (e.g. amount, frequency, duration, depth), or the subjective experience of intervention use such as attention, interest and affect[24], with measurement of extent of use occurring either using objective or self-report measures. Reviews of the extent of intervention use have identified

that the majority of studies have utilised self-report and/or subjective measures and have reported considerable variability in the types of measurement, such as number of intervention logins, number of completed modules, and length of intervention use.[3, 27, 28]

Notwithstanding differences in the measurement of web-based intervention use, many such interventions are reported to have low prevalence of such use.[25] For example, a review of 83 web-based clinical interventions targeting chronic disease (N=19), lifestyle behaviours (N=16) and mental health conditions (N=48) by Kelders and colleagues found that on average, intervention adherence (measured as the proportion of participants who adhered to the intervention as intended) was 50.3%.[29] For participants utilising chronic disease interventions, adherence was 55.3%, for those utilising mental health interventions 54.2%, and for those utilising lifestyle behavioural interventions 32.8%.

A further review by Donkin and colleagues assessed the association between the extent of intervention adherence, defined as the extent to which users followed the program as designed, and intervention outcome.[3] The authors identified 69 studies that met the inclusion criteria. Across these studies, adherence was measured by either: the number of program logins (n=36), completed program modules (n=31), time spent online (n=18), predefined activity completion or use of an online tool (n=16), content posting (n=9), email replies (n=6), pages viewed (n=5), forum visits (n=1), self-reported completion of offline (n=1) and printing requests (n=1). Almost half (n=33) of the included studies analysed the impact adherence had on study outcomes. In the narrative synthesis, Donkin and colleagues concluded that a positive relationship existed between adherence and public health outcomes (fruit and vegetable consumption, physical activity, weight management, smoking, smokeless tobacco), but not mental health outcomes (depression).[3]

The findings of the study described in Chapter 3 indicated that a web-based approach to supporting sports clubs to sustain their implementation of alcohol harm reduction policies and practices was feasible and acceptable, and that there was a high level (89%) of reported intention to use such a program. The findings

of the trial described in Chapter 6 confirmed these findings, indicating that, using objective measures (web analytic data), a high level of web-based program use at the completion of the trial (Year 3 – 80%) and high levels of completion of program components (Year 3 - assessment 81%; action plan completion 73%) (Table 7.1). These observed levels of use of the web-based program appear either greater than, or to be at the upper end of those reported in previous studies described above (29). Such positive findings may reflect the suitability of web-based approaches for providing support to sporting club officials, and/or the considered and novel application of both sustainability and technology-based (Persuasive System Design) theoretical frameworks in the design and development of the web-based sustainability intervention.[30]

Despite the overall positive sustainability results of the trial described in Chapter 6, and its high levels of intervention use in both absolute and relative terms, use of the web-based program appeared to decline over the life of the study, with logging in to the program declining from 99% in the first year to 80% in the third and final year (Table 7.1). The finding of a decline in program use suggests a possible increasing risk to participant intervention exposure over time, and hence suggests a possible need for strategies to mitigate such a risk.

Table 7.1 Intervention club engagement with web-based program over the 3-year intervention period

Intervention year	Logged into web program % (n)	Completed annual assessment % (n)	Completed action plan % (n)
2015 (N=92)	99 (91)	86 (78)	10 (8)
2016 (N=92)	88 (81)	89 (72)	75 (54)
2017 (N=87)*	80 (74)	81 (60)	73 (44)

*In 2017 N=87(5 clubs with drew)

Notwithstanding the previously described limitations to directly comparing the intervention use results of the trial described in Chapter 6 with those of previous studies of web-based intervention use, a pattern of declining rates of use of such

interventions is also suggested in previously reported studies of web-based interventions.[31] For example, in a review by Wangberg and colleagues of the prevalence of use of web-based interventions designed to improve individual health outcomes[31], the rate of web-based intervention use in three different trials was assessed: a diabetes self-care intervention for people with type 1 or 2 diabetes, a smoking cessation intervention for current smokers within the community, and a personal health record system for members of a Norwegian patient organisation for people with thyroid disorder. Engagement with the web-based diabetes intervention was reported to be low, with only 34% of participants logging into the site three or more times during the six-week intervention period, and the number of logins declining from 1.8 to 0.3 over the six-week period. Similarly, for the smoking cessation intervention, at the two-month review point only 19% of participants were using the web-based intervention, and by the end of the 12-month trial engagement had dropped to 0.8%. The final study of the use of a web-based personal health record system found that only 8% of participants self-reported using the system once or more in the last month of the three-month intervention period, indicating a decline in the number of logins per month over the intervention period from 0.16 to 0.02.[31] No reviews have been undertaken which look at the extent to which a declining pattern of web-based intervention use similarly occurs for interventions with an aim of improving service provider implementation of evidence-based care or service delivery practices.

Barriers to the use of web-based interventions

Common barriers to the use of web-based programs focused on achieving individual outcomes have been reported to include: lack of users' skills[32]; program design (i.e. user-friendly or intuitive)[33]; time required to introduce the technology (e.g. training)[34-36]; and organisational readiness for new technology (e.g. resources, skilled staff).[35] Common facilitators to web-based program use have been reported to include: program design (i.e. simple language, easy navigation, personalisation)[33]; prompts/reminders[33]; perceived ability to provide improved care[1, 34]; and improvements in productivity.[1] Whether such barriers and facilitators also apply to the ongoing use of web-based programs to support the

sustained implementation of health promotion programs by service provider organisations is unknown.

Frameworks for technology based interventions

The use of theoretical frameworks are suggested to help hypothesise and identify the determinants of behaviour (such as engagement with technology) and in doing so aid the design and delivery of interventions to improve such behaviours. At the time of this thesis, few frameworks pertaining to sustainability[37-40] and engagement with technology had been published and applied in health services research and implementation science.[30, 41] At the time of the development of the web-based intervention (Chapter 5 and 6), the Persuasive Systems Design framework was considered and utilised as the most appropriate framework for guiding its design.[30]

Recently, a unifying framework published by Greenhalgh and colleagues[42] has brought together existing concepts and theoretical underpinnings of technology-based intervention approaches to supporting program implementation and sustainability. The Non-adoption, Abandonment, Scale-up, Spread, and Sustainability (NASSS) framework was developed through two methods: 1) an interpretive systematic review of 28 theory informed frameworks for analysing technology-based programs in health and social care settings to identify key framework domains; and 2) the analysis of six empirical case studies testing the applicability of the identified domains.[43, 44] After peer-review a final framework was constructed consisting of seven domains (Table 7.2). The domains and associated questions are designed to identify aspects of technology-based programs which may need to be addressed if a programme is to be effective.

Table 7.2 Domains and questions in the NASSS framework[42]

Domain		Domain question/s
1	The condition	1A. What is the nature of the condition or illness? 1B. What are the relevant sociocultural factors and comorbidities?
2	The technology	2A. What are the key features of the technology? 2B. What kind of knowledge does the technology bring into play? 2C. What knowledge and/or support is required to use the technology? 2D. What is the technology supply model?
3	The value proposition	3A. What is the developer's business case for the technology (supply- side value)? 3B. What is its desirability, efficacy, safety, and cost effectiveness (demand-side value)?
4	The adopter system	4A. What changes in staff roles, practices, and identities are implied? 4B. What is expected of the patient and/or immediate caregiver)—and is this achievable by, and acceptable to, them? 4C. What is assumed about the extend network of lay caregivers?
5	The organisation	5A. What is the organization's capacity to innovate? 5B. How ready is the organisation for this technology-supported change? 5C. How easy will the adoption and funding decision be? 5D. What changes will be needed in team interactions and routines? 5E. What work is involved in implementation and who will do it?
6	The wider context (institutional and societal)	6A. What is the political, economic, regulatory, professional (e.g. medicolegal), and sociocultural context for program roll-out?
7	Embedding and adaptation over time	7A. How much scope is there for adapting and coevolving the technology and the service over time? 7B. How resilient is the organisation to handling critical events and adapting to unforeseen eventualities?

The NASSS framework addresses key gaps in the evidence of technology-based implementation interventions by providing a structure for examining the determinants of engagement with such interventions, and in doing so, seeks to improve program implementation, and sustainability. It is designed to be used

across all stages of program life, from the early development and design stage; to the planning and roll-out to ensure the program reaches full potential.

As the NASSS framework has only recently been disseminated, there is currently limited published studies of its application. One recently published study utilised the NASSS framework to retrospectively assess a web-based telemonitoring intervention for teenagers with Inflammatory Bowel Disease. As the intervention was found to have positive outcomes, Dijkstra and colleagues undertook a retrospective empirical case-study utilising the NASSS framework to identify whether the intervention could be translated from a demonstration project into a sustainable method of care delivery. Two assessors independently rated aspects of the web-based telemonitoring intervention against the NASSS domain questions. The authors found that the intervention: successfully supported the appropriate selection of patients to receive different models of care; had a distinct benefit for patients; was an affordable service delivery model; was able to be adapted over time; and its costs were able to be reimbursed. However, they also found that health providers had functional reasons to not use the program (double data entry), and that sustainable implementation of the intervention required a change to existing work-flows. The extent to which such factors were subsequently incorporated into the intervention and resulted in sustainable intervention use/adherence has not been reported.[45]

Neither comprehensive theory-based assessment of use of a web-based public health implementation intervention, nor the benefits of such assessment in improving use of web-based interventions have previously been reported. The application of the NASSS framework to an assessment of the web-based implementation intervention described in Chapter 6 has the potential to identify reasons for the observed decline in intervention use over the life of the trial, and opportunities to remedy identified barriers to ongoing intervention use. Importantly, such an application will also provide valuable evidence regarding a critical issue facing the burgeoning growth of web-based applications targeting either personal or professional behaviour change the long-term utility and benefit of such applications.

7.3 THESIS CONCLUSION

This thesis presents evidence that although the fields of implementation and sustainability research generally is growing, there is a dearth of evidence from such research conducted in community settings, and specifically in the sports club setting. The evidence presented in this thesis suggests that the implementation of alcohol management practices can be sustained in community sports clubs. Furthermore, the web was identified as a feasible and acceptable mode of delivering such an alcohol management program and that community sports clubs could validly self-report the implementation of some alcohol management practices. However, further understanding of the economic implications of adopting such an implementation support program compared to other modes of support is required to inform the future roll-out of the program. Additionally, understanding of the strategies for enhancing intervention engagement and exploring the barriers and enablers to this will enhance the future impact that alcohol harm reduction programs have on the community sports club members.

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APPENDIX 1 Thesis by Publication Information Sheet

Office of Graduate Studies
Information Sheet
Thesis by Publication

THE UNIVERSITY OF NEWCASTLE AUSTRALIA

A thesis may be submitted in the form of a series of published papers and the additional rules specific to this style of thesis are presented below. **It is important to note that the general rules for a University of Newcastle thesis are also applicable. Please ensure you also refer to** The Rules Governing Research Higher Degrees for the full scope of applicable rules.

Rule 39.1 A thesis by publication will include:

i. a full explanatory overview that links the separate papers and places them in the context of an established body of knowledge;
ii. a literature review;
iii. if detailed data and descriptions of methods are not otherwise given within the separate papers, they must be included in the body of the thesis or as appendices to the thesis;

Rule 39.2 For a thesis by publication:

i. the separate papers provided under sub-clause 39.1(i) must be published, in press or submitted to scholarly media only, i.e. refereed publications classified by current national standards and refereed conference papers, however at least 50% of these papers must have been published. Papers published up to three years prior to enrolment may be included provided they were published in scholarly media and do not represent more than 50% of the total papers;
ii. publications submitted by the candidate for another degree may only be referred to in the thesis literature review;
iii. the number of papers submitted should demonstrate that the body of work meets the requirements of the degree as outlined in the relevant schedule;
iv. the candidate must be the lead author in at least 50% of the papers written in the time of their formal Research Higher Degree candidature. Any published paper of which the candidate is a joint author may only be included in the thesis provided the work done by the candidate is clearly identified. The candidate must include in the thesis a written statement from each co-author attesting to the candidate's contribution to a joint publication included as part of the thesis. These statements must be endorsed by the Assistant Dean (Research Training).
v. the Assistant Dean (Research Training) may seek the approval of the Dean of Graduate Studies to include a paper that is outside the scope of these rules.

Office of Graduate Studies, East Wing, The Chancellery
Telephone: (02) 4921 6537 Fax: (02) 4921 6908 Email: research@newcastle.edu.au

Considerations

- Each discipline area will have different issues to consider in the decision to submit a thesis in the form of a series of published papers.
- It is essential that you discuss your options carefully with your supervisor(s). The thesis by publication must reflect a sustained and cohesive theme, an integrated whole that sits logically in the context of the available literature. Overall the material presented for examination needs to equate to that which would otherwise be presented in the traditional thesis format.
- The review process for some journals is significant resulting in lengthy waiting periods for papers to be accepted and this can delay thesis submission/completion. Time management and selection of journals/publishers is critical. Focusing on publication rather than research may lead to candidates being tempted to publish sections of their work prematurely and missing opportunities to fully capitalize on the significance of the work.
- Consider the thesis from the examiners' view point - if the publications do not have a clear cohesion and the contribution to knowledge is not clearly demonstrated, then the thesis may attract criticism and be rejected by examiners. The content of the thesis remains a matter of professional judgment for the supervisor(s) and candidate.
- Any published paper of which the candidate is a joint author may only be included in the thesis provided the work done by the candidate is clearly identified. The candidate must include in the thesis a written statement from each co-author attesting to the candidate's contribution to a joint publication included as part of the thesis. The statement/s need to be signed by the Faculty Assistant Dean (Research Training). A sample statement is provided below.
- We strongly advise that you arrange for the signatures from co-authors to be collected as soon as the paper is prepared or submitted for publication rather than trying to collect them at the time of thesis submission.
- There is no minimum or maximum requirement on the number of papers. Of equal, or perhaps more importance than quantity, is the quality of the journals. Please refer to your school or faculty for more specific guidance on the number and length of papers that would normally be expected in your discipline.

Alternative option

As discussed above, you need to consider if your publications will form a sufficient body of cohesive work to meet the requirements of thesis by publication. You may like to consider the other option of including publications within a standard thesis format, either in the body or as an appendix as supported in the rule below.

Rule 38.5. A thesis may:

i. Include publications arising as a consequence of the research undertaken for a thesis.
When the candidate includes a co-authored published paper or co-authored scholarly work, or a substantive component of a co-authored published paper or co-authored scholarly work in the body of the thesis, the candidate must include in the thesis a written statement attesting to their contribution to the joint publication. This statement must be signed by the supervisor. A statement is not required when publications are included as an appendix to the thesis.

APPENDIX 2 Modified TAM questionnaire

```
Information screen for interviewer:
The next questions are about an online mode of the Good Sports program,
which I will refer to as 'Good Sports online'. We are interested in
your opinion about this new mode.

Good Sports online will include:
Online completion of accreditation level reviews and level 3 monitoring
reports, tailored action plans, information and resources to support
clubs in the Good Sports program, and email prompts and reminders.

Please remember that there are no right or wrong answers - your opinions
will help to ensure that such a program would be useful, relevant and
practical for use in sporting clubs.

When answering the following questions, we ask you to keep the description
of the program in mind. I will now read out a list of statements about
the program, and ask you to rate them on a scale of 1 - 7 Where:
7 = strongly agree,
1 = strongly disagree and
4 = neither agree nor disagree.

Perceived usefulness (this heading not included in the questionnaire)

I would find Good Sports online useful in helping my club implement
Good Sports practices.
1       Strongly Disagree
2       Disagree
3       Slightly disagree
4       Neither agree nor disagree
5       Slightly agree
6       Agree
7       Strongly Agree
8       Don't know [DO NOT READ]
.R      Refused [DO NOT READ]

Using Good Sports online would improve my clubs PERFORMANCE in
implementing Good Sports practices.
1       Strongly Disagree
2       Disagree
3       Slightly disagree
4       Neither agree nor disagree
5       Slightly agree
6       Agree
7       Strongly Agree
8       Don't know [DO NOT READ]
.R      Refused [DO NOT READ]

Using Good Sports online would increase my clubs PRODUCTIVITY
in implementing Good Sports practices.
1       Strongly Disagree
2       Disagree
3       Slightly disagree
4       Neither agree nor disagree
5       Slightly agree
6       Agree
7       Strongly Agree
8       Don't know [DO NOT READ]
.R      Refused [DO NOT READ]
```

```
Using Good Sports online would help enhance the EFFECTIVENESS
of my club in implementing of Good Sports practices.
1       Strongly Disagree
2       Disagree
3       Slightly disagree
4       Neither agree nor disagree
5       Slightly agree
6       Agree
7       Strongly Agree
8       Don't know [DO NOT READ]
.R      Refused [DO NOT READ]

Perceived ease of use (this heading not included in the questionnaire)

My interaction with Good Sports online would need to be clear and
understandable.
1       Strongly Disagree
2       Disagree
3       Slightly disagree
4       Neither agree nor disagree
5       Slightly agree
6       Agree
7       Strongly Agree
8       Don't know [DO NOT READ]
.R      Refused [DO NOT READ]

Interacting with Good Sports online is not likely to require a lot of
my mental effort.
1       Strongly Disagree
2       Disagree
3       Slightly disagree
4       Neither agree nor disagree
5       Slightly agree
6       Agree
7       Strongly Agree
8       Don't know [DO NOT READ]
.R      Refused [DO NOT READ]


I would find Good Sports online easy to get it to do what I want it to do.
1       Strongly Disagree
2       Disagree
3       Slightly disagree
4       Neither agree nor disagree
5       Slightly agree
6       Agree
7       Strongly Agree
8       Don't know [DO NOT READ]
.R      Refused [DO NOT READ]

I would find Good Sports online easy to use.
1       Strongly Disagree
2       Disagree
3       Slightly disagree
4       Neither agree nor disagree
5       Slightly agree
6       Agree
7       Strongly Agree
8       Don't know [DO NOT READ]
.R      Refused [DO NOT READ]
```

Behavioural intentions to use (this heading not included in the questionnaire)

Assuming I had access to Good Sports online, I INTEND to use it.
INTERVIEWER NOTE: intend refers to planning to use the system for a specific purpose, with an outcome in mind
1 Strongly Disagree
2 Disagree
3 Slightly disagree
4 Neither agree nor disagree
5 Slightly agree
6 Agree
7 Strongly Agree
8 Don't know [DO NOT READ]
.R Refused [DO NOT READ]

Given that I had access to Good Sports online, I PREDICT that I would use it.
INTERVIEWER NOTE: predict refers to making known in advance whether you would use the system in the future, based on the information provided
1 Strongly Disagree
2 Disagree
3 Slightly disagree
4 Neither agree nor disagree
5 Slightly agree
6 Agree
7 Strongly Agree
8 Don't know [DO NOT READ]
.R Refused [DO NOT READ]

If Good Sports online was currently available, I would PLAN to use it in the next 12 months.
1 Strongly Disagree
2 Disagree
3 Slightly disagree
4 Neither agree nor disagree
5 Slightly agree
6 Agree
7 Strongly Agree
8 Don't know [DO NOT READ]
.R Refused [DO NOT READ]

APPENDIX 3 Alcohol management practice items, responses and dichotomised groups for both online and observational surveys

Practice	Response options	Dichotomised for analysis (yes or no)
State liquor licensing signage displayed at all points of alcohol sale	Yes, no	Yes= yes No= no
people serving alcohol are 18 years of age or over	never, rarely, sometimes, usually, always	Yes= always No= never, rarely, sometimes, usually
drunk or intoxicated people not permitted to enter club premises	never, rarely, sometimes, usually, always	Yes= always No= never, rarely, sometimes, usually
drunk or intoxicated people not served alcohol at club	never, rarely, sometimes, usually, always	Yes= always No= never, rarely, sometimes, usually
drunk or intoxicated people not being allowed to remain on the premises	never, rarely, sometimes, usually, always	Yes= always No= never, rarely, sometimes, usually
substantial food is available at all times when alcohol is served	never, rarely, sometimes, usually, always	Yes= always No= never, rarely, sometimes, usually
free tap water provided by club	never, rarely, sometimes, usually, always	Yes= always No= never, rarely, sometimes, usually
at least one low-alcoholic drink option is available	never, rarely, sometimes, usually, always	Yes= always No= never, rarely, sometimes, usually
at least four non-alcoholic drink options are available	never, rarely, sometimes, usually, always	Yes= always No= never, rarely, sometimes, usually

the price difference between non-alcoholic and low-alcoholic drinks compared to full strength alcoholic drinks is at least 10%	at least 10% cheaper, 0-9% cheaper, same price, more expensive	Yes = at least 10% cheaper No =0-9% cheaper, same price, more expensive
the non-conduction of any of the following alcohol-related activities	happy hours, drinking competitions, alcohol-only player awards, drink vouchers or cards, cheap drink promotions, 'all-you-can-drink' functions, alcohol-only raffle prizes, none of the above	Yes = none of the above No = happy hours, drinking competitions, alcohol-only player awards, drink vouchers or cards, cheap drink promotions, 'all-you-can-drink' functions, alcohol-only raffle prizes,
bar staff don't consume alcohol whilst on duty	never, rarely, sometimes, usually, always	Yes= always No= never, rarely, sometimes, usually

APPENDIX 4 Ethics approval

HUMAN RESEARCH ETHICS COMMITTEE

THE UNIVERSITY OF NEWCASTLE AUSTRALIA

Notification of Expedited Approval

To Chief Investigator or Project Supervisor:	**Professor John Wiggers**
Cc Co-investigators / Research Students:	**Dr Bosco Rowland** **Ms Karen Gillham** **Ms Jennifer Tindall** **Ms Maree Sidey** **Dr Luke Wolfenden** **Doctor Patrick McElduff**
Re Protocol:	**A randomised trial of a web-based intervention in sustaining best-practice alcohol management practices at community sports clubs.**
Date:	**13-Mar-2014**
Reference No:	**H-2013-0429**
Date of Initial Approval:	**13-Mar-2014**

Thank you for your **Response to Conditional Approval (minor amendments)** submission to the Human Research Ethics Committee (HREC) seeking approval in relation to the above protocol.

Your submission was considered under **Expedited** review by the Ethics Administrator.

I am pleased to advise that the decision on your submission is **Approved** effective **13-Mar-2014**.

In approving this protocol, the Human Research Ethics Committee (HREC) is of the opinion that the project complies with the provisions contained in the National Statement on Ethical Conduct in Human Research, 2007, and the requirements within this University relating to human research.

Approval will remain valid subject to the submission, and satisfactory assessment, of annual progress reports. *If the approval of an External HREC has been "noted" the approval period is as determined by that HREC.*

The full Committee will be asked to ratify this decision at its next scheduled meeting. A formal *Certificate of Approval* will be available upon request. Your approval number is **H-2013-0429**.

If the research requires the use of an Information Statement, ensure this number is inserted at the relevant point in the Complaints paragraph prior to distribution to potential participants You may then proceed with the research.

Conditions of Approval

This approval has been granted subject to you complying with the requirements for *Monitoring of Progress*, *Reporting of Adverse Events*, and *Variations to the Approved Protocol* as detailed below.

PLEASE NOTE:
In the case where the HREC has "noted" the approval of an External HREC, progress reports and reports of adverse events are to be submitted to the External HREC only. In the case of Variations to the approved

protocol, or a Renewal of approval, you will apply to the External HREC for approval in the first instance and then Register that approval with the University's HREC.

- ***Monitoring of Progress***

Other than above, the University is obliged to monitor the progress of research projects involving human participants to ensure that they are conducted according to the protocol as approved by the HREC. A progress report is required on an annual basis. Continuation of your HREC approval for this project is conditional upon receipt, and satisfactory assessment, of annual progress reports. You will be advised when a report is due.

- ***Reporting of Adverse Events***

1. It is the responsibility of the person **first named on this Approval Advice** to report adverse events.
2. Adverse events, however minor, must be recorded by the investigator as observed by the investigator or as volunteered by a participant in the research. Full details are to be documented, whether or not the investigator, or his/her deputies, consider the event to be related to the research substance or procedure.
3. Serious or unforeseen adverse events that occur during the research or within six (6) months of completion of the research, must be reported by the person first named on the Approval Advice to the (HREC) by way of the Adverse Event Report form (via RIMS at https://rims.newcastle.edu.au/login.asp) within 72 hours of the occurrence of the event or the investigator receiving advice of the event.
4. Serious adverse events are defined as:
    - Causing death, life threatening or serious disability.
    - Causing or prolonging hospitalisation.
    - Overdoses, cancers, congenital abnormalities, tissue damage, whether or not they are judged to be caused by the investigational agent or procedure.
    - Causing psycho-social and/or financial harm. This covers everything from perceived invasion of privacy, breach of confidentiality, or the diminution of social reputation, to the creation of psychological fears and trauma.
    - Any other event which might affect the continued ethical acceptability of the project.

5. Reports of adverse events must include:
    - Participant's study identification number;
    - date of birth;
    - date of entry into the study;
    - treatment arm (if applicable);
    - date of event;
    - details of event;
    - the investigator's opinion as to whether the event is related to the research procedures; and
    - action taken in response to the event.

6. Adverse events which do not fall within the definition of serious or unexpected, including those reported from other sites involved in the research, are to be reported in detail at the time of the annual progress report to the HREC.

- ***Variations to approved protocol***

If you wish to change, or deviate from, the approved protocol, you will need to submit an *Application for Variation to Approved Human Research* (via RIMS at https://rims.newcastle.edu.au/login.asp). Variations may include, but are not limited to, changes or additions to investigators, study design, study population, number of participants, methods of recruitment, or participant information/consent documentation. **Variations must be approved by the (HREC) before they are implemented** except when Registering an approval of a variation from an external HREC which has been designated the lead HREC, in which case you may proceed as soon as you receive an acknowledgement of your Registration.

Linkage of ethics approval to a new Grant

HREC approvals cannot be assigned to a new grant or award (ie those that were not identified on the application for ethics approval) without confirmation of the approval from the Human Research Ethics Officer on behalf of the HREC.

Best wishes for a successful project.

Professor Allyson Holbrook

Chair, Human Research Ethics Committee

For communications and enquiries:

Human Research Ethics Administration

Research Services
Research Integrity Unit
The Chancellery
The University of Newcastle
Callaghan NSW 2308
T +61 2 492 17894
F +61 2 492 17164
Human-Ethics@newcastle.edu.au

RIMS website - https://RIMS.newcastle.edu.au/login.asp

Linked University of Newcastle administered funding:

Funding body	Funding project title	First named investigator	Grant Ref
ARC (Australian Research Council)/Linkage Projects(**)	A randomised trial of an intervention to maintain alcohol management practices in community sporting clubs	Wiggers John,	G1201199

APPENDIX 5 Study Information sheet for club representatives

Direct Contact Details
Phone: (02) 4924 6247 Fax: (02) 4924 6028
Email: John.Wiggers@hnehealth.nsw.gov.au

October 2014

Information statement for research project:
SUSTAINING HEALTHY PRACTICES IN COMMUNITY SPORTING CLUBS

As a member of the Good Sports program, your sports club is invited to take part in a research project aimed at supporting clubs to continue to provide healthy environments for club members. The research project is funded by the Australian Research Council and is a collaborative partnership between Hunter New England Population Health, the Australian Drug Foundation (ADF), The University of Newcastle and Deakin University.

Why is the research being done?
The aim of this project is to identify the best way in which clubs can be supported in the long-term to maintain their Good Sports Level 3 Accreditation Status. Specifically we are interested to find out if providing sporting clubs with support via the internet may be effective in supporting clubs to continue to manage alcohol consistent with the Good Sports Level 3 Accreditation criteria.

Who can participate in the research?
Approximately 160 football clubs (Rugby League, Rugby Union, AFL and soccer) are being invited to participate in the project. To be eligible for participation, all clubs must:

- Have a valid and current liquor licence;
- Currently be accredited at Level 3 in Good Sports;
- Currently adhere to at least 80% of the Level 3 Good Sports criteria (as observed during a Match-Day Visit)
- Have at least one senior team in the 2014 football season; and,
- Have access to the internet (at the club or home).

What will you be asked to do?
The club president or a nominated representative of all invited clubs will be contacted via telephone to obtain consent for a Match-Day Visit (observation) to assess their club's adherence with the Good Sports Criteria and ask additional questions about the club (eg. club's access and use of technology). This will take approximately 30 minutes. We have attached a checklist to help you gather some of this information before the survey.

The Match-Day Visits will occur during a home game and researchers will record information about club alcohol policies and practices (eg. Responsible Service of Alcohol and Safe Transport Options). This information will help the research team assess a club's eligibility for the research project. During this visit, the researchers will also randomly select up to 20 adult club members and ask them if they would be willing to participate in a telephone survey about their drinking and alcohol practices at their club. If they consent, the researcher will record their name and contact details; and provide them to the research team, who will send them and information letter and contact them at a later point in time to confirm their consent and conduct the survey. The information collected via this survey will provide important evaluation data for the research project, but will not be used to assess individual clubs.

Based on the observations during the Match Day Visits, all eligible clubs will be randomly allocated to either Group 1 or Group 2. All Group 1 clubs will be provided with access to a website for at least 2 consecutive sporting seasons to assist clubs in maintaining their alcohol management practices. The website will provide a range of resources for clubs, including feedback reports, online training modules, as well as a means for Good Sports to communicate with clubs and manage club information. Clubs will be asked to provide a member of the club (ideally the club president or secretary) who will take primary responsibility for website use and provide a central point of contact for the research project. A support officer will work with Group 1 clubs to help them access and use the website.

Clubs allocated to Group 2 will not receive access to the web-based program but will be provided with usual support from the Good Sports program to maintain Level 3 accreditation in the form of face-to-face and telephone support. .

How long will it take?
Participating clubs will be asked to participate in the research project over 4 consecutive sporting seasons (2014 to 2017). This will include completing a 30 minute telephone survey in 2014 and 2017. Clubs allocated to Group 1 will be required to access the website regularly and complete required tasks (eg. Good Sports level 3 Monitoring Report). It is anticipated that the time required to complete the tasks will be the same for both Group 1 and Group 2.

What choice do you have?
Your club's participation in the research project is entirely voluntary. Whether or not your club decides to participate, your decision will not disadvantage your club in any way and will not impact your relationship with the Good Sports Program. If your club decides to participate, it may withdraw from the project at any time without giving a reason, by contacting Dr Luke Wolfenden (The University of Newcastle) on (02) 49246567.

What do you need to do to participate?
Please read this Information Statement and be sure you understand its contents before you consent to participate. In approximately 2 weeks, you will be contacted by phone to assess your clubs consent for Match-Day Visits (2015 and 2017) and pending your club's eligibility, consent to participate in the research project. If you have any questions you may ask these of the interviewer during the telephone call or you can contact the project co-ordinator (details at the bottom of this letter). Once you have completed this telephone interview, if your club decides to participate, you will need to complete and sign the attached consent form, and mail it back to the project team (in the enclosed stamped addressed envelope).

How will your privacy be protected?
- All of your responses and data will be treated in strict confidence. Information you provide about your clubs policies and practice may be provided in summary form to club committee members.
- All data will be entered into a computer, analysed, and stored securely at the Hunter New England Population Health for at least 5 years.
- Your name, sporting clubs name and contact details will be stored separately from your observation data.
- Only the Research Team identified at the bottom of this letter will have access to the data.
- With regards to storage and disposal of confidential information, we follow the principles of the Privacy of Information Act, in addition to the National Health and Medical Research Council and the University of Newcastle ethics regulations.

How will the information collected be used?
- The information you provide will assist us in helping to develop a sustainable effective web-based intervention to create more sustainable community sports clubs and reduce alcohol-related harm.
- The data will be presented in a final report to the Australian Research Council, and may be published in a scientific journal or student theses.

- The reports of our findings will include group results only. Individual participants or clubs will not be identifiable in any reports arising from the project.
- A summary of the results will be available to all participating clubs through the Good Sports Program.
- Data collected as part of this study will be used as part of a student research higher degree thesis.

Further information about the Project
If you would like further information please contact Tameka Small (The University of Newcastle) on (02) 49246289.

Thank you for considering this invitation.

Prof John Wiggers
Director, Hunter New England Population Health

Complaints about this research
This project has been approved by the University's Human Research Ethics Committee, Approval No. H-2013-0429.

Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to the Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, telephone (02) 49216333, email Human-Ethics@newcastle.edu.au.

The Research Team
Prof John Wiggers, Hunter New England Population Health and The University of Newcastle
Dr Luke Wolfenden, The University of Newcastle
Dr Patrick McElduff, The University of Newcastle
Dr Bosco Rowland, Deakin University
Ms Karen Gillham, Hunter New England Population Health
Ms Jennifer Tindall, Hunter New England Population Health
Ms Maree Sidey, The Australian Drug Foundation
Ms Tameka-Rae Small, The University of Newcastle

APPENDIX 6 Club consent form

Professor John Wiggers
School of Medicine and Public Health
The University of Newcastle
University Drive
Callaghan NSW 2308
(02) 4924 6247

Consent Form for the Research Project:
Sustaining healthy practices in community sporting clubs

(insert club name) .....agrees to participate in the above research project and freely give our consent.

We have read the Club Information Statement and understand that the project will be conducted as described in this Statement. A copy of which has been retained for our records. We understand that our club can withdraw from the project at any time and do not have to give any reason for withdrawing.

We consent to our club:

- being observed during Match-Day visits (2014, 2015 and 2017) to assess our eligibility to participate in the project and collect evaluation data;
- being randomly allocated to Group 1 to receive web-based support to maintain level 3 Good Sports Accreditation, or to Group 2 to receive usual support from the Good Sports Program;
- being involved in the research project over 4 successive football seasons (2014 to 2017);
- having regular telephone contacts with a project officer; and,
- nominating a representative to participate in surveys about the club and the club policies and practices in 2014 and 2017.

We understand that any personal information will remain confidential to the researchers. We have had the opportunity to have questions answered to my satisfaction.

Club representative name (please print):

_____

Club representative position in the club (please print):

_____

Signature:_____ **Date:** ____/_____/_____

APPENDIX 7 Club member data collection protocol

GOOD SPORTS ARC GRADUATE RESEARCH TRIAL

MEMBER RECRUITMENT – REVISED PROTOCOL

What is the Good Sports ARC Graduate Research Trial?

The aim of this research trial is to identify the best way to support clubs in the long-term to maintain their Good Sports Level 3 Accreditation. It is a Randomised Controlled Trial (RCT) involving sporting clubs that have been accredited at Level 3 of the Good Sports program ("Graduates") on or since 30th June 2011. The clubs have been randomly allocated to one of two groups ('intervention' or 'control'). There are currently 188 football clubs across Victoria and the Hunter New England area of NSW that are in the trial, with the majority being in Victoria.

Where are we up to now?

So far, the majority of clubs have received a Match-Day Visit, where teams of observers attended a 'home ground game' and collected observational data on alcohol management practices. One of the tasks during this home game was for the observers to recruit at least 15 members/supporters of the home club to participate in a telephone survey. However, for a number of reasons, some teams of observers have not been able to achieve this requirement.

Thus, we are asking teams of ipsos staff to attend additional games over the coming weeks and recruit more members.

What will I be required to do?

You will be required to attend the assigned home game at the time you have been scheduled to arrive. You need to stay until you collect 15 member names or for at least 1½ hours to ensure that you are at the game during breaks (quarter and half time) and the game.

We recommend that you complete this as a team eg. one selecting the people and one asking the questions – switch around if you like.

1. Find the club representative and introduce yourself

You will be provided with the details of the club representative that Good Sports has been liaising with by ipsos. If you are unable to identify this person, you may need to ask the bar/canteen staff or a club official (often wear a club t-shirt or jacket).

1.1 You will need to find that person and introduce yourselves as per below:

'Hi we're <name> and <name> from Good Sports, how are you today? A few weeks ago we came to the club to complete a Match Day Visit and ask some of your members if they would be willing to participate in a brief telephone survey. At that time, we were unable to recruit enough people, so we have come along today to see if we can get more. Is this OK with you?'

If they say 'yes', move onto step 2.

1.2 If they say 'no', you can show them a copy of the signed consent form (ipsos will provide to you) and remind them that they agreed to participate. If they still refuse, thank them for their time and leave the ground.

1.3 If you cannot find the listed club representative, identify whether there is another club committee members who is present at the ground that you can speak to.

1.4 If you are able to speak to another committee member, note down their name and repeat the introductory script above and follow directed.

1.5 If you are unable to speak to another committee member, leave the ground.

2. Assess the club ground for the best location to recruit members

Once the club representative or other committee member has provided approval to recruit, assess the ground and identify the best location to recruit members. As a general rule, this will usually be near the main bar service area so that you will get people on their way or way back from the bar (however, don't get in the way). You should not focus only on people drinking alcohol – you must use the random allocation process.

If there are inadequate numbers in the main bar service area, move outwards from the bar area until you reach people to recruit. For some clubs, this may mean that you leave the club house and walk around the game.

Whilst we want you to follow the protocol, there is a degree of flexibility depending on the club environment.

3. Follow the randomisation numbers to select supporters

Once you have found the best location, start using your randomisation numbers on your ipad to select people. ALL people need to be counted – it doesn't matter if they are clearly a supporter of the other team or a child, count them. These numbers have been randomly allocated by a computer program, and may look like this:

3, 2, 8, 5, 9, 5, 1, 6 etc

This means that once you start the process, count the people and approach the person that lands on that number eg. Once you have selected the 3rd person, ask them the eligibility questions and assess their interest, then move onto the 2nd person you see, then the 8th person.

It is critical that you follow this procedure in order for the member to be selected at random and to ensure the integrity of the research. Do not choose people that do not correspond your numbers and do not skip anyone that does.

4. Introduce yourselves, assess the selected supporter's eligibility and invite them to participate

For every contact, you must introduce yourselves as working on behalf of **Good Sports** not ipsos. There is a brief statement on the ipad, but we acknowledge that this will often vary depending on the person's demeanour and attitude.

<insert statement from ipad>

Remember, at this stage we are only assessing their eligibility to be included in the sample for the telephone survey based on:

- Age – must be aged 18 or over
- Club – must be a member or supporter of the home club

They will be called over the next few months (starting mid-July) for formal consent to do the survey. Thus, at this stage, we are only assessing their interest and recording their contact details if they are interested. They have the right to refuse when we call them.

You will provide them with a letter that outlines the project, their role in the project and their right to withdraw at any time. It is critical that this letter is provided to them to ensure that they provide 'informed consent' when we call them.

5. Record the outcome of the approaches and their details

It is **critical** that you record the outcome for all approaches/contacts (numbers), even if they are a child, obviously a supporter of the opposition team or if they refuse/ignore you. This is so that we can calculate a true response rate for the survey. We need this information so we can calculate how many people were approached, how many of these were eligible and how many agreed to be contacted.

If they agree to provide their details, you will need to record the following:

- Name
- Phone number (more than one if possible)
- Role with the club (supporter, player etc)
- Best time to contact them (to help us schedule the telephone surveys)

6. Thank them for their time and move onto the next number

Once you have collected the details, continue with the random numbers until you have at least 15 names. We estimate that you will probably need to approach at least 25 people to get this number, but it may be more.

7. Once you have at least 15 names or have been recruiting for at least 1.5hrs you can leave the ground

Frequently asked questions

Why is the randomisation so important?

Randomization means that each person within a sampling frame has an equal chance of being selected. By selecting randomly from a sampling frame, probability theory says that our sample, more often than not, should approximately represent the whole population.

What if I select a child?

It doesn't matter, they will simply be recorded as ineligible based on age. If it is clear they are under 18, you don't need to ask the question, however, if it is unclear, you will need to confirm their age. We will confirm that they are over 18 at the start of the telephone survey.

Why do we need at least 15 per club?

Because this is a research trial, we need to ensure that we survey members/supporters from each club in the trial. Remember, that some people will refuse to participate when we call them for the survey, so we need to maximise the number that we call.

Do they have to be a financial member?

They don't need to be a 'financial member' of the club to participate – as long as they are a supporter of the HOME club, that's all we need.

Do they have to be a drinker?

No, they do not need to be drinking alcohol at the club (or a drinker at all).

What if people are rude or ignore me, get agitated or aggressive?

Good Sports acknowledges that some people will ignore you, be rude or get agitated or aggressive towards you. Your safety is our number one priority – this is why you have to complete this task with another person, have permission from the club representative and be located in a public area.

If anyone acts this way towards you, move onto the next person. Don't react negatively in any way as this can exacerbate the situation. If you feel uncomfortable or threatened, remember, you can leave the ground (together). If you feel that you can stay to complete the task, find another location. Remember, you have permission from the club to be on the grounds recruiting members, so if need be, call on the club staff for assistance.

What if a person not included in the random number sequence looks friendly?

Often in these situations, it is easier to approach someone who looks friendly, smiles at you or is obviously happy. We understand that this is human nature, however, from a research perspective, randomisation is critical and you should not approach these people to participate.

What if a person not included in the random number sequence asks if they can participate?

Sometimes people will ask if they can participate but due to the importance of randomisation, don't include them. Thank them for their interest in the project and let them know that you have a process for selecting people, and have to follow that process.

What if someone is intoxicated?

Given that alcohol will be served at the club, it is possible that some people you approach may be intoxicated. This is OK because the process has been approved by an ethics committee and you will be providing them with an

ethics-approved letter informing them that they can withdraw at any time. However, if they are obviously intoxicated and aggressive in any way, count them as an approach and refusal, and move on.

When is the best time to complete the recruitment?

The best time will vary from club to club, but from experiences over the last few months, the best time appears to be during breaks in the game when people are moving around and not focused on the game itself. However, keep in mind that during these times, people are often on a mission eg. to get a drink, to get food or go to the toilet. So, just be mindful of this.

We have also learnt that recruitment towards the end of the game is not the best time as supporters are very focused on the game. Thus, we recommend starting during a break in the game and continuing throughout the game (if people are willing). Please be flexible to the environment of the club. Sometimes, after the game is a good time to recruit because people are more relaxed and may stay for a drink and club presentations. However, at some clubs (especially in NSW), most people will leave when the game finishes.

What if the ipad doesn't work or I have issues with the internet?

Internet connectivity has been an issue, especially in the more regional/remote areas, so if you are unable to use your ipad, please revert to your paper randomisation sheet and your paper tool to record the approaches and contact details. These can be entered into the program at a later date.

APPENDIX 8 Study information sheet for club members

Direct Contact Details
Phone: (02) 4924 6247 Fax: (02) 4924 6028
Email: John.Wiggers@hnehealth.nsw.gov.au

<insert club address>

Dear <insert club contact name>

Information statement for research project:
SUSTAINING HEALTHY PRACTICES IN COMMUNITY SPORTING CLUBS
4/8/2014

As a member of your local football club (league/union/soccer/AFL), you are invited to participate in a brief telephone survey. Your club is participating in a research project aimed at supporting clubs to continue to provide healthy environments for club members. The collaborative project is funded by the Australian Research Council and is being conducted by Hunter New England Population Health, the Australian Drug Foundation (ADF), the University of Newcastle and Deakin University.

Why is the research being done?
The aim of this project is to identify the best way in which clubs can be supported in the long-term to maintain their Good Sports Level 3 Accreditation Status. Specifically we are interested in finding out if providing sporting clubs with support via the internet is effective in supporting clubs to continue to manage alcohol consistent with the Good Sports Level 3 Accreditation criteria.

Who can participate in the research?
Club members over the age of 18 years who are a current members of selected sporting clubs participating in the 'Good Sports' program are eligible to participate in the survey. You have been randomly selected during a home-game to be invited to participate. We will randomly selected club members to participate in another survey in approximately 2 years' time. It is possible that you will be invited to participate in both surveys

What will you be asked to do?
If you participate you will be asked to complete a telephone survey. The survey should take approximately 30 minutes to complete. The survey will include questions about your association with the club (eg. grade), alcohol consumption whilst at your club, alcohol consumption in general, opinions on alcohol serving practices at your club, and simple demographic questions such as age, marital status and income level. The information collected will be strictly confidential. Participation in this survey will assist the research team in evaluating the projects effectiveness and the development of an effective longer-term project.

What choice do you have?
Participation in the study is entirely your choice - you do not have to take part if you don't want to. Whether or not you decide to participate, your decision will not disadvantage you in any way. If you do decide to participate, you may withdraw from the project at any time without giving a reason, by contacting Tameka Small on 02 4924 6289.

What do you need to do to participate?
A telephone interviewer will contact you to see if you would like to participate in the survey. You will be able to complete the survey at a time convenient to you. If you do not wish to be considered for participation in the survey, please contact < insert name and contact details>.

How will your privacy be protected?

- All of your responses to the survey will be treated in strict confidence. All data will be entered into a computer, analysed, and stored securely at Hunter New England Population Health for at least 5 years.
- Your name and contact details will be stored separately from your data.
- Only the Research Team members identified at the bottom of this letter will have access to the data.
- With regards to storage and disposal of confidential information, we follow the principles of the Privacy of Information Act, in addition to the National Health and Medical Research Council and the University of Newcastle ethics regulations.

How will the information collected be used?

- The information you provide will assist the research team in helping to developing a web-based intervention to create more sustainable and healthy community sports club environments.
- The data will be presented in a final report to the Australian Research Council, and may be published in a scientific journal or student theses.
- The reports of their findings will include group results only. Individual participants will not be identifiable in any reports arising from the project.
- A summary of the results will be available to all participating clubs through the Good Sports Program.
- Data collected as part of this study will be used as part of a student research higher degree thesis.

Further information about the Project

If you would like further information please contact Tameka Small on 02 4924 6289.

Thank you for considering this invitation.

Yours sincerely

Prof John Wiggers
Director, Hunter New England Population Health

Complaints about this research

This project has been approved by the University's Human Research Ethics Committee, Approval No. H-2013-0429Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to the Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, telephone (02) 49216333, email Human-Ethics@newcastle.edu.au.

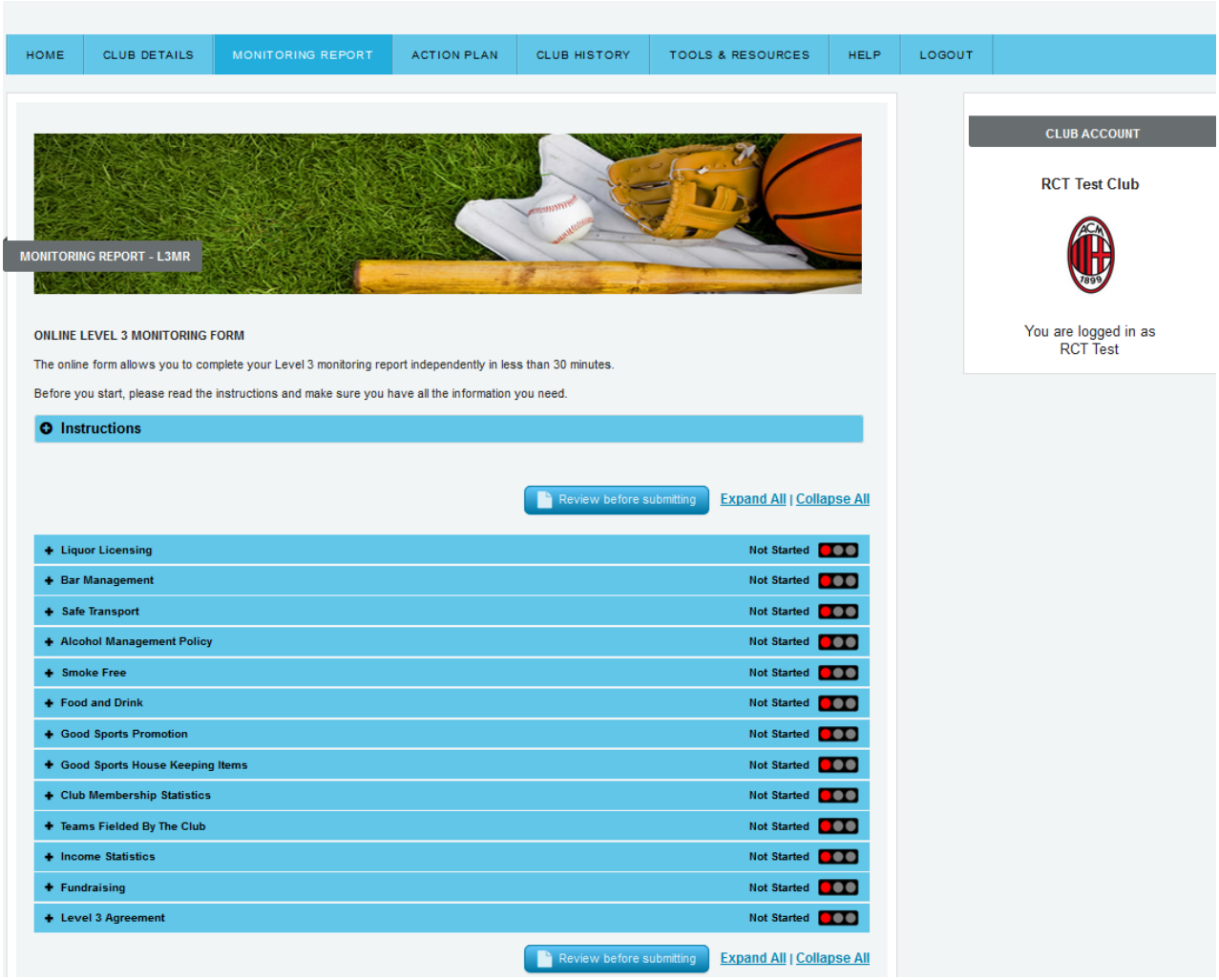
The Research Team

Prof John Wiggers , Hunter New England Population Health and The University of Newcastle
Dr Luke Wolfenden, The University of Newcastle
Dr Patrick McElduff, The University of Newcastle
Dr Bosco Rowland , Deakin University
Ms Karen Gillham, Hunter New England Population Health
Ms Jennifer Tindall, Hunter New England Population Health
Ms Maree Sidey, The Australian Drug Foundation
Ms Tameka-Rae Small, The University of Newcastle

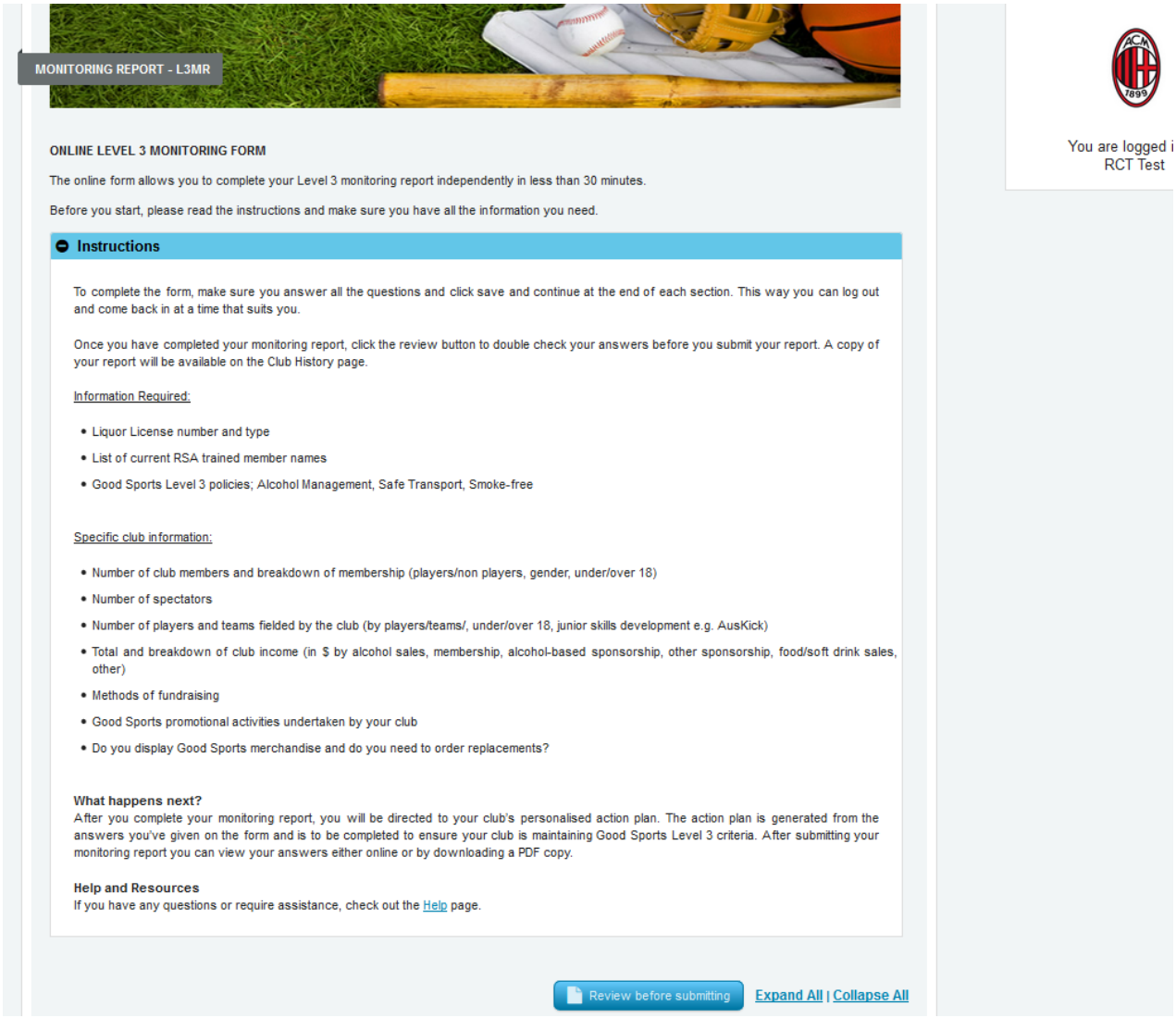
APPENDIX 9 Web imagines of the annual online assessment

Good Sports RCT intervention site

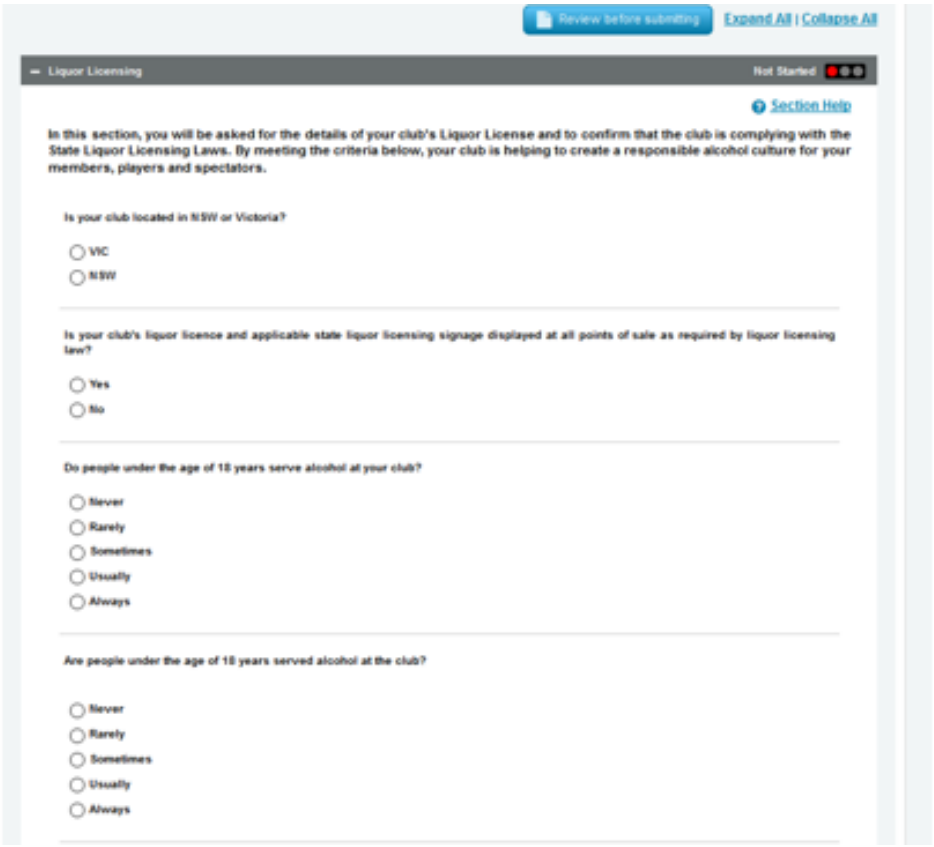
Annual online assessment (Monitoring report main tab)

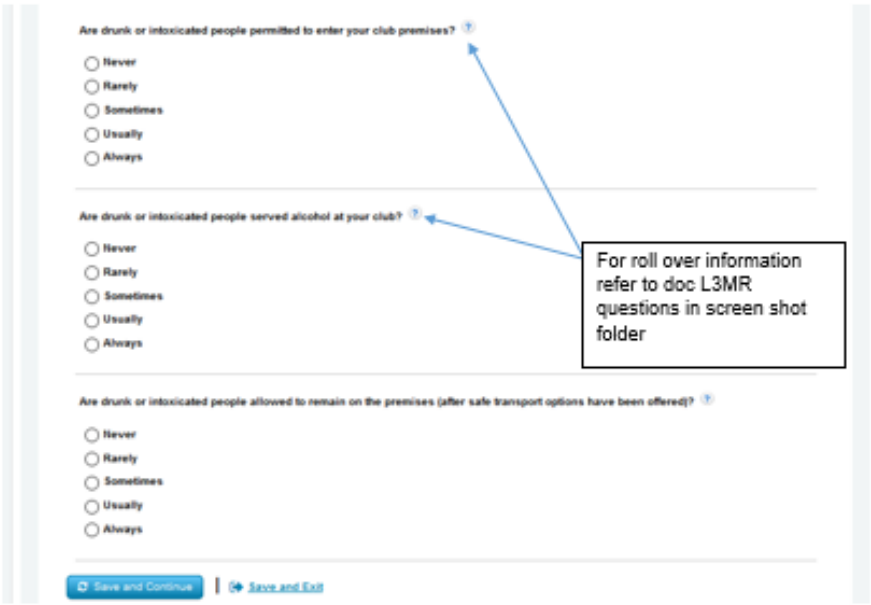


Instructions tab

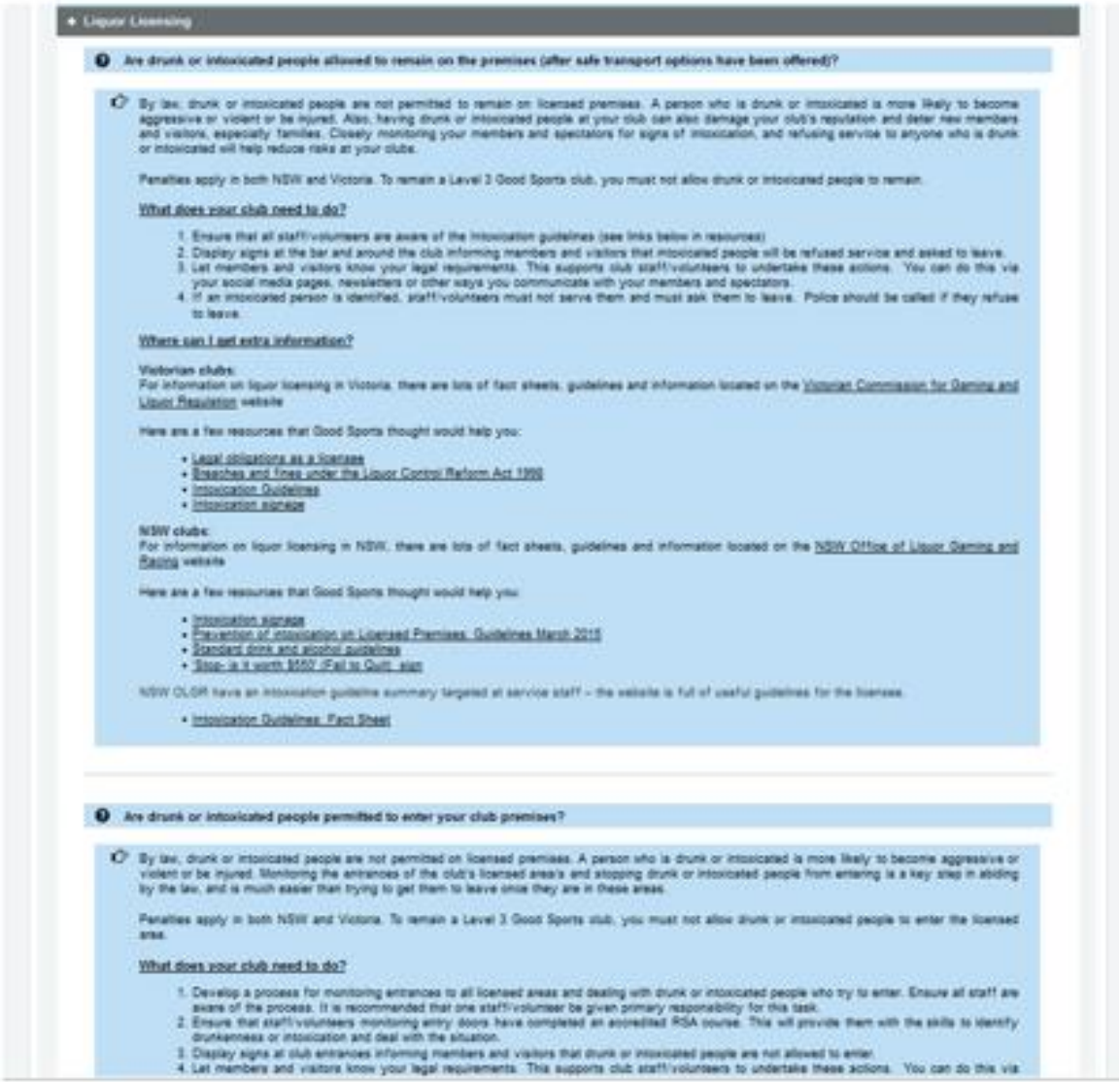


Liquor licensing section





Section help link



◆ Liquor Licensing

Are drunk or intoxicated people allowed to remain on the premises (after safe transport options have been offered)?

By law, drunk or intoxicated people are not permitted to remain on licensed premises. A person who is drunk or intoxicated is more likely to become aggressive or violent or be injured. Also, having drunk or intoxicated people at your club can also damage your club's reputation and deter new members and visitors, especially families. Closely monitoring your members and spectators for signs of intoxication, and refusing service to anyone who is drunk or intoxicated will help reduce risks at your clubs.

Penalties apply in both NSW and Victoria. To remain a Level 3 Good Sports club, you must not allow drunk or intoxicated people to remain.

What does your club need to do?

1. Ensure that all staff/volunteers are aware of the intoxication guidelines (see links below in resources)
2. Display signs at the bar and around the club informing members and visitors that intoxicated people will be refused service and asked to leave.
3. Let members and visitors know your legal requirements. This supports club staff/volunteers to undertake these actions. You can do this via your social media pages, newsletters or other ways you communicate with your members and spectators.
4. If an intoxicated person is identified, staff/volunteers must not serve them and must ask them to leave. Police should be called if they refuse to leave.

Where can I get extra information?

Victorian clubs:
For information on liquor licensing in Victoria, there are lots of fact sheets, guidelines and information located on the Victorian Commission for Gaming and Liquor Regulation website

Here are a few resources that Good Sports thought would help you:

- Legal obligations as a licensee
- Breaches and fines under the Liquor Control Reform Act 1998
- Intoxication Guidelines
- Intoxication signage

NSW clubs:
For information on liquor licensing in NSW, there are lots of fact sheets, guidelines and information located on the NSW Office of Liquor Gaming and Racing website

Here are a few resources that Good Sports thought would help you:

- Intoxication signage
- Prevention of intoxication on Licensed Premises: Guidelines March 2015
- Standard drink and alcohol guidelines
- Stop- is it worth $550! (Fail to Quit) sign

NSW OLGR have an intoxication guideline summary targeted at service staff – the website is full of useful guidelines for the licensee.

- Intoxication Guidelines: Fact Sheet

Are drunk or intoxicated people permitted to enter your club premises?

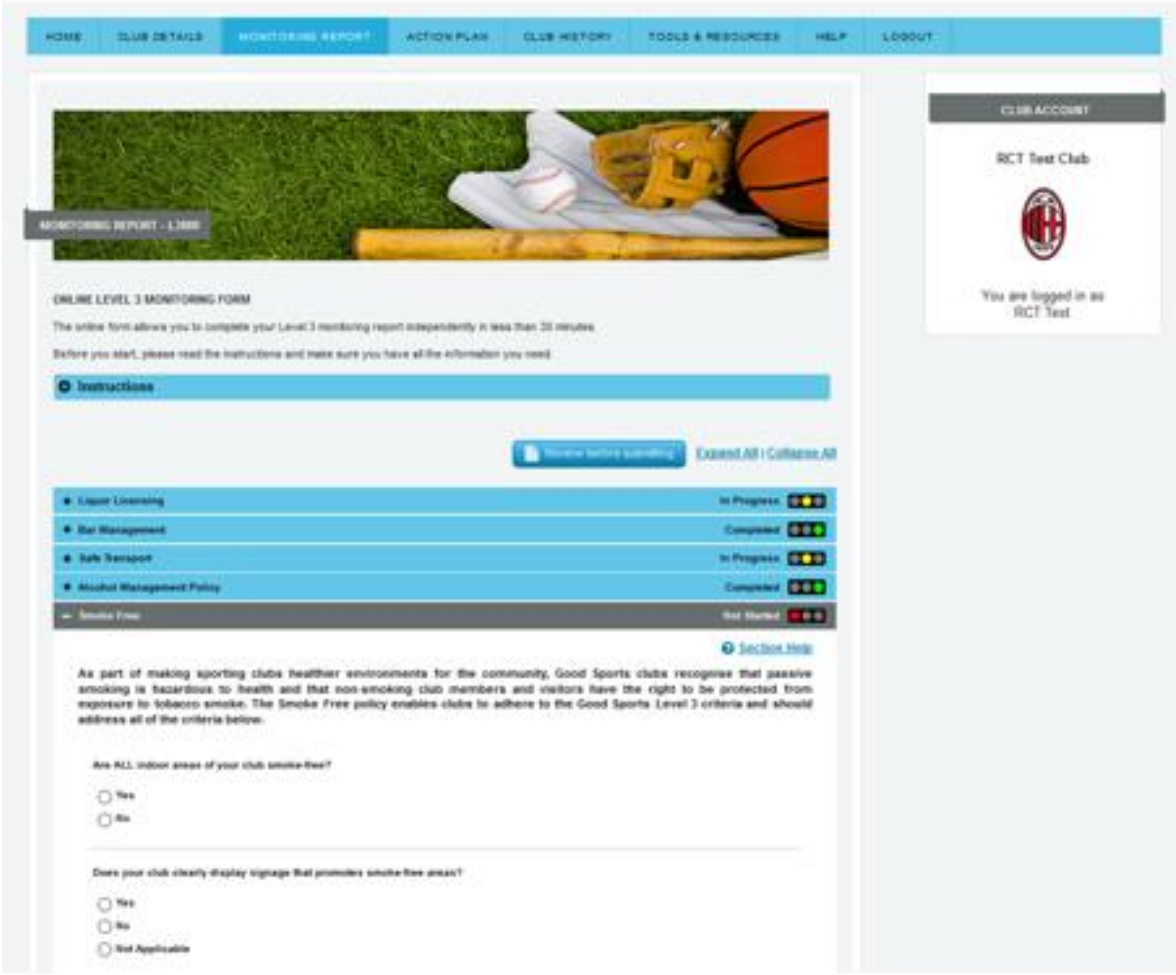
By law, drunk or intoxicated people are not permitted on licensed premises. A person who is drunk or intoxicated is more likely to become aggressive or violent or be injured. Monitoring the entrances of the club's licensed area's and stopping drunk or intoxicated people from entering is a key step in abiding by the law, and is much easier than trying to get them to leave once they are in these areas.

Penalties apply in both NSW and Victoria. To remain a Level 3 Good Sports club, you must not allow drunk or intoxicated people to enter the licensed area.

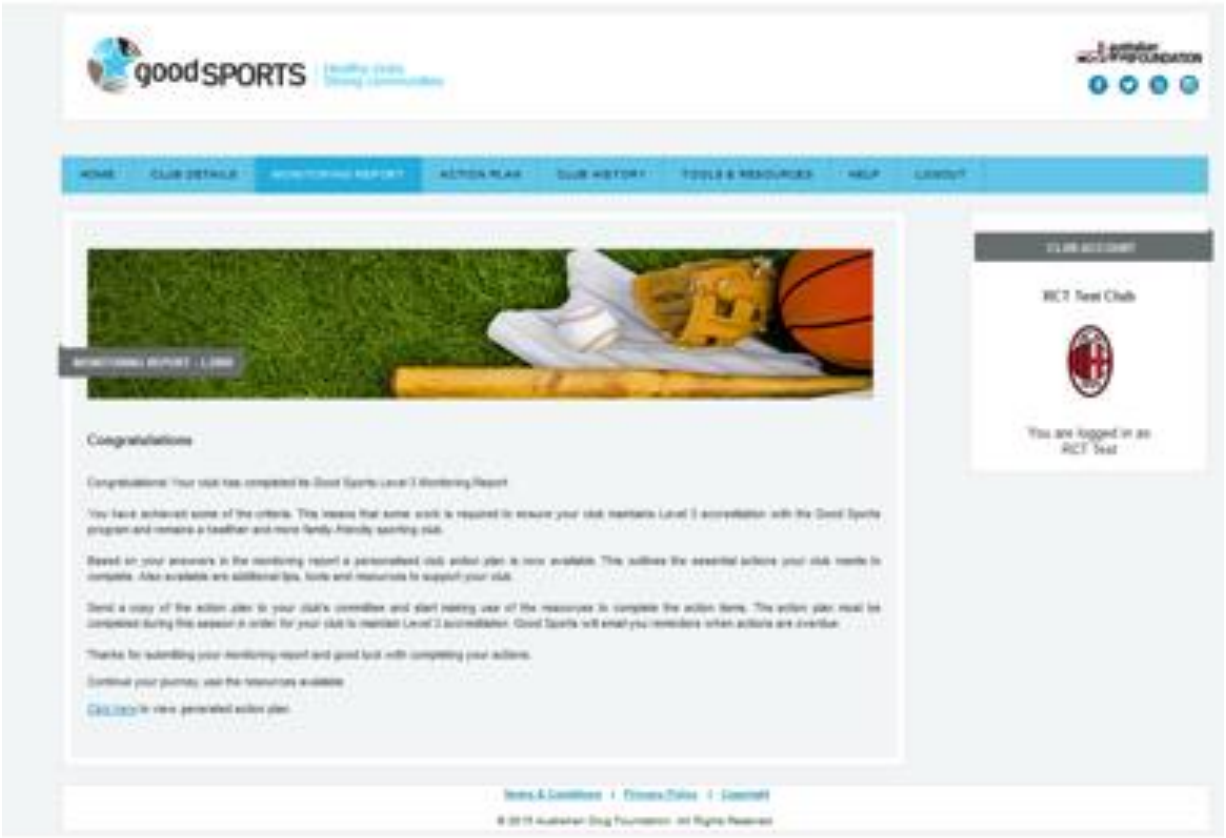
What does your club need to do?

1. Develop a process for monitoring entrances to all licensed areas and dealing with drunk or intoxicated people who try to enter. Ensure all staff are aware of the process. It is recommended that one staff/volunteer be given primary responsibility for this task.
2. Ensure that staff/volunteers monitoring entry/ doors have completed an accredited RSA course. This will provide them with the skills to identify drunkenness or intoxication and deal with the situation.
3. Display signs at club entrances informing members and visitors that drunk or intoxicated people are not allowed to enter.
4. Let members and visitors know your legal requirements. This supports club staff/volunteers to undertake these actions. You can do this via

Working through monitoring report – traffic light use



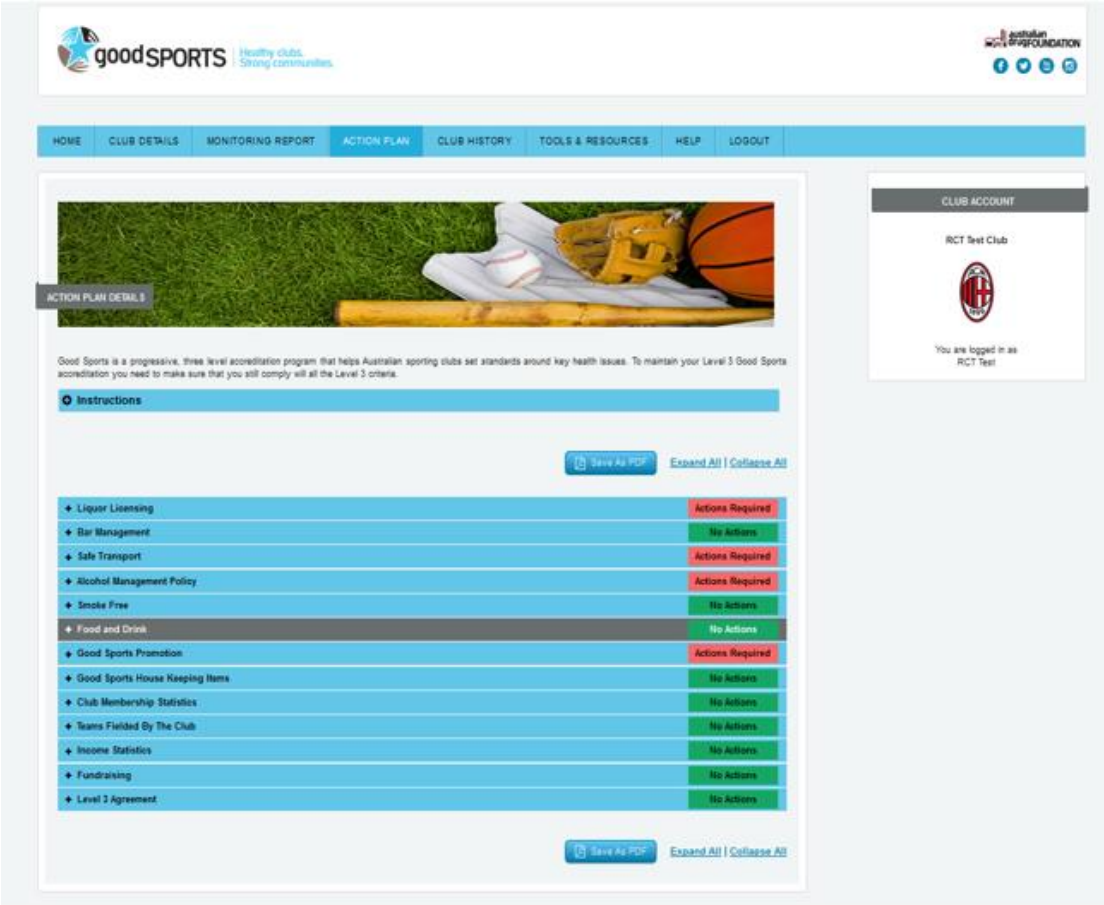
Completion of monitoring report



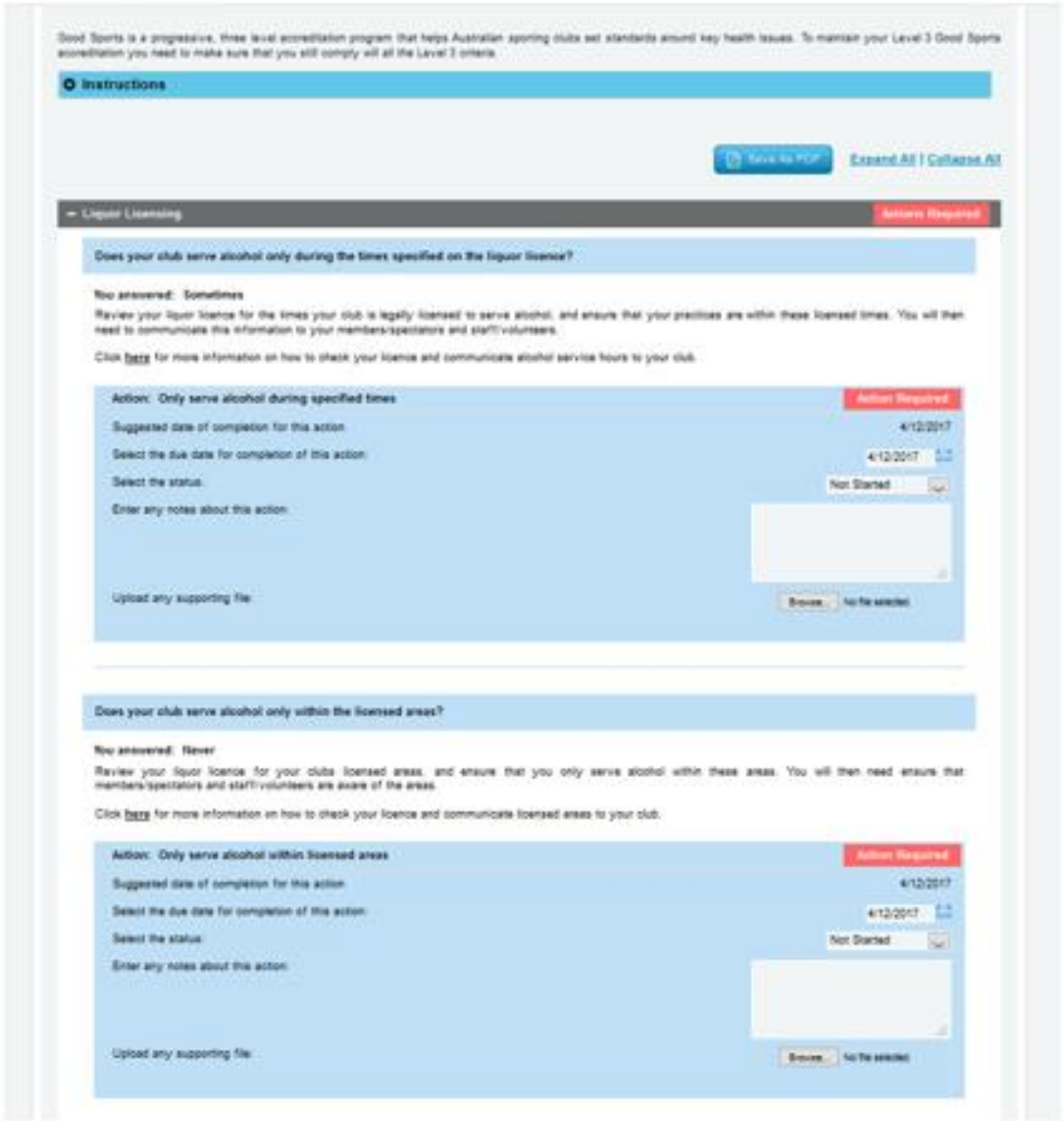
APPENDIX 10 Web imagines of the online action plan

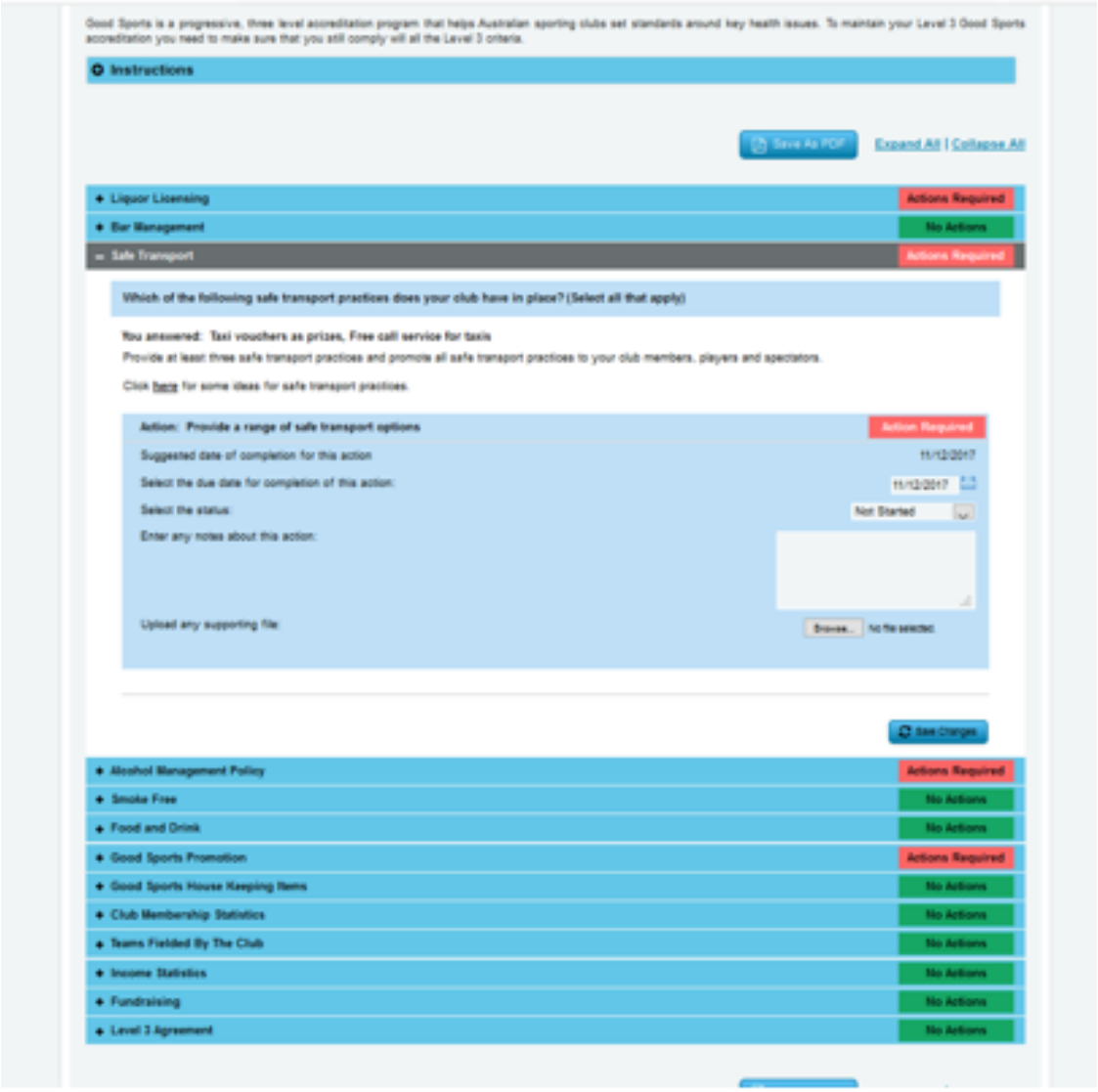
Good Sports RCT intervention site

Action plan main tab

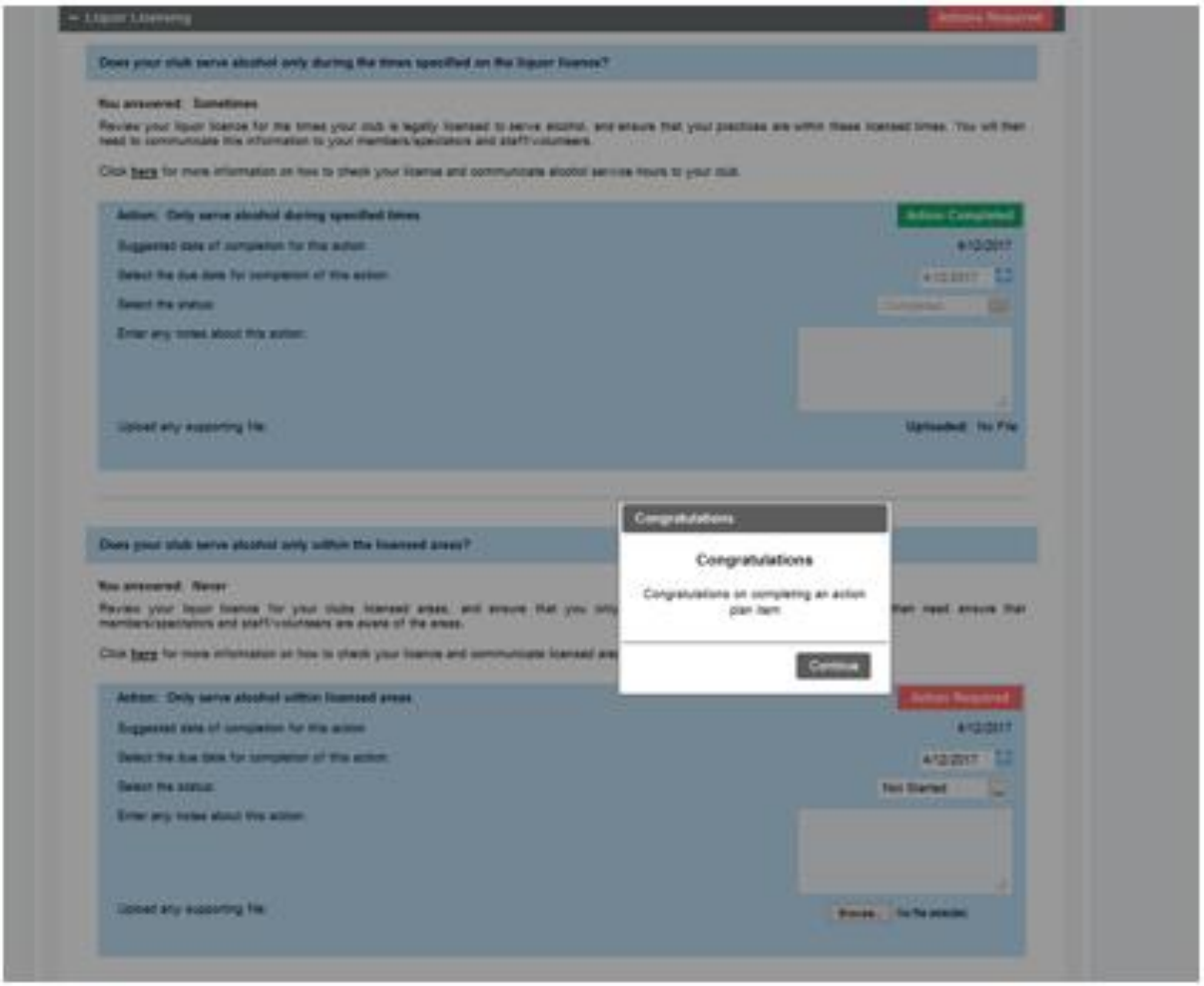


Actions required

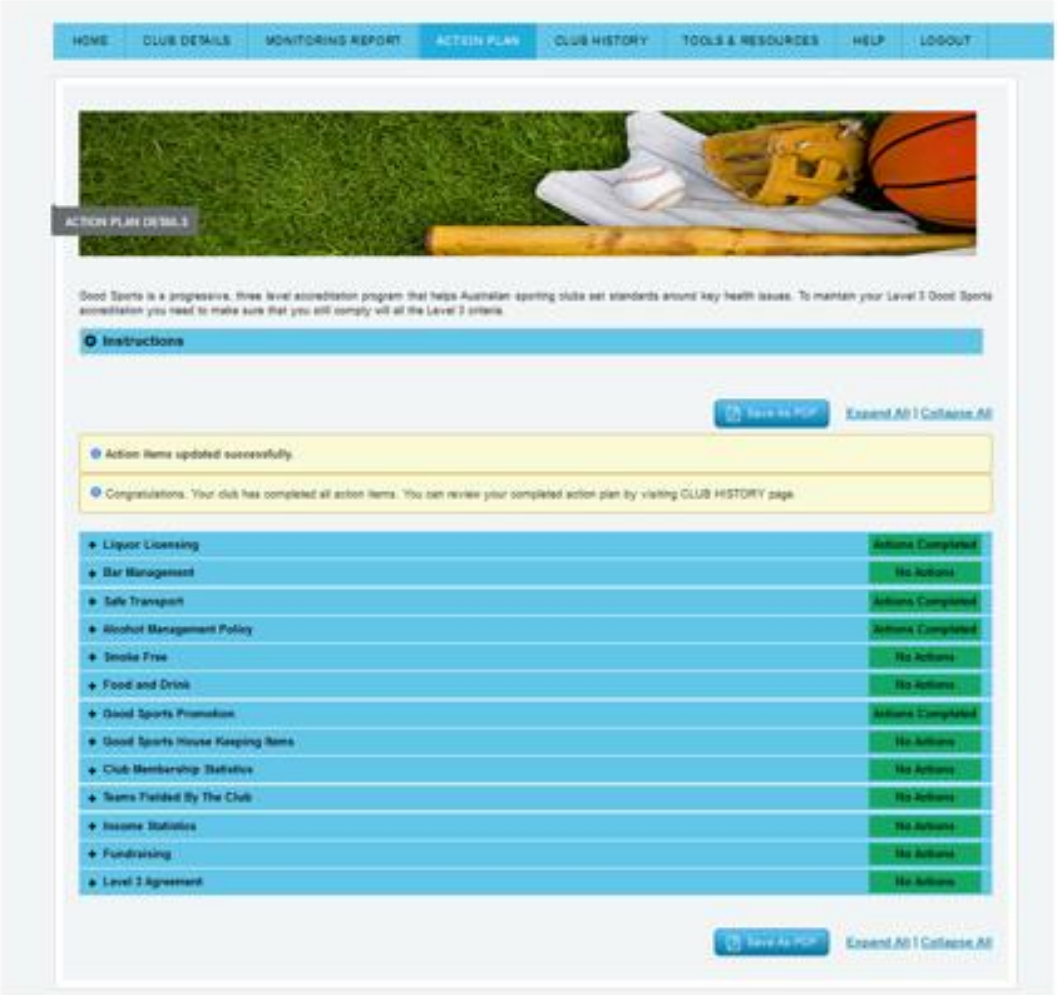



Good Sports is a progressive, three level accreditation program that helps Australian sporting clubs set standards around key health issues. To maintain your Level 3 Good Sports accreditation you need to make sure that you still comply will all the Level 3 criteria.
Instructions
Save As PDF
Expand All | Collapse All
Liquor Licensing
Actions Required
Bar Management
No Actions
Safe Transport
Actions Required
Which of the following safe transport practices does your club have in place? (Select all that apply)
You answered: Taxi vouchers as prizes, Free call service for taxis
Provide at least three safe transport practices and promote all safe transport practices to your club members, players and spectators.
Click here for some ideas for safe transport practices.
Action: Provide a range of safe transport options
Action Required
Suggested date of completion for this action
11/12/2017
Select the due date for completion of this action:
11/12/2017
Select the status:
Not Started
Enter any notes about this action:
Upload any supporting file:
Browse...
No file selected.
Save Changes
Alcohol Management Policy
Actions Required
Smoke Free
No Actions
Food and Drink
No Actions
Good Sports Promotion
Actions Required
Good Sports House Keeping Items
No Actions
Club Membership Statistics
No Actions
Teams Fielded By The Club
No Actions
Income Statistics
No Actions
Fundraising
No Actions
Level 3 Agreement
No Actions

Complete action items



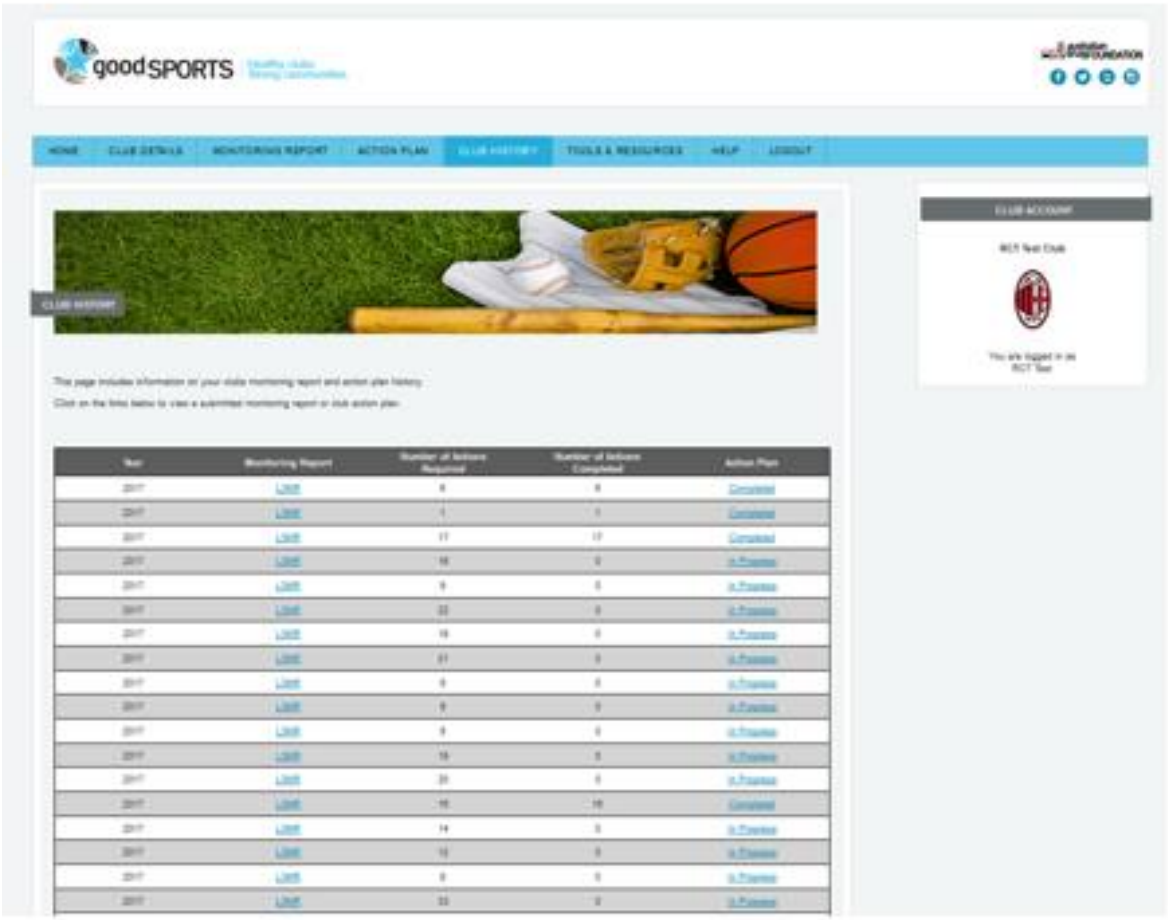
All completed items



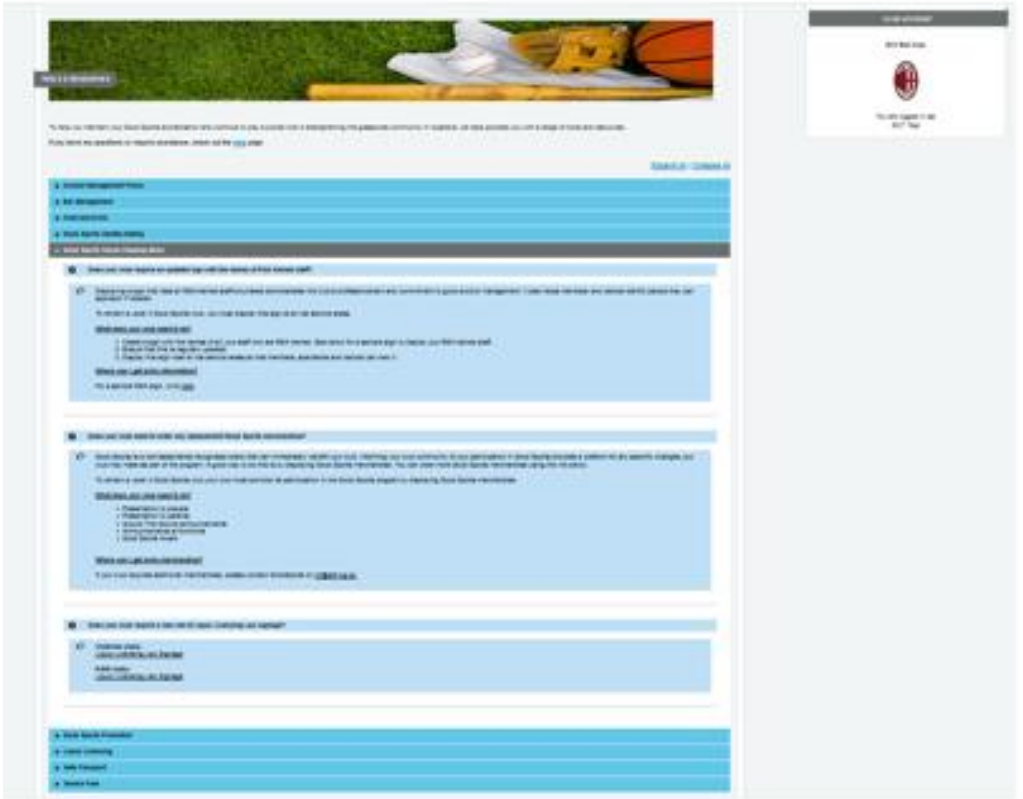
APPENDIX 11 Web imagines of additional content on intervention site

Good Sports RCT intervention site

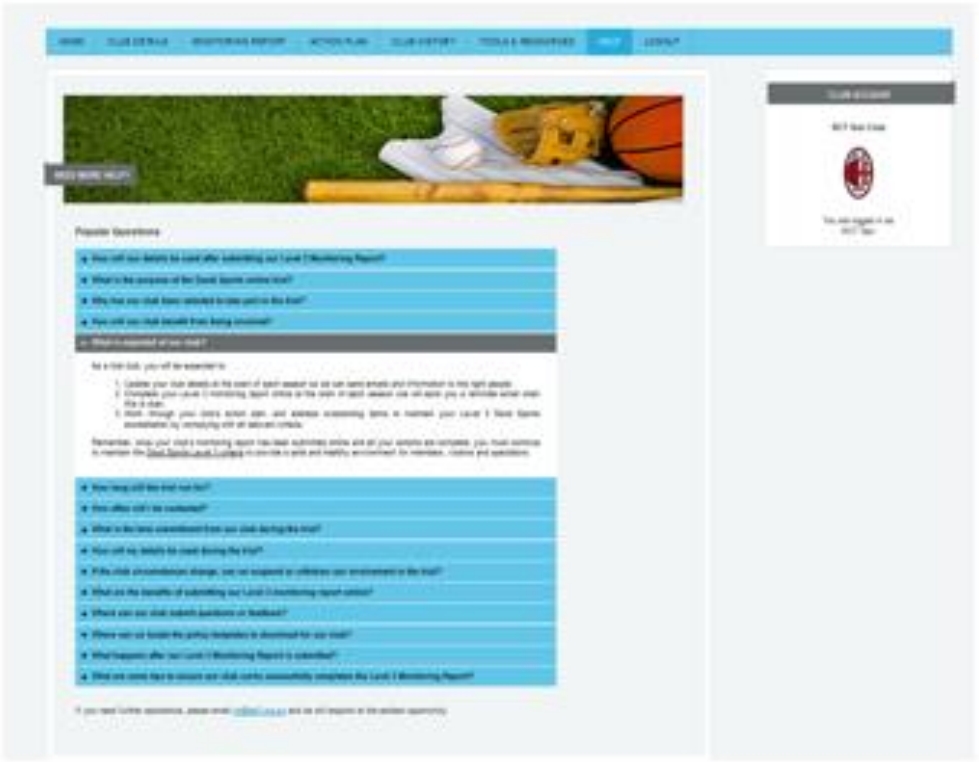
Action plan main tab



Tools and resources main tab



Help main tab



APPENDIX 12 Research assistant observation training manual

GOOD SPORTS MATCH-DAY VISITS

Training Manual

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PROJECT CONTACTS

The University of Newcastle/Hunter New England Population Health

Removed for privacy

1 WHAT IS GOOD SPORTS?

Good Sports is an initiative of the Alcohol and Drug Foundation (ADF)(previously the Australian Drug Foundation), and has been implemented with community sporting clubs since 2001. More than 6,000 Australian community sporting clubs are participating in Good Sports across Australia.

Good Sports tackles:

- excessive drinking and alcohol-related violence
- drink-driving
- unhealthy food consumption
- exposure to passive smoking

Good Sports clubs are:

- role models for other clubs and within their communities
- safer, healthier and more family-friendly
- more attractive to sponsors
- more attractive to members, volunteers and players
- involved in fewer alcohol-related problems such as binge drinking and underage drinking

Participating clubs progress through the Good Sports three-level accreditation program by meeting a range of criteria over two-years:

Level 1	Focuses on many practices clubs will usually be doing, including compliance with New South Wales (NSW) liquor licensing laws and enforcing a smoke-free environment
Level 2	Focuses on responsible management of alcohol, safe transport options and healthy food choices
Level 3	Involves clubs developing specific policies to support the changes that have been made in levels 1 and 2

2 WHAT IS THE GOOD SPORTS RESEARCH TRIAL?

2.1 What is the aim of the trial?

The Good Sports ARC Graduate Trial is a 3 year Australian Research Council (ARC) funded research project being conducted by researchers from:

- The University of Newcastle
- Hunter New England Population Health
- The Alcohol and Drug Foundation
- Deakin University

The aim of this research trial is to identify the best way to support clubs in the long-term to maintain their Good Sports Level 3 Accreditation. Specifically we are interested to find out if support via the internet can be effective in sustaining practices.

If the benefits of such interventions are to be ongoing, the changes adopted by sporting clubs need to be sustained over time.

2.2 What is the research design of the trial?

The GS Graduate Trial is a Randomised Controlled Trial (RCT) involving sporting clubs have been accredited at Level 3 of the Good Sports program ("Graduates") on or since 30th June 2011.

The clubs will be randomly allocated to one of two groups following there Match-Day-Visit (MDV):

GROUP 1: INTERVENTION	GROUP 2: USUAL GOOD SPORTS SUPPORT
Web-based intervention	Variable face-to-face intervention

2.3 How are the main outcomes being assessed?

The main outcomes of the trial are being assessed using via two methods:

1. Match-Day-Visits (MDV) to observe the maintenance of health promotion practices of the clubs accredited at level 3 in Good Sports; and,
2. Telephone surveys with club members/supporters to collect information on alcohol consumption at the club.

2.4 How many clubs are participating and what was the consent process?

There are 188 football clubs participating in the research trial. The eligibility criteria for the trial included:

- Football codes (soccer, AFL, rugby league and rugby union)
- Accredited at Level 3 in Good Sports since June 2011
- Sell alcohol at the ground
- At least one senior team
- Access to the internet

The following recruitment process was undertaken in 2014 and 2015:

Figure 1: Club recruitment process

JULY 2014
All clubs in the sampling frame were sent an ethics-approved letter inviting them to participate in the research trial

↓

AUGUST TO NOVEMBER 2014
All clubs in the sampling frame were contacted via telephone to assess their eligibility, obtain verbal consent for their club to participate, and collect some baseline data from the club themselves (eg. number teams, alcohol management practices, policies etc). During this call, all clubs were requested to sign and send back the written consent form (Appendix 1).

↓

NOVEMBER 2014 TO JULY 2015
Consent forms were received from the clubs and filed

2.5 What stage is the research trial up to?

The research trial is currently at the end of the intervention period, and progressing into the post-intervention data collection stage. Since July 2014, here is what we have achieved:

Figure 2: Research trial stages

✓ **Stage 1: Club recruitment and consent (as outlined above)(COMPLETED)**

↓

✓ **Stage 2: Baseline data collection (COMPLETED)**
In May to August 2015, Match Day Visit observational data were collected on all 188 clubs, and contact details of over 2300 members/supporters were collected.

In July to October 2015, 1000 members/supporters participated in a telephone survey focusing on their alcohol consumption at the club.

↓

Stage 3: Intervention delivery (CONTINUING)
The Good Sports Graduate On-Line Program was implemented during the 2015 winter sporting season, continued throughout the 2016 season and will continue for a few months into the 2017 season.

↓

Stage 4: Post-intervention data collection (ABOUT TO START)
In May to July 2017, post-intervention MDV will be completed. During these visits, you will be responsible for recruiting 20 adult members/supporters from each club to participate in a telephone survey during the 2017 season.

Stage 5: Data analysis and reporting (NEXT STEP)
Once we have collected all of the data, the final stage will be data analysis and reporting back to the funders (ARC) and the wider population (via peer-reviewed journals and media)

2.6 A few important points

- The findings from this research trial will be used to inform the future provision of services to sporting clubs across Australia
- Standardisation is very important for scientific quality
- There are a number of quality processes in place to ensure data quality (these are discussed later)

3 MATCH DAY VISIT OVERVIEW

3.1 Where are the clubs located?

The 188 clubs are located across Victoria (N=149) and the Hunter New England area of NSW (39).

In Victoria, the majority of the clubs are located within a 100km drive of Melbourne (92 clubs), however, some are located in more remote areas. In NSW, all the clubs are located within the Hunter New England area, with the majority of clubs being located within 100km drive of Newcastle, but there are some clubs in the Great Lakes and Upper Hunter Regions (eg. Taree and Singleton).

3.2 When will the clubs be observed?

Because of the requirement for the Match Day Visits to occur during a footy game, the vast majority will be completed on a Saturday and Sunday afternoon. However, there may be some games that are scheduled for Friday night, but it is expected that these will be limited. The MDV has to occur at the home ground of the participating clubs. The visits will be scheduled for the main game of the day (usually the senior game) and will occur generally between 12pm and 6pm. They must be selling alcohol for at least part of the visit.

The MDV are due to start the weekend of **13th May 2017** and will continue for at least 12 weeks.

3.3 How will you know which club to visit?

Given that the MDV must occur at a senior game at the home ground, scheduling the visits will be a very important task for TKW. Each club must be observed once during the 12 week observation period. This means that approximately 15-20 clubs must be visited each weekend.

We are aware that games may be cancelled due to bad weather (especially in NSW), and to ensure that all clubs are visited, each club has been scheduled twice based on their fixtures available on their websites (the second date will be back-up only).

You will be required to remain at the club ground for a minimum of 3 hours, and as such, will only get to visit one club each day.

You will be rostered each weekend by TKW and given the details of the club you will be visiting (including location and time of main senior game).

3.4 Who will be in your teams?

Each team must consist of **two observers** for safety reasons and to ensure that two sets of independent data are collected. Whilst you will be with your other team member at all times, it is important that each of you complete one MDV form each without discussing or sharing information. This is important so that we can assess the inter-rater reliability of your observations.

3.5 What are you required to do?

As an observer, there will be two main tasks for you to complete whilst at the club:

1. Observe and record practices in relation to alcohol, smoking, healthy food choices and Good Sports Promotion

2. Recruit 20 club members/supporters for the telephone survey, and record their details

These will be discussed in more detail in section 4, but the main practices relate to alcohol management, smoking at the club and healthy food choices at the club.

3.6 Do the Clubs know you are coming to observe?

The club representatives are aware that the project will be doing a MDV during the 2017 footy season, but they are unaware of when. Just prior to the start of the MDVs, a letter will be sent to all clubs reminding them that the MDV will occur during the 2017 season, and that they will be required to assist you at some point (Appendix 2). This is because people tend to change their behaviour when they know they are being observed.

You must be as covert as possible – please make use of the cheat sheet provided to ensure that you assess all the required information. This sheet can also be used to record details whilst at the club.

4 THE MATCH DAY VISIT PROCESS – 10 ESSENTIAL STEPS

STEP 1: Meet at home ground 30 mins before the start of the main senior game

Teams must arrive at the club ground 30 mins prior to the main senior game of the day. Before you enter the ground as a team, please ensure that EACH of you has the following:

- A functioning tablet each to complete the surveys at the end
- A printed pen and paper version (to use if the tablet malfunctions)
- A cheat sheet (Appendix 7)
- Resource kit (Appendix 5)

It would be advisable to keep a copy of the training manual in your bag or car – for reference if needed.

Also ensure that the team has at least one copy of the following:

- The name of the club representative that you need to locate during the game
- Access to a copy of the signed consent form (just in case)(see your email)(Appendix 1)
- A copy of the letter recently sent notifying them of the MDV in 2017 (Appendix 2)
- 20 copies of the member letter (Appendix 3)
- A copy of the member recruitment survey (Appendix 8)
- The paper copy of the randomisation sequence for the member recruitment (Appendix 4)

If an entry fee is required, note down the amount on your time sheet & this will be reimbursed fortnightly as per the pay run provided in the TKW starter kit.

STEP 2: As a team, select the best location to conduct the covert observation

As a team, walk around the ground and select the most appropriate location to start the covert observation – this should be a busy area where you can observe the practices of the bar staff and supporters. There may be differences between Victoria and NSW. In Victoria, larger clubs have club-houses (like a bar area) where alcohol is served and consumed. Whilst in NSW, clubs tend to have canteens where alcohol may be sold. You need to be at a location where you can observe the alcohol service staff and the patrons. Whilst the majority of the observation needs to be conducted at this location, you will need to walk around the ground and club spectators.

If you need to access a 'clubhouse' where alcohol is being served where sign-in is required (eg. as a member), you may need to notify the club representative earlier than usual so that you can obtain access to the clubhouse.

Because the focus of this trial is alcohol management, the club must be serving alcohol at the time of the observation. If they aren't at the start of the observation, please remain at the club until

service starts. If they do not serve alcohol, please contact your shift supervisor (Kathy Turner) for advice.

STEP 3: Conduct the covert observation (Observable survey)(most of 1st half)

During the first half of the game (or first 2 quarters in AFL), observe as many of the practices as you can. However, remember that the official observation must continue throughout the entire 3 hour period, however, there are some practices that probably won't change over 3 hrs (eg. free water, food availability, signage).

Whilst the MDV tool has been separated into two observation sections (observable and non-observable), it is encouraged that all data is collected via observation and only the information that is not easily observable be collected during contact with the club representative.

Remember, whilst completing the observation, you must remain unobtrusive, move around the ground, and recording the observation details as discretely as possible. Use your cheat sheet and resource kit to help you remember what you have to observe, and record information.

The data must be entered into the tablet at the end of the observation period.

Please see Appendix 6 for a copy of the version used in the training.

STEP 4: Contact the club representative (10 mins before half time)

About 10 minutes before half time, you will need to find the club representative. If you are not sure, just ask in the bar or canteen. Remember, this person is often the club president or secretary and are very busy during half time. The Good Sports team have recently updated this information for all clubs, but there may be some clubs where the contact has changed. In this case, find the appropriate person and talk to them instead. You will be emailed a copy of the original consent form that was signed by the club in 2014/15 – just in case you need to show it to the new club representative.

The main reasons for contacting this person are so that you can:

- Let them know you are at the club doing the MDV
- Gain access to the bar service area or canteen to complete the non-observable section of the tool
- Gain access to a bar area that requires sign-in (as stated previously, this may be needed earlier in the observation)
- Obtain permission to recruit club members and supporters to participate in a telephone survey at a later date

If the club representative is not available, ask the staff for another person you can talk to.

STEP 5: Assess the required items in the non-observable survey

Ask the canteen or bar staff (or club rep) to help you complete the non-observable practices. However, if these can be observed without their assistance, this is preferred. Remember that the canteen and bar can get very busy, especially during half time, so try not to get in the way of the staff and volunteers.

Since this section may involve asking questions, only one observer needs to ask the questions – but **BOTH** need to record the responses independently.

If you cannot complete this section of the tool at this time (eg. too busy), please complete when the game ends.

STEP 6: Recruit 20 members/supporters for the telephone survey

This process should be undertaken **during half time and 10 mins into the 2nd half of the game.** This step involves recruiting members/supporters for a telephone survey that will be conducted during the 2017 footy season.

This task should be completed as a team:

Observer 1: Selecting using randomisation process and assessing eligibility

Observer 2: Providing information letter and recording contact details

The following process MUST be followed to ensure that we obtain a sample that is generalizable:

a) Locate yourselves near the main bar service area so that you will get people on their way or way back from the bar (however, don't get in the way). If there is inadequate thoroughfare, and people are sitting at tables, you can approach them there (as long as you use the random numbers to select).

b) Use the random allocation sheet to select people and approach the selected person to:
   - Inform them that you are working on behalf of Good Sports, and asking people if they would be willing to provide their details for a telephone survey (at a later date)
   - Ask a few simple eligibility questions: are they over 18 years?, are they a member or supporter of the home club?, what is their role at the club?

c) If they are over 18 years of age and a member/supporter of the home club, would they be willing to provide their name and contact details so that we can call them in the next few months to formally invite them to participate

d) If yes, you must provide them with a copy of the member letter (appendix) and record their details (name, phone numbers, role with club and best time to contact them)

e) Continue these processes until you have 20 names or this process goes beyond the first 10 mins of the 2nd half.

This information must be entered into your tablet during the process.

At some clubs, this process can continue after the game, especially at clubs where supporters will stay for a drink. At some clubs, there may not be adequate numbers of supporters/members to recruit 20 people – this is what we would like, but 15 will suffice. However, if you are unable to get 15 people, you don't have to persist.

Remember, they are simply consenting to providing their details to the research team at this stage – the research team will be contacting them at a later date for formal consent and completion of the survey. Just because they provide their details during this process, does not mean they have to participate in the survey – they can withdraw at any time. It is important that the letter be provided to them as this is a process approved by the University of Newcastle Human Research Ethics Committee. As an alternative, we can email/send them a letter if they wish.

We will be having a practice of this process during this training session. Please see Appendix 8 for a copy of the member recruitment tool.

STEP 7: Continue the observation for the remainder of game and after game

Once you have collected the member details, continue to observe the club practices until the end of the game and for 30 mins after the game. In some instances, the canteen or bar may close before or at the end of the game, but please remain at the ground to observe member behavior.

STEP 8: Enter your data into the tablet

Once you are confident that you have collected all the data, find a quiet location within the ground to enter it into the tool loaded onto your tablet. Remember, this MUST be done independently with no discussion with your team member.

Once you start entering the information, you will need to enter all the data sequentially (question by question in order). Every question must have a response before the survey can be finished.

We will provide more information in section 5 of this manual, and an opportunity to have a practice during this session.

STEP 9: Complete the observation consensus process

One of the quality assurance processes that has been developed for this project is the 'consensus' process. During this process, you must compare all your responses. Each observer will be responsible for independently recording your data.

Once you have entered your data for both the observable & non-observable surveys, you will be asked to choose 'consensus record' or 'comparison only'. At this stage both staff members' initial data will have been saved & cannot be changed. Both tablets will then show your original responses but only changes made in the 'consensus record' will be captured. After each question the 'consensus record' will ask 'is there a consensus?' If you come across a question where you have different answers, you will choose 'no', & discuss why not. If you cannot come to an agreement there will be an explanation noted as to why not & if possible a photo captured at the end of the consensus.

However, if you come to an agreement where the answer should be the same, 'no' will still be captured & you will need to give an explanation as to why the one original answer was chosen to be correct.

You will not be able to make any changes to your original surveys.

For some behaviours/practices, it is reasonable to assume that if one observer witnessed it but the other didn't, you can reach a consensus that it did occur. For example, if one observer saw staff serving an intoxicated person and the other didn't, it should be recorded as a 'yes'.

STEP 10: Leave the ground

Once you have completed the following tasks, you can leave the ground:

- Observational practices
- Non-observational practices
- All data entry
- Member/supported recruitment (20 names)
- Consensus process

Examples of Observation for a typical AFL and Rugby League Game

Figures 3 and 4 provide examples for 2 sports (AFL and Rugby League). They are only a guide, but remember that each observation period should last a minimum of 3 hours.

Figure 3. An example of an observation for a typical AFL game starting at 2pm

The average quarter will go for 30 minutes with 6 minute breaks in between quarters and a 20 minute break at half time. Therefore, a game will go for approximately 2.5hrs including breaks. However, they may go longer if there are time-outs during the quarters.

TIME		WHAT SHOULD I BE DOING?
1.30	Start of observation period	• Arrive at the ground • Enter the club • Find the most suitable location for the observation • Start observing the observable practices
2.00	Main game kick-off	• Observe as much as you can during the 1st quarter, especially those items that are not likely to change eg. signage, food availability, free water etc.
2.30	End of 1st quarter (6 min break)	• Continue with the observations
2.35	Start of 2nd quarter	• Continue with the observations
2.55	Still 2nd quarter	• Locate the club representative and gain access to the canteen/bar to start the non-observable component
3.05	End of 2nd quarter (Half time 20 mins)	• Begin the member/supporter recruitment activity

3.25	Start of 3rd quarter	• Continue with the member/supporter recruitment and observations
3.55	End of 3rd quarter (6 min break)	• Continue with the observations
4.00	Start of 4th quarter	• Continue with the observations
4.30	End of game	• Continue with observations • Continue with member/supporter recruitment if required
5.00	Consensus process	• Find somewhere inside the ground to sit and complete the consensus process
5.15	End of observation	• Leave the ground once all tasks are completed

Figure 4: An example of an observation for a typical <u>Rugby League</u> game starting at 2pm

A typical rugby league game will go for a total of 90 minutes including breaks. They will usually have two 40 minute halves and a 10 min half-time break.

TIME		WHAT SHOULD I BE DOING?
1.30	Start of observation period	• Arrive at the ground • Enter the club • Find the most suitable location for the observation • Start observing the observable practices
2.00	Main game kick-off	• Observe as much as you can during the 1st quarter, especially those items that are not likely to change eg. signage, food availability, free water etc.
2.30	Still 1st half	• Locate the club representative and gain access to the canteen/bar to start the non-observable component
2.40	End of 1st half (10 min break)	• Begin the member/supporter recruitment activity
2.50	Start of 2nd half	• Continue with the member/supporter recruitment and observations
3.30	End of game	• Continue with observations • Continue with member/supporter recruitment if required
4.00	Consensus process	• Find somewhere inside the ground to sit and complete the consensus process
4.15	End of observation	• Leave the ground once all tasks are completed

5 DATA RECORDING

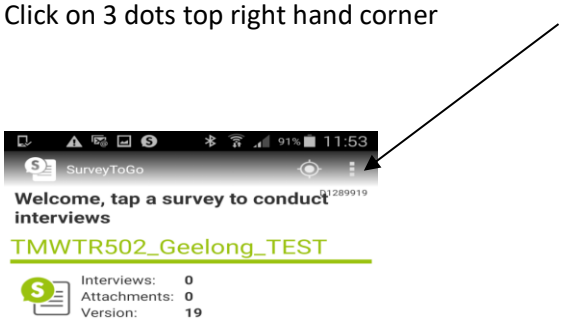
All data will be entered directly into the program/s on the TKW tablet.

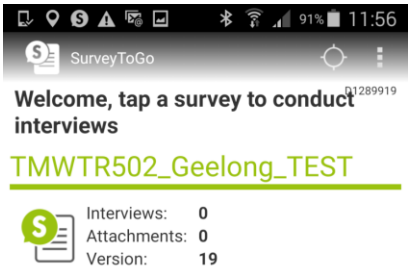
TABLETS

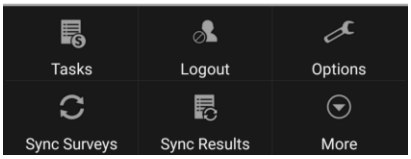
- Always ensure that the airplane mode is switched off. Be careful when logging off that you don't accidently switch this mode on.
- Ensure that your tablet is fully charged the night before each shift
- All test questionnaires and the test link will be deleted before the first day in field. Please sync your tablets at the beginning and end of each shift. Do these before you leave for a shift & when you get home in case the internet connection is poor at your location/ground. See below for further instructions.
- The user will always be your **first and surname** eg. Angela Magoga
- The password is **solutions**
- The Organisation is always TKW Research
- If asked to download a new version of S2Go, please do so
- If the following comes up, touch on yes. 'These user credentials were not found on this device. Do you want to try to login to server'
- If at any stage you need to suspend a survey, touch on the back arrow on the bottom of the tablet. An exit box will appear. Always select **Yes** to save and close. When you need to resume, go to the start/run window where you will notice an orange circle with an exclamation point. Hold your finger on this and a box will appear asking you to continue or to view. Select continue & your questionnaire will resume where you left off.

INSTRUCTIONS TO SYNC RESULTS AND SURVEY

Click on 3 dots top right hand corner







Click on sync results & then sync surveys. Once you are in field you should not see the test mode.

- At the end of each survey (observable & non-observable) you will be asked to choose who is going to run the consensus record & who will be looking at the comparison only. Ensure while you are seated next to each other that only one of you choose the consensus & the other chooses comparison.

The data collection tool has been set up so that you can still record data if you are having trouble connecting to the internet. The data can be entered and will automatically be uploaded to the internet once Wi-Fi is available.

6 QUALITY ASSURANCE

Because this is a research trial (RCT) funded by the Australian Research Council, data quality is a priority to the research team. There are a number of processes that have been built into the trial including:

- Two independent observers per club (inter-rater reliability)
- The consensus exercise at the end of the observation
- Weekly reviews of the data for errors, inconsistencies and issues; followed by reporting back to observation staff
- Quality assurance MDV by research staff

For the Quality Assurance MDV, University of Newcastle staff will be attending approximately 10% (about 20) games at the same time as you. They will be responsible for collecting the same data as you, and then we will compare the responses. We do this so that we can identify any problem questions and improve the quality of the data. Because they have to observe the same practices as you, they will need to enter the ground with you and remain with you at all times.

TKW will be aware of which games a QA observer will be attending, and you will be informed. You will need to phone the QA observer when you get to the ground and organise for a meeting time and place outside the ground (eg. at the gate). They will not be part of your observation team but an independent observer, however, make them feel welcome and have a chat. Do not talk about the tool and the practices with them. They will not be taking part in the member/supporter recruitment activity or the consensus process, but they will be observing how you complete the tasks. This is important so that they can inform us of any problems you may be facing.

7 CONFIDENTIALITY

All work undertaken is **STRICTLY** confidential. Any participant in a project should expect that their personal details are known only to those requiring it and who work directly on that project.

You must not discuss information about the MDV after it has occurred to anyone other than the project team, particularly identifying points such as club names, addresses etc. Please note – this means that you are **not** allowed to discuss specific details of the assessments with family and friends.

Any staff found to be breaching confidentiality will be removed from the project immediately; if the breach is a serious one then the result will be the termination of that person's employment with TKW. We are bound by ethics to ensure confidentiality.

In Addition to this:

- No personal information (such as member recruitment information) can be captured outside of the tablet. It is important that those details are kept strictly confidential.
- All project information (such as cheat sheets) must be returned to TKW to be destroyed at the conclusion of the project.
- You must not discuss with any other members of staff the results found from you observations
- If you would like to use your personal phone to make notes, do NOT include the club name in the notes (ie. unidentifiable) AND delete the notes as soon as you have entered the data into the tablet.

Any questions need to be directed to your supervisor.

8 SAFETY

The safety of the observation staff is of utmost importance to us. Remember that sporting clubs are often a location where alcohol is consumed and emotions are often running high, thus can be volatile environments. However, these MDVs were completed at 188 clubs in 2015 with minimal issues.

The MDV process has been approved by the University of Newcastle Safety Committee, thus, the following **must** be followed at all times:

- All teams will consist of 2 TKW interviewers.
- When parking in the club, park in a public area (e.g. car park or on a busy street).
- You must remain with your team member at all times, unless one of you is required to visit the toilet or the bar.

- You must wear sensible covered shoes to reduce the risk of injury (e.g. from broken glass). Please dress sensibly and avoid wearing sports colours (e.g. team jerseys for other teams).
- Under no circumstances are you allowed to consume any alcohol.
- Wear a hat and use sunscreen
- Ensure you drink water (good way of checking if they have free water)
- Do not wear any ID badge until you have identified yourself to the club representative
- Keep your field supervisor aware of your whereabouts

There is an expected level of behaviour whilst at the club:

- You must act inconspicuous at all times - act like any other spectator.
- You must not complete the non-observational assessment form until you have let the club know that you are at the club.
- Don't consume any alcohol whilst on duty
- You should sit in a position where you can assess the alcohol service area of the club. Converse with your team mate in a way that makes other spectators think that you are friends.
- Be aware of your body language at all times (i.e. look relaxed not tense).
- Do not sit or stand with, or start unnecessary conversations with, other spectators or staff.
- Keep a neutral expression at all times (e.g. don't frown or stare at other patrons or staff).
- If you see someone you know (staff or spectator), please minimise contact. Avoid telling them that you are working.
- If any members or supporters talk to you, be friendly and minimise the contact
- If any members/supporters or club staff/volunteers start asking you lots of questions or bother you, move somewhere else. If this becomes increasingly problematic, make yourself known to the club representative.
- If you are a smoker, please follow the legislation and do not smoke in smoke-free areas – you will be breaking the law and will be liable for the fine. If you do smoke, smoke in allowed areas only and do not expose your team member
- Drive carefully and follow the road rules

Under special circumstances:

- If you feel threatened/unsafe (e.g. if a fight starts or if any spectator/staff challenges you) or feel confronted at any time, please leave the club **immediately**. You are not expected to remain at the club.
- Each team of interviewer must carry a mobile phone for emergencies.
- If you witness any aggressive or violent situations (e.g. fights or aggression), do not intervene in any way. Call staff or the police. Remember, you can leave the club if you feel that your safety is compromised in any way.
- If you feel you need to contact the police, please do so by phoning 000. We advise that you call the police in situations where you would normally do so.
- On each weekend of the visits, a project team member will be allocated to be the emergency contact. This number will be provided to each of you before you start your shift.
- Please notify your supervisor immediately in an emergency.
- Notify your supervisor in the event of:
    - an accident where an injury has occurred (with or without property damage);
    - an incident where there has been NO injury to a person, but property damage has occurred
    - a near miss (when shift is completed)

9 ADDITIONAL EMPLOYMENT INFORMATION

9.1 Rostering

You will be sent an email within the next few days outlining the dates, times of shifts & who you will be paired up with. Each week you will be sent a reminder about your upcoming shifts. If a shift is cancelled due to bad weather, you will be given 24 hours' notice.

9.2 Timesheets

Timesheets are due each Monday before the scheduled pay date as per the form given to you in the starter kits. These can be sent via email, fax or post:

APPENDIX 1: CLUB CONSENT FORM

Professor John Wiggers
School of Medicine and Public Health
The University of Newcastle
University Drive
Callaghan NSW 2308
(02) 4924 6247

Consent Form for the Research Project:

Sustaining healthy practices in community sporting clubs

……..Club agrees to participate in the above research project and freely give our consent.

We have read the Club Information Statement and understand that the project will be conducted as described in this Statement. A copy of which has been retained for our records. We understand that our club can withdraw from the project at any time and do not have to give any reason for withdrawing.

We consent to our club:

- being observed during Match-Day visits (2014 and 2016) to assess our eligibility to participate in the project and collect evaluation data;
- being randomly allocated to Group 1 to receive web-based support to maintain level 3 Good Sports Accreditation, or to Group 2 to receive usual support from the Good Sports Program;
- being involved in the research project over 2 successive football seasons (2014 and 2015);
- having regular telephone contacts with a project officer; and,
- nominating a representative to participate in surveys about the club and the club policies and practices in 2014 and 2016.

We understand that any personal information will remain confidential to the researchers. We have had the opportunity to have questions answered to my satisfaction.

Club representative name (please print):

_____

Club representative position in the club (please print):

_____

Signature: _____ **Date:** _____/_____/_____

Please return completed form to tameka-rae.small@hnehealth.nsw.gov.au **or fax to 02 4924 6490**

APPENDIX 2: 2017 MDV NOTIFICATION LETTER

Prof John Wiggers
Phone: (02) 4924 6247 Fax: (02) 4924 6028
Email: John.Wiggers@hnehealth.nsw.gov.au

Dear <add club contact first name>

Information on the research project:
SUSTAINING HEALTHY PRACTICES IN COMMUNITY SPORTING CLUBS
Version 1: 10/4/2017

As a member of the Good Sports Program, your football club has been participating in a research project since 2014, and we thank you for your continued participation. The aim of this project has been to help us identify the best way to support clubs in maintaining their Good Sports Level 3 Accreditation. It has been a collaboration between the University of Newcastle, the Hunter New England Local Health District, the Alcohol and Drug Foundation (ADF, formerly the Australian Drug Foundation) and Deakin University.

Where is the project up to now?
You may remember in the first year of the project (2015), research staff visited your club to observe practices regarding alcohol management, smoking, and food provision. Club members/supporters were also invited to participate in a telephone survey.

The research project is now in its final year, and we will once again be conducting Match-Day Visits (MDV) during the 2017 football season during a club home game. During this visit, the research staff will:

- record information on club alcohol and smoking management, and available food choices
- invite club members/supporters to participate in a telephone survey (at a later date)

The above information is important for the evaluation of the project, and will not be used to assess individual club performance.

What will you be asked to do?
You will not be aware of the date that your MDV will occur, however, once the research staff have collected some initial information at the ground, they will make themselves known to you. You may be required to assist them with answering some questions (or ask someone else from the club to help them). The reasearch staff may also talk to you about an appropriate location for them to recruit club supporters for the telephone survey.

If you are no longer the appropriate contact person for the club, or would like the research staff to contact an alternative person on the day of the visit, please contact Jenny Tindall on **(02) 4924 6649** or email jennifer.tindall@hnehealth.nsw.gov.au.

What choice do you have?
Your club's participation in the research project is entirely voluntary. Whether or not your club continues to participate, your decision will not disadvantage your club in any way and will not impact your relationship with the Good Sports Program. Your club may withdraw from the project at any time without giving a reason, by contacting Jenny Tindall on **(02) 4924 6649** or email jennifer.tindall@hnehealth.nsw.gov.au.

How will your privacy be protected?

- All of your responses and data will be treated in strict confidence.
- All data will be observed and entered into a computer, analysed, and stored securely at Hunter New England Population Health for at least 5 years.
- Your name, sporting club name and contact details will be stored separately from your observation data.
- Only the Research Team identified at the bottom of this letter will have access to the data.
- With regards to storage and disposal of confidential information, we follow the principles of the Privacy of Information Act, in addition to the National Health and Medical Research Council and the University of Newcastle ethics regulations.

How will the information collected be used?

- The information collected will help us to develop a web-based program which will assist community sports clubs to implement effective alcohol management strategies and reduce alcohol-related harm.
- The data will be presented in a final report to the Australian Research Council, and may be published in a scientific journal or student theses.
- The reports of our findings will include group results only. Individual participants or clubs will not be identifiable in any reports arising from the project.
- A summary of the results will be available to all participating clubs through the Good Sports Program.

Further information about the Project

If you would like further information please contact the Project Officer Jenny Tindall on **(02) 4924 6649** or email jennifer.tindall@hnehealth.nsw.gov.au, or the Program Manager Dr Tara Clinton-McHarg on **(02) 4924 6510** or email tara.clintonmcharg@hnehealth.nsw.gov.au.

Thank you

Prof John Wiggers
Director, Hunter New England Population Health

Complaints about this research

This project has been approved by the University's Human Research Ethics Committee, Approval No. H-2013-0429.

Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to the Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, telephone (02) 4921 6333, email Human-Ethics@newcastle.edu.au.

The Research Team

Prof John Wiggers, Hunter New England Population Health and The University of Newcastle
A/Prof Luke Wolfenden, The University of Newcastle
Dr Bosco Rowland, Deakin University
Ms Melanie Kingsland, The University of Newcastle
Ms Karen Gillham, Hunter New England Population Health
Ms Jennifer Tindall, Hunter New England Population Health
Ms Tameka-Rae Small, The University of Newcastle
Dr Shauna Sherker, The Alcohol and Drug Foundation
Ms Rachael Heaton, The Alcohol and Drug Foundation
Ms Sharin Milner, The Alcohol and Drug Foundation
Dr Tara Clinton-McHarg, The University of Newcastle

APPENDIX 3: CLUB MEMBER/SUPPORTER LETTER

Phone: (02) 4924 6247 Fax: (02) 4924 6028
Email: John.Wiggers@hnehealth.nsw.gov.au
April 2017

Dear Club Member

Information statement for research proj
SUSTAINING HEALTHY PRACTICES IN COMMUNITY SPORTING CLUBS
Version 6; 10/04/17

As a member of your local sports club, you are invited to complete a brief telephone survey. Your club is participating in a research project aimed at supporting clubs to continue to provide healthy environments for club members. The project is funded by the Australian Research Council and is being conducted by Hunter New England Population Health, the Australian Drug Foundation (ADF), the University of Newcastle and Deakin University.

Why is the research being done?
To identify the best way to provide clubs long-term support to maintain their Good Sports Level 3 accreditation , and to determine if the internet is effective in supporting clubs to continue managing alcohol consistent with the Good Sports criteria.

Who can participate in the research?
Current members of selected Good Sports clubs who are over 18 years. You have been randomly selected to participate.

What will you be asked to do?
A telephone survey which will take about 20-30 minutes. It includes questions about your: association with the club, alcohol consumption at your club and in general, opinions on your clubs' alcohol serving practices, food purchasing at your club and demographics (e.g. age, marital status, income). The information collected is strictly confidential. Participating will help us in evaluating the project and developing an effective longer-term project.

What choice do you have?
Participation is voluntary. You do not have to participate if you don't want to. Whether or not you decide to participate, your decision will not disadvantage you in any way. If you participate, you can withdraw any time without giving a reason, by contacting the Project Officer Jenny Tindall on (02) 49246649 or via email Jennifer.Tindall@hnehealth.nsw.gov.au .

What do you need to do to participate?
If eligible, you will be asked if you consent to provide your contact details to the study team. If you provide your details, a telephone interviewer will contact you at a later time to formally invite you to participate. You can complete the survey at a time convenient to you.

How will your privacy be protected?
- Your responses will be treated in strict confidence. All data will be entered into a computer, analysed, and stored securely at Hunter New England Population Health for at least 5 years.
- Your name and contact details will be stored separately.
- Only the Research Team members at the bottom of this letter will have access

- Regarding storage and disposal of confidential information, we follow the Privacy of Information Act principles, in addition to the National Health and Medical Research Council and the University of Newcastle ethics regulations.

How will the information collected be used?

- Your information will assist in developing a web-based program to create more sustainable and healthy community sports club environments.
- Data will be presented in a report to the Australian Research Council, a student research higher degree thesis and may be published scientific journals.
- Reports will include group results only. Individual participants will not be identifiable in any reports.
- A summary of the results will be available to all participating clubs through the Good Sports Program.

Further information about the project

If you would like further information please contact the Project Officer Jenny Tindall on **(02) 4924 6649** or email jennifer.tindall@hnehealth.nsw.gov.au, or the Program Manager Dr Tara Clinton-McHarg on **(02) 4924 6510** or email tara.clintonmcharg@hnehealth.nsw.gov.au.

Thank you for considering this invitation.

Yours sincerely

Professor John Wiggers
Director, Hunter New England Population Health

Complaints about this research

This project has been approved by the University's Human Research Ethics Committee, Approval No. H-2013-0429. Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to the Human Research Ethics Officer, Research Office, The Chancellery, The University of Newcastle, University Drive, Callaghan NSW 2308, Australia, telephone (02) 49216333, email Human-Ethics@newcastle.edu.au.

The Research Team

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Dr Shauna Sherker, The Alcohol and Drug Foundation
Ms Sharin Milner, The Alcohol and Drug Foundation
Ms Rachael Heaton, The Alcohol and Drug Foundation

APPENDIX 4: MEMBER RANDOMISATION SEQUENCE

Random number sequence	Number used
3	☐
1	☐
2	☐
2	☐
3	☐
4	☐
3	☐
2	☐
2	☐
1	☐
3	☐
2	☐
4	☐
2	☐
4	☐
3	☐
4	☐
3	☐
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3	□
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3	□
2	□
4	□
2	□
4	□
3	□
4	□
3	□
1	□
1	□

APPENDIX 5: RESOURCE KIT 2017

ALCOHOL MANAGEMENT

Q1.1 Liquor licence display (VIC clubs only)

Limited Licence — Licence No. 36110641

Subject to the provisions of the Liquor Control Reform Act 1998 and any conditions specified in the licence, the Licensee is authorised to supply liquor up to and including 31 December 2014

Licensee: ARARAT EAGLES FOOTBALL AND NETBALL CLUB INC

Address for service of notices: PO BOX 373, ARARAT 3377

Licensed premises address: ALEXANDRA OVAL, WARATAH STREET, ARARAT 3377

Trading as: ARARAT EAGLES FOOTBALL AND NETBALL CLUB

Additional person(s) endorsed on licence
ANTONY McROBERTS - approved as nominee, and is liable as if the licensee, until ceasing to manage and control the licensed premises.

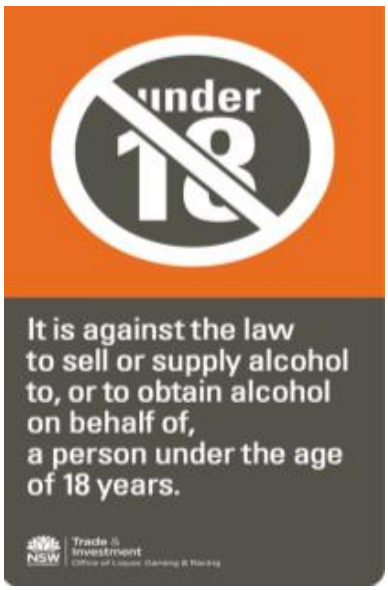
TYPE OF LICENCE
This licence is a renewable limited licence and subject to the conditions specified in this licence authorises the licensee to supply liquor:-

- on the licensed premises to a member of the club or a guest of a member for consumption on the licensed premises;
- on a part or parts of the licensed premises to a person attending a pre-booked function for consumption in the area where the function is being conducted;
- to a person from a specified point/s of sale during a sporting event.

AMENITY
The licensee shall not cause or permit undue detriment to the amenity of the area to arise out of or in connection with the use of the premises to which the licence relates during or immediately after the trading hours authorised under this licence.
The licensee shall ensure that the level of noise emitted from the licensed premises shall not exceed the permissible noise levels for entertainment noise as specified in the State Environment Protection Policy (Control of Music Noise from Public Premises) No.N-2.

Q1.2 State liquor licensing signs

NSW



VIC – BOTH must be displayed

Q1.5 Sign displaying names of RSA trained staff

Q1.10, Q1.11, Q1.12 Signs of drunk/intoxicated patrons

Speech	Balance	Co-ordination	Behaviour
• slurring words • rambling or unintelligible conversation • incoherent or muddled speech • loss of train of thought • not understanding normal conversation • difficulty in paying attention	• unsteady on feet • swaying uncontrollably • staggering • difficulty walking straight • cannot stand or falling down • stumbling • bumping into or knocking over furniture and people	• lack of coordination • spilling drinks • dropping drinks • fumbling change • difficulty counting money or paying • difficulty opening or closing doors • inability to find one's mouth with a glass	• rudeness • aggression • belligerent • argumentative • offensive • bad tempered • physically violent • loud /boisterous • confused • disorderly • exuberance • using offensive language • annoying / pestering others • overly friendly • loss of inhibition • inappropriate sexual advances • drowsiness or sleeping at a bar or table • vomiting • drinking rapidly

Q1.29 Alcohol management policy

[Insert club logo]

[INSERT CLUB NAME] ALCOHOL MANAGEMENT POLICY

[Please modify to suit your club: remove points that aren't relevant/amend points to be more relevant/insert strategies/requirements the club already implements]

Rationale

This policy provides the basis for a balanced and responsible approach to the use of alcohol at [Club name] events and activities. This policy will help to ensure the club:

- Meets its duty of care in relation to the health and safety of our members and guests who attend our club functions.
- Upholds the reputation of the club, our sponsors and partners.
- Understand the risks associated with alcohol misuse and our role in minimising this risk.

[Club name] recognises the legal responsibilities, financial and social benefits of holding a liquor license in the community. In doing, so we will adhere to liquor licensing laws and the criteria of the *Good Sports* program.

Accordingly, and to ensure the aims of the club are upheld and that alcohol is managed responsibly, the following policy requirements will apply:

- When alcohol is served by the club at our facilities or during a club function, even if offsite
- To all players, coaches, officials, members, club visitors, club facilities, club functions and other activities undertaken by the club where alcohol is consumed.

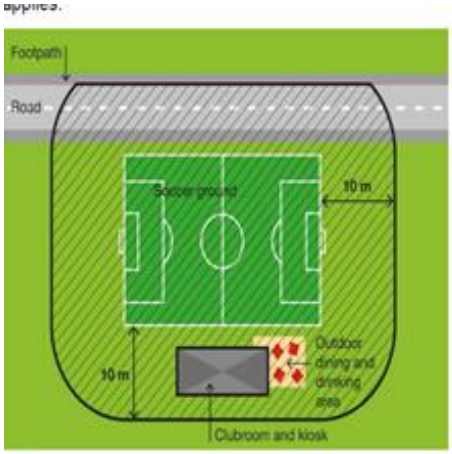
General Principles

- A risk management approach will be taken in planning events/activities involving the sale, supply or consumption of alcohol. Such events will be conducted and managed in a manner

SMOKING

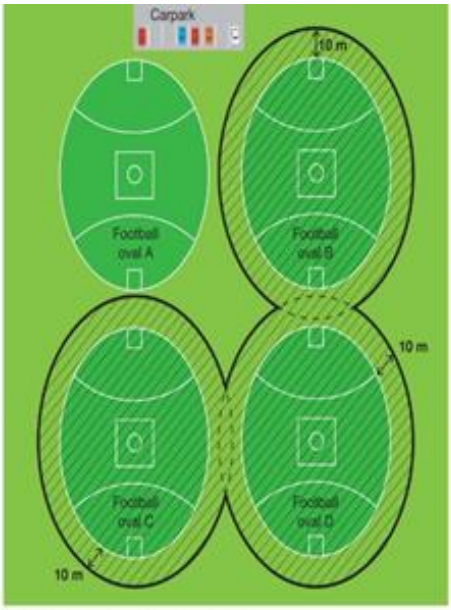
Q2.2 No smoking sign

Q2.7 Smoking within 10m of a sporting venue during an underage event



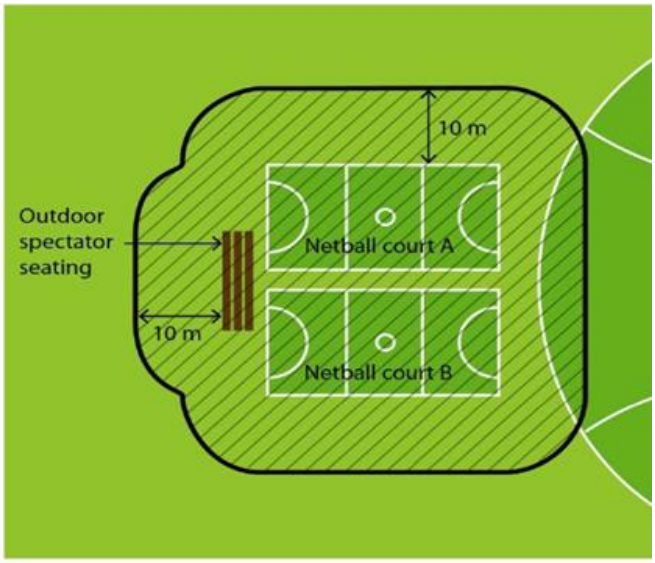
Shading indicates outdoor 'no smoking' area

In the above diagram workplace smoking laws apply to the enclosed clubroom and kiosk.



Shading indicates outdoor 'no smoking' area

In the above diagram football ovals B, C and D are being used for underage sporting events.



Shading indicates outdoor 'no smoking' area

GOOD SPORTS PROMOTIONS

Q3.1, Q3.2 & Q3.3

This is the new logo:

GOOD SPORTS
INSPIRING A HEALTHIER SPORTING NATION

This is the old logo:

goodSPORTS | Healthy clubs. Strong communities.

Certificate

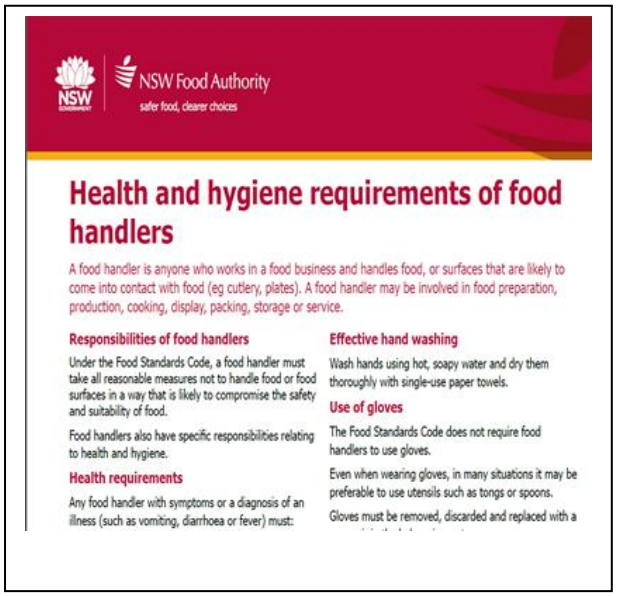
Bar Sign

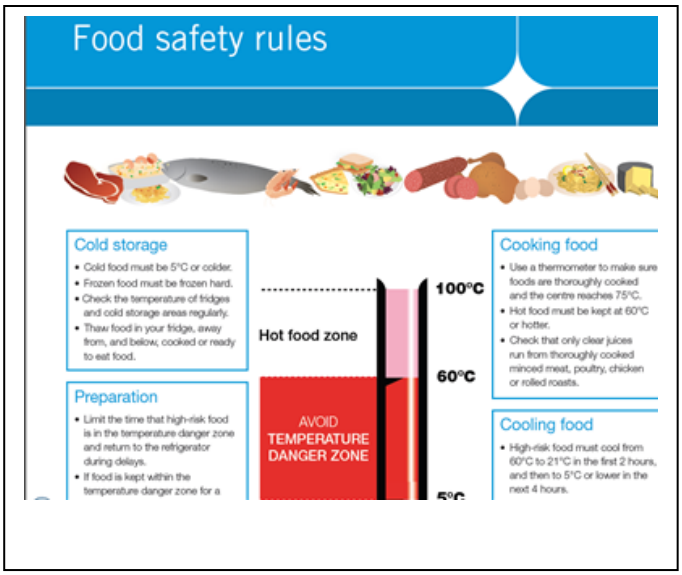
Outdoor Sign/Stickers

Bar runner

SAFE FOOD HANDLING & HEALTHY OPTIONS

Q4.1 Safe food handling sign





Q4.2 Food and nutrition policy

FOOD AND NUTRITION POLICY

As a Good Sports club, it is the policy of **[club Name]** to provide and promote healthy food options to our members and visitors.

This policy applies to food and drink sold through the club canteen, other food stalls, and fundraising activities. It applies to all members, officials, players and club visitors.

Food business

- Our club is a registered food business with the NSW Food Authority (or local council).

Food handlers

Our club will:

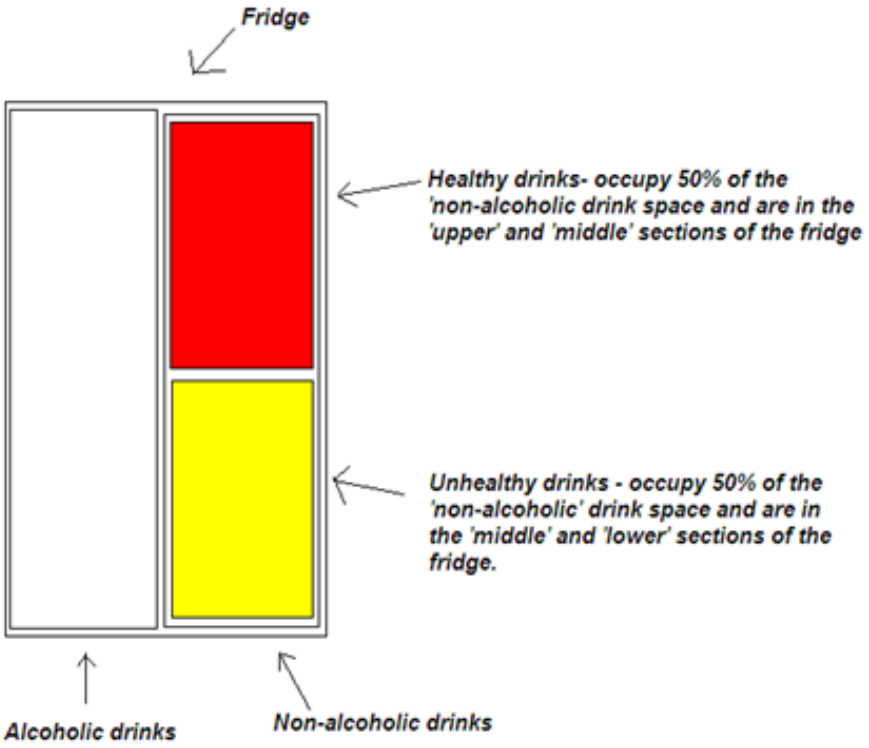
- have at least two club members trained in basic nutrition and safe food handling techniques. One of these members will be in charge of stocking and setting up the canteen
- ensure signage regarding safe food handling is displayed in the canteen and other locations food is handled.

Food sold in the canteen or at a food stall

Our club will ensure that:

Q4.3 Healthy food options and promotion

Q4.5 Estimate of drink space – non-alcoholic drinks



Q5.4 Low-alcoholic drinks

Common low-alcohol beers (% alc)	**Common low-alcohol pre-mix drinks (% alc)**
Carlton Light Ice 3.3 % Cascade Light 2.7 % Coopers Light 2.9 % Fosters Light 2.5 % Hahn Premium Light 2.7 % Tooheys Blue 2.7 % **Common low-alcohol wines (% alc)** Brown Brothers 2005 Moscato 5.5% Brown Brothers Moscato Rosa 7.0% 2008 SixPointSix Moscato 6.6% **Common low-alcohol champagne (% alc)** Yellowglen's 'Jewel' varieties Yellow and Pink 6%	Bacardi Breezers 4.8% Bundaberg Cola Super Dry 3.5% Johnnie Walker Super Dry 3.5% SKYY Blue Lime & soda/Blood Orange/Grapefruit & Soda 4.8% Smirnoff Super Dry 3.5% Vodka Cruisers 5.0%

Q5.8 Promotion of safe transport options

Getting home safely

GET HOME SAFE

As a Good Sports club we want to make sure you get home safely, especially if you've been drinking alcohol.

<DELETE TIPS THAT AREN'T APPLICABLE>

If you think you might be over the legal limit for driving, why not leave your car here and:

- Get a sober friend or family member to drive you home
- Catch a taxi – you can use the club phone to order one if you like. The number is xxx xxxxxx
- Take FREE club transport home
- Make use of the club's Designated Driver Program

good SPORTS

APPENDIX 6: MATCH-DAY VISIT OBSERVATION TOOL

This tool is divided into 3 main sections**:**

1. Observer information: This includes name, ID, date, start time, finish time etc
2. Observable practices: These are the practices that can be easily observed by the staff
3. Non-observable practices: These are the practices that can be observed by staff, but some assistance MAY be required from the club staff

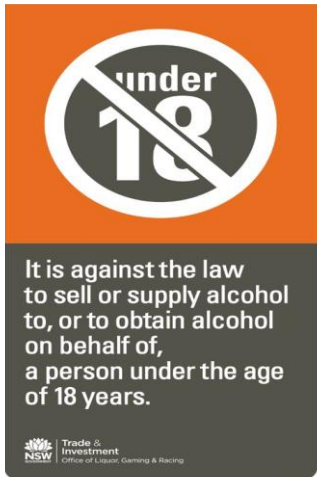
PART 1: OBSERVATION INFORMATION

1	Club name: _____
2	Club ID: _____
3	Date of observation: _____/_____/2017
4	Observer name: _____
5	Observer ID number: _____
6	Partner observers name: _____
7	Time of arrival at the ground (24hr time): ____ : _____
8	Time started MDV (24hr time): ____ : _____
9	Time ended MDV (24hr time): ____ : _____
10	Time started consensus activity (24hr time): ____ : _____
11	Time ended consensus activity (24hr time): ____ : _____
12	Time left the ground (24hr time): ____ : _____
13	Start time member recruitment activity (24hr time):

14	Finish time member recruitment activity (24hr time):
15	Location of member recruitment (be as specific as possible eg. Approx. 2 metres to left of the main bar)
16	Did the club stop selling alcohol during the MDV? 1. Yes (add time: _____ :_____) 2. No

PART 2: OBSERVABLE SURVEY

1	ALCOHOL MANAGEMENT	
1.1	**Is the club liquor licence displayed in public view in the club house?** 1. Yes 2. No 3. Not applicable (NSW clubs only)	**In VIC, the licence will look like this:** Limited Licence — Licence No. 36110641 Subject to the provisions of the Liquor Control Reform Act 1998 and any conditions specified in the licence, the Licensee is authorised to supply liquor up to and including 31 December 2014 Licensee: ARARAT EAGLES FOOTBALL AND NETBALL CLUB INC Address for service of notices: PO BOX 373, ARARAT 3377 Licensed premises address: ALEXANDRA OVAL, WARATAH STREET, ARARAT 3377 Trading as: ARARAT EAGLES FOOTBALL AND NETBALL CLUB Additional person(s) endorsed on licence ANTONY McROBERTS - approved as nominee, and is liable as if the licensee, until ceasing to manage and control the licensed premises. TYPE OF LICENCE This licence is a renewable limited licence and subject to the conditions specified in this licence authorises the licensee to supply liquor:- . on the licensed premises to a member of the club or a guest of a member for consumption on the licensed premises; . on a part or parts of the licensed premises to a person attending a pre-booked function for consumption in the area where the function is being conducted; . to a person from a specified point/s of sale during a sporting event. AMENITY The licensee shall not cause or permit undue detriment to the amenity of the area to arise out of or in connection with the use of the premises to which the licence relates during or immediately after the trading hours authorised under this licence. The licensee shall ensure that the level of noise emitted from the licensed premises shall not exceed the permissible noise levels for entertainment noise as specified in the State Environment Protection Policy (Control of Music Noise from Public Premises) No.N-2.

1.2	**At which points of alcohol sale does the club display the state Liquor Licensing signage? e.g. club bar; point of sale outlet(s)(See kit for examples). For VIC clubs, BOTH for signs MUST be displayed.** 1. All 2. Some 3. None	**In NSW:**  **In VIC:**  
1.3	**Where was alcohol <u>served</u>? (Select all that apply)**	This relates to the location of alcohol actually being SERVED, not just where people are drinking.

MULT	**Note: This related to the location of alcohol actually being SERVED, not just where people are drinking.** 1. Club house 2. From canteen/kiosk/s around the ground 3. Other designated area (Specify_____)	**Club house:** Clubs will often have a location where alcohol and food is served from. It may be a bar area (eg. looks like a bar in a club) with tables/chairs or it could be a main canteen area where food and drinks are served. **Canteen/kiosk around the ground:** This includes other canteens/kiosks around the ground and can include mobile vans, coffee trucks etc.
1.4	**When did you observe alcohol being served at the ground?** 1. Alcohol was served for the entire observation period 2. Alcohol was not being served when I arrived but began during the observation period 3. Alcohol was being served when I arrived but ceased during the observation period 4. Alcohol started being served and ceased being served during the observation period **Please record the hours/minutes (eg. 2.30pm to 5.00pm)** **_____** **NOTE: Alcohol may have been served when you were not at the ground or outside the observation period, but don't record this.**	This relates to the location of alcohol actually being SERVED, not just where people are drinking. This refers to the main senior game of the day – the one that you are there to observe. This relates to the times you actually observed. For example: • If alcohol was served for the observation period, record the whole time you were there (eg. 12-3pm) • If alcohol service started at 1pm and you left at 3pm (and alcohol was still being served), record 1-3pm.

1.5	**At which points of alcohol sale did the club clearly display the names of RSA trained staff?** 1. All 2. Some 3. None	This is a sign that lists all the RSA trained staff. The Good Sports sign looks like the one below, however, they may have developed their own. 
1.6	**Did the club provide free tap water? (Ask bar or canteen for free tap water)** **Note:** Free tap water refers to water provided free of charge. This can include: • Tap water, including jugs of water on the bar or a glass of water provided at request • Bottles of water that are free • Water dispenser 1. Yes 2. No	Free tap water refers to water provided free of charge but at a bare minimum, we tap water. This can include: • Jugs of water on the bar (with glasses) • Bottles of water • Water dispenser

1.7	**Did you see anyone under 18 years serving alcohol?** 1. Yes 2. No 3. Don't know- couldn't tell	This refers to people actually serving alcohol.
1.8	**How often was ID (proof of age) being checked for people who appeared under the age of 25 years who attempted to purchase alcohol?** **Note:** Look for club staff/volunteers asking to check an ID card before serving alcohol or allowing entry to the clubhouse. 1. Everyone was being checked 2. Some people were being checked 3. Not being checked 4. NA, no-one who appeared under the age of 25 years attempted to purchase alcohol	Look for club staff/volunteers asking to check a card before serving alcohol or entering the clubhouse.
1.9	**Where were people consuming alcohol at the ground?** **Note:** You will need to walk around the entire ground to observe this question. 1. Within the club house only 2. Within other designated area(s), other than club house 3. Within the club house AND other designated area(s) 4. Within the entire sporting ground	You will need to walk around the entire ground to observe this question.

<table>
<tr>
<td>1.10

MULT</td>
<td>Did you see any drunk or intoxicated people entering the club? (Select all that apply)

1. Yes – entering the club ground
2. Yes – entering the club house/other designated drinking area
3. No (If selected, do not select another option)

Note: The definition of drunk/intoxicated is:

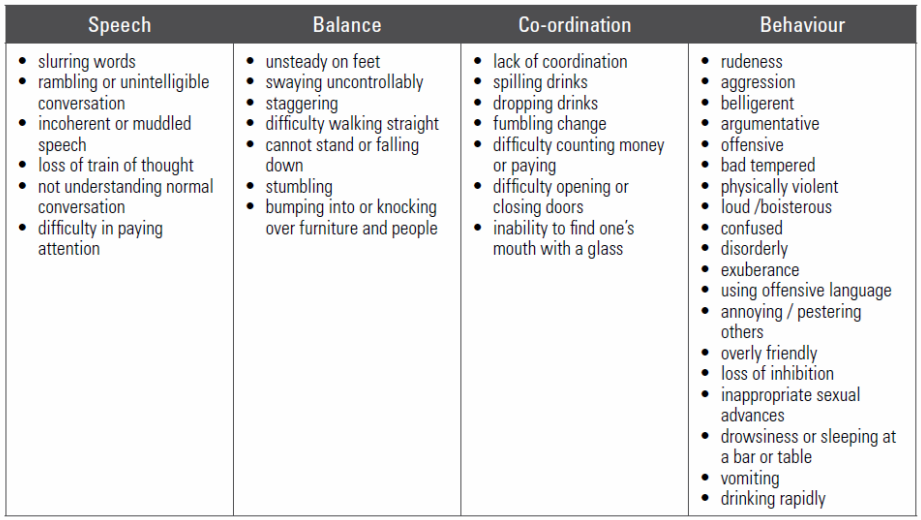
a) A persons speech, balance, coordination or behaviour is noticeable affected, AND

b) it is reasonable in the circumstances to believe that the affected speech, balance, coordination or behaviour is the result of the consumption of liquor (alcohol)

Also refer to your Observer Resource sheet</td>
<td>The definition of drunk/intoxicated is:

a) A persons speech, balance, coordination or behaviour is noticeable affected, AND

b) it is reasonable in the circumstances to believe that the affected speech, balance, coordination or behaviour is the result of the consumption of liquor

 
<table>
<tr><th>Speech</th><th>Balance</th><th>Co-ordination</th><th>Behaviour</th></tr>
<tr>
<td>• slurring words
• rambling or unintelligible conversation
• incoherent or muddled speech
• loss of train of thought
• not understanding normal conversation
• difficulty in paying attention</td>
<td>• unsteady on feet
• swaying uncontrollably
• staggering
• difficulty walking straight
• cannot stand or falling down
• stumbling
• bumping into or knocking over furniture and people</td>
<td>• lack of coordination
• spilling drinks
• dropping drinks
• fumbling change
• difficulty counting money or paying
• difficulty opening or closing doors
• inability to find one's mouth with a glass</td>
<td>• rudeness
• aggression
• belligerent
• argumentative
• offensive
• bad tempered
• physically violent
• loud /boisterous
• confused
• disorderly
• exuberance
• using offensive language
• annoying / pestering others
• overly friendly
• loss of inhibition
• inappropriate sexual advances
• drowsiness or sleeping at a bar or table
• vomiting
• drinking rapidly</td>
</tr>
</table></td>
</tr>
<tr>
<td>1.11

MULT</td>
<td>Did you see drunk or intoxicated people being served alcohol? (Select all that apply)

1. Yes – entering the club ground
2. Yes – entering the club house/other designated drinking area
3. No (If selected, do not select another option)</td>
<td>As above</td>
</tr>
</table>

	Note: The definition of drunk/intoxicated is: a) A persons speech, balance, coordination or behaviour is noticeable affected, AND b) it is reasonable in the circumstances to believe that the affected speech, balance, coordination or behaviour is the result of the consumption of liquor (alcohol) **Also refer to your Observer Resource sheet**	
1.12 **MULT**	**Did you see drunk or intoxicated people being allowed to remain at the club? (Select all that apply)** 1. Yes – entering the club ground 2. Yes – entering the club house/other designated drinking area 3. No **(If selected, do not select another option)** **Note:** The definition of drunk/intoxicated is: a) A persons speech, balance, coordination or behaviour is noticeable affected, AND b) it is reasonable in the circumstances to believe that the affected speech, balance, coordination or behaviour is the result of the consumption of liquor (alcohol)	**As above**

	Also refer to your Observer Resource sheet	
1.13	**Was alcohol served for at least 90 minutes during the observation?** 1. Yes (Go to 1.14) 2. No (Go to 1.16)	
1.14	**Were there at least 15 people present at any time during the observation?** 1. Yes (Go to 1.15) 2. No (Go to 1.16) **Note:** This includes spectators, including committee members. It does not include players that are on the field.	This includes spectators, including committee members. It does not include players that are on the field.
1.15 **MULT**	**Was substantial food available? (Substantial food is sandwiches, hot food, etc., not just snack food such as packets of chips and confectionary)(Select all that apply).** 1. Yes – at point/s of alcohol sale 2. Yes- from canteen/etc outside of club house/other designated drinking area 3. Yes- other (specify _____) 4. No **(If selected, do not select another option)**	By 'substantial food', we mean sandwiches, hot food, etc., not just snack food such as packets of chips and confectionary.

1.16	**Did you see anyone who was working behind the bar/canteen consuming alcohol whilst on duty, including during breaks?** *This is anyone working where alcohol is served, from a canteen, bar or eskies etc.* 1. Yes *2.* No	This refers to anyone working where alcohol is served, from a canteen, bar or eskies etc.
1.17 **MULT**	**Did you see the club conducting any of the following drink promotions? (Select all that apply)** 1. Happy hour (discounted drinks for a specified time) 2. Drinking competitions (eg. boatraces) 3. Alcohol-only player awards/ 4. Alcohol-only raffle prizes 5. Drink vouchers or cards 6. Cheap drink promotions (discounted drink promotions eg. 50% off, 2 for price 1) 7. 'All you can drink' functions 8. Other specify _____ 9. No **(If selected, do not select another option)**	Drink promotions that encourage people to drink alcohol excessively, more than they usually would, or over a short period of time. They may not be actually 'occurring' at the time of the observation eg. may see a sign promoting 'happy hour' on Thursday 4-6pm. As long as you are sure that the club are conducting such promotions, please include. Examples include: **Happy hour:** This practice often occurs for a specified period of time on certain days of the week (eg. Thursday 5-7pm), and involves drinks being cheaper than the regular price. **Drinking competitions:** This includes competitions where there is a winner eg. the 'boatrace' is popular and involves the team members lining up and consuming a drink (eg. pot of beer) in order until the last one in the line has completed. The team that finished first is the winner.

		Alcohol-only player awards: An example could be the 'man of the match' being rewarded with alcohol only (eg. carton of beer) and no other options. **Alcohol-only raffle prizes:** An example of this is a raffle that only has alcohol as a prize (eg. bottles of wine, spirits or beer) with no other options to select (eg. food hampers, meat trays, movie vouchers etc). **Drink vouchers or cards:** An example of this could be 'man of the match' receiving a car/voucher for alcohol and the requirement to consume on that night. **Cheap drink promotions:** These include significantly cheap prices to encourage people to drink more. **All you can drink:** These functions typically include an admission fee that covers 'all you can drink'.
1.18 **MULT**	**Did you see the club <u>serving</u> any of the following drinks? (Select as all that apply)** 1. Shots of alcohol (eg. Shots, slammers, nips) 2. Ready to drink products with more than 5% alcohol (eg. OP rum)	You may observe these drinks (eg. spirits, 'ready to drink' products) behind the bar or in the fridge, but they may not be 'serving' them during the game.

	3. Mixed alcohol drinks with more than 30 ml spirits (eg. Double nips, cocktails) 4. None of the above **(If selected, do not select any other options)** **Note:** Answer this question in relation to whether they were serving these drinks, not just whether these drinks were observed to be behind the bar or in a fridge .	**Shots:** Alcohol typically consumed 'neat' is a quick fashion, and are designed to cause rapid intoxication. These are usually not served over ice ('on the rocks'). **Ready to drink (RTD):** These are spirit-based products with a mixer, and have an alcohol concentration over 5%. Typical products include: • Bundy OP and Cola • Jim Beam Black and Cola • Johnnie Walker Premium Strength and Cola • Kentucky Straight Woodstock Bourbon and Cola • Ruski Black • Smirnoff Double Black and Cola **Mixed drinks with >30ml of spirits:** A standard nip of spirits (eg. scotch) is 30ml and is often served with a mixer (eg. cola, lemonade, soda water). This relates to any drinks with more than one standard drink of alcohol.
1.19	**Did you see the club limiting the number of alcoholic drinks that people can purchase in one transaction? e.g. point of sale outlets where maximum of 4 open cans can be purchased at any one time.** 1. Yes, limits 2. No, no limits 3. Didn't observe	This relates to the bar staff only serving up to a specified number of drinks per purchase (eg. 4 open cans of beer). If you didn't observe someone attempting to purchase multiple drinks, please answer 'didn't observe'.

1.20	**Did you see patrons 'stockpiling' unconsumed drinks? (3 or more for one person's consumption)** **Note:** This does not include people who brought their own drinks into the ground. By 'patrons', we are referring to all people/customers including players, members, spectators, club officials etc. 1. Yes 2. No	This refers to people purchasing a number of drinks (or other people purchasing for them) so that they don't have to go to the bar for service or can stockpile drinks for after the bar has ceased service. This does not include people who brought their own drinks into the ground. By 'patrons', we are referring to all people/customers including players, members, spectators, club officials etc.
1.21	**Did you see anyone bring alcohol into the club house or designated alcohol area that was not purchased at the club?** **Note:** This refers to players/spectators/members bringing their own alcohol into the club house/designated area. Look for: • Personal eskies • People bringing alcohol in their car or bags Consumption of drinks that are not sold at the club (eg. high strength RTDs, long necks of beer, brands of beer not served by the bar) 1. Yes 2. No	This refers to players/spectators/members bringing their own alcohol to the game. Look for: • Personal eskies • People bringing alcohol in their car (if cars allowed into the ground)or bags • Consumption of drinks that are not actually sold at the club (eg. high strength RTDs, long necks of beer, brands of beer not served by the bar)

1.22	**Did you see any people bringing alcohol into the ground that was not purchased at the club?** **Note:** This refers to players/spectators/members bringing their own alcohol into the club house/designated area. Look for: • Personal eskies • People bringing alcohol in their car or bags Consumption of drinks that are not sold at the club (eg. high strength RTDs, long necks of beer, brands of beer not served by the bar) 1. Yes 2. No	This refers to players/spectators/members bringing their own alcohol to the game. Look for: • Personal eskies • People bringing alcohol in their car (if cars allowed into the ground)or bags • Consumption of drinks that are not actually sold at the club (eg. high strength RTDs, long necks of beer, brands of beer not served by the bar)
1.23 **MULT**	**What drink containers did the club serve drinks in? This includes both alcoholic and non-alcoholic drinks (Select all that apply).** 1. Glass 2. Plastic 3. Cans 4. Other (please specify _____)	This relates to the risk of injury from glass containers ie. anything that breaks and can easily be used as a weapon. This includes both alcoholic and non-alcoholic drinks. Glass containers can include: • Glasses eg. middy, schooner, pot, bottles • Ceramic eg. coffee/tea cups
1.24	**Did you observe the club cease the sale and supply of liquor at least 30 minutes before the end of trade (when bar/club house was closed)?**	This relates to the actual time the club stops the service of alcohol. They may still serve non-alcoholic drinks and food, or allow people to remain to finish their drinks.

	Note: This relates to the actual time the club stops the service of alcohol. People may be finishing their drinks after this time. This does not refer to non-alcoholic drinks and food. 1. Yes 2. No 3. Was not at the game/match at end of trade	
1.25	**Did you observe any patrons rapidly consuming drinks immediately prior to the cessation of alcohol service?** 1. Yes 2. No 3. Was not at the game at the cessation of alcohol service	This practice often occurs so that people have another chance to buy another drink before the alcohol service ceases.
1.26 **MULT**	**Did you observe patrons leaving the club with any <u>opened</u> alcohol? (Select all that apply)** 1. Yes – within the club ground 2. Yes – within the club house/other designated drinking area 3. No **(If selected, do not select another option)**	This includes bottles, cans, cups (eg. plastic)
1.27	**Did you observe patrons leaving the club with any <u>unopened</u> alcohol which they purchased on club grounds? (eg. Take-away drinks)** 1. Yes 2. No	This includes bottles or cans of alcohol – like what someone would buy from a Packaged Liquor Outlet (bottle shop).

1.28	**When it was at its busiest, how crowded was the bar services area with patrons wanting to purchase drinks?** 1. 1 deep 2. 2 deep 3. 3 deep 4. 4 deep 5. 5 or more deep	This is the time during the observation when the bar was at its busiest eg. during half time, and relates to the adequacy of staffing during the observation. The depth of people waiting could be the entire length of the bar or a specified part of the bar (eg. single or multiple lines).
1.29	**Did you observe the clubs written alcohol management policy displayed in social rooms?** **(Refer to your Observer Resource sheet)** 1. Yes 2. No 3. Unsure was unable to access social rooms/club doesn't have social rooms	This policy could look like the policy below. By social rooms we mean somewhere spectators/members/players can congregate to socialise. This will typically be the bar service area.  [Insert club logo] [INSERT CLUB NAME] ALCOHOL MANAGEMENT POLICY [Please modify to suit your club: remove points that aren't relevant/amend points to be more relevant/insert strategies/requirements the club already implements] Rationale This policy provides the basis for a balanced and responsible approach to the use of alcohol at [Club name] events and activities. This policy will help to ensure the club: • Meets its duty of care in relation to the health and safety of our members and guests who attend our club functions. • Upholds the reputation of the club, our sponsors and partners. • Understand the risks associated with alcohol misuse and our role in minimising this risk. [Club name] recognises the legal responsibilities, financial and social benefits of holding a liquor license in the community. In doing, so we will adhere to liquor licensing laws and the criteria of the Good Sports program. Accordingly, and to ensure the aims of the club are upheld and that alcohol is managed responsibly, the following policy requirements will apply: • When alcohol is served by the club at our facilities or during a club function, even if offsite • To all players, coaches, officials, members, club visitors, club facilities, club functions and other activities undertaken by the club where alcohol is consumed. General Principles • A risk management approach will be taken in planning events/activities involving the sale, supply or consumption of alcohol. Such events will be conducted and managed in a manner

1.30	**Please complete the table below with details of alcohol industry advertisement/promotion/sponsorship you observed around the ground. This does not include clothing of spectators or the opposition team.**

	Alcohol supplier	Alcohol company name's	Players jersey, player accessories (eg bags, hats)	Coach or Club staff uniforms/ accessories	Banners around the playing field	Walk through banners	Poster	Merchandise at the bar coasters, stubby coolers	Dynamic advertisement (revolving/ electronic banners, boards etc)	Goal post padding	Game ball	Score board advertisement	Other (please specify)
	Alcohol manufacture (ie VB, Tooheys)												
	Alcohol retailer (ie Dan Murphy's)												

Additional info: A company that manufactures alcohol such as a beer, wine or spirits. Examples may include: Carlton, VB, Tooheys, Smirnoff, local wineries.

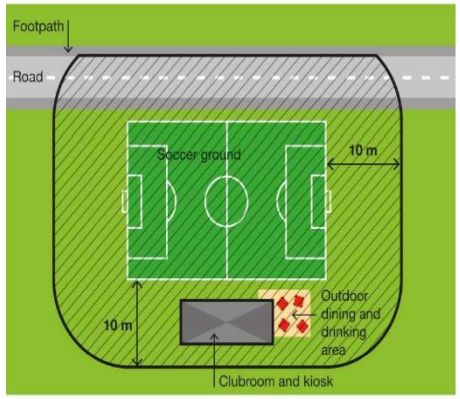
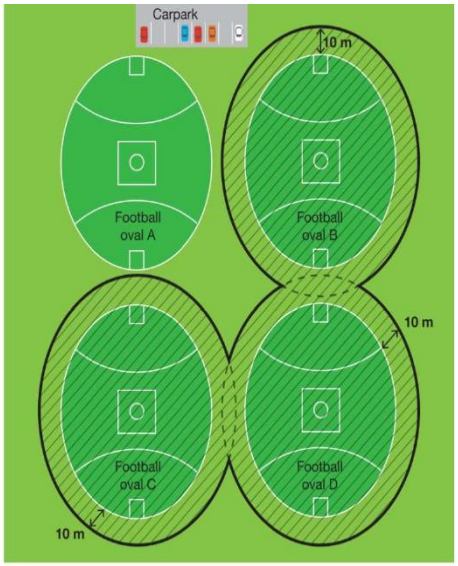
Additional info: A company that manufactures alcohol such as a beer, wine or spirits. Examples may include: Carlton, VB, Tooheys, Smirnoff, local wineries.

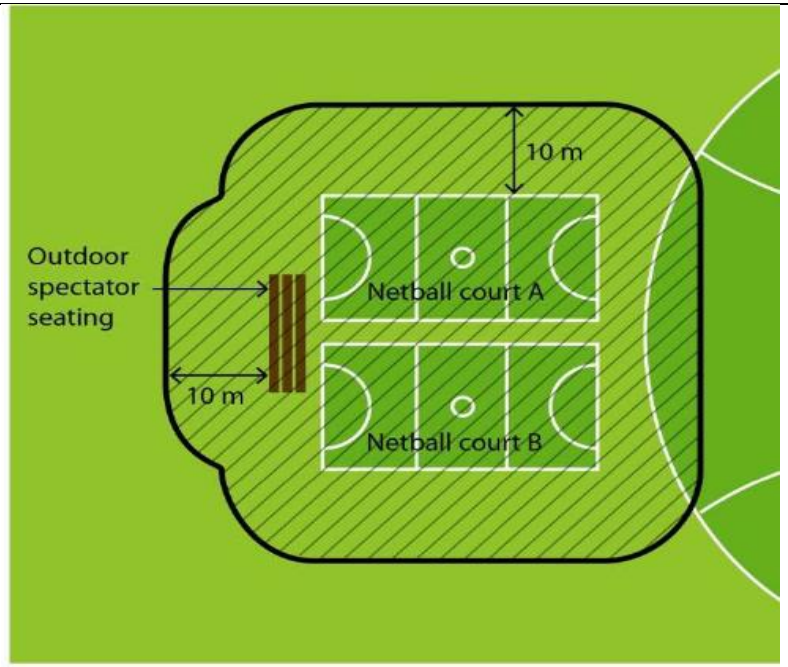
	Licensed premises (local pub). nightclub)												

Additional info: A local licensed premises eg. hotel, pub, tavern, wine bar, nightclub, licensed restaurant/café.

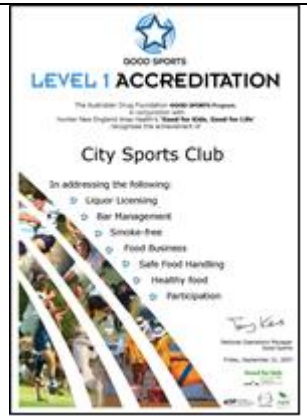
2	SMOKE-FREE ENVIRONMENT	
2.1	**Did you see anyone smoking <u>inside</u> the club house?** 1. Yes (Go to 2.2) 2. No (Go to 2.2) 3. NA, no enclosed areas (Go to 2.3)	By smoking, we mean cigarettes, cigars and pipes.
2.2	**Was the smoke-free signage in smoke-free areas clearly displayed?** *Was the sign clearly visible and not obstructed in any way? Refer to the sign in your resource kit.* 1. Yes, clearly displayed 2. Yes, but not clearly 3. No signs displayed	These signs often look like this. By 'clearly' we mean visible by everyone eg. not hidden behind a cabinet. If you can't see it, others can't see it. 
2.3	**Did the club sell cigarettes?** *Look for a vending machine or sales behind the bar.* 1. Yes 2. No	Lok for cigarettes sold behind the bar or a vending machine.
2.4	**Did you see anyone smoking on the club ground?**	By smoking, we mean cigarettes, cigars and pipes.

	Note: By 'club ground' we mean the playing ground, the spectator areas and all the amenities (including the bar). 1. Yes 2. No	By 'club ground' we mean the playing ground, the spectator areas and all the amenities (including the bar).
2.5	**Did the club provide outdoor areas for smoking patrons?** **Note:** By 'outdoor area' we mean an area where people can smoke that is well ventilated and outdoors (ie. not a room with the windows open). 1. Yes 2. No	By 'outdoor area' we mean an area where people can smoke that is well ventilated and outdoors (ie. not a room with the windows open).
2.6	**During any of the observation, did you see an organised underage sports event on the club grounds? (eg. under 18s match)** 1. Yes (Go to 2.7) 2. No (Go to 3.1)	By 'organised underage event' we mean an organised match with people under the age of 18 years.
2.7	**Did you see anyone smoking within 10 metres of a 'sporting venue' that is an outdoor public area during this underage event?** 1. Yes	Under the law, a 'sporting venue' for a football club would include: • a playing field • any permanently or temporarily erected public seating

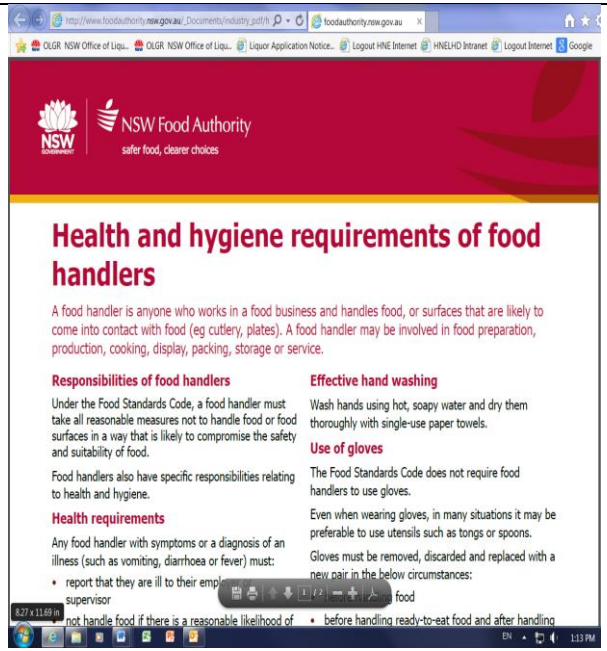
	2. No	• any seating, marshalling area, warm-up areas, podium or other part of the venue reserved for the use of competitors or officials • any part of the venue used to conduct the actual organised underage event **For example:** applies.  Shading indicates outdoor 'no smoking' area **In the above diagram workplace smoking laws apply to the enclosed clubroom and kiosk.**  Shading indicates outdoor 'no smoking' area **In the above diagram football ovals B, C and D are being used for underage sporting events.**

		 10 m Outdoor spectator seating Netball court A 10 m Netball court B Shading indicates outdoor 'no smoking' area

3	GOOD SPORTS PROMOTION	
3.1	**Did you see any Good Sports branded items on display at the club/ground?** 1. Yes (Go to 3.2) 2. No (Go to 3.3)	By Good Sports branded items, we mean merchandise provided by Good Sports (often at the time of accreditation or as a replacement throughout the season). The current Good Sports logo is: GOOD SPORTS INSPIRING A HEALTHIER SPORTING NATION But most resources will probably have this logo: goodSPORTS | Healthy clubs. Strong communities.
3.2 **MULT**	**Which of the following Good Sports branded items were on display at the club/ground? (Select all that apply)** 1. Level 3 certificate 2. Good Sports 'outdoor' metal sign 3. Good Sports Bar runner/mat 4. Good Sports bar sign	Certificate: Bar sign:

	5. Good Sports stickers 6. None of the above **(if selected, do not select another option)** 7. Other (please specify _____)	  Bar runner:  Metal outdoor sign/stickers: 

3.3	**Did you hear the club promoting to the members that it is a part of Good Sports?** 1. Yes (how? _____) 2. No	This could be by public announcement or any other method that ensures all attendees can hear.
4	**PROVISION OF SAFE AND HEALTHY FOOD**	
4.1	**Did you see the 'safe food handling' sign clearly displayed in the place where food was sold?.** This sign is specifically for the kitchen staff's use and should be clearly visible to them (i.e. not for public viewing). Refer to the sign in your resource kit. 1. Sign clearly displayed 2. Sign displayed, but not clearly 3. No sign displayed 4. Could not observe- no access to kitchen area	There are a number of signs that could be displayed to meet this criterion; however, this sign should clearly outline the basic safe food handling techniques. It should be clearly displayed where food is prepared so that all kitchen staff can see it and refer to it if required. Examples of such signs are:



NSW Food Authority

safer food, clearer choices

Health and hygiene requirements of food handlers

A food handler is anyone who works in a food business and handles food, or surfaces that are likely to come into contact with food (eg cutlery, plates). A food handler may be involved in food preparation, production, cooking, display, packing, storage or service.

Responsibilities of food handlers

Under the Food Standards Code, a food handler must take all reasonable measures not to handle food or food surfaces in a way that is likely to compromise the safety and suitability of food.

Food handlers also have specific responsibilities relating to health and hygiene.

Health requirements

Any food handler with symptoms or a diagnosis of an illness (such as vomiting, diarrhoea or fever) must:

- report that they are ill to their empl… supervisor
- not handle food if there is a reasonable likelihood of … food
- before handling ready-to-eat food and after handling

Effective hand washing

Wash hands using hot, soapy water and dry them thoroughly with single-use paper towels.

Use of gloves

The Food Standards Code does not require food handlers to use gloves.

Even when wearing gloves, in many situations it may be preferable to use utensils such as tongs or spoons.

Gloves must be removed, discarded and replaced with a new pair in the below circumstances:

health

Hygienic food preparation and handling in food businesses

Information for food premises

Don't let your food turn nasty!

Food poisoning is a serious health problem. It can cause severe illness and even death.

Food poisoning can seriously damage the reputation of a business, damage the reputation of the food industry, and damage the jobs of many workers.

As a person who handles food – whether you are a kitchen hand, a food process worker, a shop assistant or a waiter – you have an important responsibility to handle food safely. So:

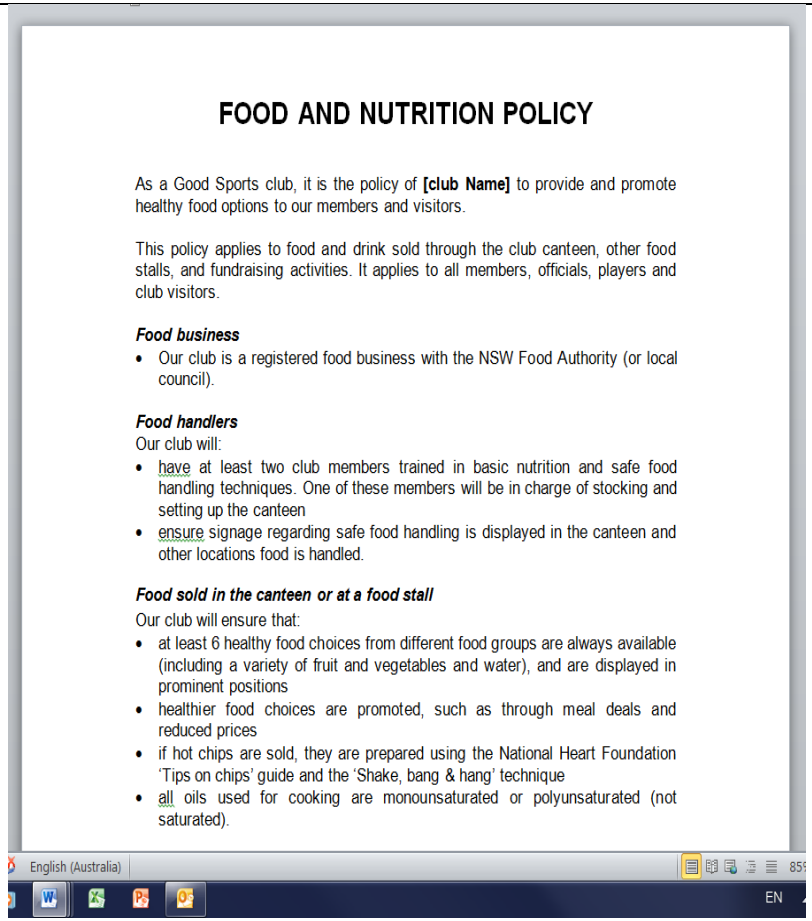
- protect other people from getting sick
- protect your reputation in the food industry
- protect your business, and
- protect your job.

Victorian and Australian food safety laws are designed to ensure that food that is sold is safe to eat and free of any contamination.

Prevent food poisoning by practicing hygienic food preparation and handling

- ☑ Keep raw foods and ready-to-eat foods separate to avoid cross-contamination.
- ☑ If possible, use separate, clean utensils and cutting boards for raw foods and ready-to-eat foods, or wash and sanitise utensils and cutting boards between uses.
- ☑ Thoroughly clean, sanitise and dry cutting boards, knives, pans, plates, containers and other utensils after using them.
- ☑ Thoroughly rinse all fruit and vegetables in clean water to remove soil, bacteria, insects and chemicals.
- ☑ Make sure food is thoroughly cooked and the centre of the cooked food has reached 75°C.
- ☑ Avoid keeping **high-risk** foods in the Temperature Danger Zone. Keep chilled foods

		
4.2	**Did you observe the clubs food and nutrition policy displayed in social rooms?** 1. Yes 2. No 3. Unsure, as was not able to access social rooms/the clubs has no social rooms	This policy could look like the policy below. By social rooms we mean somewhere spectators/members/players can congregate to socialise. This will typically be the bar service area.



FOOD AND NUTRITION POLICY

As a Good Sports club, it is the policy of **[club Name]** to provide and promote healthy food options to our members and visitors.

This policy applies to food and drink sold through the club canteen, other food stalls, and fundraising activities. It applies to all members, officials, players and club visitors.

Food business

- Our club is a registered food business with the NSW Food Authority (or local council).

Food handlers

Our club will:

- have at least two club members trained in basic nutrition and safe food handling techniques. One of these members will be in charge of stocking and setting up the canteen
- ensure signage regarding safe food handling is displayed in the canteen and other locations food is handled.

Food sold in the canteen or at a food stall

Our club will ensure that:

- at least 6 healthy food choices from different food groups are always available (including a variety of fruit and vegetables and water), and are displayed in prominent positions
- healthier food choices are promoted, such as through meal deals and reduced prices
- if hot chips are sold, they are prepared using the National Heart Foundation 'Tips on chips' guide and the 'Shake, bang & hang' technique
- all oils used for cooking are monounsaturated or polyunsaturated (not saturated).

4.3 Select all food items in the table below that the club provides, also select if those foods are displayed in a prominent position and/or promoted at the club

By 'prominent position', we mean easy for all patrons to see when they are ordering food eg. at eye level.

By 'promoted', we mean clubs are informing patrons of their availability and/or encouraging patrons to purchase such healthier options:

Signs: Poster or sign promoting their availability

Meal deals: Deals that encourage patrons to purchase healthy foods eg. salad sandwich and water at a cheaper price

Shelf tags: Tags on certain foods informing patrons that they are a healthy option eg.

Food item	Sold or available at the club	Displayed in a prominent position (at eye level, on counter)	Promoted at the club by
Fresh whole fruit (apple, banana, orange)	◻ Yes ◻ No	◻ Yes ◻ No	◻ signage ◻ meal deals ◻ discounted price ◻ shelf tags ◻ over loud speaker ◻ other_____ ◻ Not promoted
Fruit salad	◻ Yes ◻ No	◻ Yes ◻ No	◻ signage ◻ meal deals ◻ discounted price ◻ shelf tags ◻ over loud speaker ◻ other_____ ◻ Not promoted

Dried fruits - small packets of sultanas, apricots, pear	◻ Yes ◻ No	◻ Yes ◻ No	◻ signage ◻ meal deals ◻ discounted price ◻ shelf tags ◻ over loud speaker ◻ other_____ ◻ Not promoted
Canned fruits (in natural juice) - such as individual serves of pears, peaches, apples in ring pull cans or tubs	◻ Yes ◻ No	◻ Yes ◻ No	◻ signage ◻ meal deals ◻ discounted price ◻ shelf tags ◻ over loud speaker ◻ other_____ ◻ Not promoted
99% or 100% fruit juices – 300ml serve size or less	◻ Yes ◻ No	◻ Yes ◻ No	◻ signage ◻ meal deals ◻ discounted price

			◻ shelf tags ◻ over loud speaker ◻ other_____ ◻ Not promoted
99% fruit juice frozen crushed ice drinks – 200mL serve size or less	◻ Yes ◻ No	◻ Yes ◻ No	◻ signage ◻ meal deals ◻ discounted price ◻ shelf tags ◻ over loud speaker ◻ other_____ ◻ Not promoted
Mixed salads	◻ Yes ◻ No	◻ Yes ◻ No	◻ signage ◻ meal deals ◻ discounted price ◻ shelf tags ◻ over loud speaker ◻ other_____ ◻ Not promoted

Whole vegetables – carrot, celery sticks	◻ Yes ◻ No	◻ Yes ◻ No	◻ signage ◻ meal deals ◻ discounted price ◻ shelf tags ◻ over loud speaker ◻ other_____ ◻ Not promoted
Coleslaw	◻ Yes ◻ No	◻ Yes ◻ No	◻ signage ◻ meal deals ◻ discounted price ◻ shelf tags ◻ over loud speaker ◻ other_____ ◻ Not promoted
Corn on the cob	◻ Yes ◻ No	◻ Yes ◻ No	◻ signage ◻ meal deals ◻ discounted price ◻ shelf tags

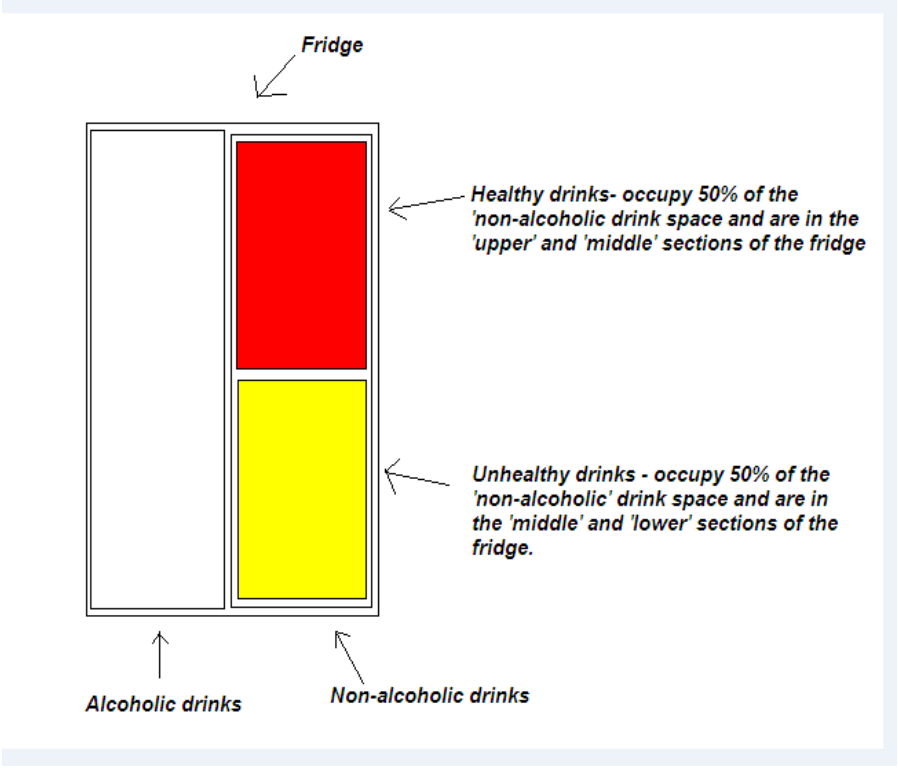
			□ over loud speaker □ other_____ □ Not promoted
Salad sandwich	□ Yes □ No	□ Yes □ No	□ signage □ meal deals □ discounted price □ shelf tags □ over loud speaker □ other_____ □ Not promoted
Roast vegetable	□ Yes □ No	□ Yes □ No	□ signage □ meal deals □ discounted price □ shelf tags □ over loud speaker □ other_____ □ Not promoted

Soup with vegetables (minestrone, pumpkin, chicken and vegetable, tomato)	◻ Yes ◻ No	◻ Yes ◻ No	◻ signage ◻ meal deals ◻ discounted price ◻ shelf tags ◻ over loud speaker ◻ other_____ ◻ Not promoted
Burger with salad (lettuce, tomato, beetroot)	◻ Yes ◻ No	◻ Yes ◻ No	◻ signage ◻ meal deals ◻ discounted price ◻ shelf tags ◻ over loud speaker ◻ other_____ ◻ Not promoted

4.4	**Did you observe all non-alcoholic drinks in containers of 375 mL or less? With the exception of plain milk and water.** 1. Yes 2. No (if no, please list non-alcoholic drinks sold in more than 375ml containers: _____ 3. NA, no non-alcoholic drinks sold	This question is assessing: 1. The percentage of the non-alcoholic drink space allocated to healthier options 2. The location of the healthy non-alcoholic drinks in the fridge in respect to the unhealthier options (ideally in the upper and middle part of the fridge) **Healthy options include:** • 375mL or less sugar free/diet soft drinks • 375mL or less 99-100% fruit juice • Low fat milk • Sugar free sports drink • Bottled water **Unhealthy options include:** • Full sugar soft drinks • 375mL or more 99-100% fruit juice • Fruit drinks that are not 99-100% fruit juice • 375mL or more sugar free/diet soft drinks • Full fat milk • Full sugar sports drink • Flavoured milk This question relates to drink containers of 375ml or less, not including water or plain milk (these can be as large as they want to stock).

4.5	**Please use the table below to provide information about the non-alcoholic drinks available (as displayed to you as a customer).** Please estimate the best that you can. We need to know how much of the total drink space (ie. fridge, eskies, vending machines etc) that is dedicated to non-alcoholic drinks listed below.	

	% of non-alcoholic drink space occupied by these drinks	**Position in drink space? Please tick all that applies for each category.**				
		a. Upper	**b. Middle**	**c. Lower**	**d. Evenly spread through out**	**e. Unable to determine**
Healthy drinks • 375ml or less sugar-free/diet soft drinks • 375ml or less 99-						



100% fruit juice • Low-fat milk • Sugar-free sports drinks • Bottled water	___%	☐	☐	☐	☐	☐	
Unhealthy drinks • Full sugar soft drinks • 375mL or more 99-100% fruit juice • Fruit drinks that are not 99-100% fruit juice • 375mL or more sugar free/diet soft drinks • Full fat milk	___%	☐	☐	☐	☐	☐	

• Full sugar sports drink • Flavoured milk **Total 100%**	

4.6	**Did you observe any fundraising, external to the canteen, using food? For example pie drives, chocolate sales, etc** 1. Yes, describe: _____ 2. No	Examples of this could be: • Pie drives • Selling chocolates for charity (eg. Freddo frogs) • Raffles with food as prizes
4.7	**What food did the club sell during the game? (Select all that apply)** 1. Fried foods (hot chips, chiko rolls, scallops, chicken nuggets) 2. Pastry foods (pies, sausage rolls, pasty, croissant) 3. Confectionery (lollies/sweets, chocolates, frogs, snakes, eucalyptus lollies) 4. Baked sweets (muffins, cakes, cupcakes, lamingtons, slices) 5. Salty snacks (packets chips, pretzels, salted nuts, popcorn) 6. Ice creams or ice blocks	This can relate to the club house, a kiosk, a canteen, a food van, a coffee truck. Basically, all types of food that could be bought for consumption whilst you are at the club.

	7. Barbequed foods (sausages, bacon, minute steak) 8. Other (please specify _____)	

4.8 **Please complete the table below with details of food industry advertisement/promotion/sponsorship you observed around the ground:**

Food company type	Food company name's	Players jersey, player accessories (eg bags, hats)	Coach or Club staff uniforms/ accessories	Banners around the playing field	Walk through banners	Poster	Merchandise	Dynamic advertisement (revolving/ electronic banners, boards etc)	Goal post padding	Game ball	Score board advertisement	Other (please specify)
Fast Food												
Sweetened Drinks												

This relates to the larger fast food chains such as McDonalds, KFC, Burger King, Hungry Jacks, Subway, Dominos Pizza

		This relates to the manufacturers of sweetened drinks such as Coca Cola, Schweppes												

PART 3: NON-OBSERVABLE SURVEY

5	ALCOHOL MANAGEMENT	
5.1	**Was the licensee or nominated person on-site during the visit?** 1. Yes 2. No (GO TO 5.4) 3. Don't know, could not determine (GO TO 5.4) 4. Not applicable (Vic only)(GO TO54.4)	The licensee is the person whose name is on the liquor licence – adherence is their responsibility. The nominated person can be someone else that the licensee has nominated to be responsible on any day the licensee is not at the game. This does not mean the 'club rep' responsible for working with Good Sports.
5.2	**What was the name of the licensee/nominated person who was on the site during the visit?** _____	
5.3	**Are they the licensee or nominated person?** 1. Licensee 2. Nominated person	

5.4 **MULT**	**What low-alcoholic drink options are available at the club? (Select as many as apply). Low alcohol beers are around 2.7% alcohol, and low alcohol wines are around 5%.** **Note:** Refer to your Observer Resource sheet for examples of low strength alcohol options. Please select the drink with the lowest alcohol percentage. 1. Low-alcohol beer (specify ___% alcohol) 2. Low-alcohol wine (specify ___% alcohol) 3. Low-alcohol pre-mix drink (RTD) (specify ___% alcohol) 4. None **(If selected, do not select another option)**	**Common low-alcohol beers (% alc)** Carlton Light Ice 3.3 % Cascade Light 2.7 % Coopers Light 2.9 % Fosters Light 2.5 % Hahn Premium Light 2.7 % Tooheys Blue 2.7 % **Common low-alcohol wines (% alc)** Brown Brothers 2005 Moscato 5.5% Brown Brothers Moscato Rosa 7.0% 2008 Six Point Six Moscato 6.6%	**Common low-alcohol pre-mix drinks (% alc)** Bacardi Breezers 4.8% Bundaberg Cola Super Dry 3.5% Johnnie Walker Super Dry 3.5% SKYY Blue Lime & soda/Blood Orange/Grapefruit & Soda 4.8% Smirnoff Super Dry 3.5% Vodka Cruisers 5.0% **Common low-alcohol champagne (% alc)** Yellowglen's 'Jewel' varieties Yellow and Pink 6%
5.5 **MULT**	**What non-alcoholic drink options are available? (Select all that apply)** 1. Bottled water 2. Reduced fat Milk – flavoured or plain 3. Full fat Milk – flavoured or plain 4. Juice (99% fruit 200mls) 5. Juice (not 99% fruit) 6. Diet Soft drinks 7. Soft drinks 8. Coffee 9. Tea 10. Hot Chocolate 11. Up'N'Go 12. Caffeinated drinks / Energy drinks (not coffee)		

	13. Sports drinks (eg. Gatorade) 14. Iced teas 15. Flavoured Mineral Water 16. Cordials 17. No non-alcoholic drinks available **(If selected, do not select another option)**	
5.6	**Please provide one example of each type of drink listing the brand name, volume and cost** *If the drink name is unavailable, please write NA in the brand name section.* **Type of drink** / **Drink name** / **Drink volume mL** / **Drink cost $** Soft drink Bottled water Low-strength beer Mid-strength beer Full-strength beer 1 Full-strength beer 2 Full-strength wine	The brand name is the company that manufactures the drink and the sub-brand eg. Schweppes Lemonade, Diet Coca Cola, Mount Franklin Water Typical low alcohol beers are listed in the question 4.4, and are usually less than 3% alcohol. Mid strength beers will usually say 'mid strength' and are usually 3-4% alcohol. Full strength beers are usually over 4.5% alcohol. 'Ready –to-drink' drinks are those drinks that are commonly known as alcopops eg. Bicardi Breezers, Stolys, cruisers, Woodstock Cola. Mixed drinks are those that require a spirit to be mixed with a soft drink such as cola or soda.

	Full-strength champagne RTDs* Mixed drink** Milk (plain/ flavoured) Sports drinks Tea/Coffee Other *RTD = ready to drinks (pre-mixed drinks e.g. Barcadi Breezer, Jim Beam & Cola can) ** Mixed drink = made on premises (e.g. bourbon and coke).	Sports drinks are those that are designed to rehydrate the body eg. Powerade, Gatorade.
5.7 **MULT**	**Did you observe the club offering any of the following 'safe transport' options? (Select all that apply)** 1. Free non-alcoholic drinks to designated drivers 2. Free non-alcohol drinks for bar servers 3. Free bar snacks for bar servers 4. Free phone calls to local taxi companies 5. Local taxi company details clearly displayed 6. Taxi vouchers for raffle prizes and awards 7. Pre-ordered taxis 8. Courtesy transport (free club transport)	**Free non-alcoholic drinks to designated drivers** – this is where clubs will provide free soft drinks or tea/coffee to designated drivers. **Free phone calls to local taxi companies –** this can either be a direct line to a taxi company, allowing patrons to use the phone to call a taxi or club staff calling a taxi.

	9. Club/committee/staff member drives people home 10. Key register 11. Free bar snacks for designated drivers 12. No safe transport options **(If selected, do not select another option)**(Go to 4.9) 13. Other (please specify _____)	**Local taxi company details clearly displayed** – this could be as simple as the local taxi company phone number near a pay phone or somewhere that patrons can easily see it to call a taxi from their mobile. **Taxi vouchers for raffle prizes and awards** – these are vouchers that cover the full or part cost of a taxi fare. **Pre-ordered taxis-**This can include the club calling a certain number of taxis at the end of the game. **Courtesy transport (free club transport)** – this can include a courtesy bus **Club/committee/staff member drives people home** – this should only be selected as a response if the service is available to all patrons (not just a select few). **Key register** – this is a service where bar staff take car keys and hand them back when requested.
5.8	**Did the club promote their availability at the ground? (eg. announcements, notices/posters)** *Refer to an example sign in your resource kit. Please note the club may use other promotional material to promote their safe transport options (eg. announcement at the game)* 1. Yes, all of those selected above were promoted 2. Some of those selected above were promoted 3. No, none of those above were promoted **(If selected, do not select another option)**	An example sign could be:


Getting home safely
GET HOME SAFE
As a Good Sports club we want to make sure you get home safely, especially if you've been drinking alcohol.
<DELETE TIPS THAT AREN'T APPLICABLE>
If you think you might be over the legal limit for driving, why not leave your car here and:
• Get a sober friend or family member to drive you home
• Catch a taxi – you can use the club phone to order one if you like. The number is xxx xxxxxx
• Take FREE club transport home
• Make use of the club's Designated Driver Program
good SPORTS

5.9

Please list the names of the staff, who are clearly serving alcohol, and indicate whether or not you saw their name on the RSA training sign AND/OR a copy of their RSA certificates in an RSA register (this is a folder somewhere near the bar).

You may need to ask the club rep or licensee to help you record bar staff names and you will need to ask the rep/licensee to view the RSA register.

Bar staff name Please enter full name	**Saw bar staff's RSA certificate in an RSA register?** Please circle response		**Saw staff member's name listed on a sign near <u>ALL</u> places alcohol was served?** Please circle response		
	Yes	**No**	**Yes**	**No**	**Some, but not all bars**
a)	1	2	1	2	3
b)	1	2	1	2	3
c)	1	2	1	2	3
d)	1	2	1	2	3
e)	1	2	1	2	3
f)	1	2	1	2	3
g)	1	2	1	2	3
h)	1	2	1	2	3
i)	1	2	1	2	3

This question is so that we can assess whether all staff working at the time of the observation are RSA trained.

You will need to write down the name of each staff member serving, and confirm that they are trained.

In NSW, the laws have recently changed:

- If they were trained before 22 Aug 2011, the club must have a copy of their certificate in a register near the bar
- If they have been trained since, they MUST wear their RSA Competency Card at ALL times.

So, in NSW, if they have a competency card, respond 'yes' to the question in the 2nd column of the table.

6.0	**Do you think that the club is in the intervention or the control group of the research trial?** 1. Intervention group (web-based intervention) 2. Control group (normal practice)	

APPENDIX 7: CHEAT SHEET

PART 1: OBSERVATION INFORMATION

Club name		**Time started member recruitment**	
Club ID		**Time ended member recruitment**	
Time arrived at ground		**Location of member recruitment**	
Time started MDV		**Did club stop seeling alcohol during MDV, if who when?**	
Time ended MDV			
Time started consensus			
Time ended consensus			

PART 2: OBSERVABLE SURVEY

	Item	Question	Notes
1.	**ALCOHOL MANAGEMENT**		
1.1	**Liquor licence**	Is the club liquor licence displayed in public view in the club house? **VIC ONLY**	
1.2	**State licensing signs**	At which points of alcohol sale does the club display the state Liquor Licensing signage? e.g. club bar; point of sale outlet(s)(See kit for examples). For VIC clubs, BOTH for signs MUST be displayed.	
1.3	**Location alcohol service**	Where was alcohol served?	

1.4	**Times alcohol service**	When did you observe alcohol being served at the ground?	
1.5	**RSA trained staff names**	At which points of alcohol sale did the club clearly display the names of RSA trained staff?	
1.6	**Free water**	Did the club provide free tap water? (Ask bar or canteen for free tap water)	
1.7	**Under 18s serving**	Did you see anyone under 18 years serving alcohol?	
1.8	**Checking ID**	How often was ID (proof of age) being checked for people who appeared under the age of 25 years who attempted to purchase alcohol?	
1.9	**Location of consumption**	Where were people consuming alcohol at the ground?	
1.10	**Drunk/intox entering**	Did you see any drunk or intoxicated people entering the club?	
1.11	**Drunk/intox served**	Did you see drunk or intoxicated people being served alcohol?	
1.12	**Drunk/intox remaining**	Did you see drunk or intoxicated people being allowed to remain at the club?	
1.13	**Substantial food**	Was alcohol served for at least 90 minutes during the observation? If YES: 1.14 Were there at least 15 people present at any time during the observation? If YES: 1.15 Was substantial food available?	
1.16	**Bar servers consuming alcohol**	Did you see anyone who was working behind the bar/canteen consuming alcohol whilst on duty, including during breaks?	

1.17	**Drink promotions**	Did you see the club conducting any of the following drink promotions? • Happy hour (discounted drinks for a specified time) • Drinking competitions (eg. boatraces) • Alcohol-only player awards • Alcohol-only raffle prizes • Drink vouchers or cards • Cheap drink promotions (discounted drink promotions eg. 50% off, 2 for price 1) • 'All you can drink' functions • Other	
1.18	**Service shots, RTDs etc**	Did you see the club serving any of the following drinks? • Shots of alcohol (eg. Shots, slammers, nips) • Ready to drink products with more than 5% alcohol (eg. OP rum) • Mixed alcohol drinks with more than 30 ml spirits (eg. Double nips, cocktails)	
1.19	**Limits on drinks**	Did you see the club limiting the number of alcoholic drinks that people can purchase in one transaction? e.g. point of sale outlets where maximum of 4 open cans can be purchased at any one time.	
1.20	**Stockpiling**	Did you see patrons 'stockpiling' unconsumed drinks? (3 or more for one person's consumption)	
1.21	**Bringing alcohol into licensed area**	Did you see anyone bring alcohol into the club house or designated alcohol area that was not purchased at the club?	
1.22	**Bringing alcohol into ground**	Did you see any people bringing alcohol into the ground that was not purchased at the club?	
1.23	**Drink containers**	What drink containers did the club serve drinks in? This includes both alcoholic and non-alcoholic drinks	
1.24	**Cease 30 mins**	Did you observe the club cease the sale and supply of liquor at least 30 minutes before the end of trade (when bar/club house was closed)?	

1.25	**Rapid consumption**	Did you observe any patrons rapidly consuming drinks immediately prior to the cessation of alcohol service?	
1.26	**Leaving with opened drinks**	Did you observe patrons leaving the club with any opened alcohol?	
1.27	**Leaving with unopened drinks**	Did you observe patrons leaving the club with any unopened alcohol which they purchased on club grounds? (eg. Take-away drinks)	
1.28	**Bar crowding**	When it was at its busiest, how crowded was the bar services area with patrons wanting to purchase drinks?	
1.29	**Alcohol management policy**	Did you observe the clubs written alcohol management policy displayed in social rooms?	
1.30	**Alcohol sponsorship**	Look for alcohol industry advertisement/promotion/sponsorship around the ground. You will need to record: • Name of company (alcohol manufacturer, alcohol retailer, licensed venue) • Where you saw the sponsorship	
2	**SMOKING**		
2.1	**Smoking inside**	Did you see anyone smoking inside the club house?	
2.2	**Smoke-free signage**	Was the smoke-free signage in smoke-free areas clearly displayed? Was the sign clearly visible and not obstructed in any way?	
2.3	**Sale of cigarettes**	Did the club sell cigarettes? Look for a vending machine or sales behind the bar.	

2.4	**Smoking around ground**	Did you see anyone smoking on the club ground?	
2.5	**Outdoor smoking areas**	Did the club provide outdoor areas for smoking patrons?	
2.6	**Underage sports event**	During any of the observation, did you see an organised underage sports event on the club grounds? (eg. under 18s match)	
2.7	**Smoking at underage event**	Did you see anyone smoking within 10 metres of a 'sporting venue' that is an outdoor public area during this underage event?	
3	**GOOD SPORTS PROMOTION**		
3.1	**Good Sports branded items**	Did you see any Good Sports branded items on display at the club/ground? If YES: 3.2 Which of the following Good Sports branded items were on display at the club/ground? • Level 3 certificate • Good Sports 'outdoor' metal sign • Good Sports Bar runner/mat • Good Sports bar sign • Good Sports stickers	
3.3	**Good Sports promotions**	Did you hear the club promoting to the members that it is a part of Good Sports?	
4	**SAFE FOOD HANDLING AND HEALTHY OPTIONS**		

<table>
<tr><td>4.1</td><td>Safe food handling sign</td><td colspan="2">Did you see the ‘safe food handling’ sign clearly displayed in the place where food was sold?</td><td></td></tr>
<tr><td>4.2</td><td>Food and nutrition policy</td><td colspan="2">Did you observe the clubs food and nutrition policy displayed in social rooms?</td><td></td></tr>
<tr><td>4.3</td><td>Healthy food options and promotion</td><td colspan="3">Look for the following food items and whether or not they are:

1. Displayed in a prominent position

2. Promoted at the club

<table>
<tr><th></th><th>Available</th><th>Prominent</th><th>Promoted</th><th></th><th>Available</th><th>Prominent</th><th>Promoted</th></tr>
<tr><td>Fresh whole fruit</td><td></td><td></td><td></td><td>Whole veggies</td><td></td><td></td><td></td></tr>
<tr><td>Fruit salad</td><td></td><td></td><td></td><td>Coleslaw</td><td></td><td></td><td></td></tr>
<tr><td>Dried fruits</td><td></td><td></td><td></td><td>Corn on the cob</td><td></td><td></td><td></td></tr>
<tr><td>Canned fruits (natural juice)</td><td></td><td></td><td></td><td>Salad sandwich</td><td></td><td></td><td></td></tr>
<tr><td>99% or 100% fruit juice (<=300ml)</td><td></td><td></td><td></td><td>Roast veggies</td><td></td><td></td><td></td></tr>
<tr><td>99% fruit juice frozen crushed ice drinks (<=200ml)</td><td></td><td></td><td></td><td>Soup with veggies</td><td></td><td></td><td></td></tr>
<tr><td>Mixed salads</td><td></td><td></td><td></td><td>Burger with salad</td><td></td><td></td><td></td></tr>
</table></td></tr>
<tr><td>4.4</td><td>Non-alcoholic drinks <=375ml</td><td colspan="2">Did you observe all non-alcoholic drinks in containers of 375 mL or less? With the exception of plain milk and water.</td><td></td></tr>
<tr><td>4.5</td><td>Estimate of drink space</td><td colspan="3">Look at the drink space and estimate how much of the total drink space is dedicated to the following non-alcohol drinks. Also remember to look at their position in the drink space. Use the space to draw!</td></tr>
</table>

<table>
<tr><td></td><td></td><td>
<table>
<tr><th>Healthy drinks</th><th>Unhealthy drinks</th></tr>
<tr><td>375ml or less sugar-free/diet soft drinks</td><td>Full sugar soft drinks</td></tr>
<tr><td>375ml or less 99-100% fruit juice</td><td>375mL or more 99-100% fruit juice</td></tr>
<tr><td>Low-fat milk</td><td>Fruit drinks that are not 99-100% fruit juice</td></tr>
<tr><td>Sugar-free sports drinks</td><td>375mL or more sugar free/diet soft drinks</td></tr>
<tr><td>Bottled water</td><td>Full fat milk</td></tr>
<tr><td></td><td>Full sugar sports drink</td></tr>
<tr><td></td><td>Flavoured milk</td></tr>
</table>
</td><td></td></tr>
<tr><td>4.6</td><td>Food fundraisers</td><td>Did you observe any fundraising, external to the canteen, using food? For example pie drives, chocolate sales, etc</td><td></td></tr>
<tr><td>4.7</td><td>Types food</td><td>What food did the club sell during the game?

• Fried foods (hot chips, chiko rolls, scallops, chicken nuggets)
• Pastry foods (pies, sausage rolls, pasty, croissant)
• Confectionery (lollies/sweets, chocolates, frogs, snakes, eucalyptus lollies)
• Baked sweets (muffins, cakes, cupcakes, lamingtons, slices)
• Salty snacks (packets chips, pretzels, salted nuts, popcorn)
• Ice creams or ice blocks
• Barbequed foods (sausages, bacon, minute steak)
• Other
•</td><td></td></tr>
<tr><td>4.8</td><td>Food sponsorship</td><td>Look for food industry advertisement/promotion/sponsorship around the ground. You will need to record:</td><td></td></tr>
</table>

		• Name of company (fast food, sweetened drinks) • Where you saw the sponsorship	

PART 3: NON-OBSERVABLE SURVEY

5	ALCOHOL MANAGEMENT		
5.1	**Licensee/nominated person present**	Was the licensee or nominated person on-site during the visit? **NSW ONLY**	
5.2	**Licensee/nominated person name**	What was the name of the licensee/nominated person who was on the site during the visit? **NSW ONLY**	
5.3	**Licensee or nominated**	Are they the licensee or nominated person? **NSW ONLY**	
5.4	**Low-alcoholic drinks**	What low-alcoholic drink options are available at the club? (Select as many as apply). Low alcohol beers are around 2.7% alcohol, and low alcohol wines are around 5%.	
5.5	**Non-alcoholic drinks**	What non-alcoholic drink options are available?	

5.6 Cost drinks

Please provide one example of each type of drink listing the brand name, volume and cost

	Brand	Size (ml)	Cost		Brand	Size (ml)	Cost
Soft drink				Full-strength wine			
Bottled water				Full-strength champagne			
Low-strength beer				RTDs*			
Mid-strength beer				Mixed drink**			
Full-strength beer 1				Milk (plain/ flavoured)			
Full-strength beer 2				Sports drinks			
Tea/coffee				Other			

5.7 Safe transport options

Did you observe the club offering any of the following 'safe transport' options?

- Free non-alcoholic drinks to designated drivers
- Free non-alcohol drinks for bar servers
- Free bar snacks for bar servers
- Free phone calls to local taxi companies
- Local taxi company details clearly displayed
- Taxi vouchers for raffle prizes and awards
- Courtesy transport (free club transport)
- Club/committee/staff member drives people home
- Key register
- Free bar snacks for designated drivers
- No safe transport options (If selected, do not select another option)(Go to 4.9)
- Other

5.8	**Promotion safe transport options**	Did the club promote their availability at the ground?	
5.9	**RSA training**	List the names of the staff, who are clearly serving alcohol, and indicate whether or not you saw their name on the RSA training sign AND/OR a copy of their RSA certificates in an RSA register. You will need to record: • Full name • Whether or not you saw their certificate in an RSA register • Whether or not you saw their name on a sign	

Staff name	RSA certificate seen		Name on sign		
	Yes	No	Yes	No	Some but not all bars

6.0	**Research trial group**	Do you think that the club is in the intervention or the control group of the research trial?					

APPENDIX 8: MEMBER/SUPPORTER RECRUITMENT SURVEY

STEP 1: Eligibility assessment

Person	(a) Eligibility If eligible go to (b)		(b) Main role		(c) Information sheet provided		(d) Consent If yes, record contact details	
1	Home member/supporter Over 18 years old Speak English **To be eligible, ALL must be ticked.**	☐ ☐ ☐	Spectator Club official Player	☐ ☐ ☐	Yes No (can send)	☐ ☐	Yes No (thank)	☐ ☐
2	Home member/supporter Over 18 years old Speak English	☐ ☐ ☐	Spectator Club official Player	☐ ☐ ☐	Yes No (can send)	☐ ☐	Yes No (thank)	☐ ☐
3	Home member/supporter Over 18 years old Speak English	☐ ☐ ☐	Spectator Club official Player	☐ ☐ ☐	Yes No (can send)	☐ ☐	Yes No (thank)	☐ ☐
4	Home member/supporter Over 18 years old Speak English	☐ ☐ ☐	Spectator Club official Player	☐ ☐ ☐	Yes No (can send)	☐ ☐	Yes No (thank)	☐ ☐
5	Home member/supporter Over 18 years old Speak English	☐ ☐ ☐	Spectator Club official Player	☐ ☐ ☐	Yes No (can send)	☐ ☐	Yes No (thank)	☐ ☐
6	Home member/supporter Over 18 years old Speak English	☐ ☐ ☐	Spectator Club official Player	☐ ☐ ☐	Yes No (can send)	☐ ☐	Yes No (thank)	☐ ☐
7	Home member/supporter Over 18 years old Speak English	☐ ☐ ☐	Spectator Club official Player	☐ ☐ ☐	Yes No (can send)	☐ ☐	Yes No (thank)	☐ ☐

8	Home member/supporter Over 18 years old Speak English	☐ ☐ ☐	Spectator Club official Player	☐ ☐ ☐	Yes No (can send)	☐ ☐	Yes No (thank)	☐ ☐
9	Home member/supporter Over 18 years old Speak English	☐ ☐ ☐	Spectator Club official Player	☐ ☐ ☐	Yes No (can send)	☐ ☐	Yes No (thank)	☐ ☐
10	Home member/supporter Over 18 years old Speak English	☐ ☐ ☐	Spectator Club official Player	☐ ☐ ☐	Yes No (can send)	☐ ☐	Yes No (thank)	☐ ☐
11	Home member/supporter Over 18 years old Speak English	☐ ☐ ☐	Spectator Club official Player	☐ ☐ ☐	Yes No (can send)	☐ ☐	Yes No (thank)	☐ ☐
12	Home member/supporter Over 18 years old Speak English	☐ ☐ ☐	Spectator Club official Player	☐ ☐ ☐	Yes No (can send)	☐ ☐	Yes No (thank)	☐ ☐
13	Home member/supporter Over 18 years old Speak English	☐ ☐ ☐	Spectator Club official Player	☐ ☐ ☐	Yes No (can send)	☐ ☐	Yes No (thank)	☐ ☐
14	Home member/supporter Over 18 years old Speak English	☐ ☐ ☐	Spectator Club official Player	☐ ☐ ☐	Yes No (can send)	☐ ☐	Yes No (thank)	☐ ☐
15	Home member/supporter Over 18 years old Speak English	☐ ☐ ☐	Spectator Club official Player	☐ ☐ ☐	Yes No (can send)	☐ ☐	Yes No (thank)	☐ ☐
16	Home member/supporter Over 18 years old	☐	Spectator Club official	☐	Yes No (can send)	☐	Yes No (thank)	☐

	Speak English	☐ ☐	Player	☐ ☐		☐		☐
17	Home member/supporter Over 18 years old Speak English	☐ ☐ ☐	Spectator Club official Player	☐ ☐ ☐	Yes No (can send)	☐ ☐	Yes No (thank)	☐ ☐
18	Home member/supporter Over 18 years old Speak English	☐ ☐ ☐	Spectator Club official Player	☐ ☐ ☐	Yes No (can send)	☐ ☐	Yes No (thank)	☐ ☐
19	Home member/supporter Over 18 years old Speak English	☐ ☐ ☐	Spectator Club official Player	☐ ☐ ☐	Yes No (can send)	☐ ☐	Yes No (thank)	☐ ☐
20	Home member/supporter Over 18 years old Speak English	☐ ☐ ☐	Spectator Club official Player	☐ ☐ ☐	Yes No (can send)	☐ ☐	Yes No (thank)	☐ ☐

STEP 2: Contact details

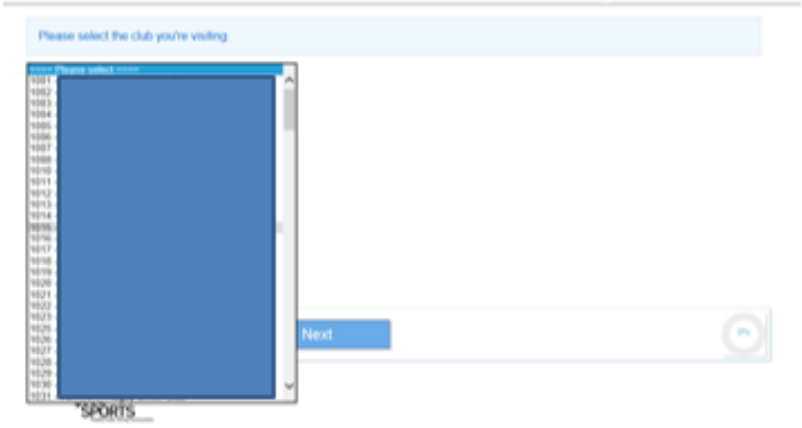
	Name	Phone (primary) Type: home, work, other	Phone (other) Type: home, work, other	Email Address	Best day/time to contact
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					

APPENDIX 13 Data collection tool for club observation visits (Alcohol practice seciton)

MATCH DAY VISITS

SCREENSHOTS FROM DATA COLLECTION TOO

0. LOGIN SCREEN



1. OBSERVABLE PRACTICES

Section 1: Alcohol management (Q1.1-1.29)

Q1_1. Is the club liquor licence displayed in public view in the club house?

Please select one answer

- Yes
- No

Q1_2. At which points of alcohol sale does the club display the state Liquor Licensing signage? e.g. club bar; point of sale outlet(s). (See kit for examples). For VIC clubs both of the state signs.

Please select one answer

- All
- Some
- None

Q1_3. Where was alcohol served?

Note: This relates to the location of alcohol actually being SERVED, not just where people are drinking.

Please select all that apply

- Club house
- From canteen/kiosk/s around the ground
- Other designated area (Please specify)

Q1_4. When was alcohol served?

Please select all that apply

- Before game
- During game
- After game

Q1_4. During what times did you observe alcohol being served:
Note: This relates to the times you actually observed. For example:

- If alcohol was served for the observation period, record the whole time you were there (eg. 12-3pm)
- If alcohol service started at 1pm and you left at 3pm (and alcohol was still being served), record 1-3pm.

	Hour	Minute
Start alcohol service time	Please select hour	Please select minute
End alcohol service time	Please select hour	Please select minute

Q1_5. At which points of alcohol sale did the club clearly display the names of RSA trained staff?

Please select one answer

- All
- Some
- None

Q1_6. Did the club provide free tap water? (Ask bar or canteen for free tap water)

Note: Free tap water refers to water provided free of charge. This can include:

- Tap water, including jugs of water on the bar or a glass of water provided at request
- Bottles of water that are free
- Water dispenser

Please select one answer

- Yes
- No

Q1_7. Did you see anyone under 18 years serving alcohol?

Please select one answer

- Yes
- No
- Don't know- couldn't tell

Q1_8. How often was ID being checked for people who appeared under the age of 25 years who attempted to purchase alcohol?

Note: Look for club staff/volunteers asking to check an ID card before serving alcohol or allowing entry to the clubhouse

Please select one answer

- Everyone was being checked
- Some people were being checked
- Not being checked
- Not applicable, no one who appeared under the age of 25 years attempted to purchase alcohol

Q1_9. Where were people consuming alcohol at the ground?

Note: You will need to walk around the entire ground to observe this question.

Please select one answer

- Within the club house only
- Within other designated area(s), other than club house
- Within the club house AND other designated area(s)
- Within the entire sporting ground

Q1_10. Did you see any drunk or intoxicated people entering the club?

Note: The definition of drunk/intoxicated is:

a. A persons speech, balance, coordination or behaviour is noticeably affected, AND

b. it is reasonable in the circumstances to believe that the affected speech, balance, coordination or behaviour is the result of the consumption of liquor(alcohol)

Also refer to your Observer Resource sheet

Please select all that apply

- ☐ Yes – entering the club ground
- ☐ Yes – entering the club house/other designated drinking area
- ☐ No (If selected, do not select another option)

Q1_11. Did you see drunk or intoxicated people being served alcohol?

Note: The definition of drunk/intoxicated is:

a. A persons speech, balance, coordination or behaviour is noticeably affected, AND

b. it is reasonable in the circumstances to believe that the affected speech, balance, coordination or behaviour is the result of the consumption of liquor(alcohol)

Also refer to your Observer Resource sheet

Please select all that apply

- ☐ Yes - on the club ground
- ☐ Yes - in the club house/other designated drinking area
- ☐ No (If selected, do not select another option)

Q1_12. Did you see drunk or intoxicated people being allowed to remain at the club?

Note: The definition of drunk/intoxicated is:

a. A persons speech, balance, coordination or behaviour is noticeably affected, AND

b. it is reasonable in the circumstances to believe that the affected speech, balance, coordination or behaviour is the result of the consumption of liquor(alcohol)

Also refer to your Observer Resource sheet

Please select all that apply

- ☐ Yes – within the club ground
- ☐ Yes – within the club house/other designated drinking area
- ☐ No (If selected, do not select another option)

Q1_13. Was alcohol served for at least 90 minutes during the observation?

Please select one answer

- ○ Yes
- ○ No

Q1_14. Were there at least 15 people present at any time during the observation?

Note: This includes spectators, including committee members. It does not include players that are on the field.

Please select one answer

- ○ Yes
- ○ No

Q1_15. Was substantial food available? (Substantial food is sandwiches, hot food, etc., not just snack food such as packets of chips and confectionary.)

Note: Substantial food is sandwiches, hot food, etc., not just snack food such as packets of chips and confectionary.

Please select all that apply

- ☐ Yes – at point/s of alcohol sale
- ☐ Yes - from canteen/etc outside of club house/other designated drinking area
- ☐ Yes - other (Please specify)
- ☐ No

Q1_16. Did you see anyone who was working behind the bar/canteen consuming alcohol whilst on duty, including during breaks?

Note: This is anyone serving alcohol from any location, eg. from a canteen, bar or esky.

Please select one answer

- ○ Yes
- ○ No

Q1_17. Did you see the club conducting any of the following drink promotions?

Please select all that apply

- ☐ Happy hour (discounted drinks for specified time)
- ☐ Drinking competitions (eg. boatraces)
- ☐ Alcohol-only player awards/
- ☐ Alcohol-only raffle prizes
- ☐ Drink vouchers or cards
- ☐ Cheap drink promotions (discounted drink promotions e.g. 50% off, 2 for 1)
- ☐ 'All you can drink' functions
- ☐ Other (Please specify)
- ☐ No

Q1_18. Did you see the club serving any of the following drinks?

Note:Answer this question in relation to whether they were serving these drinks, not just whether these drinks were observed to be behind the bar or in a fridge.

Please select all that apply

- [ ] Shots of alcohol (eg. Shots, slammers)
- [ ] Ready to drink products with more than 5% alcohol (eg. OP rum)
- [ ] Mixed alcohol drinks with more than 30 ml spirits (eg. Double nips, cocktails)
- [ ] None of the above

Q1_19. Did you see the club limiting the number of alcoholic drinks that people can purchase in one transaction? e.g. point of sale outlets where maximum of 4 open cans can be purchased at any one time.

Please select one answer

- ( ) Yes, limits
- ( ) No, no limits
- ( ) Didn't observe

Q1_20. Did you see patrons 'stockpiling' unconsumed drinks? (3 or more for one person's consumption)

Note:This does not include people who brought their own drinks into the ground. By 'patrons', we are referring to all people/customers including players, members, spectators, club officials etc.

Please select one answer

- ( ) Yes
- ( ) No

Q1_21. Did you see anyone bring alcohol into the club house or designated alcohol area that was not purchased at the club?

Note: This refers to players/spectators/members bringing their own alcohol into the club house/designated area. Look for:

- Personal eskies
- People bringing alcohol in their car or bags

Consumption of drinks that are not sold at the club (eg. high strength RTDs, long necks of beer, brands of beer not served by the bar)

Please select one answer

- ( ) Yes
- ( ) No

Q1_22. Did you see any people bringing alcohol into the ground that was not purchased at the club?

Note: This refers to players/spectators/members bringing their own alcohol into the ground. Look for:

- Personal eskies
- People bringing alcohol in their car or bags

Consumption of drinks that are not actually sold at the club (eg. high strength RTDs, long necks of beer, brands of beer not served by the bar)

Please select one answer

- ○ Yes
- ○ No

Q1_23. What drink containers did the club serve drinks in? This includes both alcoholic and non-alcoholic drinks

Please select all that apply

- ☐ Glass
- ☐ Plastic
- ☐ Cans
- ☐ Other (Please specify)

Q1_24. Did you observe the club cease the sale and supply of liquor at least 30 minutes before the end of trade (when bar/club house was closed)?

Note: This relates to the actual time the club stops the service of alcohol. People may be finishing their drinks after this time. This does not refer to non-alcoholic drinks and food.

Please select one answer

- ○ Yes
- ○ No
- ○ Was not at the game/match at end of trade

Q1_25. Did you observe any patrons rapidly consuming drinks immediately prior to the cessation of alcohol service?

Please select one answer

- ○ Yes
- ○ No
- ○ Was not at the game at the cessation of alcohol service

Q1_26. Did you observe patrons leaving the club with any opened alcohol?

Please select one answer

- ☐ Yes – observed patrons leaving the club ground
- ☐ Yes – observed patrons leaving the club house/other designated drinking area
- ☐ No (If selected, do not select another option)

Q1_27. Did you observe patrons leaving the club with any unopened alcohol which they purchased on club grounds? (eg. Take-away drinks)

Please select one answer

- Yes
- No

Q1_28. When it was at its busiest, how crowded was the bar services area with patrons wanting to purchase drinks?

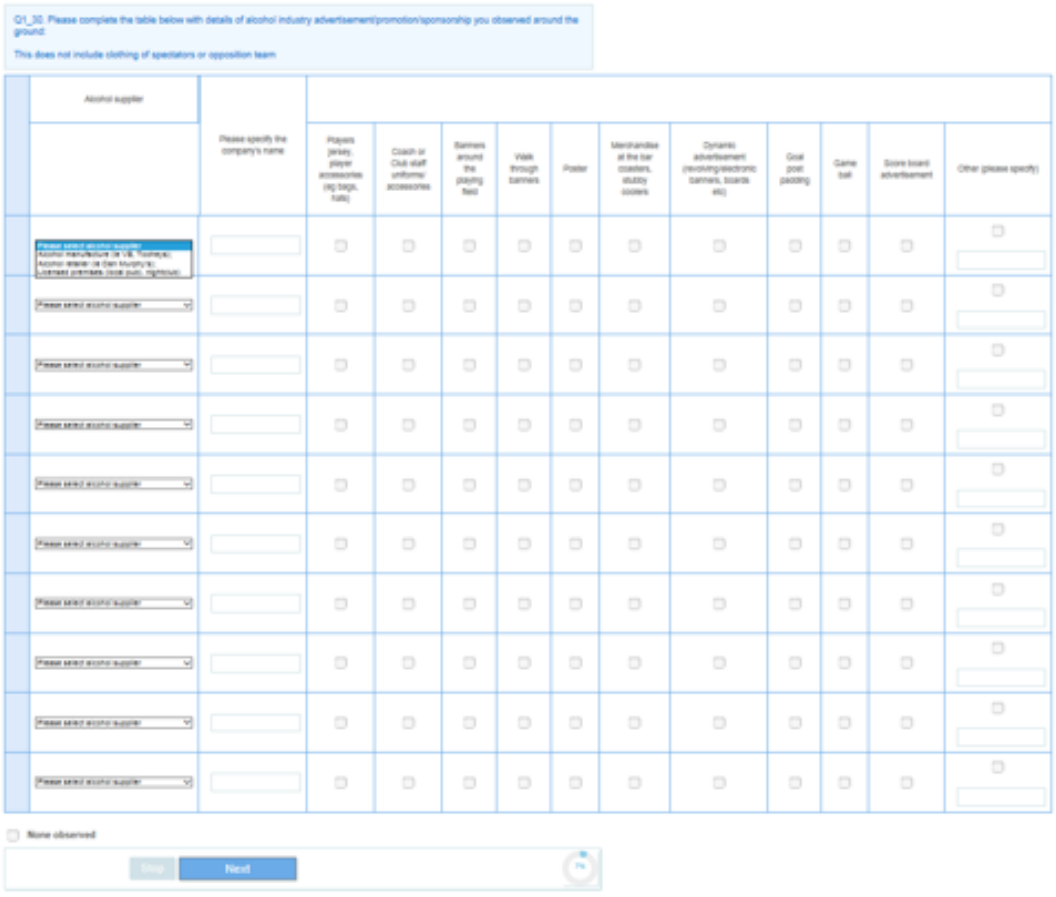
Please select one answer

- 1 deep
- 2 deep
- 3 deep
- 4 deep
- 5 or more deep

Q1_29. Did you observe the clubs written alcohol management policy displayed in social rooms?(Refer to your Observer Resource sheet)

Please select one answer

- Yes
- No
- Unsure was unable to access social rooms/club doesn't have social rooms



APPENDIX 14 Club member CATI survey script for 2015 and 2017

INTRODUCTION

INFO 1: Hello, my name is <INSERT NAME> and I am calling on behalf of Good Sports.

Q1. Could I please speak to <RESPONDENTS NAME>?

1. Speaking to that person (invite to participate now, or at another convenient time)(go to Q2)
2. Person not at home (ask for a convenient time to contact them)
3. Person unwell at the moment (ask for a convenient time to contact them)
4. Person recently died (apologise for calling them at this time, and record)
5. Someone in household recently died (apologise for calling them at this time, and record)
6. A business phone number (record as business number)
7. Person physically or mentally unable to participate (record)
8. Non-English speaking and no assistance available (record)
9. Person moved from household (record)
10. Other (please specify)
11. Refused (thank them for their time and record as refusal)

Q2. I am calling about the Good Sports program and your involvement with <insert club name>. At a recent home game, you were approached by Good Sports and invited to participate in a telephone survey. You provided your contact details and were provided with a copy of the member information letter. Do you remember receiving the letter?

1. Yes (go to INTRO2)
2. No (go to Q3)

Q3. Would you like us to send to another copy of the letter?

1. Yes (go to Q4)
2. No (go to INTRO4)
3. No, we don't want to participate (RECORD AS REFUSAL- thank them for their time today)

Q4. What address would you like the letter sent to? This can be a mailing or email address, or fax number.

Interviewer: *Please organise for a new letter to be sent to the respondent ASAP, and book a convenient call-back time.*

INFO 2: Before we go any further, I would like to ask a few questions to check that you are eligible to participate in the survey.

Q5. Before we start the survey, In order to ensure that you are over the age of 18 and eligible to participate in the survey, could you please tell me your date of birth? (DDMMYYYY)(ENTER '999' IF REFUSED AND RECORD AS REFUSAL)(Go to Q6 if eligible). If >=18 years, progress with the survey. If <18 years, let them know that they are ineligible to participate based on their current age.

Q6. Would you like to participate in the survey?

1. Yes (go to Q7)
2. No (RECORD AS REFUSAL- thank them for their time today)

Q7. Do you have 20 minutes at the moment to complete a brief survey over the phone?

1. Yes (go to Q8)
2. No (BOOK A CONVENIENT CALL BACK TIME)

Q8. Can you please tell me which of the following describes your CURRENT involvement with your sporting club? You can select as many options as apply.

1. Player
2. Non playing member (supporter)
3. Coach
4. Umpire/referee
5. Club committee member
6. Don't know
7. I am involved in other ways
8. Refused

(Go to Q9)

Q9. How long have you been involved with this club? (Enter years; if less than 1 year, enter '0')(If 'refused' enter 999; if 'don't know' enter 888).(Go to Q10).

Q10. How often would you attend your sporting club?

1 . Weekly (or more frequently)
2. Less than weekly but at least monthly
3. Less than monthly but at least twice per season
4. Rarely
5. Never
6. Don't know
7. Refused

(Go to INFO3)

ALCOHOL CONSUMPTION

INFO3: We would like to start with asking some questions about your alcohol consumption – in general and at your football club. Some of the questions may seem repetitive; however, we need to ask them in this format to get reliable data. Remember that all data is strictly confidential, so please be honest.

For all of the questions, when we talk about a 'standard drink' we mean:

In NSW: One standard drink is equivalent to around 1 middy of full strength beer, or 1 schooner of light beer. A stubby or can (375ml) of full strength beer is about 1.5 standard drinks

In VIC: One standard drink is equivalent to about 1 pot for full strength beer. A stubby or can (375ml) of full strength beer is about 1.50 standard drinks and a pint of full strength beer is around 2.2 standard drinks.

The first question asks you about your drinking at ANY time.

(Go to Q11).

Q11. How often do you have a drink containing alcohol? This refers to ANY TIME, that is, not just at your sporting club.

1. Never (Go to INFO4)

2. Monthly or less (Go to Q12)
3. 2 to 4 times a month (Go to Q12)
4. 2 to 3 times a week (Go to Q12)
5. 4 or more times a week (Go to Q12)
6. Refused (Go to INFO4)

Q12. How many STANDARD DRINKS do you have on a typical day when you are drinking?

1. 1-2
2. 3-4
3. 5-6
4. 7-9
5. 10 or more
6. Refused

(Go to Q13)

Q13. How often do you have 3 or more drinks on the one day?

1. Everyday
2. 5 to 6 days a week
3. 3 to 4 days a week
4. 1 to 2 days a week
5. 2 to 3 days a month
6. About 1 day a month
7. Less often
8. Never
9. Refused

(Go to Q13)

Q14. How often do you have 5 or more drinks on the one occasion?

1. Everyday
2. 5 to 6 days a week
3. 3 to 4 days a week
4. 1 to 2 days a week
5. 2 to 3 days a month
6. About 1 day a month
7. Less often
8. Never
9. Refused

(Go to Q15)

Q15. How often do you have 6 or more drinks in one occasion?

1. Never
2. Less than monthly
3. Monthly
4. Weekly
5. Daily or almost daily
6. Refused

(Go to Q16)

Q16. How often in the last year have you found that you were not able to stop drinking once you had started?

1. Never
2. Less than monthly
3. Monthly
4. Weekly
5. Daily or almost daily
6. Refused

(Go to Q17)

Q17. How often during the last year have you failed to do what was normally expected of you because of your drinking?

1. Never
2. Less than monthly
3. Monthly
4. Weekly
5. Daily or almost daily
6. Refused

(Go to Q18)

Q18. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

1. Never
2. Less than monthly
3. Monthly
4. Weekly
5. Daily or almost daily
6. Refused

(Go to Q19)

Q19. How often during the last year have you had a feeling of guilt or remorse after drinking?

1. Never
2. Less than monthly
3. Monthly
4. Weekly
5. Daily or almost daily
6. Refused

(Go to Q20)

Q20. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

1. Never
2. Less than monthly
3. Monthly
4. Weekly
5. Daily or almost daily
6. Refused

(Go to INFO4)

INFO4: The next 2 questions relate to occasions where you may have drunk alcohol in the past, even if you don't drink now. *Go to Q21.*

Q21. Have you or someone else been injured because of your drinking?

1. No
2. Yes, but not in the last year
3. Yes, during the last year
4. Refused

(Go to Q22)

Q22. Has a relative, friend, doctor or other health care worker been concerned about your drinking or suggested you cut down?

1. No
2. Yes, but not in the last year
3. Yes, during the last year
4. Refused

(Go to Q23)

Q23. About what age were you when you had your first full serve of alcohol?

Enter age in years. If never had a full serve of alcohol, record as '0'. If 'refuse' record as '999'. If don't know, record as '888'. Go to Q24.

Q24. Prior to turning 18 years of age, at which locations did you drink alcohol? (This relates to more than a sip of alcohol). You can select more than one option.

1. My home
2. Friend's house
3. Licensed premise (eg. pub, club, bar)
4. University, TAFE etc
5. Workplace
6. Community sports club (eg. footy club)
7. Public place
8. Car or other vehicle
9. Somewhere else (please specify)
10. Never drank before I turned 18
11. Don't know/Can't remember
12. Refused

(Go to INFO5)

INFO5: The next set of alcohol questions relate to drinking alcohol at your sporting club. *Go to Q25.*

Q25. Whilst AT YOUR SPORTING CLUB, how often in the last 3 months have you had 20 or more standard drinks in a day?
Interviewer: Do not read out the responses, but clarify the category that their response falls into.

1. Everyday
2. 5 to 6 days a week
3. 3 to 4 days a week
4. 1 to 2 days a week
5. 2 to 3 days a month
6. About 1 day a month
7. Less often
8. Never
9. Refused

(Go to Q26)

. ***Whilst AT YOUR SPORTING CLUB, how often in the last 3 months have you had between 11 to 19 standard drinks in a day?***
Interviewer: Do not read out the responses, but clarify the category that their response falls into.

1. Everyday
2. 5 to 6 days a week
3. 3 to 4 days a week
4. 1 to 2 days a week
5. 2 to 3 days a month
6. About 1 day a month
7. Less often
8. Never
9. Refused

(Go to Q27)

. ***Whilst AT YOUR SPORTING CLUB, how often in the last 3 months have you had between 7 to 10 standard drinks in a day?***
Interviewer: Do not read out the responses, but clarify the category that their response falls into.

1. Everyday
2. 5 to 6 days a week
3. 3 to 4 days a week
4. 1 to 2 days a week
5. 2 to 3 days a month
6. About 1 day a month
7. Less often
8. Never
9. Refused

(Go to Q28)

. ***Whilst AT YOUR CLUB, how often in the last 3 months have you had between 5 and 6 standard drinks in a day?***
Interviewer: Do not read out the responses, but clarify the category that their response falls into.

1. Everyday
2. 5 to 6 days a week
3. 3 to 4 days a week
4. 1 to 2 days a week
5. 2 to 3 days a month
6. About 1 day a month
7. Less often
8. Never
9. Refused

(Go to Q29)

. ***Whilst AT YOUR CLUB, how often in the last 3 months have you had between 3 and 4 standard drinks in a day?***
Interviewer: Do not read out the responses, but clarify the category that their response falls into.

1. Everyday
2. 5 to 6 days a week
3. 3 to 4 days a week
4. 1 to 2 days a week

5. 2 to 3 days a month
6. About 1 day a month
7. Less often
8. Never
9. Refused

(Go to Q30)

Q30. Whilst AT YOUR CLUB, how often in the last 3 months have you had between 1 and 2 standard drinks in a day?
Interviewer: Do not read out the responses, but clarify the category that their response falls into.

1. Everyday
2. 5 to 6 days a week
3. 3 to 4 days a week
4. 1 to 2 days a week
5. 2 to 3 days a month
6. About 1 day a month
7. Less often
8. Never
9. Refused

(Go to Q31)

Q31. Whilst AT YOUR CLUB, how often in the last 3 months have you had less than one standard drink in a day? (eg. drank half a beer or wine)
Interviewer: Do not read out the responses, but clarify the category that their response falls into.

1. Everyday
2. 5 to 6 days a week
3. 3 to 4 days a week
4. 1 to 2 days a week
5. 2 to 3 days a month
6. About 1 day a month
7. Less often
8. Never
9. Refused

(Go to Q32)

Q32. Whilst AT YOUR CLUB, how often in the last 3 months have you had no standard drinks in a day? (ie. been at the sporting club when alcohol is available but not consumed alcohol)
Interviewer: Do not read out the responses, but clarify the category that their response falls into.

1. Everyday
2. 5 to 6 days a week
3. 3 to 4 days a week
4. 1 to 2 days a week
5. 2 to 3 days a month
6. About 1 day a month
7. Less often
8. Never
9. Refused

(Go to Q33)

Q33. Have you or someone else been injured because of your drinking at your sports club? This incident could occur at the sports club or after drinking at the club.

1. No
2. Yes, but not in the last year
3. Yes, during the last year
4. Refused

(Go to INFO5)

INFO5: The following questions are about the number of standard drinks of alcohol you consumed AT YOUR SPORTING CLUBS at a home game or training session and some issues that arise from drinking. Go to Q33.

Q34. How many STANDARD DRINKS did you consume at the last home game you attended? (Enter number of drinks)(If 'refused' enter '999'; if 'don't know' enter 888). Go to Q35.

Q35. How long did you spend drinking at that home game? (In mins)(If 'refused' enter '999'; if 'don't know' enter 888)(Go to Q36)

Note to interviewers:

1hr = 60 mins

2hr = 120 mins

3hr = 180 mins

4hr = 240mins

5hr = 300 mins etc

Q36. How did you get home from that game?

1. Car driver
2. Car passenger
3. Public transport (bus, train, tram)
4. Walked or cycled

5. Other (please specify)

6. Don't know

7. Refused

(Go to Q37)

Q37. Have you been to a training session at your sporting club where alcohol was available this season?

1. Yes (Go to Q38)

2. No (Go to Q41)

3. Don't know (Go to Q41)

4. Refused (Go to Q41)

Q38. How many STANDARD DRINKS did you consume at the last training session you attended? (Enter number of drinks)(If 'refused' enter '999'; if 'don't know' enter 888). Go to Q39.

Q39. How long did you spend drinking at that training session? (In mins)(If 'refused' enter '999'; if 'don't know' enter 888). Go to Q40.

Note to interviewers:

1hr = 60 mins

2hr = 120 mins

3hr = 180 mins

4hr = 240mins

5hr = 300 mins etc

Q40. How did you get home from that training session?

1. Car driver

2. Car passenger

3. Public transport (bus, train, tram)

4. Walked or cycled

5. Other (please specify)

6. Don't know

7. Refused (Go to Q41)

Q41. This season, have you driven from your sporting club after you have consumed alcohol (any time)?

1. Yes (Go to Q42)

2. No (Go to Q44)

3. Don't know (Go to Q44)

4. Refused (Go to Q44)

Q42. How many times this season, do you think you may have driven away from the club when you are likely to have been over the legal limit?

1. Never

2. Once or twice

3. 3-4 times

4. 5 or more times

5. Don't know

6. Refused

(Go to 43)

Q43. This season, have you driven from your sporting club after you have consumed 4 or more standard drinks of alcohol?

1. Yes
2. No
3. Don't know
4. Refused

(Go to 44)

Q44. This season, have you been the occupant of a vehicle driven from your sporting club by someone who had consumed alcohol?

1. Yes (Go to Q45)
2. No (Go to Q46)
3. Don't know (Go to Q46)
4. Refused (Go to Q46)

Q45. This season, have you been the occupant of a vehicle driven from your sporting club by someone who you think was likely to have been over the legal blood alcohol limit?

1. Yes
2. No
3. Don't know
4. Refused

(Go to Q46)

Q46. This season, have you observed any club members or spectators drive from your sporting club who you think were likely to have been over the legal blood alcohol limit?

1. Yes
2. No
3. Don't know
4. Refused

(Go to Q47)

ALCOHOL-RELATED VIOLENCE

Q47. Whilst attending your sports club during THIS SEASON, have you been involved in or witnessed a serious argument or quarrel with another adult? (Please do not include incidents which occur on the sporting field)

1. Yes (Go to Q48)
2. No (Go to Q50)
3. Don't know (Go to Q50)
4. Refused (Go to Q50)

Q48. Had anyone involved in this incident been drinking alcohol?

1. Yes (Go to Q49)
2. No (Go to Q50)
3. Don't know (Go to Q50)
5. Refused (Go to Q50)

Q49. Overall, on a scale of 1 to 5, where 1 is not affected and 5 is seriously affected, how would you describe the effects of alcohol on the MOST AFFECTED person involved in the incident?

1. 1- Not affected
2. 2 -Slightly affected
3. 3- Moderately affected
4. 4- Well affected
5. 5- Seriously affected
6. Refused

(Go to Q49)

Q50. While attending your sports club during THIS SEASON, have you been involved in or witnessed an incident where someone grabbed, pushed,

shoved, hit or kicked another person in an aggressive way? (This may include incidents already reported before, please do not include incidents which occur on the sporting field)

1. Yes (Go to Q51)
2. No (Go to INFO6)
3. Don't know (Go to INFO6)
4. Refused (Go to INFO6)

Q51. Had anyone involved in this incident been drinking alcohol?

1. Yes (Go to Q52)
2. No (Go to INFO6)
3. Don't know (Go to INFO6)
4. Refused (Go to INFO6)

Q52. Overall, on a scale of 1 to 5, where 1 is not affected and 5 is seriously affected, how would you describe the effects of alcohol on the MOST AFFECTED person involved in the incident?

1. 1- Not affected
2. 2- Slightly affected
3. 3- Moderately affected
4. 4- Well affected
5. 5- Seriously affected
6. Refused

(Go to INFO6)

INFO6: The next few questions relate to the purchasing of food at your sporting club for either your own consumption or for the consumption of children. Go to Q53.

Q53. What foods do you usually purchase for your OWN consumption from the club canteen or shop? You can select more than one response. DO NOT READ OUT.

1. I don't usually purchase food from the canteen/shop for myself
2. Hot Chips
3. Pies
4. Sausage Rolls
5. Sausage Sizzle
6. Hot dogs
7. Chiko Rolls
8. Confectionery – lollies, sweets, eucalyptus lollies, frogs, snakes etc

9. Chocolate Bars
10. Packet Chips, Twisties etc
11. Cakes, lamingtons, slices, doughnuts etc
12. Chocolate coated Ice-creams
13. Sandwiches (not salad)
14. Salad sandwiches
15. Fresh fruit (whole fruit)
16. Other fruit products (dried, frozen, canned)
17. Fruit salad
18. Salads
19. Fresh vegetables (whole veggies)
20. Vegetable salads
21. Other vegetable products (dried, frozen, canned)
22. Cheese & biscuits
23. Dried fruit
24. Steak sandwiches
25. Bacon & egg rolls
26. 99% fruit ice blocks
27. Popcorn
28. Rice wheels
29. Lean meat with added veg (eg savoury mince, burger with salad)
30. No food available
31. Other (please specify)
32. Don't know
33. Refused

(Go to Q54)

Q54. What non-alcoholic drinks do you usually purchase for your OWN consumption from the clubs canteen or shop? Select as many responses as apply. NO NOT READ OUT.

1. I don't usually purchase drinks from the canteen/shop for myself
2. Bottled water
3. Reduced fat Milk – flavoured or plain
4. Full fat Milk – flavoured or plain
5. Juice (99% fruit)
6. Juice (less than 99% fruit)
7. Diet Soft drinks
8. Soft drinks
9. Coffee
10. Tea
11. Hot Chocolate
12. Up'N'Go
13. Caffeinated drinks / Energy drinks
14. Sports drinks
15. Iced teas
16. Flavoured Mineral Water
17. Cordials
18. No non-alcoholic drinks available
19. Other (please specify)
20. Don't know

21. Refused

(Go to Q55)

Q55. Do you have children aged 2 - 18 years of age who purchase food from the club canteen (or that you purchase food for)?

1. Yes (Go to Q56)
2. No (Go to INFO7)
3. Refused (Go to INFO7)

Q56. What is the current age of the youngest of these children? (Enter years)(If 'refused' enter '999'; if 'don't know' enter 888)(Go to Q57).

Q57. What gender is this child?

1. Male
2. Female
3. Refused

(Go to Q58)

Q59. How often would they attend the sporting club?

1 . Weekly (or more frequently) as a player (Go to Q60)
2. Less than weekly but at least monthly (Go to Q60)
3. Less than monthly but at least twice per season (Go to Q60)
4. Rarely (Go to Q60)
5. Never (Go to Q63)

Q60. Are they a player at the club?

1. Yes
2. No
3. Don't know
4. Refused

(Go to Q61)

Q61. Thinking about this child, what foods do they usually purchase (or you purchase on their behalf) from the clubs canteen or shop? You can select more than one option. DO NOT READ OUT.

1. Hot Chips
2. Pies
3. Sausage Rolls
4. Sausage Sizzle
5. Hot dogs
6. Chiko Rolls
7. Confectionery – lollies, sweets, eucalyptus lollies, frogs, snakes etc
8. Chocolate Bars
9. Packet Chips, Twisties etc
10. Cakes, lamingtons, slices, doughnuts etc
11. Chocolate coated Ice-creams
12. Sandwiches (not salad)
13. Salad sandwiches
14. Fresh fruit (whole fruit)
15. Other fruit products (dried, frozen, canned)
16. Fruit salad
17. Salads
18. Fresh vegetables (whole veggies)
19. Vegetable salads
20. Other vegetable products (dried, frozen, canned)
21. Cheese & biscuits
22. Dried fruit
23. Steak sandwiches
24. Bacon & egg rolls
25. 99% fruit ice blocks
26. Popcorn
27. Rice wheels
28. Lean meat with added veg (eg savoury mince, burger with salad)
29. No food available
30. Other (please specify)
31. Don't know
32. Refused

(Go to Q62)

Q62. What drinks do they usually purchase (or you purchase on that child's behalf) from the clubs canteen or shop? Select as many as apply. DO NOT READ OUT.

1. Bottled water
2. Reduced fat Milk – flavoured or plain
3. Full fat Milk – flavoured or plain
4. Juice (99% fruit)
5. Juice (less than 99% fruit)
6. Diet Soft drinks

7. Soft drinks
8. Coffee
9. Tea
10. Hot Chocolate
11. Up'N'Go
12. Caffeinated drinks / Energy drinks
13. Sports drinks
14. Iced teas
15. Flavoured Mineral Water
16. Cordials
17. No non-alcoholic drinks available
18. Other (please specify)
19. Don't know

20. Refused

(Go to Q61)

Q63. How many serves of VEGETABLES do they usually eat each day? An example of one serve is 1/ cup cooked vegetables (green or orang vegetables), 1/2 medium potato/starchy vegetable or 1 cup of salad vegetables (lettuce, cucumber, tomato etc). This relates to overall, not just at their club.

1. 1 serve
2. 2 serves
3. 3 serves
4. 4 serves
5. 5 serves
6. 6 serves or more
7. Less than one serve
8. No vegetables

9. Don't know

10. Refused

(Go to Q64)

Q64. How many serves of fruit do they usually eat each day? An example of one serve is 1 medium piece (eg. apple, banana, orange, pear), 2 small pieces (eg. apricots) or 1 cup of chopped or canned fruit. Please include fresh, dried, frozen and canned fruit. This relates to overall, not just at their club.

1. 1 serve
2. 2 serves
3. 3 serves
4. 4 serves
5. 5 serves
6. 6 serves or more
7. Less than one serve
8. No fruit

9. Don't know

10. Refused

(Go to 65)

Q65. How many cups of the following drinks do they consume per week? (Table)

	PER WEEK		PER DAY		
	1 cup of less per week	**2-4 cups per week**	**5-6 cups per week**	**1 cup per day**	**2 or more cups per day**
Fruit juice (1 cup=250ml, a household tea cup or 1 large popper)	□	□	□	□	□
Water (tap or bottled)(1 cup=250ml, a household tea cup; 1 ave bottle water = 2.5cups)	□	□	□	□	□
Soft drink, cordials or sports drinks such as lemonade or Gatorade (1 cup=250ml, 1 can soft drink = 1.5cups)	□	□	□	□	□
Diet soft drinks or diet cordial such as diet coke or sprite or coke zero (1 cup=250ml, 1 can soft drink = 1.5cups)	□	□	□	□	□

Q66. How often do they consume takeaway meals or snacks from places like McDonalds, Hungry Jacks, Pizza Hut, KFC, Red Rooster?

1. Never or rarely

2. Less than once a week

3. About 1-2 times a week

4. About 3-4 times a week

5. About 5-6 times a week

6. Everyday

7. Don't know

8. Refused

(Go to INFO7)

SMOKING, PHYSICAL ACTIVITY AND FRUIT/VEG CONSUMPTION

INFO7: The next few questions relate to your personal smoking, physical activity and overall fruit and vegetable consumption. ***Go to Q67.***

Q67. Have you personally ever tried cigarettes or other forms of tobacco?

1. Yes (Go to Q68)
2. No (Go to Q74)
3. Don't know (Go to Q74)
4. Refused (Go to Q74)

Q68. Have you ever smoked a full cigarette?

1. Yes (Go to Q69)
2. No (Go to Q74)
3. Don't know (Go to Q74)
4. Refused (Go to Q74)

Q69. Would you have smoked at least 100 cigarettes (manufactured or roll-your-own), or the equivalent amount of tobacco in your life?

1. Yes
2. No
3. Don't know
4. Refused

(Go to Q70)

Q70. Have you ever smoked on a DAILY basis?

1. Yes, I smoke daily now
2. Yes, I used to smoke daily, but not now
3. No, never smoked daily

(Go to Q71)

Q71. How often do you NOW smoke cigarettes, pipes or other tobacco products?

1. Daily (Go to Q72)
2. At least weekly (but not daily)(Go to Q74)

3. Less often than weekly (Go to Q74)
4. Not at all, but I have smoked in the last 12 mths (Go to Q74)
5. Not at all and I have not smoked in the last 12 mths (Go to Q74)
7. Refused (Go to Q74)

Q72. How many cigarettes do you smoke each day?

1. 10 or fewer
2. 11-20
3. 21-30
4. 31 or more
5. Don't know
6. Refused

(Go to Q73)

Q73. How soon after you wake up do you smoke your first cigarette?

1. Within 5 mins
2. 6 to 30 mins
3. 31-60 mins
4. After 60 mins
5. Don't know
6. Refused

(Go to Q74)

Q74. In the last week, how many times have you walked continuously, for at least 10 minutes, for recreation, exercise or to get to or from places? (Enter number)

Interviewer: Stress that this must be continuous walking (10 mins without stopping)

(If 'refused' enter '999'; if 'don't know' enter 888)(Go to Q76)

Q75. What do you estimate was the total time that you spent walking in this way in the last week? (Enter in hrs and/or mins)

Interviewer: If they seem to be having trouble, prompt them to think about each day in the last week and help them to add up the time.

(If 'refused' enter '999'; if 'don't know' enter 888)(Go to Q76)

Q76. In the last week, how many times did you do any vigorous gardening or heaving work around the yard, which made you breathe harder or puff and pant? (Enter number)

Interviewer: Could include digging, landscaping, mowing the lawn etc

(If 'refused' enter '999'; if 'don't know' enter 888)(Go to Q77)

Q77. What do you estimate was the total time that you spent doing vigorous gardening or heavy work around the yard in the last week? (Enter in hrs and/or mins)

Interviewer: If they seem to be having trouble, prompt them to think about each day in the last week and help them to add up the time.

(If 'refused' enter '999'; if 'don't know' enter 888)(Go to Q78)

Q78. The next few questions exclude household chores, gardening or yard work. In the last week, how many times did you do any vigorous physical activity which made your breathe harder or puff and pant? (eg. jogging,

cycling, aerobics, footy, etc)(Enter number)
(If 'refused' enter '999'; if 'don't know' enter 888)(Go to Q79)

Q79. What do you estimate was the total time that you spent doing vigorous physical activity in the last week? (Enter in hrs and/or mins)
Interviewer: If they seem to be having trouble, prompt them to think about each day in the last week and help them to add up the time.
(If 'refused' enter '999'; if 'don't know' enter 888)(Go to Q80)

Q80. In the last week, how many times did you do any other moderate physical activities that you have not already mentioned? (eg. gentle swimming, golf, dancing)(Enter number)(If 'refused' enter '999'; if 'don't know' enter 888)
(Go to Q81)

Q81. What do you estimate was the total time that you spent doing these activities in the last week? (Enter in hrs and/or mins)
Interviewer: If they seem to be having trouble, prompt them to think about each day in the last week and help them to add up the time.
(If 'refused' enter '999'; if 'don't know' enter 888)(Go to Q82)

Q82. How many serves of VEGETABLES do you usually eat each day? An example of one serve is 1/ cup cooked vegetables (green or orang vegetables), 1/2 medium potato/starchy vegetable or 1 cup of salad vegetables (lettuce, cucumber, tomato etc).

1. 1 serve
2. 2 serves
3. 3 serves
4. 4 serves
5. 5 serves
6. 6 serves or more
7. Less than one serve
8. Don't eat vegetables
9. Don't know
10. Refused

(Go to Q83)

Q83. How many serves of FRUIT do you usually eat each day? An example of one serve is 1 medium piece (eg. apple, banana, orange, pear), 2 small pieces (eg. apricots) or 1 cup of chopped or canned fruit. Please include fresh, dried, frozen and canned fruit.

1. 1 serve
2. 2 serves
3. 3 serves
4. 4 serves
5. 5 serves
6. 6 serves or more
7. Less than one serve
8. Don't eat fruit
9. Don't know

10. Refused

(Go to Q84)

Q84. How often do you consume takeaway meals or snacks from places like McDonalds, Hungry Jacks, Pizza Hut, KFC, Red Rooster?

1. Never or rarely
2. Less than once a week
3. About 1-2 times a week
4. About 3-4 times a week
5. About 5-6 times a week
6. Everyday
7. Don't know
8. Refused

(Go to Q85)

Q85. How many cups of the following drinks do you consume per week? (Table)

	PER WEEK		PER DAY		
	1 cup of less per week	**2-4 cups per week**	**5-6 cups per week**	**1 cup per day**	**2 or more cups per day**
Fruit juice (1 cup=250ml, a household tea cup or 1 large popper)	☐	☐	☐	☐	☐
Water (tap or bottled)(1 cup=250ml, a household tea cup; 1 ave bottle water = 2.5cups)	☐	☐	☐	☐	☐
Soft drink, cordials or sports drinks such as lemonade or Gatorade (1 cup=250ml, 1 can soft drink = 1.5cups)	☐	☐	☐	☐	☐

Diet soft drinks or diet cordial such as diet coke or sprite or coke zero (1 cup=250ml, 1 can soft drink = 1.5cups)	☐	☐	☐	☐	☐

(Go to INFO8)

INFO8: I am going to ask you some questions about Good Sports and your sense of belonging to your sports club. Please be as honest as you can (Go to Q88).

Q86. Is your sporting club a Good Sports club?

1. Yes (Q87)
2. No (Go to Q88)
3. Don't know (Go to Q88)
4. Refused (Go to Q88)

Q87. What do you think are the key messages of Good Sports? You can select more than one option.

1. Healthy clubs
2. Less drinking and better Responsible Service of alcohol
3. No smoking or smoke-free areas
4. Healthier food
5. Safe transport options to prevent drink driving
6. Other (please specify)
7. Don't know
8. Refused

(Go to Q88)

Q88. In the past 3 months, how often have you helped out at your club?

1. About once a week (or more)
2. Once every 2/3 weeks
3. Once a month
4. Not at all
5. Don't know

6. Refused

(Go to Q89)

Q89. In the past 6 months, how often have you attended a sporting club event (other than games or training) eg. fundraising events, presentations, trivia nights?

1. Three times or more
2. Twice
3. Once
4. Never
5. Don't know
6. Refused

(Go to Q90)

Q90. Are you an active member of your sporting club?

1. Yes, very active
2. Yes, somewhat active
3. Yes, a little active
4. No, not an active member
5. Don't know
6. Refused

(Go to Q91)

Q91. **Do you strongly agree, agree disagree or strongly disagree with the following few statements. Most people at my sporting club can be trusted.**

1. Strongly agree
2. Agree
3. Disagree
4. Strongly disagree
5. Don't know
6. Refused

(Go to Q92)

Q92. I feel safe when at my sporting ground or fixture.

1. Strongly agreed
2. Agree
3. Disagree
4. Strongly disagree

5. Don’t know

6. Refused

(Go to Q93)

Q93. My club has a reputation for being a safe place.

1. Strongly agree
2. Agree
3. Disagree
4. Strongly disagree
5. Don't know
6. Refused

(Go to INFO9)

DEMOGRAPHICS

INFO9: Before we finish today, I would like to ask you some questions about yourself. Go to Q94.

Q94. Are you of Aboriginal or Torres Strait Islander origin?

1. No
2. Yes, Aboriginal
3. Yes, Torres Strait
4. Yes, both Aboriginal and Torres Strait
5. Don’t know
6. Refused

(Go to Q95)

Q95. What is the highest year of primary or secondary school you completed?

1. Yr 12 or equivalent
2. Yr 11 or equivalent
3. Yr 10 or equivalent
4. Yr 9 or equivalent
5. Yr 8 or below
6. Did not go to school
7. Still at high school
8. Don’t know
9. Refused

(Go to Q96)

Q96. Have you completed any educational qualification (including a trade certificate)?

1. No (Go to Q98)
2. No, still studying first qualification (Go to Q98)

3. Yes, trade certificate/apprenticeship (Go to Q97)
4. Yes, other qualification (Go to Q97)
5. Refused (Go to Q97)

Q97. What is the highest qualification you have completed?

1. Certificate level
2. Advanced Diploma and Diploma Level
3. Bachelor Degree
4. Graduate Diploma and Graduate Certificate Level
5. Postgraduate Degree Level
6. Refused

(Go to Q98)

Q98. What is the total of all wages/salaries, government benefits, pensions, allowances and other income you usually receive? Please answer before tax.

1. $2,000 or more per week ($104,000 or more per yr)
2. $1,500 to $1,999 per week ($78,000 to $103,000 per yr)
3. $1,250 to $1,499 per week ($65,000 to $77,999 per yr)
4. $1,000 to $1,249 per week ($52,000 to $64,999 per yr)
5. $800 to $999 per week ($41,600 to $51,999 per yr)
6. $600 to $799 per week ($31,200 to $41,599 per yr)
7. $400 to $599 per week ($20,800 to $31,199 per yr)
8. $300 to $399 per week ($15,600 to $20,799 per yr)
9. $200 to $299 per week ($10,400 to $15,599 per yr)
10. $1 to $199 per week ($1 to $10,399 per yr)
11. Nil income
12. Negative income
13. Don't know
14. Refused

(Go to Q99)

Q99. What is your gender? (ASK ONLY IF UNSURE)

1. Male
2. Female
3. Refused

(Go to Q100)

Q100.How tall are you without shoes? (in feet/inches or cm)(If 'refused' enter '999'; if 'don't know' enter 888)(Go to Q101)

Q101.How much do you weigh without clothes or shoes? (In pounds or kg)(If 'refused' enter '999'; if 'don't know' enter 888)(Go to Q102)

Q102.We are now at the end of the survey. Thank you so much for your time today. If it's OK we would like to call you in the future to participate in other surveys. We would call you no more than 2 to 3 times in the next 2 to 3 years. Would this be OK?

1. Yes (Go to Q103)
2. No (Go to FINISH)

Q103.Can you please give me an alternative telephone number that we can contact you on? (eg. home phone/mobile/work). Enter .R if reused. Go to FINISH.

FINISH: That's the end of the survey. We appreciate your time to complete the survey today, and we hope to speak again in the future. Thanks.