RESEARCH GRANT

Appraisal of Warrnambool regional association for alcohol and drug dependence drink driver education program

This study of a Drink Drive Education Program conducted by the Warrnambool Regional Association for Alcohol and Drug Dependence Inc. (WRAADD) between April 1, 1991 and March 30, 1992 produced a profile of an average drink drive offender from a rural community. Some trends can be seen. The drink drive offenders are male, young and capable of achieving high blood alcohol levels (BACs) and then considering themselves fit to drive. Few relationships were found between predicted indicators of problem drinking. No clear relationships were found between second level offenders and other measures, although further data analysis is recommended. This report does not support the maintenance of the current distinction between first and second level offenders.

WARMAMBOOL REGIONAL ASSOCIATION FOR ALCOHOL AND DRUG DEPENDENCE INC.

C Brady

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Appraisal of Warrnambool Regional Association for Alcohol and Drug Dependence drink driver education program - 1993

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Abstract

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EXECUTIVE SUMMARY

This study of a Drink Drive Education Program conducted by the Warrnambool Regional Association for Alcohol and Drug Dependence Inc. (WRAADD) between April 1, 1991 and March 30, 1992 produced a profile of an average drink drive offender from a rural community. Some trends can be seen. The drink drive offenders are male, young and capable of achieving high blood alcohol levels (BACs) and then considering themselves fit to drive. Few relationships were found between predicted indicators of problem drinking. No clear relationships were found between second level offenders and other measures, although further data analysis is recommended. this report does not support the maintenance of the current distinction between first and second level offenders.

A drink drive offence per se seems to reduce offenders' self-reported drinking levels, while the DDEP seems to increase the knowledge of participants and, retrospectively, to be viewed very positively by participants. The Leader's Assessment Summary Sheet duplicated information already gathered on participants, and did not help to predict likely outcomes.

This Study has contributed to the picture of drink drive offenders by offering a brief snapshot from a rural community, The results should assist staff at WRAADD DDEP to further develop what seems to be a successful and well-regarded program, and may also be of assistance to other Drink Drive Education Programs across Victoria.

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The WRAADD Committee of Management, who have patiently seen this project through a lengthy process.

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1. INTRODUCTION

Drinking and driving are common pursuits in Australia, taken either singly or together. Both are endemic to our national culture and both past-times are particularly the preserve of young males who bring the two activities together in an often lethal combination.

In recent years, the combination of drinking and driving has contributed to deaths and accidents of epidemic proportions. One response from governments, media and the community at large has been to implement increasingly harsh penalties on the drinking driver. The means to do this is a consequence of improvements in breathalyser technology, allowing relatively quick, cheap and non-invasive intervention.

Once detected, drinking-drivers face loss of licence, possible fines and jail, the certainty of an education program and possible assessment for alcohol-related problems. Loss of licence and associated costs are recognised as effective deterrents. Less clear are the role and efficacy of the Drink-Driver Education Programs (DDEP) provided to drink-drivers. The purpose of this study is to investigate the goals and efficacy of one such DDEP conducted by the Warrnambool Regional Association for Alcohol and Drug Dependence Incorporated (WRAADD).

1.1 BACKGROUND AND PURPOSE OF THE STUDY

Breathalysers were introduced to Victoria in 1960, and in 1966 it became an offence to drive a motor vehicle with a blood alcohol content (BAC) in excess of 0.05mg/100mls.

There were other key developments in Victoria. One was the introduction of Random Breath Testing in 1976, and the other was the gradual and ad hoc introduction of Drink-Driver Programs. These programs generally were conducted from alcohol/drug treatment agencies and were based often on an initial program developed at St. Vincent's Hospital in 1973.

The Warrnambool program was developed in 1984 and was conducted by Social Work staff of the Warrnambool and District Base Hospital and a local GP.

A concerted response to drink-driving can be traced to the 1988 release of two reports from the Parliamentary Social Development Committee, one titled Alcohol Abuse and Road Safety, and the other, Drink Driver Education and Treatment. The Victorian government of the day supported the Reports, adopting most recommendations. These reports represent a watershed in drink-drive programs, and moved the emphasis of the drink/driving question from road safety to alcohol consumption. In particular, the Social Development Committee Reports point to the role of alcohol as "the single, most important factor in road crashes" (Social Development Committee, 1988.).

Subsequent legislation was enacted to require drink drive offenders to attend DDEPs and, depending on their level of offence, also to undergo assessment of their drinking history. When applying for licence restoration through the courts, some offenders must present a Licence Restoration Report, which is a written statement attesting to their assessment and attendance at a DDEP. The criteria for requiring offenders to undergo this process in its entirety are clearly mandated. The appropriateness of these criteria is the subject of much debate in the drink-drive field.

A further consequence of the Social Development Committee Reports was the development of a Standards and Procedures Manual for the Victorian Drink Driver Program. Accreditation of service providers was required. Responsibility for the management of the program rests with the Health Department Victoria through Drug Services Victoria.

Thus, in the space of a relatively few years, DDEPs have moved from ad hoc programs individually administered through alcohol and drug treatment agencies to become part of a state-wide network of accredited programs responding to specific judicial requirements.

Currently some 40 organisations are accredited to provide services at a total of 107 locations throughout Victoria (Wilson, 1992). All services to drink driving offenders are offered on a fee for service, user pays, basis. Course costs range between agencies for both the initial assessment and for the DDEP.

Programs are offered in both rural and urban locations. The WRAADD Program is of interest in that it is rural, and can offer a snapshot of drink driving offenders in a country community. For these offenders, loss of a licence may be monumental. Public transport is almost non-existent, and many jobs rely on an employee

having a licence. Socially a licence is a necessity in a rural community. Such public transport as does exist runs sporadically and rarely on weekends or evenings.

That the social activities engaged in by young rural males involve heavy drinking is a truism. The traditional bush ethos of a man and his mates, and of beer as reward (both promulgated strongly in beer advertisements) live on. Social contacts and friendships are developed in country pubs, both from tradition and in the absence of alternatives. As country towns dwindle and die, and as halls, post offices and small schools disappear, the hotel may be one of the last public features to survive. The ability to find non-drinking measures of status may be limited in the country due both to fewer physical options and to strong family and social traditions.

Some of the key issues in the Drink Driver Programs have been mentioned. These include the identification of alcohol as the significant factor, the legal requirements on drink drive offenders to complete specific programs, development of standards and guidelines for the DDEPs and costs of the program. Each of these issues will be discussed.

1.2 DRINKING DRIVERS OR DRIVING DRINKERS?

Language shapes understanding and knowledge. Traditionally, drink drivers have been thought of, essentially, as drivers who have been drinking. More recently however, research is indicating that they may be considered essentially as drinkers who happen to drive. The difference may seem pedantic, but the ramifications are significant for program planning and delivery. In the former case, the emphasis will be on a program of road safety, and in the latter, on identifying and intervening in potential problem drinking.

Alcohol is a significant factor in road traffic fatalities in Australia, contributing in 1992 to 30% of all male road traffic fatalities (Federal Office of Road Safety, 1992). Males aged 30 - 59 years had the highest proportion of alcohol related fatalities in 1986 (48%) and were also the group with the highest proportion of people (30%) with a BAL over 150mg/100mL (DH&CS, 1989). The road fatality rate per 100 million vehicle kilometres travelled in Australia was 1.9 in 1987 as compared to 1.5 in the United States of America (FORS, 1989). These figures do not include people injured and do not begin to represent the costs in human, social or economic terms of lost years of productive lives.

The trend overall in the period 1981 to 1992 has been towards a reduction in the proportion of drivers and motorcycle riders killed with BACs exceeding the legal limit (FORS, 1992). Indeed the spectacular progress in Australia during the past two decades in reducing the road toll from drink driving has been a public health achievement of major importance (Wodak, 1992). Overall per capita alcohol consumption has been declining in Australia since reaching the relatively high levels of the early 1980s (DH&CS, 1989).

Amongst other health priorities, the general public see drink driving as the major health issue in the community (Pierce, Yong, Dwyer & Chamberlain, 1985). Melburnians particularly considered the problem of drink driving to be even more significant than Sydneysiders. This difference in attitudes between the states may be attributed to the relatively aggressive response by Victorian governments to drink driving and to the climate of social influence built by anti-drink driving campaigns.

Despite the achievements and the public concern, some people continue to drink and drive. While this is clearly a public health issue, the literature has consistently defined a drink driving conviction, together with high BAC and recurrent offending, as an indicator of problem drinking (Rice & O'Sullivan, 1991). The Social Development Committee Reports (1988) stated that a drink driving conviction is prima facie evidence of hazardous drinking habits or developing alcohol problems. The Procedures and Standards Manual for Drink Driver Education Programs (1990) clearly states

> A first offence of drink driving should be viewed as a potential early indicator of hazardous drinking. It is more likely to occur before the onset of traditional indicators such as social or health problems. Therefore drink driver education programs can be viewed as an early intervention health strategy (p.7).

The overall aim of the current Victorian Drink Driver Education Program is

> To strengthen measures to reduce the harm associated with hazardous alcohol consumption through intervention with drink drive offenders (HDV, 1990, p. 6).

The manual notes that traffic and road safety information are essential components of a drink driver education program, but the emphasis is on an overall health orientated goal, within a 'harm minimisation' context.

1.2.1 LEVEL OF DRINKING AS AN OFFENCE CATEGORY

Current Victorian legislation divides drink drive offenders into four categories for sentencing (and it must be remembered that a DDEP is effectively part of a sentence).

1. Those who do not require judicial consent for relicensing. Not required to complete a drink driver education program:
Full licence holders, 25 years of age or over on a first offence, whose BAC is above 0.05gm/100ml but below 0.100gm/100ml.

2. Those required to complete a drink driver education program at a magistrate's discretion:
Full licence holders, 25 years of age or over on a first offence whose BAC is 0.100gm/100ml or above but below 0.150g./100ml. It is anticipated that magistrates will continue to refer a large number of these offenders, as is the current practice.

3. Those required to complete a drink driver education program:
Learner drivers, P-plate drivers, those driving without a licence at time of conviction and full licence holders under the age of 25 following a first offence provided the Blood Alcohol Content (BAC) is less than 0.150gm/100ml on conviction.

4. Those required to undertake assessment, attend a drink driver education program and obtain a Licence Restoration Report:
All second and subsequent offenders and first offenders where the BAC is 0.150gm/100ml or greater on conviction. All offenders convicted for refusal to be breath tested or convicted of driving under the influence.

In practice, the local magistrate in Warrnambool prefers all drink drivers to have completed a DDEP, hence many local drink drivers who fall into categories 1 and 2, above, will complete a DDEP. For drink drive offenders themselves, the distinctions are artificial.

The effects of ethyl alcohol on driving ability, both in simulated and in actual driving conditions, have been extensively researched. As

well there is the ongoing uncontrolled real-life 'experiment' on the effects of alcohol on driving ability in which many Australians participate every day.

Generally, the studies have concluded that alcohol significantly affects driving performance even at relatively low blood alcohol concentration and that alcohol is the single most important factor in road crashes (Binns, Knowles & Blaze-Temple, 1987; Commonwealth Department of Health, 1987; Social Development Committee, 1988; Howat, Sleet & Smith, 1991). Given that .05mg/100ml BAC is the legal limit, now adopted by most states, and that deterioration of driving skills is discernible at this level, it is a curiosity that the BAC level of .15 has been selected as an apparently arbitrary level at which to impose more severe penalties. Gisjbers (1992) presents a thoughtful and well articulated response to the question of whether .15 is an appropriate discriminator between levels of problem drinking. He concludes that:

> * Drivers with levels of 0.15 or more are likely to have a drinking problem BUT drivers with levels below 0.15 are just as likely to have a drinking problem.
>
> * 0.15 does not predict recidivism at 3.5 years after a drink drive course.
>
> * There is an almost 50-50 chance that the BAC of the second offence will be the opposite of the BAC of the first offence, either higher or lower.
>
> * The final conclusion is that 0.15 is a poor discriminator of a drinking problem in our drink drive course participants. (p.102)

The Federal Office of Road Safety (1993) reports a number of significant differences in road accident crashes in which the BAC was more than .15 and those crashes where the BAC lay between .05 and .15. Specifically, crashes where higher BACs were involved were more likely to

- occur at night
- involve more male than female drivers
- involve motorcyclists
- involve drivers of light commercial vehicles
- driver more likely to be the sole occupant of the car
- driver more likely to be a manual worker or unemployed person. (p. 71)

Many more significant differences occur, however, between crashes in which alcohol is not involved and those in which it is, regardless of the BAC level. Again, .15 is a relatively arbitrary criterion.

In light of data presented by both Gisjbers and the FORS, the identification of .15 as a discriminatory level at which to identify either problem drinkers or problem drivers is deserving of further thought and research. Anecdotal suggestion from the drink drive field suggests that .15 is an arbitrary discriminator and that the difference between .15 and .14 may simply be a factor of when the driver is apprehended by police in relation to the last drink consumed. An hour may be the difference.

Nevertheless, under current Victorian legislation, drink drive offenders are divided into three principal categories: under/over .05; under/over 25 years of age; under/over .15.

1.3 DDEP PROCEDURES

In response to the findings of the Social Development Committee (1988), a Drink Driver Education Program Standards and Procedures Manual (1990) was produced. This manual provides a brief rationale for DDEPs and a summary of program standards and procedures. The WRAADD Program has been accredited according to these standards.

The Manual suggests that a DDEP should be conducted as an early intervention strategy for problem drinkers with a goal of harm minimisation. To achieve these goals, presenters should be aware of the principles of both adult learning and program delivery practices such as group discussion. Agencies conducting accredited programs are required to carry out some form of program evaluation.

The WRAADD DDEP has been developed from past experience, from consultation with other DDEPs, and in consideration of state standards. Program evaluation is carried out through pre and post questionnaires investigating knowledge and attitudes.

1.4 PROGRAM COSTS

The DDEP Procedures and Standards Manual (1990) suggests a minimum fee to cover the Education component costs of $75.00 per client, based on 12 clients per program. Individual agencies wishing to vary this fee may do so based on actual costs specific to that agency.

In fact, there appears to be considerable variation between agencies and organisations in the charges applied. However, these charges are

not advertised and participants are rarely advised of charges until they present for a program. At WRAADD, the charges are as follows:

First Assessment: $ 90.00
DDEP: $100.00

1.5 PURPOSE OF THE STUDY

The purpose of the current study was to produce a profile of an average participant and to evaluate the effectiveness of the WRAADD Drink Drive Program. The alcohol consumption rates of participants was investigated.

Other issues which were investigated included the assessment procedures, administrative input to the program and costs. The underlying question of recidivism was discussed.

1.6 RESEARCH QUESTIONS

The major research questions to be addressed include:

1. What is the profile of the average drink-driver attending the WRAADD DDEP?

2. What are the average alcohol consumption rates of WRAADD DDEP participants and how do these rates compare to other available data?

3. Are there differences on demographic variables and reported alcohol consumption between first and second level offenders attending the WRAADD DDEP?

4. Do participants have an increased knowledge of alcohol and of drink driving issues at the completion of the WRAADD DDEP?

5. Is the scoring system used by the DDEP Co-ordinator a useful indicator of which participants will be most likely to complete the program and to increase their drink driving knowledge?

Other issues to be investigated include:

a. Assessment procedure and subsequent data collection.

b Administrative and other time involved in the program.

c. Costs both to participants and to the WRAADD Centre.

d. Recidivism: how is this best assessed?

1.7 DEFINITIONS

A Drink Drive Education Program (DDEP) refers specifically to the eight hours of educational sessions drink drive offenders are required to undertake. A Drink Drive Program (DDP) refers to an overall program of assessment plus education. At WRAADD, during the period of the study, all offenders were required to have an assessment. For practical purposes then, the assessment was synonymous with, and pre-requisite to, the educational program. Hence in this report, for brevity and clarity, DDEP refers both to the educational sessions and the initial assessment. In other programs, there may be clearer distinctions between a DDP and a DDEP.

1.8 LIMITATIONS

Many studies are thwarted by limitations; this study not least of all. The two independent researchers who began the project did not complete it, and the final analyses and write-up was completed by a third consultant researcher. Collaboration and consultation continued between the researchers however.

Only those people who started and completed a course during the study period were included. Those who dropped out of the course or completed a single session to make up a previous course were not included. However, 88.13% (136/154) completed the course they started and 96.1% (148/154) were known to complete a course within a short time after the survey.

None of the researchers had access to the participants in the DDEP, either at the time of the study or for any form of follow-up. In a study investigating changes in human knowledge, attitudes and behaviour and where access to the participants would not have been difficult, the lack of access to individuals seems a loss. Researchers

could have asked independent questions investigating participants' reflections on the course, their retained knowledge and any sustained effects on their drinking and driving behaviour.

2. METHODOLOGY

2.1 THE SETTING

The Warrnambool Regional Association for Alcohol and Drug Dependence Incorporated (WRAADD) is a community based outpatient Centre offering alcohol and drug assessment, counselling and education services, as well as a fully accredited Drink Drive Education Program. WRAADD has close links with an Alcohol and Drug Physician employed by the Warrnambool and District Base Hospital (W&DBH). This Physician works from the WRAADD Centre. The Centre is based in the City of Warrnambool with outreach programs extending over a 100 kilometre radius to include Portland, Hamilton and Camperdown. These towns and their hinterlands comprise the 'South West', a region with a total catchment population of over 100,000. Warrnambool is the commercial, administrative, shopping, educational and health centre for the wider region.

Figure 1. South West Victoria showing the Area of WRAADD Service.

Warrnambool is served by one Magistrate's Court where the same Magistrate has served since prior to the implementation of a local drink drive program. This Magistrate strongly supports the DDEP and has required most drink drive offenders to complete a program for licence restoration even before this became a state judicial requirement. Thus, the tradition of attendance is well established

and supported. Data have been collected on DDEP attendees in Warrnambool since 1984.

2.2 THE SAMPLE

All people who completed the full four weeks of a DDEP at the Warrnambool WRAADD Centre between April 1, 1991 and March 30, 1992 were included in the study. Of the sample of 136 people, 52% (71) lived in the City of Warrnambool. Prior to data collection, each participant was required to complete a signed consent form for release of information for statistical purposes.

The sample was comprised of 122 males (90%) and 14 females (10%). Most participants (84%) were under 40 years of age, and 48 (35%) were aged between 20 - 24 years. Most (68%) had never been married, and a further 13 (10%) were either divorced or separated.

The general level of education amongst participants was not high. Few (16%) had either attempted or completed tertiary education, and most (84 or 62%) had not completed secondary education.

2.3 INSTRUMENTS

The DDEP consists of the following activities:

1. Completion of a First Assessment by the Drink Drive Assessor and Educator including the Personal Situation and Background Questionnaire (PS&BQ)(Appendix A) and a short version of the Michigan Alcoholism Screening Test (SMAST).

The assessment includes the above measures for all offenders, and for Level 2 offenders it includes a Medical Assessment and License Restoration Report as well.

2. Completion of a Client Contract, and the study of information sheets and pamphlets;

3. Completion of a Pre-Course Questionnaire (White Paper);

4. Completion of a second Pre-Course Questionnaire (Pink Paper), after reading written materials, but before course commencement;

5. Attendance and interaction at four education sessions (eight hours);

6. Completion of a Drink Drive Diary (Green Paper);

7. Completion of a Drinking Situations Questionnaire (Yellow Paper);

8. Post Course Evaluation Questionnaire.

Three instruments were used in data collection: (a) the Personal Situation and Background Questionnaire (PS&BQ) (Appendix A), (b) the First Pre-Course Questionnaire (Appendix B) and (c) the Post-Course Evaluation Questionnaire (Appendix C).

2.3.1 Personal Situation and Background Questionnaire

The Personal Situation and Background Questionnaire was developed by WRAADD in 1991 from the South Australian Drug and Alcohol Services Council's questionnaire. The PS&BQ is the instrument used by the DDEP Co-ordinator for assessment, and consists of 83 multiple choice questions, with one hundred and twenty-six variables. Many of the questions were contingency questions, for example:

> Have you ever been in paid employment?
> 0. Yes...go to Q.2
> 1. No (Go to Q. 1.1)

Consequently, some responses were limited and those variables were discarded where more than 50% of the responses were missing under a variable.

Information from this form contributed to the profile of the average drink drive offender who completed a DDEP at WRAADD during the period of the study.

The short MAST was added to the PS&BQ. MAST is a commonly used screening instrument in the alcohol and drug field. One difficulty with the MAST is that it mixes lifetime with current experiences, and the time span identified as 'current' is undefined. A person may have had a drinking problem in the past, but there is no scope in MAST to differentiate between that problem in the past and the current situation. The short MAST is an eleven-item questionnaire.

A score of two on the SMAST is indicative of a possible alcohol problem while a score of three or more is suggestive of an actual alcohol problem.

The C.A.G.E. index, another commonly used screening instrument, is embedded within the PS&BQ. The four C.A.G.E. items are:

1. Have you ever felt the need to **Cut** down on your drinking?
2. Have you ever felt **A**nnoyed by criticism of your drinking?
3. Have you ever felt **G**uilty about your drinking?
4. Have you ever had an **E**ye-opener in the morning?

C.A.G.E. has been used consistently in clinical settings and, while not diagnostic of alcoholism, should alert a counsellor to the high likelihood of the presence of problems.

Each affirmative response to the four items is scored 1, and a score of 2+ is considered to be indicative of drinking problems.

2.3.2 Pre- and Post-Course Questionnaires

The First Pre-Course Questionnaire and the Post Course Evaluation Questionnaire were developed by WRAADD to evaluate a participant's progress through the course. The Pre-Course Questionnaire is a 12-item instrument asking open-ended questions to ascertain a drink driver's initial knowledge of alcohol and expectations of the course.

The Post-Course Evaluation Questionnaire has 17 items. Items 1 - 4 are essentially repeated in the past tense from the first questionnaire, while items 5 to 12 inclusive repeat identical pre and post questions. These twelve questions are the items of comparison for the purposes of this study.

2.4 DATA COLLECTION

Data were collected routinely by the DDEP Co-ordinator at the WRAADD Centre. The Co-ordinator completed all PS&BQs during one-to-one confidential interviews at the time of referral. The PS&BQ typically took one hour to complete. The first pre-course questionnaire was completed by each participant when collecting course materials, approximately one week prior to the education program. The pre-course questionnaire was completed prior to the person being given any reading materials. The evaluation questionnaire was completed during the last session of the course.

There were no time limits on how long the subjects could take to complete each questionnaire, and all participants were urged to take

their time and complete the questionnaires accurately and to the best of their ability.

2.5 DATA ANALYSIS

The data from the multiple choice questions in the PS&BQ were entered into EXCEL spreadsheets by individual DDEP course, and then were converted to SYLK files and imported into Statistical Package for the Social Sciences (SPSS) on an Apple Macintosh computer. The eleven courses were then concatenated into one file. Each data file was checked by the first consultant researcher to ensure accuracy after data entry phase. All subjects were given a numerical code in place of their names to protect privacy.

The data from the open-ended questions in the questionnaires were entered into EXCEL spreadsheets and later resorted under each answer. The first researcher then divided the answers under each question into groups of similar answers to allow conversion of the data into an ordinal level scale. The ordinal level scale consisted of:

1. Missing Value or incorrect answer.
2. Nonsense statement or not applicable.
3. Answer is generally acceptable.
4. Answer very acceptable.
5. Correct answer.

The purpose of the study was to evaluate the efficacy of the WRAADD DDEP, and to produce a profile of the average offender. Simple descriptive statistics were used to generate a profile and to calculate alcohol consumption rates.

The questions of differences between WRAADD participants and other DDEP participants, and between first and second level offenders, and between changes in knowledge pre- and post course (Research Questions 2, 3 and 4) were investigated using descriptive statistics, chi-square analyses, t-tests and a Wilcoxan test.

3. RESULTS

The primary purpose of this study was to evaluate the effectiveness of the WRAADD DDEP and to produce a profile of the average participant. This chapter presents the results of data analyses.

The profile of the average drink driver is reported. Descriptions of other variables and the results of some comparative analyses are presented.

3.1 PROFILE OF THE AVERAGE DRINK DRIVE OFFENDER

The average drink driver in Warrnambool is a male. He is your average Aussie bloke, and likely to be called Blue, Butch, Tiger or similar. He is young, aged between 20 and 24 years, and has never been married. Generally, he does not live alone but has an equal chance of living with a partner and/or child or with his parents. Occasionally he may live with friends. He is happy with his present living arrangements, and says he is coping with life. He has completed some secondary schooling. He may be either unemployed or employed full-time, and is less likely to be a student, pensioner, employed part-time or self-employed. If employed he will probably be a tradesman and, whether employed or not currently, has been in paid employment in the last two years.

He lives in the City of Warrnambool although many of his mates come from small towns in the surrounding shires. They all live within a forty-five minute radius of Warrnambool.

He is definitely a beer drinker, hardly bothering at all with other available alcohol. He first tasted alcohol before or on attaining the legal age and his first experience of drunkenness was about this same time, probably when he was 17 or 18. He defines drunkenness as involving slurred speech and being unsteady on your feet (although some of his mates define it as being relaxed and less inhibited, and a lesser number of others see it as losing control and being 'paralytic'). He may have been in this state himself within the last week or month, but most likely it has been longer, although it must be remembered that he is still paying the penalty for a drink drive charge. There is a slight chance he may have had a drink today, but it is probably between 2 days and a week since his last drink. Generally, he has no particular difficulty sleeping, and he does not skip meals when drinking.

When convicted on his drink drive charge, his BAC was .155, three times the legal limit. At this level, he, and virtually all his mates, felt capable of driving. Most of his mates had similar BACs, although they ranged from a low of .029 to a high of .335. He was apprehended via a Random Breath Test which he was very unlikely to refuse. Some of his friends were charged with traffic infringements, while others were involved in motor vehicle accidents. When apprehended, he probably had been drinking for five hours, and was then picked up within an hour of having had his last drink. He has most probably lost his licence for up to twelve months, although many of his mates have lost licences for considerably longer periods of time. The drink drive offender has a full licence, although a small proportion of his peers were not licensed to drive at all.

Most recently, he says he has not been drinking at all or, if drinking, his daily average alcohol intake has been 7 grams or less. Before the offence, he was likely to have been drinking daily to a higher level.

On the basis of his SMAST score, the drink drive offender does not have a defined alcohol problem, although 18% of his mates have a possible problem and 29% have a definite problem. Similarly, the CAGE questions indicate that the offender does not have an alcohol problem, although one third of his mates could have problems.

Almost two thirds of the drink drive offenders have not been convicted of the same offence previously, although more than one-third have had a prior drink drive charge.

3.2 DEMOGRAPHIC PROFILE OF WRAADD DDEP PARTICIPANTS

The Health Department Victoria completed an evaluation of the Drink Drive Offender Data System (DDODS) between April 1, and December 31, 1991. It should be noted that the data set is not complete, although data were received from 35 of the 40 accredited programs and represented 60 of the 107 operating programs (Carter, 1992). The proportion of country and city programs reflected actual proportions in the population. Nonetheless, this data set provides a point of comparison for WRAADD data collected over a similar period.

Table i. Sex of DDEP Participants.

	WRAADD	%	% DDODS (a)	Ratio (b)
Male	122	90	90.3	1.0
Female	14	10	9.7	1.0

(a) DDODS data is from the HDV Review.
(b) WRAADD to DDODS ratio. This ratio shows the proportion of WRAADD DDEP participants compared to the same group in the statewide study. These ratios will be given where possible in the tables below.

Ninety per cent of all program participants are male, which is the same ratio of males to females as occurs statewide. Given that males form about 50% of the population, they are highly over-represented in the DDEP.

Table ii. Age of DDEP Participants.

	WRAADD	%	% DDODS	Ratio
17 - 19 years	9	6.6	3.7	1.7
20 - 24 years	48	35.3	24.5	1.4
25 - 34 years	48	35.3	35.6	.98
35 - 44 years	16	11.7	20.9	.55
45 - 49	11	8.0	10.0	.8
>55 years	4	2.9	5.2	.5
Total	136	100.0	100.0	

Most participants in the WRAADD Program are young, with 42% being under 25 years of age. A further one third are in the 25 - 34 age group with fewer in the older age groups.

Compared with the DDODS data, younger age groups are over-represented in the WRAADD sample. As mentioned, 42% of WRAADD offenders are under 25, compared with 28% of the DDODS sample. Age groups over 35 years are under-represented compared to the statewide sample.

Table iii. Marital Status of DDEP Participants.

	WRAADD	%	% DDODS	Ratio
Never Married	92	67.6	47.0	1.43
Married/De Facto	31	22.7	39.4	.57
Widowed	n.a.	n.a.	.8	n.a.
Divorced	11	8.0	8.0	1.0
Separated	2	1.4	4.9	.28
Total	136	100.0	100.0	

Over half the WRAADD group have never been married, while 23% are married or living in de facto relationships. The other marital status categories are less common. No persons were listed as being widowed in the WRAADD study.

Never married people are over-represented in the WRAADD sample compared to other drink-drive programs (ratio of 1.43), while separated people are under-represented.

Figure iv. Country of Birth of DDEP Participants.

	WRAADD	%	% DDODS	Ratio
Australia	134	99.2	81.5	1.2
Other	1	.7	18.4	.03
Total	135	100.0	100.0	

WRAADD DDEP participants are overwhelmingly Australian born. In contrast to other DDEPs, non-Australian born people are under-represented in the WRAADD Program.

Figure v. Level of Education of DDEP Participants.

	WRAADD	%	% DDODS	Ratio
No Secondary School	5	3.7	3.4	1.08
Some Secondary	79	58.5	53.8	1.08
Completed Secondary	16	11.9	15.5	.76
Technical/Trade	13	9.6	15.4	.62
Some Tertiary	13	9.6	5.9	1.62
Completed Tertiary	9	6.7	6.0	1.1
Total	135	100.0	100.0	

Most of the course participants (58.5%) had completed some secondary schooling. One in four had some experience of post-school learning, either through a trade or some tertiary training.

At both the lower and upper ends of the education scale, WRAADD participants were similar to those from other programs. However, those who had attempted some tertiary education were over-represented in the WRAADD program, while those with technical training or who had completed secondary school were under-represented.

Table vi. Employment Status of DDEP Participants.

	WRAADD	%	% DDODS	Ratio
Employed	68	50.3	70.2	.71
Unemployed	48	35.5	21.4	1.64
Not in labour force	19	14.0	8.4	1.66
Total	135	100.0	100.0	

Most participants in the WRAADD program are employed. However, WRAADD sees more people in the DDEP who are unemployed or not in the labour force than is the case in other programs. The unemployed are over-represented at WRAADD in comparison to both the DDODS data and to state-wide and local unemployment figures.

The proportion of people not in the labour force is significant at WRAADD, and comprises people who are students and pensioners.

Table vii. Blood Alcohol Level (BAC) of DDEP Participants.

	WRAADD	%	% DDODS	Ratio
Less than 0.05	2	1.5	2.9	.5
0.05 to under 0.10	13	10.0	14.1	.70
0.10 to under 0.15	38	29.0	46.5	.62
0.15 to under 0.20	52	39.6	26.5	1.49
0.20 to under 0.25	20	15.2	8.0	1.9
0.25 or more	6	4.5	2.0	2.25
Total	131	100.0	100.0	

Notable differences exist between the WRAADD sample and the DDODS sample. Participants with BACs of less than 0.10 were under-represented in the WRAADD sample compared with the DDODS data (11.5% at WRAADD and 17% at DDODS). Conversely, higher BACs were over-represented at WRAADD. WRAADD had 78 participants (59.3%) with BACs of 0.15 or higher. In each of the two highest categories of BAC, WRAADD has twice the proportion of offenders as DDODS.

Table viii. Number of Drink Drive Offences of DDEP Participants.

	WRAADD	%	% DDODS	Ratio
First Offence	84	62.2	73.3	.84
Second/Subsequent	51	37.8	26.7	1.41
Total	135	100.0	100.0	

More than one third of WRAADD participants (37.8%) had been convicted of a second or subsequent drink drive offence, although the statewide proportion was about one quarter (26.7%).

Table ix. Cause of Police Attention.

	WRAADD Frequency	%
Random Breath Test	73	60.8
Motor Vehicle Accident	15	12.5
Traffic Infringement	24	20.0
Refusal Breath Test	2	1.7
Other	6	5.0
Total	120	100.0

Most participants (60.8%) were brought to police attention through the Random Breath Test (RBT). One in five were charged with a traffic infringement, and 12.5% were involved in a motor vehicle accident.

Table x. Elapsed Time Since Last Drink.

	WRAADD Frequency	%
<10 Minutes	24	19.8
<30 Minutes	34	28.1
<1 Hour	34	28.1
> 1 Hour	15	12.4
> 3 Hours	14	11.6
Total	121	100.0

Most DDEP participants (76%) were brought to police attention less than one hour following their last drink. Almost 12% however, were not detected until more than three hours had elapsed since their last drink. It would be interesting to investigate the BAC levels of these latter offenders.

Table xi. DDEP Participants Felt Capable of Driving at Time of Offence.

	WRAADD Frequency	%
Yes, capable	123	91.8
No, not capable	11	8.2
Total	134	100.0

Almost all drink drive offenders (91.8%) felt capable of driving after they had been drinking. Given the relatively high BAC levels of the group, this self-confidence seems astounding and points to a high degree of tolerance.

Table xii. Number of Drinking Hours.

	WRAADD Frequency	%
1 - 3 Hours	30	28.3
4 - 6 Hours	57	53.7
7 - 9 Hours	12	11.3
10 or more Hours	7	6.6
Total	106	100.0

Over half of the respondents to this question (53.7%) had been drinking for between four and six hours prior to their charge. One in nine had been drinking for between seven and nine hours, and one in fourteen had been drinking for more than ten hours.

Table xiii. Age of DDEP Participants at First Alcohol Intake.

	WRAADD Frequency	%
< 15 years	39	29.1
15 - 16 years	41	30.6
17 - 18 years	44	32.8
19 - 20 years	8	6.0
> 21 years	2	1.5
Total	134	100.0

More than half of the participants (59.7%) had first tasted alcohol before the age of sixteen. Approximately one-third (32.8%) had their first intake around the legal age, while a very small proportion (1.5%) waited until they were 21 years or older.

Table xiv. Age of DDEP Participants When First Drunk.

	WRAADD Frequency	%
< 15 years	22	16.8
15 - 16 years	33	25.2
17 - 18 years	62	47.3
19 - 20 years	10	7.6
> 21 years	4	3.1
Total	131	100.0

Approximately 90% of the sample had their first experience of drunkenness on or before the legal age. In response to a different question, 83% of participants stated they had commenced a regular drinking pattern before the age of 20 years. 'Regular drinking' was not defined. Further, about half of the respondents (54.8%) indicated they had had some periods of abstinence since commencing regular drinking.

Table xv. Favourite Type of Alcoholic Drink by Level

Beverage	Low Level		Medium Level		High Level	
	f	%	f	%	f	%
Beer	86	93.4	67	91.7	37	92.5
Wine	2	2.1	4	5.4	1	2.5
Spirits	1	1.0	-	-	1	2.5
Other	1	1.0	-	-	-	-
Beer & Spirits	-	-	2	2.7	1	2.5
Beer & Wine	2	2.1	-	-	-	-
Beer, Wine & Spirits	-	-	-	-	-	-
Total	92	100.0	73	100.0	40	100.0

Beer is the preferred drink for virtually all participants on virtually all occasions, whether they are drinking to a low level (e.g. with a meal), to a medium level (e.g. at parties, weekends) or to a high level (e.g. special occasions, festivals, etc.).

Table xvi. Time since last Alcoholic Drink.

	WRAADD Frequency	%
< 1 week	83	63.8
1 week - 1 month	24	18.5
> 1 month	23	17.7
Total	130	100.0

The time since the last drink refers to the time immediately before enrolling in the DDEP. Participants are expected to have a zero BAC

on both registering and participating in the program. Approximately one quarter (23.1%) have had a drink within two days of enrolling, although twenty-three (17.7%) have not had a drink for more than a month. By self-report, this group have stopped or greatly reduced their drinking in response to their drink drive charge and licence suspension.

3.2.1 Family Drinking

Participants were asked in the PS&BQ whether a family member had problems caused by drinking. 'Problems' were not defined, so there was presumably some discrepancy in responses. For example, a drink driving charge might be defined in some families as a problem, whereas in other families late stage alcoholism and accompanying dysfunction might need to be present. Sixteen per cent of participants defined their father as having a problem and 10% recognised a sibling as having a problem. Fewer than 4% recognised their mother as having an alcohol related problem.

One third of participants believed they would 'get along better with family and/or partner' if they didn't drink. Conversely, two thirds believed their relationships would not improve. Some 95% were satisfied with current living arrangements.

3.2.2 Alcoholism Indices

Table xvii. Short M.A.S.T. Scores of DDEP Participants.

Score	WRAADD Frequency	%
1.	69	51.9
2.	25	18.8
3.	19	14.3
4.	9	6.8
5.	5	3.8
6.	4	3.0
7.	-	-
8.	1	.8
9.	1	.8
Total	133	100.0

A score of 2 on the SMAST is indicative of a possible alcohol problem, and a score of 3 or more indicates an alcohol problem. Of this sample, half do not have an alcohol problem as defined by SMAST.

Almost one in five have a possible problem and 29.5% have a defined problem.

Table xviii. C.A.G.E. Scores of DDEP Participants.

Score	WRAADD Frequency	%
1.	33	24.8
2.	29	21.8
3.	12	9.0
4.	5	3.8
7. Nil score	54	40.6
Total	133	100.0

A score of one or less on the CAGE suggests there is no alcohol problem; a score of 2 suggests a possible problem and scores of 3 or more define an alcohol problem. Over half (64.8%) of this sample do not have an alcohol problem as defined by CAGE. One fifth have a possible problem and 12.8% were identified as having an alcohol problem.

Further analyses were conducted on the SMAST and CAGE scores. There was no evidence of a relationship between SMAST category (no/possible/alcohol problem) and recidivist status [$x^2(2)=1.19$, $p>.10$]. That is, a SMAST category gives no indication whether or not a participant has had a previous drink-drive conviction, nor does recidivist status give any information about an offender's SMAST category. Also, there was no evidence of a relationship between CAGE category and recidivist status [$x^2(2)=2.59$, $p>.10$].

3.3 ALCOHOL CONSUMPTION RATES

The second research question investigated the average alcohol consumption rates of WRAADD DDEP participants and compared these rates to other available data.

As noted by their BAC readings, some offenders are capable of drinking to high levels. Participants were asked to estimate their drinking according to specific social situations (low, medium and high level drinking situations). The amounts have been grouped according to NH&MRC guidelines for low, hazardous and harmful drinking levels, and calculated on the basis of 8 grams of alcohol equating to one standard drink.

Table ixx. Drinking Category According to Social Occasion.

	Low Drinking	Hazardous Drinking	Harmful Drinking	Total
Low Level	58 67.4%	17 19.76%	11 12.79%	86 100%
Medium Level	3 1.4%	7 10%	60 85.7%	70 100%
High Level	- -	- -	38 100.0%	38 100%

A considerable amount of data are missing from these questions, making analysis and comment difficult. However, some DDEP participants drink to a harmful level (more than six standard drinks per occasion) in any given situation. For example, "low level" occasions were defined in the questionnaire as meals with friends, an evening at home, etc., yet one in eight offenders said they would drink to a harmful level (more than six standard drinks) at such times.

Table xx. Drinking Level Pre and Post Offence.

	Low	Hazardous	Harmful	Total
Daily Pre Offence	78 66.1%	14 11.86%	26 22.03%	118 100%
Daily Post Offence	75 75%	13 13%	12 12%	100 100%

By self-report, offenders reduced their regular drinking level after a drink drive charge. Pre-offence, 22% were drinking to harmful levels, whereas post-offence this proportion dropped to 12%, with three quarters drinking to low levels. Pre-offence, some large daily averages were claimed. The six heaviest drinkers reported drinking amounts of between 14 and 38 standard drinks per day. This is the equivalent of between four and ten bottles of standard beer per day. When reporting their recent daily drinking average there was only one outlier, who reported drinking 25 standard drinks per day (approximately seven bottles of standard beer). Some offenders said they were not regular drinkers and that the drink drive offence was a 'one-off'.

The drinking levels reported by WRAADD DDEP offenders contrasts to a National Health Survey of Alcohol Consumption (1989-1990)

which found that a quarter (24.8%) of male drinkers aged 18 to 24 years were drinking at hazardous to harmful levels in the week prior to the survey compared to 20.2% of male drinkers overall. The DDEP sample is predominantly male and young, yet almost 34% reported their prior drinking to be at hazardous or harmful levels. Post-offence, those reporting hazardous or harmful drinking are more closely allied with the National Health Survey.

A local WRAADD survey (1991) found similar drinking patterns, although it must be noted that the 1991 sample was different with over half the respondents being female and also most respondents were older than the current DDEP sample. Nonetheless, 17.3% of respondents reported drinking to hazardous or harmful levels on those days when they drank. This was particularly the case for younger drinkers, few of whom reported drinking only 2-3 drinks on any one occasion.

Offenders under twenty-five years reported their daily average drinking to be within low levels (2 - 4 standard drinks per day). However, amongst the oldest age group, those over forty-five years, the likelihood of hazardous (4 - 6 standard drinks) or harmful drinking (more than 6 standard drinks) was increased. It may be that older drinkers' average daily intake is regularly to these levels, whereas younger drinkers may be more likely to "binge drink", consuming in one session on the week-end what averages out to be a lower daily average.

The binge drinking phenomenon common to younger drinkers may help to explain the differences, and also raises the question of the 'driving drinker' mentioned in the introduction to this report. We might hypothesise that the older offenders are entrenched daily drinkers who occasionally drive, whereas the younger drinkers may be drivers who binge drink on week-ends.

3.4 FIRST AND SECOND LEVEL OFFENDERS

Research Question 3 investigated differences on demographic variables and self-reported alcohol consumption between first and second level offenders.

Second level offenders in the DDEP are defined as those with a BAC of .15 or more and/or convicted of a second or subsequent drink driving charge. Some assumptions are made that these offenders may be more likely to have, or to be developing, alcohol problems; consequently, these offenders are required by the court to undergo

an alcohol assessment in addition to the education program. (At WRAADD, all offenders undergo a pre-course assessment, although this is not mandated judicially).

Almost three quarters (73.5%) of the WRAADD DDEP participants were second level offenders. This is not surprising given the relatively high numbers of local offenders with high BACs (Table vii) and with second/subsequent offence charges (Table viii).

There is no evidence that gender is related to offence level [$x^2(1)=2.346$, $p>.10$], although the small number of women in the program should be noted.

No significant differences were found between first and second level offenders on educational level, marital status, cause of police attention, short MAST scores or CAGE scores. Again, however, it should be noted that missing data made analysis difficult in some instances.

3.5 PRE AND POST COURSE KNOWLEDGE

Research Question 4 asked whether participants have an increased knowledge of alcohol and of drink driving issues at the completion of the WRAADD DDEP. The pre- and post-course questionnaires were analysed.

The Pre-Course Questionnaire (Appendix B) has twelve questions concerned with perceptions of the course, knowledge of alcohol and its effects on the body, and safe drinking practices. It is completed before an offender begins the DDEP. The Post-Course Evaluation Questionnaire (Appendix C), completed during the last education session, includes the first twelve questions of the Pre-Course Questionnaire as well as five course evaluation questions.

Answers to the twelve common questions were analysed by the Wilcoxan T test. Question eight was deleted due to missing and mis-matched data caused by the question being changed half way through the survey period.

(N.B. The following analysis and comments were completed by the original researcher and reproduced here with thanks.)

Table xxi. Wilcoxan Matched Pairs Signed Ranks Test for Pre-Course and Post Evaluation Questionnaires.

Question	No. of Pairs	No. of Improved	No. of Confused	Wilcoxan T Value	Z-Score	Direction
1.	51	49 (36%)	2 (1.5%)	49.0	-3.94 +	-->
2.	57	17 (13%)	40(29.6%)	394.5	-3.43 +	<--
3.	61	55 (41%)	6 (4.4%)	181.8	-5.486 +	-->
4.	71	68 (50%)	3 (2.25)	104.4	-6.72 +	-->
5.	78	78(53.5%)	6 (4.4%)	145.5	-6.948 +	-->
6.	77	39 (29%)	38(28.1%)	1008.29	-2.5 f	-->
7.	27	26 (19%)	1 (0.74%)	7.75	-4.35 +	-->
8.		Insufficient Data				
9.	39	31 (23%)	6 (4.4%)	144.5	-2.8 +	-->
10.	77	71 (53%)	6 (4.4%)	159.0	-6.82 +	-->
11.	77	77 (54%)	4 (2.96%)	71.0	-6.9 +	-->
12.	60	47 (35%)	13 (9.63%)	208.7	-5.2 +	-->

+	p > .0005	(Z > 3.09)
f	P > .005	(Z > 2.58)

All questions showed a tendency of significant change in answer from completion of the first questionnaire before attending the program and the post evaluation questionnaire after attending the program and reading the pre-reading literature. The arrow direction indicates whether there was improvement or whether the drink driver education program content and written materials caused confusion.

Question 2 ("What have you learnt (or do you expect to learn) from this course?") caused confusion, and should be re-developed, as more people changed their answer to an incorrect answer than changed their answer to a correct answer. For instance, two of the pamphlets list different ranges of body organs being affected by alcohol. A considerable number of participants listed kidney damage as an effect of alcohol, yet this information does not appear in the literature presented to them.

The highest percentage of the sample improving their score was approximately 53%. The inverse is that 43% did not improve their score and 4% changed a correct answer to an incorrect answer. The point is that for every element of the course covered by a question, a maximum of less than 60% improved their score. Although the course is effective in improving the exit knowledge of participants, the level of improvement is not as high as one may expect (say, 75%) and is probably not consistent across the whole range of material.

It is recommended that course content be reviewed for consistency of information, both in written and spoken material.

3.5.1 Qualitative Responses

Participants had opportunities to comment on their courses through the pre- and post-questionnaires. The initial question: "Why are you doing this course?" elicited a self-evident answer: "To get my licence back". Given the compulsory nature of the course, this question seems redundant.

Pre-course expectations held by participants tended to be consistent in theme also. Most participants simply stated they expected to learn more about drinking, or alcohol, and driving. A subtle, but consistent thread implicit in many answers was stated as "how much can I drink before driving".

Most participants professed to feeling 'good' or 'O.K.' about doing the course, while others had negative emotions expressed as:

> It's a waste of time and money.
> It's a nuisance.
> I'm resentful.
> I don't feel there is anything wrong with me.

The knowledge-based questions clearly indicated gaps in knowledge. However, it could not be argued that offenders entered the courses bereft of knowledge. Many gave appropriate responses to the knowledge-based pre-course questions. One-third (34%) suggested that it would take approximately ten hours for a BAC of .10 to fall to zero. Slightly less than one-third stated they did not now how long it might take, and the final third responded with estimates ranging from 1.5 hours to 4 - 5 days. When estimating recommended standard amounts of alcohol than can be drunk without risk, most respondents had no idea. Of those who did, the most common suggestion was 7 - 8 glasses for men and a lesser amount for women. However, it is possible that any randomly selected sample from the population may not have any greater idea of the NH&MRC recommended guidelines.

The post-course questionnaire elicited consistent praise for the course. Six offenders said they had had no expectations for the course, but still found it interesting and helpful. One said he 'did now know there were things to learn'. All other participants said the course either met or surpassed their expectations. The effects of

alcohol were the main learning points derived from the course, although several respondents said they learned:

> More about my own problems.
> Others are in the same boat as you.
> To think about my home life.

The doctor (Dr. Rodger Brough) was generally selected to have provided the information of most benefit. AA speakers were also nominated by some participants as being 'of greatest benefit'. The 'least useful' information drew a greater and more varied response, with the Police contribution being nominated by 15% of participants as least useful. It appeared, however, that the Police did not attend for their allotted time during one course, so these participants presumably found this session of least benefit. Other factors mentioned were the repetitive nature of information given. The DDEP Co-ordinator might consider reviewing material to ensure information provided by the Police is fresh when they provide it and not material that has been covered in previous weeks.

Finally, although generally meeting with strong acclaim, some suggestions were made to improve the course. These included increased group discussion opportunities, and also alterations to the videos shown.

3.6 CO-ORDINATOR'S EVALUATION

Research Question 5 investigated the scoring system devised and used by the DDEP Co-ordinator. The Co-ordinator has devised a grading system for assessing an individual's progress and participation through the course (Appendix D). Participants are given a score out of a possible 100 for attendance, participation, for correct answers on the questionnaires, and for essays produced. Two essays are required during the course. The marks are awarded for presenting the essay (5 marks), addressing the subject (2 marks) and for self awareness (3 marks). An overall score of less than 60% signifies a failure in the course and possible need for follow-up.

Table xxii. Cross Tabulation Comparison of Leader's Assessments and Pre-Course (Pink Paper) Questionnaire Results.

Leader's Assessment	Pre-Course Questionnaire (Pink Paper) 20-15	14.5-10	9.5-6	5.5-1	TOTAL
90+	85	1	0	0	86
80 - 89.5	37	5	0	0	42
70 - 79.5	1	3	1	1	6
60 - 69.5	0	1	0	0	1
TOTAL	123	10	1	1	135

The cross-tabulation in Table xxii suggests that if an offender scores well on the pre-course questionnaire, (Pink Paper) (Appendix E) he will also score well on the Leader's Assessment and complete the DDEP. Ninety per cent of offenders scored more than 75% on the pre-course questionnaire, and also 80% or more on the Leader's Assessment. Two people only scored in the lower 30% on the pre-course questionnaire, yet these two had passing scores on the Leader's Assessment. One person had a borderline Leader's Assessment, yet had more than 50% on the questionnaire.

Recidivists tended to have lower scores on both measures, although both recidivists and non-recidivists scored to consistently high levels.

The Leader's Assessments are time-consuming and seem to replicate data already gathered in the pre-course questionnaires. It is recommended that the Assessments be discontinued as an overall assessment tool, and that a check be kept of scores on the Pre-Course Questionnaire (Pink Paper). If, however, the Leader wishes to maintain a scoring or evaluation system as a teaching tool, and to use the information gathered to help individualise the DDEP or to provide feedback to offenders, then a system might be continued.

3.7 DDEP ASSESSMENT AND DATA COLLECTION

Assessment and data collection procedures were investigated during the course of research.

Assessment of the drinking history of second level offenders is mandatory, and a pre-requisite to the preparation of a Licence Restoration Report. WRAADD chooses to assess all other offenders in the belief that first/second level is a somewhat arbitrary distinction and that all offenders will benefit from assessment. Assessment takes the form of the Personal Situation and Background Questionnaire (PS&BQ, Appendix A). Assessments take

approximately one hour, are confidential and are conducted by the DDEP Co-ordinator.

Participants are asked whether they fully understand the nature of the assessment, and whether they are willing to proceed with the assessment. They are also required to have a breath test. The participant completes the short MAST, after which the Assessor completes the PS&BQ. On completion, the Assessor writes a summary, a Licence Restoration Report and a short report noting whether, and to whom, referral has been made.

At first glance, the PS&BQ seems very long and time-consuming, and the value must be questioned. Assessments can be of value to the client, the assessor or the agency. Ultimately, the assessment must be of value to the client.

Anecdotally, assessors report that clients benefit from assessment in a 'penny drops' fashion. In particular, drink drive offenders reportedly often are astounded to realise just how much they are drinking on a daily or regular basis, and may, for the first time, make connections between the different aspects of daily life being affected by drinking. Ostensibly, the assessment is used to assess possible alcohol problems for referral. However, the low rate of referral suggests either that few problems are identified, or that identified problems can be dealt with through the education program.

If an offender shares in the outcome of the assessment, this will have more benefit than if he is a passive contributor (similarly to the principles of adult education inherent in the education program). Assessors can assist in sharing the outcome by discussing their conclusions and showing the offender the assessor's written summary which should synthesise the process for the offender.

For brevity, and to assist in standardisation, it is recommended that the PS&BQ be reviewed in light of the HDV recommended assessment format, and any common questions standardised. The ten-point AUDIT scale should be included, enabling future comparison with other DDEP data.

3.8 ADMINISTRATIVE TIME INVOLVED IN THE DDEP

The Drink Drive Program is very time consuming to WRAADD. All staff are involved to some degree. An estimate of the processes, time and staff involved per offender follows. At best, the following

calculations are estimates, and are included for the internal information and use of the WRAADD Centre.

Table xxiii. Administrative Time Involved in DDEP per Participant.

PROCESS	STAFF MEMBER	EST. TIME
1. Phone inquiry	Admin Off	15 min
2. Letter re appointment/assess't	" "	5
3. Enrolment	" "	20
4. File Preparation	" "	10
5. Assessment and write up	DDEP Co-ord.	90
6. Prep of reading package	DDEP Ass't	5
7. Reminder letter	Admin Off	10
8. Take money and receipt	" "	10
9. Phone inquiries	" "	10
10.Course prep, photocopying	DDEP Ass't	60
11.Course prep.	DDEP Co-ord.	10
12.Course delivery (4 x 2 hrs,	DDEP Co-ord	720
plus 60 mins each night)	DDEP Ass't	720
13.Individual Evaluation	DDEP Co-ord.	60
14.Assessment Summary	DDEP Co-ord	10
15.Completion Certificate	Admin Off.	10
16. Final inquiries, follow-up	All	10
17. Data entry, HDV returns	Admin Off.	30
TOTAL TIME:		1805
		30.08HRS.

Course delivery time is shared but other time is individual. Deleting the course delivery time, the administrative and assessment time required to process one drink drive offender is approximately 365 minutes or 6.08 hours. The average number of offenders per course is 12, making the administrative time required per course 72.9 hours. Currently, the WRAADD DDEP funds the DDEP Co-ordinator (20 hours per week) and DDEP Assistant (6 hours per week plus course delivery time). Both staff members, however, contribute also to the administration and delivery of the DDEP in Hamilton and, in the case of the Co-ordinator, to assessments in Portland as well.

Figure 2. Administrative Time Required by WRAADD DDEP per Course.

Co-ordination Time Required:	
Assessments and write-ups	18 hrs
Course Preparation	2 hrs
Course Delivery	12 hrs
Individual Evaluations	12 hrs
Assessment Summaries	2 hrs
Co-ordination, Meetings, Reports	8 hrs
Hamilton, Portland programs	10 hrs
Travel time	4 hrs
Training and development, reading	6 hrs
Miscellaneous	6 hrs
TOTAL	80 hrs
Co-ordination Time Available:	
Co-ordinator @ 20 hrs/wk x 4 weeks	80 hrs
BALANCE:	00hrs.

Administrative Time Required:		
As listed in Table xxiii. (less Co-ordinator's time) x 12 participants per course	39 hrs	
Course delivery		12 hrs
TOTAL		51 hrs
Administrative Time Available:		
DDEP Assistant @ 6 hrs/wk x 4 weeks		24 hrs
DDEP Assistant course delivery		12 hrs
TOTAL:		36hrs
BALANCE (**LOSS**):		**15 hrs** per course

The WRAADD Centre absorbs considerable costs from the DDEP as it is currently structured. As an early intervention program, these additional costs can be justified. As unfunded costs over and above core funding but performed by core staff, the program causes considerable strain for a small centre.

3.9 COSTS OF THE DDEP

The following charges were levied on drink drive offenders:

Assessment (second level offenders only)	$ 90.00
Education Program	$100.00

Figure 3. Income from DDEP per Course

Second level offenders (73.5%) x $90.00	$793.80
Education Program (x 12 participants)	$1200.00
TOTAL INCOME:	**$1993.80**

Costs to WRAADD are difficult to assess, involving direct, indirect and capital costs. An attempt has been made to assess direct costs only.

Figure 4. Direct WRAADD Costs of DDEP per Course.

DDEP Co-ordinator's ($14.01/hr x 80)	$1120.80	
Less12.5% Portland/Hamilton	140.00	
		$980.70
DDEP Assistant's Salary p.a.	$5117.38	
Divided by 11 Courses p.a.		$465.21
WRAADD Admin time ($11.64/hr x 15 hrs)		$174.60
On-costs (20%)		$324.10
Physician Lecturer (1 session)		$80.00
Photocopying, paper, folders, booklets	$300.00	
Rent		$80.00
Postage, phone		$25.00
Refreshments, miscellaneous		$50.00
TOTAL COSTS per Course:		**$2479.61**

The DDEP appears to cost the WRAADD Centre $485.81 per course in direct costs, or $5343.91 per annum. Methods to increase cost recovery, or to reduce costs could be investigated.

3.10 RECIDIVISM

Recidivism and the reduction of drink driving are the obvious outcome measures for all DDEP programs.

The current study is cross-sectional rather than longitudinal, making measures of recidivist status retrospective. The number of offenders with a prior drink drive conviction, however, is concerning as is the fact that a considerable number of this group reported having completed a prior educational program. No information on the type of previous program, when it was undertaken, and whether local or not is available. It would seem that an educational program per se does not change drink drive behaviour.

WRAADD is ideally set up to conduct a longitudinal study of recidivism and its relationship to a DDEP. The population is relatively stable, and due to lack of public transport and choices, virtually all local offenders attend the WRAADD DDEP.

4. DISCUSSION, RECOMMENDATIONS AND CONCLUSIONS

This study has presented a wide range of findings. Discussion will follow of the major research findings.

4.1 DISCUSSION

A profile was developed of participants in the WRAADD DDEP between April 1, 1991 and March 30, 1992. This profile suggests that the participants in this rural program conform largely to profiles of drink drive offenders elsewhere. They were young, male and with BACs that were on average three times the legal limit. Specific characteristics of the WRAADD offenders include:

Table xxiv. Demographic Characteristics of WRAADD DDEP participants

Demographic Characteristics	%
Australian Born	99.2%
Never Married	67.6%
Some Secondary Education	58.5%
Employed	50.0%

Table xxv. Drinking characteristics of WRAADD DDEP participants

Drinking Characteristics	%
Favourite drink is beer	>91.0%
Began drinking < 18 years old	92.5%
Felt capable of driving	91.8%
First drunk <18 years old	89.3%
Detected < 1 hour after drinking	76.0%
Post-offence average drinking at low levels	75.0%
Second level offenders	73.5%
Drinking > 4 hours	71.6%
Pre-offence average drinking at low levels	66.1%
Last drink < 1 week ago	63.8%
First drink drive offence	62.2%
Detected by RBT	60.8%
BAC Reading > .15	59.3%
SMAST-defined possible alcohol problems	48.1%
CAGE-defined possible alcohol problems	34.6%

The WRAADD sample tends to be younger than participants in other Victorian programs (Carter, 1992). In Warrnambool, however, the local magistrate prefers all drink drive offenders to complete a drink drive program with the result that those not mandated to attend (<25 years old) will probably do so in greater number than in other areas. The high proportion of offenders who have never married is a likely consequence of the young age of the offenders.

Two features of local offenders - the proportion who have some tertiary education and those not in the workforce - possibly reflect Warrnambool's position as a provider of tertiary education and home to a large number of students. The university based in Warrnambool is situated in a rural setting some fifteen minutes drive from the city centre, necessitating what is possibly a relatively high degree of car ownership by students. This sub-group of the population is young, needs to travel and are in a social environment that traditionally supports heavy recreational drinking. The numbers not in the workforce possibly reflect the rural unemployment situation.

The high average level of BACs is concerning, as is the strong belief of offenders in their ability to drive when intoxicated. Comparative data from other programs would be useful. The average BAC of offenders attending the WRAADD program has been .15 for some eight years. Perhaps relatively high BACs are typical of rural drink drive offenders. Perhaps they are typical of all offenders. **Further studies of drink drive offenders would add to this picture, and are recommended.**

More than one-third (37.8%) of the present sample have been convicted of a second or subsequent drink drive offence. The DDODS data (Carter, 1992) points to a proportion statewide of 27%. In contrast, Rice and O'Sullivan (1991) report on a study of clients of Pleasant View Centre, Melbourne between 1979 and 1981, with follow-up for legal involvement up to 1986. Of the Pleasant View cohort, 55% were reconvicted for a drink-driving offence at least once over the period of data collection. **A search of Road Traffic Authority reports is to be recommended in future studies, providing objectivity and accuracy for reconviction, a measure which offenders may either deliberately under-report or legitimately forget.**

This study supported the Random Breath Test as the single most effective method of detecting drink drivers. Binns et al (1987) found that the frequency of drink driving amongst young males was related to perception of the risk of being caught. **A random and**

visible police presence through RBT stations should be continued and is recommended.

That almost all drink drive offenders felt capable of driving is astounding. Offenders drank for extended periods (averaging five hours) prior to their offence. This profile of young males, drinking to high levels over a period of hours is suggestive of binge drinking patterns. Social environments and mores are difficult to alter. Recent moves to extend liquor licensing hours (a contentious issue in the City of Warrnambool) contribute to a changing social environment. Extended licensing hours may possibly contribute to the long hours of drinking reported by some drink drive offenders. **It is recommended that further study be conducted into the effects of conventions such as extended hours and 'happy hours' on drinking and driving habits, particularly in rural communities.**

The majority of offenders had their early experiences of drinking and of drunkenness on or before attaining the legal age. More than half (54.8%) reported some periods of abstinence in the intervening years. An investigation of apparently self-imposed periods of abstinence would be of interest.

Beer was undoubtedly the preferred drink of all offenders. Anecdotally, and from personal observation, mixed drinks such as "rum and Coke" seem to be common for young people. The apparent discrepancy could be investigated. Are mixed drinks preferred by young drinkers? Do drink drive offenders prefer beer, and is this in contrast to their peers?

A change in drinking levels pre- and post-offence was obvious. It would seem that a drink drive offence per se has a mitigating effect on alcohol intake. An educational program may simply provide a framework and further knowledge on which to base a decision already made by some. **Those drinkers who do not reduce their post-offence drinking should be further studied to investigate other characteristics they may share.**

Two alcohol indices, C.A.G.E. and the short MAST, seem to identify a number of offenders with possible drinking problems. The C.A.G.E. appears a more conservative measure, identifying 12.8% of this sample as having problems, compared with the 29.5% identified with problems by the short MAST. One noted difficulty with the SMAST is that it may not identify current alcohol problems as there is no limit to the time factor in questions. It is of interest however, that a number of people are identified with likely alcohol problems in such

a young cohort. Interestingly, no correlations were found with either measure and recidivism amongst this sample. A central premise of the Victorian drink drive program is that those with more than one drink drive offence are those also most likely to have defined alcohol problems. The current study did not support this premise. **Further research is recommended to investigate correlations between the short MAST, C.A.G.E. and other characteristics of drink drive offenders.**

As well, further analysis of data gathered in the course of this report is recommended. There is much still to be learned from this program, which will be of interest both locally and to the wider community. A feature of the WRAADD DDEP is that staffing has remained constant for several years, and that data have been gathered in a systematic and commendable fashion.

Drinking and drinking patterns are clearly related to age. Here, the records kept of average daily intakes may have masked binge or bender drinking patterns. If patterns of binge drinking are identified amongst drink drive offenders, credibility may be lent to the 'drinking drivers/driving drinkers' dichotomy proposed in the Introduction to this study. It might be hypothesised that younger offenders are often drivers who sometimes binge drink dangerously. Conversely, older drinkers may contribute to the proportion of driving drinkers, those who drink regularly and heavily and are detected only when they are occasionally 'stranded', or when they run into unexpected 'obstacles' (such as police, motor vehicle accidents or RBT stations) on the way home. **It is recommended that specific questions regarding personal drinking patterns and associated costs be included in the Personal Situation and Background Questionnaire used in the WRAADD DDEP alcohol assessment.**

The WRAADD DDEP does seem to increase the knowledge of participants and, perhaps just as importantly, qualitatively is given excellent acclaim by the participants. Virtually all participants enter the program in the spirit of serving their sentences. Yet at the end of the four week educational program, verbal and written recommendations are the norm.

Some relatively minor internal anomalies exist. For example, a reference to the Vietnam War in one of the group exercises may have been relevant to offenders in the early 1980s, but is possibly incomprehensible to those now aged twenty-five years or less. **The WRAADD drink drive education program should be**

reviewed to ensure consistency and relevance of material in order to maintain the high standard of the program.

Both the pre- and post-questionnaires should be reviewed and altered to ensure greater clarity and objectivity. For instance, Question 4 asks about the helpfulness of attending a drink drive course before obtaining a licence. Only those responding positively are requested to elaborate and these respondents are asked whether they would have been more careful about driving after drinking. This retrospective hypothetical situation seems redundant, and could be made more specific as well as altered to be answered by all respondents.

It is recommended that the Personal Situation and Background Questionnaire be reviewed and, where possible, shortened. It is further recommended that the assessment summary be discussed with the offender. Even a relatively short period of discussion at the conclusion of the assessment would seem to synthesise the process, to help move the task from essentially data gathering, and to assist with establishing some individualised goals for the education program or for referral.

The DDEP Leader's Assessment Summary Sheet seems to reflect the scores obtained on the second Pre-Course Questionnaire (Pink Paper). The Leader may choose to continue use of the Assessment Sheet as a teaching tool and progress marker. However, the time involved needs to be weighed against other time demands of the program when the information gathered is repetitive, and it is recommended **that the Leader's Assessment Summary Sheet be discontinued as an evaluation tool.**

Costs of the DDEP to the WRAADD Centre are high. The DDEP has produced its own paper empire, and requires considerable administrative time. **It is recommended that the costs of the DDEP to WRAADD be reviewed with a view to greater cost recovery and to decreasing the administrative time currently provided by the agency.**

4.2 RECOMMENDATIONS OF THE WRAADD DRINK DRIVE EDUCATION PROGRAM

TITLE	RECOMMENDATION NUMBER	
Further Studies Pg 38	1	Further studies of drink drive offenders are recommended.
Recidivism Data Pg 38	2	A search of Road Traffic authority reports is recommended, providing objectivity and accuracy to recidivism data.
RBT Stations Pg 39	3	A random and visible police presence through RBT stations should be continued and is recommended.
Binge Drinking Pg 40	4	The effects of extended licensing hours and 'happy hours' on drinking and driving habits be investigated, particularly in rural communities.
Post-Offence Pg 40	5	Those drinkers who do not reduce their post-offence drinking should be further studied to investigate other characteristics they may share.
Alcohol Indices Pg 41	6	Further research is recommended to investigate correlations between the SMAST, CAGE and other

		characteristics of drink drive offenders.
Data Analysis Pg 41	7	Further analysis of data gathered in the course of this report is recommended.
PS&BQ Pg 41	8	Specific questions regarding personal drinking patterns and associated costs be included in the PS&BQ assessment.
Review of material Pg 41	9	WRAADD drink drive education program be reviewed to ensure consistency and relevance of materials.
Review of questionnaires Pg 42	10	Both the pre- and post-questionnaires be reviewed and altered to ensure greater clarity and objectivity.
PS&BQ Pg 42	11	The PS&BQ re reviewed and, where possible, shortened. The assessment summary to be discussed with the offender.
Leader's Assessment Pg 42	12	The Leader's Assessment Summary Sheet be discontinued as an assessment tool.
Cost Recovery Pg 42	13	The costs of the DDEP be reviewed and the program become self-funding.

4.3 SUMMARY

This study of the WRAADD DDEP has produced a profile of an average participant from a south-west Victorian rural community. Some trends can be seen. The drink drive offenders are male, young and capable of achieving high blood alcohol levels (BACs) and then considering themselves fit to drive. Few relationships were found between predicted indicators of problem drinking. No clear relationships were found between second level offenders and other measures, although further data analysis is recommended. This report does not support the maintenance of the current distinction between first and second level offenders.

A drink drive offence seems to reduce offenders' self-reported drinking levels, while the Drink Drive Education Program seems to increase the knowledge of participants and retrospectively, to be viewed very positively by participants. The Leader's Assessment Summary Sheet duplicated information already gathered on participants, and did not help to predict likely outcomes.

4.4 CONCLUSION

This study has contributed to the picture of drink drive offenders by offering a small snapshot from a rural community program. The results should assist staff of the WRAADD DDEP to further develop what seems to be a successful and well-regarded program, and may also be of assistance to other Drink Drive Education Programs across Victoria. Much data has been gathered in the course of the WRAADD DDEP and in the preparation of this report, and could be further analysed to assist in the development of a more comprehensive view of drink drive offenders and of the most effective education programs.

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APPENDIX A

PERSONAL SITUATION AND BACKGROUND QUESTIONNAIRE (PS&BQ)

APPENDIX B

PRE-COURSE QUESTIONNAIRE

APPENDIX C

POST-COURSE EVALUATION QUESTIONNAIRE

APPENDIX D

LEADER'S ASSESSMENT SUMMARY AND MARKING SCALE

APPENDIX E

SECOND PRE-COURSE QUESTIONNAIRE (PINK PAPER)

WARRNAMBOOL REGIONAL ASSOCIATION FOR ALCOHOL AND DRUG DEPENDENCE INC

REVIEW OF THE WRAADD DRINK DRIVE EDUCATION PROGRAM: A RURAL PERSPECTIVE ON DRINKING DRIVERS

Written by:

Carol Brady
Project Officer
August 1993

WARRNAMBOOL REGIONAL ASSOCIATION FOR ALCOHOL AND DRUG DEPENDENCE

DRIVER ASSESSMENT

CLIENTS SURNAME: _____

GIVEN NAMES: _____

MALE ☐ FEMALE ☐

DATE OF BIRTH: _____/_____/19____ AGE: _____

ADDRESS: _____

_____

FIRST LEVEL OFFENCE: ☐

SECOND LEVEL OFFENCE: ☐

FIRST ASSESSMENT: ☐

SECOND ASSESSMENT: ☐

COMMENTS

These facing pages have been left blank as detailed notes are required.

Table for question 7

Type of job	*Duration*

VOCATIONAL HISTORY

I would like to ask you some questions about your lifestyle, your work and your drinking.
I will begin with asking you about your work.

1. Have you ever been in paid employment? ☐

   0. Yes....go to Q.2
   1. No

1.1 How would you describe your occupation status? ☐
   1. Student....go to Q 10
   2. Home duties ... go to Q.10
   3. Pensioner....document
   4. Other .... document then go to Q.10

   _____

   Type of pension: _____

   _____

   Reason:_____

   _____

   Duration: _____

   .....go to Q.10

2. Are you currently employed? ☐

   0. Yes.....go to Q 3
   1. No.

2.1 Do you receive a pension? ☐

   0. Yes ... document then go to Q.6
   1. No ..... go to Q 6

   If "Yes" ask:
   Type of pension: _____

   _____

   Reason: _____

   _____

   Duration: _____

   ....go to Q.6

3. How long have you bee in your current job? ☐

   0. More than 6 months
   1. Up to 6 months

4. Do you have any problems coping with your job or your workmates? ☐

   0. No, never
   1. Not in the last 12 months
   3. Yes....document

   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____

5 Have you been unemployed in the last two years? ☐

   0. No .... go to Q.7
   1 Up to 3 months ..... go to Q.7
   3 More than 3 months

6. How long since you have been in paid work? ☐

   1. Up to 3 months
   2. 3-12 months
   3. More than 12 months.

7. How many jobs have you had in the last two years? ☐

   ...../document on facing page
   (see table)

   0. Pensioner/student
   0. Home duties
   0 One
   1. Two or three
   2. More than three
   3. None

8. Have you ever been criticised at work because of your drinking? ☐

   0. No, never
   1. Not in the last 12 months
   3. Yes

9. Have you ever lost a job because of your drinking? ☐

   0. No
   3. Yes....document: number, year last occurrence

   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____

10. Have you ever been unable to perform your normal duties because of "gastric upsets", "bilious attacks" or "hangovers"? ☐

    0. No, never . . .... go to Q.11
    1. Not in the last 12 months .....go to Q.11
    3. Yes

10.1 How frequently? ☐

    1. Less than once per month
    3. More than once per month

11. Are you satisified with your ability to save money?

    0. Yes ..... go to Q.12
    2. No

11.1 Does the money you spend on drinking seriously affect your savings?

    0. No
    3. Yes

12. Do you have family responsibilities?

    1. Yes
    2. No .... go to Q.13

12.1 Has the family ever gone short of necessities because of you spending money on drinking? ☐

    0. No, never
    1. Not in the last 12 months
    3. Yes

13. Have you ever gone into debt because of your drinking? ☐

    0. No, never
    1. Not in the last 12 months
    3. Yes

14. At what age did you first taste alcohol
    _____years

15. At what age did you first get drunk?
    _____years

16. At what age did you commence a regular pattern of drinking?
    _____years

    Time since began regular drinking pattern (circle)

    1. 0-5 years
    2. 6-10 years
    3. 11-15 years
    4. > 15 years

17. Have there been any periods of abstinence from alcohol since you commenced a regular drinking pattern. ☐

    0. No
    3 Yes - Specify

    _____
    _____
    _____
    _____
    _____
    _____

COMMENTS

_____
_____
_____
_____

DRINK DRIVING OFFENCES

18. I would like to ask you some questions about your drink-driving offences.

Write the answers to the following questions in the spaces on the table provided.

When was your current drink driving offence?

What was your B.A.C. at the time of the office?

What brought you to the attention of the police?

Codes:
1. Random Breath Test
2 M.V.A.
3. Traffic Infringement

Were you driving under suspension at the time of the offence?

Did you feel you were capable of driving safely at the time of the offence?

Repeat this sequence of questions for previous offences, starting with the most recent and working back in time. Record up to and including the last 3 offences.

Year	Month	Day	Time	B.A.C.	Offence	Suspension	Capable
						Yes/No	Yes/No
Comments:							

Year	Month	Day	Time	B.A.C	Offence	Suspension	Capable
						Yes/No	Yes/No
Comments:							

Year	Month	Day	Time	B.A.C.	Offence	Suspension	Capable
						Yes/No	Yes/No
Comments:							

For further prior offences, document number and year.

DRINK DRIVING OFFENCES - DETAILS REQUIRED FOR THE TABLE

Enquire into:

1. Alcohol consumption prior to the offence.

   Evidence of minimisation may be implied if there is a discrepancy between the blood alcohol concentration (BAC) and the quantity of alcohol the client reported having consumed prior to the offence.

2. Time period over which consumption took place.

   People are more likely to feel still capable of driving with a high BAC if they have been drinking over a prolonged period of time.

3. Time period between last drink and offence.

   A long period may indicate that a much higher BAC was previously reached.

4. Reasons for consumption on that occasion.

   It should be noted whether the given reasons correlate with the admitted drinking patter. It is important to determine whether this occasion is typical of normal consumption, ie: whether the client is likely to drink enough alcohol to frequently produce BACs over 0.05 mg%.

ALCOHOL CONSUMPTION QUESTIONNAIRE

19. I want to ask you some questions about your drinking during the last month.

How long is it since you had your last alcoholic drink?

Number of days/hours since last drink _____

When people drink they sometimes drink different amounts at different times. For example, on some days people drink only small amounts, such as before or with a meal or in the evening when invited to a friend's house. On other occasions people drink medium amounts, for example, at a bar with friends, at parties, or on weekends. Finally, *on some occasions*, people consume large amounts of alcohol, for example at weddings or other special occasions, festivals, etc.

19.1 **Low Level Drinking, Type and Amount**

Let us start with the lowest level:

What types of alcoholic beverages do you usually drink, and how much?
Remember to include both alcohol consumed with meals and between meals, for all hours.

Type of Beverage	Container Size (ml)	No. of Containers N	Alcohol per Container (g) A	Low Level Daily Quantity N x A (g)
		(1) Low Level Daily Total		

Low Level Drinking, Number of Days

On how many days during last month did you drink this much?

(2) Low Level Drinking Days = _____

Total Low Level Quantity (Q.L.) = (1)x(2) = _____ g

19.2 Medium Level Drinking, Type and Amount

Let us now go on to your medium level of consumption. What types of alcoholic beverages to you use on such occasions, and how much?

Type of Beverage	Container Size (ml)	No. of Containers N	Alcohol per Container (g) A	Low Level Daily Quantity N x A (g)
		(3) Medium Level Daily Total		

Medium Level Drinking, Number of Days
On how many days during last monthdid you drink this much?

(4) Medium Level Drinking Days = _____

Total Medium Level Quantity (Q.M.)=(3)x(4) = _____ g

19.3 High Level Drinking, Type and Amount

Finally, let us look at the special occasions where you drink the maximum of what you allow your self; e.g. at special celebrations, holidays etc. What types of alcoholic beverages do you drink on these occasions, and how much?

Type of Beverage	Container Size (ml)	No. of Containers N	Alcohol per Container (g) A	Low Level Daily Quantity N x A (g)
		(5) High Level Daily Total		

High Level Drinking, Number of Days
On how many days during the last month did you drink this much?

(6) High Level Drinking Days = _____

Total High Level Quantity (Q.H.)=(5)x(6) = _____ g

20. **Typical Drinking Behaviour**

Was last month typical for you in terms of the amount of alcohol you drank in the past six months?

Yes No

If "No", ask:

Please describe a typical (average) month:

(a) How many low level drinking days were there?
Record below

(b) How many medium level drinking days were there?
Record below

(c) How many high level drinking days were there?
Record below

	(A) Daily Total (from above)	(B) Frequency (no. of days)	Daily Quantity (A) x (B) g
(a) Low Level			
(b) Medium Level			
(c) High Level			
		Typical Monthly Total Quantity (T.M.Q.)	

$$\text{Typical Daily Average} = \frac{\text{T.M.Q.}}{30}$$

= _____ g

DRINKING HISTORY SUMMARY

Last Month's Total Quantity (L.M.Q.) = Q.L. + Q.M. + Q.H.

L.M.Q. = _____ g

Last Month's Daily Average = $\frac{\text{L.M.Q.}}{30}$

= _____ g (copy to p.44)

Typical Monthly Total Quantity (T.M.Q.) = _____ g

Typical Daily Average = $\frac{\text{T.M.Q.}}{30}$

= _____ g (copy to p.44)

Number of Drinking Days per Month = (2) + (4) + (6)

= (____) + (____) + (____)

= _____ days

How long have you been *drinking like this*? _____ years/months

In the past, have you have periods in which you have consumed more than the amount recorded for the last month? (doument details)

_____

_____

_____

Other comments:

_____

_____

_____

_____

_____

_____

_____

MEDICATION

22. I would like to ask you about the medications you have taken during the last month.

Enter responses on the table below

Have you taken any **sleeping tablets** during the last month?

If "No", go to next 'Type of Drug' listed on the table below.

If "Yes", ask:

What was the name of the drug?
Was the drug prescribed by a doctor?
For how many weeks have you been taking the drug?

As further questions concerning dose, frequency, etc , where appropriate.

Repeat the question sequence, substituting for the phrase in bold (above), each 'Type of Drug" listed on the table (below).

RESPONSE TABLE - MEDICATION

Type of Drug	Taken Yes/No	Generic Name	Pre-scribed Yes/No	Duration (Weeks)	Comments dose, frequency, etc
Hypnotic/Sedative					
Tranquillisers					
Anti-depressants					
Anti-psychotics					
Anti-convulsants					
Stimulants					
Opiates					
Hallucinogens					
Marijuana					
Analgesics					
Antacids					
Tobacco					
Others					

FAMILY ISSUES

I am now going to ask you some questions about your family life.

Have any members of your family had problems caused by their drinking?

23.	Father	0. No	2. Yes	
24.	Mother	0. No	2. Yes	
25.	Sibling	0. No	2. Yes	
26.	Paternal Relative	0. No	2. Yes	
27.	Maternal Relative	0. No	2. Yes	

Have any members of your family had problems caused by using other drugs?

28.	Father	0. No	2. Yes	
29.	Mother	0. No	2. Yes	
30.	Sibling	0 No	2. Yes	
31.	Paternal Relative	0. No	2. Yes	
32.	Maternal Relative	0. No	2. Yes	

Have any members of your family suffered from a mental disorder such as a 'nervous breakdown', anxiety, depression etc?

33.	Father	0. No	2. Yes	
34.	Mother	0. No	2. Yes	
35.	Sibling	0. No	2. Yes	
36.	Paternal Relative	0. No	2. Yes	
37.	Maternal Relative	0. No	2. Yes	

38. What are your present living arrangements? ☐

1. Living with partner/children
2. Living at home with parents
3. Living with friends .....go to Q.32
4. Living along .....go to Q.32
5. No fixed address .....go to Q.32

38.1 Would you get along better with your family and/or partner if you didn't drink? ☐

0. No
3. Yes

39. Are you satisfied with your present living arrangements?

0. Yes
2. No ..... document _____

_____

40. Have your ever been separated or divorced from a partner ☐

0. No ..... go to Q.34
2. Yes

40.1 Do you think drinking played a part in the breakdown of the relationship? ☐

0. No
3. Yes

41. Do you skip meals when you are drinking?

0. No
3. Yes ..... If yes, ask:

When was the last occurrence?
_____

How frequently? _____
_____
_____

42. Has your drinking affected your sense of general well-being and health? ☐

0. No, never
1. Not in the last 12 months
3. Yes

43. Has your drinking interfered with your normal sexual behaviour or performance? ☐

0 No, never
1. Not in the last 12 months
3. Yes

44. How well do you think you are coping currently with life situations? ☐

0. Coping ..... go to Q.38
1. Not sure
2. Not coping

44.1 Do you think your drinking has anything to do with your problems coping with life? ☐

0. No
3. Yes ..... document
_____
_____
_____

45. Have you ever felt you ought to cut down on your drinking? (CAGE 1) ☐

0. No
1. Yes

EXPLANATIONS

Q. 50-51 Assessing Tolerance

Tolerance means different things to different people. A change in tolerance should be related to changes in consumption before an assessment of its significance is made.

Q. 56 Consumption Levels

Man people have no idea of their consumption levels and consequently make no attempt to monitor them. Such people are likely to drink to excess on special occasions. Others are aware that their drinking is problematic and attempt to control it, but with limited success.

Drinking may be limited by:

1. Limiting money taken into drinking situations.
2. Limiting time in drinking situations.
3. Counting drinks.

Q. 57-57.1 Physical Withdrawal

Sleeping difficulties, especially after heavier drinking periods, may indicate physical withdrawal. This usually manifests itself as recurrent wakening during the night.

COMMENTS

46. Do you think your drinking has changed much in the last 12 months?
See EXPLANATIONS, facing page

0. Decreased
1. No change
3. Increased

Document the circumstances and amounts where appropriate.

_____

_____

_____

47. Does the same amount of alcohol have a different effect on you now than it did 12 months ago? See EXPLANATIONS

0. More effect (lower tolerance)
1. No change
3. Less effect (higher tolerance)

48. Do you think your drinking follows a regular pattern?

0. No ..... go to Q.42
1. Yes

48.1 Has the pattern become more fixed or rigid as time passes?

0. No
3. Yes

49. After you start drinking do you ever find it difficult to stop?

0. No
3. Yes

50. Would you feel restless or irritable if you couldn't have a drink when you normally would?

0. No
3. Yes

51. Do you find you think a lot about where and when you will have your next drink?

0. No
3. Yes

52. Do you ever set yourself a limit on how much you should drink? (EXPLANATIONS)

0. Yes ..... document
3. No

_____

_____

_____

53. Do you have any difficulties with sleeping? See EXPLANATIONS

0. No ..... go to Q.47

0. Initial insomnia
0. Early morning wakening
2. Recurrent insomnia

54. Do you *think* your sleeping problems are related to your drinking?

0. No
3. Yes

55. Do you find it easier to face certain situations or problems if you have a drink?

0. No
3. Yes

56. Do you find you need a drink to help you feel comfortable with other people?

0 No
3. Yes

57. Do you like to get your first drink down quickly?

0 No
3. Yes

58. Do you like to be a few drinks ahead of other people - an early starter?

0. No
3. Yes

59. Do you ever drink before lunch?

0 No
3. Yes ..... If yes, ask:

How often?

Last time?

60. Does your drinking pace change as a session progresses?

0. Slow down
1. No
3. Speed up

60.1 How many drinks do you have in the:

First hour? _____

Second hour? _____

61. Do you drink alone? ☐

0. No, never ..... go to Q.54
1. Not in last 12 months .... go to Q.54
3. Yes

61.1 Does this happen more than once a week? ☐

0. No
3. Yes ..... If yes, ask:

Where does it happen?_____
_____

How much do you drink?_____
_____

61.2 Do you prefer to drink alone? ☐

0. No
3. Yes

62. Have people ever annoyed you by ☐

0. No
1. Yes

63. Have you ever needed to hide the amount you are drinking from friends or family?

0 No, never
1. Not in the last 12 months
3. Yes

64. Do you get into fights when you are drinking? ☐

0. No, never
1. Not in the last 12 months
3. Yes

65. Have you ever felt bad or guilty about your drinking? (CAGE 3) ☐

0. No
1. Yes

66. Have you ever found you could not recall part or all of the events of the previous night after you have been drinking? ☐

0. No, never
1. Not in the last 12 months
3. Yes ..... If yes ask:

Last occasion _____
Number of occasions in last 12 months_____
Quantity drunk and period of time
_____
_____

67 Have you ever been drunk two or more days in a row? ☐

0. No, never
1. Not in the last 12 months
3. Yes

68. When was the last time you were drunk? ☐

0. Not in the last year
1. In the last year
2. In the last month
3. In the last week

69. What do you mean by drunk? ☐

1 Relaxed, less inhibited
2. Slight slurring of speech and/or unsteady on your feet
3. Loss of physical control, "paralytic" .....document frequency and severity details

_____
_____
_____
_____

70. Have you caused serious embarrassment to yourself or others when you have drunk? ☐

0. No, never
1 Not in the last 12 months
3. Yes

71. Do you ever notice a fine tremor in your hands the next morning after you have been drinking? ☐

0. No, never ..... go to Q.64
1. Not in the last year ..... go to Q.64
3 Yes

71.1 How often does the tremor make it difficult to hold a glass or a cup? ☐

0. Never
1. Less than once a month
3. More than once a month

72. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? (CAGE 4) ☐

0. No
1. Yes

73. Do you ever wake feeling drenched in sweat after you have been drinking? ☐

0. No, never
1. Not in the last 12 months
3. Yes

74. Do you get indigestion or heartburn after you have been drinking? ☐

0. No, never
1. Not in the last 12 months
3. Yes

75. Have you vomited after drinking or avoided eating or drinking for fear of vomiting? ☐

0. No, never
1. Not in the last 12 months
3. Yes

76. Have you ever noticed your heart beating faster or more noticeably than normal, the morning after drinking? ☐

0. No, never
1. Not in the last 12 months
3. Yes

77. Have you ever had a fit or a convulsion associated with drinking? ☐

0. No
3 Yes .... document frequency and date of last event

_____

_____

78. Have you ever been told to cut down or stop drinking by family or friends ☐
0. No
3. Yes

79. Have you ever been told by a doctor or nurse that you should cut down or stop drinkings? ☐

0. No ..... go to Q.72
3. Yes ..... document when this occurred

_____

_____

_____

_____

80. Was it because of damage to your health? ☐

0. No
3. Yes

80.1 Do you get depressed, anxious or panicky? ☐

0. No, never .... go to Q.73
1. Not in last 12 months ..... go to Q.73
2. Yes

80.2 Is this more than other people? ☐

0. No
3. Yes

81. Do you think these feelings could be related to your drinking? ☐

0 No
3. Yes

82. Do you use alcohol to control your feelings? ☐

0. No
3. Yes

83. Have you ever felt you should stop drinking because it was causing problems for you? ☐

0 No
3. Yes .... .If yes, ask:

How many times did you decided to stop?

_____

How many times were you able to stop? ☐

_____

.....document duration and reasons.

_____

_____

_____

_____

_____

_____

_____

ASSESSOR'S SUMMARY

Assessor's Impression:

Severity Scale	0	1	2	3	Code
Drinking History	Abstinence	Low Risk	Hazardous	Harmful	
Male Female	0 0	1-40gm 1-20gm	41-60gm 21-4-gm	≥61gm ≥41gm	
Problems Relating to Drinking	No problems	mild/moderate	Substantial	Severe	

Important Findings:

Assessor's Signature: _____

Assessor's Name: _____ Date: ____/____/19____
Printed

PRE-COURSE QUESTIONNAIRE

1. WHY ARE YOU DOING THIS COURSE?

   .....

   .....

2. WHAT DO YOU EXPECT TO LEARN FROM THIS COURSE?

   (i) .....

   (ii) .....

   (iii) .....

3. HOW DO YOU FEEL ABOUT DOING THIS COURSE?

   .....

   .....

4. WOULD YOU HAVE ATTENDED A DRINK DRIVE IF AVAILABLE BEFORE YOU GOT YOUR LICENCE?

   Comment: .....

   .....

5. IF YOUR BLOOD ALCOHOL LEVEL IS .10%, HOW LONG WOULD IT TAKE TO DROP TO ZERO?

   .....

6. DOES EATING WHEN DRINKING SIGNIFICANTLY AFFECT THE BLOOD ALCOHOL LEVEL WHICH YOU REACH?

   .....

7. IS ALCOHOL A DRUG?

   .....

8. WHAT IS TOLERANCE TO ALCOHOL?

   .....

9. NAME THREE (3) WAYS IN WHICH ALCOHOL REDUCES THE CAPACITY OF A PERSON TO DRIVE A CAR.

   (i) .....

   (ii) .....

   (iii) .....

10. NAME THREE (3) ORGANS THAT CAN BE DAMAGED BY EXCESSIVE USE OF ALCOHOL OVER A LONG PERIOD OF TIME.

(i) .....

(ii) .....

(iii) .....

11. WHAT IS THE MAXIMUM AMOUNT OF ALCOHOL YOU CAN SAFELY DRINK EACH DAY (ON AVERAGE) WITHOUT RISKING SERIOUS DAMAGE TO THE LIVER OR OTHER PARTS OF THE BODY IN THE LONG TERM?

Males: .....

Females: .....

12. DOES ALCOHOL-RELATED DAMAGE TO THE BODY IMPROVE AFTER A PERSON STOPS DRINKING?

.....

POST COURSE EVALUATION QUESTIONNAIRE

1. WERE YOUR EXPECTATIONS OF THIS COURSE MET?

   Comment: .....

   .....

2. WHAT ARE THE MAIN THINGS YOU HAVE LEARNT FROM THIS COURSE?

   (i) .....

   (ii) .....

   (iii).....

3. HOW DO YOU FEEL NOW ABOUT THIS COURSE?

   .....

   .....

4. WOULD IT HAVE BEEN HELPFUL TO HAVE ATTENDED A DRINK DRIVE COURSE BEFORE YOU GOT YOUR LICENCE?

   Comment: .....

   IF YES:

   Would you have been more aware about <u>driving after drinking?</u>

   Comment: .....

   .....

   Would you have been more aware about your drinking habits?

   Comment: .....

   .....

5. IF YOUR BLOOD ALCOHOL LEVEL IS SAY .10%, HOW LONG WOULD IT TAKE TO DROP TO ZERO?

   .....

6. DOES EATING WHEN DRINKING SIGNIFICANTLY AFFECT THE BLOOD ALCOHOL LEVEL WHICH YOU REACH?

   .....

7. IS ALCOHOL A DRUG?

   .....

8. WHAT IS TOLERANCE TO ALCOHOL?

   .....

9. NAME THREE (3) WAYS IN WHICH ALCOHOL REDUCES THE CAPACITY OF A PERSON TO DRIVE A CAR.

   1. .....

   2. .....

   3. .....

10. NAME THREE (3) ORGANS THAT CAN BE DAMAGED BY EXCESSIVE USE OF ALCOHOL OVER A LONG PERIOD OF TIME.

1. .....

2. .....

3. .....

11. WHAT IS THE MAXIMUM AMOUNT OF ALCOHOL YOU CAN SAFELY DRINK EACH DAY (ON AVERAGE) WITHOUT RISKING SERIOUS DAMAGE TO THE LIVER OR OTHER PARTS OF THE BODY IN THE LONG TERM?

Males: .....

Females .....

12. DOES ALCOHOL-RELATED DAMAGE TO THE BODY IMPROVE AFTER A PERSON STOPS DRINKING?

.. ..

13. WHAT INFORMATION IN THE COURSE WAS OF GREATEST BENEFIT TO YOU AND WHY?

.....

.....

14. WHICH SESSION CONTAINED THE LEAST USEFUL INFORMATION AND WHY?

.....

.....

15. WHAT ARE YOUR THOUGHTS ABOUT THIS COURSE AS A WHOLE?

.....

.....

.....

16. HOW CAN WE IMPROVE THIS COURSE - WHAT CHANGES WOULD YOU MAKE?

.....

.....

.....

17. IS IT WORTHWHILE CONTINUING TO RUN COURSES FOR OTHER DRIVERS?

(a) YES, WHY:.....

(b) NO, WHY:.....

WRAADD DRINK DRIVE COURSE NO: _____

LEADERS ASSESSMENT

NAME	Attendance (20)					Participation (20)					Q (20)	PreE (10)	Ess1 (10)	Ess2 (10)	PosE (10)	Total (100)	Asses.
1ST LEVEL:	1	2	3	4	Total	1	2	3	4	Total							
2ND LEVEL:																	

Key to Abbreviation:

Q	Questionnaire
PreE	Pre Course Evaluation
Ess1	1st Essay
Ess2	2nd Essay
PosE	Post Course Evaluation
Asses	Leaders Assessment

Scale:

90 -	Excellent
80 - 90	Very Good
70 - 80	Good
60 - 70	Fair
Less than 60	(possible need for follow-up)

MARKING SCALE FOR LEADERS ASSESSMENT

Attendance 5 per session	=	20
Participation (5 or part thereof) per session	=	20
Q: 1 Mark per correct answer	=	20
PreE: 2 Completing all questions 1 per Correct Answer Q5 to Q12	=	10
Ess 1: 5 Presenting Essay 2 Addressing Subject 3 Self Awareness	=	10
Ess 2: 5 Presenting Essay 2 Addressing Subject 3 Self Awareness	=	10
Pos E: 2 Completing all questions 1 per Correct Answer Q5 to Q12 Answer Q5 to Q12	=	10
TOTAL	=	100

Second Pre -Course Questionnaire (Pink Paper)

NAME_____

QUESTIONNAIRE - TO BE COMPLETED PRIOR TO THE COURSE

(Please read the information supplied in the pamphlets, very carefully, and then answer the questions below)

1. What are the Blood Alcohol Concentration (B.A.C.) legal limits in:-

   (a) New South Wales..... (b) Queensland.....

   (c) Victoria..... (d) Tasmania..... (e) South Aust.....

2. List some of the Road Crash costs to the Australian Community in

   (a) Humen Terms .....

   (b) Money Terms .....

3. What factors determine the Blood Alcohol Concentration in the body?

   .....

4. List the Short Term physical effects of a Blood Alcohol Concentration:

   1. .....

   2. .....

   3. .....

   4. .....

   5. .....

5. What is a standard drink? .....

   (Give exemples) .....

6. How does Alcohol leave the body? .....

   .....

7. Can you speed up the process of Alcohol leaving the body? Yes/No

   If Yes (How) .....

   If No (Why) .....

8. What is A.R.B.D.? .....

9. How does A.R.B.D. affect people? .....

   .....

10. Can anything be done to help a person with A.R.B.D.? Yes/No

    If No (Why) .....

    If Yes (What) .....

11. Can you be over the Legal B.A.C. for driving the next day following drinking Alcohol? Yes/No

If No (Why) .....

If Yes (How) .....

12. How can you estimate your B.A.C.? .....

.....

13. Does alcohol have a different effect on Women? Yes/No.

Give reasons .....

.....

14. List six of the long term effects of Alcohol on the body?

a)..... b).....

c)..... d).....

e)..... f).....

15. Is Alcohol a:- (Answer Yes or No and give reason if known)

a) Food ..... b) Drink .....

c) Drug ..... d) Poison .....

e) Stimulent ..... f) Depressant .....

16. List four ways that you may avoid drink driving:-

i) .....

ii) .....

iii) .....

iv) .....

17. Why is it recommended that consumption of alcohol be avoided during pregnancy?

.....

18. What percentage of alcohol is metabolized by the liver?
.....

19. How long does it take for the liver to process one standard drink?

.....

20. What things could you do to assist others to avoid drink driving?

.....

.....