Education on Alcohol, A Problem for Community Leaders

Gordon Trinca

INTRODUCTION

It would be fair to say that as many words have been written and spoken about alcohol as litres consumed but, as yet, no universal panacea has been discovered to rid the world of the ills of alcohol. This is understandable when drinking habits vary from country to country as do the availability and nature of alcohol, the economic status of the country and the control of the manufacture and distribution of alcohol (state or free enterprise).

Is not alcohol one of the best known subjects on earth — better known than sex? We are educated one way or the other by what we are told and see from an early age and what better example than that of our parents first and then later our peer groups. We have a wonderful opportunity to be educated by first-hand experience from a very early age. But it is not alcohol about which we receive this education. Instead we become well educated on beer, wine, spirits, etc. — but not alcohol.

This paper is essentially confined to the Victorian experience of education on the excess use of alcohol in the road crash situation. It describes the education and preparation of the community for its acceptance of two pieces of legislation:

1. compulsory blood sampling of road accident victims attending hospitals for treatment
2. random breath tests for motorists.

This paper is presented from a clinician's point of view — that of one who actually treats the victims of road crashes.

EDUCATION

Before describing the steps that led up to this legislation and the results achieved so far, certain important questions on education have to be asked.

What are the objectives of education as they relate to road crashes?
What groups have to be approached and what will be the response?
What are the most effective means of public education regarding road crash victims?
Can engineering measures succeed where education and legislation have failed?
Who are the community leaders considered responsible for community education on alcohol?

*Chairman, Road Trauma Committee, Royal Australasian College of Surgeons.
Now countries vary on the importance of education and the thrust of their methods. In the U.K., for example, education studies have shown that the appeal to family responsibility, authority and famous persons is more effective than horror, humour or satire. In some countries no system of education exists for the drinking driver whilst in others National Boards of Education arrange comprehensive school curricula on alcohol education.

The extent of social drinking varies from country to country and therefore the extent of social drinking compared with alcoholism as a cause of road traffic accidents. What is of concern to all countries is that alcoholic drivers and criminals are the main recidivists. Also the majority of drinking casualties are under 35 years of age.

COMMUNITY LEADERS

Community leaders considered to be involved willingly or otherwise are listed as follows:
1. Establishment (‘Wasps’), e.g. — Conservative Politicians — Captains of Industry
2. Alcohol Interface, e.g. — Medical and Legal Services, Police, Insurance Companies, Crime and Social Workers, Temperance Groups and Hotels
3. Trade Unions
4. Ethnic Groups
5. Youth Groups
6. Clubs and Societies, Service Groups
7. Religious Groups
8. Schools and Universities
9. Individuals
10. Media

Taking the Victorian scene the contribution and initiative of these leaders in educating the community on the serious effect of excessive alcohol and driving or road use has been variable and by some depressingly inadequate. It is not the purpose of the paper to identify the poor performers but it is left to their own consciences.

It would be fair to say that as regards alcohol and road trauma the action has come from small groups, individuals and above all the mass media. In the political arena individual Ministers would be more aware than the Cabinet or the whole body of parliamentary members. The Joint Parliamentary Committee on Road Safety was aware. The Australian Medical Association was aware. So was the Royal Automobile Club of Victoria. But where was the action?

Many individuals had campaigned for years but to what avail? The voices of Birrell, Santamaria, Ots, Raymond, Beard and Hossack went unheeded. Lions International, through the voice of Colin Campbell, thundered and roared. Peter Brock, champion car driver, promoted turn off before 0.05. Donald Cameron attacked through his art and some youth groups did their bit. Many others were stirring and agitating.

But where was the action by the Government?

The ground swell of public opinion was not yet big enough to stir the Government into taking some initiative in attacking the alcohol problem in road crashes. Against this activity was the glamorous promotion of beer, wine, spirits, etc., the great Australian image and little evidence of Government action to divert youth away from the beer halls.

Three groups can be identified in the community:
1. The great majority of citizens who are responsive to education and become aware and concerned when the facts are presented.
2. The punks and criminals who hate society and themselves and for whom any education process is probably useless.
3. The chronic alcoholic who, if he belongs to Group 1, wants to co-operate but can't because of his illness.
A lesser number of these would belong to Group 2 because of its lower age level.

ROAD TRAUMA COMMITTEE ACTION

Now in Victoria there were two additional forces which played a major role in community education on alcohol.
- the Road Trauma Committee of the Royal Australasian College of Surgeons, and
- the media

The Road Trauma Committee has been an effective organisation which had worked on the Government. It had campaigned vigorously for the introduction of seat belt legislation and the benefits of seat belt restraint have been proved the world over. This scientific lobby had surveyed 37,000 road accident victims treated in Victorian Hospitals in 1971–1973. At its first Road Trauma Seminar conducted by the Royal Australasian College of Surgeons in 1969, alcohol was identified as a major factor in road crashes causing death and serious injury. The formation of the Road Trauma Committee in 1970 was a direct result of that Seminar and it became the instrument to provide the clinical information obtained from surgeons treating road accident victims. The blood alcohol levels in fatalities and the opinion of surgeons treating victims indicated a high level of alcohol involvement.

CASE FOR COMPULSORY BLOOD SAMPLING

The Road Trauma Committee was determined to present the facts to the community. The object of this educational attack was to produce community awareness and concern.

It was obvious that the absence of compulsory blood alcohol sampling of all casualties prevented hard data being obtained on the alcohol and road crash accident problem.

It was felt that an aware and concerned public would accept legislation necessary for effective countermeasures. After all hadn’t this occurred in seat belt legislation? It was also realised that legislation to be effective had to be adequately enforced. There was evidence already (blood alcohol in U.K.) that effectiveness of the law decreases when the population came to appreciate that the likelihood of being detected was relatively remote.

One of the first actions of the Road Trauma Committee after its establishment was the appointment of a Working Party headed by Donald Beard, F.R.A.C.S., in South Australia, to undertake a study of the alcohol situation as it affects road accidents.

In September 1972, the second seminar on Road Trauma was conducted by the Royal Australasian College of Surgeons in Wellington, New Zealand. The Council of the College endorsed the seventh recommendation from that Seminar.

‘Recognising the prime importance of alcohol as a cause of road accidents, this Seminar reaffirms its concern and supports legislation which makes compulsory routine blood alcohol estimations on all road traffic casualties for clinical and research as well as legal reasons.’

Testing of all road accident victims was believed to have the following advantages:

1. The problem drinker would be identified, and treatment and rehabilitation could start earlier.
2. A review of data and collation with hospital records would define difficulties and errors in diagnosis and management of patients with a high blood alcohol level. Management would be improved.
3. Sociological data of elevated blood alcohol levels for all road users would be obtained, i.e. passengers, pedestrians, cyclists, as well as drivers.

4. The feedback of information to the community would aid in the re-education of the community concerning the dangers of raised blood alcohol levels in respect to road traffic accidents.

The Road Trauma Committee of the Royal Australasian College of Surgeons proceeded to present statistical and clinical evidence and intense lobbying resulted in support from the legal profession, the Australian Medical Association and the media. To their credit, the Victorian Council for Civil Liberties supported blood tests on drivers although some reservations were expressed as regards testing of passengers.

Some protests came from sections of the medical profession but much of this was from those unfamiliar with the Casualty Department scene and in isolated cases opposition was due to sheer bloody-mindedness.

MEDIA SUPPORT

The greatest support came from the mass media, particularly the Press. The media was largely responsible for the education of the community. It should be noted that as far back as 1959, the late Graham Perkin, who subsequently became Editor-in-Chief of the Age, was calling for compulsory blood testing in a series of articles headed ‘Blood on Bitumen’.

Strong editorials, graphic pictorial descriptions and special articles appeared regularly in all newspapers. Radio and television stations co-operated in a like fashion. Mention must be made of five articles published by the Age in 1972. These articles, under the heading of ‘Second-hand Alcohol’, were brilliantly compiled by Roger Aldridge and vividly portrayed the stark and tragic realities of road alcohol.

The media sought and obtained any clinical information the surgeons could provide. A public opinion poll published in the Herald early in 1973 showed that 71% of people involved were in favour of testing all road accident victims.

GOVERNMENT ACTION

The community had been informed and was aware and concerned. In this climate in March 1973, the Premier announced the Government’s intention to legislate to make blood alcohol tests compulsory on all road accident cases above 15 years who attended hospitals for treatment.

In April 1973 legislation was passed to this effect.

Because of the multifarious objectives of the legislation producing difficulties in drafting the law, interdepartmental wrangling, obstruction by some hospital authorities and cumbersome logistic arrangements, the law was not proclaimed until April 1974 and effective collection and analysis did not commence until October 1974.

Many of the problems have been solved or are in the process of being solved. But it has not been without continued vigilance by the Road Trauma Committee and the continued support of all sections of the media. The battle against the conspiracy of dedicated inertia was eventually won. Reports show that very few have refused blood tests and there is as yet no evidence that persons involved in road accidents avoid medical aid for fear of being found to have excessive blood alcohol levels.
RESULTS OF BLOOD ALCOHOL ANALYSIS

Some of the results of blood alcohol analysis are presented in the paper by Strang.\textsuperscript{b}

**The First 10 000**

Analysis of 10 896 samples taken in Victorian hospitals between 1 October 1974 and 6 June 1975 shows that:
- 70% of samples came from drivers and 30% from non-drivers.
- 58% of victims were male, 31% female and sex was not recorded in 10.7%.
- 73.5% of samples were from city hospitals and 26.5% from country hospitals.
- 24.6% of all samples had a positive blood alcohol content (BAC).
- 20.1% had a BAC in excess of 50 mgm% (legal limit in Victoria – 50 mgm%).
- 25.6% of all drivers had a positive BAC. Of those with a positive BAC, 39% were in excess of 150 mgm% and 10% in excess of 250 mgm%.
- 33% of males tested were positive as against 10% of females being positive.
- 53.2% of those admitted to city hospitals and 28.4% of those admitted to country hospitals had positive readings.

**Preston and Northcote Community Hospital Survey**

An analysis of 326 cases collected at this hospital in the three month period October—December 1974 showed that:
- 65% of positive samples were from patients under 35 years.
- 59% of patients with a positive BAC who required admission had a head injury as part of the injury pattern.

**Fatalities Survey**

An analysis of 232 autopsies on road accident victims undertaken at the Coroner’s Court Laboratory between January and July 1975 showed that:
- 36% of all drivers killed had Blood Alcohol levels greater than 50 mgm%.
- 20% of killed passengers and 25% of killed pedestrians over 15 years of age had blood alcohol levels above the legal limit.

These results in the first 12 months of testing were similar to those obtained in South Australia where similar legislation had been introduced in August 1973.

These results:
1. Confirmed the magnitude of the problem.
2. Produced the hard data needed to tackle the problem of excess use of alcohol by road users and provided material for further clinical and sociological research.
3. Identified the drunk driver – enabling action to be taken to extract him from the driving scene and direct him for treatment in a rehabilitation centre.
4. Provided information to continue the education of the community about alcohol.
5. Provided information for a Blood Alcohol Review Committee to maintain a surveillance on alcohol as a factor in road crashes and to advise the Government on the development of effective countermeasures.

Such a Committee would regularly review and collect information and following analysis present the statistical information to the media for distribution to the community. It is hoped that these data would help in developing a more responsible attitude to the use of alcohol.

\textsuperscript{b}See p.127
throughout all sections of the community. The community would be better prepared to accept the idea of early treatment and rehabilitation of drivers with serious drinking problems.

It is interesting to note that since the introduction of compulsory blood analysis there has been no reduction in the percentage of accident victims with positive alcohol. It could be argued that the legislation has not acted as a successful deterrent. This was never considered to be a main reason for the legislation.

It must be recognised that continued support and responsible reporting by the media has kept the public and community leaders informed. There has been a change in community attitude in Victoria. Discount beer sales by licensed grocers and supermarkets is given as the reason for reduced drinking in hotels and a fall in their sales of packaged beer. Perhaps the public has decided it is safer to drink at home. Certainly after-sport drinking is much less in many sporting clubs. The reduction in the Victorian toll is different from the rest of Australia. No doubt there are a number of reasons (high belt wearing, speed limit, blood alcohol legislation) but it could be that the community itself has responded — perhaps more so than its leaders. This attitude, and the continued information on alcohol, resulted in a ready acceptance of random tests which was promised by the Government in September 1975, but not introduced until a year later. Three out of four accepted the legislation, as shown by a public opinion poll.

Previous legislation on seat belt wearing had produced results and alcohol was now recognised as a major problem. The public respected the intention of the legislation — to deter the excessively drinking driver from entering his vehicle. First figures of random tests show that 3% of drivers tested were in excess of 0.05 mgm%. Evaluation of this law is at present continuing and the whole position will be reviewed by the Government this year, twelve months after its introduction.

CONCLUSION

This paper has discussed some aspects of the education of the Victorian community with regard to alcohol and road crashes and the need for legislation on blood alcohol analysis and random tests as effective countermeasures.

Such education of the community can be used to:
1. Prepare for further countermeasures by making the public aware and this is best done through the co-operation and interest of the media. Compulsory blood alcohol tests and random tests permit a careful analysis of the relationship of alcohol to the frequency of road accidents and the information should lead to better methods of education.
2. Develop comprehensive education programs along the Swedish lines commencing in primary school and continuing through school and, if applicable, national service. This must be extended to industry and sporting organisations.
3. Obtain acceptance that treatment and rehabilitation of identified drunk drivers are essential parts of the educational process.

Those who provide the financial support must recognise that an illness exists, and treatment and rehabilitation centres must be established. Such recognition will surely direct legislation to being therapeutic rather than punitive. The community may need to be educated to accept this approach.

The medical profession has the responsibility to see that doctors actively involved in the treatment of road accident victims should continue to make available to road safety authorities clinical material to which they alone have access.

Finally it would appear that the main problem is not educating the community but rather education of the community leaders themselves and those who manufacture and distribute alcohol (whether it be wine, beer, spirits, etc.).
Our leaders, from whichever field (and this includes those members of the medical profession who, whilst quite detached from the road trauma scene have the responsibility to teach medicine to undergraduates), are invited to come into the hospitals, spend some hours, better a day or even a week. See and feel and become aware at first hand. This is a dirty disease. Come and see the suffering, the disruption of the hospital scene, the involvement of people and facilities, the cost, the long term problems. Representatives of the media have come and seen and have a better perspective as a result.

Perhaps an invitation is too mild. A challenge is issued to all community leaders. The hospital doors are open any time.

REFERENCES