A MODEL FOR AN INNOVATIVE COMMUNITY BASED APPROACH TO DRINK DRIVING PREVENTION AND REHABILITATION.

Mary Sheehan, David Steadson, Jeremy Davey and Cynthia Schonfeld.

Dept of Social and Preventive Medicine, The Medical School, University of Queensland, Australia.

1. Background

In recent years there has been considerable growth in the development and testing of community based interventions to increase health related behaviours and to reduce health destructive ones. These programs have been promising both in terms of achieving change and in their high level of acceptability to the general public. Interestingly this approach remains a relatively unused strategy in the area of drink driving. In this case a distinction is being drawn between the selective use of particular preventive strategies such as advertising, or RBT, or drive-home buses and comprehensive programs which include a wide range of such strategies and target a defined community.

The fact that drink driving is tied to social and community mores has been long recognised but the comparatively slow introduction of integrated community programs may be due to the intersectoral nature of the problem. There is no particular public service or government department which effectively owns drink driving in the way for example health departments' 'own' coronary heart disease. Community intervention for this problem necessarily requires cooperation between different government and non-government groups.

One relatively recent community wide attempt to address the problem was the New Zealand Community Alcohol Action Program. This involved an intensive law enforcement program coordinated by Transport and Police Department personnel and interfaced with alcohol education components run by the local health board.

The contribution of the co-investigators L. Lumsden and A. Reynolds, Qld Dept of Health; D. Woodbury, Qld Transport; R. Bleakley, Qld Corrective Services; V. Siskind, Dept of Social and Preventive Medicine, University of Queensland is gratefully acknowledged.
and community action groups. This intervention was supported by the Alcoholic Liquor Advisory Council. Evaluations have been mixed but suggest that the intervention encountered organisational difficulties in establishing an effective coordination of the involved intersectoral agencies.

2. The framework for the model
The present paper describes the development of a model for a comprehensive community intervention to reduce drink driving in rural areas which attempts to address the intersectoral issue. The project is funded by the Australian Federal Office of Road Safety and involves senior staff from the state departments of Transport, Police, Health and Corrective Services. It is innovative in three ways. Firstly, it assumes that drink driving occurs within a particular social climate and is created, maintained and potentially can be reduced by variations in and manipulations of that context. Secondly, it uses an intersectoral framework for change which involves coordination and collaboration between all major agencies who play a role in the management of the issue. That is, it is assumed that the problem of drink driving is not solely a Police or Transport or Health or Education or Justice problem but extends beyond traditional departmental territorial boundaries and can only be contained or reduced by interdepartmental collaborative effort in liaison with community stakeholders. Thirdly, the model accepts that an effective drink driving prevention program needs to take into account the experiences and needs of the 'at risk' persons in the community, including those who have been convicted of drink driving offences.

The key issues here are (i) the need for intersectoral collaboration at both the head office and regional levels and (ii) the reciprocal relationship between community prevention, control and maintenance influences (represented by stakeholders) and the target or recipient 'at risk' groups. It is further proposed (iii) that this type of collaborative model has particular relevance to small rural communities with relatively closed networks.

The rural community selected to trial the intervention is in the central region of Queensland (See Figure 1). It has a population of approximately 281,783 (1991 census) and in 1988 approximately 1,040 drink driving offenders at >.15 were convicted. It is the Australian rural community in microcosm in that it includes both dry inland and coastal farming areas, a number of very large mines and a mining related industrial centre and port. It has regional offices for Police, Health,
Figure 1

THE INTERVENTION REGION

Population = 281,783 (1991)

Area = 190,500 km²

QUEENSLAND
Education and Corrective Services, has a University College and an established Technical and Further Education system. It has a relatively small and widely dispersed population, limited professional resources and comparatively high rates of motor vehicle accidents and drink driving convictions. The intervention focuses on the six provincial and small rural towns which have magistrates courts attached to them.

A rural region of this size provides an excellent base for the development and evaluation of community interventions of the type being proposed. It has a comparatively small population which can be geographically delineated and matched with either an existing rural community or a statistically constructed control group. Its size also means that it is easy to identify social influences and relevant community leaders and stakeholders and there is more likely to be frequent formal and informal contact between members of relevant government departments. A disadvantage of the small population size is that it can create a problem by restricting the statistical power to measure outcomes in the short term.

3. The Model
A model for the process of intervention in such a setting has been designed by drawing an Orlandi's model for community based organisation, recent work on the social controls of drink driving and further development of a model for intersectoral intervention used in the Safe Drinking Project. The model is presented in Figure 2.

At the first organisational level it is possible to identify the major agencies and personnel who have a stake in or responsibility for controlling and managing drink driving. The wide range of government or public service groups who are involved include staff from Health, Transport, Police, and Justice which includes Corrective Services, Prisons, Magistrates and private and state legal offices. Initial cooperation between these organisations at the head office level provides support for the associated relevant personnel at the regional level.

3.1 Identification of social influences.
An early objective for collaborative work in the development of a community intervention would be to identify the social influences upon drink driving within the targeted community so as to mobilise the relevant persons or institutions for change. In order to obtain a comprehensive perspective of such social influences they may be conceptualised as falling within a three dimensional framework in which influences
Figure 2
COLLABORATIVE MODEL

IDENTIFICATION OF KEY AGENCIES

KEY REGIONAL PERSONNEL

COLLABORATIVE WORK

KEY COMMUNITY STAKEHOLDERS

COMMUNITY TARGET GROUPS
and controls may be categorised as positive or negative, direct or indirect and formal or informal. Direct, formal controls which have a positive influence on the incidence of drink driving include, for example, highly visible and intensely enforced RBT and the lowering of legal BAC levels. Examples of more indirect, formal influences would be increased policing of liquor licensing laws and local "responsible drinking" campaigns. Indirect and informal positive influences might include police attitudes to enforcement, local taxi drivers attitudes towards working after midnight and the existence and activities of community pressure groups. The closing of a local movie house or the existence of a brewery which is a major local employer would be seen as informal, indirect and negative influences on drink driving.

Experience on a previous project which aimed to reduce drink driving associated with binge drinking at end of high school celebrations led to the identification of the following informal stakeholders who may have a positive or negative direct influence on drink driving in a rural community. Hoteliers, owners and licensees of alcohol sales outlets, liquor manufacturers and sports associations, service clubs, restaurants, discotheques and taxi drivers all influence the environment in which drink driving occurs. Informally and indirectly the media and relevant community action groups such as PADD, MADD, teetotaller action groups and Church groups are all potentially influential stakeholders who can be mobilised in a community setting. Other agents of change who may be under-utilised are members of local councils and local politicians. In a rural community employers, personnel officers, work safety committees and unions can also be mobilised for change. This is particularly the case in areas such as mining towns in which drink driving may have significant economic consequences. An important objective of the intervention is to reorient these and other stakeholders towards becoming a positive influence and functioning as controlling contingencies within the community. A potential benefit of this approach in a rural community is that stakeholder changes take place within a relatively closed network of interpersonal relationships, friendships and acquaintances.

It is proposed that the process by which stakeholders can be encouraged to exert a positive influence and to participate in developing strategies for change and control is through a collaborative and dynamic model for change. In the Safe Drinking and Wanganui Projects an intersectoral model was used in which each key agency worked independently to develop change strategies and to cooperate independently with aligned services and stakeholders. In the model being developed here this process is modified towards collaboration between key agents at all stages in the
development of an integrated program. Agents of change and relevant stakeholders develop combined rather than additive initiatives.

3.2 Targets for change.
The third stage of the intervention requires determining potential targets. The obvious recipient is the general community and the goal is to change the incidence of drink driving behaviour by modifying the contextual contingencies which encourage and/or reduce it. An essential underlying objective however relates to modifying the behaviour of the 'high risk' drink driving sub-groups. Two readily identified high risk groups are males in the age range 19-35; and those persons within the community who are convicted drink drivers. Research indicates that the latter group are not "every man" and "every woman" but people who may have multiple social disadvantages and problems which not infrequently include alcohol dependency. It is for this latter group that there is a need to develop a rehabilitation initiative which can be integrated and coordinated with the prevention program.

The settings in which focussed prevention interventions can target the broader group of young adult males can be readily identified. They include high schools, technical and further education colleges and the workplace. In Queensland there are two systematic prevention programs already available which can be modified for use in these situations. These are the P.A.S.S. drink driving prevention program for junior high school students and the "Thrills Without Spills" binge drinking prevention program for senior high school and TAFE students. Both programs have been evaluated and found to be effective with their target groups. There are no workplace and occupational health strategies presently available and these need to be developed.

4. Drink driving rehabilitation in a community context
Identifying the needs of the drink driving offenders and meeting these within a community intervention is a challenging task. An encyclopaedic range of drink driving management and rehabilitation programs for offenders have been trialled over the years, both in Australia and internationally. A degree of consensus has emerged that licence disqualification represents the most effective first step management strategy. Specific educational and rehabilitation programs have had mixed outcomes. The systematic program being currently undertaken in Germany is the model which is able to show the most sustained rate of remission over and above that related to loss of licence. In the present case however, given the limited resources
available in rural areas it would be difficult, if not impossible, to conduct it in the target rural community.

Another relevant issue is that most educational and/or therapeutic approaches to rehabilitation are not conceptually compatible with a community context model. These programs are based on an "individual deficiency" paradigm that holds that it is a particular individual's weakness that leads to drink driving and it is the drink driver who needs changing or strengthening to fit more readily into the community. The present model assumes that it may well be the community that needs modification to provide contingencies and resources which will control the problem. The rehabilitation program being designed for the rural drink driving intervention attempts to resolve this dilemma. (See Figure 3)

The program is designed for three levels of offender. These include first offenders with a BAC < .15; first offenders BAC £ .15 and second and multiple offenders. All offenders presently receive mandatory fines and licence disqualifications which vary depending on BAC. First offenders < .15 are ticketed by police at the time of offence and have the option to pay their fine by mail. The intervention proposed for this group is a drink driving information leaflet which suggests alternatives to drink driving and is posted to the offender with the receipt for the fine. A test on the information is included and this must be completed and presented to the local Transport Department staff before relicensing.

First offenders £ .15 will be taught a twelve session skills based course which focuses on drinking and drink driving. It will include at least one correspondence lesson based on a take-home video. The alcohol intervention component is based on the WHO multi-centre brief intervention for controlled drinking. In its original form this is a self help module and for the rehabilitation program it is adapted to be used in group sessions. This original program evaluated well in the community setting. It has been modified in the present case to include local community educators, support persons and stakeholders. The drink driving component of the program is also skills based and is directed towards increasing the likelihood that the recipient will use the alternatives which are being developed as part of the community prevention intervention.

The second component of the program involves two, one and half hour driving skills sessions. These sessions will involve contributions from local private driving
Figure 3
Drink Driving Course

Alcohol / Drink Driving Program
(10 sessions + 1 take home)

Take Home Lesson

Personal Development Program* (? Sessions)

Driver Education Program
(2 Sessions)

* Appropriate electives as defined by CSO's assessment of client needs
instructors under supervision from Transport Department staff. The key issue addressed in these sessions is the practical need for sound judgement, alertness and unimpaired reaction time for safe driving in local rural driving conditions which may include obstacles such as smoke, fog, kangaroos or road trains as well as the more usual hazards of pedestrians, other vehicles and difficult cornering situations.

Multiple offenders will be required to attend both basic components and an additional set of community based skills training electives which will be selected in consultation with their probation officer. The aims of this additional elective are to improve self-esteem and to involve community members in the program. Examples of possible electives would be attending a basic literacy course or completing a first aid certificate program.

All participants will be tested on the contents of the full program at the time of relicensing.

5. Evaluation
The model program will be implemented over the next two and half years and traffic events in the region will be monitored for evaluation over a period of three years. Baseline Transport Department data for the region and the State has been collected annually since 1988 and will be used to examine changes in drink driving offence rates.

Overall, the model represents an attempt to operationalise an intervention directed towards changing the social context of drink driving. It is also an attempt to address the fact that motor vehicle accidents and drink driving offence rates are highest in rural areas. Most intervention models, rehabilitation programs or for that matter alcohol dependency programs are dependent on resources and personnel which are virtually non-existent outside large population centres. Given the present global economic climate this is unlikely to change in the foreseeable future. The proposed approach may not answer the problem but it should open up research and development on this issue which could lead to more effective programs for rural communities in the future.
REFERENCES


14. Ibid.

15. Ibid.