

# ***One for the Road*- Group Programme for Repeat Drink Drivers**

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## **Abstract**

Alcohol-related crash deaths and injuries remain an important public health issue, accounting for 31% of fatal road crashes in New Zealand, with 72% of the alcohol-related crashes caused by repeat drink drivers or those more than 50% the legal limit for driving (Ministry of Transport, 2009, 2010). It is now generally acknowledged that preventing recidivists from re-offending is likely to have the greatest impact on alcohol-related crashes (Campbell, 2000; Joyce, 2000; Roadsafes Auckland, 2001).

*One for the Road* is an innovative, intensive, brief group therapy programme targeting repeat drink drivers in NZ. The programme which has been run over the last 4 years with over 500 drink drivers 'graduating', is based on best-practice research, adapted and re-fined into a unique structure and process for the New Zealand context. The group therapy process is the key, and this enables a focus on deeper issues in working towards change in thinking and behaviour, while the programme features specific methods designed to engage with Maori and Pacific Islander participants.

The outcomes have been encouraging, with qualitative measures indicating increased *Readiness to Change* and decreased *Risk of Drink Driving* in the future, and 97% claiming they would keep to a zero blood alcohol concentration when driving in future. Quantitative data from NZTA records show only a 4.6% *re-conviction* rate (1 in 21 people) over a period of 6 to 30 months following group completion (3.3% people reconvicted within 6 months, and a further 1.3% in the next 6-12 months).

This re-conviction rate is comparable with overseas evaluations of effective programmes and is more impressive given the profile of the *One for the Road* programme participants to date (i.e. relatively high previous drink-drive convictions compared to overseas programmes, and the high proportion of Maori and Pacific Islander participants). Furthermore, the relatively inexpensive cost of the programme indicates that it is likely to be highly cost-effective.

**Key words:** safe users, innovation, high risk drivers, crash prevention, relevance to Pacific Islanders, cost effectiveness

## **1. Introduction**

### **1.1 Background to drink driving in NZ**

Drinking and driving is a topical issue in NZ with increasing numbers of people being prosecuted. The Ministry of Transport reported 34,272 prosecutions for drink-driving in 2008 up from 29,052 in 2005 (New Zealand Herald, 2009), and reports consistently show around 30% of road deaths as being alcohol-related (Ministry of Transport, 2009). Media reports highlight the apparent callousness and lack of concern for others shown by drink-drivers,

along with the sad plight of the victims and their families (e.g. New Zealand Herald, 2009). There is also a concern about the high number of people receiving a custodial sentence for traffic and vehicle related offences (including drinking and driving) being 11,851 in 2009, making up 19% of the total number of custodial sentences (including home detention) passed (Statistics New Zealand, 2010).

Methods of social change have been attempted to improve the situation such as increased police presence and breath testing, tougher sentencing, media shock tactics, and lowering the drink-driving limit is again on the political agenda. Yet there remain persistent drink-drivers who appear immune to these interventions and who appear to feel their behaviour is justified as 'thousands do it'. To tackle alcohol-related road crashes we need to tackle societal attitudes towards both the use of alcohol (i.e. normalised binge drinking) and towards drinking and driving, which, based on our experiences in working with repeat drink drivers, is clearly still regarded as 'normal' and 'routine' by some people. Societal attitudes are based on smaller groups and family systems, and on this basis the most effective way to bring about change in behaviour is to target the individual and their peer group. The *One for the Road* programme is based on group work with repeat offenders, by using engagement, empathy, challenging world views, and eliciting commitment to change, within a peer group promoting a zero blood alcohol limit when driving. Drink drivers are likely to come from all walks of life and all parts of New Zealand, and a therapeutic group model can be utilised in any location across the country so long as an informed and effective approach is utilised.

International research suggests that a small group of repeat drink-drivers account for only 1% of all drivers on the road at night and weekends, but may be responsible for nearly half the fatal crashes at that time (National Highway Traffic Safety Administration, 1998). In New Zealand, studies and police data indicate that at least 30% of drink drive offences in the Auckland region are committed by recidivists, and it is now generally acknowledged that preventing recidivists from re-offending is likely to have the greatest impact on alcohol-related crashes (Campbell, 2000; Joyce, 2000; Roadsaf Auckland, 2001).

## **2. Drink Driver Specific Programmes**

### **2.1. Why focus on repeat drink driving?**

Levels of repeat drink-driving in New Zealand and other countries are generally poorly documented, but international studies generally report a range from 9% to over 30% depending on the follow-up period (Trimboli & Smith, 2009). Data from New South Wales indicated that overall 15.5% of drink-drivers return to court for a subsequent drink-driving offence within 5 years (Trimboli & Smith, 2009).

In New Zealand, the Ministry of Transport (2010) reports that 27% of first time drink-drivers go on to re-offend despite the current regime of fines and licence disqualification. However, data<sup>1</sup> cited in the Law Commission (2009) *Alcohol in our lives – issues report* showed that 29,739 drivers had received one or more convictions for drink-driving in 2008 with 18,924 (64%) having only one drink driving conviction in 2008 and in the 10 years prior, while a further 6,973 drivers (23%) had one conviction in 2008 and one other prior drink-driving conviction either in 2008 or the 10 years prior, and finally another 2,594 drivers (9%) had three drink-driving convictions. These data imply that there is an overall re-conviction rate of 36% over the 10 year period 1999 to 2008 in New Zealand, which appears to be high compared to overseas examples.

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<sup>1</sup> New Zealand Police National Alcohol Assessment (Wellington, April 2009) (available at <http://www.police.govt.nz>).

## **2.2. The lack of available drink driver programmes**

However many people with multiple Excess Breath Alcohol (EBA) convictions have never been referred to a 'drink-drive' intervention programme let alone an alcohol or drug service. This 'failure' by the system to effectively address individuals' alcohol issues is highlighted by Ministry of Justice figures from 2006 which indicate only 5% of those with EBA convictions were ordered by the court to attend an alcohol and drug assessment as part of sentencing (Brooking, 2007 citing unpublished figures from the Ministry of Justice). In the authors experience with *One for the Road* attendees with up to 9 convictions for EBA had identified no prior alcohol and other drug assessment of any kind. One of the reasons for this low referral rate to programmes is that very few exist across New Zealand, particularly those that can demonstrate a reduction in re-offending. These programmes typically offer group education. Based on a meta-analysis by Wells-Parker et al (1995) treatment and rehabilitation with drink-drivers had on average a small but positive influence (7-9% reduction) on the incidence of recidivism and crashes, when compared with standard punitive sanctions without treatment.

## **3. One for the Road**

The *One for the Road* programme was first implemented by Harmony Trust in 2008 as an experiment to see if a 'brief intervention' model would have any effectiveness with this population. Since then some 64 groups have been completed across the Auckland region. Referrals generally come from lawyers, probation officers, the court through 'special condition to attend', and Alcohol and Drug Services. The group is focused on engaging with 'hard to engage' clients. The group is based on both best-practice research, and utilizes some innovative ideas and strategies applied to the New Zealand context.

### **3.1. The Typical Group Member**

The following points are based on both demographic data obtained in the pre-group interview, and through the author and other colleagues observations and impressions gained in both the interview and group sessions.

#### **3.1.1. Typical Drink Driver Profile**

The typical One for the Road group member tends to be:

- Male (90%)
- Aged approximately 37years (range 16 to 72)
- Has around 4 'excess breath alcohol' (drink driving) convictions (range 2 to 22)
- Is more likely to be diagnosed with alcohol 'abuse' rather than dependency (59% scored 1-10 – i.e. low to moderate alcohol dependency, while only 11% scored over 11 on the Leeds Dependency Questionnaire –LDQ - that is a binge drinker rather than an alcoholic).
- Is defensive and has stored anger- feeling hardly done by
- Blames others – the police, partner, justice system, the government...
- Is 'pre-contemplative'- does not think they have a problem, has strong justifications for their behaviour - feels normal and certainly not a criminal
- Ethnicity- 35% Maori, 23% Pacific Islander?, 35% Pakeha, 7% Asian

#### **3.1.2. The mindset of the drink driver**

From the authors' observations drink drivers have developed very strong and compelling reasons for justifying, rationalising, and continuing with their behaviour. These justifications assist the drink driver to 'cope' with feelings of guilt, shame, hurt, victimisation, alienation, and anger. One group member described having a 'book' of justifications he could draw

upon at any point in order to 'feel' better about his behaviour. These are often statements beliefs like:

- "I only had a few"
- "I drive better when I'm drunk"
- "I'm the least drunk so I'll have to drive"
- "It's only around the corner"
- "There's thousands out there that drink and drive"
- "Where's the victim, I haven't hurt anybody"
- "I don't have a drinking problem, I just have a driving problem"
- "It's not that bad yet, if I ever killed anyone on the road I would give up for sure"

## **3.2. Key Features of the Group**

### **3.2.1. Brief Intervention**

The group is a run in an intensive style over 3 sessions-

- An interview for initial engagement, warm up, and assessments
- Group session 1: 6 hours- to develop empathy, discrepancy/ and roll with resistance
- Group session 2: 4 hours to support self efficacy- promote 'change talk and commitment language'

This suits the needs of people with impending court cases for drink driving, but also those who would not be likely to maintain engagement over a longer period. We have also found the brief intensive model assists with client retention in group, with the completion rate for *One for the Road* being approximately 80% of those commencing the group.

Alcohol and other drug intervention studies support the effectiveness of a brief intervention model in motivating a client towards behaviour change (Bill Miller, 1996; Harris and Miller, 1990; Miller and Taylor, 1980). While the majority of group participants attend because they feel they have no choice, that is they have been told to attend by their lawyer, probation officer, Judge, counsellor with the threat of great legal sanctions or longer loss of licence, the group itself represents a window of opportunity in the process of change. *One for the Road* is focused primarily on participants firstly gaining self awareness around their use of alcohol, secondly being 'brought to' reflect on and question their attitudes towards drinking, drug use, and driving, and thirdly in gaining motivation towards behaviour change. This process involves focusing on the personality traits, attitudes, and core needs, and drives that underpin their offending behaviour.

### **3.2.2. Motivational Interviewing**

The basic process followed in group parallels the work of Miller (2002) with the 'motivational interviewing process of working towards change:

- a) Expressing Empathy
- b) Rolling with Resistance
- c) Developing Discrepancy
- d) Supporting Self Efficacy

There are also studies providing support to the efficacy of brief intervention with Bill Miller concluding there is much that can be done in even a single session to initiate change in alcohol use (Miller and Rollnick, 2002). In each group the facilitators look for 'change talk' and commitment language' as indicators of motivation to change.

The idea is to take the 'window of opportunity' to walk people through the stages of change towards ongoing action by assisting them to publicly challenge and reassess their own

beliefs. The key questions posed in group are- "Do I need to change my drinking behaviour?", and "Do I need to change my drink driving behaviour?", and the programme features practical steps on how to do this. The expected outcome is that the process of change is initiated for participants, and that they leave the group in a stage of commitment and 'action' towards avoiding drinking and driving along with the tools to carry this out.

### **3.2.3. Timing and Homework**

The group is intentionally run on a Friday- during the day (Day 1) and Sunday- during the evening (Day 2). This is situated 'around' the time (Friday and Saturday night) when, in the authors experience and based on presentations and assessments at One for the Road, many of the participants are likely to go out and to drink alcohol. This brings some realism into the group and a chance to test out 'learning' and homework in a practical sense ie around drinking environments and in facing real; challenges.

### **3.2.4. Therapy Group**

*One for the Road* is a true therapy group which can be described as **experiential** (action, emotion, and activity based) rather than educational. This is more about 'being in' a situation than talking about a situation. There is a group resource booklet given to clients, and DVD's are shown but these are secondary to group process.

The therapy utilised is eclectic and features motivational interviewing, Gestalt therapy, CBT, group process, transactional analysis, role play, and relapse prevention. These are all used with the goal of developing self-awareness and challenging attitudes, belief systems, and behaviour around both drink and driving choices, and around drinking. In order to do this the group is number is kept to approximately 10 people to enhance intimacy and the capacity for depth in the therapy process.

### **3.2.5. Thinking problem vs Drinking problem**

The pre group screening tools utilized (AUDIT – Alcohol Use Disorders Identification Tool, and LDQ- Leeds Dependency Questionnaire) indicate that only few (11%) of our group members are dependent on alcohol. This means that the majority have what is termed 'alcohol abuse'. This means that they are not physically addicted to alcohol and have more of a sense of choice and potential for control around their use. They more fit the profile of 'binge drinker', which often results in poor decision making. However the other part of the equation lies in the belief systems and attitude- to the law, to risk taking, responsibility, planning, around safety and setting boundaries, and in this reflects in their resultant behaviour. The therapy process in group looks to challenge these beliefs. We do not necessarily advocate abstinence for all group members, but we do for some. For the others we would promote harm minimisation. However one of the strong themes of the group is a 'zero blood alcohol limit when driving'.

### **3.2.6. Anti-Drink Driving Peer Group**

Human beings have a strong drive for affiliation. As social animals people tend to live in groups, work in groups, and tend to drink in groups (ie 'social drinkers'). People tend choose groups within which they feel normal and which serve to normalise their behaviour. Drink Drivers who don't believe they have an 'alcohol' problem, are more likely to attend a group for 'drink drivers' than one for 'alcoholics'. There is sense of acceptance and belonging in associating with a groups, but also in distancing oneself from another group (Allport, 1954). One of the most important objectives of One for the Road is then to establish an 'anti drink driving' peer group amongst the group members, where the person who remains 'pro' drink driving and begins to feel 'abnormal'. This process will involve shame and cognitive dissonance, and is in sharp contrast to the potential 'pro' binge drinking and drink driving groups they may belong to in the community. These groups may be found within 'friends', drinking mates, work mates or family. In One for the Road we attempt to provide situations

where group members can socialize, engage, and relate in an alcohol free environment. They are offered soft drinks and food to support and model this process.

### **3.2.7. Taha Maori and Connecting with Pacific Island People**

The group is designed to cater for **Pacific Islander and Maori people**, who have made up some 50% of those in attendance. A feature of this is the focus on hospitality- a cooked kai is provided to participants, use of karaka, observance of tikanga. Both Maori and Pacific cultures are represented in group facilitators and leaders. The attendance of 'drink-driver crash survivor', Tamati Paul, Ngati Porou, who was hit head on by a drink driver when out for a drive with his family. From being a champion sportsman, Tamati has been through a process of rehabilitation and recovery, and in group provides an important catalyst for change. This session is noted to parallel elements of the powhiri (greeting) process with te wero (challenge), whaikorero (speaking), whakautu (reply), and whakawhanungatanga (connecting). Participants have noted feeling shame, whakama, then a sense of aroha and forgiveness.

### **3.2.8. Support People**

Attendance by **support people/whanau** is encouraged, however in a group of twelve there tends to be no more than 1 or 2 who bring support people. However even this small number adds significantly to group in terms of both supporting and challenging group members, as the support people come to represent support people in general, and are utilized in the therapy process.

### **3.2.9. Self Efficacy**

While the One for the Road group is a typically challenging and uncomfortable process for the drink drivers in attendance, the facilitators strive to develop a positive, strength based process in group and end on a positive note. Graduates are awarded certificates and their virtues (ie honesty, courage, compassion) are highlighted during this process. This is important as it is an opportunity for affirmation and to promote self-efficacy, and if the group member begins to feel he/she has some self-worth and self-esteem this is conducive towards self-belief and change (Yalom, 1995)

## **4. Evaluating the Group**

Aside from the challenge of working to change behaviours in repeat drink drivers is the challenge of measuring and assessing effectiveness. The difficulty here is that we are dealing with changes in attitudes and behaviour. Outcomes could be measured in terms of abstinence, harm minimisation, quality of life. Another variable is the time period without drinking and driving - 3months, 6 months, 3 years?

One for the Road is subject to both qualitative evaluations pre and post group, and quantitative in terms of re-conviction rates for graduates. Over the first 30 groups run (300 people) end of group screens indicated that 80% of graduates were more 'ready to change' (RTC- Readiness to Change) and had a lower 'Risk of Drink Driving' for the future (RODD Scale- a 12 question self report likert scale questionnaire developed by the Authors to assess attitude change within the group).

Anonymous Client Group Evaluations at end of group indicated 97% of clients agreed they would keep a zero blood alcohol limit when driving in future

Data obtained from the New Zealand Transport Agency indicated that the re-conviction rates for drink driving in the first 300 graduates from the group was 4.6% (or 1 in 21) over a period of 6 to 30 months post completion. As the group is continuously running the real time lapsed following the end of group will vary for each group. Across all groups in the first 6 months following group completion 3.3% had been re-convicted for drink driving, and in the subsequent 6-12 months a further 1.3%.

The feedback from One for the Road participants also provides some evidence as to the effectiveness of the group:

- “I felt safe to be honest”
- “I think the course was a real eye opener. I enjoyed the talking and communicating with people in the same or similar situations to myself”
- “Tamati was the initial kick start for change, then acknowledging the problem, asking the hard questions, confronting the problem, and making a plan to avoid drinking and driving”
- “I felt this course has helped me and I would recommend it to others “

#### **4.1. Limitations**

The authors are encouraged by the results, given that group is a brief intervention, and may for some be a stand-alone intervention. Other programmes these results compare favourably with may be longer term, more costly or more closely linked to probation monitoring and incentives to attend.

As with any evaluation there are a number of limitations. A key limitation is that the follow-up period for the programme is a maximum of 2.5 years. Further follow-up for all groups over a minimum of 2 years would be valid given that the intervention is intended to create sustainable changes to behaviour.

The most commonly used outcome measure in published repeat drink-driver evaluations is a subsequent drink-driving conviction as it has the advantage of being objective, however there will be those who are subsequently drink driving but ‘not yet caught’, and it may be a poor indication of actual drink-driving as the risk of being detected is relatively small (Health Canada, 2004).

The results of these evaluations have not been compared to a comparison group or other control group and therefore limit any conclusions regarding the effectiveness of this intervention in relation to people who have had no intervention.

Furthermore, no cost-effectiveness analysis has been carried out, but it is likely that given the results thus far and the relative low cost of the programme (currently funded by the New Zealand Transport Agency and The Department of Correction) that the programme is cost-effective.

### **5. Conclusions, findings and /or recommendations**

Initial results for One for the Road are promising in terms of reconviction rates of approximately 4.6% 6 to 30 months post completion of the programme. While the time elapsed to date is short, with some overseas evaluations providing results over up to 5 years (Nickel,1990; Tornos,1994), and reconviction data reported in New Zealand over a 10 year period, the reconviction rate is comparable with overseas evaluations of effective programmes. One of the most impressive of these being the New South Wales Sober Driver Program (Byrant et al, 2007) with a 5% re-conviction rate after 2 years (although it is important to note that this programme forms part of a systemic inter-sectorial approach to reducing drink-driving offending with coordinated sentencing and mandatory supervision programmes for participants). The result is substantially lower than the expected reconviction rate reported in New Zealand (i.e. 36% over 10 years).

The low reconviction rate is more impressive given the profile of the *One for the Road* programme participants (i.e. relatively high previous drink-drive convictions compared to overseas programmes, and the high proportion of Maori and Pacific participants). Further,

the relatively inexpensive cost of the programme indicates that the programme is likely to be cost-effective.

Other indicators of effectiveness include improvements in scores on the Readiness to Change (RTC) and Risk of Drink Driving (RODD) scores between pre and post programme. Scores on both these scales showed improvement between pre and post programme. Feedback from group participants is also highly positive, suggesting some success in the process of engaging and connecting with this at times 'hard to engage' population.

In conclusion, the *One for the Road* programme shows promise in an area that has been inadequately addressed in New Zealand to date. The programme shows a distinctive NZ flavour and a true therapeutic focus. It appears effective in working with 'hard to engage' and complex offenders, who without intervention are highly likely to reoffend causing harm to themselves or others.

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