Charles Darwin University

Drink and drug driving education in the Northern Territory

A qualitative study illustrating issues of access and inequity

Wright, Cassandra J.C.; Miller, Mia; Wallace, Tessa; Clifford, Sarah; Black, Oliver; Tari-Keresztes, Noemi; Smith, James

Published in:
Australian and New Zealand Journal of Public Health

DOI:
10.1111/1753-6405.13240

Published: 01/08/2022

Document Version
E-pub ahead of print

Link to publication

Citation for published version (APA):
Wright, C. J. C., Miller, M., Wallace, T., Clifford, S., Black, O., Tari-Keresztes, N., & Smith, J. (2022). Drink and drug driving education in the Northern Territory: A qualitative study illustrating issues of access and inequity. *Australian and New Zealand Journal of Public Health*, *46*(4), 450-454. https://doi.org/10.1111/1753-6405.13240

General rights
Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

- Users may download and print one copy of any publication from the public portal for the purpose of private study or research.
- You may not further distribute the material or use it for any profit-making activity or commercial gain
- You may freely distribute the URL identifying the publication in the public portal

Take down policy
If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.

Download date: 09. Dec. 2022

Drink and drug driving education in the Northern Territory: a qualitative study illustrating issues of access and inequity

Cassandra J.C. Wright,[1-3] Mia Miller,[1,4] Tessa Wallace,[1] Sarah Clifford,[1] Oliver Black,[1,5] Noemi Tari-Keresztes,[1] James Smith[1]

Abstract

Objective: In the Northern Territory, people who commit drink driving offences are required to undertake an approved course or treatment to be eligible for a driver's licence, however, course uptake is low. We investigated barriers to program uptake.

Methods: We conducted semi-structured interviews with 24 program attendees, course providers and government stakeholders. We used a framework analysis.

Results: Program coverage in remote areas was limited, leading to inequitable access. The course cost affected uptake and exacerbated existing financial hardship. There were mixed views among government stakeholders on the program. While some held a view that offenders should 'pay the price', some also saw the user-pays model and high program cost as a clear barrier to accessibility.

Conclusions: The data from this study demonstrate how the current delivery model for drink and drug driving education increases inequities for those in regional and remote areas, and Aboriginal and Torres Strait Islander people.

Implications for public health: Moving away from the current user-pays model to a subsidised or free model may facilitate greater access. Online delivery may increase accessibility; however, consultation is required to ensure the program is delivered equitably with consideration of language, literacy, cultural factors and access to technology.

Key words: drink driving, rural health, alcohol consumption, health promotion, equity

Driving while intoxicated is a major contributing factor to road trauma. The Northern Territory (NT) has the highest road fatality rate in the country, representing significant human, social and financial costs. In 2018, Smith et al. estimated that alcohol-related road accidents cost the Northern Territory $58 million annually, including through permanent disability, workforce disruption, property damage, insurance and legal costs and lost quality of life;[1] this excludes the cost of premature mortality and hospital separations. There are also significantly higher rates of alcohol use, alcohol-related hospitalisations and alcohol-related mortality in the Northern Territory compared to the rest of Australia.[1-4]

Injury incidence and mortality increase with level of remoteness,[5] related to poor road quality and lower investment in transport infrastructure, greater diversity of vehicles on the road, higher speeds and isolation from medical care centres.[6] There is a significant population spread across the Northern Territory, with 20% of residents living in remote areas and a further 21% living in very remote areas[7] creating challenges for policy, infrastructure and service delivery. Drink and drug driving prevention must also consider the needs of Aboriginal and Torres Strait Islander people.[8] Rates of injury and mortality from alcohol-related road incidents are significantly higher among Aboriginal and Torres Strait Islander people[9] and the Northern Territory has the highest proportion of Aboriginal and Torres Strait Islander people in Australia (26% compared to 3%).[7]

There are differences in the response to drink and drug driving offences across jurisdictions in Australia.[10] In addition to fines, licence demerit points and in some cases, imprisonment, most states and territories also have some form of drink and drug driver education and/or therapeutic program for offenders. These vary in length, delivery model and content but usually involve group sessions.[11]

People in the Northern Territory who commit a medium or high BAC range drink driving offence, or repeated drink driving offences, are legally required to undertake an approved course or treatment to be eligible to re-apply for their driver's licence.[12] The only approved course is the Back on Track (BoT) program. The program was redesigned

1. Menzies School of Health Research, Charles Darwin University, Northern Territory
2. Centre for Alcohol Policy Research, La Trobe University, Victoria
3. Burnet Institute, Victoria
4. The George Institute for Global Health, New South Wales
5. Deakin University, Victoria
Correspondence to: Cassandra Wright, Menzies School of Health Research, John Mathews Building, 58 Rocklands Drive, Tiwi NT 0810;
e-mail: cassandra.wright@menzies.edu.au
Submitted: September 2021; Revision requested: February 2022; Accepted: February 2022
The authors have stated they have no conflicts of interest.
This is an open access article under the terms of the Creative Commons Attribution-NonCommercial-NoDerivs License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.
Aust NZ J Public Health. 2022; Online; doi: 10.1111/1753-6405.13240

© 2022 The Authors

in 2015 by a private consultant and broadly covers education about the effects of alcohol on the body, laws and penalties for drink driving, information about consequences of drink driving, discussions of fault and responsibility, goal setting and planning to avoid drink driving. People convicted of a medium-range BAC drink driving offence must complete one unit, while people with higher BAC offences, drug driving offences or repeat offences must complete two units.[13] The program is owned by the Northern Territory Government and private third-party providers can apply to the government to become course providers. Attendees pay a fee directly to the provider, with no government subsidisation, and approved providers can charge consumers any fee they choose. At present, the Northern Territory Government does not charge providers for the licence for the course, nor do they receive any portion of the fee charged to consumers. During the research period, private providers were charging fees of approximately $300–$500 for Unit 1 and $500–600 for Units 1 and 2. Course providers often charged a higher fee to people in remote areas due to the higher costs associated with travel and delivery to those locations.

There has been no evaluation of the program since 1998. Analysis of BoT program completions and sentencing occasion data show that only 38% of those who are required to complete the program to re-apply for the licences actually do so.[11] This study was part of an evaluation funded by the Northern Territory Government Department of Infrastructure, Planning and Logistics, which aimed to identify opportunities for improvements to the course and explore alternative pathways, modes of delivery, affordability and other opportunities to increase accessibility to the program. This paper aims to describe key barriers to program completion, with a view to inform improved program design and continuous quality improvement associated with implementation. As a secondary aim, it explores participant perspectives on the suitability of an online course to improve accessibility, which was of particular interest to the funder.

Methods

Study design

We conducted a qualitative study including individual interviews with course providers, program participants and government stakeholders. We received ethics approval from the Human Research Ethics Committee of the Northern Territory Department of Health and Menzies School of Health Research (2020-3787).

Participants and recruitment

There are currently nine listed BoT course providers in the Northern Territory. A contact in the Northern Territory Government sent information about the study to providers, and the research team then followed up with each provider. Three course providers agreed to be interviewed.

Program attendees were eligible to participate if they had previously attended the BoT course. To recruit BoT program participants, course providers sent requests to attendees requesting they contact the research team if interested. Due to limited responses, we supplemented this with convenience sampling using posts on social media. Snowball sampling was subsequently adopted where BoT program participants could refer others. We recruited included nine (n=9) participants, with five identifying as Aboriginal and/or Torres Strait Islander people and four as non-Indigenous. The project funding did not include a budget for any remote travel, meaning that interviews with program participants occurred face-to-face in Darwin or via telephone.

We compiled a list of key government stakeholders in consultation with a Northern Territory Government contact person and sent an email invitation. This was supplemented by snowball sampling. A total of n=12 government stakeholders participated.

Data collection

Three interview schedules were co-developed through consultation with key government staff. Interviews focused on experiences of participating in/delivering the program, barriers to participation, strengths and weaknesses of the program, recommendations to improve the program and views on alternative formats for delivery including online modes. Each interview lasted between 30 and 60 minutes. All interviews were recorded, except for that with one stakeholder who did not consent to the recording. Recordings were transcribed verbatim via a professional transcription service.

Data analysis

We used a framework analysis approach[14] to analyse the qualitative data. Framework analysis includes five key stages: familiarisation, identification of emergent themes and issues, charting data in relation to headings and sub-headings, mapping and interpretation. We used NVivo12 to organise and store the data. The data from each group of stakeholders were analysed separately before the findings were integrated in the mapping process.

Results

Two main barriers to course uptake were identified throughout the study: accessing the course and prohibitive costs associated with undertaking the course. We also report on participant perspectives on whether online solutions could play a role in addressing accessibility challenges.

Accessing the course

Course location and availability were discussed as barriers to access for participants living in both urban and rural settings in the Northern Territory. Despite the urban area of Darwin being relatively small, participants in urban settings reported difficulties in travelling to the course as their licences were revoked as a condition of their sentence. They described that public transport options were limited, especially on weekends, leaving few options for those with lower social support. The challenge of accessing the course in urban areas was not only discussed as a deterrent to program uptake but also as harmful, as some participants felt that their only option was to drive illegally:

> *Like, unless you have like a parent or like a partner or someone to pick you up, it's hard to do, like go and do… I actually drove there, and I had no licence. Do you know what I mean? Like, otherwise I had no way to get there.* (Non-Indigenous program participant)

Accessibility for remote communities was a major issue for the BoT program reported by both government stakeholders and course providers. All three course providers who were interviewed conducted courses in remote communities; however, for some this was usually in specific communities with some regions not currently covered by any providers. Course providers noted that they frequently received requests to deliver the course in remote areas but were challenged

© 2022 The Authors

by poor financial viability. Government stakeholders recognised that it was difficult to get course providers to increase their coverage due to the high cost of travel and often unpredictable attendance at courses. Where there were gaps in delivery in remote areas, people had little other option than to travel to urban areas to complete the course. Multiple government stakeholders and one course provider noted the significant associated costs of doing so, including travel costs, accommodation and the fee to undertake the course:

> *So, it costs them around $2500 to go in and do the workshop so they could get their licence back … I used to have to try and get them to go to Darwin to do it. And the cost was prohibitive.* (Course provider, remote)

Prohibitive cost

All participants raised the cost of undertaking the course as a key concern affecting uptake and noted that it often came in the context of existing financial hardship. For some participants, losing their licence caused them to lose their job, and so the cost of the course further exacerbated the disadvantage they faced. Others described losing shifts to attend the course. This resulted in a triple financial burden – first, paying a fine; second, the course fee; and third, lost income:

> *Especially the roll-on effect from not having a licence and losing your job, then you don't have any money, so it's a continuous [cycle].* (Māori program participant)

One participant described negative impacts specific to people living in remote Aboriginal communities. They noted that for some individuals, losing and then struggling to re-obtain their licence could have significant consequences if it prevents the fulfilment of responsibilities expected of them within their community. In addition, the location of these communities often makes driving a necessity to access certain goods and services. A high proportion of people without a licence in a community can negatively impact the overall wellbeing of the community, by restricting people's mobility and access to services. In this way, the inadequate accessibility of the course was seen to have a ripple effect on other social determinants of health.

Several government stakeholders explained their views that participants should have to pay for the course as a punitive measure, and that course costs should not be borne by the taxpayer. This ideological stance was stronger in government stakeholders with no background or role in health. Another government stakeholder explained that there were misconceptions that the course fee was 'punishment' for those who had committed an offence which had been "a significant obstacle to attracting funding to subsidise training so it can be more accessible for remote area people". They noted that although legislation required that people who committed drink and drug driving offences complete a course or treatment program, the model of payment or cost of doing the course was not determined in legislation, is not gazetted, and is not set by the Northern Territory Government. Some government stakeholders appeared conflicted: while they held a view that someone who has committed an offence should 'pay the price', they saw the user-pays model and high program cost as a clear barrier to improving accessibility to people experiencing financial hardship, particularly people in remote areas.

Addressing accessibility challenges – on online solution?

Program participants were prompted to consider the potential benefits and limitations of a drink and drug driving course being delivered in an online format. Three program participants proposed that having an online option could circumvent the aforementioned challenges of physical accessibility of attending the course:

> *I guess the more ways they have of delivering it, the better, maybe for remote communities and stuff like that then do some type of online course, I guess.* (Aboriginal program participant)

Almost all government stakeholders agreed with this potential benefit. One program participant described that a self-paced online resource would enable them to complete the course at times convenient to them and at a pace that they could manage:

> *Then they can do it at their own pace as well … So, you've got plenty of time to do it. You don't have to just cram it all into one weekend.* (Māori program participant)

However, program participants also discussed that an online resource would remove many of the current perceived benefits of the course including that it is centred around learning from others. All three course providers shared concerns about an online resource compromising the effectiveness of the program by losing the ability to interact with participants, which they saw as the active ingredient of the program. One course provider noted that the face-to-face group delivery was an important mechanism to deliver the course in a culturally responsive way, as it enabled flexibility to vary their approach for specific local contexts: "I don't always deliver the same way all the time because I'm always being adaptable to meet the needs of my group". Course providers also discussed that in a face-to-face format, their ability to tailor activities to meet the literacy and language needs of individuals was crucial to engagement, especially in remote community contexts.

> *They're on their land. They're confident. They're not intimidated. If they go to Darwin, they're shy, 'cause their language, English, isn't that good. They're shy because they can't necessarily read that.* (Course provider, remote).

Course providers and some government stakeholders were both sceptical that an online resource could fulfil the needs of people with low literacy and who primarily spoke languages other than English, especially considering the diverse needs of communities across the Northern Territory.

> *That's why we do a lot of narrative stuff, because it's not fair to make people feel like shit because they can't read.* (Course provider, remote)

Government stakeholders appeared conflicted about whether an online model should be implemented or how it would work, given the potential benefits of improved access weighed against concerns about digital literacy and the quality and effectiveness of online resources.

Discussion

Significant issues around access to the BoT drink and drug driving course were identified in this study, stemming from the course cost and difficulties that participants face regarding geographical access. Given that course participation is legally required for eligibility for a driver's licence, this is problematic. Ensuring that there are sufficient opportunities for people living in remote and very remote areas to access the BoT program is integral in order to improve health, behavioural and licensing outcomes. This requires improvements to the program coverage and frequency of delivery.

The privatised, user-pays model is a key challenge in expanding the program's reach and frequency in remote and very remote

© 2022 The Authors

areas. The cost of delivering the program in remote areas is high, and from course providers' perspectives, must be recouped to sustain profitability. People in remote areas and who are financially disadvantaged therefore face greater barriers in obtaining their licence due to the high and inconsistent cost of the course, which compounds existing disadvantage as individuals without a driver's licence have reduced access to education, employment and healthcare.[15] It has been shown that when services are left to be delivered in a free market, those who already experience difficulties are those most severely impacted, leading to inequities and a widening of existing socioeconomic disadvantage.[16,17] A move away from the user-pays model, to one whereby the Northern Territory government is responsible for the funding and provision of drink and drug driving education services, may assist in overcoming disadvantages resulting from the current system. This would allow the government to ensure that programs are provided across the Northern Territory based on need rather than profitability. There are also opportunities for this delivery to be linked to the delivery of other programs and services being delivered in remote areas to consolidate costs and improve sustainability. There is an extensive body of research that demonstrates that prevention results in return on investment.[18] This may assist the Northern Territory Government to substantially reduce the $58 million per year currently spent on alcohol-related road accidents in the Northern Territory. Effective and equitably delivered drink driving programs have been found to reduce recidivism by half in other parts of Australia.[19]

There are several other models of course delivery in operation in other jurisdictions. In New South Wales, the drink and drug driving courses are delivered at no cost to the attendee in a joint partnership between Corrective Services NSW and Road and Maritime Services. The Australian Capital Territory operates a user-pays model for their course, but the government has installed a cap on fees that can be charged (however, we note that incomes in the ACT are substantially higher, inequities are lower, and licensing compliance is higher; which is part of why this system works).

One possible method to fund the drink and drug driver program in the Northern Territory could be through justice reinvestment, whereby fines that individuals are mandated to pay as a result of a drink or drug driving conviction/s could become the source of funding for the BoT program through a reallocation of funds to the health and social services sector from corrections.[20] Justice reinvestment serves both economic efficiency goals and social justice goals.[21] Previous work in regional Northern Territory has demonstrated a strong appetite for justice reinvestment from local services and Aboriginal communities.[22]

Online technology is often assumed to reduce accessibility issues caused by geographical isolation; however, it is important to consider that it can create other issues of inaccessibility and inequity, especially where there is unequal access to technology and lower digital literacy. Some participants also shared concerns that an online format would remove many of the current benefits of the group program and that an online course may not meet language and literacy needs.

Greater consultation with Aboriginal and Torres Strait Islander people, inclusive of those living in remote areas is important to ensure that program delivery is optimised. With this in mind, we recommend the Northern Territory government engage in consultations with Aboriginal and Torres Strait Islander leaders and communities across the Northern Territory to inform appropriate strategies for improving program coverage, but also to improve prevention of drink and drug driving.

This study has several limitations. While we were able to contact course providers working in remote areas via telephone, we did not recruit program participants living in remote communities, meaning that their views are not directly represented. We also did not interview people who were required to complete the course but did not attend. The barriers to attendance for these people may be different to those represented in the study.

Conclusion

This study highlights the challenges of delivering services and programs in the Northern Territory due to the sparse population, large geographical areas and poor infrastructure. The data from this study demonstrate how the current delivery model for drink and drug driving education increases inequities for those in regional and remote areas, and Aboriginal and Torres Strait Islander people. The inaccessibility of the program is particularly problematic; although it is not mandatory, offenders are required to complete the program to be eligible to re-apply for their driver's licence. An individual's inability to obtain a licence has broader personal, social, family, community and legal implications. It is therefore imperative that measures are taken to reduce these inequities.

Implications for public health

Moving away from the current user-pays model to a system where the course fee is subsidised through justice reinvestment or by the Northern Territory Government may facilitate greater access. An online program option may improve access for some, however, sufficient planning and consultation would be required to ensure the program is delivered equitably with consideration of language, literacy and cultural factors, as well as access to technology. Community consultation with Aboriginal and Torres Strait Islander people will be integral to improving prevention and response efforts.

Acknowledgements

This study was funded by the Northern Territory Government Department of Infrastructure, Planning and Logistics. CW is supported by an NHMRC Early Career Fellowship. SC is supported by an Australian Government Research Training Program Postgraduate Scholarship. We would like to acknowledge Anthony Merlino for his assistance in the fieldwork.

References

1. Smith J, Whetton S, d'Abbs P. *The Social and Economic Costs and Harms of Alcohol Consumption in the NT*. Darwin (AUST): Royal Darwin Hospital Menzies School of Health Research; 2019.
2. Riley T, et al. *Alcohol Policies and Legislation Review: Final Report*. Darwin (AUST): Government of the Northern Territory; 2017.
3. Symons M, Gray D, Chikritzhs T, Skov S, Saggers S, Boffa J, et al. *A Longitudinal Study of Influences on Alcohol Consumption and Related Harm in Central Australia: With a Particular Emphasis on the Role of Price*. Perth (AUST): Curtin University National Drug Research Institute; 2012.
4. Whetton S, et al. *Harms from and Costs of Alcohol in the Northern Territory*. Adelaide (AUST): University of Adelaide; 2009.
5. McDermott KM, Brearley MB, Hudson SM, Ward L, Read DJ. Characteristics of trauma mortality in the Northern Territory, Australia. *Inj Epidemiol*. 2017;4(1):1–10.
6. Peden AE, Franklin RC. Exploring the impact of remoteness and socio-economic status on child and adolescent injury-related mortality in Australia. *Children (Basel)*. 2021;8(1):5.

© 2022 The Authors

7. Australian Bureau of Statistics. *2016 Census QuickStats: Northern Territory* [Internet]. Canberra (AUST): ABS; 2017 [cited 2021 Jan 5]. Available from: https://quickstats.censusdata.abs.gov.au/census_services/getproduct/census/2016/quickstat/7?opendocument
8. Fitts MS, Clough AR. A different approach to Indigenous drink driving is needed to incorporate cultural factors in outer regional and remote Australia. *Aust N Z J Public Health*. 2014;38(6):592–3.
9. Henley G, Harrison JE. *Injury of Aboriginal and Torres Strait Islander People Due to Transport: 2005-06 to 2009-10*. Canberra (AUST): Australian Institute of Health and Welfare; 2013.
10. Fitts MS, Burchill R, Wilson S, Palk GR, Clough AR, Conigrave KM, et al. Drink driving among Aboriginal and Torres Strait Islander Australians: What has been done and where to next? *Drug Alcohol Rev*. 2021. doi: 10.1111/dar.13418.
11. Wright CJC, Wallace T, Smith JA, Clifford S, Tari-Keresztes N, Merlino A, et al. *Review of Drink and Drug Driver Education in the Northern Territory*. Darwin (AUST): Royal Darwin Hospital Menzies School of Health Research; 2021.
12. *Motor Vehicles Act 1949* (NT) As in force at 1 July 2021.
13. Northern Territory Government Department of Infrastructure, Planning and Logistics. *Back on Track Drink Drug Driver Program: Program Manual*. Darwin (AUST): Government of the Northern Territory; 2019.
14. Srivastava A, Thomson SB. Framework analysis: A qualitative methodology for applied policy research. *JOAAG*. 2009;4(2):72-9.
15. Cullen P, Clapham K, Hunter K, Porykali B, Ivers R. Driver licensing and health: A social ecological exploration of the impact of licence participation in Australian aboriginal communities. *J Transp Health*. 2017;6:228–36.
16. Labonté R, Stuckler D. The rise of neoliberalism: How bad economics imperils health and what to do about it. *J Epidemiol Community Health*. 2016;70(3):312–8.
17. Smith JA, Jancey J, Binns C. System reform in the human services: What role can health promotion play? *Health Promot J Austr*. 2017;28(1):1–4.
18. Masters R, Anwar E, Collins B, Cookson R, Capewell S. Return on investment of public health interventions: A systematic review. *J Epidemiol Community Health*. 2017;71(8):827–34.
19. Mills KL, Hodge W, Johansson K, Conigrave KM. An outcome evaluation of the New South Wales Sober Driver Programme: A remedial programme for recidivist drink drivers. *Drug Alcohol Rev*. 2008;27(1):65–74.
20. Brown D, Schwartz M, Boseley L. The promise of justice reinvestment. *Altern Law J*. 2012;37(2):96–102.
21. Australian Government Australian Law Reform Commission. *Pathways to Justice–Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples (ALRC Report 133)*. Canberra (AUST): Government of Australia; 2017.
22. Smith J, Allison F, Christie B, Clifford S, Robertson K, Ireland S, et al. *Katherine Youth Justice Reinvestment: Final Report*. Darwin (AUST): Royal Darwin Hospital Menzies School of Health Research; 2019.

© 2022 The Authors