

STANDARD DRINK EDUCATION PROGRAM

FINAL REPORT



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ABSTRACT

The Standard Drink Education Program (SDEP) is a project funded by the Alcohol Education & Rehabilitation Fund (AER) and implemented by Central Bayside Community Health Services (CBCHS). The local government areas (LGAs) of this program are the Cities of Bayside, Kingston and Glen Eira.

The project began in February 2005 for a period of one year with the aim to raise alcohol & standard drink awareness within large organisations and businesses in the LGAs. The method used to increase the awareness of employees was a series of seminars, delivered in workplaces, of which the evaluation results are tabled within this report.

Data was collected from over 300 employees who participated in the program and filled in the evaluation questionnaires before and after the presentation. The results obtained provide a valuable insight into existing knowledge of employees, particularly “blue collar” workers on alcohol and standard drinks. Furthermore, these results showed that the overwhelming majority of participants found the program to be a worthwhile educational experience. The average improvement in knowledge across the entire sample population was found to be 32.3%. Such a significant improvement in knowledge acquired by participants was supported by positive comments made by participants on attitude and life style changes with respect to alcohol.

This program has proved to be a great educational opportunity for workers in this region. The improvement indicated by the results is concomitant with other allied educational efforts such as the Victorian Driver Education Program founded in 1989. The findings of which indicate that brief intervention strategies can have a significant impact on an individual bringing about health awareness with harm prevention and/or minimisation benefits (Victorian Drink Drive Program 1984, 1992).

The Victorian Driver Education Program is associated with positive changes in participants’ beliefs and attitudes towards alcohol and drink driving. The spirit and philosophy of such programs is in accordance with the SDEP. As education can provide long term sustainable changes in attitude, the consequential benefits tend to both outweigh and outlast the short-term effects of media campaigns.

It is anticipated that future efforts will continue to be focussed on similar educational projects. This organisation will continue to direct its attention towards ongoing educational campaigns aimed at various social groups within the catchment area of the CBCHS. Support from funding bodies such as AER is greatly appreciated and becomes integral to the success of such worthwhile and valuable educational projects.

INTRODUCTION

Central Bayside Community Health Services (CBCHS) was funded by the Alcohol Education & Rehabilitation Foundation to conduct the Standard Drink Education Program (SDEP) in the Cities of Kingston, Glen Eira and Bayside. Provision of information regarding standard drinks and alcohol use was the focus for this Program. Using a relatively brief intervention strategy, the SDEP gave participants the opportunity to learn how to manage their behaviour in relation to consuming alcohol. By addressing social, environmental and biological factors, the program aimed to improve awareness of high-risk behaviours such as drink driving and other health related issues.

The SDEP delivered a series of targeted workshops to the workforce on site. Large manufacturing organisations such as automotive, metal fabrication and plastics were the focus as they are large employers within the Southern region. The messages presented complimented the publications of the National Alcohol Guidelines. Show bags containing National Alcohol Guidelines and allied information were given to all participants of this program.

The provision of health information, education, and skill development to employees assists with organisational development in areas such as policies and procedures, in particular alcohol and drug workplace policies. The SDEP was promoted to the employer on the basis of both short and long-term economic benefits. Advantages for the employer included improving health awareness and morale in the workplace. As it is evident that a healthy employee is a more productive and efficient worker, additional benefits may indirectly flow from the SDEP: these include factors such as reducing absenteeism, minimising alcohol-related accidents (be they on site or driving to work in the morning with residual alcohol in the blood from the previous night), reducing work cover accidents and insurance claims.

The advantages of the SDEP become self-evident from an employer's perspective, particularly the range of economic benefits. Employers were presented with the SDEP as a valuable opportunity and a worthwhile and funded educational initiative in Industry within the southern region.

MATERIALS & METHODS

1. PROJECT STAFF

The project worker employed as 0.6 EFT over 1 year is Robert Kaldawi.

Robert has significant experience and is proficient with:

- National Standard Drink guidelines
- Effects of Alcohol.
- Adult Learning principles
- Group Work
- Materials and Resources
- Program design and development
- Corporate health training
- Community development

Robert is an accredited clinical and educational provider by the VADEP (Victorian Accredited Driver Education Program, Department of Human Services, 92/003). Robert joined CBCHS in February 2005 and was assigned the task to design and deliver the SDEP as well as all related project activities such as contacting employers, identifying and obtaining resources and general marketing of the program. Robert also designed the evaluation method and administered the questionnaires to participants before and after completion of a program session.

2. DESIGN OF SDEP PRESENTATION

Whilst the content of educational sessions focused on standard drinks and their relevance to drink-driving, the general effects of alcohol, drunkenness and Blood Alcohol Concentration (BAC) were also covered.

As a base, the Australian Alcohol Guidelines provided information on topics such as what is a standard drink, how to estimate standard drinks and BAC, confusion between BAC and drunkenness, alcohol-related health risks and gender issues. Other issues included the effect of other drugs on driving particularly with the recent onset of drug detection technology on drivers in Victoria.

Educational Content of these sessions included the following topics:

- Standard Drinks
- Effects of Alcohol and relevance of BAC.
- Physical / Psychological harm
- Drug Education
- Penalties for drink driving.
- Problem solving
- Alternative skills development
- Goal setting and responsible behaviour

The program proposed to increase people's practical knowledge and awareness of what is a standard drink and the relationship between that and,

- Drinking and driving
- The health implications of alcohol consumption
- Current legislation and penalties within the state of Victoria for drink driving
- Safe work practices
- Strategies to manage drinking in a responsible manner

The SDEP was delivered in an adult learning environment and was sensitive to cultural and other learning differences. It was presented in a non-judgemental manner using harm minimisation as an approach and health intervention as a strategy.

Program numbers and style of presentation were tailored to meet the needs, infrastructure, shift work and availability of the employer. The aim was to incorporate the SDEP within the needs of the employer creating a supportive environment designed to enhance existing resources.

A series of slides were developed and the nature and content of these slides are described as follows.

A. What is a standard drink? 10 grams of pure alcohol per serve

There is a lot of confusion amongst alcohol consumers about what is a Standard Drink and how that reflects on their Blood Alcohol Concentration. Furthermore, many people often feel 'fine' after consuming alcoholic beverages and claim to be 'shocked' by the Breathalyser reading.

In this regard, the following factors contribute to such confusion and lack of understanding of the issues:

- a. Alcohol consumers often confuse 'the way they feel' (drunkenness) with BAC; Thus, people fall in the trap of assuming that these two issues are one of the same; if one feels 'fine', one makes the mistake of assuming that they must be under 0.05. In fact, this assumption is incorrect and is extremely dangerous as it often leads to making the wrong decision about driving. Significantly, drunkenness or the way one 'feels' after consuming alcohol is determined by factors other than those used to assess one's BAC. Accordingly, a person can feel 'fine' even if they are above 0.05 and by the same analysis, a person may feel quite intoxicated even when they are under 0.05.

Significantly, drunkenness is determined by the following factors:

- Tolerance
 - Mood
 - Situation
 - Personality and
 - Other Drugs consumed.
- b. Alcohol consumers often underestimate their own BAC after a given amount of alcohol consumption. Essentially, understanding one's own limit equates to understanding the factors which affect BAC.

The factors affecting BAC are:

- Fat / Muscle ratio
- Size
- Gender and
- General Health Condition (Liver / Metabolism / Age etc...)

B. Examples of Standard Drinks

Listed below are examples of standard drink sizes. This information explains standard drinks both with respect to individual serve and in terms of bottles of alcoholic beverages.

- Spirit = 30 ml (nip)
- Bottle of Spirits (700 ml) = 22 SD
- Heavy Beer = 285 ml (pot)
- Bottle of Heavy Beer (750 ml) = 3 SD
- Light Beer = 375 ml (can)
- Bottle of Light Beer (750 ml) = 2 SD
- Wine = 100 ml (small glass)
- Bottle of Wine (750 ml) = 7 SD
- Champagne = 100 ml
- Bottle of Champagne (750 ml) = 7 SD
- Port = 60 ml
- Bottle of Port = (750 ml) 12 SD
- Sherry = 60 ml
- Bottle of Sherry = (750 ml) = 12 SD

All the above beverages contain the same active ingredient, the drug Ethyl Alcohol (C₂H₅OH), which affects mood and causes intoxication.

Despite the fact that the above beverages look and taste different, they actually contain the same chemical (in different concentrations). In its natural and pure form, alcohol is a transparent colourless liquid.

C. Why is it a Standard Drink?

- **International language for Alcohol**

As alcoholic beverages are presented in different styles and concentrations, there is a standard adopted against which an individual can assess their alcohol consumption.

10 grams of alcohol per serve is the amount of pure alcohol in a defined Standard Drink. Difficulties arise when people top up their glass, loose count or even are unaware of the concentration of the alcohol in the beverage they are consuming, particularly if the beverage is 'home made'. As a result individuals would be in no position to begin to assess their own intake of alcohol or their BAC.

The adoption of a Standard Drink as a measure, enables individuals and professionals to evaluate BAC. It is understood for example that the liver requires about one hour to metabolise the alcohol contained in one standard drink; the liver cannot work any faster no matter what attempts or efforts are made by the consumer. The SDEP's aims were to highlight the false myths which exist in the community regarding metabolism of alcohol (e.g. coffee, exercise, vomiting, cold showers are all myths and have no effect on BAC).

- **Measure metabolism of alcohol - Gender, Size, Fat/ Muscle Ratio**

As mentioned previously, the use of Standard Drink measures is used to explain the different BAC readings that are shown by different individuals despite the fact that these individuals are made to consume the same amount of alcohol in the same amount of time. This highlights the effect of gender, Fat/Muscle ratio and other factors on the determination of BAC.

Research has also shown that women process alcohol differently compared to men due to their liver and enzymatic differences. Women are also generally smaller in size and have a higher fat to muscle ratio naturally. The SDEP focuses on the specific impact alcohol has on women.

- **Drinking and Driving: a limit for all**

The ability to measure individual BAC renders detecting alcohol in the system of drivers a possible outcome upon which drink drive laws are based. Similarly, it becomes possible to research and evaluate a dose/effect ratio linking given BAC values to a corresponding increase in the risk of crashing.

For example, it has been demonstrated that drivers with a BAC of 0.05 were twice as likely to be involved in an accident whilst at 0.08, drivers were four times more likely to crash. Significantly, drivers with a BAC reading of 0.15 were 25 times more likely to be involved in a motor vehicle accident. The SDEP presented these factual findings to participants.

A similar concept has been in the making regarding Drug-Driving Laws. This has only recently been rendered possible with the introduction of technology allowing the accurate detection of a variety of drugs in the system of drivers.

- **BAC as Distinct from measure for Drunkenness**

'Drunkenness' is a difficult concept to define as it represents different things to different people. Through the SDEP the presenter listed the different parameters which helped determine 'drunkenness' as opposed to BAC. Factors such as Tolerance, Personality, Mood, Environment and other Drugs are different than those used to assess BAC.

A person who is tolerant to alcohol can have a high BAC reading but feel 'ok' to drive. Another example, the same person can consume the same amount of alcohol on two different occasions and feel differently each time. Even an individual's personality can play a role; for example, a generally aggressive person, usually ends up as an 'aggressive drunk'. Similarly, a 'happy' person, usually ends up as a 'very happy' drunk. It is important to remember that personality, mood, situation, tolerance or other drugs do not affect BAC even if they increase synergistically or heighten the effect of alcohol.

Hence, the drink driving laws have a distinct section dealing with offenders Driving under the Influence of intoxicating liquor or drug.

Such issues formed an integral part of the presentation of the SDEP.

D. Where are Standard Drinks?

It is now a legal requirement to identify the equivalent Standard Drink on all alcoholic products. The attention of participants in the SDEP was drawn to this fact thereby raising awareness of the number of Standard Drinks contained in any commercially available alcoholic beverage simply by reading the label on the packaging of the product.

E. National Health & Medical Research Council Guidelines (1-12)

The National Health Guidelines, in line with the World Health Organisation define safe, moderate and low risk alcohol consumption.

The SDEP focused on these highlighting the fact that the guidelines for women are different than those for men. Further, the SDEP referred to the fact that there is a guideline for moderate alcohol consumption for every person in our society depending on their personal characteristics such as age, gender and even mental health issues.

F. Laws and Penalties

The SDEP also presented legal guidelines regarding penalties and drink drive laws.

It was deemed that participants of the SDEP would find such information both worthwhile and practical in their day- to -day living. This information included issues such as:

- 0.05 or 00 Limit for drivers
- Driving Under the Influence or DUI
- Driving whilst in charge
- Definition of a Vehicle
- Laws as they apply on private versus public roads and Penalties.

E. Further Information, Referrals, Individual Advice/Information

Participants of the SDEP had an opportunity both to learn from accurate and up-to-date resources and / or were referred whenever applicable to further help and treatment. This was conducted through CBCHS services such as the Alcohol and Drug or Counselling Programs.

Direct Line's number was also publicised as a 24 hour, seven days a week, support & confidential telephone counselling service.

Additionally, a short period of time was made available at each workshop for open or private discussion with the presenter in regards to any issues of concern. Thus, participants had an opportunity to act promptly and receive concomitant timely advice.

3. SDEP RESOURCES.

Educational and health information formed part of a significant package of information presented in a show bag and provided to each participant of these workshops.

The information in each package is described as follows:

- The *Australian Alcohol Guidelines Booklet* published by the NHMRC and the Australian Government, Commonwealth Department of Health and Ageing,
- Posters on Standard drinks (includes number of Standard Drinks on some alcohol packaging) published by the NHMRC and the Australian Government, Commonwealth Department of Health and Ageing,
- Brochure entitled *Alcohol and Your Health* published by the NHMRC and the Australian Government, Commonwealth Department of Health and Ageing,
- Coasters including Standard Drink Educational messages published by the NHMRC and the Australian Government, Commonwealth Department of Health and Ageing,
- Brochure on *Alcohol and Driving* published by Vicroads
- Brochure on *Drugs & Driving* published by Victorian Government,
- Booklet entitled *A Driver's Guide to Staying Under 0.05 BAC*, published by Australian Transport Safety Bureau.

4. PRE & POST EVALUATION METHODS

When designing the evaluation methods for the SDEP, it became apparent that there was a need to evaluate the knowledge of participants before undergoing the educational session to enable comparison and measurement of the educational potential of the sessions.

Pre and post - evaluation questionnaires were designed to assess and determine changes in knowledge. Each participant was asked first to complete a questionnaire before the presentation, and then requested to answer the same questions at the end of the presentation. The data was both specific to the topics being evaluated and the individuals themselves.

The questionnaire also contained questions relating to demographics of participants allowing the collection of valuable data regarding the educational & cultural background as well as age group of participants.

(Refer to Appendix 1 for copies of the Pre and Post evaluation Questionnaire)

5. DATA BASE

An Access database was developed to collate, analyse, interpret and present data from the project. At the end of each presentation, each questionnaire relating to results before and after the SDEP presentation was entered into the database (see Results section).

6. MARKETING

A. Launch of the SDEP.

The SDEP was launched on the 13th of May 2005 at CBCHS. Representatives from relevant stakeholders including local Councils, Project Partners, Employer Representatives and the Community were invited.

The launch attracted positive attention and could itself be deemed an intervention strategy by highlighting the Standard Drink as a relevant topic in alcohol education. The funding body AER was recognised throughout the launch.

Furthermore, the launch also attracted local media interest as an article was published in the Local 'Leader Newspapers' in the relevant regions of this project. This enhanced and promoted the SDEP and focused attention on its aims and objectives.

(Refer to copy of the Invitation to the launch in Appendix 2).

B. Media

- **Local Leader News Article**

Due to the success of the launch the Leader (Local Newspapers) publicised the launch and other details concerning the nature and characteristics of the SDEP in many relevant local papers in the southern region.

(Refer to copy of the Editorial in Appendix 3).

- **Advertising**

Various initiatives were also adopted as follows to ensure additional publicity and exposure of the SDEP:

- The project was advertised in the relevant local newspaper. (Refer to copy of the advertisement in Appendix 4).
- Local councils were engaged to help promote the project through their communication networks.
- The local Road Safety Committee supported by Vicroads and local Police took a significant interest in this Project. Consequently, Robert Kaldawi gave a number of presentations and represented CBCHS at Road Safe Committees and its individual and organisational members.
- The project was mentioned in a number of newsletters around the region, including Council and CBCHS own inaugural newsletter.

(Refer to Appendix 5 for a copy of this newsletter).

7. EMPLOYER ORGANISATIONS

The specific needs of targeted organisations were assessed and evaluated with respect to number of employees, nature of industry, availability of time and facilities provided. Subsequently, managers, human resource and OHS representatives of employer groups were approached with the proposal of running the SDEP with the focus directed at the employers themselves.

In order to maximise efficiency and utilise existing resources, Departments such as Industry Development and Health and Social Planning from Kingston, Bayside and Glen Eira Councils were used to build links with organisations and obtain valid business directory lists. This approach was particularly helpful as it allowed a relatively easier entry into a given workplace.

The task of generating leads was a colossal task in itself. Unfortunately, time and resources restricted the project from maximising the recruitment potential of employer groups.

Significantly, every effort was made to accommodate as many participants per employer organisation. Some organisations were delivered more than one presentation to account for numbers and incorporate shift workers. Employees working afternoon and night shifts were accommodated by running sessions at 6.30 am and 11pm at night.

It is worth noting that upon acceptance, each employer was asked to sign an invitation form in which details regarding the numbers of participants/sessions, address of location and the nature of equipment available. This enabled an organised and professional approach in the delivery of the project.

(Refer to Appendices 9 & 10 for the Employer Questionnaire and the information provided to employers on the aims and objectives of the SDEP).

A. Promotion

Following recruitment of major businesses and using local council business directory, it was possible to make contact with such organisations. Consequently, interest and promotion of the program was carried out by phone.

It can be argued that the initiation of such a contact, together with the mail out of information (includes show bag and project information/outline) similar to the launch of the project, was itself a health intervention approach. Even a brief intervention can result in long term benefits by introducing changes in attitudes.

B. Sample Employers and Organisations

Listed below are the organisations contacted for this project.

1. John Grundy, HR, Metaltec Precision International, Cheltenham.
2. Marty Phillips, HR, Laminex Group. Cheltenham.
3. David Bignoux, HR, ACI, Moorabbin
4. Paul Datt, Operations Manager, CocaCola, Mentone\
5. Carla Cameron, HR, Mono-Pumps, Mordialloc
6. Con Glibatsas, HR, RONSTAN, Sandringham
7. Greg Brown, HR, Australian Pacific Paper Products, Dingley
8. Kellie Barton-White, HR, Brivis, Braeside
9. Brian Harrison, HR, Phillip Morris, Moorabbin
10. Judy Newman, HR, Sara Lee, Clayton
11. Colleen Gilmour, HR, Leigh Mardon, Highett
12. Nolla Scott, HR, Linfox, Clayton
13. Anthony Kerr, OHS, Fasco Australia, Braeside
14. Peter Vardy, Operations Manager, Flavour makers, Braeside

15. Steve Liteley, HR, Forbes Fashions, Dingley
16. Gary Wright, Incolink, Building Industry Group
17. Peter Thomas, HR, Sigma Pharmaceuticals, Clayton
18. Chris Cotterill, HR, Hella Australia, Mentone
19. Julie Hayman, HR, Gale pacific, Braeside
20. Dale Lee, HR, McCormick Foods, Clayton
21. Deborah Cook, HR, Melwire, Clayton
22. Michelle Godber, OHS, National Foods Milk, Chelsea Hts.
23. Michelle Dooley, HR, Nylex, Mentone
24. Lina Dezilva, HR, Rinnai Australia, Braeside
25. Linda Tilley, Viscount Plastics, Braeside
26. Gordon Rhodes, Visypak Beverage, Clayton
27. Belinda Fraser, Leader Newspapers, Cheltenham
28. Jennifer Scott, Toyota, Brighton
29. Kevin Condon, Jefferson Ford, Mentone
30. Maria Klioumis, Summit Holden & Southern Mitsubishi, Moorabbin
31. Steve Wallwork, Gregorys Transport, Cheltenham

8. STEERING COMMITTEE

A Steering Committee was formed from relevant stakeholders including AOD services, local Councils, Police and Vicroads.

The aim of the SDEP Steering Committee was to provide an opportunity for agencies to meet and provide direction, support and exposure to the Standard Drinks Project. The objectives were as follows:

- Provide a forum for invited agencies to discuss the progress of the project and provide input for future actions.
- Network and liaise with agencies that share a common interest in this project and avoid duplication of effort.
- Develop ideas to secure resources for future projects related to this issue.

The Steering Committee consisted of representatives from Central Bayside Community Health Services, Vic Roads, Taskforce, Kingston City Council, Glen Eira City Council, Bayside City Council, Moorabbin Police and Australian Drug Foundation.

The above committee met quarterly and was comprised of the following personnel:

- Mr. Rod Glenn-Smith (Good Sports program, ADF)
- Ms Michelle Chiller (Kingston City Council)
- Ms Allison Ridge (Bayside City Council)
- Ms Marion Pennicuik (VicRoads)
- Mr. Pierre Castelino (VicRoads)
- Mr. Denis Carroll (TaskForce)
- Ms Catherine Donoghue (Glen Eira City Council)
- Senior Sergeant Hans Harm (Victoria Police, Kingston TMU)
- Mr. Shane Quinn, (Service Delivery Manager, CBCHS)
- Dr. Robert Kaldawi, (Project Officer SDEP, CBCHS).

(Refer to Appendices 6, 7 & 8 for a list of the members of the steering committee, a copy of the 'Thank You' letter issued to each member and the Committee's Terms of Reference).

RESULTS

1. DEMOGRAPHICS

A. Sample Size

The data collected throughout the SDEP corresponds to 332 participants. However, this does not reflect the actual number or attendees.

There were a significant number of individuals who attended, but did not attempt the evaluation questionnaire. Another group of attendees did not fill in the questionnaire satisfactorily, namely by completing both sections of the forms prior to and at the end of the presentation. Thus, it was not possible to obtain valid data from the entire population sample of participants.

This program manager has accounted for the above discrepancy by monitoring the number of show bags or handouts given out at the end of the presentation.

Thus, it is estimated that whilst the data corresponds to 332 participants, the actual total number of individuals that took part in the SDEP was over 500 individuals. Furthermore, whilst 332 questionnaires were actually received and accounted for, some data or questions within these were not completed. Accordingly, some sections of the results below may not totally add up to 332 participants but rather, the number of those participants that responded or entered a corresponding answer.

B. Participating Employers

A total of nine (9) organisations took part in the SDEP. This is displayed in Figure 1 depicting the extent of employees participating from each respective organisation. These organisations were: Bayside Council, Central Bayside Community Health Services, Coca Cola Amatil, Delphi Automotive Systems Australia, Leigh Mardon, Inner South Road Safe Group, Sara Lee, Hella and Stonnington City Council.

In this regard, it is shown that Delphi Automotive Systems Australia contributed towards the largest sample size of over 120 employees. Leigh Mardon is the second major contributor of sample size with almost 90 individuals participating in the program.

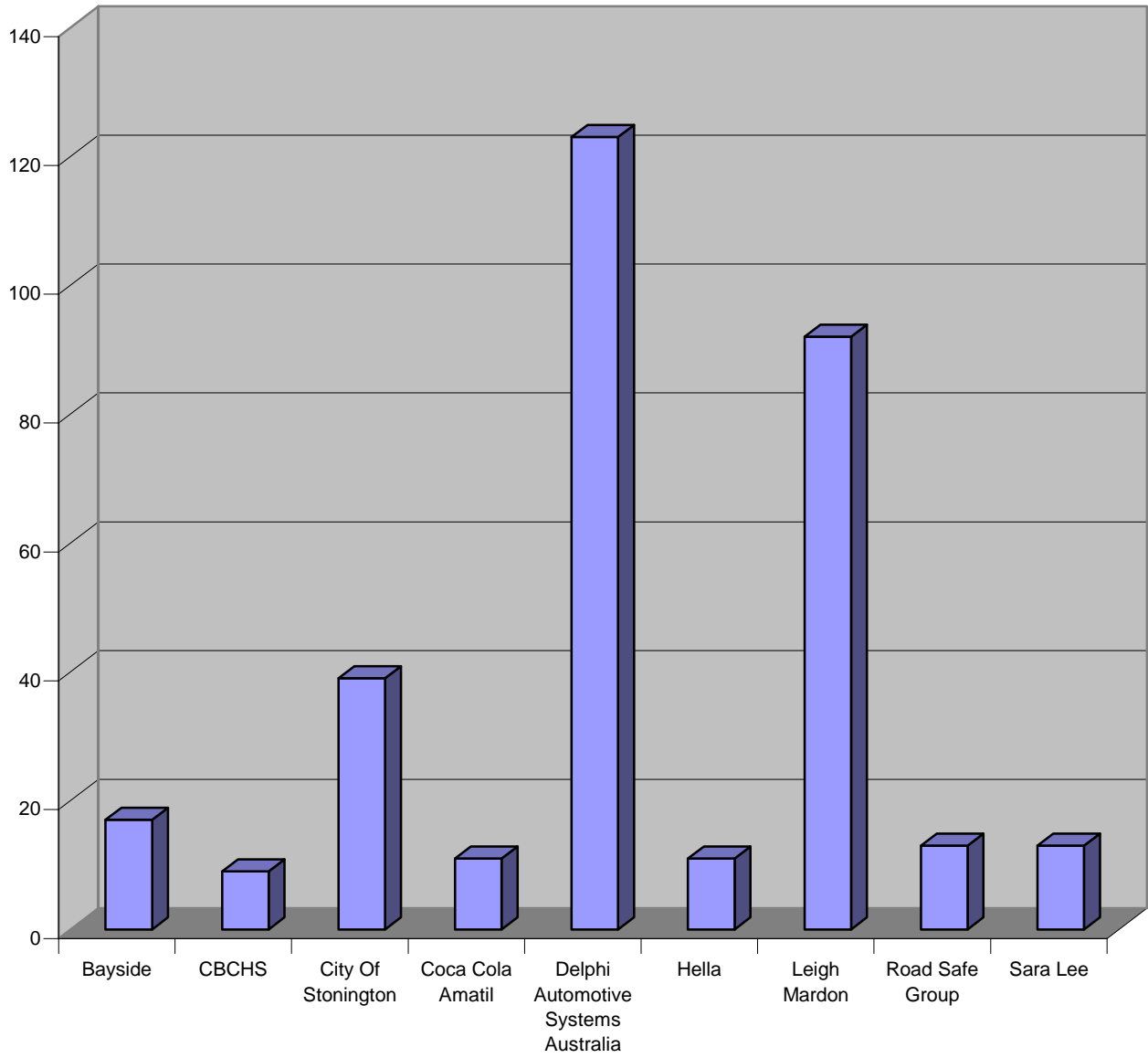
An assorted representation of under 40 in sample size corresponds to other participating organisations.

TABLE 1

Bayside	17
CBCHS	9
City Of Stonnington	39
Coca Cola Amatil	11
Delphi Automotive Systems Australia	123
Hella	11
Leigh Mardon	92
Road Safe Group	13
Sara Lee	13
Total	328

FIGURE 1

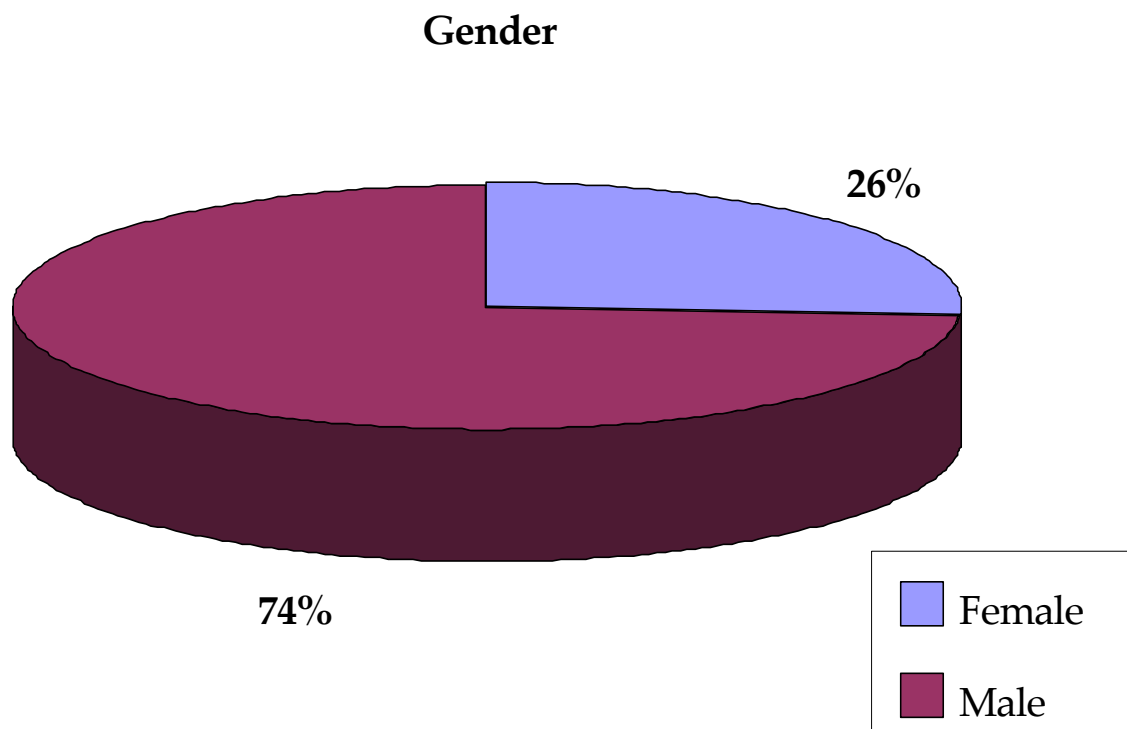
Number of Participants by Organisation



C. Participants' Gender

As shown in Figure 2 the overwhelming majority of participants in the SDEP were males forming 74% of sample size, whilst women were 26%. This may be indicative of the gender distribution in the specific industry engaged in this program, namely the manufacturing sector.

FIGURE 2



D. Participant Characteristics

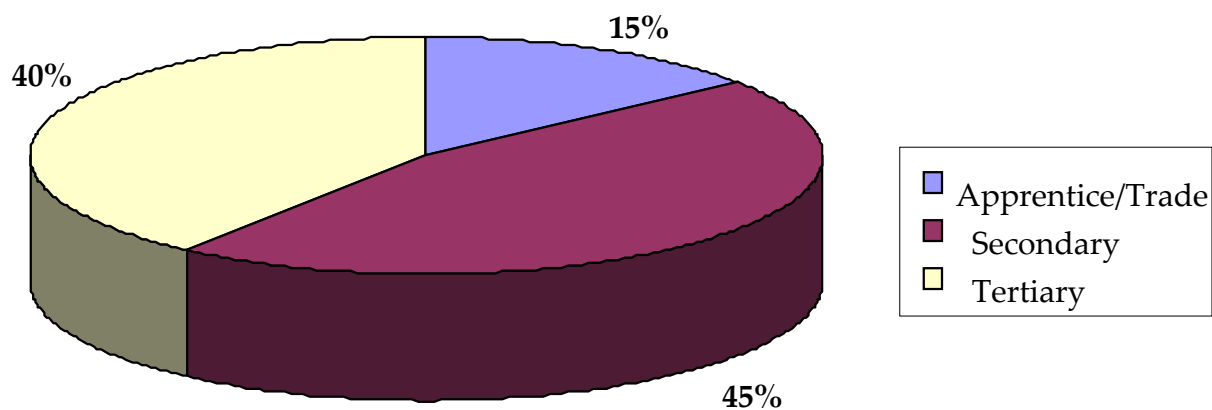
- **Education**

All attempts were made to recruit participation into the SDEP from all aspects of a workplace environment without discrimination on age, position, educational background or culture.

Accordingly, it is pleasing to note that the representation amongst participants is mixed with respect to education level and age. As shown in Figure 3, 40% of participants completed tertiary education, 45% completed secondary education, whilst 15 % came from an apprentice or trade level.

FIGURE 3

Education Level

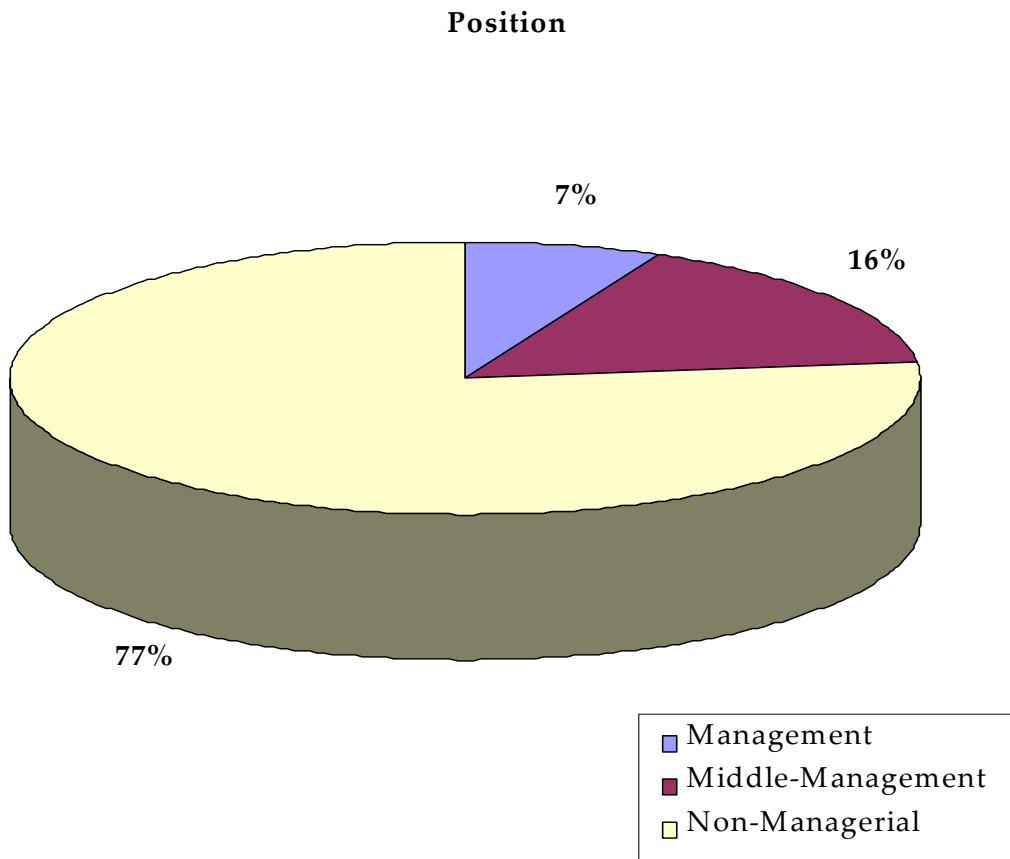


- **Position at work**

Conversely, the majority of participants occupied “non managerial” positions. As shown in Figure 4, 77 % of individuals can be described as “blue collar workers” whilst 23% occupied middle and senior management levels.

These results show that the education level of participants is not concomitant with their respective positions at work. Whilst 41% of individuals completed tertiary courses, 76% occupied non-managerial positions. There are numerous speculative reasons for this finding some of which relate to the need for overqualified individuals to find employment or those individuals trained overseas, but working in lower capacity type positions.

FIGURE 4



- **Country of Birth**

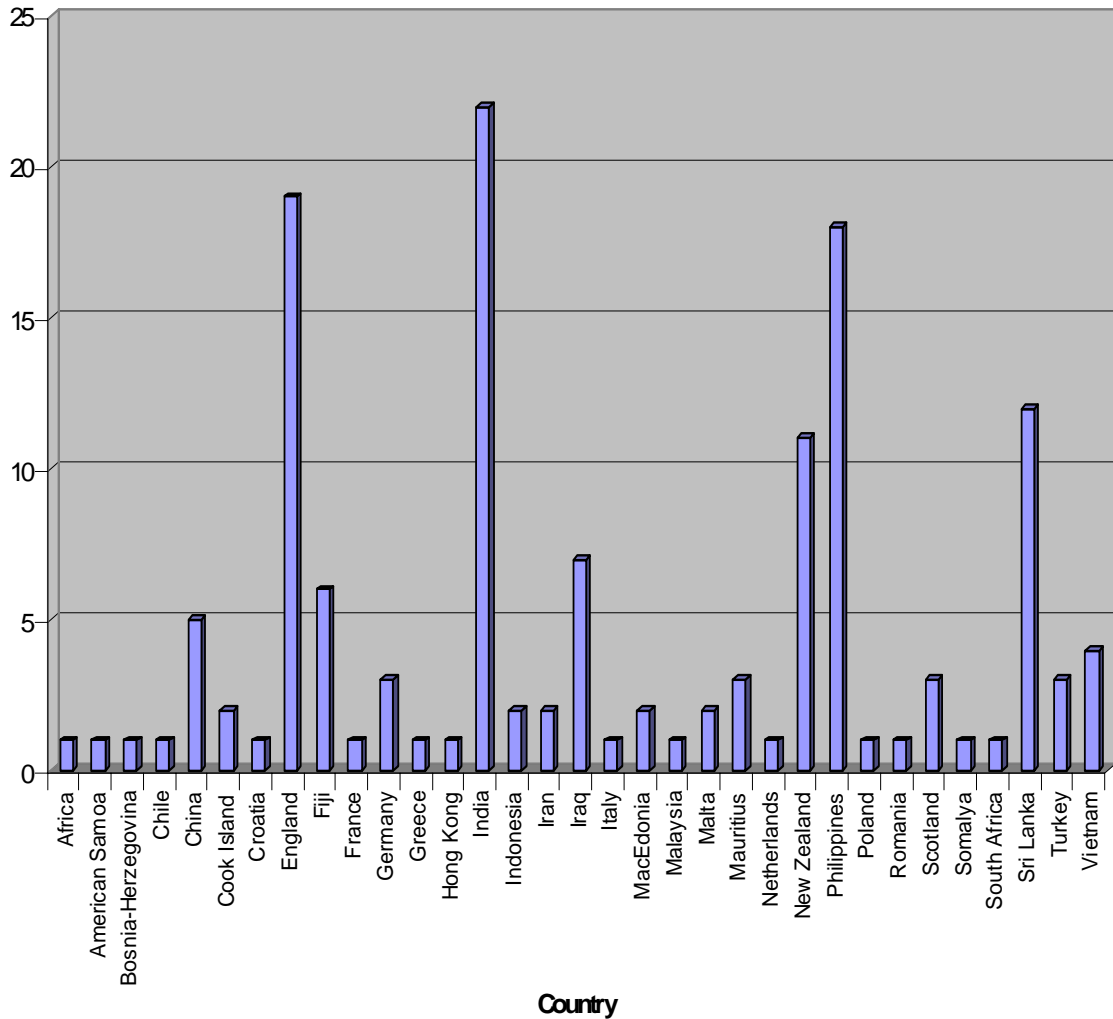
Naturally, the single most represented country of birth amongst participants was Australian (187), with approximately half of the population size reporting Australia as their country of birth.

However, again it is pleasing to report that the other half of the population of participants reported a country other than Australia as their birthplace. As shown in Figure 5, people from 33 different countries took part in the SDEP.

Second to Australia, India was the most reported country of birth (22) followed closely by England (19), the Philippines (18), Sri Lanka (12) and New Zealand (11).

FIGURE 5

Country of Birth (not Australia)



Amongst the minor representative samples (of 1-10 participants) are:

Netherlands (1), Italy (1) Bosnia (1), Malaysia (1) Poland (1), Greece (1), Romania (1), Africa (1), South Africa (1) Somalia (1), Croatia (1), Hong Kong (1), American Samoa (1), France (1), Chile (1), Macedonia (2), Indonesia (2), Cook Islands (2), Malta (2), Iran (2), Scotland (3), Mauritius (3), Germany (3), Turkey (3), Vietnam (4), China (5), Fiji (6) and Iraq (7).
(Refer to Table 2 for the list of participating cultures).

TABLE 2

Africa	1
American Samoa	1
Australia	187
Bosnia-Herzegovina	1
Chile	1
China	5
Cook Island	2
Croatia	1
England	19
Fiji	6
France	1
Germany	3
Greece	1
Hong Kong	1
India	22
Indonesia	2
Iran	2
Iraq	7
Italy	1
Macedonia	2
Malaysia	1
Malta	2
Mauritius	3
Netherlands	1
New Zealand	11
Philippines	18
Poland	1
Romania	1
Scotland	3
Somalia	1
South Africa	1
Sri Lanka	12
Turkey	3
Vietnam	4

- **Age Groups**

The number of attendees by age group (expressed as a number with the bar diagram or in percentage terms with the pie diagram) is shown in Figures 6A & 6B respectively. The distribution amongst the various age groups varied slightly. Except for the only distinct minority of the “under 21” age group (3% of the population sample in this project), the other age groups appeared to have a relatively uniform distribution (between 20-30% participation for each age group)

The SDEP was applied across a group of workers that resembles actual age groups in the alcohol consuming community across society. This would also reflect the general age group representation in the working community, namely over 21 years of age.

Figure 6 shows the actual number of participants per age group. The same data is expressed in percentage terms as an associated pie chart. Thus, the results show that 3%, 19%, 28%, 30% and 20% respectively correspond to the following age groups, under 21, 21-31, 32-41, 42-51 and above 51 years old.

FIGURE 6A

Number by Age Group

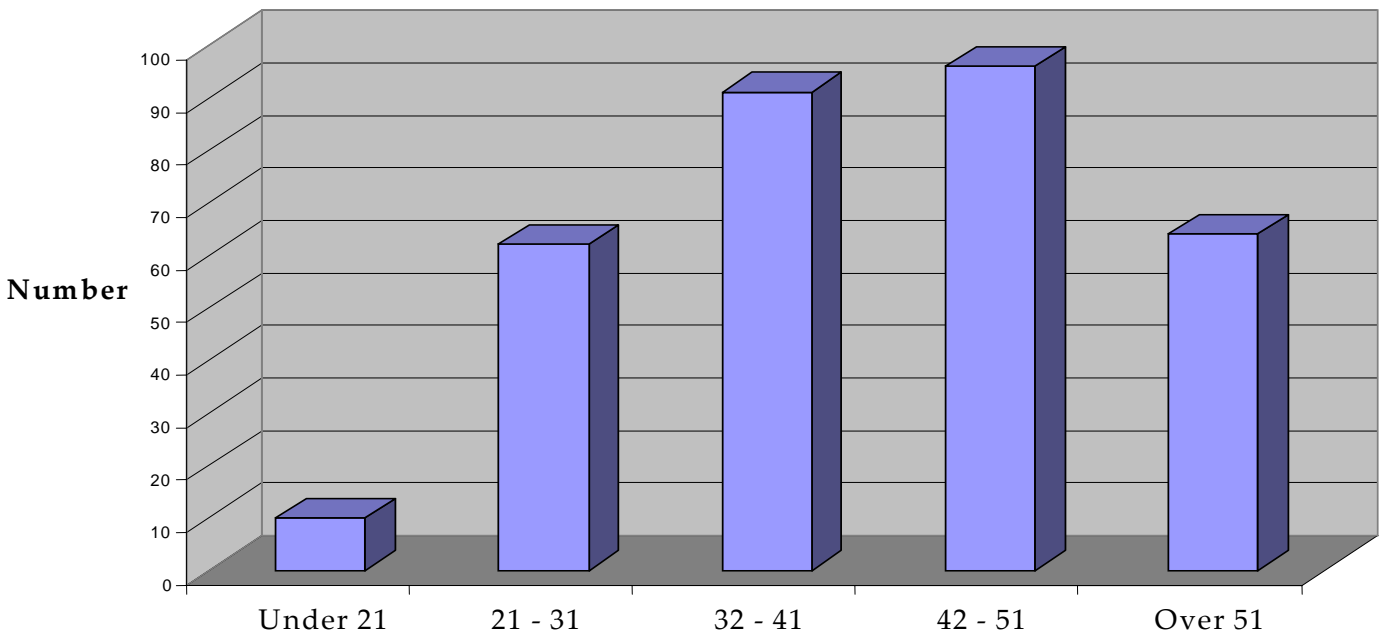
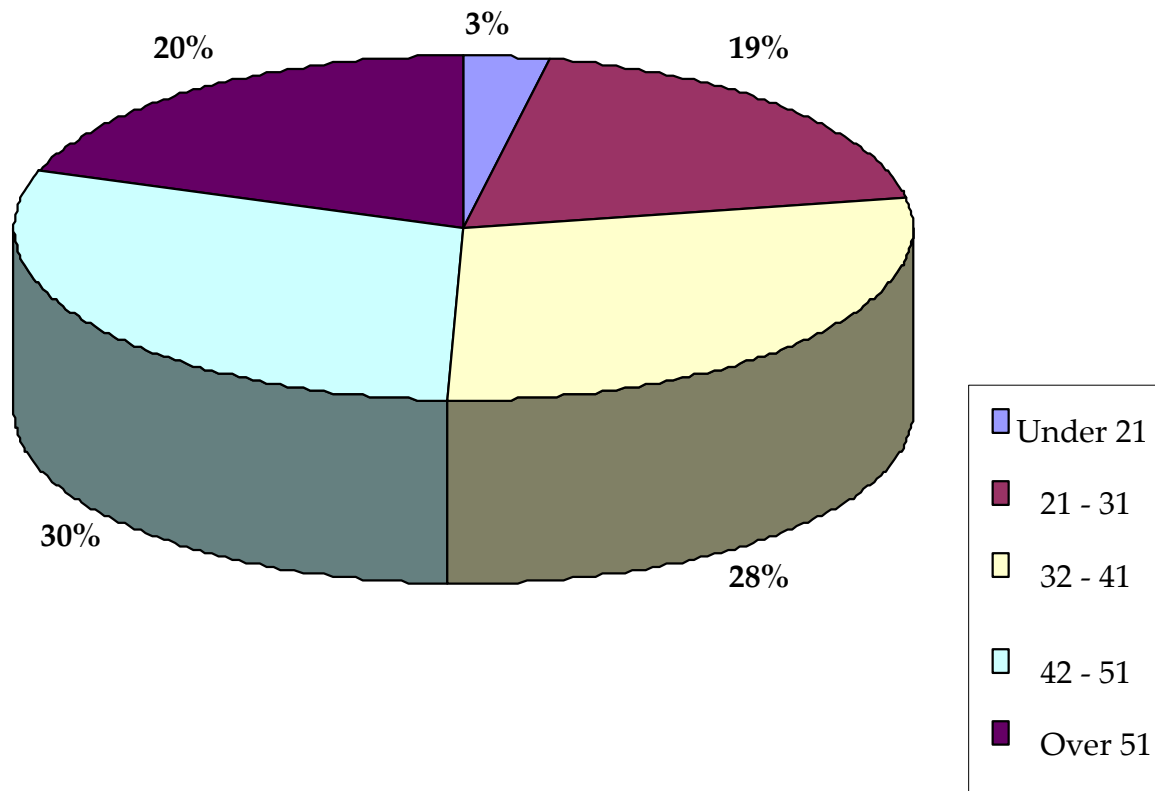


FIGURE 6B

Age Group of Attendees



2. EVALUATION

As there were 13 questions, a perfect score would be 13/13.

The questionnaire given prior to the presentation would therefore reflect the existing knowledge of any given individual or group. As the same questionnaire was completed after the presentation, the results of the latter would reflect the improvement in knowledge by the population tested.

It was advantageous to individually correlate the result of the questionnaires before and after the presentation. Accordingly, these results could be interpreted as an overall performance as well as group-specific. The evaluation of the success of the SDEP can be expressed in two main terms, namely as an average performance over the entire sample population (before and after the presentation) or as specific performance to any given sample of the population, such as any

given age group, gender, educational background, culture or even position within the workplace.

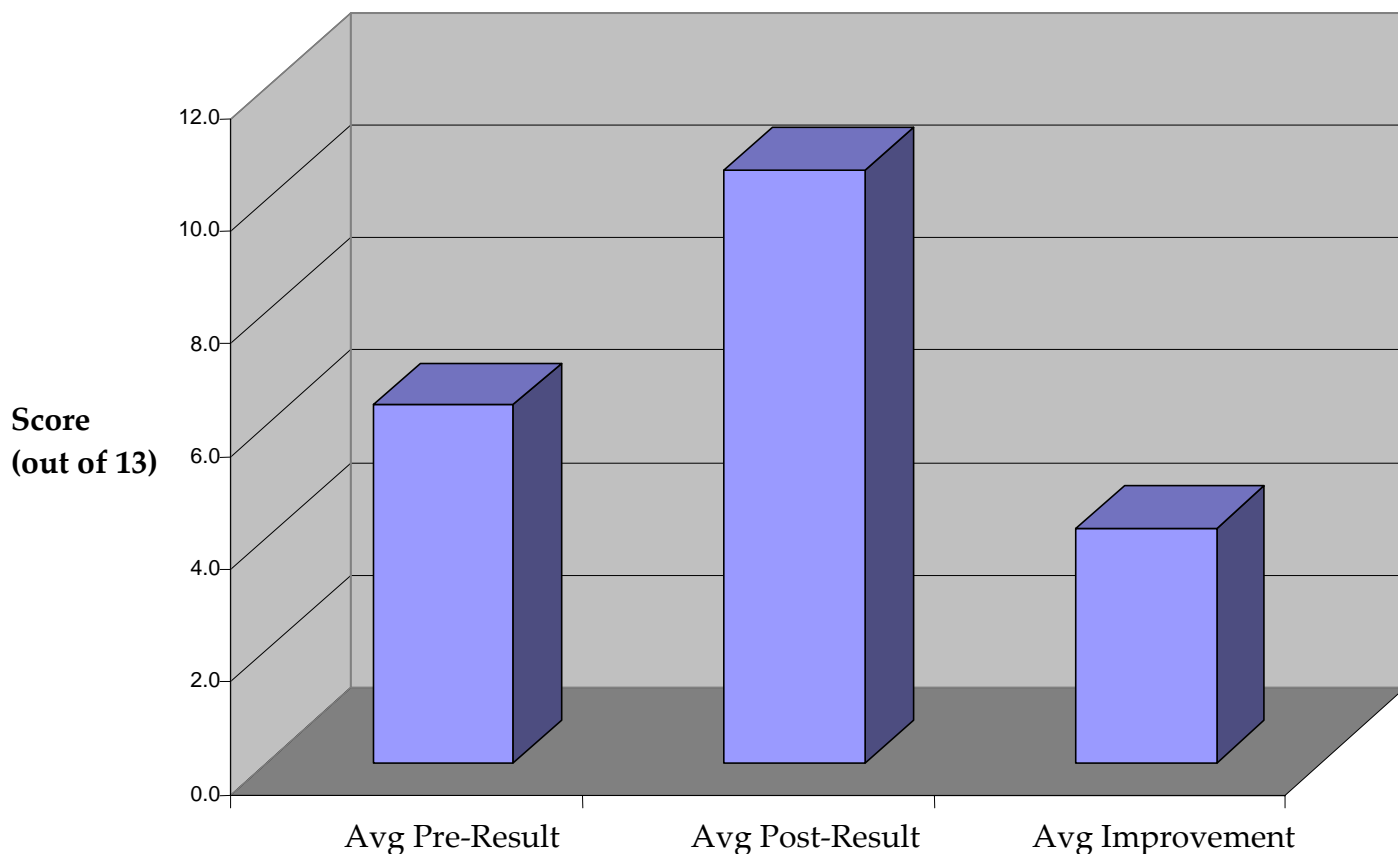
The results below have been presented first as an overall average and then as a function of specific performance of any given group.

A. Existing Knowledge & Improvement in Knowledge for the Sample Population

The results in Figure 7 show that the Average performance across the entire sample population was 6.3 (out of 13) before the presentation and 10.5 (out of 13) after the presentation. Thus, expressed as an average in terms of the number of correct answers given by any individual participant, the average improvement across the entire sample size is 4.2. The success of the SDEP or lack thereof can be reflected in this result as it would represent the individual improvement in knowledge as an average across the entire population.

FIGURE 7

Average Pre and Post Results

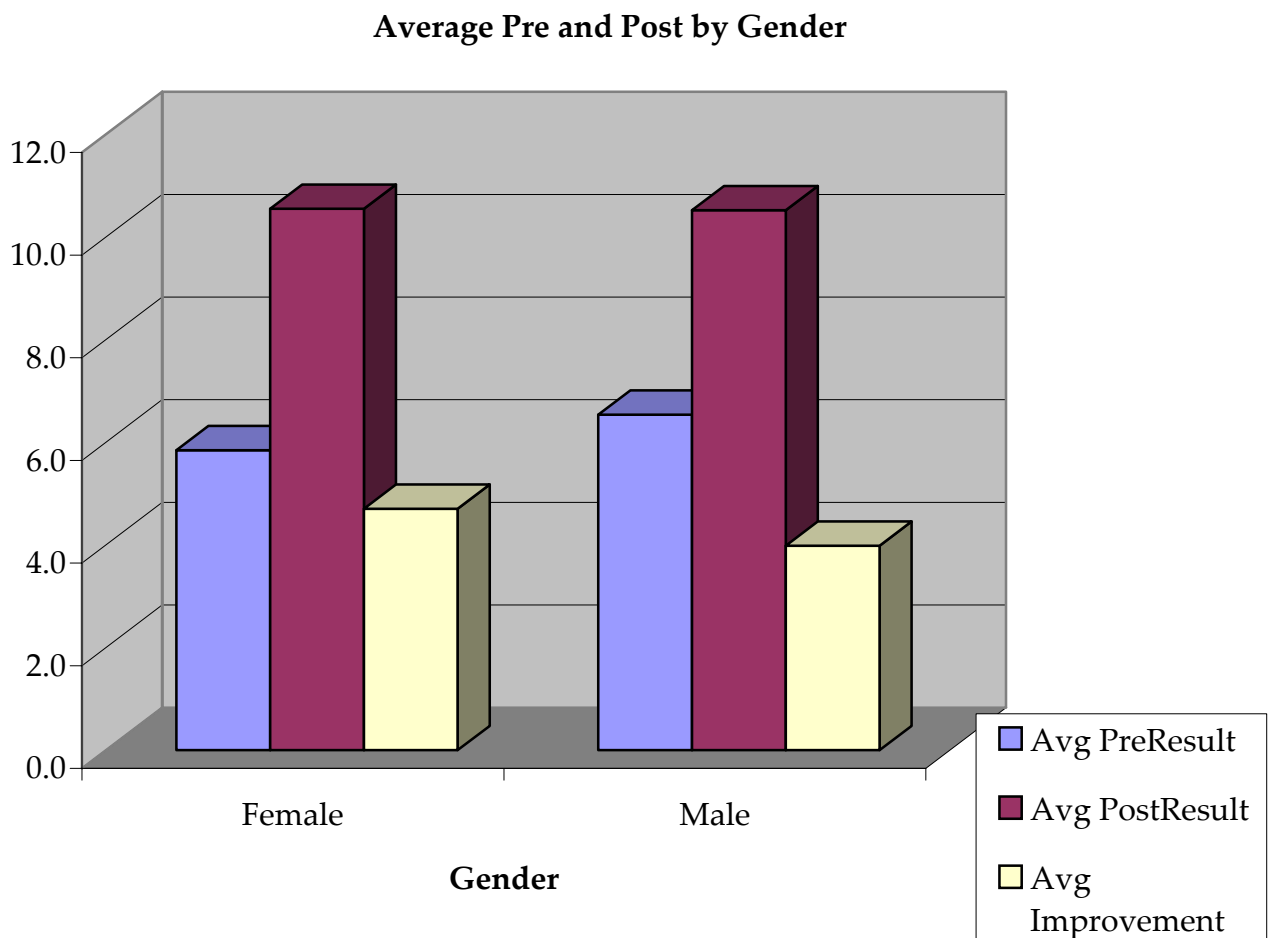


B. Existing Knowledge & Improvement in Knowledge on the basis of Gender

As shown in Figure 8, on average women scored less on the existing knowledge questionnaire (5.8) compared to men (6.5). This may be due to the nature of women's increased sensitivity to alcohol not only from the point of view of biological differences but also with respect to "tolerance" levels. However, by the end of the presentation, the knowledge level for both men and women was almost identical (10.5) which may indicate that women benefited more from the SDEP. Figure 8 shows that average improvement in the women population sample was 4.7 compared to 4.0 for the corresponding male group.

It is also worthwhile to point out that the presentation had a significant effect on improving knowledge in both men and women as shown in Figure 9.

FIGURE 8



C. Existing Knowledge & Improvement in Knowledge on the basis of Age

Figure 9 depicts the distribution of existing knowledge versus improvement in knowledge of participants as a function of age group. The results show that the current knowledge of participants (prior to the presentation) varied with their age.

It was shown that current knowledge of participants did not directly increase as might be expected with their age. Maturity and experience with respect to alcohol knowledge was not a major factor in these results.

The age group which showed the highest existing knowledge prior to the presentation was the 21-31 age group with an average result pre-presentation of 6.7. The next group showing highest pre-presentation average is the over 51 age bracket (6.6) followed by the 42-51 age bracket (6.4). The final two groups of under 21 and 32-41 age bracket had a similar average score for pre-presentation result at 5.8-5.9.

Thus, it is significant that the age bracket 21-31 seemed to have the highest existing knowledge about alcohol consumption.

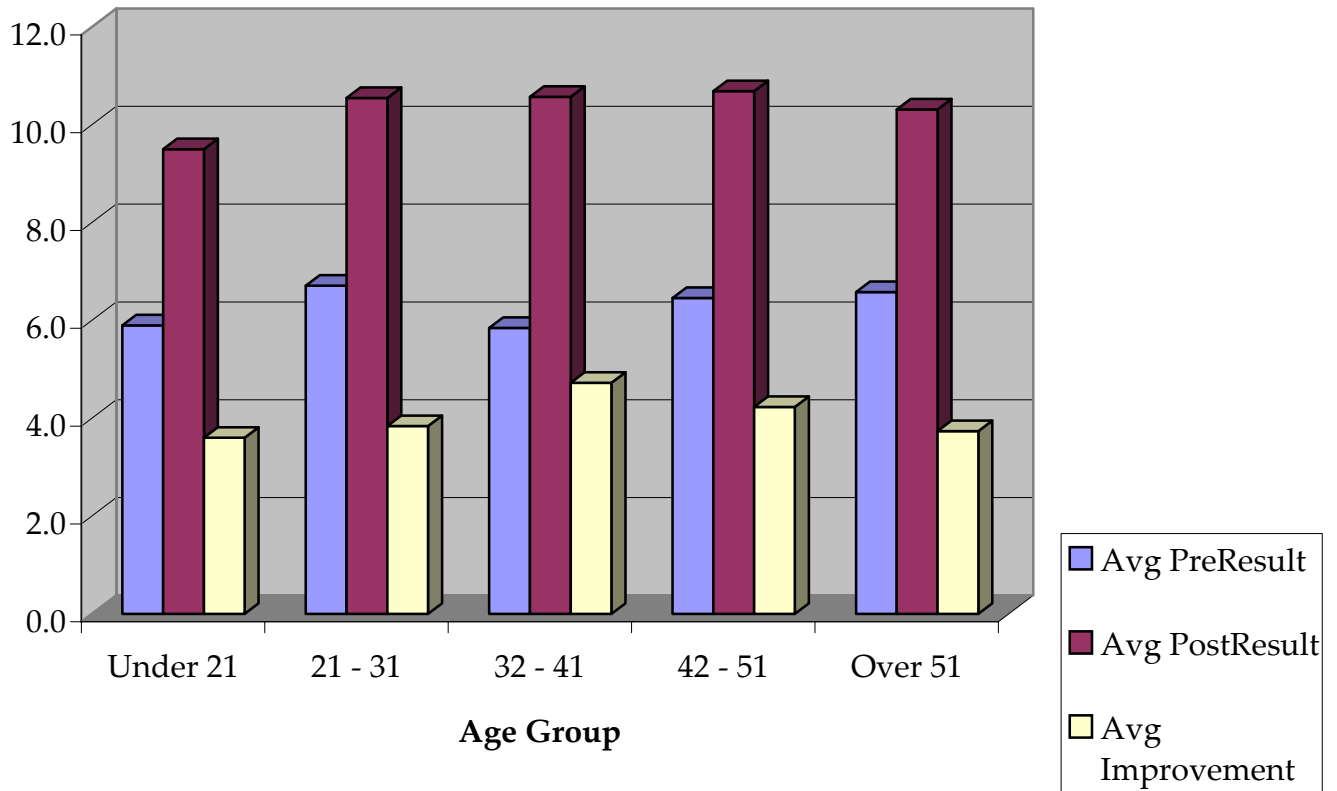
Interestingly, the knowledge attained by participants was comparable across the entire population sample with the exception of the under 21 age bracket. The average result attained post presentation was 10.3-10.6 for all age brackets except for the under 21 group at 9.5.

Whilst the presentation had a similar impact across the various age groups, it appears that the age group benefiting the most was the 32-41 age bracket given that this group started with the lowest pre-presentation score.

Furthermore, the age bracket 42-51 scored the next best improvement (4.2) whilst the other age brackets 21-31, over 51 and under 21 had a comparable average improvement post-presentation at 3.6-3.8.

FIGURE 9

Average Pre and Post by Age Group



D. Existing Knowledge & Improvement in Knowledge on the basis of Cultural background.

Figure 10 depicts the distribution of existing knowledge versus improvement in knowledge of participants as a function of place of birth.

It is initially worthwhile to point out that results, for some countries of birth, are not necessarily a true representation for that nationality due to the extremely small sample size. For example, it can be argued that the result for Italy (sample size 1), Netherlands (sample size 1) or Vietnam (sample size 4) is not a true representation for those birth places due to their relatively minute sample size. Nevertheless, it was pleasing to find participants from an assorted number of birthplaces. When considering this data, countries with a sample size under 10 were not taken into consideration with respect to significance of the result.

Most significantly and in contrast to what might have been expected, participants born in English speaking countries other than Australia, such as England and New Zealand did not score the highest with respect to their existing knowledge of the topic. As shown in Figure 10, whilst Australian born participants scored the highest pre-presentation result at 7, India and New Zealand were comparable at 6.1-6.2. These were followed by England and the Philippines at 5.7 and 5.4 respectively.

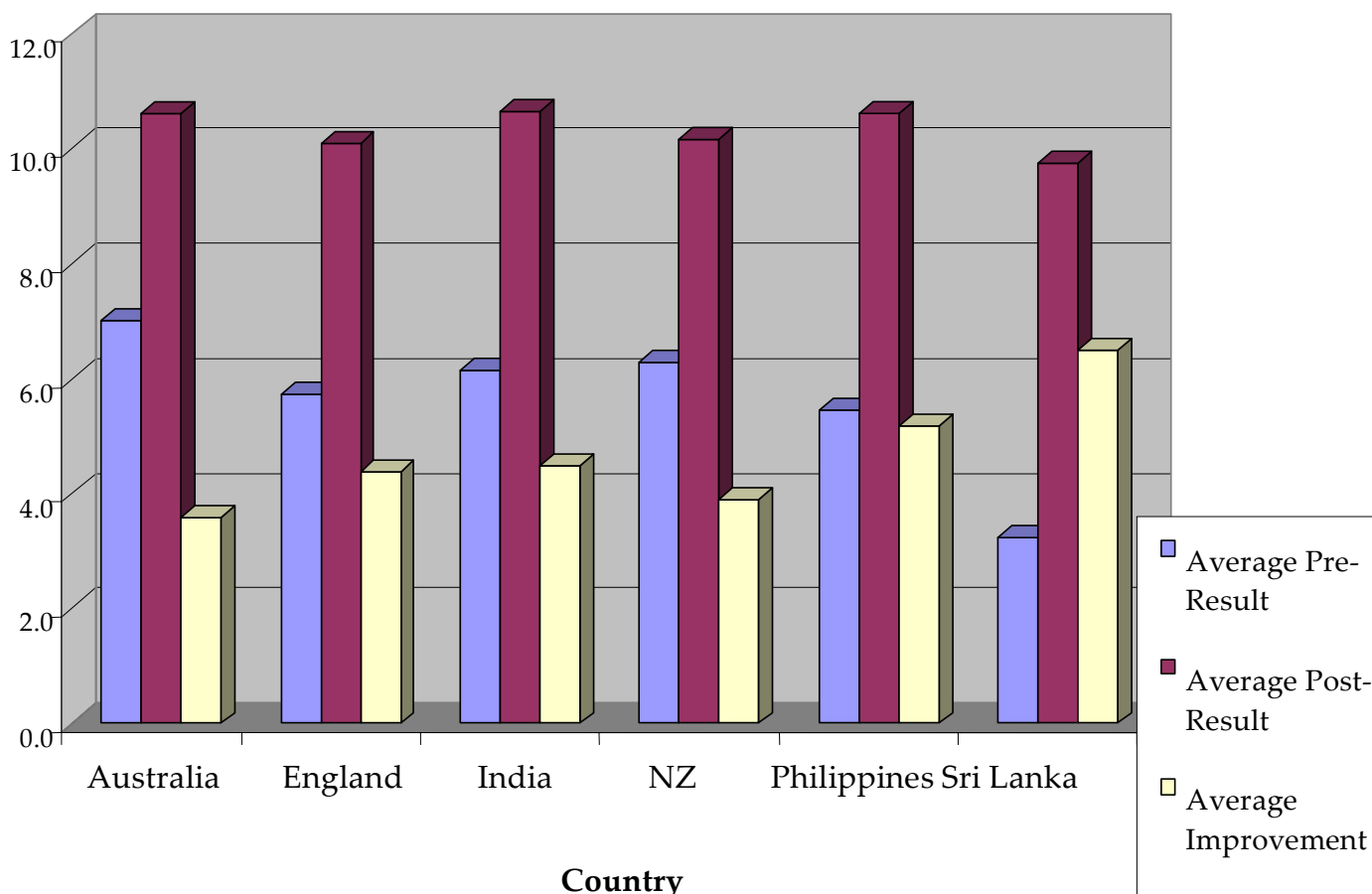
Sri Lanka, with a sample size of 12 had the lowest pre-presentation score at 3.2.

Conversely, the average post-presentation score was relatively comparable amongst the countries mentioned with the highest score attained for Australia, India & Philippines (10.6) followed by New Zealand and England, (10.1-10.2) and then Sri Lanka at 9.75.

The improvement in knowledge after the presentation was observed most significantly in participants from birthplaces which scored least on existing knowledge such as Sri Lanka (6.5), followed by Philippines (5.2), India (4.5), England (4.4), New Zealand (3.9) and then Australia (3.6).

FIGURE 10

Average Pre and Post results by Country



E. Existing Knowledge & Improvement in Knowledge on the basis of Educational background.

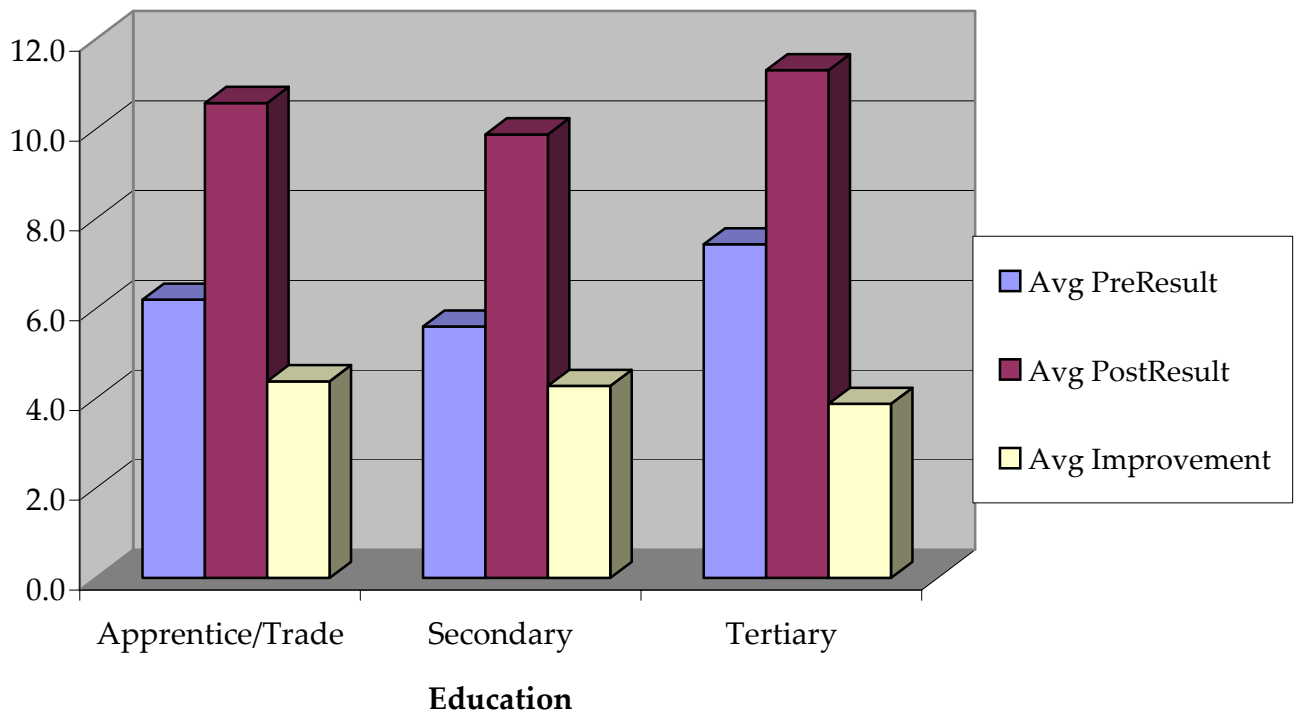
As shown in Figure 11, participants with higher education had the highest score in existing knowledge (7.4) followed by those with apprentice/trade certificates (6.2) and then participants with school education (5.6).

Similarly, participants with tertiary backgrounds scored the highest after the presentation (11.3), followed by Apprentice/trades (10.6) and then those with school education (9.9).

The SDEP benefited those with least educational background as reflected by the improvement in knowledge post-presentation. Those participants with tertiary education had the smallest improvement at 3.9, followed by the school and apprentice/trade group at 4.3.

FIGURE 11

Average Pre and Post by Education



F. Existing Knowledge & Improvement in Knowledge on the basis of position at

work.

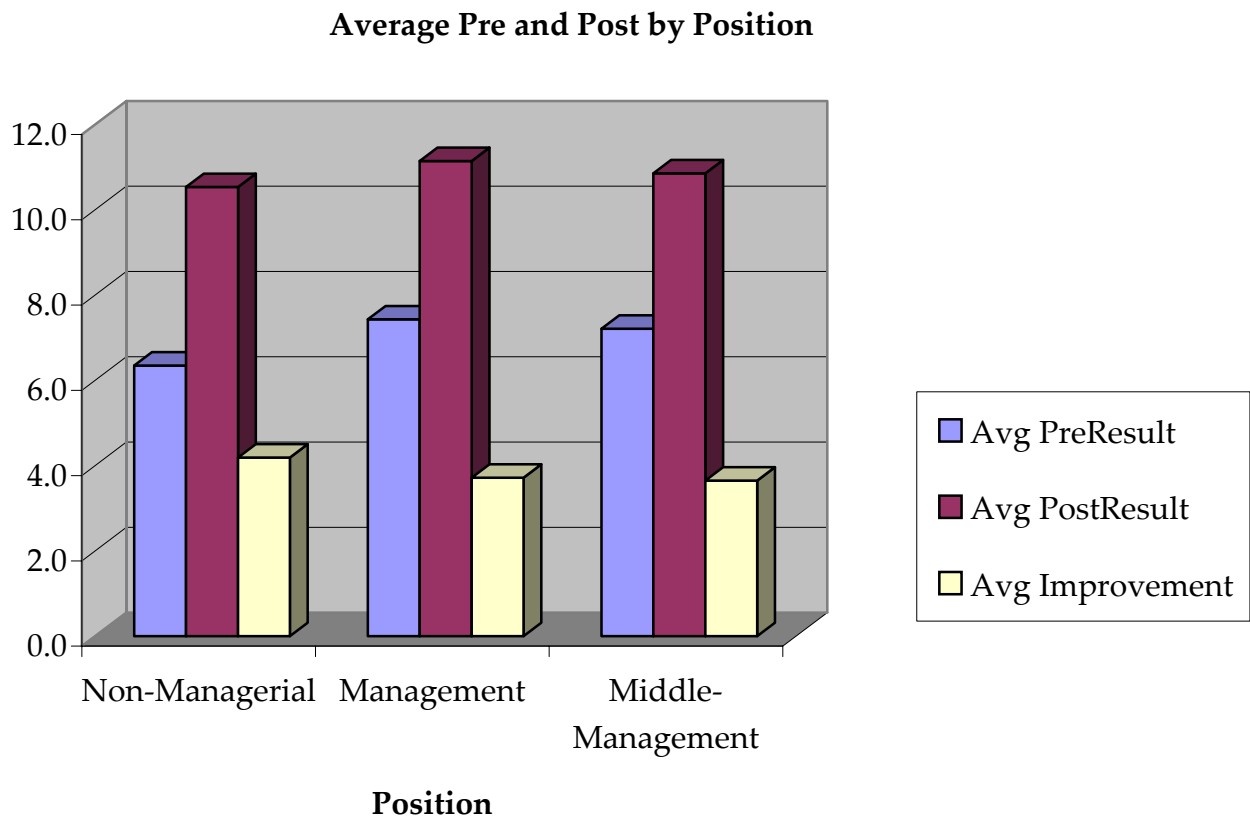
A similar trend was observed when the data was analysed with respect to position at work. This is not surprising given the fact that managerial positions are occupied by those with tertiary qualifications as opposed to middle and non-management and non-managerial positions.

As shown in Figure 12, participants with managerial positions had the highest score in existing knowledge (7.4) followed by middle management (7.2) and then non-managerial positions at 6.3.

Similarly, those with managerial positions scored best after the presentation (11.1), followed by middle management (10.8) and non-management positions (10.5).

Again, these results show that the SDEP was of more substantial benefit, in terms of improvement in knowledge, to non-managers (4.2) compared to middle and managerial staff (3.6-3.7)

FIGURE 12



G. Participants Self-reported Comments.

Participants were asked to comment on the effect of the presentation on their personal lifestyle particularly with respect to alcohol consumption. Participants were also asked to provide any additional comments or feedback regarding any aspect of the presentation itself.

Whilst most participants did not provide answers to the above two questions, as shown below, whatever answers provided were extremely meaningful in providing first, information about the success of the presentation itself and second, in giving us an insight into current perceptions by various social groups regarding alcohol.

Effect of Presentation.

As shown in Fig. 13, only 13% of participants stated that the presentation had no effect, whilst 60% and 27% stated that the presentation had some or significant effect respectively.

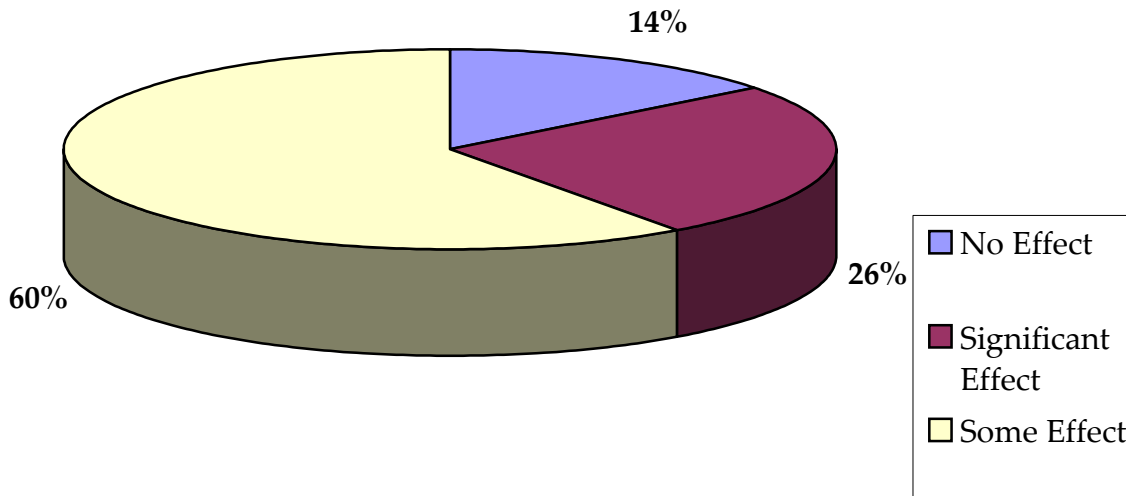
Thus, most participants (87%) were positively affected and have somewhat learnt from the presentation which represents an overwhelming success of the seminars and the SDEP in general.

In this regard, it is important to note that participants who stated that the presentation had no effect on them personally did not insinuate a lack of improvement in knowledge directly as a result of attending the seminar. This is evident from the comments made at the end of presentation as shown below. (For example: *"I am not a big drinker but this does add to my knowledge and I will pass it on to my children and friends"*).

Furthermore, it is interesting to note that the 13% of participants that were not affected in anyway by this presentation represents approximately the percentage distribution of non-drinkers in our society (comparative figures around 10%).

FIGURE 13

Effect of Presentation



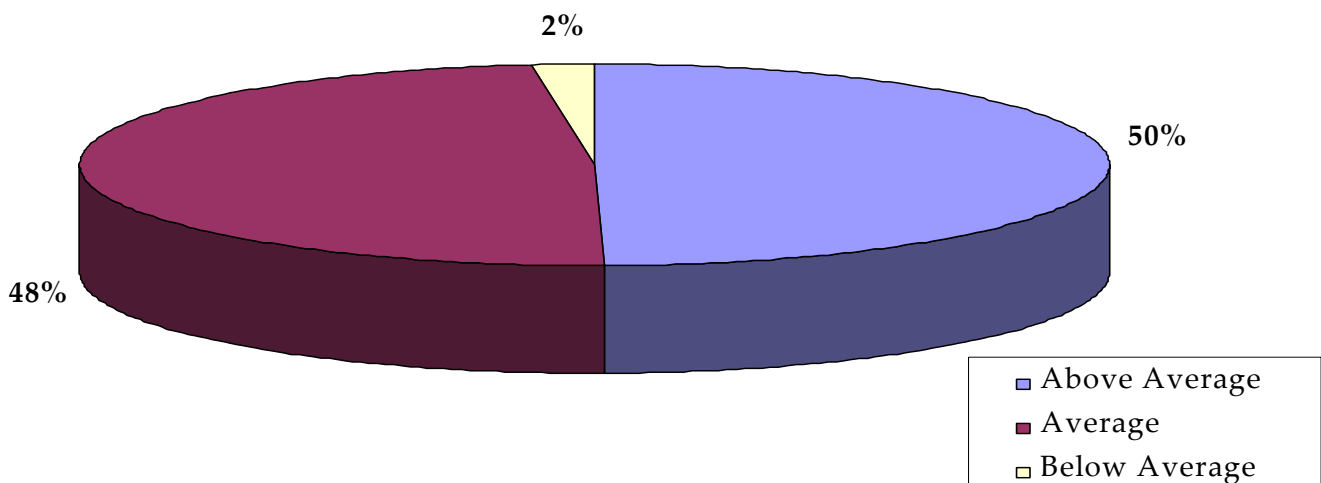
Style and Content of the Presentation.

As shown in Figure 14 half of the sample population rated the presentation at an "above average" level in style and content whilst 48 % judged this presentation as "average".

In contrast, an extremely small percentage (2%) felt that the presentation was "below average".

FIGURE 14

Style & Content



Comments and Feedback

Comments and feedback received by participants are shown in Table 3.

The comments show a variety of positive comments showing an appreciation of the seminar and the program itself. This is a credit to the funding body and CBCHS as it highlights the interest in alcohol as an educational topic.

The nature of these comments range from:

- being humorous: *"I really fancy a drink now", "fun interesting presentation", "Good stuff man", "the older you get the wiser you get"*
- offering advice: *"effects of alcohol in regard to crime, violence should be mentioned", "should be done to more groups", "I would like to see liquid actually in glasses to help recognize what means a standard drink".*
- Appreciative: *"very well done, enjoyed it. Learned a few things. Thanks", "very good information Thank you".*
- Commenting on the presentation: *"Good presentation", "wonderful presentation", " Good Course", "Good interaction with the Group"*
- Commenting on the presenter: *"Presenter needs to be more tolerant", "too serious", Presenter displayed degree of passion about the subject. Very Good"*

The comments and feedback indicate that almost all participants enjoyed the presentation and found the content to be both worthwhile and practical. This illustrates the general spirit and philosophy of an education program, namely to provide knowledge which aims at preventing and ultimately eliminating harm. The SDEP aimed to provide the guidelines for low risk alcohol consumption in an unbiased and balanced manner without focusing on an abstinence or a controlled drinking model. This point is adequately illustrated by the following feedback from a participant who plans to continue enjoying moderate alcohol consumption: *"I'll keep on drinking a great red most days".*

TABLE 3: PARTICIPANTS' COMMENTS

I really fancy a drink now

The older you get the wiser you are

Good Information

The presentation gave me a good guide line to follow in life

Effects of Alcohol in regard to crime, violence should be mentioned

Very educational and will be useful in everyday life

Very Informative

Good, learnt a lot

Presenter displayed degree of passion about subject. Very Good

Don't drink at all

Many thanks

Good Stuff man

General Info and message of not feeling drunk but may be exceeding BAC = 0.05 is important

Fun, interesting presentation

I don't drink and Drive and rarely have a drink of alcohol

The slide on standard drinks suggests that 100ml was a standard wine, yet 750 was 7 standard drinks.

No mention was made of the fact that it can be even less.

Should be done to more groups

I am not a big drinker but this does add to my knowledge and I will pass it on to my children and friends

No effect as I do not drink. Presentation is too quick.

Thanks

Thanks

Good educational information

Enjoyed the presentation and have taken away some valuable information

Good explanation between the difference between BAC and intoxication

I would like to see liquid actually in glasses to help recognize what means a standard drink.

I'll keep on drinking a great red most days

Good Interaction with the Group

Very well done, enjoyed it. Learned a few things. Thanks.

well produced video

Some interesting points brought up particularly with legal ramifications / situations.

Thank you

Was good information

Have it at lunch was too distracting

Thank you

Don't drink anymore

Presenter needs to be more tolerant

Too serious

Good Guidelines

This session was very good and educational

Good Course

Good to make people aware

Within time well done

I don't drink

Good Presentation

Wonderful Presentation

Very Good Info Thank you

Thank You

Great very beneficial

Good Video presentation

Worth knowing

I commend this presentation to all employees at Hella

Thanks for the time

Don't drink

Am aware of my own alcohol consumption/ratio. Thank you for the presentation. Very Good Presentation. Very good effect. Time for discussion and answer questions.

DISCUSSION

Health and allied interventions have developed over time, with a movement away from facts-based teaching towards teaching social skills that help resisting social and peer pressure. There is an abundance of literature on educational programs and strategies for delivery, evaluation and performance criteria spanning decades (Health Commission of Victoria 1984, 1992, ICAP).

Education is regarded as the key component for any comprehensive approach to alcohol prevention and policy and can help reduce the risk of harm (ICAP). In fact, a specific prevention resource tailored for the workplace has recently been developed in relation to use of alcohol and other drugs and related stress and burnout in Industry (Skinner & Roche, 2005).

The content of a program as well as characteristics or style of delivery both contribute significantly towards its potential for success. Interactive programs which include social influence and comprehensive life skills, require elements such as participation, communication, small group activities and corrective feedback, whilst non-interactive programs are based on delivery of knowledge through mainly didactic teaching.

There are many reports focussing on mass media campaigns and their role in affecting knowledge and attitudes rather than behaviour. As mass campaigns aim to communicate health promotion messages to the general population through a variety of media, they can also be used as part of an enforcement program (Department of Human Services, 2001).

It is envisaged that the successful delivery of educational information brings about a sustained change in beliefs and attitudes, particularly in the health and allied fields. Naturally, the ability of a presenter to deliver an educational message successfully is both dependent on the nature and accuracy of the information and their skills.

However, there is a need for better research to provide more robust evidence in evaluation of the success of such programs particularly with respect to outcomes in the area of prevention. As the basis of evaluation is generally focussed on changes in knowledge rather than behaviour, it is difficult to predict or assess outcome evaluation of such educational efforts. Nevertheless, it would prove a worthwhile project to follow up the present study and evaluate the ongoing knowledge of participants in the SDEP as a function of time. This would provide valuable information on the sustainability of such educational programs which could in turn be linked to ultimate changes in behaviour.

The SDEP proved a success judging by the results and feedback comments made by participants. Based on self-reported information, the overall program was received in an overwhelmingly positive manner.

Significantly, the results show a clear improvement in understanding of participants of those essential issues surrounding the topic of alcohol such as BAC and drunkenness. In this regard, the most difficult concept to understand is the issue of differentiating between Blood Alcohol Concentration and the way a person feels upon consuming alcohol. It was important to make clear the distinction between those two factors which are often used to gauge one's ability to drive, namely the way one feels after consuming alcohol is an essential factor in the consequential decision of whether or not to drive. Therefore the information exchange in this program highlighted the difference between intoxicating behaviour and BAC.

An interesting outcome of the SDEP is the finding that existing alcohol knowledge was comparable in some instances between people of different cultures. The results showed that Australian-born participants scored the highest pre-presentation result with people from backgrounds of India, New Zealand, England and the Philippines showing comparable values. Another important aspect of the SDEP was the information on the National Guidelines for Low Risk Alcohol Consumption as published by the National Health and Medical Research Council. These guidelines provide advice to every group of individuals in our society regardless of their age, gender, state of health and other factors. It was useful to expose participants of the SDEP to the presence of these guidelines. There are specific guidelines for individuals under 18 years of age, or young adults, or specific to women and specifically, pregnant women, or people with mental health issues or on prescribed medication. The development of the guidelines and their use in the SDEP further compliments other studies described in the literature for 'at-risk' groups (NDARC 2003, Kaldawi, R. E. 2005, ICAP). Target groups such as pregnant women or young adults, can benefit from tailored information designed to raise specific awareness and bring about behavioural changes.

In this regard, women who participated in this program were educated specifically regarding their increased sensitivity to alcohol. This is evident from the results presented showing that women had a pre-presentation score which was further enhanced compared to men. However, women remain a vulnerable group within our society due to the perceived lack of relevant education focusing on gender sensitivities with respect to alcohol. Future educational efforts should ideally focus on women and alcohol. Other educational efforts are currently specifically directed towards educating women in regards to alcohol use (Kaldawi, R. E. 2005).

Participants with educational backgrounds other than tertiary often referred to as blue collar workers, displayed a lower existing knowledge of the relevant issues pre-presentation. This group demonstrated a corresponding higher improvement in understanding compared to participants from higher education/management positions. Such a result is particularly pleasing as it is the experience of this presenter that individuals from lower socio-economic/educational backgrounds are often over represented in other alcohol educational programs such as Drink Driver Education courses. It can be argued that the SDEP has focused on a niche group within our society that is deemed most in need for such education.

However, this is not to be confused or perceived as managers or white collar workers being immune from the need of such educational programs. It is important to include the more educated in such a program. The SDEP has not even begun to tap into the educated sector of the working community as this group was not significantly represented in the SDEP. The results obtained may not reflect the true picture of alcohol education and knowledge amongst this group.

Another outcome of the SDEP is the existing knowledge regarding alcohol amongst the various age groups which participated in this program. Whilst the age group 21-31 provided the highest score of correct answers pre-presentation, all those who attended the program attained a high level of knowledge post-presentation regardless of age. This shows a significant improvement of knowledge amongst all participants and is a representation of the success of the presentations.

RECOMMENDATIONS

As mentioned above, the SDEP proved to be both a worthwhile industry-based educational project across the working community in the region. The SDEP could be regarded as a health intervention strategy through which individuals within the workforce could access further information regarding their personal use of alcohol.

Whilst the project has run its year of funding, the benefits from such a program signal the beginning of a new approach and strategy of education rather than the end. The future is very promising for new extensions of this and allied programs. In a de-regulated environment where responsibility is placed on the individual consumer, the role of education becomes crucial in ensuring that accurate harm-minimisation messages reach the largest sectors of people in the community.

This program could be expanded to cover more workplaces in this region and subsequently other industries throughout the state. Other applications of this program may involve community organisations and training bodies. As mentioned previously, a further application could be a follow up study/program which could be used both from the point of view of process evaluation and further re-enforcement of educational messages.

Whilst the steering committee played a major role in networking and promotion of the SDEP and its applications, future effort should be directed at involving additional stakeholders and interested parties. These could include Employer Groups, Union Groups and other industry associations.

In regard to the current steering committee, it is pleasing to find a common goal and forum to promote an effective educational message throughout the community. The following message is from Mr. Rod Smith, State Manager (Victoria) of the Good Sports Program at the Australian

Drug Foundation and one of the representatives on the SDEP steering committee:

“The Australian Drug Foundation (ADF) was pleased to be part of the ‘Standard Drinks Project’ Steering Committee, funded by the AER Foundation and operated through the Central Bayside Community Health Services. The ADF and the Good Sports program, along with the other steering committee members representing various stakeholders, were able to bring experience and expertise in the area of alcohol education to the project. In return, the results of the project have confirmed the need for an alcohol education and support program for work places – both from an employer and employee perspective as part of a broader work place safety policy.”

For future extensions of this or allied programs there would be a need to apply for specific funding to market the program and identify interested individuals and organisations. This task itself is extremely important for the success of the program particularly from the point of view of exposure. Regardless of how accurate and effective an educational program might be, its success largely hinges on its exposure. Hence, the marketing and publicity of a program is essential to its success and is deserving of its own funding and attention.

The success of the SDEP and the findings obtained could be used to obtain additional funding and play an education role through publication of the results. Further interest could be generated for future programs and identification of a network through which stake holders and interested parties could liaise with each other.

Finally, it is hoped that this report and its recommendations can influence and persuade those in a decision-making roles be they government, non-government or the media.

CONCLUSION

Education is an effective and popular approach to reduce harm from excessive use of alcohol and/or “binge” drinking patterns.

This program proved a successful initiative in educating a specific group within the community, namely, workforce and industry in the region of CBCHS.

The results have shown that the SDEP has aided participants in improving their knowledge on crucial issues relating to standard drinks and alcohol consumption. Provision of information and skills represents an important component of an integrated strategy of harm reduction.

The spirit and philosophy of this program is in accordance with education as a viable and effective health intervention strategy accessing various sectors of the community.

It is hoped that strategies learnt from the development and implementation of the SDEP could be adopted across other health education programs and services carried out by CBCHS.

ACKNOWLEDGEMENTS

The author wishes to acknowledge the following organisations and individuals for their contribution and support throughout the SDEP.

First, without the funding body, namely the AER, we would not have been able to carry out the SDEP. On behalf of CBCHS and those who participated in the SDEP, we wish to express our gratitude and appreciation.

Thank you to the members of the Steering Committee. In this regard, a letter has been sent to the members of this committee to thank them for their involvement in this project (Refer to Appendix 7).

Thank you to Brett Kinross from CBCHS for his help with developing the database, the volunteers from CBCHS that helped in putting the show bags together and Shane Quinn (Service Delivery Manager) for developing the submission and supervising the project.

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www.05.com.au, Accredited Provider of the Victorian Accredited Driver Education Program (VADEP DHS 92/003).

www.icap.org Alcohol policy think tank involving governments, the alcohol industry, and public health.

APPENDIX 1



Evaluation Form Before Presentation

This questionnaire is anonymous and information collected is private and confidential. Therefore, your openness and frankness is greatly appreciated.

Please circle the corresponding answer

- | | | | | | |
|--------------|--------------------------------------|-------|--------------------|--------|------------|
| 1. Gender | Male | | | Female | |
| 2. Age | Under 21 | 21-31 | 32-41 | 42-51 | Over 51 |
| 3. Born | Australia or Country of Birth: _____ | | | | |
| 4. Position | Non-Managerial | | Middle-Management | | Management |
| 5. Education | Secondary | | Apprentice / Trade | | Tertiary |

Please circle True or False

- | | | | |
|--|------|-------|------------|
| 6. If you don't feel drunk, you must be under 0.05 and therefore ok to drive. | True | False | Don't Know |
| 7. If you are an experienced drinker (tolerant), your BAC would be lower | True | False | Don't Know |
| 8. Coffee or food, reduce your BAC reading. | True | False | Don't Know |
| 9. Your BAC reading would be higher if you are on medication or other drugs. | True | False | Don't Know |
| 10. BAC reading is higher in women than men for the <u>same</u> alcohol consumed. | True | False | Don't Know |
| 11. BAC reading is higher in obese people for the same amount of alcohol consumed. | True | False | Don't Know |

12. BAC reading is higher in muscular people for the same amount of alcohol consumed.

True

False

Don't Know

13. The low risk guidelines for safe alcohol consumption are no more than 2 standard drinks on any one day for women and no more than 4 Standard Drinks on any one day for men, with at least two days per week alcohol-free.

True

False

Don't Know

A Standard Drink is one, which contains approximately 10grams of alcohol. Please mark true or false to describe whether these serves are Standard Drinks:

14. Nip or 30 ml of Spirit

True

False

Don't Know

15. 100 ml glass of Wine / Champagne

True

False

Don't Know

16. Pot of Beer (285 ml)

True

False

Don't Know

17. Can of light Beer (375ml)

True

False

Don't Know

18. 60 ml of Port or Sherry

True

False

Don't Know



Evaluation Form After Presentation

Please circle True or False

6. If you don't feel drunk, you must be under 0.05 and therefore ok to drive.

True

False

Don't Know

7. If you are an experienced drinker (tolerant), your BAC would be lower

True

False

Don't Know

8. Coffee or food, reduce your BAC reading.

True

False

Don't Know

9. Your BAC reading would be higher if you are on medication or other drugs.

True

False

Don't Know

APPENDIX 2

You are cordially invited to attend the launch of the

STANDARD DRINK EDUCATION PROJECT



A project funded by the Australian Education and Rehabilitation Foundation.

The project will be formally launched by Mr. Chris Fox – Chief Executive Officer, Central Bayside Community Health Services.

Friday 13th May 2005

11am to 12pm.

MULTI PURPOSE ROOM 3

Central Bayside Community Health Services
Multipurpose Room 3, 335 Nepean Highway, Parkdale.

RSVP: Email: rkaldawi@cbchs.org.au

By Friday 29th April 2005

Street Parking available.

APPENDIX 3

LEADER Editorial

24th May 2005 (pg 23).

NEWS

Cut drinks down to size



at a glance

- **SIZE:** 10g of alcohol in a standard drink
- **MALE:** Maximum of four standard drinks a day
- **FEMALE:** Maximum of two standard drinks a day
- **PACKAGING:** Manufacturers legally have to list how many standard drinks are in each vessel

BRIDGET CULL

IT IS not how many drinks you have, it is their size that counts, says a local health service.

Central Bayside Community Health Service started the Standard Drinks Education Program – the first of its kind in Melbourne’s South – earlier this month in the cities of Bayside, Kingston and Glen Eira.

Co-ordinator Robert Kaldawi said any local business could use the free Federal Government-funded program, which involved courses held at workplaces to educate employees on the size of standard alcoholic drinks.

“There’s a lot of ignorance out there in terms of alcohol consumption,” Dr Kaldawi said.

“It’s obvious in the general com-



Rod Glenn-Smith, Dr Robert Kaldawi and Sen-Sgt Hans Harms look at the size of a standard drink. N48MC104

munity and within business and workers – there’s a lot of binge drinking.”

A standard drink had 10g of alcohol and all alcohol packaging had to list the number of standard drinks in each vessel, he said.

“Four standard drinks is the maximum for one day for a male and two for a female – that’s if you want to avoid health problems,” Dr Kaldawi said.

He said many people wondered why they failed drink-driving tests after having one or two glasses of wine.

They needed to look at the size of their glasses, Dr Kaldawi said.

Employers had a duty of care to make sure their employees knew how to drink responsibly and the course had many flow-on benefits for businesses, he said.

“It’s about making sure

employers understand the long-term economic benefits too, from reducing Work Cover claims, accidents in the work place, health-related problems and loss of productivity that comes with all that,” Dr Kaldawi said.


» **Details:** Phone Central Bayside Community Health on 8587 0200 to join the program.

APPENDIX 4

LEADER Advertisement

29th June 2005 (pg 15).

Free Funded Program




53MCV956139F/CP/04

Central Bayside Community Health Services is running
***FREE Standard Drink Education in Work places within
Bayside, Kingston and Glen Eira.**

These consist of one hour presentations designed to explain Standard Drinks, Blood Alcohol Concentration and Alcohol Guidelines. Show Bags are also included containing important information on alcohol and health.

Employers will enjoy long term economical benefits associated with education, prevention and improved care and morale within the work place.



**CENTRAL
BAYSIDE
COMMUNITY
HEALTH
SERVICES**

**To book your session
or for more information,
please contact
Dr. Robert Kaldawi:
C.B.C.H.S. on 8587 0200
or mobile 0425 384 363.**

* Funded by the Alcohol
Education & Rehabilitation
Foundation Ltd.

APPENDIX 5

CBCHS Quarterly Newsletter Autumn 2005.



CENTRAL BAYSIDE COMMUNITY HEALTH SERVICES

Quarterly Newsletter

EDITION ► Autumn 2005

Welcome to the inaugural CBCHS Quarterly Newsletter! Each edition of the newsletter will feature an article related to healthy living. I hope you find this newsletter interesting and informative. If you have any suggestions regarding content of future articles, please let me know. With the 'silly season' just around the corner, I hope this first article helps you make better and informed decisions. This article is by Dr Robert Kaldawi, our Standard Drinks Educator. Warmest regards and look after your own health.
Chris Fox CEO

WHAT IS A STANDARD DRINK OF ALCOHOL? 10 grams pure alcohol per serve

There is a lot of confusion amongst people about what is a Standard Drink, and how that reflects on their Blood Alcohol Concentration (BAC). Furthermore, many people often feel fine after consuming alcoholic drinks, only to be shocked by the Breathalyser at a Booze Bus.

The reason people are confused about this is because of two main reasons:

1. People treat the way they feel after drinking alcohol as an indication of their BAC. So, if they feel fine, they often assume that they are fine. In fact, this is far from the truth. The way a person feels after consuming alcohol is based on parameters which are largely different than those which determine BAC. Accordingly, a person can feel "fine", not drunk at all, and have a BAC reading above 0.10. By the same token, a person can feel way over the limit despite the breathalyser reading showing below 0.05. So if you feel fine, this does not necessarily mean that you are fine.
2. People do not understand their "own limit" and in turn, the factors which affect BAC. These factors are muscle to fat ratio (build and size), gender (women are likely to blow twice the reading of their male counterparts for the same amount of alcohol consumption) and health conditions (liver/metabolism/age etc...).

FACT: You can still have alcohol in your blood 24 hours after your last drink.

Listed below are some Standard Drink sizes:

- Spirit = 30 ml (nip)
- Heavy Beer = 285 ml (pot)
- Light Beer = 375 ml (can)
- Wine and Champagne = 100 ml (small glass)
- Port or Sherry = 60 ml

FACT: All alcoholic beverages contain **Ethyl Alcohol**, the drug which affects mood and causes intoxication. So, despite the fact that beverages look and taste different, they actually contain a common active ingredient (in different concentrations). In its natural form, alcohol is a transparent colourless liquid.

Measure metabolism of alcohol - Gender, Size, Fat/Muscle Ratio
As mentioned previously, the use of Standard Drink measure can show the differential BAC measurements and highlighting those at higher risk. For example, research has shown that the liver of women is less designed to cope with alcohol than men due to enzymatic differences. Women are also generally

HEAD OFFICE
PARKDALE - COMMUNITY HEALTH SERVICES
335 Nepean Highway
Parkdale 3195
T. 8587 0200 F. 8587 0210

CHELSEA - COMMUNITY HEALTH SERVICES
23 Bath St Chelsea 3196
T. 9781 9333

CLARINDA - COMMUNITY HEALTH SERVICES
58 Viney St Clarinda 3169
T. 9552 4333

PLANNED ACTIVITY GROUPS
Day Programs For The Aged
31 Venice St Mentone 3194
T. 9583 6970

ADULT COMMUNITY OPTIONS
Day Programs For People With An Intellectual Disability
335 Nepean Highway
Parkdale 3195
T. 8587 0250



CENTRAL BAYSIDE COMMUNITY HEALTH SERVICES

Website www.cbchs.org.au
Email info@cbchs.org.au

APPENDIX 6

December 1st 2005

Steering Committee Reference Group

Standard Drink Project (Funded by AER)

C/o Central Bayside Community Health Services

335 Nepean Highway, Parkdale. 3195

Mr. Rod Glenn-Smith (Good Sports program, ADF)

Ms Michelle Chiller (Kingston City Council)

Ms Allison Ridge (Bayside City Council)

Ms Marion Pennicuik (VicRoads)

Mr. Pierre Castelino (VicRoads)

Mr. Denis Carroll (TaskForce)

Ms Catherine Donoghue (Gleneira City Council)

Senior Sergeant Hans Harm (Victoria Police, Kingston TMU)

Dear Members,

As the above project is in its final stage and a report is currently being prepared for the funding agency (AER), it gives me a great pleasure to write to you at this stage to thank you sincerely for the effort that you have made towards this program.

Your valuable time and contribution has been greatly appreciated and has had a positive impact on the success of this program.

I am enclosing herein a copy of the 1st draft of the results and I trust that each of you will receive a copy of the final report due to be completed in January 2006.

Finally, on behalf of the funding body, CBCHS and this writer: **THANK YOU.**

Sincerely,

Dr. Robert Kaldawi (Ph. D., Biochemistry)

Manager,

Standard Drink Education Program

Central Bayside Community Health Services.

APPENDIX 7

Name	Organisation	Address	Contact Numbers	email
Rod Glenn-Smith	ADF State Manager Good Sports	55 Pelham Street CARLTON VIC 3053	T: 96679220 M: 0425812414 Fax:: 96622858	rod@adf.org.au www.goodsports.com.au
Michelle Chiller	City of Kingston Health Planning and Development Officer	PO Box 1000 Mentone Vic 3194	Ph: 95814807 Fax:: 95814500	michelle.chiller@kingston.vic.gov.au
Allison Ridge	Bayside Council	76 Royal Av Sandringham 3191 Box 27	Ph: 9599-4444 Fax:: 95984474	aridge@bayside.vic.gov.au
Marion Pennicuik & Mr. Pierre Castelino (VicRoads)	Road Safety Coordinator Metro Inner South East Region, VicRoads	2nd Floor, 12 Lakeside Drive, Burwood East	T: 9881 8016 F: 9887 7590 M: 0411 015 382	Marion.Pennicuik@roads.vic.gov.au
Denis Carroll	TaskForce	421 South Rd Moorabbin	Ph: 95320811	denis@taskforce.org.au
Catherine Donoghue	Glen Eira City Council		Ph: 95243364	cDonoghue@gleneira.vic.gov.au
Hans Harms Senior Sergeant	Victoria Police Kingston Traffic Management	1011 Nepean Hwy Moorabbin	Ph: 95566106 0414181495	hans.w.harms@police.vic.gov.au

APPENDIX 8

Standard Drinks Education Project

Terms of Reference

Aim

The Reference group for the Standard Drinks Education Project provides an opportunity for agencies to meet and provide direction to the Standard Drinks Project.

Objectives

- Provide a forum for invited agencies to discuss the progress of the project and provide input for future actions.
- Network and liaise with agencies that share a common interest in this project and avoid duplication of effort.
- Develop ideas to secure resources for future projects related to this issue.

Representation

Central Bayside Community Health Services, Vic Roads, Taskforce, Kingston City Council, Glen Eira City Council, Bayside City Council, Kingston Traffic Management- Victoria Police and Australian Drug Foundation.

Meeting Dates/Venue

- The Chairing, setting of agenda, minute taking and distribution of minutes will be the responsibility of Central Bayside Community Health Services.
- Frequency of meetings-
To be decided by group. Meetings to be held at Central Bayside Community Health Services 335 Nepean Hwy, Parkdale 3195, Multipurpose Rooms or venue as deemed appropriate by group.

APPENDIX 9



Attention: _____

Fax: _____

Total Number of Pages: 1

EMPLOYER QUESTIONNAIRE

Please complete this questionnaire to book your presentation.

NAME OF COMPANY: _____

NAME OF PERSON ISSUING INVITATION: _____

TITLE / POSITION: _____

TELEPHONE NUMBER: _____

FAX: _____

EMAIL: _____

INDUSTRY CLASSIFICATION: _____

(e.g. manufacturing / retail / administration / corporate etc.)

NUMBER OF EMPLOYEES EXPECTING TO ATTEND: _____

(maximum 50 participants per presentation; we can book further sessions for additional workers)

PLEASE CONFIRM AVAILABILITY OF TEACHING AIDS:

(Please note that the minimum requirement is an overhead projector)

TV / VCR	YES	NO
White Board	YES	NO
Overhead Projector	YES	NO
Computer / Internet / Projector / Screen	YES	NO

PROPOSED DATE OF PRESENTATION: _____

PROPOSED TIME OF PRESENTATION: _____

PERIOD OF TIME ALLOCATED: _____

ACCEPTANCE CONFIRMATION

CENTRAL BAY SIDE COMMUNITY HEALTH SERVICES

(This section to be completed and faxed back to the Employer confirming attendance time / date).

Standard Drink Education Project Manager: Robert Kaldawi

Telephone: 8587 0215

Mobile: 0385 010 008

Fax: 8587 0210

Email: rkaldawi@cbchs.org.au

I hereby confirm your booking for Standard Drink presentation as indicated above.

SIGNATURE: _____

THANK YOU FOR YOUR INVITATION

APPENDIX 10



OBJECTIVES OF THE STANDARD DRINK PRESENTATION

1. Define a Standard Drink
2. List background and reason (s) for a Standard Drink.
3. Identify where Standard Drinks are specified
4. Determine purpose and when Standard Drink measurement is used.
5. List parameters which affect BAC (Blood Alcohol Concentration)
6. List parameters which affect Drunkenness or intoxication behaviour
7. Define the NHMRC guidelines to low risk alcohol consumption for men and women
8. Identify legal ramifications of Standard Drinks and Drink Driving Laws and Penalties in Victoria
9. List numbers for further help, assistance or information.

EXPECTED OUTCOMES AS PER EVALUATION CRITERIA

1. Participants will be able to define Standard Drinks
2. Participants will be able to differentiate between BAC and Drunkenness
3. Participants will be able to list the factors which affect BAC
4. Participants will be able to list the factors which affect Drunkenness
5. Participants will be able to cite where to go for further help of information
6. Participants' will be tested before and after to evaluate their relevant knowledge of Standard Drinks and to measure any improvement in their knowledge as a direct result of the presentation itself.
7. Participants' feed back will be measured with respect to the impact of the presentation in improving their lifestyle and / or attitude towards alcohol.
8. Participants' feed back will be sought regarding the content and / or style of the presentation
9. Participants' additional comments or feedback will be sought regarding general aspects of the presentation.