

Peer-reviewed papers

Road trauma education: the impact of a patient presenter on the road safety attitudes of adolescents

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Abstract

Road trauma accidents remain a significant issue in Victoria, with a high proportion involving young drivers. Given this age group, school based road trauma education programs could be successful in alleviating such incidence rates. This study evaluated the effectiveness of an existing road trauma program on 107 secondary school students and determined whether an additional education session with a patient presenter elicited an increased change in attitudes relating to traffic safety. A control group received the program only (n=43) and an experimental group received the program and an additional session (n=64). Quantitative analysis using the ‘*The Attitudes Towards Road Safety (ATRS) Questionnaire*’ displayed some statistically significant differences. However, analysis of a separate qualitative questionnaire yielded stronger evidence for the positive impact of the additional session. This study demonstrates how educating students on the long term consequences of road trauma can positively impact upon their attitudes towards risk taking behaviour.

Keywords

Road trauma, Education, Traumatic brain injury, Rehabilitation, Adolescents

Introduction

Within Victoria, 299 people died and 5,878 people were hospitalised due to injuries sustained on Victorian roads in 2012 [1]. For those who survive a road traffic accident, many are left with physical, cognitive or behavioural deficits that can severely impact their quality of life. Deficits include loss of employment, changes in social participation, marital strain or separation and loss of

friends/family support [2]. These issues can lead to social isolation and change not only the lives of those injured, but also their family, friends and local community.

Young people appear to be over-represented in these statistics, with 24% (1,430) of patients aged 16-25 years old hospitalised in Victoria in 2012 [1]. Young drivers between 18-25 years only represent 14% of the driving population yet account for 23% of fatalities. Of the 34 young drivers killed on Victorian roads in 2012, 76% were male [3]. Males have been known to have a higher rate of road accidents than females and this gender difference is most marked in the population under the age of 25 years [4]. Some of the road accident risk factors in young people include peer pressure, inexperience, inappropriate speed, failure to wear seatbelts and drugs/alcohol [5]. These factors, combined with the effect of road trauma on the community, highlight the ongoing need for road trauma education programs. Recent literature indicates that school based learning programs can be a successful approach to reducing road fatalities and trauma. Attitudes towards safety are formed at an early age and on that basis it is important to target adolescents and young adults [6]. Evidence for the effectiveness of education in reducing risk-taking in adolescence is speculative; however this does not mean that innovative education programs should not be trialled [7].

Engström et al. in 2003 argued that communication campaigns that employ persuasive, emotional messages are the most effective where young drivers are concerned [8]. A recent study utilised a focus group of young adults (17-24 years old) to discuss various factors which could affect driving behaviours. These young people spoke about campaign effectiveness and felt that ‘who delivers the message is important’. In particular, it was thought that messages from ‘accident victims or their family members’ would hit home more, especially for high school kids’ [9].

The aim of the present research was to evaluate the effectiveness of an existing road trauma program (Traffic Safety Essentials – TSE) and determine the effectiveness of an addition to this program received by the experimental group (a personal account of trauma from a road accident survivor and rehabilitation staff member). It was hypothesised that the additional session will create a greater change in adolescent attitudes towards risk taking behaviour on the road, compared with those who did not receive the additional session. A secondary hypothesis was that there will be a difference in the attitudes towards risk taking behaviour between males and females.

Method

In collaboration with the Victorian Department of Education and Early Intervention, an additional road trauma education session was offered to Year 10 students at a Melbourne secondary school. This research received ethics approval from Epworth HealthCare's Human Research Ethics Committee.

Participants

There were 160 Year 10 students (out of 269) who consented to participate (59.5% response rate). All students were eligible to participate if their person responsible (e.g. parent or guardian) consented through signing a Patient Information and Consent Form (PICF). No one declined to participate, but a significant number never returned their consent form. Participants were randomly allocated to either a control group (who received the TSE program) or an experimental group (who received an additional education session).

A male patient (aged 22) previously admitted to Epworth HealthCare following a motor vehicle accident was recruited and consented for the additional session. The patient was a passenger who sustained a severe traumatic brain injury (TBI) with multiple orthopaedic injuries and was hospitalised for approximately six months after his accident.

Inclusion criteria for selecting this patient were: aged between 18-40 years; involved in a road trauma accident over 12 months ago and sustained a TBI; support from outpatient therapists; and their willingness (and sufficient communication skills) to share their personal road trauma experience with students.

Study Intervention

All students participated in a traffic safety program routinely offered by the school known as the TSE Program, developed by the Transport Accident Commission (TAC), in partnership with other key Victorian agencies [10]. It consists of six units which cover various classroom road

safety activities. The experimental group also attended an additional education session facilitated by the researchers. The session included a presentation from a patient involved in a road traffic accident who was willing to share his road trauma and rehabilitation experience. The extra session commenced with a 15 minute introduction from a principal researcher outlining information on rehabilitation, TBI and choices/consequences around road safety. This was followed by a five minute video compiled by the patient presenter and a 25 minute semi-structured interview between the principal researcher and patient presenter.

Materials

All students were administered the 'The Attitudes Towards Road Safety (ATRS) Questionnaire' to measure attitudes relating to traffic safety issues pre and post the TSE Program and additional education session [11]. This validated instrument comprises 16 items which measure three dimensions of attitudes established through factor analysis: attitudes towards rule violations and speeding (e.g. "Speed limits are exceeded because they are too restrictive"); attitudes towards the careless driving of others (e.g. "I will ride with someone that speeds if that's the only way to get home at night"); and attitudes towards drinking and driving (e.g. "I would never ride with someone I knew has been drinking alcohol"). Each question is scored on a five-point Likert Scale with higher scores indicating a 'non-ideal' attitude and lower scores indicating an 'ideal' attitude towards road safety. Student demographics and driving experience were collected including; age, gender and learner permit obtainment. The experimental group were also given a separate questionnaire to gather feedback about the additional session.

Study Procedures

Students were allocated class numbers (A-L) and student numbers (1-26) which created their student ID numbers used for this research (e.g. A1). The control and experimental groups were administered the ATRS Questionnaire during class time. Both study groups then participated in the routine TSE Program as part of their Year 10 curriculum. The experimental group also received the additional education session conducted by the patient presenter and researcher. The ATRS Questionnaire was then readministered by their teacher six months later to both groups and approximately one week after the additional session. The experimental group were also supplied with a qualitative questionnaire pertaining to the additional session (refer to Table 2).

Data Analysis

Responses from the ATRS Questionnaire were collated and statistically analysed using the IBM SPSS statistical package (Version 19, 2010). Descriptive statistics were

computed on participant demographics and driving experience including age, gender and learner permit obtainment.

As there were only two time-points, a mixed between-within subjects analysis of variance (ANOVA) was employed with one repeated within subjects variable (time) and two between subjects variables (gender and group) [12]. The ANOVA was conducted for each dimension to assess the impact of group (control/experimental) and gender (male/female) on participants' responses across time (pre-intervention and post-intervention). Main effects of the independent variables (IV) (gender/time/group) as well as statistical interaction between the IV's were evaluated. Main effects represent the separate effect of each IV on the dependent variable (DV) (participants' responses) and interactions occur when the effect of one IV changes across the levels of another IV [13]. Independent samples t-tests evaluated any differences in age by gender and group.

Qualitative responses from the post feedback questionnaire were subjected to thematic analysis – 'a method for identifying, analysing and reporting patterns (themes) within data' [14]. Collated data containing numerous quotes and ideas were evaluated independently by two researchers (an Occupational Therapist and Social Worker). Researchers went through the routine thematic analysis process, distilling codes (items) from the responses and sorting them into various themes. Researchers ensured their independent codes and themes were compared until

full agreement was reached for each theme. Themes allowed researchers to summarise data, make 'bulky data manageable' and assisted in drawing conclusions about what is being investigated [15]. For example, the following quote from a student was categorised as 'Passenger Awareness' – "I would never get in the car with a risky driver or someone who is intoxicated because I now know the consequences and I don't want to experience them for myself."

Results

Of the 160 consenting participants, 124 (77.5%) were available at the commencement of this study and were randomly allocated to either the control group (N= 46) or experimental group (N= 78). Participants comprised 61 (49.2%) males and 63 (50.8%) females with a collective mean age of 15.20 years (SD=0.58). There were only five (4.0%) participants who obtained a learner permit for a mean of 4.80 months (SD=4.27). Of the total consenters (n=160), 43 (26.9%) were excluded due to incomplete data sets (two students completed pre-intervention questionnaire only, 35 completed post-intervention questionnaire only, one did not complete either questionnaire and five had missing data on at least one scale item). A further 10 (6.3%) were excluded due to ID errors, whereby teachers mismatched the same participants to different ID's from pre to post intervention. Overall, there were 53 (33.1%) participants excluded resulting in a final analytic sample of 107 participants.

Table 1. Mean and standard deviations by main effect

		Control			Experimental		
Main Effect	Dimension	mean	standard deviation	n	mean	standard deviation	n
Group	1 'violations/speeding'	21.14	4.55	43	22.80	5.16	64
	2 'careless driving'	4.48	1.33	43	5.72	1.95	64
	3 'drink/driving'	2.98	1.31	43	3.13	1.51	64
		Male			Female		
Main Effect	Dimension	mean	standard deviation	n	mean	standard deviation	n
Gender	1 'violations/speeding'	23.02	5.03	56	21.16	4.76	51
	2 'careless driving'	5.53	1.90	56	4.88	1.70	51
	3 'drink/driving'	3.36	1.60	56	2.75	1.15	51
		Pre-Intervention			Post-Intervention		
Main Effect	Dimension	mean	standard deviation	n	mean	standard deviation	n
Time	1 'violations/speeding'	22.84	5.52	107	21.42	5.69	107
	2 'careless driving'	5.60	2.28	107	4.84	1.86	107
	3 'drink/driving'	3.02	1.75	107	3.11	1.81	107

The analytic sample had 43 (40.2%) participants in the control group and 64 (59.8%) in the experimental group. There were 56 males and 51 females with a mean age of 15.20 (SD=0.44) and 15.29 (SD=0.65) respectively. Independent samples t-tests revealed no statistically significant differences in age by gender ($t = -0.88$, $p = 0.38$). There were also no significant differences in age between the control group ($M = 15.27$, $SD = 0.50$) and the experimental group, ($M=15.22$, $SD = 0.58$); ($t = .42$, $p = 0.68$). Only four (3.7%) students obtained a learner's permit for a mean of 3.75 months ($SD = 4.11$); a rate much lower than those actually eligible for a permit (students aged ≥ 16 years: 20.6%).

Statistical analyses are presented according to each attitude dimension within the questionnaire. For each dimension, means and standard deviations (Table 1) were calculated by main effect (group, gender and time).

Dimension 1: Attitudes towards rule violations and speeding

ANOVA assessed the impact of group type (control: experimental) and gender (male: female) on participants' responses to Dimension 1 at pre and post intervention. There was no statistically significant interaction between gender, group and time, ($F_{1,103} = 0.75$, $p = 0.39$), suggesting that the effect of time is not a function of gender or group type.

There was a significant main effect for time, ($F_{1,103} = 6.02$, $p = 0.02$), with participants showing a decrease in scores from pre-intervention ($M = 22.84$, $SD = 5.52$) to post-intervention ($M = 21.42$, $SD = 5.69$) irrespective of group or gender. There were no statistically significant main effects for group or gender, although the latter trended towards statistical significance with males yielding higher scores ($M = 23.02$, $SD = 5.03$) than females ($M = 21.16$, $SD = 4.76$), ($F_{1,103} = 3.4$, $p = 0.07$).

Dimension 2: Attitudes towards the careless driving of others

There was no statistically significant interaction between gender, group and time, ($F_{1,103} = 2.19$, $p = 0.14$). There was a significant main effect for time, with all participants, regardless of gender or group showing a reduction in scores from pre-intervention ($M = 5.60$, $SD = 2.28$) to post-intervention ($M = 4.84$, $SD = 1.86$), ($F_{1,103} = 15.02$, $p < .0001$).

There was also a main effect for group, with participants in the control group ($M = 4.48$, $SD = 1.33$) scoring lower than the experimental group, irrespective of gender or time ($M = 5.72$, $SD = 1.95$), ($F_{1,103} = 11.79$, $p = 0.001$). Gender did not produce a statistically significant main effect, however it approached statistical significance ($F_{1,103} = 2.86$, $p = 0.09$) with males scoring higher ($M = 5.53$, $SD = 1.90$) than females ($M = 4.88$, $SD = 1.70$).

Dimension 3: Attitudes towards drinking and driving

There was no statistically significant interaction between gender, group and time, ($F_{1,103} = 0.439$, $p = 0.51$). The main effect for time was also non-significant, with participants showing no change in scores over time, ($F_{1,103} = .453$, $p = 0.50$).

There was a significant main effect for gender, with males ($M = 3.36$, $SD = 1.60$) scoring higher than females ($M = 2.75$, $SD = 1.15$), ($F_{1,103} = 5.07$, $p = 0.03$). Group type did not produce a statistically significant main effect.

Qualitative Data

A qualitative post questionnaire was completed by 84 students who attended the additional session, however some students failed to complete certain questions. The number of responses from the students ranged from 73 to 84 and so all percentages are based on the number of students who answered the questions (rather than the total amount of questionnaires returned). Table 2 is a summary of the categories identified through thematic analysis and examples of direct quotes to highlight particular responses. A maximum of two quotes per student were used to capture more diversity.

Discussion

The quantitative data displayed some statistically significant differences between the variables, namely main effects for gender and group, although these results did not differ across time. Young male drivers have been known to be more prevalent in statistics on road trauma and consequently fatalities in Australia. The cause behind this can be multifold; however literature has highlighted alcohol involvement as a main contributor to road fatalities and injuries [16]. In Australia, there is an increased prevalence of drink driving in young adults, ranging from 20-25% [17]. The results of this study were in line with these general findings, with males displaying significantly increased scores (non-ideal attitudes) towards drinking and driving (Dimension 3) than females. Although not significant, males also scored higher than females on the two remaining dimensions indicating increased non-ideal attitudes towards rule violations/speeding and careless driving of others. The experimental group also scored significantly higher than controls (irrespective of gender or time) for attitudes towards the careless driving of others (Dimension 2). The reasoning behind this is unclear; however it queries whether the additional session could have honed in on this particular dimension.

The qualitative data provided stronger evidence of the impact that the additional education session had on students. Even though the post questionnaires were

completed one week after the presentation, 62% of students mentioned the patient presenter by name in their responses. It may have been that for many of the students, the patient presenter became the face of road trauma for them. Meeting a victim in 'real-time' could have personalised each student's experience by showing them the long term consequences of risk taking behaviour. Of the students, 58% reported feeling emotional, sad or sorry for the patient presenter and 32% described the presentation as 'eye opening'. The emotional responses from the students to the additional session demonstrated that this format was one which has the potential to make a significant impact over time. The students' positive responses towards increased awareness of TBI and in particular of choices and consequences demonstrated how the messages put forward during the additional session were heard and clearly understood.

Further evidence of the connection between students and the patient presenter is that 45% of students reported that "getting into the car with a drunk driver" was a risk they would not take (categorised as 'Passenger Awareness'). The patient presenter spoke of his accident circumstances; accepting a ride home with a driver he did not realise was over the legal limits for alcohol consumption. Other common responses such as not speeding or driving under the influence were expected, but the researchers feel that the large portion of students who referred to 'passenger awareness' was directly linked to the patient presenter's personal story.

A focus of the principal researcher's presentation within the additional education session involved 'choices and consequences'. The term 'hidden road toll' was used during the principal researcher's presentation to discuss the high number of road trauma victims who suffer long term consequences for the remainder of their lives. It is noted that 74% of the students made reference to 'choices and consequences' when answering the qualitative question related to what they learnt from the presentation. There were also 41% of students that referred to 'choices and consequences' when answering how the presentation changed their views on risk taking. The researchers believe that this demonstrated the importance of providing a framework for the students; assisting them to process and further understand the emotional and confronting personal account told by the patient presenter. A secondary gain from the additional education session was an improved understanding of TBI by the students; thirty-five percent referred to an improved understanding of TBI and its impact on someone's overall life in their qualitative responses.

When asked the best way to try and reduce young people taking risks on the road, no students recommended the school based TAC TSE Program. Forty six percent recommended the additional session involving the patient

presenter and principal researcher and 28% recommended more policing and/or harsher penalties for driving offences. Interestingly, only 6% recommended more television advertising, questioning this as an effective means of targeting this age group. The students were asked whether all Year 10 students should have an opportunity to attend a similar education session and 96% answered yes. Forty percent of the students rated the additional session a 10 out of 10 and 91% rated the additional session as an eight or higher indicating a very positive response.

One of the challenges for the principal researchers was trying to connect with and impact upon young male students. Fifty one percent of the students who completed the qualitative questionnaire were male, and 48% reported feeling emotional, sad or sorry for the road trauma presenter. One male student wrote that he "*felt moved by the presentation. It changed my perspective of road safety and decision making skills.*" Another wrote that "*this presentation had a deep impact on me emotionally.*" The additional session's focus on choices and consequences had an impact on the male students, with 65% using those terms in their responses. One male student wrote that "*it eliminated the wishful thinking of 'it won't happen to me' or 'even if it does happen to me, it can't be that bad'.*" Another wrote that "*it made me realise how precious life is and how one stupid mistake can wreck your life.*" These results demonstrate how the additional session can impact upon one of the main target groups for risk taking behaviour, young males.

When reviewing the qualitative responses from students the principal researchers were also looking for any constructive criticism from the students. There were only two comments made by all of the 84 students that were classed as feedback or constructive criticism; "*It could have been a little more hands on or audience involved*" and "*Could have used 2 patient presenters.*"

A limitation of this type of study is the possibility of "ceiling effects", whereby pre-questionnaires contained a high level of 'ideal' responses. Ceiling effects arise when scores cannot increase because they are already close to the maximum scale value [18]. Due to the wide use of road safety campaigns in the media, the students may already have had attitudes that were close to ideal, and so there may have been little room for improvement on the post-intervention questionnaire. This may have been a barrier to ascertaining the effectiveness of the additional session, which may have been 'preaching to the converted' as it were. A further limitation of this study was that the ATRS Questionnaire was developed in 2004 for Norwegian adolescents. While the questions appeared to be relevant to an Australian population, further research on scale validation would be required.

With regard to future education programs, the principal researchers are keen to highlight the importance of using a semi-structured interview to support the patient presenter, as it allows for rehearsal, emotional support and guidance as required. The concern from allied health clinicians and family was that the patient presenter's cognitive deficits including poor attention and memory could lead to a repetitive presentation that lacked structure and guidance. Further research opportunities also exist by exploring the benefits for patient presenters. As well as providing a vocation and sense of value, it may also improve self esteem and confidence. Future road trauma educational programs focused on young males may also be justified to reduce driving under the influence and improve the already established 'non-ideal attitudes' towards drink driving [17].

Conclusion

The researchers hope that the findings of this research will help to shape future road trauma education strategies for students. It is possible that one of the biggest challenges in road trauma education is bridging the gap that lies between students 'knowing' and 'making' the right choices. The researchers believe that this study demonstrates that one of the best ways to bridge this gap is through improving the students' understanding of the severe long term consequences following a road trauma accident.

It is not possible to demonstrate the long term consequences of road trauma education. It cannot be ascertained whether an additional education session such as the one facilitated by the researchers will actually impact upon someone's choice to participate in risk taking behaviour in the future. However the researchers believe that it is imperative that students are made aware of the consequences of such risks, utilising the personal stories of road trauma survivors as a medium that has the potential to leave a lasting impression on them.

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Table 2. Qualitative responses

Question	Responses	Participants' Quotes
How did you feel after hearing the presentation and why?	<ul style="list-style-type: none"> • 58% reported feeling emotional, sad or sorry for the road trauma presenter. • 32% referred as 'eye opening.' • 18% reported feeling a need to change their current behaviour. • No students reported that it did not impact upon them. 	<ul style="list-style-type: none"> • <i>"I felt changed after hearing the presentation and felt guilty for not being careful enough. It made me be more careful but it was powerful due to it's personal experience that made it real"</i> • <i>"I feel invincible and Sam did too but based on what happened to him it scared me a little"</i> • <i>"I felt moved by the presentation. It changed my perspective of road safety and decision making skills"</i>
What did you learn from the presentation?	<ul style="list-style-type: none"> • 74% used the terms choices and consequences. • 35% refer to an improved understanding of TBI. • 1% did not report learning anything from the presentation. 	<ul style="list-style-type: none"> • <i>"I learnt that even if you are lucky enough to escape a crash with your life, there may still be horrible consequences and will take a lot of pain, patience, work and rehabilitation, and even then you may never be the same"</i> • <i>"...the hidden road toll which included those who have been severely injured and their lives basically changed forever. No-one sees that figure of 6,000 people"</i> • <i>"The consequences...doesn't have to be death, it could be worse"</i>
What risks would you never take when it comes to road safety?	<ul style="list-style-type: none"> • 80% reported that they would never drive under the influence of alcohol or drugs. • 45% referred to passenger awareness and not getting into the car with a drunk driver. • 27% reported that they would not speed. 	<ul style="list-style-type: none"> • <i>"I would never get in the car with a risky driver or someone who is intoxicated because I now know the consequences and I don't want to experience them for myself"</i> • <i>"I would never drive more than 10km faster than the speed limit"</i>
What was the most effective part of the presentation and why?	<ul style="list-style-type: none"> • 46% mentioned the patient presenter's video. • 72% mentioned the patient presenter and principal researcher discussion. • 5% mentioned the principal researcher presentation. 	<ul style="list-style-type: none"> • <i>"When he spoke about his life...it really showed that it doesn't necessarily stop, it's a life time consequence"</i> • <i>"The most effective part of the presentation was when he spoke to the class because he told us in more detail the pain and suffering he has had to go through to get where he is today"</i> • <i>"Having Sam there was very effective because he is a real person and not just a statistic. We could see how his life was effected and all the struggle he went to"</i>

Question	Responses	Participants' Quotes
<p>In what way, if any, did the presentation change your views about risk taking on the road?</p>	<ul style="list-style-type: none"> • 41% reported being more aware of choices and consequences. • 41% reported that they would now be more cautious. • 26% reported that it was a reminder about risk taking. • 12% reported that it did not change their views. 	<ul style="list-style-type: none"> • <i>“It made me realise if someone is in an accident and they make it out - surviving is just the start of the journey. There is a long road to get back to normal, if that is possible”</i> • <i>“It made the consequences seem more real and scary meeting a survivor of an accident. I want to be even more careful on the road”</i>
<p>In what ways can a severe injury from a road accident affect your life in the future?</p>	<ul style="list-style-type: none"> • 66% referred to changes in everyday life, work and study. • 45% referred to physical issues. • 31% referred to cognitive issues. • 30% referred to a decreased level of independence. • 29% referred to friendships and relationships issues. 	<ul style="list-style-type: none"> • <i>“A severe injury can break apart friendships, make someone lose their memory and physically hinder them from going on with the rest of their life”</i>
<p>What would be the best way to try and reduce young people taking risks on the road?</p>	<ul style="list-style-type: none"> • No students recommended the school based TSE Program. • 46% recommended the additional session involving the patient presenter and principal researcher. • 28% recommended more policing and/or harsher penalties for driving. • 22% recommended more education but did not specify what type. • 6% recommended more television advertising. 	<ul style="list-style-type: none"> • <i>“Educate them more, especially more of the presentations that Epworth does”</i> • <i>“Show examples of people who have experienced them. Not holding back any details and giving all the information and outcomes”</i> • <i>“By demonstrating the significance severe accidents can have and showing real life examples such as Sam showing how it has affected his life”</i>
<p>Should all Year 10 students have an opportunity to hear a similar presentation? If so, why?</p>	<ul style="list-style-type: none"> • 96% answered yes to the question. • 1 student answered no to the question, stating that “some students may be aware of road trauma or similar instances.” • 2 students answered “I don’t know.” 	<ul style="list-style-type: none"> • <i>“The reality is more real when in front of you, not just in videos or TV adverts”</i> • <i>“Yes, because it was a moving presentation with a good message. Some people may change their views about road safety after seeing it”</i> • <i>“Some won’t listen until they hear it from someone who has been in an accident and they see the consequences”</i>
<p>Overall, what would you rate the presentation out of 10?</p>	<ul style="list-style-type: none"> • 40% rated the presentation a 10 out of 10. • 91% rated the presentation as an 8 or higher. • The lowest score was a 6 out 10 from 1 student. 	<ul style="list-style-type: none"> • <i>“This presentation had a deep impact on me emotionally”</i> • <i>“More aware, hits you stronger than just a board presentation (billboard) or TV advert”</i> • <i>“I cried and stayed behind to talk to Sam because it had a big impact on me and I would recommend everyone seeing it”</i> • <i>“I liked how Sam showed how his life was before because he was normal like everyone else but that decision made his life change”</i>