Department for Transport

Road Safety Compliance Consultation
Don't Die from a Broken Heart

Response from the Institute of Alcohol Studies
Elmgren House, 1 The Quay, St Ives, Cambridgeshire, PE27 5AR

Drink driving

The IAS welcomes the opportunity to respond to the Road Safety Compliance Consultation "Don't Die from a Broken Heart". We confine our response to '3 Drink driving' and 'Annex B Summary of consultation questions 6 – 11'.

We note the emphasis contained in the consultation document on 'the minority of drivers' who pose a danger to themselves and other road users. Whilst recognising the need to address this issue, we also consider that drink driving counter-measures should continue to focus on total population approaches in order to maximise the deterrent potential of each counter-measure and to prevent future drivers from drinking and driving.

6. Do you have any comments on the use of targeted checkpoint testing for drink drivers?

The introduction of targeted checkpoint testing is certainly one of the most effective known counter-measures and should be introduced systematically across the UK. When the targeted checkpoint testing system is introduced we hope that clear guidelines will be issued to Chief Constables in regard to the operation of checkpoints and the selection of drivers for testing. It should also be made clear that the primary purpose of targeted checkpoint testing is deterrent rather than apprehension.

We hope that increased police powers will not be restricted to the targeted checkpoint testing system.

We hope that the Government will also consider the introduction of campaigns to ensure high-profile awareness of the function and use of targeted checkpoint testing in order to maximise public support. The experience of North Wales Police and their success in engaging the general public is noted.

We note that in European countries where there is no random breath testing, 46% of drivers think that they will never be checked compared to 22% of drivers in countries where random breath testing is allowed. The perception of increased enforcement is strengthened by the introduction of

random breath testing. The IAS notes that the 2001 European Commission Recommendation on random breath testing hopes that all drivers are checked for drinking-driving, on average, once every three years.

We consider that the introduction of targeted checkpoint testing during early mornings as well as at high risk times would increase the impact of this counter-measure. With the extension of licensing hours and changing patterns of drinking in the population the introduction of morning checkpoints may increase road safety compliance at a critical time for vulnerable road users (such as children on their way to school). In addition, this will help detect the High Risk Offenders.

Engagement with the public is seen as a paramount consideration. There is substantial public support among drivers for drink-driving countermeasures[1] and meaningful engagement with the public along these lines should allay fears of encroachment of civil liberties. The purpose and function of drink-driving checkpoints should be communicated to the general population by a coordinated media campaign.

We consider that certainty of detection is the most effective deterrent even when compared to swiftness and severity of punishment.[2]

7. Do you think we should withdraw the statutory right to a blood or urine test as an alternative to a breath test?

The IAS supports the withdrawal of this statutory right, with the following caveats:

1 That there is sufficient protection for those who cannot provide a valid evidential breath test at the roadside. The IAS recognises that for a minority of the population there is a real reason for the failure to provide a breath sample, for example, those with asthma, chronic obstructive lung disease. The Police should advise these individuals that they can provide a blood or urine sample.

2 That the effectiveness and accuracy of the new evidential testing devices that are expected to be in use in 2010 be communicated to the general public.

The IAS considers that the introduction of evidential breath testing at the roadside could result in greater efficiency in detection procedures and could also lead to an increase in the deterrent value of this counter-measure.

8. Please comment on three options in respect of the proposal to take away cover for High Risk Offenders (HROs) to drive after submitting a reapplication for a licence, while medical procedures are being carried out:

we move now to implement the change provided for in the Road Safety Act 2006 on the basis that we are satisfied that existing procedures allow ample time for medical examinations before a disqualification expires; or

we develop further powers either to require an HRO to submit a medical report with their re-application for a licence or to give them that option, to be implemented probably after we have removed the cover to drive; or

we defer implementing the change provided for in the Road Safety Act until we also have powers either to require HROs to submit a medical report with their re-application for a licence or give them that option

The IAS supports measures that do not allow high risk offenders to drive before a medical examination has been carried out and the results of the examination have been found to be satisfactory.

We would, therefore, support the second option, ie that the Government develops further powers either to require an HRO to submit a medical report with their re-application for a licence or to give them that option, to be implemented probably after removal of the cover to drive.

The IAS proposes that a system of annual monitoring of high risk offenders is introduced after their licences have been restored. This could take the form of an annual medical examination.

9. Do you agree that the costs of implementing and enforcing a judicial alcohol ignition interlock scheme would be disproportionate?

The IAS notes the conclusions of the Road Safety Research Report No 88 and agrees that the introduction of the alcohol ignition interlock scheme could be useful as a preventative measure, if introduced voluntarily as fleet interlocks. However, we do not consider this measure to be as effective as other counter-measures in changing drinking or driving behaviour in the longer term and we consider the overall cost to be disproportionate to the desired outcome.

The IAS considers that additional investment in counter-measures such as targeted checkpoint testing will result in greater compliance with drinking driving laws and reduce alcohol-related harm. These measures are also known to impact drivers with high blood alcohol level.

The introduction of ignition interlock schemes seems to be effective in achieving short term change and can separate the drinking behaviour, resulting in greater reassurance for family members and other passengers.

10. What priority do you think should be given to a change in the prescribed alcohol limit for driving?

The IAS would encourage the Government to give high priority to a change in the previous alcohol limit for driving.

The UK should legitimately and pragmatically reduce our alcohol limit to match most of Europe, ie 50mg%. In regard to young and novice drivers we believe that there is good evidence that a differential lower limit saves lives. Newly qualified drivers are reported to be particularly at risk of alcohol-related road crashes as a result of their limited driving experience. The highest rates of drink-drive accidents per 100,000 licence holders occur in the 17 to 19 age group, followed by those in the 20 to 24 age group. [3]

Evaluation of the introduction of lower BAC limits as part of new driver licensing systems in other jurisdictions have shown them to be effective in reducing collisions among young drivers and novice drivers.[4]

We note the Chief Medical Officer's call for a zero alcohol limit for drivers aged between 17 and 20. However, for technical reasons we believe that the limit cannot be set literally at zero and our recommendation is for the limit to be set at 20mg% for young and novice drivers.

11. What evidence are you able to offer – and what further evidence do you consider should be obtained – to support a fully considered decision whether or not to change the limit?

The evidence is clear that risk of accident rises steeply from 50mg% upwards. Some of this evidence is presented in the consultation document.

We refer to the evidence on lowering the blood alcohol limit, presented in Chapter 4 of the Alcohol in Europe Report[5] and also to that contained in the report 'Reducing Drinking and Driving in Europe' produced by Peter Anderson on behalf of the Institute of Alcohol Studies, European Commission and German Centre for Addiction Issues (DHS)[6] :

"the evidence of lowering BAL levels it appears that reductions in alcohol-related collisions, injuries and/or fatalities have been observed in most jurisdictions in which the legal limit has been reduced. The findings are not all consistent (cf. Kloeden and McLean, 1994; McLean et al., 1995; Bernhoft, 2000) which may be related to methodological differences between studies, as well as to differences in measures used and the specific social and historical context. In some cases, it appears that beneficial effects may decline over time (Vingilis et al., 1988; McLean et al., 1995), but lasting reductions in alcohol-related collisions and fatalities have also been reported (Henstridge et al., 1997; Norstrom & Laurell, 1997).

"The major impact desired with a new or reduced BAL limit is a general deterrent effect, where people who might otherwise drink and drive are deterred from doing so by knowledge of the law and the consequences of violating it (Homel 1990; Vingilis, 1990). Studies have demonstrated that the introduction of new drinking-driving laws or policies can have a substantial general deterrent effect if they are introduced under certain conditions. A classic example is the impact of the British Road Safety Act in 1969 which initially led to a significant and marked decline in collisions most influenced by alcohol (single vehicle night-time collisions), although the collision rate appeared to return to pre-law levels after about 1 year (Ross 1973). This initial impact may be due to an increase in perceived risk of being caught that is caused by the high level of publicity associated with new legal sanctions, while the subsequent reduction in impact is due to the realization that the actual risks of apprehension are not as high as initially believed (e.g. Ross, 1973; Vingilis and Salutin, 1980; Homel, 1990; Vingilis, 1990)."

With regard to the requirement for further evidence, the IAS considers that the following area of research should be undertaken.

Current estimates of alcohol attributable fractions (AAFs) for road casualties are based on accident data only. In order to get an accurate picture of the number of deaths and injuries due to alcohol it is necessary to obtain baseline, population data. To this end breath tests should be conducted on a random sample of motorists (also cyclists and pedestrians), stratified by type of road user, type of road and time of day, to correspond to data presented in 'Road Casualties in Great Britain'.

Breath alcohol levels should be recorded to the highest level of accuracy possible, to allow for subsequent analysis by whatever categories are politically relevant (e.g. above and below the current legal limit; above and below a proposed legal limit).

It would also be desirable to improve the reporting of breath or blood alcohol levels after accidents, as the current levels of reporting are fairly low. If higher levels could be encouraged for the duration of the study this would provide valuable data, even if this could not be sustained indefinitely.

Such data would allow for the calculation of AAFs using methods currently applied to illness data.[7]

References:

[1] AA/Populus Panel. Call for Cut to Drink Drive Limit. 21 April 2008

[2] Ross, 1982; Andenaes, 1983; Homel, 1988;
Alcohol Policy and the Public Good; Griffith Edwards et al, p 155; Ross, 1992
Alcohol: no ordinary commodity – p 160; Babor, T; Caetano, P; Casswell, S; Edwards, G; Giesbrecht, N; Graham, K; Grube, J; Gruenewald, P; Hill, L; Holder, H; Homel, R; Osterberg E; Rehm, J; Room, R; Rossow, I

[3] Department for Transport, Scottish Executive and National Assembly for Wales (2007) Road casualties Great Britain 2006. London: The Stationery Office

[4] Simpson HM and Mayhew DR (1992) Reducing the risks for new drivers: a graduated licensing system for British Columbia. Ontario: Traffic Injury Research Foundation.

Mayhew DR, Simpson HM, Ferguson SA et al (1999) Graduated licensing in Ontario: a survey parents. Journal of Traffic Medicine 27: 71-80.

Boase P and Tasca L (1998) Graduate licensing system evaluation: interim report. Ontario: Safety Policy Branch, Ontario Ministry of Transportation.

Bouchard J, Dussault C and Simard R (2000) The Quebec graduated Licensing system for novice drivers. A two-year evaluation of the 1997 reform. In: Proceedings of the 15th International Conference on Alcohol, Drugs, and Traffic Safety, T-2000. Stockholm, Sweden.

[5] Alcohol in Europe – A public health perspective; Anderson & Baumberg, 2006

[6] Reducing Drinking and driving in Europe – Anderson, P; 2008

[7] Jones et al; NWPHO; 2008

27th February 2009