Drink driving

This is a snapshot of alcohol policies in twenty five member states[1] of the European Union as at 31 December 2007. The data were collected as a joint initiative between the World Health Organization and the European Union as part of the World Health Organization's global alcohol database. Further information was taken from and is available in two publications of the World Health Organization: Evidence for effectiveness and cost-effectiveness of interventions to reduce alcohol-related harm [http://www.euro.who.int/document/E92823.pdf], and handbook for action to reduce alcohol-related harm [http://www.euro.who.int/Document/E92820.pdf].

The Alcohol Policy Series includes the following ten fact sheets documenting the state of the European Union's member state alcohol policy:

1. Infrastructures for alcohol policy
2. Price and tax measures
3. Awareness raising activities
4. Counselling and treatment
5. Availability regulations
6. Drink driving legislation
7. Health warning labels
8. Alcohol advertising
9. Alcohol sponsorship
10. Monitoring and evaluation.

The present fact sheet deals with drink driving and considers three issues:
1. The evidence for the impact of drink driving activities
2. The current situation
3. Considerations and next steps

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[1] Austria; Belgium; Bulgaria; Cyprus; Czech Republic; Denmark; Estonia; Finland; France; Germany; Hungary; Ireland; Italy; Latvia; Lithuania; Malta; Netherlands; Poland; Portugal; Romania; Slovakia; Slovenia; Spain; Sweden; and United Kingdom

1. THE EVIDENCE BASE

In general, drink–driving fatalities and accidents have been declining in most European countries, although there remains considerable room for improvement. Mortality data and police records of traffic violations can provide some information on the size of the problem, broken down by gender and age groups. Although young people have the greatest relative risk of a drink–driving accident, in absolute terms drink–driving and related accidents and fatalities are more common among middle-aged people. Survey data and opinion polls can provide information on the public's views and attitudes on drinking and driving, as well as their knowledge of legal BAC limits. Surprisingly, a significant proportion of European residents do not know the legal drink–driving limit in their own country, and many drivers admit to driving under the influence of alcohol. Nonetheless, most Europeans support tougher measures to reduce drink–driving, including greater enforcement by the police. With a growing number of private and professional drivers crossing borders, there is an increasingly good argument for harmonizing drink–driving laws, enforcement levels and sanctions across the European Region. Historically, once stricter drink–driving measures have been introduced, they gain greater public support. Repeated offences or very high blood alcohol levels can be an indicator of alcohol use disorders and alcohol dependence, for which treatment should be systematically available.

Many alcohol policy measures have been shown to reduce alcohol-related traffic fatalities. These measures include increased alcohol prices, minimum purchase ages and reductions in the density of sales outlets, supported by mass media campaigns.

Action on drink–driving is a policy measure which enjoys overwhelming public support. And not only does it reduce the risk of harm to the driver, but also the risk of harm to passengers, pedestrians and other divers (in the EU, drinking drivers comprise only about 2/5 of all drink–driving fatalities). One of the most effective interventions is simply reducing the legal BAC limit for driving. For any country with a BAC limit above 0.5 g/l, it is beneficial to reduce the level to 0.5 g/l, while countries with a level of 0.5 g/l will benefit from reducing the level to 0.2 g/l. However, a lower legal blood alcohol level is only effective if it is enforced. The best method of enforcement is random breath testing, followed by sobriety checkpoints. Enforcement should be supplemented by public educational campaigns to ensure that the public knows the consequences of being apprehended. Enforcement also works best when punishment is immediate, e.g., with on-the-spot fines, driving licence penalty points and, as appropriate, driving licence suspension. It can be further reinforced by court-mandated treatment and the use of alcohol ignition locks for specified periods. Alcohol locks can also be used as a preventive measure, notably for professional drivers.

2. DRINK DRIVING

Four countries had a zero level for the maximum blood alcohol consumption for driving, four countries between 0.2 g/L and 0.4 g/L and 14 countries at 0.5 g/L, Figure 1. Three countries had a level of 0.8 g/L. Seven of the 14 countries with a level of 0.5g/L for the general population had a lower level for novice drivers (two at 0g/L and 5 between 0.1g/L and 0.4g/L), Figure 2. Four of the 14 countries with a level of 0.5g/L for the general population had a lower level for commercial drivers (one at 0g/L and 3 between 0.1g/L and 0.4g/L), Figure 3.

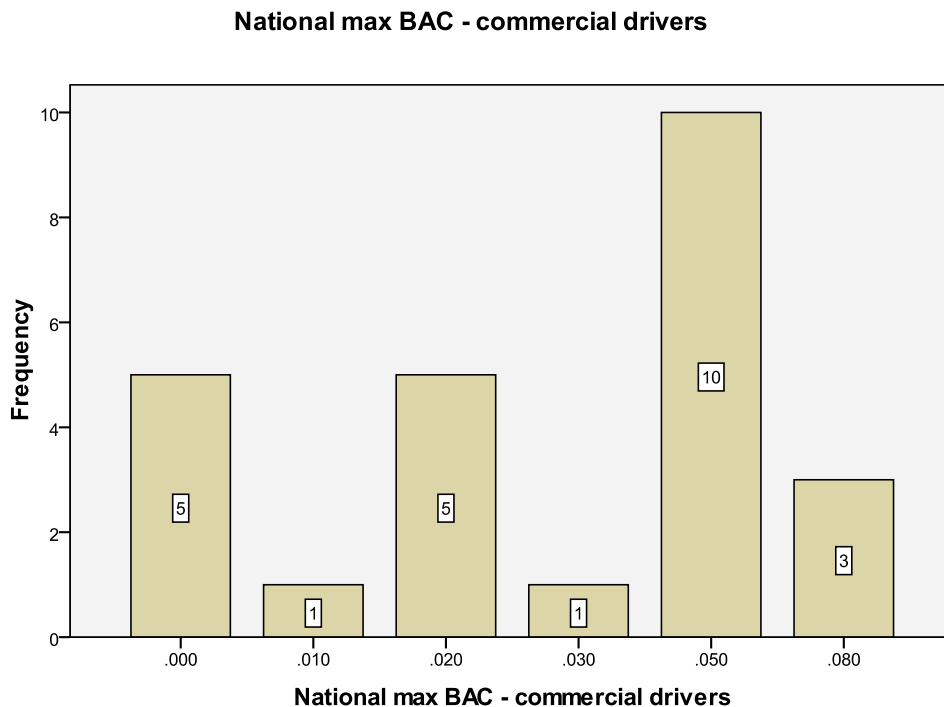**National max BAC - general population**
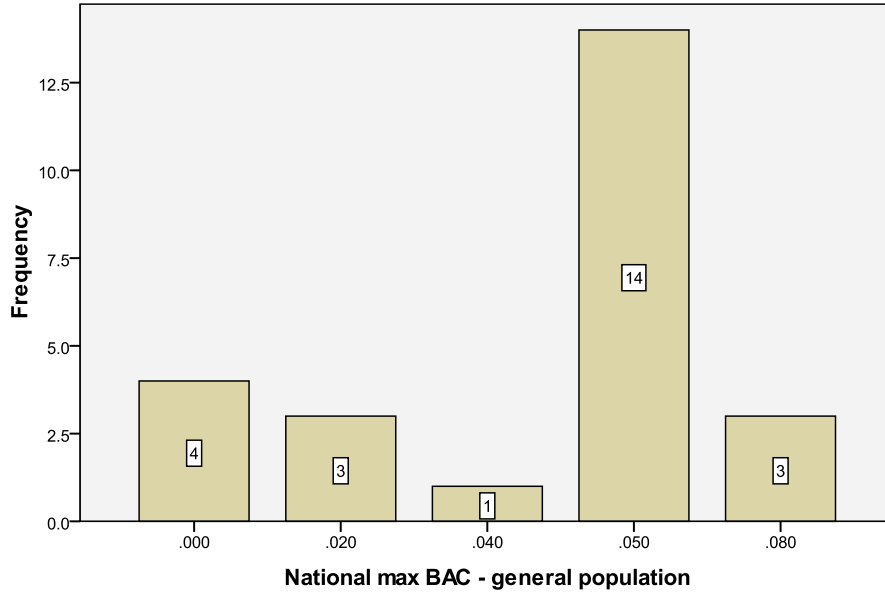
Figure 1 National maximum legal BAC level for general population

National max BAC - novice drivers
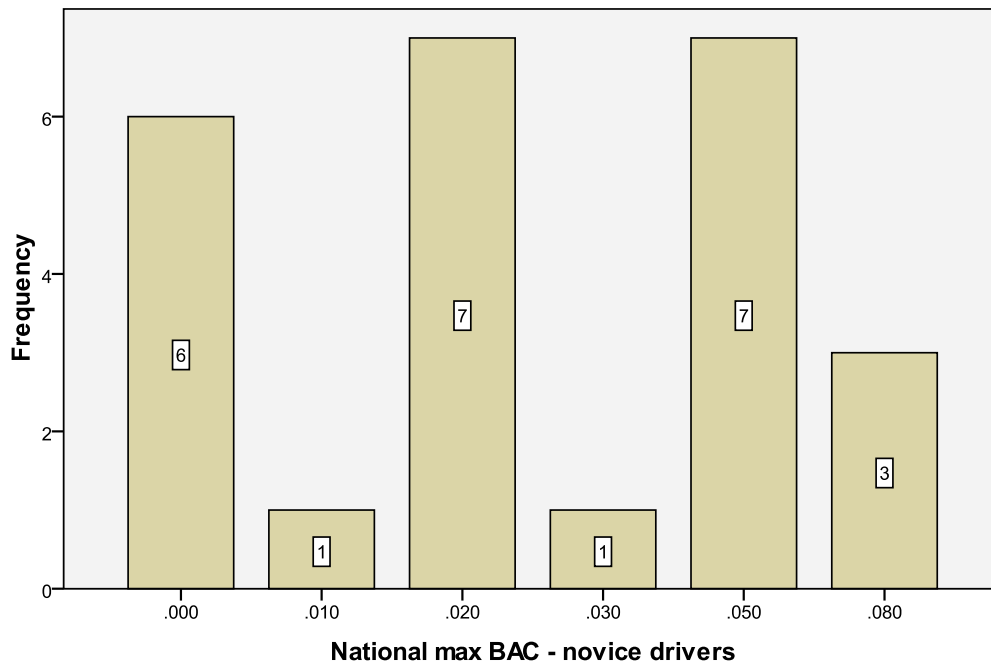
Figure 2 National maximum legal BAC level for novice drivers

National max BAC - commercial drivers

Figure 3 National maximum legal BAC level for commercial drivers

Sixteen countries had a system of random breath testing, with the other countries having selective breath testing or breath testing in the event of an accident. Responses to law infringement included fines in 23 countries, license suspension in 18 and imprisonment in 18. Thirteen out of 25 countries (52%) had mandatory driver education.

The estimated mean (standard error of the mean) level of enforcement for drink driving on a scale of 0 (not enforced) to 10 (fully enforced) was 6.5 (sem 0.5). The mean value did not differ between the 10 respondents who based the enforcement on statistical information (6.9) and the 13 respondents who based it on expert opinion (6.8).

3. CONSIDERATIONS AND THE NEXT STEPS
There remain opportunities for lowering the legal blood alcohol concentration level for drinking and driving and increasing the level of enforcement.

Questions to consider

1. ***Are there sufficient data systems in place to monitor drink–driving accidents and fatalities?*** Mortality data will capture driving fatalities, although the extent to which routine data are available on the proportion of these due to alcohol varies from country to country. Ideally, every person who dies from a traffic accident should have their blood alcohol level measured, so that the prevalence of drink–driving fatalities can be measured and monitored. (It should be noted that in some jurisdictions, when there is a one-car accident

that kills the driver but nobody else, post-mortem tests may not be legal due to the rights of the deceased). Police records should include data on all road traffic accidents, including the age and gender of the driver and the location of the accident. Ideally, every driver who is a causal agent in an accident should have his or her breath measured for alcohol, so that alcohol's possible contribution can be measured and monitored. A standardized measure of what to classify as a drink–driving accident should be agreed upon across the European Region, for example, any accident involving a driver who has a blood alcohol level over 0.2 g/l.

1. *Is it possible to incorporate into regular public opinion polls and surveys some questions on attitudes to drink–driving policies, knowledge of legal BAC limits, and drink–driving behaviour?*

2. *Is there in place an effective road safety transport policy that addresses drink–driving together with road safety measures to reduce the severity and risk of drink–driving accidents?* Such measures might for instance address infrastructure and speed limits. Drink–driving policies should be embedded in overall road safety transport policies. At a given blood alcohol level, drink–driving accidents can be more severe or more common when high speeds or poor road design are involved.

3. *Are traffic police willing to mount joint campaigns and activities with the ministry of health to reduce drink–driving?* Usually the police are positive supporters of increased action against drink–driving, and joint actions and campaigns can increase public awareness of the problem and the measures being used to address it.

4. *Do the police have adequate resources for effective enforcement? Can fines be used to finance police activity?* Effective enforcement of drink–driving laws requires a significant amount of police time to conduct and process random breath-testing activities and sobriety checkpoints. Resources are also required to pay for breath-testing equipment.

5. *Does the health sector have specialist services to provide treatment for recidivist drink–drivers?* High BAC levels and frequent drink–driving offences are a sign and symptom of alcohol use disorders and alcohol dependence. Resources need to be available for treating such cases, perhaps as mandated by a court order.

Options for action

- *Maintain the status quo* and do not change the BAC limits or levels of enforcement. However, very few countries would *not* benefit through lowering their existing BAC limits or improving enforcement. Choosing to continue the current policy misses an opportunity to reduce preventable deaths and injuries among both drinking drivers and others.

- *Reduce the legal BAC level for drinking and driving for all drivers.* Whatever the present legal blood alcohol level, evidence suggests that more deaths can be saved by reducing it closer to 0.2 g/l. This action sends a basic message and helps establish it as a cultural norm: no drinking and driving. To be effective, however, a lower BAC limit needs to be backed up by enforcement.

- *Enhance enforcement*, either through increased random breath-testing or greater use of sobriety checkpoints. For BAC limits to be effective, the driving public needs to know that there is a real risk of being stopped and breath-tested at any time. Enforcement should be supported by immediate action, including on-the-spot fines, the addition of penalty points to a driving licence and, for gross violations, the loss of a driving licence. The revocation of a licence usually indicates an alcohol-use disorder, and it should be accompanied by mandatory treatment, and by the installation of an alcohol ignition lock when a licence is reinstated.

Stakeholders for action

- The key stakeholder for reducing drink–driving accidents is the police, who are responsible for enforcing drink–driving laws and who generally support stepping up drink–driving countermeasures. Such countermeasures require adequate resources.
- Another important stakeholder is the department of transport, which normally has responsibility for implementing drink–driving laws and other policies to improve road safety.
- Those who serve alcoholic beverages are also stakeholders to the extent that they are responsible for not serving excess alcohol to drivers.

Bibliography

Anderson P (2008). *Reducing drinking and driving in Europe.* Hamm, German Centre for Addiction Issues (DHS) (http://dhs.de/makeit/cms/cms_upload/dhs/drink_driving_report.pdf, accessed 14 August 2009).

This document provides evidence on the impact of drink–driving policies. It was published by Pathways for Health, a project that is cofinanced by the European Commission and managed by DHS.

Anderson P (2009). *Evidence for the effectiveness and cost–effectiveness of interventions to reduce alcohol-related harm.* Copenhagen, WHO Regional Office for Europe.

This report, a companion document to the present handbook, details the available evidence for the impact of measures to reduce drinking and driving.

WHO (2009). WHO-CHOICE interventions: hazardous alcohol use [web page]. Geneva, WHO (http://www.who.int/choice/interventions/rf_alcohol, accessed 11 August 2009).

The WHO-CHOICE project has modelled the cost, impact and cost–effectiveness of a range of alcohol policy measures in reducing alcohol-related harm, including drinking and driving. Several publications discuss the results (see Anderson, 2009).