Addressing Driver Impairment Through Challenging Attitudes and Improving Education - A UK Success Story

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Background
Today I want to address aspects of driver impairment. Inevitably this is a huge area and I will only be able to scratch the surface, as you are probably aware there are a number of things which cause impairment including alcohol, drugs and when we talk about drugs we include not just illicit but also prescribed and over-the-counter medicines, and of course fatigue. Primarily today I wish to raise your awareness of what has been described as the Department for Transport’s most successful education initiative; the drink-drive rehabilitation scheme.

The breathalyser was introduced into the UK in 1967; and there was an impact on reducing road related accidents as a result. However in the 1980's the figures reached a plateau and following the North Report an amendment to the Road Traffic Act was made enabling the Department of Transport to introduce a pilot rehabilitation scheme from January 1993, in an attempt to impact once again on the figures.

Initially 18 course providers were approved to run the course. The Department of Transport determined the broad course content, duration and fees. A variety of organisations were approved to run the courses; Probation Services, Health Trusts, Alcohol charities and private companies including “Not for Profit”. We were one of those initial providers and have therefore been involved since the inception of the scheme; we are now the largest of the providers in England and Wales.

TTC is a "not for profit" company, whose key aim is to improve community safety. We run courses at more than 80 venues and our ethos of only using community venues e.g. rooms owned by charitable or community run organisations, where the hire charges benefit the community means that last year alone, we put more than £140,000 back into the communities we serve.

There remain about 85,000 convictions for drink-driving each year. It remains a significant challenge to reduce the number of people who continue to drink and drive. Unlike many other offences this is one, which cuts across all social classes. We have Doctors/Surgeons/Solicitors/Police Officers/Journalists/Teachers - in fact virtually every profession you can think of, trades people and manual workers.

At the inception of the pilot the Department of Transport had the foresight to contract with the Transport Research Laboratory to monitor and evaluate the project. Interestingly few other road safety initiatives have been as carefully introduced. The research was designed to assess the effectiveness of courses in three main areas:

1) To increase knowledge (regarding alcohol and driving)  
2) To challenge attitudes towards drinking and driving  
3) To reduce reconviction rates.
The scheme was monitored with a sophisticated and comprehensive evaluation tool. We are pleased to say the quality of this evaluation has enabled the Department for Transport to say this is the most successful scheme they have been involved in.

The initial results were extremely encouraging and in January 1998 the pilot was expanded enabling a smoother transition to a national scheme when, following legislation in 1999, the scheme became nationwide and permanent in January 2000.

The key incentive for attending the course is that the period of disqualification is reduced by up to 25%, you also get access to insurance companies who recognise the value of the course in reducing risk and therefore offer reduced premiums. The course, which TTC 2000 runs, consists of seven modules; Alcohol education (strengths/volumes/absorption rates), Health; Law relating to the breathalyser, responsible driving, (this session includes DfT information on speed and fatigue), Sentencing considerations, victims and strategies for the future.

Many of the people we see do not have a poor attitude towards drinking and driving in fact for some there is nothing at all wrong with their attitude, for example almost 20% of the people we see on courses have done everything right on the night; but because they have a significant gap about alcohol knowledge they get caught the next day. Unfortunately whilst it may be a new day our bodies are still processing yesterday's inputs!

Also we have to counteract many of the myths around; "A man can drink 2.5 pints before going over the limit and is therefore safe to drive". We do have to deal with some very mixed messages from government. It's okay to be impaired so long as you are not very impaired. Also 2.5 pints may represent 5 units which is approximately the drink drive legal limit in males but of course its only 2.5 pints of 3-3.5% alcohol. Many beers and lagers are now much stronger than this both on tap and in bottles/cans. Also any amount of alcohol WILL impair driving; it is irresponsible to have even one drink if you intend driving. "I was over the limit because I drank on an empty stomach".

The amount of alcohol you take in is the same to your blood whether your stomach is empty or full. Food only prolongs elimination time as the body can only eliminate certain amounts at any one time. Food therefore does NOT soak up the alcohol- however much we might want it to!

One glass of wine is always one unit of alcohol". This is one of the biggest myths often perpetuated by alcohol education leaflets/media coverage etc. Look around and see how many sizes of wine glass there are. The trend now is towards larger glasses but even if you can still find 125ml glasses you would need to hunt for 7-8% wine to go into it. Most wine purchased in this country is between 11 and 13% in other words 50% stronger so a small (125ml) glass will be 1.5 units Most pubs now serve 175 or 250 ml glasses so there will be 2 or 3 units in each. The sobering fact is that the body eliminates alcohol very slowly; it takes at least one hour to get rid of one unit of alcohol after absorption.

Alcohol is known as the acceptable drug, the lubricant of social life, it is involved in virtually all celebrations from the cradle to the grave. However it is a depressant and there is evidence that alcohol abuse is a major concern within the NHS. At a recent conference Doctors described alcohol abuse as crippling the NHS. In March this year the government finally launched the long awaited "National Alcohol Harm Reduction strategy" there are many interesting statistics in that document, including 6 million people binge drink, 17 million working days are lost and alcohol misuse costs the UK at least £20 billion per annum.
We are not talking about extreme cases of alcoholism, but the many health problems caused by drinking rather than the BMA recommended limits of 21 units a week for a man and 14 units for a woman.

Following careful tracking by the TRL, at regular intervals, of 3,500 participants for at least 72 months; nearly two and a half times more non-course attenders than course attenders had reoffended (17.9% of non course attenders compared with 7.6% of course attenders). This ratio of the rate of reconviction of non-course attenders to the rate for course attenders is similar at 3, 4, 5 and six years after conviction. The positive effect of the courses on reoffending rates, which was reported after three years, still persists after six years. For men, after six years, the course is most successful for;

- offenders from the middle social groups
- offenders aged between 30 and 39 years
- offenders who have been convicted of two drink drive offences with blood alcohol concentration (BAC) between one and 2 1/2 times the legal limit within ten years

Women drink drive offenders re-offend less than male offenders. At 72 months 7.8% of women who had not attended a course had reoffended compared with 3.7% course attenders. The research also showed significant increase in knowledge, significant change in attitude towards drink-drive and taking into account selection bias, reconviction rates have been reduced by more than 50%. An unexpected but welcome addition showed the education was being cascaded amongst families/friends/colleagues.

As part of our company policy, at TTC2000, we continue to apply our own monitoring of quality. These include: an evaluation sheet completed by every participant, all of these are read. Each contains some numerical information (pre and post course alcohol knowledge scores) these are fed back to staff on a quarterly basis; every trainer completes an evaluation questionnaire regarding each course, a telephone survey is undertaken with a random 25-30% of all participants from each course. We also undertake a senior management appraisal of every trainer by observing a full course at least annually and utilise mystery shoppers.

Careful and ongoing evaluation of the government backed Drink-Drive Rehabilitation course has shown the scheme to be overwhelmingly successful. We hope shortly to assist with the introduction of a similar pilot for drug driving. We already have a programme for such offenders prepared and ready for delivery to help make roads safer.

**Drugs and Driving**

When as a society we talk about drugs many people assume that only illicit drugs are a danger I hope to dispel this as a myth. When we talk of drugs we talk of three groups; prescribed, over the counter and illicit. In view of the short time available rather than go through each of these it would be more helpful to consider the drug families: 1) Drugs which slow the system down 2) Drugs which speed up the system, 3) Drugs which alter perception 4) Drugs which kill pain and Drugs which enhance performance.

A wide range of drugs will therefore affect driving skills, only some of which are considered by general society to be problematic. This is dangerous because it allows individuals to be complacent about substances, which may have a substantial impact on their driving ability. So even basic cough and flu remedies, which most people will have consumed at some time, will make a difference to judgement and perception. What about the millions who
take painkillers for basic ailments, headaches/arthritis etc. The whole point of these is to kill pain; this inevitably means depressing parts of the brain to experience less pain. The whole point is that it is probably delaying or altering judgement if it is being effective in killing pain. Last year we consumed in the UK 300 million tranquillisers, 1 in 7 adults take them. If tranquillisers work you might consider what happens to our reaction times and judgement?

Why do we have a problem? Well Britain, as a typically western culture has a long history of drug usage. There is also the cyclic nature of cause and effect we take a "recreational drug -this could be alcohol or an amphetamine, when we wake up with a headache the next day we simply reach for the aspirin. We may then end up with an upset stomach. The legitimate market for drugs both over the counter and prescribed is a highly contentious area. It is also a growing problem with drug use rising at 1.5% per annum. Given the number of people in work in the UK many/most of the 1 in 7 adults who take tranquillisers will be in the workforce- are they in yours? Some are almost certain to be. Consider what tranquillisers do, i.e. cause you to relax/become tranquil. Are these useful when operating machinery, driving etc?

The last 20 years has seen drug related deaths rise by more than 700 %. In 1998 there were 2,922 drug-related deaths recorded. We also need to bear in mind the age at which people first use drugs has reduced radically over the past twenty years.

Drug driving is clearly a major issue when it comes to driving ability. But again we are not just talking about illicit many over the counter drugs have a depressant affect i.e. make you drowsy.

RAC research shows that:

- 800,000 people have travelled in a car where the driver has been under the influence of cannabis and 280,000 with a driver under the influence of amphetamines. 140,000 have travelled with drivers under the influence of other drugs.

The shift towards drug impaired driving in Britain is huge, with drug related deaths accounting for 20% of all deaths in fatal road accidents.

We would like to consider culpability especially in relationship to prescribed and over the counter medicines. Frequently we hear or see the phrase "if affected do not drive" however we are then being asked to make a judgement we are no longer able to make. Once you have taken the drug it is not always easy to see the degree of change that your body is experiencing as a result of the drug. We believe that the warning given both verbally and on packaging should be changed to "you will be affected by this drug, you therefore should not drive or operate machinery". We also wonder in this increasingly blame ridden culture whether Doctors, Dentists and Pharmacists will need to get patients to sign to say they have been given this warning.

Turning to fatigue, this has recently been highlighted by some high profile cases. Alertness is critical to our lives. We suffer both physically and psychologically if we do not get enough sleep and with workforces being under greater pressure than ever to deliver, alertness really needs to be taken seriously. Research by the Department for Transport and North Yorkshire Police show that people with sleep problems are twice as likely to have an accident at work. The same study shows at least 40,000 serious injuries and
nearly 3,500 deaths occurred on our roads last year with drowsiness considered to be the greatest single cause. Each of those deaths cost about 1.2 million pounds—the human costs are of course incalculable.

In a report recently published by BRAKE 2 out of 3 drivers admitted falling asleep at the wheel. Also 50% of those interviewed admitted falling asleep at the wheel more than twice.

The UK’S leading sleep research centre at Loughborough published research showing:

- Almost 25% of accidents on major non-urban roads are due to sleepiness.
- Sleepiness kills more drivers and passengers than alcohol
- Accidents are worse due to high impact i.e. speed with little or no evasive action

Parts of the difficulties we face in addressing driver fatigue are the myths about it:

1. Only lorry drivers/reps fall asleep at the wheel, you only have to look at the statistics above to realise this is simply not the case.

2. Driving with the window open or with the radio on will reduce fatigue. Neither of these is effective, the only safe thing to do is to take a break and have a sleep. There is no room for compromise when life is at stake.

3. High-energy drinks will help you get to your destination safely. There are a number of very real concerns about these drinks firstly they do not all seem to work, some research seems to indicate it is the additional ingredients interacting with the caffeine rather than the presence of caffeine itself. Secondly and most important if you use these drinks they may be effective in the short term but say they work for 45 minutes to an hour when they wear off, they do so very quickly. Consequently you will then be one hour more tired and therefore more dangerous than when you first took the drink. They are not a panacea for driver fatigue—only sleep will genuinely provide that!

Why should employers worry about all these issues e.g. alcohol, other drugs and fatigue? Well there is a whole raft of both current and some proposed legislation, which increases employer's liability to ensure a safe working environment for all staff. Consequently we should not just address these problems in regard to drivers but within the workplace generally where safety can be compromised. Good employers will have policies and training in place to keep the workplace safe. If they do not there is plenty of legislation waiting for accidents to happen.

New Developments/Conclusions
There is growing awareness of driver impairment and the impact of impairment in the workforce generally. Current and pending legislation is designed to improve safety but place greater responsibility on employers.

At some point in the future we may get the drink-drive limit reduced to 50mg but without accurate up to date education this is likely merely to increase the number of convicted drivers.

We need to recognise that impairment on the road and in the workplace is a growing problem and one that affects us all one way or another. To address it Government strategies need to be more pro-active and accurate. In the meantime we can all take
measures as individuals and employers to increase our own responsibility to educate ourselves so that we do not become a statistic caused by impairment.

The success of the drink-drive rehabilitation scheme is likely to mean an increasing number of other education initiatives, some of which may well like the drink drive rehabilitation scheme involve courts. Part of our success in developing this initiative has been attributed to good communication with courts this has included awareness of the magistrates training system and in particular getting training on our scheme approved as part of magistrates training i.e. they can count hours spent learning about the scheme towards their annual training commitment. Also providing liaison staff for all courts, providing good quality feedback information on the success of the scheme through annual reports newsletters etc and attendance at court open days. As a result of these strategies courts in all of the areas with serve refer an average of 85 to 90% of their drink drivers with many exceeding 90%. To make road safety initiatives work we need to engage with Magistrates.

**One Final Thought**

"Whether you are tough, fit, young or old,
Short, fat, thin be told.
All livers are slow to clear your drinks
Only cans, kegs and bottles
Can really hold their drinks!
So have none for the road

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