walkway of 1,200 students because their school is embraced by this public space. Once identified and brought in the authorities for this case study, the people's involvement (the students) pursued a safe community that leads healthy lives within their surrounding. The government accountability represents central and local administration. In 2010 central government issued to the local borough officials the technical guidelines and the monetary quote for restoring the sidewalk, but local officials disregarded them. In 2011, we obtained the funds at the CDMX Legislative Assembly, but the public work (2012–2013) resulted in a poor executed pedestrian infrastructure that remains unsafe so far.
Conclusions Central and local governments are ultimately accountable to their people for the health consequences of their actions. People should encourage the potential for producing and promoting *healthy public spaces* on the recognition of a fundamental human right and sound social investment.

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327 ADVOCATING FOR THE IMPLEMENTATION OF GRADUATED DRIVER LICENSING IN THE UK

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Background Although crash rates in the UK are some of the lowest in the world and are at their lowest levels ever, improvements are still possible and necessary. Analysis of crash data has shown that young drivers, aged 17 to 19 years, have crash rates that are disproportionately high when considered against the numbers of licence holders and size of the population of this age group.
Description of the problem Young drivers hold only around 2% of driving licences, but are involved in 10–16% of crashes, casualties and fatalities. Review of the evidence has shown that Graduated Driver Licensing (GDL) has successfully reduced crashes in other parts of the world, but it is not currently used in the UK. This paper discusses efforts to advocate for the implementation of GDL in the UK.
Results The project began in 2008. The author is an epidemiologist/public health specialist so, analysed UK data, with guidance from experts from New Zealand, to determine whether young drivers crashed in circumstances reasonably covered by GDL. These data, along with evidence from Cochrane reviews and primary research, were then used in presentations to raise the profile of GDL. Efforts were made to present the evidence and data as widely as possible and to engage with politicians, policy makers, policy enforcers, the media and members of the general public. Understanding political drivers, both directly and indirectly related to road safety, has been vital. It has also been important to work, and develop strong links, with other academic sectors, mainly psychology, as well as the voluntary sector. Efforts have also been made to regularly update the evidence and reanalyse the data.
Conclusions There is no simple "how to" guide to public health advocacy, nor a quick way to get things done. GDL has not yet been implemented in the UK; but it is being more widely discussed and has a higher profile than at any time previously. Advocacy takes a very long time.

328 TRANSLATING TO PRIMARY CARE PHYSICIANS AN EFFECTIVE SAFETY PROGRAM FOR PARENTS OF YOUNG DRIVERS

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Background Crashes among US novice young drivers remain too high. Addressing this problem, one effective program for parents is Checkpoints, which raises parents' awareness of risks to their young drivers and offers ways to reduce those risks. But its most effective approach was in driver education classrooms and not widely available. A federally-funded study adapted Checkpoints to a website that could be promoted in several ways. This study promoted the Checkpoints website in brief interventions by Primary Care Practitioners (PCPs), and examined dissemination to/implementation by parents.
Methods The website, *youngdriverparenting.org (with an interactive parent-teen driving agreement, PTDA)*, and brief intervention protocol were developed in collaboration with leadership of Paediatric Research in Office Settings at the American Academy of Paediatrics. PCPs delivered interventions and materials to parents, referred them to the website, and completed follow-up surveys. Google Analytics was used to assess parents' website use.
Results Focus groups of parents/teens determined the website adaptation successful. Most of the 133 PCPs from 16 states reported delivering interventions with fidelity, and thought the program important and feasible. Brief interventions/website referrals, averaging 4.4 minutes, were delivered to 3,465 (87%) of 3,990 eligible parents over an 18-week average in 2012–2013. Website visits (1,453) were made by 42% of parents exposed to the intervention, who spent on average 3.53 minutes viewing an average of 4.2 pages. The PTDA was viewed by 24%, and 10% registered for an interactive PTDA.
Conclusions Translation of an evidence-based parent program to a PCP-promoted website was demonstrated. Delivering the brief intervention/website referral was feasible and acceptable to PCPs. This program costs little (its website, training and promotional materials are available) and could be one component of a comprehensive approach to reducing young driver crashes.

329 A RANDOMISED TRIAL TO IMPROVE NOVICE DRIVING

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Background Motor vehicle crashes are a leading cause of death worldwide, and novice drivers have the highest crash risk. Interventions that integrate parents in motivating safe teen driving are a promising strategy.
Methods A randomised trial tested two intervention strategies: in-vehicle video feedback and a parent-focused communication program called "Steering Teens Safe (STS)." For the in-vehicle video feedback, two small video cameras with GPS recorded driving and driving errors (exceeding a threshold for acceleration/deceleration or lateral movement). A blinking light alerted drivers of an error, and parents received a weekly report card with video clips and a summary. STS trained parents to improve the quality