SURGEON GENERAL'S WORKSHOP ON
DRUNK DRIVING

Proceedings

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Office of the Surgeon General

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Foreword

This Surgeon General's Workshop marks the beginning of a coordinated campaign to save the 25,000 lives that are lost each year because Americans persist in drinking and driving. As with smoking, the issues are many and complicated, and even small steps toward alleviating the problem trigger emotions and controversy.

Coordination began with having five Federal Departments sponsor the workshop – Defense, Education, Justice, Health and Human Services, and Transportation. The experts who participated in the workshop represent the broad array of specialists who must work together to bring this pervasive behavior under control. The difficulties they face were immediately apparent in the number of invited experts who declined to attend.

The participants spent 3 days generating solutions in 11 interrelated areas and developing recommendations that affect the wide range of people – from beverage servers to carmakers, from legislators to treatment providers, from advocates to advertisers – who can play some role in alleviating this problem.

The participants also suggested strategies for implementing the recommendations and set up timeframes for their accomplishment. They are included in this volume. Now it is our turn to act to make the Nation safe from the tragedies precipitated by combining alcohol and motor vehicles.

C. Everett Koop, M.D., Sc.D
Surgeon General

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Abbreviations

402 Programs	23 U.S.C. 402 Highway Safety Programs. These formula grants to the States for highway safety programs are administered by the Governors' Representatives for Highway Safety.
408 Programs	23 U.S.C. 408-I incentive grants to States for alcohol traffic safety programs
410 Programs	23 U.S.C. 410-I incentive grants to States for drunk driving prevention programs
ABC	Alcohol Beverage Control
ADAMHA	Alcohol, Drug Abuse and Mental Health Administration
ASAP	Alcohol Safety Action Projects
ASTHO	Association of State and Territorial Health Officers
BAC	Blood Alcohol Concentration
BIA	Bureau of Indian Affairs
CDC	Centers for Disease Control
CPL	Certified products list
DHHS	Department of Health and Human Services
DOJ	Department of Justice
DOT	Department of Transportation
DUI	Driving Under the Influence
DWI	Driving While Intoxicated The terms DWI and DUI are synonymous, meaning either driving while intoxicated or driving while under the influence. These are general terms referring to the criminal action of driving a motor vehicle either (1) while "illegal per se" or (2) while impaired, under the influence, or intoxicated by alcohol or other drugs.
EMS	Emergency Medical Systems
FARS	Fatal Accident Reporting System
FBI	Federal Bureau of Investigation
FCC	Federal Communications Commission

IACP	International Association of Chiefs of Police
IHS	Indian Health Service
Illegal per se	Refers to State laws that make it an offense to operate a motor vehicle while at or above a specified blood alcohol level.
MADD	Mothers Against Drunk Driving
MCD	Multiple Cause of Death file taken from death certificate data by National Center for Health Statistics
NAB	National Association of Broadcasters
NAGHSR	National Association of Governor's Highway Safety Representatives
NCADD	National Commission Against Drunk Driving
NCADI	National Clearinghouse for Alcohol and Drug Information
NCIC	National Crime Information Center
NHTSA	National Highway Traffic Safety Administration
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NIDA	National Institute on Drug Abuse
NSA	National Sheriffs Association
OJJDP	Office of Juvenile Justice and Delinquency Prevention
OSAP	Office for Substance Abuse Prevention
PHS	Public Health Service
PI&E	Public information and education
PSA	Public service announcement
RADAR	Regional Alcohol and Drug Awareness Resource Network
RFP	Request for proposals
RWID	Riding With Intoxicated Driver

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Opening Remarks

Good afternoon. I am Faye Abdellah, Deputy Surgeon General, U.S. Public Health Service (USPHS), and am serving as moderator for this opening session.

First – Welcome to all of you to this historic Surgeon General's Workshop. The first was initiated by Dr. Koop in 1981.

The Surgeon General's Workshop is a concept, now inveterate, of convening experts to advise the Surgeon General and to identify the public health implications of major health problems demanding resolution.

This workshop provides you, the experts, with the opportunity to come together to advise the Surgeon General, within the constraints of his office, on how best to approach the problem of drunk driving from the perspectives of needed education, services, research, and health policy.

Previous workshops have addressed equally complex problems such as the needs of ventilator/handicapped children, child abuse, elder abuse, pornography, pediatric AIDS, self-help groups, and, most recently, health promotion and aging. For example, during the last workshop, one panel dealt with the problems of alcohol abuse in the elderly – often starting when they were adolescents. The recommendations of this panel were incorporated into the research agenda of the National Institute on Alcohol Abuse and Alcoholism (NIAAA). This is precisely the kind of result that we would like to see come out of your deliberations.

Soon after the workshop is completed, the workshop proceedings and background papers will be published and widely disseminated to appropriate groups at Federal, State, and local levels as well as private sector groups.

The purpose of this workshop is to develop a comprehensive set of recommendations that can help the Surgeon General bring drunk driving under control and eliminate drunk driving as the leading cause of death among young Americans.

Participants are encouraged to examine each expert panel charge in light of the following questions:

1. What do we know about the problem and its extent?
2. What have we done so far? Have these actions been effective or ineffective?

3. What do we need to know?
4. How do we put our knowledge into practice effectively? What will really work?

This is your mandate.

Let me now introduce this afternoon's speakers.

Introduction of Surgeon General C. Everett Koop

Dr. Koop, the 13th Surgeon General of the USPHS, has become the most effective Surgeon General since the establishment of that position. Why has he been so effective?

Dr. Koop has paid his dues to the health establishment many times over. His inimitable courage as a pioneer in pediatric surgery for more than four decades helped him climb mountains in the pediatric world never before surmounted. His appointment as the U.S. Surgeon General in November 1981 presented him with new mountains to climb; for example, planning and implementing the strategy to achieve a smoke-free society by the year 2000; introducing regulations to protect the newborn; protecting the confidentiality of those who are HIV positive, yet still seeking new ways of obtaining prospective data such as volunteer testing of college students; setting new guidelines for nutrition; and most important, strengthening the PHS Commissioned Corps to make this cadre of health professionals proud to serve throughout the United States and in many other parts of the world.

Not only does this Surgeon General climb mountains that appear to be insurmountable, but during his college days at Dartmouth, he was also known to jump off mountains. Does he fly? — NO. He does not have to. His enormous energy propels him on at least 16 cylinders!

Ladies and gentlemen, the U.S. Surgeon General C. Everett Koop.

Opening Remarks

C. Everett Koop. M.D., Sc.D.
Surgeon General of the U.S. Public Health Service
U.S. Department of Health and Human Services

Greetings to hosts, guests, and friends.

I want to thank you all for traveling to this workshop from so many parts of the country. You represent a cross-section of a nation deeply concerned

about the annual toll of death and disability caused by drunk and drugged drivers.

You were chosen by a thoughtful, hard-working interagency planning committee. Its members came from five cabinet-level departments: Transportation, Justice, Education, Defense, and Health and Human Services. I'd hardly call it a parochial group, and I'm delighted that they found the name and address of each one of you.

I also wish to recognize a member of the House of Representatives who is with us today—Congressman William F. Goodling of Pennsylvania.

Congressman Goodling has been a dedicated and tireless leader in every major effort by the U.S. Congress to fight the scourge of drunk driving. The American people are very fortunate to have had him on their side so far, and we can look ahead to his continued leadership and support in the 101st Congress when it convenes next month. Welcome, Congressman Goodling, I'm very pleased to have you with us this afternoon.

All of you, gathered here this week, are respected experts in this field, but that doesn't mean you all think alike. I'm sure as the workshop sessions continue, we will become aware of the wide range of opinions and interests represented here.

I know this is not the best time of year to ask people to leave their homes and families and spend a few days at a conference. But I believe that this workshop is different. There's an urgency about the subject: drunk and drugged driving.

The urgency is almost palpable in the many letters that come in to my office from State and local officials of every area of the country. The urgency is also clear in the cards, letters, and telegrams I've received from surviving family members grieving over the loss of a loved one—someone killed by a drunk driver.

The urgency is clear from the response we've already had to the alcoholism and alcohol abuse initiative launched by Secretary Otis R. Bowen last year and reinforced at a major national meeting in San Diego this past October.

And it's clear from the sentiment expressed by 99 United States senators and from a unanimous House of Representatives, who have asked me to take on this issue and do whatever I can to bring it under control.

Although they are not here today, I do want to recognize two other individuals who have been of immeasurable help in the United States Senate—Senator Claiborne Pell of Rhode Island and Senator John W. Warner of Virginia, the two gentlemen who cosponsored that letter signed by them and 97 of their colleagues. And, again, Congressman Goodling can take great credit for the passage of that resolution—House Concurrent Resolution 276—in the recent 100th Congress.

The Congress knows – as I certainly do, and as most of you know, also – that the powers of the Surgeon General are carefully circumscribed. I do not allocate funds, or operate programs, or carry out any specific legislation. Nor do I *pretend* that I do.

On the other hand, the power and authority of my office are heavily invested in *public education.*

My principal assignment, therefore, is to inform the American people of any threats to their health and to advise them of ways to avoid such threats, if they are known. I inherited that power and authority when I assumed the office of Surgeon General more than 7 years ago. And the credit for that goes to my 12 predecessors, going back for more than a century.

When the time comes for me to take my leave, I hope and pray that I will have done nothing to compromise the integrity and credibility of this great office. On the contrary, I hope I also might be remembered as having done something to further strengthen this office in the eyes of the Nation.

In this matter of drunk driving, the Surgeon General's role is virtually nothing more – but certainly nothing less – than public education. And by "the public," I include not only lay citizens but also my colleagues at all levels of government – Federal, State, and local – and my fellow citizens in the private sector, both in profit and nonprofit activities.

As Surgeon General, I have a responsibility to speak to them *all.* And I do, whether they are comfortable with what I have to say or not.

One of the mechanisms I have used for this purpose is the Surgeon General's Workshop. The workshop provides, as it were, an umbrella under which individuals and groups representing many diverse interests and points of view can assemble and talk out an issue of significance to the health of the American people.

That umbrella – to be effective – *has to be neutral.* Hence, let me assure all of you that I do not come to this workshop with any prearranged conclusions or recommendations or any preset ideas about what we should do next.

But let there be no mistake: I am *not* neutral about the issue of drunk driving. No sensible person can be neutral about that. Where we differ may be on the approach that the United States should take, as a civilized society, to *reduce* and maybe one day *eliminate* this terrible thief of health and life.

I ask you to please adopt this spirit as you take part in the working sessions tomorrow and Friday. In other words, I ask you to be willing to share your ideas, but also be willing to listen, and be willing to learn new things and maybe adjust some of your thinking, if need be.

If we have that kind of participation from everyone, then we may get a good deal closer to the core of this problem and the essence of its solution.

And that brings me to the announcement that the working sessions

tomorrow and Friday will *not* be open to the press. That is consistent with past practices.

I have conducted nearly a dozen Surgeon General's Workshops during my two terms in office. The issues have included AIDS, liver transplantation, the care of handicapped children, family violence, pornography, and so on.

In each workshop, the main or plenary sessions, like this one, have always been open to everyone, including the press. But the *working* sessions have *not* been open. They have always been closed to nonparticipants, again, including the press.

The reason is simple enough. I want all invited participants to go into these sessions ready to speak their minds, ready to engage in open and candid give-and-take with colleagues and counterparts, and, yes, in the course of the debate, ready to change their own minds, if need be.

This approach is not only legal, it's very successful. And I am sure it will be equally successful for us at *this* workshop, too. Let me assure you, however, that, while the actual deliberations of the working sessions will be closed, the *results* of those sessions will be made public at the final open session on Friday. The recommendations will be presented to me by the persons who lead the sessions. I will take a little time to review them and then come back to you with my response in the final session, Friday afternoon.

Now, one more word about these recommendations.

This *is* the *Surgeon General's* workshop. And *I am* the Surgeon General. But I hope *you* will look *beyond* the office of Surgeon General when you make your recommendations.

As I indicated a moment ago, there's really only one recommendation for the Surgeon General – to speak out publicly on the issue of drunk driving. Well, I'm already doing that.

That's why I urge you to set your sights beyond the Surgeon General's office and recommend future action for education – State, local, public, and private – for law enforcement, for the health professions and the public health community, for the transportation and highway interests, and for communications, including advertising and broadcasting.

So, with those few ground rules in mind, let us move forward with our agenda, because time is not on our side. Even as we deliberate here in the safety of these hotel walls during this otherwise festive season of the year, alcohol consumption is up and so is the toll of alcohol-related traffic injuries and deaths.

Hence, we can expect that 1988 – like 1987 and 1986 before it – will be a year in which 24,000 *more* Americans will have died on our highways in alcohol-related accidents.

And many thousands more will have been killed in accidents that are

drug-related, a fact we want to emphasize during this week, which is National Drunk and Drugged Driving Awareness Week.

During my brief time at this microphone – 20 minutes or so – one of our citizens will be killed by a drunk driver.

While you were grabbing a quick lunch at noontime, two more were killed.

And this evening, in the hour when you relax over dinner, *three more* will be killed in the same way.

An average of two to three of our fellow citizens are killed on our streets and highways every hour, around the clock, because they or others had their judgment and reflexes impaired by alcohol and other drugs.

By this time tomorrow, some *65* Americans will have died on the highway in alcohol-related accidents.

That's the picture in regard to alcohol-related fatalities. But over *a million* alcohol- and drug-related crashes occur every year on our highways, and most of them do *not* end in death. But they *do* result in injuries – *a half-million* injuries at a minimum.

When the vehicular wreckage is towed away, the *human* wreckage is left behind – the permanent brain damage, the spinal cord injuries, the lost or permanently deformed limbs, the blindness, and the impotence – the lifetimes crippled with disability and haunted by recurrent nightmares of how it all happened.

Tens of thousands of deaths, hundreds of thousands of injuries. Those are numbing statistics. But they are also *more than* just statistics.

They are real people, real human lives.

Unfortunately, a disproportionate number of highway victims are *young* people, young men and women between the ages of 15 and 24. No other comparable age cohort has such a record of death and injury on the highway.

And this age group, by itself, accounts for more than 8,000 alcohol-related fatalities, or about a third of all fatalities each year in which alcohol is implicated.

Fortunately, young people themselves are becoming more and more sensitive to this issue. That was one of the most encouraging aspects of the recent report of the public hearings held by the National Commission Against Drunk Driving.

Young people who testified at those hearings supported the minimum drinking-age law, seatbelt laws, more public education, and so on.

Also, according to the National Commission, young people themselves, "with near unanimity, declared that advertising encourages adolescents to drink," and the Commission went so far as to recommend that "in the absence of alcohol industry action, legislation should be enacted to regulate alcohol beverage advertising."

Young people may not be numerically represented here as they are in the death and injury statistics each year, but they should be uppermost in our minds during our deliberations today, tomorrow, and Friday.

And now, a final word. I've been spending some time lately preparing for the 25th anniversary of the publication of the first *Surgeon General's Report on Smoking and Health.* In doing so, I've been looking over that 25-year record of progress, and I find it very instructive.

Twenty-five years ago the public health community, with the support of citizens' groups and members of Congress, embarked upon a systematic program of research into the relationship between smoking and health.

At the same time, and in a responsible way, they also looked at the public policy implications of the research results, as those came to light.

From that information they were able to plan ways to help the American people end their high-risk romance with tobacco. Chief among these ways was a far-reaching program of public education and instruction.

And so it appears to me that we may now be—in terms of alcohol and drunk driving—where we were 25 years ago in terms of tobacco and the fatal diseases caused by smoking.

And that brings me to the particular charge for this workshop, the specific areas of interest I hope you address in the next 2 days:

- *First,* let's consider the *research agenda* required for this issue of drunk and drugged driving. We know quite a bit about the issue now, but much still remains to be learned. We clearly need to build a strong scientific base which either *confirms* alcohol's role in highway trauma, or *refutes* the connection between highway trauma and alcohol and other drugs.

- Next, we need to look at—or anticipate, if possible—the many *policy implications of that research.* In other words, *we* may feel we're justified by experience to have strong opinions about this and that, but the *country* needs an objective assessment of the knowledge base and its implications for public policy.

- Third—and also on the strength of an ongoing research program and its policy implications—we need to lay out *a plan with near-term and long-term public health objectives.* In other words, what kinds of actions must we take, in both the public and private sectors, in regard to drunk and drugged driving? What are our goals and objectives, and how should we go about reaching them, soon and over the long run?

- And finally, we need to devise *an overall strategy* for carrying out such a national plan. In these days of restricted and limited resources, we must make every person and every

dollar count. That means not only having a plan, but also having a coherent and cost-effective approach to the *implementation* of that plan.

Those four elements, then, constitute my charge to this workshop: *research, policy, a plan of action,* and *an implementation strategy* for that plan.

That's a big assignment for a 3-day workshop. But I've found in workshops past that people tend to work more creatively and at a higher energy level if time is of the essence.

In any case, this workshop is not an on-the-job training experience for any of you. You are all seasoned and experienced individuals. Also, I'm not searching for the ultimate statement on the issue of drugged and drunk driving. Rather, I'm hoping for a document that will give the country a strong push in the most fruitful direction.

This may be the first meeting of this kind – and it's an important one – but I doubt that it will be the last one.

I am sure all of you can think of some people who are missing from this workshop. Maybe they will be at the next one – and the ones that will follow. But first, let's make the very best start we can.

Again, thank you for joining me this week at this workshop. I appreciate it, and the country will surely benefit from your contribution.

Thank you.

Introduction of Secretary Bowen

Dr. Bowen is the first physician to serve as Secretary of the Department of Health and Human Services. Having served two highly successful terms as Governor of Indiana, we are most privileged to have this physician as Secretary of DHHS.

Secretary Bowen has been able to accomplish what no other secretary has, namely, the introduction and successful passage of legislation related to catastrophic illness. President Reagan publicly stated that this legislation is the most important of his administration.

Why is it so important that Secretary Bowen be with us at this workshop? He has accomplished the following related to drunk driving.

- *He made alcoholism and other alcohol-related problems a special priority for the Department of Health and Human Services.*
- *November 1987, the Department announced a 14-point initiative to raise public awareness about alcohol-related problems in America.*

- *The Department created a public affairs campaign to help get the message across.*
- *The Department established a National Citizens Commission on Alcoholism.*

Ladies and gentlemen, Secretary Otis R. Bowen.

Opening Remarks

Otis R. Bowen, M.D.
Secretary of Health and Human Services

I'm delighted to join such distinguished company in addressing a very real problem that should be of concern to every single American.

I think this is a very appropriate time of the year to be focusing on this matter. The holiday season, from Thanksgiving to New Year's, unfortunately, is the occasion for a general increase in alcohol intake by the average person. All too often, what ought to be a joyous celebration of the revival of the human spirit is utterly destroyed by the abuse of alcohol and the tragedies that follow in its wake.

It's well to remember that, for our purposes, drunk driving is a misnomer. What we're really talking about is drinking and driving. It isn't necessary to be intoxicated; just a drink or two can make somebody behind the wheel a threat to themselves and to others.

The fact that the holiday season is usually marked by weather that makes road and highway conditions treacherous simply compounds the matter.

Now, I don't want to be the grinch that stole Christmas. But I do think this is as good a time as any to renew our annual plea that conviviality and good times shouldn't extend to the point of endangering lives and property.

I'll let Dr. Koop terrorize those who want to enjoy a big steak and a good cigar. Let me just sound the note of caution that's in keeping both with our purpose and its timing.

I don't think there is anyone who doesn't realize that alcohol abuse and alcoholism are having a devastating effect on American society.

And it's going to get worse.

Recent studies indicate that the annual cost to the country of alcohol abuse and alcoholism will reach $136 billion by the end of next year and will rise to $150 billion by 1995.

The checklist of statistics makes a sad litany indeed.

- In all, some 18 million American adults are either alcoholics or have alcohol abuse problems.

- Alcohol is a factor in things like teenage pregnancy, poor scholastic achievement, crime and violence, the gap in health status between white Americans and Americans from minority group backgrounds, and general loss of American productivity.
- An estimated 4.6 million adolescents annually—3 out of every 10 American teenagers—have alcohol problems.
- Nearly 9 out of 10 teenage automobile accidents involve alcohol.
- Alcohol is a major disciplinary, vandalism, and crime problem on most college campuses.
- Some 40,000 babies are born each year at increased risk because of their mother's drinking during pregnancy.
- Fetal alcohol syndrome is one of the top three causes of birth defects and is the only one that's preventable.
- Women are the fastest growing component of the alcohol abuse segment of the population.
- Black, Hispanic, and Native American minorities suffer disproportionately from alcohol-related problems.

In an attempt to do something about this national catastrophe by increasing public awareness, I launched a 14-point initiative a year ago in the U.S. Department of Health and Human Services. Since putting alcohol abuse and alcoholism in the spotlight, we have been able to accomplish a number of things.

- We've established a National Citizens Commission on Alcoholism.
- We've created a special public affairs campaign to inform the American people of the serious health effects of alcohol.
- We've developed a new publication called *Alcohol Alert* to expedite the delivery of research findings into the hands of clinical practitioners.
- We've held two national conferences on alcoholism and alcohol abuse that brought together more than a thousand clinical practitioners, researchers, and prevention specialists.
- And we've joined forces with the American Medical Association to improve the training of physicians in the detection and treatment of alcohol problems.

There is, of course, much that still needs to be done. One of the major alcohol issues that demands our attention is the operation of a motor

vehicle while under the influence of alcohol. And that's the reason for this workshop.

Alcohol-related motor vehicle accidents are a very serious national public health problem. Every year, they inflict lingering spinal cord and brain injuries and other trauma on half a million people. And they kill 24,000 in this country alone. The toll in human misery is awesome and intolerable.

Dr. Koop is to be highly commended for organizing this 3-day workshop. He has enlisted in his cause the Federal Departments of Defense, Education, Justice, and Transportation.

And from our Department of Health and Human Services, the Centers for Disease Control, the Health Resources and Services Administration, the Indian Health Service, and the Alcohol, Drug Abuse, and Mental Health Administration all work together on this problem.

In the past, there have been honest disagreements on the best ways to solve this problem of alcohol-impaired driving. This workshop will attempt to bring together all the public health, academic, government, public safety, law enforcement, and advocacy points of view. And hopefully, it will produce the best background research and recommendations on the problem, from which can come a comprehensive plan to reduce alcohol-impaired driving and eliminate it as a leading cause of disability and death among Americans, many of them unacceptably young.

When these findings reach every level of our society, perhaps that process can begin.

Dr. Koop is going after alcohol-impaired driving the way he has gone after cigarette smoking. His goal is to save lives. I support his effort.

And even though my stewardship is about to end, the commitment of the Department of Health and Human Services will not. In fact, planning has already begun for the third national conference on alcoholism and alcohol abuse. The second conference, last month in San Diego, was enormously successful, with more than 1,400 people in attendance. The next conference promises to be even better.

We aren't the only ones with these concerns. Maybe from others in the international community we can learn new ways to combat the problem that brings us together today, and maybe we can teach them something of what we know.

There may be no magic bullet to end the tragedy of alcohol abuse and driving, but I think we can begin to develop at this workshop ways and means of dealing with it that will be just as effective.

I am pleased to see that several members of the Congress are participating in this workshop. They can play a vital role in anything we hope to accomplish.

Thank you for coming. I wish you every success in your deliberations.

Introduction of M. George Reagle

Mr. George Reagle is representing Secretary Burnley of the Department of Transportation. Mr. Reagle is the Associate Administrator, National Highway Traffic Safety Administration, Department of Transportation. The Department of Transportation has a long history of cooperation with the Department of Health and Human Services and has been working under an interdepartmental agreement with us for many years in a cooperative fashion on this issue. The Department of Transportation historically has been involved in drunk driving issues since the 1960s when they implemented alcohol safety action programs. This is another step in their ongoing efforts to address this issue of drunk driving.

Ladies and gentlemen—Mr. George Reagle.

Opening Remarks

George Reagle
Associate Administrator for Traffic Safety Programs
National Highway Traffic Safety Administration

Distinguished panel, ladies, and gentlemen.

I want to thank you for the opportunity to address this gathering of experts on the problem of drunk driving. I sincerely hope that your deliberations over the next few days can provide us with additional energy and information to reduce drunk driving and its tragic consequences.

Alcohol Safety Action Projects

During the 1970s, the National Highway Traffic Safety Administration (NHTSA) placed a great deal of emphasis on the problem of drunk driving via a national demonstration program involving 35 Alcohol Safety Action Projects (ASAPs). These 35 projects were designed to reduce drunk driving at the local level by combining the various elements (e.g., enforcement, licensing, adjudication, public information) into a system at each locality. Prior to this time, persons in these different areas frequently did not coordinate their efforts to deal with the drunk driving problem.

Evaluation was a major component of these ASAPs, and we were able to get a reading on how successful we were. By the end of the projects, we had demonstrated significant reductions in nighttime fatal crashes in 12 of

the 35 sites. Still, from 1970 to 1976, we were not able to detect any significant, national level changes in the problem of drunk driving.

Indepth Demonstration Projects

We then began to look in depth at the various countermeasure elements to see if we could find ways to improve them and demonstrate their effectiveness. We conducted a DWI enforcement demonstration project in Stockton, California that showed that specially trained and motivated officers were able to significantly increase DWI arrests and to make small but significant reductions in alcohol-related crashes. We conducted probation demonstrations in Mississippi and Tennessee and found that long-term followup with a diagnostic and assessment program called the "Life Activities Inventory" resulted in significant reductions in recidivism among convicted drinking drivers. In addition, we conducted a comprehensive DWI treatment demonstration in Sacramento, California which showed that intensive treatment and long-term followup could significantly reduce recidivism among convicted drinking drivers.

Again, however, we detected no changes in the national levels of drinking and driving or in the fatalities or crashes involving drinking drivers during this period (1976-80).

1980: A Pivotal Year

By 1980, we had done much groundwork in attempting to find solutions to the problem of drunk driving. We had conducted and evaluated local level, comprehensive programs; we had looked in depth at individual countermeasures, and we had reviewed the results of international efforts to reduce drunk driving during the past several decades. As a result of our experiences and those of foreign nations, we began to place significantly greater emphasis on *general deterrence* of drunk drivers. This meant that deterrence activities such as roadside sobriety checkpoints, swift and sure license actions, jail sentences for multiple offenders, and increased fines received greater emphasis and more media attention. To convey this new emphasis to State and local highway safety leaders, in 1980 we initiated a series of *alcohol-safety workshops* to review the results of the past decade and to convey the latest technology to these leaders.

About the same time, however, a much more important development emerged. Citizen activist groups, which had begun as early as 1978, became more visible across the Nation. These groups represented an element that had been missing in the efforts to reduce drunk driving in the United States – a concerned public. Recognizing the potential of such groups to bring about needed changes, we included them in our series of State workshops and gave them an opportunity to voice their concerns to State highway safety leaders.

The program we were advocating at that time was a six-point program involving (1) general deterrence, (2) prevention and intervention, (3) citizen activist support, (4) emphasis on a total systems approach, (5) financial self-sufficiency, and (6) a focus on the community level.

Suffice it to say that energy produced by the emergence of citizen activists, combined with the new emphasis on general deterrence measures, resulted in the most dramatic progress ever experienced in this Nation in terms of reducing drunk driving. The activists, and the media attention that they produced, resulted in dramatic increases in DWI legislation, arrests, convictions, sanctions, education programs, designated driver programs, responsible server programs, etc.

Most importantly, the alcohol-related proportion of fatal crashes decreased nearly every year since 1982. For example:

- The alcohol-related proportion of fatalities was reduced from 57 percent (in 1982) to 51 percent (in 1987), a reduction of 11 percent from the 1982 level.
- The proportion of fatalities involving an intoxicated driver was reduced from 46 percent (in 1982) to 40 percent (in 1987), a reduction of 13 percent from the 1982 level.
- The alcohol-related proportion of fatalities among youth (under age 21) was reduced from 63 percent (in 1982) to 51 percent (in 1987), a 19-percent reduction.
- The proportion of youth fatalities involving an intoxicated driver was reduced from 49 percent (in 1982) to 35 percent (in 1987), a 29-percent reduction.

Never before in the history of this Nation had such reductions been recorded. They were larger than ever before, and they were documented in several successive years. Unfortunately, since 1985, these reductions appear to have slowed or stopped.

Problems Remaining

Unfortunately, we have a long way to go to eliminate or even greatly reduce the tragedies that result from drunk driving. More than half of all fatal crashes continue to be alcohol-related. More than 80 percent of these alcohol-related fatal crashes involve a legally intoxicated driver (i.e., with a blood alcohol concentration greater than 0.10). Similarly, more than half of all fatal crashes involving youth continue to be alcohol-related, and approximately 70 percent of these alcohol-related fatal crashes involve an intoxicated driver.

Primary Objectives for Reducing Drunk Driving

To further reduce drunk driving, we must concentrate on specific program objectives. Some of the most important include the following.

- Deterring drinking drivers who have not been caught (but who will contribute to approximately 75 percent of alcohol-related fatal crashes in the future)
- Reducing the impaired driving recidivism of drivers who have already been arrested and processed through our criminal justice and/or administrative sanctioning and rehabilitation processes
- Preventing drinking and driving by such means as public information, education, more responsible serving and hosting practices, intervention by friends, designated driver programs, safe ride programs, and preventing the sale of alcoholic beverages to minors

We can act to reduce this problem in many areas. It is important that we look at all of them. I am encouraged to see so many topical areas being addressed at this workshop.

What NHTSA Hopes to Gain From the Workshop

From our perspective at NHTSA, this workshop provides us with an opportunity to inject new energy into the anti-drunk driving movement. Clearly, such additional energy and motivation is necessary if we are to again realize significant reductions in the tragic consequences of this serious behavior.

The recommendations made by workshop participants will broaden the activities and number of organizations involved in the efforts to stop drunk driving. We expect that this workshop will be a major factor in our current attempts to make drunk driving a public health issue and to enlist the aid of public health and medical groups in our efforts.

Thank you for taking your time to come here and address this problem. I wish you success in developing recommendations that can actually make a difference in reducing this most serious public health problem, drunk driving.

Recommendations

After meeting and debating for 2 days in closed sessions, the panels prepared and presented to the workshop participants and the Surgeon General the following recommendations and strategies for implementing them.

Note to readers:

On December 14, 1988 the National Beer Wholesalers Association filed a lawsuit in the United States District Court seeking relief under the Federal Advisory Committee Act to postpone or cancel the Surgeon General's Workshop on Drunk Driving. Pursuant to the Court's order, the Surgeon General opened the workshop to members of the public. Thereafter, the parties resolved the remainder of the lawsuit by entering into a settlement agreement in which the Surgeon General agreed to accept and consider comments from interested parties until January 31, 1989. The Surgeon General also agreed that the final recommendations would not be made before February 28, 1989 and that the final recommendations or report would consider any such written comments. Since the legal ruling was delivered after the opening plenary session of the workshop, its stipulations were not reflected in the opening remarks.

Extensive comments were submitted but are not included in these proceedings because they were not part of the offical workshop deliberations and because they were so lengthy. The comments were considered; however, they did not alter the recommendations published in this report. The comments will continue to be used in the implementation of strategies to eliminate alcohol-impaired driving.

Panel A

Pricing and Availability

Chair:	Harold Holder, Ph.D.
Background Paper:	Alexander Wagenaar, Ph.D.
Recorder:	Mary Ganikos, Ph.D.
Panel Members:	George McCarthy
	Dennis Nalty, Ph.D.
	Michael Jacobson, Ph.D.
	Charles Phelps, Ph.D.
	Sandy Heverly

The Pricing and Availability Panel was charged with discussing matters of concern and controversy, i.e., the pricing and availability of alcoholic beverages. A significant portion of American industry is involved in the production, distribution, and wholesale and retail sale of beer, wine, and distilled spirits. The panel does not challenge the rights of these industries or businesses to produce and sell alcoholic beverages. However, the panel found that by changing pricing and availability of alcoholic beverages, alcohol-impaired driving injuries and fatalities could be reduced.

The panel prefers the adjective "alcohol-impaired" rather than "drunk" in reference to driving. This acknowledges the increased risk of crash, injury, and death for drivers and others when even small amounts of alcohol are consumed. This is particularly true for young drivers.

The panel's deliberations and recommendations are based on two sources of information:

- Scientific research on relationships between alcoholic beverage price and availability and alcohol-involved driving
- Experience and expert knowledge of panel members and others in the field

Price

Research evidence shows that an increase in the excise tax could have the largest long-term effect on alcohol-impaired driving of all policy and program options available. Since Federal excise taxes differ widely by beverage type, and the effective tax rates have declined by three-quarters because of inflation since 1951, the panel makes the following recommendations to Federal and State Governments.

A-1 Recommendations to the Federal Government

A-1.1 Equalization – Equalize Federal excise tax rates by ethanol (pure alcohol) content across all beverages by raising rates for beer and wine to that of distilled spirits.

A-1.2 Adjustment for past inflation – Adjust the resulting equalized excise tax rate to reflect the change in the Consumer Price Index (CPI-U) since 1970.

A-1.3 Future indexing – Annually adjust the resulting excise tax rate to reflect changes in the Consumer Price Index (CPI-U) for the previous year.

A-2 Recommendations to State Governments

A-2.1 Equalization – Equalize excise tax rates by ethanol content across all beverages by raising rates for beer and wine to that of distilled spirits.

A-2.2 Adjustment for past inflation – Adjust the resulting equalized excise tax rate to reflect past inflation.

A-2.3 Future indexing – Annually adjust the resulting excise tax rate to reflect the change in the Consumer Price Index (CPI-U) for the previous year.

A-2.4 States with relatively low tax levels should increase their rates to at least the levels in bordering States.

Strategy

For Recommendations A-1 and A-2, the Surgeon General should take the following steps by April 1, 1989 to achieve equalization, adjust for past inflation, and provide indexing for future inflation for Federal excise taxes on beer, wine, and distilled spirits. The Federal excise tax increases should be part of the FY 1990 budget.

1. *Write letters to all members of the U.S. Congress concerning the need to raise taxes as a means of reducing alcohol-impaired driving and the Federal budget deficit.*
2. *Write similar letters to all State Commissioners of Health requesting that they urge their State's congressional delegation to support higher Federal excise taxes. The Surgeon General should also offer assistance to review State alcohol excise tax laws.*
3. *Write letters to President Bush, the Secretaries of Health and Human Services and Treasury, and the Director of Office of Management and Budget addressing the need for both increasing alcohol excise taxes and ending the tax deductibility of alcoholic beverage purchases.*
4. *Urge the National Economic Commission to include Federal alcoholic beverage excise tax increases in its recommendations.*
5. *Convene a meeting with appropriate Congressional leaders in health and financial matters on the health and budgetary benefits of raising Federal alcohol excise taxes.*
6. *Prepare a position paper on the health and fiscal benefits of raising alcohol excise taxes, addressing alcohol-impaired driving and other alcohol-related problems as well as increased revenues.*
7. *Urge organizations and citizens concerned about alcohol-impaired driving, other alcohol problems, and the Nation's economic and social well-being to urge the President and their congressional representatives to support higher alcohol taxes.*

Preventing Increased Availability

The availability of alcoholic beverages in a community can significantly affect the extent of alcohol-impaired driving. The effects of small increases in availability on alcohol-impaired driving are difficult to measure.

Nevertheless, the cumulative effect of several such changes can be substantial.

Therefore, the panel recommends:

A-3 Federal, State, and local governments should not adopt policies that result in increased availability of alcoholic beverages without careful analysis, study, and public debate about the potential effects on alcohol-impaired driving. This applies particularly to bars, restaurants, and other public facilities, since research shows that the majority of alcohol-impaired drivers obtain alcohol at such places.

Reducing Availability

To reduce alcohol-impaired driving, State and local governments, and/or the Federal Government where appropriate, should consider applying the following measures.

A-4 Adopt or strengthen server/seller liability statutes and policies to encourage responsible serving and selling practices.

A-5 Prohibit "happy hours" and other reduced-price promotions.

A-6 Require training and certification of sellers and servers of alcoholic beverages.

A-7 Restrict alcohol sales by time and place at sporting, music, and other public events.

A-8 Adopt open-container laws that prohibit drinking while driving.

A-9 Permit local governments to enact regulations that are more restrictive than State Alcohol Beverage Control (ABC) laws.

A-10 Strengthen laws concerning hours of sale, characteristics and density of outlets, and other factors relating to retail availability of alcoholic beverages.

A-11 Increase enforcement of existing State and local Alcohol Beverage Control regulations and increase resources available for enforcement.

A-12 Eliminate the tax deductibility of alcoholic beverage purchases for business purposes.

A-13 Prohibit or discourage serving and selling practices that increase the level of alcohol-impaired driving.

A-14 The Federal Government has a primary responsibility for these matters in three important settings – military bases, commercial aviation crews and travelers, and general aviation pilots – and should adopt a strong leadership role in appropriately controlling pricing, availability, and use of alcoholic beverages in these settings.

Strategy

For Recommendations A-1 thru A-14, the Surgeon General should take the following steps by November 1, 1989 to reduce alcohol-impaired driving by limiting and reducing alcohol beverage availability.

1. *Write letters to a broad range of health and other civic organizations and parents, asking that they support higher Federal and State alcohol taxes and other measures that limit and reduce alcoholic beverage availability.*
2. *Convene no later than June 1989 a conference of State budgetary and health officials to describe and discuss the health and fiscal benefits of raising alcohol excise taxes. The Surgeon General should pay special attention to States that have relatively low excise taxes.*
3. *Write letters to governors, mayors, ABC administrators, and State and local police leaders to recommend measures they could take that would reduce alcohol-impaired driving through better control of alcoholic beverage availability.*
4. *Give a national address on alcohol-impaired driving and the need to increase excise taxes and reduce alcoholic beverage availability.*
5. *Urge owners and managers of stadiums and other such public facilities to restrict alcoholic beverages as necessary to reduce alcohol-impaired driving.*
6. *Urge sellers and servers of alcoholic beverages, through their trade associations, to end reduced price promotions such as happy hours, eliminate serving practices that increase risk of*

alcohol-impaired driving, and implement server and seller training.

Future Research

Finally, in support of these above recommendations, the following research should be undertaken.

A-15 Evaluate the impact on alcohol-impaired traffic problems as policy recommendations of this panel are implemented at Federal, State, and local levels.

A-16 Determine the specific price sensitivity of changes in alcohol-impaired driving by age and gender.

A-17 Document the contribution of location, density, and hours-of-sale of alcohol outlets to alcohol-impaired driving and resulting injuries and fatalities.

Estimating Effects of Increased Federal Excise Tax on Alcoholic Beverages

Charles E. Phelps, Ph.D.*

The Pricing and Availability Panel of the Surgeon General's Workshop on Drunk Driving proposed a three-step strategy for dealing with Federal excise taxes (FET) on alcoholic beverages. This note describes the proposed changes and their consequences.

Increases in the Federal Excise Tax

Equalize all tax rates to that of distilled spirits. Currently, distilled spirits are taxed at $12.50 per gallon of 100-proof alcohol. This converts directly to $2.50 per fifth of 100-proof alcohol, or $2 per fifth of 80 proof. A standard drink of 1.41 oz of 80-proof alcohol thus has a Federal excise tax of $0.11 attached to it.

The equivalent tax on beer is derived by assuming that beer is, on average, 4.7 percent alcohol (some more, some less). This is 9.4 proof, so to equalize rates, beer should be taxed at 9.4 percent of the rate for 100-proof alcohol, or $1.175 per gallon. This equals $0.11 per 12 oz serving of 4.7-percent alcohol, the standard drink of beer.

The equivalent tax on wine is derived for wine with 12 percent alcohol content, or 24 proof. Thus, a gallon of wine should be taxed at 24 percent of $12.50, or $3 per gallon, or $0.60 per fifth (25.6 oz). Thus, a standard drink of 4.7 ounces of wine has a tax of $0.11 attached to it after equalization.

Correct for inflation since 1970. The 1970 distilled spirits tax was $10.50 per proof gallon, or $1.68 per fifth of 80 proof. Inflation correction since 1970 provides a multiplying factor of 3, so the equivalent 1989 tax would be $5.04 per fifth, an increase of $3.04 per fifth from the current tax, or $0.167 per standard drink, to a tax per standard drink of $0.277. This becomes the 1989 standard tax.

The current tax on beer is $0.027 per 12 oz serving, so the equivalent inflation-corrected tax would increase by $0.25 to $0.277 per 12 oz serving.

The current tax on wine is $0.17 per gallon and $0.034 per fifth. Raising

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*Professor of Political Science and Economics and Director, Public Policy Analysis Program, University of Rochester

it to the inflation-corrected distilled spirits tax brings the wine tax to $1.50 per fifth of 12-percent wine, (again) $0.277 per drink. This represents an increase of $1.47 per fifth of wine, or $0.271 per standard drink.

Index for future inflation. This will prevent erosion of the real Federal excise tax in the future.

Relative Price Changes

The following calculations assume, as would occur in standard competitive industries, that a tax increase will be added to retail price on a dollar-for-dollar basis. In a monopoly, the cost-passthrough would be less, using standard monopoly pricing models.

Distilled spirits. Currently, the average retail price of distilled spirits is approximately $11.50 per fifth. The added tax of $3.04 per fifth represents a 26-percent increase in the price of distilled spirits. The relative increase is smaller for premium brands (and conversely for low-price brands), since the proposed tax is based on alcohol content, not price.

Beer. Currently, the average price of beer is approximately $0.70 per can, or $4.20 per six pack. The tax would increase by $0.25 per can, representing an average increase of 36 percent. Again, the relative change would be smaller (larger) on relatively high (low) priced beers.

Wine. Currently, a bottle of wine is taxed at $0.036. The current average price has been estimated at $3.07 for table wines, higher for coolers, fortified wines, and naturally carbonated wines. On this base, an increase of $1.47 per bottle represents an increase of 48 percent.

Consumption Changes

The demand elasticity has been estimated for distilled spirits and wine at about –0.5 to –1. For beer, –0.4 is a reasonably well-established estimate.

Distilled spirits quantity. The quantity response to a 26-percent increase in price would be a decline of 11 to 21 percent, using the assumed range of elasticities.* With the current apparent consumption at 44 billion drinks, the decline would range from 4.9 to 9.2 billion drinks, giving a new

*These calculations assume a constant/elasticity demand model. The new consumption relative to current consumption is found by raising (1+t) to the power of the elasticity. For example, if the elasticity is -0.5, and if the tax adds 26 percent to the current price, then the new consumption is old consumption multiplied by (1.26 raised to the -0.5 power), which equals 0.89. Thus, current consumption would fall by 11 percent.

total of 39.2 to 34.8 billion drinks. The midrange of these estimates is a decline of 7 billion drinks to 37 billion drinks.

Beer quantity. The quantity response to a 36-percent increase in the price of beer, using an elasticity of –0.4, is a decline of 11.6 percent. The estimated current volume is 58 billion drinks annually; the projected decline of 6.7 billion would bring the new annual total to 51.3 billion drinks.

Wine quantity. The response to a 48-percent increase in the price of wine is as follows. Current consumption is estimated at 13.2 billion drinks. For a price elasticity of –0.5 to –1, consumption would decline by 18 to 32 percent. The new quantities would be 10.8 billion to 9 billion drinks. The average of these, 9.9 billion drinks, represents a decline of 3.4 billion.

Implications for Federal Tax Revenue

On the new quantity of 37 billion distilled spirits drinks, the Federal excise tax would total $10.25 billion. The current FET of $0.11 per drink imposed on 44 billion drinks produces a current revenue of $4.84 billion, thus the net increase in FET would be $5.4 billion.

On the new quantity of 51.3 billion beer drinks, the Federal excise tax would be $14.2 billion. The current tax of $0.027 per drink on 58 billion drinks produces revenues of $1.57 billion. Thus, the net increase would he $12.6 billion.

On the new quantity of 9.9 billion wine drinks, the Federal excise tax would be $2.7 billion. The current tax of $0.006 per drink on 13.2 billion drinks yields $80 million. Thus, the net increase would he $2.6 billion.

Combining these three sources, the estimated increase in FET would be $20.6 billion. These estimates rise (fall) as the assumed elasticity is smaller (larger) than the mid-range estimates used in this calculation.

Lives Saved

The estimates from Saffer and Grossman, from Cook, and from Phelps all suggest that the elasticity of fatalities with respect to alcohol price is about –0.7 to –1. The current proportions of drinks in the total market are 50 percent for beer, 38 percent for distilled spirits, 12 percent for wine. Thus, the weighted price change recommended by the Pricing and Availability Panel is 33.6 percent. The ensuing reductions in highway fatalities would be 19 to 25 percent. On an approximate base of 44,000 highway fatalities in 1988, this represents the avoidance of some 8,400 to 11,000 premature deaths annually.

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Panel B

Advertising and Marketing

Chair:	Robert Denniston
Background Paper:	Charles Atkin, Ph.D.
Recorder:	LCDR Joyanne Murphy
Panel Members:	Doris Aiken
	Jan Howard, Ph.D.
	Lawrence Wallack, Dr. P.H.
	Michael Mazis, Ph.D.
	James W. Swinehart, Ph.D.
	Jean Kilbourne, Ed.D.
	Rae Tyson
	Beverly Campbell
	Mary Beth Robinson

Education about alcohol is a critical first step toward a comprehensive approach to alcohol problems in our society. Mass communication is one major source of learning about alcohol use, especially for youth. In particular, alcohol advertising tends to glamorize alcohol use and to give a one-sided view without providing information about the consequences of such use. Hence, more complete and accurate information is needed. Therefore, the panel makes the following 17 recommendations in six categories.

Advertising and Promotion

B-1 Match the level of alcohol advertising with equivalent exposure for effective pro-health and safety messages to provide more complete and accurate information.

Strategy

Assuming continued limitations on public service media availability, a mandate to government to allocate funds to purchase time for alternative/counteradvertising is necessary. If this goal is not adequately met within 1 year, a system for mandated counteradvertising should be implemented.

B-2 Eliminate alcohol advertising and promotion on college campuses where a high proportion of the audience reached is under the legal drinking age.

Strategy

1. *The Surgeon General should request that the alcohol industry cease advertising and promotion efforts on such college campuses by September 1989.*
2. *The Surgeon General should*
   - *write to such university presidents recommending that they disallow advertising and promotion of alcohol and*
   - *provide guidelines and training sessions to the universities.*
3. *Alcoholic beverage industry codes should be revised to incorporate this recommendation.*
4. *The public should be informed of the extent and consequences of alcohol advertising and promotion on college campuses.*
5. *Sanctions (legal or economic) should be developed against the alcohol industry, and possibly universities, if alcohol advertising and promotion on such campuses do not cease by September 1990.*

B-3 Eliminate alcohol advertising, and promotion and sponsorship of public events (e.g., musical concerts, athletic contests), where the majority of the anticipated audience is under the legal drinking age.

Strategy

1. *The Surgeon General should request that the alcohol industry cease advertising and promotional efforts at such public events as well as sponsorship of such public events by September 1989.*

2. *Industry codes should be revised to incorporate this recommendation.*
3. *A letter from the Surgeon General should ask event promoters, sponsors, etc., to disallow advertising and promotion of alcohol at such events.*

B-4 Eliminate official sponsorship of athletic events (e.g., the Olympics) by the alcohol beverage industry.

Strategy

1. *The Surgeon General should request that the alcohol industry cease advertising and promotion efforts through the sponsorship of athletic events.*
2. *Industry codes should be revised to incorporate this recommendation.*

B-5 Eliminate alcohol advertising and promotion that portray activities that can be dangerous when combined with alcohol use.

Strategy

1. *The Surgeon General should request that the alcohol industry cease advertising and promotion efforts that portray activities that can be dangerous when combined with alcohol use.*
2. *Industry codes should be revised to incorporate this recommendation.*

B-6 Eliminate the use of celebrities who have a strong appeal to youth in alcohol advertising and promotion.

Strategy

1. *The Surgeon General should request that the alcohol industry cease advertising and promotion efforts through the use of celebrities with a strong appeal to youth.*
2. *Industry codes should be revised to incorporate this recommendation.*

B-7 Eliminate tax deductions for alcohol advertising and promotion other than price and product advertising.

Strategy

1. *Introduce legislation in the 101st Congress to address this recommendation.*
2. *Introduce legislation in State legislatures to address this recommendation.*

B-8 Warning labels, now required (as of November 1989) on alcoholic beverage containers, should also be required, clearly and conspicuously, in all alcohol advertising.

Strategy

Introduce legislation in the 101st Congress to extend the warning label law to include warning labels on all advertising consistent with the timetable of the current law.

B-9 Develop and implement training for local community groups regarding advertising and promotion issues and about voluntary and legal approaches for addressing this problem.

Entertainment Programming

B-10 Encourage the creative community to more fully and accurately portray the dangers associated with drinking and driving, and to provide highly visible role models for prevention. We acknowledge and commend the efforts of the creative community to date.

Strategy

1. *The Surgeon General should communicate with appropriate individuals through letters.*
2. *Workshops should be developed to stimulate increased attention to alcohol-related issues.*

News Coverage

B-11 Encourage comprehensive news reporting of alcohol-related problems in general, and crashes in particular.

Strategy

1. *The Surgeon General should develop and disseminate a fact*

sheet on alcohol to be distributed to news organizations. This fact sheet should include information such as the following.

- *Alcohol is a drug, and beer is the alcoholic beverage of choice.*
- *Alcohol is addictive.*
- *The number of alcohol-related deaths includes approximately 25,000 traffic fatalities annually.*

2. *Encourage inclusion of information about the role of alcohol in news reporting of local crashes when appropriate.*
3. *Develop and disseminate twice annually a news release from the Surgeon General providing the latest available information on drinking and driving.*

B-12 Encourage the news media to provide coverage on alcohol issues commensurate with the nature and scope of the problem.

Public Campaigns

B-13 Institute and sustain high visibility public information efforts about issues related to drinking and driving.

Strategy

1. *Continue to expand and publicize existing programs already in place, e.g., alcohol awareness week.*
2. *Create a coalition of public and private agencies to provide focus and promote coordination of drinking/driving campaigns.*
3. *Increase State and local levels of public funding, as appropriate, and encourage private sector involvement.*

Regulatory Responsibilities

B-14 Consider moving the responsibility for regulation of the alcoholic beverage industry to the Food and Drug Administration, DHHS.

Research

B-15 Fund research to determine—

B-15.1 The effect of alcohol promotion, advertising, and other media content on different populations, e.g., underage youth, high-risk audiences, and juries.

B-15.2 Which specific advertising and entertainment features contribute to higher versus lower levels of excessive drinking and alcohol-impaired driving.

B-15.3 The most effective media campaign strategies, as part of a comprehensive intervention effort to reduce drinking and driving.

B-15.4 Whether a relationship exists between the amounts of alcohol-related advertising and editorial content in magazines.

B-15.5 The potential effects of informing audiences about compensated inclusion of alcohol products in theatrical motion pictures.

B-16 Provide a research testing service to measure target audience reactions to:

- public information campaign messages voluntarily submitted prior to dissemination; and
- new alcohol advertisements appearing in the mass media.

B-17 Assess the effects of these recommendations, as implemented, on alcohol problems.

Strategy

1. *Federal and State Government agencies should allocate funding for this research.*
2. *Private foundations should increase funding in this area.*
3. *Private sector organizations should increase funding in this area.*

Panel C

Epidemiology and Data Management

Chair:	M.W. Perrine, Ph.D.
Background Paper:	Carl E. Nash
Recorder:	LCDR Marlene Cole
Panel Members:	Allan Meyers, Ph.D.
	Richard Waxweiller, Ph.D.
	Darryl Bertolucci
	John Donovan, Ph.D.
	Carl Soderstrom, M.D.
	Lawrence A. Greenfeld
	Ted Doege, M.D.

The Panel on Epidemiology and Data Management submits recommendations regarding drunk driving data collection and data management and on drugged driving.

In the area of data *collection*, we recommend the following.

C-1 Require State and local police to obtain the blood alcohol concentrations (BAC) of all drivers and nonmotorists involved in fatal and serious injury motor vehicle crashes.

C-2 Obtain and record a BAC for all patients of appropriate age admitted for treatment of acute injury for the purposes of:

- patient diagnosis and clinical management;
- aiding in the diagnosis of alcohol abuse; and
- providing data to document the epidemiology of alcohol in all types of injury.

C-3 Develop a research agenda to identify the range of factors that inhibit the uniform collection of blood alcohol data. There appear to be institutional, professional, and economic barriers to the collection of blood alcohol data on people involved in motor vehicle crashes. To carry out the first set of recommendations, these barriers will have to be understood and addressed.

Strategy

Implementation of recommendations C-1 and C-2 are addressed in C-3, the development of a research agenda. The members of the epidemiology panel are to prepare a draft research agenda and submit to Dr. Perrine, Workshop Chairperson, for compilation. This material will be forwarded to the Surgeon General's office. This panel requests that the Surgeon General:

1. *define such a research agenda by April 1989,*
2. *assign this agenda to one or more Agencies, and*
3. *assign a 1-year timeframe for completion of the research.*

C-4 A voluntary standards organization should establish a consensus committee to set standards for definitions, questions, data elements, and methodologies used in research and data collection relating to drunk/drugged driving.

Strategy

The panel advises the Surgeon General to invite an organization to establish a consensus committee charged with the task of assembling an initial set of definitions within a year.

To obtain improved exposure data, the panel recommends the following.

C-5 Change policies to facilitate periodic roadside surveys to collect valid and complete data on the BAC of an appropriate sample of all drivers using public roads.

C-6 Conduct roadside surveys at enforcement checkpoints and other sites to collect data on BAC at all levels starting at zero.

C-7 Develop policies and procedures to ensure that accurate alcohol

data are obtained for commercial motor vehicle operators using the highways.

C-8 Encourage development and testing of a valid, cost-effective surrogate for roadside surveys.

Strategy

1. *A policy needs to be generated to encourage and facilitate the roadside surveys that receive the endorsement of the Surgeon General.*
2. *A change in State and local policies is needed to facilitate the collection of data, which include zero BAC.*
3. *Commercial motor vehicle operators should undergo drug testing during roadside data collection when feasible.*

C-9 Determine more accurately the characteristics of drunk drivers and identify the contributions of those characteristics to the risk of serious motor vehicle crashes.

Strategy

Focus should be placed on those characteristics of drunk drivers amenable to intervention.

A major purpose of collecting epidemiologic data is to indicate possible points of intervention. Therefore –

C-10 Evaluate all drunk driving countermeasures – whether they apply to people, vehicles, or environment – for effectiveness, safety, acceptability, and cost.

In the area of data *management*, we recommend the following.

C-11 Develop standards and procedures for keeping and linking records relating to drunk/drugged driving and related offenses, from arrest through prosecution, conviction, and disposition. These should be adopted by all jurisdictions in the country.

C-12 Convene a study committee to:

- inventory existing routinely collected data bases,

- inventory data bases that have the potential to provide useful information,
- assess the validity, completeness, and comparability of these data bases and the ability to access and link them, and
- identify needs for additional data that should be routinely collected.

C-13 Develop a central locus for assembling relevant drunk driving data bases and describing their contents to potential users. The panel on epidemiology finds that the resources applied to data collection and analysis on alcohol and motor vehicle crashes is minuscule compared to losses from crashes involving alcohol. To achieve a significant improvement in motor vehicle safety will require substantially more and better information, and the commitment of substantially more resources to epidemiologic research on drinking and driving.

Strategy

The Surgeon General should ensure that this study committee be assembled with government and nongovernment representation. The optimum size of this ad hoc committee would be 12 members. This committee would be in existence within 1 year and receive funding on a prorated basis from the Federal Agencies sponsoring this workshop. The committee would provide a written report on the tasks outlined in C-12 and C-13 to the Surgeon General and the Agencies involved in this workshop.

Considerably less is known about drugged driving that about drunk driving. Therefore –

C-14 Define a research and data collection agenda to determine the nature and magnitude of the drugged driving problem.

Strategy

The Surgeon General should convene a workshop on drugged driving in 1989.

Panel D

Education

Chair:	Patricia Waller, Ph.D.
Background Paper:	Bruce Simons-Morton, Ed.D., M.P.H.
Recorder:	Joan White Quinlan
Panel Members:	Katherine Armstrong, Ph.D.
	Michael Goodstadt, Ph.D.
	Elizabeth A. Weaver
	Delores Delaney
	John Harvey
	Alvera Stern, Ph.D.
	David Sleet, Ph.D.
	David Anderson, Ph.D.

The Education Panel recognizes that driving while intoxicated (DWI) is a leading cause of death and disability and *the* leading cause of death among young people. A variety of efforts are needed to address this problem, and education plays an important role.

The private and public sectors have a shared responsibility to educate and protect the public against impaired driving. Health, alcohol, and traffic safety communities must work together in designing and implementing effective education and behavior-change programs.

Educational efforts should be designed to help overcome DWI social acceptability and reduce myths surrounding DWI. DWI information should be factual and current. It should help the public, professionals, and decisionmakers understand what they can do to help change DWI policy and practices.

Education leading to effective policy development at Federal, State, and community levels is a critical step in this process.

Education does not occur in a vacuum. It must be part of a comprehensive public health approach to DWI that includes social and environmental action.

Properly designed and implemented educational efforts can influence knowledge, attitudes, and practices and are cumulative and additive in their effects.

The goal of education programs for those under 21 years of age should be to promote no use of alcohol (or other drugs). For those 21 and over, educational efforts should promote the concept of low-risk choices – choosing not to drink in high-risk situations.

Educational interventions must be undertaken within worksites, the family and community, health care agencies, and schools. Within these settings, targets include the general public, at-risk individuals, and decisionmakers.

Most DWI educational programs are insufficiently based in theory and should reflect current knowledge in the fields of social psychology, mass communication, and organizational change.

Research should be ongoing and should help to identify effective education and promotion strategies needed to reduce DWI in specific community settings. Once identified, these strategies should be widely disseminated.

Objectives

The Education Panel offers the following objectives for all drinking and driving education programs.

- To decrease the frequency of drinking in association with driving
- To reduce the frequency of drinking in other traffic-related situations (motorcycles, bicycles, boats, snowmobiles, etc.)
- To reduce the average blood alcohol concentration among drinking drivers to less than 0.05 percent, and promote zero tolerance as the standard for the public
- To decrease the frequency of riding with drinking drivers
- To promote social norms that do not tolerate drinking and driving
- To promote personal responsibility for discouraging drinking and driving among friends and acquaintances
- To promote support by the general public and actions by decisionmakers for public policy, environmental control, and environmental protection and programs regarding drinking and driving

General Recommendations

The Education Panel offers the following general recommendations.

- Drinking and driving education should be considered an essential component of a comprehensive public health approach to DWI reduction.
- Drinking and driving education should be integrated into all health promotion/risk reduction programs.
- Drinking and driving information should be included in health professional training.
- All drinking and driving public information and education programs should be based on sound learning theories, as well as social marketing and communication strategies.
- All decisionmakers should be educated about the development and implementation of effective policies to prevent drinking and driving.
- The impact of alcohol beverage advertising should be balanced with fair time counteradvertising.

Specific Recommendations

Policy Education

D-1 Develop model policies for worksite, school, health care, community, and recreational settings regarding alcohol.

Strategy

Set up an advisory group to review existing policies and to identify current promising policies. Convene a consensus panel to select policies for each setting.

D-2 Develop a decisionmaker's guide to drinking and driving policy development.

Strategy

Using the policies selected by the consensus panel, develop and publish a manual. Subsequently, conduct training for local, city, and State decisionmakers.

D-3 Develop guidelines for training education, health care, and other professionals.

Strategy

Provide small grants to professional organizations to develop training manuals for their membership to reduce drinking and driving and consider this training as part of the requirements for maintaining their certification.

D-4 Develop guidelines for the sponsorship, promotion, use, and sale of alcoholic beverages in relation to lifetime leisure activities (recreation, sports, drinking establishments).

Strategy

Develop a guide for communities on environmental and social policy including responsible recreational events; make camera-ready copies available and develop a distribution list and mechanism for distribution.

Encourage State and local governments to implement environmental controls, such as eliminating happy hour promotions, banning alcohol advertising on billboards and at fairs, and posting warning labels where alcoholic beverages are sold.

D-5 Educate decisionmakers about how to implement incentives regarding the parental supervisory role.

Strategy

Conduct research to determine if analytical skills are permanently impaired by preadolescent and adolescent drinking.

Have parents educate and encourage other parents to teach their children not to drink and drive, as well as inform decisionmakers about the important role parents can play.

D-6 Increase revenues for drinking and driving programs by raising taxes on alcoholic beverages and/or increasing fines for a DWI offense.

Strategy

Develop model legislation for use by legislators and track legislation as it is being passed.

Have exhibit booths at annual conferences of mayors, governors, and city managers. Educate these target groups by making information available.

D-7 Expand warning labels on alcoholic beverages.

Strategy

Provide research findings to citizen activist coalitions on the wide range of health effects from alcohol consumption and encourage them to work toward more comprehensive warning labels.

D-8 Encourage stronger law enforcement and adjudication of existing drinking and driving laws.

Strategy

Establish a monitoring system to identify areas having exemplary, as well as poor, enforcement and adjudication of drinking and driving laws. Regularly publish the names of those cities and counties having the "best" enforcement and adjudication rates, as well as the 10 "hot spots."

Develop a guide for State Attorneys General identifying liability issues, encouraging dram shop liability, and providing guidance on responsible business practices.

Professional and Provider Education

For health care providers, schools, worksites and communities (law enforcement, elected officials, parents, clergy, media, etc.) –

D-9 Increase the level of knowledge and awareness about drinking and driving prevention.

Strategy

Distribute copies of the recommendations to a wide variety of national groups and organizations in the following areas: education, highway safety, judicial and law enforcement, driver licensing, public health, and medical. Ensure that associations not represented at this workshop receive copies of the recommendations. When the recommendations are distributed, include a list of recipients.

Encourage these groups and organizations to use the recommendations to (1) create a State Task Force on Impaired Driving or (2) motivate existing State Task Forces.

Include a diversity of State and local groups and organizations in implementing these recommendations.

Provide accurate information on drinking and driving to science and health editors and writers, as well as free-lance writers, for inclusion in health and scientific journals.

D-10 Increase the number of professionals who receive education about drinking and driving prevention as well as the importance of modeling and how their behavior affects the public.

Strategy

Provide small grants to professional organizations to develop training manuals for their membership to reduce drinking and driving, and consider this training as part of the requirements for maintaining their certification.

Work with textbook editors and publishers to ensure that accurate information is included and updated regularly.

Request that relevant groups and organizations monitor alcohol education materials for accuracy and messages.

Work with curriculum developers in health programs to include and update materials on impaired driving, including the nature of alcohol advertising and marketing.

Provide information on how to access health promotion funds that could be used for reducing impaired driving.

D-11 Include training in professional practices for professionals and providers.

Strategy

Provide small grants to professional organizations to develop training manuals for their membership to reduce drinking and driving and consider this training as part of the requirements for maintaining their certification.

D-12 Educate on how to overcome barriers to implementing policies and programs.

Strategy

Publish a guide on how communities can overcome barriers to policy changes.

D-13 Provide education and training in support of community coalition development to citizens, traffic safety, public health, and medical professionals.

Strategy

Give widespread recognition and utilization to systems-based, community development approaches, i.e., the Centers for Disease Control's program entitled PATCH - Planned Approach to Community Health.

Expand the scope of existing coalitions to include impaired driving issues and strategies, i.e., Traffic Safety Now and the Safe Kids Campaign.

Have NIAAA's Chief Executive Officer Task Force form a subcommittee on drinking and driving to explore ways corporations can reduce drinking and driving.

D-14 Provide incentives to increase and recognize those professionals and providers who develop and implement effective and innovative programs.

Strategy

Create a well-recognized award program in the Departments of Transportation and Health and Human Services to recognize effective and creative impaired-driving programs conducted by private/public sector partnerships.

Public Education

D-15 Increase the quality and quantity of exposure of the public to how they can reduce drinking and driving by:

- affecting policy
- reducing tolerance for drinking and driving
- advocating for legislative changes

- perceiving how their behavior affects those around them

Strategy

Prepare a Surgeon General's letter on impaired driving myths and facts. Facts would include: problem of crash involvement, the difference between impaired and drunk driving, gender/individual differences, genetic and biological vulnerability, the effects of alcohol consumption on sexuality and weight, the temporary effects of alcohol consumption (i.e., "hangover effect"), the risks for impaired pedestrians, and the concept of "low-risk" choices. Myths would include: even though alcohol consumption is legal for adults, it is not necessarily safe; driving performance is not improved by consuming alcohol; beer is an intoxicating beverage; it is dangerous to be able to "hold your liquor"; and a 12 oz wine cooler contains more alcohol than a can of beer.

Prepare a strong statement for the Surgeon General to issue on encouraging the nonuse of alcohol by those under age 21. The message should include the association with health problems, especially when combining alcohol with other drugs.

Develop a plan for disseminating the workshop recommendations. Document current Federal drinking and driving activities.

Have the Surgeon General hold a press conference to disseminate the above information to the public.

Use motivational techniques to help people maintain a commitment to not drink and drive and to encourage communities to maintain a long-term commitment to reduce the problem.

Ensure that information on drinking and driving is included on electronic bulletin boards for use by the media, educators, science writers, etc., in informing the public.

Print the names and BACs of convicted drinking drivers.

Work with television programmers and writers to include messages in the electronic media on drinking and driving.

Provide the automobile industry (manufacturers, dealers, etc.) with information they can provide to customers.

D-16 Base public information campaigns on effective social marketing theories.

Strategy

Conduct research on the knowledge, attitudes, and practices of the American public and develop materials and messages accordingly.

Market drinking and driving messages, theories, and strategies in an easy-to-read manner. Provide materials that contain graphics and are written for appropriate reading levels. Request support from the private sector in developing these materials.

Have NIAAA and other relevant Institutes compile a review of their most recent research and grant findings. Provide this information to science writers and other writers to use in developing public information articles.

D-17 Educate the public (1) concerning the effects of marketing and advertising by the alcohol beverage industry regarding alcohol consumption and (2) about the relationship between increased taxes on alcohol beverages and reduction in drinking and driving crashes.

Strategy

Provide small incentive grants to associations to have the public identify ways to overcome the alcohol beverage industry's advertising and marketing practices.

Use findings from NIAAA-sponsored studies and grants on the relationship between increased taxes and a decrease in motor vehicle crashes to inform the public.

D-18 Educate the public about the impairing effects of low levels of alcohol on driving performance.

Strategy

Conduct research to determine the length of time that low, moderate, and high doses of alcohol affect performance of adolescents, young adults, adults, and older individuals.

Research Needs

D-19 Conduct research on the relationship between media messages and "traditional" classroom instruction.

D-20 Test and replicate social marketing strategies with targeted audiences.

D-21 Conduct ongoing systematic evaluation of the alcohol beverage industry's advertising marketing and promotion efforts and their relationship to alcohol consumption and drunk driving; explore the relevance of these efforts to educational initiatives.

D-22 Conduct research on effective community approaches to drinking and driving prevention.

D-23 Reexamine drinking and driving education to improve its effectiveness.

D-24 Translate research findings for practitioners and determine the most effective means for disseminating this information.

D-25 Determine the most effective combination of approaches for a community program to reduce impaired driving.

D-26 On an ongoing basis, expand and maintain existing national data bases on knowledge, attitudes, and practices regarding drinking and driving.

D-27 Monitor and assess implementation of these recommendations.

Strategy

Coordinate the research plans for agencies such as NIAAA, NHTSA, CDC, and NIDA, in particular, CDC's Injury Prevention Research Centers.

Request that the Transportation Research Board study these recommendations and develop its own research implementation plan.

Expand funding for research from existing sources, e.g., request that Congress include drinking and driving research in the Omnibus Drug Bill.

Panel E

Judicial and Administrative Processes

Chair:	The Honorable James D. Rogers
Background Paper:	James Nichols, Ph.D.
	H. Laurence Ross, Ph.D.
Recorder:	CDR Gloria Ames
Panel Members:	William Hayes
	Ray Larson
	Joel Watne
	Paul Kamenar
	Kay Chopard

The judicial, prosecutorial, and administrative functions play a very important role in dealing with the subject of this workshop, but cannot be the total solution. Responsible action is needed from citizen support groups, community leaders, the hospitality industry, manufacturers of alcoholic beverages, and automobile manufacturers.

The judicial, prosecutorial, and administrative functions should act to change the behavior of those who are apprehended for drunk driving and those who are not apprehended.

The panel makes the following recommendations.

E-1 Apply "hard" driver's license revocation (i.e., no exceptions for hardship, occupation, treatment, or other reasons) for a minimum of 90 days for first offenders. The time of revocation should be substantially increased for repeat offenders.

Most jurisdictions have some form of "Limited Driver's License" process. This nullifies the beneficial results of the loss of the driving privilege.

In jurisdictions with "hard" license revocation, it has been found that

very few people have lost their jobs, and none have been unable to attend treatment or aftercare programs.

E-2 Increase emphasis on reducing driving without a valid driver's license due to driving while under the influence or other alcohol-related charges, as this is an intentional offense. The panel recommends singly or in combination:

- License plate confiscation (License plate confiscation should be used by judges as a condition of pretrial release. Administrative hearing officers should also use license plate confiscation. The judge may consider the issuance of special plates.)
- Incarceration of the violator
- Impoundment of the vehicle used in the violation

E-3 Do not reinstate driver's licenses lost for an alcohol-related offense without the offender providing proof of compliance with an alcohol assessment and any court order.

E-4 Make the following sanctions mandatory in addition to "hard" license revocation.

- *Fines*. The monies should be used to fund educational programs on the use of alcohol and driving and to compensate victims.
- *Jail*. This may be stayed for first-time offenders on compliance with court-imposed conditions. The stay should be for at least 2 years.

E-5 Discourage plea negotiations. All negotiations shall be placed on the record, and all proceedings shall be in open court.

E-6 Make driving illegal per se at 0.08 blood alcohol concentration. All presumptions of not being under the influence of an alcoholic beverage or nonintoxication should be repealed.

This still recognizes that driving with any alcohol concentration presents an increased hazard to the driver and the public.

E-7 Encourage States and the District of Columbia to regularly review their existing implied consent laws to determine if they are meeting their desired goals. The penalties associated with such laws should be sufficiently more severe than penalties associated with failure of a chemical

test or of an alcohol-related conviction to provide an incentive to submit to a chemical test.

E-8 Adopt administrative per se driver's license laws. In this type of a procedure, the offender's driving privileges can be revoked for driving with a blood alcohol concentration at or above a set level.

E-9 Give prosecution and defense the same rights of appeal. (In some jurisdictions, the prosecution has no right of appeal.)

E-10 Have an alcohol assessment, by a competent certified person, selected by the court, made available to the judge prior to sentencing of all defendants in alcohol-related driving offenses.

E-11 Provide sufficient funding for judges, prosecutors, and administrative hearing officers for continuing education in alcohol and related driving offenses. This funding should not only allow for training within the State but out of State at such locations as the National Judicial College.

E-12 Recognize the rights and roles of victims and adopt the *Statement of Recommended Judicial Practices* which were adopted December 2, 1983, by 102 judges – two from every State and the District of Columbia – at a Conference at the National Judicial College. *

"Giving victims the right of allocution at sentencing hearings has not resulted in any noteworthy change in the workloads of either the courts, probation departments, district attorneys' offices or victim witness programs." **

E-13 Admit evidence from the criminal proceedings in any resulting or related civil proceedings.

E-14 Establish a uniform State and national record system for all moving traffic violations.

- Reporting to both State and national systems shall be mandatory with sanctions for noncompliance.

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*Copies of the *Statement of Recommended Judicial Practices* may be secured from National Institute of Justice/NCJRS, Box 6000, Rockville, Maryland, 20850.

**National Institute of Justice, Executive Summary, *Victim Appearances Under the California Victims' Bill of Rights*. Page 59.

- Each State and the District of Columbia shall participate in the national system.
- Each State and the District of Columbia shall regularly audit and review their systems for compliance.
- The national system shall be regularly reviewed for compliance and uniformity.

E-15 Apply judicial, prosecutorial, and administrative penalties to parties, other than the driver, who contribute to the offense, such as the legal or illegal providers of the alcoholic beverages.

E-16 Develop self-sufficient systems and programs for prosecution, adjudication, sanctioning, and treatment of alcohol-related driving offenders. (Use fines, fees, and alcohol consumption taxes.)

E-17 Use existing special programs and further devise others for juvenile drinking drivers. They must use both education and comprehensive actions of the court centered around their driving privilege.

E-18 Develop programs for the 18- to 26-year-old group for both education and sentencing procedures. This age group is involved in a disproportionate number of alcohol-related driving offenses.

The panel realizes that some recommendations may work well in all jurisdictions and others may be less effective in some. Certainly, no jurisdiction has solved the problem, and no jurisdiction should sit back and be complacent. Each jurisdiction should regularly reexamine its own methods and also look at those used by others. All too often the statement is made that "We have the toughest laws in the country." This may be true, but tough laws are meaningless if they are not enforced and implemented by the courts, prosecutors, administrative hearing officers, and law enforcement agencies.

Panel F

Law Enforcement

Chair:	Maury Hannigan
Background Paper:	John Lacy, Ph.D.
	Robert Voas, Ph.D.
Recorder:	LTJG Dorothy Stephens
Panel Members:	Peter O'Rourke
	Dean Gerstein
	Ralph Hingson, Sc.D.
	Johnny Mack Brown
	John Moulden
	Howard P. Patinkin
	James P. Donovan

Driving Under the *Influence* (DUI) enforcement is a short-term control over a much more fundamental problem – public attitudes toward alcohol abuse. This public health problem must be addressed in the long range by effective education programs beginning in our primary schools and extending to adult programs, mass media, advertising, and regulation. This will require a concerted and cooperative effort among agencies concerned with health, education, transportation, commerce, and the administration of justice. Enforcement can contribute to this longer range process through well-publicized programs enforcing community standards regarding drinking and driving.

We recommend six high-priority measures that would make DUI enforcement more efficient and effective in the apprehension of DUI offenders. The goal of enforcement is deterrence. The recommended measures are likely to increase the volume of DUI arrestees and thus affect other components of the DUI control system – notably the courts, corrections, and licensing agencies.

The Law Enforcement Panel of the U.S. Surgeon General's Workshop on Drunk Driving makes the following recommendations.

F-1 Develop a comprehensive DUI training program for chief executives of law enforcement agencies. The graduates of the program should—

- Understand the specific nature and extent of the DUI problem;
- Understand state-of-the-art strategies and technologies of DUI enforcement;
- Be able to implement and use DUI data systems in their jurisdiction; and
- Be able to identify and effectively draw on relevant organizations and resources at the local, State, and national level.

Strategy

An executive training program should be developed by NHTSA, in conjunction with the International Association of Chiefs of Police (IACP) and the National Sheriffs Association (NSA). This training program should be disseminated nationwide to all chief law enforcement executives through the auspices of IACP and NSA.

- *Timeframe: development of program in 1989*
- *Timeframe: implementation of program in 1990 and beyond*

F-2 Apply innovative techniques of DUI enforcement such as passive sensors, preliminary breath testing (PBT) devices, BATmobiles (mobile breath alcohol testing units), drug recognition experts, and horizontal gaze nystagmus. Adopt appropriate enabling legislation where needed and train field officers and court personnel in appropriate evidentiary use and interpretation of these techniques.

Strategy:

A program should be established by NHTSA in conjunction with the National Bureau of Standards and the IACP to certify passive breath sensors for DUI enforcement.

Such a program shall include minimum standards for these devices, a quantification test, the development of a certified products list (CPL), and a quality-control sampling procedure. This program should be established in consultation with the NSA.

- *Timeframe: develop standards and CPL by January 1990.*
- *Timeframe: establish quality-control procedures by January 1991*

NHTSA, IACP, and NSA should educate law enforcement personnel in the use of devices (passive sensors, PBTs) and techniques (drug recognition experts, horizontal gaze nystagmus) and encourage their application and wide utilization.

- *Timeframe: begin implementation by calendar year 1989 and beyond as necessary*

NHTSA should also continue to evaluate devices and techniques through appropriate research.

- *Timeframe: ongoing*

F-3 Implement DUI checkpoints in those jurisdictions currently not using this technique, and expand their use in jurisdictions currently using them. To enhance the efficiency and effectiveness of checkpoints, we advocate the use of BATmobiles, passive sensors, and/or PBT devices and the adoption of legislation to permit sobriety checkpoints where necessary. These techniques should be used in accordance with the standards set forth by the United States Supreme Court and/or respective State Courts. Also, research data on the effectiveness of checkpoints should be broadly disseminated.

Strategy

The IACP and NSA should conduct leadership workshops on the conduct of single and multiple agency checkpoints during their 1989 annual conferences, to be followed by a series of workshops across the country to disseminate this information to line supervisors, with the assistance of each State's Governor's Highway Safety representative.

- *Timeframe: Calendar year 1989 and continue thereafter*

Where checkpoints are currently not being used, consult with the attorney general of that State for the purpose of meeting the constitutional requirements of that State, relative to the application of checkpoints or drafting necessary constitutional/legislative amendments to allow their application.

- *Timeframe: immediate*

F-4 Make blood alcohol concentration testing mandatory for all drivers involved in fatal and serious injury traffic collisions, both for data collection and prosecution, as appropriate.

Strategy

NHTSA should develop and disseminate model legislation for application by the states.

- *Timeframe: during calendar year 1989*

F-5 Adopt administrative license suspension and revocation procedures for DUI that are designed to keep to a minimum the time required for field officers to carry out their testifying functions.

Strategy

The Surgeon General should write a letter to the governors of those States that currently have no administrative license suspension legislation (administration per se) to encourage such legislation.

- *Timeframe: immediate*

F-6 Maximize public perception of the risk of arrest and punishment for driving under the influence through law enforcement public information and education efforts. These efforts are essential to the deterrent effectiveness of DUI enforcement.

Strategy

To deter drunk driving through enforcement, public information and education (PI&E) efforts must be tailored to the specific activities of the enforcement agency and thus must be developed at the local level. NHTSA should develop and disseminate basic PI&E resources and materials for training in their adaptation and use at the local level. NHTSA should work with the Governor's Highway Safety Representatives (NAGHSA), IACP, and NSA to conduct training to foster the use of these materials at training sessions sponsored by these organizations.

- *Timeframe: no later than 1989, annual IACP, NSA, and NAGHSR conferences, and ongoing*

Panel G

Transportation and Alcohol Service Policies

Chair:	Joseph Gusfield, Ph.D.
Background Paper:	Robert Saltz, Ph.D.
	Robert Apsler, Ph.D.
Recorder:	Michael Impellizzeri
Panel Members:	William Scott
	Perla Niguidula
	James Peters
	Terry Pence

The Transportation and Alcohol Service Policies Panel was charged with reviewing the role of alternative forms of transportation, such as taxis and designated driver programs, and their ability to reduce the problem of drinking-driving. The panelists were further charged with reviewing and recommending policies that might also have a direct bearing on the drinking-driving event, such as drinking establishment patterns, server education, and employee assistance programs.

The panel focused its attention on the environment of transportation opportunities and on social and commercial practices for serving alcohol. One element common to both concerns was the aim of disengaging prevention of the driving act from the drinking act. We recognize that policies to affect transportation and server practices have received scant attention in public health circles. Among alternative forms of transportation, the support of and information about designated driver, safe ride, and employee assistance programs are important adjuncts to public transportation and private commercial transportation.

No less important are the practices of beverage service establishments in the prevention of drinking-driving. Training servers and other beverage service personnel to monitor and recognize patrons at risk should be a significant aspect of beverage service enterprises. The panel further

recognized that commercial beverage serving establishments have an obligation to be concerned about safe transportation for patrons whose drinking creates a risk to themselves, passengers, and/or pedestrians. The role of such enterprises, as well as social hosts, is vital to a successful program to curb drinking-driving.

The panel was also convinced that the cogency and feasibility of such service programs and alternative transportation forms depend on particular local conditions of servicing agencies and transportation facilities. They also require the cooperation and support of community agencies and groups. The need for implementing programs at the local and communal level was stressed. The purpose of the special community task force recommended below is to create community standards for serving practices by social hosts and commercial establishments so as to prevent drinking-driving and ensure compliance with existing local rules and regulations. In addition, the task force would examine and encourage improvements in alternate systems of transportation. Such task groups are important since, in the past, transportation and server practices have been overlooked in public health prevention efforts.

The panel recognizes the possible danger that programs to provide safe transportation for drinkers may encourage drinking and risk exacerbating other alcohol problems. Servers and others should be aware of these risks and not view the recommendations here as encouraging any lessening of other actions to prevent problems related to the use of alcohol.

Community Focus

G-1 Each community should form or expand a task group to review and implement, in a systematic way, interacting policies and priorities as to alcohol service and alternative transportation. Such groups should include, but not be limited to, representatives of public transportation, taxi associations, alcohol and drug abuse authorities, traffic safety professionals, hospitality industry associations, zoning authorities, licensing agencies, citizen support groups, insurance companies, alcohol beverage authorities, educational institutions, and other public and private sector groups.

The agenda for this community effort includes the recommendations in the three broad areas of transportation, server practices, and implementation strategies.

Transportation

Alternative transportation plans enable impaired drinkers to reach their destinations without risking harm to themselves or others.

G-2 The designated driver program should be a community-wide approach addressing all types of drinking situations at all hours and involving drinkers, commercial establishments, social hosts, transportation alternatives, and special events, including sports events. Servers and social hosts must not allow guests or patrons to become intoxicated and thus become a danger to themselves and others, not only through drinking-driving but in other dangerous situations as well. Designated driver programs should incorporate these features:

- The designated driver does not drink any alcoholic beverages.
- Establishments or social hosts provide easy availability of and promote food and alcohol-free beverages.

G-3 Information describing the relationship among alcohol consumption, blood alcohol level, and risk of injury or death should be provided to all individuals obtaining a new or renewal license for operating any type of motor vehicle.

G-4 The hours of drinking establishments should be consistent with the hours of alternative transportation.

G-5 Improving the effectiveness of taxi cabs and other similar forms of transportation as alternatives to drinking and driving should be explored with representatives of the taxi and other pertinent industries.

G-6 The automotive industry and the National Highway Traffic Safety Administration should continue to explore the viability of ignition interlocks and their incorporation in future vehicle design.

G-7 As a condition of obtaining a license to serve alcohol, including "one day" or special permits, an organization must develop and implement a specific plan to provide transportation for individuals who are impaired. Social hosts should do the same.

G-8 Programs to promote safe or alternative transportation (designated driver, safe rides, etc.) should keep in mind that problems related to impairment are not limited to driving automobiles, but also include operating motorcycles, bicycles, boats, snowmobiles, and airplanes; horseback riding; skiing; and even being an impaired pedestrian.

Beverage Service Policies and Practices

Alcohol service training and intervention refer to a broad set of strategies

that address environmental reforms at two basic levels: the legal environment and the specific environment of the licensed establishment. The following policy considerations are recommended in order to achieve a consistent and effective prevention plan.

G-9 Crowd management: Licensees must maintain an adequate ratio of staff to patrons in order to monitor beverage sales, consumption, and patron behavior.

G-10 Promotions: Licensees should not encourage drinking as a focus of activity through promotions such as free drinks, drinking contests, discounted drinks, or multiple drink purchases (e.g., happy hours).

G-11 Training: Training appropriate to the type of facility should be made available to all managers and servers of alcoholic beverages, consonant with policies recommended here.

G-12 Written policies: Written policies must be posted and made available to all employees. These should be included and made a part of alcohol service training.

G-13 Food options: Food should be offered and available during all hours of operation.

G-14 Alcohol-free beverages: Alcohol-free beverages of all types should be promoted, offered, and made available where alcoholic beverages are sold.

G-15 Alternative transportation: Alternative transportation options must be made available wherever and whenever alcoholic beverages are served.

G-16 Serving sizes: All alcoholic beverage drinks should be served in single- serving standard sizes (e.g., 12 oz beer, 5 oz wine, or 1 ¼ oz 80-proof liquor).

G-17 Drinking on the job: Managers and staff are required to be alcohol-free while on duty.

G-18 Age identification: All patrons must produce a valid identification when a server is in doubt as to legal drinking age. Two forms of identification, one with a photo such as government identification or drivers license, are recommended.

G-19 Intoxicated patrons: Service to intoxicated patrons is prohibited.

G-20 Employee assistance programs: All alcohol service employees must have access to an employee assistance program.

Implementation and Incentives

It is recognized that responsible beverage service policies will be followed only in a legal, economic, and social environment that encourages them. The following specific recommendations serve to foster that environment.

G-21 Server practices require vigilant enforcement by regulatory agencies. Those agencies must be adequately funded to carry out that task. In addition, State regulatory agencies (Alcohol Beverage Control boards) should be reviewed to determine current practices, conflicts of interests, scope of authority, and enforcement of existing statutes. State legislatures should review the structure of their Alcohol Beverage Control agencies to emphasize their place in the promotion of public health.

G-22 State licensing regulations should be adopted to provide incentives, such as adjustment of licensing fees, for compliance with responsible server practices as recommended.

G-23 State legislatures should review and reform their dram shop (liquor) liability laws to maximize their preventive impact and to encourage business to adopt responsible serving practices. (The 1985 Dram Shop Act, *Western State Law Review* 12:417-517, 1985, can serve as a reference.)

G-24 States should review and certify server and manager training programs to assure that they accomplish prevention goals, and that the implementation of monitoring and certification of trainees is consistent with other vocational and educational programs in the State.

G-25 State insurance commissioners should review the rate-setting practices of liability insurance companies to ensure incentives for implementing risk management practices that minimize drinking-driving.

G-26 Adequate records of the site of the last drink should be kept in all cases of all officially reported alcohol-related incidents.

G-27 A representative from each of the 11 panels from this workshop

should be selected to serve on the advisory board of the governmental interagency implementation group.

G-28 The final report of this workshop should be widely disseminated to a broad range of agencies and enterprises in public and private sectors, including regulatory agencies, insurance companies, trade associations, and local workshops and conferences such as Responsible Service Forums and Life Savers. Dissemination might include representatives from the implementing groups or from the workshop panels.

Panel H

Injury Control

Chair:	John M. Templeton, Jr., M.D.
Background Paper:	Julian Waller, M.D.
Recorder:	CDR Richard J. Smith III
Panel Members:	Martin R. Eichelberger, M.D.
	George L. Reagle
	Lawrence Schneider
	Clark Watts, M.D.
	Stephen Teret, J.D.
	Katherine McCarter
	Susan McLoughlin, M.S.N., R.N.
	Chief Ricky Davidson

Injury control in drunk driving crashes requires examination of all components covering precrash, crash, and postcrash phases. These phases are not isolated but are intimately linked and interrelated. Injury prevention, injury control, and rehabilitation are inseparable parts of the treatment of alcohol abuse as a disease.

Specific concrete recommendations concerning injury control require direct and indirect approaches. Direct approaches concern prevention and treatment programs directed at the drinking driver as a perpetrator of injury. Indirect approaches concern programs directed at generic injury control, such as improved environment and behavior modification. Specific agencies and groups should be designated to help in the implementation of these approaches.

Injury Control in the Precrash Phase

H-1 Establish a program to integrate at the national, State, and local level

highway safety personnel, highway engineers, maintenance personnel, and Federal and State Departments of Transportation. The program should –

- Stress injury prevention; and
- Foster technology transfer and implementation.

H-2 State governors: Develop a State-sponsored injury control coalition in each State comprising components from public health, education, traffic safety, judiciary, alcohol beverage control, communications, alcohol and drug abuse, and others, including balanced representation from grassroots citizen groups. The goals of the coalition should be to –

- Develop scientifically based education in injury prevention;
- Evaluate the program to measure the impact of education;
- Develop expertise in the correlation of injury severity scores on crash analyses;
- Identify high-risk roadway and environmental conditions, and to implement programs to correct these hazards; and
- Propose legislative initiatives designed to implement injury control.

H-3 State governors: Establish a Fatal Crash Review Panel in each State to include broad government and lay community representation. Its goals would be to –

- Produce better epidemiological reporting of the crash event by police and other authorities;
- Analyze causation, including multiple components of causation; and
- Recommend changes in action programs and environmental improvements such as signs, guard rails, etc.

H-4 Federal Department of Transportation: Establish a national safety feature checklist to be displayed on all new cars, highlighting objective scores concerning rollover potential, front end yielding, intrusion protection, fields of vision, etc. Mandated standards should include –

- A defined numerical range for each feature;
- The vehicle's specific score for each feature; and
- Consumer education programs for the public.

H-5 FCC and Congress: Develop and implement national policies and programs to lessen the use of alcohol seen in TV programs and feature movies.

H-6 FCC and Congress: Develop and implement national policies and programs for television that encourage positive lifestyle decisions such as routine buckling up, refusing to drive after drinking, and refusing to ride with a driver under the influence.

H-7 FCC and Congress: Establish national policies requiring equal time on television for public service announcements to advise the public of the hazards of alcohol.

H-8 NHTSA and State and local authorities: Develop demonstration programs to study the use of an interlock mechanism for the vehicle of anyone convicted of a DUI offense, and encourage the use of interlock mechanisms where proven effective.

Injury Control in the Crash Phase

H-9 Federal DOT: Promote enactment in every State of effective mandatory seatbelt laws to include "primary" enforcement with an adequate fine.

H-10 Federal DOT: Promote enactment of laws requiring airbags for drivers and front seat passengers as standard equipment.

H-11 Federal DOT: Promote the proper use of seatbelts and child safety seats in both cars and trucks. Stress –

- 3-point harness devices and improved technology for the protection of young children and low birth weight infants;
- Use of seatbelts even in vehicles with airbags; and
- Use of seatbelts in front and back seat.

H-12 Federal DOT, HHS, and Justice: Promote Federal policies that foster passage and maintenance of laws regarding mandatory helmet usage for all motorcycle riders.

H-13 NHTSA: Encourage industry and consumer programs to retrofit used vehicles with appropriate standard restraint devices and air bags.

H-14 Federal DOT, HHS, and Justice: Foster policies for mandatory fitting of large trucks with devices to prevent "underride."

Injury Control in the Postcrash Phase

H-15 Regionalize emergency medical service systems for the care of injured patients throughout the Nation.

- Establish guidelines for the care of injured patients in the prehospital, inhospital, and rehabilitation phases of care.
- Define regionalization guidelines for urban and rural areas.
- Develop "self-sufficiency" funding mechanisms such as a surcharge on DUI and other traffic violations.
- Develop new approaches to the financing of inhospital and rehabilitation care of indigent patients.
- Encourage public education in the structure and function of emergency medical systems.

H-16 DHHS and medical care professional groups: Develop and implement comprehensive rehabilitation programs for—

- Physical rehabilitation;
- Psychosocial intervention for the drinking driver; and
- Psychosocial rehabilitation of the victims and the family of the victim.

H-17 DHHS: Require BAC testing of all age-appropriate trauma victims of traffic-related injuries as a component of their medical care and management.

H-18 DHHS interacting with professional education organizations: Encourage the teaching of alcohol abuse and injury control as a public health issue in the curricula for health care providers.

H-19 States: Establish State trauma registries as an important part of a system to provide epidemiological data on death, disabilities, and costs to government and private resources.

Strategy

1. The Surgeon General should speak to the National Governor's Conference on what each governor can do to be a catalyst for administrative and legislative action on drinking and driving within each State.

- *Stress that injury is a preventible disease that requires a comprehensive approach to reduce*

the human and financial cost of alcohol abuse and traffic-related injuries.

- *Provide specific recommendations regarding improved vehicle safety, environmental safety, and injury prevention behavior.*
- *Support regionalization of injury care systems.*

2. *The Surgeon General and his office should also address the issue of drinking and driving through—*
   - *TV programs to educate the public (as done with AIDS);*
   - *A speech to the National Governor's Conference; and*
   - *A formal congressional hearing on the issue of drinking and driving.*
3. *The expertise and assistance of the following specific agencies and groups, as listed with the individual recommendations made by the injury control panel, should be enlisted:*
   - *Department of Transportation (NHTSA)*
   - *Federal Communications Commission*
   - *Department of Justice*
   - *Department of Health and Human Services (CDC)*
   - *U.S. Congress*
   - *State Departments of Transportation*
   - *State governors*
   - *State legal authorities*
   - *National Association of State Emergency Medical Services Directors*
   - *Medical care professional groups*
   - *Professional education organizations*

Panel I

Youth and Other Special Populations

Chair:	Galen Davis
Background Paper:	Michael Klitzner, Ph.D.
	Philip May, Ph.D.
	Elsie Taylor
Recorder:	CDR Phillip Smith, M.D.
Panel Members:	Allan F. Williams, Ph.D.
	Anthony J. Heckemeyer
	Judy Zundel
	Raul Caetano, M.D., Ph.D.

The several recommendations coming out of this Surgeon General's workshop may be effective in the general population. However, their effectiveness in ethnic minority groups will depend on the extent to which those interventions are tailored to the social and cultural identity of the specific ethnic group. Educational efforts, for instance, need to take into account the best media for dissemination of information as well as sensitive use of meaningful cultural symbols and images.

Drunk driving as a major public health problem affects youth and ethnic minority groups disproportionately. Specifically targeted interventions are needed. However, drinking and driving occur in the context of social norms, and cultural and regional trends are influenced by a multitude of other factors.

Drinking and driving among youth are frequently determined by their adult role models. Action at the school level should include more than just classroom prevention programs; a restructuring of the schools to improve student commitment to education and other social values is also needed. Concerted efforts should be aimed at improving self-concept, coping skills, and psychological adjustment.

The panel finds it difficult to provide specific recommendations for the special populations as distinct entities given the lack of data on the extent

and correlates of the problems within each group. Therefore, the panel addresses those issues which the various ethnic groups have in common while highlighting the specific needs of certain ethnic groups. The following recommendations are based on this premise.

Relative to drinking and driving, we recommend the following programs, policies, and countermeasures.

I-1 Increase local, State,and Federal taxation on alcoholic beverages.

I-2 Increase justice system training.

I-3 Increase health care system training (i.e., cross-train disciplines where possible).

I-4 Increase the precision and consistency of present data collection systems (i.e., the Fatal Accident Reporting System (FARS), Multiple Cause of Death (MCD) file, death certificates) to collect and record data on drinking and driving among youth and at-risk minority groups.

Strategy

Research funds should be allocated from NIAAA, probably the epidemiology branch. The request for proposals (RFP) announcement should include provisions for evaluation of data collection measures. Results should be realized within 2 years of implementation.

- *Timeframe: 3 months for RFP*
  9 months to go through review and award system

I-5 Renew governmental regulatory guidelines on motor vehicle design and road safety.

I-6 Support community involvement through proven strategies and programs.

I-7 Restrict Federal highway funds if States do not institute administrative drivers license revocation for DUI.

I-8 Ensure swift and sure sanctions including making the sanctions reflect the magnitude of the problem.

I-9 Support enactment and enforcement of the 1987 National Commission Against Drunk Driving (NCADD) checklist of countermeasures.

Strategy

The National Highway Traffic Safety Administration should include the 19 countermeasures of the 1987 NCADD Checklist of Countermeasures in their 408 or 410 DWI countermeasure incentive programs. States must attain 80 percent of the countermeasures to be eligible for the incentive grant funds in the first year and 90 percent to be eligible for the second and subsequent years. Special grant incentives should be set up for 100- percent attainment.

- *This program should be implemented during the 1990 Federal fiscal year.*

I-10 Encourage comprehensive school-based K-12 alcohol and other drug abuse education and educator training programs of proven efficacy.

Strategy

By the end of 1990, NIAAA in conjunction with NHTSA should award a series of 5-year contracts to evaluate existing and/or innovative educational strategies and teacher-training efforts in terms of student behavioral outcomes, including age of first use, drinking patterns, DWI/RWID, and other alcohol-related problems.

Teacher training should be evaluated in terms of increased teacher awareness and knowledge, increased comfort with addressing alcohol-related issues, increased skill in implementing alcohol education, and increased skill in action planning of prevention for the school and community.

These contracts should be restricted to individuals and institutions who have not participated in the development of the programs and who have no financial interest in the dissemination of the programs.

I-11 Add funds for States to develop and evaluate innovative programs to prevent and reduce drinking and driving.

I-12 Encourage civil liability for intentionally providing, directly or indirectly, alcohol to minors.

I-13 Institute night driving curfews for beginning drivers under 18 years of age.

Strategy

- *NHTSA and the Office of Juvenile Justice and Delinquency Prevention (OJJDP) should develop model curfew and 0.02 legislation by the end of 1990.*
- *States failing to adopt legislation conforming to these models by the end of 1992 should forfeit 10 percent of their Federal highway funds.*
- *By the end of 1992, NHTSA and OJJDP should have developed a training curriculum for local law enforcement officers in methods for identifying youth driving with low BACs.*
- *By the end of 1992, training of trainers conferences of the above curriculum should be held in all NHTSA program regions.*
- *By the end of 1992, NHTSA should award a 3-year contract to study the implementation of curfew and 0.02 legislation in all States.*

I-14 Increase the effectiveness of minimum alcohol purchase age laws.

I-15 Support mandatory seatbelt and motorcycle helmet laws and tie them to Federal highway funds.

I-16 Endorse the following recommendations of the National Commission on Drunk Driving report on youth:

- Administrative per se license suspensions should be statutorily permitted.
- Open container laws should be promulgated.
- Strict sanctions should exist for the sale or transfer of alcoholic beverages to youths under the legal drinking age.

Appropriate State agencies and State legislatures should consider legislation in the following areas.

I-17 Make classroom instruction on alcohol use, other drug use, and impaired driving mandatory for grades K-12; develop curriculum guidelines for each grade level.

Strategy

By the end of 1990, based on current knowledge, NIAAA in conjunction with NHTSA and Department of Education should develop guidelines for the selection and development of curricula and teacher-training methods by local school districts. This effort should be overseen by a national panel of experts who do not have a financial interest in any such programs.

NOTE: The Department of Education recently did this for drug education (including alcohol and tobacco), but there is little (if any) traffic safety thrust in their materials.

I-18 Encourage insurance rebates for drivers who take an approved driving risk-reduction course and have a clean driving record.

I-19 Include a mandatory component on alcohol use and impaired driving in driver education courses.

I-20 Discourage and/or limit beverage advertising and promotion that is directed at youth and minorities.

Strategy

Implementation should follow guidelines set up by the Advertising and Marketing Panel.

I-21 Endorse 0.08 BAC for DWI for all the population 21 years of age and older.

I-22 Endorse additional penalties over and above standard liquor law violations for those under age 21 with an 0.02 BAC or above.

I-23 Increase the enforcement of DUI laws relative to youth.

I-24 Increase professional and public information and education with regard to youth and other special populations. Proven strategies for prevention and remediation should be utilized. Emphasis should be placed on providing education to:

- Criminal justice personnel
- Health care professionals
- Educators

- Media professionals
- Other policymakers
- Other community leaders
- General public

Prevention media communications should take into account the appropriate culture and ethnic values when delivering their message.

I-25 Provide broad-based education of Indian tribal leaders and tribal members on policy options pertaining to alcohol.

Strategy

Require the Federal Agencies, in consultation with tribal communities, to develop strategies and plans for providing training on tribal specific and appropriate alcohol policy, e.g., to include personnel plans and policies, law and order codes and ordinances, school criteria and guidelines for education, diagnosis and treatment protocols in clinics and hospitals, and quality assurance plans for all treatment and rehabilitation programs.

The lead Agencies should be the Bureau of Indian Affairs (BIA), the Indian Health Service (IHS), NIAAA, NHTSA, etc.

- *Timeframe: By December 1990*

I-26 Increase Indian tribal law enforcement resources.

I-27 Expand traffic safety initiatives among Indian tribes.

I-28 Better utilize all sources of funding for education, recreation, and economic development. In particular, improve the socioeconomic status of the American Indian.

I-29 Support Federal/tribal/State cooperation for the establishment of detention and treatment centers for American Indians.

I-30 Improve social and cultural relevance in all programming and countermeasures.

I-31 For American Indians and Alaska Natives, seek support of tribal governments in the development of tribal resolutions for establishing policy actions on alcohol and operation of motor vehicles while under the influence of alcohol or other drugs.

Strategy

Amend P.L. 99-570, the Anti-Drug Abuse Act of 1986, to include incentives for tribal governments to formulate, execute, and enforce tribal-specific drinking-driving policies. Lead agencies: Bureau of Indian Affairs, Indian Health Service

- *Timeframe: December 1989 for amended legislation*

I-32 Develop and implement educational efforts to increase Hispanics' awareness of the risks associated with drinking and driving and to minimize drinking practices that lead to the consumption of higher volumes of alcohol per occasion. The target groups should be youth and males aged 21-39 years.

Strategy

A campaign should be developed nationwide with sponsorship from the Office for Substance Abuse Prevention (OSAP). Proposals should include carefully laid out plans for evaluations of campaign effectiveness.

- *Timeframe: 3 months to request proposals*
  4 months to proposal deadline
  2 months for review
  3 months for funding

I-33 Encourage special training of law enforcement officers to ensure nondiscriminatory DUI law enforcement.

I-34 Increase community recreational resources for black (and American Indian and Hispanic) youth.

Strategy

Funds may be allocated from State block grants or from OSAP for demonstration projects to set up neighborhood afterschool programs (e.g., music, drama programs; physical rehabilitation programs; occupational therapy programs; RAP and counseling programs).

- *Timeframe: 1 year for implementation of program*
  1 year for evaluation of success of programs
  look for results in 1992

I-35 Increase education of religious and other black community leaders about alcohol abuse and drunk driving.

Strategy

Include an appeal to religious leaders in their religious training programs.

Institute training curricula in ministerial schools.

Encourage black community leaders to set up neighborhood RAP sessions and programs.

Funds may be allocated from the Office for Substance Abuse Prevention or the National Highway Traffic Safety Administration.

- *Timeframe: One year setup time to implement programs; one additional year to see how or if the program works and produces results.*

I-36 Increase religious and community programs on alcohol and other drug abuse for blacks.

Research

In the area of research, the panel recognizes the extreme lack of data on specific minority populations with regard to drinking and driving. Descriptive data are needed on the following topics.

I-37 Describe effective alcohol and other drug abuse assessment tools for youth.

I-38 Identify effective support groups for youth and ethnic minorities returning from treatment.

I-39 Develop more precise and consistent measures to collect and record data on drinking and driving among youth and ethnic minority groups.

I-40 Determine the extent of drinking and driving among ethnic groups and the major demographic characteristics of individual members of the group who engage in such behavior.

I-41 Study the relationships among drinking patterns such as volume consumption per occasion and drinking and driving.

I-42 Investigate the attitudes toward drinking and driving among blacks/Hispanics/American Indians and how deviance is defined in the specific group.

I-43 Track arrest patterns to assess the question of the validity of high prevalence of DUI arrest among Hispanics as it relates to law enforcement practices.

I-44 Assess the effectiveness of first and multiple offender rehabilitation programs for youth and ethnic minorities.

I-45 Assess the effectiveness of driver's license sanctions associated with DUI convictions.

I-46 Assess the effectiveness of State laws that apply special license sanctions to youth for alcohol-related violations.

I-47 Evaluate the effect of liquor advertisements on the use of alcohol by minors.

1-48 The panel endorses the research questions listed in Dr. Perrine's background paper for the Epidemiology Panel as they relate to the different age groups in the minority population. (See background papers in separate volume.)

In specifically addressing the recognized research priority needs among American Indians, the panel makes the following additional recommendations.

I-49 In the area of epidemiology, research is needed on the following issues relevant to American Indians:

- Motor vehicle accidents based on geographic location, i.e., reservation/off-reservation, urban or rural sites
- Adult prevalence studies
- Survey of tribal alcohol policies
- Prevalence and level of impairment due to drinking and driving related motor vehicle accidents

I-50 In the area of social-psychological research, the following topics are of major importance to American Indians:

- Social-psychological studies of accident victims

- Attitudinal values and trends on drinking and driving

Strategy

Sponsorship for this research should come from the National Institute on Alcohol Abuse and Alcoholism. The mechanism for funding would be the basic RO1 grant funding of the extramural research program.

- *Timeframe:* *February 1, 1989* *Receive proposals*
  June 1989 *Initial review*
  October 1989 *Council review*
  December 1989 *Funding awarded*

I-51 Organize Federal coordination efforts to provide technical assistance to tribes regarding legislation implementation.

Strategy

Lead agencies: Bureau of Indian Affairs, Indian Health Service, NHTSA, NIAAA, etc.

- *Timeframe: December 1990*

I-52 Evaluate the effectiveness of policy execution by:

- Process evaluation – the stages of passing and implementing new policy; and
- Outcome measures – maintain accident (e.g., pregnancy, morbidity and mortality) data and alcohol (e.g., alcohol-related problems) data on a longitudinal database.

Strategy

Lead agencies: Indian Health Service, NIAAA, and private sector agencies.

I-53 Identify potential State, Federal, tribal, and private funding resources to implement tribal policy.

Strategy

Lead agencies: IHS, BIA, NIAAA

- *Timeframe: ongoing*

I-54 Develop interagency plans for prioritizing funding needs and technical assistance to meet tribal priorities such as:

- Public health planning
- Legal aid
- Media and information services
- Plans for dissemination of knowledge and sharing experience among local communities.

Strategy

Lead agencies: *BIA, IHS, tribal governments*

- *Timeframe:* *Plans by December 1990*
  Implementation: *ongoing as process evolves*

Panel J

Treatment

Chair:	Robert Niven, M.D.
Background Paper:	Vernon Ellingstad, Ph.D.
	Kathryn Stewart
Recorder:	CAPT Frank Hamilton, M.D.
Panel Members:	Loran Archer
	Harvey Siegel, Ph.D.
	Mark Goldman, Ph.D.
	Chauncey Veatch III
	James A. Farrow, M.D.
	John Allen, Ph.D.
	Jeri Shaw

Drinking and driving is a serious social and public health problem. Because of the enormous human and economic costs of drinking and driving on our society, the Panel on Treatment unanimously agrees that prevention and deterrence from drinking and driving are beneficial to all our society.

To improve traffic safety in the United States, the panel advocates the position that the safest blood alcohol level is 0.0 percent while driving and strongly recommends that the public service message should clearly state:

"If you are going to drive, don't drink."

The panel further advises that contrary or different messages, including "Know your limit" messages, should not be used.

From a public health perspective, all of the following recommendations are important. The panel opts to prioritize and rank order these recommendations according to which are most pressing and would enhance an effective response to this problem.

Prevention

Rehabilitative countermeasures, even if 100-percent successful, can have only a limited impact on traffic safety. The main approach to eliminating alcohol/drug-related injuries or fatalities must be focused on *prevention.*

J-1 Prevention measures, including both general and specific deterrence aimed at eliminating the behavior of driving while under the influence, are essential if major declines in mortality and morbidity are to be achieved. Prevention measures to be considered include traditional educational approaches and also public policy, enforcement, legal sanctions, and treatment measures. All messages, verbal and behavioral, should be clear, concise, noncontradictory, and focused on eliminating the joint activities of drinking and driving.

Strategy

The Surgeon General should immediately begin to promote a single public health message concerning drinking. This message should be "Don't drink and drive." Any contrary messages to this should be discouraged, including "Know your limits" messages.

The Surgeon General should ensure that all Federal Government promotional materials about drinking and driving be revised to reflect this position by the National Drunk and Drugged Driving Awareness Week in 1989 and should ask all voluntary agencies concerned with drunk driving to adopt an identical message and to discourage contrary messages.

The Surgeon General should convene a multidisciplinary task force to develop mechanisms to coordinate and increase prevention efforts and the recommendations from this and other task forces involved in the Surgeon General's Workshop on Drunk Driving.

The Surgeon General, acting through the Public Health Service, should create a variety of educational materials on drunk driving, which should be widely distributed (including through chemical dependency and other health care facilities and organizations) and incorporated in health care training didactic and clinical curriculums. The creation and dissemination of these materials should be completed by the National Drunk and Drugged Driving Awareness Week in 1989, or as soon as possible.

Treatment

J-2 Treatment should not routinely be used as a *substitute* for legal sanctions, but rather as an important component of a comprehensive traffic safety program.

Driving under the influence of alcohol or other drugs is a multifaceted problem for which there is no *single* effective treatment of any type (medical, legal, or punitive).

Treatment programs reduce driving related alcohol/drug incidents in those alcohol/drug dependent persons successfully treated, both those with and those without prior DUI offenses. Such programs are also a resource (as are other components of the health care delivery system) to further the dissemination of prevention materials.

A systematic approach to offenders using qualified personnel, appropriate standards, with oversight and quality assurance controls and without conflict of interest, is necessary to assess those persons who may benefit from one or a combination of treatment approaches. Such a systematic approach also needs ongoing evaluation to develop answers to relevant questions and enhance cost-effectiveness.

The traditional short-term, low-intensity educational programs that are broadly applied have been of limited effectiveness, and more intensive, longer term treatment options may be more beneficial (albeit more costly) and perhaps applicable to a selected population of offenders.

Strategy

Since a significant body of research supports the role of legal sanctions, in particular licensing sanctions, in reducing DUI recidivism, the Surgeon General should encourage Federal, State, and local governments to adopt and promulgate policies and practices that offer treatment in combination with licensing penalties and other sanctions proven to be effective and to discourage offering treatment in lieu of other known, effective sanctions.

Because of the wide variations in the structure and quality of assessment and treatment programs from State to State, the Surgeon General should promote and encourage States to develop mechanisms for high-quality diagnostic and referral procedures for DUI offenders and, specifically, should encourage the use of uniform diagnostic criteria and assessment instruments and treatment approaches, since this would greatly facilitate research studies on the effectiveness and cost-effectiveness of treatment.

Research

J-3 Develop a precise data base on the incidence and prevalence of driving under the influence in different population groups. Since drunk drivers comprise a heterogeneous population, specific demographic identifiers among this population need to be defined. Special populations (i.e., youth, minorities, and women) should be targeted in obtaining these data.

J-4 Intensively investigate the neuroscientific basis of high-risk, impulsive behavior and recidivism in this population.

J-5 Develop a scientific evaluation of treatment modalities and the combination of various treatment options for the heterogeneous group that makes up the drunk-driving population.

J-6 Evaluate the effectiveness of new, short-term low-intensity programs that have an impact on behavior from both an outcome and a process perspective.

J-7 Develop and evaluate newer treatment modalities in high-risk populations.

Strategy

The Surgeon General should encourage and foster research and the coordination of research activities of various U.S. Government Agencies involved in this field, to increase the quantity and quality of research focused on the drunk driving issues identified by the task force. A priority in this area, which requires an immediate increase in research, is the assessment of subpopulations who are already underrepresented in existing knowledge bases.

The Surgeon General should encourage States and local government agencies to develop uniform data collection, assessment, and treatment methodologies, since such information would provide an invaluable basis for the further development of public policy initiatives aimed at minimizing the enormous adverse impact of drunk driving.

Resources

Significant increases in fiscal and personnel resources will be required for success, but this is not seen as the sole responsibility of the Federal or State Governments.

J-8 Since DUI has significant economic impact, funds should be used judiciously at all levels of State, local, and Federal Government. In allocating resources to address this issue of traffic safety, funds earmarked for public education should be given the highest priority. Evaluation and reevaluation of current treatment programs that are most cost effective and provide the most efficient treatment are encouraged.

J-9 Coordination and leadership, at the highest levels of government and in the private sector, are also necessary if impaired driving is to be eliminated. Involvement of health, judicial, law enforcement, transportation, and education departments, in an intense and truly cooperative effort, will facilitate the involvement of universities, business, and private groups in developing, implementing, and testing strategies to eliminate this national tragedy.

J-10 The cost of treatment should be borne as much as possible by individuals convicted of DUI, based on their ability to pay. If the individual is unable to pay, the individual's high-risk group (those convicted of DUI) should bear the cost.

Resources for supporting this prevention and rehabilitative endeavor would be derived from revenue from fees, penalties, and other appropriate sources.

Strategy

In view of scientific data indicating the limited effectiveness of short-term, low-intensity educational programs, which are the most common approach to DUI offenders, the Surgeon General should encourage States and local governments to reassess the use of resources currently devoted to such programs and to consider retargeting resources to other treatment or prevention strategies.

Panel K

Citizen Advocacy

Chair:	Howard Filston, M.D.
Background Paper:	John McCarthy, Ph.D.
Recorder:	CAPT Patricia D. Mail
Panel Members:	Mickey Sadoff
	Rebecca Brown
	Ann Esch
	Nancy Ricci
	Ritchie Aanderud
	Marsha Woodward
	Harold Brandt, M.D.
	Wes Roy
	Sue Rusche

Citizen advocacy represents a broad focus of concern that cuts across the more specifically defined issues associated with driving while intoxicated (DWI). Having its roots in the towns and communities of the Nation where the problem of DWI is most omnipresent, the citizen advocate's concerns encompass all aspects of DWI from advertising and marketing through enforcement, judicial and administrative issues, and treatment. But the greatest concentration of effort is in education, for it is through education of the judiciary, legislature, and citizenry that the dramatic efforts to reduce and eliminate DWI are concentrated. Only continued community awareness can bring about the type of behavioral and attitudinal changes necessary to ensure the safety of the Nation's highways from impaired operators of motor vehicles.

The Citizen Advocacy Panel was charged with addressing a range of issues, many of which are being addressed by other panels in the workshop. After wrestling with these charges, it became apparent that continued deliberations would only serve to duplicate the recommendations of the other panels. Each of the charges represented a vital and important issue,

and there was insufficient time to address each in the detail required. The panel members are concerned that citizen advocates were not empaneled as members of each of the other panels, for only in that fashion could the citizen advocates voice their unique concerns.

The citizen advocate is able to represent the perspectives and issues that cut across jurisdictional lines; represent victim viewpoints; challenge inaccuracies and inconsistencies in the law, its enforcement, and disposition; and speak out as a conscience for necessary action.

The panel proceeded to address several issues that were of particular and continued concern to advocacy groups. The panel also went on record as supporting and endorsing the recommendations of the *Presidential Commission on Drunk Driving* (1983) and the *Youth Driving Without Impairment Report of the National Commission Against Drunk Driving* (1988). In addition, the panel addressed the special roles and responsibilities of citizen advocates and supported the mandate provided by their inclusion in this workshop that citizen advocacy groups continue to give the issue of DWI the full force of concern in our society which this grave problem deserves.

The panel makes the following recommendations to the Surgeon General.

Recommendations for Advocacy Groups

K-1 Develop a coalition of national and local advocacy groups for the purpose of coordination, exchange of information, and strategic planning.

Strategy

An agency should be identified, such as the National Highway Traffic Safety Administration (NHTSA), under whose sponsorship a meeting of advocacy groups could be convened to initiate coalition building. This conference could occur in conjunction with the next Lifesavers Conference, April 1989.

The NHTSA grant programs should provide funding for regional workshops on drinking and driving to facilitate coalition building on a regional basis. Because of the already established networks of NHTSA, the Surgeon General should encourage the Congress to increase appropriations for NHTSA's grant programs. If coordination with Lifesavers is not feasible, then other sources of support for a coalition-building conference should be sought and a preliminary meeting held during 1989.

K-2 Establish a national clearinghouse of information about impaired driving issues and advocacy activities as a resource for advocates and the general public.

Strategy

The Surgeon General should provide the leadership to coordinate appropriate agencies to identify funding and establish a National Impaired Driving Prevention Information Clearinghouse to help advocacy groups and other interested parties.

- *This should be initiated by the end of fiscal year 1989.*

K-3 Advocacy groups should educate themselves with regard to all aspects and issues of impaired driving to ensure that they have the most accurate and up-to-date knowledge about the problems.

Strategy

The National Impaired Driving Prevention Information Clearinghouse would serve as a major source of information and training materials for advocacy groups and individuals interested in becoming advocates. Advocates who interact with the press or the legislators must know current laws and legislative initiatives for improving them.

K-4 Of all the activities in which advocates are involved, the major efforts should be directed toward four primary activities that are not emphasized by any other group:

- Court monitoring
- Victim assistance
- Influencing public policy and legislation
- Ongoing awareness and public education

Strategy

The National Clearinghouse would be a resource for information to support these activities, provide training material, serve as a repository for model legislation, and provide assistance with the development of appropriate materials. However, nothing will be accomplished without energetic and vigilant efforts by local advocates.

K-5 Advocacy groups should continue to expand their volunteer base, drawing on both victims and potential victims.

K-6 It is important for advocacy groups to keep their volunteers happy and productive. Volunteers require training in order to be well prepared and comfortable with their tasks. A variety of activities should exist that challenge and utilize the broad range of volunteer skills and talents that the individual members bring with their commitment.

Strategy

Advocate participants need to take back to their organizations the recommendations presented at the workshop and to seek ways to both implement and encourage support for the recommendations, giving them wide publicity and assuring the widest possible distribution of the subsequent report.

The Proceedings of the Surgeon General's Workshop on Drunk Driving should be sent to all of the following:

- *State governors*
- *State legislators*
- *State Attorneys General*
- *Members of the U.S. Congress*
- *National advocacy groups*
- *Federal Judges and members of the U.S. Supreme Court*
- *Members of the Presidential Commission on Drunk Driving*
- *Advocacy group officers*
- *Members of the citizen advocacy panel.*

In addition, copies should be made available to the National Clearinghouse for Alcohol and Drug Information for distribution to advocacy group chapters nationally through NCADI's Regional Alcohol and Drug Awareness Resource (RADAR) Network and the National Institute of Justice Clearinghouse.

Copies should also be sent to the national officers and all State presidents of the League of Women Voters.

K-7 Advocacy groups must continually seek a variety of resources within their communities to support their activities, including help from corporations, foundations, individuals, and governmental entities.

K-8 Advocates should seek opportunities to recognize and reward those individuals whose behavior and actions are necessary and appropriate to the task of removing impaired drivers from the streets and streams of America. Appropriate behavior should be reinforced and recognized, whether through the services of volunteers or from administrators, law enforcement officers, judges, probation officers, legislators, or other professionals.

Strategy

When a national clearinghouse is established, one service might be the development and dissemination of a newsletter that would feature volunteers and professionals and recognize their important contributions to getting impaired drivers off the Nation's highways.

K-9 Advocates must be on the alert to identify the unaddressed potential situations in their communities that create a climate for excessive alcohol consumption. Excessive drinking at sporting events or festivals should be discouraged. Those individuals responsible for the planning of public events should be encouraged to seek ways to reduce and control the ready availability of alcohol and to actively discourage DWI while promoting alternatives.

Strategy

This activity is a major responsibility of local advocacy groups. Distribution of the workshop proceedings will help to disseminate this information.

K-10 Advocates must be constantly on the alert for attempts within their community or State to revoke and/or weaken established laws and policies by appending revocation language onto otherwise unrelated bills.

Strategy

A clearinghouse would help make such attempts widely known, and the tactics in one State would be exposed for all to learn from and guard against in their own States.

Additional Recommendations

In addition to recommendations specific to citizen advocates, the panel also wishes to go on record regarding issues that are of great concern to citizen advocates.

K-11 Emphasize that DWI is a national catastrophe (crisis) representing a most serious threat to the public health and deserving of extensive and continuous attention at all levels of government and society.

K-12 State clearly that Driving Under the Influence (DUI) or Driving While Intoxicated (DWI) is a crime and deserving of criminal sanctions, even for the first offense. Use a twofold attack consisting of administrative license revocation per se combined with criminal sanctions. Although some leniency in punishment and emphasis on education toward behavior modification are appropriate for first offenders not involved in crashes resulting in injury or death, the importance of establishing a record of this first offense as a *crime* cannot be overstated, for it then becomes the basis for more punitive sanctions for the multiple offender.

Strategy

This needs to be stated and restated, not only by the Surgeon General, but by the U.S. Attorney General and Federal and State attorneys.

To help publicize the magnitude of this issue and to give prominence to the pervasiveness of DWI in the country, reports of DWI and related criminal activities, such as hit-and-run, should be regularly incorporated in the FBI's Uniform Crime Report.

- *Incorporation of such reporting to be initiated by October 1989.*

K-13 Increase national attention on DWI and the events leading up to this act. To accomplish this, use of properly descriptive language must be strongly encouraged. This includes the fact that alcohol-related crashes and injuries are not "accidents."

Strategy

The Surgeon General should encourage all major medical organizations and the Centers for Disease Control to define alcohol-related episodes as crashes, with resultant injuries where appropriate, and to cease using the word "accident." The CDC should commence regularly reporting alcohol-related crash injuries and deaths. These deaths and injuries due to DWI should be regularly tracked and reported in the Center for Disease Control's Morbidity and Mortality Weekly Report. The latter will help to raise health professional awareness about the magnitude of the problem.

- *This should be initiated by October 1, 1989.*

K-14 Increase the use of sobriety checkpoints on the Nation's roads and highways and reinstate them in those States that have declared them unconstitutional.

Strategy

The U.S. Attorney General should promulgate the model standards for setting up such checkpoints. A summary of the issues relating to this recommendation may be found in the Impaired Driving Issues Compendium (1989), *prepared by Mothers Against Drunk Driving:*

The National Association of Chiefs of Police, other law enforcement associations, the Justice Department, and NHTSA should all strongly urge the use of checkpoints. NHTSA should encourage State Attorneys General to review their local laws and make changes as needed to implement checkpoints, as well as to provide guidelines to their members and the various states on the legal implementation of such checkpoints.

Advocates need to inform themselves about this issue and determine what their local and State policies are regarding checkpoints. With volunteer legal consultation, conduct a review of local laws to determine where modification may be needed to implement or reinstitute checkpoints.

- *All of the above with preliminary implementation by December 31, 1990.*

K-15 Significantly lower the per se BAC of 0.10 and apply this lowered standard to the general public consistently throughout the United States. Standards should be consistent with either the recommendations of the American Medical Association (.05) or those currently being applied to commercial transportation operators (.04). The permissible BAC for drivers under the age of 21 should be established at 0.00 nationally.

Strategy

The U.S. Public Health Service should charge its appropriate Agencies to begin a review of all relevant research immediately to determine appropriate BAC levels to safely operate motor vehicles, and issue a report on their findings not later than December 30, 1990.

When this determination is made, the information should be forwarded to NHTSA and the Departments of Justice, Education, and Defense for the widest possible promulgation. In addition, the PHS should forward a recommendation to the appropriate

Congressional Committees to consider development of legislation to establish this level nationally.

Advocacy groups should urge the adoption of the level on a State-by-State basis.

If all legislative avenues to establish a physiologically relevant standard fail, then the Congress should consider withholding Federal highway trust funds from States, as part of a total package of mandating model standards for the public health and safety.

- *Effective legislation and enforcement could be in place by 1992. The PHS can probably conduct a review of research and make a recommendation by the end of FY 1990.*

K-16 Adopt uniform graduated penalties for DWI in the States and territories, with special focus on multiple offenders, especially those individuals driving with revoked licenses.

Strategy

The Surgeon General should ask NHTSA to work with advocacy groups, law enforcement officials, and appropriate judiciary organizations to develop such models and supportive educational material.

The resources of NHTSA should be directed to convening an expert working group to establish standard graduated sanctions, with particular emphasis on multiple offenses, driving under license revocation, and penalties for those who knowingly lend a vehicle to an individual who has a revoked license.

K-17 Establish a national computer registry of DWI offenders in which the recognition of DWI in any State has reciprocity and recognition in all other States. This should be available to licensing bureaus and all enforcement officers through a network like the Federal Bureau of Investigation's National Crime Information Center (NCIC).

Strategy

The Congress is urged to appropriate funds to implement the 1988 Drunk Driving Prevention Act, and advocacy groups nationally should also urge passage of the provisions of this law in their individual States.

In addition, the Surgeon General should request participation of the

Justice Department and other appropriate law enforcement agencies and institutions to review and recommend the most expedient manner for creation of this data base.

- *Review and recommendations regarding feasibility and cost could be completed by the end of FY 1990 and the Registry be implemented by the end of FY 1992.*

K-18 All States should incorporate into their driver qualification tests questions on the effects of drinking and driving and the penalties for violations.

Strategy

Advocacy groups should urge incorporation through their legislators and licensing bodies.

- *To begin immediately.*

K-19 Testing for BAC should be mandatory as evidence in any crash, injury, or death in which a motorized vehicle is involved (including boats, snowmobiles, and other all-terrain and off-road vehicles).

Strategy

The U.S. Attorney General should restate the requirements of the Uniform Vehicle Code as they pertain to mandatory testing, and testing should be applied in all traffic crashes resulting in fatalities or bodily injury.

- *This emphasis needs to be promulgated immediately and consistently, certainly as soon as possible after the new Attorney General takes office January 20, 1989.*

K-20 Require all medical personnel in trauma centers and emergency rooms to conduct BAC testing and report suspected DWI offenders to the proper authorities. These laws would be similar to the child abuse laws in which clinicians are protected against prosecution for compliance, but compliance is mandatory.

Strategy

The U.S. Attorney General should recommend legislation to provide protection from prosecution of medical personnel and request that this requirement be inserted into appropriate legislation.

Advocates should work with their local medical societies, State medical associations, and the Attorney General to draft legislation to implement and enforce this reporting.

- *Mandatory reporting to be passed by at least five States by December 1992.*

K-21 Establish programs of victim assistance for the injured as well as the dead. These programs should provide help not only with court proceedings, but with compensation and treatment, both physical and psychological.

Strategy

Advocacy groups, working with the Department of Justice and NHTSA, should establish a Victims Bill of Rights, to be incorporated into newly drafted highway safety legislation that is designed to fill the gaps in the current drunk driving legislation.

The Department of Justice should promote the Victims Bill of Rights, including the admissibility of Victim Impact Statements for adoption into law.

- *By December 1, 1990.*

A model law needs to be developed to address the issue of nonfatal injuries incurred in an alcohol-related crash. This must include restitution/compensation for any degree of injury that occurs. This model law needs to be incorporated as a statute in new legislation. Such legislation should be developed during a consensus conference sponsored by NHTSA.

- *By December 31, 1991.*

K-22 The Department of Justice and other interested parties should file amicus briefs before the next session (and, if necessary, in any future sessions) of the Supreme Court (e.g., *South Carolina* vs. *Gathers* 88-305 or others) in an effort to reverse the high court's decision on *Booth* vs. *Maryland* (107 S.Ct, 2529 [1987]) regarding the admissibility of Victim Impact Statements.

Strategy

The U.S. Attorney General should submit an amicus brief to the court in support of the admissibility of Victim Impact Statements.

- *By April 1, 1989.*

K-23 Focus increased attention on the issue of alcoholic or codependent denial and its insidious influence on those who are charged with the public responsibility of addressing and dealing effectively with impaired driver issues at all levels. This includes impaired or addicted individuals in education, the criminal justice system, the medical care system, and private citizens whose own illness may negatively impact their ability to behave in an appropriate and lawful manner.

Strategy

The U.S. Public Health Service, through appropriate agencies, should facilitate increased awareness of addiction and the attributes of an impaired individual, with strong encouragement for the increased availability of employee assistance programs and other detection and treatment measures. This education should be conducted cooperatively with NHTSA and the Departments of Defense and Education.

- *Preliminary information on denial and codependency should be provided to professional preparation institutions, both law and medicine, by December 31, 1989.*
- *Supervisors in all major Federal Agencies should receive information on impairment and the availability of employee assistance programs in their Agencies by October 1, 1990.*

The PHS, through the educational resources of the CDC, should develop counteradvertising messages for youth to illustrate the negative consequences of alcohol abuse and to foster a climate of nonalcoholic sociability.

- *Public service announcements should be pilot tested and available by June 30, 1990.*

The panel reiterates that the most important single element in addressing all the issues of drunk driving is *education*. Continual community awareness about the severity and seriousness of DWI must be the responsibility of all individuals who wish to protect themselves, their property, and their lives from serious injury or death.

The members of the Citizen Advocacy Panel wish to thank Surgeon General C. Everett Koop for his concern and his willingness to put the full weight of his office and the attention of the U.S. Public Health Service on the issue of drunk driving.

NOTE: The Citizen Advocacy Panel recommends to all concerned readers the MADD *Impaired Drivers Issues Compendium*, which provides detailed information about many of the issues discussed at the workshop.

Closing Remarks

C. Everett Koop, M.D., Sc.D.
Surgeon General of the U.S. Public Health Service
U.S. Department of Health and Human Services

I'm certain there are no reasonable people who believe that drunk driving should be tolerated. Yet people shy away from any discussion deeper than "isn't it terrible." Leadership is hard to come by, because it is a lonely position. Although this workshop had the enthusiastic representation of five cabinet departments in planning, only one cabinet secretary—Dr. Otis Bowen—appeared at this meeting.

It is never an easy assignment to respond to workshop recommendations because the time is short, the number of recommendations great, and the Surgeon General has neither budget nor power, save the power of moral suasion.

It has been my custom to keep the participants and other interested individuals and organizations apprised of initiatives undertaken and other activities 6 months and 1 year after publication of the booklet. On selected subjects in former workshops, annual progress reports have also been provided to participants.

I am pleased that Jeffrey Miller and Loran Archer have been able to respond to your deliberations and, believe me, I am grateful to them. They have indicated a willingness to work with us, and you have heard what a resource they are for you.

I find myself in the cleanup position, and since the other respondents and I have already conferred, I will try not to be repetitious. Since the subjects of many of the panels are crosscutting, generic remarks covering all panels seem appropriate. Obviously, I will properly refer recommendations with a narrow focus to appropriate agencies. And when recommendations are sent, *all* will be sent because of the overlaps and crosscutting of some issues and panels.

The advertising and marketing recommendations remind me of the first, and at times faltering, steps taken 25 years ago in reference to tobacco advertising. I'm not being critical; that's a compliment.

In reference to the research recommendations, you have already heard from Mr. Archer. I will discuss them with Mr. Archer and Dr. Gordis of NIAAA, and with Dr. Fred Goodwin, Administrator of ADAMHA, as well as getting them exposure in appropriate media catering to the academic community.

I will present the epidemiology panel's recommendations to Dr. James Mason, Director of the Centers for Disease Control (CDC), for a critique for feasibility on the part of the Federal Government and request that he report on current and future plans of the CDC that may address specific recommendations. I will also ask for the cooperation of the CDC in wide dissemination of the panel's findings.

Education is probably where I can be most effective, and I pledge myself to this effort both now as your Surgeon General and later when I leave this office for the private sector.

I will seek appropriate counsel regarding the broad dissemination of the judicial and administrative enforcement recommendations to those agencies most likely to have responsibility and/or the ability to act.

I will undertake to deliver to organized medicine by appropriate means – personal and by transmittal – concerns and recommendations of the injury control and treatment panels. I will be contacting these organizations early on:

- American Medical Association – especially the student sector
- National Medical Association – for some of the ethnic considerations
- American Academy of Pediatrics
- American College of Surgeons
- American College of Preventive Medicine
- American Academy of Family Physicians
- American Trauma Society and others that will come to mind or be suggested by you.

Appropriate contact will also be made with the following groups to expedite the recommendations on youth and other special populations.

- National PTA
- National School Board Association
- The various associations of school principals
- The National Education Association.

My work with these groups over the past few years regarding AIDS gives me easy access and ready credibility.

But also: Boy Scouts, Girl Scouts, Camp Fire Girls, 4-H Clubs, and others.

I note the crosscutting nature of the concerns of the citizen advocacy panel. I will convene a group (and welcome suggestions from the panel) to consider the formation of a nonprofit corporation of the 501(c)3 type to act as an umbrella for a coalition to be supported by dues – to set its own agenda. I will provide funds to pay legal fees and other expenses to get this off the ground.

I will seek to put this new organization in touch with possible ongoing sources of funding. Believe me, this is an effective and productive tool, judging from our post-workshop experiences with organ procurement for transplants, child abuse, resource location for handicapped children, self-help, and so on. I will see that these recommendations reach the widest possible audience, because we *all* must be advocates.

And now for some comments that apply to all panels – I will:

- Use my relationship with organized medicine to give the final product of this workshop the broadest applications.
- See that a copy of the final document goes to each Senator and each Congressman with an appropriate covering letter from me.
- Do the same for the chiefs of staff of the various congressional committees that could have a legislative interest in these recommendations.
- Present these findings in detail and with additional comments to the Association of State and Territorial Health Officers at their annual meeting in the spring.
- Seek an appropriate opportunity to address municipal and county health officers in the same manner.
- Personally sit down with the new Secretary of the Department of Health and Human Services soon and with the new Surgeon General eventually and solicit their personal involvement because of the gravity of the situation and the need for action, and
- Wherever possible, I will lay the burden on government agencies, private agencies, and academia and seek cooperation at every level.

When the new administration is underway, I will see that the governors of each State and territory receive the complete set of documents with a covering letter from me.

Now for a final word. Strange as it may seem, there are a few people and organizations who would have preferred that we *not* meet on this subject this week – or maybe ever.

I guess by now everyone knows of my correspondence with Mr. Edward O. Fritts, President of the National Association of Broadcasters (NAB) inasmuch as the press had his letter to me when I received my copy. His is a key organization, I won't deny that. I wanted him and the NAB to be here with us. I wanted everyone to hear the NAB's point of view not only because broadcasters are very influential – as we all know – but because they also have so much at stake in this issue. Hence, they certainly have a right to be here.

That's why I invited Mr. Edward Fritts. And that's why I also invited Mr. John O'Toole, the Executive Vice-President of the American Association of Advertising Agencies (the "4-A's"), and Mr. Dewitt Helm, the President of the Association of National Advertisers, the people who are the *clients* of the 4-A's.

But all three declined. Mr. O'Toole and Mr. Helm suggested that our workshop lacked "good balance." They also said they had very little time to prepare for the discussion that would no doubt take place here. And each person suggested I cancel the workshop.

I was sorry to get their replies. But, if I may say so, I think their complaints and suggestions are quite unfair. Now, it is true that one message that might be heard at this workshop is this one: *alcohol contributes to injury and premature death.*

That's a troubling message, to be sure, and one's instincts might well be, figuratively speaking, to "kill the messenger" – in this case, discredit this workshop or have it cancelled. If so, then Mr. O'Toole's and Mr. Helm's strategy didn't work.

However, the letter to me from Mr. Fritts of the NAB was a bit more unsettling because it contained this observation:

> At best, this workshop is designed to politicize the emotional tragedy of drunk driving. At worst, it is a total abuse of the policy-setting process.

In addition to being surprised at that *unfortunate* choice of words, I was taken aback by that observation, since over the past 7 years I have personally convened and conducted a dozen workshops, several at the request of President Reagan, dealing with such difficult issues as –

- Organ transplantation;
- Domestic violence;
- The needs of handicapped children and their families; and

- The role of the self-help movement in public health.

And I've conducted workshops on child pornography and public health and on the care of children who are born with AIDS, and so on. *None* of these workshops was called to "politicize an emotional tragedy," and *all* these workshops contributed significantly to the policymaking process of this administration. As will *this* one, I am sure.

I don't wish to dwell on the NAB's criticism because it may be nothing more than an early and predictable phase in the industry's learning process.

That's been the immediate response from the broadcasting and the advertising industries. We obviously must wait for them to offer something more helpful. But what are the chances that will happen? If history is any guide, the chances might be slim.

I hope that's not the case, because the history of smoking and health is not encouraging. I've reviewed the way the tobacco, broadcasting, and advertising industries behaved around the time my predecessor, the late Dr. Luther Terry, released the first *Smoking and Health Report* 25 years ago. From that review I can see that, even at this early stage of discussion, there are already similarities of behavior.

And that's a shame. I think we'd all prefer that these industries—and their chosen leaders—would heed the oft-quoted wisdom of George Santayana, who wrote

> Those who cannot remember the past are condemned to repeat it.

I can tell you that I, for one, would rather *not* repeat the difficult times we had in the past. I do not think the confrontations were always necessary or fruitful.

But some aspects of the past *are* worth noting and worth emulating. For example, 25 years ago the public health community, with the support of many citizens' groups and a substantial number of members of Congress, embarked upon a systematic program of research into the relationship between smoking and health.

At the same time, and in a responsible way, we also began to look at the public policy implications of the research results, as they came to light. From that information we were able to plan ways to help the American people cast off this high-risk health behavior: smoking. And that meant principally a long-range and unremitting program of public education and instruction. That's what happened regarding the issue of smoking and health. And certainly drinking and driving is high-risk behavior amenable to education and instruction.

I respectfully suggest that Mr. Fritts, Mr. O'Toole, and Mr. Helm—and

their colleagues – review that history as I did, because the American people may now be – in terms of alcohol – where we were 25 years ago in terms of tobacco.

The relationship of the National Commission Against Drunk Driving and this workshop provides a puzzle not easy to solve. That we – the Commission and this workshop – have the same presumed goal should be obvious. That we should stand together makes sense.

Yet Mr. Adduci, Chairman of the Commission, cleverly suggested to me in a letter of November 28, 1988, that "you may be considering the following along with other options." One option was to "disregard the views and position of the National Association of Broadcasters." Another was to postpone this meeting, and a third was to "notify all panelists that (my) office had overlooked or was unaware of the fact that DOT had given the National Commission a $100,000 grant to do a 16-month assessment of its initiatives."

After further correspondence with me and conversations with my staff, it was agreed that Mr. Adduci and I would let no light be seen between us as we stood side by side in this effort to reduce the carnage on our highways and streets. And that either Mr. Aducci or his program director, Dr. Grant, would speak at the opening plenary session.

This seemed very appropriate in view of the published report of the commission on "youth driving without impairment," excerpts of which both Dr. Bowen and I read the day before yesterday at the plenary and commented upon favorably.

Yet when the confirmatory letter was faxed to me on the 13th – the day before this workshop opened – there was a quid pro quo. In return for that speech, we would not release conclusions or recommendations of two of our panels until the commission had completed its assessment project – a minimum of 16 months from whenever they start.

I thought that would be unacceptable to you and, therefore, the Commission refused to speak at the opening plenary session. I thought the proposed delay – 16 months – was particularly inappropriate in view of the fact that the National Beer Wholesalers Association and the National Association of Broadcasters, with participating legal counsel, in the most intense discussions Wednesday, Thursday, and today, requested only a 45-day comment period followed by a 30-day delay before final publication.

As for me, I intend to ignore those who would lynch or execute a first offender in drunk driving, just as I would ignore those who say that it has not yet been proven that alcohol is responsible for impaired driving. I intend to assume what leadership role I may between these two extremes and, as I have with other issues, transmit what energy, enthusiasm, and credibility I have to this war against impaired driving.

I will think of lots more and keep you posted.

Thanks to Amy Barkin, Steve Moore, and many others who have brought us this far with the workshop and thank you, Susan Lockhart, for all you will do with me as we face this problem in the new year.

And thank all of you for coming. Have a blessed holiday season and all that's good in the new year.

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