UNITED STATES OF AMERICA

NATIONAL TRANSPORTATION SAFETY BOARD

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In the matter of: *
*
REACHING ZERO: ACTIONS TO ELIMINATE *
SUBSTANCE-IMPAIRED DRIVING *
*
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Board Room and Conference Center
National Transportation Safety Board
429 L'Enfant Plaza East, S.W.
Washington, D.C. 20694

Tuesday,
May 15, 2012

The above-entitled matter came on for hearing, pursuant to Notice, at 8:30 a.m.

BEFORE: BOARD OF INQUIRY
National Transportation Safety Board

APPEARANCES:

NTSB Board of Inquiry

DEBORAH A.P. HERSMAN, Chairman
CHRISTOPHER A. HART, Vice Chairman
ROBERT L. SUMWALT, Member
MARK R. ROSEKIND, Ph.D., Member
EARL F. WEENER, Ph.D., Member

Technical Panel

DANIELLE ROEBER, J.D., Chief, Safety Advocacy Division, Office of Communications, NTSB
RAFAEL MARSHALL, Ph.D., M.P.H., Project Manager, NTSB
ROBERT MOLLOY, Ph.D., Chief, Report Development Division, Office of Highway Safety, NTSB
STEPHANIE DAVIS, Transportation Safety Advocate, Safety Advocate Division, Office of Communications, NTSB

Panel 1: The Substance

JAMES HEDLUND, Ph.D., Principal, Highway Safety North
ROBERT L. DuPONT, M.D., President, Institute for Behavior and Health

Panel 2: The Problem

JAN WITHERS, National President, Mothers Against Drunk Driving
ANNE T. McCARTT, Ph.D., Senior Vice President for Research, Insurance Institute for Highway Safety
TERRY SHELTON, Associate Administrator, National Center for Statistics and Analysis, National Highway Traffic Safety Administration
DARLENE SCHWARTZ, Information System Supervisor, Division of Motor Vehicles, Wisconsin Department Of Transportation

Panel 3: Education and Outreach

MICHAEL L. BROWN, Director, Office of Impaired Driving & Occupant Protection, National Highway Traffic Safety Administration
GRANT T. BALDWIN, Ph.D., M.P.H., Director, Division of Unintentional Injury Prevention, National Center for Injury and Control (CDC)

DEE ALLSOP, Ph.D., CEO, Managing Partner, Heart + Mind Strategies

APPEARANCES (Cont.):

Panel 4: Enforcement

TECHNICAL SERGEANT DOUGLAS J. PAQUETTE, New York State Police
WARREN DIEPRAAM, J.D., Chief Prosecutor, Trial Division And Vehicular Crimes Section, Montgomery County District Attorney's Office
JEANNE M. SALVATORE, Senior Vice President, Public Affairs and Consumer Spokesperson, Insurance Information Institute

Panel 5: Consequences

WARD VANLAAR, Ph.D., Vice President Research, Traffic Injury Research Foundation
TERRENCE D. WALTON, Director of Treatment, Pretrial Services Agency for the District of Columbia
THE HONORABLE MICHAEL J. BARRASSE, Judge, Court of Common Pleas, Lackawanna County, Pennsylvania
JOANNE E. THOMKA, J.D., Director, National Traffic Law Center

I N D E X

ITEM	PAGE
Welcome and Opening Remarks by Chairman Hersman	10
Logistics for Forum by Member Rosekind	15
SESSION 1: THE CURRENT STATE OF AFFAIRS	
PANEL 1: THE SUBSTANCE	
Introduction	17
Presentations:	
James Hedlund, Ph.D.	18
Robert L. DuPont, M.D.	27
Questions posed by the Board of Inquiry:	
By Vice Chairman Hart	37
By Member Sumwalt	45
By Member Weener	48
By Member Rosekind	52
By Chairman Hersman	57
PANEL 2: THE PROBLEM	63
Introduction and Presentations:	
Jan Withers	64
Anne T. McCartt, Ph.D.	70
Terry T. Shelton	78
Darlene Schwartz	84

I N D E X

ITEM PAGE

Questions posed by the Board of Inquiry:

By Vice Chairman Hart 89

By Member Sumwalt 94

By Member Weener 98

By Member Rosekind 100

By Chairman Hersman 104

SESSION 2: CURRENT INTERVENTIONS

PANEL 3: EDUCATION AND OUTREACH 114

Introductions and Presentations:

Michael L. Brown 114

Grant T. Baldwin, Ph.D., M.P.H. 122

Dee Allsop, Ph.D. 128

Questions posed by the Board of Inquiry:

By Member Sumwalt 136

By Member Weener 142

By Member Rosekind 146

By Vice Chairman Hart 150

By Chairman Hersman 153

PANEL 4: ENFORCEMENT 159

Introductions and Presentations:

Tech. Sgt. Douglas J. Paquette 159

Warren Diepraam, J.D. 171

Jeanne M. Salvatore 179

I N D E X

ITEM	PAGE
Questions posed by the Board of Inquiry:	
By Member Sumwalt	185
By Member Weener	190
By Member Rosekind	193
By Vice Chairman Hart	198
By Chairman Hersman	203
PANEL 5: CONSEQUENCES	208
Introductions and Presentations:	
Ward Vanlaar, Ph.D.	208
Terrence D. Walton	218
Questions posed by the Technical Panel:	
By Ms. Roeber	228
By Ms. Davis	233
By Ms. Roeber	237
By Ms. Davis	240
By Ms. Roeber	242
Questions posed by the Board of Inquiry:	
By Member Sumwalt	244
By Member Weener	248
By Member Rosekind	251
By Vice Chairman Hart	255
By Chairman Hersman	259

Adjourn - Chairman Hersman 263

1 P R O C E E D I N G S
2 (8:30 a.m.)
3 CHAIRMAN HERSMAN: Good morning. Welcome to the
4 Boardroom of the National Transportation Safety Board.
5 My name is Debbie Hersman, and it is a privilege to
6 serve as Chairman of the NTSB. Today I am joined by my
7 colleagues: Vice Chairman Chris Hart, Member Robert Sumwalt,
8 Member Mark Rosekind and Member Earl Weener.
9 We are here today to focus on the number one killer on
10 our roads, substance-impaired driving. Let me put a face on this
11 problem. Three young faces.
12 Twenty-four years ago yesterday, in Carrollton,
13 Kentucky, a drunk driver drove his pickup on the wrong side of
14 I-71. He collided with a bus and killed 27 people, 24 children
15 and 3 adults.
16 The children were part of a church youth group on their
17 way home to Radcliff, Kentucky, after spending the day at an
18 amusement park in Cincinnati. Mary Catheryn Daniels was 14. She
19 would be 38 years old today. Were it not for that intoxicated
20 driver, Mary Catheryn might be worrying about her own children
21 going on a field trip today. Fifteen-year-old Anthony Marks loved
22 football, and we will never know what the now 39-year-old would
23 have accomplished with his life. Shannon Fair, a Radcliff Middle
24 School band member, was 14. Her life was ahead of her. Would she
25 still be making music today if she were alive?

1 Harold Dennis, who survived that accident, has joined us
2 today, as have a number of safety advocates and people that have
3 been personally affected by substance-impaired driving.
4 It has been 24 years since that deadly night in
5 Carrollton, Kentucky. Since then, more than 300,000 people have
6 perished at the hands of impaired drivers. 300,000. What have we
7 learned in a generation? What has changed? And what have we
8 accomplished?
9 Yes, we have accomplished things. Through the efforts
10 of government, law enforcement, the judicial system, highway
11 safety advocates, educators and more, the number of annual lives
12 lost from impaired drivers is down from 18,611 in 1988 to 10,222
13 last year, and down from 41 percent of highway fatalities to 31
14 percent of highway fatalities.
15 But the percentage of alcohol-related fatalities has
16 been stuck between 30 and 32 percent of overall highway fatalities
17 since 1995; 16 years that we've been stuck at about 30 percent.
18 With so many crashes and lives lost, it could be so easy to grow
19 complacent and think the task is just too daunting, that we can
20 never eliminate substance-impaired driving. However, I propose
21 that complacency is part of the problem. All of us involved in
22 high safety, including the NTSB, bear some responsibility for this
23 complacency.
24 Many believe in educating drivers about their
25 responsibilities behind the wheel, but with more than 10,000

1 fatalities every year, I just think we might receive a failing
2 grade if after a generation we couldn't show better results for
3 our education efforts.
4 And, yes, this issue has many facets: cultural
5 attitudes about drinking, social norms, political pressures, but
6 we need fresh approaches, renewed commitment and the will, the
7 personal and political will, to make a difference. Every life
8 lost to a substance-impaired driver is a tragedy. What is an even
9 greater tragedy is that these crashes can be all be prevented.
10 And the biggest tragedy would be for us to sit this one out and
11 say that enough is being done.
12 We need as much attention today on impaired driving as
13 we saw in the early 1980s when organizations like MADD were
14 founded and the drinking age became 21. Over that decade, real
15 progress was achieved in the United States.
16 And it certainly won't be easy. There are many issues
17 associated with social drinking, with addiction and with repeat
18 offenders. When it comes to addressing substance-impaired
19 driving, we recognize the myriad complex social, legal and medical
20 challenges that exist, but the solution is not complicated. In
21 fact, it is quite elementary. Don't drive after you've been
22 drinking or doing drugs. It's that simple.
23 If people can't stop themselves from endangering others,
24 the safety leaders assembled here today have got to identify ways
25 to do it for them.

1 So what needs to be done to reach zero? That's the
2 point of this forum, identifying actions to eliminate deaths and
3 injuries on our roadways.
4 One area of emphasis is law enforcement. In fact, this
5 is National Police Officers' Memorial Day, which recognizes law
6 enforcement officers who have lost their lives in the line of
7 duty. More than 200 police officers have been killed by impaired
8 drivers since the 1988 Carrollton, Kentucky accident. And, as
9 first responders to impaired-driving crashes, police officers
10 truly understand the cost of complacency.
11 Another area with the potential to be a game changer is
12 technology. Through the years, we have seen tremendous safety
13 advances as new technologies have been integrated into the vehicle
14 fleet. From airbags to stability control, we know that technology
15 and design improvements can help protect vehicle occupants.
16 Here's how Jan Withers, MADD's national president, put it: We
17 should turn cars into the cure.
18 I commend the work of the National Highway Traffic
19 Safety Administration and the automotive community to turn cars
20 into the cure. I look forward to hearing more about this from
21 several of our panelists today.
22 And tomorrow, we will hear from the Office of National
23 Drug Control Policy, from their director, Gil Kerlikowske. He's
24 going to talk about the growing problem of drug-impaired driving.
25 It's time to recognize that when it comes to impairment, the

1 problem goes beyond alcohol, and many drivers are impaired by
2 multiple substances when they're behind the wheel. In fact, in
3 2009, NHTSA found that of the fatally injured drivers for whom
4 toxicology test results were known, about one-third tested
5 positive for drugs. The proportion of drivers testing positive
6 for drugs has increased over the 5-year study as well.
7 Drug impairment can, and should, be addressed. Just
8 last week, in the Queen's speech, opening this session of
9 Parliament, the United Kingdom announced new penalties for drug
10 driving offenses and plans to approve and use roadside drug
11 screening devices. Yes, where there is a will, there is always a
12 way.
13 In his book, *One for the Road: Drunk Driving Since
14 1900*, author Barron Lerner quoted physician, Ralph Hudson, who
15 said: "This national embarrassment and disgrace has not been just
16 the accumulation of death and injury but, rather, the strange
17 acceptance of death and injury as a way of life."
18 It is time for all of us in the highway safety community
19 to renounce this strange acceptance. We must stand together and
20 say, "This is not acceptable." We must also identify and support
21 new measures to curb the carnage on our highways.
22 In closing, I want to mention the name of that group
23 that was on the bus in Carrollton, Kentucky. They were the First
24 Assembly of God youth group, and they called themselves, "Life Is
25 For Everyone." Yes, it is. Life is for everyone.

1 Now I will turn to my colleague, Member Mark Rosekind,
2 who has done an absolutely outstanding job organizing this forum
3 by consulting with our colleagues and our staff and working
4 closely with external experts to identify the science, the
5 knowledge, the technology, the experience and, yes, the passion,
6 that we need to address the deadly issue of substance-impaired
7 driving.
8 Member Rosekind.
9 MEMBER ROSEKIND: Thank you, Chairman Hersman, and good
10 morning, everyone. Let me briefly outline the logistics for the
11 next two days.
12 We have a packed agenda with eight different panels.
13 The agenda is available in the lobby and also on the NTSB website.
14 Also on the website are the full biographies for all of our
15 panelists as well as staff, and I want to take this opportunity to
16 thank all of our panelists over the two days for having graciously
17 made themselves available to participate over this week.
18 This forum is being held en banc, which means that all
19 five members of the Board will participate, and each of the panels
20 will have a Board member lead and an NTSB staff member technical
21 lead. So the panels will each open with presentations, and then
22 the Technical Panel will ask a series of questions followed by
23 questions from the Board members, and then in some circumstances,
24 we'll go right to Board member questions.
25 Though we have many panelists, and many areas are going

1 to be addressed over the next two days, clearly all stakeholders
2 are not represented personally at this forum and, therefore, we
3 are encouraging individuals and organizations to submit written
4 materials and documents to our docket. So you can submit
5 electronically through e-mail to reachingzero, that's all one
6 word, reachingzero@ntsb.gov and the docket will be open until June
7 13, 2012. We encourage you to submit information.
8 And now just a few final items. We have a full agenda.
9 So we're going to ask everybody to appreciate and respect
10 everybody's time, and so if everyone cooperates, we'll be able to
11 maintain the schedule. Panels, in particular, please respect the
12 time limits. We have some excellent timekeepers with us today,
13 and keep your discussions and answers focused, please.
14 There's going to be a midday break for lunch. There are
15 a variety of options upstairs on the promenade, and then two other
16 breaks during the day as well, one in the morning and then one in
17 the afternoon.
18 As a safety organization, please take note of the
19 nearest emergency exit for you. In case of an exit, you can exit
20 through the rear doors that you came in through the conference
21 center and for you to note, that on your right-hand side in the
22 front, is another exit as well.
23 Please take a moment to silence your electronic devices.
24 Thank you. Please take a moment. Silence those electronic
25 devices.

1 The Board is WiFi equipped and you can connect to the
2 Internet through the NTSB's Verizon connection.
3 And finally, I want to thank the NTSB staff for just
4 their tremendous effort on organizing this forum. The team that
5 has produced this forum has done just an outstanding job literally
6 across the board. They've identified and worked with a world
7 class group of panelists. They've developed a comprehensive and
8 varied agenda, and they've coordinated with exhibitors to enhance
9 our educational experience and opportunities, and also arranged
10 for several special events that are going to be included in the
11 forum. Personally it's been a real pleasure to work with the
12 staff from the Offices of Communications and Highway Safety, and
13 their efforts along with others at the NTSB, those of our
14 panelists and everyone here, are going to be critical to
15 identifying the actions that are needed to eliminate substance
16 impaired driving.
17 Dr. Molloy, now if you will introduce our first panel.
18 DR. MOLLOY: Thank you, Member Rosekind. For the first
19 panel, just a little housekeeping before we begin, when you get
20 ready to speak, there's a button on your microphone. Press that.
21 In the center it says push. Press that once, it'll turn on. Just
22 remember to press it again when you're done, so we don't get
23 feedback.
24 To start our forum, we will hear from two experts to
25 discuss the substances, alcohol and drugs, which will lead to

1 impaired driving. Our first presenter, Dr. James Hedlund, from
2 Highway Safety North, will present information on alcohol and the
3 ways it affects driving. Dr. Hedlund.
4 DR. HEDLUND: Thank you very much, Rob, and thanks to
5 the panel and to the Board for, first, inviting me to lead off
6 this panel, and second, for addressing this issue again. If I
7 could have my slides up, please?
8 I'll begin, I've been asked to talk about alcohol only,
9 and I thank you for that because alcohol is at least two orders of
10 magnitude simpler than drugs, which you will hear about from my
11 colleague, Bob, afterwards.
12 What I will do in the next 12 minutes or so, is give you
13 a little overall context about drinking and driving. Very good.
14 I'll talk about my assignment of alcohol chemistry and its effect
15 on the body, give you a very little bit of data and then talk
16 about what has been done, what can be done, what works in terms of
17 moving forward. And I have been told that there is a little
18 trapdoor underneath my chair which opens in 15 minutes, so I shall
19 be brief.
20 A little context first. Alcohol has been around society
21 for 7,000 years. There are wine jars in Turkey that are dated
22 that old with stains of wine on them.
23 Alcohol has integrated into our society and into
24 American life. The NIAAA says that two-thirds of American adults
25 drink, some of them to excess. The alcohol industry is a major

1 player in the economy. Alcohol is perfectly legal. We've tried
2 prohibition once, and it didn't work. Whenever you go out to a
3 restaurant, beyond the fast food, you will be offered alcohol as
4 part of your meal. It's engrained into our society.
5 But driving is also engrained into our society. We've
6 built our towns and our suburbs so that we have to drive. So what
7 you have is a cultural conflict of two things that are both very
8 integral to the way in which we operate. We drink and we drive,
9 and it is very difficult to separate those two.
10 Alcohol chemistry is remarkably simple. Alcohol is
11 absorbed into the body very quickly and into the body means
12 everywhere into the body: into the blood, into the breath, into
13 saliva, into sweat, and into the brain. So if you see it one
14 place, you see it anywhere. Blood equals breath equals brain, and
15 there are standard conversion factors between amount of alcohol in
16 blood and amount of alcohol in breath and so forth.
17 The standard measure of this as you all know is BAC,
18 blood alcohol concentration, and that's the terms in which
19 everyone will speak.
20 Just to give you an idea of what those look like, here
21 is a standard chart, one of many of the similar things that is
22 handed out to show the rough effects of alcohol at a specific BAC
23 level on driving. I wish you to notice two things in this chart.
24 The first is the little legend on the right that says, only safe
25 driving limit, says 00. Then as BAC increases, the signs on the

1 left say skills affected, legal penalties and so forth.
2 The second thing I want you to notice about this is that
3 the amount of impairment varies by weight. This is a chart for
4 women, and the lighter you are, the more quickly you become
5 impaired at a given amount of alcohol intake. So impairment is
6 not the same for everybody.
7 In fact, if you look at the same chart for men, you'll
8 see that men have an advantage. It takes them a little bit longer
9 to get impaired for a man of a given weight than it does for a
10 women of that weight. The takeaway from this is that impairment
11 happens to everybody but varies by individual characteristics, sex
12 and weight being two of those characteristics.
13 Alcohol effects, what does it do? It gets into the
14 central nervous system. So that means it affects virtually
15 everything you do, how you process information, how you control
16 your muscles, your memory, your perception, your reaction time.
17 It's all there. Different things get affected at different BAC
18 levels. I'm not saying that everything gets affected immediately,
19 but sooner or later, they all do.
20 As I just said, this all happens very quickly. Within
21 15 minutes, some effects are evident, and there is no threshold
22 below which there are no alcohol effects. And as we just saw, the
23 effects increase as the BAC limits increase.
24 Who? Everybody. Everybody is affected and we just said
25 it varies by individual.

1 And I want you to take away three words from this. The
2 effects of alcohol are certain, they are swift and their severity
3 varies by BAC. Remember those three words: certain, swift and
4 severe, because we will come back to those.
5 I'll show you a picture of the same -- before we do
6 that, here is a picture of how swift is swift. This is a chart of
7 impairment after various drink levels, one, two, three, four, as a
8 function of time; time across the horizontal axis. See how
9 quickly those curves rise. Within 15 minutes, major effect occur,
10 even with one drink, even more two, three and four drinks. It
11 happens very rapidly, and notice the tail end of the curve as
12 well. It takes quite a while for the effects to wear off. These
13 are just four drinks. If you go to a really good drinker with 10
14 or 12 drinks, this can last to the next morning, to the next
15 afternoon even.
16 This chemistry and these effects have a couple of useful
17 consequences. Here is the first one which is the risk of crash at
18 a given BAC level. These are an old paper of Paul Zador, about 20
19 years old, but the results are pretty much the same. Between .02
20 and .04, very minimal levels, that's one or two drinks for most
21 people, your crash rate is 40 percent higher than when you were
22 sober. By .05, it gets up to 1100 percent and that's getting to
23 be a big number that I can't understand. So 11 times higher than
24 at baseline. By .10, it gets up to 48 times higher, and by the
25 time you get to .15, it gets to be about 380 times the crash risk

1 of a sober driver.

2 And I might point out that a BAC of .15 is about the
3 median BAC of an impaired driver in the FARS system, impaired in a
4 fatal crash. Those folks are really drunk.

5 Here's another picture of the crash risk, this time
6 broken out by age and sex. Some data from the mid 1990s, some
7 data from the mid 2000s. This is a paper that came out just this
8 year. What I want you to notice is that the curve starts rising
9 immediately and by the time you get up to .06, .07, .08, the
10 current legal limit, the crash risk is substantially higher than
11 for sober drivers.

12 This chemistry and these effects have a couple if
13 important consequences, and these are probably obvious but I'll
14 say them anyway. There are two sorts of laws regarding impaired
15 driving.

16 The first one says it is illegal to be in control of
17 your vehicle when you are "impaired" by anything at all. And
18 impaired means that you cannot competently operate the vehicle.
19 This is a subjective judgment call that law enforcement must make.
20 There is no objective standard of impairment.

21 But because alcohol is so simple and because you can
22 relate crash risk to BACs so carefully, we have established the
23 so-called per se laws. If you have a given amount of alcohol in
24 your system, you are per se, by that fact alone, guilty of
25 violating this law, and in every state in the United States that

1 per se limit is .08. That means you don't have to make subjective
2 judgments of impairment. You can test the driver, and if that
3 driver's breath or blood shows a level over .08, that driver is
4 per se guilty of impaired driving. It's really simple.
5 Testing is done by either breath or blood. It can be
6 done with evidentiary machines that meet very precise standards.
7 NHTSA puts out a conforming product list of these standards. They
8 are evidence in court.
9 It can also be done by so-called screening machines,
10 either the preliminary breath tester, or PBT, or the passive
11 alcohol sensor. These devices are handheld devices. They can be
12 used at the side of the road. The passive sensor is very useful
13 in checkpoint situations to determine presence of alcohol, yes or
14 no, and then one must go on to do an evidentiary test and other
15 things.
16 Brief data, and you've heard about this from the
17 Chairman previously, but I'll repeat it and show you a picture.
18 These are the number of fatalities in the United States in a crash
19 in which any driver had a BAC of .08 or above, and as the Chairman
20 pointed out previously, that's gone from over 20,000 back in 1982,
21 the first year in which FARS started collecting and reporting good
22 alcohol data, to just over 10,000 in 2010. That's good.
23 Notice also the pattern. Substantial drop during the
24 first half of that period, and then a long flat spell, and then
25 decrease in the past two or three years. It looks like we're

1 making progress. Yes? Well, not exactly.
2 Here is the same data but now percent of fatalities
3 involving a driver with a BAC of .08 or above, and again as the
4 Chairman pointed out, nothing has happened here for the last 15
5 years or so. The progress in recent years has only been because
6 all fatalities have been going down, and drunk driving fatalities
7 have gone down at the same rate.
8 I've done my assignment, but now I'll take a couple of
9 minutes before the trapdoor opens, to give you a little context
10 about the major ways in which you can address this. There are
11 three.
12 The first is prevention and education, trying to
13 persuade someone not to drink and drive or using laws such as age
14 21. Communications fits in here as well.
15 The second is intervention. To keep drinkers from
16 driving, some physical means to separate the two, of which alcohol
17 interlocks are by far the most effective.
18 And finally, there's deterrence: laws, enforcement,
19 sanction. The principle of deterrence is to change behavior
20 through the fear of consequences. If you know you do something,
21 something will happen to you, certainly, swiftly, and that
22 something will be bad, you don't like it, there's a high chance
23 you will change your behavior. This is not specific to drunk
24 driving. This happens throughout life. If you want to affect how
25 your children operate, this is a very good principle to try, but

1 remember those three words? Okay. The consequences must be
2 certain, they must be swift, and they must be severe, precisely
3 the same words as the effects of alcohol on your system.
4 What works? Well, prevention and education has had some
5 effect, and the thing that I use as an example of this is that
6 when I was growing up, the word after a party was, one for the
7 road, and the drunk was a funny person. Now the word after the
8 party is designated driver. So there has been a major change in
9 social norms over that 30 or 35 years. However, we still will
10 drink and it's not the case of just telling somebody to do
11 something is a very effective way of making behavior change.
12 Intervention, alcohol interlocks, as I said, are the most
13 effective way that has been used so far. They're fairly limited
14 at present, and the research is very clear that while the
15 interlock is on the car, assigned for convicted drunk drivers,
16 they don't drink and drive. As soon as the interlock comes off
17 the car, they go right back to where they were before.
18 Deterrence is the most effective, but what does it have
19 to be? It has to be certain, it has to be swift, and it has to be
20 severe.
21 Is it certain? Estimates of the number of trips you
22 must take as a driver with a BAC of .08 or above before you get
23 picked up are at least 1 in 50, maybe 1 in 500. I've seen
24 estimates as high as 1 in 1,000.
25 Are the consequences swift? I leave it to others to

1 talk about our legal system, but things can go on for quite a
2 while.
3 And are they severe? In many jurisdictions those
4 immediate charges for first time offenders are plea bargained,
5 they're diverted, things don't happen. The system can be improved
6 substantially to make it more swift and certain and severe.
7 Effective strategies. My suggestions are the following:
8 Intervention and education. They are critical to
9 support deterrents, but by themselves they probably won't do very
10 much more. Examples, how did seatbelt use change? Not when the
11 first campaign came out that said please bucket your belt. It
12 changed when laws were passed and when those laws were enforced.
13 How about the war on drugs? Just say no. Has there
14 been a major effect of that? I leave it to you to judge.
15 How about the current efforts on obesity? Please don't
16 eat so much of that really good tasting stuff because you'll get
17 fat.
18 Intervention. Alcohol interlocks are really good
19 things, and you'll hear lots more later on in this forum about
20 DADSS. The unobtrusive alcohol interlock system does not require
21 a driver to actively blow into a BAC test device. So I charge you
22 to listen to those suggestions.
23 Deterrence will work but it needs time. It needs help.
24 It needs resources. It needs commitment. You need to increase
25 the perceived risk of detection so it's not 1 in 50. You need to

1 increase the swiftness and certainty of the sanctions.
2 And I leave you with this final thought. There is no
3 silver bullet. There's no simple way to do this. To paraphrase
4 Mencken, every difficult issue has a simple strategy that is
5 quick, cheap and completely ineffective.
6 Separating the All American behaviors of drinking and
7 driving is hard work, and it requires resources, commitment, time
8 and commitment from lots of different players working together
9 including this Board. Thank you very much for the opportunity to
10 address you.
11 DR. MOLLOY: Thank you, Dr. Hedlund.
12 Next we'll hear from Dr. Robert DuPont with the
13 Institute for Behavior and Health. Dr. DuPont will discuss the
14 state of knowledge regarding drugs and driving and some of the
15 challenges in determining how they impair drivers. Dr. DuPont.
16 DR. DuPONT: Thank you very much. It's a great
17 privilege for me to --
18 CHAIRMAN HERSMAN: Can you activate your microphone?
19 DR. DuPONT: Here we go. It's a great privilege for me
20 to be here today, and I welcome this opportunity and I'm delighted
21 to have the Board looking into the problem of impaired driving --
22 CHAIRMAN HERSMAN: Dr. DuPont, could you pull it a
23 little bit closer.
24 DR. DuPONT: I'm happy to have you addressing the issue
25 of drugs as they relate to impaired driving. This is historic,

1 and I want to point out to you that this is a unique moment of
2 opportunity in many ways, but particularly I point out the
3 leadership that is being provided by Gil Kerlikowske, ONDCP, and
4 from David Strickland. We have a changed environment for dealing
5 with this problem within the federal government that is very
6 opportune for the Board to get involved with this issue.
7 Now, second, I want you to think with me about how we
8 get to this. It's commonly said that drugs have been around for a
9 long time; there's really nothing new here. That couldn't be more
10 wrong. The modern drug abuse epidemic is as new as the computer.
11 Many drugs have been around for a long time, but never before in
12 history have entire populations been exposed to many drugs by
13 potent routes of administration, particularly smoking and
14 injecting. That epidemic started in the late 1960s, and it
15 continues at this time.
16 CHAIRMAN HERSMAN: Dr. DuPont, would you mind just
17 pulling the microphone just a tad closer? We have some folks who
18 still can't hear you.
19 DR. DuPONT: I'm practically down my throat with the
20 microphone.
21 CHAIRMAN HERSMAN: Okay. We can ask them to turn it up,
22 too.
23 DR. DuPONT: I'm not unfamiliar with microphones, but
24 I've never had to swallow one before. Thank you.
25 I wanted to say about the drug epidemic and how this is

1 affecting highway safety or transportation safety, and that is
2 this rapid rise of the use of a variety of drugs by entire
3 populations. And a little statistic that gives you an idea, last
4 year, for the first time, more American youth smoked marijuana
5 than smoked cigarettes. So this has become a very common part of
6 our lives, including on our highways.
7 I also want to point out, particularly with respect to
8 the NTSB, the importance of major events that capture the public
9 attention. As the Chairman said about the story from Kentucky,
10 those are opportunities for learning for the country as a whole.
11 And I want to point out to you one in the drug area and that was
12 the crash of an Amtrak and a Conrail train on January 4, 1987.
13 That crash, in which 17 people were killed, created the modern
14 response to transportation and drugs.
15 That's when the DOT regulations for commercial drivers
16 and others came out. That also was the time -- Dr. Hedlund in his
17 wonderful presentation pointed out about .08 BAC. That was not
18 the standard until we had federal intervention that forced the
19 states into BAC .08. It's now become standard, but there was
20 leadership from the President that required that, that changed the
21 environment on that also at that same time. And what happened
22 with commercial drivers, I'm going to say is a very important
23 precedent for us to use. So let me go onto the slides, and run
24 through these fairly quickly.
25 These are some of the organizations that are focused on

1 the drug issue.

2 I'm going to focus on this slide for a moment. This is
3 a study from the Shock Trauma Unit of seriously injured drivers.
4 So these are drivers in the State of Maryland who were seriously
5 injured and medevac'd to the Shock Trauma Unit, and they were
6 studied for their drug use. And you'll notice there, to me the
7 most striking is, that only 34 percent of them did not have either
8 drugs or alcohol. That is quite amazing to think that you've got
9 two-thirds of the seriously injured drivers with drugs or alcohol
10 or both.

11 You notice the alcohol numbers are 31 percent of the
12 drivers were positive for alcohol. Fifty-one percent of the
13 drivers were positive for drugs. Two-thirds of the alcohol-
14 impaired drivers were also positive for drugs, and one-third of
15 the drug-positive drivers were positive for alcohol, but marijuana
16 alone was 28 percent in this, to get some idea of the prevalence
17 of this problem.

18 Now here's the demography. I'm not sure what you want
19 to focus on here, but it's useful. Down at the bottom, look at
20 the age, and you'll notice between 18 and 44 is roughly two-thirds
21 of the drivers who had drugs.

22 Now here's the FARS data that the Chairman referred to,
23 and you see the increase there in the fatally injured drivers and
24 the use of drugs, and the importance of this is only beginning to
25 be appreciated.

1 Now, the problem in the drug field, impaired driving
2 related to drugs, builds on a 70-year experience of dealing with
3 alcohol-impaired driving. And that experience enlightens and
4 guides everything we do with drugs, but it also provides a
5 precedent that is potentially crippling, and that is the
6 expectation that we're going to have a .08 equivalent for drugs of
7 abuse. And I have submitted to the Board a paper looking at that
8 in great detail. It is really important because what is commonly
9 said is we need more research.
10 I was the first director of the National Institute on
11 Drug Abuse, starting in 1973. The third research report we put
12 out in 1975 was about drugged driving. This is not a subject that
13 has lacked for research. We have abundant research on this, and
14 what it tells us is we are not going to find the equivalent of a
15 .08 and looking for that is a mirage that is going to
16 substantially detract from our efforts to deal with it.
17 And Dr. Hedlund's presentation was very helpful to set
18 me up to make this point because if you'll notice on his chart,
19 impairment did not start like a light switch at .08. It started
20 at .01. The decision to go to .08 is a decision that was made
21 prudently balancing a number of factors, but it wasn't because
22 impairment was .08. Commonly when this is talked about, people
23 say, well, alcohol impairment means .08. That is not correct, and
24 the point of impairment that I want to have you think about with
25 me is impairment is not a single function. It's a whole range of

1 activities measured over all kinds of situations related to
2 driving, and the idea that somehow you're going to get a bright
3 light that's going to say here's my number is not correct, and
4 that's very much of a distraction for us.
5 And here's the ideal cutoffs. A simple way to think
6 about this -- I use it as an example. I worked in drug treatment
7 a lot, and methadone is a commonly used treatment in drug
8 treatment for opioid addiction. A standard dose of a methadone
9 patient is 100 milligrams a day. Forty milligrams a day is lethal
10 to a non-tolerant individual. Now think of how you're going to
11 establish a cutoff level for methadone for the highway when you've
12 got those kind of numbers, and you realize this is much more
13 complex than can be submitted to that kind of an analysis.
14 And I think one of the things that this Board could do
15 is look into this question and make a clear statement about it. I
16 think you'll find that both NHTSA and ONDCP will support that.
17 But I think looking at that specifically from the Board, any
18 recommendations is going to be very helpful.
19 The per se standard has been adopted by 17 states. It's
20 also used in Western Europe extensively, and I think the major
21 precedent that I call your attention to is in commercial drivers.
22 Since 1988, we have used that standard for commercial drivers with
23 little conflict, and it's worked out very well for us to use that
24 standard. And for those who say, well, that's commercial drivers,
25 we wouldn't want to necessarily do that for every driver on the

1 highway, I ask you, what other human activity has the kind of
2 safety implications for the public that driving on the highway
3 does? And if you really think that the standard used for the
4 commercial driver is unreasonable in terms of public safety to be
5 applied to the public at large, why wouldn't you also then remove
6 that as unfair in the commercial driving area?
7 If you're thinking about, not politics, but if you're
8 thinking about safety, you can't have it both ways. Either it
9 does affect driving to a significant extent and it is serious
10 enough to do something about or it isn't, and we've got a lot of
11 precedent to point out that it is. And go back to the Chase,
12 Maryland crash. The driver of the train that caused the crash,
13 the Conrail train, was named Ricky Gates. No one saw him impaired
14 the day he came to work. There was nothing unusual about his
15 behavior to identify. He tested positive for marijuana.
16 I was on the MacNeil/Lehrer Show two nights later
17 debating with somebody who said, well, that was just an incidental
18 thing; it had nothing to do with whether he was impaired or not.
19 And I said on the air, would you want your family to be riding on
20 a train that had a driver who tested positive for marijuana? And
21 the fellow didn't answer and that was the end of that discussion
22 about that. But I think we really need to think about that when
23 we think about what we want to have on our highways.
24 Now, prescription drugs is also a problem to think about
25 because a lot of people take medicines that are useful to them but

1 also potentially impairing, and this becomes very, not only
2 complicated, but actually stops action in terms of the per se
3 laws, with respect to prescription drugs.
4 And there is a way out of this, and as detailed in my
5 presentation that I've submitted to you, and it is this: that if
6 the person had, the driver, has a prescription for that drug, then
7 that is an affirmative defense against the per se standard, but
8 that driver can still be prosecuted under the impairment statute.
9 It is illegal to drive impaired no matter whether you have a drug
10 on board or not.
11 And so that is very important to understand how that
12 distinction is, and that uses the bright line of legality in terms
13 of making that distinction. That is a very important bright line
14 that makes life possible, that makes safety much more possible to
15 do and also protects the use of medicines, appropriate medicines,
16 without having highway safety have a chilling effect on medical
17 practice. And we've got more about that if you want to go into
18 it, but it's another very important issue.
19 Now, this is about the issue about the future goals, and
20 ONDCP has established a goal of reducing the drug driving problem,
21 and you see here some of the issues that I think are important. I
22 would just like to highlight a few that I think are particularly
23 important for the Board to think about with respect to these
24 opportunities.
25 I think the most important by far is the support of the

1 per se standard, the per se laws. I think that is the alpha and
2 the omega. That's the deal, of being able to do that. That is
3 the standard that is adopted by ONDCP in the federal strategies
4 and has been since 2010. It's very important.
5 Second, I think we need to test all impaired drivers,
6 not only for alcohol but for drugs. This will give us important
7 data about the prevalence of drug driving, which drugs are being
8 used, how much of that is going on, and that is very important.
9 And also to make driving with drugs on board a separate offense to
10 give the police officers an incentive to do this drug test even
11 when people who test positive at .08.
12 One of the reasons it's a mirage to think about a
13 finding of .08 is that many of these drivers, as you saw in that,
14 have multiple substances in their bodies. That changes that
15 calculation completely for drugs and for alcohol. And the
16 solution to that is to have a separate offense for drugs so that
17 there are two charges for the person who has -- not one, and it
18 also gives an incentive to get this data.
19 It's very important also that all the FARS studies
20 should include drug testing as well as alcohol testing and
21 particularly important is the public education, particularly for
22 young drivers. Right now drug driving is barely mentioned. Most
23 young people have no idea that driving after using drugs is a
24 problem to them, either, as Dr. Hedlund said, in terms of being
25 arrested, but also in terms of their risk. And it's very

1 important to put that out there and make that very clear as the
2 Chairman said in her opening.
3 And finally, I want to say this about the Board and the
4 opportunity. I think you may -- I don't underestimate and I
5 applaud the potential the Board has for bringing public attention
6 to a very underappreciated problem, not only the extent of the
7 problem, but the potential solutions to that problem. The key
8 here is to find a path forward to deal with the impact of the drug
9 epidemic in terms of transportation safety. That's what we're
10 talking about, and I think the Board can do a tremendous job in
11 doing that, particularly with your report, but also an
12 investigation of major transportation catastrophes as they relate
13 to drugs, just like happened in the Chase, Maryland crash where
14 that crash changed the world. There was an example of something
15 that made a huge difference, and I think there will be other
16 opportunities coming up, and I thank you for this opportunity to
17 address you today.
18 DR. MOLLOY: Thank you, Dr. DuPont. That concludes our
19 opening presentations for the first panel, Chairman Hersman. Time
20 for questions.
21 CHAIRMAN HERSMAN: Thank you very much, Dr. Molloy, also
22 Drs. Hedlund and DuPont for giving us a great start to our forum,
23 and laying the groundwork for us.
24 We will begin this round of questions with the Vice
25 Chairman who is going to lead the questions for the Board.

1 VICE CHAIRMAN HART: Thank you, Chairman Hersman. Good
2 morning, everyone, and thank you, panelists, for taking time out
3 of your busy schedule to come and help us with these complicated
4 and difficult issues.
5 I'm going ask a series of questions that may be more
6 granular than are knowledge. So excuse me if that's the case, but
7 they're just some things that occurred to me.
8 For example, Dr. Hedlund, on your presentation you have
9 sort of a standard set of slides but I'm wondering, I remember an
10 accident when I was at the Board previously and there was a subway
11 operator who was found after the crash to have a BAC of .3, and
12 this was a few hours after the crash when they found him in a bar.
13 So that meant when he was actually operating the subway it was
14 even higher than that but yet that very morning when he showed up
15 at work, people as close as I am to Member Rosekind didn't really
16 notice an impairment. So he clearly had built up a tolerance, and
17 I'm just wondering to what extent are the charts and the numbers
18 and everything that you've showed us affected -- I mean is that
19 sort of a baseline of people with no tolerance and to what extent
20 are those numbers affected by people's build up of tolerance over
21 time?
22 DR. HEDLUND: No, tolerance doesn't affect your
23 impairment. What it can affect, as Dr. DuPont said, is your
24 appearance of impairment. You may look to the person next to you
25 as though you're not impaired, but you're still impaired. It also

1 may affect your sense of impairment because if you're long
2 accustomed to drinking alcohol, you think you can operate at .15,
3 at .30, but you're still impaired.
4 VICE CHAIRMAN HART: Okay. So it's not the impairment
5 itself but the appearance of impairment that --
6 DR. HEDLUND: The outward appearance and your perhaps
7 internal perceptions of impairment may differ.
8 VICE CHAIRMAN HART: Okay. Another variable that we've
9 been talking about here at the Board, especially since Member
10 Rosekind came as a fatigue expert, to what extent are these
11 impairment numbers affected by an individual's fatigue? Do we
12 have any sense of that?
13 DR. HEDLUND: Fatigue won't change how alcohol
14 metabolizes into your body and gets into your brain. So you're
15 just as impaired. What happens is that fatigue also induces
16 impairment in different ways. So what you have with the fatigued
17 person is a tired drunk driver who is even more dangerous than a
18 wide awake drunk driver.
19 VICE CHAIRMAN HART: So it's an accumulative type of
20 impairment if you will?
21 DR. HEDLUND: It can be accumulative, yes.
22 VICE CHAIRMAN HART: I see. Okay. And how about things
23 like stress? I mean, I'm just stressed out at work or my son's
24 flunking out of college or my mortgage is overdue. I mean, do we
25 have any understanding of how stress affects our -- the extent to

1 which we're impaired from alcohol?
2 DR. HEDLUND: Not to my knowledge. But, again, any of
3 these things that are happening in your psyche, in your brain,
4 won't affect how the alcohol metabolizes in your body and how it
5 gets into your brain. It's still there and it still impairs.
6 VICE CHAIRMAN HART: Are there any circadian effects
7 that we know of?
8 DR. HEDLUND: I do not know of any but I'm not an expert
9 in this.
10 VICE CHAIRMAN HART: Okay. And one of the charts that
11 was interesting that Dr. DuPont showed was the rate of use was
12 increasing since the late '60s, and I'm just wondering, I don't
13 have any sense of it. It seems to me just sort of anecdotally
14 that people don't drink as much now as they used to. You
15 mentioned that the drunk person used to be funny, and I remember
16 that character on Jackie Gleason that was always drunk and
17 everybody was laughing, boy, that's really funny and, like you
18 said, one for the road and all that.
19 My impression, but correct me if I'm wrong, or I don't
20 even know if we have data, but my impression is people don't drink
21 as much as they used to or at least hard liquor maybe. I'm not
22 sure, but I just have that impression. I don't -- I wonder if we
23 have any data that addresses any of that?
24 DR. HEDLUND: I do not have the data on top of my head.
25 There are data about per capita alcohol consumption that can be

1 obtained that can provide some evidence for this. My feeling
2 anecdotally is the same as yours, that social drinking in
3 particular has decreased. If you're at the bar at the golf club
4 after playing 18 holes, you will have 2 or 3 drinks perhaps, but
5 you won't have 6 or 8.
6 VICE CHAIRMAN HART: And that's the reason I asked the
7 question because if the rate -- if the percentage of fatals, of
8 alcohol involved in fatal accidents has been in the 30s for a long
9 time, but the rate of consumption is going down, that concerns me
10 even more that maybe the problem is actually getting worse than it
11 appears.
12 DR. HEDLUND: I'd like to look at those data on per
13 capita consumption before I even attempt to answer that question.
14 VICE CHAIRMAN HART: I understand. I understand.
15 DR. HEDLUND: Thank you.
16 VICE CHAIRMAN HART: Then last, this question was
17 brought up by Dr. DuPont. What about the interaction between
18 drugs and alcohol? Do we have -- again your charts assume a drug-
19 free person, I assume. So that -- so I guess that's also not well
20 understood at this point what those effects on impairment from
21 alcohol are as affected by drugs?
22 DR. HEDLUND: Let me take a quick stab at that. The
23 alcohol testing is done on drug-free persons, yes. So those
24 charts are absent any drug. I do not know of any experiments that
25 have been done with drugs and alcohol jointly.

1 DR. DuPONT: I don't know of any, but there are such
2 things, not many though.
3 VICE CHAIRMAN HART: Okay. Thank you. That's very
4 helpful. Now, Dr. DuPont, now it's your turn. I want to ask some
5 similar questions of granularity to you. One of the ones again is
6 on the tolerance issue, is that -- I guess there's so many drugs
7 it's probably hard to generalize. There may be different
8 tolerance effects for different drugs, but I just wonder if you
9 have any comments in general on the tolerance issue?
10 DR. DuPONT: Yes, I was thinking about a -- I work with
11 many physicians who have had significant alcohol and drug problems
12 and I was talking to a cardiologist a couple of years ago who is
13 in recovery. He's gone through what's called a physician's health
14 program and is monitored for not using any drugs and alcohol, so
15 he was -- this was behind him. But he said that he did cardiac
16 catheterizations repeatedly when he was drunk and he felt he was
17 better doing it when drunk than most of his colleagues were sober,
18 and that he never had any problem associated with it.
19 Now whether that testimony is credible or not is a
20 question you might raise, but it's striking. I had an experience
21 in my practice where I saw a patient come in and talk to me for 50
22 minutes and go out and, without having any drinking after that, he
23 got arrested for drunk driving, and he was point .24.
24 VICE CHAIRMAN HART: Wow.
25 DR. DuPONT: And he went for 50 minutes with me without

1 my detecting any problem with him.

2 VICE CHAIRMAN HART: Wow. That's interesting you say

3 that. I remember as a high school summer job, one of the jobs was

4 highway construction, and I remember the operator of the blade

5 that leveled out, he always came to work drunk, and everybody

6 said, yeah, he works better when he's drunk, and that's

7 interesting that you say that.

8 DR. DuPONT: I don't think that we're improved in

9 performance. Please, I'm not saying that. But I just --

10 VICE CHAIRMAN HART: I understand.

11 DR. DuPONT: -- I think that tolerance is a very

12 confounding factor with any drug. And the other thing is practice

13 makes a big difference. When you've done the thing over and over

14 again, you're going to get a different kind of impairment of the

15 thing than when you haven't done it over and over again.

16 VICE CHAIRMAN HART: Right. Well, let me ask on the

17 issue of impairment. Again, because there's so many different

18 types of drugs and we're so early on this learning curve, can I

19 assume that the type of impairment is not necessarily the same

20 with different types of drugs? Some drugs have some types of

21 impairment and other drugs have other types, or what can you tell

22 me about that?

23 DR. DuPONT: Oh, absolutely. There's total variation.

24 And so -- I mentioned that there are a thousand different and more

25 ways you can measure impairment. It's not just one thing, there's

1 an impairment scale and that's it. It's all kinds of functions
2 that you can measure, and they vary -- the reductions in
3 performance on various measures are different for different drugs.
4 It also changes over time and, unlike with alcohol, which is a
5 relatively simply chemical that is very low potency, so there's a
6 whole lot of it in the body, in drugs it also goes through the
7 whole body, like Dr. Hedlund said, and it's detectable anywhere.
8 But the relationship between impairment and blood level is not
9 linear. It is not simple. And many drugs, the blood level peaks
10 long before the impairment does and oftentimes the blood levels
11 have fallen very low and the impairment is still very high. But
12 as you say, it's different for different drugs.
13 And I want to point out, we've had 70 years of
14 experience with alcohol, and we've still got a lot to learn. When
15 you think about drugs, when you've got 1,000 drugs to deal with,
16 the idea that you would have the capacity to do that kind of
17 research on all of those drugs, and even if you could do that,
18 then you've got to deal with a combination of the drugs and
19 alcohol, you realize that that path is a path to no action, to
20 inaction.
21 VICE CHAIRMAN HART: I understand. Thank you. That's
22 very helpful. And then my last question relates to the per se
23 standard that you mentioned. That basically means if we can
24 measure it, then you're illegal. Is that basically what that
25 means?

1 DR. DuPONT: That does. If you've got it in you, in the
2 driver, then that's illegal. That's the correct word. It's a
3 violation.
4 VICE CHAIRMAN HART: Okay.
5 DR. DuPONT: It is illegal, yes.
6 VICE CHAIRMAN HART: So then there's not a number
7 associated to that. Basically that's -- the sensitivity of the
8 measuring equipment is what determines that in that case?
9 DR. DuPONT: Yes, that's right.
10 VICE CHAIRMAN HART: Okay. Great.
11 DR. DuPONT: And for some drugs, that is several days.
12 But marijuana, people talk about long periods of time that it's
13 positive. When they talk about that, they're talking about
14 chronic users. If a person has a joint or two, 40 percent of them
15 test negative on urine testing the next day, and all of them will
16 be negative within 5 days at the standard cutoff levels. The
17 people who have these long periods of time are very heavy users
18 and I think there's pretty good evidence to show that the heavy
19 users are impaired long after those blood levels come down.
20 VICE CHAIRMAN HART: Well, thank you. That's very
21 helpful. Again I want to thank the two panelists for helping us
22 with these difficult issues. I worked with Dr. Hedlund when I was
23 at NHTSA, and I enjoyed that thoroughly, and the amazing
24 coincidence with Dr. DuPont is that he and I graduated from the
25 same high in Denver, Colorado. So what a small world.

1 DR. DuPONT: Proudly from East Denver Public High
2 School.
3 VICE CHAIRMAN HART: Yea, East. Thank you very much.
4 CHAIRMAN HERSMAN: Member Sumwalt.
5 MEMBER SUMWALT: Thank you. I think that there's
6 probably not a person in this room that hasn't been affected in
7 some form or fashion by an impaired driver, and I'll tell a quick
8 story about two cousins in my family. I will always remember
9 December of 1980, when I had to stand in the kitchen of my house
10 and tell my wife that her first cousin had been killed in a
11 driving accident and the person that ran into her was drunk. They
12 both lost their lives that day.
13 And then a year ago, on the other side of the scale, I
14 was in my office just flipping through the local news in my
15 hometown, and I saw where something about a preacher had been
16 killed in an automobile accident. I didn't read the story. I see
17 so many like that. But as I was leaving my office that night, my
18 sister called me and told me that my first cousin's daughter had
19 run into somebody. She had run into a preacher and killed him,
20 and she was, my first cousin's daughter, the driver, was impaired
21 by some form or fashion.
22 So this is a problem that affects everybody. I suspect
23 everybody in this room knows somebody who has been killed in an
24 impaired driving accident. So it is a problem. And we've set the
25 goal here, we said reaching zero, and I suspect having been

1 involved in such campaigns in other modes of transportation over
2 the years that people say, well, you'll never get there. But if
3 you don't set that goal, you will never get there.
4 And what it appears to me, and I'd be curious to hear
5 each of your opinions on this, but it appears that as society -- I
6 realize that all of the people in this room, and there's a lot of
7 groups that are actively working to reduce this problem and that's
8 probably -- that's largely why it's come down from 41 percent of
9 all traffic fatalities down to somewhere around 31 percent, but
10 it's plateaued. So we've gotten a lot of mileage out of all the
11 efforts that have been made in the past, but it has plateaued, as
12 the Chairman said, for the last 15 or 16 years.
13 So is the problem that we as society, generally
14 speaking, have just accepted this as a norm? And, please, Dr.
15 Hedlund and then Dr. DuPont.
16 DR. HEDLUND: To some extent we have. Those 10,000
17 fatalities occur by 1's and 2's. They aren't the 100 fatalities
18 of a major plane crash or something like that. But it's also an
19 issue of commitment and resources. Checkpoints, drunk driving
20 enforcement, that takes law enforcement resources. There's
21 tremendous strains on state and community budgets these days. Are
22 we willing to commit the resources there rather than somewhere
23 else? It's attention. It's resources. We know what to do. We
24 just have to do it.
25 MEMBER SUMWALT: And Dr. DuPont.

1 DR. DuPONT: I think that what Dr. Hedlund said was very
2 moving to me in the way he went right to the heart of the issue of
3 enforcement. Education is a great thing and is very helpful, but
4 without the enforcement, the education has relatively little
5 effect or not enough effect anyhow, and the enforcement really is
6 the key, and just as he said, you have to change that risk
7 perception from the current one. He said not just 1 in 50, but I
8 think more like 1 in 500 is kind of the number.
9 The problem is that an awful lot of drunk drivers and
10 drug drivers get home and nothing happens to them, and that
11 reinforces that behavior. And I think what society needs to do is
12 change that calculation that is made about the likelihood of
13 getting away, and the swiftness and certainty of the consequences
14 and the severity all need to be managed much more effectively.
15 MEMBER SUMWALT: As we get into other panels throughout
16 the day, I want to talk about some radical paradigm shifts that
17 I've thought about, but not right now. I do want to ask, in
18 Europe, in Western Europe, do they have a significantly less
19 number of driving impaired accidents than -- fatal accidents than
20 we do here in the U.S.?
21 DR. DuPONT: I don't have those numbers immediately
22 available. I can submit them to the Board.
23 MEMBER SUMWALT: That would be nice if you could submit
24 for the record and, Dr. Hedlund, what do you know about that?
25 DR. HEDLUND: I'd rather not speak without looking at

1 the numbers.
2 MEMBER SUMWALT: Okay. Thank you. Just out of
3 curiosity, what do -- Dr. DuPont, you gave a briefing to some of
4 us last week. What does Western Europe do for legally impaired
5 BAC?
6 DR. DuPONT: The BAC is .05 throughout most of Europe.
7 In Scandinavia, it's .02.
8 MEMBER SUMWALT: Okay. It would be interesting to look
9 at those figures and see how -- what percentage of their accidents
10 are related to impaired driving versus ours since they have a
11 much --
12 DR. DuPONT: It makes it more clear about not drinking
13 and driving. What the Chairman said I thought was a very
14 wonderful presentation: don't drink and drive. It's not the same
15 thing as saying don't drive drunk. Those are entirely different
16 messages. And I think that BAC level has a lot to do with
17 distinguishing between those two things, and I think the clearer
18 message is don't drive after drinking.
19 MEMBER SUMWALT: Thank you very much.
20 CHAIRMAN HERSMAN: Member Weener.
21 MEMBER WEENER: Thank you. I'm curious about the
22 residence time of alcohol. You know, there's lots of old stories
23 about being able to sober up quickly. Is there such a thing as
24 being able to sober up quickly?
25 DR. HEDLUND: No.

1 DR. DuPONT: Amen.
2 MEMBER WEENER: So it just takes time for the alcohol to
3 metabolize?
4 DR. HEDLUND: It's in your body and it has to get out.
5 MEMBER WEENER: I'm curious. We keep talking about the
6 term impairment. Are there standards, objective standards for
7 impairment? What does impairment really mean?
8 DR. HEDLUND: In law enforcement circles, impairment is
9 inability to operate your vehicle safely, and that's judgmental.
10 One can make standards on virtually all of the things that become
11 impaired. For example, reaction times, there is no single
12 standard that says you're impaired if your reaction time is longer
13 than "X" because individuals vary. Your reaction time and my
14 reaction time may well be different. The same thing is true with
15 perception and muscle control and things of that sort. There is
16 no single standard that says, on any of these, you are impaired at
17 this level, no bright line.
18 DR. DuPONT: Could I comment on that for just one
19 second? General Motors 20 years ago had an idea of having a way
20 of identifying impaired driver, driving related to drug -- I mean,
21 alcohol use in particular. And that was they put a keypad in the
22 car and it would flash up a series of numbers and then the person
23 had to be able to push those numbers within a certain short period
24 of time to be able to operate the car. And what they found was
25 that many drunk people could do it and many sober people couldn't

1 do it, and that ended that experiment.
2 MEMBER WEENER: So on a roadside stop, what's the
3 judgment process for determining an impairment if there's a
4 suspicion of alcohol?
5 DR. HEDLUND: You will hear more about this from law
6 enforcement later on this forum, but quick once over: Do I smell
7 alcohol? Do I have some reason to ask the person to step out of
8 the car? This is required. I can't just ask you to arbitrarily
9 step out. The standard thing on the side of the road is either
10 use a screening device, which I spoke about earlier to test
11 whether there's alcohol in the system, and/or use the standard
12 roadside sobriety tests. And these are a set of three tests that
13 have been calibrated: one leg stand, walk and turn, and so forth,
14 that have specific performance levels associated with them and if
15 you cannot perform these satisfactorily, that's sufficient
16 evidence, articulable suspicion to arrest you and take you to the
17 station to do an evidentiary test.
18 MEMBER WEENER: So, Dr. DuPont, in a similar sort of
19 situation, what kind of tests are there for an officer who
20 suspects drug-related impairment?
21 DR. DuPONT: Usually they use the same tests, and the
22 drug people often fail those tests. For example, when an officer
23 identifies a driver as impaired and takes him to the stationhouse,
24 for those people who blow .08 or higher, that is, the per se
25 standard of impairment, about 20 percent of them will test

1 positive for drugs; but of those who are below that, below .08,
2 about 50 percent of them test positive for drugs. So they all
3 should be tested, and that's one of the things that I think is
4 really important is to test everybody who's pulled over for
5 impairment, that are arrested for impairment and then take them to
6 the stationhouse and tested for alcohol, to test them for drugs at
7 that point, too. So I think the current way it is done is pretty
8 good at identifying drivers.
9 Now, you're going to miss people. You would have missed
10 Ricky Gates, for example, with that. And that's why you need to
11 do more than just test impaired drivers, and I think that that's a
12 very important concept of where we need to go, but the first step
13 is test the ones who are identified already as impaired, which is
14 a large number of drivers.
15 DR. HEDLUND: A quick add on to that. One of the other
16 roadside tests is horizontal gaze nystagmus which measures eye
17 jerking. It's very tightly controlled. Second, is there's a
18 standard battery of tests for drug impairment called the drug
19 evaluation and classification test, which are performed in the
20 stationhouse, again, well calibrated.
21 MEMBER WEENER: We talked about illegal drugs causing
22 impairment and controlled substance, and you mentioned that
23 prescription drugs, the presence of prescription drugs is related
24 to impairment. What about the over-the-counter drugs that
25 everybody's familiar with?

1 DR. DuPONT: Many of those are sedating also,
2 antihistamines being a classic example of that, and you can be
3 impaired with those, too. And I think that identifying the
4 impairment, even in the absence of a chemical test, is a violation
5 of the law and can be prosecuted.
6 The problem with that is, and you can see this very much
7 by how we describe what the tests are for impairment, when you go
8 to a jury and say this person couldn't do this, stand on one leg
9 and turn kind of thing and other things, the juries will raise an
10 eyebrow and it becomes difficult to get a prosecution. That's why
11 the per se law is so important for alcohol because it clears that
12 out of the way. It's either .08 or higher or it isn't. It makes
13 a huge difference in the prosecution of that. But the issue of
14 impairment is a very important part of this, and it's quite varied
15 with different drugs.
16 MEMBER WEENER: Very good. Thank you for sharing your
17 expertise, gentlemen.
18 CHAIRMAN HERSMAN: Member Rosekind.
19 MEMBER ROSEKIND: First, it's just incumbent, because of
20 my role to say, you've just had a chance to understand how
21 precocious our Board members are; we actually have a whole panel
22 tomorrow on international flavor of what's going on here to talk
23 about the numbers.
24 DR. DuPONT: Thank you. You saved me submitting that to
25 you. Thank you.

1 MEMBER ROSEKIND: And we also have some law enforcement
2 coming to talk about standardized field sobriety tests, SFSTs,
3 what goes along with that. So a lot of that is coming, but you
4 can see our heads are going pretty fast about what we want to talk
5 about.
6 I'd actually like to start, I'm wondering if you could
7 think very broadly about what data is still needed? I think,
8 Dr. DuPont, you started getting to that. For example, there's a
9 tendency, you find alcohol, you don't necessarily test for drugs
10 or maybe a full range of drugs. But when the two of you think
11 about, not research per se, but what data would help us understand
12 and address this problem, what are data needs in that area for
13 drugs and alcohol?
14 DR. HEDLUND: I'll take it for alcohol. In fatal
15 crashes, we currently test about two-thirds of all dead drivers in
16 fatal crashes and about 25 percent of all surviving drivers. So,
17 big deal need, test all drivers in fatal crashes for alcohol and,
18 while you're at it, test them for drugs.
19 DR. DuPONT: Exactly. I think that that's right. It is
20 very important for that. As I said, I think testing all impaired
21 drivers is going to be very important. I would think it would be
22 useful to test drivers who are involved in accidents with serious
23 injuries also for both drugs and alcohol would be very important.
24 But I want to go with Dr. Hedlund about the FARS data.
25 I think the FARS data has been a kind of benchmark in our field

1 for a long time, and to make that data better, we're going to have
2 to change things. We're going to have to have standardized cutoff
3 levels, which drugs are tested for, give some guidance of how that
4 is done and see that that is done systematically with all fatally
5 injured drivers. I think that would be very, very helpful to do.
6 I also would like to see data -- I showed you this Shock
7 Trauma data from Maryland. I think it would be very helpful to
8 identify five or six centers around the country that see a lot of
9 seriously injured drivers, and systematically every year do
10 studies on drugs and alcohol, and that would give us a lot more
11 flexibility than we have with the FARS data. You could test
12 different drugs in different areas. You could change it over the
13 course of time, what you're doing. You could do various kinds of
14 studies, but if you had centers like that, five or six of them,
15 doing that on an ongoing basis, you would have a listening post
16 for what's going on, on the highway that could be calibrated, I
17 think, much more quickly and learn a lot more than you can get
18 from the FARS data.
19 MEMBER ROSEKIND: So I want to talk about another issue
20 that I think we're going to hear about over the next two days, and
21 Member Weener started with this. I was going to ask you about
22 defining and measuring impairment, but frankly, it sounds from
23 your discussion and many others we've talked to, impairment
24 actually is a misnomer and, if anything, it's a distraction that
25 people use not to talk about what sounds like a relative risk.

1 So going to the 20-year-old data that you showed us, you
2 know, .02 to .04, there's a 40 percent increase in fatal vehicle
3 single crash, and then when you get to the .05 to .09, it goes to
4 110 percent increase, right?
5 DR. HEDLUND: Yes.
6 MEMBER ROSEKIND: So it seems like relative risk is the
7 issue and that every time people keep talking about impaired, it's
8 a distraction because everyone wants to say all the nice anecdotal
9 studies and anecdotal expressions about you made it home, this and
10 that; people use that not to basically acknowledge what seems to
11 be very simple. And one of the things I think that's fascinating,
12 and we'll all listen tomorrow to the international crowd, is they
13 don't talk about drunk driving. They talk about drink driving.
14 That distinction between, you know, drinking and driving together.
15 So impairment seems like a distraction, and the per se
16 laws seem to get us away from that. It's 0, 1; you got it or you
17 don't, and that's what the cutoff is. This other part, and how
18 sophisticated we've gotten to try and prove whether you're
19 impaired or not, et cetera, seems like it just takes us away from
20 the core issue. Can you address that from sort of a drugs and
21 alcohol issue perspective?
22 DR. DuPONT: Well, I think you're absolutely right, but
23 I want to talk to you a second about the relative risk study on
24 alcohol. That's relatively easy to do because you have so many
25 drivers with alcohol. With other drugs, you have a much smaller

1 N. It's much more difficult to do that with a variety of drugs.
2 And you have the problem that the tissue levels, which in alcohol
3 have a very straightforward simple relationship to impairment,
4 don't with the drugs. And the combination of those two things,
5 makes it impossible to do a relative risk crash study without
6 doing hundreds of thousands of samples, which is impossible from a
7 practical point of view.

8 So as attractive as the relative risk is for
9 establishing those cutoff levels, I want to point out two things.
10 One is there's no bright line in that. You have nothing in that
11 said .08 was the number. You could put in a lot of different
12 places in that because the impairment starts right away. And
13 second of all, you've got too many drugs to do, and the
14 pharmacokinetics are more complicated than that. So I think
15 that's not going to be a solution for our problem with drug
16 driving.

17 MEMBER ROSEKIND: And just -- I'll get you there in just
18 a second, but just what's interesting is, somebody made a
19 political decision, not a scientific one, about the .02 to .04.
20 Somebody said 40 percent was okay, right, and 110 percent is not,
21 but I'm also hearing you say that that kind of 0/1 line is not so
22 bright for the drug issue.

23 DR. DuPONT: Well, that's right. Yes, that's right.
24 I'm saying for the relative crash risk, it's going to be a problem
25 with it because you don't have a straight relationship.

1 MEMBER ROSEKIND: Right.
2 DR. HEDLUND: Just to make the point that I don't want
3 you to think that per se is the only alcohol law. There is also
4 impaired by alcohol. You don't want everything to be based on per
5 se because if for some reason you do not get a BAC test on this
6 driver who's obviously impaired, you still want to be able to
7 arrest, convict and so forth. So it's a balance between the two.
8 The per se makes life a lot simpler for alcohol. It will not do
9 that for drugs except for the illicits. You need both.
10 DR. DuPONT: In prescription drugs, you have the same
11 kind of issue. You have a legal activity where you don't have
12 that legal bright line, and then you do need that impairment law
13 to be able to make that work. So that's right. You need both of
14 them.
15 MEMBER ROSEKIND: But both sort of in an order, right?
16 I mean, if you've got the per se part, there's a presence, you
17 shouldn't necessarily have to --
18 DR. HEDLUND: Game's over. Per se is far simpler.
19 Game's over.
20 MEMBER ROSEKIND: Right. Thank you.
21 CHAIRMAN HERSMAN: Thanks. I want to go to Dr. DuPont
22 and talk about the commercial side. You made a statement that you
23 thought that what happened in the commercial drivers was a very
24 important model. And so I think there's actually several facets
25 to why that was successful. And so, you know, the Chase, Maryland

1 was actually one of the last big impaired accidents. There had
2 been a lot of them before but that was the last one that was kind
3 of the straw that broke the camel's back.
4 DR. DuPONT: Right.
5 CHAIRMAN HERSMAN: And out of that, one of the big
6 accomplishments was getting not just pre-employment drug and
7 alcohol tests, but random drug and alcohol tests on the job, as
8 well as having a standard that's more significant, the .04 for
9 people, pilots, mariners --
10 DR. DuPONT: Right.
11 CHAIRMAN HERSMAN: -- railroad engineers, commercial
12 drivers. But, in fact, I think also what happened was there
13 became a zero tolerance from employers. It wasn't .04. .04 you
14 could lose your license, but anything, with certain employers, it
15 was understood that you would lose your job.
16 DR. DuPONT: Right.
17 CHAIRMAN HERSMAN: And so can you talk about what you
18 think the areas of success that we could model, not on the
19 commercial side, but for the general public would be?
20 DR. DuPONT: Yes, I think that's wonderful. I was very
21 much involved with all of those laws, and was the expert witness
22 in many of the cases that led up to what happened in 1987 and
23 1988, and so I was intimately involved in all of that.
24 I think you're right that that was a moment in history
25 and the issue was zero tolerance, and I think that that's the

1 bright line that needs to be enforced, and it did happen in the
2 workplace in a very dramatic way. But the effort to make drug
3 testing more general in the workplace was limited around privacy
4 issues and political considerations, and so what we have now is
5 widespread, if not universal, pre-employment testing. That is a
6 very big change that didn't exist before that's there.
7 We use urine tests. It's often said that a pre-
8 employment urine test for drugs is not so much a drug test as an
9 intelligence test because all the person has to do is refrain for
10 three days and they're negative. It's remarkable the percentage
11 of people -- in some industries, as much as 50 percent fail, which
12 maybe says something about the intelligence as well as the
13 prevalence of drug use. But in any event, that's pre-employment.
14 And then we have testing for safety-sensitive positions,
15 and most safety-sensitive positions, in fact, the whole safety-
16 sensitive industry, such as the nuclear power industry, where it
17 becomes industry wide, random testing is adopted. What has not
18 happened is random testing of all employees. Private employers
19 have the option of doing that. Some have done that. I think that
20 there are many reasons to think that that's a good idea, but that
21 has not been adopted more widely, and I think that was where the
22 wave, if you will, sort of ended at that point and since then,
23 there has not been a lot of further development in the workplace
24 drug testing.
25 CHAIRMAN HERSMAN: But if we apply that to the roadside,

1 I think one of the things that we don't see in the U.S., which we
2 do see in other countries, is random roadside testing for alcohol
3 or drugs. And so --
4 DR. DuPONT: And that is really important, exactly, to
5 do that to raise that perception of risk for everybody being
6 identified and prosecuted for drugs and alcohol. I agree with
7 you. That is very important.
8 CHAIRMAN HERSMAN: Dr. Hedlund.
9 DR. HEDLUND: If I may add to that? To the random
10 roadside, there's a small issue of the United States Constitution,
11 which says this is not allowed in the United States, where it is
12 in most of the rest of the world.
13 In terms of commercial, we hold people at work to
14 different standards than we do when they're on their own at home.
15 We require far higher standards to license a pilot or a commercial
16 motor vehicle driver than we do to license an average anybody
17 driver. We can expect more in terms of drug standards and alcohol
18 standards.
19 The real issue is that societal issue of conflict
20 between drinking and driving that I mentioned earlier. What are
21 we willing to tolerate in our everyday life in terms of these
22 controls, and that's something that we all have to wrestle with.
23 DR. DuPONT: Could I just say about the constitutional
24 issue about -- of identifying impairment as a cause for the test?
25 The Constitution does not -- it talks about a reasonable

1 suspicion, and it's a balancing test between the public interest
2 and the privacy interest. I believe if that were litigated today,
3 you'd get a different answer because the perception of risk on the
4 highway has increased greatly so that that balance, I believe, has
5 shifted, and if it were subjected to another hearing at the
6 Supreme Court, I think the answer would go the other direction.
7 CHAIRMAN HERSMAN: Let me ask more specifically about
8 drugs. Regardless of whether they're prescription or illegal
9 drugs, many prescription drugs come with a warning: do not
10 operate heavy machinery when you're taking these drugs. Do you
11 think people think that driving a car means operating heavy
12 machinery?
13 DR. DuPONT: I agree with you. I think we need to be a
14 lot more specific than that.
15 CHAIRMAN HERSMAN: Okay. And if we were to identify
16 drugs that we would need to do testing for, what types of drugs do
17 you think are the most important for us to try to pick up?
18 Because we've seen in many of our investigations that it's
19 actually licit, legal drugs, prescription and over-the-counter
20 drugs that actually are impairing many operators in our
21 investigations. And so what do you think are the most important
22 drugs to pick up?
23 DR. DuPONT: Well, the controlled substances as a class
24 I think probably would be part of that. What makes a drug a
25 controlled substance is it's subject to abuse by drug addicts and

1 alcoholics. If people don't understand what makes it a controlled
2 substance, that's what it is. But there are many other drugs,
3 both prescription and non-prescription that are sedating and I
4 think sedating is really probably the key element you're thinking
5 about. And so I think it would be very reasonable to ask the
6 question about sedation and to include that in the warnings.
7 We've talked repeatedly this morning about tolerance,
8 and I am a specialist in anxiety disorders where the
9 benzodiazepines are commonly used. Those are classic examples of
10 sedating drugs and associated with highway risk. There's no
11 questions about it, but once a patient has been on one of the
12 benzodiazepines at a stable dose for a long period of time, it's
13 pretty much like the opioids, that there is no sedation under
14 those circumstances. I've seen people with massive doses of
15 benzodiazepines who show no signs, as long as it's gone up slowly.
16 So the public education is not so simple of what you're saying
17 about it. Most of the problems for many of these drugs come early
18 in the first use of the medicine; later on there's much less.
19 So I don't think you've got a real clear message to
20 patients, and I think there's a danger of a message that isn't
21 clear, actually discouraging appropriate medical treatment. So
22 there's a balance there that has to be struck. I think it needs
23 to be struck other than where it is now, but going to that next
24 step is going to be a challenge.
25 What's really important though is that the first periods

1 of time you're using the drug, when you're just using it, and also
2 using the drug with alcohol. I think those are the things that
3 are particularly high risk.
4 CHAIRMAN HERSMAN: Thank you all so much. I know that
5 there are many questions that didn't get asked today. I have a
6 few myself, but I think the ones that were asked and answered were
7 very illuminating and thank you so much for your candor and your
8 presentation. You've given us a lot to think about.
9 We are now going to take a break. We do have a number
10 of manufacturers and groups that are displaying out in the foyer
11 and the Conference Room A and B. So please take an opportunity to
12 go see their displays and their materials, what they have.
13 We're going to break until 10:15, when we will come back
14 in for our second panel.
15 (Off the record at 10:00 a.m.)
16 (On the record at 10:20 a.m.)
17 CHAIRMAN HERSMAN: Welcome back. We are ready for our
18 next panel. Dr. Molloy, will you please introduce our second
19 panel?
20 DR. MOLLOY: Thank you very much. The next panel, we
21 will address what we know about the problem, individuals who drive
22 impaired, knowledge of the scope of the alcohol and drug driving
23 problem through crash injury and fatality data, and the challenges
24 in collecting data.
25 Our first panelist, however, will remind us of the faces

1 behind the numbers. Jan Withers, MADD's national president, will
2 provide a mother's perspective on the lasting consequences of
3 impaired driving. Ms. Withers.
4 MS. WITHERS: Dr. Martin Luther King, Jr. once said, "We
5 are now faced with the fact that tomorrow is today. We are
6 confronted with the fierce urgency of now."
7 In this unfolding conundrum of life and history, there
8 is such a thing as being too late. This is not time for apathy or
9 complacency. This is a vigorous and positive action.
10 I'm Jan Withers, and I serve as the national president
11 of Mothers Against Drunk Driving.
12 Yesterday was the 24th anniversary of the Kentucky
13 school bus crash that killed 27 people. I communicated with one
14 of those mothers yesterday and she was telling me that it still
15 hurts. On May 14, 1988, 27 people, mothers began their lifelong
16 journey through sorrow, and 2 days ago was Mother's Day, a day
17 that is generally a joyous occasion.
18 However, just the day before in Baltimore, I stood among
19 hundreds of mothers who would not be able to experience full joy
20 on Mother's Day because their precious children were killed by a
21 drunk driver. They now have a deep pain that forever tugs at
22 their hearts. Arm in arm, these mothers along with fathers and
23 siblings, grandparents and friends, Walk Like MADD, to raise
24 awareness and revenue to continue our work to eliminate drunk
25 driving.

1 We're saying enough is enough. We have already
2 experienced the ultimate agony. I'm sure if you ask anyone of us,
3 you would hear Dr. King in our voices saying, "In this unfolding
4 conundrum of life and history, it's too late for us." And you
5 would hear us echo his remaining challenge. "This is not the time
6 for apathy or complacency. This is a time for vigorous and
7 positive action."
8 I am representing all of those individuals because my
9 own daughter, Alisa Joy, was killed by a drunk drive when she was
10 only 15. I always thought it would happen to someone else, but on
11 April 16, 1992, I became that someone else. It started with my
12 husband receiving a phone call that Alisa had been in an accident.
13 That's what they called it at that time. The truth is, as it
14 turned out, it wasn't an accident at all. The truth is someone
15 made a choice, a tragic choice to drink and then drive.
16 Nobody thinks it can happen to them. Even in that
17 moment as my husband told me we needed to go to the hospital
18 immediately, it never crossed my mind that she would die. Never.
19 Today I want to tell you about Alisa's story because behind these
20 statistics are real people, real lives cut short.
21 We met up with my older children at the hospital. Alisa
22 was in surgery. We waited what seemed an eternity until the
23 surgeon came in after several hours of working on her. He sat me
24 down in a chair and then he sat down across from me. I will never
25 forget the exact words he said very matter of factly. He looked

1 at me and he said, "All of your daughter's ribs are broken. Her
2 lungs are punctured. Her diaphragm is ripped to shreds. Her
3 heart sack is torn. Her kidneys are cut in half, and her liver is
4 pushed up in her throat." And then he was silent.
5 Finally I put out any words that I could think of, and I
6 uttered what must have seemed like an absolutely inane question.
7 I asked, "What will the quality of her life be now?"
8 Now at this point you're probably thinking, Jan, you
9 must have realized Alisa wasn't going to make it, but you would be
10 wrong because the doctor never said it. And again I never thought
11 I would be that someone else who would have a daughter killed by a
12 drunk driver.
13 He briskly replied, "That's the least of our worries.
14 Right now we're sending her up to nuclear medicine to see if there
15 is brain function." Well, when they moved her into a recovery
16 room, we were finally able to see her. After a few moments, I
17 turned to Alisa's older sister and I said, "We'd better start
18 notifying Grandma and Grandpa and the rest of the family." The
19 nurse who was attending Alisa stopped and she touched my
20 shoulders. "No, dear," she said, "she doesn't have long now. You
21 need to spend every moment with her that you can." That was the
22 first time that I was told she was going to die.
23 For the next I don't know how long, I sat down next to
24 her and I held her hand and I kept kissing her and telling her
25 that I loved her. Finally I leaned down and I whispered in her

1 ear, and I said, "Baby, you can go. You don't have to stay for
2 us. I love you, and you need to know, I will always love you."
3 And you know, she died at that moment.
4 In the wake of her death, details of the crash surfaced.
5 The day started like any other. Alisa was spending the night at
6 her best friend's house during spring break when they asked her
7 parents if they could go out with two senior boys. What the girls
8 didn't know is that the boys picked up a couple of cases of beer
9 earlier in the evening. So they hopped in their car not realizing
10 the danger. They drove to our local pond where only the boys
11 continued drinking. When it came time to go home, the driver, now
12 intoxicated, decided to try to scare the girls with excessive
13 speed. He lost control of the car and throwing Alisa in the
14 woods. I'm most haunted because I know she laid there alert and
15 suffering all alone in the darkness.
16 The first gentleman on the scene heard the other
17 passengers in the car calling for her and so he looked and found
18 her and he sat with her until they medevac'd her to Shock Trauma.
19 Alisa and I, as her mother, represent millions of
20 victims and survivors of drunk driving. Drunk driving is not just
21 a policy issue to MADD volunteers. It's a deadly, serious matter
22 for us. To be blunt, I would rather be with my daughter today
23 than be here in this room, but I'm here because I'm dedicated to
24 be making sure that others do not face this tragedy.
25 MADD volunteers changed the national culture on drunk

1 driving specifically and traffic safety generally. We've put a
2 face and a name to those numbers. My predecessors accomplished a
3 great deal, the 21 minimum drinking age law, .08 as the national
4 standard, zero tolerance for youth, high visibility enforcement
5 campaigns like the country has never seen before, on the passage
6 of hundreds of state laws that have saved thousands and thousands
7 of lives. MADD drove the interest in these policies and created
8 the environment for political support.
9 We continue to seek enactment of laws and policies that
10 work. Science and data are our guide. We developed the campaign
11 to eliminate drunk driving six years ago as a response to that
12 stalled progress, to look forward and decide how we are going to
13 truly stop this carnage on our roadways based on rigorous
14 scientific evidence.
15 The campaign has three tenants: support of sobriety
16 checkpoints in conjunction with high visibility law enforcement,
17 require all convicted drunk drivers to use alcohol interlocks, and
18 development of advanced alcohol detection technology like the
19 alcohol detection system for safety, or DADSS. You learn more
20 about DADSS when you hear from Bud Zaouk.
21 The campaign has changed the national conversation on
22 drunk driving by making enormous progress at both state and
23 federal levels. In the states, we've passed 16 new all offender
24 interlock laws since the campaign began when only 1 state at that
25 time did so. And we are making great strides on Capitol Hill,

1 with the House and Senate incorporating nearly all of the campaign
2 in their respective versions of the surface transportation bills.
3 I want the legacy of my term as national president to be
4 the further advancement of the campaign to eliminate drunk
5 driving. We have a plan that will wipe out the need for MADD.
6 MADD looks at this forum as an opportunity to work with our
7 partners in highway safety and to eliminate drunk driving.
8 Martin Luther King said, "Human progress is neither
9 automatic nor inevitable. Every step requires sacrifice and
10 struggle, the tireless exertions and passionate concern of
11 dedicated individuals." I'm really proud to say that so many of
12 us who have made the ultimate sacrifice and experienced the
13 suffering of having a loved one killed or injured by drunk driving
14 are passionately dedicated to working until drunk driving is a
15 footnote in our history books.
16 And I'm also proud to share this with you. At our Walk
17 Like MADD, as many people who have not been personally victimized
18 by drunk driving also walked arm in arm with those of us who have.
19 The passionate concern and tireless exertions that Dr. Martin
20 Luther King refers to, of these dedicated individuals, are also
21 evident because they don't ever want to become that someone else
22 who must deal with the hole in their hearts on Mother's Day.
23 Thank you.
24 DR. MOLLOY: Thank you very much, Ms. Withers, for
25 sharing your story.

1 Our next speaker is Dr. Anne McCartt from the Insurance
2 Institute for Highway Safety who will tell us a little bit about
3 what the statistics tell us about the impaired driver.
4 DR. McCARTT: I'm pleased to be here today, and I want
5 to thank the Board for focusing on this important topic.
6 CHAIRMAN HERSMAN: Dr. McCartt, I'm sorry. I think that
7 microphone must be a little temperamental. Can you pull it a
8 little closer to you?
9 DR. McCARTT: Yes. So I'm going to be talking a little
10 today about the profile of alcohol-impaired drivers. I'm going to
11 be talking about a current profile and then how that might have
12 changed over time. I'm focusing on alcohol-impaired drivers
13 because, as you'll hear from Terry, we don't have really good
14 national detailed data on drug driving. And I'm going to focus in
15 particular on data from fatal crashes. We also don't have good
16 national detailed data on arrests and convictions for DUI.
17 So I'm going to be taking a look using the percentage of
18 drivers in fatal crashes who have a BAC of .08 or higher or
19 legally impaired. And here you see just a start, a trend since
20 1982, and the percentage of pedestrians and then different types
21 of drivers who are legally impaired. So if you look at the darker
22 blue line, this is most of the drivers. These are passenger
23 vehicle drivers, and you can see there was a decline that we've
24 heard about through the mid '90s and then progress has stalled.
25 Looking at the lighter blue line, these are

1 motorcyclists. They have a higher rate of impairment. Their
2 decline lasted a little longer, but still if you look at the last
3 decade, things have been pretty flat for them, too.
4 And then finally that yellow line at the bottom, those
5 are large truck drivers. They have very low rates of impairment,
6 largely because they're regulated and required to have BACs of no
7 higher than .04 percent.
8 You might also note, we're not talking about
9 pedestrians, but you can see quite a large percentage of
10 pedestrians are impaired and we've not made much progress in that
11 area.
12 So I'm going to start by walking through several slides
13 that show the rate of impairment of drivers in fatal crashes. The
14 first column will show 2010. That's the most recent data we have,
15 and then the column on the right will show 1996, about 15 years
16 ago and when progress began to stall.
17 And what you'll see as I move through these slides is
18 that really almost hardly anything has changed when we look over
19 the last 15 years, and you'll also see that impairment tends to be
20 associated with other kinds of risk factors for involvement in
21 fatal crashes.
22 So just to start, you'll see, and I think most of us
23 know that males are -- male drivers in fatal crashes are much more
24 likely to be impaired than women. The rate of impairment is
25 highest at ages 21 to 30, followed by ages 31 to 40. And when we

1 look at unrestrained drivers, the rate of impairment is much
2 higher than when we look at drivers who are buckled up.
3 One quick word about age trends. We did make, as you've
4 heard, tremendous progress in the U.S. in focusing on underage
5 drivers. So this is a slightly different age breakdown. The red
6 line are underage drivers, and you can see from 1982 to the mid
7 '90s, they had by far the biggest decline due largely to the
8 minimum drinking age laws and zero tolerance laws. This slide
9 also shows, if you look at that top blue line, those are people 21
10 to 24. They are the highest of any of the age groups in terms of
11 their rates of impairment.
12 So moving to other characteristics of drivers, drivers
13 who don't have a valid license are much more likely to be impaired
14 than drivers who have a valid license.
15 We have information on driving records for three years
16 for people in fatal crashes. So based on this information,
17 drivers who had a prior traffic conviction in three years have a
18 higher rate of impairment than those without a traffic conviction.
19 Not surprisingly, people who had a prior DUI or more than one
20 prior DUI in the last three years have very high rates of
21 impairment compared to drivers who don't, and that is one thing
22 that has improved when you go back and look at 15 years prior.
23 The rate of impairment did not vary in 2010 or earlier, when we
24 look at people with a prior crash in the three years or not a
25 crash.

1 Drivers in fatal crashes on urban roadways have about
2 the same rate of impairment of drivers on rural roadways.
3 The impairment rate for people in single vehicle crashes
4 is higher than for drivers in multiple vehicle crashes.
5 And time is a big factor in impairment crashes. So 44
6 percent of drivers in fatal nighttime crashes in 2010 were
7 impaired versus only about 12 percent at other hours. If you look
8 at single vehicle nighttime fatal crashes, 55 percent of the
9 drivers in those crashes were impaired. And the rate of
10 impairment is also higher during the weekend. About a third of
11 those drivers were impaired.
12 So again what you see is this very consistent profile of
13 impaired drivers and risk factors, such as not being buckled up,
14 often being present with impairment.
15 One last point to make about the profile, we do see a
16 difference among the states and the rates of impairment, and Terry
17 I think is going to talk a little more about this.
18 So the rate of impairment ranges from 14 percent to 31
19 or 32 percent, and there are many things that contribute to these
20 differences. Certainly laws make a difference, but also socio
21 demographics, the nature of the vehicle fleet. But the variations
22 also reflect big differences in the reporting of alcohol in fatal
23 crashes, and I think Terry will talk about this more as well.
24 So the range of known BACs of drivers in fatal crashes
25 goes from 17 to 87 percent. So, you know, obviously a huge

1 difference in states in terms of how well they report alcohol
2 presence.
3 Another great source of information on alcohol-impaired
4 driving and now drugs are national roadside surveys. These are
5 conducted periodically on night, weekends, and for a
6 representative sample of drivers on the roads at those times,
7 alcohol BAC levels and drug presence, beginning in 2007, is
8 detected.
9 So what you see here is the profile of the ages --
10 profiles of BACs by different age groups over these four surveys
11 that have been conducted.
12 Impairment is down a lot. It continues to be down, and
13 I might point out, this does not line up with what you see in
14 FARS. When we look at these roadside surveys, we see a continuing
15 decline in impaired drivers, but again in FARS, we're not seeing
16 that. So that's kind of something interesting to think about.
17 But for all age groups, impairment is down, again, using
18 .08 percent or higher. It's down most for underage drivers. And
19 one thing that's interesting, if you look at these sets of bars
20 and focus on the gold bars, those are people 21 to 24. They're
21 now the highest, the group most impaired, as opposed to 1973, that
22 wasn't the case.
23 We also see for men and women comparable declines in
24 impairment over time.
25 So I'm going to talk just a couple of minutes about a

1 subgroup that people are often focused on, the group kind of
2 referred to as the hardcore. And there's been a suggestion over
3 time that these are really the people we should worry the most
4 about. So the term hardcore was coined to refer to people who
5 drink and drive repeatedly and are resistant to change despite
6 being sanctioned, despite going to alcohol treatment, being
7 educated. And the suggestion is that these are the people that we
8 should focus on; they're the bigger part of the problem; they're
9 becoming an even bigger part of the problem, and that some of the
10 things that work for most drivers, publicized enforcement, for
11 example, haven't been effective.
12 This slide shows trends in different BACs of drivers in
13 fatal crashes over time, and I want to make a couple of points
14 with this slide. The first is when you look at different BACs,
15 you see similar trends. So whatever was working up until the mid
16 '90s was working for the people with a very high BACs as well as
17 the people with lower BACs.
18 The other point I'd like to make, that blue line, these
19 are drivers with BACs below .15. Often the hardcore are defined
20 by people with BACs above .15 or repeat offenders. So if you look
21 at this lower BAC from .08 to .14, those represent about a third,
22 depending on the measure you're using, about a third of the
23 impaired drivers in fatal crashes. So they're not the majority
24 but they're still a substantial percentage.
25 Again, FARS is limited in looking at prior convictions.

1 I have data only for the last three years, but if you look at
2 drivers in fatal crashes depending on whether they have a prior
3 DUI conviction, it's a pretty small percentage of all the drivers,
4 and it's an even bigger -- even smaller percentage if you look at
5 people with two or more prior convictions. So you're missing a
6 lot of the problem if you're focusing, using fatal crashes as a
7 measure, focusing on people who have many convictions.
8 One last point. Again we don't have good national
9 conviction data, but we recently completed a study in Washington
10 State. We were looking at interlock laws in that state, and we
11 did get very good data on convictions over time. So these are
12 counts of DUI convictions in Washington State, and it's broken
13 down into whether the conviction was the first offense -- that's
14 that upper blue line -- or a repeat offense, the lower red line.
15 And as you can see, about three-quarters of the convictions in
16 Washington State were first offenders, and this is typical of
17 other states.
18 So again, people who are first offenders, who I should
19 say are convicted for the first time of DUI, are really the
20 majority of people convicted in most states.
21 So just to close, I was asked to suggest what I think
22 would be the top priority countermeasures. It's kind to hard to
23 pick out the top, but -- these aren't necessarily in the order of
24 importance, but I think one thing that we are increasingly
25 focusing on is expanding requirements for alcohol ignition

1 interlocks to DUI offenders and all DUI offenders, not just repeat
2 offenders or high BAC offenders. And beyond that, we just
3 finished research showing that recidivism would be even lower with
4 interlocks if all people required to get them actually install
5 them. Rates can be -- in Washington, for example, just a third of
6 the offenders actually installed. We think states could do a
7 better job publicizing interlock laws so that they would be a
8 general deterrent to all drivers.
9 The second point is kind of an issue close to my heart
10 starting in New York in 1982 in drunk driving research. There's
11 still just huge loopholes in most states that allow people
12 arrested for DUI to plead out of alcohol to a traffic offense, and
13 typically those traffic offenses would not have those DUI
14 penalties, including interlocks.
15 We believe the use of high visibility sobriety
16 checkpoints and other kinds of enforcement should be expanded, and
17 we're quite supportive of the development of advanced alcohol
18 detection technology, not just to see that technology available,
19 but to begin to build support among the public for how that could
20 really make a difference.
21 And finally, just to show how it might make a
22 difference, we estimate each year the potential lives that could
23 be saved if BACs of drivers were limited to different levels. And
24 so if you look at that first column, those are just eliminating
25 legally impaired driving. You can see if we prevented that among

1 people with multiple offenses we would save about 100 --

2 DR. MOLLOY: Dr. McCartt, if we could just wrap it up?

3 DR. McCARTT: Sure. If we could prevent all drivers

4 from driving impaired, we could save about 7,000 lives a year.

5 DR. MOLLOY: Thank you, Dr. McCartt.

6 Our next speaker is Ms. Terry Shelton from the National

7 Highway Traffic Safety Administration. Ms. Shelton will provide

8 more of an overview of the data and address some of the challenges

9 in collecting good data for impaired driving. Ms. Shelton.

10 MS. SHELTON: Thank you very much, and I want to thank

11 the Board again for having this forum on this important topic, and

12 I also want to thank Jan for putting a face on these statistics

13 that I quote every day but sometimes forget we're talking about

14 real people.

15 So I think most of the speakers before me have kind of

16 given this overview but I wanted to just again present -- I'm

17 going to present information only on fatal crashes and that's

18 because our data is best for fatal crashes. It comes from the

19 Fatality Analysis Reporting System, and we consider a driver at

20 .08 or above impaired. When we count fatalities in alcohol-

21 impaired driving crashes, we're counting any fatality in that

22 crash- the driver, the pedestrian, anybody.

23 Now, I'm going to focus on alcohol, but I want to

24 mention at least one time that drug involvement in traffic crashes

25 is a whole different story in terms of reporting. Although in

1 FARS we do collect information on drug involvement, not
2 impairment, there are just too many variables. There's so many
3 different drugs. We can record up to three drugs on our forms,
4 but that could be a prescription drug; that could be an illegal
5 drug. There's just such a wide range. There's actually 1,000
6 drugs to choose from.
7 Obviously, as the previous panel mentioned, there are
8 testing issues. Separate testing for different drugs are
9 required. They're expensive. So there are a number of issues not
10 just on reporting them to FARS but just at the state level with
11 collecting the data.
12 Now, we've seen this chart a number of times. We
13 started our alcohol collection in 1982 with FARS, even though it's
14 been around since 1975, and the numbers have declined
15 significantly over time. Just comparing 1982 to 2010, in 1982,
16 there were 43,945 fatalities. This is not on the chart. Last
17 year, 2010, the last year we have complete data, we had 32,885
18 fatalities. So just looking at overall fatalities -- again, it's
19 not on this chart -- we've reduced fatalities significantly, but
20 alcohol-impaired fatalities have actually declined more. When we
21 look in 1982 to 2010, there's a 52 percent drop in alcohol-
22 impaired fatalities. But when you look over the last couple of
23 years, as Chairman Hersman said earlier, they have flattened out
24 at about 31 percent of total fatalities.
25 On a state level, there's a number of ways to look at

1 alcohol-impaired driving fatalities. The map on the left shows
2 you just total numbers of alcohol-impaired fatalities by state,
3 where the green are the lower third in total numbers, the middle
4 are the yellow, and the red are the upper third. And as you
5 expect, some of the bigger states have the higher numbers. But
6 when you look on the right side, the map on the right side -- that
7 is per 100 million VMT, which is a common rate we use for
8 measuring different rates in safety -- there's a considerable
9 change. For example, California which has a large number of
10 alcohol-impaired fatalities, when you look at per driving, it
11 changes to the lower third. Several states though still appear in
12 red. Just to point out, Texas, Louisiana, Mississippi, Alabama,
13 Oklahoma and South Carolina, whether you look at total fatalities
14 or rate, they remain in the upper third.
15 I also wanted to mention here some of the challenges by
16 state. I think earlier Jim Hedlund mentioned that for surviving
17 drivers, we have testing rates at just a couple percent up to 90
18 percent. For fatally injured drivers, the testing rates vary by
19 state from 15 to 90 percent. So that's quite a challenge when
20 you're talking about reporting the data.
21 When we look again at the total alcohol-impaired driving
22 fatalities by person type, most often the person killed in the
23 crash is the alcohol-impaired driver. However, this chart is all
24 crashes together, single vehicle and multi-vehicle. So if we took
25 this chart and redid it for single vehicle, for example, the

1 drivers and the passenger in those vehicles would be up around 90
2 some percent. When we look at multi-vehicle crashes, the drivers
3 are actually less than the majority. So in multi-vehicle crashes,
4 more often the deaths occur in non-occupants, occupants of other
5 vehicles.
6 Turning now to the drivers in fatal crashes, not the
7 fatalities but the drivers in fatal crashes, Anne already
8 mentioned this, that 71 percent had no prior conviction and a
9 small percent have some prior DWI or suspended license conviction.
10 I wanted to also mention here that if you did compare these
11 drivers who were alcohol impaired to drivers that weren't alcohol
12 impaired, the impaired drivers were four times more likely to have
13 a prior conviction. So even though the numbers are small, there's
14 definitely a significant difference between an alcohol-impaired
15 driver and a non-alcohol-impaired driver.
16 Just looking at ages, and these -- the blue bars here
17 show total fatalities in 2010, and the red bars show alcohol-
18 impaired driving fatalities, and across the bottom, we have the
19 different ages. It's kind of interesting to note that the age of
20 the drivers really doesn't -- excuse me, the age of fatalities
21 don't really track either alcohol or overall -- I mean, they track
22 the same. In fact, there's a spike at 21 for total fatalities,
23 and there's also a spike at 21 for alcohol-impaired driving
24 fatalities.
25 When we look at drivers in fatal crashes with any level

1 of BAC, and up until now I've been talking only about impaired
2 drivers, there really are some very significant numbers here.
3 Across the bottom we have the blood alcohol concentration values.
4 They range from 0 up to over .45. If you look at the first orange
5 bar, that's the illegal per se or the .08 level, but if you look
6 at the median, it falls at .16, meaning that 50 percent of the
7 drivers in fatal crashes that have BAC over 0 are .16 or above.
8 So double the illegal per se.
9 Now, the reporting rates, as I mentioned earlier, really
10 depend on whether the driver survived or not, and we have enormous
11 challenges here on reporting. And this chart shows over time that
12 there has been some increases in the reporting rates, but if you
13 look at 2009, which is the next to the last bar, and I refer you
14 to that one because 2010 is not totally complete, we have just
15 over 50 percent reporting BAC rates. There are still 40 percent
16 of the drivers that are not tested at all. There's a couple of
17 people that are tested that we can't get the results, and then
18 there are some we don't know if they were tested or not. So we
19 have a lot of work here to do on improving the data.
20 And getting to that point, there's really not a silver
21 bullet for improving the data. Some states have passed mandatory
22 testing laws and that's worked, and other states that passed
23 mandatory laws it hasn't worked as well. Some states have certain
24 roadblocks, some insurance issues that prohibit testing or put a
25 roadblock in front of testing.

1 From the FARS analyst point of view, even though we have
2 a FARS analyst in every state, it's difficult sometimes for them
3 to get the information and find out if the driver -- if the driver
4 is dead, then we kind of know where they are, but if they're taken
5 to a facility for treatment, you may not get that information. So
6 there are a lot of issues in tracking the testing data. We're
7 hopeful that there will be some technology solutions in terms of
8 electronic data transfer in the future that might solve this
9 problem.
10 And I wanted to wrap up that all the statistics I've
11 presented so far were based on known BAC levels and imputed BAC
12 levels. So imputation is a method, a statistical method of
13 calculating values for the missing data. It's well used across
14 many government agencies and researchers. It's a method has been
15 validated. It actually does help reduce our bias.
16 We use related variables when we estimate the unknowns,
17 specifically the vehicle type. As Anne pointed out in her chart,
18 there's wide range by vehicle type and BAC levels. We use 10
19 other variables that are related to alcohol involvement, and the
20 first trigger is actually the police reported alcohol involvement,
21 and that helps us better estimate the values for BAC.
22 And I do have a publication that I'll offer on that, and
23 we have a fact sheet on alcohol that I'll put into the record.
24 Thank you.
25 DR. MOLLOY: Thank you very much, Ms. Shelton.

1 Ms. Darlene Schwartz from the Wisconsin Department of
2 Transportation will conclude this panel with a presentation on how
3 states collect data, and examples and ways the data sources can be
4 integrated.
5 MS. SCHWARTZ: Thank you, and I'd like to thank you for
6 inviting Wisconsin to participate on this forum.
7 I'm going to first start by just giving you an overview,
8 a little bit of a snapshot of Wisconsin and the crash counts and
9 OWI counts that we have up there.
10 To start with, and I'm just looking at a five-year
11 comparison, the crashes are decreasing as the trend shows. Fatal
12 crashes have decreased over 100.
13 Now, if you look at 2011 data, this is all preliminary.
14 We're hoping to close the file within the next month. Fatalities
15 have gone down over 150 since 2007.
16 Alcohol-related crashes, if you look at both alcohol-
17 related crashes and fatalities, they have both decreased close to
18 30 percent since 2007. Unfortunately, the percentage of alcohol-
19 related fatalities has only gone down about 6 percent.
20 Drug-related crashes, they're kind of staying stagnant.
21 They're not increasing but they're not really dropping either.
22 Drug-related fatalities though have increased along with the
23 percentage of drug-related fatalities. It's going up.
24 Our convictions in Wisconsin, we have about 4.1 million
25 drivers, licensed drivers, and close to 590,000 OWIs, at least 1

1 OWI on records. Close to 68 percent of them, or 400,000, have one
2 OWI on the record. That's close to 14 percent.
3 One thing you should note is since January of 1989, we
4 began keeping track of all OWIs on people's records and we're not
5 removing them. They're on for life now. So that number will only
6 grow.
7 Just as a snapshot for one year -- I used 2010 because
8 it will take anywhere from six months to a year before an OWI
9 conviction, before they go to court and we receive the conviction.
10 So we've got about 35,000 OWIs. Again, almost 21,000 were first
11 offense, and we had 759 OWIs that were drug convictions, drug
12 driving.
13 Over the last 5 to 10 years, NHTSA has really been
14 stressing that we need to improve traffic record data by getting
15 it more timely, more complete and more accurate. So we adopted
16 the national model, Traffic and Criminal Software. It's a free
17 software application that the State of Iowa manages, and it's a
18 data collection tool for law enforcement. So right at the
19 vehicle, law enforcement can enter the data into a software
20 application and then send it all electronically.
21 We created both a crash and uniform traffic citation for
22 the State of Wisconsin, because every state has different crashes
23 and citation forms, and we implemented that in 2005. So by these
24 charts you can see since 2005, we are now receiving 82 percent of
25 our crashes electronically and 89 percent of our citations

1 electronically.
2 To show you how the timeliness has improved, just
3 looking at crash data, since in 2005, it took close to 60 days
4 from the date of the crash until the date it hit our driving
5 record or our database. So now, in 2011, it's only taking 10 days
6 on average for the electronic crashes. So now we have a month and
7 a half -- that data a month and a half earlier than we used to.
8 Now I'm going to talk a little bit about how we collect
9 the data in Wisconsin. This is a very high level or a very
10 simplistic view of collecting it. Law enforcement again, they
11 will have TraCS in their squad cars. So if they were to pull
12 someone over for speeding or even OWI, they can look up the driver
13 and vehicle information by using our TIME system. That's a system
14 that just goes and pulls up warrants and driver information and
15 vehicle information. It comes from the DMV, from the driving
16 record and registration files.
17 So that data is then pulled up in their squad car and
18 that data can then automatically be imported into the TraCS
19 software, which then they will just print the citation, hand it to
20 the offender and they can be on their way. The officer will then
21 take that data and, either using wireless or by a thumb drive,
22 submit it to their headquarters where a supervisor will review the
23 data, and then they send the citation information off to the
24 Courts. So it will be sent electronically via a web service.
25 We partnered with our Office of Justice Assistance to

1 create a web service. So this web service, when they send a
2 citation, if it's a criminal citation, it knows to go to the
3 district attorney's office or if it needs to go to a circuit
4 court, it will go there or a municipal court, depending on the
5 jurisdiction of that law enforcement agency.
6 Then the courts, they don't need to reenter any
7 information because it's all there in the record management
8 system. All they need to do is after adjudication just enter the
9 disposition and then they electronically submit that to the DOT or
10 DMV, and at that point, that evening, once we receive the data, it
11 is then uploaded into the driver -- onto the driving record and
12 into our database.
13 So again very simplistic. Simply that's kind of how the
14 data is routed. So it kind of makes a full circle. Once it gets
15 onto the driving record, then law enforcement again is able to use
16 that data. Now, crash reports, they just send directly to DMV.
17 Some different people in projects that we share the
18 data, both crash and conviction data with. Once we have the data,
19 everything is stored in DB2 database and then we create flat files
20 to share that data with whoever would like it. Sometimes there's
21 a small fee, but typically we'll just give it out for research and
22 others.
23 We integrate crash data with CODES, the hospital
24 emergency room data. We have internal data warehouses to analyze
25 crash information. We have a web transportal at the university

1 that engineers will use to improve highway safety. We have a
2 community maps project, which is basically an electronic pin map.
3 We run lots of reports for legislation anytime they're
4 trying to pass a bill or introduce a bill. We run statistics both
5 on convictions and crash to either support or combat the bill.
6 Then many times after a bill has been implemented, they will come
7 back and they want to see what the results are; has that bill
8 really made a difference, or the new law.
9 We also, again, give to research, advocacy groups, NHTSA
10 and other government agencies, different SCRAM projects, the media
11 and the general public.
12 One challenge that we have in Wisconsin is the fact that
13 we don't know what the prevalence of drug driving is. Law
14 enforcement, when they pull someone over, and they go through
15 their normal test along the side of the road, and they go back and
16 they give them a breathalyzer, if it comes up positive for alcohol
17 at .08 or above, they will not then continue and test for drugs.
18 If it doesn't come up to .08, and they feel they are impaired,
19 they will then submit for drug testing.
20 Some of the issues with that, it can take up to 10
21 months before they get the results back for that drug, and we need
22 to send it out of state. I don't believe there are enough
23 resources to get that drug information in an efficient time.
24 There are additional costs. Also the penalties are the same. If
25 they're able to get them for alcohol -- you know, for drug, the

1 penalties are the same. So there is no enhancement for them or
2 advantage for them to test for drugs and not alcohol.
3 So I want to thank you.
4 DR. MOLLOY: Thank you, Ms. Schwartz. That concludes
5 the presentations for Panel 2. We can open it up for questions
6 now.
7 CHAIRMAN HERSMAN: Thank you very much. Thank you,
8 ladies, for your presentations. They were very clear and
9 coherent, and I know we'll have a lot of questions for you.
10 Our Vice Chairman will lead again on this round of
11 questioning.
12 VICE CHAIRMAN HART: Thank you, Chairman Hersman, and
13 thank you for very fine presentations. Those were very
14 fascinating and informative.
15 One of the things that stuck out to me was the amazing
16 variability amongst the states, and I'm just -- I'd like to sort
17 of ask this question to all of you to see if you have any sense of
18 why there's so much variability. I have to assume they're
19 exchanging notes with each other on how to do it, on what's
20 working, what's not working, on best practices, but yet there
21 seems to be an amazing amount of variability. I don't know
22 whether that's scientific or political, some states just have a
23 will to do it and others don't.
24 So I'd just like to throw that out to all of the
25 panelists to see if you have any thoughts on (a) why is there so

1 much variability; and (b) what can we do about it to try to make
2 the best practices the prevailing practices?
3 DR. McCARTT: I'll go first. I think there are several
4 factors. I think undoubtedly some states have much stronger laws
5 than other states. If you look at interlock laws, for example,
6 there are now 17 states, I believe, that require interlocks for
7 all offenders. Some don't mandate interlocks for any offender.
8 So laws definitely make a difference.
9 But I think there are other -- and enforcement would be
10 another one. Not all states, for example, can conduct sobriety
11 checkpoints. Some are prohibited by doing so either by their
12 state constitution or state law, but I think there are other
13 factors that are harder to measure. In a state like New York, for
14 example, where I live, a lot of the state, Downstate, has access
15 to public transportation. Some states have different, you know,
16 different populations, more young people, for example. So I don't
17 think it's only a factor of laws.
18 And I think the other issue which I mentioned, and
19 Terry, too, is that states' reporting varies. So it gets tricky
20 to be sure, when you're looking at differences in the rates of
21 impairment, that some of what you're seeing is not just that 17
22 percent of the drivers, for example, in fatal crashes have alcohol
23 reporting.
24 MS. WITHERS: I would also like to talk about the
25 political issue. It's been my experience that the politics in

1 different states very significantly, and the politicians, and it's
2 according to what their background is. If they're defense
3 attorneys, whatever, will make a difference in how they decide on
4 the legislation.
5 The one thing in my experience that I notice makes it
6 universal across the country is when there's federal legislation.
7 And it worked in underage drinking law and it worked in .08, where
8 in federal legislation only when there was a sanction placed on
9 the states -- not even incentives, were strong enough, but
10 sanctions placed on the states by the federal government that it
11 became universal and uniform across the country.
12 VICE CHAIRMAN HART: Very interesting. Anybody else who
13 would like to chime in on that one?
14 MS. SHELTON: Just that, you know, there are a couple of
15 issues. One is for fatally injured drivers, the testing rates are
16 much higher, so -- overall, there's still a wide variation. For
17 surviving drivers, that's where you see kind of the lower rates
18 across states, and there's just logistically, as Darlene pointed
19 out, there's -- logistically, tracking information differs from
20 state to state. If they have electronic tracking or if the driver
21 is taken to one facility or if the driver is not even injured,
22 trying to make sure you get that information, it just -- it
23 depends on the state and how they record information and that
24 varies widely by state. Even though we try to put together some
25 guidelines for uniform reporting on many variables, how they

1 report the data differs widely.

2 MS. SCHWARTZ: One quick comment. I agree with Anne

3 and, you know, the laws are different. I know Wisconsin was one

4 of the last states to adopt to the .08 per se, and I'll be honest,

5 that has a lot to do with our culture up there, and everything

6 that goes on, it seems like alcohol seems to be involved with it.

7 And so it's -- I think it's going to be a -- it'll take a lot to

8 change culture. You just can't do it overnight. But I think

9 there is differences from state to state.

10 VICE CHAIRMAN HART: So am I correct that they are

11 exchanging notes a lot; it's just that they are going back home to

12 different environments and don't necessarily have the capability

13 to do the same thing with those notes they're exchanging?

14 MS. SCHWARTZ: Correct.

15 VICE CHAIRMAN HART: So then what we can do about it,

16 Ms. Withers mentioned the federal legislation that helped

17 certainly in this, and we've seen it with .08, but any other steps

18 that we can pursue at this point that would help to make the best

19 practices the prevalent practices?

20 MS. SCHWARTZ: I guess off the top of my head, I don't

21 know offhand. I can't say.

22 DR. McCARTT: One suggestion I might have in terms of

23 the data is to get -- to require states to do better at reporting

24 arrest and conviction data. That would allow more state

25 comparisons, and that's a way of shining a light, you know, on the

1 good and the bad states to see how well their systems are working
2 in terms of convicting, conviction rates, for example, testing
3 drivers for -- testing alcohol of drivers.
4 So sometimes data sounds boring, but it's really
5 important, I think, when you get into comparing states, that if
6 you don't have the data, you really can only speculate about some
7 of the effects of the laws.
8 VICE CHAIRMAN HART: Has the federal government ever
9 gotten into that arena of more uniformity in reporting?
10 MS. SHELTON: I'll have to defer to some of the
11 panelists that are going to be here tomorrow for that.
12 VICE CHAIRMAN HART: Okay. And then just a general
13 question that I asked of the last panel is that I don't have a
14 good sense of the rate of consumption of alcohol in the U.S.
15 population. It just seems to me that it's not as much as it used
16 to be, but that's one of the overlays that I don't see in terms of
17 -- you know, we see what happens after -- you know, what the crash
18 involvement is, but I don't have a sense of the actual consumption
19 rate of alcohol in the American population. Does anybody have any
20 sense of that or place I can go to find that? I don't even know
21 where to go look for that. I don't see it anywhere. Anybody have
22 any thoughts on that?
23 MS. WITHERS: I think the concern about the rate of
24 consumption, as we're here in this forum and what we're concerned
25 about, are fatalities or injuries or impaired driving on the

1 roadways, and that hasn't decreased, or that's why we're looking
2 at different avenues in order to decrease it because that's our
3 issue right there.
4 VICE CHAIRMAN HART: Right.
5 MS. WITHERS: We know that there's more awareness and
6 there's less excuse for driving impaired, but that doesn't mean
7 that the rate still isn't very high.
8 VICE CHAIRMAN HART: Right. Any other comments on that
9 one?
10 Well, again thank you to the panelists for taking time
11 out of your busy schedule to come and help us with this difficult
12 and complicated issue. I relinquish the remainder of my time.
13 Thank you, Chairman Hersman.
14 CHAIRMAN HERSMAN: Member Sumwalt.
15 MEMBER SUMWALT: Thank you very much. I think one thing
16 that Dr. McCartt and Ms. Shelton pointed out is that the
17 rhetorical question is, are we focusing too much on the hardcore
18 drinking driving? I remember -- basically I've had that question
19 for the 5½, almost 6 years that I've been at the Board. And we
20 had a most wanted list that we re-engineered about a year ago, but
21 one of the issues on there was eliminate hardcore drinking
22 driving.
23 I remember going on an advocacy trip with Ms. Roeber to
24 South Carolina, and asking that very question, why are we focusing
25 only on the hardcore drinking driving? I think in round numbers

1 about 60 percent of the accidents involved hardcore drinking
2 drivers. Yeah, let's target that, but that means that's there's
3 40 percent that are not the repeat offenders or the hardcore
4 drinking drivers. So I'm glad that you raised that point. I hope
5 that moving forward this Agency can put the focus on the broader
6 view of the whole problem, the total problem and not just the
7 hardcore drinking driving.
8 I think you mentioned in one of the slides -- I think
9 Ms. Shelton had, slide 7, showed that 71 percent of the drivers in
10 the FARS database had no prior DUI. So that in itself is fairly
11 compelling.
12 While we've got that slide up, let's move two slides
13 towards the beginning, slide 5, if we could pull that one up, and
14 there it is right there. I am concerned about all the states.
15 South Carolina is one near and dear to my heart, and that's where
16 both of the fatalities that I mentioned earlier occurred involving
17 people on either side of my family that were cousins. So I look
18 at South Carolina and 32 percent of the drivers in that state
19 involved in fatal crashes were impaired in South Carolina. That's
20 on the high end of the fatalities.
21 But then I look at Georgia, which is green, that's the
22 lower third, and to the north of South Carolina, we have North
23 Carolina. All three of these states are basically similar
24 socioeconomic conditions. They all basically involve the same
25 population demographically speaking. Rural roads are predominant

1 throughout each of those states. So I want to know why is the
2 difference? Why are two states, right next to each other, why is
3 one in the upper third, one is in the lower third and one is in
4 the middle third?
5 And so, Ms. Shelton, since that's your slide, I'll let
6 you take a shot at that and then we'll hear from Dr. McCartt and
7 Ms. Withers.
8 MS. SHELTON: Well, I don't have an answer for you,
9 unfortunately. You know, the states differ. We talked about the
10 laws differ. The environments differ. The testing rates differ.
11 There are just many variables that contribute to the situation,
12 and I don't know that there's a single thing we can identify, and
13 I really -- I would like to look into that more before trying to
14 answer.
15 MEMBER SUMWALT: Well, and I'm going to contend that the
16 environment, if we're talking about the physical environment,
17 probably is not tremendously different between those states. The
18 same topography. If anything, North Carolina has more mountains
19 than South Carolina, and yet they're in a little bit lower
20 category. So I think those are the kinds of things we need to
21 study there. I suspect that politics has a lot to do with it,
22 having gone and spoken to some of the politicians in that state,
23 which is my home state, but we need to figure that out. Why are
24 those differences? We want to move all the states towards the
25 green.

1 Dr. McCartt, do you have a thought on the same question?
2 DR. McCARTT: I think it's a great question, actually,
3 and I would look at the laws, and I don't know the laws in these
4 three specific states. I know that North Carolina by tradition
5 has been, they had a very strong, a very successful anti-DUI,
6 highly publicized campaign that other states have used as an
7 example. So I would look at the laws, and I suspect that the laws
8 differ and the level of enforcement differs in these states.
9 MEMBER SUMWALT: Well, and, yeah, we need to study that.
10 Ms. Withers, I only have about 12 seconds. So if you
11 could just give us a quick answer if you have thoughts on this?
12 MS. WITHERS: Well, I agree. I think it's the
13 countermeasures that are in those various states and how they're
14 enforced. We know that ignition interlocks for offenders with --
15 only a repeat offender or with a high BAC is ineffective in
16 states. Only ones for all offenders are effective. So it varies
17 with the countermeasures.
18 MEMBER SUMWALT: Thank you. And here's what I'm going
19 to charge staff to do, is I'd like to see a side-by-side
20 comparison of the laws in each of those three states since all
21 three of the panelists who answered that seem to think that the
22 difference is in the laws. So let's take a side-by-side look at
23 those.
24 Thank you very much.
25 CHAIRMAN HERSMAN: Member Weener.

1 MEMBER WEENER: Thank you. I have an interesting
2 observation, I think, from Dr. McCartt's chart number 2.
3 Nicholas, could you put that up?
4 The bottom line strikes me from the perspective of the
5 similarity to commercial transportation and aviation. The airline
6 operations are considerably safer than the general aviation
7 operations and those operations are conducted by professional
8 crews, so that's a very low accident rate. And I see the same
9 thing here; commercial truck operators, a very low rate.
10 The other thing that strikes me is the number of
11 pedestrians, the percentage of pedestrians that have been struck
12 and I guess I make the observation that it's probably safer to
13 drive home from the bar drunk as it is to walk home from the bar
14 drunk. I wasn't aware that pedestrians were hit in that kind of
15 rate.
16 The next data chart I'd like to talk about for a moment
17 is Ms. Shelton's chart number 4, which is a chart of alcohol-
18 impaired driving fatalities, both the number and the rate. And
19 we've had some discussion about the rate being flat over a period
20 of about 10 years from the mid '90s to about 5 or 6 years ago. So
21 if you look at the red line, the rate, is there any understanding
22 as to why the rate was flat during that period?
23 MS. SHELTON: Can I make a correction here? The rate
24 I'm showing on this chart are the total alcohol-impaired driving
25 fatalities divided by the vehicle miles of travel. The rate that

1 Chairman Hersman referred to in the beginning that's remained flat
2 are the percent of fatalities that are alcohol impaired per total
3 fatalities, and that number is shown on the chart as 31 percent,
4 but that rate line that's actually visible on the chart is the per
5 VMT rate. So I just want to make sure we have clear what you're
6 looking at there on the chart. But, in fact, that 31 percent has
7 remained fairly flat since the last 15 years or so.
8 MEMBER WEENER: Okay. But the rate chart, over the last
9 5 or 6 years, indicates about a 25 percent decrease in the rate.
10 MS. SHELTON: Right. If you --
11 MEMBER WEENER: That's fatalities per 100 million
12 vehicle miles --
13 MS. SHELTON: Correct.
14 MEMBER WEENER: -- traveled, right?
15 MS. SHELTON: Correct.
16 MEMBER WEENER: Is there any insight as to why we've had
17 a period of stability followed by, in the past 5 years, a decrease
18 in the rate?
19 MS. SHELTON: Well, I'd like to say that it's due to
20 increased awareness, enforcement, all the aspects. Certainly the
21 alcohol-impaired driving tallies over time have decreased more
22 than overall fatalities, but in recent years both are riding down
23 together in a sense. I mean, overall alcohol-impaired driving
24 fatalities and fatalities are going down together. It's just the
25 percent of those seem to remain the same and I really don't have a

1 good explanation for that.
2 MEMBER WEENER: Okay. That would imply then that the
3 reasons for the decrease apply to fatalities in general in the
4 same way that they apply to fatalities related to alcohol.
5 I think the number we've talked about before is about 30
6 percent of the fatalities are due to alcohol-related, and if my
7 memory serves me right, about 9 percent is due to distractions.
8 What makes the other 60 percent? You know, assuming that we have
9 restricted resources to put on the problem, and we focus on
10 impaired driving, what are we missing in the other percent, 60
11 percent that we're not addressing?
12 DR. McCARTT: Speed is -- a third of deaths, year after
13 year, involve speed or speeding.
14 MEMBER WEENER: A third are speeding?
15 MS. SHELTON: If I could add, those are not mutually
16 exclusive. In other words, a crash can involve alcohol, speeding,
17 distraction. It's not -- we're not necessarily saying that the
18 alcohol was the only cause or factor in the crash. It could be a
19 combination of factors. So it's not quite as simple as saying a
20 third are this and 60 percent are something else. It's confounded
21 by a number of issues.
22 MEMBER WEENER: All right. Very good. Thank you. And
23 thank you for the data.
24 CHAIRMAN HERSMAN: Member Rosekind.
25 MEMBER ROSEKIND: Just to show my memory's working

1 across meetings, Member Weener always likes to go for the big
2 bars, and I think your point is very well taken, in the case of
3 roadway safety, those bars are not pure, and if anything --
4 actually my first question is what other kinds of -- you've each
5 talked about it a little bit, I'm curious from all of you on the
6 panel, what other data do we need that's going to help us
7 understand not just this problem but where to focus our actions?
8 DR. McCARTT: I think we need better data. I've said
9 this about sort of the system within states, convictions and
10 arrests, and how that would help us figure out better than we can
11 now which laws work better than others. And I think we have a
12 huge hole with what we know about drugged driving.
13 If you want to think about why things have been flat in
14 impaired driving, I think some of it is the complacency, having a
15 hard time keeping energy up to address drunk driving, but I think
16 some of it lies in people having multiple risk factors: so people
17 who don't buckle up, who tend to speed, who are young, also tend
18 to be impaired. But I think the other unknown is drugs, and the
19 more we're having crashes where drugs and alcohol are present, but
20 we're just really beginning to get an understanding of drugs. I
21 think if we understand drugs better, we'll actually understand
22 alcohol impairment and the role it has in crashes better.
23 MS. SHELTON: I agree with Anne. If we can get more
24 data on drugs. Right now it seems like the impaired drugs are
25 increasing. Unfortunately the resources for that is not

1 increasing. You know, just trying to have more outlets where, you
2 know, drugs can be tested so it doesn't take 10 months, you know,
3 or even 6 months, if we can get that back almost as quickly as we
4 can for alcohol, I think law enforcement would be more apt to also
5 test for drugs so we can get a better handle on that.
6 MEMBER ROSEKIND: And can anybody just add, and
7 Dr. McCartt started this, but other metrics? People focus on
8 fatalities. You started with arrests and other things. I mean
9 what -- you know, usually it's a big pyramid; everybody looks at
10 this piece but it's everything underneath. In this arena, what
11 other data sources, what other metrics should be collected to get
12 a sense, not just of the problem, but when interventions are being
13 evaluated, how do we have evidence-based data if we don't have
14 good evidence in the first place? What other kinds of things
15 should we be collecting?
16 MS. SHELTON: Well, I certainly -- you know, we're
17 limited at NHTSA with our FARS data in terms of alcohol and drugs.
18 We don't have that information, for instance, at the state level
19 for injuries or any other lower level crash. It certainly would
20 be a large expense to suggest that we test every single driver
21 involved in a crash for drugs or alcohol so I think we have to be
22 slightly selective. But I think to move forward, I think it would
23 be very helpful to understand at least serious injury crashes and
24 data related to those, and maybe that can be done in some states
25 or with a different methodology than a national collection program

1 like we have with FARS.
2 MEMBER ROSEKIND: Ms. Withers, this one is specifically
3 for you. There's been an interesting discussion about the numbers
4 and that's kind of hitting, you know, a flat line here for about
5 15 years and the word complacency has been thrown around a lot,
6 but my two questions to you are: You know, from where you sit,
7 what do you view as sort of what the ingredients have been to that
8 complacency over the last 15 years? And what things do you think
9 need to be done now to address that?
10 MS. WITHERS: I believe that the complacency about this
11 is that people continue to drive drunk or drive impaired because
12 they can. It's just that simple. We still let them do it. And
13 so that is exactly why MADD went back to the drawing board. It
14 was so frustrating for me a few years ago, I just wanted to
15 scream. I felt like all this work and we're still just getting
16 the same numbers. So that is why MADD went back to the drawing
17 table, to look at the research, the data, and only focus on what
18 is effective.
19 So alcohol ignition interlock for all offenders is
20 effective. That's really a powerful number. In Arizona and
21 Oregon, they've reduced their fatalities by over 50 percent and,
22 of course, that's just for people who have been convicted of drunk
23 driving, but we still have people who have not, and people drive
24 80 times -- that's a conservative number -- before they're ever
25 first caught driving impaired. So that's why I'm excited about

1 the advanced technology that is coming forward, and we'll hear
2 about that later, but the DADSS program is very exciting because
3 then a person will just be in the driver's seat and the car will
4 accurately detect how much alcohol is in their system and not
5 function if they're above .08.
6 MEMBER ROSEKIND: Great. Thank you.
7 CHAIRMAN HERSMAN: Thank you. Nicholas, can you be
8 ready to pull up a couple of slides? The first one I'm looking
9 for is the roadside survey slide from Dr. McCartt, the Voas slide.
10 It doesn't have a number on it.
11 Dr. McCartt, I wanted to ask, how these roadside survey
12 collections are done? Since we've talked in the last panel that
13 we can't compel anyone to take a breath test and a random check at
14 the roadside, how do you actually get good information and are
15 these numbers masking the problem because people have to volunteer
16 or something?
17 DR. McCARTT: There have been four surveys slightly
18 differing in the methodology. The last one was conducted by
19 NHTSA. But it's based on a national representative sample of
20 sites. Drivers are pulled over and asked to volunteer to give --
21 to do a breath test for alcohol, and then in the last survey, some
22 were asked to actually either give blood for a drug test or
23 saliva, and the compliance rates were actually quite high, quite
24 surprisingly high. And in the last survey, a larger percentage
25 did refuse, but the researchers did some follow up and were able

1 to establish there weren't too big of differences between those
2 who refused and those who didn't by using something called a
3 passive sensor, which is a device that can just be held near the
4 driver and can pick up -- it's not as precise as breath testing
5 equipment, but it can pick up whether or not the person, you know,
6 is impaired, has a positive alcohol.

7 So I think these are good surveys. There's certainly --
8 you can never account totally for people who refuse to be tested,
9 but there -- I think they are by far the best information we have
10 on what's happening out there on the road as opposed to what's
11 happening in crashes.

12 CHAIRMAN HERSMAN: Okay. And I apologize because we
13 have limited time. I have a couple of follow-up questions. Can
14 we actually pull up Ms. Schwartz's slide that has to do with the
15 Wisconsin convictions, and it's slide number 4.

16 So -- and we've heard Ms. Withers talk about you can
17 drive 80 times before you get caught drunk. So here we have just
18 one state. Looking at Wisconsin's convictions and their total
19 numbers, and I'm not the best at math, but I think when we look at
20 the total numbers of drivers, licensed drivers, and then the
21 number of drivers with a conviction, with an OWI on their record,
22 it's about 14 percent of your driver population. That is
23 astounding to me. If we look just in this room and look at 14
24 percent of the people, I think we can understand why there's so
25 much objection to trying to stiffen up these laws if we've already

1 got this many people convicted.

2 And so, Ms. Schwartz [sic], I was wondering, is this
3 Wisconsin data consistent with the data from the rest of the
4 country with respect to what we see for the number of total
5 drivers versus the numbers with a conviction on their record?

6 MS. SCHWARTZ: Well, I only have crash data. Is this
7 crash data? Yeah. This may be a little high because some of
8 these OWIs that are on people's driving records, they technically
9 do not have a driver's license. Unfortunately, we have a lot of
10 individuals who will drive without a license.

11 CHAIRMAN HERSMAN: Sure. And that's okay, and these
12 aren't fatalities --

13 MS. SCHWARTZ: No.

14 CHAIRMAN HERSMAN: -- but I think this goes back to the
15 kind of earlier chart that Dr. McCartt had shown about the
16 perceptions and what's changed, and we're talking a lot about the
17 data and seeing the numbers come down, and even though we are
18 frustrated that the percentage is remaining stagnant, we have seen
19 a huge decrease in the number of fatalities overall, and I think
20 what this is demonstrating to us is there's a lot of interdiction
21 going on. There's intervention. There's people who are being
22 pulled over. There's people who are making it through the system
23 with -- these are convictions on someone's record whether or not
24 they killed anybody or not, these people who have been pursued
25 through the process. But I think it's a sad state of where we

1 are, is if you can drive 50 times or 80 times, depending on whose
2 numbers you want to use, before you get caught, and we've still
3 got this many numbers here.
4 So I wanted to ask you all about data because we know
5 about the FARS data, the .08 and higher, and we know about
6 convictions when you get a per se conviction. What do we know
7 about the fatal accidents that involve drivers who have some blood
8 alcohol level but it's below .08? How many fatal accidents
9 involve a driver that does have a measurable amount in their
10 system but they're not illegal and they can't get a conviction
11 that way? Do we know?
12 MS. SHELTON: Well, if you look at slide 9, that showed
13 drivers above 0 BAC. There are represented on that slide, and
14 this is for 2010, 11,432 drivers in fatal crashes with BACs over
15 0, some positive amount. The ones at .08 and above, I believe,
16 was 9,694. So we do have a couple thousand drivers that fall
17 below, and I don't have a breakdown as Anne did for all the
18 different characteristics, but it's certainly something we could
19 have for you.
20 CHAIRMAN HERSMAN: Okay. So as Member Sumwalt was
21 talking about, we capture the majority at high BAC. There's still
22 a section that is at a, you know, illegal BAC, but then there's
23 still another piece of it that either isn't detected, isn't
24 reported, isn't tested, that could be at an even lower, be it
25 below the illegal limit. Is that correct? You're reporting it

1 some 2,000.

2 MS. SHELTON: Right, for 2010, there were about a couple
3 of thousand below the .08 level, that we have -- we have test
4 results, but I don't have the breakdown, you know, how do they
5 differ from the other ones.

6 CHAIRMAN HERSMAN: Sure. Okay. So let me ask you all a
7 question about the impairment issue. Dr. Hedlund said that for
8 people who didn't test positive for .08 or higher, to get the
9 conviction and then had a subsequent follow-up drug test because
10 law enforcement identified them as impaired, 50 percent of them
11 showed up drug positive. And so here we have also a situation
12 where we don't know what we don't know because a lot people are
13 not being tested so we're having a different level of impairment
14 -- and I think, Ms. Schwartz, you talked about this, too, we don't
15 know; there could be more out there. What do we need to do to
16 address that issue?

17 MS. SCHWARTZ: I think part of it would -- laws would
18 have to be changed because right now there's no difference in
19 penalty. If we can get them for the alcohol, law enforcement will
20 test that way, and if they're positive, then they charge them with
21 that. If it's below that legal limit of .08, and they feel
22 they're more impaired than that, they will test for drugs. But
23 again, I think some laws would have to be changed to get law
24 enforcement to test for drugs.

25 CHAIRMAN HERSMAN: Okay. Are there any laws that serve

1 as a deterrent to testing? And I want you all to think about this
2 not in a specific way about the issue that Ms. Schwartz just
3 mentioned, but I've been to an accident, and it was actually a
4 boating accident where there was intoxication, and it was very
5 surprising to me when there was very clear evidence in the boat, a
6 lot of alcohol, the first responders saw it, that we actually had
7 a boat operator that was not automatically tested for alcohol upon
8 admission to the hospital. And so help me to understand if there
9 are any procedures or policies or laws that serve as a deterrent
10 for getting these tests?
11 MS. SCHWARTZ: Can I speak quick? In Wisconsin, prior
12 to just a year or so ago, even in a fatal crash, if there was no
13 probable cause to test the surviving driver, law enforcement could
14 not test. Now our law has just changed that now if there is a
15 death or great bodily harm, that law enforcement could test if
16 they violated a law. And if there's substantial injury, they are
17 now allowed to test if they see reasonable -- if they see -- if
18 there's alcohol -- yeah, I'm not coming up with the words right
19 now. But if they see either drugs or alcohol, maybe it's now
20 probable cause. So there were limitations that law enforcement
21 could not just test.
22 MS. WITHERS: That's reasonable suspicion; isn't that
23 the phrase? Reasonable suspicion and then probable cause.
24 In my view, when we're talking about drugs and alcohol
25 together, the only deterrent I would see is to have every state

1 require that blood be taken and tested for every crash, literally,
2 so we would know. And, of course, in our freedom of rights, you
3 know, in America, that's a very difficult thing that I don't know
4 if it will every happen, but that's literally what would be
5 required in my point of view.
6 CHAIRMAN HERSMAN: Dr. McCartt.
7 DR. McCARTT: Another issue in terms of testing is some
8 states have much stronger laws encouraging people not to refuse
9 the test. Obviously this wouldn't pertain if a driver's died, but
10 for surviving drivers, and then when people are arrested, a lot of
11 states have, for example, the penalties for refusing the alcohol
12 test are actually greater than taking the test and flunking it,
13 and some states even make it criminal to refuse the test, and
14 those laws are quite effective in encouraging, as you can imagine,
15 encouraging people to take the alcohol test.
16 CHAIRMAN HERSMAN: One issue that you all haven't
17 brought up that was raised to me when I had asked the question of
18 the Florida authorities about why it didn't happen, was that they
19 had had some recent legislation passed about their healthcare
20 system and how reimbursements occur, and that there was a
21 prohibition on insurance providing some reimbursements if there
22 was an at-fault type of issue. And so hospitals were reluctant to
23 actually test people that they knew were going to show up positive
24 because it would create challenges for them with respect to cost
25 recovery and billing. Has anybody else heard of this?

1 Ms. Shelton.
2 MS. SHELTON: Yes, I've been told that's one of the
3 challenges, that insurance mandates result in medical facilities
4 not testing injured drivers. And certainly when you're talking
5 about drug testing, there can be very costly tests. As Darlene
6 pointed out, it can take months to get results and that sort of
7 thing. So there are other issues, too. And just requiring the
8 testing, we have to know what we're going to test for in a lot of
9 cases and determine what levels. As Dr. DuPont said earlier,
10 there isn't an absolute level for all the different drugs and
11 there are thousands of them, so.
12 MS. WITHERS: And my only thought to that is make sure
13 that law enforcement is doing the testing in addition to the
14 hospital.
15 CHAIRMAN HERSMAN: Thank you all so much and, again, I
16 think we've probably left a number of questions on the table, but
17 we really appreciate being able to talk with you all this morning
18 and get this information out there.
19 This afternoon, we're going to have three panels, and so
20 we are going to break for lunch. You saw during the break that we
21 had some PSAs and some other things running. Those will continue
22 to run during the breaks for the conference, but I would encourage
23 you to get your lunch and bring it back to the Board Room. We
24 don't usually let people eat, but I think we'll have a special
25 exception today, here in the Board Room. To commemorate the

1 anniversary of the Carrollton accident, there is a documentary
2 that's being developed in preparation for the 25th anniversary and
3 Harold Dennis, who is a survivor of the accident, is going to be
4 here, and he is going to show a trailer for that video, and answer
5 questions, and the special program is going to start at noon and
6 will end at 12:45. We will resume our proceedings at 12:45. We
7 stand adjourned.
8 (Whereupon, at 11:42 a.m., a lunch recess was taken.)
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1 A F T E R N O O N S E S S I O N

2 (12:50 p.m.)

3 CHAIRMAN HERSMAN: Welcome back. Ms. Davis, will you
4 please introduce the third panel, please?

5 MS. DAVIS: Our first panel this afternoon will explore
6 the role that education and outreach play in changing impaired
7 driving behavior.

8 Mr. Michael Brown, from the National Highway Traffic
9 Safety Administration, will open the panel with a discussion of
10 media campaigns previously and currently used and provide
11 information on their effectiveness. Mr. Brown.

12 MR. BROWN: Thank you, and good afternoon, Chairman and
13 Members.

14 If I could real quickly, Member Sumwalt, you mentioned
15 earlier about a personal tragedy in impaired driving, and I think
16 it's important for me at this point to also recognize the
17 importance of that kind of a statement, and it said a lot on the
18 issue of impaired driving.

19 I'm named after a grandfather who I never met who was
20 killed by a drunk driver, and in my prior life, I also am very
21 much aware and remember fondly and very strongly, the impact I had
22 on the first time I made a death notification as a young officer
23 on break-in, and it was because of a drunk driver. So I'm very,
24 very much aware of that. I think many, many others, not just in
25 the room, but across the nation are as well.

1 So having said that, I'll go real quickly through some
2 basic stuff that we're trying to do in terms of outreach and
3 community outreach and communications, and then what I'd like to
4 do, if I could, is talk a little bit more about some of the
5 philosophical issues we have regarding high visibility enforcement
6 in a general sense, and the messaging that we use or seem to see
7 across the country.
8 Real quickly, we have a number of education programs.
9 We have, for example, an impaired driving program offered through
10 the Traffic Safety Institute out in Oklahoma City which we make
11 available to practitioners and people that are interested in this
12 type of issue. We also have a number of things that we do for
13 specific types of topics. For example, we have a cooperative
14 agreement with TIRF to do ignition interlock training and
15 workshops across the country as well.
16 But a great deal of our stuff in the area of research
17 and case studies that we have available and make available
18 passively through our website. We also have programs and resource
19 guides, for example, community guides to deal with the issue of
20 youth access to alcohol as it applies to impaired driving.
21 We also have tool kits, a number of them. Most recently
22 the one that seems to be the most impressionable upon a lot of the
23 practitioners is the No Refusal Tool Kit, which we released a
24 little over a year ago, and that's taking some traction across the
25 country, which basically is a means to get a blood test even

1 though you have a refusal.

2 These are things that we do in terms of programs at
3 NHTSA to try and educate, again, practitioners and the community
4 on opportunities and alternatives by which they may be able to
5 address their local issue.

6 And again, a lot of it goes through our website, and
7 this is an example of what we could pull down, for example, and
8 research. We have a searchable database which allows individuals
9 who want to look at actual data, numbers and studies that we've
10 done in terms of the impaired driving issue, they can pull down
11 information directly that's current and also go back into our
12 archives which are available online as well.

13 One of the things that we spend a lot of time doing is
14 pushing out issues on impaired driving alone. One of the tags
15 under the website is the impaired driving section, which in this
16 case here talks about April 2012 being Impaired Driving Month, and
17 in that we have a number of different programs that we have
18 scheduled during the month and again throughout the year.

19 Of those, you'll probably know that we have several that
20 deal specifically with the issue of crackdowns, and part of that
21 is the crackdowns that we do over Labor Day and the crackdowns
22 that we do over the holiday season in December of each year.

23 This is our traditional outreach program which is the
24 high-visibility enforcement program. It requires several
25 elements, and one is publicity. In other words, a visible message

1 that's out there and then, secondly, a visible enforcement
2 presence. This gets back to what was discussed earlier this
3 morning with regards to that perception of fear or the perception
4 of fear of prosecution or jeopardy, and it's a social control
5 model, if you will.
6 We do that through a number of partners. For example,
7 we have the state highway safety offices. Every state has a state
8 highway safety office, and you'll hear from a representative of
9 the Governor's Highway Safety Administration later on in your
10 agenda which they'll talk about their role. We do it through law
11 enforcement. We work with prosecutors and judges and federal
12 agencies and all these that are listed up there.
13 We have means of producing information and sending it
14 out to them to keep them current on issues regarding impaired
15 driving. One of our best marketing vehicles in terms of
16 information sharing on impaired driving goes through what we call
17 the LELs, JOLs and TSRPs. And those acronyms stand for law
18 enforcement liaisons that we have which are within almost all the
19 states at this point, at one level or another. We have them in
20 all of our 10 regions, and they work with police and sheriffs
21 across the country in dealing with this and other issues. We have
22 seven judicial outreach liaisons. These are retired judges who
23 are actively engaged and are working with their colleagues and
24 peers in trying to share information on impaired driving, and then
25 we have the traffic safety resource prosecutors which are in 47

1 states across the country, and also we have a cooperative
2 agreement with the National District Attorney's Association, the
3 ability to give information on impaired driving issues to them as
4 they get ready for trial and things of that nature.
5 So there's a lot of things that go on in outreach. And
6 part of that also goes to the point that we push information out
7 through these partners. For example, every other month we push
8 information out to the sheriffs and the police chiefs, especially
9 the small agency chiefs through the State Association of Chiefs of
10 Police, which means that they actually get some information on
11 their desktops through their own, you know, personal e-mail at
12 work so that they can know exactly what's taking place and get
13 some kind of idea what trends are developing and everything else
14 with regards to impaired driving.
15 I want to spend a little time if I could talking about
16 communications. We have principally two messages, and I know this
17 came up a little bit earlier. The big issue for us now, the
18 message for us is to Drive Sober or Get Pulled Over. This we
19 introduced last year. This is the invisible cop type concept
20 where you have an individual that kind of blended in and it was
21 that sense of omnipresence with the officer being there, so don't
22 drink and drive.
23 That replaced, if you recall, Over the Limit Under
24 Arrest, and I know there's some interest by some of the members
25 with regards why we changed that. One, we had run it for a number

1 of years, and sometimes things get stale. Secondly, there was a
2 lot of good issues raised with regards to the whole issue about
3 being over the limit and under arrest. As you've heard from some
4 of the earlier testimony, you don't necessarily have to be over
5 the limit to be under arrest and/or successfully prosecuted.
6 So this message is a little cleaner. Basically drive
7 sober or get pulled over, and with that presence of mind at some
8 point, we might be able to get some kind of perception or fear
9 that they might be, you know, prosecuted if they are, in fact,
10 impaired.
11 The second message is Buzzed Driving is Drunk Driving.
12 This we worked -- it's a social norming message that we've worked
13 out with the Ad Council. We've worked with them for a number of
14 years on that. You probably have seen that, and we use both
15 messages. The social norming normally comes through when we're
16 not doing the high visibility enforcement message.
17 These messages are available, as are other planning
18 materials, on a website we have which is called
19 trafficsafetymarketing.com. We invite people to use them. We
20 give license to incorporate and input their own slogans into them
21 on many occasions. We try to get the states, in particular, to
22 push this information out locally, but we also recognize that
23 there's limitations on both of those. Some of the research that
24 we have done in the past clearly shows that, especially as it
25 applies to seatbelt enforcement, that social norming doesn't

1 necessarily move the needle, but the enforcement piece, the high
2 visibility enforcement message tends to be getter compliance.
3 Click It or Ticket is a good illustration of that, and many of our
4 annual reports on that demonstrated that very thing.
5 We found the same thing with the impaired driving
6 message. In 1993, we did a study in Tennessee on checkpoints, and
7 we realized that the same high visibility approach did work, and
8 it did, in fact, over a 12-month study show that there was a
9 significant change in behavior and a decrease in the number of
10 fatal accidents related to impaired driving.
11 A study that we conducted in '06 and '07 in seven states
12 yielded different results in terms of that kind of message. One
13 of the states, Georgia in this case, did actually have a good
14 response in terms of the high visibility messaging. There were a
15 number of other issues in the other states, different types of
16 enforcement, different types of activities, which basically caused
17 us the opportunity -- or the concern that we're going to go ahead
18 and take a look at why, and drill and figure out exactly what
19 changes take place.
20 One thing that I think we kind of have to keep in mind
21 with messaging, especially with law enforcement, is this is a
22 different type of enforcement tactic, which I'm sure you'll hear
23 from your enforcement representative later on. In a ticket
24 situation, like seatbelts, when somebody stops them on the side of
25 the road, they write the ticket. They're still on the road. When

1 they conclude the enforcement stop, they're able to proceed and
2 move forward and still be out there on visible patrol.
3 Not so with an impaired driver. Absent a checkpoint or
4 something like that, when you take somebody into custody, you
5 leave the road. You're processing that individual through an
6 arrest mode. So that presence of visibility creates a different
7 type of dimension largely because of the requirements on the
8 officer for the arrest.
9 All in all though, we have a great deal of interest in
10 trying to pursue high visibility enforcement. It's worked for us.
11 We want to keep that there, but we also recognize that messaging
12 is a key part of this.
13 I'm on the yellow light, so I'm going to conclude real
14 quickly, and that is basically that we have one real big issue
15 that I'd like to put out there, and that is how do we keep this as
16 a viable public issue?
17 You've heard MADD mention earlier about what took place
18 years ago. In fact, MADD was one of the ones, along with a lot of
19 law enforcement back in the '70s and '80s when I started law
20 enforcement, that created a public outrage that brought this issue
21 on the table, and I think to some extent we are, in fact, a little
22 bit complacent.
23 MS. DAVIS: Thank you, Mr. Brown.
24 Dr. Grant Baldwin from the CDC will give our next
25 presentation on public health campaigns in general and their

1 effectiveness. Dr. Baldwin.
2 DR. BALDWIN: Thank you. Good afternoon. Chairman and
3 Members, it's a pleasure to be here with you today.
4 I'll be talking about nine keys to health communication
5 campaign success, broadly across topics. I draw heavily from
6 recent CDC and NHTSA campaigns to underscore my main points and
7 make a distinction between campaigns that simply sound good to
8 ones that actually make a difference.
9 Before I start, I want to recognize and appreciate
10 Shelley Hammond, a colleague of mine at CDC who helped prepare
11 these remarks and is providing health communication leadership at
12 the Injury Center.
13 By the end of my remarks, my hope is that you understand
14 the potential impact of a well-planned health communication
15 campaign as one of the tools we can use in reaching our shared
16 goal of zero substance impaired driving deaths.
17 The first key to a successful health communication
18 campaign is to know your goal. Campaigns, alone or in combination
19 with other intervention strategies, have the potential to do a
20 number of things, including increase knowledge and raise
21 awareness; influence perceptions, beliefs and attitudes; or even
22 change a social norm. For us, our goal is to stop the behavior of
23 impaired driving. To date, some of the most successful
24 communication campaigns addressing this issue refute myths and
25 misconceptions and identify consequences of driving impaired.

1 I'll talk more about this later when I discuss the Drive Sober or
2 Get Pulled Over campaign.
3 The second key is to work the process. There is a four
4 stage, iterative and cyclical process to make health communication
5 campaigns most impactful. It begins with effective planning and
6 strategy development and continues to pretesting concepts,
7 messages and materials to make sure they resonate with your
8 intended audience. After implementing the program through
9 relevant communication channels, the final stage is to evaluate
10 the outcome of your campaign and feed this back to inform
11 revisions of the campaign. Fidelity to this process is essential.
12 Some of the subsequent keys to success highlighted in my
13 presentation tease out some of the finer points of the cycle.
14 The third key is to select the right type of appeal that
15 will resonate with your intended audience. You can touch
16 someone's heart, evoke fear or give them straight facts. Humor
17 based campaigns may make sense in some context, too, but need to
18 be selected carefully. To a large extent, it is the goal of the
19 campaign that drives appeal selection. Here are three recent CDC
20 health communication campaigns to illustrate the different types
21 of appeals.
22 The Protect the Ones You Love campaign raises awareness
23 of parents and caregivers of the risks of child injury and
24 provides simple prevention tips to safeguard our children. It is
25 a positive emotional appeal.

1 The Tips From Former Smokers campaign show cases of the
2 consequences of smoking and deglamourizes what it means to be a
3 smoker. It is a fear based appeal.
4 And finally, the Parents Are The Key campaign provides
5 parents and caregivers with the tools and resources they need to
6 stay involved with their teens' driving, leading by example,
7 practicing with them and enforcing safety driving rules.
8 Each campaign works because the appeal matches the
9 audience and/or main objectives.
10 The fourth key is to properly segment your audience.
11 This ensures your messages and materials are relevant to your
12 audience's current behaviors as well as their needs, preferences,
13 beliefs and cultural attitudes. Effective segmentation can help
14 with channel selection, too, making sure the distribution methods
15 chosen synchronize with audience preferences.
16 While the Protect the Ones You Love campaign targets
17 parents and caregivers, we realized there was an opportunity to
18 reach children, too. The Color Me Safe coloring book shown in the
19 bottom right, is an immensely successful addition to the main
20 campaign and teaches children about safety in a fun and easy way.
21 The fifth key is to pretest your messages and materials.
22 Effective pretesting makes sure the message you want heard is
23 actually received. Here's an example from the CDC Parents Are The
24 Key campaign on teen driving safety and how we shifted emphasis
25 after pretesting. From focus group work, we learned that parents

1 wanted straightforward materials. Initially we worked up a tag
2 line, Bigger Wheels Are a Bigger Deal, shown on the left. It took
3 too much time for busy parents to understand what we were talking
4 about. The revised campaign materials, shown on the right, was
5 more to the point and parents more readily understood our key
6 message and the essential role they play when their teen is
7 learning to drive. By the way, it's also critical to pretest for
8 readability to make sure your messages correspond to the literacy
9 levels of the audience. Simple, unambiguous messages are
10 preferable.
11 The sixth key is to take advantage of the diversity of
12 communication channels available, including social media to
13 amplify or repeat your core messages. The need to leverage
14 multiple channels is even more pressing today given the wide range
15 of avenues people access information. At CDC, we set up a
16 Facebook page for Parents Are The Key, and regularly tweet out
17 reminders to parents and caregivers. We have blogged about that
18 campaign and had CDC scientists record podcasts, too. Equally
19 important, we created badges, buttons and other tools that someone
20 can place on their website to drive traffic to the main campaign
21 webpage. We also provided key partners with customizable
22 materials they could adapt for use in their states and
23 communities.
24 Most recently, we created a compelling I Pledge video to
25 make an emotional appeal to parents and had an insert placed in

1 *USA Today*. Finally, we have placed a small number of Google ads
2 to call attention to the campaign. This also gives us more
3 metrics of the campaign's success because we can trace the number
4 of times the add was delivered and how many times they were
5 clicked on.
6 By repeating the message by using a range of channels,
7 it is more likely the message will be received. The key is to be
8 clear, consistent and compelling.
9 The seventh key is to link the campaign with other
10 supporting activities. While some communication campaigns can
11 stand alone and achieve their desired outcome, this is not always
12 possible. With driving behavior, it is often important to link a
13 campaign with high visibility enforcement.
14 Shown here is the NHTSA Click It or Ticket campaign. It
15 was not enough for them to simply promote seatbelt use. They
16 needed to have law enforcement issue citations for non-use during
17 the day and at night for the campaign to make a different. It was
18 the combination of the campaign and the stepped up law enforcement
19 that mattered.
20 This leads to the eighth key, set clear outcome metrics.
21 For the Click It or Ticket campaign, a key outcome metric is the
22 number of citations issued. In 2007 alone, law enforcement issued
23 just shy of 675,000 tickets during a 2-week period. By having a
24 clear outcome metric, you can measure progress year to year.
25 Click It or Ticket is a longstanding campaign, having begun in

1 1993, in North Carolina and nationwide for almost a decade now.
2 At least part of the social norm for seatbelt use wearing can be
3 linked to campaigns like Click It or Ticket.
4 And the final key is to ground the campaign in the
5 scientific literature. The CDC-supported Community Guide to
6 Preventive Services provides scrupulous analysis and dissemination
7 of evidence-based public health practices. In 2004, the
8 independent task force took up the issue of using mass media
9 campaigns to reduce alcohol-impaired driving. The task force
10 recommends using mass media campaigns under the conditions listed
11 on this slide. When met, the task force found a median 10 percent
12 decrease in injury-producing alcohol-related crashes from the
13 available literature.
14 Finally, I want to tie it all together, tie all the nine
15 keys to success together by showcasing the Drive Sober or Get
16 Pulled Over campaign that Mr. Brown spoke about. This campaign,
17 featuring the invisible cops, is an update to the Over The Limit
18 Under Arrest campaign. The target of the campaign is young men.
19 The goal is to debunk the myth that you can drive impaired without
20 consequence.
21 To plan this campaign, NHTSA conducted focus groups with
22 young men within the target age range of 21 to 34 in March and
23 April of last year. The focus groups looked at the creative
24 concepts and revealed that of several options, invisible cops was
25 the campaign approach that most effectively conveyed the message

1 that police are stepping up enforcement.
2 The 2011 Drive Sober crackdown on impaired driving went
3 hand-in-hand with an ad on the radio and TV as well as securing
4 online advertising. Increased enforcement via sobriety
5 checkpoints and other high visibility activities showed the
6 campaign was more than just words.
7 So what is the one thing within the domain of education
8 and outreach that I think can make a real and sustained difference
9 and reduce substance-impaired driving? I believe and the
10 scientific literature supports that a well planned, theory-based,
11 carefully executed health communication campaign combined with
12 stepped up enforcement can have dramatic results, especially for
13 reducing alcohol-impaired driving.
14 More broadly, as was spoken about this morning, I
15 believe ignition interlocks for all DUI offenders and increased
16 utilization of sobriety checkpoints are essential.
17 Thank you very much.
18 MS. DAVIS: Thank you, Dr. Baldwin.
19 Our final presentation is from Dr. Dee Allsop from Heart
20 + Mind Strategies. He will discuss how to develop strategic
21 communications and effective media campaigns providing a
22 perspective outside the transportation safety and public health
23 sectors. Dr. Allsop.
24 DR. ALLSOP: Thank you, and thank you for inviting me
25 here this afternoon. I'm here, as she said, to talk a little bit

1 about a proven approach that's been used largely in private
2 industry with brands and products to effectively communicate, and
3 it's based on the premise that our values, those things that shape
4 our lives, are based on having both rational and emotional
5 components to them that touch in and evoke those feelings that are
6 driven by our personal values. Effective communications happen
7 when you're able to speak to both the heart and the mind.
8 Now, values-based communications are behind several of
9 the most iconic brands that are out there. These are campaigns
10 that we've been involved with: The Milk Your Diet campaign
11 targeted at young women and mothers that increased milk
12 consumption about 9 percent; the Las Vegas, What Happens Here
13 Stays Here campaign; as well as American Public Transportation,
14 several others, and more recently have been applying this approach
15 into some of the risk behavior, National Cyber Security, which is
16 a public awareness on digital citizenship and cyber security at a
17 personal level, and also just some recent work which I will be
18 sharing with you that we did for the AAA Foundation for Traffic
19 Safety. Several of these campaigns have been recognized by the
20 Advertising Research Foundation, the David Oligvy Award for
21 excellence and success in persuasive communications.
22 Now, this approach is based on the simple premise that
23 effective communications persuade by reason but also they motivate
24 through emotion, and it's built on the fact that people do process
25 both rational cognitive thoughts as well as the emotional

1 elements, and that good communications do both of those things.
2 Now, in this particular area, we clearly recognize that
3 choices are not effectively made when they're impaired, and so
4 some aspects of this doesn't apply in this particular area, but
5 there are lots of choices in this area that are made by people:
6 do I choose to take a substance or do I choose to get into a car
7 or do I choose to allow my friend to get into a car? So there are
8 several components of human decision making that would be affected
9 by this approach.
10 And the idea is that there exists this strategic hinge
11 that affects the actual attribute or the product and connects it
12 to individuals at a personal and highly relevant level, and that
13 is this level of values. And it's based on a lot of scientific
14 theory which recognizes that hinge, and through research, we
15 operationalize it by interviewing people through kind of a blank
16 sheet. We don't have any preconceived notions. What are the
17 aspects of this particular product or behavior or issue that are
18 most salient to them? Then we identify for them, out of all of
19 the ones they mentioned, which is the most important.
20 We begin to do what we call laddering, which is peeling
21 back the layers, getting back inside their mind to see what are
22 the functional or physical consequences of that particular issue,
23 and then if that's present, then what are the emotional
24 consequences, and if emotional consequences are there, they're
25 there because of what personal values that you have.

1 And so it uses this theoretical framework to interview
2 people. Often we do this in about an hour and a half interview
3 probing one on one to get inside the minds of people of what it is
4 that's driving them.
5 I wanted to give you one example. This is the one that
6 comes from the AAA Foundation for Traffic Safety, research in
7 distracted driving amongst teens. And this is work that was done
8 about a year ago, and it is similar in many ways because
9 distracted driving is impaired driving, but there are differences
10 as well that I'm sure you'll recognize. And I should mention that
11 the Ontario Provincial Police just launched a campaign yesterday
12 that's based on this particular approach and this strategy.
13 And to do it and talk about it a little bit, I want to
14 just give you a little background about distracted driving in
15 teens. This is something that they're very familiar with, not
16 just the texting side, but the distraction and it's relatedness to
17 possibly having accidents. Nearly half of all teenagers say they
18 personally have had a near miss, and about the same goes to their
19 family. And when you broaden the circle to their friends, nearly
20 two-thirds of them have had a near miss with some kind of an
21 accident. So this is something they know and it is close to them,
22 near and dear to them.
23 Yet, you know, teens have this heroic assumption -- and
24 this is based on an interview sample of over 1,000 teens that have
25 devices and drive. Nearly four out of five of them think they're

1 much better than everybody else and four out of five think they're
2 much safer than everybody else, and we did not know when we
3 started this, that so many teens come from Lake Wobegon where all
4 the children are above average, but that's where our teens are.
5 And so that's just kind of the foundation of where we
6 come at when we look at teens and distracted driving.
7 And as we did the values research, we started out by
8 asking them the simple question, what are the types of things that
9 you do that might be distracting while you're driving? And in the
10 bottom left corner are the things that they identified that they
11 do, and they do things like writing a text or looking at music or
12 reading a text. Reading and writing, that's about one-third of
13 all the things they do that they think are distracting.
14 Then we say out of all of those that you've mentioned,
15 which is the one that's most important to you personally that you
16 think is distracting? And so we let them kind of start this
17 ladder process and we ask them, okay, what would be the
18 consequence or what might happen to you if you were driving
19 distracted? That takes us up to box number 2, where they self-
20 identify the consequences, which for most of them is, I could be
21 in an accident or some even saying, I could kill somebody.
22 And then we push them a little bit farther. If that
23 were to happen to you, how would that make you feel? And that
24 comes to this emotional level of it would make me feel
25 extraordinarily guilty, I'd feel awful, or others expressed they

1 would -- and this is often, you know, the way teens think -- oh,
2 it would be stupid, it would make me feel stupid. But stupid does
3 not mean dumb. For them it means I'd feel guilty about something
4 I knew better than to do.
5 And so that's kind of the approach that we use. That in
6 essence creates what is the strategic hinge for distracted driving
7 among teens. Texting causes accidents that can injure or take a
8 life which would create guilt or shame because I knew better and
9 that would rob me of my sense of peace of mind.
10 So as was mentioned earlier, there are emotional appeals
11 that can be used in these, and this is one of those emotional
12 appeals, and it's designed to identify what is the emotional
13 appeal of a product or brand in this particular case, distracted
14 driving.
15 Now, you notice that this is not about social
16 acceptance. It's not about humor. It's not just a rational
17 argument, and it's also very blunt and explicit in terms of its
18 implications for execution.
19 We took this then into testing. In testing, we tested
20 several different concepts. I'm just going to point out a couple
21 of those. The one that's number 4 down, is this idea that, "Your
22 world could end at the push of a button. Texting and driving can
23 kill -- it's that simple. Don't tempt fate; that text can wait."
24 Very explicit, very graphic, very directed to the point.
25 That one is the most -- you know, 48 percent identified as most

1 effective in helping them realize in what to change about their
2 behavior.
3 The other one, number 2 down there, "If you text and
4 drive, a ticket may be the least of your problems. Can you live
5 knowing you took a life? Be smart. Be safe. If not for your
6 sake, then for everyone else." Those that were less explicit,
7 more kind of oblique and more nuance, were not nearly as effective
8 with these groups.
9 Secondly, we identified who were effective spokespeople
10 from which the message ought to be coming. Right at the top of
11 that list are the victims or the families of the victims, that
12 make that that much more relevant and that much more personal and
13 makes the emotional connection more real. Your spouse, your
14 friend or your parents, who also have close association personally
15 and relevance, also were effective spokespeople.
16 We then took the step of testing various messages that
17 are out there, some that we felt were very close to the strategy
18 identified in the strategic hinge and others that were a little
19 bit more nuanced or one, in the case of the one that was with
20 Allstate, which was a more humorous approach to distracted
21 driving.
22 The one on the left is one that some of you may have
23 seen. This is actually a 4-minute production from the UK, Gwent
24 Police Department, very graphic consequences of four young women
25 driving, texting, having fun, in an accident that had terrible

1 consequences for them and others that were involved in that.
2 The other one that was pretty explicit was the one that
3 was put out by the Department of Transportation, a 30-second spot,
4 that had four vignettes showing different walks of life, people
5 texting and talking on the phone and then showed accidents that
6 resulted from them.
7 AT&T was one that really didn't say much. It had this
8 -- it was 15 seconds. It said, "This is the text from me that my
9 sister was reading, right before she flipped her car and was
10 killed on impact."
11 And so those are kind of the ones that we tested. We
12 saw that the results came in very clearly. The one that was
13 simplest to understand was the DOT. It also got high scores on
14 other things, but the one that had the most high scores in terms
15 of making me wanting to stop doing anything that might be
16 distracting or makes me feel that this really does matter was the
17 one that was by the Gwent Police Department. The most explicit,
18 graphic consequences of driving distracted. Scores in the 8 you
19 should know are exceptional scores.
20 And then just getting to kind of how this strategy for
21 them sums up is because children know, and they know better.
22 They're most susceptible and responsive to messaging that directly
23 confronts them with the tragic consequences of not acting on what
24 they know.
25 And in terms of implications, just three quick things

1 here: That human values are the cornerstone of relevant,
2 impactful communications because they persuade by reason and
3 motivate through emotion. They speak to our hearts and minds.
4 And we have scientific and numerous social issue campaigns where
5 we have demonstrated this is effective, and that exploring a
6 values-based approach in the communications strategy to substance
7 impaired driving to reach a zero goal might be an effective avenue
8 for you to pursue. Thank you.
9 MS. DAVIS: Thank you, Dr. Allsop.
10 Chairman Hersman, that concludes the presentations for
11 this panel.
12 CHAIRMAN HERSMAN: Thank you very much. I can see a lot
13 of us are thinking in our heads about better ways that we can talk
14 about different things, and Member Sumwalt's going to lead the
15 questioning for this panel.
16 MEMBER SUMWALT: I'll start with a story about, gosh,
17 when my daughter was 4. One Sunday night we went to Baskins and
18 Robbins to get some ice cream, and she got an ice cream cone and
19 I'm sure got it all over herself. And on the way back, I was
20 drinking a milkshake, and I heard this sweet little voice come
21 from the back of the car saying, "Daddy, don't drink and drive."
22 And I appreciate that message very much, and she learned that
23 somewhere, and she learned it probably on watching Nickelodeon or
24 something like that. So it does show that that sort of a message
25 even for kids is effective because it helps to put pressure on the

1 parents. If, in fact, I was drinking an alcoholic beverage, I
2 would have gotten the message there that I shouldn't have been
3 doing it. But those are also the future drivers of America, so
4 that's good.
5 What I'm wondering is, and I wanted to look real
6 quickly, I think, Mr. Allsop -- I think it was slide 13 of yours.
7 I tried to look at the numbers just real quickly, but it was the
8 one -- and Nicholas is in the process of pulling it up I think.
9 Let's see if we can get that slide. It talks about, and that is
10 it.
11 So we look at the AT&T one, for example. It says, the
12 third column -- well, let's see what it starts. It's simple and
13 easy to understand. So what's that saying? 8.4 percent of the
14 252?
15 DR. ALLSOP: 8.4 on a 1 to 10 scale, a rating.
16 MEMBER SUMWALT: Okay. So 8.4 on a 1 to 10 scale.
17 Thank you. It catches my attention, 7.8; makes me want to stop,
18 7.6. But then the last one is concerning, too. Makes me feel
19 like this really, okay, does matter a lot for people like me. So
20 these are pretty high scores. But just because somebody feels
21 that way, how much does it really change their behavior? And
22 we're seeing wonderfully moving videos during the breaks that
23 catches our heart, but at the end of the day, how much do these
24 things actually change the behavior?
25 DR. ALLSOP: Well, I think it's been pointed out here,

1 and we would agree, you can't do it strictly by emotional
2 messaging. There have to be other touch points. There have to be
3 other angles -- it has to become more of a social norm -- that
4 have to accompany this, but you do need to have a strong emotional
5 appeal that gives people a reason to want to change as the
6 cornerstone of whatever you're doing.
7 MEMBER SUMWALT: Thanks. And what would those other
8 pieces be? You made a good case right there for the
9 advertisement. So what are those other parts of the puzzle?
10 DR. ALLSOP: There's a social acceptance in terms of
11 others that you interact with that needs to be more of a shared
12 belief that others are trying to work for. An enforcement
13 component is always a critical part in terms of making people know
14 that there's additional consequences personally that will change
15 their life. I think those are the two most -- and then I'd add
16 maybe a third, and that is there needs to be some weight behind
17 this in terms of people seeing it frequently, coming in contact
18 with it frequently, so that it becomes more than would just happen
19 if nature ran its course, that the message is not getting out
20 strong enough on its own.
21 MEMBER SUMWALT: And Mr. Brown mentioned this, and he
22 was quoting the Chairman, that says that we might have gotten a
23 little complacent as society, and I do feel that there is not a
24 great enough outrage that we're still losing 33,000 people a year
25 on our nation's roadways and one-third of those are due to

1 impaired driving. So how do we -- and, Mr. Brown, I'll start with
2 you -- how do we incite this social outrage? How do we get there?
3 MR. BROWN: Well, I think in some respects the model is
4 there. I mean, if you think about where we were in the late '70s
5 and the early '80s, it was people like Candace Lightner and MADD
6 that took on this and put a face on the issue. You heard Jan
7 Withers talking about that this morning and putting a face on the
8 issue of impaired driving. Your experience and the experience of
9 others in this room and across the country, I think play into
10 that.
11 The other piece is that -- we've got to recognize that
12 we have to be competitive. There's a lot of different public
13 policies and issues out there that are competing against it, and
14 we have to be able to find a way to grab the attention of the
15 public-at-large that they'd be willing to at least listen to the
16 messages.
17 We spend a great deal of money putting out a branded
18 message across this country on impaired driving. It's what
19 Congress gives us. We put it out there and you've seen the
20 results that we've talked about in terms of how we put that
21 message out, but the reality is that it resonates well but it's
22 not effective without the enforcement piece. But still, we
23 haven't been able to move that third -- you know, that standard
24 percent of the population that's been there for the last 15 years.
25 And somehow we need to galvanize that public support or as you put

1 it, frankly, the outrage issue.
2 MEMBER SUMWALT: That kind of goes back to what we've
3 seen in other things like distracted driving, seatbelt usage,
4 these sorts of things. It's a three-pronged approach. It sounds
5 like we need education, we need good strong laws, and we need
6 visible enforcement. Do you agree with that, Dr. Baldwin?
7 DR. BALDWIN: Yes, I do. I think the literature, the
8 scientific literature supports that communication campaigns are
9 only effective in and of themselves without other components with
10 things like single item or episodic events like screening
11 behaviors, like going to get a cancer screening, installing a
12 smoke alarm, but for complex behaviors like driving impaired, I
13 think it really does require -- and I like you're connecting the
14 communication and education, the laws and the enforcement. That
15 makes sense to me.
16 MEMBER SUMWALT: So, Dr. Baldwin, while I've got you on
17 the hook, how did NHTSA and the CDC work together to make sure
18 that various campaigns complement each other? And we'll hear from
19 both sides. We'll hear from you and then from Mr. Brown.
20 DR. BALDWIN: Sure. NHTSA and CDC have worked closely
21 together, hand and glove really at the staff level, for many
22 years. It was only in December of 2010 that CDC Director Frieden
23 and NHTSA Administrator Strickland signed a memorandum of
24 understanding to codify the relationship to make sure that we were
25 best leveraging each other's strengths. Given CDC's partnerships

1 and connections to the public health community, the state health
2 departments, we're leveraging that network more effectively now,
3 but we have had a longstanding relationship across data and
4 surveillance and education and communication working closely with
5 NHTSA.

6 MEMBER SUMWALT: Mr. Brown.

7 MR. BROWN: Well, I would agree with that. Not only do
8 we believe that it's a public health issue, we want to, of course,
9 leverage their contacts just like we leverage ours in the highway
10 safety community, and it's a great partnership. We have a lot of
11 dialogue. We share information on our different activities. We
12 do things jointly, which before we did at the staff level, but
13 we're now doing it in many cases with our leadership. So it's a
14 great collaboration, I believe.

15 MEMBER SUMWALT: Well, it is a public health issue, and
16 I think the American public needs to really understand that and
17 embrace that idea. And, you know, any idea how many, at CDC, from
18 an epidemiological perspective, what other means of death are
19 comparable to impaired driving? We know that there was about
20 10,000, 10,300 people last year that died due to impaired driving.
21 So what else compares to that? How many people die every year in
22 this country due to AIDS, for example? Any idea?

23 DR. BALDWIN: Not off the top of my head, but injury is
24 the leading cause of death for Americans, 1 to 44, and that's
25 largely driven by motor vehicle crashes. So as a statement to it

1 being a public health issue, CDC Director Frieden named motor
2 vehicle injury prevention, including alcohol-impaired driving, as
3 one of his six winnable battles. These are the six issues that he
4 is paying the most attention to and that myself, the Injury Center
5 director, and other staff are meeting with him regularly to talk
6 about the public health approach to motor vehicle injury
7 prevention. It's a priority at CDC.
8 MEMBER SUMWALT: I'm so glad to hear that. It needs to
9 be a priority not only within the governmental agencies but with
10 our society as a whole. So thank you very much.
11 Madam Chairman, I yield the balance of my time.
12 CHAIRMAN HERSMAN: Thank you, Member Sumwalt. Member
13 Weener.
14 MEMBER WEENER: Yeah, thank you. I have a question for
15 Mr. Brown. NHTSA develops these messages and who are the users
16 for these messages?
17 MR. BROWN: We do several different approaches to try
18 and put the messages out. We do a national buy with the
19 crackdowns, again, around Labor Day and then, of course, the
20 December holiday period. About 30 percent of it goes into -- in
21 the buy goes into TV, about 35 percent into cable, 12 percent into
22 radio, and then the balance in a variety of different things,
23 including social media.
24 We also partner with our highway safety offices across
25 the country. Every state has a highway safety office. We enlist

1 their support in these various crackdowns. We provide them what
2 we call a PEAK kit, which is basically an enforcement preparation
3 kit in preparation for the crackdown. The enforcement activity is
4 tailored towards the crackdown period.
5 In addition to that, we make available to them, if
6 they'd like to use that same type of public service announcement
7 for the local activities across the country that they do at the
8 state level. Many of them use Section 402 or 410 money for
9 enforcement purposes that they do at the localized level, and
10 we'll use the same message, which we certainly encourage for the
11 branding purposes that we talked about.
12 MEMBER WEENER: Are these messages most effective when
13 combined with a campaign as opposed to just institutional ads?
14 MR. BROWN: The Buzzed Driving is Drunk Driving is the
15 social norming message. The other one is designed to be done with
16 enforcement. If you're going to talk about, you know, Drive Sober
17 or Get Pulled Over, it kind of defeats the purpose if you don't
18 have the enforcement, the high visibility enforcement, the
19 presence of law enforcement at the same time.
20 We encourage the use of the buzzed driving message if
21 you're looking at something incremental in between various
22 crackdowns.
23 MEMBER WEENER: So following a campaign, where you've
24 put the messages out and you've had heavy enforcement, what's the
25 falloff in terms of effectiveness with time?

1 MR. BROWN: It depends upon the state and the local
2 enforcement that goes on, on a continuous basis. We have some
3 states that have various crackdowns, for example, around other
4 types of events like St. Patrick's Day, Super Bowl Sunday, the 4th
5 of July holiday, all of those kinds of things that they've
6 identified as a local data-driven issue for them. And if they do
7 it in some states -- and there's a few states that are very
8 aggressive on this, for example, Tennessee when they do their
9 summer program. Georgia is another one where they do a really
10 pretty effective program throughout the year. You don't see the
11 radical bumps because they've integrated that into their culture
12 in terms of an enforcement and a crackdown strategy. It's
13 happening in recurring fashion throughout the year.
14 MEMBER WEENER: All right. Well, thank you.
15 Dr. Allsop, the study that you described was aimed at
16 teens.
17 DR. ALLSOP: That's correct.
18 MEMBER WEENER: Have you done an equivalent sort of
19 study with regard to finding out, let's say, adults, 20 to 30, or
20 some of the ranges where there is the most incidence of impaired
21 driving?
22 DR. ALLSOP: No, that's not been done yet. Impaired
23 driving -- let me be specific, distracted driving with texting.
24 I've not done that study.
25 MEMBER WEENER: Okay. So your study was on texting.

1 DR. ALLSOP: Yes.
2 MEMBER WEENER: Rather than impaired driving?
3 DR. ALLSOP: That's correct.
4 MEMBER WEENER: How would that be imported over into an
5 impaired driving situation?
6 DR. ALLSOP: Well, a couple of things. One is the
7 primary reason I was here is because the approach that we use in a
8 lot of campaigns, and I tried to pick one campaign that was as
9 near as possible to, you know, impaired driving, and that was the
10 texting and driving, and I think there are aspects of it that do
11 apply particularly in terms of the consequences of decisions that
12 get made when you're driving impaired from texting, and I think
13 that that's really a key thing. But I think in impaired driving,
14 there's other decisions that are just as important. Do you get
15 into a car with somebody that's been drinking or do you -- you
16 know, how do you make sure that person has a safe driver? Those
17 are other decisions which we did not look at that I think also
18 could be explored.
19 MEMBER WEENER: So there's basically a potential for a
20 parallel sort of campaign to what you did with texting?
21 DR. ALLSOP: Yeah, and actually I've seen some of the
22 things during the break that are using this kind of an emotional
23 appeal, and I think that those can be an effective component on
24 making an emotional reason why people want to begin to make these
25 choices in the correct way.

1 MEMBER WEENER: All right. Thank you.
2 CHAIRMAN HERSMAN: Member Rosekind.
3 MEMBER ROSEKIND: So we all keep crediting NHTSA because
4 we like to cite three elements that have proven to be effective:
5 strong laws, education, high visibility enforcement. So I'm
6 curious. Let's get concrete -- and this is for all of you, but
7 you don't have to all answer, whomever would like to. What are
8 the optimal outcomes and effectiveness of just education and
9 outreach? So be very specific, tell me, from an education and
10 outreach program, what kind of outcomes can we expect to see and
11 give me some numbers about effectiveness? What can that really
12 change? What kind of difference can that make?
13 MR. BROWN: I think in the outcomes, one of the things
14 that we're always concerned about is that very number that you
15 talked about at the end, the fatal accident report, the analytics,
16 in terms of how many people that are killed, that are involved in
17 impaired driving. But beyond that, when we look at messaging and
18 marketing, a couple of other things we do look at is whether or
19 not the message resonates, whether or not it gets to the things
20 that Dr. Allsop was talking about.
21 Many of the focus groups that we did, for example, ask
22 that string of questions many times to try and figure out whether
23 or not we were looking at our target audience and reaching those
24 values that they, you know, that they hold dear.
25 And then the other piece is obviously we count the

1 number of agencies participating, the number of arrests
2 participating in crackdowns, to get an idea as to a threshold
3 that's acceptable in terms of participation. I will tell you that
4 it has been a little bit of a concern for us in terms of
5 challenges for capacity for law enforcement of late, largely
6 because of the economic issues that's faced local government.
7 We've had some situations where they've had to make some real
8 tough choices because of capacity. We haven't seen a significant
9 problem in terms of participation, but we have seen some
10 indications that caused us a little bit of concern on the
11 enforcement side.
12 MEMBER ROSEKIND: So just -- I'm going to push
13 Mr. Brown. Because I know him, I can push. So give me, and I
14 realize that the education doesn't necessarily have to go to the
15 fatality outcome, and there are models about people being ready to
16 change, et cetera, and that's what you're looking at, but as we go
17 forward here, give me some numbers. What are you measuring and
18 how have you been able to evaluate that these programs are
19 actually working for the things you want them to do?
20 MR. BROWN: Well, one of the things that I mentioned
21 earlier, we talk about the study we did in '06 and '07 when we
22 looked at the seven states, and it raised more questions than it
23 did answers. One of the things that we're doing in the study that
24 we're initiating now is looking at what are the different types of
25 modeling that's done by law enforcement. Do they have, you know,

1 a fully integrated model? Do they have a partially integrated
2 model, or do they just do periodic crackdowns, along those lines.
3 What kind of feedback and community observations do we see with
4 respect to their perception of enforcement? The certainty of
5 actually being captured and perhaps prosecuted if, in fact, they
6 did violate the law, impaired driving, these are the kinds of
7 things that we're trying to go after a little bit so we can find
8 out exactly the effectiveness of a particular program for modeling
9 across the country in similar type communities.
10 MEMBER ROSEKIND: Gentlemen, anyone?
11 DR. BALDWIN: Yeah, you know, I don't believe that an
12 optimal outcome can be achieved, and I think the Community Guide
13 review of the evidence suggests that there would be insufficient
14 evidence to support implementing a mass media campaign focused on
15 substance-impaired driving without the enforcement component.
16 Some of the outcome metrics I would use besides deaths
17 would be, of course, the number of arrests or the self-reported
18 alcohol-impaired driving events, but independent of the
19 enforcement component, I don't believe I would recommend doing
20 them independently.
21 MR. BROWN: If I could add one other thing? As you saw
22 earlier this morning about the differences between the states,
23 this is such a complex issue within the states, and everyone's a
24 little bit different, to come up with something that's not a
25 really big aggregate number is difficult to do that has any

1 application for every particular state. The states that we talked
2 about earlier this morning, the three in the south, I'm familiar
3 with two of them very much so, and they have entirely different
4 politics, entirely different criminal court procedures, entirely
5 different, you know, enforcement postures, and that makes it
6 difficult to come up with an aggregate number that would really
7 have some, you know, usefulness across the entire country. We are
8 trying to develop mechanisms to look at that at the local levels
9 so that we can give some guidance to local communities in the
10 highway safety offices on how to deal with our issues.
11 MEMBER ROSEKIND: Can anybody say anything about the
12 time course of what an education outreach program needs to
13 actually have some effect in the community?
14 MR. BROWN: Well, I can tell you we don't know if we
15 have an exact time course. I do know from our experience with
16 Click It or Ticket, now we started to see movement in the,
17 quote/unquote, "needle on compliance" within a couple years. I
18 mean, clearly the message started to get out and we started to see
19 some change. But it wasn't just the enforcement and the messaging
20 that took place, as well, if you recall, there was a great deal of
21 law changes, you know, various primary seatbelt laws, secondary
22 seatbelt laws.
23 We have a lot of laws on the books on impaired driving
24 as well, and some of them you've heard this morning are perhaps
25 legal challenges that might, you know, bear some fruit in terms of

1 actually changing some of the behavior. But the timeline for that
2 again is very difficult because it's a myriad of things that are
3 out there across the country.
4 MEMBER ROSEKIND: And I'm going to interrupt you because
5 we're in the red, and I'm going to ask another question and get a
6 one word answer. For what's not being done now, in this area of
7 education and outreach, what is the one thing you think that
8 impaired driving would benefit from seeing being done as soon as
9 possible in the education and outreach arena?
10 MR. BROWN: More enforcement.
11 MEMBER ROSEKIND: In the education and outreach arena,
12 high visibility enforcement?
13 DR. BALDWIN: I would say that campaigns combined with
14 more enforcement done randomly.
15 DR. ALLSOP: I would say more weight behind the
16 messaging.
17 MEMBER ROSEKIND: Great. Thank you.
18 CHAIRMAN HERSMAN: Vice Chairman.
19 VICE CHAIRMAN HART: Thank you, Chairman Hersman. I'm
20 going to express a very high level of frustration because the
21 laws, the enforcement, the education, those are all crucial and
22 they've all accomplished amazing results, but the bottom line is
23 we've been stuck for 15 years on the same rate, and that's where I
24 think, to paraphrase Einstein, "If we keep doing what we've been
25 doing, we'll keep getting what we've been getting."

1 Now, I'm not suggesting stopping any of those amazing
2 efforts. They have to continue, but I view them as necessary but
3 not sufficient, and the question is, what can we do different that
4 we need to do if we're not going to expect to see the same results
5 forever?
6 And two things that occur to me, and I just want to
7 throw this out for anybody who wants to comment on it. One is
8 sort of a media strategy; the other one is not.
9 The media strategy is something that relates to what
10 Member Sumwalt said about his 4-year-old daughter. She saw that
11 on TV someplace, Sesame Street or someplace. That is a very
12 powerful influence and I'm just wondering, I'm thinking, you know,
13 Starsky and Hutch never buckled seatbelts. They didn't even have
14 seatbelts, but, you know, now you would look at any mass media
15 outlet -- it's not an educational thing, it's not something you're
16 looking at to receive a lesson, but it's something that you would
17 see nonetheless and it becomes part of your background. You used
18 to see smoking on TV in movies a lot; you don't see that anymore.
19 So, you know, I have not heard yet any outreach to the
20 mass media, if you will, to the movie makers and to the TV program
21 makers, cable program makers, about how they can reach the general
22 populous through a subtle background message, not you should do
23 this, but just a subtle background message. So that's one thing
24 that may be different that I'd like to throw out to you to ask,
25 have there been any efforts to reach out to the mass media outlets

1 to see if they can depict things that will affect people's
2 behavior because in the background, people just don't do these
3 things any more. People buckle their belts now. People don't
4 smoke now as much. All those things that we saw in the mass
5 media. Have there been any outreach, any systematic outreach
6 efforts to the mass media?
7 MR. BROWN: I can speak a little bit to that. We have
8 done that. It's difficult to do when that's part of a script, but
9 when it's something that's not part of a script, we weighed in on
10 that several times especially with replacement TV. In my prior
11 life, I will tell you we had an awful lot of contact with
12 production crews in California on that very issue. When it's part
13 of the script, it's difficult to get them to change that because
14 there's some underlying message. We've done it with seatbelts as
15 well, and we'll continue to do that. I think subliminal pieces
16 are a big part of it. Some of our staff will tell us, for
17 example, when they see somebody not wearing a seatbelt, and
18 they'll just say that person should have had a seatbelt on, on a
19 major TV show. Those kind of things take place, I know from
20 NHTSA, and we've done that also with our highway safety offices
21 that we work with.
22 DR. BALDWIN: Yeah, the Centers for Disease Control
23 works through a number of organizations, including Hollywood
24 Health & Society, to make sure that screenwriters are accurately
25 portraying the health issues that we deal with in the every day.

1 So although we have not dealt directly with alcohol or substance-
2 impaired driving, we have dealt with issues like diabetes and
3 violence prevention on shows like Army Wives and Grey's Anatomy,
4 where CDC science is best and most accurately portrayed through
5 those sort of screenwriter's renditions of the science.
6 DR. ALLSOP: I don't have anything to add on that.
7 VICE CHAIRMAN HART: Okay. Thank you. And the other
8 sort of different thing is something we're going to hear about
9 later, so it's not appropriate for this panel, and that's some of
10 the new technologies that we're seeing inserted into this equation
11 that can hugely affect the outcome. Some of them are so amazing
12 to show, you know, what the BAC is at the point when the person
13 blows into it and shows us where they are and just a wealth of
14 information that we can do. But in terms of the media, that's one
15 that I can't say that I have seen very much of is a lot of
16 systematic outreach to the mass media, and that's why I raised
17 that question. Because it seems to me, just going back to the way
18 drunk people used to funny on the mass media and they're not
19 anymore, and I think that had a huge impact on reducing alcohol
20 consumption in general. And so that's why I think that that is an
21 avenue that perhaps we could explore further. Thank you very
22 much.
23 CHAIRMAN HERSMAN: I'd like to follow up on that
24 question. Do you think that alcohol and drug use is glamorized or
25 accepted in mass media?

1 MR. BROWN: I guess I would have to see a lot of the
2 mass media. I just don't know if I see that much TV and movies,
3 but I think that there are certain groups that are very, very
4 attentive to that, and they're very -- you know, you don't see
5 some of the stuff that you saw on the old Jackie Gleason Show,
6 which I used to watch as a young person as well.
7 I think that there are some things that may, you know,
8 push the envelope a little bit, but that's part of the script
9 piece, but I would hate to get us in a situation where we're
10 characterizing free speech issues. But I think more importantly I
11 think the other message, you know, we take to the public is a
12 little bit stronger in terms of what is acceptable, normative
13 behavior, and that's perhaps the message we should stick to, to
14 the extent that we can.
15 CHAIRMAN HERSMAN: Okay. Well, let me just ask the
16 question in a different way. Maybe it was a little too open
17 ended. Do you think that the treatment of people who have some
18 fame or notoriety who get arrested for driving under the influence
19 is certain, swift and severe? Do you think the public sees that?
20 MR. BROWN: In some cases I would say probably, yes.
21 There have been, for example, several cases reported on TMZ and
22 Access Hollywood with public celebrities who have been arrested
23 and their mug shot has been there. That doesn't normally happen
24 to the average person arrested for being under the influence of
25 anything, and frankly, some of them have suffered, you know,

1 public fallout as a result of that as well.
2 I think that's true with any individual who has some
3 kind of a, you know, public personage, if you will, or persona,
4 that there's that possibility that should they be arrested for
5 impaired driving, that becomes, especially in this day and age,
6 public knowledge rather quickly.
7 DR. BALDWIN: I don't believe it's accurately portrayed,
8 and I don't believe the consequences of impaired driving are as
9 accurately portrayed as they could be.
10 CHAIRMAN HERSMAN: So let's talk about a different
11 issue. The words that we use to talk about events like this, and
12 I was reminded earlier about using the word accident when talking
13 about a highway event, and that accident is not the accepted word
14 to use and it should be crash. So let's talk about the words that
15 we use to talk about events and why it's important, and I know you
16 all in this community are familiar with that debate. Let's talk
17 about the words that we use.
18 DR. ALLSOP: I can respond there. I mean, the words
19 that we use have clear connection to the emotional responses that
20 they create, and in terms of accident or crash, in terms of the
21 responsibility that's -- you know, who's responsible for it, and
22 the consequences of it. So I think any words that we use that
23 more directly and bluntly address what the consequences are, are
24 going to be more effective in helping people realize what's at
25 stake.

1 DR. BALDWIN: In particular, I think the word accident
2 implies chance, fate and inevitability in ways that, frankly, we
3 know is not the case.
4 MR. BROWN: Let me go back and talk about impaired
5 driving. Years ago it used to be drunk driving and, you know, we
6 use the phrase impaired because you don't have to be falling down
7 drunk to be impaired to be involved in a crash with some
8 consequence. What was interesting though is when we did the focus
9 groups for this particular message, Drive Sober or Get Pulled
10 Over, the target audience that we were looking at principally was
11 young men, 21 to 34. They resonated with drunk driving because
12 they didn't understand impaired driving, and so there is a
13 disconnect.
14 I think the words are very important. They're very
15 important for a reason, but the target audience that we're working
16 with doesn't necessarily connect with that sometimes in the
17 language because they look at language a little bit differently.
18 CHAIRMAN HERSMAN: Okay. So we're focusing a little bit
19 on the protagonist, to the individual, but there's also a lot of
20 enablers that exist in society around them and I'd like to
21 understand how we change that behavior. We haven't talked a lot
22 about it. It's about the person who's getting behind the wheel
23 and making the decision, but there are also people who allow them
24 to get behind the wheel or actually get in the car with them, and
25 I know I've in my lifetime had these experiences where I've gotten

1 in the car with somebody and I thought the whole time, why am I in
2 the car with this person? And I remember seeing The Girl With The
3 Dragon Tattoo and there's a scene in there where Blomkvist goes
4 back into Lun's (ph.) house and Lun challenges him, "You didn't
5 feel comfortable with this. Why did you come back in? Is your
6 fear of offending stronger than your self-preservation?"
7 And I thought, gosh, you know, that's like a lot of
8 decisions that we make, and why do people put themselves in a
9 situation? How do we encourage people to have some sort of
10 ability to say no when they're in that situation where there is
11 some sort of societal pressure on them to be polite or to not
12 argue or get into that? How do we get to them because they're
13 people who are getting killed, too, and they're potentially not
14 the protagonist here.
15 MR. BROWN: We've developed over the years a number of
16 social norming messages for different target groups. For example,
17 we've done some programs as well as advertising that deal with --
18 the Every 13 Minutes Program is one that was put out with a lot of
19 the highway safety offices with the endorsement of NHTSA, and that
20 was really to do some peer recognition of the impact of this, and
21 asked the same questions that you just asked: Why am I in this
22 car? Why do I want to be driven home by this person? Why do I
23 want to let this person drive home? Can I be something -- instead
24 of an enabler, can I intervene at some level?
25 We've had other kinds of programs like that. Some of

1 the vignettes on our buzzed driving campaign, will speak to that
2 subliminally. There's a lot of effort to try and do that, but
3 again it gets down to the empowerment piece that individuals have
4 to seek within themselves.
5 DR. BALDWIN: I think there's an opportunity to educate
6 bar and restaurant owners as well, and I know that laws can cut
7 across and have an impact on them as well in terms of their
8 serving to people who are physically impaired. So I think there's
9 an avenue there, with some our communication and education
10 efforts, to reach them.
11 DR. ALLSOP: This, I think, actually goes to an earlier
12 question that was raised, how do you get beyond some of the
13 things, some of the levels of success that you kind of seem stuck
14 at? And part of it is you've identified relevance as those that
15 are the users that are impaired. If you can broaden the relevance
16 so that it goes to a broader group, then you're going to get more
17 people who care about the issue.
18 I think a lot that happened in smoking was the
19 definition of this secondhand smoke, and once that was defined,
20 then it wasn't just that smoker but it was everybody in the family
21 involved there. It was everybody who came in contact with it. It
22 was your baby. It was everything else.
23 And so by broadening the circle of relevance, I think in
24 the way that you're describing here, are those who make the choice
25 to get in the car, those who make the choice to let that person

1 drive home, that I think extends the potential for you to have a
2 greater reach.
3 CHAIRMAN HERSMAN: Great. Thank you all so much. This
4 has been an outstanding panel, and I believe we're moving to
5 straight to the fourth panel. We won't be taking a break. So
6 thank you all very much for your input, and I know some of you
7 have been with us before. So thank you for coming back.
8 Ms. Davis, do you want to go ahead and identify the next
9 panel while we're switching?
10 MS. DAVIS: Our next panel will describe how impaired
11 drivers are identified and arrested and the role that insurance
12 companies can play to enforce sober driving.
13 Technical Sergeant Doug Paquette from the New York State
14 Police will open the panel with a presentation on measures for
15 locating impaired drivers and determining impairment. Sergeant
16 Paquette, when you're ready, you can begin.
17 TECH SGT. PAQUETTE: Good afternoon. I just want to
18 thank the Board for the opportunity to come and speak to you folks
19 today on the enforcement perspective dealing with the impaired
20 driving issues.
21 When I was asked to come and participate in this, I was
22 asked what would be the best tool to help us identify those
23 impaired drivers. And it comes right down to Standardized Field
24 Sobriety Tests. And when we talk about that, the initial portion
25 of it says, well, it's the three-test battery. It's horizontal

1 gaze nystagmus, walk and turn, and one-leg stand. But it's
2 actually the overall process.
3 In other words, when we teach a class, not only do we
4 teach officers across the country to identify using those tests,
5 but we also say, hey, it's the whole process, it's that vehicle in
6 motion, you know, what helped you recognize the car? Why did you
7 stop it? And then when you stopped the car and you talked to the
8 people, you know, what went on there to make you think that maybe
9 there was some sort of impairment close by, and then at that
10 point, you would ask them to get out of the car and move on to the
11 field sobriety tests.
12 All right. So you went too far, but okay. So as we go,
13 there's questions that you'd ask. There's actual visual clues
14 that you could use for that driving component, you know, making a
15 wide turn, weaving in the lane, erratic speed, erratic braking;
16 there's all sort of cues there that you could use.
17 And then the face-to-face contact where you're talking
18 to them about, you know, where are you going to, where you're
19 coming from, ask for their license, registration, proof of
20 insurance, things of that nature. Are they having trouble finding
21 that? Can they follow your question? And, if you think there's
22 something else there, you would go ahead and go through the gaze
23 nystagmus, walk and turn, and one-leg stand.
24 But we have to build that case. We have to build a
25 common law case. And I heard throughout the course, people talk

1 about, well, why don't we just stop them and give them a
2 preliminary breath screen device or, you know, screen them right
3 there mechanically using an instrument. Well, we need to build a
4 common law case. We need to be able to -- because when we go to a
5 judge, or we go to a jury and we testify, they want to be able to
6 close their eyes, they want to listen to what we say and literally
7 be able to visualize what it was that night when we were out there
8 stopping them and talking to them, and if we don't do a real good
9 job painting that word picture, we're not going to get there
10 because not every case is Uncle Fred at the wedding reception
11 dancing with a lampshade on their head, all right. That's not
12 what we're dealing with.
13 Many times we're dealing with the folks that are the
14 .10, the .11, .12. Those signs of impairment are not always that
15 obvious. So we really need to do a good job with the common law
16 to be able to support later on when you do the evidentiary breath
17 testing, and it truly is the totality because we could lose
18 anything along the board. If we lost -- the judge decided, hey,
19 that reason you stopped the car, I don't like that, it's not going
20 to work, everything else after that goes away. All right. And so
21 we really need to build that case right from the ground up as we
22 go across. I'm having a challenge technically. Okay.
23 So again, go back through. It's the totality, and this
24 kind of shows it here as you would look through it. All right.
25 What was the initial observation? How did they stop the car?

1 Little things, like how did they stop the car? Did they pull over
2 right away? Did you chase them? Did they pull over normally?
3 Little things like that. How did they get out of the car? I
4 mean, did they open the door or did you help them out of the car?
5 Did they have to climb out of the car? Did they fall out of the
6 car? Could they stand up without leaning against the car?
7 There's all these little things that you need to observe and build
8 and put together to be able to articulate as you go on just what
9 it is that you're seeing there at the roadside.
10 Go through the cycle of physical tests, HGN, walk and
11 turn, one-leg stand, and after I have preliminary breath testing
12 -- and not every agency has a little gray pocket box that you can
13 pull out and say, here, right at the end, check. Sometimes we
14 become too reliant on that. We forget to build that common law
15 case. So if they have it, they would use it, but not in every
16 case as we go across. But it's the totality, and again building
17 that up as to why we stopped and made the arrest.
18 We talk about the validity of the Standardized Field
19 Sobriety Tests, and there were studies done in the late '70s and
20 early '80s to validate the initial Standardized Field Sobriety
21 Program, pushed things to some challenges in court. We went ahead
22 or NHTSA went ahead and did a second batch of validation studies,
23 and we talk about it being recent, but that's the most recent we
24 have.
25 Colorado has kind of nice study because there they used

1 trained officers and it was statewide for a full year. So you had
2 folks working up in Aspen in the wintertime. You had folks
3 working in Denver in the middle of the summer. So we had a full
4 spectrum of weather conditions and officers as far as training is
5 concerned and a very good result.

6 In Florida, down in Pinellas County where they held that
7 one, that was our first study where we dealt with a .08, and up
8 until then, certain states were already coming into the .08 realm,
9 and they were, well, you know, these were validated at .10; how do
10 we still know they work at .08? And this gave it to us, and
11 again, they used seasoned officers and it was within a county and
12 good results came about.

13 And then the last study up there would be the study out
14 of San Diego, and the San Diego study gave us something besides a
15 great overall result. It also gave us a re-breaking down of the
16 individual tests. In other words, what's the degree of
17 reliability for horizontal gaze nystagmus? What's the degree of
18 reliability for walk and turn, and for the one-leg stand? And
19 again, they were much stronger than the numbers we had seen in the
20 original studies that got the whole program moving.

21 So how's it all set up? Well, when you look at this
22 slide here, you'll see that we go through the whole process; I go
23 through my field sobriety test. Am I going to arrest them or am I
24 not going to arrest them? Is it the fact that they were sleepy?
25 All right. And the fact that I turned those red lights on behind

1 them, a little bit of adrenaline woke them up, and they did well
2 on those sobriety tests. Maybe they just weren't paying
3 attention, there was something else in the car that had them
4 distracted. So it's to arrest or not to arrest, and if it is to
5 arrest, then we bring them back and we work with the breath test,
6 the evidentiary breath test.
7 And one of the things we talk about, is the impairment
8 we saw at roadside consistent with what that BAC is? And it
9 doesn't take long for law enforcement and an officers to go out
10 who are making arrests to kind of in their own mine equate the
11 impairment they see to what they would expect someone to be at .10
12 or someone to be at .15 or someone to be at .24, and then all of a
13 sudden, you put them on the box, and they're .06, they're an .07,
14 and that impairment is not consistent. And then you start to say,
15 well, okay, what else is there? What else is causing that
16 problem?
17 Well, there are three other things we can think about.
18 One, maybe they're just not a good drinker. I mean, they drink
19 twice a year and this just happens to be the time you caught them,
20 or it could be because they have a medical problem or it could be
21 that there's another substance other than alcohol or, in this
22 case, it would be the combination of alcohol with another
23 substance causing the impairment. When possible in those cases,
24 that's the opportunity for the drug recognition expert to step in
25 and do an evaluation to develop the probable cause, to go ahead

1 and say, you know what, we're going to get a blood sample and
2 here's why we need to go get a blood sample and set that whole
3 piece up.
4 If the DRE is not available, there is training out there
5 for the officers, whether it's part of the old Standardized Field
6 Sobriety course which was Drugs that Impair Driving or the new
7 ARIDE, Advanced Roadside Impaired Driving Enforcement course.
8 We've given them some other options. So if DREs are not available
9 and you can't get one there or, you know, there's one available
10 but it's going to be 3 hours for them to get there or 2 hours for
11 them to get there, based on what we know about drug half lives and
12 such, they go ahead and process them anyway.
13 So those officers do have a little bit of base
14 information to go ahead and make the arrest. Is it the ideal?
15 No, but it's better than letting them go. It's better than not
16 having anything. So we try to use that. And then as the process
17 goes through, either we use the DRE evaluation or we have an
18 officer process as they normally would.
19 Let's face it, when I came on the job in the mid '80s,
20 we were making drugged driving arrests without a DRE program.
21 It's a nice tool to have, but we were still making the arrests
22 back then.
23 So that's kind of the process, how it sets up. As we
24 work through, again, you know, you develop your probable cause,
25 you make the arrest, you get them back, you see what the blood

1 alcohol concentration level is. Once you have that, you decide
2 whether or not you're going to process or move on and look for
3 possibly other substances.
4 All right. And I heard before, too, someone talked a
5 little bit about time, and depending on where you are in this
6 country, you can be anywhere from maybe an hour and a half to
7 process your impaired driver to certain areas 20 hours, and it
8 comes down to paperwork and lodging protocols and do you have to
9 stay with that person. And it's difficult because if you start a
10 checkpoint out with seven people, and suddenly you make three
11 arrests, now you're down to four bodies, and is there going to be
12 an issue of safety with cars and everything moving by? So the
13 processing time really does come into play across the board and
14 that depends on local jurisdictions. What do the courts want?
15 What do the prosecutors want? What's expected in that paperwork?
16 And it varies county to county, state to state as well.
17 So on this slide here, we talk about the training
18 pyramid, so to speak. Coming from New York it is a training
19 snowman. And on the bottom are the SFSTs, and that's the thing
20 that all officers need to have, and NHTSA is working very, very
21 hard to make sure that that is occurring. And in New York, I can
22 that all officers get Standardized Field Sobriety Training as part
23 of their basic academy class. So we've overcome that hurdle.
24 And then from there we move on to the next level, and
25 again, in the ARIDE class, there's a refresher of the field

1 sobriety tests because people get into bad habits, and we want to
2 make sure everybody's up to speed. So the ARIDE course was
3 designed to provide a refresher with a proficiency and then add
4 some basic information on the drugs. And then kind of using that
5 as a guide, you pick the best of the best and you send them to DRE
6 school, which is a 2-week classroom training with some intense
7 hands-on field evaluations and those are the folks that come in
8 with that extra symptomatology, knowledge that can correlate what
9 they see symptomatology-wise to a category of drugs.
10 So we talked about enforcement techniques earlier, and I
11 just have to agree, education is crucial to let the public know
12 but if you're not there to back it up with some enforcement, it
13 kind of falls by the wayside.
14 And in New York we use our seatbelt model, and we've
15 really improved our seatbelt usage, but it was a great model to
16 follow at least from my perspective as a program manager. We did
17 education and then we did enforcement, and we waited a little bit,
18 a short period of time, and we came right back and did another
19 batch of enforcement, including results of our last enforcement
20 wave, and went back and did another enforcement, and we just
21 repeated it over and over and over almost to the point where the
22 public got tired of hearing about it, but it made a difference.
23 Our compliance rate started out, when we started the
24 waves, was around 45 percent. The compliance rate is now over 90
25 percent using that model. So, you know, that kind of process, and

1 you heard it from the panelists just before, it works, and that
2 would be something that you could possibly use in impaired driving
3 again.

4 But it's a little more time consuming than just, here's
5 your ticket, have a nice day, and I alluded to the time involved,
6 but also the idea of checkpoints and saturation patrols and those
7 are kind of the two major keys that we have in our back pocket.

8 We have general enforcement, and let's face it, that's
9 the job of every officer when you get out there, traffic safety,
10 you know, write your tickets and arrest your drunks, but we also
11 know -- and I'll talk in a minute about some of the other things
12 that pull at us. But, you know, when you run a checkpoint, we're
13 going to have a checkpoint this weekend; it's the holiday weekend,
14 within 15, 20 minutes we're on Twitter, we're on Facebook.
15 Everybody knows where we are, and everybody's using the side
16 streets to try to get around us.

17 So those programs work really well, those programs that
18 have a checkpoint, but they also have those saturation patrols
19 that roam the side roads looking for the folks who are trying to
20 avoid us. And the other checkpoints that work well are the ones
21 that they can pick them up and move. Thirty, 40 minutes at one
22 spot, and you pick it up and you move to another spot, and
23 suddenly they think you're all over, but at the same time, keep
24 those saturation patrols out there to get the folks who are trying
25 to look around you. So really, in an ideal world, it's a

1 combination of both that we'll work on.
2 And also we can't rule out the community involvement.
3 In that, in New York and in the Albany area, on New Year's -- we
4 have a county DWI Board, and they actually pay for rides home for
5 people. You know, they're letting people know. They do a public
6 information campaign. They let people know about the risks and
7 they say, hey, listen, if you are going to go out and you are
8 drunk and you don't have a ride, well, then call this number and
9 we'll get you home because we don't want to deal with the
10 fatalities and such that occur on the backside. So it has really
11 helped a lot. They're getting the community involved. So, yes,
12 it's law enforcement. Yes, it's education, but also getting the
13 community to buy in and assist us as well.
14 So one of the last things that I was asked to talk about
15 deals with what are our challenges? And manpower is a big one and
16 budget cuts and such. Patrol coverage. When you have a
17 checkpoint, you're out there looking for people to come in on
18 overtime to staff the checkpoint. Why? Because your normal guys
19 are out handling the domestics, handling the burglaries, handling
20 the normal stuff that we also have to do besides traffic safety.
21 So manpower is an issue, making sure you cover the
22 patrol areas, and in a large state such as New York, obviously we
23 have different -- the state patrol, the state police, we have
24 different responsibilities as far as covering large areas. But
25 even in a metropolitan area, you still have the same things. You

1 have less officers on patrol. They still have the same amount of
2 calls and things, maybe even more calls for service. So how do we
3 balance that all out? How do we make sure that we can do
4 everything as part of it?
5 You know, doing those specialized details, staying out
6 there, a lot of times we have to rely on 402, 410 funds to do
7 overtime, to pay to have folks come back in.
8 And then training, if officers feel they're trained
9 well, they can withstand the scrutiny and cross-examination from
10 the defense bar, which is a big portion of it nowadays. They're
11 going to be more inclined to go out and make those arrests. If
12 they think, my gosh, if I go out and make this arrest, and I have
13 all this court paperwork, I'm going to go out and get thumped up,
14 they may be hesitant to do it.
15 And basically you ask, where should we go? Well, that's
16 really simple. Encourage traffic safety enforcement. You don't
17 get walk-by shootings, and when you're out there doing traffic
18 enforcement, you're finding guns, you're finding drugs, you're
19 finding the gang bangers. You're doing all that stuff and you're
20 also saving lives. It's a proactive way to save those lives.
21 And then consistency across the board, consistency with
22 the penalties that the folks receive, consistency with chemical
23 testing, all right, making sure all the labs are testing for the
24 same drugs at the same level across the board, and then develop
25 some more technology for passive sensors to assist us at our

1 checkpoints. Thank you.
2 MS. DAVIS: Thank you, Sergeant Paquette.
3 We will next hear from Warren Diepraam from the
4 Montgomery County District Attorney's Office who will discuss an
5 innovative program for securing evidentiary BAC tests that lead to
6 more convictions. Mr. Diepraam.
7 MR. DIEPRAAM: Thank you. Chairman, Members of the
8 Board, I appreciate the opportunity to come here and talk to you
9 today.
10 CHAIRMAN HERSMAN: Do you have your microphone on?
11 MR. DIEPRAAM: Sorry.
12 CHAIRMAN HERSMAN: There we go.
13 MR. DIEPRAAM: I appreciate the opportunity -- did you
14 all hear me okay?
15 All right. The No Refusal Program is a concept that was
16 created a few years ago in Houston, Texas, and it brings together
17 -- it's unique aspect is that it brings together all aspects of
18 law enforcement. When we're here talking about enforcement, most
19 people think police officers on the street making arrests. But if
20 that's what we think of as enforcement, well, then we're in
21 trouble with DWI. Because if 80 percent of the DWI arrestees are
22 being released or dismissed after the case goes away, then there's
23 no teeth in the police officers out there doing the street.
24 Exactly the same with police officers and prosecutors as
25 prosecutors and judges. If you've got prosecutors that are out

1 there fighting for the conviction, fighting for enforcement,
2 fighting for the police officers, but the judges find 89 percent
3 of the people not guilty of DWI, then we've got a problem that
4 needs to be addressed.
5 So unfortunately there is no one magic bullet that will
6 cure the DWI problem, but No Refusal is something that has come
7 around recently that is making a huge difference in DWI
8 enforcement. So No Refusal, the concept, what it is, there's many
9 reasons why we would need No Refusal and how it can help in, not
10 every county in Texas, but every single state in the United
11 States. And I've listed something here. I'd like to go over them
12 individually just real briefly.
13 Now, as we've heard many times today, traffic deaths are
14 not declining like they should. The numbers are going down and
15 that's a good thing, but we have reached a plateau. One thing
16 that nobody has really discussed in depth today is the number of
17 drug impaired deaths that are increasing and how difficult it is
18 to track drug impaired deaths. That's a huge problem in DWI
19 enforcement today. We can do a whole bunch more and No Refusal
20 helps us to solve that.
21 Refusal rates are something that have pretty much stayed
22 the same. I've chosen a few of the worst states here. In Rhode
23 Island and New Hampshire, more than 80 percent of the people who
24 are arrested for DWI refuse to give a scientific sample to a
25 police officer. You can see some of the other states there,

1 including Texas, where it's above 40 percent.
2 The dismissal rates, these were a few individual
3 jurisdictions that I was able to find in some of these states, but
4 the dismissal rates in one jurisdiction in Texas was well above 70
5 percent, and that's just sad when that happens. That is a hole in
6 DWI enforcement.
7 The trial conviction rate can also be low. The *Boston*
8 *Globe* did an article last year on conviction rates for DWI in
9 those particular jurisdictions and in some jurisdictions there was
10 only a 10 percent conviction rate for DWI. So that is a huge
11 problem with these sorts of cases.
12 We don't know what drugs are on board. If a person
13 gives a breath sample or if they refuse, 50 percent of the people,
14 as this statistic shows -- and as most of us that are in the field
15 know, 50 percent of the people are also under influence of some
16 other type of substance, be it a legal substance or an illegal
17 substance, such as Xanax or Soma or something of that nature.
18 People have difficulty with breath testing. I just
19 quickly Googled a couple of places on the Internet, and I found
20 one in Houston that I'm familiar with, where about 1,000 DWI cases
21 got thrown out because of some tampering with the government
22 record by the person who supervises breath testing. The other one
23 I found in San Francisco, about the same number of cases were
24 going to get thrown out because of the same thing there. Breath
25 testing is creating some issues. People have difficulty with

1 breath testing because defense attorneys attack breath testing.
2 They can't necessarily do it with blood.
3 And No Refusal is basically our project innocence. Some
4 people may actually be innocent. If a defense attorney tells
5 people to refuse to provide a sample of breath or blood to a
6 person's system, that person who has one or two drinks at dinner
7 may not actually be impaired and gets out there and refuses, they
8 could actually be convicted, and that's a great fear of mine as a
9 prosecutor, is to convict an innocent person. So we need
10 scientific evidence in these sorts of cases.
11 The CSI effect, that's another one. Juries expect
12 science. They expect technology. They expect us to get fancy
13 schmancy in the courtrooms with all the sort of stuff and the No
14 Refusal program can bring it to us.
15 So blood is basically the answer to all of these things,
16 or one of the answers to all of these things.
17 No Refusal basically is in most states, I think about 40
18 states approximately, a suspect does not have the right to refuse.
19 They have to give a sample as the law dictates, but they have the
20 ability to refuse. A police officer cannot go and force them to
21 give a breath test in these sorts of cases. So that's kind of a
22 problem getting a scientific sample in these sorts of cases.
23 Now, some states criminalize refusals and other states
24 don't have an implied consent law, so that's not necessarily an
25 issue with them. However, even in those states and even in those

1 cases, we're still putting prosecutors to trial without the best
2 evidence in these cases, and, namely, that's scientific evidence
3 or blood evidence.
4 So what a No Refusal program does is, it takes away the
5 suspect's ability to refuse to provide a scientific sample of
6 impairment or intoxication. During the No Refusal process, police
7 officers work with prosecutors at the police station in reviewing
8 probable cause for the arrest. We then take a case of a refusal
9 to a judge who's there. We hire nurses or paramedics to come in
10 and take the blood sample, and we have other people there. So
11 you've got all three aspects of the enforcement community: the
12 police, the prosecutors and the judges, working to review these
13 cases and make them stronger.
14 I basically refer to it as our super due process for
15 defendants. Ordinarily a defendant gets arrested based upon the
16 decision of a police officer. In these situations, when it's No
17 Refusal, you've actually got a prosecutor and a judge reviewing
18 the process. Now, that has some ancillary benefits which I'll go
19 over later, but instead of just a police officer making arrests,
20 now you've got the entire criminal justice field working together.
21 So for a No Refusal, funding is an issue. When we set
22 up a No Refusal program, like I said, we have many people working
23 together. We have a phlebotomist which is either a nurse or an
24 EMT or a paramedic coming down. We have a prosecutor who comes
25 down, a judge who comes down or works remotely from their home via

1 telephone, via fax, via e-mail or some other form of technology.
2 We like to have a police officer who is a drug recognition expert
3 or a field sobriety test expert together working on the program.
4 It could be the same person as a No Refusal coordinator. We get
5 MADD or victim's advocates to come down as well. What these
6 people do is they make sure that the evidence is collected
7 concisely, properly documented, placed in one facility so that we
8 don't have any problems with the chain of custody for the
9 particular evidence.
10 So basically what happens with the No Refusal, it
11 doesn't change the DWI arrest process. You've got a police
12 officer conducting the field sobriety tests on the side of the
13 road. You've got the arrest. The person is taken into custody,
14 taken down to the transport. The police officer reads the
15 statutory warnings telling them what their rights and obligations
16 are to give a breath test or a blood test, at which point the
17 subject refuses to give a breath sample or a blood sample. Only
18 at that point after the entire DWI process is complete, does a
19 prosecutor get involved.
20 So basically we've got a DWI refusal case, and then the
21 prosecutor gets involved and drafts a search warrant and presents
22 it to the judge. The judge does not interact with the police
23 officer or the suspects. We keep them separate for those
24 purposes. After a judge reviews the search warrant, signs the
25 search warrant, the prosecutor then takes it to the police officer

1 at which point the nurse takes the blood.
2 So the benefits are, briefly, right there. They'll save
3 the agency money in the long run because the police officers get
4 back on the street faster. You've got people in the jail working
5 together. It gives us good, solid evidence of impairment that
6 defense attorneys can't beat. Because of the publicity factor, it
7 decreases the number of DWIs and it cuts down on the officer's
8 court time. Defense attorneys have a very difficult time beating
9 blood test cases as opposed to refusal cases or other cases.
10 We do get a lot of publicity because it is something
11 new. Just like Vice Chairman Hart said, it's not doing the same
12 thing and getting the same result. No Refusal is something new
13 that is getting new and significant results, namely, saving lives.
14 The ancillary benefits, real quickly, media coverage
15 increases. We understand police officers more where they're
16 coming from, what problems they go through. We work with the
17 medical community a lot closer. So if there is a mandatory blood
18 draw situation because of a fatality or something, the police
19 officers and the medical staff develop a trust with each other,
20 and search warrants are less likely to result in suppressions
21 because we've already got a judicial finding of reasonableness for
22 the arrest. Then we have more informed judicial decisions on
23 interlocks and also for probations because we know what's
24 affecting them. We know about that.
25 If you want to see how to conduct a No Refusal, as some

1 folks have already said, you can go to nhtsa.gov, check on No
2 Refusal or tdcaa.com/dwi.
3 But these are the results. This is why I'm so proud of
4 No Refusal. We've had a 80 percent drop in DWI fatalities in my
5 jurisdiction alone once TXDOT funded No Refusal. We've had 20
6 percentage point drops in our refusal rates with these sorts of
7 cases and in those refusals, that's when we are getting the
8 scientific evidence. So we get scientific evidence in 100 percent
9 of our DWI cases when we do No Refusal.
10 Our trial conviction rates have increased significantly.
11 We see there, the blue line there, the DWIs, and then also the No
12 Refusal cases that have gone to trial. We have 100 percent
13 conviction rate with those cases.
14 We also did the nation's first statewide No Refusal
15 where multiple agencies participated on that and we saw a 50
16 percent drop in DWI fatalities from the reporting agencies and the
17 refusal rate dropped from 45 percent to 25 percent. We've had
18 exactly the same results in every single jurisdiction in Texas and
19 also in the multiple states that have picked up No Refusal around
20 the country. We're all reporting the same results with
21 significant drops in fatalities.
22 There are a few problems that we've had, real briefly,
23 some legislative hurdles that we have. For example, some states
24 criminalize search warrants for DWIs and don't allow them in
25 court. Many other cases, or there are many other situations where

1 we have problems with DWIs -- and I think that's it. I'm a little
2 bit over. I apologize. I'm an attorney and it's my job to do
3 that.
4 MS. DAVIS: Thank you, Mr. Diepraam.
5 Our final presentation is from Ms. Jean Salvatore from
6 the Insurance Information Institute. She will address how
7 insurance companies handle or respond to impaired driving
8 convictions by their clients and the regulations, what steps
9 insurance companies can take. Ms. Salvatore.
10 MS. SALVATORE: Thank you. Today I'm going to be
11 talking a little bit about the insurance implications of impaired
12 driving, and this is an insurance issue for a number of reason.
13 In particular, it affects auto, home and also commercial
14 insurance.
15 Historically, the whole issue of impaired driving has
16 actually been a key issue for the industry. We funded the
17 Insurance Institute for Highway Safety, which is the leading
18 organization that does research and analysis, and insurance also
19 provides extremely important financial reimbursement, which is
20 something that I think needs to be stressed, that if you are the
21 victim of an impaired driver, that it is insurance dollars in many
22 ways that's going to help repair the property, vehicles, medical
23 bills, and unfortunately even funeral expenses.
24 Now in terms of auto insurance specifically, I want to
25 point out that if you are legally entitled to drive, once again if

1 you are legally entitled to drive, then you must purchase
2 insurance, and insurance is mandatory in every single state except
3 for New Hampshire, and this is something that has got basically
4 public support, that insurance must be mandatory.
5 So if you are somebody who has been convicted of
6 impaired driving, you are going to have, quite frankly, a
7 difficult time getting insurance, and it's going to cost you.
8 This is actually one of the few instances that a private insurance
9 company -- so the insurance companies that you see advertised on
10 television, can say to somebody, I don't want to write you an auto
11 insurance policy; you're too much of a risk. Or, they can say,
12 we're going to charge you a lot more.
13 Insurance is a state regulated system, and if you go
14 through the laws, in almost every state, this is something that is
15 consistent, that insurance companies do have that right. So
16 anybody who has been convicted of this is going to find that they
17 have a lot less choice of insurance.
18 So there may be a private insurance company -- every
19 state's different. There's a lot of insurance companies but, if
20 not, then they're going to have to go to an insurance company
21 that's going to specialize in high risk drivers, and it's high
22 risk drivers of all types, not just an impaired driver. But those
23 particular insurance companies are going to charge a lot more.
24 Now, if this is a real problem driver, somebody maybe
25 who has had more than one arrest, but once again, is still legally

1 allowed to drive, it's possible that even those sort of
2 specialized carriers will say, no thank you; this risk is too
3 much.
4 And then in that case, the driver is going to have to
5 get insurance through what they call a residual market, and this
6 is basically a state run insurance sort of pool that's set up
7 specifically for high risk drivers. In this instance, it's going
8 to be a very basic insurance policy, and it's probably going to
9 cost a lot of money. So it is, hopefully, that this is sort of an
10 economic, you know, incentive to not do these things. This is
11 going to hurt somebody and their family in the pocketbook.
12 Nationally, residual markets, at this point it's about
13 1 percent, in 2009, is the last year. So it's a small number but
14 those people are going to be paying a lot more for insurance.
15 And the other thing about this which it really is
16 important, this economic incentive -- because the other thing is
17 that it's quite simply this lack of choice, and the fact that you
18 will have lack of choice is going to be what is going to drive
19 that cost.
20 Now, if somebody, on the other hand, who has gotten
21 themselves into trouble, but then over time has proven to be a
22 good driver, on the other hand, over time they will find that they
23 will have more insurance available and then hopefully this would
24 be a positive economic incentive to continue to be a good driver
25 because over time, you'll have more choice and then you can pay

1 less for auto insurance.

2 But the other thing that I want to point out is that by
3 charging more for the impaired drivers, for those people who have
4 -- you know, there's been a record, a problem here, good drivers
5 are not subsidizing the bad drivers. We're charging more for
6 those people who have the record. But once again, I can't
7 emphasize enough that this is hopefully sort of an economic
8 deterrent.

9 The other sort of interplay that insurance has with the
10 impaired driving is actually with homeowner's insurance, which
11 most people seem to be surprised at this, that every state has
12 what they call social host liability. Basically you have a party
13 in your home, you serve liquor, you can be legally liable for the
14 actions of your guests when they leave the home. You are not
15 specifically liable for the person who is the impaired driver. So
16 if they leave your house and do something, they get hurt, you're
17 not liable for that, but you could be liable for their actions,
18 basically for third party. So if that person, you serve alcohol,
19 they get into an accident or they do something stupid, they ride
20 over somebody's front lawn, do all kinds of damage, the physical
21 damage that they cause or if they cause an injury to somebody
22 else, you can be legally liable and, in fact, 37 states have
23 either laws or case law that basically permits social hosts to be
24 financially liable.

25 So the reason why this is a home insurance issue is

1 because part of what you get with the home insurance policy is
2 liability. So you will have coverage for this.
3 And the same with auto, that basically that money will
4 help for the injured person. So if that person does cause -- you
5 know, hurts somebody or their property, there's coverage under the
6 home insurance policy. And this is actually something that we
7 spend a lot of time trying to educate people about, that I would
8 say for every single holiday, we put out a news release reminding
9 people that, okay, it's really nice to serve a good bottle of wine
10 with that Thanksgiving turkey, but think about those drivers that
11 are going to leave your home. And we have specific tips that
12 would basically say, you know, either guests should stay over, you
13 should have rides home, there should be a designated driver, but
14 it's a reminder that you are not just morally responsible but you
15 are legally responsible when you serve liquor in your home.
16 So I just put this up as sort of an example, that I
17 would say over the course of a year, we probably have about a
18 dozen releases. This is just what we've done this year, but we
19 will use literally every single holiday you can think of to remind
20 people that they do have both legal and moral responsibility when
21 they serve alcohol in their home.
22 And then the third way where there's an interplay with
23 impaired driving and insurance is with commercial insurance. So
24 not surprisingly, you know, restaurants, bars, that they are also
25 legally responsible if they get into -- if they serve alcohol to

1 somebody and then there's an accident. So insurance companies who
2 write the coverage for restaurants and bars, that's part --
3 they're selling liability protection but part of when they're
4 selling that insurance, they also provide a lot of educational
5 programs, and there are insurance incentives and discounts to bars
6 and restaurants and other establishments that have implemented
7 programs that will prevent patrons from drunk driving. So there's
8 all kinds of loss prevention programs in place because they're
9 very, very cognizant of the fact that, you know, if you're serving
10 alcohol in a bar or restaurant, there is also this liability.
11 It's hard to see this chart here but on our website, we
12 have all of the different states and basically we outline the
13 social host liability, but also the commercial server liability,
14 whether there's a law in place or whether there is some sort of
15 case law that would hold either the homeowner or the restaurant,
16 bar liable and that is on our website which is www.iii.org.
17 Now, as we're a non-profit organization, we don't lobby
18 but we do have a lot of information and links to a number of other
19 organizations. So we do have a lot of information in terms of
20 compulsory auto, all the liability issues, auto safety. If you
21 are particularly interested in the residual markets for auto
22 insurance, we have a white paper on that that explains the
23 insurance mechanism that's available to make insurance available,
24 and then also a lot of information for consumers who are going to
25 throw a party in terms of being responsible hosts with alcohol.

1 MS. DAVIS: Thank you, Ms. Salvatore.
2 That concludes the presentations for this panel.
3 CHAIRMAN HERSMAN: Thank you, all, very much. Member
4 Sumwalt's going to lead.
5 MEMBER SUMWALT: Sergeant Paquette, we know that
6 sometimes drivers, in fact, many cases, they drive even with
7 suspended driver's licenses and, in fact, one study, I think a
8 California study, shows that nearly 9 percent of the driving
9 population is on a suspended license. I saw just last week in my
10 hometown there was somebody intoxicated, ran over a pedestrian,
11 and he had a suspended license from a DUI, previous DUI. So what
12 can be done about this? You know, if you take away somebody's
13 license, it's not a disincentive for them to stay out of a car.
14 So what can we do about this?
15 TECH SGT. PAQUETTE: Well, possibly we could get uniform
16 utilization of those ignition interlocks, and if they're driving a
17 vehicle, it has to have that on there. That would be number one.
18 Number two, one of the things I can say is that many
19 times law enforcement working in a small community or a small
20 area, you get to know the folks because you know who's getting
21 arrested, when and where or maybe their photographs and pedigrees
22 show up in the local paper, and so you see them go by, and you
23 spin on them and get right on it. So that's part of it, is
24 knowing the area. But in reality, in a large area, if they're
25 suspended and they decide that they're going to go out and drive,

1 whether they borrow their friend's car or whatnot, there's not a
2 lot we can do.
3 MEMBER SUMWALT: Yeah, it kind of takes away the
4 disincentive. What does it mean if your license is suspended if
5 you're going to ignore that?
6 And, Ms. Salvatore, along the same line as it relates to
7 insurance, what keeps uninsured drivers from driving?
8 MS. SALVATORE: Well, that's another problem and that's
9 actually something that we talk about a lot because if you don't
10 know, you know, it is this legal requirement, but that's also a
11 law enforcement issue. You are supposed to have insurance to
12 drive legally.
13 MEMBER SUMWALT: And you're supposed to have a driver's
14 license, too.
15 MS. SALVATORE: Right.
16 MEMBER SUMWALT: So, okay. We've got to think how we're
17 going to tackle both of those issues there.
18 Is it Diepraam, Diepraam?
19 MR. DIEPRAAM: Diepraam, yes, it is.
20 MEMBER SUMWALT: Diepraam, very good. Thank you. I
21 think you mentioned that defense attorneys will oftentimes contest
22 the breath tests. Did you say something along those lines?
23 MR. DIEPRAAM: Yes, I did. The breath test is basically
24 an extrapolation of how much alcohol is in a person's blood, and
25 there are many different requirements for breath testing that are

1 not there for blood testing. So defense attorneys frequently do
2 attack breath tests.
3 MEMBER SUMWALT: So it's not a 1 or a 0. It's not a
4 discrete. It's not either you meet the per se requirement or you
5 don't. That can be contested apparently is what you're saying.
6 MR. DIEPRAAM: Yes. In addition to that, there's also
7 -- in some states, we have to relate the test back to the time of
8 driving. Many states have a rule that if the person is tested
9 within 2 hours, it's presumed that they are .08 or above. Other
10 states don't. So the defense attorneys -- that's called
11 extrapolation. So defense attorneys will attack the
12 extrapolation. They'll come up with their own extrapolation and
13 argue that the person was not above the illegal limit, as we like
14 to call it, of .08. So there's many angles of attack that a
15 defense attorney could take with a breath test and they do.
16 They're much more successful at winning breath test cases than
17 they are blood test cases.
18 MEMBER SUMWALT: Okay. Thank you.
19 Sergeant Paquette, I think you mentioned that not all
20 law enforcement officers are training in the SFST.
21 TECH SGT. PAQUETTE: Yes, that's correct, and there's
22 been a big push over the last, say, 8 to 10 years to try to get
23 everybody trained and many, many of the states have the SFST
24 training as part of their basic academies. It's just going back
25 and catching the dinosaurs and getting them through the schools

1 and getting them caught up.

2 MEMBER SUMWALT: And we've got so many acronyms here,
3 but you were nice and you provided a glossary of terms, and so --
4 I think that that was you that provided that. Standardized Field
5 Sobriety Test battery is that. So how many more arrests do you
6 think there would be if every officer did have this training and
7 was capable of performing this battery of tests?

8 TECH SGT. PAQUETTE: I'd really be guessing, but I
9 figure it would be 20, 30 percent more.

10 MEMBER SUMWALT: Yeah. Okay. Along the same lines --
11 well, this is a different line of questioning, but also to you,
12 Sergeant Paquette, what challenges are out there with the
13 synthetic drugs that, you know, we're seeing, the bath salts and
14 all these things, that in many states are still not legal -- or
15 still not illegal? So what challenges are law enforcement
16 officials facing with these?

17 TECH SGT. PAQUETTE: The new synthetics that are out
18 there, it's a challenge first of all to the lab, in that if I grab
19 a blood test off of someone, the lab may or may not be up to speed
20 to test for them. So there is no corroborating toxicology, number
21 one.

22 Number two, from a DRE standpoint, drug recognition
23 expert, when I do an evaluation, it's going to come out possibly
24 looking like a cannabinoid, a cannabis style case, or a
25 hallucinogen case, again depending on the substance. So I'm going

1 to call what I'm seeing, and it may very well, if it comes back as
2 one of the synthetics and that synthetic is not considered a drug
3 by whatever means the individual state defines a drug, and there's
4 various definitions, the person may very well walk.
5 MEMBER SUMWALT: Thanks. Mr. Diepraam, I want to go
6 through one time in my mind, the idea of the No Refusal, to just
7 make sure I've got it straight here. So basically through that
8 program, a suspect is not allowed to refuse. They have to end up
9 taking a blood test. Is that right?
10 MR. DIEPRAAM: That is correct. They can exercise their
11 option, not their right, but their option to refuse a breath test
12 or a blood test. So up until that time, it's treated as a regular
13 DWI arrest. Only if they refuse or when they refuse, we then step
14 in, draft a search warrant and take away their ability to refuse
15 by asking a Judge to order them to give us a blood sample.
16 MEMBER SUMWALT: And how many communities have this -- I
17 think you had a figure on how many states may have this or is it
18 communities? How many -- widespread is this?
19 MR. DIEPRAAM: It's not as widespread as it should be.
20 There are about 12 states now that have No Refusal in one form or
21 another. In Texas, we have about 50 counties that use No Refusal
22 on either a small basis or a large basis, and there's about 200
23 counties left to go.
24 MEMBER SUMWALT: Okay.
25 MR. DIEPRAAM: So it's a brand new process but with

1 numbers like that, and when people see the statistics that we get,
2 I think it's going to increase significantly.
3 MEMBER SUMWALT: Thank you for coming today to educate
4 the Board on what that is, and we'll be looking carefully at that.
5 I yield the balance of my time, Madam Chairman.
6 CHAIRMAN HERSMAN: Member Weener.
7 MEMBER WEENER: Thank you. Earlier today we kind of
8 jumped the gun and asked some questions about the field sobriety
9 tests. Now I think I have the experts to talk about this. When
10 it comes to identifying an alcohol-related impairment versus drug-
11 related impairment, how does the field sobriety tests
12 differentiate or is there any differentiation?
13 TECH SGT. PAQUETTE: There is and there's not. In other
14 words, are they impaired? Yes or no. With the exception of
15 certain categories, drugs don't cause horizontal gaze nystagmus.
16 So I may check the person and there's no horizontal gaze nystagmus
17 but yet the walk and turn and one-leg stand, they failed those
18 plus they had the overall driving profile, et cetera. Then, you
19 know, you may be able to get back and say, well, I didn't see HGN
20 and alcohol causes HGN, so maybe I have to start looking the other
21 way for another substances other than alcohol.
22 But initially at roadside for the average officer,
23 they're going to be impaired and you're going to check for being
24 impaired, and they're going to arrest for that impairment at
25 roadside, and when they get them back to the station, they're

1 going to sort them out. Other than some very subtle clues -- now
2 unless you're a DRE, and if you're a drug recognition expert, or
3 you've been through the ARIDE training and you're there at
4 roadside and you see dilated pupils and they're blown right out,
5 and they're not responding to any kind of light or they're
6 constricted really, really down, or things like that, that are
7 taught in these various courses, then you start to maybe think
8 along that direction.
9 But you have to remember very few cases is it just the
10 drug without anything else there. A substance other than alcohol
11 in combination with alcohol, tends to be the norm if I'm dealing
12 with a drug impaired driving case. Alcohol is used to mask
13 because they know, heck, if the officer stops me and I mess up
14 those tests, and he screens me, and I'm low, .04, .05, .06, he's
15 probably going to cut me loose, let me go. So I'm going to use
16 that alcohol as a mask and try to get by one on them.
17 So impairment is impairment, and those tests are great
18 for use there at roadside to articulate the impairment.
19 MEMBER WEENER: Now, at a checkpoint, and you talked
20 about that, set up a checkpoint and then go for saturation to pick
21 up the people who are going around the checkpoint.
22 TECH SGT. PAQUETTE: Uh-huh.
23 MEMBER WEENER: I think it was brought up earlier that
24 there is a passive alcohol detector which can tell you whether or
25 not there's a presence just in the air within the automobile.

1 TECH SGT. PAQUETTE: Uh-huh.
2 MEMBER WEENER: But you don't have anything of that sort
3 for drug-related issues?
4 TECH SGT. PAQUETTE: No. No, we do not.
5 MEMBER WEENER: So then it's a matter of identifying the
6 impairment and then basically arresting the individual and then do
7 a tox screen as well as a --
8 TECH SGT. PAQUETTE: Well, I have to develop the
9 probable cause to go get that tox. So, in other words, they're
10 impaired. They get arrested. I come back. We rule in or rule
11 out the alcohol as the cause of the impairment. So once I've made
12 that determination and say, okay, yes, alcohol's causing it or
13 it's alcohol plus something or no, there's no alcohol. What else
14 is causing it? And then I have to investigate further to develop
15 a probable cause and say, hey, I need to go get some blood.
16 MEMBER WEENER: And can you talk just a bit about what
17 defines probable cause? What -- how do you determine probable
18 cause?
19 TECH SGT. PAQUETTE: For alcohol and/or other drugs?
20 MEMBER WEENER: Well, for both.
21 TECH SGT. PAQUETTE: Well, with alcohol I use the
22 sobriety tests and they were validated through the process and we
23 can correlate based on those studies back to alcohol. So if
24 they're failing those, I bring them back, put them on the
25 evidentiary box, and we get a breath reading.

1 As far as drugs are concerned, to develop that probable
2 cause, I'm going to be looking at some other indicators and see
3 what size are their pupils? How do they react to light? What are
4 the vital signs, pulse, blood pressure, body temperature? Is
5 nystagmus there? Is there vertical gaze nystagmus? Is there a
6 lack of convergence? There's a whole 12-step evaluation process
7 that I would go through as a drug recognition expert to be able to
8 say, yeah, you know what, this is representative of cannabis or
9 this is representative of a stimulant or this is representative of
10 a hallucinogen. And that's what I would go to the judge with to
11 say, hey, this is why I took the subject for a blood test.
12 MEMBER WEENER: Very good. Thank you. I'll yield the
13 balance of my time.
14 CHAIRMAN HERSMAN: Member Rosekind.
15 MEMBER ROSEKIND: So in her opening remarks, the
16 Chairman commented today is National Police Officers' Memorial Day
17 and cited that since 1988, 200 officers have lost their lives in
18 crashes that involved drunk drivers. The complement of that, of
19 course, is that nobody ends up in the system if you folks aren't
20 doing your job on the frontline, and you're just a critical
21 element of ever seeing these people in any other part of the
22 system is they've got to get identified, and the data show that
23 we're not getting a lot of them, given the sort of large number of
24 trips, et cetera.
25 But I'm curious, and this is actually for each of you in

1 your perspective, is where you feel DWI fits and the levels of
2 priorities within your organizations and among your colleagues?
3 So from a straight, you know, on the street law enforcement, from
4 a DA perspective, insurance, where does DWI fit?
5 TECH SGT. PAQUETTE: I'll speak first, and we can go
6 down through. For us, DWI is a high priority and our
7 superintendent has made that known and we pass that information
8 down to the troopers out there on the road.
9 Once you've gone to a house at 2:00 in the morning and
10 knocked on that door, and you have said, I'm sorry to tell you,
11 but your wife, kids, your husband, was just killed in a car crash,
12 and you know that it's alcohol related, it changes your
13 perspective on things. The old, well, can you just take me home?
14 I don't think so.
15 So that really helps cement law enforcement across the
16 board. I don't care, you can talk to any of the officers who are
17 here for the National Memorial. They'll say that's one of the
18 toughest things we do, and we see that as a direct relationship to
19 impaired driving. So for us, it is a high priority.
20 MEMBER ROSEKIND: And just quantify that for me. We
21 won't hold you to it, but you're on the record. Is it top two,
22 top three, top five? Where's it fit for you?
23 TECH SGT. PAQUETTE: Traffic safety is in the top one or
24 two in our agency.
25 MEMBER ROSEKIND: Great. Thank you.

1 MR. DIEPRAAM: DWI enforcement is very complex because
2 there's a lot of scientific issues that we have to deal with, and
3 that kind of complicates the process. But just to answer your
4 question specifically, in my jurisdiction, and I feel in other
5 jurisdictions it's probably the same, we have more people who die
6 a violent death because of vehicular crimes or vehicular crashes
7 than we do all other violent crimes combined. So it's the top
8 priority in my jurisdiction with my boss, the district attorney.
9 With the law enforcement agencies, the polices officers,
10 it's the number one crime committed in my county and that's DWI.
11 So we focus on it pretty heavily. The Texas Department of Public
12 Safety sends more troopers to my jurisdiction to focus on DWI but
13 that's because we're such a deadly county. Other counties are not
14 as deadly as my jurisdiction, unfortunately -- or fortunately for
15 them, I guess. But I would say that DWI and traffic safety
16 enforcement is a top three for police officers and for
17 prosecutors.
18 MS. SALVATORE: Auto safety is a primary issue for the
19 insurance industry, not just from the economic incentive that I
20 was saying we will charge more for somebody who's been convicted
21 or denied private insurance, but historically insurance companies
22 have been huge financial supporters of all of the organizations
23 that basically work in the community. You see insurance companies
24 and agents volunteering their time, that auto safety is a bread
25 and butter issue for the insurance industry, all aspects of auto

1 safety.
2 MEMBER ROSEKIND: And for our two law enforcement folks,
3 I'm curious if you can comment on the workload. I had somebody
4 basically explain that they could spend more time doing paperwork
5 on DWI than in a homicide. I'm sure on the prosecution side also
6 it's got its challenges. So can you tell us anything about sort
7 of the barriers or challenges of just the workload of trying to
8 deal with DWI?
9 TECH SGT. PAQUETTE: There is a lot of paperwork no
10 matter how you cut it. We need to make sure all our I's are
11 dotted and all our T's are crossed because if we don't, then
12 prosecution's going to have a tougher time winning that case, and
13 I've got to say, too, it's not just law enforcement doing it, but
14 if we do everything we do, and the prosecutor doesn't, then the
15 case falls apart. If we don't do what we're supposed to do, no
16 matter how good your prosecutor is, it's not going to fly. So we
17 really have to work together with the prosecution to package these
18 up.
19 But paperwork is and inconsistency in paperwork. In New
20 York, in some areas, counties have their own paperwork. So if I
21 was to send a trooper from one area of the state down to work a
22 detail in another area, there may be a difference in paperwork
23 that he or she has to file, and that just complicates it. It
24 takes that much longer. So, yes, there's a lot of paperwork
25 involved.

1 MR. DIEPRAAM: And it's also a huge burden on the court
2 system, being the number one crime in my jurisdiction or the top
3 three in other jurisdictions. It takes up a lot of time, a lot of
4 our resources in trying to combat these. So we've dealt with it
5 by increasing the fines that we charge DWI offenders. So it goes
6 back into the community, back into enforcement efforts, but that's
7 just one of the ways we address it.
8 In Texas and in other jurisdictions that I've seen all
9 around the country, that's the number one complaint is that
10 there's so many DWI cases it's a burden on the system.
11 MEMBER ROSEKIND: So we're at red. So I'm going to ask
12 one real quick one again. If there was one new innovative tool
13 that was available to you, just each of you, what would that be
14 that you think would make a real difference? Think broadly,
15 whether it's a passive sensor in a flashlight or a short online
16 DWI form, you know, what's the one tool that would really make a
17 difference on this issue for you?
18 MR. DIEPRAAM: I hate to toot my own horn, but No
19 Refusal is something that is making a big difference because we're
20 getting rock solid scientific evidence in these sorts of cases
21 with 100 percent conviction rates on these sorts of cases going to
22 trial. The defense attorneys will plead guilty on these cases,
23 they'll pay the higher fines, because they know that they can't
24 beat the case. Right now, that seems to be making a huge
25 difference in the jurisdictions that are using No Refusal, but

1 there's not one answer. There are many answers.
2 TECH SGT PAQUETTE: I would take a passive sensor for
3 the checkpoints. I want to get them off the road. If I can find
4 them and get them off the road, I'll deal with the paperwork down
5 the road, but I want to get them before they hurt themselves or
6 somebody else.
7 MS. SALVATORE: Technology actually could be a help
8 also. There's some of the technology that will simply shut the
9 car off. The person will have to sit in the car. They can't go
10 anywhere.
11 MEMBER ROSEKIND: Thank you.
12 CHAIRMAN HERSMAN: Vice Chairman.
13 VICE CHAIRMAN HART: Thank you, Chairman Hersman, and
14 thank you to the three of you for taking time to come and help us
15 with these issues. That was a good segue into the No Refusal
16 because I, frankly, Mr. Diepraam, I'm kind of confused about how
17 this works in the moment. So if you would walk this through me,
18 you know, 1:30 in the morning, I'm assuming erratic behavior. So
19 now the person is stopped, okay. So from that point on, walk me
20 through the No Refusal process.
21 MR. DIEPRAAM: It's handled like a regular DWI stop.
22 You've got the police officer that sees the traffic violation,
23 stops the violator, notices the signs of intoxication, does field
24 sobriety tests, arrests the individual for DWI, reads them their
25 warnings, offers them a breath test.

1 VICE CHAIRMAN HART: So by now the person is actually
2 under arrest?
3 MR. DIEPRAAM: Yes.
4 VICE CHAIRMAN HART: Yes.
5 MR. DIEPRAAM: It is a post-arrest process.
6 VICE CHAIRMAN HART: Okay.
7 MR. DIEPRAAM: So you've got your regular DWI. You've
8 got your refusal. Only when you get that refusal does the No
9 Refusal process begin.
10 VICE CHAIRMAN HART: Okay. So it's 1:30 in the morning,
11 and the person says no.
12 MR. DIEPRAAM: Then the police officer will re-cuff the
13 suspect, put them to a bench, walk over to the next room where the
14 prosecutor is sitting and say, I've got a DWI suspect that refused
15 to give me a breath test or a blood test, and I'm requesting a
16 search warrant.
17 VICE CHAIRMAN HART: So you, the prosecutor, are there
18 at 1:30 in the morning?
19 MR. DIEPRAAM: I'm there at 1:30 in the morning on New
20 Year's Eve or Halloween or whenever it is with the police
21 officers. We talk about the arrest. We draft a search warrant.
22 We've got a little form search warrant where we check in the boxes
23 because we've got so many different -- we've only got so many
24 different types of DWIs. So we'll check off odor of alcoholic
25 beverage, failed field sobriety test, admitted to driving,

1 admitted to drinking, portable breath test result. We'll put all
2 of those into the search warrant, and then we'll walk it over to
3 the judge who is in a different --
4 VICE CHAIRMAN HART: Also at 1:30 in the morning, he's
5 there? I mean all these people are there 24/7; is that what we're
6 hearing?
7 MR. DIEPRAAM: Well, not 24/7 because it's a pretty
8 expensive project to pay for.
9 VICE CHAIRMAN HART: That's why I'm asking the question.
10 MR. DIEPRAAM: Yeah. We only do it on high drinking
11 holidays like --
12 VICE CHAIRMAN HART: Oh, I see. Okay.
13 MR. DIEPRAAM: -- Christmas Eve, Halloween, 4th of July,
14 Memorial Day, Labor Day, St. Patrick's Day. Because of a TXDOT
15 grant, we're able to do No Refusal operations about 80 times a
16 year, but most jurisdiction are not lucky. They don't have grants
17 that enable them to do that. They use volunteers probably
18 somewhere between 5 and 15 times a year.
19 VICE CHAIRMAN HART: So what's the success rate on your
20 search warrant now? You take that to the judge and have the judge
21 review your search warrant. What's the success rate on your
22 search warrant?
23 MR. DIEPRAAM: Because it's a process that we're all
24 very familiar with, that we've worked on, that we have specialized
25 police officers and prosecutors working together, probably about

1 99 times out of 100, when the judge reviews the warrant, the judge
2 will sign the warrant. But the good thing about No Refusal is
3 that if there's a problem with the search warrant, the judge can
4 say, hey, you left out the fact that the person was driving, and I
5 can fix that. If there's No Refusal, there's nothing I can do to
6 fix that; it's over. But 99 times out of 100, we get it right,
7 the judge reviews it and signs it, we go back and take the blood.
8 We can get the whole process done in about as little as 15
9 minutes.
10 VICE CHAIRMAN HART: Now, is life any more difficult for
11 the person who refused than for the person who said upon arrest,
12 yes, I will take the test? In other words, is there any
13 disincentive to refusing?
14 MR. DIEPRAAM: The disincentive to refusing is that you
15 get a longer license suspension in Texas, as you do in most
16 states, for refusal. And the other disincentive is, if you refuse
17 we're going to get your blood anyway. So now we've got the
18 refusal, which is admissible as evidence of guilt, but we also get
19 the blood test.
20 VICE CHAIRMAN HART: Okay. So if I had a .1 and I did
21 that because I didn't refuse, versus a .1 after I went through
22 this whole process of me refusing and you getting a search warrant
23 and stuff, the one who refused is going to end up suffering more
24 consequences than the one who didn't refuse?
25 MR. DIEPRAAM: That is correct, yes.

1 VICE CHAIRMAN HART: I see. Okay. And once you go
2 through that whole process, you said the conviction rate is pretty
3 much 100 percent?
4 MR. DIEPRAAM: The trial conviction rate in my
5 jurisdiction is 100 percent for No Refusal cases, and the overall
6 DWI rate for people charged with this sort of a case, when we get
7 this type of evidence, blood evidence, is approximately 95 percent
8 in my jurisdiction and also in many of the other jurisdictions
9 that I've helped to implement the No Refusal process.
10 VICE CHAIRMAN HART: So is the trial any quicker or is
11 that a moot point because the defense attorneys settle out because
12 they know that they're likely to get convicted?
13 MR. DIEPRAAM: The trial length is a little bit longer
14 because there's more scientific evidence but not substantially
15 longer, but the benefit is that most of these defense attorneys
16 are settling and pleading to DWI and not getting dismissals or
17 reductions or not guilties.
18 VICE CHAIRMAN HART: So the last question. How many
19 other jurisdictions do you know of, outside of Texas I'm talking
20 about, not counties in Texas, but how many other jurisdictions do
21 you know of that are trying this? It sounds like a very expensive
22 but a very innovative process. How many other jurisdictions that
23 you know of are trying this?
24 MR. DIEPRAAM: In Louisiana, there are four parishes.
25 In Missouri, there are three counties. In Illinois, I'm aware of

1 about four or five counties. In Arizona, they pretty much do it
2 statewide. So it's an expanding process. It can be very
3 expensive if you pay the nurses, if you buy all the equipment and
4 all that, but it doesn't have to be expensive. When we started, I
5 volunteered my time, and we got equipment given to us by fire
6 stations because they knew that if we're doing a better job
7 enforcing DWI, that's fewer calls for them to go to.
8 VICE CHAIRMAN HART: And are they also doing it on high
9 drinking events, or is it a 24/7 in any of those, do you know?
10 MR. DIEPRAAM: There are a few jurisdictions that
11 because of grant funding are doing it 24/7. Bear County, which is
12 San Antonio, they're doing it 24/7, and some of the smaller
13 jurisdictions that also have grant funding are doing it 24 hours a
14 day.
15 VICE CHAIRMAN HART: Okay. I have questions for the
16 other two but my time is up. Thank you very much for that.
17 CHAIRMAN HERSMAN: Thank you, and I'm going to turn to
18 Ms. Salvatore because you haven't gotten a lot of questions.
19 MS. SALVATORE: Okay.
20 CHAIRMAN HERSMAN: I was actually a little bit surprised
21 to hear about the social host and so I don't know if any of my
22 other colleagues -- did you know, Member Sumwalt? Had you known
23 about that?
24 MEMBER SUMWALT: Well, I've known it was a problem but
25 it's really a problem now that I know I might have to invite my

1 guests over to stay.

2 MS. SALVATORE: That's right.

3 CHAIRMAN HERSMAN: Member Weener, I don't know if you

4 were familiar with the social host penalties and insurance

5 clauses. I wasn't.

6 MEMBER WEENER: I've heard of it before.

7 CHAIRMAN HERSMAN: Yeah. Others?

8 So I think my question is, is if you're doing all of

9 these campaigns around every holiday period, and many of us are

10 very safety conscious and safety minded here, what is your

11 penetration for reaching your target audience if you're trying to

12 convey to people not to be the enablers? And I think this is

13 really getting back to the panel that came before you, talking

14 about the secondhand smoke issue and casting a wider net, and

15 understanding how these things are happening. How do you measure

16 success when you're looking at commercial establishments or

17 homeowner social hosts?

18 MS. SALVATORE: Well, we're a communications

19 organization. So we basically look at how effective we are in

20 terms of with the news media. So what we try to do is to get

21 media to cover this, and so that if over each holiday, we get

22 local television or we get a really good article in a national

23 newspaper, that's how we would define success, in the sense that

24 we're hoping that over time that this message will start to

25 penetrate, that people will think a little bit differently when

1 they throw a party, and that's really why we put this out. It's a
2 safety issue for us.
3 CHAIRMAN HERSMAN: How often are insurance companies
4 actually going after commercial establishments or homeowners?
5 MR. SALVATORE: Well, it's not that they're going after
6 them. It's that they provide liability protection. So one of the
7 things you get in a commercial insurance policy is liability. You
8 get liability in your homeowners, so that they're paying for this.
9 In the event that the homeowner is held liable, that's going to be
10 covered under insurance. So it's important that the homeowner
11 understands that, yes, their homeowner's insurance will help pay
12 for some of that, but it's also going to cost them more money, the
13 homeowner, the next time when they want to renew that home
14 insurance policy.
15 CHAIRMAN HERSMAN: But it's probably an insurance
16 company that's having to go after another insurance company to
17 collect on that, correct? Let's say there's an event where you
18 have a fatal accident and someone is killed.
19 MS. SALVATORE: It could be. Each situation is
20 different.
21 CHAIRMAN HERSMAN: Okay. I guess the question is how
22 many times is that exercised, I'm trying to figure out in the real
23 world, because I think one of the stories would be is people don't
24 know about this but actually the news value is look and see what
25 happened here.

1 MS. SALVATORE: You know, that's a data point that I
2 don't specifically have. We've actually just looked at this
3 recently with dog bites, believe it or not, because that's another
4 safety issue and one-third of all homeowner's liability claims are
5 for dog bites, but we haven't done the analysis for this. That is
6 something we could certainly look into.
7 CHAIRMAN HERSMAN: Okay. And are there any policies
8 that are voided if people violate their agreements for, not
9 necessarily for damage to others, but maybe something for
10 themselves?
11 MS. SALVATORE: Well, you know, in terms -- if a
12 homeowner is held liable -- and once again, every company's
13 different; states have different laws, so that the impact will be
14 different, but essentially a couple of things could happen. They
15 could get non-renewed. If a homeowner throws a party and their
16 guests get into an accident and it was caused by drunk driving,
17 they could be non-renewed. They could be charged more. They
18 could have a more difficult time getting insurance. But each
19 situation is going to be different and it's looked at on its own
20 merits.
21 CHAIRMAN HERSMAN: Okay. And how about on the
22 enforcement and the legal side, is there ever situations that you
23 can recall where homeowners or commercial establishments have been
24 faulted?
25 TECH SGT. PAQUETTE: We've arrested folks for underage

1 parties where they've served alcohol to kids and there's been
2 wrecks as a result, and we try to use that as publicity, PSAs and
3 such down the road.
4 CHAIRMAN HERSMAN: Only on underage drinking?
5 TECH SGT. PAQUETTE: There are some establishments that,
6 bars and taverns that have been, but I don't know the final
7 outcome of those litigations.
8 CHAIRMAN HERSMAN: Okay. But it's focused on underage?
9 TECH SGT. PAQUETTE: The home parties were, but the bars
10 and taverns, that was someone who was in their late 20s who had
11 way too much and probably should not have been served, and New
12 York has a law about not serving intoxicated patrons, and that was
13 not adhered to and the person went out and there was a fatality as
14 a result.
15 CHAIRMAN HERSMAN: Okay. Thank you all so much.
16 Obviously there are so many issues that I think we could continue
17 to follow up on. It's certainly very interesting for us. We
18 appreciate you all being here and sharing your personal
19 experiences and many of your accomplishments because I think some
20 of those serve as great examples for what we can model around the
21 country. So thank you very much for being here.
22 We are going to take an afternoon break. Once again, I
23 encourage you to visit our displays and also be on the lookout for
24 some of those PSAs and other activities that are coming your way.
25 We're going to reconvene at 3:20.

1 (Off the record at 3:05 p.m.)
2 (On the record at 3:20 p.m.)
3 CHAIRMAN HERSMAN: If everyone can take their seats,
4 we're about to begin.
5 Welcome back. We will now proceed with our final panel
6 for today. Ms. Davis, will you please introduce the panelists?
7 MS. DAVIS: Our final panel will describe what happens
8 after the arrest and address the benefits and challenges that the
9 judicial system faces in dealing with substance impaired drivers.
10 Please note that after the presentations, we have
11 scheduled 20 minutes of questions from the technical panel before
12 proceeding to Board member questions. Also, two of our panelists,
13 Judge Michael Barrasse from the Lackawanna County Court of Common
14 Pleas, and Joanne Thomka, from the National Traffic Law Center,
15 will not be giving formal presentations but will be prepared to
16 address questions about the judicial system.
17 Our first presentation is from Dr. Ward Vanlaar, from
18 the Traffic Injury Research Foundation. Dr. Vanlaar will provide
19 an overview of the adjudication sanctioning system with a specific
20 focus on the law and order elements of prosecution, adjudication,
21 vehicle sanctions, licensing sanctions, probation and DWI and drug
22 courts. Dr. Vanlaar.
23 DR. VANLAAR: I'd like to thank you for having me. It's
24 a great honor to travel all the way from Canada and to be able to
25 give you our perspective.

1 Before talking about some of the measures that I want to
2 focus on, I wanted to basically provide some broader context, and
3 what I'm trying to say is I think times are changing. We may not
4 always notice it because change can be very slow but still it's
5 there, and in light of this change, what we see is that the
6 justice system has traditionally focused heavily on traditional
7 punitive approaches and that's not sufficient. I'm not here to
8 say that punishment is not important. I think punishment serves
9 an important function in our society, but I think if we're going
10 to do something about reducing this risk in the long term, we are
11 going to have to do something in addition to that.
12 Also as researchers, we're always good at producing
13 scientific research, studies, publish them, but we're not always
14 great in terms of making it meaningful for practitioners. So with
15 that, it's really important to put an emphasis on knowledge
16 translation.
17 I wanted to show you a specific example of knowledge
18 translation that we have worked on. Basically, I'm going to
19 continue talking until the presentation is up again. What I
20 wanted to talk about is a unique example of knowledge translation
21 that we have worked on at the Traffic Injury Research Foundation.
22 Someone is playing tricks on me.
23 So on the next slide, what you an see is an example of
24 knowledge translation that the Traffic Injury Research Foundation
25 has worked on, and basically this consisted of a review of the

1 criminal DWI system in the United States with funding from
2 Anheuser-Busch and the goal was really to identify priority
3 problems and practical solutions to improve the efficiency and
4 effectiveness of the criminal DWI system.
5 We like to refer to this project as a unique one because
6 we were able to engage and include thousands of frontline
7 professionals, which basically they informed all of this research.
8 So ultimately this has led to the creation of the working group on
9 DWI system improvements, and on the next slide, you can see some
10 of the members of this working group. It's quite a long list.
11 On the next slide, you will also see actually that NTSB
12 has at times participated in the activities of the working group.
13 Everything that I'm going to tell you really is based on
14 activities of this working group as well as the scientific
15 research.
16 So the first measure I want to talk about is alcohol
17 ignition interlocks. You may have heard about this before. These
18 are breath testing devices that are connected to the starter
19 system or the on-board computer of a vehicle. It prevents the
20 starting of a vehicle if an alcohol breath test shows that the
21 result is greater than a preset limit, which typically is .02
22 percent. This is really a proven technology that's very robust
23 and that's very difficult to circumvent.
24 When you look at the research, first I want to
25 emphasize, this has been mentioned before today, but there's

1 actually a lot of research showing that many people who are
2 suspended, revoked or otherwise unlicensed, they continue to drive
3 anyway. Also we have about 30 years worth of research about
4 alcohol ignition interlocks. So this is really a well studied
5 measure that's been proven to work really well.
6 As you can see, studies show that the average reduction
7 in recidivism compared to offenders who are not on the interlock
8 is about 64 percent, which is quite amazing.
9 In terms of crash rates, we do have some limited data
10 about crash rates. It's not as robust as the data that we have
11 about reductions in recidivism, but overall still we see that
12 crash rates are similar to general driving populations and, more
13 importantly, the alcohol-related crashes are lower than those for
14 suspended drivers.
15 Here you can see another monitoring technology that's
16 available in the form of ankle bracelets. They basically measure
17 whether you've been drinking using vaporous perspiration. They're
18 worn as anklets. You can see two pictures there of two different
19 devices. We know today now that there's more than two devices on
20 the market. They're used with offenders who use alcohol,
21 including drunk drivers. However, it's important to highlight
22 that this is a different type of technology. It doesn't
23 necessarily physically prevent the drink driver from starting a
24 vehicle. It's a different type of technology that may serve
25 different purposes.

1 The research about this is also quite extensive.
2 There's about 22 peer reviewed studies available and a variety of
3 experimental studies that really establish that consumed alcohol
4 can be measured in perspiration in a valid fashion.
5 What you can do with this technology is distinguish
6 between people who have not been drinking at all, people who have
7 been drinking moderate amounts of alcohol and people who have been
8 drinking a lot.
9 The effectiveness and success rates of transdermal
10 alcohol bracelets are very promising. Some devices have been
11 evaluated but in all fairness, if you compared them to interlocks,
12 the literature about this is more limited, which is not surprising
13 given that this technology hasn't been around as long as
14 interlocks.
15 There's many implementation challenges with
16 technologies. We don't have time to really zoom in on all of
17 them. What I do want to mention is that something that we've
18 noticed with all of the work that we've done is that there's a
19 limited education available which makes it difficult for frontline
20 practitioners to really intimately understand how these
21 technologies work and what their limitations are.
22 Another thing that we notice or that we observe when we
23 work with jurisdictions is that often there can be poor
24 communication. We deliver technical assistance to jurisdictions
25 in the United States to help them with the delivery of alcohol

1 ignition interlock programs with funding from NHTSA, and what we
2 see is that in those jurisdictions where communication is really
3 coordinated and there's good coordination, often delivery of the
4 program is of a better quality.
5 The next measure that I want to talk about was DWI
6 courts. This is a specialty court. Unlike a traditional court,
7 this is about convicting or convicted drunk drivers who are less
8 likely to be deterred by traditional penalties and interventions.
9 These are really courts that try to find the right balance between
10 supervision, screening and assessment and treatments.
11 What's perhaps most important is that they use a team-
12 based approach to develop a program based on offender risks and
13 needs and accountability and supervision.
14 What you can see here on this slide is that it's really
15 about a coordinated effort. The judge plays a very important role
16 but there's many other parties that are involved and that are
17 needed to be involved to really make this work.
18 There's also quite a lot of research available about
19 this. For example, a Michigan study of three DWI courts found
20 offenders were 19 times less likely to be arrested for another
21 DWI. There's another set of studies of three courts who showed an
22 80 percent retention rate and recidivism rate of 9 percent
23 compared to recidivism rates of 24 percent in traditional courts.
24 And, yes, there are some barriers. Some judges are
25 reluctant to use DWI courts. This may be related to the fact that

1 some judges think that some of the things that are needed to
2 successfully deliver a DWI court, some of these things may be
3 outside the scope of their expertise. For example, when you're
4 delivering -- when you're involved in a DWI court, it's not only
5 about taking up your role as an objective arbiter, but you're now
6 also as a judge going to be involved in decisions about treatment,
7 monitoring, and not all judges are comfortable with that.
8 Also there can be a lack of agency buy-in. As you have
9 seen on this previous slide, obviously many stakeholders are
10 involved. If not all of them are looking into the same direction,
11 trying to obtain the same goals, that might create a challenge for
12 this to work.
13 The next measure that I wanted to mention is community
14 supervision. Community supervision is about agencies who
15 supervise individuals in the community as an alternative to
16 incarceration. The goal is to protect the public and promote
17 rehabilitation. This is about managing offenders at different
18 levels, and the level of supervision is individualized. Some of
19 the tools that are being used with supervision include, for
20 example, random testing, electronic monitoring, alcohol monitoring
21 and so on.
22 There's general research available that shows that
23 incarceration is not necessarily the most effective thing to do,
24 and that other things work better. Treatment programs have
25 actually been shown to be more effective when delivered in a

1 community setting. For example, one of the reasons why that is,
2 is offenders are then shielded from the negative effects of
3 incarceration. Also you basically provide them an opportunity to
4 maintain their family life, maintain employment, which are
5 important risk factors.
6 In all fairness, few studies have specifically examined
7 the effectiveness of community supervision, reducing recidivism
8 among DWI offenders, but it's fair to assume that at least on a
9 general level what we see with all offenders would also work with
10 DWI offenders.
11 Most importantly for this particular measure, there's a
12 lack of funding. The budgets for probation, for example, have
13 been stagnant for a long time or have been reduced. In addition
14 to that, there's large caseloads which really this actually
15 encourages people to emphasize or to limit their emphasis on
16 enforcement at the expense of rehabilitation, which goes back to
17 what I said at the beginning, that there's really a need for a
18 better balance.
19 I also wanted to talk quickly about traffic safety
20 resource prosecutors. I think it's been mentioned before today
21 that DWI cases are among the most challenging to process. Often
22 they're handled by the least experienced prosecutors. These
23 traffic safety resource prosecutors really are people who have a
24 lot of experience in this particular area, and they can serve as a
25 resource and a liaison to work with other parties or other

1 stakeholders that are involved. They can also, for example, help
2 prepare for very complex DWI cases.
3 There are no studies available that specifically examine
4 the effectiveness of the traffic safety resource prosecutors.
5 It's certainly possible from a theoretical point of view, but it
6 would be difficult or challenging to tease out really the
7 effectiveness and to account for all of the other confounding
8 factors. However, what we have learned from the work that we've
9 done with the working group on DWI system improvements is that one
10 of the most important problems that were put forth was the lack of
11 communication and cooperation among professionals, and from that
12 point of view, it's certainly fair to say that a traffic safety
13 resource prosecutor would help overcome that challenge.
14 One last slide about administrative license suspension.
15 Yes, this works. There's a lot of research to show that it works,
16 but it also is not a complete solution to the problem. Again,
17 we've heard many times before today that people who are suspended
18 continue to drive anyway and there's better alternatives out there
19 for dealing with this population.
20 So I was asked to conclude by saying what I think needs
21 to be done, and then specifically with recommendations for NTSB.
22 What we often like to say at the Traffic Injury Research
23 Foundation is that we don't think that there's necessarily a need
24 to revolutionalize the system. We think that the existing system
25 actually has many strengths. What we do need is a more consistent

1 use of proven measures within the existing system. Specifically
2 with adjudication and sanctioning, which I was asked to talk
3 about, this can be accomplished by enhanced legislation and
4 regulation, greater use of technology, improved
5 communication/cooperation, enhanced training and education and
6 more resources.
7 And then finally what do we think NTSB can do? Well,
8 with respect to the system, we would argue that -- we would
9 encourage NTSB to support and promote approaches that acknowledge
10 the complexity of the system, and that without
11 communication/coordination, offenders will really benefit from the
12 loopholes that will be created as a result of that. This goes
13 back to the importance of, for example, DWI courts and TSRPs.
14 With respect to the measures, we would encourage NTSB to
15 promote the adoption of a productive balance between punishment
16 and rehabilitation, with the ultimate goal of protecting the
17 public in the long term, support and promote implementation of
18 proven measures, the technologies that I touched on, and then
19 promote individualized approaches that can provide tailored
20 responses based on risk level and needs.
21 And with that, I thank you for your attention.
22 MS. DAVIS: Thank you, Dr. Vanlaar.
23 Mr. Terrence Walton, from the Pretrial Services Agency
24 for the District of Columbia, will give us a presentation, an
25 overview of the role that treatment should play in adjudication

1 and the different treatment modalities. Mr. Walton.
2 MR. WALTON: Thank you, and thank you to the Chairman,
3 Vice Chairman and Members. It's a pleasure for me to be here
4 today.
5 I speak from a couple points of view. I'm a treatment
6 practitioner of many years, and I have worked for the last 15
7 years in the criminal justice system delivering treatment
8 services, also as a part of the faculty of the National Center for
9 DWI Courts. I spend lots of time working with two major systems,
10 the criminal justice system and the treatment delivery system,
11 trying to help them work together better, both primarily to
12 provide services for men and women who have either drinking-
13 related driving offenses or some other illicit drug-related
14 offense.
15 And, I guess I want to begin by just talking a little
16 bit about one of the challenges for policymakers as well as for
17 people like me who are trying to help systems work together, is
18 the fact that there are varying perspectives and priorities, that
19 there is sort of a personal health versus public health, a
20 personal safety versus public safety perspective that the two
21 systems adopt; primarily the criminal justice system being
22 concerned with primarily with public safety, the treatment systems
23 at least traditionally being more concerned with personal safety
24 -- I'm sorry, with personal health and then also personal safety.
25 So one of the things from a policy perspective and also

1 for a program development and collaboration perspective is really
2 helping these systems to understand the other perspective, the
3 other side's perspectives and priorities to help them work
4 together better because that's really what this is. This is in
5 order for offenders who have alcohol and drug issues, particularly
6 offenders who are substance dependent, the two systems have to
7 work hand-in-hand in order for us to get the kind of results that
8 we're hoping for.
9 Some of the things that I have found, and I think that
10 as we try to help these systems work together is that if you look,
11 for instance, at sort of the treatment perspectives on the
12 criminal justice system, that there is sometimes distrust, as well
13 as that there are demands that are placed on treatment from the
14 justice system to which we are often not accustomed. That
15 distrust is often not understanding the role of a judge in
16 ordering treatment that has to be voluntary. That doesn't feel
17 right to many treatment professionals. As well as the fact that
18 the courts require a level of accountability that many in my field
19 are just becoming accustomed to.
20 There are also opportunities that are presented that I
21 believe individuals see from the treatment perspective that are
22 positive, and that is that the justice system has been very
23 helpful in programs recruiting, finding individuals, and in some
24 cases being able to fund them. The justice system also has access
25 to other resources that the treatment community can engage.

1 I suppose the biggest advantage of court involved
2 treatment, court involved or coerced DWI treatment is the fact
3 that retention is helped by that. From my time in the private
4 sector before I started working with the justice system, one of
5 the biggest challenges was not delivering effective treatment, but
6 was keeping participants engaged and present long enough for it to
7 kick in, for them to get the benefits, that retention is one of
8 the advantages. So those are the things that we emphasize when
9 we're trying to help the systems work together.
10 On the other side, and I don't think you actually have
11 this slide, but on the other side, we could look at a similar kind
12 of analogy or description of criminal justice perspectives on the
13 treatment system, and the only piece I'll emphasize here is that
14 it's been my understanding, my experience, that there are two big
15 questions that criminal justice professionals have about
16 treatment. Number one is, well, what's actually happening? There
17 are so many different programs, different models, different
18 intensities; what actually occurs in treatment? We're investing a
19 lot in this concept. What actually happens?
20 And then despite whatever happens, is it effective?
21 Treatment effectiveness is a question. Fortunately researchers
22 and others are helping us with some of that. We know so much more
23 today about what works in treatment than we did some time ago.
24 And so I want to spend really the rest of my time sort
25 of talking about what we believe works as it relates to especially

1 the treatment of offenders and treatment specifically of offenders
2 who are charged with alcohol-related offenses.
3 A couple of things that I just want to emphasize as we
4 begin and that is that one of the paradoxes of what I'm describing
5 is that by law, treatment has to be voluntary in almost every
6 case. There is some exceptions but, by and large, people have to
7 consent to participate in treatment.
8 However, mandated and coerced treatment is common and
9 has been found to be effective and so -- but, nonetheless,
10 programs that are well structured find ways to emphasize the
11 choices that individuals make about deciding not to face the
12 consequences of not receiving treatment, as well as some degree of
13 choice in the particular kind of treatment that they engage in.
14 That is sometimes challenging for the justice system because we're
15 used to being very prescriptive, and best practices say that to
16 the extent there are options that participants can be given,
17 they're more likely to engage more quickly, and as long as those
18 options are appropriate for their level of need and risk, that the
19 possibility of effectiveness is increased.
20 Much of what I'm going to talk about for the rest of our
21 time is based on a meta analysis done in 2006 that looked at all
22 of the research on court-mandated treatment for drinking drivers.
23 That is an article that's in public docket and that I believe you
24 have available to you, and so I wished -- I wanted to find the
25 most recent analyses I could, and I think this is it where it

1 looked at a number of studies, all of the studies that in any way
2 address this issue, and there were some findings that they
3 observed that are very consistent with my anecdotal observation,
4 and I want to talk about a few of those.
5 First of all, when we talk about treatment for DWI or
6 drinking drivers, that the term treatment means almost nothing
7 because there are so many different variations of what's
8 delivered, levels of intensity, number of hours, whether it's
9 really treatment or simply education, which model was used. It
10 ranges -- there's some programs that have interventions that are
11 very brief, one or two sessions. Some have interventions that
12 last for months and months and followed up by aftercare. But the
13 term treatment is so broad and so generic, that in and of itself
14 it doesn't have much meaning.
15 And so as we look at the various programs, the alcohol
16 safety action programs, even programs that are serving DWI courts
17 across the country, what treatment means may be different
18 jurisdiction by jurisdiction and program by program.
19 This is a potential problem, but as we try and find the
20 most effective models -- and if there's any policy implications
21 here, I suppose it might be that if there's a way we can encourage
22 communities to adopt standardized rules for how we identify which
23 people need help, as well as how we identify specifically what
24 treatment means, and how we determine what we're doing within the
25 treatment programs. And this is a point made in the article.

1 They talked about how even through the studies they looked at,
2 that there were so many different variations that trying to
3 determine effectiveness was challenging. Despite that, they did
4 find that in general what they describe as at least a moderate
5 effective, a moderate positive effect from these programs on
6 drinking-related crashes, and that I think is significant.
7 There's a couple of things that might explain the
8 variability, and sometimes it is for perfectly valid reasons that,
9 first of all, we don't want a one size fits all approach and that
10 there needs to be a range of treatment options based on need.
11 There are varying risk levels, varying need levels, and so there
12 are assessments that can be conducted to help determine which
13 level and which kind of treatment is most effective.
14 Now, if that explains the variability, that's not an
15 issue. That's appropriate. That's research based. It's what we
16 want to encourage. However, there are also, especially within the
17 justice system, there may be other reasons for the variability.
18 Sometimes it's because a court will order a particular kind of
19 treatment, a particular level of care, and while that is certainly
20 within the judge's prerogative, best practices say and research
21 says that if we deliver treatment at a level different than what
22 they need, even if it's more intense than they need, that the
23 effects, the impacts, the results are not good.
24 So variability is a problem if it is not based on
25 objective, primarily clinically based reasons. And so anything we

1 can do to encourage that, to encourage standardization and a
2 common standard for determining both who gets treatment and what
3 kind of treatment they get, I think is a step forward.
4 There's some components that are important here, and
5 that is, it starts with an effective assessment, and that, I
6 think, is probably a point I want to linger with for just a
7 moment, that one of the challenges for the court and for the
8 justice system in dealing with drinking driving offenses and
9 offenders is determining what kind of care they need.
10 We know that not every drunk driver is substance
11 dependent. There are many drinking drivers who would be able to
12 abstain from drinking alcohol if they were told to do so and
13 believed it was in their best interest to do so. There's no
14 question about that. Those individuals probably don't need
15 treatment at all. Control strategies and other approaches would
16 probably be the best use of resources and would get us everything
17 we need.
18 The category of offenders that I am involved with most
19 often are those who are assessed as abusers or more frequently as
20 substance dependent as alcoholics, and we know there are many
21 factors that go into whether or not an individual -- not every
22 alcoholic drinks and drives, but that's totally a risk factor that
23 can't be ignored, and if we have an individual with a current DUI
24 charge who is also diagnosed with alcohol dependence, treatment is
25 absolutely necessary for them. And so communities adopting

1 standardized approaches and procedures for ensuring that people
2 are assessed using valid tools and the treatment is matched to
3 what the assessment shows is critical.
4 Now, I'm going to skip a lot of what I have here, and we
5 can address it during the questions, but let me just say a couple
6 things to point out to you, and that is, I put in your notes a
7 study that talks about the kinds of things -- they did a study
8 trying to determine which DUI offenders would recidivate. And
9 that study looked at several factors, but among the factors that
10 were found to be most predictive was the level of alcohol
11 severity, the problem's severity. Not a surprise. But it just
12 seemed to find research to back that up, that those who have
13 higher problem severity, those who have more serious involvement,
14 are more likely to recidivate, which I don't believe is a surprise
15 to anyone. And this is the study. I'm going to skip this and go
16 to the recommendations here in our final minute.
17 And there are a couple of things that I think are
18 important here. First of all, and I don't know which of these
19 items the Board can have any influence over, but I'll list the
20 things that I think are important and perhaps some of them you can
21 help support.
22 That, as I've mentioned, promoting evidence-based DWI-
23 related treatment is important, that there is a body of research
24 now that says there are certain approaches that are more effective
25 in treatment in general, and a smaller body, but still existing,

1 of research that indicates what kinds of alcohol-related treatment
2 is most effective. And I'll just say that for the offender
3 population, having alcohol-specific interventions were found to be
4 more effective than generic counseling.
5 It's also, I think, as I believe I mentioned earlier,
6 that we want to encourage less variability in the treatment that's
7 delivered to similarly situated offenders by ensuring the
8 treatment decisions, whether or not a person needs treatment at
9 all, as well as what treatment they get is based on a valid
10 assessment, and then apply it to placement criteria like those
11 endorsed by the American Society of Addiction Medicine.
12 We would also be helped by further encouraging increased
13 DWI-specific treatment research. There's actually an impressive
14 body of research about what works in treatment in general and
15 alcohol treatment in particular. That's been studied longer than
16 anything else, but we need more research on what specifically
17 works for DWI offenders and related offenders.
18 And then finally, something we haven't talked much
19 about, and if you have any questions, I'll be happy to answer them
20 later on, is about the issue of drug driving. We think often
21 about alcohol-impaired drivers. There is a growing interest in
22 drug driving and its impact, and one of the things that, it's
23 really not a treatment issue, but if, in fact, we conclude that
24 drug driving is something that's worthy of our attention, then the
25 laws across the states and across jurisdictions vary widely on how

1 this issue is addressed, and one of the big challenges is
2 determining whether or not an individual who has used drugs and is
3 driving and maybe has got into a crash, whether or not they were
4 impaired at the time that that crash occurred. A person can have
5 a drug in their system and still not be impaired. So that's a big
6 challenge, and so some jurisdictions have adopted sort of a per se
7 zero tolerance law that say you can't have drugs in your system at
8 all, and that is one approach.
9 However, if we have some time --
10 MS. DAVIS: Mr. Walton, we're going to have to ask that
11 you wrap up your presentation please.
12 MR. WALTON: Oh, I'm sorry. I saw that -- that 2-minute
13 means --
14 MS. DAVIS: That you're past your time.
15 MR. WALTON: I didn't realize that. Thank you. I
16 thought I had 2 more minutes. So I would have been going forever
17 because it's counting up, right? Wow, we would have been going
18 for a while. I apologize to the Board.
19 So we have time to answer any questions that you have
20 about drug driving or others when we go to the question and answer
21 period. Thank you.
22 MS. DAVIS: At this time, we'll begin 25 minutes of
23 questions from the Technical Panel. Ms. Roeber.
24 CHAIRMAN HERSMAN: Ms. Davis, did you introduce the
25 qualifications and background for the other two panelists?

1 MS. DAVIS: I did, but I can do that again.
2 CHAIRMAN HERSMAN: Okay. No, it's okay. I just wanted
3 to make sure that the audience had heard about them. Great.
4 Thank you.
5 MS. ROEBER: And along that line, our first two
6 questions or first series of questions are really going to be
7 geared towards Judge Barrasse and Ms. Thomka. And one of the
8 first questions I have is, we talk about education, legislation
9 and enforcement, and I think people have a tendency to think of
10 enforcement as the high visibility enforcement, but I'd like to
11 expand that definition of enforcement and say, you know, if we
12 want strong enforcement, what's the prosecutor's role and the
13 judge's role in that area?
14 MS. THOMKA: First I'd like to begin by thanking the
15 Chairman, the Vice Chairman and the Members for including the
16 National District Attorney's Association in this presentation,
17 because I think to answer Ms. Roeber's question, it's critical
18 that the concept of communication involves all the players. And
19 law enforcement and the judicial system, one of the critical roles
20 is the role of the prosecutor. And without putting those factors
21 together and putting our position into this -- we can have all the
22 high visibility enforcement out there, we can have the courts
23 creating new systems to make work, but we need to be involved to
24 actually bring that to the court and make the conviction happen.
25 I think communication, to answer Danielle's question, is

1 critical amongst all of us, and it starts from the time that the
2 arrest is made. It actually starts, as Warren Diepraam said
3 earlier, when the arrest is in process, when the officers are
4 doing their job, when they are making decisions whether or not an
5 arrest needs to be made, and subsequently whether or not a warrant
6 needs to be issued. By working together, by getting those factors
7 together, communicating amongst each other that we have all the
8 factual basis we need to approach a judge to issue a warrant, to
9 then take the case all the way through to arraignment the next
10 morning, is something we all have to be able to do on a regular
11 basis.
12 I think one of the best things we have done in recent
13 past is, and through the benefits of working with NHTSA and the
14 other agencies within DOT, is seeing more and more education and
15 communication among law enforcement and prosecutors. We are now
16 seeing on a national level, I would say 90 to 95 percent of our
17 trainings that we're conducting are being done jointly with law
18 enforcement officers sitting next to prosecutors from their
19 jurisdiction and talking about issues that are being raised: What
20 problems are we having in our particular jurisdiction? How can we
21 make this better? What are we missing? What are our judges
22 saying we're not having? How do we effectively communicate that
23 to the jury?
24 JUDGE BARRASSE: Thank you, and I want to thank the
25 Board for this opportunity to allow people that are working in the

1 trenches of the criminal justice system to talk about a
2 devastation that we see on a daily basis and how we need to
3 approach it.
4 I think one of the questions in regard to, not only
5 enforcement, but two prior speakers talked about the research that
6 was done in regard to communication, and the reality of the fact
7 is that the court never really played well in the sandbox with
8 treatment. Treatment was this namby-pamby, you know, type of
9 situation that basically was singing Kumbaya, and we were more
10 concerned about getting, you know, mandated sentences done, work
11 with the prosecutors. And so as time has gone on, we've learned
12 that the court has to change its attitude in the way it's looking
13 at these cases, that it's not a matter about just calling balls
14 and strikes, but it's really changing behavior.
15 And if we're going to change behavior, we have to look
16 at the best evidence that's out there and we have to realize with
17 the four tenants of sentencing that are there, that we've done a
18 very good job and enforcement has done very well. Deterrents, the
19 general and specific, in regard to DUI laws, that we're going to
20 punish somebody for what they're doing and part of that is going
21 to be a punishment from themselves in regard to deterrents, but
22 second in regards to the public. So you're going to have, whether
23 it be the mass media, whether it's going to be the checkpoints,
24 everything that was talked about earlier, that's done a great
25 service for deterrents in regard to DUI. And we obviously have

1 done a great job in regard to the punitive part, in regard to
2 retribution or punishment, mandated sentencing. We've been able
3 to look at that, incapacitation being the third tenant. But, the
4 fourth tenant, that we have not looked at well, and it's really
5 something that has to be looked at in totality, as Terrence spoke
6 about, is rehabilitation.
7 So when we look at enforcement, we have to really look
8 at it in regard to enforcement of all the things that we are
9 supposed to be doing to have a changed behavior in the individual,
10 and that really has to be the result, not just the enforcement
11 part, but what's the result of that enforcement? And so the more
12 we look at changed behavior and what the best evidence is to allow
13 that changed behavior, I think serves not only the criminal
14 justice system but society.
15 MS. ROEBER: As a follow-on to that, not to put you all
16 on the spot, but how would you say that substance-impaired driving
17 offenses are viewed among your other colleagues, judges and
18 prosecutors?
19 JUDGE BARRASSE: With that one, let me -- traditionally
20 I would have to agree with slides that were placed up there
21 earlier, that often the youngest prosecutors got your DUI cases.
22 When you look at the total number of cases that come into a
23 system, often your DUIs can be a third of your system.
24 Unfortunately, in past years, prior to really looking at
25 the exposure that DUI and the devastation that goes along with it,

1 DUI was more about processing cases than it was effectively
2 handling cases. So you knew that a third of your caseload was
3 going to be DUIs. What you're really trying to look at is how can
4 we get them through the system the fastest? And really it was
5 more about moving the sand piles than it was about what we're
6 doing to effect change.
7 So I think the big difference I have seen with
8 colleagues especially now coming on the bench and those that have
9 now seen some of the results of the research that's been given, is
10 that they're now looking at what we could do to effect change and
11 it's really becoming of greater importance than it ever was
12 before, but previously it wasn't.
13 MS. THOMKA: And I also think that from a prosecutorial
14 perspective, there was often a perception that it was just a DWI,
15 that DWI was not a crime. It was an average Joe situation. It
16 could be the bank president coming home from the Christmas party.
17 It could be the soccer coach. There was not this perception of
18 crime and criminal behavior. We also saw it as whenever there was
19 a fatality involved, in a motor vehicle crash that was the result
20 of some impaired driving, that it was not a real homicide, and for
21 lack of a better phrase, we all joke around in DA's offices that
22 we have the homicide prosecutors and everybody else, and that was
23 never inclusive of an alcohol-related fatality or a drug-impaired
24 fatality. And I think we're working every day to change that
25 perception.

1 The other thing that now we're facing in drug-impaired
2 driving is that the perception is, oh, poor Mrs. Smith. She
3 really didn't do anything wrong. She was just taking her
4 medicine. Or, it's medical marijuana. So why is that wrong? He
5 needs that for his glaucoma or some other treatment so they're
6 really not committing a crime. And I think by holding our
7 defendants accountable, by having swift and certain punishment and
8 all the things that Dr. Hedlund explained this morning, by doing
9 that, by publicizing that, by increasing the media's involvement,
10 the public's awareness, that these certainly are crimes, I think
11 we're changing the perception. I've certainly seen that in my
12 world.
13 MS. DAVIS: I'll address this question to Ms. Thomka and
14 Judge Barrasse. From a traffic safety perspective, what would you
15 say the benefits and disadvantages of plea bargaining are for both
16 alcohol and drug related?
17 JUDGE BARRASSE: In regard to the impaired safety part,
18 I think one of the things that has been looked at for a number of
19 our DUI courts is that they are voluntary, and that many of the
20 courts, while being post-conviction, have allowed as part of the
21 plea bargaining process the person be placed into a DUI court.
22 I believe that there is a great opportunity here in that
23 regard, that an arrest in many ways should be a positive thing,
24 and I believe that for many people that I have seen that have
25 completed DUI court, that they, at time of graduation, will get up

1 and say I want to thank the officer for the arrest that was made.
2 It was their participation, and part of it was through a plea
3 agreement that they would be participating in DUI court, that
4 allowed them to get the intervention they need and the successful
5 treatment they need which was long enough, based on evidence-based
6 research, that they needed, that they got involved in recovery,
7 and that they started to change their life around.
8 I think there's a lot more things that could be done in
9 effective plea bargaining. Number one, I truly believe that
10 license revocation and suspension should be part of that, and that
11 often what we're doing is we're taking away or putting great
12 demands on these people, that they have to go to work, take care
13 of their families, get the treatment and do all other kinds of
14 mandated factors from the court and yet we're saying, give us your
15 license. And many of these people live in very rural areas, and
16 we know, to be real about it, we know that many of them drive
17 anyway. So if we're going to be effectively using plea
18 bargaining, let's do it so there's not only sanctions involved,
19 but there's incentives involved and that it's based on evidence-
20 based treatment and evidence-based research and that it's not just
21 done blindly.
22 The other thing, I think we have to make sure of, is
23 that when we look at it, that there's fidelity to the model, so
24 that you don't have the great disparity -- and unfortunately as a
25 reality, we know that there's great disparity in each jurisdiction

1 as to what plea bargaining is. So plea bargaining could simply be
2 a pass in which there's no benefit to society except for the fact
3 that you're moving a case through and you're saving money, or it
4 could be used as a positive for society. What we need to do in
5 the criminal justice system is figure out, if we're going to plea
6 bargain, how can that be done that it's going to most help society
7 and the individual that's going through the system.
8 MS. THOMKA: And I agree very much with the Judge's
9 comments, and I'd also just like to add, however, that with plea
10 bargaining, it's not always just the dismissal of a case. It's
11 not always a diversion program to avoid something. It's having
12 the prosecutor assess the case, assess the validity of the case,
13 the strengths and weaknesses of the case, and what should be the
14 proper decision or the proper outcome of that particular case.
15 Often when cases are reduced, some states don't allow a
16 reduction to a non-alcohol-related offense. Some cases allow a
17 complete reduction to a reckless driving or something called a wet
18 reckless, which I still don't quite understand what that means.
19 But I think that we have to always have some accountability when
20 there is an impaired driving case that we have the ability to
21 prosecute. We have to keep that in the back of our minds for the
22 defendant, for society. What are we telling society if we plea
23 bargain these cases away from the crime of DWI? What emphasis are
24 we placing on society that these are severe crimes that we should
25 be paying attention to?

1 The main problem I see with reducing a case or plea
2 bargaining a case down to something that is not an alcohol or a
3 drug driving offense is there's no longer a record of that
4 offense. We may never know that that defendant had a prior charge
5 of DWI when maybe it should have been prosecuted as a first
6 offense. Now we have them back a year later, had we known that
7 case and prosecuted that case effectively, we may now have a
8 felony charge against the defendant. So we have to be aware of
9 the importance of what comes next.
10 DR. VANLAAR: If I may, I'd like to make an additional
11 comment to that question. I'd like to echo basically what the two
12 other speakers just said. A couple of years ago when we did the
13 research on the DWI system, basically many of the practitioners
14 did say like, yes, we truly believe that the bargaining is
15 necessary to make the system work. Having said that, there's a
16 need for putting limitations on the plea bargaining. It should
17 not be or it must not be possible to plea down from an alcohol to
18 a non-alcohol-related offense.
19 The other things that were mentioned was that it's
20 important to state the reason for the plea bargaining such that
21 the next prosecutor will understand what the previous case was
22 about, as well as stating the original charge. This would also
23 make it possible to truly distinguish between first offenders and
24 recidivists, which if you don't have that information, it might be
25 really difficult to do that.

1 MS. ROEBER: This question is really open to all four of
2 you or mostly everyone except Dr. Vanlaar because he's already
3 talked about the ignition interlocks, but I would like your all's
4 perspective on the role that the interlock should play in the
5 system, and even consider administrative, you know, before --
6 could we tie it to administrative license revocations somehow
7 instead of waiting for the actual conviction? And I'm going to go
8 reverse order. Ms. Thomka, then the Judge, and then I really want
9 to hear how you could use it in connection with treatment.
10 MS. THOMKA: We as prosecutors very often view the use
11 of ignition interlock, the use of any other instrument to help in
12 this fight, as a tool, a tool in the toolkit as we've all used
13 this phrase. It can be a very effective tool. It can be one of
14 many things, but I don't think we can look at ignition interlock
15 in a vacuum. The data is there about the benefits of it, but it
16 needs to be used in conjunction with other things. And that's
17 where I think when we're looking at something new, the new
18 technology that's come out that we can use as that tool, we need
19 to look at the multidisciplinary approach. What do the treatment
20 providers think? What does the assessment tool say? Because as
21 prosecutors, we make sentencing recommendations to the court, and
22 we need to know how these tools work, where they can fit and how
23 they best fit for this particular defendant.
24 I think personally for administrative licensing issues,
25 I don't see why a judge would hesitate to use that if he thinks

1 that that's something that will work effectively while this case
2 is pending, but I think that's a good lead into the Judge.
3 JUDGE BARRASSE: Thank you, Joanne. I think -- I agree
4 100 percent. I think it has an effective place. I don't think
5 there is a silver bullet answer by any means. You know, a great
6 concern obviously is you can have it on there, and is that the
7 person that's actually starting the vehicle or are you driving
8 another vehicle? So there are some concerns obviously, and we
9 don't want to look at it as just being the answer, but it
10 definitely has great benefit depending on how it's used. And I
11 think that one of the things that we look at in regard to
12 operating a court is not just catching the person doing something
13 bad, but realizing that when they haven't done something bad.
14 And so the utilization of, whether it be an ignition
15 interlock or any other type of tool, that shows that this person
16 is effectively doing the treatment that they need in making the
17 change in their life, the behavioral change, and that this is
18 allowing us to monitor that, allows us to recognize the positive
19 that the person is doing as well as looking for the swift,
20 certain, severe penalties if they fail to do what they need to do.
21 MR. WALTON: I agree with everything the two panelists
22 have described. I think certainly for those who are assessed as
23 something other than with substance-related disorder, who are not
24 abusers or dependent, certainly an option like ignition interlock
25 or other control strategies, in the absence of anything treatment

1 related, may be a perfectly appropriate approach. For those who
2 are in treatment, who are assessed as alcohol dependent or other
3 drug dependent, this is especially useful.
4 The reality is research shows the treatment works but
5 not immediately, and especially for those who are in the community
6 who are not in residential treatment, during the period of time
7 they are in outpatient or intensive outpatient, anything at all
8 that can both minimize -- certainly minimize drinking and driving
9 so that we don't have a person who goes out and commits another
10 crime and then is removed from treatment and all of that, but
11 anything that will discourage the individual from drinking while
12 they're in treatment is very valuable.
13 Keep in mind, most of these individuals would not have
14 gone to treatment on their own. They don't yet have the internal
15 motivation to develop their own control strategies. So things
16 like these devices, as well as SCRAM bracelets and other things,
17 other devices, are a very useful component to treatment especially
18 at the beginning before the changes are internalized.
19 MS. ROEBER: And not to put Dr. Vanlaar on the spot, to
20 know what all the research says in the history of this issue, but
21 I'd be curious if you could articulate a few things that the
22 research has shown over the last 30, 40 years are not effective?
23 I think it's important to know that as well as to know what does
24 work so we don't repeat the mistake, I guess.
25 DR. VANLAAR: Well, I think most importantly I just want

1 to emphasize again that even though some of the research partially
2 shows that administrative license revocation does work, there's
3 other things that work better. So perhaps it's not necessarily a
4 question of things that don't work at all. It's just that there's
5 other options out there that work better than some of the options
6 that we've been traditionally using.
7 Another thing that I just want to throw out there, in a
8 former life when I was the coordinator of the European Alcohol
9 Ignition Interlock Program, many of the judges that we worked with
10 shared the exact same concern that Judge Barrasse was sharing with
11 us in terms of being sure that when you're using a certain
12 technology like interlocks, it's actually -- the person who's
13 delivering the breath sample is actually delivering the breath
14 sample, and I would argue that perhaps the industry has been
15 somewhat slow at the beginning, but they're certainly now
16 improving their technologies to make that aspect foolproof as
17 well. For example, more and more devices are coming out with
18 cameras, such that you can see who's actually delivering the
19 breath sample.
20 MS. DAVIS: Judge Barrasse, you started out as a
21 traditional court judge. Would you share with us what prompted
22 you to explore DUI and drug courts?
23 JUDGE BARRASSE: Well, I actually started out in
24 prosecution. I was a DA for a number of years, the elected DA for
25 a number of years, and quite frankly, now what I see is

1 grandchildren of the people I prosecuted 30 years ago, and the
2 reality is we have choices to make here. We can either continue
3 doing what we've been doing that hasn't been working or we can
4 look for an effective change. And probably the greatest reward
5 that I now have is seeing people that are literally changing their
6 lives, and when they see you out on the street, they're coming up
7 with their children; they've got a job. We are seeing that
8 there's real changes being made in their life which protects
9 society.
10 We were really in many ways just moving sand from one
11 spot to the other when we look at just the other factors of
12 sentencing, just the punitive nature. And unfortunately our
13 system is set up as being adversarial. So you've got the DA and
14 the defense, and one side was winning and one side's losing, and
15 quite frankly, that doesn't create change for that person.
16 And while I was DA is when we started our court, and I
17 truly believe that it's not only personally rewarding to see this
18 change, but if we are going to look at reduction of deaths on the
19 highway, if we're going to look at having productive citizens, if
20 we're going to look at reducing the number of people that die and
21 lives that are completely lost because of DUI, that a drug court
22 and a DUI court model, if, if the court follows fidelity to the
23 model, is going to be one of the biggest changes that we see in
24 the criminal justice system for our lifetime.
25 The problem, with that being said, is if we don't have,

1 as Terrence has said in regard to treatment, if that treatment,
2 number one, isn't correct, and second of all, if the court and the
3 prosecutor and everyone else isn't keeping the fidelity to the
4 model and, for example, has a DUI court which is really nothing
5 but seeing how quickly we can get a case through the court, then
6 we're going to have a problem. But if they really stick to the 10
7 principles and make sure treatment is there and effective
8 supervision and effective accountability, so that that person
9 knows that if they don't follow it, they're going to be held
10 accountable and placed in prison, that we're going to really see
11 major changes for everyone. It's a win-win. Thank you.
12 MS. ROEBER: As a follow up, I'm guessing there's been
13 at least one or two people that just couldn't keep with your
14 program, your DWI. How do you reach that conclusion that the
15 person is just not -- this is not working for them, and then what
16 happens to that person?
17 JUDGE BARRASSE: Well, there are some people that I'm
18 sure Terrence would describe as being constitutionally incapable
19 of completing treatment. There are other individuals that, you
20 know, the first time they see that red light in their mirror,
21 they're going to make a change in their life. They got pulled
22 over. That's the last time that they're ever going to drink and
23 drive. A bell curve. Other people that are at the other end, no
24 matter how many times they're pulled over, no matter how many
25 interventions, they're not going to change.

1 We have to realize that the people that are in the
2 middle there, we're hoping that their behavior is going to change,
3 but we also have to realize that we can't jeopardize our program,
4 and we can't jeopardize the public's safety. So if the person has
5 technical violations, we look to see if they're having the
6 appropriate response. Earlier it was mentioned about being
7 certain, swift and severe. If a person misses a testing, they
8 automatically go into the prison. It might be for the weekend.
9 It might be for a repeat one for much longer. So there are
10 consequences that go with their actions or failures to act.
11 There comes a point when I, as the judge, regardless of
12 treatment, saying I really believe he can do it this time, I have
13 to say my role is to sit back and look for the safety of the
14 public and make sure that his rights are being protected. He's
15 been given enough chances; it's now time that he face prison. And
16 in many of our cases in Pennsylvania, that person will be on what
17 we call a 5-year program facing 1 year in prison up front. And so
18 they know when they come into my program, that they're facing 1
19 year.
20 MS. ROEBER: This is probably my last question.
21 Mr. Walton, I would have thought that court-ordered
22 treatment, given the fact that you have the hammer, is the most
23 effective because they can put you in jail for a year. But then I
24 got the sense maybe from some of your slides that there has to be
25 a voluntary component for it to really be effective. Could you

1 explore that a little bit, explain that a little bit more?
2 MR. WALTON: Thank you for allowing me to do that.
3 Treatment can be court ordered and coerced and research
4 shows that it is just as effective and in some cases, more
5 effective than those who report on their own. The voluntary
6 aspect says that even despite a judge ordering treatment, an
7 individual can always say I'm not going to do that and face those
8 consequences. And the reason, you know, how that's relevant is
9 that because from treatment perspectives it has to be voluntary,
10 from their perspective. Them trying to understand how can
11 something that's coerced be voluntary, that's something that we
12 have to help them sort through. So coerced treatment is
13 effective; however, a person can always say no despite that
14 coercion and that is important by law.
15 MS. DAVIS: Chairman Hersman, that concludes our
16 questions.
17 CHAIRMAN HERSMAN: Thank you. Member Sumwalt.
18 MEMBER SUMWALT: Thank you. Mr. Walton, you said that
19 -- well, you made a point that a number of DUI offenders are not
20 addicted to alcohol. So do you have any feel for about how many
21 are alcohol addicted versus not?
22 MR. WALTON: That's an excellent question that I don't
23 really have a good answer for. Let me just say it this way, that
24 most of what we know about the percentage of individuals who are
25 dependent versus those who are abusers versus those who are social

1 drinkers, are really based on what we know about the prevalence of
2 addiction, including alcoholism, in the general population, and we
3 know that about 10 percent of the population in any given time
4 needs some kind of treatment --
5 MEMBER SUMWALT: Right.
6 MR. WALTON: -- for abuse or dependence. We can assume,
7 though I don't know, but maybe my colleague does, you can assume
8 that it's probably higher than that for those who actually have
9 offenses. We can be rather certain it's higher than that for
10 those who have more than one offense, but I don't have the stat,
11 but I'll be happy to look for something and put it in the public
12 docket on that topic.
13 MEMBER SUMWALT: If any of you have that information, it
14 would be interesting, but the point is, and I think Judge Barrasse
15 made this point, is that what motivates one person isn't
16 necessarily going to work for the other, and so -- but it sounds
17 to me like a large percentage of the DUI population are not
18 alcohol addicted. So what is a disincentive for the alcohol
19 addicted population is going to be probably different than the
20 rest of the population, and so Judge Barrasse made the point that
21 what we're trying to do is change behavior, and I agree with that,
22 and whatever we have been doing has worked, but it needs to work
23 that next iteration now. We've got to make the next incremental
24 change on this behavior.
25 One thing that I think was a big game changer for people

1 that I know was when -- I come from an aviation background, and
2 when the FAA started really cracking down on DUIs, you could lose
3 your medical certificate, thus your ability to fly an airplane, if
4 you had DUIs, and so I think that that changed a lot of behavior.
5 I think that when you're in public service, you realize that if
6 you get a DUI, they're going to be looking for your resignation.
7 So, you know, these are good ways to influence people to do the
8 right things.
9 So I've tried to think about it, what paradigm shifts
10 can we make? I mean, what we're doing is having some effect but,
11 Judge Barrasse, do you have any thoughts for how we can make that
12 next incremental change?
13 JUDGE BARRASSE: I think a couple of things you just
14 pointed out in regard to where the person is -- well, one of the
15 things that Terrence indicated, all the approaches aren't going to
16 work the same for everyone, but if we concentrate our efforts, and
17 there's going to be different efforts in this, on your second or
18 hardcore offenders, so that when you look at -- and you asked the
19 number about how many are truly dependent on alcohol. We do have
20 research showing the higher risk number of times driving DUI, if
21 you were a second a time, or fatal accidents if it's a second
22 time, or their blood alcohol is above .5. So we do have certain
23 parameters that allow us as a court to say we are going to work
24 with this set of offenders differently than we are the first-time
25 offender. But on the other hand, I've got to say, I had a first-

1 time offender once that was .52. So obviously she had worked very
2 hard at getting to that level and she deserved to be in my court,
3 but that's not going to be the normal type of person that we take.
4 So the paradigm shift is going to be looking at the
5 person rather than just the offense. And one thing that we've
6 learned that for many, many years in the criminal justice system,
7 the elephant in the room has been the drug and alcohol addiction
8 or alcoholism. And all we looked at was a grid, and the grid
9 would say, you were arrested for this charge, and that gave you
10 this OGS score, Offense Gravity Score, and we looked at a prior
11 record score, and we then said, okay, this is your sentence, but
12 what it did not look at is the fact that this person had a disease
13 and we weren't treating the disease.
14 So we therefore were placing and still are placing at
15 the prison people that are addicted and are alcoholics and we're
16 basically warehousing them, and when they come back out, they're
17 still going to be an alcoholic or addicted. If we don't look to
18 make a paradigm change to say, we need to do all four tenants in
19 regards -- all four goals of sentence and we have to make sure
20 that it's the individual that we're treating, not just the crime,
21 we're not ever going to make a complete change in this.
22 MEMBER SUMWALT: Thank you, and it is, as Ms. Thomka
23 said, it is a crime, and that's the point we've got to remember.
24 Thank you.
25 CHAIRMAN HERSMAN: Member Weener.

1 MEMBER WEENER: Earlier today we talked about the
2 difference in trying to identify whether somebody was impaired by
3 drugs or impaired by alcohol, and this question is for Ms. Thomka
4 and the Judge. That difference between impairment with drugs
5 versus alcohol, how does that follow through the prosecutorial
6 process, as well as do outcomes typically differ between those
7 different kinds of impairments?
8 MS. THOMKA: I think what I could address first to maybe
9 help explain that is the difference between an alcohol-related
10 charge and perhaps a drugged driving charge, and some of the
11 challenges that we face in the two of them, and then perhaps the
12 Judge could respond to the second part of your question.
13 We have a lot of challenges to detection and the concept
14 of impairment, and the system being developed now which Technical
15 Sergeant Paquette was talking about, the DRE program, the Drug
16 Evaluation Classification program, is helping us to face that
17 challenge. What do we see when we see someone who is impaired but
18 the alcohol concentration is not there? We know that something is
19 impairing this persons ability to operate the motor vehicle safely
20 on our roads, but what is it? And the detection question then
21 comes into play. What is now impairing him? And what we have to
22 do to start addressing that question is educating our law
23 enforcement officers, educating our prosecutors, educating our
24 judges to understand what the different effects of the seven drug
25 categories are and how these signs and symptoms of intoxication

1 under drugs really play, and what they really look like. So I
2 think that's one thing that we need to look at.
3 The other challenge that we're having, and I also think
4 that Sergeant Paquette addressed this, is being able to test for
5 these drugs. Once we've made these determinations through the DRE
6 protocol, what are we actually seeing in the blood tests? Are we
7 getting the blood test from the defendant to confirm what the
8 officers are calling as the form of impairment. So that's another
9 challenge that we're looking at.
10 We're also seeing that, as was earlier discussed, it's
11 not just confined to illegal substances. We're having young kids
12 that are driving vehicles that are huffing, inhaling Dust Off or
13 they're using the bath salts or they're using some other chemical
14 that they're getting by walking into a local CVS or walking into a
15 local head shop. So how are we going to educate everyone to what
16 those impairing factors are, and how we're going to be able to
17 present those to a jury?
18 And finally I think that one of the things we have to be
19 cognizant of in the drug-impaired driving world is, in fact, the
20 reaction of the jurors. Are we appropriately educating them as to
21 the dangers of these drugs, that it isn't just the medical
22 marijuana or the prescription drug, that these are impairing, that
23 they are creating the same dangers on the roadway as alcohol.
24 They can create as much devastation as someone who's at .08.
25 JUDGE BARRASSE: Education is primary. We're talking

1 about drug driving. Terrence made a point in regard to illegal as
2 compared to legal, and in regard to the illegal, we have to look
3 to make sure that there's a per se law put in place. So if a
4 person does have heroin or some type of illegal drug on board,
5 that the officer is not put to the same test. The person has an
6 illegal drug to begin with in their system, and it should be
7 handled in a different way.

8 One of the things that the courts have to be, and I'm
9 glad you realize that judges can be educated, but many people
10 don't believe that, and I want to thank, whether it be NHTSA or
11 the National Judicial College or NDCI or the National State
12 Courts, they've done a great job at reaching out to the judges to
13 make sure they understand this.

14 One of the real problems we see though is the number of
15 elderly people that are coming in that are on prescription drugs
16 that say, my doctor gave this to me. So I think one of the things
17 we have to look at in regard to education is not just the legal
18 system, but the medical system in regard to whether or not these
19 people realize, the patients realize that the medicines that
20 they're on, that they should not be driving, and it simply
21 shouldn't be a warning. At some point there has to be notices
22 given by a doctor that you cannot drive, and it's an increased
23 problem that we've never really faced in the numbers that we are
24 today.

25 MEMBER WEENER: Are most of the outcomes punitive or do

1 you go for treatment?

2 JUDGE BARRASSE: I think it depends on the individual.
3 If you find a person that's simply med seeking and is going to ERs
4 to get different scripts and is an addict that has other criminal
5 tendencies, then you're going to again look at the individual and
6 look at the offense to say what is it that we need to do? But we
7 have to always realize that over 90 percent of these people are
8 going to get out of jail. So if we don't look at incorporating
9 treatment in regard to our overall sentencing scheme, then we are
10 missing the picture, and especially for those people that are just
11 simply med seeking. When they get back out of prison, the answer
12 of saying, you know, just say no is not going to work. They're
13 going to leave and the first thing they're going to do is go see
14 where they can score again. So we have to combine both the
15 accountability part of having some type of incapacitation with
16 treatment.

17 MEMBER WEENER: Thank you.

18 CHAIRMAN HERSMAN: Member Rosekind.

19 MEMBER ROSEKIND: Judge, can you identify what elements
20 you think really distinguish the effectiveness of the DWI courts?

21 JUDGE BARRASSE: I think one of the first questions that
22 was first brought up before was how it's viewed, and when you look
23 at DUI, there's a paradigm there in regard to -- well, really it's
24 -- you look back years ago where nothing happened, a person was
25 given a ride home; Uncle Joe's a nice guy, to all of a sudden

1 mandatory sentences.

2 What wasn't looked at is what we're going to do to look
3 at the underlying causes here, the problems, and I think what DUI
4 court allows them to do is that person realizes, when they first
5 start the program, often every other week, that they're going to
6 be held accountable to do their treatment, that there's going to
7 be a -- as both Terrence would say and Dr. Marlow would say,
8 there's distal and proximal goals that they have to reach.

9 We recognize that in the beginning they can't just not
10 use it. They're not ready for it. That may be a distal goal.
11 But for today, to go to treatment is something that they're going
12 to be held accountable by the court. And realized that the longer
13 that that person is in treatment, the better chance we have of
14 them lowering the recidivism rates and actually not using again.

15 So what the court is essentially doing is holding their
16 feet to the fire with treatment to get that angle and also to
17 force them into the situation of making that decision as to
18 whether or not voluntarily they're going to make the change. It's
19 an external force hopefully driving an internal change for that
20 individual at the end.

21 So I think also the interaction between the court
22 actually talking to the person and not just saying, you know, go
23 to jail and, you know, make your changes. And also realizing that
24 the people around that table -- I mean, you saw this. It's not
25 just the judge. It's not just treatment. It's the probation

1 officer. It may be CYS. Many of these people have children, and
2 so their children may be taken away from them. Well, now also
3 there's a CYS worker there. There's a social worker there. Many
4 of these people we know have a co-occurring problem. Well, now we
5 have a mental health person there, and they realize that, you know
6 what, these people actually do care about me.
7 And it's amazing to see the change that they present
8 from -- we have a graduation coming this Thursday night, 60 some
9 individuals. The first thing I did was I got a picture of all
10 their booking pictures and all their pictures today as they're
11 graduating, so that they can see the change that they made in
12 their life, and I think that's what it allows.
13 MEMBER ROSEKIND: And so if I can pull those together,
14 you're talking about looking at the underlying issues,
15 accountability --
16 JUDGE BARRASSE: Correct.
17 MEMBER ROSEKIND: -- and that treatment is one of the
18 mechanisms that's used to get to the underlying, and holding them
19 personally accountable.
20 JUDGE BARRASSE: Absolutely.
21 MEMBER ROSEKIND: Great. Mr. Walton, treatment was
22 thrown around a lot. What are we talking about here, and this
23 one's got to be brief because I'm going to let Dr. Vanlaar get the
24 last question, but just give us a sense of what kind of treatment
25 modalities, time to change and what kind of effectiveness, you

1 know, outcome data is available?
2 MR. WALTON: The approach is, the modalities most
3 associated with DWI-related treatment is it can occur in any
4 modality. It could be outpatient, intensive outpatient or actual
5 residential. It's normally intensive outpatient. Some have to be
6 preceded by medical detoxification.
7 Once you get inside the level of care, the modalities
8 that are standard and evidence-based are those that are cognitive
9 behavioral in nature, those that help with motivation enhancement,
10 and most, I think, importantly and often lacking is medication-
11 assisted treatment. There are two or three medications that are
12 FDA approved for working with alcoholics and two in particular,
13 Naltrexone and Acamprosate, are especially effective and frankly
14 many programs don't incorporate them, but evidence shows that the
15 addition of medication-assisted treatment to the overall treatment
16 can increase effectiveness.
17 MEMBER ROSEKIND: So, Dr. Vanlaar, top three evidence-
18 based effective treatments?
19 DR. VANLAAR: Interlocks, certainly DWI courts. I think
20 if you look at all the evidence, the evidence for technologies and
21 DWI courts is probably the strongest, and the individualized
22 approaches that are possible in DWI courts and with community
23 supervision.
24 MEMBER ROSEKIND: Great. Thank you.
25 CHAIRMAN HERSMAN: Vice Chairman.

1 VICE CHAIRMAN HART: Thank you. First a very technical
2 question and then a much higher level question. I was curious
3 about that ankle bracelet, you were talking that it can sense
4 alcohol through the sweat?
5 DR. VANLAAR: Yes, it does.
6 VICE CHAIRMAN HART: I noticed he was wearing it outside
7 of his sock. Can it even do that through the sock?
8 DR. VANLAAR: I don't -- I think you have to wear it on
9 your skin.
10 VICE CHAIRMAN HART: Okay.
11 DR. VANLAAR: So perhaps you can pull up the picture
12 again to verify that but, yes, you would have to wear it on your
13 skin.
14 VICE CHAIRMAN HART: Okay. Well, that's the technical
15 one. Now the higher level question. When I first heard about the
16 DWI courts, I assumed it was just a substantive specialty, like
17 the Tax Court and the Patent and Trademark Court or something, but
18 apparently what you're saying is it's a whole fundamentally
19 different way of doing business from, you know, putting people
20 through guilty/not guilty, jail/not jail, to a behavioral change
21 process. Is that --
22 JUDGE BARRASSE: We're looking at -- you can look at it
23 in many different ways. You can look at it as a silo and say,
24 well, it's a silo, we're just doing it, but really what we're
25 looking at, it's really a return to traditional -- what courts

1 were intended to do. And unfortunately the whole change in regard
2 to single mandated sentences fails to take a look at the
3 individual. And what we're really looking at doing is saying,
4 we're going to look at the individual here and what the needs are
5 of that individual and what the risks are for that individual to
6 the community. We're going to match up the risk of the individual
7 and the needs of the individual and treat that, not necessarily
8 this grid that we've created. So it's a change in regard to
9 saying, we've got to look at underlying facts why individuals are
10 committing these crimes, whether it be a drug-related or DUI-
11 related crime, we have to start looking at underlying factors and
12 work with that.
13 VICE CHAIRMAN HART: Well, based on my experience as a
14 litigator -- most of that's civil, but to see the court process,
15 what you're describing is a fundamental paradigm shift in the way
16 courts work. And so my question is it -- what's your prognosis
17 for the -- like you sort of said, sometimes courts have trouble
18 coming to the sand box to play this game of -- not game, that's
19 the wrong word, but you understand, to engage in this role?
20 JUDGE BARRASSE: No, I mean, well, typically what a
21 judge would say is, whether it be 30 days or a year, whatever it
22 may be, no drugs or alcohol, and get a treatment evaluation and
23 abide by it. And that's the last time that they would ever hear
24 anything about the case and there would be nothing enforcing that
25 treatment. So, yes, there's a change in regard to that, but when

1 you think about it, we were signing these worthless pieces of
2 paper that said get this done and follow it and we weren't
3 enforcing our own orders.
4 VICE CHAIRMAN HART: So my question is, what's your
5 prognosis on such a major change, which sounds like a marvelous
6 idea, getting -- you know, becoming pervasive through the system
7 enough to really have an impact?
8 JUDGE BARRASSE: To give you an idea, all 50 supreme
9 courts have endorsed the project, the National District Attorney's
10 Association. I mean, really, everyone's on board. Implementing
11 it in a way which has fidelity to the model is going to be the
12 real kicker here because if all of a sudden people say, well,
13 there's funding out there or I'm going to do this because it's a
14 novelty court, and not have fidelity to the model, that's when
15 we're going to have problems.
16 VICE CHAIRMAN HART: Let me ask you a question based on
17 what we heard from the previous panel about the No Refusal system.
18 I'm just curious, sort of functionally, whether that process is
19 consistent or inconsistent with the direction that the court is
20 taking with the DWI courts?
21 JUDGE BARRASSE: Those are really two separate animals.
22 I really truly believe that arrest doesn't always mean -- is a
23 help often in an individual's life. It allows intervention in
24 that person's life and it could be looked at as being one of two
25 things: a positive event that allowed them -- or a negative event

1 in their mind, but allowed them to make a positive change in their
2 life; or something that they just look at the negativity of it and
3 they are forever blaming everyone else for the fact that they got
4 arrested.

5 The refusal is a complete different legal matter which
6 probably Joanne can talk about. I really believe that it does
7 have some validity. I don't know if you're going to find me
8 sitting there at 3:00 in the morning on Christmas night to sign
9 those orders, but certainly there are provisions that can be made
10 for that.

11 MS. THOMKA: I think with the No Refusal, it works quite
12 well right into this system for exactly the reasons the Judge
13 said. It could be that one defining moment for that one defendant
14 where all he's seen are ads on TV or things that splash on ESPN,
15 call this number if you're arrested, don't do this if you're
16 arrested. So they say, well, I don't want to lose my license, so
17 I'll refuse. They don't know any better. They're inundated with
18 these crazy advertisements and so they go ahead and refuse. They
19 get arrested, they lose their driving privileges and case
20 proceeds.

21 We hope that through the intervention then of the court
22 system and everybody involved in it, that we're going to weed that
23 person out. So whether it's a No Refusal because he's frightened
24 or just thinks he's going to outsmart the system, or he really is
25 in need of help, that can be determined down the road.

1 I think, if I could just add one more thing to what the
2 Judge said. I think it's important for the Board to know, and I
3 don't mean to be presumptuous, but in DWI courts, the defendant is
4 convicted of the crime. There is that criminal nature of it.
5 This is just giving them the opportunity to get that treatment, to
6 develop a different sentencing system for him, and even if he
7 successful completed and, Judge, please correct me if I'm wrong,
8 the 60 people he's going to graduate in his court next week, are
9 still going to be convicted offenders. They will have completed
10 their program and avoid harsher sanctions.
11 JUDGE BARRASSE: Correct. Unlike the traditional drug
12 courts that will often have dismissals and expungements, most DWI
13 courts, for good reason, do not have dismissals and they're
14 convicted just like everyone else.
15 VICE CHAIRMAN HART: Well, thank you very much for
16 educating us about this important concept and best of luck in
17 creating a model that helps to make this more pervasive because it
18 sounds like an amazingly wonderful direction to take this. Thank
19 you.
20 CHAIRMAN HERSMAN: Okay. I wanted to start with
21 Ms. Thomka. You shared with us some, kind of inside baseball,
22 about how different fatality situations rank within the
23 prosecutor's world, and one of the things that's always troubled
24 me is why do we as a society, and I'm not just saying it's the
25 prosecutors, because it's certainly not, it's all of us, why is a

1 death not a death? And for a mother that's lost their child to a
2 drunk driver, it's virtually the same as if somebody would have
3 come up to them with a gun and shot them. I mean, they've lost
4 their child but somehow we have -- and I don't know if society --
5 it's just so pervasive and it goes back to our first
6 presentations. Everyone drives. Everyone drinks. And it's an
7 attitude, there but for the grace of God go I, and people have
8 thought that somehow these deaths are less than other deaths, that
9 seem to have greater penalties and harsher societal scrutiny and
10 scorn and, you know, the way you look at people.
11 MS. THOMKA: Chairman, I think that you hit the nail on
12 the head. I think the concept, there but for the grace of God go
13 I, is the prevailing, a lot of the prevailing attitude. When
14 people look at DWI, they look at it as an average Joe crime. It
15 could happen to me. I could be sitting in that chair. That could
16 be my son. That could be my sister. That could be anybody, and
17 they see it, and whenever there's a death or a serious physical
18 injury that results, it was just an accident.
19 And, I so appreciated your comments earlier about the
20 use of that word, and we hope from now on the non-use of that
21 word, accident, because it does certainly send a different message
22 to our public. And if we're looking at it and we're presenting
23 that to our jurors and our news media are saying, oh, it was just
24 an accident; he didn't mean to wipe out that family of three; he
25 meant to get home after the Christmas party; it wasn't on purpose.

1 And I think the perception in our society before was always that
2 any other homicide was an intentional crime or there was some kind
3 of higher lever of culpability. I think thankfully we are getting
4 away from that and people are realizing the violent devastation in
5 these events, and they're seeing it more now as the crime for
6 which it is.
7 I think Ms. Withers was very eloquent this morning in
8 talking about that, that we're seeing that it's a bad choice.
9 They made that choice. It is their fault. They didn't have to
10 drive. There were other options available. And I think the more
11 we emphasize that to our society, that once you make that choice,
12 the ramifications are on your head, and we have to emphasize that
13 amongst ourselves.
14 I also appreciated your comments about the use of
15 language in questioning the other panels about the use of
16 language, because you can see the effect that it has. And we had
17 mothers of children who were killed, and it had a very dramatic
18 effect on them sitting in the audience. So I think if we can
19 continue to do that, we as the people that are being heard, I
20 think we can effectuate the change.
21 CHAIRMAN HERSMAN: Thank you. And just to follow up on
22 the treatment side -- I'm sorry, I don't mean to be a downer, but
23 when do you give up on people? When do you say, you know, they're
24 repeat offenders, they've done it too many times? We might put
25 them through a program, but they're back again, and when do you

1 just say, you know what, we're not going to be able to help this
2 person and we need to take more drastic action?
3 MR. WALTON: Well, that's a good question which is very
4 difficult to answer. I guess one of the things that's important
5 is that it is rarely the right course to keep doing the same
6 thing, that we know that treatment takes a while. We know that
7 addiction is a condition which is prone to relapse, but even the
8 first relapse, or the first return to problem behavior means
9 something. It's time to reassess and readjust.
10 And so if a person comes back through again, it's about
11 looking at what went wrong and seeing what we need to do
12 differently. Is there a different treatment intervention? Is
13 there a core disorder we haven't address? Are there ways of
14 thinking in belief that weren't intervened against?
15 So we continue as long as the public can be made safe
16 while we're trying to get this person clean, and as long as we
17 have more we can do. There's a concept called maximum benefit
18 gain which sometimes is a situation where the person's not
19 responding. We are doing everything we need to do, including
20 enhancing treatment and looking at other underlying factors, and
21 we make decisions to move forward.
22 The one thing that works well about DWI court, that
23 model, is that it's really a team decision. The treatment makes a
24 recommendation, others weigh in, and we decide on a case-by-case
25 basis, based on some general objective criteria, that enough is

1 enough. But the public has to be safe, and so I love things like
2 ignition interlock devices and residential treatment and other
3 options that make it more difficult for people to put the public
4 at risk while they're trying to get better.
5 DR. VANLAAR: It has actually been suggested that some
6 people will have to be on a technology such as transdermal alcohol
7 testing or interlocks for the rest of their lives.
8 CHAIRMAN HERSMAN: Thank you all so much. I think we
9 have all been very impressed by the work that's being done, and we
10 recognize that probably we've taken you from a day of intervention
11 activities to be here with us and share your experiences, and we
12 do appreciate that. It will help us as we move forward. Thanks.
13 This concludes our final panel on our first day of our
14 forum, and we will be back tomorrow, and we're going to explore
15 prevention opportunities, international approaches, and the
16 actions that are needed to take us to zero. We will have a
17 special presentation tomorrow from our drug czar, Gil Kerlikowske,
18 an outside expo during lunch, and so we hope you'll join us back.
19 We begin at 9:00 a.m. tomorrow morning. We stand adjourned.
20 (Whereupon, at 4:50 p.m., the hearing was adjourned, to
21 be reconvened on Wednesday, May 16, 2012, at 9:00 a.m.)
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CERTIFICATE

This is to certify that the attached proceeding before the

NATIONAL TRANSPORTATION SAFETY BOARD

IN THE MATTER OF: REACHING ZERO - ACTIONS TO ELIMINATE SUBSTANCE-IMPAIRED DRIVING

PLACE: Washington, D.C.

DATE: May 15, 2012

was held according to the record, and that this is the original, complete, true and accurate transcript which has been compared to the recording accomplished at the hearing.

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Timothy J. Atkinson, Jr.
Official Reporter