Regional Activities to Reduce Impaired Driving in the Metropolitan Washington Area

This report was produced by the
Metropolitan Washington Council of Governments.

Abstract

Title: Regional Activities to Reduce Impaired Driving in the Metropolitan Washington Area

Date: November 2003

Author: Nancy Rea, Department of Human Services, Planning, and Public Safety
Taskforce on Regional Activities to Reduce Impaired Driving of the Metropolitan Washington Council of Governments

Agency: The Metropolitan Washington Council of Governments (COG) is the regional organization of the Washington area's major local governments and their elected officials. COG works toward solutions on regional issues such as growth, transportation, affordable housing, air pollution, water supply and quality, and economic development. COG serves as the regional planning organization for the metropolitan Washington area.

Abstract: During the 1980's and 1990's, the rate of impaired driving crashes decreased. In the new century, the trend has reversed and crashes have taken an upturn. COG commissioned the Taskforce on Regional Activities to Reduce Impaired Driving to develop recommendations on collecting data, legislation, judicial, enforcement, and public education and outreach measures to combat alcohol and drug related automobile accidents. This report is a companion piece to the 2003 "How Safe are Our Roads" report of the Washington Regional Alcohol Program.

Price:

Number of Pages: 85

Publication Number: 20038165

Order Copies: Information Center
Metropolitan Washington Council of Governments
777 North Capitol Street NE, Suite 300
Washington DC 20002-4239
(202) 962-3256 (9:30 a.m. - 5 p.m. weekdays)
Order online at http://www.mwcog.org.

Table of Contents

This page left blank intentionally.

METROPOLITAN WASHINGTON COUNCIL OF GOVERNMENTS
Public Safety Policy Committee
Est. 12/2002/ Updated August 8, 2003

Chair - Hon. Penelope A. Gross, Board of Supervisors, Fairfax County
Vice Chair- Hon. Tony Knotts, Prince George's County Council
Vice Chair- Ms. Margret N. Kellems, D.C. Deputy Mayor for Public Safety & Justice

Jurisdiction	Member
District of Columbia:	
	Margret Kellems
Suburban Maryland:	
Bowie	VACANT
College Park	Hon. Karen Hampton
Frederick County	Hon. John L. Thompson
Gaithersburg	Hon. Sidney Katz
Greenbelt	Hon. Edward V.J. Putens
Montgomery County Council	Hon. Tom Perez
Montgomery County Executive Office	Bill Mooney
Prince George's County Council	Hon. Thomas (Tony) Knotts
Prince George's County Executive Office	Carla Blue
Rockville	Hon. Anne Robbins
Takoma Park	Hon. Carol Stewart
MD General Assembly	Hon. Anne Healey
Northern Virginia:	
City of Alexandria	Hon. Paul Smedberg
Arlington County	Hon. Walter Tejada
City of Fairfax	Hon. Gary Rasmussen
Fairfax County	Hon. Penelope Gross
Falls Church	Hon. Ron Parson
Loudoun County	Hon. Eleanore Towe
Prince William County	Hon. John Jenkins
VA General Assembly	VACANT

Taskforce on Regional Activities to Reduce Impaired Driving

Lt. Patrick Burke
Metropolitan Police Department*

Lynne Breaux
Restaurant Association
of Metropolitan Washington*

Lt. David Falcinelli
Montgomery County
Police Department*

Robert Hordan
Prince George's County Health
Department
Division of Addictions & Mental Health*

Emily DeTitta
Washington Regional
Alcohol Program*

Kathie Durbin
Montgomery County
Department of Liquor Control*

Kurt Erickson
Washington Regional
Alcohol Program*

Annie Powell
Maryland State Highway Administration
Office of Highway Safety*

Jerry Stemler
Fairfax County Police*

William H. Williams
Fairfax - Falls Church
Community Services Board
Alcohol & Drug Services*

Assisted by COG Health Substance Abuse Staff:
Nancy Rea
Sandra Adomako-Bempong
Sean O'Donnell
Robert Washington

*Organizations are listed for identification purposes only and have not been asked to review or approve the content of this report.

Executive Summary

In February 2003, the Board of Directors of the Metropolitan Washington Council of Governments (COG) received an update on impaired driving crash and arrest data from the Washington Regional Alcohol Program (WRAP). At that meeting, the Board adopted Resolution R9-03 directing the Public Safety Policy Committee to convene a Taskforce on Regional Activities to Reduce Impaired Driving. This Taskforce was commissioned "to develop recommendations on data collection, legislation, judicial, enforcement, and public education and outreach measures to combat alcohol and drug related automobile accidents." This report is a companion piece to the 2003 WRAP "How Safe Are Our Roads" report.

Findings

Crash data is readily available at the local, state and national levels. However, data on resources that would be useful for program evaluation are not always available.

Keeping impaired driving efforts lively and in the public eye is difficult. High visibility and leadership are important. These efforts need to be multi-dimensional, involving several strategies. It is unclear who is responsible for monitoring the effectiveness of individual or combined programs across the region and in local jurisdictions.

Only nine of 17 laws proven to be highly effective in reducing impaired driving are in place in all three primary jurisdictions (Maryland, Virginia, and the District of Columbia). Many jurisdictions use similar names for different strategies or activities. Three well-researched strategies accepted across the region, but implemented in a somewhat sporadic and uncoordinated basis, are sobriety checkpoints, responsible beverage server/seller certification, and programs to address underage drinking.

The burden on the justice system and treatment providers is growing due to population growth and increased substance abuse. Court systems suffer from delays and from the lack of current knowledge of officers, prosecutors and judges.

Recommendations

Recommendation 1*: Increase strength of leadership.*

- The region needs strong leadership from elected officials, judges, prosecuting attorneys, law enforcement, media, and from the private sector, to return this issue to the public's awareness, to obtain resources, and to change community norms of behavior.
- The region needs champions who are not professionals in this field but have high profiles in the community to speak out on behalf of these changes and hold jurisdictions accountable for results.
- The region needs to establish dedicated funding streams that will build an infrastructure responsible for outcomes.
- The region needs to assign responsibility for coordinating and evaluating these efforts.

Recommendation 2*: Increase data gathering and sharing locally and regionally*

- Each local jurisdiction should evaluate its strategies for collecting data, identifying data that is needed for local program evaluation. They must work to make data useful for as many purposes as possible and disseminate reports widely to avoid special requests for expensive data mining.
- The COG Impaired Driving Taskforce should continue to meet and develop regional standards for data collection
- Local taskforces and coalitions need to share their data with each other on a regular basis via combined regional reports to allow ongoing evaluation.

Recommendation 3*: COG and its member jurisdictions should continue advocacy efforts until all 17 laws are in place in the District of Columbia, Maryland, and Virginia.*

- Local jurisdictions should participate in their state coalition supporting these laws.
- COG should support passage of laws as it did .08 BAC laws.

Recommendation 4*: Increase use of prevention and treatment strategies with both strong research based results and broad-based acceptance while exploring the feasibility of new, less tested or more controversial approaches.*

- Increase use of checkpoints through a regionally cooperative effort, and increased publicity.
- Increase programs that work with retailers to help them develop best business practices, including site assessments and server/seller training.
- Continue to develop and increase sharing of new best treatment practices.
- Identify ways to combine resources to provide updates on research and training on best practices.

Recommendation 5*: Increase evaluation of court system effectiveness in reducing recidivism and increase effective use of treatment.*

- The taskforce should develop regional protocols to identify repeat offenders across jurisdictions and track specific (individuals) and general (population) deterrence.
- The region should evaluate different methods of assessment.
- The region should educate judges, prosecutors, employers, insurance companies, and doctors about the cost benefits of interventions
- The region should track caseloads in courts and treatment as regional population and need for services grow.

Discussion Items for elected officials

- Since elected officials will be using the data for planning programs and budgets, which data have the highest priority?
- *What level of involvement should COG take to support, and/or advocate for state laws?*
- How can the region assign responsibility for selecting and evaluating interwoven programs to produce the best results, as shown by comprehensive programs with multiple approaches?

- How can the region increase the resources available for effective programs?
- How can the region work with high visibility individuals to champion this issue?
- What resources other than grant funding are available for these steps?
- What can professionals in the field do to involve policy makers to keep the issue "on the front burner?"

This page left blank intentionally.

Introduction

Purpose

The Metropolitan Washington Council of Governments (COG) is an independent, nonprofit association composed of 18 local governments surrounding our nation's capital. COG provides a focus for action and develops sound regional responses to issues such as the environment, affordable housing, economic development, health and family concerns, human services, population growth, public safety, and transportation. Substance abuse issues, including alcohol and driving, have long been a point of concern for the region. For many years, COG has worked with the Washington Regional Alcohol Program (WRAP) on issues related to alcohol.

The Washington Regional Alcohol Program is an award-winning public-private coalition formed to fight drunk driving, drugged driving and underage drinking in the metropolitan Washington area.

In February 2003, COG's Board of Directors received an update on drunk and drugged driving crash and arrest data from the Washington Regional Alcohol Program. At that meeting, the Board adopted Resolution R9-03 directing the Public Safety Policy Committee to convene a Taskforce on Regional Activities to Reduce Impaired Driving. This Taskforce was commissioned "to develop recommendations on data collection, legislation, judicial, enforcement, and public education and outreach measures to combat alcohol and drug related automobile [crashes]."

WRAP and COG have worked as partners over many years to address impaired driving in the National Capital Area. During the 1980's and 1990's, the rate of impaired driving crashes decreased. In the new century, the trend has reversed and crashes have taken an upturn. This may reflect a change in the exact nature of the problem. It may reflect interest and resources diverted away from impaired driving into other problem areas.

More than 20 years ago, victims' personal stories began to attract attention to the issue of impaired driving. The region responded with various counter measures. Since then, data has become a driving force in allocation of resources. Programs that can define a problem and show progress towards reducing it are more likely to receive support than programs based on "good ideas." Programs must now show the relationship between input and outcome – getting the most "bang for the buck." Evaluation has become almost as important as selection of strategies.

Methodology

The Taskforce on Regional Activities to Reduce Impaired Driving, which consists of individuals from a variety of professions and jurisdictions, gathered to provide a snapshot (based on national and local sources) of what is known about anti-impaired driving efforts in the metropolitan Washington region. Rather than duplicating studies done elsewhere, the taskforce looked for information from a variety of sources that was not compiled previously in one place.

This data will provide the region with the information to identify gaps in policies, programs, and information and look for specific improvements of a regional nature that would benefit from consistency, protocols, or coordination.

With that in mind, the Taskforce on Regional Activities to Reduce Impaired Driving attempted to find ways of measuring input and intermediate outcomes that will lead to a reduction in crashes. This report and "How Safe Are Our Roads" are designed to complement each other. In an attempt to reduce data requests, WRAP and the COG Taskforce conducted a joint survey of the jurisdictions on practices and data. The two reports are being coordinated. The WRAP report will focus on the impact of drunk and drugged driving on highway safety in the region while the COG report will answer the question, "What are we doing about it and how can we do better?"

For this report, no new data sources were created except for the survey of local jurisdictions. Gathering data, whether mining it from existing sources or just locating existing reports, is time consuming and expensive. Building a new data source is even more so. Therefore, we need to be cautious in defining our data needs to ensure that we are not duplicating efforts, or seeking data that will not answer the right questions. The focus was on looking for what might be already in existence in research, data, activities, strategies, laws, and policies that would help evaluate efforts and show their relationship to outcomes, explain progress or lack of progress, and identify where the region should focus.

Barriers to Reducing Impaired Driving

Historically, impaired driving is relatively new. While impairment has existed for centuries, driving is less than 100 years old. Until cars and traffic developed into their current state, drunk driving seemed fairly harmless and even humorous. It was rarely considered a crime. Impaired driving was acceptable until someone was hurt other than driver. Changing community norms is difficult in any situation, but even more so when the environment and the knowledge are changing constantly. We know a lot about which strategies will reduce drinking. Some of them are too draconian for our society, for example executing of drunk drivers. Others are too expensive, such as round-the-clock supervision during treatment. Some are pushed aside by ideas that may have been around for a long time but have been shown recently to be ineffective like zero tolerance vs. parents hosting "responsible drinking" parties for teens. In *A Study of the Alcohol Policy Development Process in the United States* (1999), Thomas Greenfeld said, "In light of the typically adversarial nature of the alcohol policy process, …enactment should be viewed as a long-term process requiring sustained and flexible effort."

It is not feasible or realistic to do everything concurrently with the existing (and limited) resources. Therefore, prioritizing efforts and greater efficiency in programs are necessary. The task force hopes that the information and recommendations in this report will help the policymakers in COG's member jurisdictions, separately and together, as they make those hard decisions. Information and recommendations in this report do not necessarily represent the official positions of the organizations or agencies of the taskforce members.

Data Availability and Use

State of the Knowledge

Data on impaired driving falls into three categories: (1) crash data, (2) physical and behavioral effects of alcohol, and (3) evaluation of countermeasures (both process and outcome).

Crash data, available from the national Fatality Analysis Reporting System (FARS), is available readily at the local, state, and national levels. In addition to alcohol- and/or drug-impairment, the system includes crash data; injury and fatality counts; driver and weather information; and time of day, locations, and type of vehicle. National progress in addressing impaired driving has improved since outcome measures (crashes, fatalities, etc.) have become available. One cautionary note — when working with data generated for FARS, different levels of government may compile the figures slightly differently. The state may report different numbers for a county than the county reports for itself. Federal data reported may also be different.

There is a large body of research ([16])* on how alcohol affects the body and behavior, although not all of it is related to drinking and driving. Because risky behaviors tend to cluster, much of this research is useful. While the region may participate in this type of research, it is not a normal part of local governmental responsibility. Therefore, it is not addressed in this report other than providing a basis for best practice information.

Nationally, researchers have been successful in evaluating a variety of countermeasures, but many gaps exist. Countermeasures used in the criminal justice system have been studied the most. Recent research indicates that implementing programs in a non-research setting may add variables that necessitate local evaluation.

Impaired driving is not included in the index of crimes reported to the federal government. Therefore, most jurisdictions do not report them along with other crimes. They are sometimes included with substance abuse statistics as indicators of need, but usually not included in substance abuse arrest counts.

State of the Region

Research done on a national basis is useful for many program-planning purposes and often can be used in place of locally specific data. This is especially true in designing best practices. However, even when best practices are used, it is important to have local evaluation of the fidelity of implementation and to provide measures of the extent of use for evaluation and planning purposes.

* Superscript numbers in parentheses refer to items listed in Bibliography and Resources Section at the end of the document.

The National Highway Traffic Safety Administration (NHTSA) has a formula that estimates the cost of impaired driving at the state level. The estimates include monetary costs and quality of life costs.

	Monetary Cost	Quality of Life Cost	Total
District of Columbia	$0.2 Billion	$0.2 Billion	$0.4 Billion
Maryland	$0.9 Billion	$0.8 Billion	$1.7 Billion
Virginia	$1.4 billion	$1.2 Billion	$2.6 Billion

Source: ([38])

The costs impaired driving are not shared equally among local jurisdictions. However, to give a rough approximation of the cost in each jurisdiction, a chart in the appendix presents what that cost might be if it were shared equally among all residents of the state. This method may produce double counting of residents in municipalities that are within a county. The regional total of these approximations is $1,763,500,000. That is more than $385 per person.

Some useful local information is now available on Internet sites, particularly from state agencies. Virginia's Social Indicator Reports, available at http://www.dmhmrsas.state.va.us for each jurisdiction are a good example. In Maryland, alcohol and drug data are available for each county at www.cesar.umd.edu/dews. They include rates of use, treatment, crashes and arrests. The District of Columbia data on substance abuse is available at http://www.doh.dc.gov/services/administration_offices/apr/pdf/Appendix_A.shtm.

However, data that would be useful for program evaluation are not always available. The taskforce found that throughout the jurisdictions, treatment and referral data are not collected in a uniform manner. This makes it difficult to track or compare the number of DWI arrests and the number of individuals who were evaluated and/or referred to treatment services. Data requested often are not currently available. When data are collected, databases are incompatible or impossible to link, making it difficult to look at systemic issues or to detect trends.

Sometimes impaired driving information is included in, or combined with, other subject areas, such as in measuring time spent in law enforcement. Sometimes the information is complex (i.e., the availability of treatment). In some cases, the difficulty might be attributed to lack of staff resources or lack of concern over how the data might be used or interpreted. Often it is difficult to find someone who knows if the data exists or where information is captured. For instance, in attempting to locate one particular report, three people spent several hours on the telephone being transferred from one person to another, even though they were able to describe the report based on an outdated sample of the report in hand. After locating the contact person for that the report, a written request to a high-level official or director was required before the data were released.

Several agencies or jurisdictions are in the process of developing data systems that will help evaluate programs to reduce impaired driving. Currently, there are no standard protocols for collecting or reporting data other than crash data. There is interest in designing compatible new systems in order to gain the most benefit.

Virginia's Governor's Task Force to Combat Driving Under the Influence of Drugs and Alcohol reported, "Databases are often designed to meet specific administrative needs and data cannot be readily retrieved for other purposes. For example, the Virginia Alcohol Safety Action Program (VASAP) client information database was designed to track clients and to allow case managers to ensure that each client meets all requirements of his or her probation. Recidivism rates for various client groups requested by the Task Force required that the data be aggregated. To do this would be time-consuming and require costly new programs."

A report from the District of Columbia Mayor's Interagency Task Force on Substance Abuse Prevention, Treatment and Control says, "Currently, there is no single information system available to criminal justice stakeholders in the District. In addition, there is no clearinghouse of available treatment programs or data-tracking system to capture treatment outcomes." The Criminal Justice Coordinating Council is working to develop a system to manage information.

Some of the data currently available in the region are included in Appendix A.

The Taskforce on Regional Activities to Reduce Impaired Driving lists the following data as needed, but not currently available for all jurisdictions:

- Information on underage drinking
- Separation of arrest and treatment data by age
- Behavioral risk factors for adolescents
- Court referrals for treatment
- Recidivism rates
- Sentencing
- Consumption location
- Number of people trained (sales/servers; officers, judges, prosecutors)
- Treatment costs
- Funding sources

<u>Recommendation</u>

Increase data gathering and sharing locally and regionally

- Each local jurisdiction should evaluate its strategies for collecting data, identifying data that is needed for local program evaluation. They must work to make data useful for as many purposes as possible and disseminate reports widely to avoid special requests for expensive data mining.
- The COG Impaired Driving Taskforce should continue to meet and develop regional standards for data collection
- Local taskforces and coalitions need to share their data with each other on a regular basis via combined regional reports to allow ongoing evaluation.

<u>Discussion Items For Local Elected Officials</u>

Since elected officials will be using the data for planning programs and budgets, which data have the highest priority?

This page left blank intentionally.

Best Practices:
Legislation

The State of the Knowledge:

According to Wagenaar and Associates, traffic laws as countermeasures to impaired driving (even when not combined with enforcement, adjudication and sanctioning) are estimated to reduce alcohol-impaired driving and crashes by 3% to 14% ([34]). Not all laws have been scientifically evaluated. Several that have been evaluated are strongly recommended by a wide variety of traffic safety organizations, including the National Highway Traffic Safety Administration, Mothers Against Drunk Driving, the Governors' Highway Safety Association, the National Commission Against Drunk Driving. and the Washington Regional Alcohol Program.

Laws may address pre-driving behavior, such as serving alcohol to intoxicated persons or minors; driving behavior, such as operating a motor vehicle with a Blood Alcohol Content (BAC) above a specified level; or vehicle and road safety equipment, such as seat belt usage.

Cost and savings associated with laws vary widely. Who bears the cost and who benefits from the savings also vary. Some laws have administrative costs which may or may not be covered by user fees. Some laws have costs to the offender. These may be paid by a government for low-income offenders. Other laws have costs for both government and offender. There are laws that have a cost to alcohol retailers, such as those preventing underage drinking and driving; which may manifest in lost sales. Finally some laws, such as alcoholic beverage taxes have costs for the general population or some segment of it. Enforcing laws is a government expense, but public information about laws and enforcement campaigns may be shared with private, nonprofit organizations, and the media.

Research indicates that an increase in the price of alcoholic beverages (from taxes or reduced availability) would reduce the probability of drinking and driving, especially among young drivers who 21 years old and under ([3]).

The State of the Region:

Impaired driving is defined by state and District law. These definitions are listed in Appendix A.

Most laws that reduce impaired driving are state laws, rather than local ordinances. In the past, the region has worked together to support passing of similar laws, such as the .08 BAC law and keg registration laws.

The following chart lists seventeen laws shown by scientific research ([5, 15, 33]) to be effective in reducing impaired driving. Half of the laws (shaded rows) are in place across the metropolitan Washington region. Four of the recommended laws have not been adopted by any of the jurisdictions. The other three have been adopted by one or two of the jurisdictions.

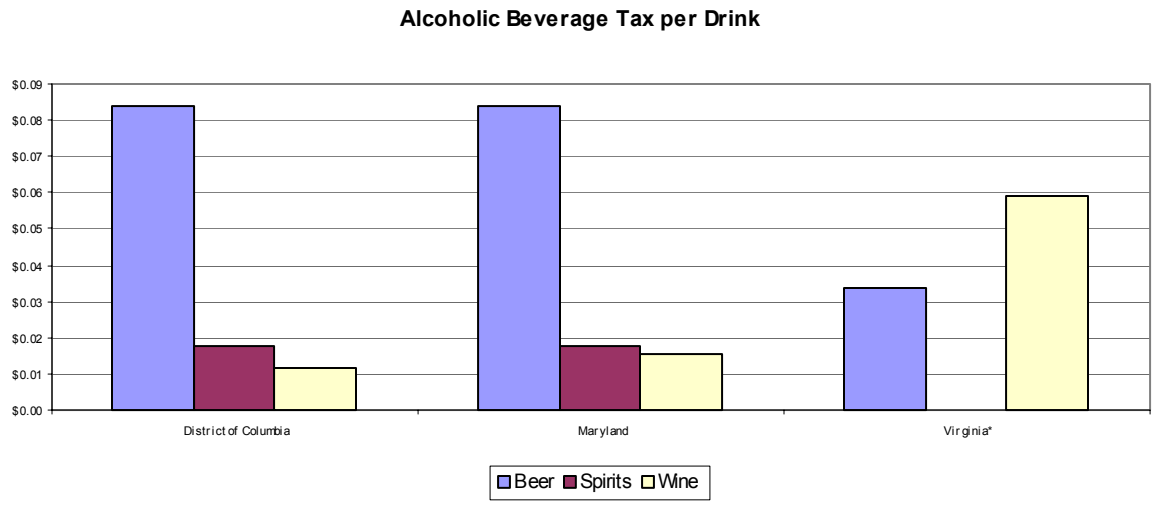
State Laws that Reduce Impaired Driving

	District of Columbia	Maryland	Virginia	Savings estimate [a]	Hard cost[a]
Administrative License Revocation (automatic and immediate loss of driving privileges for failing or refusing to submit to a BAC test)	Following a hearing	X	X	Estimated savings $54,000 per driver sanctioned	$762 /suspension
08 Illegal per se	X	X	X	Estimated savings $40 per licensed driver	$0.13/driver
Ignition interlock (BAC test devise disables car if alcohol is detected)	X[b]	X	X	Estimated savings $7,900 per vehicle equipped	$950/vehicle
License plate confiscation			X		
Vehicle impoundment/boot	X	X		Estimated savings $4,100 per vehicle impounded	$800/vehicle
Vehicle confiscation					
Vehicle sanctions for driving while suspended	X	X	X		
Mandatory alcohol assessment/treatment					
Sobriety Checkpoints legal	X	X	X	Estimated savings $62,000 per checkpoint	$8,476/checkpoint
Primary enforcement seatbelt law	X	X		Estimated savings $4,600 per new belt user	$5/new user
Enhanced penalty for high BAC	.20		.20		
Mandatory BAC test of killed drivers					
Mandatory BAC testing of surviving drivers	X	X	X		
Graduated licensing	X	X	X		$24/new driver
21 legal minimum drinking age	X	X	X	Estimated savings $540 per youthful driver	$149[c] youth 18-20
Under 21 zero tolerance ("any alcohol in the system" or .oo, or .02 BAC is illegal for drivers under 21)	X	X	X	Estimated savings $700 per youth driver	$1/drive under 21
Prohibit insurance refusal to cover medical costs if injury occurred while under the influence		X			

aSavings and cost estimates come from *Impaired Driving in the United States,* National Highway Transportation Safety Administration, 2002 (http://www.nhtsa.dot.gov/people/injury/alcohol/impaired-drivingusa/US.pdf) ; [b] The District has not previously used ignition interlocks. The mayor is in the process of starting a program. [c]The dollar value of alcohol purchases foregone, including sales tax.

In Virginia, the Commonwealth controls alcohol wholesale and retail sales of spirits and wine the through the Department of Alcoholic Beverage Control (ABC). Their website states, "Sales are a major source of revenue for the Commonwealth, generating yearly profits in excess of $40 million. In addition, ABC collects taxes of approximately $130 million on alcoholic beverages sold in Virginia. The taxes and ABC profits are used by the Commonwealth and its localities to provide citizens with a variety of services." In Maryland, where local alcoholic beverage laws differ but are enacted by the state, only Montgomery County has a similar Department of Liquor Control that conducts wholesale distribution of beer, wine and spirits. The District of Columbia is not a control jurisdiction.

Alcoholic beverage taxes in the region have remained the same for many years. The District set the tax on spirits and beer in 1970, and on wine in 1990. Maryland set the tax on beer and wine in 1970. Virginia, set the taxes on beer and wine in 1970 and taxes spirits on the basis of retail price.



* In Virginia, spirits are taxed based on a percentage of the retail price.

Recommendations

COG and its member jurisdictions should continue advocacy efforts until all 17 laws are in place in the District of Columbia, Maryland, and Virginia.

- Local jurisdictions should participate in their state coalition supporting these laws.
- COG should support passage of laws as it did .08 BAC laws.

Discussion Item for Elected Officials

What level of involvement should COG take to support, and/or advocate for state laws?

This page left blank intentionally

Best Practices:
Enforcement and Prevention

State of the Knowledge

The federal government is encouraging combined countermeasures that integrate work led by the U.S. Departments of Transportation, Justice, and Health and Human Services, and segments of the private sector. A difficulty for evaluation is to separate the countermeasures from each other and from external factors. For example, the effect of an increase in traffic enforcement might be confused by special events that affect officer availability for impairment enforcement and changes in traffic patterns and drinking levels.

Countermeasures can be categorized in several ways. They can address different parts of the problem, including: reducing drinking before driving, reducing driving after drinking, reducing crashes or reducing damage from crashes. They can address target populations and specific locations or times. They may be sorted by whether they are used before, during or after an incident of drunk driving and can focus on human factors, the vehicle and equipment, or the environment. Some examples of countermeasures are:

- Designated driver campaigns, including expanded use of public transit
- Ignition interlock
- White lines on the side of a road and arrests after driving has commenced
- Treatment and punishment intended to prevent subsequent events
- Server training
- Seatbelts
- Control of outlet density and hours

Research has provided a list of best practices ([3,5, 13, 16, 17, 24, 26, 28, 30, 33, 34]) indicating enforcement combined with strong public information can result in nighttime crash reductions of up to 30 percent, but with an average of 6-12 percent ([34]). Studies have shown that sobriety checkpoints reduce alcohol-related fatalities by 8 percent to 71 percent. The best results were achieved when checkpoints were coordinated throughout a large region over many months with extensive media coverage and public service announcements. ([26]) Training for area police would also strengthen enforcement efforts. A Criminal Justice Summit on Impaired Driving, held in November 2002, recommended that law enforcement training in DWI should be "mandatory and standardized across jurisdictions." ([5])

Combining law enforcement efforts with the work of community groups can be an effective tool for preventing impaired driving. Coalitions or taskforces can leverage their resources to bring a variety of disciplines together to create well-rounded programs. Holder et al found that "a coordinated, comprehensive community-wide intervention strategy can reduce high-risk alcohol consumption and alcohol-related injuries resulting from motor vehicle crashes and assaults" ([14]). The intervention included "community mobilization, responsible beverage service, reduction of underage drinking, increased law enforcement for drinking and driving laws, and limiting access to alcohol by zoning changes." Preventing young people from drinking

before they reach age 21 will reduce impaired driving both while they are minors and throughout their adulthood. Coalitions should include prosecutors, elected officials, media, law enforcement, and substance abuse treatment and prevention professionals.

Complex arrest procedures and paperwork limit the number of offenders that law enforcement officers can handle during each shift. It can take up to three hours to process one arrest, meaning a driver could be back on the streets before the officer completes all of the necessary paperwork.

State of the Region

One attractive feature of socializing in the region is visiting venues away from one's home jurisdiction. Because the region is a single media market, consistent practices across the region would reduce confusion among all drivers, patrons and servers. Some jurisdictions have received funding to develop model programs that match specific needs of the region. For example, some culturally specific neighborhood programs combine server training with increased police presence to lower drunk driving in entertainment or restaurant districts. Other model programs address underage drinking enforcement, education, and as in the Drug Recognition Expert, special training of police officers.

Since the 1980s, all jurisdictions have increased participation in local or regional coalitions or partnerships. However, since these tend to be voluntary collaborations, there is often no permanent group that is officially responsible for local agency coordination of planning and funding services. A recent report by the Montgomery Office of Legislative Oversight found ten groups trying to coordinate various prevention programs with varying degrees of emphasis on prevention of alcohol, tobacco and other drug abuse. Because none of these is in a position to fulfill the County Council's expectation, the report recommended amending the County Code to designate a lead coordinating committee and elevating the level of the County's Prevention Coordinator position.

The coalitions are self-selected and their degree of professionalism and knowledge of the 'state of the art' is mixed. Participants my select programs on the basis of popularity or 'gut reaction' rather than scientific evaluation. This is due to lack of resources for evaluation or a desire to deliver as many services as possible under the theory that 'it can't hurt.' Yet research shows that in some cases, well-intentioned programs can be counter-productive. These programs also use up money that could otherwise be spent on more effective efforts.

Keeping impaired driving efforts lively and in the public eye while difficult, is very important for prevention. Virginia and Maryland each have statewide coalitions or commissions bringing people together to work on legislation. The District of Columbia and several local jurisdictions have multiple groups working on traffic safety and alcohol and other drug abuse. The Washington Regional Alcohol Program and COG provide opportunities for regional coordination. Most groups have little or no funding for activities; many have no official responsibilities. Instead, they work as advocates at networking opportunities. They may have some funding for coordination, but depend on voluntary contributions for joint efforts. Some of

these coalitions, including the District's National Capital Coalition to Prevent Underage Drinking (NCCPUD), the University of Maryland Alcohol Taskforce, WRAP, and Montgomery's Drawing the Line on Underage Drinking (DTL), focus heavily on reaching young people. Others, such as Fairfax County's Oversight Committee on Drunk Driving focus on driving issues. Mothers Against Drunk Driving has experienced difficulty recruiting and retaining leaders and members and obtaining donations. Most of their chapters are much smaller or have been combined with others. A list of coalitions is included in Appendix A.

Different jurisdictions have similar names for different strategies or activities. Although every jurisdiction involves law enforcement in student education programs, the types of programs and resources allocated vary widely. In addition, a question included in the survey instrument for this report regarding working with managers elicited two sets of responses. Some jurisdictions focus on managers of licensed beverage establishments and training on alcohol laws while others focus on reaching potential impaired drivers through their employers. Often programs have been in place without evaluation but may have names that are easily confused with an evaluated best practice. Most professionals have a difficult time keeping up with the research, as they usually lack the time or the staff to do outcome evaluations.

Jurisdictions see the benefits of coordinated activities, such as collaborated checkpoints. Grouping checkpoints by time not only makes them seem to be everywhere, but also allows public service announcements and media coverage across the same media market to serve more agencies. Companion checkpoints on the same street in two jurisdictions gets more than double the attention.

In response to situations where no national model exists, some jurisdictions have piloted programs. Washington, Fairfax and Montgomery Counties have hospitality resource panels and have worked with other jurisdictions to develop a national model of panels that involve businesses in joint problem solving with government agencies.

In a region as diverse as the metropolitan Washington area, all programs and agencies need to be culturally competent. This includes having staff that reflect the ethnic makeup of the region, including language abilities. Members of the various target populations must be involved in the design of strategies to ensure methods that will be most effective within each population. Translating a one-size-fits-all program into other languages does not work. Elected and spontaneous leaders of various cultural groups and neighborhoods need to be recruited as spokespersons. Despite the lack of quantitative research in this area, anecdotal information indicates agencies are most successful when they actively recruit and/or train staff of various ethnicities.

Police Department Activities to Address Impaired Driving

		Alexandria	Arlington	District of Columbia	Fairfax City	Fairfax County	Falls Church	Loudoun	Manassas City	Manassas Park	Montgomery County	NIH police	Prince Georges	Prince William	WMATA
Public Information and Education (PI&E)	Have a countywide plan for all Impaired Driving PI&E		X	X				X			X		X		
	Develop own PI&E campaign & materials		X	X	X	X	X		X						
	Host or participate in media events	X	X	X		X	X	X	X	X	X		X		
School Programs	School programs (at high risk times)	X	X	X		X	X		X					X	
	School programs (traffic safety)		X	X		X	X	X		X	X			X	
Community Employer Programs	Provide info to community employers & encourage programs aimed at employees		X	X	X									X	
	Provide management training to recognize and address alcohol & drug impairment		X						X		X			X	
Responsible Alcohol Service	Retailers involved in education programs	X	X	X		X	X		X		X		X		
	Implement & enforce program to eliminate underage sales	X	X	X		X	X		X		X				
	Implement “Cops in Shops”			X					X		X				
	Implement “Sticker Shock”			X		X									
	Info to retailers on responsibility for damages caused by patron served when visibly intoxicated		X	X		X					X			X	
Transportation Alternatives	Sponsor designated driver (safe rides and other alternative transportation programs)	X	X	X			X		X						
	Promote safe ride programs (such as *SoberRide*)		X	X	X	X	X		X		X		X	X	X
Deterrence	Number of check points in 2002	1	1	36		12		12	3	1	10		X	13	
	Number of phantom check points	4		6				2	0		4				
	Coordination with other jurisdictions on checkpoints		X			X		X	X		X		X	X	
PI&E for Deterrence	General PI&E programs to maximize perception of risk of getting caught	X	X	X		X					X			X	
	Seasonal education & enforcement program		X	X		X		X	X		X			X	

		Alexandria	Arlington	District of Columbia	Fairfax City	Fairfax County	Falls Church	Loudoun	Manassas City	Manassas Park	Montgomery County	NIH police	Prince Georges	Prince William	WMATA
Enforcement	SFST training etc.	X	X	X		X	X	X	X		X		X	X	X
	Adequate equipment	X	X	X		X	X	X	X	X	X			X	X
Program Planning	Implement plan based on problem definition using fatality, injury, crash & arrest data		X	X		X		X					X	X	
Program Control	Ensure activities are implemented as intended	X	X	X		X		X	X					X	
	Measure progress in achieving goals and objectives	X	X	X		X		X						X	
Local Task Force & Community Traffic Safety Programs	Encourage and participate in sate and community impaired driving task force and programs		X	X	X	X	X	X	X	X				X	
Data and Records	Maintain records of alcohol/drug related fatalities, crashes, arrests, injuries	X	X	X		X	X	X	X	X	X			X	X
	Inclusion of data on impaired driving convictions		X			X									X
Evaluation	Conduct surveys, focus groups or assessments to determine community traffic safety concerns/needs?	X	X	X			X	X		X				X	
Funding	Specific funding for impaired driving programs	X	X	X				Grant	90,000				SHA		
	Percent of funds from local budget	22,000	84%	varies		95%			10,000	3%					
	Percent of funds from grants		16%	almost all		5%		$6,000	90%	$2,000			100%	$3,000	
	Percent of budget from other sources		No					0		$0					
	Funds adequate for program needs		No					x							
	Are funds steady?		Local yes; grant no	X		X			X						
	Costs paid by the impaired drivers														

Statistics for 2002

		Alexandria	Arlington	District of Columbia	Fairfax City	Fairfax County	Falls Church	Loudoun	Manassas City	Manassas Park	Montgomery County	NIH police	Prince Georges	Prince William	WMATA
Fatalities	Total fatalities	2	10	50	1	52	1	13	1	0	71	0	141	19	0
	Total alcohol/drug traffic fatalities 2002	1	0	4 (+14 pending)	0	20	0	4	0	0	11	0	35	8	0
	Under 21 alcohol/drug traffic fatalities	1	0	1	0	3	0	0	0	0		0	N/A	0	0
Injuries	Total traffic injuries	519	1377	5650	377	5434	3	1040	390	40	8733	0	10062	2712	0
	Total alcohol/drug traffic injuries	18	122	213	14	433	2	103	37	4	377	0	415	N/A	0
	Total under 21 alcohol/drug traffic injuries	1	N/A	N/A	0	83	0	N/A	N/A	0	82	0	N/A	N/A	0
Crashes	Total number of traffic crashes	2150	3740	17734	1125	16913	197	3150	846	118	13784	35	16602	4897	0
	Alcohol/drug crashes	111	286	N/A	29	1078	10	195	65	9	963	0	1024	333	0
Arrests	Total impaired driving arrests	427	694	1492	243	2769	11	557	347	144	3451	0	N/A	767	11
	Total juvenile impaired driving arrests	8	3	8	3	49	0	7	7	1	56	0	N/A	19	0

Recommendations

Increase use of prevention and treatment strategies with both strong research based results and broad-based acceptance while exploring the feasibility of new, less tested or more controversial approaches.

- Increase use of checkpoints through a regionally cooperative effort, and increased publicity.
- Increase programs that work with retailers to help them develop best business practices, including site assessments and server/seller training.
- Continue to develop and increase sharing of new best treatment practices.
- Identify ways to combine resources to provide updates on research and training on best practices.

Discussion Items for Elected Officials

- How can the region assign responsibility for selecting and evaluating interwoven programs to produce the best results, as shown by comprehensive programs with multiple approaches?
- How can the region increase the resources available for effective programs?

This page intentionally left blank.

Best Practices:
Courts and Treatment

State of the Knowledge

The court system can help reduce impaired driving by decreasing delaying tactics, finding ways for judges to control court schedules, and evaluating case management. ([5, 13,28,34]) Prosecutors should prioritize cases and use administrative courts when possible. People involved in the justice system (including police officers, prosecutors, judges, probation officers, and treatment providers) need to be educated and trained on evidentiary issues, creative sentencing options, and specialized courts. Courts need access to scientific evaluations of sanctions. Reduced caseloads allow increased contact time with offenders. This should be combined with improved data gathering, uniform paperwork and requirements for substance abuse evaluation.

Because many clients suffer from chronic addiction and participate in treatment only when pressured, best results in court occur when treatment is supported by sanctions for failure to participate. DWI/Drug courts provide a balance between level of treatment and level of punishment. This approach requires cooperation among judges, prosecutors, probation officers and treatment providers. DWI courts, which use a combination of treatment and penalties to manage cases, are more effective than regular courts. Finding funding for the increased time, or even finding time in a fully packed court docket, can be difficult. Insurance companies may refuse to cover enough time for adequate treatment. They also may require treatment providers to write reports for the court. Judges and prosecutors report that caseloads are growing faster than resources. It is important to decrease delaying tactics that add to court backlogs.

Providing education and training for judges is important but not always feasible. Judges have little time to attend training sessions. When one county proposed bringing a week of training to local organized to meet their schedules, it was turned down. The Criminal Justice Summit on Impaired Driving recommended that "prosecutors and public defenders should help coordinate and be involved in DWI training, particularly with law enforcement officers, to help improve the quality of cases brought to court."([5])

Traffic safety is enhanced by suspending or revoking drivers' licenses, particularly when the suspension or revocation was administrative and immediate. Suspending licenses for refusing a breath test reduced alcohol-related fatal crashes by about 70%. ([34])

There have been many studies on the use of treatment and rehabilitation to reduce recidivism. Results have varied; however a meta analysis indicates an eight to nine percent reduction of crashes. ([34]) Deferring prosecution as an incentive for entering a treatment program was not effective. Best results came from a combination of treatment modalities. Some studies have questioned the effectiveness of the education programs offered to offenders assessed to be social drinkers.

Placing emphasis on reaching drinking drivers after they have created a risk by driving has been a common practice in this country. Other ways of encouraging people to modify their

behavior (either by education in a teachable moment or by helping them receive treatment sooner) include increasing insurance coverage for substance abuse treatment and interventions by doctors (including primary care providers and in emergency rooms), family members and employers before it is necessary for the courts to intervene.

State of the Region

This region has seen rapid population growth in some jurisdictions. Creation and filling of new judgeships usually lags behind growth. Courts often rely on retired judges who may have less timely knowledge and improper attitudes about impaired driving. The size of the caseload affects how cases are handled by prosecutors and judges. The heavier the load, the less time available for individualizing each case. A court study in Montgomery County found that the District Court gave an impression of "assembly line" justice whereby police officers were not supported by prosecutors in preparing for testimony. The study also reported that courts were reluctant to impose harsh penalties on drunk drivers for fear the number of appeals to the circuit court would become too burdensome.

Because the court systems in each jurisdiction are significantly different, comparing the caseload per judge cannot be done between states. Although, caseloads can only be compared within each state, there is great variance among jurisdictions within each state.[1]

Maryland

	District Court Cases Per Judge (FY 02)*
Frederick	6,864
Montgomery	2,295
Prince George's	1,973
State	4,514

* "motor vehicle cases" (Source: Annual Report of the Maryland Judiciary- 2001-2002)

[1] Data from the District of Columbia is not provided because it is a single jurisdiction.

Virginia

	Cases Per Judge (CY 02)*
Alexandria	19,606
Arlington	31,784
Fairfax City	94,515
Fairfax County	25,738
Falls Church	7,117
Loudoun	30,922
Prince William	26,551

"traffic cases" (Source: Commonwealth of Virginia Caseload Statistics of the District Courts 1/2-12/02)

It is widely believed by the public and judges that "no one can tell a judge what to do." However, judges will respond to information offered to them in less time consuming ways or when it is presented through the media. Judges often welcome data on recidivism-sanction connections. Outreach and education should include other people that influence court case outcomes. Following a court watch in 1996, the Montgomery County State's Attorney's Office took the lead in creating a new, more consistent way of handling underage alcohol cases. As part of the court watch study, a judge education program delivered "factoids" on postcards that could be read easily. The judges requested the mailings continue.

The court watch in Montgomery County found that usually judges reduce or waive fines and fees in impaired driving cases without a request from the offender. This practice may impact court resources and contribute significantly to penalty reduction.

Judges and substance abuse professionals have anecdotal concerns about the quality of assessments. In Montgomery County, approximately 10 percent of drivers arrested for DWI are under age 21. Twenty-five percent of those youths had a BAC of .25 or higher, yet the court did not mention age, even though this should be a factor in considering sanctions.

A memo dated March 29, 2000 from Maryland's Department of Health and Mental Hygiene talks about the practice of "private providers … erroneously assessing offenders who come to them because of a DWI charge…and [placing them] into a program for the 'Social Drinker" (12-hour educational) when these offenders would be more appropriate for a "Problem Drinker" program (6 month outpatient treatment).…This practice encourages lawyers to send additional referrals to this program." Several judges and prosecutors, as well as treatment professionals, have recommended that assessments should be done by a single government agency on site at the courthouse to ensure standardization and quality, and to eliminate delays in court.

Repeat offenders may be mislabeled as "first time" offenders when their records in other states are not checked for convictions or when they have qualified for expungement[2].

[2] Expungement is the process of removing records from public inspection. In some states it does not include motor vehicle records.

The Taskforce on Regional Activities to Reduce Impaired Driving was not able to obtain conviction rates for the District of Columbia or Virginia. However, the Maryland District Court reports that both conviction rates and failure to show rates have gone down over the last four years for which data are available. ([6]) Frederick County showed a large drop. The County had an increase in total cases and in the number of cases in which charges were dropped.

The District of Columbia Mayor's Interagency Task Force on Substance Abuse Prevention, Treatment & Control reports that the District began a one-year pilot Family Treatment Court because a "truly effective and fair criminal justice system requires comprehensive case management."

The need for treatment slots continues to grow as the region's population increases and as the percentage of people seeking treatment climbs. Early intervention before impaired driving takes place or prompt recognition at the time of first offense could decrease the need for more expensive types of treatment. Changing intervention behaviors in the region may be difficult. Both Virginia and the District of Columbia allow insurance companies to exclude payment for injuries that occurred while the patient was under the influence of alcohol or drugs. This discourages abuse of emergency room services for fear of non-payment. Primary care physicians are not encouraged by training or insurance providers to include screening as part of routine visits. Substance abuse treatment frequently has more restrictive insurance coverage than other medical services. Employers are fearful of increased insurance premiums and other potential problems brought on by encouraging treatment. Yet studies show that untreated substance abuse causes increased health care costs, lost productivity, and increased absenteeism at work for the entire family.

Use of Best Practices by State Level Jurisdictions

	District of Columbia	Maryland	Virginia
Review new licensees for outstanding suspensions/revocation in other states	Yes	No	No
Count DUI/DWI from other state as prior	Yes	No	No
Require assessment	No unless getting license reinstated	Yes Results provided to judge, prosecutor and probation	Post conviction; does not affect sentencing
Mandated treatment	No	Possible	Possible
Ignition interlock device	Legal[a]	Yes	Yes
Police Drug Recognition Experts	Yes	Yes	Yes
Electronically monitored home detention	Yes		Yes
"Look back" period for prior offenses	10-15 years	10 years	10 years
Use of pre-trial or pre-conviction diversion	Yes, but counts as a prior offense	Yes, probation before judgment	

Sources: Governors Highway Safety Association www.statehighwaysafety.org ; National Hardcore Drunk Driver Project , http://dwidata.org/states). [a] Ignition interlocks are legal in the District, but have not been used. Planning is underway to initiate use.

Recommendation

Increase evaluation of court system effectiveness in reducing recidivism and increase effective use of treatment.

- The taskforce should develop regional protocols to identify repeat offenders across jurisdictions and track specific (individuals) and general (population) deterrence.
- The region should evaluate different methods of assessment.
- The region should educate judges, prosecutors, employers, insurance companies, and doctors about the cost benefits of interventions
- The region should track caseloads in courts and treatment as regional population and need for services grow.

This page left blank intentionally

Best Practices:
Leadership and Resources

State of the Knowledge

Factors that lead to success in reducing impaired driving include high visibility leadership from elected officials, broad-based community support, and the use of a wide variety of science-based strategies with good evaluation. These factors must have stable funding to allow long range planning and development including tracking efforts and results over time.

Leadership of elected officials and broad-based community support go hand-in-hand. Elected officials are ideally situated to influence community attitudes and priorities.

Use of science-based strategies and evaluation also go hand-in-hand. Strategies must be carefully selected to increase the likelihood of success and carefully evaluated for proper implementation and usefulness to the specific community. Adequate evaluation will free up resources wasted in ineffective, but sometimes popular, programs. Poor programs not only divert funds from effective programs, but may also decrease support by making people feel efforts are wasted or the problem is "just too difficult."

Institutionalized funding streams earmarked and kept at high priority provide for ongoing emphasis and high visibility. Funding streams can come from penalties paid by offenders, such as enhanced penalties for impaired crashes, fees paid by all drivers, or dedicated funds from taxes. Nationally, advocates are drawing attention to the need for access to treatment. Insurance companies along with employers or individuals, would cover the cost of treatment, which would be at least partially offset by reduced costs associated with other related areas, such as other health care issues and lost productivity.

State of the Region

Keeping impaired driving efforts energized and in the public eye requires constant effort. Virginia and Maryland each have a statewide coalition or commission that brings people together to work on legislation. The District and several local jurisdictions have multiple groups working on traffic safety and alcohol and other drug abuse. The Washington Regional Alcohol Program (WRAP) and COG provide opportunities for regional coordination. WRAP describes itself as a "public-private partnership." At a recent needs assessment session, board members were careful to describe WRAP as an organization made up of equal partners.

Since the 1980s, all jurisdictions have developed coalitions or partnerships. Many of these coalitions are led by private partners. Most of these groups have little or no funding for activities. Many have no official responsibilities and work as advocates or as networking opportunities. Many jurisdictions have no standing committee officially responsible for coordination of planning and funding services. They may have some funding for coordination, but depend on voluntary contributions for joint efforts. No one entity is responsible for monitoring the effectiveness of programs. A recent report by the Montgomery Office of

Legislative Oversight (http://www.montgomerycountymd.gov/content/council/OLOReports/alcohol.pdf) found ten groups trying to coordinate various prevention programs with varying degrees of emphasis on prevention of alcohol, tobacco and other drug abuse. None of these is currently able to fulfill the County Council's expectation. The report recommended amending the County Code to designate a lead coordinating committee, and elevating the level of the County's prevention coordinator position.

The focus of these coalitions is influenced by the source of coordination funding. Some, including the District's National Capital Coalition to Prevent Underage Drinking (NCCPUD), the University of Maryland Alcohol Taskforce, WRAP, and Montgomery's Drawing the Line on Underage Drinking (DTL) focus heavily on reaching young people. Others, such as the Fairfax county Oversight Committee on Drunk Driving, focus on driving issues. Mothers Against Drunk Driving has experienced difficulty recruiting and retaining leaders and members and obtaining donations. Most of their chapters are much smaller or have combined with others. A list of coalitions is appended.

In Virginia, Governor Warner has provided high visibility leadership, which, along with some legislative leadership, led to legislative progress in 2002. In Maryland, members of the state legislature have led the charge and have met with some success in previous years. Evidence of leadership for non-legislative strategies is harder to find. It has been several years since any local jurisdiction has had a council member spearheading efforts to reduce impaired driving.

There is little coordination among governments across the COG region on impaired driving, except what WRAP is able to provide. The District's Interagency Taskforce recommends "a coordinated and focused regional response to the problem of substance abuse" and the "adoption of consistent and mutually supportive anti-substance abuse laws and policies across jurisdictions." The National Highway Traffic Safety Administration has coordinated impaired driving efforts across the NHTSA Region III, which includes other states as well as those in the COG region.

Budget cuts and re-allocation of resources to other programs, such as homeland security, have cut into ongoing efforts in enforcement and prevention. Treatment budget problems have caused providers to go bankrupt.

Recommendations:

The region needs to express strong support for anti-drunk driving programs by leadership example and by establishing responsibility and funding through entities that can be held accountable.

- The region needs strong leadership from elected officials, judges, prosecuting attorneys, law enforcement, media, and from the private sector, to return this issue to the public's awareness, to obtain resources, and to change community norms of behavior.

- The region needs champions who are not professionals in this field but have high profiles in the community to speak out on behalf of these changes and hold jurisdictions accountable for results.
- The region needs to establish dedicated funding streams that will build an infrastructure responsible for outcomes.
- The region needs to assign responsibility for coordinating and evaluating these efforts.

Discussion Items for Elected Officials:

- How can the region develop a group of high visibility people to champion this issue?
- What resources other than grant funding are available for these steps?
- What can professionals in the field do to get and keep policy level people involved, especially in keeping the issue "on the front burner?"

This page left blank intentionally

Bibliography and Resources

1) University of Minnesota, Alcohol Epidemiology Program. (2001*). Alcohol Policies in the United States: Highlights from the 50 States*
http://www.epi.umn.edu/alcohol/pdf/Chrtbook.pdf

2) University of Minnesota, Alcohol Epidemiology Program. (2002*). Youth Access to Alcohol Survey Summary Report*
http://www.epi.umn.edu/alcohol/pdf/2002_report.pdf
http://www.epi.umn.edu/alcohol/pdf/Charts_Appendices.pdf

3) Chaloupka, F.J., Grossman, M., & Saffer, H. (2002). The effects of price on alcohol consumption and alcohol-related problems. *Alcohol Research and Health*. (26) 1:22-34.
http://www.niaaa.nih.gov/publications/arh26-1/22-34.pdf

4) Commonwealth of Virginia. (2003). *General District Courts of Virginia History of Commenced Cases, 1993-2002*
http://www.courts.state.va.us/csi/gd_basic_commenced_history_1993-2002.pdf

5) National Highway Traffic Safety Administration and National Criminal Justice Association. (2003). *Criminal Justice Summit on Impaired Driving*
http://www.nhtsa.dot.gov/people/injury/enforce/CrimJustSum-HTML/images/CrimJustSum.pdf

6) District Court of Maryland, TA21-902 Reports, FY 1993, 1999, 2000, 2001, 2002,

7) District of Columbia Alcoholic Beverage Regulation Administration. (2001-2003). *Fiscal Year Statistics* http://www.abra.dc.gov/information/performance.shtm

8) District of Columbia, Department of Health, Addiction Prevention and Recovery Administration. *Drug-Related Data for the District of Columbia*

9) Foster, S.E., Vaughan, R.D., Foster, W.H., Califano, J.A. Jr. (2003). Alcohol Consumption and Expenditures for Underage Drinking and Adult Excessive Drinking. *JAMA, 289,* 989-995.

10) Goldberg, N., & Anderson, D. (2002). *How Safe Are Our Roads?* Washington Regional Alcohol Program
http://www.wrap.org/highwaysafety02.pdf

11) Governors Highway Safety Association. http://www.statehighwaysafety.org

12) Greenfield, T.K., (1999). *A Study of the Alcohol Policy Development Process in the United States.* Substance Abuse Policy Research Program. http://www.saprp.org

13) Hedland, J. (*Drunk Driving: Seeking Additional Solutions.* American Automobile Association Foundation for Traffic Safety.

http://www.aaafoundation.org/pdf/DrunkDriving-SeekingAdditionalSolutions.pdf

14) Holder, H., Gruenewald, P.J., Ponicki, W.R., Treno, A.J., Grube, J.W., Saltz, R.F., et al. (2000). Effect of community-based interventions on high-risk drinking and alcohol-related injuries. *JAMA, 284 (18),* 2341-2347

15) Montgomery county Maryland Board of License Commissioners. *Alcohol Awareness Training Requirements*. http;//montgomerycountymd.gov

16) National Institute on Alcoholism and Alcohol Abuse. (2000). *10th Special Report to U.S. Congress on alcohol and Health*. http://www.niaaa.nih.gov/publications/10report/intro.pdf

17) National Institute on Alcoholism and Alcohol Abuse. (2000). Latest Approaches to Preventing Alcohol Abuse and Alcoholism. *Alcohol Research & Health.* (24) 1: 42-52. http://www.niaaa.nih.gov/publications/arh24-1/42-52.pdf

18) National Institute on Alcoholism and Alcohol Abuse. (2003). *Per capita ethanol consumption for States, census regions, and the United States, 1970-99.* www.niaaa.nih.gov/databases/consum03.txt

19) National Institute on Alcoholism and Alcohol Abuse. *Alcohol Beverage Taxes: Beer.* www.niaaa.nih.gov

20) National Institute on Alcoholism and Alcohol Abuse. *Alcohol Beverage Taxes: Wine.* www.niaaa.nih.gov

21) National Institute on Alcoholism and Alcohol Abuse. *Alcohol Beverage Taxes: Distilled Spirits*. www.niaaa.nih.gov

22) National Center on Addiction and Substance Abuse at Columbia University. (2001). *Shoveling Up: The Impact of Substance Abuse on State Budgets.* www.casacolumbia.org/publications

23) National Hardcore Drunk Driver Project http://dwidata.org

24) National Institute on Alcohol Abuse and Alcoholism. (2001). *Alcohol and Transportation Safety.* Alcohol Alert No. 52. http://www.niaaa.nih.gov/publications/aa52.htm

25) National Institute on Alcohol Abuse and Alcoholism. (2002*). Screening for Alcohol Problems – an Update*. Alcohol Alert No. 56. http://www.niaaa.nih.gov/publications/aa56.htm

26) Peek-Asa, C. (1999). Effect of random alcohol screening in reducing motor vehicle crash injuries. *American Journal of Preventive Medicine, 16* (1S): 57-67.

27) Restaurant Association of Metropolitan Washington. (2003). A Brief Overview of Legislative Issues/Promotion/Notions Affecting the Metropolitan DC Hospitality Industry. *The Cloak Room, Vol. 2 Issue 8*.

28) Robertson, R.D., & Simpson, H. (2003). DWI System Improvements for Dealing with Hard Core Drinking Drivers. Traffic Injury Research Foundation. http://www.trafficinjuryresearch.com/anheuserBusch/dwi_system.htm

29) Schmoke, K.L. (2003). *Ending Discrimination Against People with Alcohol and Drug Problems.* Join Together National Policy Panel. www.jointogether.org

30) Treno, A.J., & Lee, J.P. (2002). Approaching Alcohol Problems Through Local Environmental Interventions. *Alcohol Research and Health*. (26) 1:35-41 http://www.niaaa.nih.gov/publications/arh26-1/35-41.htm

31) Tucker, J., Ellickson, P.L., Tucker, J.S., & Klein, D.J. (2003) Ten-Year Prospective Study of Public Health Problems Associated with Early Drinking. *Pediatrics, 111 (5)*, 949-955

32) U.S. Department of Labor, Working Partners for an Alcohol- and Drug-Free Workplace. *Driving Under the Influence (DUI), Driving While Intoxicated (DWI) and other State Laws.* www.dol.gov/asp/programs/drugs/party/duidwi.htm

33) Rivara, F.P., Dunn, C., & Simpson, E. (2000) *Addressing Alcohol-Impaired Driving: Training Physicians to Detect and Counsel Their Patients Who Drink Heavily.* US Dept. of Transportation / NHTSA. http://www.nhtsa.dot.gov/people/injury/research/pub/impaired_driving/

34) Jones, R.K; & Lacey, J.H. (2001) *Alcohol and Highway Safety 2001: A Review of the State of Knowledge.* US Dept. of Transportation / NHTSA. http://www.nhtsa.dot.gov/people/injury/research/AlcoholHighway/

35) Subramanian, R. (2003). *Alcohol Involvement in Fatal Crashes 2001*. National Center for Statistics and Analysis. http://www-nrd.nhtsa.dot.gov/pdf/nrd-30/NCSA/Rpts/2003/809-579.pdf

36) Foss, R.D., Marchetti, L.J., & Holladay, K.A. (2001). *Development and Evaluation of A Comprehensive Program to Reduce Drinking and Impaired Driving Among College Students*. US Dept. of Transportation / NHTSA. http://www.nhtsa.dot.gov/people/injury/research/ReduceCollege/

37) US Dept. of Transportation / NHTSA. (1997). *Summary of Important Statutory Provisions and Court Decisions Concerned with Drunk Driving.* http://www.nhtsa.dot.gov/people/injury/alcohol/pub/alcsumry.pdf

38) U.S. Department of Transportation. (2000*). Impaired Driving Guide in the United States.* www.nhtsa.dot.gov

39) NHTSA / NCSA. (2003). *2002 Traffic Safety Facts Sheets.* http://www-nrd.nhtsa.dot.gov/departments/nrd-30/ncsa/

40) Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services. (2002*). Archival Social Indicator Study. Virginia Prevention Needs Assessment: Alcohol and Other Drugs. Final Report*. http://www.dmhmrsas.state.va.us/Organ/CO/Offices/OSAS/Prevention/Prevention2001/SIStudyFinaReport.pdf

41) Wiliszowski, C.H., Rodriguez-Iglesias, C.E., Lacey J.H., Jones, R.K., Cyr, E. (2001). *A Study of Outstanding DWI Warrants.* US Dept. of Transportation / NHTSA. http://www.nhtsa.dot.gov/people/injury/research/pub/Outstanding_Warrants/Warrants_index.html

Appendices

Appendix A

Suggested Activities for Leaders

Individuals and leaders who are not subject matter experts on DWI could do the following to reduce impaired driving:

- Take a nominal leadership role in a taskforce, even if you don't have time to do much. This puts your name on letterhead and in media releases, and provides the opportunity to be the spokesperson at press conferences.
- Use your position to have your agency or government lend credibility and put the weight of your organization behind the activities that are being done already.
- Encourage new activities or programs that your organization can co-sponsor (even if only by name or publicity) and recruit other co-sponsors to show community support.
- Encourage local businesses and foundations to fund equipment purchases, educational programs and events. For example, a trailer that carries checkpoint equipment can demonstrate community support for the effort by having sponsor names on the side. Another option is to give sporting events tickets to drivers who have not been drinking.
- Offer to speak at local events such as holiday campaign kick-offs.
- When you meet with local groups of voters, ask them how they feel about the issue, and tell them what you are trying to do. Provide a moment of education and tell them that you need their participation.
- Take advantage of any "teachable moments."
- Write a letter to the editor (or op-ed piece), especially when impaired driving has made the news.
- When reporters interview you about a related issue, always make the connection to impaired driving. Related issues may include:
    - Traffic congestion and safety (drunk driving makes it more dangerous)
    - Pedestrian safety
    - Behavior around entertainment venues, including stadia, concert halls and night club districts (if people are drinking heavily in parking lot or seats, they will be impaired when they drive home)
    - Underage drinking (problem drinkers usually start young)
    - Crime on the streets (drunk driving is a crime)
    - Violent crime (a car is as deadly as a gun)
    - Zoning regulations (if outlets are too densely located they can't stay in business unless they break the law)
    - Colleges and universities (alcohol abuse is rampant on campuses and around them and students often drive home afterwards)
- Encourage or require any special event that serves alcohol to follow responsible practices.
- Request reports on program outcomes related to impaired driving. Then follow up as appropriate to improve programs. Reports topics might include:
    - Treatment accessibility (waiting period, case loads, etc.)
    - Recidivism rates

    - Local enforcement efforts (number of officers trained, number of special enforcement actions, number of man hours spent in traffic enforcement),
    - Local prevention efforts (screening families of offenders for counseling needs, school programs, server training)
    - Liquor license violation rates and penalties
    - Where funding for [prevention, enforcement, treatment] comes from
    - Where court fines go
    - Who coordinates cross-discipline efforts, and how responsible they are for results.
- Request a court watch or a report on court case outcomes
- Policy and program changes that are cost effective
    - Require that programs include evaluation as part of their plans.
    - Make one person and program responsible for reporting outcomes
    - Request the scientific basis for program selection
    - Ask program staff to devote time, even just one hour per week, to keeping up with the research
    - Make sure anti-drunk driving information is included in required training for appropriate staff such as police, treatment providers and social workers.
- Make sure your employees have health insurance coverage for substance abuse treatment
- Support legislation

Be a high visibility role model – say, “No thank you, I’m driving tonight”

Appendix B

Regional Information

What is "Impaired Driving"?

Washington D.C.

The legal drinking age in the District of Columbia is 21 years of age, and there are three very distinct drinking and driving laws that are enforced:

- **Driving While Intoxicated (DWI)**
  DWI applies to a person having a statutorily prohibited blood alcohol concentration of .08 or higher. The suspect can be convicted in court solely on the breath, blood, or urine results without any structured field sobriety test.
- **Driving Under the Influence (DUI)**
  DUI applies to a person having a blood alcohol concentration of .05 percent - .07 percent. The suspect can be convicted in court of this charge if the officer has other clues of impairment from a structured field sobriety test.
- **Under Age Drinking**
  Persons under the age of 21 years of age cannot purchase, consume, or possess any alcoholic beverages of any kind. If they are found to be operating a motor vehicle with any measurable amount of alcohol, they will be placed under arrest and charged with DWI—Driving While Intoxicated.

(Source: http://www.mpdc.dc.gov/info/traffic/duihome.shtm#test5)

Maryland

§ 21-902. Driving while under the influence of alcohol, while under the influence of alcohol per se, while impaired by alcohol, or while impaired by a drug, a combination of drugs, a combination of one or more drugs and alcohol, or while impaired by a controlled dangerous substance.

(a) *Driving while under the influence of alcohol or under the influence of alcohol per se.*-

(1) A person may not drive or attempt to drive any vehicle while under the influence of alcohol.

(2) A person may not drive or attempt to drive any vehicle while the person is under the influence of alcohol per se.

(b) *Driving while impaired by alcohol.*- A person may not drive or attempt to drive any vehicle while impaired by alcohol.

(c) *Driving while impaired by drugs or drugs and alcohol.*-

(1) A person may not drive or attempt to drive any vehicle while he is so far impaired by any drug, any combination of drugs, or a combination of one or more drugs and alcohol that he cannot drive a vehicle safely.

(2) It is not a defense to any charge of violating this subsection that the person charged is or was entitled under the laws of this State to use the drug, combination of drugs, or combination of one or more drugs and alcohol, unless the person was unaware that the drug or combination would make the person incapable of safely driving a vehicle.

(d) *Driving while impaired by controlled dangerous substance.*- A person may not drive or attempt to drive any vehicle while the person is impaired by any controlled dangerous substance, as that term is defined in § 5-101 of the Criminal Law Article, if the person is not entitled to use the controlled dangerous substance under the laws of this State

§10-307. Same – Results of analysis and presumptions….
(b) Alcohol concentration of 0.05 or less. – If at the time of testing a person has an alcohol concentration of 0.05 o9r less, as determined by an analysis of the person's blood or breath, it shall b presumed that the person was not under the influence of alcohol and that the person was not driving while impaired by alcohol.

(c) Alcohol concentration of more than 0.05 but less than 0.07 – If at the time of testing a person has an alcohol concentration of more than 0.05 but less than 0.07, as determined by an analysis of the person's blood or breath, this fact may not give rise to any presumption that the person was or was not under the influence of alcohol or that the person was or was not driving while impaired by alcohol, but this fact may be considered with other competent evidence in determining whether the person was or was not driving while under the influence of alcohol or driving while impaired by alcohol.

(d) Prima facie evidence of impairment. – IF at the time of testing a person has an alcohol concentration of at least 0.07 but less than 0.08, as determined by an analysis of the person's blood or breath, it shall be prima facie evidence that the person was driving while impaired by alcohol.

(e) Prima facie evidence of alcohol in blood. – If at the time of testing a person has an alcohol concentration of 0.02 or more, as determined by an analysis of the person's blood or breath, it shall be prima facie evidence that the person was driving with alcohol in the person's blood.

(f) Prima facie evidence of violation of *§16-113 of the Transportation Article. – If at the time of testing a person has an alcohol concentration of 0.02 or more,, as determined by an analysis of the person's blood or breath, it shall be prima facie evidence that the person was driving in violation of an alcohol restriction under §16-113 of the transportation Article.*

(g) Under the influence of alcohol per se. – If at the time of testing a person has an alcohol concentration of 0.08 or more, as determined by an analysis of the person's blood or breath, the person shall be considered under the influence of alcohol per se as defined in §11-12.1 of the Transportation Article.

(Source Maryland code http://198.187.128.12/maryland/lpext.dll?f=templates&fn=fs-main.htm&2.0)

Virginia

§ 18.2-266. Driving motor vehicle, engine, etc., while intoxicated, etc.

It shall be unlawful for any person to drive or operate any motor vehicle, engine or train (i) while such person has a blood alcohol concentration of 0.08 percent or more by weight by volume or 0.08 grams or more per 210 liters of breath as indicated by a chemical test administered as provided in this article, (ii) while such person is under the influence of alcohol, (iii) while such [person is under the influence of any narcotic drug or any other self-administered intoxicant or drug of whatsoever nature, or any combination of such drugs, to a degree which impairs his ability to drive or operate any motor vehicle, engine or train safely, or (iv) while such person is under the combined influence of alcohol and any drug or drugs to a degree which impairs his ability to drive or operate any motor vehicle, engine or train safely.

§ 18.2-266.1. Persons under age twenty-one after illegally consuming alcohol penalty.

A. It shall be unlawful for any person under the age of twenty-one to operate any motor vehicle after illegally consuming alcohol. Any such person with a blood alcohol concentration of 0.02 percent or more…shall be in violation of this section.

§ 18.2-266.10. Evidence of violation of § 18.2-266. or § 18.2-266.1. In any trial for a violation of § 18.2-266. or § 18.2-266.1 or a similar ordinance, the admission of the blood or breath test results shall not limit the introduction of any other relevant evidence bearing upon any question at issue before the court, and the court shall, regardless of the result of nay blood or breath tests, consider other relevant admissible evidence of the condition of the accused. IF the test results indicate the presence of any drug other than alcohol, the test results shall be admissible only if other competent evidence has been presented to relate the presence of the drug or drugs to the impairment of the accused's ability to drive or operate any motor vehicle, engine or train safely. The failure of an accused to permit a blood or breath sample to be taken to determine the alcohol or drug content of his blood is not evidence and shall not be subject to comment by the Commonwealth at the trial of the case, except in rebuttal; nor shall the fact that a blood or breath test had been offered the accused be evidence or the subject of comment by the Commonwealth, except in rebuttal.

The court or jury trying the case involving a violation of clause (ii), (iii) or (iv) of § 18.2-266. or § 18.2-266. shall determine the innocence or guilt of the defendant from all the evidence concerning his condition at the time of the alleged offense.

(Source: http://vatrafficlaw.com/dwiprimer.html)

Estimated Cost of Impaired Driving by Jurisdiction

The National Highway Traffic Safety Administration has a formula that estimates the cost of impaired driving down to the state level. The state estimates include monetary costs and quality of life costs.

	Monetary Cost	Quality of Life Cost	Total
District of Columbia	$0.2 Billion	$0.2 Billion	$0.2 Billion
Maryland	$0.9 Billion	$0.8 Billion	$1.7 Billion
Virginia	$1.4 billion	$1.2 Billion	$2.6 Billion

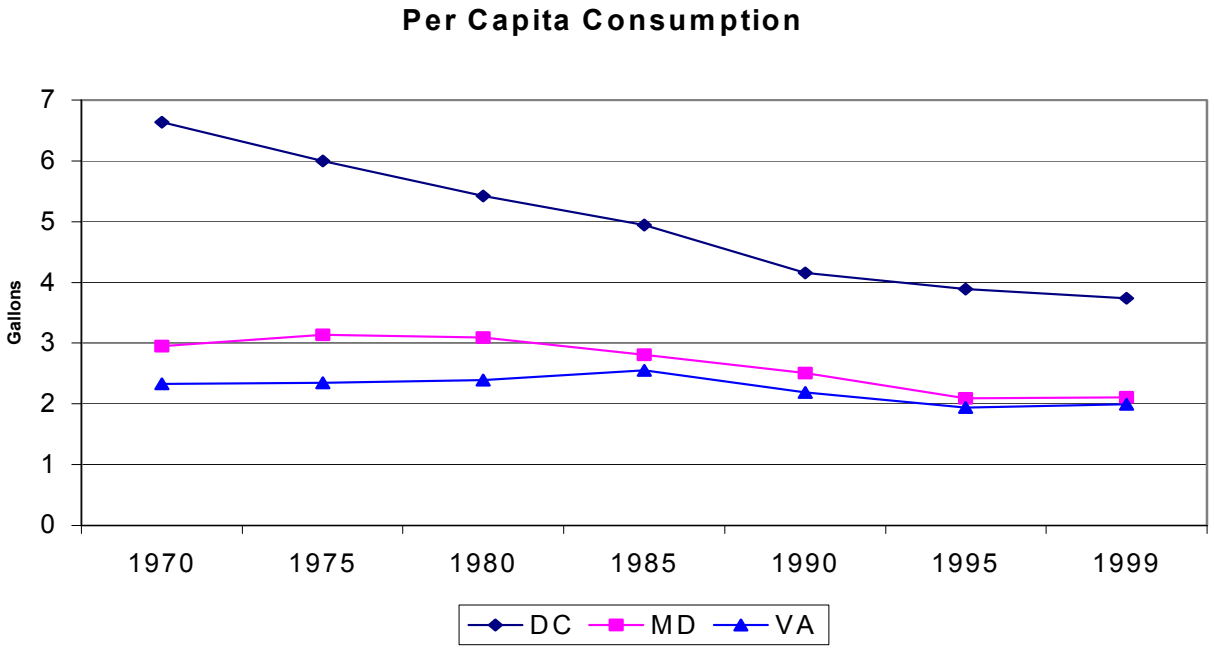
Like impaired driving itself, the cost is not shared equally among local jurisdictions. However, to give a rough approximation of the cost in each jurisdiction, the chart below presents what the cost might be if it were shared equally among all residents of the state. This method may produce double counting of residents in municipalities that are within a county. The regional total of these approximations is $1,763,500,000. That is more than $385 per person.

Jurisdiction	Population	Fraction of State Population	Share of State Cost of Impaired Driving (In millions)
Alexandria	132,700	0.018	$46.8
Arlington County	187,469	0.026	$67.6
Bowie	51,400	0.01	$17.0
College Park	24,700	0.005	$8.5
District of Columbia	571,822	1.	$400.0
Fairfax City	21,700	0.003	$7.8
Fairfax County	985,161	0.14	$364.0
Falls Church	10,400	0.001	$2.6
Frederick County	203,789	0.038	$64.6
Gaithersburg	54,000	0.01	$17.0
Greenbelt	21,200	0.004	$6.8
Loudoun County	190,903	0.027	$70.2
Manassas	35,300	0.005	$13.0
Montgomery County	900,706	0.169	$287.3
Prince George's County	815,417	0.153	$260.1
Prince William County	298,707	0.042	$109.2
Rockville	49,800	0.009	$15.9
Takoma Park	17,300	0.003	$5.1
Total for region	4,572,474		$1,763.5

Per Capita Ethanol Consumption for States
(Gallons of ethanol, based on population age 14 and older)*

	DC	MD	VA
1970	6.64	2.95	2.33
1975	6	3.14	2.35
1980	5.42	3.09	2.39
1985	4.94	2.81	2.55
1990	4.16	2.51	2.19
1995	3.89	2.09	1.94
1999	3.74	2.11	1.99

*adapted from www.niaaa.nih.gov/databases/sonsum03.txt



Alcohol Sales Outlet Density

Outlet density can have an affect on impaired driving rates two ways. If the number of outlets is too large, for the population size, to provide adequate income for the businesses while using responsible practices The competition for sales may lead to drink specials ("all you can drink for $XX", "bladder buster night," "pitcher specials") overall lower prices, and illegal sales to intoxicated or underage persons. These practices encourage over drinking and impaired driving. Outlet density may also result from clustering outlets in a few neighborhoods, such as beer and wine stores in lower socio-economic neighborhoods[3] or entertainment districts. Either way, if the purchasers are traveling a longer distance to buy and consume alcohol, they then have a longer, impaired, drive to return home.

Jurisdiction	Outlet Density/ 100k Population (2000)
Alexandria	311.03
Arlington County	288
Bowie	
College Park	
District of Columbia	272.11
Fairfax City	2707.23
Fairfax County	180.25
Falls Church	751.66
Frederick County	
Gaithersburg	(Included in Montgomery County)
Greenbelt	
Loudoun County	211.68
Manassas	227.69
Montgomery County	96.59 (2002)
Prince George's County	
Prince William County	
Rockville	(Included in Montgomery County)
Takoma Park	(Included in Montgomery County)

[3] At one time the small business administration encouraged alcohol stores in failing retail strips. Research has found that this exacerbates the downward spiral of the neighborhood as problems associated with carryout sales, such as loitering and drug problems, drive other businesses out.

Responsible Beverage Service and Sales Training

The District of Columbia will soon start requiring that all managers be trained in responsible alcohol service. More than 130 hospitality workers have been trained since June 1.

Maryland requires that all license holders have one person trained in responsible alcohol service. Montgomery County requires that each establishment have a trained person on the premises during business hours. Maryland law requires that trainers register all trainees at the time of certification with the State Comptroller and the local Board of License Commissioners (BLC). However, Montgomery County reports only 800 certified trainees have been registered with the county even though there are 870 licensees. Indicators suggest additional servers have been trained, but have not been registered by their trainers. The BLC has a strict enforcement program with few obvious violations of certification requirements. However, there are concerns about quality of some training programs, especially for people who do not speak English.

Virginia does not require manager or server training. Virginia sends an informational video and a confirmation-of-receipt form to all in-state ABC license holders.

District of Columbia Arrests for Liquor Law Violations

	1998	1999	2000	2001	2002
Adults	200	106	139	287	306
Juveniles	1	1	2	2	0

Treatment Admissions

District of Columbia Treatment Admissions
Rate/ 100K population

	Number Admitted	**Rate**
FY 00	6,175	
FY 01	10,604	1,854
FY 02	4,481	

Source: Adapted from DC Dept. of Health
Addiction Prevention and Recovery APRA
Screening and Detox/Treatment Figures

Maryland Treatment Admission
Rate per 100K Population

Jurisdiction	**FY 98**	**FY 99**	**FY 00**	**FY 01**	**FY 02**
Frederick	885.9	931	1,019.10	1,046.20	1,059
Montgomery	655.4	556.1	487.3	506.6	558.5
Prince George's	480.50	450.30	432	483.00	495
Maryland	1,152.40	1,145.50	1,109	1,141.20	1,281

Source: Adapted by CESAR and COG from data from the Substance Abuse
Management Information System (SAMIS), Maryland Alcohol and Drug Abuse Administration (ADAA),
Department of Health and Mental Hygiene

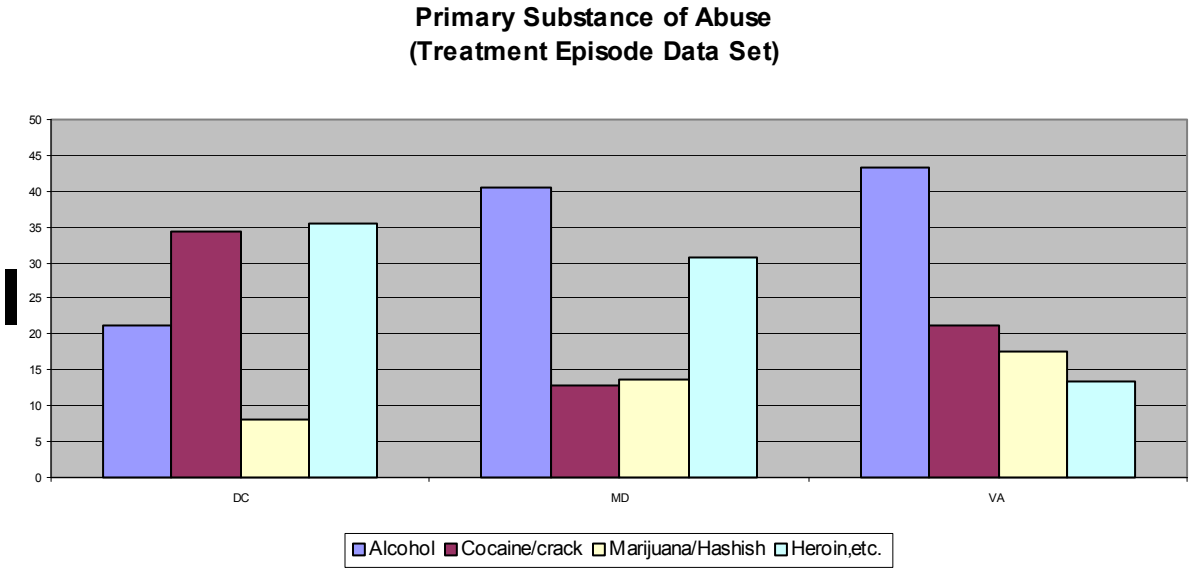
Virginia Treatment Admissions

The taskforce had great difficulty in getting treatment data from Virginia jurisdictions- most do not have a uniform way of collecting this data or have never been asked to produce this data before. "Social indicator data collected from the Department of Mental Health, Mental Retardation, and Substance Abuse Services (VDMHMRSAS)…are incomplete. The local Community Service Boards are not required to report this data to the VDMHRSAR, resulting in incomplete data."[4]

[4] Archival Social Indicator Study Final Report, May 2002.

What Substances Are Causing Impairment?

The laws refer to "alcohol, alcohol and drugs, or drugs" as causing impairment. Data are not available to tell us exactly what the drivers have been using when arrested. However, the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Data Archive does provide information at the state level on primary substance of abuse as reported by treatment episodes. The region does not necessarily reflect the statewide data for Maryland and Virginia, but the data show that substances of abuse are different in the three jurisdictions.



(Adapted from: US DHHS Substance Abuse and Mental Health Data Archive www.icpsr.umich.edu:8080/quicktables/quickoptions.do)

Coalitions Addressing Impaired Driving in the COG Region

Mothers Against Drunk Driving (MADD)

LOUDOUN COUNTY
P O Box 4252
Leesburg, VA 20177
Phone: 703-771-8127
Fax: 703-430-5744
E-mail: maddloudoun@aol.com
Website: http://www.maddloudounva.org/

NORTHERN VIRGINIA
P O Box 1066
Fairfax, VA 22030
Phone: 703-352-3944
Fax: 703-379-1930
E-mail: office@maddnova.org
Website: http://www.maddnova.org

CENTRAL MARYLAND
104 Cathedral Street
Annapolis, MD 21401
Phone: 410-268-7900
Fax: 410-990-9668
E-mail: madd.centralmd@verizon.net
Website: http://www.madd.org/md/central/

National Commission Against Drunk Driving (NCADD)

8403 Colesville Road, Suite 370
Silver Spring, MD 20910
Phone: 240-247-6004
Fax: 240-247-7012
Website: http://www.ncadd.com/index.html

Washington Regional Alcohol Program (WRAP)

1420 Spring Hill Road, Suite 250
McLean, VA 22102
Phone: 703.893.0461
Fax: 703.893.0465
Email: wrap@wrap.org
Website: www.wrap.org

Drawing the Line on Under-21 Alcohol Use

Montgomery County Department of Health & Human Services
Meg Baker Program Coordinator
Health Promotion and Substance Abuse Prevention
2424 Reedie Drive
Wheaton, MD 20902
Telephone: 240-777-1123
Fax 240-777-3295
Website: http://www.montgomerycountymd.gov/mc/services/hhs/phs/drawingtheline

Maryland Impaired Driving Coalition

Coordinator: Susan Laine
Phone: 301-530-6231
Email: Slaine@erols.com
Website: http://www.stopdrunkdrivinginmaryland.net

National Capital Coalition to Prevent Underage Drinking (NCCPUD)

1400 16th Street, NW, Suite 750
Washington, DC 20036
Telephone: 202 - 265 - 8922
Fax: 202 - 265 – 8056
Email: info@nccpud.com
Website: http://www.nccpud.com/index.html

Commission on Virginia Alcohol Safety Action Program

Telephone: (804) 786-5895
Website: http://www.vasap.state.va.us/asap/index.htm

District of Columbia Impaired Driver Support Unit

Telephone: (202) 727-6717
Website: http://www.mpdc.dc.gov/info/traffic/duihome.shtm

Alcohol and Other Drug Abuse Advisory Council of Montgomery County (AODAAC)

UMD

Oversight Committee on Impaired Driving (N.VA or Fairfax?)

Traffic Safety Committees

Prince Georges
Frederick
Montgomery

Appendix C

Local Reports

TO THE HONORABLE
MARK R. WARNER
GOVERNOR OF VIRGINIA

FROM THE GOVERNOR'S TASK FORCE TO COMBAT DRIVING UNDER THE INFLUENCE OF DRUGS AND ALCOHOL

Report and Recommendations

July 2003

EXECUTIVE SUMMARY

Governor Mark R. Warner created the Task Force to Combat Driving Under the Influence of Drugs and Alcohol to assess current efforts to eliminate driving under the influence (DUI) and recommend new strategies to further curtail impaired driving and boating under the influence (BUI). Task Force members reviewed data on state and national trends, reviewed relevant state programs and procedures and heard presentations from numerous speakers concerning high priority issues. A survey of judges, prosecutors, chiefs of police and sheriffs (supplemented by focus group discussions and telephone interviews) gathered additional information and insight into the problem.

Virginia has made significant progress during the past 20 years in its efforts to reduce DUI and BUI. Legislation has been enacted to improve efforts to detect, apprehend and prosecute offenders. Societal changes, such as the growth of organizations such as Mothers Against Drunk Driving (MADD), Virginians Opposing Drunk Driving (VODD) and Designated Driver programs, have increased public awareness of the problems and consequences. Overall, alcohol-related crashes, injuries and deaths have declined.

Despite these accomplishments, there is room for improvement. Both national and Virginia data suggest that some of the positive trends may be reversing. Estimated 2002 national crash data document 17,970 alcohol-related deaths, the third straight year of increase after a decade of decline.[1] In Virginia, alcohol-related motor vehicle crashes increased between 1999 (10,942) and 2002 (11,788) at a rate of 7.73%. Three hundred seventy five fatalities occurred in 2002 as a result of drunk driving, comprising 41 percent of total highway fatalities that year.[2]

Since 1997, the percent of boating fatalities that were alcohol-related was almost double that for boating crashes in general.[3] This finding is similar to findings concerning alcohol-related motor vehicle crashes, except that the percentage of fatal motor vehicle crashes that are alcohol-related is about three times as high as the percent of total alcohol-related motor vehicle crashes.

The Task Force identified eight high-priority issues requiring increased attention:

1. **Underage drinking and driving**. Although young drivers are less likely than adults to drive after drinking alcohol, their risk for a crash is substantially higher when they do.[4] Continued vigilance is required to develop and reinforce safe driving habits at an early age.

---

1. *Motor Vehicle Traffic Crash Injury and Fatality Estimates: 2002 Early Assessment*. National Highway Traffic Safety Administration, May 2003.
2. Transportation Safety Services, Virginia Department of Motor Vehicles, 2003.
3. Edward Steinkoenig, Virginia Department of Game and Inland Fisheries, 2003.
4. *Alcohol and Underage Drinking.* Insurance Institute for Highway Safety, December 2002, Arlington, VA.

2. **Public support and high visibility leadership**. Public outreach and education campaigns must continue to maintain and build public support for drunk driving and boating initiatives. The Governor's office should continue to provide high visibility leadership, supporting as in 2003, such initiatives as a primary safety belt law and other appropriate highway safety programs.

3. **Differing perspectives**. Law enforcement personnel, prosecutors, judges and others involved in combating DUI and BUI differ in their views regarding the most effective deterrents. Expanding understanding and implementation of effective approaches and practices is needed.

4. **Technology resource allocation**. State-of-the-art techniques and tools are not available or in use across the Commonwealth. Laptop computers in police cars and boats, drivers' license scanners and other tools can help improve law enforcement efficiency and effectiveness by providing timely access to information and improving accuracy of data collection.

5. **Adequacy of current substance abuse programs**. Treatment and rehabilitation programs are inadequate to address the demand for services. Data-driven substance abuse screening tools and treatment programs can improve DUI and BUI recidivism prevention efforts.

6. **Repeat offenders and hard core drunk drivers**. This group is involved in a disproportionate number of alcohol-related crashes and fatalities. In 2001, 57 percent of all drivers and 41 percent of drivers under the age of 21, involved in an alcohol-related fatal crash, had a BAC test result of .15 or higher.[5]

7. **Legal issues**. The current complexity of DUI and BUI laws and procedures make enforcement and prosecution efforts both difficult and time-consuming.

8. **Data management**. The absence of a unified, coordinated data management system has made it virtually impossible to track DUI and BUI events from arrest through resolution, hampering efforts to determine emerging trends and issues.

To address these issues, the Task Force offers thirty-three recommendations for implementation within the next five years (pages 20-26).

---

5. *2001 Report on Alcohol-Related Traffic Fatalities in the United States*. The Century Council, Washington, D.C.

5. Recommended new strategies with initiatives to address high-risk populations such as underage drinkers and repeat DUI offenders;

6. Recommended actions to sustain and enhance the public's awareness and concern for the danger posed by driving under the influence;

7. Identified potential funding sources for recommendations;

8. Recommended strategies for improved coordination of management, funding and resources at state and local levels.

This report summarizes the Task Force's activities, accomplishments, and recommendations for the next five years.

COURT WATCH 2002-2003

Citizen Volunteers Look at How Montgomery County's District Court Handles Underage Drinking and Drunk-Driving Cases

Sponsored by

Montgomery County, Maryland's
Drawing the Line on Underage Alcohol Use

August 2003

EXECUTIVE SUMMARY

Six citizen volunteers trained in court-observation techniques spent much of 2002 watching how almost 425 alcohol-related cases were handled by Montgomery County, Maryland's, District Court. These citizens gathered data and perceptions about the way the District Court deals with cases that involve the violation of laws on the possession of alcohol by youth under the age of 21, the illegal furnishing of alcohol to minors, and driving vehicles with a blood-alcohol concentration level that is above the limit set by law. Between January and June 2002, 213 underage drinking and 208 drunk-driving cases were observed.

Conclusions:

The good news is that the Court Watchers found that nearly all court personnel (judges, state's attorneys, police, the court clerk's staff, bailiffs, and the County Department of Correction's Alternative Community Service professionals) were genuinely interested in strengthening sanctions in alcohol-related cases. The Court itself requested the Court Watch, a positive act in its own right. Clearly the court is concerned about alcohol misuse.

Court Watch volunteers further concluded, however, that while progress has been made in some areas, when looking at drunk-driving cases, little has changed since September 2000 when a series in *The Washington Post* described Montgomery County's District Court as being consistently lenient in these cases. This comes in spite of: 1) increased national concern about the negative effects of the misuse of alcohol on community life, 2) recently strengthened Maryland state laws related to drinking and driving, and 3) the repeated statement by all parties involved in court that alcohol misuse underlies the majority of the cases it handles. This translates to repeated endangerment of our community by drunk drivers as well as a missing message to teenagers about the dangers—to them and to others—of illegal alcohol use.

History:

Montgomery County's District Court has twice requested a Court Watch. The first "watch" was conducted in 1995-1996 and focused only on underage drinking cases. Its findings brought about specific, positive changes in the way 18-20 year olds convicted of illegal possession of alcohol are handled in the District Court's Criminal Court. Most importantly, it brought about a greater standardization of

sanctions, making it impossible to "judge shop." The result of this is that by 2002 each offender in underage drinking cases has a relatively similar and equal experience in court.

In late 2001, the Administrative Judge of the District Court, concerned about the pervasive, negative impact of alcohol in a large proportion of all court cases, requested that a second Court Watch be conducted. The 2002 Court Watch focused on two courts: the District's Criminal Court where underage drinking cases are handled, and its Traffic Court, the venue for drinking and driving cases. The goal of the 2002 observation was to come up with a citizens' description of how these courts handle misuse-of-alcohol-cases and, based on this description, to make recommendations for strengthening the impact of court actions on both underage and adult offenders.

Findings:

Overall Findings in Both Criminal and Traffic Courts: During the spring of 2002, Court Watchers regularly observed in both courts. They recorded data on standardized forms and noted their perceptions gained over the six months of their work. The clear consensus of this study is that Montgomery County's District Court is more lenient than it may think it is in its handling of alcohol-related cases, especially those having to do with drunk driving. In both underage drinking and drunk-driving cases the observers found that:

- ✓ The majority of the judges were not viewed by Court Watchers as being tough in alcohol-related cases either in the way they speak about alcohol misuse from the bench nor in the sanctions they impose. In the opinion of the Court Watchers, judges are missing an opportunity to use the bench as a bully pulpit to inform the public about the dangers of alcohol misuse by young people and by drivers.

- ✓ Sanctions are not as strong as they could be within the law (probation before judgment is offered by some judges even when it is not requested by the defense or state's attorneys; fines and court costs are waived for no obvious reason; and, more often than not, supervised probation is waived).

- ✓ There is an overriding sense of production-line justice. With such a large number of cases being handled daily in each court, the details of each case

get lost in the shuffle, reducing the impact of court proceedings on defendants, both underage drinkers and adults.

- ✓ An enormous amount of time is wasted due to "no shows" (43 percent in Criminal Court and 21 percent in Traffic Court). This both clogs the courts and reduces its ability to deal firmly and constructively with each individual case. (Note: The Administrative Clerk of the court points out that the District Court has "no administrative or statutory procedure to do anything about "no shows," although if the person doesn't show up the Judge *can* impose sanctions." (Italics added by report writer.)

- ✓ Police could use more backing if they are to be effective voices in court. (Note: The Administrative Clerk of the District Court points out that such support needs to come from the State's Attorney's Office and from the Police Department itself.)

- ✓ The courts are less severe in the sanctions they give defendants in drunk-driving cases than they are in the sanctions imposed in underage alcohol possession case. This sends the message that although underage drinking is somewhat serious business, drunk driving is not that big a deal.

***Findings in Underage Drinking Cases**:*

A key finding of the 2002 Court Watch is that improvements have been made since 1995-1996 in the way underage drinking cases are handled. There is greater consistency in sanctions across the board in underage drinking cases than there was six years ago. This means that young people coming into court are dealt with even-handedly among the different judges (and assistant state's attorneys) with fines, court costs, and community service sanctions being roughly the same from judge to judge.

Other, more negative, observations in underage drinking cases include:

- ✓ Young offenders do not take their time in court seriously. This stems in part from friends who were at the same party being handled in the same court session, resulting in a party-like atmosphere in the hallways. It also stems from the huge press of court business that prevents an individualization of cases.

- ✓ The Alternative Community Service (ACS) program of the County's Department of Corrections is not providing information about all three of the alcohol and other drug education programs that are available. This reduces the number of young people selecting these constructive options.

- ✓ Judges do not consistently support the underage drinking law. One judge said in front of the courtroom and the underage defendant that he really thought that the drinking age should be set at 18, not 21.

Findings in Drunk-Driving Cases:

The Court Watch volunteers agreed to a person that the consequences of drunk driving are inadequate to protect other drivers on the road.

Leniency in drunk-driving cases showed up in the following ways:

- ✓ Judges sometimes give the impression of being on the defendant's side, accepting defendant's self-description as being social drinkers who indulge rarely or as addicts who are therefore not fully responsible for their actions.

- ✓ Judges are missing a "teachable moment." Rarely do judges speak forcefully from the bench about the deadly consequences of driving while intoxicated.

- ✓ Fines are considerably lower than they are allowed to be within the law. Without even asking if defendants have financial problems, court fees and other costs are regularly waived or reduced by more than half.

- ✓ Probation before judgment (PBJ) is given frequently by judges without request by defense or state's attorneys.

- ✓ Unsupervised probation is given in the largest portion of cases. It is given more often than supervised.

- ✓ Underage drivers who had been drinking were charged *only* with the drunk driving charge, not for illegal possession of alcohol at their age. The court, the State's Attorney's Office, and the Police Department did not acknowledge the underage factor. Court Watchers felt that the underage status should be featured and that additional sanctions should be imposed.

Recommendations:

Overall recommendation:

Court Watch 2002-2003's main recommendation is that Montgomery County's District Court—in both Criminal and Traffic Court cases—should more consciously and consistently convey the message that alcohol misuse has concrete consequences and is "serious business." In the case of underage drinking it endangers young people's mental and physical health. In the case of drunk driving it endangers all other drivers on the road.

Ways this overall message can be conveyed are to:

- ✓ Strengthen sanctions across the board by raising fines (at least to keep up with inflation), increasing community service hours, and reducing the number of PBJ decisions.

- ✓ Take greater advantage of "teachable moments."

- ✓ Tighten administrative practices such as tackling the "no show" issues, balancing the cases allocated to each courtroom, and providing more support to police testifying in alcohol-related cases.

- ✓ Improve Circuit Court backing of District Court decisions.[5]

Recommendations in Underage Drinking Cases:

Court Watchers recommend several ways to increase the impact of the court experience:

- ✓ Individualize cases: Reduce the sense of "cookie-cutter" justice by taking a few additional seconds in court to individualize each case.

- ✓ Ensure proportional justice: Make sure that the young people who choose to go to trial but are then convicted of underage drinking offenses don't receive

[5] *This Court Watch did not include any observations of Circuit Court. However, judges and state's attorneys repeatedly mentioned to Court Watch volunteers that they avoid higher sanctions out of concern that such cases will be appealed to the Circuit Court, whose docket already is clogged and whose backing of District Court decisions is uncertain.*

lower sanctions than those who volunteer from the start to take part in the County's diversion program.

- ✓ Educate offenders: Require an alcohol and other drug education component be present in each diversion program. Also, strengthen these programs and even offer them more than once to offenders. Studies show that often the first several classes don't take hold. Right now, court sanctions go right from ACS the first time to $1,000 the second offense. Maybe a portion of the $1,000 could go to further, intense, long-term education to attack the problem.

- ✓ Target providers of alcohol to youth: In a social marketing anti-furnishing campaign, make a special target of adult men who are the primary providers of alcohol to teenagers. (During the Court Watch *only* men showed up as accused providers.)

- ✓ Strengthen sanctions for youth with prior offenses. Second-time youthful offenders were not perceived by Court Watchers as receiving significantly harsher sanctions than those who appeared in court for the first time.

Recommendations in Drunk-Driving Cases:

Court Watchers felt that the message the District Court conveys in drunk-driving cases should be significantly strengthened:

- ✓ Use the bench as bully pulpit: Judges should speak more forcefully from the bench about the serious consequences of drunk driving.

- ✓ Strengthen sanctions: Significantly increase sanctions for those convicted of driving drunk (impose maximum fees, make PBJ the exception, require supervised probation, and take away drivers licenses).
- ✓ Identify underage drinking-and-driving defendants. Handle young people ages 18-21 differently from adults in Traffic Court, charging them with both drunk driving citations *and* illegal possession of alcohol.

In conclusion, the 2002-2003 Court Watch found that an unintended disconnect exists between court personnel's view that alcohol negatively underlies a huge percentage of all court cases and an excessive leniency in sanctions, especially in Traffic Court. The extremely large number of cases, as well as the natural courtesies embedded in an egalitarian meting out of justice, seem to lessen the

sharp message that harm is done when young people consume alcohol illegally or when someone who is drinking gets caught behind the wheel of a car—a deadly weapon.

Given that the 2002-2003 Court Watch was requested by the court itself and that the large majority of professionals involved in the Courts were supportive of this effort, the citizen volunteers involved as well as the *Drawing the Line* community hope that these findings will be taken seriously and that the recommendations included in this report will be implemented.

Employee Alcohol Abuse:
Is It Costing Your Government Money?

A Report on the Impact of Employee Alcohol Abuse on Governments

September 18, 2003

This report was produced by the
Metropolitan Washington Council of Governments

Abstract

Title: Employee Alcohol Abuse:
Is It Costing Your Government Money?
A Report on the Impact of Employee Alcohol Abuse on Governments

Date: September 18, 2003

Author: Nancy Rea (Project Manager)
Robert D. Washington (Writer)
Department of Human Services, Planning, and Public Safety
Metropolitan Washington Council of Governments

Agency: The Metropolitan Washington Council of Governments (COG) is the regional organization of the Washington area's major local governments and their elected officials. COG works toward solutions on regional issues such as growth, transportation, affordable housing, air pollution, water supply and quality, and economic development. COG serves as the regional planning organization for the metropolitan Washington area.

Abstract: Health care spending has been on the increase since the late 1990's. Employers are searching for ways to manage these costs and the associated reasons for these increases. Many employers are unaware that alcohol use is one of the factors. In fact, health care costs for employees who have alcohol problems are nearly twice as high as for those who do not. (NIAAA. 2000. Tenth special U.S. Congress on Alcohol and Health. Washington: U.S. Department of Human Services.)

This report provides information on the estimated direct health care costs for alcohol-related injuries and health problems, and the indirect costs for absenteeism, loss productivity, workplace injuries, workers compensation, and disability claims that all affect employer's bottom lines. Expanding treatment benefits makes good fiscal sense. Research has shown that alcohol treatment saves money over the long run.

Price: Free

Number of Pages:

Publication Number: 23809

Order Copies: Information Center
Metropolitan Washington Council of Governments
777 North Capitol Street NE, Suite 300
Washington DC 20002-4239
(202) 962-3256 (9:30 a.m.- 5 p.m. weekdays)
Order online at http://www.mwcog.org.

Table of Contents

The Problem

Alcohol abuse is a major problem for employers everywhere. While most employers don't tolerate drinking on the job, many are less aware of workplace problems resulting from problem drinking off the job. Individuals who drink before work, during lunch, or after work as well as during work hours, present a potentially harmful situation for any employer. Drinking during work hours or at lunch may be more easily identified, but drinking during non-work hours may create less obvious problems that are costly to the employer and more difficult to deal with. Even problem drinking by an employee's relatives can be costly to an employer. These problems usually are exhibited in the following ways:

- Absenteeism
- Performance and productivity
- Accidents
- Cost through loss of staff and recruitment

Put another way, when an employee or a family member has an alcohol problem, employers face increased healthcare costs, lost productivity, absenteeism, accidents, staff turnover, and liability. Healthcare costs for the untreated substance-abusing employee cost the employer an estimated $640 million annually. (Center for Substance Abuse Treatment, January 1999).

Almost half of all trauma and injury visits to hospital emergency rooms and 20 - 30 percent of all trips to the emergency room are alcohol related. (CDC 2000 Alcohol Problems Among Emergency Department Patients: Proceedings of a Research Conference on Identification and Prevention). Employees who are under stress due to alcohol abuse by a spouse or other family member also have lower productivity and a higher rate of absenteeism.

Staff turnover is high when alcohol is abused. Yet employers often may find it more cost effective to help an employee deal with the problem rather than recruit and train a new employee.

Liability costs are higher with alcohol abusers because the company is responsible for the safety of other employees and the public. Additionally, company equipment may get damaged and work may have to be repeated because of sloppy or incorrect work. Problem drinkers and their family members also have higher healthcare care costs.

According to the CDC, excessive alcohol use is a key factor in more than 100,000 deaths per year in the U.S. Approximately 20-30% of patients seen in U.S. emergency departments have problems related to alcohol abuse. Nearly half of alcohol-related deaths are the result of injuries from motor vehicle crashes, falls, fires, drowning, homicides, and suicides. Insurance companies may refuse to pay for treatment when alcohol is a factor in an injury, preventing emergency medical staff from providing intervention or referrals for substance abuse treatment. Yet studies have shown that providing treatment for alcohol addiction lowers healthcare costs for the entire family more than enough to offset the cost of the treatment.

The Challenge

The public perception of alcohol dependent workers evokes images of employees drinking at the workplace. However, a more accurate portrayal is what happens to the workplace as a result of alcohol dependence and associated problem behaviors off the job. Problem behaviors may include binge drinking, drinking and driving, drinking and violence, or hangovers. Habitual heavy drinkers also can cause family stress and contribute to mental illness.

Alcohol abuse exacts a heavy tool on productivity and destroys individuals, families, and communities. Nearly eight million Americans suffer from alcoholism, and nearly six million have related problems, according to the report, "Pubic Health Implications of Excessive Alcohol Consumption" by Drs. Glen Hanson and Kai Li. They also found that the economic cost of substance abuse exceeds $484 billion per year, with $185 billion attributable to alcohol abuse. The misuse of alcohol, as well as smoking and illicit drug use, accounts for untold numbers of illnesses, disabilities, and deaths, even though substance abuse is as preventable as many other health challenges. Of the more than two million U.S. deaths each year, approximately one in four is attributable to alcohol, tobacco, and illicit drug use. Despite family hardship and business loss, only two to three million individuals are treated per year.

The Alcohol Cost Calculator

Ensuring Solutions to Alcohol Problems, an initiative of the George Washington University Medical Center, has devised a new tool to demonstrate how alcohol-related problems increase health care costs and reduce workforce productivity. This tool, the Alcohol Cost Calculator, provides actual, industry-specific information about the impact of drinking. Released publicly in April 2003, it computes business losses due to alcohol abuse in actual dollars. The Alcohol Cost Calculator examines the following areas:

- Prevalence of alcohol related problems in different sectors
- Absenteeism
- Decreased productivity
- Extent of employees' alcohol-related hospital and emergency room visits

Listed below are the cost calculations for the 18 city and county government workforces in the COG footprint. Workforce numbers were provided to COG by the jurisdictions' human resource departments and public information offices. The Alcohol Cost Calculator was utilized to prepare calculations for each of the local governments.

Alcohol Cost Calculation for the Metropolitan Washington Council of Governments Members

	Number of Government Employees	Estimated number of problem drinkers in workplace	Number of family members who are problem drinkers	Work days lost because of sickness, injury, and absence	Approximate work days of lowered productivity	Alcohol-related healthcare costs (in thousands)
Alexandria	2,000	100	254	942	500	$532
Arlington	3,427	171	436	1,614	857	$911
Bowie	203	10	26	96	51	$54
College Park	125	6	16	59	31	$33
District of Columbia	30,000	1,500	3,815	14,130	7,500	$8,000
Fairfax City,	392	20	50	185	98	$104
Fairfax Co.	11,411	571	1,451	5,375	2,853	$3,000
Falls Church	250	12	32	118	62	$66
Frederick Co.	1,800	90	229	848	450	$478
Gaithersburg	250	12	32	118	62	$66
Greenbelt	170	8	22	80	42	$45
Loudoun	2,466	123	314	1,161	616	$655
Manassas	410	20	52	193	102	$109
Montgomery	8,099	405	1,030	3,815	2,025	$2200
Prince George's	5,659	283	720	2,665	1,415	$1500
Prince William	3,300	165	420	1,554	825	$88
Rockville	525	26	67	247	131	$140
Takoma Park	120	6	15	57	30	$32
TOTAL	**70,607**	**3,528**	**8,981**	**33,257**	**17,650**	**$18,700**

Covering Alcohol Treatment Makes Sense

Direct healthcare costs for alcohol-related injuries and health problems and indirect costs for absenteeism, productivity, workplace injuries, worker's compensation, and disability claims all affect employers' bottom lines. Expanding treatment benefits makes good fiscal sense. Research shows that alcohol treatment pays for itself in subsequent healthcare reductions.

A study by Ensuring Solutions to Alcohol Problems shows that one employee prevention resource might include comprehensive health insurance benefits (alcohol treatment comparable to other medical conditions and illnesses). A managed care plan would pay an extra $5.00 per member per year to include insurance coverage for alcohol or other drug addiction. Human resources departments should work with their health plans to develop the continuum of care for alcohol abuse.

Alcohol abuse is not readily obvious, manifesting itself in emergency room visits, extra hospital days, and missed days from work. Employers can implement preventative strategies to reduce costs.

Another cost saving measure is intervention, which consists of providing as many as four short counseling sessions to discuss problem drinking and health risks. They may be conducted by primary care practitioners, mental health specialists -- including social workers, psychologists, psychiatrists, and substance abuse counselors, or the Employee Assistance Program staff.

Praise of the Tool

"This excellent new tool will be invaluable in efforts to educate the American public and businesses about the impact of alcohol abuse. Using this calculator, businesses will be able to quantify the economic costs of untreated alcohol abuse and will take steps to provide treatment for their employees."

- Congressman Jim Ramstad (D-MN), U.S. House of Representatives

"The Alcohol Cost Calculator gives employers reliable, quantitative evidence of alcohol's impact on their workforce. This tool will provide the business cause to reduce costs and health effects by preventing and treating alcohol abuse appropriately."

- Helen Darling, president of the Washington Business Group on Health.

"The data analyzed by Ensuring Solutions came from the Substance Abuse and Mental Health Services Administration's National Household Survey on Drug Abuse. Eighty percent of problem drinkers are employed. Companies can combat alcohol abuse by addressing it in totem with other preventative workplace health activities. The sooner you intervene in alcohol abuse -- before a person loses a job or a family -- the more likely that treatment will be successful."

-Charles Curie, an administrator with the Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

"We are pleased that data derived from National Institute on Alcohol Abuse and Alcoholism (NIAAA) supported research that helped produce a tool that employers can use to understand the impact of alcohol on the health of their businesses and their employees."

- Dr. Ting-Kai Li, the Director of the National Institute on Alcohol Abuse and Alcoholism.

" We believe this is a useful tool that can help focus attention on a very important issue."

- Eric Goplerud, Ph.D., Director of Ensuring Solutions

Strategies for Businesses

Ensuring Solutions suggests the following strategies for businesses:

- Offer comprehensive health Insurance
- Monitor and maintain standard of care
- Enact treatment-oriented workplace policies
- Intensify health education
- Promote confidential screening
- Offer/expand employee assistance programs
- Manage employees' time off

First Citywide Comprehensive Substance Abuse Strategy for the District of Columbia

EXECUTIVE SUMMARY

A SUBSTANCE ABUSE STRATEGY FOR THE DISTRICT OF COLUMBIA

In response to the impact of substance abuse on the District's health, safety, and financial stability, Mayor Anthony Williams appointed an executive-level task force to prepare and recommend the citywide Substance Abuse Strategy (Strategy) and budget. In May of 2001, Mayor Anthony Williams established the Interagency Task Force on Substance Abuse Prevention, Treatment, and Control (Task Force) and formally commissioned the group to oversee the District's substance abuse policies and interagency and intergovernmental substance abuse activities. According to the mayor's order, the Task Force is charged with "enhancing the effectiveness of the city's health, social service, and criminal justice system by monitoring use of federal grant funding together with local funding to implement innovative substance abuse programs." Furthermore, the mayor's order requires the Task Force to "establish well-defined performance outcome measures that will facilitate an assessment of costs and benefits in investments in substance abuse prevention, treatment, and control."

DC Drug Fact: The overall illicit drug use rate of 9.6 percent in the District is a striking 52 percent higher than the nationwide rate of 6.3

A RESULTS-DRIVEN STRATEGY

The Task Force has worked closely with the mayor's staff as well as with a wide variety of experts and stakeholders to develop a substance abuse strategy that is both accountable to taxpayers and well-coordinated with existing District agency plans and budgets. At a minimum, the Strategy is designed to address two enormous and perhaps ambitious challenges by 2010: reducing the city's addicted population by 25,000 from an estimated baseline of 60,000 and reducing the cost of substance abuse by $300 million from an estimated baseline of $1.2 billion. To aid in the accomplishment of these outcomes, the Strategy also targets the overall rates of substance use among District youth ages 12 to 17; the Strategy seeks to reduce this population's substance abuse prevalence by 20 percent and increase the average age of new substance abuse initiation for alcohol, tobacco, and marijuana by one year.

DC Drug Fact: Approximately 60,000 residents – nearly one in ten – are addicted to illegal drugs or alcohol.

The Mayor's Substance Abuse Strategy for the District represents a firm commitment to address *both* public safety and public health aspects of substance abuse. Therefore, the Strategy's line of attack relies on the four elements necessary for a balanced approach: prevention, treatment, law enforcement and regional activities. His selection of Task Force leadership reflects this comprehensive view. Department of Health Director James A. Buford and Metropolitan Police Department Chief Charles H. Ramsey are working in close collaboration with the mayor's staff and District agencies to ensure a fair and balanced plan.

FIRST SURVEY OF THE DISTRICT SUBSTANCE ABUSE PROBLEM

The Task Force needed to fully understand the District's substance abuse problem to formulate an effective strategy as well as to track its progress. In December of 2000, the DC Department of Health engaged Westcom International, Ltd. to conduct the nation's first-ever, comprehensive citywide household survey on substance abuse. The results of the survey of 1,535 District households revealed startling information. For illegal drugs alone, the rate of *addiction* in DC is nearly 40 percent higher than the rate of addiction for the nation that same year. Nine percent of District residents report a dependence on drugs and alcohol, compared with a national estimate of 4.8 percent identified by the federal government's 2000 National Household Survey on Drug Abuse. Moreover, one out of six adolescents–children between 12 and 17 years old–reported having consumed alcohol in the month leading up to the survey and 7 percent reported using an illicit drug within the past month.

***DC Drug Fact*:** For first-time drug use—"substance abuse initiation"—the DC Household Survey reveals that initiation occurs at an earlier age for DC youth than for youth across the nation.

FIRST INVENTORY OF SUBSTANCE ABUSE PROGRAM SPENDING

The Task Force required an analysis of the District's substance abuse programs and governmental expenditures to properly inform the Strategy. Each District agency provided the Task Force with an inventory of substance abuse-related programming and financial figures. The analysis of this information revealed substance abuse-related expenditures of $356 million in Fiscal Year 2003. It must be clearly understood, however, that the $356 million includes an extensive array of programming that targets substance abuse secondarily to other issues. In other words, only $53 million, or 15 percent, of the total $356 million expenditure can be tied to programs whose primary focus is substance abuse-related. Furthermore, only $35 million of the $53 million is dedicated solely to the direct provision of substance abuse treatment programs.

FIRST SET OF COMPREHENSIVE LONG-TERM SUBSTANCE ABUSE GOALS

To guide the District's substance abuse activities over the next several years, the Task Force, based upon input from a wide range of stakeholders, has identified the following four strategic goals:

The District's Substance Abuse Strategy Goals

Goal #1: Educate and empower District of Columbia residents to live healthy and drug-free lifestyles.

Goal #2: Develop and maintain a continuum of care that is efficient, effective, and accessible to individuals needing substance abuse treatment.

Goal #3: Increase the public's safety and improve treatment access for offenders to ensure fair and effective administration of justice in the District.

Goal #4: Encourage a coordinated and focused regional response to the problem of substance abuse.

POLICY AND PROGRAM PRIORITIES

To achieve the four Strategy goals, the Task Force identified policy and program priorities. The following includes some of the activities that support the Task Force's plan of action:

• The Addiction, Prevention and Recovery Administration (APRA) as well as other District agencies with prevention activities, will double the number of appropriate evidence-based prevention programs in the District by fall 2005.

• APRA will add an additional 164 treatment slots—creating the capacity to serve 325 adolescents per year--by the end of 2003.

• The Department of Mental Health and APRA will help individuals with co-occurring disorders through a newly implemented joint-initiative based on the Comprehensive, Continuous, Integrated System of Care model.

• The District will streamline APRA into a "true" single state agency to increase focus on management versus delivery of prevention and treatment services.

• The Metropolitan Police Department's (MPD's) Community Partnership Project will target open-air drug markets and work closely with Neighborhood Services to broaden community involvement, build community capacity, and initiate long-term prevention efforts.

• The MPD's undercover Narcotics Strike Force will refine tactics in its work with the Homicide Investigation Unit to gain information on homicides and reduce the violence associated with drug dealing.

• Through an effort spearheaded by the Office of the Deputy Mayor for Children, Youth, Families, and Elders and the DC Family Court, APRA is collaborating with the Child and Family Services Agency, the Departments of Mental Health and Human Services, and other critical stakeholders to support the implementation of a new Family Treatment Court based on best practices.

• A single information system that provides improved access to data across criminal justice agencies will be developed through the efforts of a working sub-group of the Mayor's Criminal Justice Coordinating Council (CJCC).

• The District will work in partnership with local organizations, both non-profit and university based, to study the similarities and differences among anti-substance abuse laws across the region and determine what changes and adjustments are required to produce a region-wide united front against substance abuse.

• The CJCC and APRA will work with regional planning groups, including the Metropolitan Washington Council of Government's Substance Abuse Treatment Committee, to identify and resolve specific barriers to treatment access, referral, and service delivery.

FIRST PERFORMANCE MEASUREMENT AND ACCOUNTABILITY SYSTEM

The Task Force will track the Strategy's progress toward the achievement of three results by 2010. Accordingly, the Task Force has instructed APRA, with the concurrence and support of other District agencies, to improve three Strategy performance measurement tools as follows:

• **Estimating Social Costs of Substance Abuse:** The Task Force directs APRA to take the lead for developing a biennial estimate of social costs in the District and to report biennially to it for purposes of tracking the Strategy's progress. The first estimate is expected by spring 2005.

• **Counting the Number of Addicted Individuals:** The Task Force directs APRA to develop recommendations on how to improve estimates of the number of individuals addicted to substances. The first estimate is expected by spring 2005.

• **Monitoring Youth Substance Use:** The Task Force will monitor the 12 to 17 age cohort of the DC Household Survey to determine the success of programs targeting youth. The Task Force directs APRA to develop recommendations by fall 2003 on how the District may conduct biennial substance use surveys. The first estimate is planned for fall 2004.

THE ROAD AHEAD

Finally, the mayor intends to rely on the Task Force to manage and oversee substance abuse efforts in the District and to report on the District's progress toward achieving results. Over the next year, its efforts and responsibilities will include the following:

• **Annual Report to the District:** The Task Force will prepare an annual report to the District on its progress in achieving results and biennially discuss those results as defined by the performance outcomes.

• **Budget Review:** The Task Force will prepare annually a consolidated substance abuse budget describing government expenditures in the District to include local and federal expenditures. The Task Force will work with the city administrator to help coordinate the mayor's budget priorities for substance abuse.

• **Action Plans:** The Task Force will convene regular meetings of the prevention, treatment, criminal justice, and regional Working Groups to build "action plans" for each objective by logically outlining what activities and outputs should occur, by whom, and by when.

r care
istrict
are connected with

• **Data Analysis:** The Task Force will coordinate the biennial collection of data to illuminate the nature and extent of substance abuse and drug trafficking in the District. It will oversee the collection of local data and coordinate with national organizations for assistance in data collection.

The District has completed the first two phases of its substance abuse-related strategic planning process (see Figure 1). More must be done and the Task Force members are committed to seeing that it is. Although many government-generated reports are quickly forgotten, the Task Force, according to the mayor's order, will report regularly on the District's progress toward achieving results and continue to consult with the stakeholders to whom it is accountable, and who stand to gain the most by the Strategy's advances and outcomes.

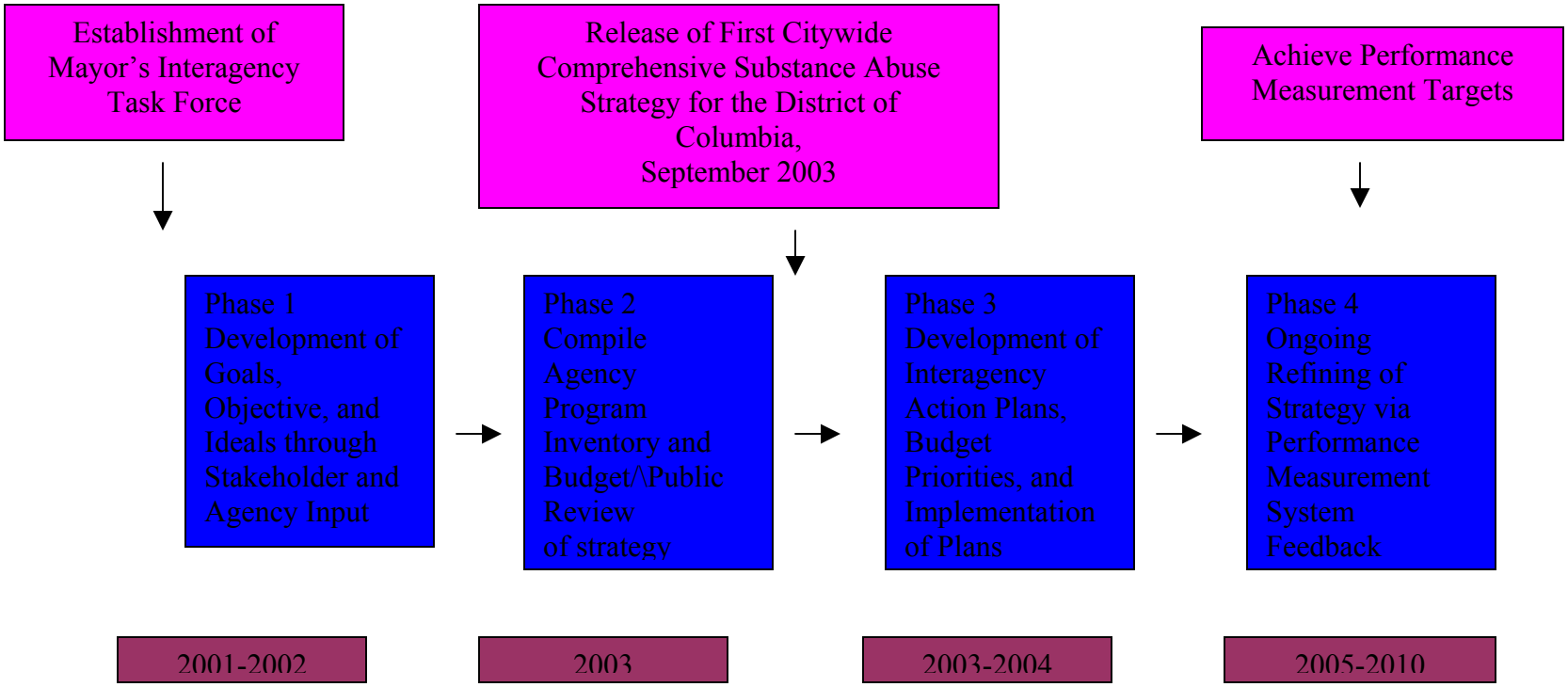

Establishment of Mayor's Interagency Task Force
Release of First Citywide Comprehensive Substance Abuse Strategy for the District of Columbia, September 2003
Achieve Performance Measurement Targets
Phase 1 Development of Goals, Objective, and Ideals through Stakeholder and Agency Input
Phase 2 Compile Agency Program Inventory and Budget/\Public Review of strategy
Phase 3 Development of Interagency Action Plans, Budget Priorities, and Implementation of Plans
Phase 4 Ongoing Refining of Strategy via Performance Measurement System Feedback
2001-2002
2003
2003-2004
2005-2010

Figure 1