

Combatting DWI in New Mexico: What Really Works?

This issue of DWI Highlights focuses on different researched approaches and programs whose purpose is to reduce or eliminate the death and injury drinking drivers cause. Many deterrents have been tried; which work and which don't? Of those demonstrated to work, which are most efficient, that is, which provide the most effect for the resources expended? In a world of unlimited resources we could implement every measure which causes any reduction in DWI. In the real world we are forced to allocate limited resources only to the programs which work best.

Overview: DWI Prevention Programs

A recent NHTSA-funded report divided approaches to preventing DWI into those clearly effective, and those whose effectiveness is less clear. The following report by R.K. Jones and J.H. Lacey, "Alcohol and Highway Safety: A Review of the State of Knowledge," was published in November 2001.

Nearly all countermeasure programs that have been evaluated have focused on the pre-crash phase. Their objective has most often been to reduce driving after drinking, although there has been increasing attention given to reducing excessive drinking before driving. The great majority of programs have used strategies of deterrence and incapacitation carried out by elements of the criminal justice system.

Countermeasures with strong evidence favoring their effectiveness are:

- Administrative license revocation (ALR) laws in conjunction with strong public info, education activities and efficient case processing procedures;
- Laws reducing the legal BAC limit to .08, in conjunction with ALR laws;
- For drivers under the age of 21, laws raising the illegal minimum drinking age and laws lowering the legal BAC to zero or near-zero;
- Alternative sanctions requiring extended contact with offenders, including intensive supervision probation, electronic monitoring, and sanctioning programs tailored to individual offenders;
- Comprehensive community-based programs; and multi-component pedestrian programs.

- Comprehensive changes to state laws accompanied by enhanced activity to implement those laws;
- Enforcement of existing DWI laws in general (and sobriety checkpoints in particular) with strong public information and education components
- Traditional sanctions against the driver license;
- Carefully designed treatment and rehabilitation programs used in combination with other sanctions;
- Alcohol interlocks (while the interlocks are installed);
- Comprehensive community-based programs; and multi-component pedestrian programs.
- Removal of an offender's vehicle, or access to it;

Promising countermeasures for which evaluations of alcohol-crash impact are as yet inconclusive are:

- Alternative sanctions such as day reporting centers;
- Enforcement of laws against alcohol sales to minors;
- Year-around ride-service programs;
- Server training programs; and
- School-based education programs.

R.K. Jones and J.H. Lacey, "Alcohol and Highway Safety: A Review of the State of Knowledge," National Highway Traffic Safety Administration, November 2001.

DWI Checkpoints

Checkpoints are a uniquely valuable tool for fighting DWI: they allow law enforcement to identify an impaired driver, actually on the road, before he/she has a chance to cause death or injury. Two reports illustrate the effectiveness of DWI checkpoints in reducing alcohol-related crashes. The first (Lacey & Jones) analyzes data from a Tennessee sobriety checkpoint program, and the second (Fell & Lacey) reviews 15 different checkpoint studies.

Checkpoint Tennessee

Recently, an evaluation of a large-scale checkpoint program in Tennessee was completed, bolstering these earlier results significantly (Lacey, Jones, and Smith, 1999). In March 1994, Tennessee implemented an extensive statewide sobriety checkpoint program called Checkpoint Tennessee. Checkpoints were scheduled on each weekend of the year in at least four counties in the state. On five weekends checkpoints were scheduled in each of the state's 95 counties. The volume of checkpoints increased from about 15 in the preceding year to nearly 900 in the program year. The checkpoint activity was publicized extensively both through public service advertising and earned media. Interrupted time series analyses were used to evaluate the program, indicating that the program resulted in a 20.4% reduction in alcohol-related crashes, extending at least 21 months after conclusion of the formal program. Extensive checkpoint activity was continued after the formal program completion.

R.K. Jones and J.H. Lacey, "Alcohol and Highway Safety: A Review of the State of Knowledge," National Highway Traffic Safety Administration, November 2001.

Sobriety Checkpoint Studies

This study reviewed the latest literature on the effectiveness of sobriety checkpoints and random breath testing in reducing motor vehicle crash injuries. Six studies were reviewed that met the study criteria of including an evaluation of checkpoints, with a control or baseline comparison. All six studies found that checkpoints were effective in reducing alcohol-related fatalities and injuries. The third study was conducted by the Centers for Disease Control (CDC) and involved a systematic review of the evidence regarding interventions to reduce alcohol-impaired driving. Fifteen studies of the effectiveness of sobriety checkpoints were summarized and a meta-analysis showed a median reduction of 20 percent in fatal and injury crashes associated with sobriety checkpoint programs. The authors concluded that these studies "provide strong evidence" that sobriety checkpoints are effective in preventing alcohol-related fatalities and injuries.

JC Fell, JH Lacey "Putting Research into Action: Sobriety Checkpoints Save Lives," RB Voas Pacific Institute for Research and Evaluation

Alcohol Treatment Programs

Although treatment is an essential element of any comprehensive DWI program, it need not necessarily be long term. Brief intervention has been demonstrated to be effective in decreasing problem drinking. This study conducted by Project TrEAT (Trial for Early Alcohol Treatment) and Project GOAL (Guiding Older Adult Lifestyles) examined brief intervention and reported several positive findings.

Brief intervention is a time-limited, patient-centered counseling strategy that focuses on changing patient behavior and increasing compliance with therapy. There are six essential components to the brief intervention. The physician:

- States his/her concern.
- Provides specific feedback to patients on how their drinking is affecting them (e.g., elevated blood pressure, liver function problems, family problems).
- Gives a clear recommendation about changing their alcohol use.
- Negotiates a drinking contract.
- Provides a self-help booklet.
- Establishes follow-up procedures.

Results from the study highlight several long term positive effects from brief intervention:

1. Brief intervention can generate a positive economic benefit.

As reported in *Medical Care*, 12 months of data from Project TrEAT found savings of \$195,448 in emergency room and hospital use and \$228,071 in avoided costs resulting from motor vehicle events and crime, for a combined economic benefit of \$423,519, or \$1,151 per subject. The estimated total economic cost of the intervention was \$80,210, or \$205 per subject. The benefit-cost ratio was 5.6:1, or \$56,263 in benefit for every \$10,000 invested. No significant differences between control and intervention subjects were present for baseline alcohol use, age, socioeconomic status, smoking, depression or anxiety, conduct disorders, drug use, motor vehicle accidents, or health care utilization.

2. Brief intervention delivered by a physician decreases alcohol use in problem drinkers, age 65 and older.

As reported in the *Journal of Family Practice*, older adults who received brief intervention demonstrated a significant reduction in seven-day alcohol use, episodes of binge drinking, and frequency of excessive drinking compared with the control group at 3, 6, and 12 months after the intervention. There was a 34% reduction in seven-day alcohol use, a 74% reduction in mean number of binge drinking episodes, and a 62% reduction in the percentage of older adults consuming more than 20 drinks per week. There were no significant changes in health status. Patterns of health care utilization were not extensively analyzed because of the small number of events. No significant differences were found between the control and the intervention groups at baseline in alcohol use, age, socioeconomic status, depression, onset of alcohol use, smoking status, activity level, or use of mood-altering drugs.

3. Brief intervention delivered by a physician decreases alcohol use over the long-term in problem drinkers, ages 18 to 64.

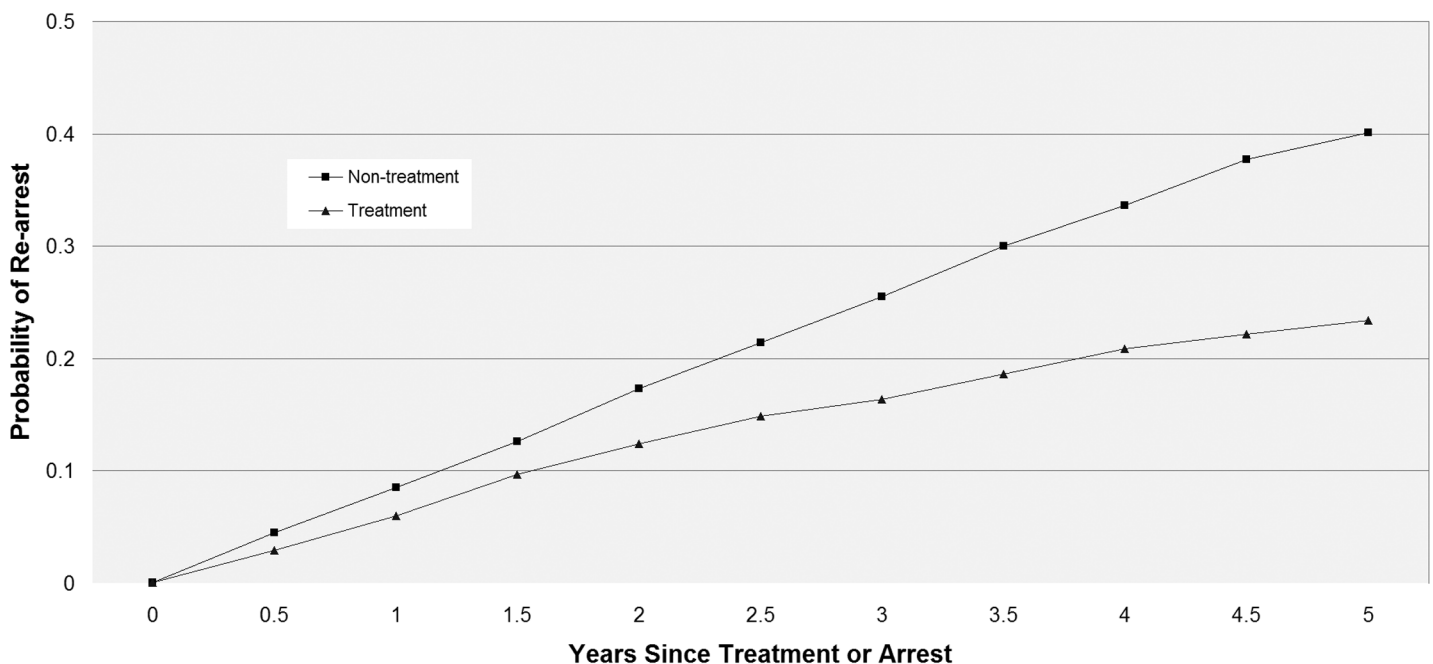
As reported in an unpublished manuscript, the investigators found significant reductions in seven-day alcohol use, the number of episodes of binge drinking, and the frequency of excessive drinking among recipients of the Project TrEAT intervention (compared with the control group) 48 months after the intervention. The treatment recipients also experienced fewer days of hospitalization and fewer emergency room visits. A benefit-cost analysis found that for every \$10,000 invested in early intervention, there is a \$43,000 reduction in future health care costs. There were even larger economic benefits to society in terms of fewer motor vehicle accidents and life-years lost.

Michael Fleming, MD, MPH and the University of Wisconsin-Madison Medical School, "A New Rx for Problem Drinking: Brief Physician Counseling." (Madison, Wisconsin: Sept. 2000). Funded by grant by Robert Wood Johnson Foundation. Reproduced with permission from the Robert Wood Johnson Foundation, Princeton, NJ.

Studies of Alcohol Treatment Programs in New Mexico

New Mexico researchers studied the effect of a DWI treatment program in San Juan County on DWI re-arrest rates. Results indicate a long-term positive relationship between DWI treatment and lower re-arrest rates. The study is published in the November 2002 issue of the *American Journal of Public Health*, and is reproduced with permission from Gill Woodall, PhD. All copyrights reserved.

San Juan County Probability of Re-Arrest: Treatment & Non Treatment Groups Compared



In addition to lower re-arrest rates among first time offenders, the study published by Woodall's group also estimates that if all appropriate DWI offenders went through the treatment program, there would be at least 170 fewer DWI offenses per year in San Juan County.

Ignition Interlock Devices

Ignition interlocks can be very effective if and while they are installed. There are several issues which must be addressed to make them more than an infrequently-used, temporary measure. A paper by the International Council on Alcohol, Drugs and Traffic Safety (ICADTS) outlines methods to improve the efficiency of interlock programs and increase the rate of reduction of DWI offenses by repeat offenders.

Breath alcohol ignition interlock devices, when embedded in a comprehensive monitoring and service program, lead to 40-95% reductions in the rate of repeat DWI offenses of convicted DWI offenders. Reducing the DWI rate is an important indicator of a public safety impact because DWI is a strong predictor of crash risk involvement.

While it may be a safe assumption that reduction in DWI will lead to fewer crashes, there has not yet been any study with sufficient statistical power to demonstrate a direct reduction in crash risk attributable to an interlock program. In the U.S. and Canada, which have the most interlocks in service, only a few percent of eligible offenders ever enter an interlock program, so interlocks have not yet made an important contribution to highway safety at the population level. This may change soon as many more states, provinces, and nations are writing interlock legislation. The purpose of this document is to point out issues worthy of consideration for those who influence policy.

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Because of the manner in which interlocks are assigned to prior DWI offenders, the most dangerous repeat DWI offenders only rarely become eligible for an interlock and then only for a brief period of time. Research is called for that would evaluate the impact of lowering the threshold for entry into an interlock program and raising the threshold for exit from an interlock program. If such an approach were successful it could put more of the most dangerous repeat offenders under control of an interlock program and retain them until evidence is available documenting their readiness to drive without an external monitor. Two methods that could be used to provide evidence of readiness for full license reinstatement without an interlock include interlock device data logs that document the BAC test results over the preceding months, and the measurement of blood borne biological markers associated with alcohol dependence.



Policy makers should consider several key points when designing or adopting ignition interlock programs:

- The alcohol interlock device must be configured as part of a comprehensive program of monitoring, recording, and reporting in order to be considered complete. The device by itself is not sufficient.
- A central national authority should manage device certification and evaluate features of interlock programs that become part of the interlock standard requirements.
- Interlock programs are most often used as a form of secondary prevention to prevent impaired driving by people identified as high-risk due to prior DWI offenses. These programs reduce recidivism by 40-95% as long as the interlock remains on the car. The period of interlock use does not lead to the adoption of enduring safer driving decisions in the longer term since the recidivism rate increases to control levels after the interlock is removed. Effort needs to be made to prevent the post-interlock increase in the rate of DWI offenses.
- Interlock programs also hold some promise as a primary prevention strategy for improving highway safety such as when used by people who operate mass transportation or hazardous materials vehicles. Some individuals or fleet owners may elect to use interlocks to reduce risk exposure by proactively preventing alcohol impaired driving.

- Not all drivers of interlock-equipped vehicles will be equally motivated to comply with the interlock restriction and monitoring authorities need to be attentive to these differences. The evidence base for interlock effectiveness in reducing DWI is strong but most studies to date have evaluated the effects of interlocks on offenders who are motivated to be compliant with the law. Most current interlock program effectiveness data are based on volunteer programs in which the driver installs the interlock to reduce the hard suspension time; court-ordered offenders may be less compliant.

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- The majority of convicted DWI offenders whose licenses are suspended choose to drive anyway, and since an alcohol interlock program can improve monitoring and prevent impaired driving, it is worth evaluating the public safety impact of an early post-conviction interlock requirement relative to simply suspending the driver's license.
- If the tradition of long license suspension for DWI offenses were relaxed in favor of issuing restricted licenses that require an interlock device, it would be critically important to closely monitor the driving behavior of such high-risk drivers. But, public safety should be the highest priority for DWI control legislation.

- Motor vehicle authorities and courts should give consideration to criterion-based removal of the interlock devices rather than to simply require that these devices be used for a pre-ordained period of time. Criteria for removing the device could be based on a combination of biomarkers and objective behavioral evidence that public risk exposure related to drinking-driving by an offender has been reduced.
- In most interlock programs, the offender pays to cost of the program at approximately \$65 U.S./month equivalent. There is no evidence that the interlock is a serious cost-burden, but insurance carriers might be able to overcome any cost impact with an offsetting adjustment in insurance rates if data show evidence that DWI offenders driving with an interlock installed have lower overall crash risk.
- It may be impractical to require that an interlock be installed on every vehicle owned by someone who will be required to use an interlock device. As an alternative the driver license of such drivers should be clearly marked showing that the driving privilege is exclusively contingent upon use of interlock vehicles.
- In the future, the interlock will likely be an integral part of advanced driver recognition and control systems. In the meantime it is very easy for a driver to circumvent the interlock by using a different vehicle without the interlock. Accordingly, at the current stage of technological development, an offender's motivation for compliance with the interlock restriction is expected to be a factor in effectiveness. Brief motivational interventions delivered while drivers are captive in the interlock program may help improve motivation for making lasting behavior changes.

Raising Alcohol Taxes To Reduce DWI

Increasing alcohol taxes is generally supported by the public, and can both reduce DWI and have additional beneficial effects.

A nationwide poll by the American Medical Association (AMA) finds that most Americans support state tax hikes on alcohol to fund education, healthcare, and law-enforcement efforts related to drinking. The survey by the AMA Office of Alcohol and Other Drug Abuse also found that 90 percent of Americans are worried about teenage and underage drinking.

"Alcohol abuse costs Americans more than \$148 billion each year in healthcare and social costs. Among the most vulnerable of these drinkers are teens," said AMA President-elect John Nelson, MD, MPH. Currently seven states are considering increases in their alcohol tax to address underage-drinking problems.

"As with smoking, the price of alcohol matters, especially with teenagers," said Richard Yoast, M.D., director of the AMA's Office of Alcohol and Other Drug Abuse. "Just as price increases for tobacco reduce consumption and disease, higher alcohol prices are proven to reduce everything from violent crimes to rape. The difference is taxes on cigarettes have been increased frequently and significantly over the years while alcohol taxes have remained astoundingly behind the times."

The telephone survey of 800 registered voters nationwide took place from April 15 to 18.

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Raising taxes is particularly effective in reducing DWI among younger people, who are increasing as a proportion of the population as the children of the Baby Boom age.

Much of the alcohol-related economic research considers alcohol consumption by all segments of the population. Nevertheless, it is crucial to focus on the price sensitivity of youth and young-adult drinking and heavy drinking because the incidence of alcohol-related problems, particularly drinking and driving, is disproportionately high among these age groups. Fatal motor vehicle crashes are the leading cause of death of people under the age of 35, and alcohol is involved in more than one-half of these fatal crashes. In 1995, fatalities per car miles of travel of people between the ages of 16 and 24 were more than twice as large as those of people ages 25 and over (Dee and Evans 2001). Moreover, abuse of and dependence on alcohol are highest among people between the ages of 18 and 29 (Grant et al. 1991). Finally, it is important to focus on the young because alcohol abuse in adolescence appears to be associated with alcohol abuse in later life (Rachal et al. 1980). Consequently, policies to curb alcohol abuse by youths and young adults might be the most effective means to curb it in all segments of the population

Chaloupka and colleagues (1993) concluded that higher beer excise taxes are among the most effective means for reducing drinking and driving in all segments of the population. For example, between 1982 and 1988, a policy adjusting the Federal beer tax for the inflation rate since 1951 would have reduced total fatalities by 11.5 percent and fatalities among 18- to 20-year-olds by 32.1 percent.



Matt Felix of the National Council on Alcoholism and Drug Dependence holds up a button from a campaign supporting a two-cent alcohol tax increase.

More recent research using both aggregate and individual-level data similarly has concluded that increases in beer taxes and MLDAs, as well as strong laws related to drinking and driving, can reduce self-reported drinking and driving and involvement in nonfatal traffic crashes. For example, a comprehensive study using aggregate data for the period from 1982 through 1988 found consistent evidence that higher beer taxes significantly reduce motor vehicle crash fatalities in a variety of models that account for potential omitted variables biases (Ruhm 1996).

These findings are notable because most of the models used included State-fixed effects. Another study based on self-reported data on drinking and driving obtained in the 1985 National Health Interview Survey estimated that a 10-percent increase in the price of alcoholic beverages would reduce the probability of drinking and driving by about 7.4 percent for men and 8.1 percent for women (Kenkel 1993). Even larger reductions of 12.6 percent among men and 21.1 percent among women would occur among people ages 21 years and younger. A study using self-reported data on involvement in traffic crashes obtained during the 1982 and 1989 Monitoring the Future surveys concluded that a policy adjusting the Federal beer tax for the inflation rate since 1951 would reduce the probability of nonfatal traffic crashes by almost 6 percent for both men and women (Chaloupka and Laixuthai 1997).

Two studies examined factors contributing to the mortality rate resulting from motor vehicle crashes among 18- to 20-year-olds between 1977 and 1992 (Dee 1999) or between 1977 and 1997 (Dee and Evans 2001). Both studies also reported significant negative effects of increases in the beer tax on the motor vehicle mortality rates. Dee (1999) and Dee and Evans (2001) dismiss these findings, however, because the researchers found similar tax effects regardless of whether they studied nighttime fatalities (which commonly are attributable to alcohol use) or daytime fatalities (which are related to alcohol use much less often). Yet one could argue that the potential pool of youth victims of fatal daytime crashes (i.e., youths who drink during the day and then drive), while smaller than the potential pool of victims of nighttime crashes, may be more sensitive to price than other youth drinkers. This would be the case if the youths in question are frequent or heavy drinkers, because as mentioned earlier, evidence suggests that those youths who drink frequently or heavily are quite sensitive to price.

Another study analyzed fatal motor vehicle crashes among people of all ages for the years 1984 to 1992 using fixed-effect models (Mast et al. 1999). These analyses found that the beer tax has no effect on the overall fatality rate but has a significant negative effect on the fatality rate for drivers involved in nighttime, single-vehicle crashes, which commonly involve alcohol. The investigators downplayed the importance of the beer tax, however, because the size of its effect varied when other variables were introduced into the models. Nevertheless, a careful examination of the study's results reveals significant negative tax effects in most of the fixed-effects models used.

Frank J. Chaloupka, Michael Grossman, Henry Saffer. "The effects of price on alcohol consumption and alcohol-related problems." *Alcohol Research & Health*, Winter 2002

Safe Ride Programs

Saferide programs attempt to entice drinkers to not drive rather than attempting to deter them from drinking. The effectiveness of "saferide" programs is most frequently based on the number of rides given. As a recent evaluation of Wisconsin's SafeRide program indicates, quantifiable savings are difficult to estimate.

For the purposes of this report, "effectiveness" is defined as the ability of the SafeRide program to avoid-alcohol related crashes and their associated costs. However, "effectiveness" must also be viewed in the context of other tools and strategies (e.g., public information and education, enforcement, engineering, treatment, incarceration etc.). These tools, when utilized in combination, work together to reduce the incidence of impaired driving. The "fight against drunk driving" requires a multifaceted approach.

SafeRide will not change a person's abusive, drinking behavior, and because of the program's limited funding, is only capable of removing a small percentage of the total number of impaired drivers from the road. Therefore, SafeRide should not be seen as the "silver bullet" to eliminate all impaired driving but rather as one additional tool that, when actually used and in combination with other approaches, can be effective in reducing the incidence of impaired driving in situations involving bar patrons.

The following analysis based upon the Rothchild Analysis Model measures the "effectiveness" of SafeRide with respect to the incidence of crash avoidance and their associated cost savings in the 2003 SafeRide communities. The analysis concludes that for 2003, SafeRide avoided 12 alcohol-related crashes totaling \$704,772 at a cost savings of \$589,154.

Caution: Note that the Rothchild analysis provides an empirical estimate of the number of alcohol-related crashes avoided. However, the results obtained from the Rothchild model should be viewed as a conservative estimate and caution should be exercised in interpreting the results. One weakness of the model is that it is unable to quantify, with precision, the individual circumstances and human behavioral factors involved in each SafeRide situation. Therefore, the actual number of alcohol-related crashes avoided may be much higher, especially given the fact that more than 16,000 rides were provided to "potentially impaired drivers."

Source: Wisconsin Department of Transportation, "2003 Wisconsin SafeRide Annual Report and Evaluation," WDT, Division of Wisconsin State Patrol, Bureau of Transportation Safety, March 30, 2004

Server Training Programs

Server training programs have many obstacles to overcome in order to be effective. Researchers from the University of Montreal reviewed 19 studies of server training, and drew the following conclusions:

- The programs are effective for increasing awareness and changing the attitudes of serving staff.
 - Results are not as clear with regard to behavior. Various factors can affect the effectiveness of the programs.
 - Although serving staff know how to deal with an inebriated customer or someone they suspect is a minor after training, this knowledge does not get put into practice.
 - Customers will be unhappy if they are refused service, and servers then have to deal with the situation and the fact that they will not get a tip.
 - If the establishment does not support responsible beverage service practices, servers who follow them risk being reprimanded or even fired.
 - Some servers wait longer between drinks, offer coffee and make comments about impaired faculties, all while pouring the customer another drink.
 - Responsible service practices cannot be implemented without environmental support. Such support includes the manager or owner who encourages training and/or sets clear house policy.
 - Programs are effective when they are mandatory and backed by sanctions (studies in Oregon, Texas and Michigan).
- The issue is to identify the factors that limit and facilitate responsible service:
- The server is often portrayed as the person whose job it is to provide pleasure.
 - That leads to ambiguity when he or she must stop serving drinks.

H. Sacy and S. Beauchamp Ph.D., "Responsible Beverage Service Training Programmes: A Good Way to Decrease Alcohol, Related Problems. Éducalcool, Québec, Canada. University of Montréal, Montréal.

Evaluations of New Mexico server training programs indicate that the quality of server training programs is inconsistent, but that when effective training occurs, it can result in a reduction of alcohol service to obviously intoxicated patrons.

In 1993 the State of New Mexico instituted a state mandated alcohol server-training program, with the intent of reducing the number of person who drive drunk. Project S.I.R.V.E. evaluated the effectiveness of the training, identified factors which facilitated and obstructed its ability to change server behavior and evaluated the impact of the law on serving practices in New Mexico.

The evaluation included interview with servers, employing actors (psuedo patrons, PP's) to appear intoxicated and request service, policy training for owners and managers, an enhanced training for servers, enhanced enforcement, interviews with alcohol and gaming and night time crash data analysis. Reported here are some initial results of interviews with servers, psuedo patron visits along with some suggestions for the general public, the hospitality industry and the Division of Alcohol and Gaming.

Overall findings from the interviews were that classes were inconsistent, some trainers taught to the test, others gave the test and did not provide a class, others provided a wealth of information. The content and emphasis varied from class to class, information was inconsistent and in some classes incorrect.

Servers were asked the top five reasons why apparently intoxicated patrons would be served they were: intimidated by the customer, fear of losing tips, the layout of the establishment prevented them from keeping track of who and how much people were drinking, management telling them to serve regardless or lack of support when cutting someone off, and they tended to serve people who were regulars more than other people.

To evaluate the behavior of servers we used psuedo patrons (PP) who appeared intoxicated. PP's entered establishments, engaged in a conversation with the server and attempt to order beer in an opaque bottle. If they are served they disposed of the first beer and in a fairly short period of time attempt to order another. Psuedo patrons present the server with the most overt situation in which service it supposed to be refused and model the behavior most at risk for crashing. During the last quarter of 1994, prior to the majority of servers taking the alcohol server training, PP's attempted to purchase beer a total of 302 times. They were refused service 54 times (17.9%). PP's were sent out again in early 1996, 433 attempts were made resulting in 176 refusals (40.6%) and increase of almost 23%. Two years later PP's attempted to purchase beer 457 times and were refused 152 (33.3%) times.

Results of Psuedo Patrol Server Evaluation

Timeline	Number of Sites	Attempts/Refusals
Baseline: Late October to mid December	151 on-premise outlets in Albuquerque & Gallup	302 attempts 54 refusals (17.9%)
Round One: April to Early July 1996	219 on-premise outlets in Albuquerque, Gallup & Las Cruces	433 attempts 176 refusals (40.6%)
Round Two: March through June 1998	230 on-premise outlets in Albuquerque, Gallup & Las Cruces	457 attempts 152 refusals (33.3%)

These refusal rates demonstrate that training of servers can significantly reduce service to apparently intoxicated patrons. Interviews with servers demonstrate the need to improve the quality of the training and standardize the curriculum.

Following are recommendations to increase the likelihood of compliance with the alcohol server training program in New Mexico.

Recommendations for members of the public: support servers who refuse service and support enforcement of serving laws.

Recommendations for hospitality industry: adopt policies and procedures that support responsible alcohol service, monitor the door, actively market food, promote non-

alcoholic beverages, train all staff on responsible alcohol service, adopt safe transportation strategy, manage intoxicate customers, publicize and market your commitment to responsible alcohol service, monitor drinking of all customers

Recommendation to the Division of Alcohol and Gaming: standardize training and its implementation, increase training oversight, enhance skills and abilities in delaying and refusing alcohol service, increase drink counting skills and their utilization, increase buy-in by owners and managers of responsible alcohol service.

Denise R. Wheeler in collaboration with Robert F. Saltz, W. Gill Woodall, Paula Stanghetta and Mitzi Lewis, "Project S.I.R.V.E., An Evaluation of the NM Alcohol Server Education Act: Some Preliminary Findings." June 18, 2003

The Importance of Data Collection

Data collection and analysis must be included in any program to combat DWI. Not all prevention measures work equally well for all people in all areas. Data collection is essential to tailor to countermeasures to the problem.

New Mexico has one of the country's highest rates of driving while intoxicated (DWI). Thus, it was no surprise when the Northern New Mexico Health Care Alliance (NNMHCA) chose this issue as the focus of its San Miguel County American Society for Quality/Institute for Healthcare Improvement (ASQ/IHI) Collaborative project. (The ASQ/IHI Collaborative on the Prevention of Motor Vehicle Injuries is described in the August/September 1997 issue of BSC). The NNMHCA team examined each step in the legal system (including enforcement, adjudication, penalty, and treatment) to define problems; implemented interventions targeting those problems; and identified process measures that used local data to evaluate changes in the system. Beth Leopold, NNMHCA director, describes how local data played a key role in this process:

"By the time we get state data, it's 12 to 18 months old. The state also reports means for the year, not the months, so they lose a lot of detail. We [San Miguel County] now collect data on a monthly basis so we can detect variations and target our interventions accordingly."

"New Mexico has very good data compared to some other states. But the problem with the state data is the problem everywhere: by the time we get state data, it's 12 to 18 months old. The state also reports means for the year, not the months, so they lose a lot of detail. We [San Miguel County] now collect data on a monthly basis so we can detect variations and target our interventions accordingly.

"We work very closely with our law enforcement agencies. They all use the same detention center. We receive the jail log every day, which includes the name of the offender and the offense. At the end of the month, we can count the number of DWI arrests and immediately know what is going on within our system. We can figure out why arrests have increased or decreased. For example, May had a high number of arrests due to graduations; it's also a holiday month. The state data would not tell us anything about this monthly variation. Local data enable us to plan interventions targeted to where and when problems are occurring.

"A key quality-improvement principle is that decisions should be based on data. The data can show if a part of the process is not working. The data can locate system

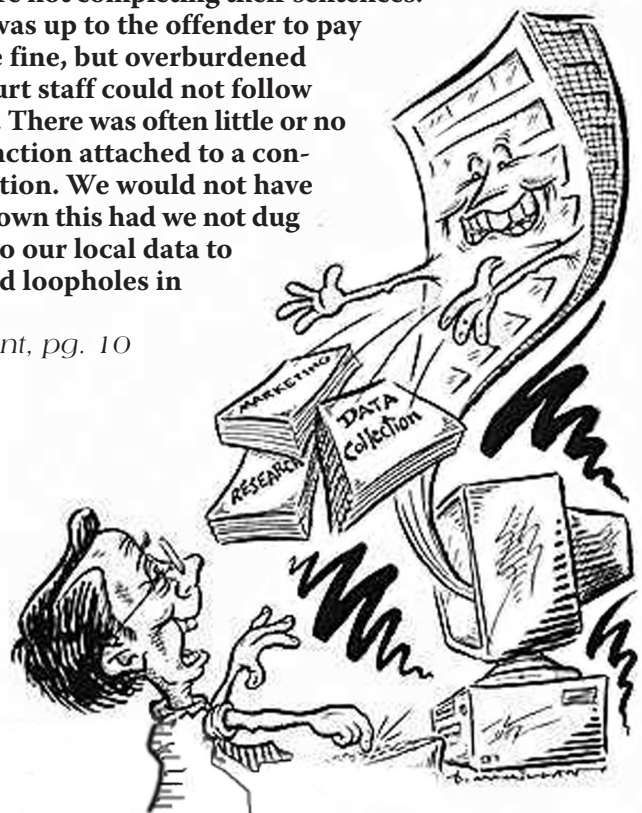
failures. The measures that we used were tied closely to our interventions. People often use readily available measures that are not really relevant to their processes or interventions. We selected measures related to adjudication and convictions. We looked at cases that did not resolve in conviction. We selected that measure because we believe that if arrests are being made properly--if the system is working--we should have very few arrests that don't result in convictions. Then we found that a major reason arrests didn't result in convictions was a lack of probable cause or insufficient evidence. In order to address that system failure, we now certify 100 percent of our officers in field sobriety testing.

"We also used a technological intervention to improve the quality of evidence. We are adding video cameras to all of our police cars and to the detention center. Now we have a chain of evidence--a visual representation of the arrest from the time of the traffic stop through booking. When offenders see their behavior on videotape, they know it's not a matter of the offender's word against the officer's word, and they are more likely to plead guilty.

"The state data provide a lot of information on convictions. But the data do not tell whether the offender actually serves time or pays the fine. Examination of the county detention center records showed that many offenders were not completing their sentences.

It was up to the offender to pay the fine, but overburdened court staff could not follow up. There was often little or no sanction attached to a conviction. We would not have known this had we not dug into our local data to find loopholes in

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"We took data about offenders who were not completing their sentences to the state and said that we wanted to use some of our budget to hire a supervisory probation officer to track offenders all the way through the system. New Mexico requires that everyone convicted of DWI be screened for alcohol abuse before sentencing. Many convicted offenders were not showing up for screening. They caught on that if they didn't go for screening, the report never came back to the judge and the sentence was never enforced. The probation officer now makes the appointment for screening before the offender leaves the courtroom. If the offender does not comply, the judge issues a bench warrant. This ensures swift and certain sanctions.

"Another interesting thing about this process is its impact on other problems. We do a lot of work with SAFE KIDS on seat belt enforcement. The system for seat belt enforcement is the same as for DWI. We believe that once we get our enforcement and adjudication system straightened out, it will pay off in other areas, like seat belt enforcement and domestic violence. We're really

looking forward to taking this process to other counties in New Mexico for DWI and using it within San Miguel County for other safety issues."

Building Safe Communities, NHTSA, Vol.1 No. 3, Dec. 1997/Jan. 1998

Data from sources beyond the particular countermeasure can be important as well, as one study of treatment of DWI offenders concluded:

- **Investigators studying alcohol use should collect data from as many sources as possible, including self-report, medical record reviews, claims data, and other sources. Although claims data are considered the gold standard for providing the most accurate data on health care utilization, the researchers found that people often do not report alcohol-related events to insurance companies.**
- **Studies that require long-term follow-up should get a backup contact from subjects and hire researchers for the duration of the study. When obtaining informed consent, researchers should ask for the name and telephone number of a family member or friend who will know how to reach the subject should he or she relocate during the study. Follow-up rates also are higher if the same researcher initiates each subject contact.**
- **Benefit-cost analyses require the direction of a health economist.**
- **Researchers tracking down subjects for follow-up should consult the Social Security Death Index to check whether subjects have died. Death certificates can be requested at:
<http://www.ancestry.com/ssdi/advanced.htm>**

Michael Fleming, MD, MPH and the University of Wisconsin-Madison Medical School, "A New Rx for Problem Drinking: Brief Physician Counseling." (Madison, Wisconsin: Sept. 2000). Funded by grant by Robert Wood Johnson Foundation. Reproduced with permission from the Robert Wood Johnson Foundation, Princeton, NJ.