National Advisory Council to the NIAAA
"Impaired Driving Programs of the National Highway Traffic Safety Administration"

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February 6, 2003

I am pleased to be here today to talk with you today about our nation's alcohol-related crash problem. My boss, U.S. Department of Transportation Secretary Nom Mineta, is serious about the Department's safety mission. It is our number one priority. The Secretary has shown what happens when our Department focuses on an issue as we did in creating the Transportation Security Administration. The result? We met all of the 35 goals that Congress set for us to get this agency up and running.

We will be focusing on the safety of Americans on the highway with equal vigor in the coming months over the short term. We're stepping up high visibility enforcement to reduce impaired driving on our nation's highways, but that's not the long-term solution.

We know what works right now is to have visible enforcement. Impaired driving is a focus of 2003. I'm glad to be here to talk to you about it because I'd like your help with a longer-term strategy.

First, a little bit of history about NHTSA. In 1966, the National Highway Safety Act created a Bureau within the Department of Commerce, which was the forerunner to the National Highway Traffic Safety Administration. Two years later, Dr. Phil Haddon, a renowned figure known as the father of injury control, led the agency.

Dr. Haddon, who was forward thinking, wrote some well-known papers about injury as a disease. Since that time, we've had several NHTSA Administrators and I'm pleased to join their ranks.

As we approach this disease, the good news is that the fatality rate in 1966 was 5.0 fatalities per 100 million vehicle miles traveled (VMT). Today it's 1.52 deaths per 100 million VMT, so there's been a great improvement overall in highway fatality rates.

The rates are getting better but we're still killing more than 42,000 people on highways, which we did last year, and another 3 million were injured. The good news is because of vehicle safety and people wearing their safety belts, injuries are actually down to 4.9% from 2000 to 2001.

The numbers are just not getting any better. Here's a graphic representation of fatalities by year. The trend in the number of fatalities on U.S. roads from 1988 to 2001 has been very flat.

Unintentional injuries are the number one killer of people under of 35 years of age. You can view these data on the Centers for Disease Control and Prevention (CDC) web site. The National Center for Injury Prevention and Control at the CDC has a nice graph of the 10 leading causes of deaths in the United States. Traffic crashes are the top cause of these unintentional injury deaths every day, at every age.

In addition to the human toll, we asked our analysts to update the economic costs from every vehicle crash in the United States based on 2000 data. We did this recently and took everything into account. These are the non-injury components: 26% property damage, and 11% travel delay. Direct and indirect medical costs total about $33 billion. This is what we spend on highways every year. That's a huge economic drain in our country, at a total of about $230.6 billion each year.

I also asked our planning and policy people to look very carefully at the fatality reduction potential of the many different countermeasures we might implement. I asked them to look at: intersection safety, large truck branches, pedestrians, kids in their child seats, and the entire range of items. I asked them to tell me what the most effective countermeasures are for the big pieces of the pie chart.

If we reduce impaired driving by a third, we will achieve one third of the possible lives that can be saved. If we get safety belt use to 90%, we will achieve 34% of the total lives that can be saved. So it's very easy to figure out where we should be spending our energy right away: It's safety belt use and impaired driving.

So let's talk about alcohol. There were 17,448 alcohol-related traffic fatalities in 2001, representing a slight increase over 2000. The fatality rate is .63 million VMT. If we just look at those persons killed with an above .08 blood alcohol concentration (BAC), it's nearly 15,000 of those 17,000.

We have set a goal that the fatality rate should not be more than .53 on overall alcohol-related fatalities per 100 million vehicle miles traveled (VMT) by the end of 2004. And it's a problematic challenge getting from .63 million VMT to .53 million VMT.

As we break this down, there are population groups that clearly contribute to a large part of the problem. There are also geographic groups that contribute to this. Unless we focus in on the alcohol abuse, we are not going to change the slope of this curve. As you can see, from back in the 1980s, there was and is a huge opportunity for a public education.

I think you'll agree with me, if you think back, that it's now no longer acceptable to drive drunk. It's socially reprehensible, in fact, to drive drunk. I think everyone will agree with that. It was a "wink and a nod" 20 years ago. It's not that gray an area anymore. The educable have been educated. The problem rests with a different part of the population. So, not only is it focused on geographic areas, it's also demographic groups, which we'll talk about in a minute.

We look at states by both the number of fatalities in alcohol-related crashes and their alcohol fatality rates. Some states have both high rates and high numbers of fatalities.

We could begin to focus in on these things with some sound science. Now, to me this is the most disturbing slide of all. This is why I need you. This is a distribution of blood

alcohol concentrations levels for drivers in fatal crashes with any alcohol in their system, basically any alcohol-related crash. The red bar is the median BAC for drinking drivers, and it is .16 grams per deciliter.

I think you'll agree with me that to get to the .16 BAC, the aim is to get drunk. It is not a social indiscretion; it's not a bottle of wine shared during a three-hour dinner by two people. These are primarily people who are drinking a lot of alcohol and making the choice to get behind the wheel of the car. This is a disease, it's a social problem, it's a medical problem, and we need focused research in this area.

We can look at prior driving while intoxicated (DWI) convictions, getting into the system, not getting into the system, or escaping detection. In 2001, 1,461 fatalities occurred in crashes involving alcoholic impaired or intoxicated drivers who already had at least one previous DWI conviction. This group accounts for 8.4% of all alcohol-related fatalities.

So this group of impaired drivers in fatal crashes simply is not getting the message, even with law enforcement. Most of them are younger than 35 years of age, 82% are male, 65% of drivers in fatal crashes are not belted, and from surveys that we've done, 80% of impaired drivers are beer drinkers.

This slide shows the number of impaired drivers in fatal crashes by their age. We are still a population that consumes our young. We changed the drinking age and the entire graph

down at this end moved to the right. That's the good news. We are now protecting our 16-year-olds and 17-year-olds and 18-year-olds. Our 19-year-olds are not quite so protected. And nearly 700 drivers involved in alcohol-related fatal crashes were 21 years of age, more than any other age group.

Drivers with any alcohol relationship make up the largest group of fatalities in alcohol-related crashes at 55%. Passengers represent 23% of fatalities in alcohol-related crashes. Drivers with a BAC of .00 are 7% and non-occupants are 15%. Impaired pedestrians, bicyclists, and motorcyclists contribute significantly to the problem. In 2001, nearly 2,700 deaths resulted from crashes where someone other than the driver was impaired.

We can also break down the occupant fatality rate by type of vehicle in alcohol-related crashes. I want you to pay close attention to this. I told you that our goal was to have not more than .53 fatalities per 100 vehicle per miles traveled. I mentioned reaching .53 VMT is a measurement of success. And, in some respects, we have already reached it. We now have passenger cars at .51 VMT; light trucks at .52 VMT; large trucks, which are commercial vehicles on the highways, at .03 VMT; and motorcycles at 14 deaths per 100 million VMT.

Motorcyclist riders are a significant part of the problem and one that is unfortunately increasing. Now it may have to do with the character of the motorcyclist. In 2001, 3,181 people died in motorcycle crashes and 36% of them involved a rider who had been drinking.

It clearly has to do with the character of the vehicle. And on a motorcycle, any error can cost you your life. Particularly if you're unhelmeted, going into a curve if you don't lean at the right time, if the motor memory is disturbed because of alcohol, then you can have a crash. So we really need your help in this area.

Alcohol is an evolving problem among fatally injured adult pedestrians. Once again, 40% of all fatally injured pedestrians over 14 years of age have a positive BAC. Years of data show that crashes involving an alcohol impaired or intoxicated driver or non-occupant are about 50% more likely to result in an injury or a fatality than crashes in which alcohol is not involved.

If we are zeroing in on risk, clearly alcohol is a major factor. I'll just read this content to you. At .04 BAC, a driver is 18% more likely to be involved in a crash. At .08, a driver is 2.5 times as likely. At .10, a driver is five times as likely. And at .15, a driver is 22 times as likely to be in a crash than someone who has not consumed alcohol. So there's a clear linear relationship with crash risk and BAC, according to this recent research by NHTSA and NIAAA. This graph shows the risk of crash involvement accelerates rapidly as BAC rises. So it makes some sense that we have per se laws at .08, making it illegal to drive at .08 and above.

So here are some needs that are also the needs of society, not just NHTSA. In order to adequately address this problem, we need better data. We need these data to help us

more fully understand the problems we are facing. Improvement is needed in post-crash-BAC testing. Currently only about 60% of drivers in fatal crashes are tested for alcohol. It should be more than this. We also need more uniform state data and more complete reporting of data that are collected. We need definitions that are the same from state to state. We also need more states to adopt laws that have been shown to reduce alcohol-related crashes. This is includes Administrative License Revocation (ALR) and .08 BAC laws.

ALR is a law, which seems to have some determined value. Under ALR, your license is removed immediately if you go over the maximum percent alcohol concentration of breath or blood, or if you refuse the drug test. Ten states have yet to pass an ALR law and 15 states have yet to lower the blood alcohol concentration per se maximum level from .10 BAC per se to .08 BAC per se. I think you saw from the relative crash risk slide there's good evidence to suggest that it's scientifically sound to implement such laws.

We're also engaging in some longer-term needs. I don't know exactly how we can begin to think about this together but I'd like you to put your thinking caps on and help me figure it out.

It's not just about law enforcement, it's also about the entire adjudication process and it's about getting people into the system. The system is your system. Intervention by a judge is one of the most effective ways to give people the treatment that is available. As a physician, I practiced alcohol screening and intervention. And in my emergency

department, I would stop right there and report them. There was a place for me to report them to. Did they go? You know, I just don't know. But the judge should know where they go, so we're trying to better train prosecutors and judges about alcohol.

We have funded special DWI prosecutors in some jurisdictions. We have judge training and we're working very hard on this. I'd like to see better data and better interface between the judicial system and the medical system.

There are programs in which we at NHTSA and NIAAA are already collaborating. This includes research on crash risk and guides for DUI sentencing for use by judges. We have also developed a sentencing and disposition guide for judges and prosecutors for younger offenders (younger than 21 years of age).

We also need better screening procedures for convicted offenders of all types. Once identified, we need to make sure that appropriate treatment programs are available for those offenders with alcohol and drug problems. In my emergency department, 14% of people who were stone cold sober after a traffic crash tested positive when screening for alcohol problems.

I have dealt with the population of people whose alcohol impairment is associated with motor vehicle crashes or other risking taking behavior. This is one at-risk population and there are others. They have alcohol problems and yet all these people drive. So please help us. There's more to do. We need to train more physicians to be able to recognize

alcohol problems in their patients so they can screen patients in the emergency department and conduct brief interventions.

I believe in parity of health insurance coverage for people with alcohol problems because this really does cut down all other costs of medical care. We need more training for medical personnel and for law enforcement that need training in detecting impaired drivers, legal intervention, and evidence handling.

We're going to increase highly publicized and visible enforcement of DWI laws, to create an expectation of consequences among drivers and to continue to elevate public health concern over this health problem. Here is the slide, which shows some examples of current NHTSA-supported campaigns.

Here's a list of areas we've all been working on together, such as research on crash risk and the sentencing guidelines for prosecutors and judges. Dr. Compton from my office here is very familiar with many of your researchers and your contractors.

Our planned activities include: updated sentencing guidelines, a co-sponsored meeting in March on treatment for DUI offenders, co-sponsored research on randomized sanctions to reduce DUI recidivism, and the Governors' Wives program, in which NIAAA has the lead.

Here's what I'd like you to consider. I pledged to the Secretary and to the President and to the Congress that we would not enter into any expensive programs unless they're based on good solid research evidence.

Now having said that, we usually find we need better data for our impaired driving programs. So we really could use your help. And when you are sending grants out there to alcohol researchers, I would like you to get them thinking about driving. All people with alcohol problems drive, some even whether or not they've got suspended licenses. So I would encourage you to direct some of your research in that direction. I would like to see us develop a joint research program for impaired driving so that we can prioritize and strategize on research priorities for the country that will help cure this public health problem.

NHTSA is a very small agency; our total budget for operations in research is about $225 million. The rest is based on grant programs. About half of our budget is in vehicle safety and the other half is in behavioral programs. Our office is really small but we award prestigious-sized grants for our size. But we really need your participation to help us solve this alcohol-related crash problem.

Thank you.