

HONOLULU POLICE COMMISSION
City and County of Honolulu
State of Hawaii
Minutes of the Regular Meeting
April 18, 2018

CALL TO ORDER Chair Sheehan called the meeting to order at 2:00 p.m. on Wednesday, April 18, 2018, in Conference Room A at the Honolulu Police Department Alapai Headquarters

PRESENT Loretta A. Sheehan, Chair
 Steven H. Levinson, Vice-Chair
 Shannon L. Alivado, Member
 Karen Chang, Member
 Jerry G. Gibson, Member
 Richard T. Grimm, Member
 Max J. Sword, Member

 George P. Ashak, Acting Executive Officer
 Denise Wong, Deputy Corporation Counsel
 Erin Marie Yamashita, Secretary

ALSO PRESENT Susan Ballard, Chief of Police
 John D. McCarthy, Deputy Chief of Police
 Jonathon B. Grems, Deputy Chief of Police
 Lynne Y. G. Uyema, Legal Advisor

ASCERTAINMENT Counsel Wong ascertained that a quorum was present
OF QUORUM

CHIEF OF POLICE REPORT

Chief Ballard informed commissioners that the Department's accreditation will begin next week. This will be HPD's fifth accreditation and HPD currently holds the gold standard.

The 189th Recruit Class began on Monday, April 16, 2018. The class has 22 members (20 males and 2 females) and will graduate in 6 ½ months. The 190th and 191st classes will begin in August and December of 2018. Commissioners asked about the ratio of males to females and what determines how many male recruits and female recruits will be in each class. Chief Ballard informed commissioners that applicants that have completed the process will be selected and there is no set rule on the number of male or female recruits per class.

Commissioner Grimm wanted to know if there would be another seatbelt survey conducted and how frequent the surveys were conducted. Chief Ballard reported that the National Highway Traffic Safety Administration (NHTSA) conducts the seatbelt survey once a year in various states to compare seatbelt usage versus accidents and fatalities. HPD personnel are not utilized.

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APPROVAL OF MINUTES

Commissioner Grimm made a motion to approve the March 21, 2018, meeting minutes. Commissioner Sword seconded the motion.

Discussion: None.

Vote: By a unanimous vote, the motion carried.

PUBLIC TESTIMONY

Mr. Robert Lee Perry

Mr. Perry attended the meeting and informed commissioners he had misplaced copies of the complaints he filed with the Honolulu Police Commission. He requested copies of the complaints that he has filed against police officers but was told the records had been purged and are no longer available. Mr. Perry also said the investigators who assist him at the Commission's office are threatening to him, and that when he is a victim or defendant he does not have the equal opportunity of providing a written statement because officers refuse to let him write out his statement.

Mr. Perry also requested officers stop using profanity when speaking with him, calling him the n-word, and should assist him when he requests police assistance in filing a police report. Chair Sheehan thanked Mr. Perry for attending the meeting and agreed no officer should be using profanity, including the n-word, and that there is a process for him to request copies of his records. Mr. Perry answered that when he requested copies of the complaints he has filed against police officers he was told the records had been purged and are no longer available.

Mr. Perry also complained that an officer provided his social security number to a third party business that was alleging he was trespassing. Chair Sheehan indicated that he should file a complaint with the Honolulu Police Department's Professional Standards Office for a procedure complaint. She also explained that he could go the Department of the Prosecuting Attorney's Victim Witness Kokua Services and request assistance if he felt a crime has been committed against him.

NEW BUSINESS

Mothers Against Drunk Driving (MADD)

Ms. Carol McNamee and Mr. Arkie Koehl provided commissioners with the history of MADD, which will celebrate its 35th anniversary in 2019 in the State of Hawaii, partnerships with county police departments, and the importance of sobriety checkpoints as the mission of MADD is to end drunk driving, help stop drugged driving, support the victims of these violent crimes, and prevent under-age drinking.

Mr. Koehl provided commissioners with fact sheets on sobriety checkpoints and a study from the Centers for Disease Control and Prevention on Alcohol-Impaired Driving Among Adults. Commissioners were made aware that Hawaii's DUI problem is the worst in the nation as reflected in the CDC study.

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Mothers Against Drunk Driving (Continued)

Ms. McNamee further explained that sobriety checkpoints are a deterrent for drunk driving as they are techniques for law-enforcement officials to evaluate drivers for signs of alcohol or drug impairment at specific points on the roadways, and that in 1986 the Hawaii State Legislature set protocol and guidelines for roadblocks. She explained that the HPD's Traffic Division's sobriety checkpoints normally involved federally funded officer overtime under a NHTSA/DOT Grant, 5212 (52-weeks/12-months per year) along with other enforcement efforts during regular shifts. During the holidays or special times of the year, MADD volunteers partner with HPD in sign holding campaigns and will occasionally provide rewards to drivers.

Currently MADD and HPD are experimenting with legacy checkpoints--a checkpoint commemorating specific victims, dates of crashes, or locations of crashes. The intent is to make it more interesting and meaningful to the public and to honor victims and survivors identified by MADD. Ms. McNamee then invited those in attendance to the upcoming event on April 24, 2018.

(Copies of the sobriety checkpoint fact sheet and the study on alcohol-impaired driving will be attached to the minutes.)

Report on Actions Taken at the Executive Session of March 7, 2018

Commissioner Alivado reported at the Executive Session of March 7, 2018, commissioners approved the February 7, 2018, executive session minutes and took action on one case involving one officer.

Complaint number 17-072 involved one complainant and one officer. The complaints of discourtesy-harassment, conduct unbecoming an officer, and threatening were sustained. Vice-Chair Levinson seconded the motion.

Discussion: None.

Vote: By a unanimous vote, the motion carried.

Commissioner Individual Reports on Commission Business

Chair Sheehan and Commissioners Sword, and Alivado each provided a report on their actions concerning the City Council's Budget Committee and conversations with the Budget Committee Chair and his staff members. Chair Sheehan did attend the April 11, 2018, City Council Budget Committee Meeting with HPD and answered questions from committee members on travel related to the Commission.

Chief Ballard also provided commissioners with an explanation of the previous Budget Committee meeting that occurred shortly after the City Council's reorganization, and informed commissioners that the City Council's Public Health Safety and Welfare Committee has asked HPD, along with other departments, to provide an informational briefing on the FY19 goals and objectives. Chief Ballard will be discussing her goals and any budget issues that could affect HPD in the upcoming years.

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Commissioner Individual Reports on Commission Business (Continued)

During discussion, commissioners suggested councilmembers be made aware of what the HPD's budgetary needs are before the presentations and suggested HPD find a way to proactively reach out to councilmembers. Chief Ballard also explained the budget process HPD and all City departments follow prior to budget briefings at the City Council and answered questions from commissioners. Commissioners appreciated the discussion and Chair Sheehan encouraged commissioners to attend the meeting, if available.

Chair Sheehan shared that she and Commissioner Sword will participate in an interview with assessors for the CALEA accreditation of the Honolulu Police Department. The public will be able to call in comments from 2 p.m. to 4 p.m. and a public hearing will take place at 5:30 p.m. on April 24, 2018. Chair Sheehan and Chief Ballard explained the benefits of being an accredited department as well as achieving the gold standard, which HPD currently maintains.

Formation of the Permitted Interaction Group (Selection Panel for Executive Officer)

In accordance with HPC Rule 7-4, Chair Sheehan appointed Commissioners Shannon Alivado and Max Sword to serve along with her as the permitted interaction group that will serve as the selection panel to interview and rank applicants for the executive officer position.

The next step for the selection panel will be to interview and rank applicants and provide a report to the entire commission.

EXECUTIVE OFFICER'S REPORT

Acting Executive Officer Ashak reported as of April 18, 2018, the Commission has received 26 complaints compared to 30 in 2017. Eight complaints are pending, ten were referrals to PSO, and there are ten pending requests for legal counsel. With regard to the pending requests for legal representation, Chair Sheehan made a disclosure that she would recuse herself from any decision making with regard to the Garcia v. City lawsuit because she was contacted by Ms. Garcia in 2017 and may be considered a witness.

EXECUTIVE SESSION

At 3:25 p.m., Commissioner Gibson made a motion to enter into executive session to review agenda items pursuant to HRS 92-5(a), subsections (2), (4), (5), (6) and (8): to consider the hire, evaluation, dismissal, or discipline of an officer or employee or of charges brought against the officer or employee, where consideration of matters affecting privacy will be involved; to consult with its attorneys on questions and issues pertaining to the Board's powers, duties, privileges, immunities and liabilities; to investigate proceedings regarding criminal misconduct; to consider sensitive matters related to public safety or security; to deliberate or make a decision upon a matter that requires the consideration of information that must be kept confidential pursuant to state or federal law, or a court order.

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EXECUTIVE SESSION (Continued)

During this meeting, discussion with the Chief of Police and her staff regarding internal strategies and sensitive criminal investigation matters relating to public safety that disclosure could significantly risk the circumvention of law and undermine the effectiveness of police protection of the public.

Commissioner Sword seconded the motion.

Discussion: None.

Vote: By a unanimous vote, the motion carried.

RETURN TO OPEN SESSION

The Commission returned to the open session at 4:20 p.m.

ANNOUNCEMENTS

Chair Sheehan announced the next meeting Honolulu Police Commission will be on May 2, 2018 at 2 p.m.

ADJOURNMENT

At 4:21 p.m. Commissioner Gibson made a motion to adjourn the meeting. Commissioner Sheehan seconded the motion.

Discussion: None.

Vote: By a unanimous vote, the motion carried.



Sobriety Checkpoint Fact Sheet

Pertinent Information from the National Highway Traffic Safety Administration, Governors Highway Safety Association, Mothers Against Drunk Driving, Centers for Disease Control & Prevention, Hawaii Department of Transportation, Insurance Institute for Highway Safety. Supporting Data Available Upon Request.

April 18, 2018

The Problem

Since MADD started in 1980, awareness and education have cut drunk driving fatalities roughly in half. Those who still drink and drive do so because they can. They don't respond to rational or conscience-driven messaging. What they care most about is not getting caught. That is why MADD and others believe that frequent, well-publicized sobriety checkpoints are one of the most effective deterrents to drunk driving today — and why the federal government provides significant funding to states for this purpose.

This position is based not just on logic but on numerous studies by highly regarded researchers confirming the effectiveness of checkpoints. A CDC study, for example, showed that checkpoints have the potential of preventing one out of ten DUI deaths.

How Bad is Hawaii's DUI Problem?

- In its most recent behavioral study, in 2012, the Centers for Disease Control completed interviews with 467,334 U.S. adults regarding their impaired driving behavior. As measured by the number of self-reported alcohol-impaired driving episodes in a year, Hawaii was worst in the nation. The national average was 505 alcohol-impaired driving episodes per year per 1000 population. Utah came in best with only 217 episodes. Hawaii weighed in at 995 episodes!

What are Checkpoints?

- Sobriety checkpoints are a technique where law enforcement officials evaluate

drivers for signs of alcohol or drug impairment at specific points on the roadway.

- In Hawaii, HPD Traffic Division sobriety checkpoints normally involve federally-funded officer overtime under a NHTSA DOT grant known as 52-12; smaller, district roadblocks are done during regular shifts.
- MADD Hawaii has long partnered with HPD in major checkpoints: waving signs, giving soft drinks and snacks to drivers who successfully “pass,” etc.
- Currently MADD and HPD are experimenting with “Legacy Checkpoints.” These are major checkpoints commemorating specific victims, dates, or locations, honoring victims and survivors identified by MADD.

How Long Have Checkpoints Been in Use?

- Sobriety checkpoints were first introduced in Scandinavia in the 1930s and became common in the United States in the early 1980s. In 1990, the U.S. Supreme Court ruled in favor of the constitutionality of sobriety checkpoints; however, the debate over checkpoints has continued, and some individual state courts have deemed them illegal for violating state constitutions.
- The Hawaii State legislature set protocol and guidelines for roadblocks in 1986.

How are Checkpoints Conducted

- Vehicles are stopped in a specific sequence such as every other vehicle or every fourth, fifth or sixth vehicle.
- Checkpoints are typically publicized in advance and signs are posted at the approaches to the checkpoints warning drivers that a checkpoint is ahead.
- Checkpoints must be located at fixed sites for a maximum 3 hour period and minimum safety precautions must be met.
- Police must have a reason to believe the driver stopped at a checkpoint has been drinking before a breath test can be conducted.
- Vehicles are pulled over at random according to their order in the predetermined sequence.
- Law-abiding people are sent on their way within minutes.
- Average stop time is about the length of a cycle at a stop light.

Why do Checkpoints?

- The primary goal of a sobriety checkpoint is not to arrest people, but rather to deter people from committing DUI.
- Sobriety checkpoints help stop drunk drivers who would likely remain under the

radar.

- The publicity from checkpoints reminds people who drink that drinking and driving don't mix.
- Research shows that for every dollar invested in checkpoints, communities save between \$6 and \$23 in costs from alcohol-related crashes.
- Alcohol-related crashes cost Americans over \$100 billion per year.
- Research shows that checkpoints, if done correctly, can be effective with as few as three to five officers.
- Knowledge that checkpoints will be set up around Oahu on certain weekends may motivate partygoers — especially those under 50 — to use Uber, Lyft, taxis or other public transport.

Do all States Conduct Checkpoints?

- **37 states, the District of Columbia, the Northern Mariana Islands and the Virgin Islands** conduct sobriety checkpoints.

How Effective are Checkpoints?

- From the Centers for Disease Control & Prevention: “CDC’s systematic review of 11 high-quality studies found that checkpoints reduced alcohol-related fatal, injury, and property damage crashes each by about 20 percent ([Elder, Shults, et al., 2002]). Similarly, a meta-analysis found that checkpoints reduce alcohol-related crashes by 17 percent, and all crashes by 10 to 15 percent ([Erke, Goldenbeld, and Vaa, 2009]).”
- **Crucially, the higher the profile (public awareness) of checkpoints, the greater their deterrent value.** Media coverage is essential. For this reason checkpoints are often conducted during “high risk” periods such as holidays, graduation season, summer weekends, etc.

About Mothers Against Drunk Driving

- *Founded in 1980 by a mother whose daughter was killed by a drunk driver, Mothers Against Drunk Driving® (MADD) is the nation’s largest nonprofit working*

to end drunk driving, help fight drugged driving, support the victims of these violent crimes and prevent underage drinking. MADD has helped to save more than 350,000 lives, reduce drunk driving deaths by more than 50 percent and promote designating a non-drinking driver. MADD's Campaign to Eliminate Drunk Driving® calls for law enforcement support, ignition interlocks for all offenders and advanced vehicle technology. MADD has provided supportive services to nearly one million drunk and drugged driving victims and survivors at no charge through local victim advocates and the 24-Hour Victim Helpline 1-877-MADD-HELP.

- *MADD **Hawaii** was chartered in February, 1984 and has worked toward the National mission for more than 34 years. Its office is in downtown Honolulu. A MADD memorial to the Victims of impaired driving and other violent crimes was erected in Kakaako Waterfront Park in 2003.*



Morbidity and Mortality Weekly Report (*MMWR*)

Alcohol-Impaired Driving Among Adults — United States, 2012

Weekly

August 7, 2015 / 64(30);814-817

Amy Jewett, MPH¹; Ruth A. Shults, PhD¹; Tanima Banerjee, MS²; Gwen Bergen, PhD¹

Alcohol-impaired driving crashes account for approximately one third of all crash fatalities in the United States (1). In 2013, 10,076 persons died in crashes in which at least one driver had a blood alcohol concentration (BAC) ≥ 0.08 grams per deciliter (g/dL), the legal limit for adult drivers in the United States (2). To estimate the prevalence, number of episodes, and annual rate of alcohol-impaired driving, CDC analyzed self-reported data from the 2012 Behavioral Risk Factor Surveillance System (BRFSS) survey. An estimated 4.2 million adults reported at least one alcohol-impaired driving episode in the preceding 30 days, resulting in an estimated 121 million episodes and a national rate of 505 episodes per 1,000 population annually. Alcohol-impaired driving rates varied by more than fourfold among states, and were highest in the Midwest U.S. Census region. Men accounted for 80% of episodes, with young men aged 21–34 years accounting for 32% of all episodes. Additionally, 85% of alcohol-impaired driving episodes were reported by persons who also reported binge drinking, and the 4% of the adult population who reported binge drinking at least four times per month accounted for 61% of all alcohol-impaired driving episodes. Effective strategies to reduce alcohol-impaired driving include publicized sobriety checkpoints (3), enforcement of 0.08 g/dL BAC laws (3), requiring alcohol ignition interlocks for everyone convicted of driving while intoxicated (3), and increasing alcohol taxes (4).

BRFSS is an ongoing, state-based, random-digit-dialed telephone survey that collects health risk data from noninstitutionalized adults aged ≥ 18 years (5). Data from the 2012 BRFSS survey were analyzed to estimate prevalence, number of episodes, and rate of alcohol-impaired driving by selected individual characteristics and rates by state and U.S. Census region. Data from all 50 states and the District of Columbia were included. In 2011, BRFSS began conducting interviews of respondents with mobile phones in addition to landline interviews (6). In 2012, approximately 78% of respondents completed the survey using a landline phone; response rates were 49% for landline and 35% for mobile phones (5), with 467,334 completed interviews. The 2012 BRFSS data were weighted using the raking method, which reduces the potential for bias (6). Respondents who reported consuming any alcoholic beverages within the past 30 days were then asked, "During the past 30 days, how many times have you driven when you've had perhaps too much to drink?"

Estimates of the annual number of alcohol-impaired driving episodes per respondent were calculated by multiplying the reported episodes during the preceding 30 days by 12. These numbers of episodes were summed to obtain state and national estimates of alcohol-impaired driving episodes. Annual rates of alcohol-impaired driving episodes were calculated by dividing the annual number of episodes by the respective weighted population estimate from BRFSS for 2012. For the 13 respondents who reported more than one episode daily, annualized alcohol-impaired driving episodes were truncated at 360. Rates were suppressed for five states because the number of episodes was < 50 or the standard error was $> 30\%$.

Alcohol-impaired driving prevalence was stratified by sex and reported by age, race/ethnicity, education level, marital status, household income, number of binge drinking episodes, seat belt use (always wear or less than always wear) and U.S. Census region. Binge drinking was defined as women drinking four or more alcoholic beverages per occasion and men drinking five or more alcoholic beverages per occasion. Seat belt use among alcohol-impaired drivers was examined separately by type of state seat belt law. Primary enforcement seat belt laws (primary laws) permit law enforcement to stop motorists solely for being unbelted, whereas secondary laws permit ticketing unbelted motorists only if they are stopped for another reason (7). New Hampshire, the only state without a seatbelt law for adults, was included with the secondary law states. Differences between subgroups were analyzed using t-tests, with a p value of

≤0.05 indicating statistical significance.

In 2012, 1.8% of respondents reported at least one alcohol-impaired driving episode during the preceding 30 days. This represented 4.2 million adults who reported an estimated 121 million annual alcohol-impaired driving episodes, a rate of 505 per 1,000 population (Table 1). Among those who reported driving while impaired, 58% indicated one episode, 23% indicated two episodes, and 17% indicated 3–10 episodes in the past 30 days; 0.8% of respondents reported they drove while impaired at least daily. Men accounted for 80% of alcohol-impaired driving episodes. Young men aged 21–34 years, who represented 11% of the U.S. adult population, reported 32% of all episodes.

Persons who reported binge drinking accounted for 85% of alcohol-impaired driving episodes, and the 4% of the adult population who reported binge drinking at least four times per month accounted for 61% of all alcohol-impaired driving episodes. Persons who wore a seat belt less than always had an annual alcohol-impaired driving rate (1,321) three times higher than those who always wore a seat belt (398). Among alcohol-impaired drivers, those living in states with a secondary seat belt law were less likely to always wear their seat belt (55%) compared with those in states with a primary law (74%).

Annual alcohol-impaired driving episode rates varied more than fourfold among states, from 217 (Utah) to 995 (Hawaii) per 1,000 population (Table 2, Figure). The Midwest U.S. Census region had the highest annual alcohol-impaired driving rate at 573 per 1,000 population.

Discussion

During 2012, an estimated 4.2 million U.S. adults reported driving while impaired by alcohol at least once in the preceding 30 days, resulting in an estimated 121 million alcohol-impaired driving episodes annually, and a national rate of 505 episodes per 1,000 population. Alcohol-impaired driving rates varied more than fourfold among states. Because BRFSS made changes in the survey weighting methodology and added a mobile telephone sampling frame since the alcohol-impaired driving question was last asked, direct comparisons of the 2012 results with those from earlier years were not possible. Nonetheless, the estimated number of alcohol-impaired driving episodes reported by U.S. adults in 2012 fell within the range of the 112 million to 161 million annual episodes reported from 1993 to 2010 (8). Also, young men aged 21–34 years and persons who binge drink have consistently reported the highest rates of alcohol-impaired driving. Likewise, persons living in the Midwest have consistently reported higher alcohol-impaired driving rates than those living in other regions.

Although reasons for the variation in alcohol-impaired driving across the United States are not fully understood, individual-level and state-level factors likely contribute. For example, in 2013, the estimated proportion of adults who consumed alcohol varied from 31% in Utah to 65% in Wisconsin (9). Additionally, effective prevention strategies have not been adopted by all states; for example, as of February 2015, 12 states prohibited the use of publicized sobriety checkpoints (10).

Seat belts are about 50% effective in preventing driver fatalities in crashes (1), and seat belt use is higher in states with a primary seat belt law compared with use in states with a secondary law (7). In this report, persons who did not always wear a seat belt had alcohol-impaired driving rates three times higher than those who were always belted. In addition, consistent seat belt use was especially low among alcohol-impaired drivers living in states with a secondary seat belt law. Taken together, these findings suggest that fatalities among alcohol-impaired drivers could be substantially reduced if every state had a primary seat belt law.

The findings in this report are subject to at least four limitations. First, self-reported alcohol-impaired driving as defined by the BRFSS survey cannot be equated to a specific BAC; however, 85% of episodes were reported by persons who also reported binge drinking. Second, because alcohol-impaired driving carries a stigma, these self-reported estimates might be underestimated because of social desirability bias. Third, BRFSS survey respondents were aged ≥18 years; therefore, alcohol-impaired driving episodes among younger drivers were not included. Finally, the median response rate for the 2012 BRFSS survey was only 45% (5), which increased the risk for response bias.

Alcohol-impaired driving crashes have accounted for about one third of all U.S. crash fatalities in the past two decades (1,2). To reduce alcohol-impaired driving, states and communities could consider effective interventions, such as expanding the use of publicized sobriety checkpoints (10); enforcing 0.08 g/dL BAC laws and minimum legal drinking

age laws (3); requiring ignition interlocks (i.e., breath-test devices connected to a vehicle's ignition that require a driver to exhale into the device, and that prevent the engine from being started if the analyzed result exceeds a preprogrammed level) for all persons convicted of alcohol-impaired driving (3); and increasing alcohol taxes (4). Additionally, all states might consider enacting primary seat belt laws that cover all passengers to help reduce fatalities in alcohol-impaired driving crashes (7).

Acknowledgment

Gina Perleoni, Geospatial Analysis, Research, and Analysis Program, CDC.

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Summary

What is already known on this topic?

Alcohol-impaired driving crashes account for nearly one third of all motor vehicle crash fatalities.

What is added by this report?

In 2012, an estimated 4.2 million U.S. adults reported at least one episode of alcohol-impaired driving during the preceding 30 days, equating to an estimated 121 million annual alcohol-impaired driving episodes.

What are the implications for public health practice?

To reduce alcohol-impaired driving, states and communities could consider increasing the use of effective interventions such as publicized sobriety checkpoints, strictly enforcing 0.08 g/dL blood alcohol content laws and minimum legal drinking age laws, requiring ignition interlocks for all persons convicted of alcohol-impaired driving, and increasing alcohol taxes. To reduce alcohol-impaired driving fatalities, states and communities also might consider enacting

primary enforcement seat belt laws.

TABLE 1. Percentage of adults reporting alcohol-impaired driving episodes during the preceding 30 days and annual rate of episodes per 1,000 population, by sex and selected characteristics — Behavioral Risk Factor Surveillance System, United States, 2012

Characteristic	Overall				Men				Women			
	%	No. of episodes	Annual rate	(95% CI)	%	No. of episodes	Annual rate	(95% CI)	%	No. of episodes	Annual rate	(95% CI)
Total	1.8	120,840,680	505	461–550	2.8	96,137,414	828	741–914	0.8	24,703,266	201	173–229
Age group (yrs)												
18–20	1.4	6,341,797	431	294–569	2.2	4,963,761	650	427–873	—*	—	—	—
21–24	4.2	16,709,636	1,004	814–1,195	5.8	12,301,238	1,450	1,113–1,787	2.6	4,408,397	540	373–708
25–34	3.0	32,662,609	794	630–958	4.5	26,597,672	1,282	962–1,602	1.5	6,064,937	297	240–355
35–54	1.9	44,360,681	527	450–605	3.0	35,183,421	844	700–988	0.9	9,177,260	216	158–274
≥55	0.8	20,631,892	252	210–295	1.4	16,987,417	453	365–541	0.3	3,644,475	82	56–108
Race/Ethnicity												
White, non-Hispanic	1.9	81,297,896	524	472–575	3.0	63,627,635	846	747–945	0.9	17,670,261	221	184–258
Black, non-Hispanic	1.8	12,262,181	440	349–531	2.7	8,901,599	698	528–869	1.0	3,360,582	222	137–308
Hispanic	1.8	18,638,930	518	363–673	2.9	16,579,282	917	611–1,223	0.6	2,059,648	115	78–152
Other, non-Hispanic	1.3	5,865,091	398	217–580	2.1	4,597,655	626	290–962	0.5	1,267,436	172	32–311
Multiracial, non-Hispanic	1.8	1,250,064	355	246–463	2.7	966,111	567	361–772	0.9	283,953	156	74–239
Education												
Less than high school	1.2	15,863,682	446	306–586	2.0	14,421,682	786	517–1,054	0.3	1,442,000	84	46–122
High school	1.6	33,534,025	486	422–551	2.6	27,365,716	792	676–907	0.6	6,168,309	179	120–239

Some college	2.0	42,280,497	578	472– 684	3.3	33,526,025	1,012	788– 1,237	1.0	8,754,472	219	162– 275
College	2.2	29,162,476	474	426– 522	3.2	20,823,990	691	607– 775	1.3	8,338,485	266	219– 313
Marital status												
Married	1.2	34,523,699	289	260– 318	1.9	27,665,693	467	412– 521	0.6	6,858,006	114	91–137
Unmarried couple	3.2	12,386,722	1,052	697– 1,408	4.7	10,903,950	1,790	1,107– 2,473	1.6	1,482,771	261	177– 345
Previously married	1.6	24,538,321	521	422– 619	3.0	18,620,065	1,051	811– 1,291	0.7	5,918,256	201	138– 265
Never married	3.0	48,329,111	798	670– 927	4.2	37,973,371	1,155	930– 1,379	1.6	10,355,740	374	284– 465
Annual household income (\$)												
<20,000	1.4	19,675,457	436	345– 527	2.4	15,497,797	776	581– 970	0.7	4,177,660	166	112– 220
20,000–34,999	1.9	23,173,002	539	440– 639	3.0	18,655,935	902	707– 1,097	0.8	4,517,067	203	139– 267
35,000–49,999	2.1	14,735,381	501	406– 596	3.0	11,177,179	747	578– 917	1.2	3,558,202	246	163– 329
50,000–74,999	2.1	18,848,567	592	414– 770	3.2	15,351,294	943	612– 1,274	0.9	3,497,274	225	110– 339
≥75,000	2.3	34,301,686	584	512– 656	3.3	26,883,422	853	730– 977	1.2	7,418,264	272	209– 336
Binge drinking												
No binge drinking	0.8	14,753,474	181	158– 204	1.2	10,177,543	253	211– 296	0.5	4,575,932	111	91–131
1 time per month	4.7	11,359,118	840	690– 989	5.5	8,213,096	1,027	791– 1,263	3.6	3,146,022	569	440– 698
2–3 times per month	8.2	19,039,754	1,611	1,388– 1,834	9.7	13,917,849	1,832	1,566– 2,097	5.5	5,121,905	1,213	812– 1,614
≥4 times per month	14.8	73,285,148	5,637	4,875– 6,398	16.2	61,905,024	6,520	5,519– 7,522	11.0	11,380,124	3,244	2,453– 4,035
Seatbelt use												

Less than always	4.0	42,356,829	1,321	1,101–1,541	5.3	36,527,500	1,843	1,497–2,190	2.0	5,829,329	477	344–609
Always	1.5	81,376,707	398	357–439	2.4	62,180,982	656	574–738	0.8	19,195,724	177	148–205

Abbreviation: CI = confidence interval.

* Sample size was <50 or relative standard error was >0.30.

TABLE 2. Annual rate of self-reported alcohol-impaired driving episodes per 1,000 population, among adults, by U.S. Census region and state — Behavioral Risk Factor Surveillance System, United States, 2012

U.S. Census region	State	Rate	(95% CI)
National		505	(461–550)
Northeast		481	(389–572)
	Vermont	881	(309–1,452)
	Pennsylvania	701	(409–992)
	Connecticut	558	(400–717)
	Rhode Island	522	(363–680)
	Massachusetts	510	(390–630)
	New York	372	(209–536)
	New Jersey	360*	(262–458)
	Maine	324	(172–476)
	New Hampshire	313*	(203–423)
South		525	(433–616)
	Louisiana	811	(463–1,159)
	Delaware	729	(429–1,028)
	Texas	703	(348–1,058)
	South Carolina	663	(346–980)
	Alabama	539	(241–837)
	Florida	539	(346–733)
	Maryland	527	(364–690)
	Georgia	491	(230–751)

	Oklahoma	467	(250–685)
	District of Columbia	409	(152–665)
	North Carolina	389	(253–525)
	Kentucky	388	(251–525)
	Virginia	308*	(206–409)
	Arkansas	—†	—
	Mississippi	—	—
	Tennessee	—	—
	West Virginia	—	—
West		422	(351–493)
	<u>Hawaii</u>	<u>995§</u>	(641–1,349)
	Montana	885§	(655–1,116)
	Wyoming	807	(342–1,272)
	Washington	706	(265–1,147)
	Nevada	489	(292–686)
	Colorado	477	(305–650)
	California	375	(273–477)
	Idaho	362	(122–602)
	Arizona	300*	(192–408)
	Oregon	285*	(168–402)
	New Mexico	273*	(180–367)
	Utah	217*	(98–337)
	Alaska	—	—
Midwest		573	(498–649)
	Nebraska	955§	(689–1,221)
	North Dakota	855	(473–1,238)
	Wisconsin	828	(536–1,121)
	South Dakota	733	(519–946)
	Iowa	715	(547–882)

Minnesota	646	(457–835)
Missouri	569	(294–843)
Ohio	566	(415–716)
Michigan	497	(326–667)
Kansas	482	(335–629)
Illinois	475	(223–727)
Indiana	432	(224–639)

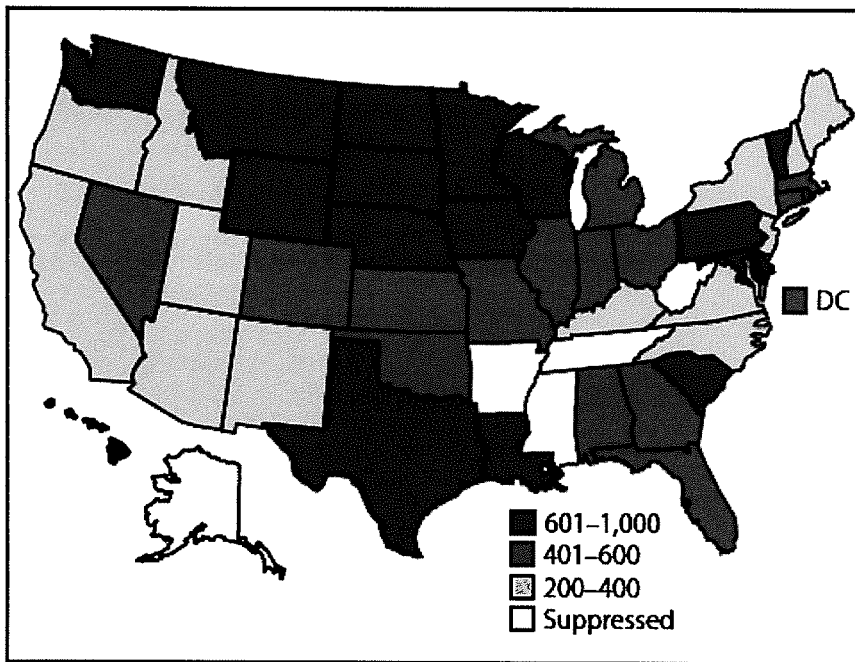
Abbreviation: CI = confidence interval.

* Significantly lower than the national rate.

† Sample size was <50 or relative standard error was >0.30.

§ Significantly higher than the national rate.

FIGURE. Annual rate* of self-reported alcohol-impaired driving episodes per 1,000 population, among adults — Behavioral Risk Factor Surveillance System, United States, 2012



Abbreviation: DC = District of Columbia.

* Rates were suppressed if sample size was <50 or relative standard error was >30%.

Alternate Text: The figure above is a map of the United States showing the annual rate of self-reported alcohol-impaired driving episodes per 1,000 population among adults during 2012.

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