

Publicized Sobriety Checkpoint Programs to Reduce Alcohol-Impaired Driving

Recommendation of the Community Preventive Services Task Force

Community Preventive Services Task Force

Task Force Finding

The Community Preventive Services Task Force recommends publicized sobriety checkpoint programs based on strong evidence of effectiveness in reducing alcohol-impaired driving.

Definition

Publicized sobriety checkpoint programs are a form of high-visibility enforcement at which law enforcement officers select vehicles in a systematic manner to stop and assess the driver's degree of alcohol impairment. Media campaigns to publicize the enforcement activity are an integral part of these programs. The program goal is to reduce alcohol-impaired driving by increasing the public's perceived risk of arrest while also arresting alcohol-impaired drivers identified at checkpoints.

There are two types of sobriety checkpoints:

- Selective breath testing (SBT): police must have suspicion of impairment, based on observation, to request a breath test, as done in the U.S.
- Random breath testing (RBT): all stopped drivers are given breath tests for blood alcohol concentration (BAC) levels. RBT is used in Australia and several European countries.

Basis of Finding

The Task Force finding is based on earlier evidence from a Community Guide systematic review published in 2001 (Shults et al.,¹ 23 studies, January 1980–June 2000 search period) along with more recent evidence (Bergen et al.,² 15 studies, July 2000–March 2012 search period) reviewed in 2012. Based on the updated review,

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the Task Force recommendation for the effectiveness of this intervention remains positive and unchanged.

Considerations for Implementation

Primary considerations for implementation include legal restrictions against using checkpoints in 12 states. Additionally, an integral part of publicized sobriety checkpoint programs is the use of media, either paid ads or news stories (i.e., “earned” media), to publicize the program and increase the population's perceived risk of arrest for alcohol-impaired driving.

Securing the necessary law enforcement staff to implement sobriety checkpoints presents another challenge to implementation, owing to limited resources and competing needs. In addition, sobriety checkpoints are typically conducted during times when alcohol-impaired drivers are most likely to be on the roads, such as weekend evenings, and staff overtime is often required. On the other hand, checkpoints may help law enforcement officers detect violations of the law that would otherwise be missed (e.g., use of mandated safety restraints).

Another implementation challenge is conducting sobriety checkpoints in a manner that maximizes effectiveness. The National Highway Traffic Safety Administration publishes a how-to guide³ for planning and publicizing sobriety checkpoints, which describes how to implement checkpoints effectively.

Potential harms of sobriety checkpoints are inconvenience to and intrusion into the privacy of drivers required to stop. However, the U.S. Supreme Court ruled that checkpoints are a minimal and acceptable intrusion given the benefit of preventing impaired driving and the small amount of time required of non-impaired drivers.⁴

Most studies were conducted in the U.S. (with one in New Zealand) and focused on the general population. Two studies that focused on college-aged youth and young men found reductions in alcohol-involved driving outcomes; showing publicized sobriety checkpoint programs are also effective among young adults, a particularly high-risk

population. Additionally, “low-manpower” staffed checkpoints—those using 11 law enforcement personnel or fewer—appear to be effective.

The economic evidence indicated that benefits exceed intervention costs. Low-staffed sobriety checkpoint programs cost less to run than regularly staffed programs (≥ 12 officers). The cost of media varied based on type of media used and the length, density, and duration of publicity.

Evidence Gaps

The original Community Guide review, published in 2001,¹ discussed several evidence gaps, most of which were not addressed by the additional evidence found during the updated search period. The most important evidence gaps identified in the updated search period concerned the effects of different configurations and costs of checkpoints, and the role of media.

Although two studies were conducted on low-staffed checkpoints, more evidence is needed on the effect of various sobriety checkpoint configurations (e.g., intermittent blitzes versus continuous; weekend nights versus random time periods; low staffing versus regular staffing).

Information about the costs of conducting sobriety checkpoints was either missing or incomplete. Reporting complete costs for implementation, staffing, and media

efforts—including the cost of paid media and dollar equivalent of earned media—is necessary for a complete review of economic effectiveness. Further research also is needed to clarify the long-term economic benefits of publicized sobriety checkpoint programs.

Information in studies from the updated search period was insufficient to determine whether paid versus earned media had different effects on study outcomes because most studies either used both types or did not report which type was used. Further research should include descriptions and measures of media used.

Additional evidence gaps are described in the accompanying paper.²

References

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