

# ***Excellence in Prevention*** – descriptions of the prevention programs and strategies with the greatest evidence of success

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## **Name of Program/Strategy: Sobriety Checkpoints**

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### **1. Overview and description**

The traditional strategy for increasing perceived certainty of apprehension is to increase the frequency and visibility of drinking-and-driving enforcement, for example, by simply intensifying police enforcement in the form of short-term intensive checkpoints during holidays. Increasing the probability of arrest could translate into a higher perceived probability of detection and fewer accidents. At sobriety checkpoints, only motorists who are judged by police to have been drinking are asked to take a breath test. This approach greatly weakens the deterrent potential because experienced offenders believe (with some justification) that they can avoid detection.

### **2. Implementation considerations (if available)**

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## **3. Descriptive information**

<b>Areas of Interest</b>	Substance abuse prevention
<b>Outcomes</b>	
<b>Outcome Categories</b>	Alcohol
<b>Ages</b>	
<b>Gender</b>	Male Female
<b>Races/Ethnicities</b>	American Indian or Alaska Native Asian Black or African American Hispanic or Latino White Race/ethnicity unspecified
<b>Settings</b>	
<b>Geographic Locations</b>	Urban Suburban Rural and/or frontier Tribal
<b>Implementation History</b>	
<b>NIH Funding/CER Studies</b>	
<b>Adaptations</b>	
<b>Adverse Effects</b>	
<b>IOM Prevention Categories</b>	Universal

## **4. Outcomes**

### **Scientific Evidence**

The effectiveness of sobriety checkpoints was confirmed in a review of evidence of interventions to reduce alcohol-impaired driving. (Shults et al., 2001).

Such campaigns do generally reduce accidents, but once again, their effects are generally short lived (Ross, 1982).

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***Excellence in Prevention*** is a project of Oregon Addiction and Mental Health Services and Washington Division of Behavioral Health and Recovery. Information is drawn from many sources, including the National Registry for Effective Prevention Programs (NREPP), sponsored by the Center for Substance Abuse Prevention.

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The perception of risk was directly related to the level of enforcement as represented by the number of breath-test devices provided to the police departments, the number of officers trained at the experimental sites, and the amount of local newspaper coverage of enforcement activities (Voas et al., 1997).

An estimate is that police miss as many as 50 percent of drivers with BACs higher than .10 at sobriety checkpoints (McKnight & Voas, 2001).

Substantial and consistent evidence from research shows that highly publicized, highly visible, and frequent sobriety checkpoints in the United States reduce impaired driving fatal crashes by 18 to 24 percent. However, a recent survey of checkpoint use demonstrated that, despite the U.S. Department of Transportation's efforts to encourage checkpoint use through publications and the provision of funds for equipment and officers' overtime, only about a dozen of the 37 states that conduct checkpoints do so weekly due to lack of local police resources and funding, lack of support by task forces and citizen activists, and the perception that checkpoints are not productive or cost-effective (Fell, Lacey & Voas, 2004).

Low-staffing sobriety checkpoints conducted by as few as three to five officers have been shown to be just as effective as checkpoints conducted by 15 or more officers.

A modified sobriety checkpoint program using passive alcohol sensors (*PASpoints*) can be implemented by small- to moderate-sized communities in the United States to deter impaired driving. If implemented in a majority of communities, this strategy can potentially reach the high level achieved by several Australian states in their RBT programs.

The *PASpoint* system calls for a small group of three to five officers on traffic patrol duty to converge on a preset site and conduct a mini-checkpoint, returning to their standard patrol duties within 2 hours.

- 5. Cost effectiveness report (Washington State Institute of Public Policy – if available)**
- 6. Washington State results (from Performance Based Prevention System (PBPS) – if available)**
- 7. Who is using this program/strategy**

Washington Counties	Oregon Counties
None	

- 8. Study populations**
- 9. Quality of studies**

The documents below were reviewed for Quality of Research. The research point of contact can provide

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information regarding the studies reviewed and the availability of additional materials, including those from more recent studies that may have been conducted.

## **References**

Fell, J. C., Lacey, J. H., & Voas, R. B. (2004). Sobriety checkpoints: Evidence of effectiveness is strong, but use is limited. *Traffic Injury Prevention*, 5(3), 220-227.

McKnight, A. J., & Voas, R. B. (2001). Prevention of alcohol-related road crashes. In N. Heather, T. J. Peters, & T. Stockwell (Eds.), *International handbook of alcohol dependence and problems* (pp. 741-769). Chichester, UK: John Wiley and Sons Ltd.

Ross, H. L. (1982). *Deterring the drinking driver: Legal policy and social control*. Lexington, MA: Lexington Books.

Shults, R. A., Elder, R. W., Sleet, D. A., Nichols, J. L., Alao, M. O., Carande-Kulis, V. G., Zaza, S., Sosin, D. M., Thompson, R. S., & Task Force on Community Preventive Services. (2001). Reviews of evidence regarding interventions to reduce alcohol-impaired driving. *American Journal of Preventive Medicine*, 21(4 Suppl), 66-88.

Voas, R. B. (1997). Drinking and driving prevention in the community: Program planning and implementation. *Addiction*, 92(Supplement 2), S201-S219.

## **10. Readiness for Dissemination**

The Washington State Supreme Court ruled DUI sobriety checkpoints unconstitutional in 1988. Law enforcement officials may, however, conduct DUI emphasis patrols.

## **11. Costs (if available)**

## **12. Contacts**

National Highway Traffic Safety Administration  
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West Building  
Washington, DC 20590  
(888) 327-4236

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