

**Motor-Vehicle Occupant Injury:  
Strategies for Increasing Use  
of Child Safety Seats, Increasing Use  
of Safety Belts, and  
Reducing Alcohol-Impaired Driving**

**A Report on Recommendations of the Task  
Force on Community Preventive Services**

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
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# **Motor-Vehicle Occupant Injury: Strategies for Increasing Use of Child Safety Seats, Increasing Use of Safety Belts, and Reducing Alcohol-Impaired Driving**

## **A Report on Recommendations of the Task Force on Community Preventive Services**

### **Summary**

*The Task Force on Community Preventive Services has conducted systematic reviews of interventions designed to increase use of child safety seats, increase use of safety belts, and reduce alcohol-impaired driving. The Task Force strongly recommends the following interventions: laws requiring use of child safety seats, distribution and education programs for child safety seats, laws requiring use of safety belts, both primary and enhanced enforcement of safety belt use laws, laws that lower the legal blood alcohol concentration (BAC) limit for adult drivers to 0.08%, laws that maintain the minimum legal drinking age at 21 years, and use of sobriety checkpoints. The Task Force recommends communitywide information and enforcement campaigns for use of child safety seats, incentive and education programs for use of child safety seats, and a lower legal BAC for young drivers (in the United States, those under the minimum legal drinking age). This report provides additional information regarding these recommendations, briefly describes how the reviews were conducted, and provides information to help apply the interventions locally.*

## **BACKGROUND**

Motor-vehicle-related injuries kill more children and young adults (i.e., those aged 1–24 years) than any other single cause in the United States (1,2) and are the leading cause of death from unintentional injury for persons of all ages (3,4). Approximately 41,000 persons in the United States die in motor-vehicle crashes each year (5). Moreover, crash injuries result in approximately 500,000 hospitalizations and 4 million emergency department visits annually (6).

Viewed from an economic perspective, crash injuries and deaths are a burden to society. Motor-vehicle-related deaths and injuries cost the United States approximately \$150 billion annually (7,8), including \$52.1 billion in property damage, \$42.4 billion in lost productivity, and \$17 billion in medical expenses (7). Alcohol-related crashes contribute substantially to these costs, with a direct economic impact of approximately \$45 billion in 1994 alone (7).

Reducing motor-vehicle injury remains a formidable public health challenge, despite sharp declines in motor-vehicle-related death rates since 1925 (9). Use of child safety seats and safety belts and deterrence of alcohol-impaired driving are among the most important preventive measures to further reduce motor-vehicle occupant injuries

and deaths (10,11). This report provides recommendations on interventions to increase use of child safety seats, increase use of safety belts, and reduce alcohol-impaired driving.

## INTRODUCTION

This *MMWR* report is the third to be completed for the *Guide to Community Preventive Services* (the *Community Guide*), a resource that will include multiple chapters, each focusing on a preventive health topic. The first two reports were on vaccine-preventable diseases and tobacco use prevention and reduction (12–17). This report provides an overview of the process used by the Task Force on Community Preventive Services (the Task Force) to select and review evidence and summarizes the recommendations of the Task Force regarding interventions to reduce motor-vehicle occupant injury. A full report of the recommendations, supporting evidence (i.e., discussions of applicability, additional benefits, potential harms, existing barriers to implementation, and economic evaluations), and remaining research questions will be published in the *American Journal of Preventive Medicine* later this year.

The independent, nonfederal Task Force is developing the *Community Guide* with the support of the U.S. Department of Health and Human Services (DHHS) in collaboration with public and private partners. CDC provides staff support to the Task Force for development of the *Community Guide*. The recommendations in this report, although developed independently by the Task Force, are consistent with current CDC recommendations.

## METHODS

The *Community Guide's* methods for conducting systematic reviews and linking evidence to recommendations have been described elsewhere (18). In brief, for each *Community Guide* topic, a multidisciplinary team conducts a review by

- developing an approach to organizing, grouping, and selecting the interventions;
- systematically searching for and retrieving evidence;
- assessing the quality of and summarizing the strength of the body of evidence of effectiveness;
- summarizing information regarding other evidence; and
- identifying and summarizing research gaps.

For motor-vehicle occupant injury, the development team focused on interventions to promote use of child safety seats, promote use of safety belts, and deter alcohol-impaired driving. These areas were chosen because a) use of child safety seats and use of safety belts are below national goals (19); b) 38% of traffic deaths still involve alcohol (5); and c) nonuse of child safety seats, nonuse of safety belts, and alcohol-impaired driving are among the most important contributors to motor-vehicle occupant injuries, and reducing these three risk behaviors could dramatically reduce these injuries. This report includes the goals of the National Highway Traffic Safety Administration (NHTSA) and the *Healthy People 2010* initiative (19) in these areas (Table 1).

**TABLE 1. Selected National Highway Traffic Safety Administration\* (NHTSA) goals and *Healthy People 2010* objectives related to motor-vehicle occupant injury**

NHTSA goal	<i>Healthy People 2010</i> objective <sup>†</sup>
<b>General</b>	
Reduce the number of fatal and nonfatal injuries by 20% by the year 2008 (from 42,065 fatal injuries and 3,511,000 nonfatal injuries in 1996). <sup>§</sup>	Reduce deaths caused by motor-vehicle crashes from 15.0/100,000 persons (1998 preliminary data age-adjusted to the year 2000 standard population) to 9.0/100,000. (Objective 15-15a)
	Reduce deaths from 2/100 million vehicle miles traveled (in 1997) to 1/100 million vehicle miles traveled. (Objective 15-15b)
	Reduce nonfatal injuries caused by motor-vehicle crashes from 1,270/100,000 persons (in 1997) to 1,000/100,000 (21% improvement). (Objective 15-17).
<b>Child Safety Seats</b>	
Reduce child (aged 0–4 years) occupant fatalities by 25% by the year 2005 (from 653 fatalities in 1996). <sup>¶</sup>	Increase use of child restraint devices for passengers aged 0–4 years from 92% (1998 preliminary data age-adjusted to the year 2000 standard population) to 100%. (Objective 15-20)
<b>Safety Belts</b>	
Increase national seat belt use to 90% by the year 2005 (from 68% in 1996). <sup>**</sup>	Increase use of safety belts from 69% (in 1998) to 92% (33% improvement). (Objective 15-19)
<b>Alcohol-Impaired Driving</b>	
Reduce alcohol-related fatalities to $\leq$ 11,000 annually by the year 2005. <sup>††</sup> (Achieving this goal will reduce deaths caused by drinking and driving by approximately 5,000 each year.)	Reduce deaths caused by alcohol-related motor-vehicle crashes from 6.1/100,000 persons (1997 baseline) to 4/100,000. (Objective 26-1a)
	Reduce injuries caused by alcohol-related motor-vehicle crashes from 122/100,000 persons (1997 baseline) to 65/100,000. (Objective 26-1b)
	Reduce the proportion of adolescents who report that during the preceding 30 days they rode with a driver who had been drinking alcohol from 37% (in 1997) to 30%. (Objective 26-6)
	Extend administrative license revocation laws or programs of equal effectiveness for persons who drive under the influence of intoxicants from 41 states (in 1998) to all states and Washington, D.C. (Objective 26-24)
	Extend legal requirement for maximum blood alcohol concentration levels of 0.08% for motor-vehicle drivers aged $\geq$ 21 years from 16 states (in 1998) to all states and Washington, D.C. (Objective 26-25)

\* U.S. Department of Transportation.

<sup>†</sup> US Department of Health and Human Services. *Healthy People 2010*, vols I and II. 2nd ed. Washington, DC: US Government Printing Office, November 2000.<sup>§</sup> 1998 NHTSA Strategic Plan, available on the Internet at <<http://www.nhtsa.dot.gov/nhtsa/whatis/planning/StratPlan.1998/>>.<sup>¶</sup> NHTSA. Presidential Initiative for Increasing Seat Belt Use Nationwide: Recommendations from the Secretary of Transportation. Washington, DC: US Department of Transportation, NHTSA, 1997; publication no. DOT HS 808 576.<sup>\*\*</sup> Presidential Initiative to Increase Seat Belt Use Nationwide, available at <<http://www.nhtsa.dot.gov/people/injury/airbags/buckleplan/presbelt2/#2>>.<sup>††</sup> NHTSA Alcohol-Impaired Driving Goals: NHTSA Impaired Driving Division, available at <[http://www.nhtsa.dot.gov/people/outreach/safesobr/ydydyl/imp\\_drive.html](http://www.nhtsa.dot.gov/people/outreach/safesobr/ydydyl/imp_drive.html)>.

The consultation team\* generated a comprehensive list of strategies and created a priority list of interventions for review based on a process of polling consultants and other specialists in the field regarding their perception of the importance and practicality of various interventions.

Interventions reviewed were either single-component (i.e., using only one activity to achieve desired outcomes) or multicomponent (i.e., using more than one related activity). Studies were grouped on the basis of the similarity of the interventions being evaluated. Some studies provided evidence for more than one intervention. In these cases, the studies were reviewed for each applicable intervention. Interventions and outcome measures were classified according to definitions developed as part of the review process. The nomenclature used here might differ from that used in the original studies.

To be included in the reviews of effectiveness, studies had to a) be primary investigations of interventions selected for evaluation rather than, for example, guidelines or reviews; b) be published in English during 1966–June 2000; c) be conducted in established market economies;† and d) compare outcomes among groups of persons exposed to the intervention with outcomes among groups of persons not exposed or less exposed to the intervention (whether the comparison was concurrent between groups or before-after within groups).

For each intervention reviewed, the team developed an analytic framework indicating possible causal links between the intervention under study and predefined outcomes of interest. To make recommendations, the Task Force required that studies show increases in use of child safety seats or safety belts, decreases in alcohol-impaired driving, or decreases in motor-vehicle crashes or crash-related injuries.

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† Established market economies as defined by the World Bank are Andorra, Australia, Austria, Belgium, Bermuda, Canada, Channel Islands, Denmark, Faeroe Islands, Finland, France, Former Federal Republic of Germany, Germany, Gibraltar, Greece, Greenland, Holy See, Iceland, Ireland, Isle of Man, Italy, Japan, Liechtenstein, Luxembourg, Monaco, The Netherlands, New Zealand, Norway, Portugal, San Marino, Spain, St. Pierre and Miquelon, Sweden, Switzerland, the United Kingdom, and the United States.

Improvements in behavioral outcomes (i.e., use of child safety seats, use of safety belts, and decreases in alcohol-impaired driving) are acceptable because

- child safety seats are 55%–70% effective in preventing deaths (20);
- safety belts are 45%–60% effective in reducing deaths and 50%–65% effective in reducing moderate-to-critical injuries (21); and
- the risk for fatal crash involvement increases as blood alcohol levels increase (22).

Each study that met the inclusion criteria was evaluated using a standardized abstraction form and assessed for suitability of the study design and threats to validity. On the basis of the number of threats to validity, studies were characterized as having good, fair, or limited execution (18,23). Results on each outcome of interest were obtained from each study that met the minimum quality criteria. For studies that reported multiple measures of a given outcome, the “best” measure with respect to validity and stability was chosen according to consistently applied rules. Measures that were adjusted for the effects of potential confounders were used in preference to crude effect measures. For studies in which such adjusted results were not provided, net effects were derived when possible by calculating the difference between the changes observed in the intervention and comparison groups. A median was calculated as a summary effect measure for each outcome of interest. For bodies of evidence consisting of seven or more studies, an interquartile range is presented as an index of variability; otherwise, a simple range is reported.

The strength of the body of evidence of effectiveness was characterized as strong, sufficient, or insufficient on the basis of the number of available studies, the suitability of study designs for evaluating effectiveness, the quality of execution of the studies, the consistency of the results, and the effect size (18).

The *Community Guide* uses systematic reviews to evaluate the evidence of intervention effectiveness, and the Task Force makes recommendations based on the findings of these reviews (18). The strength of each recommendation is based on the strength of the evidence of effectiveness (e.g., an intervention is “strongly recommended” when there is strong evidence of effectiveness or “recommended” when there is sufficient evidence) (18). Other types of evidence can also affect a recommendation. For example, evidence of harms resulting from an intervention might lead to a recommendation that the intervention not be used if adverse effects outweigh improved outcomes. In general, the Task Force does not use economic information to modify recommendations.

A finding of insufficient evidence of effectiveness should not be seen as evidence of ineffectiveness. Such a finding is important for identifying areas of uncertainty and continuing research needs. In contrast, adequate evidence of ineffectiveness leads to a recommendation that the intervention not be used.

## RESULTS

Searches of six computerized databases (i.e., Medline, Embase, El Compindex, Sociological Abstracts, Psychlit, and Transportation Research Information Services [TRIS]\*) yielded a list of 10,948 titles, from which 3,653 articles were retrieved as possibly

\*These databases can be accessed through the Dialog Corporation at <<http://www.dialog.com>>.

relevant. Of these, 277 met the inclusion criteria. Team members also reviewed reference lists and consulted with other specialists in the field to identify relevant studies. All studies of economics, ethics, or feasibility that were applicable to the interventions under study were also examined. Among all the studies reviewed, 102 were excluded on the basis of limitations in their execution or design or because they duplicated information provided in an already included study. Excluded studies were not considered further. The remaining 175 studies were considered qualifying studies. The 12 Task Force recommendations in this report are based on the systematic review and evaluation of these qualifying studies, all of which had good or fair quality of execution.

On the basis of the evidence of effectiveness, the Task Force either strongly recommended or recommended 11 of the 12 interventions evaluated (Table 2). These 11 include four interventions to increase use of child safety seats (i.e., laws requiring use, communitywide information and enhanced enforcement campaigns, distribution and education programs, and incentive and education programs), three interventions to increase safety belt use (i.e., laws requiring use, primary enforcement laws, and enhanced enforcement programs), and four interventions to reduce alcohol-impaired driving (i.e., 0.08% blood alcohol concentration [BAC] laws, lower BAC limit laws for young [in the United States, those under the minimum legal drinking age] and inexperienced drivers, laws requiring a minimum drinking age of 21 years, and sobriety checkpoint programs). The Task Force found insufficient evidence on which to make a recommendation regarding the 12th intervention — education-only programs to improve child safety seat use — because of inconsistencies in the curricula, target populations, and effects of reported interventions.

In addition to these 12 interventions, reviews for two additional interventions to prevent motor-vehicle occupant injury — incentive programs to increase safety belt use and intervention training for servers of alcoholic beverages — are underway and will be included in a subsequent report.

## **USE OF THE RECOMMENDATIONS IN STATES AND COMMUNITIES**

Given that motor-vehicle occupant injuries are the leading cause of death among persons aged 1–34 years in the United States (24), reducing the number of motor-vehicle crashes and crash-related occupant injuries should be relevant to most communities. States and communities can compare their current interventions and activities to prevent motor-vehicle injury with recommendations in this report, as well as with other relevant recommendations proposed by NHTSA (25), the National Transportation Safety Board\* (NTSB) (26), DHHS (19), the American Medical Association (27), and the American Academy of Pediatrics (28,29).

The Task Force recommendations can be used to support or expand child safety seat distribution programs, bolster the use of incentives, and employ enhanced enforcement campaigns, all in conjunction with communitywide education efforts. For example, the recommendation for child safety seat distribution and education programs could help a community decide to concentrate the distribution of low-cost or no-cost child safety seats in low-income neighborhoods or to seek local sponsorship to defray the costs of seats distributed to needy families. In selecting and implementing interventions, communities should strive to develop a comprehensive program to reduce

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\*Available on the Internet at <<http://www.nts.gov>>.

**TABLE 2. Recommendations from the Task Force on Community Preventive Services regarding the use of selected interventions to increase use of child safety seats, increase use of safety belts, and reduce alcohol-impaired driving**

Intervention (No. of qualifying studies)	Task Force recommendation for use	Intervention description	Key findings* Median (range), number of studies
<b>Interventions to increase child safety seat use</b>			
Child safety seat law (n=9)	Strongly recommended	Requires infants and young children traveling in motor vehicles to be restrained in federally approved child safety seats appropriate for the child's age and size. State laws vary regarding the children to whom the laws apply (e.g., according to age, height, weight, seating position, or a combination of factors).	Child safety seat use: +13% (+5% to +35%), 3 studies.  Fatal injuries: -35% (-57.3% to -25%), 3 studies.  All fatal and nonfatal injuries: -17.3% (-35.9% to -10.5%), 5 studies.
Communitywide information and enforcement campaigns (n=4)	Recommended	Use media support and child safety seat displays in public sites to promote use.  Use special enforcement strategies (e.g., checkpoints, dedicated law enforcement officials, or alternative penalties) to enforce existing child safety seat laws.	Child safety seat use: +12.3% (+3.8% to +20.8%), 5 studies.
Distribution and education programs (n=10)	Strongly recommended	Provide approved child safety seats to parents through loans, low-cost rentals, or giveaways.  Include educational components of varying intensity.	Child safety seat use: +22.6% (+4% to +62.3%), 11 studies (range of follow-up times: immediate to 2 years).
Incentive and education programs (n=4)	Recommended	Provide rewards to children and parents for purchasing and correctly using child safety seats.  Include educational components of varying intensity.	Child safety seat use: +9.9% (+4.8% to +36%), 6 studies (within first 5 months of program operation).
Education-only programs (n=6)	Insufficient evidence <sup>†</sup>	Provide information and teach skills to parents, children, or professional groups regarding the use of child safety seats.	Insufficient evidence to assess effectiveness in changing correct use or other outcomes.  Three studies of perinatal education programs for parents regarding correct use of child safety seats.

**TABLE 2. (Continued ) Recommendations from the Task Force on Community Preventive Services regarding the use of selected interventions to increase use of child safety seats, increase use of safety belts, and reduce alcohol-impaired driving**

Intervention (No. of qualifying studies)	Task Force recommendation for use	Intervention description	Key findings* Median (range), number of studies
			One study of a preschool education program for children regarding correct use of child safety seats.
			Two studies of professional education — one for nurses on implementation of patient education programs and one for law enforcement officers on citation rates.
<b>Interventions to increase safety belt use</b>			
Safety belt law (n=34)	Strongly recommended	<p>Requires the use of safety belts by motor-vehicle occupants not covered by the state’s child safety seat laws. Existing safety belt laws vary in their requirements. Most are age-based and cover occupants (usually front seat occupants) aged ≥16 years. These laws leave major gaps in coverage for occupants, primarily those aged 4–16 years.</p> <p>Specific requirements (e.g., age, seating position, fines, exceptions) vary by state.</p> <p>Studies assessed laws in the United States.</p>	<p>Observed safety belt use: +32% (+19.6% to +36.3%), 9 studies.</p> <p>Self-reported safety belt use: +15.8% (+13% to +18.7%), 4 studies.</p> <p>Police-reported safety belt use: +20.4% and +26%, 2 studies.</p> <p>Nonfatal injuries: -3.5% (-14.5% to +10.6%), 6 studies.</p> <p>Fatal injuries: -8.4% (-9% to -5%), 7 studies.</p> <p>Fatal and nonfatal injuries: -8.3% (-19.7% to -2.6%), 9 studies.</p>
Primary enforcement law (n=13)	Strongly recommended (instead of secondary law)	<p>Primary enforcement law allows a police officer to stop a vehicle solely for an observed belt law violation (without having other reasons for stopping the vehicle).</p> <p>Secondary enforcement law allows a police officer to issue a belt law citation only if the vehicle has been stopped for another violation.</p>	<p><b>Primary laws compared with secondary laws</b> Observed safety belt use: +14.1% (+12% to +22.6%), 5 studies.</p> <p>Self-reported safety belt use: +22% and +1%, 2 studies.</p> <p>Fatal injuries: -7.7% (-13.9% to -3.1%), 3 studies.</p>

**TABLE 2. (Continued ) Recommendations from the Task Force on Community Preventive Services regarding the use of selected interventions to increase use of child safety seats, increase use of safety belts, and reduce alcohol-impaired driving**

Intervention (No. of qualifying studies)	Task Force recommendation for use	Intervention description	Key findings* Median (range), number of studies
Enhanced enforcement (n=16)	Strongly recommended	Increased, rather than routine, enforcement at specific locations and times to target violations of safety belt laws.  Media campaigns that publicize the enforcement activity are an important component.	Observed safety belt use: +17% (+8.3% to +24.0%), 16 studies.  Fatal and nonfatal injuries: -6.7% and -15.3%, 2 studies.
<b>Interventions to reduce alcohol-impaired driving</b>			
0.08% blood alcohol con- centration (BAC) law (n=9)	Strongly recommended	Lowers the BAC at which it is illegal to drive a motor vehicle from 0.10 g/dL to 0.08 g/dL (0.08%).	Alcohol-related fatal crash outcomes: -7% (-15% to -4%), 25 measures.
Minimum legal drinking age (MLDA) (n=33)	Strongly recommended (i.e., maintaining MLDA at age 21 years)	Specifies an age below which the purchase or consumption of alcoholic beverages are not permitted.	<p><b>Among the targeted age group</b></p> <p><u>Raising the MLDA</u> Fatal crashes: -17% (-30% to -7%), 9 studies. Injury crashes: -15% (-33% to -6%), 4 studies. Other crashes: -21% and -18%, 2 studies. Fatal crash outcomes: -12% (-17% to -8%), estimated from 9 regression-based studies.</p> <p><u>Lowering the MLDA</u> Fatal crashes: +8% (+2% to +38%), 3 studies. Injury crashes: +5% (-2% to +22%), 4 studies. Other crashes: +22% and +186%, 2 studies.</p> <p>Insufficient evidence regarding the impact of raising the MLDA on alcohol-related crashes among adolescent drivers not directly affected by the law change.</p>
Lower BAC for young and inexperienced drivers (n=6)	Recommended	Establishes a separate, lower illegal BAC (usually ≥0.02 g/dL) for drivers targeted by the law.  Studies assessed changes in state laws in the United States and Australia. U.S. laws apply to all drivers under the MLDA. In other countries, laws apply to either newly licensed drivers or newly licensed drivers under a specified age.	Alcohol-related fatal crashes: -17% (-24% to -9%), 3 studies.  Injury crashes: -17% and -4%, 2 studies.  Other crashes: -11%, 1 study.

**TABLE 2. (Continued ) Recommendations from the Task Force on Community Preventive Services regarding the use of selected interventions to increase use of child safety seats, increase use of safety belts, and reduce alcohol-impaired driving**

Intervention (No. of qualifying studies)	Task Force recommendation for use	Intervention description	Key findings* Median (range), number of studies
Sobriety checkpoints (n=23)	Strongly recommended	<p>At random breath testing (RBT) checkpoints, all drivers stopped are given breath tests for BAC. Such checkpoints are not conducted in the United States.</p> <p>At selective breath testing (SBT) checkpoints, police must have reason to suspect the driver has been drinking before using breath tests.</p> <p>Media campaigns that publicize the enforcement activity are an important intervention component.</p>	<p><b>Random Breath Testing (RBT)</b> Fatal crashes: -22% (-36% to -13%), 6 studies. Injury crash outcomes: -18% (-21% to -12%), 11 studies. Other crashes: -26% and -15%, 2 studies.</p> <p><b>Selective Breath Testing (SBT)</b> Fatal crashes: -26% and -20%, 2 studies. Injury crashes: -21% (-24% to -5%), 6 studies. Other crashes: -24% (-35% to -13%), 5 studies.</p> <p>No discernible differences in effectiveness between RBT and SBT checkpoints.</p> <p>Similar magnitude of effects at long-term (&gt;1 year) and short-term (≤1 year) follow-up.</p>

\* Median effect sizes are a) absolute percentage point differences for all measures of child safety seat use and safety belt use and b) relative percent changes for all measures of injuries, crashes, and crash outcomes. When <7 studies are available, the range represents the entire range of effect measures identified; for ≥7 studies, an interquartile range is presented.

† A determination that evidence is insufficient should not be seen as evidence of ineffectiveness. A determination of insufficient evidence helps identify a) areas of uncertainty regarding effectiveness of an intervention and b) specific continuing research needs. In contrast, evidence of ineffectiveness leads to a recommendation that the intervention not be used.

motor-vehicle occupant injuries that includes legislation, enforcement, public education, training, and other community-oriented strategies. Improvements in each category will contribute to reductions in occupant-injury-related morbidity and mortality, and success in one area could contribute to improvements in the other areas.

The Task Force recommended or strongly recommended six state public health laws. Of these, three are in effect in all 50 states (i.e., laws requiring use of child safety seats, lower legal BAC for young or inexperienced drivers, and a minimum legal drinking age of 21 years). In addition, 49 states have laws requiring use of safety belts (New Hampshire has no such law).

Other laws reviewed by the Task Force were 0.08% BAC and primary enforcement safety belt laws. As of March 2001, 0.08% BAC laws had been enacted in 21 states, Washington, D.C., and Puerto Rico, and primary enforcement laws were in effect in 17 states, Washington, D.C., and Puerto Rico. In support of 0.08% BAC laws, the U.S. Congress included a provision in the 2001 Department of Transportation and Related Agencies Appropriations Act (30) requiring states to implement 0.08% BAC laws by fiscal year 2004 or risk losing federal highway construction funds.

The Task Force recommendations can be used to promote the adoption, maintenance, or strengthening of state or national laws or regulations. For example, at the state level, injury control program directors can use these recommendations to develop testimony regarding the evidence of effectiveness of different traffic safety laws for presentation to state legislatures. State legislators and their staff members can use the recommendations as they draft, debate, and vote on new or amended legislation. Advocacy and community groups can use the information to develop position statements regarding pending legislation at the state level. Health agencies can help educate the community regarding the importance and effectiveness of the laws and their enforcement.

Choosing effective interventions that are well-matched to state and local needs and capabilities, then carefully implementing those interventions, are vital steps in improving use of child safety seats and use of safety belts and in deterring alcohol-impaired driving. In setting priorities for the selection of interventions to meet local objectives, recommendations and other evidence provided in the *Community Guide* should be considered along with such local information as resource availability, administrative structures, and the economic, social, and regulatory environments of available organizations and practitioners. Involving other partners in these efforts could be useful. Examples of such partners are each state's Governor's Office of Highway Safety or local chapters of the National SAFE KIDS Campaign, available on the Internet at <<http://www.safekids.org>>; the National Safety Council, <<http://www.nsc.org>>; and Mothers Against Drunk Driving, <<http://www.madd.org>>. Additional information regarding applicability and economic information will be provided in the full report. Taking into consideration local goals and resources, the use of strongly recommended and recommended interventions should be given priority for implementation or enforcement.

## **ADDITIONAL INFORMATION REGARDING THE *COMMUNITY GUIDE***

During 2001–2002, *Community Guide* topics will be prepared and released as each is completed. Upcoming topics include diabetes, oral health, physical activity, sexual

behavior, cancer, and the sociocultural environment. A compilation of the recommendations and supporting evidence for these topics will be published in book form. Additional information regarding the Task Force and the *Community Guide* is available on the Internet at <<http://www.thecommunityguide.org>>.

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