Counseling about Proper Use of Motor Vehicle Occupant Restraints and Avoidance of Alcohol Use while Driving: U.S. Preventive Services Task Force Recommendation Statement

**U.S. Preventive Services Task Force**

**Description:** An assessment of the independent effectiveness of primary care interventions to increase the proper use of child safety seats, booster seats, and lap-and-shoulder belts to prevent motor vehicle occupant injuries (MVOIs) and to prevent alcohol-related MVOIs in adolescents and adults.

**Methods:** The U.S. Preventive Services Task Force reviewed evidence on the effectiveness of counseling in primary care about the proper use of child restraints in motor vehicles to prevent injury, as well as evidence on the impact of primary care counseling to prevent alcohol-related MVOIs in adolescents and adults. This included information gathered in the process of making their 1996 recommendation, as well as the accompanying systematic review of English-language articles published through 2005.

**Recommendation:** Current evidence is insufficient to assess the incremental benefits, beyond the efficacy of legislation and community-based interventions, of counseling in the primary care setting to improve rates of proper use of motor vehicle occupant restraints. (I statement)

Current evidence is insufficient to assess the balance of benefits and harms of routine counseling of all patients in the primary care setting to reduce driving while under the influence of alcohol or riding with drivers who are alcohol-impaired. (I statement)


*For a list of members of the U.S. Preventive Services Task Force, see the Appendix (available at www.annals.org).*

**INTRODUCTION**

The U.S. Preventive Services Task Force (USPSTF) makes recommendations about preventive care services for patients without recognized signs or symptoms of the target condition.

It bases its recommendations on a systematic review of the evidence of the benefits and harms and an assessment of the net benefit of the service.

The USPSTF recognizes that clinical or policy decisions involve more considerations than this body of evidence alone. Clinicians and policymakers should understand the evidence but individualize decision making to the specific patient or situation.

**SUMMARY OF RECOMMENDATIONS AND EVIDENCE**

**Recommendation 1: Counseling about Proper Use of Motor Vehicle Occupant Restraints to Prevent MVOIs**

The USPSTF concludes that the current evidence is insufficient to assess the incremental benefit, beyond the efficacy of legislation and community-based interventions, of counseling in the primary care setting, in improving rates of proper use of motor vehicle occupant restraints (child safety seats, booster seats, and lap-and-shoulder belts). (See the Clinical Considerations section for definitions of proper use.) This is an I statement.
**Clinical Guidelines**

**Rationale**

**Importance.** Motor vehicle occupant injury is the leading cause of death in U.S. children, adolescents, and young adults age 3 to 33 years and of unintentional injury-related deaths for persons of all ages. Proper use of motor vehicle occupant restraints (child safety seats, booster seats, and lap-and-shoulder belts) is associated with a 45% to 70% reduction of fatality risk. Improper use reduces the efficacy of restraints substantially.

**Recognition of behavior.** Approximately 80% of adults use seat belts. General use of child safety seats is 90%, and booster seat use is rapidly increasing. However, proper use of child safety seats and booster seats in infants and children is low.

**Effectiveness of counseling to change behavior.** Legislation and community-based interventions along with counseling in primary care settings have dramatically increased the use of motor vehicle occupant restraints and have reduced the incidence of MVOIs in all populations. However, the incremental benefit of primary care counseling for general restraint use in the context of legislation and community interventions is unknown. There is insufficient evidence addressing the efficacy of counseling in the primary care setting to increase the proper use of motor vehicle occupant restraints in the current high-use environment. This constitutes a critical gap in the evidence for counseling.

**Harms of counseling.** There is no evidence addressing the harms of counseling; however, these potential harms are estimated to be none or minimal in magnitude.

**USPSTF assessment.** The USPSTF concludes that current evidence is insufficient to assess the net benefit of counseling interventions in primary care settings to increase proper use of motor vehicle occupant restraints to reduce MVOIs in children, adolescents, and adults.

**Recommendation 2: Counseling to Prevent Alcohol-Related MVOI in Adolescents and Adults**

The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of routine counseling of all patients in the primary care setting to reduce driving while under the influence of alcohol or riding with drivers who are alcohol-impaired. This is an I statement.

**Rationale**

**Importance.** Alcohol use is involved in nearly 40% of all traffic-related fatalities.

**Effectiveness of counseling to change behavior.** There is evidence that screening for misuse of alcohol and targeted counseling of those persons who screen positive reduce alcohol consumption and alcohol-related MVOI. However, there is a critical gap in the evidence of the efficacy of behavioral counseling interventions directed to all patients in the primary care setting to reduce driving while under the influence of alcohol or riding with drivers who are alcohol-impaired.

**Harms of counseling.** There is no evidence addressing the harms of counseling to prevent alcohol-related MVOI; however, these potential harms are estimated to be none or minimal in magnitude.

**USPSTF assessment.** The USPSTF concludes that the evidence is insufficient to assess the net benefit of universal counseling in the primary care setting (in the absence of screening and targeted counseling) to reduce the incidence of alcohol-related MVOI.

**Clinical Considerations**

**Patient Population**

This recommendation refers to behavioral counseling interventions performed in the primary care setting, addressing parents of all infants and children, children, adolescents, and adults.

**Elements of Effective Counseling Interventions**

The injury prevention benefits of child safety seat and booster seat use require proper use. (That is, the seats should be age- and weight-appropriate and should be installed and placed into the vehicle correctly.) Infants younger than 1 year of age and weighing fewer than 20 pounds should be placed in rear-facing, infant-only car safety seats or convertible seats positioned in the back seat. Infants younger than 1 year of age and weighing between 20 and 35 pounds should be placed in rear-facing convertible seats positioned in the back seat. Rear-facing child safety seats must not be placed in the front passenger seat of any vehicle that is equipped with an airbag on the front passenger side. Death or serious injury can result from the impact of the airbag against the child safety seat. Toddlers 1 to 4 years of age weighing 20 to 40 pounds should be restrained in a forward-facing convertible seat or forward-facing–only seat positioned in the back seat. Young children 4 to 8 years of age and up to 4’9” (57 inches) in height should be placed in a booster seat in the back seat. After this age (or height), lap-and-shoulder belt use is appropriate. Children younger than 13 years of age should sit in the back seat with lap-and-shoulder belts.

Behavioral counseling interventions that include an educational component, as well as a demonstration of use or a distribution component, are more effective than those that include education alone.

**Other Approaches to Prevention**

Clinical counseling in conjunction with community-based interventions has been effective in increasing proper use of child safety seats. Over the past decade, legislation and enforcement have contributed substantially to the increasing trends in child safety seat and seat belt use. A comprehensive strategy that includes community-based interventions, primary care counseling in the primary care setting, legislation, and enforcement is critical to the improvement of proper safety restraint use and decrease in the incidence of MVOI.
Recommendations can be accessed at www.preventiveservices.ahrq.gov.

**Primary care counseling for proper use of motor vehicle occupant restraints.**

Multiple interventions in these areas have been recommended:

- Reducing alcohol-impaired driving
- Increasing the use of safety belts
- Increasing the proper use of child safety seats

Interventions to reduce motor vehicle occupant injuries, focused on 3 strategic areas:

- The Guide to Community Preventive Services has reviewed evidence of the effectiveness of selected population-based interventions to improve the proper use of car seats, booster seats, and seat belts.
- There is good evidence that community and public health interventions, including enforcement campaigns, seat belt distribution campaigns, media campaigns, and other community-based interventions, are effective in improving the proper use of car seats, booster seats, and seat belts.
- Current evidence is insufficient to assess the incremental benefit of counseling in primary care settings beyond increases in improving the proper use of car seats, booster seats, and seat belts.
- Links between primary care and community interventions are critical for improving proper use of car seat.

CDC = Centers for Disease Control and Prevention.

**Recommendation**

- Consultation for proper use of motor vehicle occupant restraints

**Population**

- General Primary Care Population

**Grade: Insufficient Evidence**

No recommendation
**Table 1. What the U.S. Preventive Services Task Force Grades Mean and Suggestions for Practice**

<table>
<thead>
<tr>
<th>Grade</th>
<th>Definition</th>
<th>Suggestions for Practice</th>
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<tbody>
<tr>
<td>A</td>
<td>The USPSTF recommends the service. There is high certainty that the net benefit is substantial.</td>
<td>Offer or provide this service.</td>
</tr>
<tr>
<td>B</td>
<td>The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is small.</td>
<td>Offer or provide this service.</td>
</tr>
<tr>
<td>C</td>
<td>The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is moderate or high certainty that the net benefit is small.</td>
<td>Offer or provide this service only if other considerations support offering or providing the service in an individual patient.</td>
</tr>
<tr>
<td>D</td>
<td>The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.</td>
<td>Discourage the use of this service.</td>
</tr>
<tr>
<td>I statement</td>
<td>The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.</td>
<td>Read the clinical considerations section of USPSTF Recommendation Statement. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms.</td>
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* The U.S. Preventive Services Task Force (USPSTF) defines certainty as "likelihood that the USPSTF assessment of the net benefit of a preventive service is correct." The net benefit is defined as benefit minus harm of the preventive service as implemented in a general, primary care population. The USPSTF assigns a certainty level based on the nature of the overall evidence available to assess the net benefit of a preventive service. USPSTF = U.S. Preventive Services Task Force.

**Table 2. U.S. Preventive Services Task Force Levels of Certainty Regarding Net Benefit**

<table>
<thead>
<tr>
<th>Level of Certainty*</th>
<th>Description</th>
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<tr>
<td>High</td>
<td>The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.</td>
</tr>
<tr>
<td>Moderate</td>
<td>The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by such factors as: the number, size, or quality of individual studies inconsistency of findings across individual studies limited generalizability of findings to routine primary care practice lack of coherence in the chain of evidence. As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.</td>
</tr>
<tr>
<td>Low</td>
<td>The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of: the limited number or size of studies important flaws in study design or methods inconsistency of findings across individual studies gaps in the chain of evidence findings that are not generalizable to routine primary care practice a lack of information on important health outcomes. More information may allow an estimation of effects on health outcomes.</td>
</tr>
</tbody>
</table>

* The U.S. Preventive Services Task Force (USPSTF) defines certainty as "likelihood that the USPSTF assessment of the net benefit of a preventive service is correct." The net benefit is defined as benefit minus harm of the preventive service as implemented in a general, primary care population. The USPSTF assigns a certainty level based on the nature of the overall evidence available to assess the net benefit of a preventive service.
Other Relevant USPSTF Recommendations

The USPSTF currently recommends screening for alcohol misuse and counseling targeted to those patients identified as risky or harmful drinkers (1).

OTHER CONSIDERATIONS

Implementation

There is good evidence that community and public health interventions, including legislation, law enforcement campaigns, car seat distribution campaigns, media campaigns, and other community-based interventions, are effective in improving proper use of child safety seats, booster seats, and seat belts.

Links between primary care and community interventions are critical for improving proper child safety seat, booster seat, and seat belt use.

Research Needs

On the basis of the effectiveness of legislation and community-based interventions in increasing child safety seat and seat belt use, increasing booster seat use will probably require similar interventions. Randomized, controlled trials (RCTs) of counseling interventions are needed to clarify the effectiveness of counseling parents and children in the primary care setting to improve proper use of child safety and booster seats.

DISCUSSION

Burden of Disease

Motor vehicle–related injuries are the leading cause of death for children, adolescents, and young adults between 3 and 33 years of age in the United States and of unintentional injury-related deaths for persons of all ages. Adolescent and young adult drivers have the highest MVOI fatality rates, even when controlling for vehicle miles traveled. Increasing the use of occupant restraint devices, such as child safety seats and lap-and-shoulder safety belts, and reducing alcohol-impaired driving are among the most important behavioral methods to reduce motor vehicle–related deaths (2).

The rising prevalence of restraint use over the past decade is considered a public health success (3). A combination of public health interventions, including state legislation, media campaigns, and primary care counseling, has contributed to this increase in child safety seat and adult lap-and-shoulder belt use. In the mid-1990s, state regulations mandating child safety seat and lap-and-shoulder belt use were put into place. All 50 states currently have laws requiring safety seats for infants and children, and 49 states and the District of Columbia have adult seat belt use laws, but only half of the states that have these child safety laws include guidance for children 4 to 8 years of age in booster seats. State legislation largely varies, such as permitted unrestrained travel for different specific circumstances or the inability of drivers to receive a citation from the police unless they have been stopped for another traffic violation. States with primary enforcement have increased restraint use by 12% to 23% and have decreased motor vehicle–related fatality rates.

The current prevalence of restraint use is more than 90% for children 1 to 3 years of age; however, proper use of car seats in infants and children is estimated to be only 20% (4, 5). For children 4 to 8 years of age, booster seat use is less prevalent—premature advancement to seat belts occurs, leading to an increased risk for injuries (2). When used correctly, child safety seats reduce fatality risk by more than 70% for infants up to 1 year of age and 54% for children 1 to 4 years of age (2). Variation in restraint use depends on the occupant’s sex, age, seating position, economic status, race, and ethnicity. Restraint use for children younger than 9 years of age is complicated by the additional need to correctly use the age-appropriate car safety seat or belt-positioning booster seat (5). Between 20% and 84% of the time, misuse is severe enough to compromise the effectiveness of the child safety seat or booster seat.

Alcohol use plays an important role in motor vehicle–related fatalities. Thirty-nine percent of MVOI deaths in individuals 3 to 34 years of age are related to alcohol. More than 80% of alcohol-impaired driving episodes reported by people also include binge drinking (6). Evidence from multiple time-series studies demonstrates that raising the legal drinking age or lowering legal blood concentration limits can statistically significantly reduce alcohol-related, fatal crashes (2).

Effectiveness of Counseling to Change Behavior

There is fair-quality evidence from 1 group-level controlled clinical trial (CCT) that a combination of community and clinical interventions aimed at increasing the correct use of restraints reduces the risk for MVOI by 39.2 injuries per 10 000 children per year; however, the independent contribution of the primary care counseling interventions could not be determined. On the basis of 13 CCTs and RCTs, there is fair-quality evidence that, among infants and children up to age 4 years, behavioral counseling interventions are effective in increasing short-term, correct use of infant and child safety seats at the time of hospital discharge or within 2 months after initially delivering the intervention (2). Two fair-quality CCTs and 2 fair- to poor-quality CCTs or RCTs demonstrated that counseling by pediatricians during well-child clinic visits increases the self-reported proper use and observed correct use of restraints for at least 2 months. Three of these studies with follow-up at 4 months or later showed no statistically significant increase in restraint use in the intervention group compared with the control group (7–9). One fair- to poor-quality group-level RCT demonstrated that well-child clinic education in addition to coercion, incentives, and rewards by nonphysician primary care clinic staff and health educators results in a 10% higher rate of observed infant and child safety seat use at 12 months after program
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initiation in the intervention group compared with the control group that received usual well-child clinic education only (10). Investigators of 1 fair- to poor-quality RCT and 1 fair-quality RCT evaluated the effect of counseling pregnant women during the last trimester of pregnancy and measured self-reported use or observed correct use at discharge after delivery, at 6 to 8 weeks after delivery and discharge, or at both times. In 1 study, an intervention of education plus car seat distribution, compared with education only, resulted in an increase in observed correct use at discharge. At 6 weeks after discharge, the difference was not statistically significant. In the second trial, self-reported use at 2 months did not statistically significantly differ between a counseling education group and control group (11). Trials demonstrate that car seat distribution in addition to educational interventions provided in the inpatient peripartum setting results in greater differences in use than do educational interventions alone (2).

Two studies of counseling interventions in primary care settings for older children and adolescents have been published. One fair-quality CCT of children 5 to 19 years of age who were not wearing their seat belts en route to the office visit reported short-term improvement in observed seat belt use among the children immediately after pediatrician-delivered counseling (12). A fair-quality RCT reported no difference in seat belt use by fifth and sixth graders who received education through an office-based injury prevention program that involved counseling and a written family contract, compared with a control group that received similar information that targeted alcohol and tobacco use at 12 to 36 months (13).

No RCTs have been conducted for behavioral counseling for booster seat use in the age group of 4 to 8 years in the primary care setting. Investigators of 1 fair- to poor-quality RCT evaluated booster seat education with and without distribution of a free booster seat in the emergency department (14). The study demonstrated high self-reported use in the education plus distribution or installation group compared with education only and control groups; however, it has limitations in internal and external validity. A 2006 Cochrane Collaboration meta-analysis demonstrated that interventions outside of the primary care setting that included distribution and education, incentives and education, and enforcement components resulted in 2-fold increases in the use of booster seats (15).

One RCT addressed the effects of counseling adults to use seat belts. Investigators of this fair- to poor-quality RCT studied adults who watched a 6-minute film, and they compared self-reported seat belt use at 6 months between the group that watched a film on seat belt use and the group who watched a film of comparable length that did not mention seat belt use (16). Self-reported seat belt use increased equally in both the control and treatment groups. However, strong evidence suggests that safety belt laws, primary enforcement strategies, and enhanced enforcement strategies increase seat belt use (17).

No evidence has addressed the effect of behavioral counseling interventions delivered to all patients in the primary care setting in reducing driving while under the influence of alcohol or riding with an alcohol-impaired driver.

Potential Harms of Counseling

There is no evidence on harms of counseling in the primary care setting, with respect to the use of age- and weight-appropriate restraints or the avoidance of driving while under the influence or riding with alcohol-impaired drivers. Potential harms are estimated to be none to minimal in magnitude.

Recommendations of Other Groups

The Centers for Disease Control and Prevention’s Guide to Community Preventive Services (18), known as “The Community Guide,” recommends child safety seat use laws, community-wide information and enhanced enforcement campaigns, and distribution or incentive programs plus education programs to increase safety seat use in infants and children. The Community Guide recommends safety belt legislation, primary enforcement laws, and enhanced enforcement programs to increase seat belt use in adolescents and adults. The Community Guide recommends 0.08 blood alcohol concentration laws, lower blood alcohol concentration laws for young drivers, minimum legal drinking age laws, sobriety checkpoints, mass media campaigns, school-based programs, and alcohol server intervention training programs.

The American Academy of Family Physicians supports the counseling of all parents and patients older than 2 years of age about accidental injury prevention, including the use of child safety seats and lap-and-shoulder belts; encourages the development of uniform standardized tests to determine alcohol or drug impairment in all U.S. states; and encourages its members to take an active role in developing strategies to promote the increased use and availability of restraint systems, including air bags. The American Academy of Family Physicians also supports primary enforcement of occupant restraint system legislation, encourages authorities to document the use of occupant restraint systems, and encourages the media to report use as appropriate (19).

The American Medical Association supports mandatory seat belt use laws that do not simultaneously relieve automobile manufacturers of their responsibility to install passive restraints and supports education of state medical societies about these laws; discussion of MVOIs between physicians and their patients; and the use of active, approved restraints for both adults and children (20).

The American Academy of Pediatrics recommends that clinicians provide up-to-date, appropriate information for parents on car safety seat choices and proper use (21).

The American College of Obstetricians and Gynecologists recommends that clinicians counsel all women on the use of seat belts; that pregnant women be counseled on
proper seat belt fit during pregnancy and proper use of a car seat for their infant; and that adolescent women be counseled to avoid driving or other situations requiring full attention after drinking or riding with a driver who has been drinking (22–25).

The National Highway Traffic Safety Administration (www.nhtsa.gov) recommends education, training, enforcement, outreach, and legislation to increase proper restraint use by children, adolescents, and adults. It recommends community and legislative interventions for and screening and clinical counseling of patients who drink heavily to reduce alcohol- and drug-impaired driving.

From the U.S. Preventive Services Task Force, Agency for Healthcare Research and Quality, Rockville, Maryland.

Disclaimer: Recommendations made by the USPSTF are independent of the U.S. government. They should not be construed as an official position of the Agency for Healthcare Research and Quality or the U.S. Department of Health and Human Services.

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Requests for Single Reprints: Reprints are available from the USPSTF.

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References


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†This list includes members of the Task Force at the time this recommendation was finalized. For a list of current Task Force members, go to www.ahrq.gov/clinic/uspsxftab.htm.