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ZEROING IN ON REPEAT OFFENDERS
REPEAT

DWI

NATIONAL COMMISSION AGAINST DRUNK DRIVING

CONFERENCE ON RECIDIVISM

Atlanta, Georgia
September 16, 1986

A Summary of the Proceedings

National Commission Against Drunk Driving

The National Commission Against Drunk Driving was established on January 1, 1984, as the successor to the Presidential Commission on Drunk Driving. Among the 30 recommendations made in its Final Report of December 1983, the Presidential Commission on Drunk Driving called for a non-governmental body to ensure a continuing focus on the national campaign against drunk driving. Governor John A. Volpe of Massachusetts served as its first chairman, as he had chaired the Presidential Commission. V.J. "Jim" Adduci is the present chairman with Lawrence H. Williford, vice chairman.

The National Commission has held state hearings on the value of administrative license revocation; tracked state activities on key legislative measures; testified in support of the age 21 drinking laws; published model programs that have proven effective as educational/preventive tools; and serves as a clearinghouse on national efforts to counter drunk driving.

WELCOME

Welcome Ladies and Gentlemen to this very important conference on the D.W.I. repeat offender problem. On behalf of the National Commission Against Drunk Driving, we want to share our enthusiasm for this forum and the opportunity to further the commission's charge to heighten public awareness of the seriousness of the drunk-driving problem and to help develop solutions.

The D.W.I. recidivism problem is one that has been comparatively neglected over the years. If we're ever going to resolve the problem of the drunk driver, we must give serious attention to the people with chronic alcohol problems driving on our highways. These people are overly represented in the 1.9 million arrests and 650,000 serious injuries and fatalities recorded each year. Today's goal is to bring to you the best available expertise and information in a way that can be integrated with the total court-support system approach. We all have a role to play: the judiciary, law enforcement, prosecutors, rehabilitation, corrections, legislators, government agencies, and private enterprise. This approach exactly parallels a major conclusion and recommendation of the Presidential Commission on Drunk Driving. I'd like to quote this brief passage from the Commission's final report to President Reagan in November 1983:

> "Because attempts to deal with the (drunk driving) problem involves a large number of governmental agencies and private groups, a ***Systems Approach*** must be employed to ensure that the activities of these groups are coordinated and interrelated smoothly to enhance their effectiveness."

Ladies and gentlemen, that quote is one of the major charges which the Presidential Commission placed in the hands of its successor organization, the National Commission Against Drunk Driving. And speaking on behalf of the Commission and today's co-sponsors, Allstate Insurance Company and the Licensed Beverage Information Council, it is our hope that this conference will prove a catalyst for enhancing the coordination, interrelationships and effectiveness of a total systems approach to the recidivism issue.

Chairman
Vincent J. Adducci
NCADD

Vice Chairman
Lawrence H. Williford
NCADD

PANELISTS

DR. VINCENT D. PISANI, a psychologist, has been the clinical director at Central States Institute of Addiction, Chicago, since 1963. He also served as consultant and associate at a number of hospitals and medical schools in the Chicago area.

Dr. Pisani has written and lectured extensively on all aspects of alcohol/social problems both in Europe and in the United States. He is a leading advocate of the systems approach to alcohol highway safety programs.

CHARLES F. LIVINGSTON has been involved in traffic and transportation safety for some 25 years. He was the first director of the Office of Alcohol Countermeasures in the U.S. Department of Transportation, where he also served as Associate Administrator of Traffic Safety Programs.

Mr. Livingston served as policy advisor to the Presidential Commission on Drunk Driving 1982-83; and in 1984 was executive director of the National Commission Against Drunk Driving, the successor body to the Presidential Commission. He is currently a consultant to the Highway Users Federation for Safety and Mobility.

DR. LEE P. ROBBINS was a principal participant in a 1983-85 study of 570 judges in six states conducted by the Department of Social Systems Science, The Wharton School, University of Pennsylvania, and a member of the American Bar Association Advisory Board on its 1984-85 Project to Evaluate DUI Laws and Sanctions. He participated in a project for Judiciary Centered Education and Redesign of the Philadelphia DUI System and was an advisor in an ongoing study on the views of juvenile judges on issues of juvenile-offender drug and alcohol abuse.

He holds degrees in economics from Harvard University and the University of Pennsylvania, is currently completing his Ph.D. dissertation and teaches part time in the Human Resource Administration Department of Temple University.

JUSTICE CHARLES L. CARNES, has been chief judge of the State Court of Fulton County since 1981. He is serving his second term in that office. Prior to joining the Court he served for 12 years as a representative in the Georgia legislature.

Judge Carnes as a lawyer, legislator and judge, has been interested in the problems relating to DWI for many years. He brings the needed experience of the court to this conference as new laws and new programs address the issue.

Conference committee assembles preceeding the day's events.
Left to right: John Grant, Project Director, National Commission Against Drunk Driving
Lieutenant J. L. Howell, Revocation and Suspension Supervisor, Georgia State Patrol
Lawrence H. Williford, Vice Chairman, National Commission Against Drunk Driving and Vice President, Corporate Relations, Allstate Insurance Company
Paul F. Gavaghan, Secretary, Licensed Beverage Information Council
Vincent D. Pisani, Ph.D., Director, Central States Institute for Addiction
Charles Carnes, Chief Judge, Fulton County, Ga.
Lee P. Robbins, Ph.D., Wharton School, University of Pennsylvania.

DUI RECIDIVISM:
IMPLICATIONS FOR PUBLIC POLICY AND INTERVENTION *

PRESENTED AT

NATIONAL COMMISSION AGAINST DRUNK DRIVING CONFERENCE ON RECIDIVISM

ATLANTA, GEORGIA

SEPTEMBER 16, 1986

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Introduction

Of the varied forms of alcohol and drug abuse in the United States, driving under the influence of alcohol or drugs (DUI) is one of the more costly to society. Intoxication is a major source of accidents, injuries, and fatalities. Driving under the influence (of alcohol or other mind/mood altering substances) is not in itself an illness. More properly, it is deviant behavior; a specific type of "improper vehicular management." Besides the irreplaceable loss of human life and the emotional costs of death and injury, there are other serious losses in the forms of property damage, time lost from work, medical expenses, and loss of the productive abilities of persons killed in highway accidents to justify more sophisticated efforts to reduce DUI.

Intoxication in any form can be a source of hazards due to the deterioration of sensorimotor function and the loss of self-control it produces. Even under ideal conditions, driving is at best a risky business because of: a) imperfect design and function of the vehicle itself; b) rather lax licensing of drivers; and c) continual overcrowding of imperfect highway systems.

When such conditions are combined with a variety of physical or emotional stress factors, including alcohol or drug abuse, the operator of a vehicle experiences an "additive stress effect" which often significantly impairs the ability to maintain control of the vehicle. Persons who are involved in this behavior come from a variety of genetic and psycho-social backgrounds.

Included among the policies aiming to solve this problem is mandatory participation in educational and therapeutic programs by persons convicted of DUI. Measures of this type do not wholly replace other sentencing options, but do provide for a less punitive approach to DUI offenders which promises to yield longer-lasting changes in behavior.

DUI is a human condition, an unacceptable misbehavior. In order to deal with it effectively, we must define and measure it. We should initially "type" the behavior, measure its "intensity," and then determine its "duration." Next we must match the appropriate existing methods and levels of intervention with the configuration of the above dimensions as they exist in a particular, unique person's genetic and psycho-social background.

Since alcohol and drug abusers are a varied population and reach therapists by a variety of paths, it is interesting to note that the DUI offender reaches intervention as a result of a legal decision. Despite the diversity of DUI referral clients, it is possible to make a few generalizations that apply to most of them. The most important of these is simply that the majority of DUI clients are not alcoholics or drug addicts. Programs of intervention designed for alcoholics or drug addicts are not necessarily suited to ***their*** needs. Rather, they need programs specifically designed for ***them.*** DUI is a serious enough social problem to compel the development of effective programs of intervention.

No program can be justified on the basis of good intentions alone. At some point in its development, efforts must be made to find out what effect it is having. In the case of DUI, the desired effect is to prevent a repeat of the offense or recidivism of offenders and, by so doing, reduce the number of offenses and the frequency of alcohol-related accidents. Empirical data are starting to become available that permit the evaluation of educational and therapeutic DUI programs.

One of these programs is the Alcohol and Drug Assessment Services program of Cook County, Illinois. This program is unusual in its explicit recognition of the diversity of DUI offenders, and its effort to provide varied services to such offenders and to place offenders in appropriate subprograms. This approach may offer a model for efforts to cope with DUI through non-punitive methods.

This presentation will review the literature on a number of topics related to DUI. Among these are the diversity of alcohol abusers, the characteristics specific to DUI offenders, the law relating to this offense and the process through which offenders come to treatment, the initial assessment of offenders, approaches to intervention, and recidivism and other criteria for evaluating DUI programs. After this overview, the Cook County program will be described in some detail and evidence will be presented as to its success. Finally, an examination will be made of a research project which analyzes the differences between first-time and multiple DUI offenders and aims at measuring the effectiveness of the various interventions designed to reduce recidivism.

Part One: Varieties of Alcohol and Substance Abusers

Popular images of alcohol and drug problems usually are cast in "either/ or" terms. Some people are "alcoholics" or "drug addicts;" other people are not and have no problems with alcohol or drugs. People who drink or use drugs and develop problems are likely to draw the boundaries of alcoholism or addiction very narrowly, keeping themselves outside such a perception as long as possible.

Other people may sometimes draw much more all-inclusive boundaries, perhaps counting everyone with any alcohol- or drug-related problems as an addict. This kind of thinking, for example, is implicit in the referral of DUI offenders, as such, to treatment programs. But, in fact, alcohol or drug abuse is much more diverse than this simple pair of opposite concepts suggests, and this diversity must be taken into account in all efforts at education and therapy.

How the spectrum of alcohol abuse is to be broken down is not universally agreed upon. Peer et al. (1982) recognize four stages in the development of alcohol consumption: alcohol as mood changer, as coping mechanism, as need, and as survival. Smart et al. (1980), on the basis of a survey of 993 subjects, divide respondents into abstainers, social drinkers, semi-dependent drinkers, and problem drinkers. McCreery (1976) distinguishes among social drinkers, dependent drinkers, and alcoholics, and notes a need for differential treatment. In parallel to this recommendation, Pisani (1967, 1969, 1977, 1982) suggests that alcohol and drug abusers can only be helped after evaluation of the bio-psycho-social deficit present and the amount of regression or deterioration generated; after such evaluation, appropriate forms of intervention must be chosen from such further possibilities as education, guidance, counseling, and therapy, each of which is suited to a specific degree of pathology.

All these systems of categories represent more or less arbitrary divisions of an underlying continuum, based on partially related variations in levels of intoxication reached, frequency of intoxication, and degree of dependence on alcohol, and possibly other variables as well. Some attempts have been made to quantify these dimensions, with ambiguous results. While Brown (1981), comparing problem drinkers, drinking drivers, and normal drivers with respect to such variables as sip size and sip frequency, finds definite differences of behavior among the three groups, Saunders and Richard (1978) observed no such differences in a study conducted in a real-life setting. In their interpretation, previously

observed differences may be due to such artifactual factors as separation of "alcoholic" and "control" groups, prior alcohol deprivation of alcoholics, measures reducing prominent aftereffects to alcoholics, and use of a hospital setting in which alcoholics are more at ease than controls. It is not at present possible to exactly quantify stages of alcohol abuse operationally.

Despite this, the existence of a spectrum of identifiable behavior is clear. And it should be recognized that DUI offenders do not necessarily occupy the far end of the spectrum. In fact, most of them are not alcoholics or drug addicts, and programs intended for alcoholics or drug addicts do not meet their needs. To design appropriate programs, it is first necessary to recognize DUI offenders as they are.

Part Two: The DUI Offender

To understand DUI offenders, it is necessary to contrast them with two other populations: alcoholics or drug addicts (many of whom are not DUI offenders) and bad drivers (some of whom are not intoxicated). The distinctive traits of the DUI population must be identified, its major subpopulations described, and its impact on highway safety measured. This effort is the necessary basis for any attempt to shape appropriate policies for highway safety.

Certainly some DUI offenders are alcoholics, but not all or most. Brown (1981) finds that DUI offenders are midway between social drinkers and problem drinkers in drinking behavior; Selzer et al. (1977), comparing alcoholics, drunk drivers, and controls, find a similar pattern of differences. Panepinto et al. (1982) explicitly point out that drunk drivers do not fit the alcoholism model, and recommend that treatment should be based on this realization. Miller et al. (1984), based on findings from a population of 2,061 DUI offenders, find that blood-alcohol levels at arrest, together with the Mortimer-Filkins test, predict alcoholism, and recommend using these to differentiate between alcoholic and non-alcoholic offenders in making treatment decisions. Richman (1985) also notes the distinction between alcoholics and drinking drivers.

Nor can all problem drivers be assumed to have abused alcohol. Donovan, Marlatt, and Salzberg (1983) specify five main antecedents of traffic accidents, of which alcohol is only one, the other four being

demographic variables, personality traits, emotional distress, and driving attitudes. They see abuse of alcohol and personality factors as independent codeterminants of risky driving. Donovan, Queisser, Salzberg, and Umlauf (1985) report differences between DUI offenders and high-risk drivers on drinking behavior, driving-related attitudes, and demographic characteristics, while noting that the two are similar in personality traits and hostility. Scoles, Fine, and Steer (1984), in a study of 124 high-risk drivers, found that nearly 50% did have alcohol problems; the others, however, did not. Richman (1985), in a description of typical DUI-related accidents, states that these commonly are single-vehicle crashes, whereas other accidents are seldom of this type.

Nonetheless, DUI is a major factor in the etiology of traffic accidents. Richmond (1985) estimates that 31% of fatal accidents involved drinking drivers. Similarly, Donovan et al. (1983) report that one-third of injuries and one-half of fatalities are related to alcohol abuse. Sutton (1983) describes the impairment following use of alcohol or of alcohol in combination with marijuana, an especially lethal combination. A general profile of the DUI offender is provided by McCord (1984), who contrasts 36 men convicted of DUI with 430 men from similar backgrounds without such convictions. DUI offenders often gave evidence of histories of alcoholism or of serious criminal behavior. The two groups were distinguished by how often they had been in trouble due to drinking, their self-confidence, and their expression of anger through action rather than words. McCord argues that drunken drivers can be considered as markedly different from other people, and their offenses as far from isolated incidents. It should be noted, however, that McCord's total population was derived from boys who had taken part in a youth program started in 1936 as an attempt to prevent delinquency; this may not be representative of the full population from which DUI offenders are drawn.

Scoles and Fine (1977) note the diversity of DUI offenders as a major obstacle to successful intervention. McGuire (1982) specifically points out that programs which have a favorable impact on light drinkers can be unsuited to heavier drinkers. Steer et al. (1979) present a cluster analysis that distinguishes among seven types of DUI offenders, each of which requires a different form of intervention.

In examinations of more specific populations, Kern et al. (1977), comparing drivers who complete an alcohol education program with those who drop out, find that dropping out is associated with non-white

ethnicity, lower age, and higher blood-alcohol content when arrested. Christmas (1978) suggests that existing alcoholism services are often more suited to the white middle class, and not for minorities; this point may also be applicable to DUI offenders. Wechsler et al. (1984), drawing on data from 623 tenth-grade Boston residents, note that DUI behavior is frequent and that many of their subjects were not aware of its danger. Well-Parker et al. (1983) describe distinctive characteristics of older DUI offenders, many of whom have been free of problems of this type until the occurrence in their lives of stressful events such as retirement or loss of spouse. Meck and Baither (1980) report that under-26 offenders have greater perceived maladjustment and emotional upset and suggest that they have differential treatment needs. Selzer et al. (1977) report that the similarity between alcoholics and DUI offenders varies with age and with which characteristic is being examined. These findings give reasons to recognize differences based on ethnicity and age among DUI offenders; sex and social class/status differences may also be relevant.

From these varied studies, two conclusions emerge: first, that DUI offenders and chronic alcohol or substance abusers cannot simply be equated; second, that DUI offenders are far from a homogeneous population, but have differing characteristics and problems. Both these conclusions have important implications for the design of thereaupeutic interventions for offenders.

Part Three: DUI and the Law

The traditional response of society to DUI has been punitive, relying on court-ordered sanctions such as fines and jail sentences. With the recent growth of concern regarding DUI, such measures have regained public support, and have been mandated by new laws in a number of states. Such laws are typically justified within the conceptual framework of deterrence theory, and their success has been evaluated on that basis in a number of studies.

Beshai (1984), discussing the first year of implementation of a tougher DUI law in California, states that driving behavior appears to have improved. Salzberg and Paulsrude (1984), examining a similar law in Washington state, under which DUI was defined legally as 0.10% or higher blood alcohol and mandatory jail sentences were imposed, do not find that DUI is deterred by such sentences, and suggest that licensing sanctions may be sufficient. Another Washington study, by Grube and Kearney (1983), finds that mandatory two-day jail sentences for DUI offenders in Yakima, Washington, while well received by law enforcement officials and by the public, did not reduce the involvement of alcohol in accidents. A program of intensive law enforcement in a Wisconsin city, described by Sykes (1984), in contrast, is reported as having reduced DUI over a six-month period.

In a more philosophical examination of the issue, Ross (1984) argues that there are two possible approaches to deterrence: increased certainty and increased severity of penalties. Of these, increased severity appears to have little effect. Increased certainty produces short-term improvements but no long-term changes, apparently because the actual costs of raising certainty to meaningful levels are too high; as the public comes to perceive that the chances of avoiding apprehension are still high, behavior returns to its previous pattern. A second paper by Ross (1985) notes that increased severity is ineffective partly because the criminal justice system shifts homeostatically to maintain penalties at a level felt by the public to be reasonable, even if this means informal reinterpretations that distort the system's workings. Further, Ross suggests here, the present orientation of many DUI offenders makes deterrence less effective against them. An earlier paper also by Ross (1983) complements this argument by pointing out that drunk driving is "normal behavior" in the United States, making enforcement of laws against it an uncertain enterprise. Ross calls for changes in technology to make accidents less destructive.

On the subject of public attitudes, Gusfield (1985) makes a contrary point, arguing that DUI offenders are in fact typically perceived punitively. Gusfield points out that driving when seriously fatigued, which can produce impairment as great as DUI, is typically not subject to penalties nearly as severe. In fact, though, these two sets of attitudes may combine in a peculiar symbiosis: On the one hand, public condemnation of drunk drivers may be expressed in the abstract through harshly punitive laws that gratify the wish to take action against them; on the other, individual offenders brought to trial may face a sympathy and tolerance that work to reduce the penalties actually imposed upon them. By formally stating strict rules that in practice can often be made less strict, the public is able to satisfy both sides of its arguably ambivalent feelings about alcohol and driving.

At least one form of penalty, however, seems to offer benefits apart from deterrence: licensing sanctions. Williams et al. (1984), on the basis of data on 1,111 DUI offenders who received license suspensions, found that 65% of them drove, but that 65% of those who drove displayed reduced and more careful driving. The higher sanctions attendant upon unlicensed drivers' offenses may work to improve their behavior; and, in addition, roughly one-third of these offenders are taken off the roads. These measures need not be interpreted as aimed at deterring the general public; their effect is to improve the behavior of individuals already known to have driven while intoxicated.

Sanctions of this type may indeed profitably be combined with another approach, which is increasingly gaining favor: the education and rehabilitative treating of DUI offenders. Hart (1977) describes the creation of 35 Alcohol Safety Action Projects by the U.S. Department of Transportation; the aim of these projects was to have drivers sentenced to accept treatment and education as an alternaive to license revocation. But these two approaches need not be incompatible. McCarty et al. (1985) discuss an approach taken in Massachusetts that managed to harmonize them. Under this approach, a new sentencing option was provided for DUI cases: Judges could continue cases without a finding by placing defendants on one-year probation and assigning them to driver alcohol-education programs based on the Alcohol Safety Action Project model. In this approach, the probability of sanctions being imposed following an arrest was increased, but at the same time the sanctions were often rehabilitative rather than punitive in character. The results of this change in the law were increased DUI arrests, but reduced three-year recidivism.

In other words, court-mandated treatment or education can not only provide beneficial effects in itself for many offenders, but also can aid in the deterrent goals of the legal system. By making penalties less severe, it makes them more likely to be imposed; moreover, it gives offenders a highly focused incentive to change their behavior after they have been apprehended. The role of legal and rehabilitative measures need not be antagonistic, but can be complementary.

Part Four: Assessment

The first stage in programs directed to DUI offenders must be evaluation of the individual offenders and their needs. Not all offenders are the same; what helps one may be useless for another, or may even evoke active resistance.

One means of such assessment has been developed by Skinner and Allen (1982): a scale designed to measure the degree of alcohol dependence in a given client. Their test of this scale with 225 subjects revealed high internal consistency. A high score was typically associated with more drinking, social consequences from drinking, psychopathology, physical symptoms, and failure to keep appointments with the therapist. Since variation in level of dependence is one of the crucial variables affecting treatment of DUI offenders, this scale is potentially very useful for such treatment.

Miller et al. (1984) describe another means of measuring this variable: the combined use of the blood alcohol count at time of arrest and the Mortimer-Filkins test. These two measures, they report, are highly predictive of recommendations that DUI offenders be advised to undergo treament for alcoholism. Wendling and Kolody (1982) do not find the Mortimer-Filkins test an effective predictor or recidivism among DUI offenders, but this does not invalidate its use for other purposes, including measurement of alcohol dependence. There is no implausibility in supposing that offenders with differing dependence levels are roughly equally likely to recidivate, and this supposition would account for these two findings.

Gurnack (1984) describes experience in the application of alcohol assessment to drunk drivers, following the passage of a Wisconsin law that makes such assessment mandatory. Out of a total of 1,326 completed assessments, 76% were interpreted as showing irresponsible use of alcohol, and only 24% as showing actual dependency. However, 64% of offenders were sent to a group dynamics and traffic-safety school program, and 36% to treatment, primarily because repeat offenders were sent to treatment whether or not they were found to be alcohol dependent. The typical person referred to treatment was a repeat offender and had a relatively high blood alcohol concentration when arrested. Gurnack finds this approach superior to systems that do not provide for mandatory psychological assessment in suiting treatment to needs.

Neff and Landrum (1983) report on the use of another instrument, the Current Status version of the Life Activities Inventory. Interestingly, they report that simply completing this questionnaire, without any other form of intervention, appears to reduce recidivism among lower-risk DUI offenders.

In sum, the need to start intervention by finding out what individual offenders' conditions and needs are is being increasingly recognized. No one means of accomplishing this is universally favored, but a variety of methods are being tested. It can be hoped that some assessment procedure will win general acceptance in the future.

Audience listening to presentations.

Part Five: Interventions

A primary fact to be noted in designing DUI programs is that clients' involvement in such programs is almost never wholly voluntary. Vogler et al. (1976) found 75% of a group of clients to have been referred for treatment through the legal system. This has been noted above, in Part Three, but it has implications that must be taken into account in working with clients. Involuntary participation sometimes weakens the client's motivation to cooperate with the therapist. This is somewhat counterbalanced by the fact that DUI programs usually appear as more desirable alternatives to license loss, fines, or jail sentences. However, problems remain that must be taken heed of, as in Pringle's discussion (1982).

In the therapeutic setting, these problems take a form often known as resistance. Cavaiola (1984) discusses this issue, describing a typical sequence of psychological states: anger, testing limits, compliance, anger, self-deprecation, and surrender and acceptance. The DUI counselor or therapist must be prepared to cope with these reactions from clients. In a related discussion, Chng and Giles (1983) criticize behavior modification techniques as commonly used for their reliance on aversive and punitive methods, asking whether the end justifies the means.

Clients should be assigned to treatment modalities appropriate to their needs. Annis and Chan (1983) distinguish between high and low self-esteem clients for programs directed to alcohol and drug abuse, and report that clients with high self-esteem do better in intensive outpatient therapy, while clients with low self-esteem do better in institutions. At a level closer to that of DUI programs, McLellan et al. (1983) describe a process of matching alcohol-dependent veterans to "best fit" programs chosen from six alternative possibilities, and find the results encouraging.

The simplest specific form of intervention is provision of information. Such information may include the effects of alcohol and drugs, the legal regulations on DUI, and the long-term consequences of alcohol and drug use. Rohrer et al. (1984) find such a program to have been effective with 66 institutionalized juveniles who were provided with alcohol education and traffic safety instruction. Clients who are simply unaware of such information may change their behavior once they have received it.

The factor of resistance, however, may limit the acceptance of such information. When this happens, it becomes necessary to provide various forms of motivation, counseling, and therapy. A variety of emphases is possible in such efforts: cognitive restructuring, development of social skills, behaviorally oriented programs, and traditional psychotherapy are among them.

Whelan and Prince (1982) recommend a cognitive emphasis, based on cognitive confrontation designed to replace unrealistic beliefs about drinking with realistic ones. Oei and Jackson (1982) also include cognitive restructuring in their program, and report that this approach is relatively effective in producing long as opposed to short-term change.

Social skills training also forms part of Oei and Jackson's approach (1982), though they consider it effective only in producing short-term change. Collins and Marlatt (1981) center their approach on social modeling of alternative forms of behavior. Orosz (1982) describes a program centered on assertiveness training in a group context. Holser (1979), working with alcoholics, developed a flexible program designed to improve clients' social skills and give them alternative leisure activities not focused on drinking. Most of these approaches reflect the theory that a significant cause of excessive drinking is inadequate social skills.

Strickler et al. (1981) describe a program based on directly teaching skills useful in attaining moderate drinking behavior, as does Brown (1980). In these programs, changes in behavior are sought directly. It should be noted that these programs assume that the DUI offender or other alcohol abuser wishes to drink moderately rather than to incapacitation, but lacks the ability to do so. If this assumption is true, such programs may be effective; but when it is not true—when resistance occurs—then other measures may be needed. Also, when resistance occurs, the problems discussed by Chng and Giles (1983) become salient.

At this point, the appropriate forms of intervention are counseling and therapy. Two programs of this sort have been described in the literature. Panepinto et al. (1982) offer a program based on two evaluation sessions, followed by from 12 to 16 90-minute group sessions. They describe their work as founded on situational crisis theory, adjustment demand theory, and treatment contracts. Another psychotherapeutic approach is presented by Miller (1983), who describes it as motivational interviewing.

In a model founded on internal responsibility and avoidance of labeling, Miller begins by contrasting ongoing behavior with its negative consequences, seeking to arouse dissonance which is then channeled to behavior change, while efforts are made to avoid low self-esteem, low efficacy, and denial. This latter program clearly has links to cognitive and behavioral approaches, but appears also to focus on questions of motivation such as typify traditional psychotherapy. The goal here in these psychotherapeutic approaches is to change the motivational factors that support abusive drinking behavior.

Finally, for those clients who actually are alcoholics or drug addicts, direct medical therapy may be appropriate. This can include controlled withdrawal from alcohol or drugs, and drug therapy to aid such withdrawal. In the case of clients who have suffered long-term physical deterioration through chronic abuse, measures to correct the deterioration may also be appropriate.

Thus, the spectrum of possible interventions runs from an educational model, through a psychotherapeutic model, to a medical model. Choosing the appropriate range of treatments for each client is difficult, but essential. In fact, it is an expression of the clinical tradition from which psychotherapy derives, for that tradition does not treat all clients uniformly, but examines the peculiarities of each individual and attempts to respond to them. If DUI programs are to claim to provide clinical help for their clients, only this kind of multiple programming can fulfill that promise.

Part Six: Recidivism and Program Evaluation

A variety of studies has attempted to measure the success of DUI programs. At least two such measures are possible, in principle: improvement in the overall level of highway safety in areas where such programs are in effect, and improvement in the behavior of persons who have completed such programs. In practice, the second is preferable, both because the offenders enrolled in such programs are not necessarily a sufficiently large part of the total population to affect regional statistics and because other factors may influence driving behavior, making inferences from such behavior to program effectiveness unsound.

The system of federally sponsored Alcohol Safety Action Projects (ASAPs) described by Hart (1977) has been evaluated twice, in two of the largest-scale studies in this area. The first of these, by the Comptroller General of the United States (1979), based on examination of the 35 ASAPs conducted in 1971-1978, reveals mixed results. While no reduction in the number of highway deaths is evident, improvements are apparent in the number of drunken drivers and the number of problem drinkers referred to rehabilitative programs. The second, by Saunders (1979), examining 25 ASAP pilot projects, notes as their advantages both early identification of problem drinkers and encouragement of treatment acceptance. It must be pointed out that many of these ASAP programs were poorly designed, weak in content and often lacked planning and follow through.

Several studies describe specific programs and their success levels. Swenson et al. (1981), reporting on a program in Arizona, find little evidence for the effectiveness of short-term treatment in a sample of midrange problem drinkers. Hagen et al. (1978), comparing license revocation or suspension to participation in a one-year alcohol abuse treatment program in California, find no significant favorable effects of program participation, and one unfavorable effect: Since program participants drove much more than offenders with suspended or revoked licenses, their driving records after entry into the program were much worse. Michelson (1979), describing a Florida program sending DUI offenders to an alcohol safety school, found no statistically significant differences between subjects and controls over a three-year follow-up period. Holden (1983) describes a study in which 4,126 DUI offenders were exposed to probation supervision, education and therapy, both, or neither; after a two-year follow-up, none of these conditions differed significantly from others in effects on rearrest rates. Salzberg and Klingberg

(1983) compare DUI offenders who received deferred prosecution and alcoholism treatment to offenders who received normal judical sanctions, and find higher rates of alcohol-related traffic violations in the treatment group than in the control group.

In contrast to these essentially negative findings, three studies present results that are neutral or favorable. Reis (1983) describes a program in which 5,700 DUI offenders took part in year-long educational counseling with or without chemotherapy, as appropriate to individual cases; results were no more effective than brief but personal counseling—an equivocal finding, but one that supports the need for individualized treatment. McGuire (1982), in a comparison of DUI offenders referred to six programs of treatment to offenders not referred to such programs, finds favorable effects on light drinkers, but not on heavy drinkers, as measured in changes in alcohol-related and general traffic violations and accidents over a two-year period. Snowden (1984) analyzes treatment results with 178 problem drinking drivers, and reports that factor analysis reveals two factors in client characteristics: a general improvement factor linked to psychopathology, and a resistance factor (expressed in continued drinking) linked to alcohol use. Both of these factors were linked to involvement in the program as well.

An additional study focused specifically on program participation was conducted by Steer (1983). Steer reports that age, symptom severity, and employment predict the participation of DUI offenders in outpatient alcoholism treatment, and urges attention to the needs of young and unemployed offenders.

In addition to these, two studies have provided general overviews of the field. Kunkel (1983) finds previous attempts to evaluate DUI programs methodologically flawed in several ways. Among these are the inadequacy of rearrest rates as recidivism measures, the need for self-report data, the diverse aims of the programs being assessed, and the fact that attitudinal change may not underlie behavioral change. Kunkel concludes that most DUI offenders are problem drinkers whose drinking behavior must be changed. A second study by Mann et al. (1983) reviews the literature from 1970 to 1982, and finds further methodological flaws: the lack of controlled treatment assignments and the weakness of measures used to assess results. They consider it possible to draw only weak conclusions, but suggest that education improves attitudes but may not prevent recidivism, while lifestyle modification works more effectively. They consider the two main at-risk populations to be depressives and sensation seekers.

Overall, then, there are few definitive conclusions to be drawn from the research literature. As yet the

various DUI programs are too diverse for overall evaluation, and the means of measuring results too uncertain, to permit firm conclusions. Before such evaluations can be undertaken, it will be necessary to attain a more uniform state-of-the-art in both treatment and evaluation.

Until this is possible, the only guide available must be clinical judgment. And, at present, the consensus of such judgment is that education, counseling, and psychotherapy are capable of being effective with at least some DUI offenders. A useful research strategy at this point might be to attempt to identify factors discriminating among clients with whom they typically fail. Here is a task to which recidivism statistics are particularly suited.

In an overview of educational and rehabilitative programs, Hagen (1985) states that such programs are better than doing nothing at all, but cannot substitute for licensing sanctions, which lead to reduced driving exposure and more careful driving. Hagen specifically suggests that license restrictions be used in conjunction with treatment programs, both as incentives to participate in the program and as a means of interrupting old driving habits during the initial stages of the program. Hagen views sanctions as one part of a total program which should also include education and therapy. In particular, he recommends the development of less restrictive licensing sanctions, such as licenses that may be used only when traveling between home and work and/or treatment. This argument reflects a similar view of the symbiosis of law and therapy to that advanced in Part Three above. Hagen's various proposals and suggestions should be considered carefully in any attempt to design future DUI programs.

Part Seven: The Illinois DUI Law and the Cook County Court System

Central States Institute of Addiction (CSI) has been operating the Alcohol and Drug Assessment Services (ADAS) program in cooperation with the Circuit Court of Cook County since 1971. The program provides a comprehensive assessment of the DUI offender for the court, and recommends an intervention strategy consistent with the defendant's perceived level of impairment. The intervention, if the court concurs with the recommendation, is conducted by existing facilities within the substance abuse/health care system that a) have a proven ability to provide comprehensive services to the client, and b) have an approved service agreement with CSI as provided for in Circuit Court of Cook County Rule 11.4. Types of intervention include education, guidance, counseling, and therapy.

Part 7: The Illinois DUI Law

A number of legislative and administrative changes regarding driving under the influence laws have occurred in the state of Illinois since 1982. The most recent changes became effective January 1, 1986. The DUI statute in Illinois is considered to be a "per se" law (per se: by (or in) itself, inherently) in that "the alcohol concentration in such person's blood or breath (of) 0.10 or more" constitutes, by (or in) itself, guilt. The current sanctions are as follows:

First Conviction

Loss of driver's license for one year.
Possible imprisonment up to 364 days or fine up to $1,000, or a combination of both.

Subsequent Conviction

Loss of full driving privileges for a minimum of one year.

Mandatory minimum of 48-hour imprisonment or a minimum of 10 days of community service for a second conviction in a five-year period.
Possible imprisonment up to 364 days or fine up to $1,000, or a combination of both.

Further, if a person who while under the influence is involved in a motor vehicle accident where great bodily harm or permanent disability or disfigurement results, the offender is guilty of a Class 4 felony and is subject to imprisonment of one to three years. Should such an accident result in death, the offender is guilty of a Class 3 felony (reckless homicide) punishable by two to five years in prison.

Refusal to submit to blood/breath alcohol testing upon arrest for DUI, or testing indicating a BAC of .10 or more, incurs a statutory summary suspension of driving privileges automatically taking effect on the 46th day after arrest and notification of suspension. Beginning January 1, 1987, the statutory summary suspension will take effect on the 31st day after notice.

First Offense

Refusal to submit to a chemical test results in a six-month driver's license suspension.

Chemical test indicating a BAC of .10 or greater results in a three-month driver's license suspension.

Subsequent Offense

Refusal to submit to a chemical test or test results indicating a BAC of .10 or greater results in a 12-month driver's license suspension.

The offender is allowed to petition the court for a judical hearing to rescind the statutory summary suspension. The court may either continue to rescind the suspension after a determination of the issues. If the court should continue the summary suspension, the offender may than seek alternative relief in the form of a Judicial Driving Permit (JDP). If a JDP is granted, however, it does not become effective until after the 30th day of the original suspension. This results in a hard 30-day suspension from which there is no relief.

The petition for a JDP must contain a report that the offender submitted to and was evaluated by a professional evaluator as to alcohol or other drug use. In addition, the offender must show that he is employed and has no other means of commuting to and from the job, or that he drives as a condition of employment, or that he must transport himself or a family member to treatment for alcohol or other medical problems, and that his driving background does not show a disrespect for public safety and that he is likely to obey the limits of the JDP.

The conditions of the JDP limit its application to operation of a motor vehicle between the driver's home and place of employment, specifying the days of the week and hours worked, as well as other restrictions or privileges as the court creates. The court may not grant a JDP to any person who is a repeat offender and may cancel the JDP if the driver commits another alcohol-related offense, violates a condition of the JDP, or is convicted of any traffic offense while driving on the JDP. A subsequent offender is not eligible for a JDP but may receive a restricted driving permit after 90 days from the effective date of suspension through the Secretary of State.

Prior to any disposition of the DUI violation itself, the offender is required to undergo a professional evaluation to determine if alcohol or other drug abuse exists and to what extent. (ILL. Rev. Stat. ch. 95-1/2, sec. 11-501.1; sec. 6-208.1)

The Circuit Court of Cook County

The Circuit Court of Cook County serves a population of more than 5 million residents in an area covering over 950 square miles. It is reputed to be the largest single court system in the world.

The court is divided into municipal districts with a presiding judge, judiciary, and support staff in each district. Each district is responsible for all civil, criminal, traffic, and ordinance violations that occur within its geographic boundaries. The general makeup of the minicipal districts is as follows:

The First Municipal District includes the City of Chicago with a population of approximately 3,000,000.

The Second Municipal District includes 18 North Suburban Cook County municipalities with a total population of 500,000.

The Third Municipal District includes 19 Northwest Suburban Cook County municipalities covering 200 square miles with a population in excess of 550,000. It is the largest of the suburban municipal districts.

The Fourth Municipal District includes 17 West Suburban Cook County minicipalities covering 43 square miles with a population of 400,000. It is the smallest of the suburban municipal districts.

The Fifth Municipal District includes 31 Southwest Suburban Cook County municipalities with a population of 400,000.

The Sixth Municipal District includes 35 South Suburban Cook County municipalities with a population in excess of 500,000.

To illustrate the size and complexity of each suburban municipal district, the Third Municipal District, which covers an area of over 200 square miles and has a population in excess of 550,000, serves a resident population as large as Atlanta, Georgia, or Kansas City, Missouri. This district by itself would rank among the 25 largest cities in the United States. It is geographically larger than Miami, Florida; Fort Worth, Texas; and substantially larger than Salt Lake City, Utah; or Albuquerque, New Mexico.

Effective January 1, 1986, all DUI offenders are required by law in the state of Illinois to undergo an alcohol/drug assessment by a state-licensed facility before the offense may be adjudicated. In addition, Circuit Court Rule 11.4 requires that a full recidivism/screening review be made prior to trial. Prior to this new legislation, all offenders were referred directly from the court of venue by court order. Currently defendants are either being referred to the program in this traditional manner or, on advice of defense counsel, voluntarily submit to the assessment process prior to the first court date.

New targets have been established for the delivery of services to the court, especially for the initial assessment/evaluation report. Prior to January 1, 1986, a minimum of 30 days and a maximum of 90 days were allowed for the assessment process. Because of the requirements of the new legislation, these time frames have been collapsed to a minimum of same-day service to a maximum of 30 days for preparation of the assessment report. Timely filing of all assessment reports is also a provision of Circuit Court Rule 11.4.

CSI maintains an office in each municipal district. Therefore, the services are easily accessible to the offenders, and the court and its agencies have instant, direct access. As an example of the effectiveness of this network, the presiding judges stipulated that all DUI defendants be monitored, tracked, and physically report for the entire term of the sentence. A cooperative effort was immediately established between the court's Social Service Department and CSI to implement this directive. As of July 1, 1986, all convicted DUI defendants on supervision, conditional discharge, or probation will physically report to an assigned agency which will monitor the individual activity. There are an estimated 20,000 offenders annually that receive these sentences.

The general flow of the DUI population in the Circuit Court of Cook County is as follows:

Arrest	1)	Offender is arrested by law enforcement agency. Initial Contact.
Initial Contact/ Assessment	2)	Offender either voluntarily reports or is sent by the court to assessing agency. If court referral, case is continued to next regular court date (usually 28 to 30 days). Assessment is conducted within five days of initial contact.
Preparation of Court Report	3)	Assessment instruments scored and level of impairment assigned. Components summated and risk factor assigned. Assessment report completed.
Court Appearance	4)	Assessment report presented to the court on next court date which is within 30 days. Program representative is present in court for testimony regarding assessment.
Implementation of Assessment Recommendations	5) a)	Court accepts report and recommendations: non-problematic (0-1s) under jurisdiction of CSI for remedial intervention; problematic (2-3s) to Social Service Department to implement guidance, counseling, or therapy.
	b)	Court declines recommendations.
Follow-up	6)	"Reporting" sequence is established for the defendant by the agency responsible. Frequency of reporting determined by the perceived level of repairment.
Violations	7)	Violations or non-compliance with recommendations reported immediately. Prosecution immediate.
Termination	8)	Final report prepared for the court at termination of sentence.

Program Recidivism

In 1985, a total of 18,309 DUI offenders were tracked for the purpose of measuring the number and percentage of individuals who had previously been assigned to the Alcohol and Drug Assessment Services (ADAS). The 18,309 offenders represented the total DUI population in the Circuit Court of Cook County, both program referrals and those screened for recidivism who were not program referrals. These offenders are presumably representative of the DUI population in Cook County, Illinois.

The results were as follows:

Total Population	18,309	
Program Recidivists	1,514	8.3%

In addition, a separate study was conducted between September 1985, through March 1986. Data was examined on 5,644 cases. The purpose of this study was to identify multiple repeat offenders who had not been referred to the ADAS program, and compare that population statistically with the program's recidivists.

The results, by municipal district, are as follows:

First Municipal District

	Number		Percent
Total Cases		1,000	
Multiple Offenders	235		23.5
Program Recidivists	85		8.5
Total Repeat Offenders		320	32.0
Total First Offenders		680	68.0

Second Municipal District

	Number		Percent
Total Cases		1,320	
Multiple Offenders	220		16.7
Program Recidivists	103		8.0
Total Repeat Offenders		323	24.7
Total First Offenders		997	75.3

Third Municipal District

	Number		Percent
Total Cases		1,080	
Multiple Offenders	164		15.3
Program Recidivists	98		9.0
Total Repeat Offenders		262	24.3
Total First Offenders		818	75.7

Fourth Municipal District

	Number		Percent
Total Cases		481	
Multiple Offenders	93		16.3
Program Recidivists	67		17.0
Total Repeat Offenders		160	33.3
Total First Offenders		321	66.7

Fifth Municipal District

	Number		Percent
Total Cases		1,046	
Multiple Offenders	197		19.4
Program Recidivists	121		12.0
Total Repeat Offenders		318	31.4
Total First Offenders		728	68.6

Sixth Municipal District

	Number		Percent
Total Cases		717	
Multiple Offenders	127		19.1
Program Recidivists	93		13.0
Total Repeat Offenders		230	32.1
Total First Offenders		487	67.9

Countrywide

	Number		Percent
Total Cases		5,644	
Multiple Offenders	1,049		18.6
Program Recidivists	567		10.0
Total Repeat Offenders		1,616	28.6
Total First Offenders		4,028	71.4

A ratio of 1.9 to 1 exists when comparing non-program multiple offenders with program recidivists. This statistic is consistent with studies conducted in previous years and strongly indicates that program participation by multiple or repeat offenders can reduce their chances of repeating the offense by 50%.

Part Eight: The ADAS Program

The Alcohol and Drug Assessment Services (ADAS) program of Cook County, Illinois, is an attempt to deal with the problem of DUI and related problems through varied forms of intervention designed to meet the individual offender's needs. The approach followed includes education and guidance, monitoring, punishment, and referral for counseling or therapy with a holistic, modified punitive framework. Measures suited to the individual offender are selected through a systematic assessment procedure at the start of intervention.

The program is conducted in cooperation with the court system. Typically, clients are contacted before trial, and participation in ADAS is presented to them as an alternative to the attempt to avoid conviction, with which the courts are prepared to cooperate. Since the penalties for DUI range as high as 364 days in jail and a $1,000 fine, this alternaive is generally attractive to clients who have actually engaged in DUI. The client is asked to take part voluntarily, commiting himself or herself to the program, in exchange for avoiding the additional legal punishments and the status of a convicted DUI offender.

The availability of ADAS does not preclude the use of more traditional penalties for DUI offenders. Sentencing judges retain the option of imposing fines, jail sentences, and suspension of driving privileges. But ADAS gives judges the opportunity to offer a wider array of options than a strictly punitive sentence.

McDermott and Moran (1981) have stated that, while the primary purpose of ADAS is evaluative and educational, an equally important function is to refer clients with life problems involving alcohol or drug abuse to appropriate agencies. Recommended counseling or treatment may be either voluntary or mandatory at the discretion of the judge.

For first offenders, the courts are typically favorable to this option. The impact of traditional punitive sanctions is negative enough to make judges hesitant about applying them. ADAS offers them a wider range of choices. Legally, participation in the ADAS program is a form of probation. Thus, a DUI offender can be "sentenced" to take part in this program as an alternative to traditional penalties. Even when dealing with repeat offenders, judges often welcome the added option for cases where it appears more effective than traditional measures in protecting society from the harmful effects of DUI.

Clients are motivated to cooperate with the program, as well, by a number of factors. In the first place, the program is presented initially as working in the client's interests rather than against him or her, making it more likely that he or she will be cooperative. In the second place, the client begins participation immediately after a court appearance, at which the facts regarding the client's behavior have been made clear, and social disapproval of that behavior has been expressed in unequivocal terms. Finally, successful completion of ADAS is generally required before a client can be removed from probationary status and regain driving privileges lost while occupying that status. All of these effects work together to motivate the client's cooperation with the program.

The basic purpose of the program is to change the client's behavior by changing his or her attitudes and motives. An attempt is made to convince the client that driving an automobile after consuming any significant amount of alcohol is simply unacceptable behavior. External penalties are not sufficient to achieve this; those who are deterred by such penalties will normally avoid DUI and thus not come into ADAS. What is needed is a change in the client's own attitude to DUI behavior.

The first and most crucial step in the program is assessment. (See Appendix) Before the client can be helped, it is essential to determine his or her position and needs, so that the help will be useful rather than irrelevant. ADAS uses several tests and measurements to achieve this. They include:

a Personal Data Form which includes information on demographic and social status variables and current use of alcohol and other drugs;

an Attitudinal Study which assesses attitudes toward drinking and driving, and seeks to elicit how much responsibility the client feels for the DUI incident which resulted in referral;

the Michigan Alcohol Screening Test which measures the degree of dependence on alcohol;

the ADAS Substance Abuse Assessment comprising 10 questions regarding use of alcohol and other drugs;

an interview with an Education and Referral Officer (ERO) during which the client completes a Behavior Assessment Scale (BAS) consisting of several psychometric tests of perceptual, cognitive, emotional, social and motor functioning.

The results of these measurements are used to determine a risk factor ranging from 0 to 3. Two subscores are computed, one for the Behavior Assessment Scale and one for all other measures. These computations are made separately and "in the blind", i.e., from two separate individuals, a psychologist for BAS and an ERO for other measures. They are then averaged, with greater weight being given to that obtained by the ERO. The risk factors are interpreted as follows:

(0) the client is not experiencing any particular difficulty with life problems;

(1) the client is experiencing mild life problems in the areas of health/emotional problems and/or social concerns;

(2) the client is experiencing moderate life problems of one or both types, such as that referral to an outside source is recommended;

(3) the client is experiencing severe life problems, such as that referral to an outside source of therapy is mandatory.

Recommendations are made to the referring court on the basis of the risk factor determined for the client. Experience with this system shows about 20% of clients to have a risk factor of 0, 42% of 1, 35% of 2, and 3% of 3.

After determination of a client's risk factor, appropriate interventions are selected. A basic scheme is used which comprises four broad levels of intervention after the initial assessment phase: education, guidance, counseling, and therapy. The first two of these are in general provided by ADAS itself, the latter two by outside agencies.

Education is offered to all clients. Basically, this consists of furnishing information on the effects of alcohol and drug use on human behavior generally and driving specifically.

Clients also take part in guidance programs which seek to make them aware of their own patterns of substance abuse and of the risks that these entail. The focus of this effort is to ensure that the client treats the information presented in educational sessions as personally relevant rather than as abstract or applicable only to others. This is necessary to provide motivation for change to many clients.

Clients with patterns of chronic substance abuse are referred to outside agencies for counseling. The aim here is to aid the client in resolving any problems which contribute to the pattern of abuse.

A minority of clients are found to have problems so severe as to necessitate medical treatment in hospital-based facilities. This option is arranged through a referral procedure. Clients at this level include those who fit the classic pattern of alcoholism or drug addiction. They receive treatment which may include psychotherapy and/or various somatic therapies.

With these latter two groups of clients, the Cook County Social Service System in collaboration with ADAS retains the role of overall coordinator, and is responsible to the courts for monitoring the client's progress. Clients are not referred directly to hospital or community-based programs, but only indirectly through ADAS, and ADAS holds responsibility for accounting to the courts for the credentialing and success or failure of participating programs. Extensive records are kept on clients to be furnished to the appropriate courts. Under Illinois state law these records are confidential and, in fact, written consent of clients is required both to transfer records from any sub-agency to ADAS or from ADAS to the courts.

A client's failure to complete a program, however, results in immediate notification of courts and other concerned agencies. The result can be a full hearing on the client's violation of the terms of his or her probation, with possible results including revocation of the previous disposition of the case, entry of a finding of guilty on the client's record, and appropriate penalties. These sanctions provide clients with an incentive to complete the entire program.

Within this overall system, two distinct levels have been defined for intervention. Level I is intended primarily for clients who lack information about the effects of alcohol on behavior; level II for clients who exhibit more profound behavioral problems. In both levels, clients undergo initial needs assessment; such assessment may lead to referral of clients from level I to level II, though other factors, such as a history of alcohol— or drug-related charges, or voluntary admission of serious alcohol— or drug-related problems, may also indicate initial referral to level II to be appropriate. Level I clients attend four two-hour sessions devoted to lectures, films, and discussion groups, which provide information on the effects of alcohol, the factors which trigger its use, the methods of gaining improved control over alcohol use, and the laws regulating alcohol consumption. Level II clients are referred to appropriate collaborating agencies for the development of an intervention or treatment plan.

Within level I, several distinct tracks are available: the general population program, a youthful offender program, a women's program, a Hispanic population program, special language programs, and a poly-drug program designed for clients aged 17-30 who have abused substances other than or in addition to alcohol.

These programs thus cover a wide range of client situations. Options exist for clients with mild or severe alcohol problems; for clients with other drug problems; for clients with difficulty in learning or communicating; and for clients with special social, psychological, or physical needs. This diversity is central to the design of ADAS.

A comprehensive judgment as to the effect of ADAS remains difficult to obtain. However, more specific data will be reviewed in the following section. It is worth noting that very few ADAS clients have been referred to ADAS previously, suggesting some effectiveness in preventing recidivism. In 1980, 96.3% of participants had never previously taken part in ADAS. Prevention of recidivism is ADAS's primary goal, and this information at least suggests that it may be accomplishing it.

In addition, ADAS makes a number of referrals of problem drinkers to other programs. This group is more likely than others to experience repeated arrests for DUI and for other alcohol-related charges. In referring them to other forms of intervention, ADAS has been concentrating the resources of these other agencies on the recipients with the greatest need for them.

Beyond this, ADAS is supported by two further sources of testimony. Clinical experience reveals improvements in clients of ADAS. Further, the legal system of Cook County, Illinois, has come to regard ADAS as a useful alternative to conventional means of dealing with DUI offenders. These two findings, together with such statistical data as are available, support the viability of ADAS as a useful program of intervention in DUI cases.

ADAS is one program among many. It is unique, however, in its use of a holistic, modified punitive approach with multiple levels of intervention. If it has attained any successes, this approach is the reason.

It has long been recognized that the better a program matches the actual characteristics of the target population, the more success it will attain. A wrongly conceived program will have no effects, or will even be counterproductive. A too narrowly conceived program will aid a subgroup of clients while failing with other subgroups. It may be speculated that these two problems account for some of the reported unsatisfactory results of other programs. ADAS seeks to avoid these faults. It does not assume that all clients are of the same type or have the same needs; it provides varied paths of intervention and seeks to assign clients optimally among them. Most specifically, it does not define all DUI offenders as alcoholics or drug addicts which most of them are not, nor offer treatment suited to alcoholics or addicts to all of them. It provides a program specifically designed for the characteristics of DUI offenders. This specific approach to design is the basis for such success as ADAS has attained.

If ADAS is capable of being a model for other programs, this basic concept is its essential feature as a model. The use of a diversified and holistic approach, which seeks to meet all of each client's unique and individual needs in one comprehensive framework, appears to be the approach best suited to the complex realities of DUI behavior.

Part Nine: The Cook County Research and Evaluation Project

As was described in Part Eight, Central States Institute of Addiction (CSI) has from its inception developed its DUI intervention component on the assumption that, when it comes to driving behavior, there is a synergy between a person's bio-psycho-social level of functioning (state of human performance at any given time) and the effects of alcohol or other mind-altering drugs. This synergy can elevate the risk of operating a vehicle in an unsafe manner. Although a chronic or transitory disturbance in physiological or psychological state or the presence of a psychoactive substance in the body can each independently influence a driver's ability, when combined the effect may be more than just cumulative. The issue for the DUI field is one of determining how these physical, emotional, and social factors interact to induce a DUI offense.

Assessing a person's level of bio-psycho-social dysfunction together with the exacerbating effects of alcohol or drugs may provide a more effective way of identifying and classifying DUI offenders. In so doing, the individual can better be matched to the appropriate intervention and intervention can ultimately reduce recidivism significantly.

The CSI technique of assessing and "treating" the DUI offender has previously been described at length (Section VII above, McDermott & Moran, 1981; Pisani, McDermott, and Kilbane, 1982). In summary, the general approach is to assign clients to intervention programs on the basis of levels of risk to commit future DUI offenses. Risk level is defined in terms of DSM III Criteria (Axis 5), court promulgated criteria, and measures of bio-psycho-social dysfunction. These criteria are combined and result in a cumulative risk factor. This cumulative risk factor determines whether an offender will receive Education/Guidance (Level I), Counseling (Level II), or Therapy (Level III).

Central States Institute, with its nearly 20,000 court referrals a year, operates the largest DUI program in the United States. Within the judicial and treatment community the program was believed to be effective, but there had never been a scientific study to determine whether this belief was justified. It was from the need to measure the success of the program that the Cook County Research and Evaluation Project (CCREP) was formed in 1984. The Cook County Research and Evaluation Project is a not-for-profit corporation specifically organized to conduct an independent evaluation of the Cook County Court's DUI intervention practices.

The primary purpose of the research project is to measure the effectiveness of the various interventions designed to reduce recidivism. A secondary purpose is to provide the judicial system and the treatment community with a sizable data base to determine factors that relate to DUI.

The research design utilized a three-step process:

Phase I	Assessment and development of research procedures
Phase II	Data collection and formative evaluation
Phase III	Data analysis and summative evaluation

Phase I was completed and Phase II begun during 1985. During Phase I, program policies and procedures, forms, and documentation were reviewed. Every effort was made to ensure the validity, reliability, and completeness of the information collected.

The purpose of this first major study of the CSI population is an attempt to contrast persons who have only committed one DUI offense with those who have committed multiple offenses. The specific aim is to identify variables that eventually may be used to predict recidivism.

In reviewing the literature, it appears that only a few studies have been done that directly relate to this study. Steer and Fine (1978) tested whether men with first arrests and men with second arrests provided comparable retrospective descriptions of their moods during the month preceding their arrest. The findings provided evidence that different levels of effect may exist in persons arrested for DUI.

In another study Landrum and Windham (1981) compared 379 non-repeaters with 82 repeaters on demographic and behavioral variables. Demographic differences were insignificant, but behavioral variables, such as previous public drunkenness, were significant. Steer (1982) administered the SCL 90 inventory to 290 men arrested for DUI. Three distinct symptom profiles were identified: paranoid, somatic, and obsessive-depressed.

Although not exactly similar to the present study, some earlier attempts at developing a typology for DUI offenders deserve mention. Donovan, et al. (1982, 1983 & 1985) identified subtypes among male DUI offenders. Steer et al. (1979) identified seven clusters among 1,500 male DUI offenders. Finally, Arstein-Kerslake & Peck (1985) analyzed a sample of first and multiple offenders (N = 2,889) with the result that nine "cluster types" were identifiable.

Method

Subjects

The data for this report are based upon 7,025 DUI offenders referred to the Central States Institute of Addiction by the Cook County court system between November 1, 1985, and March 31, 1986. These subjects were selected for inclusion in the study because their intake records were relatively complete and they had not exhibited any overt language or reading problems, which could have affected their understanding of the questions. The 4,360 selected offenders represent approximately 57% of the total referrals to CSI during this period.

Data Collection

The data were collected by means of a self-administered questionnaire, a self-administered psychometric test instrument, and a structured intake interview. All data collection was closely monitored and conducted prior to offenders entering court-ordered remedial education or treatment programs. Data collection took place in the six assessment centers operated by CSI. The size of the study dictated that the data collection procedures be fully automated, therefore, data collection instruments were machine scored and computer analyzed. All responses, including those resulting from the intake interview, were made directly onto machine-readable answer sheets. These sheets were fed into the Scantron 5200 Optical Mark Reader and IBM-PC/AT.

Instruments

Pre-program Questionnaire. This 159-item, multiple-choice instrument has questions related to:

1. Demographic information
2. Arrest history
3. Alcohol/drug history
4. Personal attitudes toward substance abuse
5. Prior attempts at alcohol/drug treatment
6. Current patterns of alcohol/drug abuse
7. Alcohol/drug use within friendship group
8. Physical/emotional health
9. Employment and income status
10. Family history
11. Knowledge of the effects of alcohol and drugs
12. Self-appraisal of substance abuse problem

Intake Interview. This structured interview centers around a series of questions that further elaborate on the areas covered in the Pre-program Questionnaire. The interview is conducted by a Certified Alcohol/Drug Abuse Counselor who assesses the risk of the offender commiting future DUI violations and recommends an appropriate level of intervention.

Behavioral Assessment Scale (BAS). The BAS was developed by the author as a substance-abuse screening device, intelligence test, and index of psychopathology. It is a 141-item paper-and-pencil test that, when scored, yields 15 scales.

1. Alcohol/Drug Problem (26 items)
2. Vocabulary (40 items)
3. Abstraction (20 items)
4. Conceptual Quotient
5. I.Q.
6. Stimulus Seeking (15 items)
7. Anxiety (5 items)
8. Manic (5 items)
9. Paranoia (5 items)
10. Hostility (5 items)
11. Psychosis (5 items)
12. Somatization (5 items)
13. Depression (5 items)
14. Obsessive Thinking (5 items)
15. Cumulative Pathology

Groups

The subjects were divided into two groups according to their answers to the question, "Prior to this arrest, have you ever been arrested for driving under the influence?" The appropriate responses were: "Yes—once"; "Yes—twice"; "Yes—three or more times"; and "No—never". The greatest proportion of the offenders (71%) had not had a DUI arrest prior to entering CSI. Next came those with one prior arrest (16%), then those with two prior arrests (12%), and finally those with three or more previous arrests (1%).

For the purpose of this study, all of the individuals with at least one previous arrest were placed into a "multiple Offender Group" while those with no prior arrest were designated as the "First Offender Group". This categorization led to 29% of the subjects being classified as Multiple Offenders and 72% as First Offenders.

Results

Demographic Differences

Sex. While 86% of the DUI offenders seen by CSI are male, they constitute more than 90% of the Multiple Offender Group. Or, viewed another way, while the First Offender is six times more likely to be a male than a female, the Multiple Offender is nine times more likely to be a male than a female. Needless to say, these differences are statistically significant. (Table 1)

Table 1
Sex

	Multiple		First		All	
	N	%	N	%	N	%
Female	114	10	464	15	578	14
Male	1054	90	2573	85	3627	86
Total	1168	100	3037	100	4205	100

Chi-Square = 21.20; df = 1; p .001

Race and Ethnic Background. The subjects fell into three racial categories. Approximately 80% were white, 14% were black, and 6% were of other races. However, the blacks and those in the other racial categories were overrepresented in the Multiple Offender Group. (Table 2) When viewed in terms of ethnicity, those with African and Hispanic origins were more likely to be found in the Multiple Offender Group than were those of European or Asian lineage.

Table 2
Race

	Multiple		First		All	
	N	%	N	%	N	%
Black	220	18	391	13	611	14
White	936	76	2508	81	3444	80
Other	77	6	183	6	260	6
Total	1233	100	3082	100	4315	100

Chi-Square = 19.97; df = 2; p .001

Age. The data revealed that fewer drivers under the age of 30 and over the age of 60 were Multiple Offenders than would have been expected from their numbers in the general CSI population. It was the 30 to 59 year-olds that had a greater percentage of their members in the Multiple Offender Group. (Table 3)

Table 3
Age

	Multiple		First		All	
	N	%	N	%	N	%
16-19	31	3	159	5	190	5
20-29	509	42	1387	46	1896	44
30-39	344	28	815	27	1159	27
40-49	184	15	385	13	569	14
50-59	107	9	170	6	277	6
60 or older	33	2	87	3	120	3
Total	1208	100	3003	100	4211	100

Chi-Square = 35.09; df = 5; p .001

Education. There was a clear relationship between a person's level of education and the likelihood of committing multiple DUI offenses. When the analysis was limited to offenders over the age of 19, it was found that those who did not finish high school were overrepresented among the Multiple Offenders. While 39% of the offenders with less than an elementary school education were Multiple Offenders, only 27% of college graduates and 25% of those with some graduate school experience fell into the Multiple Offender Group. (Table 4)

Table 4
Education

	Multiple		First		All	
	N	%	N	%	N	%
Less than elementary	31	3	55	2	86	2
Completed elementary	286	25	443	16	729	18
High School Graduate	613	53	1612	57	2225	56
College graduate	190	16	562	20	752	19
Some graduate school	42	4	145	5	187	5
Total	1162	100	2817	100	3979	100

Chi-Square = 50.10; df = 4; p .001

Employment Status and Occupation. At the time of entering CSI, 17% of the offenders over the age of 19 were not working. This group had the largest proportion of Multiple Offenders. It does not appear to matter whether unemployment resulted from retirement, disability, or simply from an inability to find a job. All of these forms of unemployment were overrepresented in the Multiple Offender Group.

An offender's occupation is also related to the probability of committing multiple offenses. Blue-collar workers had the largest number of their group categorized as Multiple Offenders (34%). They were followed by business owners, white collar workers, and professionals. Students had the lowest rate of Multiple Offenders within their ranks. (Tables 5 and 6)

Table 5
Employment Status

	Multiple		First		All	
	N	%	N	%	N	%
Full Time Employment	801	69	2126	76	2927	74
Part-time Employment	126	11	241	9	367	9
Unable to find job	197	17	371	13	568	14
Retired	16	1	35	1	51	1
Disabled	19	2	36	1	55	1
Total	1159	100	2809	100	3968	100

Chi-Square = 18.57; df = 4; p .001

Table 6
Occupation

	Multiple		First		All	
	N	%	N	%	N	%
Blue collar	662	59	1309	47	1971	51
White collar/Professional	355	32	1145	41	1500	38
Student	28	2	114	4	142	4
Business Owner	83	7	196	7	279	7
Total	1562	100	3781	100	5343	100

Chi-Square = 46.90; df = 3; p .001

Personal Income. Offenders were asked, "In the past year, what was your personal income from all sources?" Generally, among individuals over 19 years of age, there is an inverse relationship between income and likelihood of committing multiple DUI offenses. The higher a person's income, the less likely that they will be a Multiple Offender. Thirty-three percent of the offenders with incomes under $10,000 were Multiple Offenders. In contrast, only 23% of the 344 offenders with incomes in excess of $40,000 were Multiple Offenders. (Table 7)

Table 7
Annual Personal Income

	Multiple		First		All	
	N	%	N	%	N	%
0 - 9,999	366	32	747	27	1113	28
10,000 - 19,000	335	29	834	30	1169	30
20,000 - 29,000	250	22	640	23	890	22
30,000 - 39.000	121	10	323	12	444	11
40,000 and over	79	7	265	9	344	9
Total	1151	100	2809	100	3960	100

Chi-Square = 15.29; df = 4; p .01

Age at First Use. The data revealed that individuals who had had their first alcohol or drug use experience early in life (before the age of 16), were more likely to eventually become Multiple Offenders than were individuals who experienced alcohol or drugs later in life. (Table 8)

Table 8
Age at First Use

	Multiple		First		All	
	N	%	N	%	N	%
Under 13 years of age	71	6	120	4	191	4
Between 13 and 15	225	18	483	16	708	16
Between 15 and 21	757	61	2024	66	2781	65
21 and over	180	15	456	15	636	15
Total	1233	100	3083	100	4316	100

Chi-Square = 13.01; df = 3; p .01

Blood Alcohol Content (BAC). When the BAC of the Multiple Offender was contrasted with the BAC of the First Offender, there was a greater representation of Multiple Offenders found in the BAC category of .25 and over. In contrast, the Multiple Offender showed a smaller representation in the middle ranges of the BAC (.10 to .24%). (Table 9)

Table 9
Blood Alcohol Content

	Multiple		First		All	
	N	%	N	%	N	%
0 - .09	42	6	115	6	157	6
.10 - .24	595	85	1828	89	2423	88
.25 and over	63	9	110	5	173	6
Total	700	100	2053	100	2753	100

Chi-Square = 12.13; df = 2; p .01

Behavior Assessment Scale

Significant differences between the two groups were found for the majority of the BAS scales.

Alcohol/Drug Problems. Multiple Offenders experience a substantially greater number of substance abuse related problems as measured by this scale. The mean number of problems reported by Multiple Offenders was 8 as opposed to 5 problems reported by First Offenders. In fact, 14% of the First Offenders reported no previous substance abuse related problems, while only 6% of the Multiple Offenders were problem free.

Intelligence. The two scales related to intellectual functioning (Vocabulary and Abstraction) also differentiated between Multiple Offenders and First Offenders. Both the Vocabulary and Abstraction scales were lower for Multiple Offenders. The BAS contains an overall I.Q. score which also differentiated between the groups. Here again, Multiple Offenders had lower I.Q. scores than did the First Offenders. (Table 10)

Index of Psychopathology. Multiple Offenders scored higher and, therefore, exhibited greater pathology on seven of the BAS scales. Depression and Hostility were the two scales that most clearly differentiated between the two offender groups. Multiple Offenders scored higher on both of these scales, as they also did on the Anxiety, Manic, Psychosis, and Somatization scales. The large number of differences was also reflected in the Cumulative Pathology Scale, which is a simple compilation of all of the other personality scales. Multiple Offenders clearly reported more pathological symptoms than did the First Offenders. (Table 10)

Table 10
BAS Intelligence and Psychopathology Scales
for Multiple and First Offenders

Scale	Multiple		First		z
	Mean	SD	Mean	SD	
			Intelligence		
Vocabulary	21.96	7.31	23.67	6.62	-6.12***
Abstraction	22.53	7.64	24.32	6.79	-6.16***
Conceptual Quotient	102.87	57.61	101.39	43.27	- .72
I.Q.	104.47	12.74	106.89	10.33	-5.21***
			Psychopathology		
Stimulus Seeking	5.02	3.39	4.89	3.21	1.02*
Anxiety	.63	1.13	.49	.99	3.09***
Manic	1.35	1.20	1.23	1.18	2.49***
Paranoia	1.16	.99	1.11	.97	1.38
Hostility	.33	.81	.23	.64	3.47***
Psychosis	.70	1.08	.61	.98	1.96**
Somatization	.55	.94	.44	.81	3.24*
Depression	.46	.95	.34	.81	3.53***
Obsessive Thinking	1.52	1.31	1.48	1.26	.91
Cumulative Pathology	6.69	5.72	5.92	5.03	3.58***

*p .05; **p .01; ***p .001

Summary

A sample of DUI offenders from one of the largest DUI programs in the world was reviewed to compare the differences between the first and multiple offender. In addition to demographic material, the offenders were characterized by a variety of other data, including cognitive and social/emotional functions.

There are clear differences between and within these groups. Multiple Offenders appear to be significantly more disturbed in emotional and social areas than do First Offenders. These findings further substantiate the need for multi-dimensional assessment and variably intense approaches to intervention.

Conclusions

Public concern has noticeably increased in recent years toward the problems of alcohol and drug abuse, particularly regarding driving under the influence of alcohol or drugs. Along with the policies intended to deter DUI behavior generally (such as public education on alcohol- and drug-induced impairment, and demands for strict enforcement of DUI laws and increased probability and severity of sanctions), specific attention has been given to programs intended to prevent recidivism among DUI offenders.

One approach has been mandatory participation in educational and therapeutic programs aimed at changing the attitudes and behavior of persons convicted of DUI, as well as providing appropriate counselling or treatment to those experiencing the underlying life problems related to alcohol and drug abuse. Since such programs often take the place of more punitive sanctions allowed by law (such as fines and incarceration), they must be justified on the basis of their effectiveness in preventing recidivism and, in so doing, reducing the number and frequency of alcohol-related offenses.

Alcohol and drug abuse is more diverse than a simple dichotomy between being an "alcoholic" or an "addict" or not; rather a broad spectrum of behavior exists. Since most DUI offenders are not alcoholics or addicts, but, in fact, exhibit a wide range of characteristics and problems, treatment programs need to reflect that diversity in order to be effective. While being assigned to a treatment program appropriate to their needs, offenders must also understand that their behavior is unacceptable to society. Consequently, licensing sanctions may be appropriate and necessary both as an incentive to participate in an educational or therapeutic program and as an unequivocal expression of social disapproval for DUI behavior.

The Alcohol and Drug Assessment Services (ADAS) program of Cook County, Illinois, attempts to deal with the problem of DUI and its related issues by taking into account the diversity of offenders and treating them with measures suitable to the individual. In addition to this multifaceted approach, the ADAS program is integrated with the judicial process resulting in a holistic, modified punitive framework for dealing with DUI offenders. These measures appear to be accomplishing ADAS's primary goal of preventing recidivism.

It has been suggested that other public policies would contribute to lowering recidivism among DUI offenders and thus reduce the social and economic costs of alcohol- and drug-related driving offenses. One more recent suggestion is to lower the level of blood/breath alcohol content indicative of intoxication. As Healey (1986) points out, this proposal stems in part from the inadequacy of reliance on the obvious signs of intoxication, such as slurred speech or difficulty in walking, when accumulating data suggest that objective impairment precedes these clinical signs. However, there is some disagreement as to the effectiveness of lowering the minimum legal BAC level. Hjelle (1986) suggests that recent studies show no elevated risk of causing a fatal traffic accident if the BAC is below .09. Further, while there is an evolving public awareness and concern about driving under the influence, there is still a degree of societal tolerance for drunk drivers in the United States, and lowering the BAC level for per se intoxication may not be acceptable for what is perceived by some as "normal behavior." In addition, as demonstrated by the recent evaluation project in Cook County, BAC level upon arrest does not seem to predict for multiple offenders in the lower and middle ranges of intoxication exhibited by most offenders. Consequently, a policy of lowering the BAC level as determinative of per se intoxication may not be effective in preventing recidivism.

Another approach suggested is to increase the severity and certainty of punitive sanctions, particularly in the form of mandatory incarceration. Actual sentences may

depend as much on the attitudes and discretion of judges and prosecutors, and the heavy demands on the court system and incarceration facilities. In many instances, the more severe the penalty, the less likely it will be imposed. If the probability of punishment is so low as to be negligible, then the severity of threatened punishment cannot be expected to influence behavior. Additionally, studies show that mandatory jail sentences do not deter DUI behavior.

While such legislation may be accurately regarded as a public statement with respect to the sanctions desired and the punitive feelings toward such behavior, individual offenders brought to trial may face a sympathy and tolerance that work to reduce the penalties actually imposed. Criminal justice systems may shift to maintain penalties at a level felt to be reasonable by the public, even if this means an informal reinterpretation of the law. "Law" itself may not be well served by such equivocations.

Punitive and rehabilitative measures for treating DUI offenders are not only compatible, but may also be the most effective deterrent to DUI behavior by preventing recidivism. When such treatment or education is court-mandated and imposed along with legal sanctions, it can provide both beneficial effects in itself as well as an incentive to change behavior in the future. These less severe but more prudent penalties have a far greater likelihood of being imposed and thus be more effective in lowering recidivism among DUI offenders than the more stringent standards being proposed.

The assessment of the impact on recidivism is much more difficult to ascertain. The repeat offenders with chronic alcohol problems must be the special concern of any campaign if we are to make drunk driving socially unacceptable. Court-mandated punishment coupled with rehabilitative measures can be effective deterrents to DWI behavior in lowering recidivism. Therefore, the implementation and impact of appropriate legislation need to be monitored to ensure that judges and the entire court system apply the law properly and to learn how the sanctions are regarded in the public mind.

The following categories derived from Axis #5
from DSM-3 American Psychiatric Association

Clinical assessment — Levels of Functioning

0

- Effective functioning in physical, social, and occupational areas, and use of leisure time.
- Average functioning in physical, social, and occupational areas, and use of leisure time.

1 — Some impairment in physical, social, or occupational functioning.

2 — Moderate impairment in physical, social, or occupational functioning, or some impairment in all three.

3

- Marked impairment in physical, social and occupational functioning.
- Gross impairment in virutally all areas of functioning.

ALCOHOL AND DRUG EDUCATION SERVICES

D.U.I. RISK FACTOR

ARRIVED AT THRU INFORMATION FROM:

Education Referral Officer

A. Personal Data Form
B. Attitudinal Study
C. Mast or Equivalent
D. A.D.E.S. — Substance Abuse Assessment
E. Personal Interview

Above Information Results
In Risk Category: 0, 1, 2, or 3

Behavioral Assessment Scales (BAS)

A. Cognitive
B. Perceptual Motor Functioning
C. Social/Emotional

Above Information Results
In Risk Category: 0, 1, 2, or 3

Summated Risk Factor =

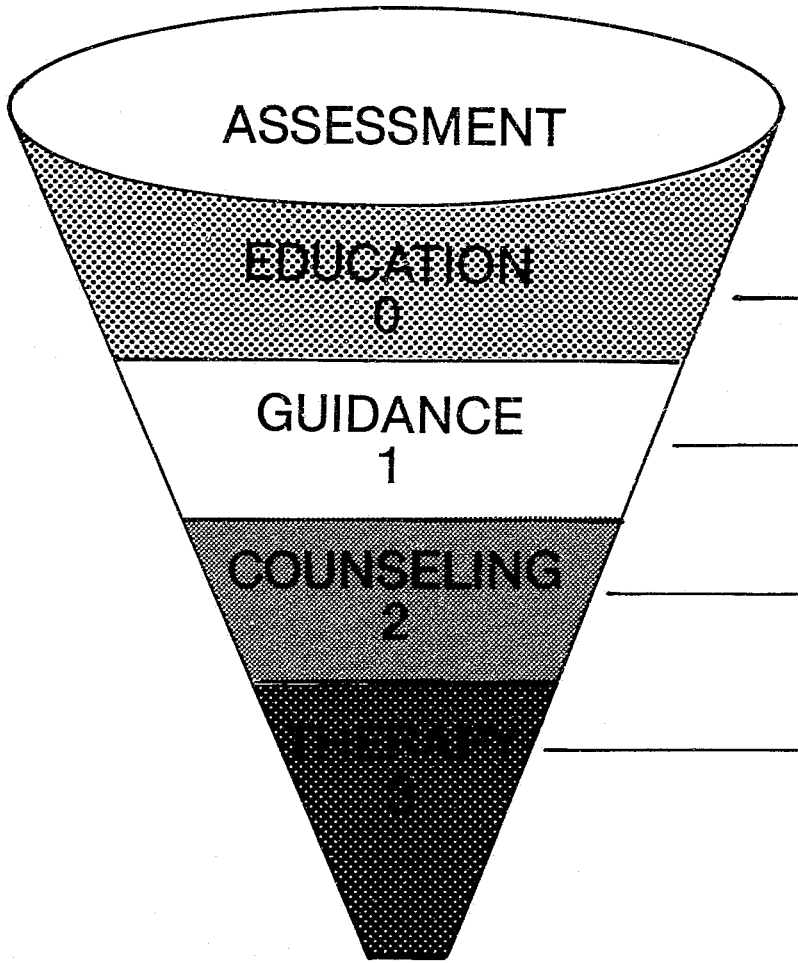
ERO CATEGORY
\+ **BAS** CATEGORY

÷ **2**

RISK FACTOR — Risk factor is rounded with greater weight given to education referral officer's impression.

Appears on court report

THE HOLISTIC APPROACH* TO INTERVENTION THRU:



RISK FACTOR 1 — Mild Life Problems

RISK FACTORS 0 — No Apparent Life Problems

RISK FACTOR 2 — Elevated Life Problems

RISK FACTOR 3 — Marked/Severe Life Problems

*As found in:
D.U.I. Levels of Intervention,
A Ten Year Experience
Presented in 1982 at the 33rd Conference of the
International Council on Alcoholism and Addictions,
Tangiers, Morocco

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REPEAT OFFENDERS

BY

CHARLES F. LIVINGSTON

How many times in the DWI arrestee arena have you heard the statement: "He or she is a first offender; therefore, we need only give him a slight fine and send him to a eight- to 10-hour traffic-safety-education program?"

I suspect that those of you involved in the prosecution and defense of DUIs hear it day in and day out concerning between 75-85 percent of the individuals who have been arrested for driving while intoxicated.

That is because normally 75-85 percent of the arrestees are first-time arrestees, but that does not equate with first-time offenders.

This morning I'd like to briefly highlight some studies that were undertaken by two former colleagues of mine and attempt to put into perspective the population that we are truly dealing with when we have a drunk driver before us.

First, let us examine information about the drinking habits of a random sample of the general population and then look at data on the kind of drinking required by DUI drivers that are arrested.

Certainly, the norm for drinking as shown by this table is not to drink five or more drinks at a sitting.

The above data is in sharp contrast to the kind of drinking required by DUI drivers who are arrested. To get arrested for DUI, you generally must have a BAC of 0.10 percent or more, with BACs of 0.18 to 0.20 percent being average. An inspection of Table 2 shows the amount of alcohol that you would need to consume to reach both the average and the minimum BAC generally required for a DUI arrest.

As shown in Table 2, even a 100-pound person would have to drink seven or more drinks to reach the average BAC of those arrested for DUI, and would have to do it on an empty stomach and in a one-hour period, which is highly unlikely. Since most DUIs are men (about 90 percent), weights of 160 lbs. or more being normal, at least 11 or more drinks would have to be consumed to reach the average BAC.

Further, even BAC minimums of about 0.10 percent require abnormal consumption of alcohol. For

example, to reach a BAC level of 0.10 percent, a 160-pound person must consume six or more ounces of alcohol in an hour, even more if eating is involved and the drinking period is extended. Again, this use of alcohol is in excess of norms.

In summary, a comparison of consumption levels of alcohol required to reach BAC levels typical of DUI arrestees against information about normative drinking levels indicates abnormal use of alcohol.

Now if we look at the classification made by a number of agencies for the screening and disposition of drunk-driving cases, we can see the potential level of the problem facing the court system and the health treatment community. Later on, the problems that police have in truly deterring the vast majority of drunk drivers will be highlighted.

Albuquerque

Over a three-year period beginning in 1982, the National Council on Alcoholism in Albuquerque, New Mexico, screened more than 7,000 drunk drivers who were considered to be first-time offenders. The classification of these drunk drivers was based on scores on questionnaires, diagnosis by trained interviewers, and the person's BAC at the time of arrest. This was the case with almost all of the agencies contacted. The average BAC of these first offenders was 0.168 percent with many at or above 0.20 percent BAC or a consumption of approximately 15 drinks. Of these 7,000 persons reviewed, almost 60 percent were considered to be problem drinkers. Considering that this survey only covered first offenders, one should expect a higher proportion of problem drinking among multiple offenders.

Colorado

In Colorado, the law requires that everyone arrested for drunk driving be screened for alcohol problems; in 1985, over 25,000 people were screened. The average BAC of these people was found to be 0.17 percent. Over 50 percent of these persons were classified as problem drinkers and another 30 percent were considered to be "incipient" problem drinkers (those in the early stages of problem drinking).

New York

The Pre-trial Services Corp. of the Monroe County New York Bar Association runs a county-funded screening and assessment program. In New York, all persons with at least one prior drunk-driving conviction must be screened. In the more than 300 interviews in 1985, over 70 percent were considered problem drinkers. The average BAC of this multiple-offender group was 0.20 percent.

Maryland

The DWI Monitoring Program of the State of Maryland is responsible for tracking the progress of over 16,000 persons arrested for drunk driving in 1985. According to assessments made by the Health Department, more than 70 percent of these persons are considered problem drinkers.

Philadelphia

A recent study of the DUI treatment program in the city of Philadelphia found that 75 percent of the 21,000 convicted drunk drivers were problem drinkers or alcoholics. The average BAC at the time of arrest was 0.19 percent.

New Jersey

The state of New Jersey Division of Alcoholism estimated that half the people evaluated in its screening program were referred for treatment of serious alcohol problems, and that most drivers convicted of drunk driving were "usually well over 0.10 percent BAC."

So we can see that the majority of DUI arrestees are being classified as problem drinkers or alcoholic. If we extrapolate from those data to the number of DUI trips needed to generate an arrest, we can clearly see that our first-time arrestee is not in all likelihood a first offender, but a repeat offender who was only recently apprehended.

What are the implications of these data? Clearly, they tell us that police need better tools and more resources if our level of deterrence is going to get high enough to impact the problem drinker. Secondly, the treatment resources in most communities need beefing up if we are really going to assist the individual who has a problem. The courts need the tools to properly diagnose the individual and refer that person to the right health agency.

Most importantly, we must all realize that quick fixes and slogans will not dramatically alter the drunk-driving problem in this nation until we all become socially committed to reducing drunkenness and drunk driving within our everyday social and work environments.

Let me hasten to add that these findings and recommendations are not new. They were the basis of the Alcohol Safety Action Program started in 1970 by the U.S. Department of Transportation and they were embodied in the Report of the Presidential Commission on Drunk Driving.

Table 1
Frequency of Drinking Five or More Drinks
1974, 1980 and 1981 Data for Persons Who Drink

Frequency of 5+ Drinks	1981 Total	1981 Male	1981 Female	1980 Total	1974 Total
At least weekly	10.9%	16.6%	4.5%	14.6%	12.0%
6 times/year					
2-3 times/month	24.6%	30.2%	18.3%	22.1%	20.4%
1-5 times/year	19.8%	20.5%	19.1%	19.5%	25.2%
Never	44.7%	32.7%	57.9%	43.8%	42.2%
	799	415	384	481	832

Table 2
Estimated Number of Drinks of 80 Proof Liquor Needed to Reach Given Levels of Alcohol in the Blood*

Weight	One-Hour Period		Four-Hour Period	
	0.10%	0.20%	0.10%	0.20%
100	4	7	5	8
130	5	9	6	10
160	6	11	8	13
180	6	12	9	15
200	7	13	11	17

*Empty stomach, with little or no food intake prior to drinking.

Table 3
Probability of DUI Arrest
Based on Number of Trips
With BAC 0.10% +
For Selected Arrest Levels

Number of DUI Trips		Percent of Licensed Drivers Arrested for DUI* 2.0% (1 in 140)	1% (1 in 280)	0.5% (1 in 560)
1		.007**	.004	.002
2		.014	.007	.004
4		.028	.014	.007
8		.056	.028	.014
12	(1/mo.)	.082	.042	.021
14	(average)	.095	.049	.025
16		.108	.056	.028
20		.154	.069	.035
24	(2/mo.)	.158	.082	.042
32		.205	.108	.056
48	(4/mo.)	.291	.158	.082
52	(1/wk.)	.311	.170	.089
104	(2/wk.)	.526	.311	.170

* Probability of DUI arrest is a function of % of licensed drivers arrested for DUI. See "Determining the Risk of DUI Arrest." - Crancer 1983.

** Probability of DUI arrest of .007 is the fractional equivalent of the chances of a DUI arrest of 1 in 140 trips.

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Driving Under the Influence of Alcohol & Drugs: The Judge's Role

Lee Robbins

Presented at the National Conference on DWI Recidivism of the National Commission Against Drunk Driving.
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Summary:

Judges view existing DUI/DUID law objectives as overemphasizing punishment with a resultant cost to deterrence and rehabilitation. So concluded a 1984 study of 570 judges who hear driving under the influence of alcohol and drugs (DUI/DUID) cases in California, Colorado, Georgia, Maryland, Pennsylvania and Wisconsin. Judges prefer a sanction "package" (e.g., fines, rehabilitative treatment/education, license suspension, community service or short jail term) for the typical offender rather than any single solution—a conclusion also supported by a 1986 Minnesota study of 79 judges. Alcohol problem assessments were also viewed as accurate and useful.

Judges expressed widest overall support for license suspensions as a sanction for both first and repeat offenders. They strongly supported rehabilitation programs and fines for both first and repeat offenders. A large majority supported mandatory jail sentences for repeat offenders but not for first offenders.

Slightly over half (59 percent) of the judges in the six-state study believed DUI laws were "good" or "very good" for first offenders; less than half (48 percent) place DUI laws in these categories for recidivists.

During and after the study, judges doubted the effectiveness of existing sanctions and whether sentences were always executed by heavily burdened jails and licensing bureaus. Informally, judges expressed concern about the neglect of DUID (driving under the influence of drugs) which, limited research indicates, may account for 10-30 percent of the DUI problem.

Judges showed great concern for the problem of driving under the influence of alcohol and drugs and favored increased education for the judiciary on DUI/DUID issues. Implied in their stance is a need for greater involvement by judges in solving complex DUI and DUID problems and greater—rather than less—discretion for both local communities and judges.

A model of the existing system, entitled the "Punishment-Response Model," is then presented. Logical analysis and empirical research refute the validity of this model and thus throw into question existing DUI strategy. The paper closes with suggestions for alternatives.

Driving Under the Influence of Alcohol and Drugs: The Judge's Role

by Lee Robbins

Introduction:

Mandatory jail sentences for driving under the influence of alcohol (DUI) and drugs (DUID) have become highly popular due to a common perception that judges help offenders rather than society—they are "soft on crime." Mandatory sentences have been seized upon as the solution for a variety of other offenses—prominently the use and sale of illicit drugs—reflecting a general trend toward determinate sentencing and an underlying belief in a punishment-response model of human behavior.

Highway accidents—and the possibility that drug and alcohol abuse by drivers was an important factor in their occurrence—have been a concern since the invention of the automobile. Strong citizen activism, a revival of prohibitionist and neo-prohibitionist sentiment, and striking (though difficult-to-interpet) statistical data on accidents inspired massive public campaigns. These campaigns were based on a popular view that severe laws and firm enforcement would vastly reduce deaths and injuries.

Citizen activism focused on harsh laws prohibiting the use of marijuana, pornography, abortion, and drunk driving during the '80s. Success in curbing these activities remains doubtful or limited while there is scant scientific evidence supporting the effectiveness of strong punitive sanctions. But failure often led to demands for still stronger solutions—longer jail terms and more aggressive detection. Voters respond not to statistical research, but to strong passions. Campaigns led by two organizations, Mothers Against Drunk Driving (MADD) and Remove Intoxicated Drivers (RID), publicized complaints about the judiciary and its handling of DUI/DUID. These groups originated with those angered that punishment meted out to drunk drivers responsible for the loss of their loved ones seemed insufficiently harsh.

Their pain fuels our anger. Their organizing and publicity ensures our attention. Without the efforts of these activists, many achievements in traffic safety of the last decade would not exist.

However, we may reasonably speculate that activist groups attract those angered by lenient judges more than they do those who thought their cases fairly adjudicated. These angry voters, dissatisfied by weak sentences, first demanded swifter, surer punishment; then harsher laws; then mandatory jail sentences; and finally mandatory rules for prosecutors.

Their anger exempted the police—who sympathized with the activists — but held accountable those judges who attempt to balance punishment with other social needs (particularly deterrence and rehabilitation). Legislators, influenced by the media and activist groups, enacted laws in the absence of any scientific research on the views and behavior of judges.

Implied is that the demand for mandatory sentencing is a means to control judges (and prosecutors). If they do not support such sentencing, the inference is that judges and prosecutors are "weak" on crime. Since this odd inference cries out for explanation, the MADD and RID groups explain that many judges hearing DUI cases are "soft on criminals" because they drink and drive themselves and think, "There, but for the grace of God, go I." Another explanation for those unpersuaded by this view, (unsupported by any scientific evidence) is that judges do not recognize the seriousness of the problem. Indeed, in earlier times this latter explanation may have had some merit, but it is not supported by the research of 1984 and 1986.

Results of existing studies of judges' views:

The 1984 Wharton study and the 1986 Minnesota DWI Task Force study do not support the conclusion that judges are excessively sympathetic to DUIs or that they fail to recognize the seriousness of the DUI problem. In the Wharton study of 570 judges (1984), the most common answer to the "one change" judges would make in existing DUI law was to "increase the penalties." They believe it is existing law, not adjudication, which is too lenient (see Table I). In the Minnesota study (1986) when judges were asked, "In your opinion, what sanction or combination of sanctions is most effective in preventing DUI recidivism?" jail ranked first (see Table II).

Table I

The one Change in DUI Law Judges Would Make

(570 judges; Calif., Colo., Ga., Md., Pa., Wi.; 1984)

Change They Would Make	Percentage of Respondents
Increase available penalties	30
Increase judicial discretion	11
Require therapy	6
Increase certainty/publicity of penalties	5
Decrease jurisdictional differences in sentencing	5
No change needed	9
Various other changes	16
No response/don't know	15

Table II

Sanction(s) Believed Most Effective in Preventing Recidivism

(79 judges; Mn.; 1986)

Sanction (s)	Number of Respondents Citing
Jail	43
Treatment	31
Education	24
Suspended jail sentence	18
Fine	16
Probation/supervision	10
Loss of license	9
Other	28
Other	16

These two studies were conducted in seven states. The 1984 study achieved a high response rate of 60 percent; the 1986 Minnesota study, with fewer resources for follow-up, drew a strong but lower rate of 41 percent.

The studies are not based on a statistically random sample of states; hence, their reliability as an indication of the views of U.S. judges as a whole cannot be statistically inferred. They do, however, reliably reflect the views of a majority of judges hearing DUI/DUID cases in seven states having DUI laws in the broad, middle range of severity. The Minnesota survey studied the entire population of 217 while the Wharton study covered a random sample of 1,038; response numbers were respectively, 88 and 570. The strong response rates are an indicator of the seriousness with which judges view the DUI/DUID problem as well as their commitment to solve the problem.

The single sanction for DUI offenders most widely supported by judges in the 1984 study was licensing suspensions and/or revocations—particularly for repeat offenders. (In Minnesota, licensing sanctions are primarily a responsibility of license administrators rather than the courts.) While judges in the 1984 study gave considerable support to mandatory minimum sentences for repeat offenders, few regarded mandatory sentencing as valuable for first offenders. These findings emerged when the Wharton study (1984) asked judges to cite their preferred disposition of a typical first and repeat DUI offender, (see Table III). Judges were asked in a later question to rank 11 alternatives for "usefulness" in handling all DUI offenders. They ranked License Suspensions and Revocations first again.

Table III

Most Appropriate Dispositions for Typical Offenders

(570 judges; Calif., Colo., Ga., Md., Pa., Wi.)

Disposition	(% of Judges) First Offenders	Repeat Offenders
License Suspension/Revocation	69	88
Rehabilitative Programs	69	64
Discretionary Jail Sentence	46	29
Mandatory Jail Sentence	20	74
Fines	71	71
Driver's Education	45	24
Avg. number of sanctions imposed per offender	3.6	3.9

Though judges are committed to strong DUI laws, most judges in each of six states covered by the 1984 study believed existing law overstressed punitive objectives at the cost of inadequate emphasis on deterrence and rehabilitation. The data indicates that they would decrease the focus on the objective of punishment by a third (34 percent) and substitute increased emphasis on deterrence (19 percent) and rehabilitation (17 percent) (see Figure 1).

*Thomas A. Cowan, Lee P. Robbins, and Jacqueline R. Meszaros, "How Judges View Drunk Driving Laws: A Survey;" Judges' Journal, Vol. 24, No. 4, Fall, 1985, p55.

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More than half (59 percent) of the judges believed DUI laws were "good" or "very good" for first offenders; less than half (48 percent) place DUI laws in these categories for recidivists.

Sixty percent of judges saw mandatory DUI sentencing as leading to jail overcrowding and half thought such provisions slowed the overall work of the courts (Wharton, 1984).

A three-year study was conducted (Ilich, 1986) on the effects of the tougher 1982 California law on the Los Angeles Municipal Courts. These courts hear over 100,000 DUI cases each year—more than many states. The 1982 law added mandatory jail and fines, restricted plea bargaining and required alcohol programs for most offenders. Ilich found that jury trials increased by 33 percent, guilty pleas dropped 2 percent and probation revocation hearings increased 64 percent. Significantly, the report states that civil trials decreased by almost the same percentage as DUI/DUID trials increased, and states that some of the courts' success in handling the increased DUI/DUID caseload may have been at the expense of the civil caseload. In a study of the effects of the 1982 law on Alameda County, California, (Hepperle and Klein, 1985) significant increases were found in the time and effort to close a DUI/DUID case: time needed went from 48 days in 1981 to 86 days in 1984. The report also notes that fully 55 percent of DUI/DUID offenders studied had either a prior, or subsequent DUI/DUID arrest and points out that this is a conservative figure as only data on Alameda County DUI/DUID arrests were available.

The National Institute of Justice (1984) studied the impact of mandatory jail confinement in a total of four jurisdictions with one each in the states of Minnesota, Ohio, Texas, and Washington. The Institute concluded that arrests increased and "new and heavy" demands were placed on the courts, on jail facilities and on probation services. Notably, conclusions on the effectiveness of mandatory sentences in reducing recidivism or alcohol and drug abuse were not present in the three reports.

In the 1986 study, Minnesota judges were divided 50/50 on the desirability of guidelines for sentencing uniformity, but only one-quarter favored legislative mandate as the means of obtaining uniformity. In the light of (1) strong concern by judges for the DUI problem, (2) their general support for some shift of emphasis from punishment to deterrence and rehabilitation, (3) the one-third who support increased severity, and (4) support for a multiplicity of different sanctions, it appears that judges disagree about how best to achieve deterrence and rehabilitation. Thus even judges favoring "increased severity" do not necessarily equate "increased severity" with "more jail time"—particularly for first offenders.

With one exception, research evidence provides little indication that jail time served is effective in decreasing DUI incidence or recidivism. An exception is the recent experiment in Hennepin County, Minn. (included in the National Institute of Justice study) where voluntary guidelines developed by local judges' calls for two-day jail sentences. The Hennepin County program depended not upon legislative mandate, but upon voluntary cooperation and agreement by local judges. Nighttime injury accidents showed a statistically significant 20 percent reduction compared with the pre-existing monthly average.

Apparently, Hennepin County judges believe the program works. After two years and an extensive turnover of judges, roughly 82 percent of DUI offenders are reportedly sentenced to two-day jail terms. Other studies of DUI jail sentences have not demonstrated an impact upon accidents. A working hypothesis which cries out for further trial programs and evaluation is that voluntary collaboration in judge-designed programs can achieve more than legislative mandates.

Existing research supports license suspension/revocation as the sanction most likely to decrease recidivism. Even though a large proportion of offenders, estimated as high as 80 percent, drive with a suspended or revoked license, research indicates that they drive less frequently and more safely. In short, judges want sanctions that work. As a group they define "success" primarily as deterrence and rehabilitation though still with some attention to the issue of retribution. Further support for this view of judges' definition of success is provided in Cowan et. al. (1985) where it was found that judges least supportive of mandatory sentencing were also those most skeptical of the effectiveness of mandatory sentencing in reducing alcohol-involved accidents. The minority, who were more optimistic than most on the effect of mandatory jail sentences on accidents, were the most supportive of such sentences.

According to the 1984 and 1986 studies, judges prefer a sanction "package" (e.g., fine, rehabilitative treatment/education, license suspension, community service or short jail term) for the typical offender rather than trusting to any single solution. Judges suggested 3.6 separate sanctions for the typical first offender and 3.9 for the recidivist. This appears to reflect the seriousness with which they regard DUI/DUID cases as well as the complexity of the problem. It is consistent with research evidence which does not support any single solution; it is consistent with the multiple objectives supported by judges.

Judges do not think they know all they need to know for reducing DUI/DUID. They are eager to learn more. On a scale from 1 (not at all useful) to 5 (extremely useful), 82 percent of 570 judges in the

Wharton study supported increased judicial education on DUI/DUID with a rating of 3 or higher. However, despite the interest in wider availability of judicial education on DUI reflected by the 1984 study, most judges (58 percent) in the 1986 Minnesota study had not attended a continuing education seminar on DUI/DUID in the preceding two years. Sources for judicial DUI education in addition to local resources include seminars of various durations offered by the National Judicial College in Reno and the National Highway Traffic Safety Administration both of which will produce seminars in localities desiring them; regrettably, similar treatment of DUID is not yet available.

Conversations with judges indicate that their commitment to participation in DUI/DUID judicial education would grow if judges played a direct role in designing DUI/DUID seminars. In one project in a major metropolitan city in which the author participated, judges committed substantial time to better understanding of DUI/DUID laws and the effectiveness of various sentencing alternatives—but only when judges participated in framing the questions and setting the form of the educational sessions. In the process, the project discovered a number of discrepancies in the operation of other parts of the system—poor tracking of offenders by probation departments, lack of evaluation of the effectiveness of rehabilitation programs for repeat offenders, declining arrest rates, and a very low rate of detection of DUI/DUID offenses by juveniles. Initiatives by judges in other localities have led to more comprehensive, better coordinated and more energetic efforts to reduce DUI/DUID problems.

In the Wharton study, judges rated offender alcohol/drug problem assessments more favorably in states like Minnesota, where such assessments were already widely used. In other words, experience with the assessments appeared to produce a more favorable evaluation of their value. Mansell, one of the foremost experts on the treatment of alcoholism, (Mansell and Mello, 1985) discusses at length the variability of the nature of drinking problems, the variability of treatment modalities, and the importance of appropriate matching of patient and treatment form. He also points out that the process is dependent upon an effective system of programs and referral procedures in the local community.

Informal discussions with judges indicate they recognize a growing problem of impaired driving due to drugs other than alcohol, but they state that cases of drug impaired (DUID) or combined alcohol and drug impaired (DUI/DUID) are rarely presented to their courts. For example, in all of Minnesota, only five DUID cases were brought in the first half of 1986. Limited research data on the prevalence of

drugged driving suggests that instances of DUID and DUI/DUID may account for 10 - 30 percent of substance-impaired driving incidents.

Until greater attention is focused on DUID, we will not know to what extent a perceived alcohol-involved traffic-safety problem is really a drug problem—or a problem of drugs and alcohol abuse combined. Estimates by Virginia police on the proportion of drivers stopped for being impaired who may actually be under the influence of drugs, other than alcohol, ranged from 10 percent to 40 percent with a mean of 17 percent (1985; Paltell and Booz). The same study reports that of 1,877 people referred for DUI-alcohol treatment in 1983 and 1984, a conservative use of drugs other than alcohol based on self-reports was 25 percent. Of those cases reported, half used drugs several times a week or more. Los Angeles police, who work with DUID offenders in one of the only programs around the country for this purpose, estimate a likely rate of impaired driving due to drugs other than alcohol at 10 percent to 20 percent of total impaired driving. In a major study of drugs and alcohol found in fatally injured young male drivers in California, Williams et. al. (1985) found one or more drugs (including alcohol) in 81 percent and two or more in 43 percent. While alcohol was the most prevalent substance found, presence of drug(s) not combined with alcohol was found in 17 percent of the cases. A different kind of study on adults arrested for criminal offenses other than DUI in a large Southeastern city, found 63 percent tested positive for one or more drugs excluding marijuana and alcohol. The U.S. attorney involved with the study commented, "All of these people drive at one time or another during the day." In other words, there is no reason to think that the increasing number of people abusing drugs are any less likely to drive under their influence than those who abuse alcohol. Yet anecdotal stories abound of the heavily drugged individual who carefully consumes a drink or two before driving, is stopped by police for erratic driving, but is then released to return to the highways when his BAC tests below the legal limit.

The development of the Drug Recognition Expert (DRE) Program by the Los Angeles Police Department provides us with the technology to begin examining and treating the DUID problem. This program, developed by the police in conjunction with leading drug-abuse and traffic-safety researchers, involves a series of non-invasive tests by which officers certified in the program can detect impairment due to drugs other than alcohol. A double-blind study of DREs (Bigelow et. al.; NHTSA, 1985) found that if the DREs judged a test subject as impaired due to drugs, the test subject had in fact received a drug in 98.7 percent of the cases. He also found that DREs were able to correctly identify the impairment as due to a particular class of drugs (e.g., depressants, stimulants, marijuana, etc.) in 91.7 percent of these instances. Currently the National Highway Traffic Safety Administration, which partially funds

the Los Angeles program, is developing a course to train police officers in DRE methodology for use in pilot programs in other city and state highway police departments.

Though a positive finding by a DRE is followed up by a blood test in Los Angeles, the procedure has major advantages over generalized chemical testing programs. Unnecessary expense is avoided, probable cause exists in response to possible objections by defense attorneys or civil liberties organizations, and actual impairment is identified by officers trained to testify effectively in court to behavior likely to endanger highway safety. DRE testimony is very well accepted by Los Angeles judges and prosecutors. As a social systems consultant, the author suggests that the existence of an organizational unit dedicated to addressing the DUID problem is as important as the specific detection techniques used.

Implications:

Arguments for a punitive approach—greater severity and certainty — possess intuitive validity for those who make our laws and form public opinion and are themselves often social users of alcohol. Using introspection, legislators and reporters can reason, "If penalties were greater, detection surer, punishment swifter, social disapproval clearer, surely people (like myself) would stop or decrease proscribed behavior." The punitive model is depicted in Figure II following. Simply put, the message of the model is that punishment deters and increased punishments deters even more. But is this simple message also true?

Figure II

THE PUNISHMENT-RESPONSE MODEL: Valid or Simplistic?

DRIVERS + drug/alcohol abuse

DEATH/INJURIES to others

1) The offenders are bad.

or

2) Their behavior is bad.

3) Victims need retribution.

4) Public needs protection.

INCREASE PUNISHMENTS

(severity, certainty, speed)

1) For justice (retribution)

2) For deterrence

Underlying assumptions:

- severe, swift punishment is painful
- people wish to avoid pain
- they will avoid the proscribed behavior (DUI/DUID)

AND—implicit assumptions —

1) There are no offsetting effects in the system.

2) Accidents/injuries rise or fall synchronously with DUI/DUID incidence.

Making the underlying model explicit enables us to ask, "Do the assumptions make sense? Are they empirically supported?"

Most researchers regretably and puzzlingly estimate that problem drinkers and alcoholics comprise 50-80 percent of all DUIs (alcohol). (Lack of attention to and funding for research on drugged driving allow only the suggestive DUID estimates cited earlier.) We could ask, "Is it reasonable to assume that those who are drunk or drugged at private parties or public drinking places, lacking the judgment and reflexes to drive safely, will calculate the increased penalties and choose not to drive?" At a conference for judges which I attended, this question was posed to the founder of MADD who replied, "No, but they can decide not to drive to the event while they're still sober." This constitutes a reasonable answer, but is it realistic? Can we expect that alcoholics and drug abusers who are injuring their own health, their families, and their jobs will be "reasonable?"

Hans Laurel, researcher at the Swedish National Traffic Safety Institute, (in discussions with the author, 1984, 1986) examining traffic safety results in Sweden where laws are far harsher, legal BAC limits lower, and social disapproval far more universal than in the U.S., cited the following: Late Friday night roadside surveys indicate that less than one-half of 1 percent of drivers sampled were legally intoxicated (Blood Alcohol Content, BAC, .05). At first examination this would support the "Scandinavian model" of swift, certain punishment and widespread publicity. But in contrast to the one half of 1 percent of drivers found intoxicated in roadside surveys at peak alcohol impairment hours, official coroners' reports cite 8.0 percent to 15.0 percent of auto fatalities as intoxicated. Because coroners are legally required to report only the direct cause of death, and listing "intoxication" is likely to be disturbing to surviving family members, Laurel suspects these figures are strongly underestimated. He cites small-scale but meticulous studies, conducted after the major features of the Scandinavian system had long been in place (1972, 1977), showing 30 percent to 35 percent of auto fatalities above the legal BAC limit. In other words, the apparent result of the punitive method was success in stopping those individuals from drinking and driving who rarely drink, drive and crash, but far less success in stopping those who drink, drive and die in highway accidents.

These results are consistent with assumptions supported by considerable empirical data: 1)

alcoholics and problem drinkers are at the heart of the problem of alcohol-involved accidents; and 2) alcoholics and problem drinkers are little deterred by the punitive approach—as we found to our cost in the Prohibition experiment. Not inconsistent with the research indicating the conjunction of depression and a variety of life problems with alcoholism and problem drinking is the suggestion by another researcher, Michael Balter, (1985) that, rather than asking, "Are some accidents really suicide?" we should consider a trichotomy of impaired drivers including the suicidal, the survival, oriented and the somewhat indifferent. Research based on such a threefold classification would also examine the hypothesis that some drivers when drunk or drugged attempt to compensate by slower speeds and safer routings while others increase their risk-taking. Gusfield (1981, p. 166) — in a comprehensive study of the nature of society's definition and response to drinking and driving which deserves far more attention by policymakers than it has received—comments, "Research now in progress leads me to believe... drinkers often distinguish instances and situations when they feel incompetent to drive and frequently relinquish the wheel..." In other words, similar physiological effects of alcohol or drugs in different individuals, may produce very different risks of occurence of severe crash depending upon psychological co-factors leading to risk aversion or risk avoidance.

These points cast major doubt on the model's implicit assumption that a decline in the amount of driving under the influence of drugs or alcohol will produce a commensurate decline in deaths and injuries in alcohol and drug-involved accidents—presumably our real intention. The likelihood is that those who respond readily to the punishment-response model will be persons least impaired, most protective of themselves and others and least likely to have their drinking or drug-use behavior combine with serious crashes. We may question whether those who are willing to risk death, injury on the highways and the more certain damage to their health, careers and family ties due to alcohol and drug abuse are as responsive to the avoidance of legal punishment as the model assumes.

Since only the greater certainty of "severe, swift and certain" punishment can be recognized as possibly more threatening than the inherent costs of DUI/DUID accidents and drug and alcohol abuse, it is not surprising that researchers (e.g., Ross, 1982) have found that publicity and certainty, not severity, have some correlation with decreased DUI/DUID behavior. Mandatory sentencing with accompanying publicity might seem to meet at least this criterion. However, this still leaves untested

the final assumption—lack of other compensatory system effects. Research on this point equivocates on whether the criminal justice system can absorb increased penalties for DUI/DUID without compensating through such measures as decreased arrests, long delays, failures to execute sentences passed, and the introduction of education/rehabilitation programs with little bite. Nor is it clear whether the public is willing to pay the increasing costs of providing more judges, more jails, more police or tolerate the downgrading of other kinds of cases handled by the same court system.

To sum up, the assumptions of the punitive model bear a very questionable validity. At a minimum they need to be tested by the kind of research that is beginning to be done on the questions raised; in the meantime, these questions need to be carefully considered in the planning decisions of each local community authority and state legislature.

The question then remains of how to handle the serious problem of driving while drunk or drugged and what judges can do about them.

The 1984 Department of Social Systems Sciences, The Wharton School; University of Pennsylvania study (Cowan et. al., p.55) recommended:

* 1) "Legislation should incorporate a wide range of sentencing options and flexible judicial discretion. In brief, trust the judges more rather than less;" and
* 2) "Efforts to promote local DUI programs rather than national utopian schemes may be more effective." These recommendations were balanced with and supported by the further proposition:
* 3) "Increased education for judges on DUI issues should be encouraged."

Research to date provides scant support for effectiveness of jail or fines as DUI/DUID deterrents, though these penalties may still serve the punitive function. The threat of jail may serve to support other alternatives including:

1) long-term treatment and administrative control where a serious alcohol or drug-abuse problem is found;
2) the use of interlock systems to deter drunk driving, particularly for recidivists, problem drinkers, and young drivers; and
3) community-service programs in which offenders themselves are required to develop and implement programs to discourage DUI/DUID.

Treatment for drug and alcohol abuse is improving in sophistication and effectiveness. Though research on very long-term programs is limited, indications are that administrative control over participation by the abuser in follow-up treatment over long-term periods (measured in years rather than weeks or months) correlates with major increases in remission of the abusive behavior. Programs utilizing long-term administrative control such as those of the Federal Aviation Agency and some corporate employers' Employee Assistance Programs (EAPs) claim success rates in the 75 percent to 90 percent range. While these programs deal with more manageable populations, development of court-supervised long-term programs for selected DUI/DUID offenders might allow successful intervention at an earlier stage of dependency.

Interlock systems which prevent or deter the intoxicated driver from starting or continuing to drive the vehicle do not address underlying problems of alcohol abuse and do not exist for drugs, but they do address the need to separate the alcohol abuser and his vehicle. The cost for breath-type systems with maintenance is now in the range of $400 - $500 a year—far less expensive than the alternatives. The objection sometimes raised is that such systems might be evaded; one answer is that the technology has improved to the point where this is unlikely. A more important response is that even occasional evasion would be considerably more successful than the results on DUI recidivism of jail, fines and other programs.

Finally, existing community-service programs rarely attempt to directly address the reduction of DUI/DUID in the local community. One proposal, for which this author is currently investigating pilot sites, would bring offenders together in groups (under a trained facilitator) to act directly on DUI/DUID as one part of their sentence. Groups would develop and implement such small, but multiple local programs as safety campaigns, safe-driver programs, speaking bureaus, awareness campaigns in local taverns or factories, and other means which the offender groups would invent suited to their capabilities and local needs. Offenders would not be released from this part of their sentence until they produced such a program. While the effect of each individual group would be small, the multiple effects of many groups in a community could significantly decrease the problem. An important additional hypothesis is that some offenders would come to recognize and seek assistance for a previously denied drug or alcohol problem.

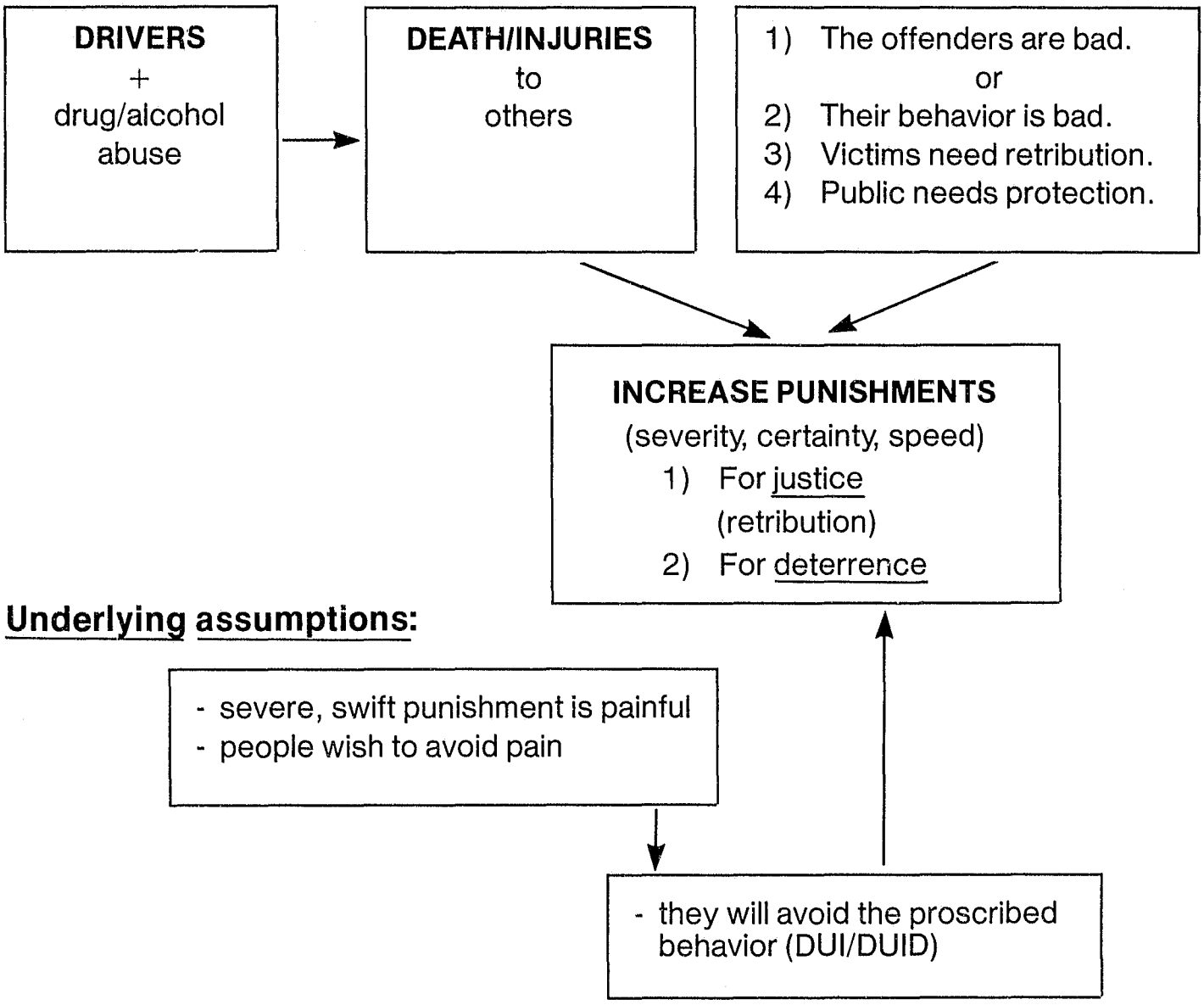
Judges should effectively increase their contribution to reducing the DUI/DUID problem in a variety of ways including:

1) demand and participate in effective education on DUI and DUID issues;
2) become familiar with the quality and availability of evaluation and treatment resources for alcohol and drug abuse;
3) insist that police and prosecutors arrest and prosecute DUID cases as well as DUI cases;
4) actively foster and participate in systemwide DUI/DUID task forces to evaluate current practices and develop system improvements;
5) encourage and assist scientific evaluation of the impact of sentencing alternatives—from which voluntary judicial guidelines can be developed.

Finally, the uncertainties of existing DUI models and programs increase the importance of the fact that even alcohol-involved accidents include less than 50 percent of highway fatalities with drugs adding some unknown percentage.

This figure vastly overstates the contribution of alcohol and drugs to causation of traffic fatalities., Ross (1984), author of Deterring the Drinking Driver (1982), testifying before the first meeting of the American Bar Association's Project to Assess the Effectiveness of DUI Sanctions and Enforcement Techniques commented, "Passage of legislation requiring air bags would save more lives than all the drunk-driving laws in existence." The effort to cut down on driving under the influence of alcohol and drugs must not be allowed to diminish other efforts toward highway safety including passive-restraint systems, safer cars and easier to drive streets and highways.

Figure II
THE PUNISHMENT-RESPONSE MODEL: Valid or Simplistic?



AND — implicit assumptions —

1) There are no offsetting effects in the system.
2) Accidents/injuries rise or fall synchronously with DUI/DUID incidence.

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A judge's view of the Drunk Driving Recidivism problem.

The Honorable
Charles L. Carnes
Chief Judge of the State Court of Fulton County, Georgia

Remarks by Justice Carnes:

When I came to Atlanta some 35 years ago, it was a relatively rural country town. Back then, there were not many places where alcoholic beverages were available. Many people didn't own cars and didn't have the time to spend on recreation that we do today.

Prosperity in America has changed the availability and accessibility of alcohol and automobiles. The nation's highways are becoming more congested as the population and the number of cars per family continue to increase.

While some young adults can handle the responsibility of properly operating a motor vehicle, many are not mature enough to handle alcohol. Furthermore, statewide studies have proven that states which have returned the legal age for drinking to 21 have greatly reduced fatality rates among the 18 to 20 year-old age group.

Many of us that volunteered our time lobbying for stronger restraints against drunken and drugged drivers should be pleased with the progress we have attained. Nothing gives me more pleasure than to announce that in 1986, as a result of programs implemented here in Fulton county, we have been able to reduce the level of recidivism by 20 percent.

We've got the ball rolling, but there are still many challenges to be met. It certainly takes a combined effort between the executive, legislative and judicial branches of government to truly deal a meaningful blow to the menace of the repeat offender. I believe the process must be initiated through aggressive law enforcement. That can only take place with the complete and enthusiastic support of the chief executive officer in each community.

The executive officer must make himself or herself aware of the strong popular anger over drunk driving. Public opinion opposes not only the repeat offender drunk driver but also those judges who consistently refuse to incarcerate convicted repeat drunk drivers — especially in aggravated cases such as those growing out of severe traffic crashes and injuries caused by drunk drivers.

All of us can help keep recidivism in check by continuing to make our legislators and our local media more aware of the problems that persist.

Public awareness programs, media exposure, printed materials, community involvement and other forms of communication have made drinkers more aware of drunk driving laws and fines. Education of the public has resulted in drivers better judging the amount they drink at social gatherings and bars . . . often skipping that proverbial "One of the road."

Even though I am a strong believer that fear is a great deterrent, fear of receiving a stiff fine and loss of driving privileges is not in itself the solution.

If we seriously want to stop the spread of drunk driving and to get the drunk driver off the nation's highways, then a portion of the revenues collected from DUI/DUID fines should be used to develop evaluation programs, provide films and support materials to area high schools, hire more probation officers to accommodate increased case loads, and construct additional space for minimum security facilities. By effectively using our resources, we can provide those people who really need help with the tools to correct their mistakes.

Solving the repeat drunk driving problem calls for substantial investment of state and local resources over a period of time. One-shot programs won't work. Every state and locality has the basic elements to deal with the drunk driver problem — police, courts, driver licensing authorities and media. By coordinating these elements, effective long-range programs can be launched and sustained.

Judge Charles Carnes, Chief Judge of Fulton County, Ga., discusses his experience with repeat offenders.

The Honorable Joe Frank Harris, Governor of the State of Georgia, was the conference's luncheon speaker.

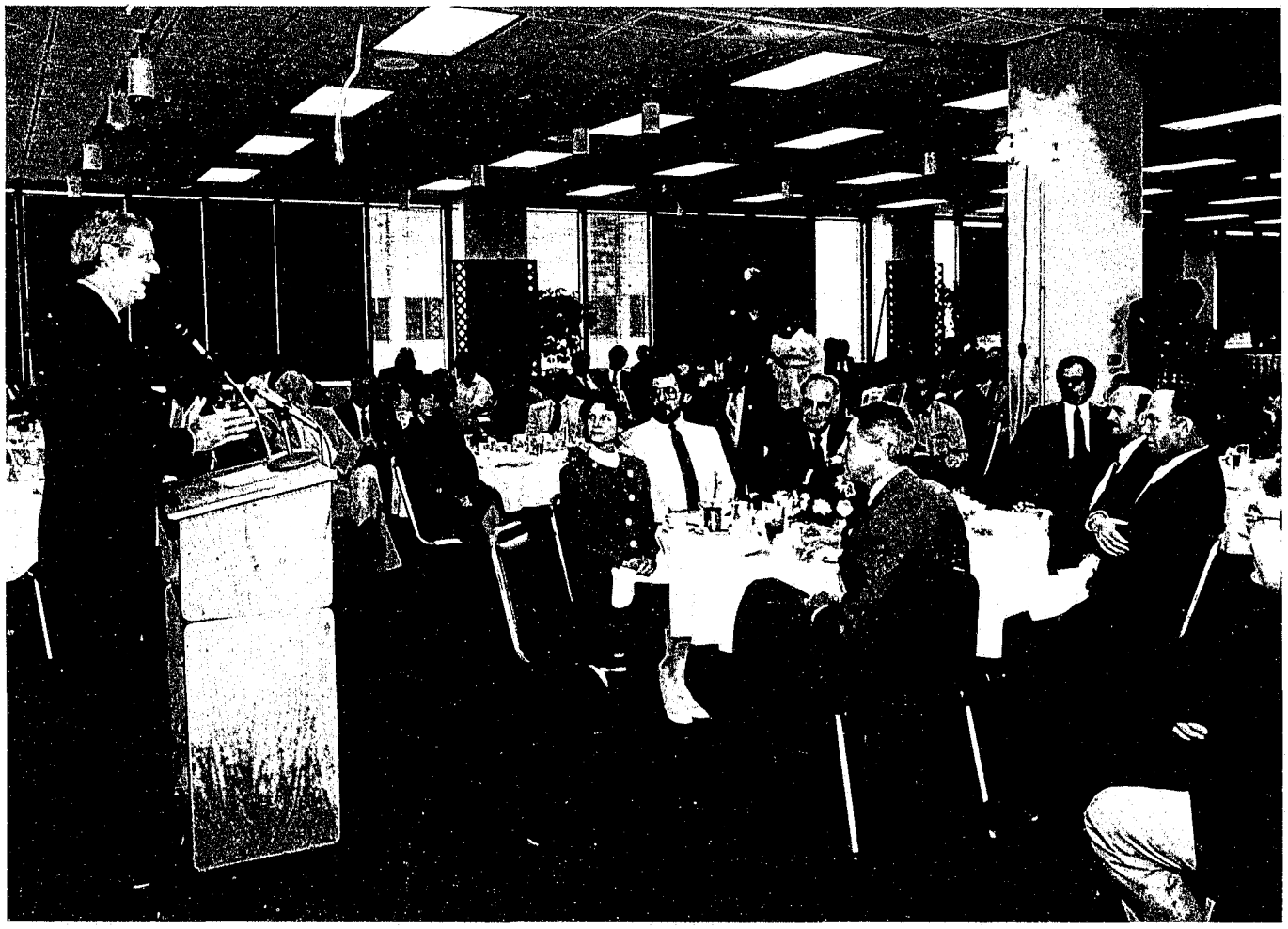
Remarks by Governor Joe Frank Harris

Thank you, Mr. Williford. I am honored to have this opportunity to speak to the members of your commission today. On behalf of the people of Georgia, I am also honored that you have chosen our state to host your conference, and I trust that makes a positive statement for the progress Georgia has made in dealing with the very serious problem of drinking and driving.

I would like to commend the officers and staff of the National Commission for organizing this conference, as well as the Allstate Insurance Company and the Licensed Beverage Information Council for providing the financial support and resources for this meeting. Your involvement is an excellent example of the private sector realizing the impact of the most important issues facing our nation, and then taking the initiative to do something about them. I also want to thank Judge Dorothy Beasley from our state for the part she had in planning this conference.

I know that your commission emphasizes the team approach, and the participation of leaders from all walks of life is evidence of the team concept. Just yesterday, I was in Jesup, in southeast Georgia, to help kick off a local campaign against DUI. This effort was organized by the publisher of the local newspaper there, and judges, law enforcement agents, legislators, educators and community leaders have joined forces to combat drinking and driving in that area of our state. The Jesup program will include a speakers' bureau and education program in the schools, as well as printing the names of DUI offenders in the local paper. The publisher of the paper is a past president of the Georgia Press Association, and he is encouraging his friends at other newspapers across the state to follow his lead.

As Mr. Williford mentioned a few moments ago in his introduction, four years ago, when I was campaigning for governor, I listened to the concerns and tragedies of Georgians all across our state about drinking and driving. At that point, my wife Elizabeth and I made a commitment that if I had the opportunity to serve the people of Georgia as governor, we would launch a serious effort to combat the serious problem of drinking and driving.



Hon. Joe Frank Harris, Governor of Georgia, discusses the DWI issue.

Early in my administration, I established the Governor's Safety Council to increase the visibility and public awareness of this problem, and make it absolutely socially unacceptable to drink and drive. I appointed Elizabeth as the spokesperson and chair for the Council, and she approached the project with a great deal of energy and enthusiasm. We knew if the Council was organized and active, it could make a real difference in Georgia's war on drunk drivers.

The Council consists of 30 individuals from the public, civic and private sectors, and they work closely with the Governor's Office of Highway Safety. An important part of this team is an Atlanta advertising and public relations agency, which in the past three years has prepared some of the finest television and radio public-service announcements in the nation, and did them free of charge. A few years ago, one of the young executives from the ad agency was riding in a car with his pregnant wife and was hit by a drunk driver. They escaped with only some cuts and bruises, but it was a sobering experience for them. When I was elected governor, they came to me and said they wanted to help us in this effort in any way they could. The theme of our campaign is "Drunk Driving Is Just Murder On Our Roads," and I'm proud to report that there's been a substantial decline in these murders in the past year here in our state.

Alcohol-related fatalities in Georgia fell by 18 percent in 1985 compared to the previous year. Last year, there were 424 drunk-driving deaths in our state compared to 515 in 1984. That's 91 lives that were spared. Sometimes when we hear statistics, we all have a tendency to let them go in one ear and out the other. But we're not talking about dollars or any other frequently used statistic; we're talking about human lives, and I won't rest in this cause until there's not a single death in Georgia because of drinking and driving.

I understand the focus of your conference is "recidivism," and I have some ideas along those lines. I'm proud that Georgia has a variety of programs in place to deal with the problem of repeat offenders in both our Department of Human Resources and Department of Corrections. These programs deal with alcoholism and drunk drivers through treatment and education, as well as through incarceration, probation, and community service.

We have alcohol and drug-treatment centers for detoxification and outpatient care throughout the state. In addition, our corrections system has recently announced three sites for probation detention centers which will utilize our nationally recognized shock incarceration program and give inmates a taste of what the work ethic is all about.

Georgia has adhered to many of the recommendations of your commission, including raising the legal drinking age to 21, and enacting tougher penalties for DUI offenders. Before obtaining a driver's license, every beginning driver is required to participate in a drug and alcohol education class, which is offered in our high schools. I realize you have experts here representing a number of perspectives on the problem of drinking and driving, but I'd like to offer some "food for thought" for your afternoon discussions. There are a few ideas I'd like for you to consider:

We are making an effort in Georgia to strengthen the partnership between our criminal justice system and our medical treatment programs, but we still have a way to go in that respect. I encourage you to give some thought to how all our states can build this bridge more effectively, and make punishment and rehabilitation a workable link. I believe that's what the team approach should be all about.

And while we must continue to provide alcoholics help to deal with their problems, and continue to incarcerate habitual offenders, the most important thing we can do is to keep people from drinking and driving in the first place. I know your organization has focused on efforts to make it socially unacceptable to drink and drive, and that goal is the foundation of what we have tried to accomplish in Georgia.

There is another thought that occurred to me in preparing to speak to you today. There has been a great deal of publicity recently about efforts to stop drug trafficking and drug abuse. We already have a full-scale war on drugs here in Georgia, and if the people allow me to serve as governor for a second term, we are planning to step up our drug-education efforts to make taking drugs as socially unacceptable as drinking and driving.

However, since drugs seem to be the hottest issue of 1986, we cannot let that deter us from continuing to build support for our war on drunk driving. After all, alcohol is a drug, and we cannot put everything we have worked for on the "back burner." Drunk driving will simply not go away, and we must remain committed to exploring new and better ways to continue the progress that has been made.

My final thought involves all of you and myself. There is a tremendous groundswell of support in this country—here in Georgia and in your states—to stop drinking and driving. We must keep leaders from all walks of life—business people, judges, educators, law officers, doctors, social workers, presidents, congressmen, governors, mayors, and elected officials in every community—involved. Through these leaders, we can reach the people of this country and make an impact. Eliminating drinking and driving is an issue that not only affects us today, it affects the future of our nation. Thank you for this opportunity to speak to you today. Thank you for bringing your conference to Georgia, and God bless each one of you.

A question-and answer session followed the luncheon segment of the Conference. This enabled the attendees to make individual comments and pose questions to the morning session's speakers.

The following pages contain a sampling of the issues and questions posed.

Editor's Note: Paraphrasing was employed for print clarity and uniformity of format in re-capping the conference's question and answer session.

Questioner: Doris Aiken
President, RID-USA

I feel very privileged to have listened to your panelists this morning because I learned an awful lot, especially from Mr. Robbins' presentation. But on the subject of trusting judges: Should we trust judges? We should not trust district attorneys or legislators; we should not trust people like me, head of the citizen activist groups. You should look only at the bottom line: Judges are told what to do by state legislators; they should receive an evaluation by community groups and the evaluation should be on the front pages of our newspapers. Then we shall see as we have seen in N.Y.: a five-year continuing drop in deaths in New York and 23.3 percent drop in road deaths every single year since 1981. New York is the only state that has achieved this record. We are the 2nd largest state in the nation and the largest, California, shows a 9 percent drop and the national drop is 14 percent.

So I would like to say that we shouldn't trust anybody because this is a life-and-death matter. We have to examine what is reasonable and put it into place. Mandated jail for the first offense is not reasonable because it does not work and we have always opposed it.

My question for the panel is "While we have all agreed that public education is the key to deterring drunk driving, deterring recidivism, we have ignored the most powerful educational tool that we have in this nation and that is commercial network TV, what do you think of counter ads and how can we get them? You will never see RID on the national networks. Ever since we came out with the Smart campaign, we have been blackballed from the national networks since 1983, and we won't get on. So we have to appal to the local media who have been very good with the citizens activists. We have to appeal to groups that are in this room; we have to appeal to the national commission. Are we going to get alcohol counter ads on TV? Now what do you fellows think?

Response: Lt. J. L. Howell
Georgia State Patrol

Now I think it is an excellent idea to use our national TV. We do work very closely with the media concerning our drunk-driving problem in Georgia. We are continuously on Channels 2, 5, and 11 and we try to air our ads during Saturday mornings, the programs that attract teen-agers. We have a group of men who specialize in this area and one of them is an exceptional speaker; he came to us right out of a radio station. He does an extremely good job in appealing to our young people about safety education and goes from one school to another and talks to the teen-agers about drinking and driving. As far as the national media, that's beyond my control.

Response: Dr. Pisani
Clinical Director, Central States Institute of Addiction

I'm a clinician primarily but I don't think there is any question that we all agree that there has to be better public education on the drunk driving issues. Maybe I'm in the minority but I have a particular bent about this whole question of DUI which may be in some ways different from a lot of people. We have a very mixed population in DUI. I think we have people who are high-risk drivers that don't drink. I think we need some education about driving, I think there needs to be education about responsibility. That responsibility and education should start even before the media. In the media, I think children's shows can be utilized to talk about responsibility, and responsibility in terms of all actions.

Now maybe some people think my use of the term responsibility here is watering down something. I hope not because I certainly am in full sympathy with all of us who are interested in this problem of drinking and using drugs and driving. It is very bad today and the research that I have been involved in and have read about more and more talks about the drug problems. I think you are going to hear more about other kinds of problems that contribute to mismanagement of the vehicle.

So I think all kinds of education are important. I really can't respond directly to what kinds would be effective here because that is not my expertise. But I hope and wish there would be a balance so people could make responsible decisions. I think that's what it's all about. We need to teach your young people, especially, how to be reasonable and how to make responsibile decisions and how to get the information. I think we need to give them the information so that they can make responsible decisions and we should do that in any way we can.

Response: Judge Carnes
Chief Judge, Fulton County, Georgia

I have no problem using the national network TV for public education, but I do not pin my hopes on that. What makes national policy is a lot of local folks doing it; I mean local stations and local programs here in Georgia and in Illinois and every where else. That's what makes national policy. I much prefer them teaching my kid in school here in Sandy Springs than depending on somebody in New York broadcasting something over national TV and thinking that they're going to get to my kid. I have no problems with what you've said. I don't know that you'll ever accomplish that goal. I hope you do, but still, my best reliance is going to be what we can do on the local level.

Response: Lee P. Robbins, Ph.D.
Wharton School
University of Pennsylvania

Thank you. I'm only a researcher and model builder and what we do is look at data and attempt to spin theories. Some of the data shows that PSAs don't work. They seem like a nice idea and seem like a good thing to do. But the research that has been done does not support it; I mean support any evidence that they're having an effect on drunk driving, recidivism, drugs or otherwise.

Secondly, I would wonder if we use the model that seems to be suggested, why President Reagan seems to think we have a drug problem. I don't see ads for marijuana on national TV or I don't see ads for cocaine on national TV. I don't even see them in local papers. And yet that does seem to have eliminated the problem.

If we shift to another crude international comparison, we could finally select a country that not all of us are fond of, the Soviet Union. They have an immense drinking problem. It has been documented and they're starting to admit it publicly and yet they don't have any advertising for alcohol. So, I'm somewhat skeptical of this as a solution. I don't know that it would do any harm. I don't know that it would do any good.

I grew up in a time when cigarettes were widely advertised and certainly favorably portrayed, but I've never smoked or never tried tobacco. I attributed that to three things. One was by happenstance, the peer group I grew up with in high school didn't smoke.

Secondly, there was a class in Life Science, which it was called in my school, which addressed the issue of smoking. The only thing I remember was an experiment. The teacher smoked, by the way, so there was not a role model. They had this device, I don't know what you would call it, and inside of it was a big wad of cotton. He blew cigarette smoke through it and then took this wad out that looked all black. He said that's what happens to your lungs when you smoke and I know I shouldn't do it. I'm not going to tell you how long ago it was, but I've never forgotten it since.

The third thing, which I think was interesting perhaps in view of my paper, was how my parents handled it. My mother smoked occasionally, not real often, maybe once every couple of weeks. My parents continually said we don't think you should smoke but if you want to do it, do it in front of us. I was faced with a nasty situation. One was I could do it in front of them and feel silly, which is what I would feel. Second was that I could do it and hide it from them. I felt silly about that because they just told me and I believed them. I didn't have to hide it from them so it didn't really seem to leave me with many options.

The moral that I want to draw is that it occurred as a result of their educating me and not attempting to control me. Believe me, I was a rebellious kid; my mother didn't have any choice. It was either buckle under or rebel and yet if she had said, "You're not going to smoke," I would have smoked.

Response: Doris Aiken
President, RID-USA

I would like to respond to one question. First of all, the Russian alcoholism problem has been around before cars, before advertising, before anything. It is a cultural ethic there. It has to do with being very cold and not knowing what else to do. I think we should examine the cigarette problem and alcohol in the U.S., which are very similar problems.

When counter ads appeared on national network TV showing the roted lungs and the bad kidneys and teeth falling out, the cigarette companies voluntarily took off their advertising. We sold 2 billion fewer cigarettes last year and the largest group and the only group that is newly starting to smoke are young people as a macho symbol of their rebellion. I think that is a lesson to all of us and I have to say that I believe in local groups educating too.

It is the national network media that comes over Monday night football and all the programming that families watch together and it works. I know I drink light beer at night while watching a football game. Suddenly, after watching the commercials, I have an urge to drink beer, so I know it works. So I'm asking that people get interested in the subject of counter ads. If you want to know how you can help, you can write to your local newspapers and say, "I saw so many counter ads on TV last night and I don't like it." The networks are reading the local newspapers all the time and they are going to get interested, not only in their pocketbooks but in the vast problem of education, to which they hold the power lines.

Comment: David Bloodworth
State's Attorney
Palm Beach County, Florida

First, I'd like to introduce myself, David Bloodworth, State's Attorney for Palm Beach County, Florida, fastest-growing area in the U.S. I'd like to thank this committee and Allstate for the opportunity to come here. I hope that in Florida that we can repeat this recidivism conference for our 20 circuits; we have a great need.

David H. Bloodworth, State's Attorney, 15th Judicial Circuit of Florida (Palm Beach), makes a comment to the panel.

Comment: Mark Laurel
Secretary of State's Office, Chicago, Illinois

Thank you. My name is Mark Laurel. I feel a little gun-shy because I'm both an attorney and work with the administrative driver's licensing authority and I have head a little criticism of both in the last few minutes. I'm an attorney for the Secretary of State's Office in Chicago, Illinois. The Secretary of State in Illinois is the driver's licensing authority.

Before I get to my comment though, I'd like to add something to the discussion here on permanent revocation. One of my responsibilities at the Secretary of State's Office is to review requests from people who were convicted of DUI in Illinois and have moved to other states, usually the Sun Belt states. We've found that the new state won't give them anything to drive on until they've cleared their Illinois driving privileges. Illinois revocation following a conviction for DUI is a permanent or indefinite loss of driving privileges until the Secretary of State decides to give them back to you. There is a driver's license compact, a national compact which Illinois is a member of. I think Florida, as well as several other states, has a provision which says that after a person has resided in that state for at least a year, the new state can issue that person a valid driver's license. It's my distinct impression that most states are ignoring such provisions and instead requiring people to have their privileges in their old state cleared before giving them anything to drive on. I think that is a technical thing but I think it is of questionable legality. We have an Appellate Court decision in Illinois which held that if someone were revocated in Illinois and moved to Indiana and lived there for a year and got an Indiana license, could not be convicted in Illinois of driving while his Illinois privileges were revocated or suspended because of the driver's license compact.

My other comment is on the evaluation or assessment process. In Illinois we call it evaluation. My department recently conducted it's own survey, it's own study of recidivists within our department. We checked the driver's records of everyone who was issued either a restricted privilege or granted full reinstatement of driving privileges within the last year. I think the survey ran from July 1985 to June of this year. What we found, and what our department was rather proud of, was the fact that we had a very

low rate of recidivism, less than 5 percent. The most striking feature that I found from the study was the high percentage of evaluations that were incorrect in our view. The absolute figure was that 53 people committed another DUI after having been granted some relief from our department. Out of those 53 people, in 35 of those cases, the evaluator had classified that persons use of alcohol as non-problematic. Within less than a year of having been so evaluated, the person committed another DUI. It seems to me, in reviewing both the National Commission's Task Force and my participation on the American Bar Association's Committee for driving and the project with Mr. Robbins and our own Governor's Task Force, the assumption being made is that an agency, or government agency or the court, can obtain a credible and/or reliable evaluation.

The fact is, in both Illinois and reviewing evaluations from throughout the country, it has become obvious to us, that this is simply not the case. The quality of evaluation being written both in Illinois and throughout the country is mediocre at best. A great deal more time in education and training needs to be done with evaluators so that courts and administrative agencies can place more reliance on what they find. We had a very large problem in Illinois, because up until about four years ago before the Secretary of State hot heavily involved in this issue, the evaluation programs were totally unregulated. It was a free-enterprise, capitalistic-type system. Anyone could get in the evaluation business and they were totally unregulated. When we started requiring people to submit to an evaluation in order to get their driving privileges back, we found that we just weren't getting very good information. This was through the hearing process.

There are a couple of ways to deal with this problem. The Judge suggested on in which you could have the government take full responsibility for producing these evaluations, but the fact is, it doesn't make any difference whether the person who does the evaluating works for the government or a private agency. He still has to be trained on how to do a good evaluation.

The other thing we are trying to do in Illinois is to license evaluation programs or perhaps even the individuals who do the evaluating. We set minimum standards that the program has to meet in compiling the evaluation. We've just started doing that since the first of the year. The progress has been very slow, but we're going to keep working at it. But the point I want to make is that regardless of where you come from, if you're relying on evaluations without examining them closely, you're probably making a mistake. And a lot more effort needs to be put into making sure that you're getting a good document and that can only happen by training better evaluators. I don't think it's going to be an easy process. I'd be curious on whether people from other states have encountered the same problem. Thank you.

Response: Dr. Pisani
Clinical Director, Central States Institute of Addiction

There's no question that what's been said is of extreme importance. The state of Illinois has a tremendous job on its hands trying to get these agencies to get together and evaluate in a way which is reliable and based on criteria that everybody agrees on. There's no question that there is a lot of educating that needs to be done. Fortunately, we have a good relationship with the state. In fact, this particular program that I do consulting for in Cook County's program has been in existence for 15-16 years. The state has been very good about coming to us and it is a reciprocal kind of relationship. We borrow from them and they borrow from us and it works out very well.

However, you know, I think despite the fact it's difficult to train people, it can be done. We, in cook county, have been attempting to do that not only for our own people but for people outside the system. One of the things that is going to cause problems later on is this whole business of what we call people with alcohol problems or drug problems; because the professionals themselves are in a dither about who you call an alcoholic and who you call a drug addict. What are the criteria in terms of the problem? Is the problem a problem drinker or social drinker? There are not real heard criteria for that. This is one of the reasons we've gone in the direction of talking about life problems. It's a little bit easier not to get hung up on these nomenclatures. And by the way, it's been my experience, being in the field as long as I have, and I hate to tell you how long that is, that recovery from these problems, especially alcohol and drug problems, does not really depend on the diagnosis. That might sound strong but it's true.

Questioner: Dr. Frank Thompson
Conference Attendee

I'd like to address just Dr. Pisani. I agree with you that we need to have an evaluation and different levels of treatment. This is appropriate and it is not appropriate to treat everybody the same. I've been in the alcohol and drug field a long time. We see people who are DUI and there are many types of alcohol offenders. If we don't take care of the underlying life problems, we're just going to have repeat problem drinkers. I agree with that.

Another problem that I see in our field is lack of education. We do a lot of marketing and I think we are real good at identifying the problems. We're not too good at solving them. But what I'd like to know is what the commission is doing with the rehabilitation movement across the country to better educate them; I mean education on how to take care of some of this underlyiung stuff and not to be looking at alcohol and drug abuse as primary.

In other words, maybe the house is on fire and you've put out the fire but you'd better find the short circuit because otherwise you'll have another fire. Not much is being done. I also don't see a whole lot being done in the criminal justice system. I trust the system, but I don't trust the attorneys. I see DWIs as extremely profitable for the attorneys. They rip them off. Most programs I see are good efficient programs that could work. But they seem to fail because of the pressure that's put on the judges by the attorneys. I'd like to know what the National Commission is doing in educating the Bar Association. I think those folks need a little education; or maybe some laws passed where they don't need an attorney. Why do they have to pay $500 to an attorney? There's a whole lot of things that i see that goes on within the criminal justice system that completely defeats what we do in the treatment field. And those are some of my concerns and some of the things I'd like to see be taken care of.

Response: Dr. Pisani
Clinical Director, Central States Institute of Addiction

Well, I can't tell you of many other places but I can talk about Cook County, Illinois. And the marriage between the treatment system and the judiciary is very critical. We're fortunate in Cook County because the judges are in support of the program very much. They have mandated that everybody goes through the program. That's it! At least they go through it for an assessment. The judges take it very seriously, the assessment that's being made.

As far as education is concerned, there's a lot of education going on in Cook County with counselors and also drug counselors and those kinds of people but one of the things that we're very concerned about is that the evaluation is done in such a way that it deals with not just or merely with the alcohol or drug issue. You've got to go beyond that; that's why I keep saying over and over again that you have to provide the judges with a sufficient amount of information that they can make a wise choice themselves. I think it's easy to go around lambasting judges but when you're in the court situation and they have so many people they have to see, you see them operating like they are machines. You can't help but have some kind of sympathy for them, especially when they won't have anybody advising them and they don't have a setup where they are going to get the right kind of evaluation. But I think we are moving in that direction. I think as Judge Carnes said, he's hoping for help in that area. I think people more and more are interested in the kind of evaluation you're looking for. I trust both systems and I think you need a system approach. You need a relationship between the two systems.

As far as lawyers are concerned, in the Chicago area, in Cook County, we have educational programs for them too. Many times these DUI chasers are coming to court with their favorite little evaluation by someone outside the system. But the judge says that's fine. It looks nice but we have to go through out system too. I think these things can happen with the kinds of meetings we are having today and they should be encouraged as much as possible.

John Grant, of the National Commission Against Drunk Driving and conference moderator, recognizes an audience comment, as Larry Williford, the Commission's Vice Chairman looks on.

Comment: William McCormick
Conference Attendee

I'd like to comment. I'm a prosecutor but in all due respect there are many, many fine defense lawyers. They know if we don't have a case on a guy and rightfully afford their clients the best defense possible. They're not all out there trying to make all the money in the world. I don't think we can paint all the lawyers with the same brush. It's very essential that we look at a lot of people in the treatment business. they deserve some looking at too, because frankly, and again from the prosecutor's point of view, it takes both parties to make the system work.

Questioner: Nancy Nogg
Director of Judicial Affairs, Guardian Interlock Systems

My name is Nancy Nogg and I'm director of judicial affairs for Guardian Interlock Systems. We're one of the companies who do an ignition interlock for vehicles which is an innovative way to deter a repeat offender.

But primarily what I wanted to say is that everyone seems to be putting blame on the media, judges, attorneys or rehab people. No one talks about the department of motor vehicles which in many states holds much more power than anybody in the judicial system. The problem is that you have no statistics across the board nationally. so, if you got someone who's an offender in Maryland and tried in Delaware, they have no idea if whether or not they've been a drunk driver before. And I think that in order to get equal statistics across the board to see where we need improvement, we need better exchange of information. There really are problems. You've got individual state records but there's nothing across the board. Maybe a national driver's license will help. No one knows from Illinois to Florida if someone has been a repeat offender. So a judge may be dealing with a first-time offender, that he thinks is a first-time offender, who actually has been apprehended before. That's a question I'd like to throw out.

Response: John Grant
Project Director, National Commission Against Drunk Driving

Can I respond? The National Drivers Register is a basic problem and a possible solution. right now the National Highway Traffic Safety Administration is in a four-stage pilot project. These are states that are involved in a commitment to the computering of the Driver Register. The exchange of information could be immediate. But I have to tell you this is going to be a countrywide program no earlier than 1990. There will be computerized exchange of information from state to state, jurisdiction to jurisdiction. It's going to take that long for instant record access at the state level.

Let me give you an example: In 1982, probably one of the most publicized accident cases that took place in the Presidential Commission years was the case of the truck driver that who want through the 95 toll gate exchange near Hartford, Connecticut, and killed 11 people. He had 27 moving violations in his record spread among 11 states, so he had licenses from one state to another. There were two questions there; not only the driver's escaping from the exchange of driving record situation, but also why would a private trucking company want this at-risk driver to be driving its truck?

The problem is not going to be resolved, easily, and I suggest that whatever technological instrumentation is going to evolve, is one area we can be hopeful for. I am a native of Massachusetts and if I got picked up on an offense in massachusetts and a driving record search has to be referred to New Hampshire or Maine, the mail takes 14 days. What Lt. Howell would hope for, and the law enforcement people of the future, is instant record access. Law enforcement officers need and are entitled to a system which provides immediate on-line record access, an in-vehicle computer which will tell them in a matter of seconds the countrywide driving record history of the offender. But again, such a system is still years away.

Comment: Dr. Pisani
Clinical Director, Central States Institute of Addiction

In the meantime, there are some states which are working out relationships with adjoining states as we do in Illinois. I think that can be a help in the meantime while we are waiting for the computer.

The National Commission against Drunk Driving wishes to thank the following individuals and organizations for their assistance in the September 16, 1986 Conference on Recidivism:

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  State Director, Programs

ALLSTATE INSURANCE COMPANY

Allstate Insurance Company has been dedicated to automobile, driver, and highway safety since the early 1950s.

Recognizing drunk driving's ravages on society, the company has fostered programs to combat the needless waste of lives and property on our nation's roads.

Through the years Allstate has embraced anti-drunk driving public- awareness programs, assisted the court support system, legislators and regulators in identifying effective countermeasures, and encouraged countrywide and community organizations to take responsible approaches to the issue.

Allstate's presence and service on the National Commission Against Drunk Driving highlights its belief in the importance of a clearinghouse to coordinate local and national efforts to alleviate the drunk-driving problem.

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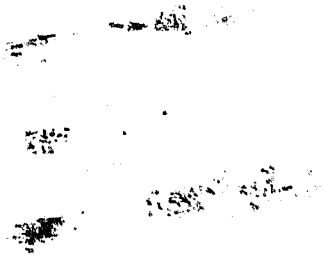
The Licensed Beverage Information Council has been conducting programs of professional and public education since 1979. LBIC members represent all levels of the alcohol beverage industry, including producers, wholesalers and retailers of beer, liquor and wine.

LBIC programs address drunk driving, drinking and pregnancy, alcoholism as a treatable illness, and teen-age drinking. Projects are carried out by leading professional organizations, many with cooperation of federal departments including the Departments of Transportation, Health and Human Services and Treasury.



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