PB 294 743

DOT HS 804 023

AN ANALYSIS OF DIAGNOSTIC AND REHABILITATION EFFORTS - 1976
Tampa ASAP Analytic Study #5/6

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Contract No. DOT HS-062-1-080
Contract Amt. $3,691,000

PRINTED APRIL 1979
FINAL REPORT

Prepared For

U.S. DEPARTMENT OF TRANSPORTATION
National Highway Traffic Safety Administration
Washington, D.C. 20590

Technical Report Documentation Page

1. Report No.	2. Government Accession No.	3. Recipient's Catalog No.
DOT HS 804 023		

4. Title and Subtitle	5. Report Date
AN ANALYSIS OF DIAGNOSTIC AND REHABILITATION EFFORTS 1976 - Final Report Tampa ASAP Analytic Study #5/6	May 1977
	6. Performing Organization Code
7. Author(s) R. E. Reis, Jr. - Daniel P. Westra	8. Performing Organization Report No. #052777:R
9. Performing Organization Name and Address University of South Florida * Department of Criminal Justice Tampa, Florida 33620	10. Work Unit No. (TRAIS)
	11. Contract or Grant No. DOT HS-062-1-080
12. Sponsoring Agency Name and Address U.S. Department of Transportation Office of Driver & Pedestrian Programs Washington, D.C. 20590	13. Type of Report and Period Covered Final Report 1/1/72 - 12/31/76
	14. Sponsoring Agency Code

15. Supplementary Notes

* Under contract to: City of Tampa
Metropolitan Development Agency
1420 Tampa Street
Tampa, Florida 33602

16. Abstract The performance of the Tampa ASAP rehabilitation subsystem was examined. A detailed description of Tampa's judicial/rehabilitation system structure was provided. Descriptions of procedures related to the Short Term Rehabilitation (STR) program, and descriptions of the treatment modalities used by ASAP were presented. Normal referral to a treatment modality was interrupted in 1975 and 1976 when a research design randomly assigning clients to treatment and control conditions was put into effect. Social drinkers were assigned to either DWI school or a minimum exposure read only "control" group. Problem drinkers were assigned to group therapy plus school, school only, or read only treatment on an equal probability basis. Extensive profile comparisons on a number of variables failed to show any substantial assignment biases.

Social drinkers assigned to DWI School had a significantly lower recidivism rate at twelve months (6.3%) and eighteen months (7.9%) after referral than social drinkers assigned to read only (8.5% and 12.1% correspondingly). The analysis of problem drinker referrals revealed no significant differences in recidivism among the research design groups (group plus school, school only, and read only). There was evidence that group plus school treatment may be effective in reducing DWI recidivism if clients complete treatment. STR clients consisted of a problem drinker subset of research design clients who completed Life Activities Inventories. Analysis of treatment effectiveness on five life activities dimensions revealed no effects on employment/economic stability, current physical health problems, or social interaction. The group plus school and school only STR clients showed marked improvement on the dimension of current quantity/frequency of drinking while the read only group did not. All three groups evidenced improvement on the dimension current drinking problems following treatment.

17. Key Words	18. Distribution Statement
Alcohol safety action project (ASAP), DWI recidivism, Life activities inventory (LAI), alcohol rehabilitation, alcohol diagnosis	Document is available to the U. S. public through the National Technical Information Service, Springfield, Virginia 22161

19. Security Classif. (of this report)	20. Security Classif. (of this page)	21. No. of Pages	22. Price
Unclassified	Unclassified	132	

METRIC CONVERSION FACTORS

Approximate Conversions to Metric Measures

Symbol	When You Know	Multiply by	To Find	Symbol
		LENGTH		
in	inches	*2.5	centimeters	cm
ft	feet	30	centimeters	cm
yd	yards	0.9	meters	m
mi	miles	1.6	kilometers	km
		AREA		
in^2	square inches	6.5	square centimeters	cm^2
ft^2	square feet	0.09	square meters	m^2
yd^2	square yards	0.8	square meters	m^2
mi^2	square miles	2.6	square kilometers	km^2
	acres	0.4	hectares	ha
		MASS (weight)		
oz	ounces	28	grams	g
lb	pounds	0.45	kilograms	kg
	short tons (2000 lb)	0.9	tonnes	t
		VOLUME		
tsp	teaspoons	5	milliliters	ml
Tbsp	tablespoons	15	milliliters	ml
fl oz	fluid ounces	30	milliliters	ml
c	cups	0.24	liters	l
pt	pints	0.47	liters	l
qt	quarts	0.95	liters	l
gal	gallons	3.8	liters	l
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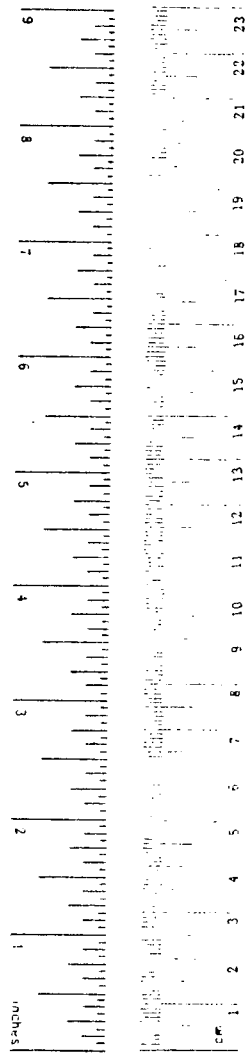
yd^3	cubic yards	0.76	cubic meters	m^3
		TEMPERATURE (exact)		
F	Fahrenheit temperature	5/9 (after subtracting 32)	Celsius temperature	C

*1 in = 2.54 (exactly). For other exact conversions and more detailed tables, see NBS Misc. Publ. 286, Units of Weights and Measures, Price $2.25, SD Catalog No. C13.10:286.



Approximate Conversions from Metric Measures

Symbol	When You Know	Multiply by	To Find	Symbol
		LENGTH		
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cm	centimeters	0.4	inches	in
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m	meters	1.1	yards	yd
km	kilometers	0.6	miles	mi
		AREA		
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km^2	square kilometers	0.4	square miles	mi^2
ha	hectares (10,000 m^2)	2.5	acres	
		MASS (weight)		
g	grams	0.035	ounces	oz
kg	kilograms	2.2	pounds	lb
t	tonnes (1000 kg)	1.1	short tons	
		VOLUME		
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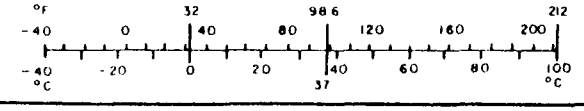
l	liters	1.06	quarts	qt
l	liters	0.26	gallons	gal
m^3	cubic meters	35	cubic feet	ft^3
m^3	cubic meters	1.3	cubic yards	yd^3
		TEMPERATURE (exact)		
C	Celsius temperature	9/5 (then add 32)	Fahrenheit temperature	F



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FINAL REPORT

Analytic Study #5/6, 1976

Executive Summary

The present study was concerned with the performance of the Tampa ASAP rehabilitation subsystem from its beginning in late 1971 through the end of 1976. A detailed description of Tampa's judicial/rehabilitation system structure and case flow was provided, procedures related to the Short Term Rehabilitation (STR) program were addressed, funding of judicial/rehabilitation countermeasures was discussed, and descriptions of treatment modalities used by ASAP were presented. Data analyses were organized under: (1) an administrative summary of diagnostic, referral, and rehabilitation activities and (2) specific evaluative topics.

Summary of Activities: 3363 diagnostic interviews (not including a very small number of interviews which resulted in non-alcohol drug problem diagnoses) were conducted in 1976. These interviews resulted in 2033 (60.5%) problem drinker diagnoses and 1330 (39.5%) social drinker diagnoses. During the entire period of ASAP (1971 to 1976) 18,178 diagnostic interviews were completed, which resulted in 9331 (51.3%) problem drinker diagnoses and 8847 (48.7%) social drinker classifications.

The normal referral to treatment modality process was interrupted in 1975 and 1976 by (1) judges prohibiting treatment referrals for approximately the first six months of 1975, and (2) the research design in effect between 7/1/75 and 6/30/76. There were 1284 referrals to treatment modalities (other than school) in 1976. The specific modalities of 580 of these cases were unknown because of referrals to an agency such as HCMHC which provided several treatment modalities. Of the known treatment modalities, 417 were didactic (other than school), 238 were group therapy, and 46 were individual therapy.

Virtually all of the non-school referrals (99.1%) were to HCMHC in 1976. There has been a general decrease in the use and/or availability of other alcohol treatment and supportive community resources since 1974.

There were 4016 referrals to alcohol safety school in 1976 compared to 3738 in 1975 and 3941 in 1974. Approximately 98% of all clients referred to alcohol treatment programs were also referred to school.

The termination status of all 1976 treatment referrals (as of quarter one, 1977) were as follows: 42.9% complete, 9.1% no show, 10.7% drop, and 37.4% still in treatment. The 1975 completion rate for all agencies was 62.8% and, disregarding clients still in treatment;

the 1976 completion rate was roughly 68%. Of the 4016 clients entering DWI alcohol safety school in 1976, 95% completed the course. The completion rate for the entire period of Tampa ASAP (1971 - 1976), involving 19,127 clients entering DWI school, was also 95%.

Reliability of the Diagnostic Process: The proportion of ASAP clients diagnosed as problem drinkers increased from about 30% in the first quarter of 1972 to slightly over 50% in the second quarter of 1973. Since the second quarter of 1973 diagnostic performance has been reasonably consistent through the first quarter of 1976. There was an atypically large percentage of problem drinker diagnoses during the second and third quarters of 1976 (67.1% and 69.3% respectively), followed by a substantial decrease to 46.3% during the final quarter of the year. This variation appears to be the result of inconsistencies or deliberate changes in the interpretation or recording of diagnostic data.

There was considerable variability between individual counselors in the diagnostic results. For example, at the two extremes in 1976, one counselor diagnosed 24.6% of his clients as problem drinkers while another counselor diagnosed 71.6% of her clients as problem drinkers. Average total Mortimer-Filkins scores for individual counselors in 1976 have a rough correspondence to the diagnostic results, suggesting that some counselors were not probing intensively when receiving evasive responses or were interpreting and recording M/F data to correspond to their individual conceptions of problem drinking.

Treatment Group Profile Comparisons: For the purposes of assessing treatment effectiveness Tampa ASAP randomly assigned clients to treatment programs during the period 7/1/75 to 6/30/76. These random assignment groups were compared in terms of client sex, race, age, total Mortimer-Filkins score, and BAC at the time of arrest. Results indicated that client characteristics were equivalent among the two social drinker design groups and among the three problem drinker design groups, both for all assigned clients and for those clients only who completed treatment.

Extensive profile comparisons were also conducted for the Short Term Rehabilitation (STR) groups. (STR clients were a subset of randomly assigned research design clients who were diagnosed as problem drinkers and completed Life Activities Inventories (LAI's).) Results indicated no practical differences between treatment groups for STR clients completing the initial inventory, for STR clients completing the six month inventory, or for those clients completing the twelve month inventory on the profile variables of sex, race, age, arrest BAC, total Mortimer-Filkins score, prior A/R traffic offenses, prior non-A/R traffic offenses, prior accidents, and prior treatment entries. Further comparisons between clients who received six month LAI's and those who didn't, and between clients who received twelve month follow-up LAI's and those who didn't suggested that the six-month and twelve month follow-up samples may have had a slightly

lower proportion of young, male clients relative to the initial inventory groups. The author suggested these differences were not of sufficient magnitude to limit the generalization of treatment effects.

Effect of Treatment on DWI Recidivism: Social drinkers referred to DWI School had a significantly lower recidivism rate at twelve months (6.3%) and eighteen months (7.9%) after referral, compared to social drinkers referred to a read only - minimum exposure "control" group (8.5% and 12.1% correspondingly).

The analysis of problem drinker referrals revealed no significant differences in recidivism among the research design groups (group therapy plus school, school only, and read only).

The analysis of problem drinker clients who completed treatment indicated that there were no significant differences in twelve month recidivism rates between group plus school and school only, and between group plus school and read only groups. The twelve month recidivism rates for group plus school (6.0%) and read only (10.8%) were sufficiently different; however, to suggest that group therapy plus school treatment may be effective in reducing DWI recidivism, providing clients complete the program.

Effect of Treatment on Life Changes: The effect of STR treatments on five life activities dimensions (derived through factor analysis of portions of the LAI package) was assessed. Clients were assigned scores on each factor based on their responses to the LAI. Changes along the five dimensions were measured by re-administering the LAI package at six and twelve month intervals such that clients had three scores (initial - upon being assigned to treatment, six month, and twelve month) on each factor. Results of analysis indicated that group plus school and school only clients showed marked improvement on Factor I (current quantity/frequency of drinking) while the read only group showed no improvement over initial scores at the six and twelve month intervals. No practical differences between groups or across time were found for Factor II (employment/economic stability), Factor III (current physical health problems), or Factor IV (social interaction). There were no differences between groups on Factor V (current drinking problems) but all three groups combined showed significant improvement in this dimension. The three groups had lower scores(indicating less drinking problems) at the six month inventory than at the initial inventory and sustained these lowered scores at the twelve month inventory.

I. INTRODUCTION

One of the most innovative countermeasures of the Tampa Alcohol Safety Action Project (ASAP) was the use of alcohol treatment and retraining programs in addition to traditional punitive sanctions for individuals convicted of Driving While Intoxicated (DWI). The need for rehabilitation was premised on the observation that certain individuals arrested for DWI had long histories of alcohol-related (A/R) traffic offenses and convictions with the associated fines, jail, and license revocations. Thus there appeared to be strong evidence that punitive sanctions alone were ineffective in deterring individuals who may have psychological or physical addiction to alcohol.

The primary goal of alcohol rehabilitation as a component in the ASAP drinking-driver control system was to modify the behavior of drivers found guilty of A/R traffic offenses in a manner which reduced the probability of subsequent drinking-driving behavior. In order to achieve this goal, Tampa ASAP coordinated procedures for diagnosis of drinking problem severity and for referral of individuals to the appropriate educational and treatment resources in the community.

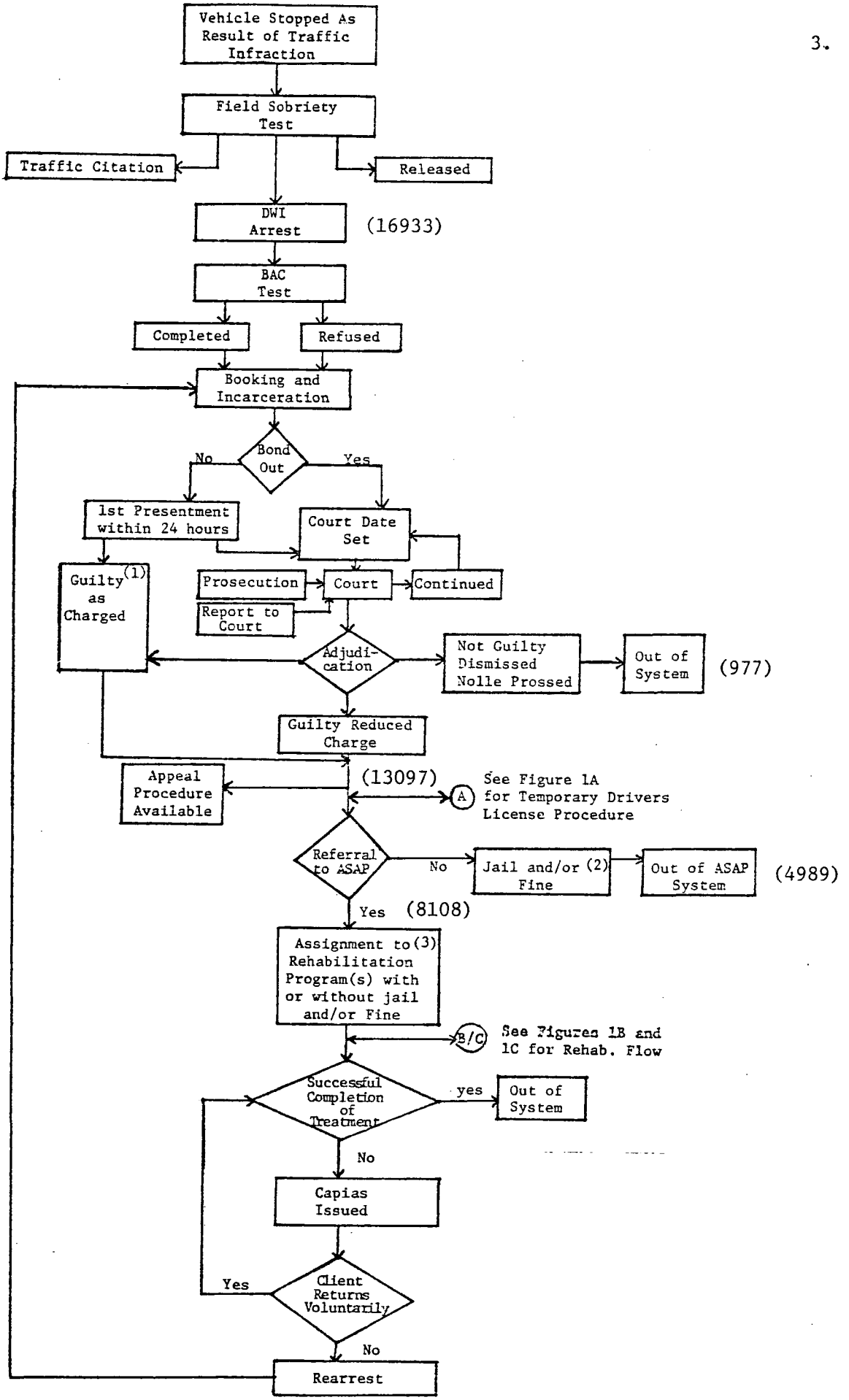
The present study concerns itself with ASAP diagnostic, referral and rehabilitation activities from their beginning in late 1971 through the end of 1976. Section I.A. which follows provides a detailed description of Tampa's judicial/rehabilitation system structure and case flow. Procedures related to the Short Term Rehabilitation program are addressed in Section I.B., funding of judicial/rehabilitation countermeasures is discussed in Section I.C., and summary descriptions of treatment modalities used by Tampa ASAP are presented in Section I.D. The last introductory section (I.E.) of this analytic study describes the general organization of data analyses.

A. Overview of Judicial/Rehabilitation System Structure and Case Flow

An illustration of the Tampa judicial/rehabilitation system and case flow is presented in Figure 1. This illustration emphasizes the system as it existed at the end of 1976, with major changes occurring throughout the operational period being noted. In the text below, the case flow is described and atypical procedures are discussed where appropriate.

All DWI arrests originated with the halting of a vehicle after the observation of a traffic infraction. Florida's law requires probable cause, which is routinely demonstrated by a traffic infraction. After the field sobriety test (typically; finger-to-nose, picking up coins, walking, balance), the motorist was either given a traffic citation, released, or informed that he was under arrest for DWI and would be transported to jail. At the Central Breath Testing Laboratory adjacent to the jail facility, a blood alcohol concentration (BAC) test was offered and either completed, or a refusal was noted. This being completed, the individual was booked and incarcerated. The individual's auto was impounded. The Tampa Police required impounding, while the Florida Highway Patrol had the option of releasing the car to an authorized individual (with the owner's permission). In the case of release of the auto, the recipient was either in the auto at the time of arrest, or arranged to pick up the car at the scene of the arrest.

After booking, the offender had the option to bond. Time restrictions prior to bond varied, but averaged two hours minimum. If the offender was able to post bond, he was released. He was reminded that the court date on his citation was binding, but should he decide to change it he could do so through the "Violations" office. The court date entered on the citation was usually six weeks from the date of arrest. Those who did not bond out were brought before the judge within 24 hours. At that point (commonly called "First Presentment") a plea was taken. If the plea was guilty, the case was disposed of at that time, in the same manner which applied to dispositions of guilty at any other point in the process. If a not guilty

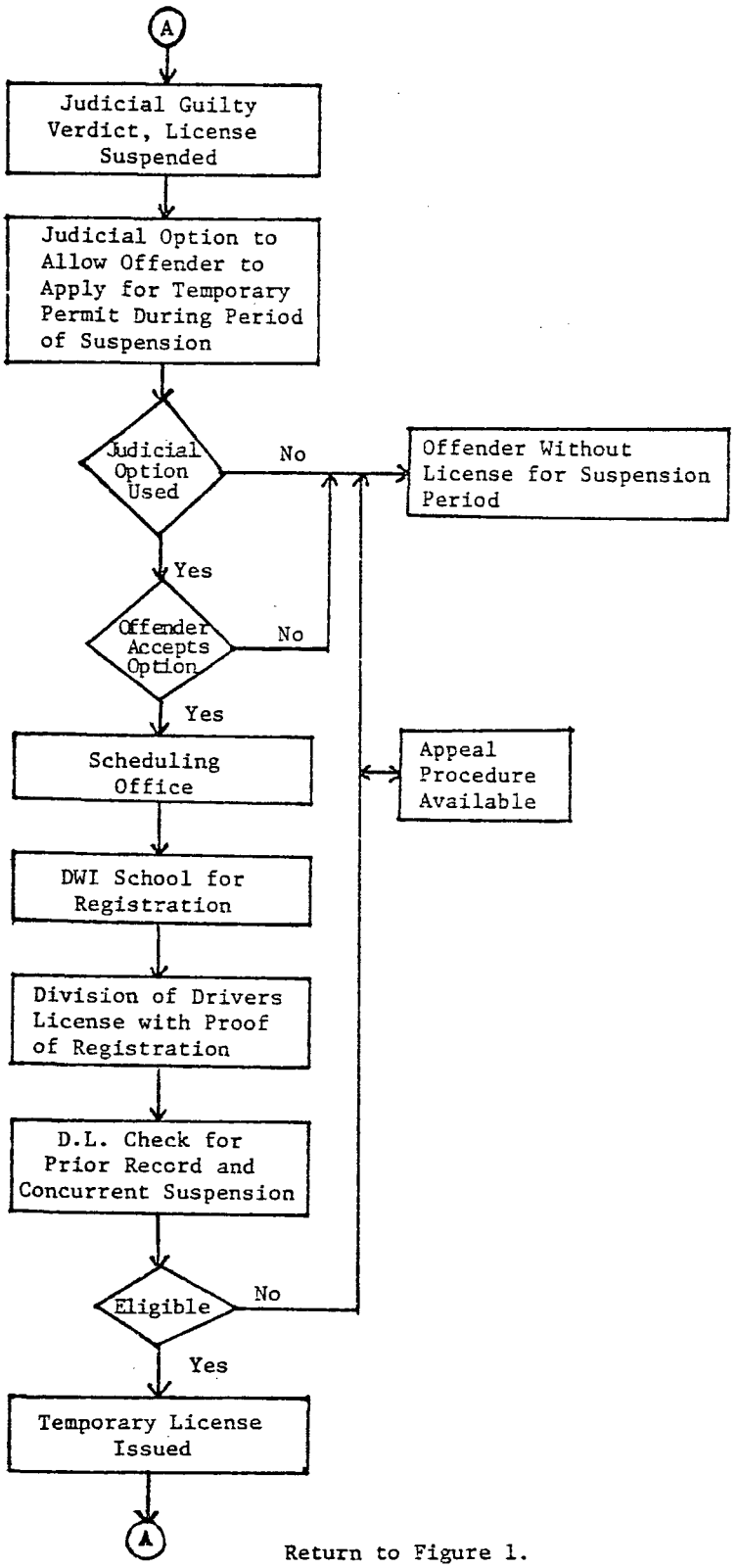


(combined 1975 and 1976 data)

FIGURE 1

Judicial/Rehabilitation System Flow
Tampa ASAP

TEMPORARY DRIVERS LICENSE PROCEDURE (4)



Return to Figure 1.

FIGURE 1A

FLOW FOR ALL NON-RESEARCH DESIGN CLIENTS

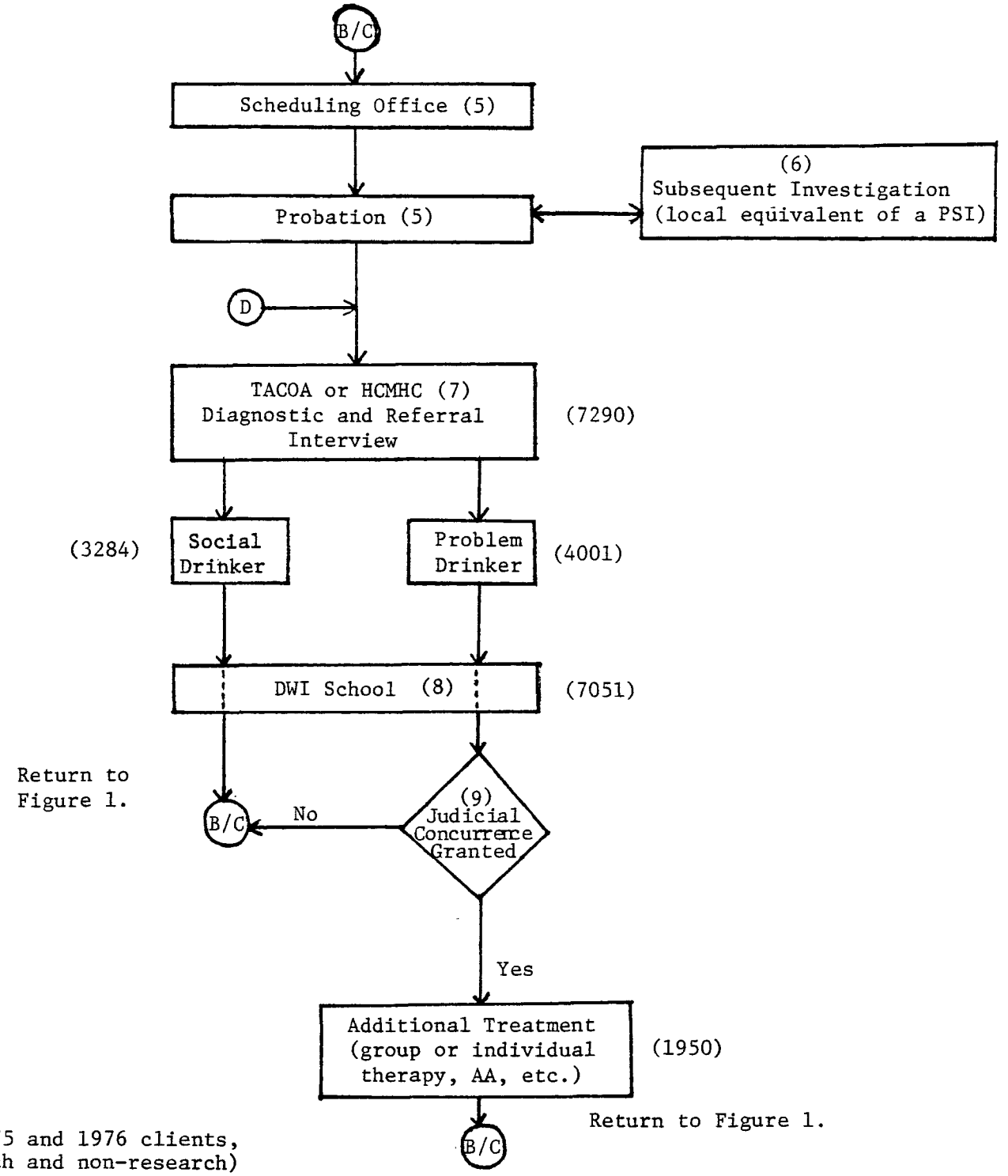


FIGURE 1B

FLOW FOR ALL RESEARCH DESIGN CLIENTS:
Six-Months Court Orders Only

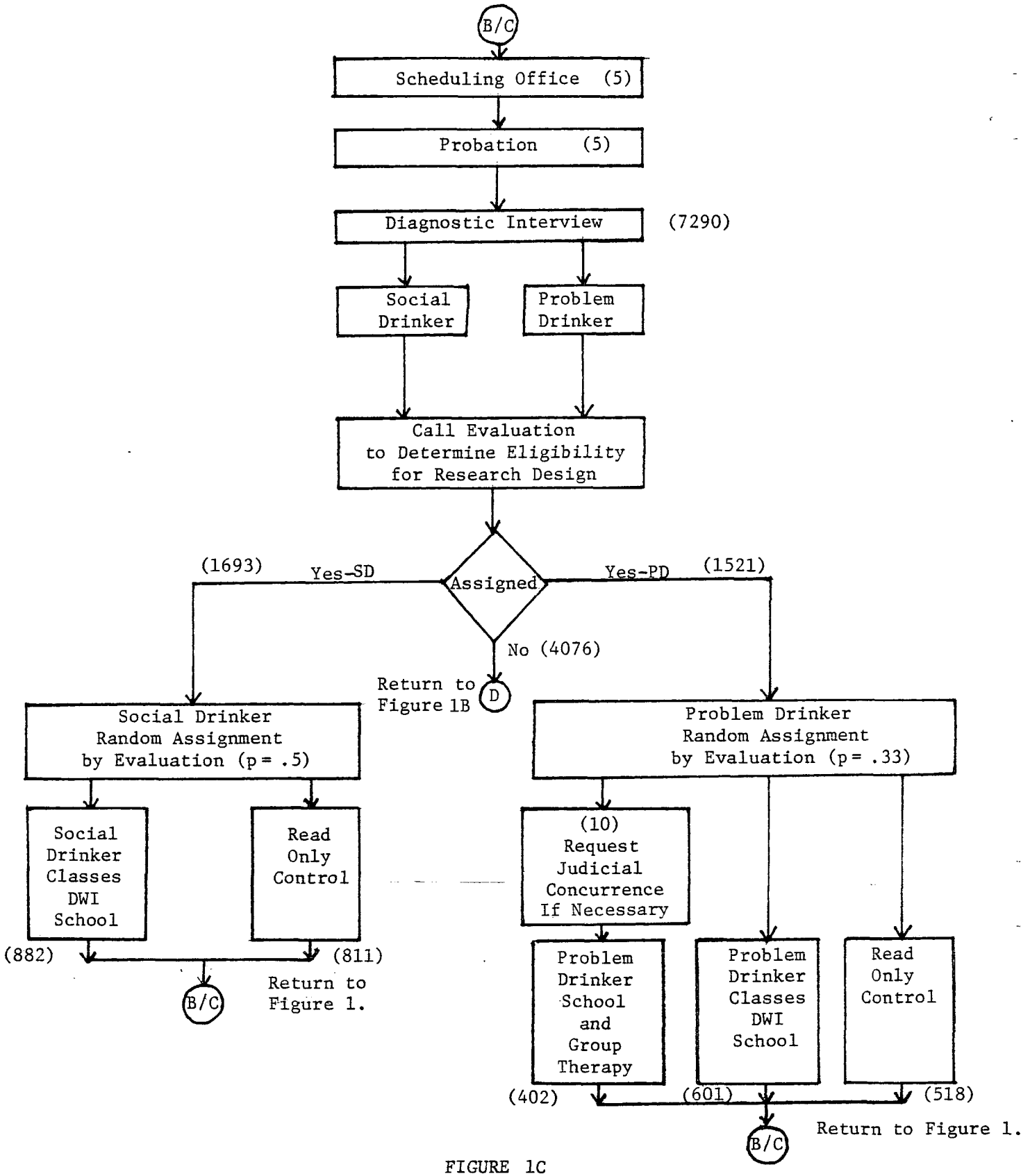


FIGURE 1C

NOTES FOR JUDICIAL/REHABILITATION SYSTEM FLOW CHART

(1) To December 31, 1974: "Guilty" typically meant that adjudication was withheld and the defendant was referred to probation (and possible diagnosis/rehabilitation). Where concurrent referrals to probation were absent, "guilty" meant a formal, recorded DWI conviction.

January 1, 1975 forward: Mandatory adjudication law takes effect, all quilty dispositions are recorded convictions.

(2) Convicted individuals could be assessed jail and/or fine with or without probation (or probation only until 7/1/75).

(3) Most clients were court ordered to the diagnostic unit with subsequent referral to DWI school, and if appropriate, additional treatment. Some clients, however, were referred directly to DWI school.

(4) Effective 1/1/75 forward. Procedure was independent of any court ordered treatment referrals.

(5) Probation was actual until 7/1/75 when State eliminated misdemeanor probation. After 7/1/75, judges selected Phase I or II court orders providing six months "unsupervised" probation or a Phase III court order providing two years of "unsupervised" probation. Monitoring of compliance with court order was left to the treatment agencies.

ASAP-sponsored scheduling office became operational 10/1/74. Prior to this time scheduling was done by probation officers. Between 10/1/74 and 7/1/75 (when probation was eliminated) clients went from court to the scheduling office (for assignment to diagnostic interview), and then to probation. After 7/1/75 clients went directly from the scheduling office to the diagnostic interview. Scheduling for DWI school and additional treatment was done by the diagnostic unit.

(6) Eliminated 7/1/75.

(7) To 10/30/74: While shown preceding DWI school, it could have occurred either before, during, or after school.

Beyond 10/30/74: It always occurred prior to school.

Diagnostic agency changed from TACOA to HCMHC in 9/75.

(8) After 11/74, separate curricula were used for social and problem drinkers.

(9) Judicial concurrence for treatment (in addition to DWI school) was required at the judges' discretion. Requests for concurrence were initiated at the diagnostic interview.

(10) Clients remained in research design groups (school + therapy) whether or not judicial concurrence was received.

plea was entered, a court date was set, and the decision was made concerning the individual's release from incarceration. If the judge did not feel release was warranted, the trial date was set (usually within two weeks), and the person returned to jail. It should be noted that only the judge and probation staff were present at First Presentments. Neither law enforcement nor prosecution were required to attend.

Assuming a court date had been set, a non-jury trial took place on that date with law enforcement, prosecution and defense attorneys present. Unless a continuation was granted, the case was adjudicated and sanctions were imposed in one court session. Mandatory adjudication for alcohol-related offenses became effective January 1, 1975. This particular change in the State law had a profound effect upon Hillsborough County residents. Prior to that date, judges traditionally withheld adjudication of DWI charges, enabling them to treat the defendant as though he was found guilty (and thus enforce court ordered rehabilitation), without the guilty verdict and subsequent points being added to the individual's driving record maintained in Tallahassee. Under that structure, the defendant kept his driver's license. Defendants frequently lost their driving privileges and had the conviction entered in their driving record if they failed to comply with the conditions of court-ordered rehabilitation programs.

The chief criticism of the adjudication withheld procedure was that the individual did not have an official record of the DWI conviction. Thus, second offenders were rare, and law enforcement as well as other interested individuals were able to document a series of instances where individuals had been arrested and processed for alcohol-related offenses many times in the past, but because of the adjudication withheld structure, had continued to maintain their driver's license. In addition, the State of Florida has a "habitual offender" act, which automatically terminates the driving privilege based upon a series of offenses within specific time periods. Depending upon the offenses involved, that law can result in either a one year or five year revocation. Obviously, the ability of that law to

fulfill its intent was severely weakened by the absence of convictions being recorded on the driving record.

With mandatory adjudication, an additional offense was added to the Florida statutes. That offense was "driving with an unlawful blood alcohol level" (UBAC in local nomenclature), which carried lesser penalties. Intended as an option when the blood alcohol level was between .05 and .10, the eventual language of the statute allowed plea bargaining in the .05 to .20 range. The DWI statute was altered to include per se guilt at .20. The "presumptive" nature of .10 remained in the DWI statute.

Beginning on June 16, 1975, the Tampa ASAP provided traffic court judges with a "Report to Court" form at each non-jury DWI trial. This form shown in Appendix A, indicated the current arrest BAC (or refusal) for each offender as well as prior DWI arrests and prior court referrals to treatment/retraining programs, thus supplementing the information provided by the State DMV standard records check. The judges utilized these data in determining appropriate sanctions, and in particular rehabilitation referrals.

Although the vast majority of court trials were non-jury, procedures were available for obtaining a trial by jury. Furthermore, a guilty decision, regardless of the type of traffic court session in which it occurred, could be appealed in higher courts. The procedures for obtaining a jury trial and appealing a judicial decision are delineated in Appendix B of this report.

Included in the mandatory adjudication statute which became effective in the State of Florida on January 1, 1975, was a procedure by which a defendant could obtain a temporary driver's license should the defendant be convicted of an alcohol-related offense after the first of the year. Figure 1A presents this procedure in graphical form. (All guilty verdicts for alcohol-related offenses after January 1, 1975 carried with them mandatory license suspensions.) In such cases, a judicial option existed for allowing the defendant to apply for a temporary driving permit during the period of suspension. It

is important to note that the temporary driver's license procedure was independent of any court ordered treatment referral which required a six month or two year "unsupervised" probationary period and a diagnostic interview (unless the judge chose to bypass the interview and order the individual directly into the DWI school). Evaluation has no data on the frequency with which judges exercised the temporary permit option, but the general impression was that the option was used in the majority of cases.

Once a judge had decided to use the option open to him, he presented to the defendant a form for obtaining the temporary permit. At this point, the defendant had the option to comply with the regulations on the form, or simply to ignore them. If the defendant chose not to apply for his temporary license, he was of course without a license for the period of suspension.

For those defendants who applied for their temporary license, they first visited the scheduling office (if court-ordered rehabilitation was also part of the judicial disposition) or went directly to the DWI school. Once at the school, the defendant obtained a short form indicating his registration. This form was taken to the Division of Drivers License and presented to the licensing examiner along with the form received from the judge. Driver license examiners routinely checked all individuals so applying. If the driving record indicated there were no concurrent suspensions, or that the defendant had not been refused the privilege of driving for any other reason, the individual was judged eligible and issued a temporary permit.

The temporary permit procedure was not a carte blanche arrangement; rather, specific criteria had to be met in order to comply with the Department of Highway Safety and Motor Vehicles procedures, as specified in State law. The most frequent reason for issuing the temporary permit was "business purposes only". "Business purposes only" was interpreted locally to include travel to and from work, in addition to such necessary activities as grocery shopping and attendance at any court-ordered rehabilitation.

Individuals denied the temporary permit by the driver license examiner did have the option of appealing through the court to the Department of Highway Safety and Motor Vehicles. When such appeal was made, the Department of Highway Safety and Motor Vehicles held a hearing within 14 days of the date of the appeal to determine the eligibility status of the client. During the 14-day period, a complete background investigation was made on the client, and that information was used during the hearing to make the decision regarding the issuance of a temporary permit.

The period of suspension after conviction of an alcohol-related offense varied. If the defendant was convicted of first offense DWI, the suspension period was 90 days. If the individual was convicted of UBAC the suspension period was 30 days. There have been some as yet undocumented reports which indicated that some individuals convicted of UBAC simply chose not to exercise the option of applying for a temporary permit for the 30 day suspension. In the absence of court-ordered rehabilitation, they successfully avoided attendance at the school in this fashion.

If a judge decided to assign a guilty offender to ASAP rehabilitation programs prior to 1/1/75, the typical judicial procedure for assuring the client's cooperation was to withhold adjudication and place the client on probation. Punitive sanctions, typically fines, were assessed at the judge's discretion. In this manner, attendance at the diagnostic interview, DWI school, and any additional treatment recommended by the ASAP-sponsored diagnostic unit were incorporated into the conditions of probation, and thereby given the status of court-ordered requirements. Two types of probation/court orders were used specifying either unsupervised or supervised (reporting) probation.

Under this situation, probation could function as the enforcement arm of the court, requiring attendance at school, the interview, etc., and issuing rearrest orders for non-compliance. Probation personnel also appeared at all probation revocation hearings (the inevitable result of a rearrest order properly served), and reported

the individual's progress through rehabilitation, and recommended continuation of probation or revocation. Revocation typically resulted in jail, fine, loss of license or all three, and the guilty verdict being entered on the driving record.

After 1/1/75, all ASAP clients were formally convicted of DWI or UBAC and placed on either supervised or unsupervised probation (at the discretion of the court). During the first six months of 1975 there were probation officers available to monitor the progress of convicted DWI offenders through the rehabilitation programs. In actuality, however, there was little active monitoring of DWI cases by the State Probation and Parole Office. When the State eliminated all misdemeanor probation after 7/1/75, the monitoring of compliance with court order requirements was left totally to the treatment agencies.

The capias issuance procedure was developed by the Tampa ASAP to enforce court-ordered participation in the rehabilitation system. Initiated during the third quarter of 1975, the ASAP capias process replaced and expanded the monitoring and enforcement functions performed by the State Probation and Parole Office.

When a client failed to show or dropped out of a rehabilitation program, or failed to show up at the ASAP scheduling office or the diagnostic and referral interview, the responsible agency sent an affidavit of non-compliance to the ASAP. ASAP staff members prepared the capias and carried it, with a copy of the affidavit, to Tampa Police Department Violations Office where they were signed by a Deputy Clerk of the Court.

The capiases were typically served by a Deputy of the Sheriff's Office who picked them up daily at the TPD Traffic Violations Office. If an individual was located, he was arrested for contempt of court (a non-bondable offense), taken to Central Booking, and incarcerated until his hearing. Judges hearing capias cases were provided with a copy of the ASAP affidavit of non-compliance for each defendant as well as information indicating what the defendant specifically failed to do, the ASAP treatment recommendation, and other relevant informa-

tion which could assist judges in returning clients to their appropriate place in the ASAP rehabilitation system.

It was not always necessary to arrest a client to accomplish the objectives of the capias process. It was quite common for a client upon learning that a warrant had been issued for his arrest, to report voluntarily to the appropriate treatment agency. In such cases the capias was withdrawn.

Shortly before the elimination of misdemeanor probation a new set of court orders was designed. The three types of court orders in use from the second quarter of 1975 through July of 1976, called Phase I, II, and III, are shown in Appendix C. All three court orders required attendance at the ASAP-sponsored diagnostic interview and DWI school. The Phase I and II court orders specified six months of unsupervised probation. Clients violating the conditions of the court order were in contempt of court. Phase I and II court orders differed in only one respect: if additional alcohol treatment (beyond school) was determined to be appropriate for Phase I clients, the treatment recommendations had to receive judicial concurrence. Concurrence was obtained through an administrative procedure in which the judges periodically reviewed Phase I court orders received from ASAP. On a Phase II court order all treatment recommendations made by the diagnostic counselors automatically became part of the court order and judicial concurrence was not necessary. The Phase III court order was similar to the Phase II in that judicial concurrence was not necessary, however the Phase III court order provided two years of unsupervised probation.

Tampa ASAP made recommendations concerning the appropriate court orders for DWI offenders on the Report to Court. ASAP recommended Phase I for first time offenders with BAC's less than .15. Phase II was recommended for individuals with BAC's $\geq$ .15 and/or prior DWI arrests but with no prior ASAP treatment experience. Phase III court orders were recommended for individuals with prior ASAP treatment experience. All court orders were implemented, of course, at the discretion of the presiding judge.

Although the traffic court judges frequently placed clients on Phase I court orders automatically requiring judicial concurrence, subsequent requests for concurrence were rarely denied. Consequently, in August of 1976 ASAP revised the court orders to expedite the referral process. The revised Phase I six-months court order no longer required judicial concurrence for treatment referrals unless the judge specifically indicated this requirement on the court order. The revised Phase II court order was essentially equivalent to the old Phase III specifying two years of unsupervised probation. The revised court orders are shown in Appendix D.

Guilty individuals who were not referred to the ASAP rehabilitation system typically received a license suspension, a fine, and occasionally a jail sentence. Until 7/1/75, non-referred individuals could be put on active probation with or without punitive sanctions. Furthermore, effective 1/1/75 non-referred individuals were often given the opportunity to obtain a temporary driving permit by voluntarily enrolling in DWI school, as previously discussed.

For court-referred clients, the normal (non-research design) case flow is depicted in Figure 1B. The ASAP-sponsored scheduling office became operational as of 10/1/74. Prior to this time the scheduling of ASAP clients was performed by probation officers. Between 10/1/74 and 7/1/75 clients went from court to the scheduling office (where they were assigned a date for the diagnostic interview), and then to probation. After 7/1/75 clients went directly from the scheduling office to the diagnostic interview. Scheduling for DWI school and additional treatment was done by the diagnostic unit.

The subsequent investigation completed by probation (shown in Figure 1B) was not directly used by ASAP, but was used by probation and the court, particularly where revocation hearings were involved, or where the individual was a repeat offender. This procedure was eliminated along with all misdemeanor probation functions in 7/1/75.

The primary source of referral decisions in the Tampa ASAP was the diagnostic and referral interview conducted by the Tampa Area

Council on Alcoholism (TACOA) until September, 1975, at which time this function was assumed by the Hillsborough Community Mental Health Center (HCMHC), Alcoholism Services Division. This interview was approximately one hour in duration.

Prior to June, 1975, the determination of drinking problem severity was primarily based on the results of the Mortimer-Filkins questionnaire and interview and the clients BAC at time of arrest. With the initiation of the ASAP Report to Court, prior arrest and prior treatment data were made available to the diagnostic counselors. The end product of the diagnostic process was the classification of clients as social or problem drinkers. Upon completion of the diagnostic portion of the interview, all ASAP clients were scheduled to attend alcohol safety school conducted by DWI Counterattack, Inc. After 11/74 separate curricula were used for social and problem drinkers. Special classes were also available for illiterate, Spanish speaking, and youthful offenders. The diagnostic counselors also made a determination as to the most appropriate alcohol treatment alternative (beyond school) for problem drinker clients. When required, judicial concurrence with treatment recommendations had to be obtained before clients could be officially scheduled into rehabilitation programs. If concurrence was not granted, the clients' participation in the ASAP rehabilitation system ended with the successful completion of DWI school.

It should be mentioned that although Figure 1B shows the diagnostic and referral interview preceding DWI school, prior to 10/30/74 it could have occurred either before, during, or after school. In this situation clients were usually referred directly to DWI school from the courts and the probation office. However, after 10/30/74, the interview always occurred prior to school.

Figure 1C illustrates the temporary modifications of the normal case flow and treatment decision process necessitated by the requirements of Tampa ASAP's rehabilitation research design. This research design, applicable only for clients on six-months court orders, was in effect from January, 1975 through June, 1976. Upon completion

of each diagnostic interview, the counselor called the ASAP evaluation group to determine the client's eligibility for inclusion in the research design. Much of this pre-screening process was accomplished by the diagnostic counselor during the course of the interview. For example, if a client was determined to be illiterate or Spanish speaking, or if a client had previously participated in court enforced rehabilitation programs he was excluded from the research design. The evaluation staff made a confirmatory search of the client files for previous participation in treatment/retraining programs, answered any questions a counselor might have had about the criteria for eligibility, and then made the final decision to include or not include an individual in the research design.

Social drinkers included in the design were then assigned by ASAP evaluation on a random (equal probability) basis to DWI school social drinker classes, or to a special "read only" minimum exposure condition in which individuals received educational materials to be read at home.

Problem drinker design clients were assigned on a random basis to DWI school problem drinker classes, to "read only", or to problem drinker classes plus group therapy. The therapy program was the short term didactic and group therapy conducted by HCMHC: Alcoholism Services Division.

Those individuals not eligible for the research design were referred to the treatment/retraining programs determined appropriate by the diagnostic counselors, as was discussed with Figure 1B.

Judicial System Re-Organization: The most significant departure from the system described in Figure 1 existed prior to January 1, 1973. Prior to that date, three independent court systems were in effect in Hillsborough County. The Municipal Courts processed all misdemeanor arrests made by the Tampa Police Department, while the Justice of the Peace Courts processed all misdemeanor arrests made by other law enforcement agencies. Circuit Courts handled jury trials and felony cases. Separate booking facilities and jails also existed.

Court consolidation created by a constitutional amendment made all courts State courts, subject to State rules and procedures and abolished all Municipal and JP courts.

B. STR Program

In August, 1975 the Tampa ASAP joined ten other participant ASAP sites in a federal program concerned with assessing the effectiveness of short term rehabilitation (STR) modalities currently in use for problem-drinker drivers. One of the outstanding aspects of the STR program evaluation was the use of client life changes as criteria of rehabilitation effectiveness. The initial STR evaluation instrument, called the Life Activities Inventory (LAI) package, consisted of four parts: 1) Mortimer-Filkins questionnaire (routinely filled out by all ASAP clients), 2) two self-administered questionnaires, the Personality Assessment Scale (describing client's personality along several dimensions), and the Current Status Questionnaire (describing current behaviors, feelings and attitudes toward drinking, family and social life, employment, etc.), 3) LAI interview (assessing client's behavioral activities in various spheres of his life during the previous six-month period, e.g., employment/financial, health, drinking activities, marital/family, social/recreational), 4) records check (documenting prior traffic and non-traffic offense arrests/ convictions and index arrest information).

The STR program evaluation was superimposed on Tampa ASAP's previously described rehabilitation research design in the following manner. Beginning in early November, 1975, all ASAP clients diagnosed as problem drinkers and determined to be eligible for the rehabilitation research design were administered the LAI package. The initial STR data were collected by the HCMHC diagnostic and referral counselors immediately after receiving the treatment assignment from ASAP evaluation (i.e., problem drinker school plus group therapy, problem drinker school only, or read only @ 33 1/3%). Initial data collection continued through March, 1976 providing over 100 LAI's for each of the three treatment/control groups.

Life changes potentially resulting from the treatment interventions were measured by re-interviewing the STR clients at six-month and twelve-month intervals from the date of the initial interview. Although all STR clients were put on six months of unsupervised probation (old Phase I and II court orders), the wording of the court orders was such that those individuals on Phase I court orders (the majority of STR clients) who were not assigned to group therapy were not required to attend the follow-up interviews. Therefore, the ASAP capias procedure could not be used to enforce participation in six and twelve-month interviews. For the layman, however, the wording of the Phase I court orders was rather confusing and one could expect that many STR clients would assume that they were under court order to return for a follow-up interview. In order to interview as many STR clients as possible before their court orders expired, individuals were scheduled for their first follow-up interview at five months from their initial interview date. If despite the early follow-up, the court order had expired (i.e., the court order had been signed a month or more prior to the initial interview date), clients were scheduled to return at six months from the initial interview.

STR clients were scheduled for their last interview at exactly twelve months from the date of their initial interview. Since the clients were clearly not under court order to return for their last interview, they were paid $10 for their participation. All twelve-month follow-ups were completed by the end of April, 1977.

The standard procedure for contacting STR clients was as follows: ASAP sent a letter to each client one month before the scheduled follow-up interview date requesting his or her attendance. A second copy of this letter was mailed two weeks prior to the interview. Finally, an attempt was made to contact each STR client by telephone no earlier than the Wednesday preceding the interview (all follow-up interviews were conducted on Saturdays). Those clients unable to attend the originally scheduled follow-up interview were rescheduled at a later date. STR clients who could not be contacted or who failed

to show up for their interview were sent additional reminder letters by the HCMHC. The ASAP and HCMHC client contact letters are shown in Appendix E. The six-month contact letters were sent by certified mail. However, a number of clients reported embarrassment when such personal service came to the attention of their neighbors. Consequently, all twelve-month contact letters were mailed first class.

If all attempts to contact a client by letter and telephone failed, an HCMHC staff member tried to locate the individual in the field and conduct the follow-up interview at his or her home.

C. Funding of Judicial/Rehabilitation Countermeasures

During the last six months of 1973 and the first six months of 1974, Tampa ASAP funded a nine-man unit within the State Probation and Parole Office. The ASAP probation unit consisted of eight probation officers each with an average monthly caseload of 225 in 1974 and one supervisor who carried no caseload. The principal function of ASAP probation officers was to monitor, at least administratively, the performance of DWI probationers in compliance with their conditions of probation. In addition, ASAP probation officers scheduled probationers for attendance at alcohol safety school and at the diagnostic/referral interview.

Although ASAP funding of probation officers ceased after June, 1974, the State Probation and Parole Office continued to schedule ASAP clients until the ASAP-sponsored scheduling office became operational in October, 1974. The scheduling office scheduled clients for diagnostic/referral interviews and in turn the diagnostic/referral unit scheduled clients for alcohol safety school and additional treatment. ASAP funds initially supported diagnostic and referral activities in 1971 and 1972, however, this process began self-supporting through fixed client fees in 1973. During 1975 clients were required by court order to pay a $25 fee to cover the cost of the diagnostic/referral interview. A portion of this fee was used to support the scheduling office. In addition, when the

Tampa STR program began in November, 1975, ASAP paid the HCMHC diagnostic and referral unit $15.47 per client to administer the Life Activities Inventory package.

After the complete elimination of misdemeanor probation on July 1, 1975, Tampa ASAP absorbed the costs of the clerical and organizational/administrative activities necessary for the maintenance of the capias process.

ASAP funds were also expended in 1975 for the maintenance of the judicial/rehabilitation tracking system, a client file used by ASAP management to produce the Report to Court which provided the judges and the diagnostic/referral counselors with client arrest and treatment histories.

Tampa's alcohol safety school conducted by DWI Counterattack, Inc., began operation in May, 1971. ASAP assisted the start-up of DWI school in 1971 by purchasing equipment. In 1972, Tampa ASAP paid $10 of every client's $30 fee in order to reduce the financial burden on DWI's referred to the school. However, the only ASAP funds allocated for DWI school during 1973 and 1974 were for the purpose of data collection, and by 1975 all ASAP funding was terminated. During 1975 the DWI school raised the client fee for the four-session classes to $40, while research design clients assigned to the special one-session "read only" class were charged $30.

Tampa ASAP supported a group therapy program located in Plant City for individuals in an outlying area of the county not generally served by other treatment modalities. This program began receiving ASAP referrals in 1972 but both ASAP referrals and funding were terminated during the last quarter of 1974.

ASAP also supported a group therapy program within the State Clinic (Bureau of Alcohol Rehabilitation) in 1972 but that support was withdrawn in 1973 and ASAP referrals were switched to the NIAAA (now HCMHC) treatment program.

The chemotherapy program conducted by HCMHC Alcoholism Services Division was the only other treatment modality receiving ASAP funds. During 1975 and 1976 ASAP paid for the physical examination (@ $25) and the Antabuse ($.20 per administration). The actual group therapy sessions, however, were funded through client fees assessed on a sliding scale basis.

Thus by the end of 1975 a major proportion of the diagnostic, referral and rehabilitation system was supported through court-ordered client fees. Summaries of expenses during the most recent twelve-month accounting periods are shown in Appendix F, for DWI Counterattack and HCMHC Alcoholism Services. These summaries present an overview of the cost basis for providing alcohol treatment and education services in the Tampa area.

D. Treatment Modality Descriptions

Since 1971 a variety of community based, usually group oriented, alcohol treatment and retraining programs have received ASAP referrals. Brief descriptions of the major modalities are presented below.

1. DWI Counterattack

DWI Counterattack is Tampa's alcohol safety school. The stated purposes of this program are: (1) to give reasonable people enough information about the drinking-driver problem to modify or change their future drinking and driving behavior, and (2) to offier the opportunity for enough self-understanding that those who have a drinking problem will be able to recognize it and take appropriate steps to change it, including seeking help if necessary. The Counterattack program offers five different curricula for social drinkers, problem drinkers, Spanish speaking, illiterate, and youthful offenders. With the exception of youthful offender classes which are five sessions long, all DWI school programs consist of four 2 1/2 hour sessions conducted once per week. On the average, there are approximately 20 students present at each meeting with one

instructor. The content of social drinker class sessions (which must be taken in sequential order) is summarized as follows:

Session 1 (Week 1) is an introduction to the program explaining its purpose of modifying, or otherwise changing, DWI behavior. Scope, seriousness, and gravity of the drinking-driver problem is emphasized.

Session 2 (Week 2) explains how drinking affects individual functioning and how it impairs driving skills. Blood alcohol concentration and the breathalyzer are explained. The importance of maintaining a BAC of under .05%, if the individual is going to then drive, is stressed.

Session 3 (Week 3) defines problem drinking and alcoholism, and these subjects are discussed. The students are then assisted in determining the extent of their individual involvement with alcohol.

Session 4 (Week 4) focuses on the student's plan to prevent future DWI's by reviewing the main factors of the influence of alcohol on driving, the drinking driver problem, and problem drinking. It is stressed that some students will need long term help, as they have lost the ability to control their drinking once they start. Resources available to help these individuals are discussed.

Problem drinker classes present similar factual material but with emphasis on different topics. For example, Session 1 of the social drinker class stresses the cost of a DWI resulting from fines, jail and increased insurance premiums, while in the first session of the problem drinker class students are confronted with the fact that they have been identified as problem drinkers. The instructor discusses how the diagnosis was made and introduces the alcoholic continuum. Sessions 3 and 4 of the problem drinker

class involve longer and more intensive discussion of problem drinking, treatment resources, and developing realistic plans to avoid future DWI arrests. The latter plans, while also developed in social drinker classes, are directly challenged by both the instructor and the other students in problem drinker classes.

For the purposes of Tampa ASAP's rehabilitation research design, DWI Counterattack conducted a special "read only" class. Clients assigned to this class filled out a personal data form, received educational materials to be read at home, paid their fee, and were advised of their drivers license status. The entire process took 10-25 minutes. Materials include the following:

The Way to Go, by Kenneth A. Rouse

The Alcoholic is a Sick Person, by the National Council on Alcoholism, Inc.

When Drinking and Driving Mix, by Paul Ditzel

The Modern Approach to Alcoholism, by the National Council on Alcoholism, Inc.

The ABC's of Drinking and Driving, by Channing L. Bete

What Everyone Should Know About Alcoholism, by Channing L. Bete

The read only classes were conducted by a Florida Highway Patrolman with a BA in Criminal Justice and pursuing an MA in Criminal Justice. Instructors for the four-session classes had degrees of Master's level or above in the behavioral sciences and experience in the field of alcoholism treatment.

2. HCMHC Short Term Didactic and Group Therapy

The short term didactic and group therapy program conducted by the Hillsborough Community Mental Health Center: Alcoholism Services Division is designed for beginning and mid-range problem drinkers. The entire program consists of approximately 24 sessions over a six-month period (1 session/week). Each session is one hour long with 8-11 clients present at each meeting and one therapist.

The objectives of this modality are:

a) To facilitate in helping the clients gain a better understanding of the effect drinking can and is having on their lives.

b) Emphasis is placed upon the individual responsibility and accepting consequences resulting from his behavior.

c) To allow for some consideration on client's part of how his use and/or abuse of alcohol is affecting his life style.

d) To use the group process to give support in helping those who wish to change their behavior to do so.

The procedures used to achieve the objectives of this modality are:

a) To educate the client about alcohol and its effects on the client.

b) The use of the eclectic group modality approach incorporating the different therapies such as rational, gestalt, analytical, etc., to most effectively meet the needs of each client.

The typical client receives 6 weekly didactic sessions followed by 5 months of group therapy. However, some of the clients who are experienced with alcohol may skip the didactic sessions and enter directly into 5-6 months of group therapy. Both didactic and therapy sessions are of the same size (i.e., 8 - 11 clients).

All therapists are psychiatric social workers with Master's degrees and specializing in the field of alcoholism.

The didactic sessions were first implemented in July, 1974. However, the treatment agency which is now HCMHC: Alcoholism Services has been providing group therapy for ASAP clients since 1972. During its first years of operation the treatment agency was primarily supported by an NIAAA grant but by 1975 the alcohol treatment programs were funded by a number of state and federal sources as well as client fees assessed on a sliding scale.

3. HCMHC Extended Group Therapy and Chemotherapy

The HCMHC extended group therapy and chemotherapy modalities are designed for the mid-range problem drinker to alcoholic clients. Both treatment programs consist of 50 - 100 sessions (1 session/week) over a one to two year period. The duration of each client's program is at the discretion of the treatment agency. Sessions are one hour long with an average of 8 - 10 clients present at each meeting and one therapist. The objectives of this modality are:

a) Emphasis placed upon individual responsibility and accepting consequences of his behavior.

b) To help the client become aware of how he is abusing the use of alcohol.

c) Use of group process to give support in helping those who wish to become more responsible and in control of their drinking.

d) To enable the clients to gain some insight concerning the reasons why they drink. This requires a good deal of understanding of the dynamics of alcoholism and indepth study of individual history, current situation and level of functioning by the group.

e) To make use of the group process to elicit such information and understanding to give support to foster change in one's behavior.

The procedures used to achieve the objectives of this modality are:

a) The first is the use of didactic sessions to help educate the clients about drinking and driving. In addition to educate the client about alcohol and its effect on each client.

b) The use of the eclectic group modality approach incorporating the different therapies such as rational, gestalt, analytical, etc., to most effectively meet the needs of each client.

All therapists are psychiatric social workers with Master's degrees and specializing in the field of alcoholism.

The chemotherapy modality combines extended group therapy with antabuse maintenance. Antabuse is administered (in liquid form) twice weekly under supervision.

4. TACOA Intermediate Step (Information and Education: I & E)

The Intermediate Step (I & E) program conducted by the Tampa Area Council on Alcoholism (TACOA) was designed for clients diagnosed as "gray area"/beginning problem drinkers. I & E comprised two sessions (1 session/week) each of two-hours duration. There was an average of 30 persons present at each meeting. TACOA absorbed the entire cost of this modality.

The first hour of each meeting was devoted to films concerning alcoholism, Al-Anon, and the results of alcohol abuse. The second hour was consumed with discussion of the topics raised in the films, where treatment resources were located, and how one might contact those resources. The majority of the meetings were held in an AA clubhouse.

The TACOA Intermediate Step program terminated activities during the first quarter of 1975.

5. TACOA Group Therapy and TACOA Youth Group Therapy

TACOA group therapy programs were designed for problem drinkers. The treatment length was ten weeks, one two-hour session per week. There was an average of 15 clients present at each meeting. Clients were assessed a $10 fee per weekly session.

Groups were conducted by Ph.D. clinical psychologists in conjunction with an alcoholism specialist. "Drink-a-logs" were kept for the first five weeks and were used in therapy discussions. Therapy was reality-oriented, and covered the physical aspects, emotional aspects, conversant aspects, and cultural aspects of problem drinking. Unity of the vital life areas was stressed. Summaries of drinking patterns were noted during the problem analysis.

The effort was made to invite spouses and/or friends to come with the individual in order to build the beginnings of a social group not dependent upon alcohol for interaction. Further discussions centered on family/interpersonal interactions, community resources, determining alternatives, and developing and testing action plans.

During the last four weeks, individuals were actively pointed toward other community resources which were available for continued support.

Youth group therapy was specifically for individuals 25 years of age or under while the adult therapy was for individuals over that age.

TACOA youth group therapy activities were terminated in 1974, and adult group therapy terminated during the first quarter of 1975.

6. ASAP Supported Group Therapy (Plant City)

ASAP supported group therapy was designed for problem drinkers. The treatment program consisted of one three-hour session per week for four months. There was an average of 15 clients present at each meeting.

This treatment modality used the "typical" group therapy approach, utilizing reality-oriented therapy as well as non-directive techniques. The individual in charge has an MSW, is a vocational education counselor, and has some 10 years experience dealing with alcoholics. Since more time is available in this treatment modality than in the TACOA group therapies, a good deal more interaction occurs, specifically related to problem identification and problem solution. Considerable effort is given in the last two months to the results of group participants' efforts at changing their drinking and driving behavior according to certain guidelines which they have helped establish.

ASAP funding and referrals to this modality terminated during the last quarter of 1974.

E. Organization of Data Analyses

Section II of the present study provides an administrative summary of diagnostic, referral, and rehabilitation activities which is intended to be primarily descriptive in nature. System performance in two areas is addressed:

1) Results of diagnostic and referral processes (e.g., diagnoses by years, referrals to modalities and treatment agencies/programs by years).

2) Client participation in rehabilitation programs (e.g., completion, drop, no show rates).

The third section takes a more analytic approach to specific evaluative topics. These topics are as follows:

1) Reliability of the diagnostic process.

2) Treatment group profile comparisons.

3) Effect of Treatment on DWI recidivism.

4) Effect of treatment on life changes.

Research methodology is introduced as appropriate and conclusions are drawn for each evaluative topic.

II. SUMMARY OF DIAGNOSTIC, REFERRAL, AND REHABILITATION ACTIVITIES

A. Results of Diagnostic and Referral Processes

The end product of the diagnostic process was the classification of ASAP clients as social or problem drinkers. However, a very small number of clients (e.g., five in 1975) were determined to have drug problems other than alcohol, and were eliminated from analysis in the present study.

Table 1 presents the annual proportions of social and problem drinker diagnoses. During the last quarter of 1971 and the first operational year, the diagnostic and referral counselors classified approximately 35 percent of their clients as problem drinkers. But the proportion of problem drinkers increased to 50.6 percent in 1973 and remained relatively constant through 1975. During the last operational year, 60.5 percent of the ASAP clients were classified as problem drinkers. This represents the highest annual proportion of problem drinker diagnoses in the Project's history. Overall, between 1971 and 1976 more than eighteen-thousand diagnostic interviews were completed, which resulted in approximately 51% problem drinker and 49% social drinker diagnoses.

TABLE 1

Drinker Type Diagnoses by Years

		1971	1972	1973	1974	1975	1976	1971-76
Problem Drinker	#	32	784	2199	2315	1968	2033	9331
	%	42.1	34.4	50.6	55.3	50.2	60.5	51.3
Social Drinker	#	44	1498	2151	1870	1954	1330	8847
	%	57.9	65.6	49.4	44.7	49.8	39.5	48.7
Column Total	#	76	2282	4350	4185	3922	3363	18,178
Percent Total	%	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Upon completing the diagnostic portion of the interviw, clients were referred to the appropriate treatment and/or education programs. This normal referral procedure was interrupted throughout 1975 and during the first six months of 1976 by ASAP's rehabilitation research design which required that clients be randomly assigned to specific treatment and minimum exposure conditions. Major changes in the referral process over the operational period and the relative use of different modalities are illustrated in Table 2. This table shows the number of referrals to various treatment and education modalities by drinker type. It should be noted that individual clients who were referred to more than one agency/program from the same interview are represented in Table 2, once for each agency they were referred to. Virtually all clients receiving a diagnostic interview were referred to school with or without additional treatment (approximately 98% in 1976). This has been the case throughout the operational period. Further, during the first three operational years counselors would frequently refer clients to two or more treatment agencies (typically AA in combination with a psychotherapy program), in addition to school. This practice became rare in 1975 and during 1976 there were no multiple treatment agency referrals reported to ASAP evaluation. If a client was referred to one agency offering several treatment modalities, and if the specific modalities to which a client was exposed could be identified, the client was represented once in Table 2 under the primary modality offered by the agency.

One of the most apparent performance changes evident in Table 2, was the dramatic decrease in the total number of treatment referrals in 1975 (from 2,267 in 1974 to 666 in 1975). The number of treatment referrals increased again to 1,284 in 1976 but this referral volume was still well below the 1973 level. There were two primary reasons for the observed reduction in treatment referrals. First, for almost the first six months of 1975, traffic court judges did not permit the court-ordered referral of DWI offenders to any rehabilitation modalities other than alcohol safety school. Secondly, of those problem drinkers eligible for the research design between 7/1/75 and 6/30/76,

TABLE 2

ASAP Referrals to Treatment Modalities
1972 - 1976

MODALITY	1972			1973			1974			1975			1976			1972 - 1976 All Clients	
	PD	SD	All	PD	SD	All	PD	SD	All	PD	SD	All	PD	SD	All	#	%
Alcohol Safety School	1000	1924	2924	1928	2245	4173	1900	2041	3941	1731	2007	3738	2442	1574	4016	18,792	-
Other Didactic (TACOA I & E, HCMHC Didactic Only)	0	0	0	423	6	429	725	24	749	140	9	149	417	0	417	1744	28.5
Group Therapy	221	1	222	548	0	548	471	0	471	233	2	235	237	1	238	1714	28.0
Individual	11	1	12	30	1	31	70	0	70	40	1	41	46	0	46	200	3.3
In-Patient	6	0	6	11	0	11	10	0	10	1	0	1	0	0	0	28	0.5
Chemotherapy	0	0	0	0	0	0	1	0	1	1	0	1	0	0	0	2	< 0.1
AA	515	1	516	804	0	804	881	3	884	120	0	120	1	0	1	2325	38.0
Supportive	41	8	49	15	3	18	34	1	35	7	0	7	2	0	2	111	1.8
Total Known Treatment Referrals	794	11	805	1831	10	1841	2192	28	2220	542	12	554	703	1	704	6124	100.0
Unknown *	26	0	26	97	0	97	47	0	47	112	0	112	580	0	580	862	-
Total Referrals Other Than School	820	11	831	1928	10	1938	2239	28	2267	654	12	666	1283	1	1284	6986	-

*Treatment type could not be identified. (Agency refused to tell, client's records were lost, or client referred to agency providing several treatment modalities and either no show or still in treatment programs.)

only one third were randomly assigned to the group therapy (plus school) treatment condition while the others were assigned to school only or to the "read only" minimum exposure condition.

Table 2 also shows a sharp decrease in referrals to AA and a relative increase in referrals to group therapy beginning in 1975. The change in the use of these modalities was in part an effect of the research design and the judges, and partly because the HCMHC counselors who assumed the referral function in September, 1975 did not refer clients to AA.

For the period 1972 through 1976, 38.0 percent of all known referrals to treatment beyond school (6,124) were to AA, 28.5 percent were to didactic modalities (other than school), and 28.0 percent of the total known referrals were to group therapy. There were an additional 862 referrals for whom the modality was unknown. Most of the unknown cases were in 1975 (112) and 1976 (580). A modality was unknown when a client was referred to a treatment agency providing several modalities, like HCMHC. The modality or modalities were identified through termination reports or by searching agency files. Virtually all of the 1975 cases were the result of lost or misplaced agency records. While a substantial proportion of the 1976 cases represent individuals who were still in treatment at the close of the ASAP operational period, many of these unknown cases were also the result of lost or misplaced records, and clients who dropped out but were not yet officially terminated (thus ASAP evaluation did not receive the termination reports). Considering both known and unknown modalities, a total of 6,986 referrals were made to various alcohol treatment and supportive programs in the Tampa area during the operational period. In addition, a total of 18,792 referrals were made to alcohol safety school which included 1,329 referrals to read only.

Referrals to particular treatment agencies and/or major programs within these agencies are presented in Table 3. Treatment agencies were dichotomized into direct alcohol rehabilitation and supportive

TABLE 3

ASAP Referrals to Treatment Agencies/Programs
1972 - 1976

	1972		1973		1974		1975		1976	
	#	%	#	%	#	%	#	%	#	%
I. DIRECT ALCOHOL REHABILITATION										
Primarily Group Therapy										
Plant City Extended Therapy - ASAP	19	2.3	55	2.8	50	2.2	0	0.0	0	0.0
State Clinic (BAR)										
ASAP	118	14.2	0	0.0	0	0.0	0	0.0	0	0.0
Non-ASAP	36	4.3	6	0.3	3	0.1	0	0.0	0	0.0
S.T.A.R. House	1	0.1	5	0.3	7	0.3	1	0.2	0	0.0
HCMHC Alcoholism Services/NIAAA	71	8.5	332	17.1	295	13.0	456	68.5	1273	99.1
Didactic Only Group, Individual, Chemo. Unknown	(0) (48) (23)		(0) (244) (88)		(60) (190) (45)		(118) (227) (111)		(417) (276) (580)	
Tampa Area Council on Alcoholism (TACOA)										
Extended Group Therapy (Adult)	0	0.0	206	10.6	221	9.7	39	5.9	0	0.0
Youth Group Therapy	0	0.0	16	0.8	4	0.2	0	0.0	0	0.0
Intermediate Step, I & E (didactic)	0	0.0	429	22.1	689	30.4	31	4.7	0	0.0
Primarily Individual Therapy/Counseling										
Private Medical	3	0.4	11	0.6	25	1.1	8	1.2	3	0.2
Guidance Center	9	1.1	14	0.7	6	0.3	0	0.0	0	0.0
Guidance Center of Brooksville	0	0.0	1	0.1	3	0.1	0	0.0	0	0.0
Primarily In-Patient										
Avon Park	2	0.2	3	0.2	3	0.1	0	0.0	0	0.0
Bowling Green Inn	1	0.1	1	0.1	0	0.0	0	0.0	0	0.0
V.A. Hospital	2	0.2	29	1.5	22	1.0	4	0.6	0	0.0
Hillsborough County Hospital	1	0.1	4	0.2	0	0.0	0	0.0	0	0.0
W. T. Edwards (Chronic Inebriate Detox. Program)	0	0.0	1	0.1	2	0.1	1	0.2	0	0.0
AA	516	62.1	804	41.5	884	39.0	120	18.0	1	0.1
Other Alcohol Treatment Agencies	3	0.4	6	0.3	24	1.1	2	0.3	5	0.4
II. SUPPORTIVE SERVICE AGENCIES (Vocational Rehab. etc.)	49	5.9	15	0.8	29	1.3	4	0.6	2	0.2
TOTAL REFERRALS	831	100.0	1938	100.0	2267	100.0	666	100.0	1284	100.0
# of Supportive Service Agencies Referred to:	10		7		7		3		2	

(non-alcohol related) services. Those agencies providing alcohol rehabilitation programs were further organized according to the primary treatment modalities offered. The data in Table 3 were not subdivided by client drinker type since so few social drinkers were referred to programs beyond school.

As previously discussed, the combined effects of the traffic court judges, the random assignment procedure, and a decrease in the use of AA as a treatment source for non-design clients by HCMHC counselors, resulted in a decrease in the total number of treatment referrals and the number of community agencies receiving ASAP referrals during 1975. This decrease in the variety of treatment alternatives could also be attributed in part to the loss of the TACOA programs which were phased out during the first quarter of 1975. Although the random assignment procedure ended in June of 1976 and the total number of treatment referrals increased during 1976, the trend toward the use of fewer community treatment resources continued. The number of supportive service agencies (vocational rehabilitation, marriage counseling, etc.) utilized by diagnostic/referral counselors also decreased from seven in 1974 to two in 1976. Of the 1,284 treatment referrals made in 1976, 99.1% were to HCMHC Alcoholism Services.

Alcoholism Services provided several different treatment modalities for ASAP clients. Table 4 presents the number of clients exposed to HCMHC modalities and modality combinations for 1975 and 1976. The data indicate that there was a substantial decrease in the proportion of clients receiving a combination of group therapy and didactic sessions (23.8% in 1975 to 0.6% in 1976), while there was a concomitant increase in the proportion of clients receiving the didactic sessions only (31.6% in 1975 to 54.5% in 1976). These changes suggest that the recent increase in referrals to Alcoholism Services may be overloading the professional staff, necessitating the use of short term, didactic modalities for many middle range problem drinkers.

TABLE 4

ASAP Referrals to HCMHC Alcoholism Services By Treatment Modalities and Modality Combinations 1975 - 1976

Modalities/Combinations	1975		1976		1975-1976	
	#	%	#	%	#	%
Group Therapy Only	103	29.9	222	32.0	325	31.3
Didactic Only	109	31.6	378	54.5	487	46.9
Individual Only	32	9.3	43	6.2	75	7.2
Chemotherapy Only	1	0.3	0	0.0	1	0.1
Group + Didactic	82	23.8	4	0.6	86	8.3
Group + Individual	5	1.4	7	1.0	12	1.2
Didactic + Individual	9	2.5	39	5.6	48	4.6
Group + Didactic + Individual	4	1.2	0	0.0	4	0.4
Total Known Referrals	345	100.0	693	100.0	1038	100.0
Unknown	111	-	580	-	691	-
Total Referrals	456	-	1273	-	1729	-

The final analysis of the referral process examined the results of the random assignment procedure. Table 5 shows the total number of ASAP clients randomly assigned to the research design groups during 1975 and 1976. A total of 1,691 social drinkers and 1,524 problem drinkers participated in Tampa ASAP's rehabilitation effectiveness study.

TABLE 5

Distribution of ASAP Clients Randomly Assigned to Research Design Groups: 1975 plus 1976

	#
Social Drinkers:	
SD School	881
Read Only - Control	810
Problem Drinkers:	
PD School + Group Therapy (HCMHC)	402
PD School Only	603
Read Only - Control	519

B. Client Participation in Rehabilitation Programs

Client participation in treatment and education programs is of course essential to the successful modification of drinking-driving behavior. Table 6 shows the termination status of ASAP treatment referrals to HCMHC (the primary treatment agency during the last two operational years) as well as the status of referrals to all treatment agencies combined. Termination data were collected during the first quarter following the year of referral, with the exception that referrals to AA, supportive services, and out-of-County treatment agencies were not followed up.

The completion rate for all agencies increased substantially between 1972 (45.1%) and 1973 (75.7%), and remained at this level through 1974 (77.1%). During 1975 and 1976 as the relative proportion of referrals to HCMHC Alcoholism Services increased, the Table 6 category labels "HCMHC" and "All Agencies" approached synonymity. The 1975 HCMHC completion rate was 64.1 percent. Of those clients not completing treatment 13.8 percent were no shows, 18.1 percent were dropouts, and 4.0 percent were still in treatment as of January, 1977. For 1976 referrals with known termination status, 37.3 percent were still in HCMHC treatment programs as of January 1977 (or had dropped out but had not yet been officially terminated). By disregarding those clients still in treatment, the 1976 HCMHC completion rate was roughly estimated to be 68 percent.

Client participation in DWI Counterattack's alcohol safety school is examined in Table 7. The first row of Table 7 contains the number of clients referred to school each year. The second row contains the number of clients beginning class each year, some of whom were referred in the previous year. Thus the difference between the referrals and entries does not give an accurate account of the annual no show rates. Furthermore, because of technical difficulties, no shows to school were not recorded on a case-by-case basis. However, based on the composite 1971 - 1976 data, a reasonable estimate of the overall no show rate was about 4.6 percent.

TABLE 6

Termination Status of ASAP Treatment Referrals

Termination Status	1972				1973				1974				1975				1976			
	HCMHC		All Agencies		HCMHC		All Agencies		HCMHC		All Agencies		HCMHC		All Agencies		HCMHC		All Agencies	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Complete	36	50.7	114	45.1	192	59.6	724	75.7	172	58.7	775	77.1	273	64.1	300	62.8	373	42.9	373	42.9
No Show:	10	14.1	39	15.4	44	13.7	96	10.0	58	19.8	118	11.7	59	13.8	70	14.6	79	9.1	79	9.1
Court excused prior to treatment	(-)		(-)		(-)		(-)		(-)		(-)		(19)		(19)		(48)		(48)	
Drop:	25	35.2	100	39.5	86	26.7	137	14.3	63	21.5	112	11.1	77	18.1	91	19.0	93	10.7	93	10.7
Switched programs (e.g., client moved, agency request)	(2)		(21)		(20)		(43)		(9)		(32)		(5)		(5)		(12)		(12)	
Client died	(1)		(3)		(1)		(1)		(1)		(2)		(3)		(3)		(1)		(1)	
Probation over	(15)		(45)		(10)		(16)		(1)		(3)		(6)		(6)		(16)		(16)	
Court excused during treatment	(3)		(3)		(11)		(14)		(4)		(8)		(14)		(26)		(6)		(6)	
Poor attendance/Quit	(0)		(24)		(37)		(55)		(44)		(58)		(38)		(40)		(35)		(35)	
Rearrested during treatment	(1)		(1)		(1)		(1)		(3)		(8)		(6)		(6)		(7)		(7)	
Rejected by agency	(3)		(3)		(6)		(7)		(1)		(1)		(5)		(5)		(16)		(16)	
Still In Treatment	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	17	4.0	17	3.6	324	37.3	325	37.4
Total Known Status	71	100.0	253	100.0	322	100.0	957	100.0	293	100.0	1005	100.0	426	100.0	478	100.0	869	100.0	870	100.0
Unknown Status	0	—	13	—	10	—	159	—	2	—	321	—	30	—	61	—	404	—	406	—
No Follow-Up (AA, Supportive, etc.)	0	—	565	—	0	—	822	—	0	—	941	—	0	—	127	—	0	—	8	—
Total Referrals	71	—	831	—	332	—	1938	—	295	—	2267	—	456	—	666	—	1273	—	1284	—

TABLE 7

Drop Rates for ASAP Clients Entering DWI School
1971 - 1976

	1971	1972	1973	1974	1975	1976	1971 - 1976
# Referred	335	2924	4173	3941	3738	4016	19,127
# Enter	314	2607	4011	3646	3706	3967	18,251
# Drop	19	112	234	246	104	199	914
Drop Rate	6.1%	4.3%	5.8%	6.7%	2.8%	5.0%	5.0%
Completion Rate	93.9%	95.7%	94.2%	93.3%	97.2%	95.0%	95.0%
# Instructors Active	5	23	22	19	22	12	--

Once a client entered DWI school, ASAP evaluation could accurately determine whether he or she had completed the required number of sessions (on the same court order). The drop rate decreased from 6.7 percent in 1974 to 2.8 percent in 1975. This decrease resulted from the referral of over one thousand clients to the read only class in 1975. During 1976 the drop rate increased again to 5.0 percent. Between 1971 and 1976, 18,251 clients entered the school and 95 percent of them completed their programs.

III. EVALUATIVE TOPICS

A. Reliability of the Diagnostic Process

The reliability of the diagnostic process was defined as the consistency with which available information was employed in the determination of drinker classifications. In the present context reliability represents the degree to which all clients at a given point on the social drinker/alcoholic continuum were diagnosed as having drinking problems of equal severity.

Until September 1975 the classification of DWI offenders as social or problem drinkers was conducted by the Tampa Area Council on Alcoholism. All of TACOA's diagnostic counselors were recovered alcoholics. They used a shortened version of the Mortimer-Filkins questionnaire and interview which eliminated most of the non-scored items. The counselors were free to probe where they felt a client was avoiding the issue or not telling the truth. An attempt was made to force clients to resolve inconsistent responses so that the interview could be scored appropriately.

If a chemical test was administered, the arrest BAC was available on the court order (or a refusal was noted). However, prior arrest records and records of prior treatment (other than TACOA programs) were not routinely available to the diagnostic counselors until the ASAP Report to Court became operational in June, 1975.

During September, 1975 the diagnostic function was assumed by the Hillsborough Community Mental Health Center's Alcoholism Services Division. The HCMHC counselors were not recovered alcoholics but rather came from a counseling/social work background with specialization in alcoholism. Most of the HCMHC counselors had four year college degrees. They used the complete Mortimer-Filkins questionnaire and interview with all non-scored items present. While both diagnostic agencies used the original M/F cut off scores, HCMHC counselors were specifically advised to make use of other diagnostic information in the final determination of drinker type. It was suggested that a

total M/F score of 59 or below was indicative of social drinking unless there was evidence to the contrary (e.g., a high BAC and/or a prior DWI arrest). Scores in the 60-84 range were considered highly presumptive of problem drinking, although if there was no additional evidence of a problem, clients were sometimes diagnosed as social drinkers. Mortimer-Filkins scores over 84 were considered almost certain evidence of problem drinking.

Last year's report examined in considerable detail the consistency of TACOA and HCMHC diagnostic performance, using discriminant analysis and classification procedures. The present assessment of diagnostic reliability utilizes simpler, descriptive techniques to evaluate the reliability of the diagnostic process throughout the operational period, with an emphasis on HCMHC performance during the final operational year.

1. Methodology

Two different analytic procedures were employed to assess diagnostic reliability. The first procedure involved plotting the percentage of problem drinkers (vs. social drinkers) over time. This analysis was based on the assumption that the actual percentage of problem drinkers in the client population has remained constant throughout the ASAP operational period. Given that this assumption is correct, a reliable diagnostic process should result in a relatively constant proportion of problem drinker diagnoses across time. Variability in the percentage of problem drinkers could result from inconsistencies in the interpretation and recording of diagnostic data during the interviews and from random short term fluctuations in the characteristics of DWI offenders referred from the court.

Since chance fluctuations will have a greater influence on smaller sample sizes, it was felt that a more accurate assessment of reliability could be made by inspecting both monthly and quarterly data. All drinker diagnoses (less clients with drug problems) occurring in 12/71 through 12/76 were used in the

analysis. Of the 61 monthly samples, four contained less than 100 diagnoses, four contained between 100 - 200 diagnoses, and the other 53 months each contained over 200 diagnoses. When percentages were computed on quarterly data the 1971 diagnoses were dropped from the analysis.

The second method used to determine the reliability of the diagnostic process was a comparison of diagnostic results between individual counselors. One can assume that all counselors interviewed similar clients. Thus the proportion of problem vs. social drinker diagnoses and the average total Mortimer-Filkins score for diagnosed clients should be similar for all counselors. Substantial between counselor differences in drinker classification would suggest that the diagnostic counselors did not possess a common definition of problem drinking. Variation in average M/F scores could reflect individual differences in interviewing technique and specifically the degree to which counselors were aware of inconsistent responses and probed to resolve them.

The intercounselor comparison was based on the results of 1976 interviews conducted by eight principal HCMHC counselors. Each of these counselors conducted at least 200 interviews, and together accounted for 91 percent of all 1976 diagnostic interviews. An additional fifteen counselors also conducted interviews during 1976, however none of them had more than 51 interviews to their credit. Such sample sizes were too small for analysis.

2. Results

With the exception of a few clients who were diagnosed as having non-alcohol drug problems (and dropped from the analysis), all ASAP referrals were classified as either social or problem drinkers. Figure 2 presents pictorically the percentage of problem drinkers over time, monthly intervals in the lower graph, and quarterly intervals in the upper graph. During the first three quarters of 1972 the percentage of clients diagnosed as problem drinkers fluctuated around 30 percent. This percentage

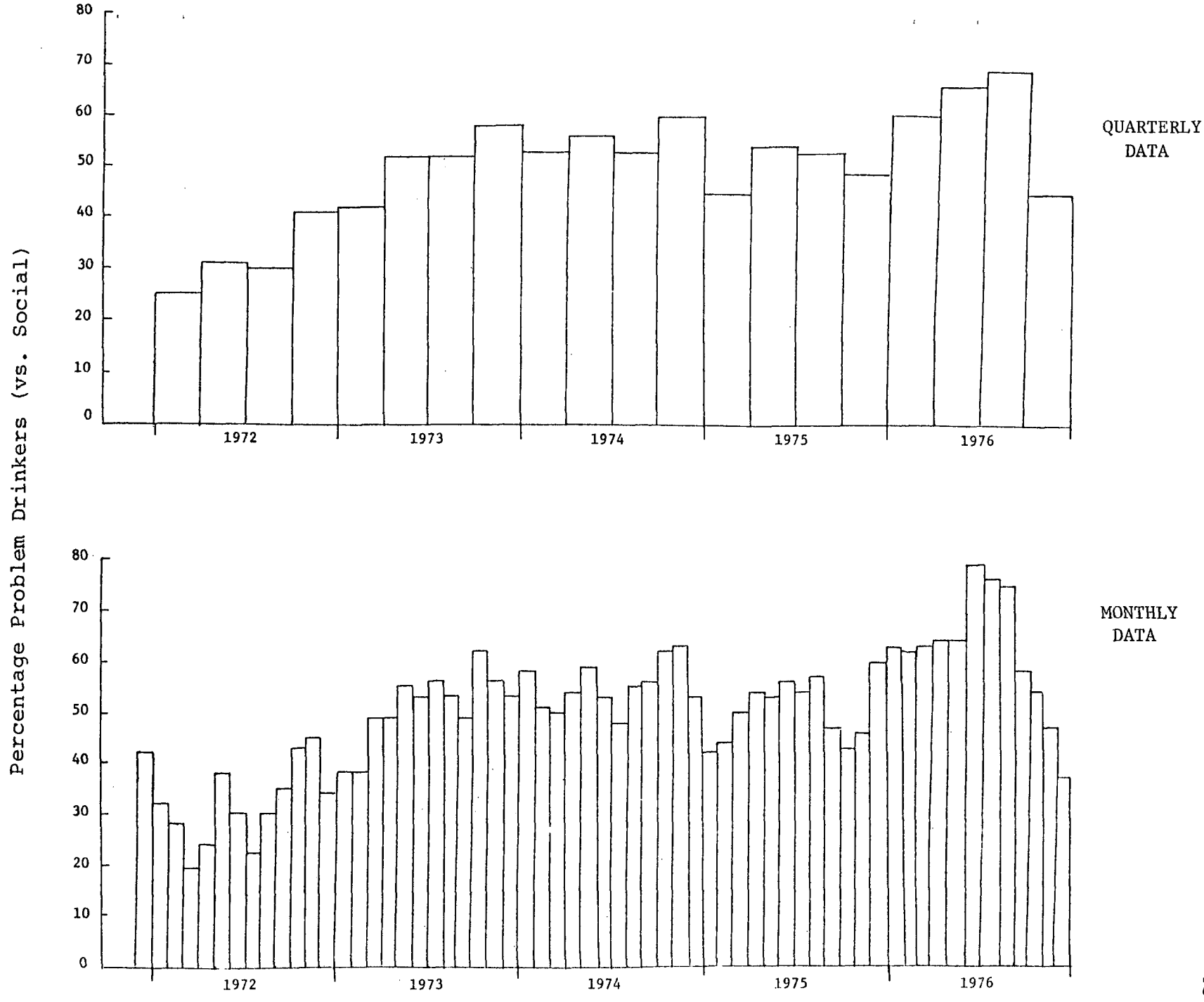


FIGURE 2

Percentage of Problem Drinkers Across Time: Monthly and Quarterly Data

increased to approximately 40 percent during the last quarter of 1972 and the first quarter of 1973, and then increased again to slightly over 50 percent during the second quarter of 1973 where it remained relatively constant through the first quarter of 1976. As discussed in last year's study, there were several factors which could have resulted in the observed increase in the proportion of problem drinkers during the early operational period including: 1) an increase in counselor experience with the admnistration of the Mortimer-Filkins, 2) several programs for early and middle range problem drinkers began operation in 1973 and problem drinker diagnoses would have expedited judicial referral to these programs, and 3) judicial prescreening -- judges originally referred almost all clients to ASAP but in 1973 began to selectively refer approximately 63 percent of the guilty disposition cases.

Examining the last three quarters of 1976 indicated an atypical rise in the percentage of problem drinkers during the second and third quarter (67.1% and 69.3% respectively), followed by a substantial decrease to 46.3 percent during the final quarter of the year. The monthly interval graph illustrates these changes more precisely. The diagnostic performance of HCMHC counselors evidenced considerable stability between December of 1975 and May of 1976. Monthly proportions of problem drinkers ranged from 59.5 percent to 61.8 percent for this six-month period. However, in June the proportion of problem drinkers soared to 78.8 percent and remained above 74 percent through July and August. This unusually high period was followed by a drop back to 57.6 percent in September, and then a progressive decline to 36.9 percent in December of 1976.

As previously discussed, the proportion of DWI offenders referred by the courts for diagnosis remained relatively constant from 1973 through 1976. Furthermore, during the 33-month period between 4/1/73 and 12/31/75, the difference between the highest and lowest monthly proportions of problem drinker diagnoses was

18 percent. In contrast, the maximum difference in monthly proportions during 1976 was 42 percent. Thus, there is no reason to believe that the diagnostic performance of HCMHC counselors corresponded to actual changes in the characteristics of the clients interviewd in 1976. The radical variation of the counselors' performance over time appears to be the result of inconsistencies or deliberate changes in the interpretation or recording of diagnostic data.

The 1976 diagnostic performance of individual counselors is summarized in Table 8. There was considerable variability in the diagnostic results. At the two extremes, one counselor diagnosed only 24.6 percent of his clients as problem drinkers, while another counselor diagnosed 71.6 percent of her clients as problem drinkers. Obviously, the HCMHC counselors did not share a common definition of problem drinking.

The average total Mortimer-Filkins scores are also presented for each counselor in Table 8. These scores show between counselor differences which have at least a rough correspondence to the diagnostic results. For instance, the counselors with the three lowest proportions of problem drinkers have the three lowest mean M/F scores. These results suggest that some of the counselors were either not probing intensively when they received conflicting or evasive responses, or they were interpreting and recording M/F interview data to correspond with their individual conceptions of problem drinking.

3. Summary and Discussion

The analysis of diagnostic performance over time indicated an acceptable degree of consistency from the second quarter of 1973 through the first quarter of 1976. During this period the quarterly proportions of clients diagnosed as problem drinkers fluctuated about the 54 percent level. The examination of diagnostic results at monthly intervals revealed a period of extremely

TABLE 8

Drinker Type Diagnoses by Principal Counselors: 1976

	Problem Drinkers		Social Drinkers		Total	
	#	%	#	%	#	Mean Total M/F Score
Ed Beckshaw	291	63.7	166	36.3	457	77.8
William Cade	161	59.2	111	40.8	272	52.8
Clarence Harris	50	24.6	153	75.4	203	46.0
Gail Henderson	354	64.8	192	35.2	546	58.5
Phil Jackson	150	48.9	157	51.1	307	54.1
Charles Miller	367	67.5	177	32.5	544	70.6
Lynn Morgan	347	68.4	160	31.6	507	64.8
Pat Reynolds	169	71.6	67	28.4	236	70.5

stable performance between December, 1975 and May, 1976, during which time the monthly proportions of problem drinker diagnoses ranged from 59.5 percent to 61.8 percent. However, this period of stability was followed by a series of radical fluctuations in diagnostic results. During the last seven months of 1976, the monthly proportions of problem drinker diagnoses ranged from 78.8 percent to 36.9 percent.

The analysis of 1976 intercounselor performance also showed substantial variability in the results of the diagnostic process. The proportion of problem drinkers identified by individual HCMHC counselors ranged from 24.6 percent to 71.6 percent. It was further observed that, in general, counselors who identified the fewest problem drinkers had the lowest average Mortimer-Filkins scores. Since there was no reason to believe that the counselors were interviewing different client populations, the performance differences were most likely the result of inadequate or inconsistent interview techniques as well as the liberal interpretation and recording of M/F interview data so as to correspond with individual definitions of problem drinking.

B. Treatment Group Profile Comparisons

A major obstacle in assessing treatment effectiveness was the creation of treatment and control groups with equivalent client characteristics. Tampa ASAP minimized group bias through a random assignment procedure. Only clients with minimal prior exposure to court ordered treatment programs were considered eligible for random assignment. Consequently all clients who had been previously arrested for an A/R traffic offense and referred to the ASAP system were ineligible unless they met one of the following criteria:

1. They had not completed DWI school.

2. The previous interview was at least one year ago at which time they were diagnosed as social drinkers (thus referred to the regular "social drinker" class) but the current diagnosis was problem drinker (allowing referral to problem drinker class).

Clients were also excluded from the research design under any one of the following conditions.

1. Illiterate.
2. Non-English speaking.
3. Problems not related to alcohol (e.g., other drug dependencies, psychoses).
4. Currently participating in an alcohol treatment program.
5. Alcohol problems needing immediate attention (e.g., detoxification).
6. Non-residents of Hillsborough or Pinellas counties.

Eligible social drinkers were randomly assigned between 1/75 - 2/76 to either the alcohol safety school (four-session social drinker curriculum) or the read only class (minimum exposure condition). The assignment probabilities were 60 percent to school and 40 percent to read only until August, 1975 when they were reversed. The 40/60 (school/read only) ratio was maintained until the social drinker group quotas were attained.

Eligible problem drinkers were randomly assigned from January through June, 1975 to either the alcohol safety school (four-session problem drinker curriculum) or the read only class on an equal probability basis. In July, 1975 it became possible to assign problem drinker clients to a third treatment condition, school plus HCMHC didactic and group therapy. Problem drinker assignments (at 33 1/3% per group) continued through the end of June 1976.

Tampa ASAP's short term rehabilitation (STR) treatment groups consisted of a subset of problem drinker design clients who were administered the Life Activities Inventory (LAI). Initial LAI interviews began in November, 1975 and the quota of 100 STR clients per each of the three problem drinker design groups was reached by the end of February, 1976. However in a number of cases, delays in

receiving judicial concurrence had left insufficient time on six-month court orders for clients to complete or even enter HCMHC group therapy. In order to compensate, initial LAI interviews were continued through the end of March, 1976 for only those clients randomly assigned to the school plus group therapy condition. STR clients were re-interviewed at six and twelve-month intervals in order to measure life changes potentially resulting from treatment interventions.

The random assignment procedure was controlled by the ASAP evaluation staff. From the initiation of the rehabilitation research design through 12/16/75, assignments were determined by drawing folded slips of paper indicating group designations. The slips of paper were shuffled first and then replaced after the assignment was made. After 12/16/75 assignments were made from computer generated randomly ordered lists of the treatment/control groups. Specifically, samples of 100 or 102 numbers (e.g., 1-2 @ 40%/60% and 1-2-3 @ 33 1/3%) were randomly ordered and the corresponding modality labels were listed.

A series of profile comparisons were conducted for the purpose of determining whether the random assignment procedure had actually produced treatment and control groups with equivalent client characteristics. Additional group comparisons were made to identify possible confounding factors in several experimental and quasi-experimental analyses of treatment effectiveness.

1. Methodology

For comparisons between ASAP research design groups, the profile variables were client sex, race, age, total Mortimer-Filkins score, and BAC at time of arrest. Each variable was crosstabulated with treatment assignment. The following subsets of randomly assigned clients were analyzed:

1) All social drinkers referred to treatment.
2) Only social drinkers completing treatment.
3) All problem drinkers referred to treatment.
4) Only problem drinkers completing treatment.

Problem drinkers assigned to school plus group therapy had to successfully complete both modalities in order to be included in the completion analyses.

Comparisons were also made between STR treatment groups using the following profile variables:

1) Sex
2) Race
3) Age
4) Total Mortimer-Filkins score
5) Arrest BAC
6) # Prior A/R Traffic Offenses
7) # Prior Non-A/R Traffic Offenses
8) # Prior Accidents
9) # Prior Treatment Entries

Because not all STR clients returned for follow-up interviews, there was the possibility of a selective attrition from among the assignment groups. In order to assess the extent of between group bias introduced by selective attrition, if any, profile comparisons were conducted separately on initial, six-month, and twelve-month interview groups. There was a total of 353 clients in the initial interview groups, of which 272 returned for their six-month interviews, and 230 returned for their twelve-month interviews. However, at the time that the analyses in the present study were conducted, only 198 twelve-month interview cases were available for analysis. Of these 198 cases, seven clients missed their six-month interviews. Since the analyses of treatment effect on life changes presented in this study were performed on the subset of STR clients who had completed all three interviews, the seven clients with missing data were eliminated, leaving an effective sample size of 191.

A final set of profile comparisons was conducted to determine whether, as a whole, the clients who returned had different characteristics than those who did not. This was accomplished

by comparing the 272 clients who returned for their six-month interviews vs. those who did not, and the 191 clients who returned for their twelve-month interviews vs. those who did not, by each of the STR profile variables.

The statistical significance of differences in group profiles was assessed with chi-square tests. The alpha level was set at .05. However, in addition to statistical significance, the practical significance of differences in group profiles was also examined. Practical significance was defined as the degree to which differences in client characteristcis will affect criteria measures and confound assessments of treatment effectiveness.

2. Results

Table 9 presents the profile comparisons between social drinker random assignment groups. Considering all clients referred, there were no statistically significant differences in sex, race, age, or BAC between the read only and school (social drinker curriculum) groups. While there was a statistically significant difference on total Mortimer-Filkins score ($p = .013$), it was the authors' opinion that this difference was not of sufficient magnitude to affect recidivism rates. Inspection of Table 9 shows that only 16 out of 810 read only clients, and 37 out of 878 school clients had M/F scores above 59 (the original cut-off point for social drinkers). None of the social drinker clients had M/F scores of 85 or above.

The analysis of clients completing their assigned education or minimum exposure conditions produced results similar to those for the referral groups. This was anticipated since the completion rate for social drinker clients was 96.7 percent. There were no statistically signficant differences in sex, race, age, or BAC, and no practically significant difference in M/F scores.

TABLE 9

Profile of ASAP Social Drinker Research Design Groups:
Total Referred and Completions

	Read Only Referrals		School Referrals		Analysis of Referral Groups*	Read Only Completions		School Completions		Analysis of Completion Groups*
	#	%	#	%		#	%	#	%	
Male	708	87.4	772	87.6	Sex: χ^2 = 0.004,	691	87.2	736	87.3	Sex: χ^2 = 0.001,
Female	102	12.6	109	12.4	df = 1, p = .950 (ns)	101	12.8	107	12.7	df = 1, p = .970 (ns)
White	720	88.9	772	87.6	Race: χ^2 = 0.531,	703	88.8	738	87.5	Race: χ^2 = 0.469,
Black	90	11.1	109	12.4	df = 1, p = .466 (ns)	89	11.2	105	12.5	df = 1, p = .494 (ns)
<20 yrs.	66	8.1	49	5.6	Age: χ^2 = 6.776,	64	8.1	45	5.3	Age: χ^2 = 6.928,
20-29	283	34.9	320	36.3	df = 5, p = .238 (ns)	275	34.7	298	35.3	df = 5, p = .226 (ns)
30-39	177	21.9	208	23.6		172	21.7	202	24.0	
40-49	151	18.6	178	20.2		149	18.8	172	20.4	
50-59	91	11.2	88	10.0		90	11.4	88	10.4	
60 +	42	5.2	38	4.3		42	5.3	38	4.5	
Average	35.0		35.1			35.1		35.4		
<.10	27	5.5	33	6.2	BAC: χ^2 = 0.605,	27	5.5	32	6.1	BAC: χ^2 = 0.733,
.10-.14	139	28.1	157	29.3	df = 5, p = .988 (ns)	139	28.2	155	29.6	df = 5, p = 0.981 (ns)
.15-.17	126	25.5	133	24.9		125	25.4	129	24.6	
.18-.20	85	17.2	92	17.2		85	17.2	92	17.6	
.21-.23	57	11.5	60	11.2		57	11.6	58	11.1	
.24 +	60	12.1	60	11.2		60	12.2	58	11.1	
Average	17.0		16.7			17.0		16.7		
0-59	794	98.0	841	95.8	M/F: χ^2 = 6.227,	777	98.1	804	95.7	M/F: χ^2 = 6.933,
60-84	16	2.0	37	4.2	df = 1, p = .013 (np)	15	1.9	36	4.3	df = 1, p = .009 (np)
85 +	--	--	--	--						
Average	38.2		41.5			38.1		41.5		

* (ns) means not statistically significant.
(np) means group differences exceed .05 significance level but no practical significance (i.e., differences not of sufficient magnitude to confound assessments of treatment effectiveness).

The profile comparisons for problem drinker assignment groups are presented in Table 10. The analysis of total referrals indicated no statistically significant differences in sex, age, BAC, or M/F scores between the treatment groups. However, there was a somewhat higher proportion of black clients in the school + group condition ($p = .038$) but this could hardly be expected to confound assessments of treatment effectiveness since the proportion of blacks in the total problem drinker sample was small (14%), as was the relative difference in the proportions of blacks in each group. The group proportions ranged between 15.4 percent (Group + School) and 10.1 percent (School only).

Completion group profile comparisons are shown on the right-hand side of Table 10. As in the case of social drinkers, problem drinker clients who were assigned to school (problem drinker curriculum) or read only, had a high completion rate (94.8%). Of those clients referred to school plus group therapy, however, only 55.0 percent completed both modalities. Despite such a large difference in completion rates, the groups had comparable client characteristics. There were no statistically significant differences in sex, age, BAC, and M/F score, and no practically significant difference in race between treatment completion groups.

The STR treatment groups represent a temporal cross section of all problem drinkers randomly assigned to the overall ASAP rehabilitation research design. Table 11 presents the profile comparisons for the STR groups based on all clients referred to treatment and control conditions, whether or not they successfully completed their assignments. Separate between group comparisons were made for all initial interview cases ($N = 353$), all six-month interview cases ($N = 274$), and available twelve-month interview cases ($N = 191$). In order not to present an excessive amount of redundant information, the distributions of profile variables were presented only for the initial interview cases. However,

TABLE 10

Profile of ASAP Problem Drinker Research Design Groups:
Total Referred and Completions

	Read Only Referrals		School Referrals		School & Group Referrals		Analysis of Referral Groups*	Read Only Completions		School Completions		School & Group Referrals		Analysis Completion Groups*
	#	%	#	%	#	%		#	%	#	%	#	%	
Male	455	87.8	528	87.6	343	85.3	Sex: χ^2= 1.490,	434	87.5	496	87.5	187	84.6	Sex: χ^2= 1.335,
Female	63	12.2	75	12.4	59	14.7	df = 2, p = .475 (ns)	62	12.5	71	12.5	34	15.4	df = 2, p = .513 (ns)
White	458	88.4	542	89.9	340	84.6	Race:χ^2= 6.564.	438	88.3	511	90.1	181	81.9	Race:χ^2= 10.256,
Black	60	11.6	61	10.1	62	15.4	df = 2, p = .038 (np)	58	11.7	56	9.9	40	18.1	df = 2, p = .006 (np)
<20 yrs.	30	5.8	25	4.1	24	6.0	Age: χ^2= 8.693,	29	5.8	24	4.2	13	5.9	Age: χ^2= 10.008,
20-29	168	32.4	183	30.3	119	29.6	df = 10, p = .561 (ns)	160	32.3	167	29.5	64	29.0	df = 10, p = .440 (ns)
30-39	140	27.0	147	24.4	108	26.9		131	26.4	135	23.8	62	28.1	
40-49	120	19.7	148	24.5	89	22.1		99	20.0	145	25.6	48	21.7	
50-59	63	12.2	76	12.6	53	12.9		62	12.5	74	13.1	30	13.6	
60 +	15	2.9	24	4.0	10	2.5		15	3.0	22	3.9	4	1.8	
Average	35.4		36.9		36.0			35.5		37.2		36.2		
<.10	6	2.4	2	0.7	4	2.2	BAC: χ^2= 7.500,	5	2.0	2	0.8	0	0.0	BAC: χ^2= 7.635,
.10-.14	37	14.9	45	16.8	32	17.6	df = 10, p = .678 (ns)	37	15.2	44	16.7	19	19.0	df = 10, p = .665 (ns)
.15-.17	49	19.8	54	20.1	36	19.8		48	19.7	53	20.2	19	19.0	
.18-.20	41	16.5	55	20.5	30	16.5		41	16.8	55	20.9	15	15.0	
.21-.23	55	22.2	45	16.8	30	16.5		53	21.7	44	16.7	20	20.0	
.24 +	60	24.2	67	25.0	50	27.5		60	24.6	65	24.7	27	27.0	
Average	19.9		19.9		20.0			19.9		19.9		20.2		
0-59	129	25.0	149	24.9	107	26.7	M/F: χ^2= 5.494,	125	25.3	138	24.5	55	25.0	M/F: χ^2= 1.470,
60-84	237	45.9	255	42.6	155	38.7	df = 4, p = .240 (ns)	227	46.0	246	43.6	95	43.2	df = 4, p = .832 (ns)
85 +	150	29.1	195	32.6	139	34.7		142	28.7	180	31.9	70	31.8	
Average	75.1		76.3		77.5			74.9		76.1		76.1		

* (ns) means not statistically significant
(np) means group differences exceed .05 significance level but no practical significance (i.e., differences not of sufficient magnitude to confound assessments of treatment effectiveness).

TABLE 11

STR Group Profile Comparisons for Initial, Six-Month, and Twelve-Month Interviews: Total Referred Only

	Initial Read Only Group		Initial School Group		Initial School + Group Therapy Group		Analysis of Initial Interview Groups* N = 353	Analysis of 6-Month Follow-Up Groups* N = 274	Analysis of 12-Month Follow-Up Groups* N = 191 (of 230)
	#	%	#	%	#	%			
Sex:							Sex:	Sex:	Sex:
Male	91	65.8	94	91.3	123	85.4	$\chi^2 = 2.113$,	$\chi^2 = 4.372$,	$\chi^2 = 2.943$,
Female	15	14.2	9	8.7	21	14.6	df = 2, p = .348 (ns)	df = 2, p = .112 (ns)	df = 2, p = .230 (ns)
Race:							Race:	Race:	Race:
White	97	91.5	96	93.2	118	81.9	$\chi^2 = 8.940$,	$\chi^2 = 10.535$,	$\chi^2 = 5.204$,
Black	9	8.5	7	6.8	26	18.1	df = 2, p < .02 (np)	df = 2, p = .005 (np)	df = 2, p = .074 (ns)
Age:							Age:	Age:	Age:
< 20	12	11.3	11	10.7	7	4.9	$\chi^2 = 13.573$,	$\chi^2 = 14.687$,	$\chi^2 = 11.425$,
20 - 29	37	34.9	35	34.0	40	27.8	df = 10, p = .193 (ns)	df = 10, p = .144 (ns)	df = 10, p = .325 (ns)
30 - 39	28	26.4	20	19.4	36	25.0			
40 - 49	21	19.8	18	17.5	34	23.6			
50 - 59	7	6.6	15	14.6	21	14.6			
60+	1	0.9	4	3.9	6	4.2			
BAC:							BAC:	BAC:	BAC:
< .10	2	2.2	2	2.1	4	3.2	$\chi^2 = 9.302$,	$\chi^2 = 6.872$,	$\chi^2 = 5.580$,
.10 - .14	10	10.9	19	20.0	13	10.3	df = 10, p > .50 (ns)	df = 10, p = .738 (ns)	df = 10, p = .849 (ns)
.15 - .17	13	14.1	16	16.8	25	19.8			
.18 - .20	22	23.9	13	13.7	20	15.9			
.21 - .23	16	17.4	17	17.9	21	16.7			
.24 +	29	31.5	28	29.5	43	34.1			
M/F:							M/F:	M/F:	M/F:
0 - 59	35	33.0	35	34.0	53	36.8	$\chi^2 = 1.622$,	$\chi^2 = 3.928$,	$\chi^2 = 2.866$,
60 - 84	48	45.3	40	38.8	57	39.6	df = 4, p > .80 (ns)	df = 4, p = .416 (ns)	df = 4, p = .581 (ns)
85 +	23	21.7	28	27.2	34	23.6			
Prior A/R Traffic Off.:							Prior A/R Traf. Off:	Prior A/R Traf. Off.:	Prior A/R Traf. Off.:
0	83	78.3	73	70.9	112	77.8	$\chi^2 = 4.720$,	$\chi^2 = 3.743$,	$\chi^2 = 1.029$,
1	21	19.8	23	22.3	28	19.4	df = 4, p = .317 (ns)	df = 4, p = .442 (ns)	df = 4, p = .905 (ns)
2+	2	1.9	7	6.8	4	2.8			
Prior Non-A/R Traf. Off.:							Prior Non-A/R Tr. Off	Prior Non-A/R Tr.Off.	Prior Non-A/R Tr. Off
0	28	26.4	36	35.0	53	36.8	$\chi^2 = 3.266$,	$\chi^2 = 4.748$,	$\chi^2 = 6.712$,
1	27	25.5	23	22.3	33	22.9	df = 4, p = .514 (ns)	df = 4, p = .314 (ns)	df = 4, p = .152 (ns)
2 +	51	48.1	44	42.7	58	40.3			
Prior Accidents:							Prior Accidents:	Prior Accidents:	Prior Accidents:
0	61	57.5	67	65.0	78	54.2	$\chi^2 = 5.092$,	$\chi^2 = 3.364$,	$\chi^2 = 3.793$,
1	29	27.4	28	27.2	42	29.2	df = 4, p = .278 (ns)	df = 4, p = .499 (ns)	df = 4, p = 0.435 (ns)
2 +	16	15.1	8	7.8	24	16.7			
Prior Treatment Entries:							Prior Treat. Entries:	Prior Treat. Entries:	Prior Treat. Entries:
0	90	84.9	86	83.5	126	87.5	$\chi^2 = 1.127$,	$\chi^2 = 1.170$,	$\chi^2 = 1.922$,
1	12	11.3	14	13.6	14	9.7	df = 4, p = .890 (ns)	df = 4, p = .883 (ns)	df = 4, p = .750 (ns)
2 +	4	3.8	3	2.9	4	2.8			

*(ns) means not statistically significant.

(np) means group differences exceed .05 significant level but no practical significance (i.e., differences not of sufficient magnitude to confound assesements of treatment effectiveness).

the results of statistical analyses on six-month and 12-month data were summarized in the two rightmost columns of Table 11. The initial STR groups profile was very similar to the profile of the total ASAP problem drinker design groups, which one would expect since the STR clients were a subset of all randomly assigned problem drinkers. There was no statistically significant difference between initial STR treatment groups in sex, age, BAC, and M/F score, and no practical difference in racial composition.

Several additional profile variables were available for the STR clients including the number of prior A/R traffic offenses, non-A/R traffic offenses, accidents, and prior treatment entries. The results of the chi-square tests indicated that there were no statistically significant differences in the distribution of these variables between the initial STR treatment groups. It is important to note that while prior arrest and accident data were not available on all randomly assigned problem drinkers, the STR clients were a representative sample of all problem drinker clients in the research design. Thus, it is reasonable to assume that the total problem drinker random assignment groups (shown in Table 10) are comparable in terms of prior arrests, accidents, and treatment entries.

Analysis of the six-month and twelve-month follow-up cases indicated that the STR treatment groups remained comparable, even though all clients did not return for follow-up interviews. In the present study the analysis of life changes was based on a subsample of 191 STR clients who had initial, six-month, and twelve-month interviews. The group profile comparisons for this subsample revealed that none of the nine profile variables showed statistically significant differences between the read only, school, and group therapy plus school treatment groups.

The upper portion of Table 12 presents the six-month and twelve-month return rates for each STR treatment group. The

TABLE 12

Profile Comparisons of STR Clients Returning and Not Returning for Follow-Up Interviews

	Six-Month Interview		No Six-Month Interview		Analysis of Clients Returning After Six Months	Twelve-Month Interview*		No Twelve-Month Interview		Analysis of Clients Returning After Twelve Months
	#	%	#	%		#	%	#	%	
GROUP RETURN RATES										
Read Only	87	82.1	19	17.9	$\chi^2 = 1.831$,	67	63.8	38	36.2	$\chi^2 = 8.454$
School	79	76.7	24	23.3	df = 2, p = .400 (ns)	59	59.0	41	41.0	df = 2, p = .015
Group + School	108	75.0	36	25.0		65	46.1	76	53.9	
TOTAL SAMPLE										
Sex:					Sex:					Sex:
Male	234	85.4	74	93.7	$\chi^2 = 3.063$,	160	83.8	143	92.3	$\chi^2 = 4.912$,
Female	40	14.6	5	6.3	df = 1, p = .080 (ns)	31	16.2	12	7.7	df = 1, p = .027
Race:					Race:					Race:
White	238	86.9	73	92.4	$\chi^2 = 1.308$,	169	88.5	135	87.5	$\chi^2 = 0.051$,
Black	36	13.1	6	7.6	df = 1, p > .20 (ns)	22	11.5	20	12.9	df = 1, p > .80 (ns)
Age:					Age:					Age:
< 20	25	9.1	5	6.3	$\chi^2 = 13.797$,	18	9.4	11	7.1	$\chi^2 = 9.439$,
20 - 29	81	29.6	31	39.2	df = 5, p = .017	51	26.7	60	38.7	df = 5, p = .093 (ns)
30 - 39	58	21.2	26	32.9		42	22.0	40	25.8	
40 - 49	60	21.9	13	16.5		45	23.6	26	16.8	
50 - 59	40	14.6	3	3.8		28	14.7	15	9.7	
60 +	10	3.6	1	1.3		7	3.7	3	1.9	
BAC:					BAC:					BAC:
<.10	4	1.6	2	2.9	$\chi^2 = 3.681$,	4	2.3	2	1.5	$\chi^2 = 8.285$,
.10 - .14	31	12.7	14	20.3	df = 5, p = .596 (ns)	17	9.9	28	20.7	df = 5, p = .141 (ns)
.15 - .17	45	18.4	9	13.0		27	15.8	24	17.8	
.18 - .20	44	18.0	11	15.9		33	19.3	20	14.8	
.21 - .23	42	17.2	12	17.4		30	17.5	22	16.3	
.24 +	78	32.0	21	30.4		60	35.1	39	28.9	
M/F:					M/F:					M/F:
0 - 59	182	66.4	45	57.0	$\chi^2 = 2.679$,	61	31.9	60	38.7	$\chi^2 = 6.612$,
60 - 84	72	26.3	28	35.4	df = 2, p = .262 (ns)	90	47.1	52	33.5	df = 2, p = .037
85 +	20	7.3	6	7.6		40	20.9	43	27.7	
Prior A/R Traffic Off.:					Prior A/R Traf. Off.					Prior A/R Traf. Off.
0	204	74.5	64	81.0	$\chi^2 = 1.489$,	140	73.3	122	78.7	$\chi^2 = 1.656$,
1	59	21.5	13	16.5	df = 2, p = .475 (ns)	44	23.0	27	17.4	df = 2, p = .437 (ns)
2+	11	4.0	2	2.5		7	3.7	6	3.9	
Prior Non-A/R Traf. Off.					Prior Non-A/R Tr.Off					Prior Non-A/R Tr. Off
0	95	34.7	22	27.8	$\chi^2 = 1.289$,	67	35.1	48	31.0	$\chi^2 = 1.583$,
1	63	23.0	20	25.3	df = 2, p = .525 (ns)	40	20.9	41	26.5	df = 2, p = .453 (ns)
2+	116	42.3	37	46.8		84	44.0	66	42.6	
Prior Accidents:					Prior Accidents:					Prior Accidents:
0	155	56.6	51	64.6	$\chi^2 = 3.369$,	106	55.5	94	60.6	$\chi^2 = 1.460$,
1	77	28.1	22	27.8	df = 2, p = .186 (ns)	55	28.8	43	27.7	df = 2, p = .482 (ns)
2+	42	15.3	6	7.6		30	15.7	18	11.6	
Prior Treatment Entries:					Prior Tr. Entries:					Prior Tr. Entries:
0	231	84.3	71	89.9	$\chi^2 = 1.889$,	161	84.3	134	86.5	$\chi^2 = 0.449$,
1	33	12.0	7	8.9	df = 2, p = .389 (ns)	23	12.0	17	11.0	df = 2, p = .799 (ns)
2+	10	3.6	1	1.3		7	3.7	4	2.6	

*A total of 230 clients returned for 12-month interviews but only 191 cases were available for analysis in the present study.

return rates for six-month interviews ranged between 82.1 percent for the read only group and 75.0 percent for group therapy plus school group, which was not a statistically signifcant difference. In contrast, the twelve-month return rates were 63.8 percent for read only, 59.0 percent for school only, and 46.1 percent for group therapy plus school. This was a statistically significant difference ($p = .015$). However, the author believes that the relatively low return rate for the group therapy plus school group was largely an artifact resulting from the availability of only 191 cases out of a total of 230 individuals who actually returned for twelve-month interviews. The reader should recall that initial interviews ended in February of 1976 for clients assigned to the read only and school conditions but continued through March of 1976 for clients assigned to the group therapy plus school condition. Thus, a large proportion of the cases which were not available for inclusion in the present study were group plus school assignments (approx. 72%). The fact that the apparent difference in twelve-month return rates did not result from a selective attrition, accounts for the similarity of client characteristics between treatment groups for the twelve-month interview sample.

The lower portion of Table 12 presents a descriptive comparison between clients who returned for their interviews and those who did not. While there were no strong or obvious differences between these two groups, several of the profile variables did reach statistical significance. Comparing clients returning vs. not returning for six-month interviews, there was a significant difference in age ($p = .017$). The proportion of younger clients (20 - 39 yrs.) was higher among persons not returning. The proportion of male clients also appeared to be slightly higher among persons not returning but this difference was not statistically significant ($p = .080$).

For the twelve-month interview sample, the proportion of male clients was significantly higher among non-returnees ($p = .027$),

and while the tendency toward a higher proportion of younger clients among non-returnees was still evident in the data (in the 20 - 29 yr. category), the difference was no longer statistically significant ($p = .093$). There was also a statistically significant difference in M/F scores between clients returning vs. not returning for twelve-month interviews ($p = .037$). The nature of this difference was a relatively lower proportion of clients with M/F scores in the middle range (60 - 84), and slightly higher proportions of clients with scores in the lower (0 - 59) and upper (85+) ranges, among the persons not returning. These differences were not readily interpretable.

In general, the data in Table 12 suggest that the follow-up interview sample may contain a slightly lower proportion of young, male clients than the initial interview sample. However, such a small effect, if it actually exists, does not appear likely to influence life change scores in either a positive or negative direction, or limit the generalization of treatment effects.

3. Summary and Discussion

The profile comparison between ASAP social drinker treatment groups indicated that there were no statistically significant differences in the sex, age, race, or BAC of clients referred to the read only, and school only treatment conditions. While there was a statistically significant difference in Mortimer-Filkins scores, only 2.0 percent (16/810) of the read only clients and 4.2 percent (37/878) of the school only clients had scores above 59 (the original cut off point for social drinkers). Thus the observed difference in M/F scores was of such small magnitude that it had no practical significance as a confounding influence on assessments of treatment effectiveness.

The profile comparison between ASAP problem drinker treatment groups indicated there were no statistically significant differences in the sex, age, BAC, and M/F scores of clients referred to the

read only, school only, and school plus group therapy treatment conditions. Furthermore, there was no practically significant difference in the racial composition of problem drinker treatment groups.

The conclusion drawn from the above results was that the Tampa ASAP random assignment procedure was successful in producing treatment and control groups with equivalent client characteristic. Therefore, between group differences in recidivism rates can be safely attributed to the effects of treatment interventions.

Profile comparisons were also conducted between groups of clients completing the randomly assigned treatment conditions. The results indicated that client characteristics were equivalent between the social drinker completion groups, and between the problem drinker completion groups. The comparability of problem drinker treatment completion groups was surprising considering the substantial difference in completion rates between treatment conditions (95% for read only and school only, and 55% for group plus school).

The profile variables for STR treatment group comparisons were sex, race, age, BAC, M/F score, # prior A/R traffic offenses, # prior non-A/R traffic offenses, # prior accidents, and # prior treatment entries. The comparison between initial interview groups (N = 353) indicated no statistically significant differences on eight of the nine profile variables. Only client race showed a statistically significant difference, which upon closer inspection proved to be of no practical significance. It is worthwhile to note that although prior arrest and accident data were not available for all randomly assigned problem drinkers, the STR clients were a representative sample of all problem drinkers in the research design. Thus, it is reasonable to assume that the total problem drinker treatment groups are also comparable in terms of prior arrests, accidents, and treatment entries.

STR treatment group comparisons based on all six-month interview cases (N = 274), and on available twelve-month interview cases (N = 191) indicated no profile differences of practical significance. Analyses of treatment effect on life changes presented in this study were performed on the above mentioned sample of twelve month interview cases. None of the nine profile variables examined showed statistically significant differences between treatment groups for the twelve-month cases. Thus significant between group differences in life change scores can be attributed to treatment effects.

The final set of analyses involved a descriptive comparison of clients who returned for follow-up interviews vs. those who did not. The results suggested that the six-month and twelve-month follow-up samples may have a slightly lower proportion of young, male clients relative to the initial interview group. However, the apparent difference was so slight that it does not limit the generalization of treatment effects.

C. Effect of Treatment on DWI Recidivism

As traffic safety countermeasures, alcohol treatment and education programs have the primary goal of modifying the behavior of DWI offenders in a manner which will reduce the probability of subsequent drinking and driving, thereby reducing alcohol-related traffic accidents. While A/R accident data were not available for analysis, a reduction in the frequency of drinking-driving behavior was inferred from rearrest (recidivism) rates for DWI offenses.

The present section of this study contains the final comparison of recidivism rates for the ASAP random assignment groups. The evaluative question was whether clients assigned to longer duration and more intensive treatment/retraining conditions had lower rates of recidivism than clients assigned to shorter duration and less intensive conditions. Significantly lower recidivism rates for school alone or group therapy plus school relative to read only, or a lower recidivism rate for group therapy plus school relative to school alone would provide an empirical demonstration of treatment effectiveness.

1. Methodology

Recidivism analyses were conducted separately for three subsets of randomly assigned clients: all social drinkers referred to treatment/control conditions, all problem drinkers referred, and problem drinkers who successfully completed the treatment/control conditions. Approximately 97 percent of all social drinkers referred to read only or school successfully completed. Thus, an analysis of social drinker completion groups would provide no useful information beyond that obtained from the analysis of referral groups. However, problem drinkers referred to group therapy plus school had only a 55 percent completion rate. Consequently, it was of evaluative interest to compare the recidivism rate for problem drinkers completing group and school with the recidivism rates for problem drinkers completing school alone, and read only.

The comparison of all clients referred to treatment (regardless of whether they successfully completed) was necessary

because it was only at the point of referral that a true experimental design existed, with all groups having equivalent (randomized) client characteristics. Subsequent to referral, differential client attrition between the treatment groups can introduce between-group differences in client characteristics. In Tampa's research design, selective attrition could have occured simply because it required considerably more client motivation to complete a five-month group therapy program than a one-session read only class. Moreover, clients in longer duration treatment programs or program combinations have a correspondingly longer exposure time for rearrest prior to successful completion. In other words, one can expect proportionately more clients to be rearrested during group therapy than while participating in a four-session school. Since clients rearrested during treatment were not counted as successful completions, the subset of clients completing the shorter duration treatment programs could be expected to contain a relatively higher proportion of "potential recidivists", compared to the subset of clients completing longer duration programs. The "potential recidivists" essentially removed themselves from the latter subset of clients. In light of the potential confounding factors, the comparison of recidivism rates between completion groups must be considered a quasi-experimental procedure which produced basically descriptive results.

For analytic purposes, a recidivist event was defined as an arrest for DWI subsequent to the date of referral (for referral group comparisons), and subsequent to the date of completion (for completion group comparisons). The completion date for problem drinkers assigned to group therapy plus school was the date they completed their last modality (chronologically). This was typically group therapy. In the description of statistical procedures below, the referral group analysis was used as an example.

Treatment group recidivism was assessed with survival rate analysis, a procedure originally developed for biomedical research (see Cutler and Ederer, 1958). One of the most important

aspects of the survival rate technique is that it takes into account the continuous nature of the random assignment process. In the present analysis all clients assigned between 1/1/75 and 6/30/76 were "tracked" from the date of referral (or completion) through 12/31/76 to determine whether they had been rearrested. Therefore only those clients referred in January, 1975 had between twenty-three and twenty-four months of exposure to rearrest while clients referred in June, 1976 had no more than seven months of exposure. If not controlled for, between group differences in exposure time provide an alternative explanation for differences in group recidivism thereby confounding an analysis of treatment effectiveness.

The first stage of the survival analysis involved the calculation of a cumulative survival rate over monthly intervals of exposure time for each treatment group. The number of clients rearrested within the month of referral was divided by the number of clients exposed to the risk of recidivism during the month of referral to obtain the proportion of recidivists for the first monthly interval after referral. Similarly, the number of clients rearrested during the first month after the month of referral was divided by the number of clients exposed to the risk of recidivism during the first month after the month of referral to obtain the proportion of recidivists for the second monthly interval after referral. In this manner the proportions of recidivists were determined for the third through the twenty-fourth month after referral. By subtracting these proportions of recidivists from unity, the proportions surviving each monthly interval were obtained (i.e., surviving each month without being rearrested). By cumulatively multiplying the proportions surviving each monthly interval one obtained the cumulative proportion of clients surviving from referral to the end of each monthly interval without being rearrested (i.e., the cumulative survival rate).

In an analysis of the subtle behavior modifying effects of alcohol treatment and retraining programs it is necessary to examine recidivism over the longest possible period of exposure.

Four of the five treatment groups in the present study had a maximum of twenty-four months exposure to rearrest. The exception was the group therapy plus school group for which assignments began in July, 1975 providing a maximum of eighteen months exposure. Because the survival rate procedure incorporates rearrest information for all clients in the computation of the twenty-four month cumulative survival rate, it provides a more reliable estimate of the "true" twenty-four month recidivism rate than does simply calculating the proportion of recidivists among only those clients with a full twenty-four months of exposure. However, the survival rate procedure can not create data where they do not exist. Very few clients referred to read only or school actually had between twenty-three and twenty-four months of exposure, and very few clients referred to group therapy plus school actually had between seventeen and eighteen months of exposure. As a result, the estimates of survival rates furthest from the point of referral were considerably less reliable than the estimates of shorter duration survival rates. Although the present study examines twelve-month, eighteen month, and when possible, twenty-four-month survival rates, the longest duration survival rate was given less weight in the interpretation of treatment effects.

After calculating the cumulative survival rate for each of the random assignment groups, the standard errors and 95% confidence intervals were determined for the twelve, eighteen, and twenty-four-month survival rates. From the standard error (s) and the survival rate (p) the effective sample size was computed according to the following formula (example for 12-month rate):

$$N = \frac{P_{12}\ (1 - P_{12})}{s_{12}^{2}}$$

The effective sample size can be interpreted in the present case as the number of clients who must be tracked for a full twelve months in order to obtain an estimate of the twelve-month recidivism rate as reliable as the estimate obtained with the survival rate technique. Technically the phrase "as reliable as" means equivalent standard errors.

The statistical signifiance of the difference between two survival rates (or conversely recidivism rates) was determined with a t-test using the following formula:

$$t = \frac{P_{GP1} - P_{GP2}}{(s_{GP1} + s^2_{GP2})^{\frac{1}{2}}}$$

$$df = (N_{GP1} + N_{GP2}) - 2$$

The following pairwise comparisons were made:

1. Total Referred: Social Drinker School vs. Read Only (12-mn., 18-mn., and 24-mn. recidivism rates).

2. Total Referred: Problem Drinker School vs. Read Only (12-mn., 18-mn., and 24-mn. recidivism rates).

3. Total Referred: Group Therapy + Problem Drinker School vs. Read Only (12-mn., and 18-mn. recidivism rates).

4. Total Referred: Group Therapy + Problem Drinker School vs. Problem Drinker School (12-mn., and 18-mn. recidivism rates).

5. Completions Only: Group Therapy + Problem Drinker School vs. Read Only (12-mn., and 18-mn. recidivism rates).

6. Completions Only: Group Therapy + Problem Drinker School vs. Problem Drinker School (12-mn., and 18-mn recidivism rates).

All t-tests were two-tailed. The alpha levels were set at .10 for total referral group comparisons, and at .05 for completion group comparisons. The non-traditional alpha level of .10 was established a priori in last year's Analytic Study #5/6 (pp. 101).

2. Results

The calculation of the cumulative survival rate for all social drinkers referred to the read only group is presented in Table 13a. Column 1 of this table indicates the twenty-four consecutive monthly intervals after referral. Columns 2 through 7 show the intermediate steps in computing the cumulative survival rate which is shown in Column 8 for each monthly interval. The cumulative recidivism rate is shown in Column 11. Finally, Columns 9 and 10 show the initial steps in calculating

TABLE 13a

Cumulative Survival and Recidivism Rates For Total Referred Social Drinkers: Read Only

Months After Referral (1) t to t+1	Enrolled at Beginning of Interval (2) E_t	Recidivists During Interval (3) R_t	Withdrawn Surviving During Interval (4) W_t	Effective Number Exposed to the Risk of Recidivism (2) - ½(4) (5) E'_t	Proportion Recidivists (3)÷(5) (6) q_t	Proportion Surviving 1.0 - (6) (7) p_t	Cumulative Proportion Surviving Through End of Interval $(p_1 \cdot p_2 \ldots p_t)$ (8) P_t	(5) - (3) (9) $E'_t - R_t$	(6) ÷ (9) (10) $q_t/(E'_t - R_t)$	Cumulative Proportion Recidivating Through End of Interval 1.0 - (8) (11) $1.0 - P_t$
0 - 1	810	2	0	810.0	.002	.998	.998	808.0	.000002	.002
1 - 2	808	5	0	808.0	.006	.994	.992	803.0	.000007	.008
2 - 3	803	10	0	803.0	.012	.988	.980	793.0	.000015	.020
3 - 4	793	8	0	793.0	.010	.990	.970	785.0	.000013	.030
4 - 5	785	2	0	785.0	.003	.997	.967	783.0	.000004	.033
5 - 6	783	7	0	783.0	.009	.991	.959	776.0	.000012	.041
6 - 7	776	5	0	776.0	.006	.994	.953	771.0	.000008	.047
7 - 8	771	9	0	771.0	.012	.988	.942	762.0	.000016	.058
8 - 9	762	4	0	762.0	.005	.995	.937	758.0	.000007	.063
9 - 10	758	4	0	758.0	.005	.995	.932	754.0	.000007	.068
10 - 11	754	8	39	734.5	.011	.989	.923	726.5	.000015	.077
11 - 12	707	5	60	677.0	.007	.993	.915	672.0	.000010	.085
12 - 13	642	3	57	613.5	.005	.995	.912	610.5	.000008	.088
13 - 14	582	4	84	540.0	.007	.993	.904	536.0	.000013	.096
14 - 15	494	4	94	447.0	.009	.991	.896	443.0	.000020	.104
15 - 16	396	2	55	368.5	.005	.995	.892	366.5	.000014	.108
16 - 17	339	2	58	310.0	.006	.994	.886	308.0	.000019	.114
17 - 18	279	2	50	254.0	.008	.992	.879	252.0	.000032	.121
18 - 19	227	2	33	210.5	.010	.990	.871	208.5	.000048	.129
19 - 20	192	1	29	177.5	.006	.994	.865	176.5	.000034	.135
20 - 21	162	2	25	149.5	.013	.987	.854	147.5	.000088	.146
21 - 22	135	1	40	115.0	.009	.991	.846	114.0	.000079	.154
22 - 23	94	0	47	70.5	.000	1.000	.846	70.5	.000000	.154
23 - 24	47	0	47	23.5	.000	1.000	.846	23.5	.000000	.154

TABLE 13b

Cumulative Survival and Recidivism Rates For Total Referred Social Drinkers: School

Months After Referral (1) t to t+1	Enrolled at Beginning of Interval (2) E_t	Recidivists During Interval (3) R_t	Withdrawn Surviving During Interval (4) W_t	Effective Number Exposed to the Risk of Recidivism (2) $-\frac{1}{2}$(4) (5) E'_t	Proportion Recidivists (3) ÷ (5) (6) q_t	Proportion Surviving 1.0 - (6) (7) p_t	Cumulative Proportion Surviving Through End of Interval ($p_1 \cdot p_2 \ldots p_t$) (8) P_t	(5) - (3) (9) $E'_t - R_t$	(6) ÷ (9) (10) $q_t/(E'_t - R_t)$	Cumulative Proportion Recidivating Through End of Interval 1.0 - (8) (11) $1.0 - P_t$
0 - 1	881	0	0	881.0	.000	1.000	1.000	881.0	.000000	.000
1 - 2	881	2	0	881.0	.002	.998	.998	879.0	.000002	.002
2 - 3	879	9	0	879.0	.010	.990	.988	870.0	.000011	.012
3 - 4	870	2	0	870.0	.002	.998	.986	868.0	.000002	.014
4 - 5	868	7	0	868.0	.008	.992	.978	861.0	.000009	.022
5 - 6	861	8	0	861.0	.009	.991	.969	853.0	.000011	.031
6 - 7	853	8	0	853.0	.009	.991	.961	845.0	.000011	.039
7 - 8	845	8	0	845.0	.009	.991	.952	837.0	.000011	.048
8 - 9	837	3	0	837.0	.004	.996	.948	834.0	.000005	.052
9 - 10	834	5	0	834.0	.006	.994	.942	829.0	.000007	.058
10 - 11	829	2	20	819.0	.002	.998	.941	817.0	.000002	.059
11 - 12	807	3	40	787.0	.004	.996	.937	784.0	.000005	.063
12 - 13	764	2	42	743.0	.003	.997	.934	741.0	.000004	.066
13 - 14	720	2	40	700.0	.003	.997	.931	698.0	.000004	.069
14 - 15	678	1	66	645.0	.002	.998	.929	644.0	.000003	.071
15 - 16	611	3	60	581.0	.005	.995	.925	578.0	.000009	.075
16 - 17	548	0	45	525.5	.000	1.000	.925	525.5	.000000	.075
17 - 18	503	2	74	466.0	.004	.996	.921	464.0	.000009	.079
18 - 19	427	0	61	396.5	.000	1.000	.921	396.5	.000000	.079
19 - 20	366	0	69	331.5	.000	1.000	.921	331.5	.000000	.079
20 - 21	297	2	55	269.5	.007	.993	.915	267.5	.000026	.085
21 - 22	240	1	54	213.0	.005	.995	.910	212.0	.000024	.090
22 - 23	185	2	88	141.0	.014	.986	.897	139.0	.000101	.103
23 - 24	95	1	94	48.0	.021	.979	.878	47.0	.000447	.122

standard error. To obtain the standard error of the twenty-four-month survival rate in Table 13a, the numbers in Column 10 were summed and the square root of this sum was multiplied by the twenty-four-month survival rate (.846). The 95% confidence limit was the twenty-four-month survival rate plus or minus two times the standard error.

Table 13b presents the cumulative survival and recidivism rates for social drinkers referred to the school. The cumulative recidivism rates for both social drinker research design groups are illustrated in Figure 3. The two recidivism rates remained approximately parallel for the first ten months after referral, and then began to diverge as the recidivism rate for the read only group increased steadily. However, between twenty-two and twenty-four months after referral the recidivism rate for the school group showed a rapid increase, approaching the read only rate. The rapid increase resulted from the arrest of only three individuals among a relatively small number of clients exposed to rearrest for this length of time. In the authors' judgment, the data beyond twenty-two months after referral can not support reliable assessments of treatment effectiveness.

Table 14 summarizes the results of the survival rate analyses for the social drinker groups. For the school group the twelve-month survival rate was .937 with a lower 95% confidence limit of .921 and an upper 95% confidence limit of .953. The confidence limits may be interpreted as follows: If the ASAP research design was repeated 100 times under similar conditions, one would expect the survival rate for the social drinker school group to be between .921 and .953, 95 out of 100 times. For the read only group, the twelve-month survival rate was .915 with a 95% confidence interval of .895 to .935. The results of the t-test indicated the twelve-month survival rates (or more appropriately recidivism rates) were significantly different ($p < .10$). The twelve-month recidivism rate for referrals to read only (8.5%) was slightly higher than the twelve-month rate for referrals to school (6.3%). Eighteen-month recidivism

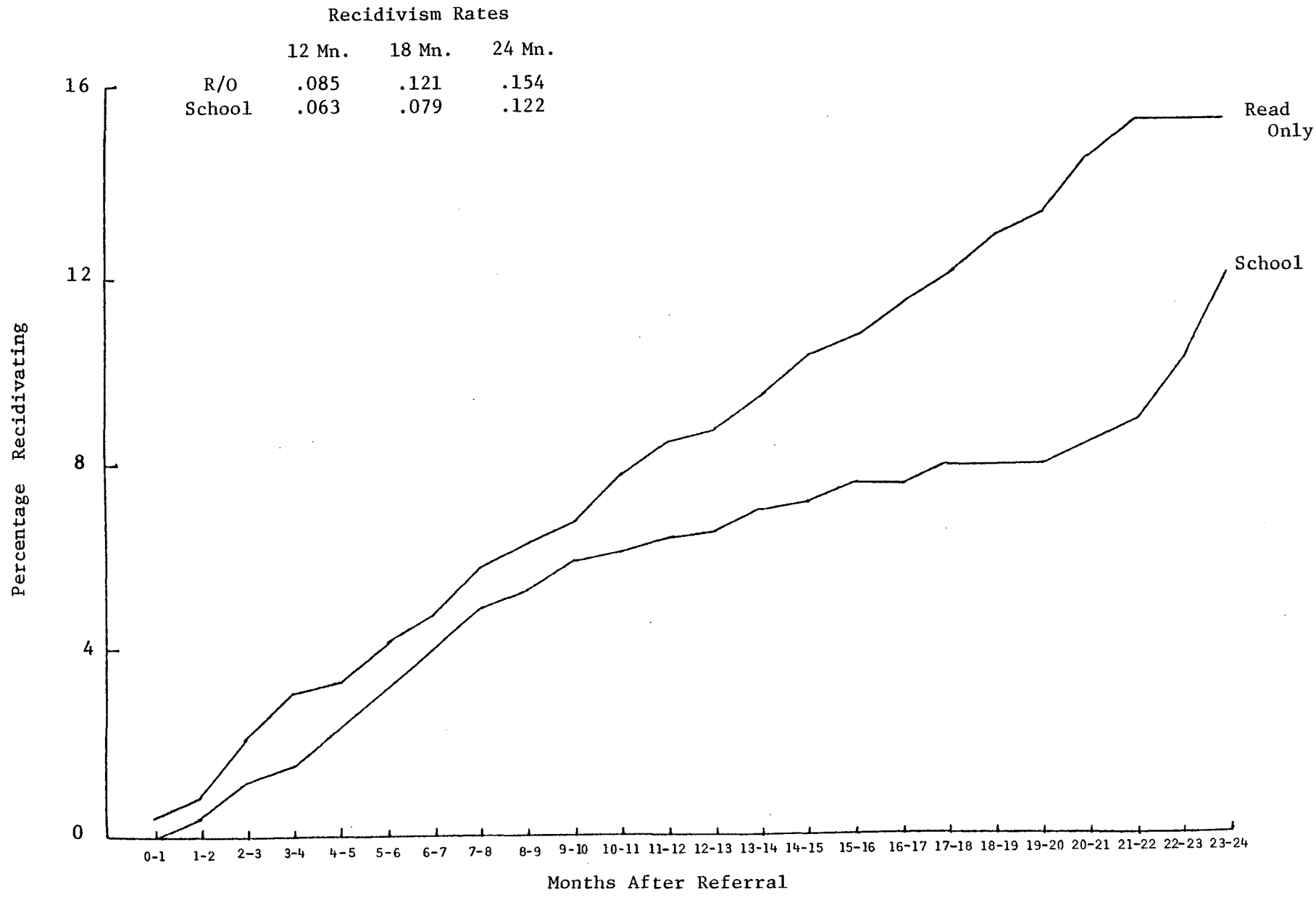


FIGURE 3

Cumulative Recidivism Rates for Social Drinker Research Design Groups: Total Referred

TABLE 14

Summary of Survival Rate Analyses for Social Drinker Referral Groups: School vs. Read Only

Groups:	Social Drinker School	vs. Read Only
12 Month Recidivism Rate	.063	.085
12 Month Survival Rate	.937	.915
Standard Error	.0082	.0099
Lower 95% Confidence Limit	.921	.895
Upper 95% Confidence Limit	.953	.935
Effective Sample Size	878	794

$t = 1.711$, $p < .10$, $df = 1670$

Groups:	Social Drinker School	vs. Read Only
18 Month Recidivism Rate	.079	.121
18 Month Survival Rate	.921	.879
Standard Error	.0094	.0131
Lower 95% Confidence Limit	.902	.853
Upper 95% Confidence Limit	.940	.905
Effective Sample Size	823	620

$t = 2.605$, $p < .01$, $df = 1441$

Groups:	Social Drinker School	vs. Read Only
24 Month Recidivism Rate	.122	.154
24 Month Survival Rate	.878	.846
Standard Error	.0233	.0184
Lower 95% Confidence Limit	.831	.809
Upper 95% Confidence Limit	.925	.883
Effective Sample Size	197	385

$t = 1.078$, $p > .20$, $df = 580$

rates showed a greater difference between groups (7.9% and 12.1%, school and read only respectively), which was statistically significant at the .01 level. However, the twenty-four-month recidivism rates (12.2% school vs. 15.4% read only) did not differ significantly ($p > .20$).

The cumulative survival and recidivism rates for all problem drinkers referred to the research design groups are presented in Tables 15a, 15b, and 15c (read only, school, and group plus school respectively). The cumulative recidivism rates from Column 11 of these tables are plotted in Figure 4. During the first fifteen months after referral the group recidivism rates were very similar, intersecting each other several times and displaying no consistent differences between groups. After fifteen months the recidivism rates began to separate, with read only showing the highest rate, then school, and then group plus school with the lowest rate. Table 16 presents the survival rate analyses for the comparison of problem drinker school and read only referrals. The results of the t-tests indicated that there were no significant differences in recidivism between the school and read only groups, at 12, 18, and 24 months after referral. The recidivism rates for school referrals were 9.6%, 13.4%, and 13.4% (12-mn., 18-mn., and 24-mn. respectively), while the corresponding rates for read only referrals were 10.8%, 14.2%, and 19.0%.

Table 17 summarizes the results of the comparison of group therapy + school vs. school only. At twelve months after referral the recidivism rates for group + school (10.4%) and school (9.6%) were not significantly different. The analysis of eighteen-month recidivism rates also showed no significant difference (11.2% vs. 13.4%, group + school, and school respectively).

Table 18 presents the final set of analyses for problem drinker referrals. The twelve and eighteen-month recidivism rates were respectively 10.4% and 11.2% for group therapy plus school, and 10.8% and 14.2% for read only. Neither the twelve-month nor the eighteen-month recidivism rates were significantly

TABLE 15a

Cumulative Survival and Recidivism Rates For
Total Referred Problem Drinkers: Read Only

Months After Referral (1) t to t+1	Enrolled at Beginning of Interval (2) E_t	Recidivists During Interval (3) R_t	Withdrawn Surviving During Interval (4) W_t	Effective Number Exposed to the Risk of Recidivism (2) $-\frac{1}{2}$(4) (5) E'_t	Proportion Recidivists (3) ÷ (5) (6) q_t	Proportion Surviving 1.0 - (6) (7) p_t	Cumulative Proportion Surviving Through End of Interval $(p_1 \cdot p_2 \ldots p_t)$ (8) P_t	(5) - (3) (9) $E'_t - R_t$	(6) ÷ (9) (10) $q_t/(E'_t - R_t)$	Cumulative Proportion Recidivating Through End of Interval 1.0 - (8) (11) $1.0 - P_t$
0 - 1	519	0	0	519.0	.000	1.000	1.000	519.0	.000000	.000
1 - 2	519	4	0	519.0	.008	.992	.992	515.0	.000016	.008
2 - 3	515	8	0	515.0	.016	.984	.976	507.0	.000032	.024
3 - 4	507	5	0	507.0	.010	.990	.966	502.0	.000020	.034
4 - 5	502	6	0	502.0	.012	.988	.955	496.0	.000024	.045
5 - 6	496	9	0	496.0	.018	.982	.938	487.0	.000037	.062
6 - 7	487	1	46	464.0	.002	.998	.936	463.0	.000004	.064
7 - 8	440	1	21	429.5	.002	.998	.934	428.5	.000005	.066
8 - 9	418	4	37	399.5	.010	.990	.924	395.5	.000025	.076
9 - 10	377	5	41	356.5	.014	.986	.912	351.5	.000040	.088
10 - 11	331	2	38	312.0	.006	.994	.906	310.0	.000019	.094
11 - 12	291	4	36	273.0	.015	.985	.892	269.0	.000056	.108
12 - 13	251	2	26	238.0	.008	.992	.885	236.0	.000034	.115
13 - 14	223	0	16	215.0	.000	1.000	.885	215.0	.000000	.115
14 - 15	207	2	29	192.5	.010	.990	.877	190.5	.000052	.123
15 - 16	176	2	19	166.5	.012	.988	.866	164.5	.000073	.134
16 - 17	155	0	24	143.0	.000	1.000	.866	143.0	.000000	.134
17 - 18	131	1	28	117.0	.009	.991	.858	116.0	.000078	.142
18 - 19	102	0	28	88.0	.000	1.000	.858	88.0	.000000	.142
19 - 20	74	0	32	58.0	.000	1.000	.858	58.0	.000000	.142
20 - 21	42	2	12	36.0	.056	.944	.810	34.0	.001647	.190
21 - 22	28	0	8	24.0	.000	1.000	.810	24.0	.000000	.190
22 - 23	20	0	12	14.0	.000	1.000	.810	14.0	.000000	.190
23 - 24	8	0	8	4.0	.000	1.000	.810	4.0	.000000	.190

TABLE 15b

Cumulative Survival and Recidivism Rates For Total Referred Problem Drinkers: School

Months After Referral (1) t to t+1	Enrolled at Beginning of Interval (2) E_t	Recidivists During Interval (3) R_t	Withdrawn Surviving During Interval (4) W_t	Effective Number Exposed to the Risk of Recidivism (2) $-\frac{1}{2}$(4) (5) E'_t	Proportion Recidivists (3) ÷ (5) (6) q_t	Proportion Surviving 1.0 - (6) (7) p_t	Cumulative Proportion Surviving Through End of Interval $(p_1 \cdot p_2 \cdot \ldots \cdot p_t)$ (8) P_t	(5) - (3) (9) $E'_t - R_t$	(6) ÷ (9) (10) $q_t/(E'_t - R_t)$	Cumulative Proportion Recidivating Through End of Interval 1.0 - (8) (11) $1.0 - P_t$
0 - 1	603	0	0	603.0	.000	1.000	1.000	603.0	.000000	.000
1 - 2	603	1	0	603.0	.002	.998	.998	602.0	.000003	.002
2 - 3	602	9	0	602.0	.015	.985	.983	593.0	.000025	.017
3 - 4	593	3	0	593.0	.005	.995	.978	590.0	.000008	.022
4 - 5	590	9	0	590.0	.015	.985	.963	581.0	.000026	.037
5 - 6	581	6	0	581.0	.010	.990	.954	575.0	.000017	.046
6 - 7	575	10	39	555.5	.018	.982	.937	545.5	.000033	.063
7 - 8	526	5	32	510.0	.010	.990	.927	505.5	.000020	.073
8 - 9	489	2	31	473.5	.004	.996	.924	471.5	.000008	.076
9 - 10	456	3	45	433.5	.007	.993	.917	430.5	.000016	.083
10 - 11	408	0	34	391.0	.000	1.000	.917	391.0	.000000	.083
11 - 12	374	5	45	351.5	.014	.986	.904	346.5	.000040	.096
12 - 13	324	4	43	302.5	.013	.987	.893	298.5	.000044	.107
13 - 14	277	2	17	268.5	.007	.993	.886	266.5	.000026	.114
14 - 15	258	1	23	246.5	.004	.996	.883	245.5	.000016	.117
15 - 16	234	3	21	223.5	.013	.987	.871	220.5	.000059	.129
16 - 17	210	0	30	195.0	.000	1.000	.871	195.0	.000000	.129
17 - 18	180	1	40	160.0	.006	.994	.866	159.0	.000038	.134
18 - 19	139	0	35	121.5	.000	1.000	.866	121.5	.000000	.134
19 - 20	104	0	45	81.5	.000	1.000	.866	81.5	.000000	.134
20 - 21	59	0	34	42.0	.000	1.000	.866	42.0	.000000	.134
21 - 22	25	0	10	20.0	.000	1.000	.866	20.0	.000000	.134
22 - 23	15	0	7	11.5	.000	1.000	.866	11.5	.000000	.134
23 - 24	8	0	8	4.0	.000	1.000	.866	4.0	.000000	.134

TABLE 15c

Cumulative Survival and Recidivism Rates For
Total Referred Problem Drinkers: Group Therapy Plus School

Months After Referral (1) t to t+1	Enrolled at Beginning of Interval (2) E_t	Recidivists During Interval (3) R_t	Withdrawn Surviving During Interval (4) W_t	Effective Number Exposed to the Risk of Recidivism (2) $-\frac{1}{2}$(4) (5) E'_t	Proportion Recidivists (3) ÷ (5) (6) q_t	Proportion Surviving 1.0 - (6) (7) P_t	Cumulative Proportion Surviving Through End of Interval $(P_1 \cdot P_2 \ldots P_t)$ (8) P_t	(5) - (3) (9) $E'_t - R_t$	(6) ÷ (9) (10) $q_t/(E'_t - R_t)$	Cumulative Proportion Recidivating Through End of Interval 1.0 - (8) (11) $1.0 - P_t$
0 - 1	402	1	0	402.0	.002	.998	.998	401.0	.000005	.002
1 - 2	401	4	0	401.0	.010	.990	.988	397.0	.000025	.012
2 - 3	397	3	0	397.0	.008	.992	.980	394.0	.000020	.020
3 - 4	394	1	0	394.0	.003	.997	.977	393.0	.000008	.023
4 - 5	393	5	0	393.0	.013	.987	.964	388.0	.000034	.036
5 - 6	388	2	0	388.0	.005	.995	.960	386.0	.000013	.040
6 - 7	386	1	43	364.5	.003	.997	.957	363.5	.000008	.043
7 - 8	342	4	28	328.0	.012	.988	.945	324.0	.000037	.055
8 - 9	310	4	38	291.0	.014	.986	.932	287.0	.000049	.068
9 - 10	268	4	35	250.5	.016	.984	.917	246.5	.000065	.083
10 - 11	229	1	42	208.0	.005	.995	.913	207.0	.000024	.087
11 - 12	186	3	31	170.5	.018	.982	.896	167.5	.000107	.104
12 - 13	152	0	27	138.5	.000	1.000	.896	138.5	.000000	.104
13 - 14	125	1	20	115.0	.009	.991	.888	114.0	.000079	.112
14 - 15	104	0	29	89.5	.000	1.000	.888	89.5	.000000	.112
15 - 16	75	0	27	61.5	.000	1.000	.888	61.5	.000000	.112
16 - 17	48	0	28	34.0	.000	1.000	.888	34.0	.000000	.112
17 - 18	20	0	20	10.0	.000	1.000	.888	10.0	.000000	.112

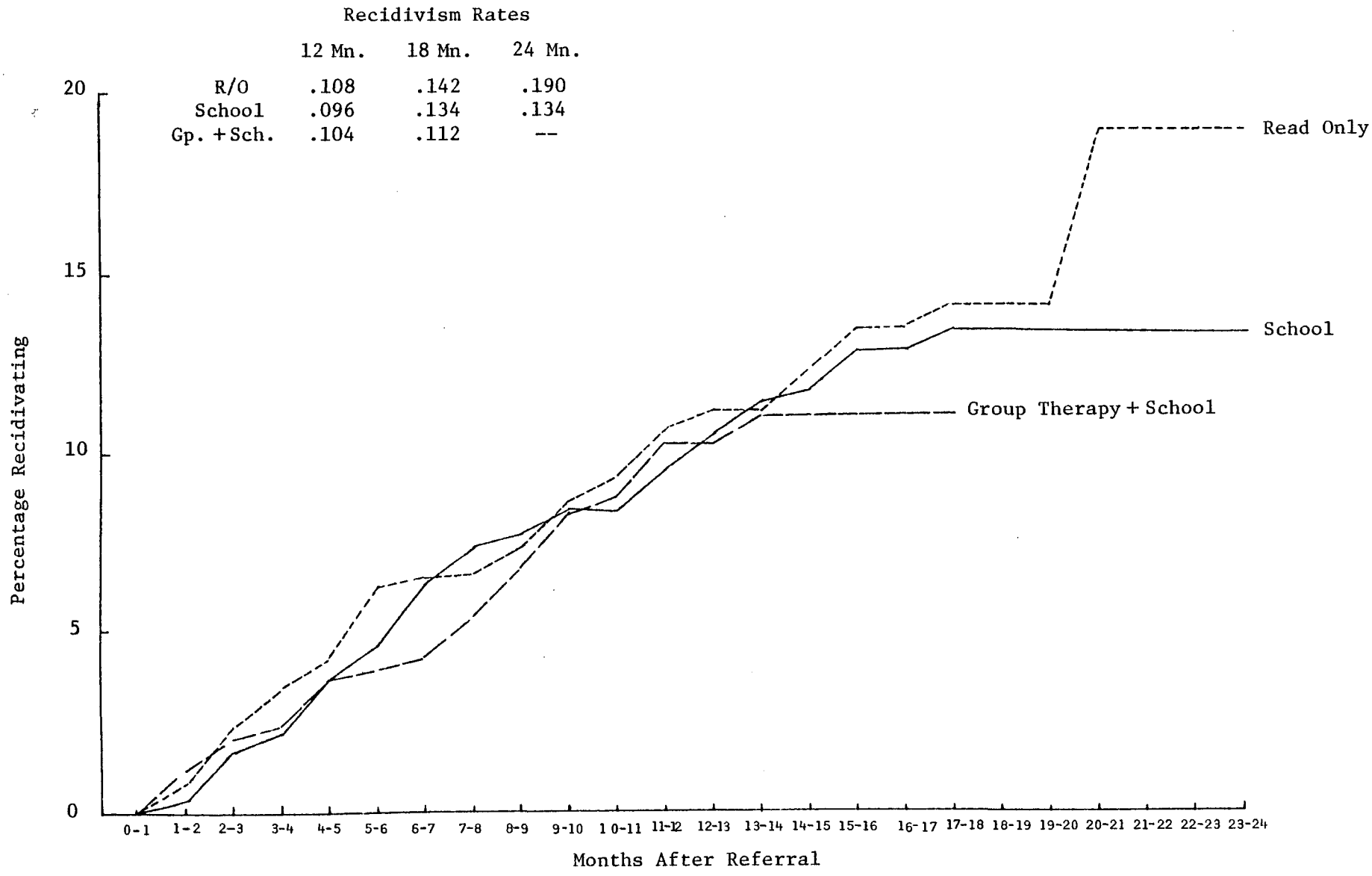


FIGURE 4

Cumulative Recidivism Rates for Problem Drinker Research Design Groups: Total Referred

TABLE 16

Summary of Survival Rate Analyses for Problem Drinker Referral Groups: School vs. Read Only

Groups:	Problem Drinker School	vs. Read Only
12 Month Recidivism Rate	.096	.108
12 Month Survival Rate	.904	.892
Standard Error	.0127	.0149
Lower 95% Confidence Limit	.879	.862
Upper 95% Confidence Limit	.929	.922
Effective Sample Size	538	434

$t = 0.613$, $p > .50$, $df = 970$

Groups:	Problem Drinker School	vs. Read Only
18 Month Recidivism Rate	.134	.142
18 Month Survival Rate	.866	.858
Standard Error	.0169	.0195
Lower 95% Confidence Limit	.832	.819
Upper 95% Confidence Limit	.900	.897
Effective Sample Size	406	320

$t = 0.310$, $p > .50$, $df = 724$

Groups:	Problem Drinker School	vs. Read Only
24 Month Recidivism Rate	.134	.190
24 Month Survival Rate	.866	.810
Standard Error	.0169	.0377
Lower 95% Confidence Limit	.832	.735
Upper 95% Confidence Limit	.900	.885
Effective Sample Size	406	108

$t = 1.355$, $p < .20$, $df = 512$

TABLE 17

Summary of Survival Rate Analyses for Problem Drinker Referral Groups: Group Therapy + School vs. School

Groups:	Group Therapy + School	vs. School
12 Month Recidivism Rate	.104	.096
12 Month Survival Rate	.896	.904
Standard Error	.0178	.0127
Lower 95% Confidence Limit	.860	.879
Upper 95% Confidence Limit	.932	.929
Effective Sample Size	294	538

$t = -0.366$, $p > .50$, $df = 830$

Groups:	Group Therapy + School	vs. School
18 Month Recidivism Rate	.112	.134
18 Month Survival Rate	.888	.866
Standard Error	.0193	.0169
Lower 95% Confidence Limit	.849	.832
Upper 95% Confidence Limit	.927	.900
Effective Sample Size	267	406

$t = 0.858$, $p > .20$, $df = 671$

TABLE 18

Summary of Survival Rate Analyses for Problem Drinker Referral Groups: Group Therapy + School vs. Read Only

Groups:	Group Therapy + School	vs. Read Only
12 Month Recidivism Rate	.104	.108
12 Month Survival Rate	.896	.892
Standard Error	.0178	.0149
Lower 95% Confidence Limit	.860	.862
Upper 95% Confidence Limit	.932	.922
Effective Sample Size	294	434

$t = 0.172$, $p > .80$, $df = 726$

Groups:	Group Therapy + School	vs. Read Only
18 Month Recidivism Rate	.112	.142
18 Month Survival Rate	.888	.858
Standard Error	.0193	.0195
Lower 95% Confidence Limit	.849	.819
Upper 95% Confidence Limit	.927	.897
Effective Sample Size	267	320

$t = 1.093$, $p > .20$, $df = 585$

different between assignment groups. Thus, none of the group comparisons provided evidence of treatment effects for problem drinker referrals.

From the standpoint of proper experimental design, the analysis of all individuals referred to treatment programs is the most appropriate procedure for eliminating alternative explanations (i.e., other than treatment effects) for observed differences in recidivism rates. However, if a substantial proportion of the clients who were referred did not complete their assigned treatment programs, any actual treatment effects would be diluted. In the present study, the completion rates for problem drinkers referred to read only or school were 95.8% and 94.0% respectively, but the completion rate for referrals to the group plus school combination was only 55%. Consequently, a comparison of group plus school completions with school completions, and with read only completions would provide interesting descriptive information.

Tables 19a, 19b, and 19c present the cumulative survival and recidivism rates for problem drinkers completing read only, school, and group therapy plus school. The recidivism rates for the completion groups are illustrated in Figure 5. As expected, the recidivism rates for completions and referrals were virtually identical for the read only and school groups. However, there was a considerable difference between the recidivism rates for clients completing vs. those referred to group plus school: the completion group showing a lower recidivism rate.

The survival rate analyses, presented in Table 20, indicate no significant difference between the twelve-month recidivism rates for group plus school and school only (6.0% vs. 9.8% respectively). By eighteen months after completion, however, there was a statistically significant difference in recidivism ($p < .01$) for clients completing group plus school (6.0%) relative to clients completing the school only (14.0%).

Table 21 presents the survival rate analyses comparing group therapy plus school and read only completions. The twelve-

TABLE 19a

Cumulative Survival and Recidivism Rates For Problem Drinkers (Completions Only): Read Only

Months After Referral (1) t to t+1	Enrolled at Beginning of Interval (2) E_t	Recidivists During Interval (3) R_t	Withdrawn Surviving During Interval (4) W_t	Effective Number Exposed to the Risk of Recidivism (2) $-\frac{1}{2}$(4) (5) E'_t	Proportion Recidivists (3) ÷ (5) (6) q_t	Proportion Surviving 1.0 - (6) (7) P_t	Cumulative Proportion Surviving Through End of Interval $(p_1 \cdot p_2 \ldots p_t)$ (8) P_t	(5) - (3) (9) $E'_t - R_t$	(6) ÷ (9) (10) $q_t/(E'_t - R_t)$	Cumulative Proportion Recidivating Through End of Interval 1.0 - (8) (11) $1.0 - P_t$
0 - 1	497	0	0	497.0	.000	1.000	1.000	497.0	.000000	.000
1 - 2	497	4	0	497.0	.008	.992	.992	493.0	.000016	.008
2 - 3	493	7	0	493.0	.014	.986	.978	486.0	.000029	.022
3 - 4	486	5	0	486.0	.010	.990	.968	481.0	.000021	.032
4 - 5	481	6	0	481.0	.012	.988	.957	475.0	.000025	.043
5 - 6	475	9	0	475.0	.019	.981	.939	466.0	.000041	.061
6 - 7	466	1	43	444.5	.002	.998	.937	443.5	.000005	.063
7 - 8	422	1	19	412.5	.002	.998	.934	411.5	.000005	.066
8 - 9	402	4	34	385.0	.010	.990	.925	381.0	.000026	.075
9 - 10	364	5	41	343.5	.015	.985	.912	338.5	.000044	.088
10 - 11	318	2	37	299.5	.007	.993	.905	297.5	.000024	.095
11 - 12	279	4	35	261.5	.015	.985	.892	257.5	.000058	.108
12 - 13	240	2	25	227.5	.009	.991	.884	225.5	.000040	.116
13 - 14	213	0	15	205.5	.000	1.000	.884	205.5	.000000	.116
14 - 15	198	2	28	184.0	.011	.989	.874	182.0	.000060	.126
15 - 16	168	2	19	158.5	.013	.987	.862	156.6	.000083	.138
16 - 17	147	0	24	135.0	.000	1.000	.862	135.0	.000000	.138
17 - 18	123	1	27	109.5	.009	.991	.855	108.5	.000083	.145
18 - 19	95	0	25	82.5	.000	1.000	.855	82.5	.000000	.145
19 - 20	70	0	29	55.5	.000	1.000	.855	55.5	.000000	.145
20 - 21	41	2	12	35.0	.057	.943	.806	33.0	.001727	.194
21 - 22	27	0	7	23.5	.000	1.000	.806	23.5	.000000	.194
22 - 23	20	0	12	14.0	.000	1.000	.806	14.0	.000000	.194
23 - 24	8	0	8	4.0	.000	1.000	.806	4.0	.000000	.194

TABLE 19b

Cumulative Survival and Recidivism Rates For Problem Drinkers (Completions Only): School

Months After Referral (1) t to t+1	Enrolled at Beginning of Interval (2) E_t	Recidivists During Interval (3) R_t	Withdrawn Surviving During Interval (4) W_t	Effective Number Exposed to the Risk of Recidivism (2) $-\frac{1}{2}$(4) (5) E'_t	Proportion Recidivists (3) ÷ (5) (6) q_t	Proportion Surviving 1.0 - (6) (7) p_t	Cumulative Proportion Surviving Through End of Interval $(p_1 \cdot p_2 \ldots p_t)$ (8) P_t	(5) - (3) (9) $E'_t - R_t$	(6) ÷ (9) (10) $q_t/(E'_t - R_t)$	Cumulative Proportion Recidivating Through End of Interval 1.0 - (8) (11) $1.0 - P_t$
0 - 1	567	0	0	567.0	.000	1.000	1.000	567.0	.000000	.000
1 - 2	567	1	0	567.0	.002	.998	.998	566.0	.000004	.002
2 - 3	566	9	0	566.0	.016	.984	.982	557.0	.000029	.018
3 - 4	557	3	0	557.0	.005	.995	.977	554.0	.000009	.023
4 - 5	554	9	0	554.0	.016	.984	.961	545.0	.000029	.039
5 - 6	545	5	0	545.0	.009	.991	.953	540.0	.000017	.047
6 - 7	540	10	35	522.5	.019	.981	.935	512.5	.000037	.065
7 - 8	495	5	28	481.0	.010	.990	.925	476.5	.000021	.075
8 - 9	462	2	25	449.5	.004	.996	.922	447.5	.000009	.078
9 - 10	435	3	44	413.0	.007	.993	.915	410.0	.000017	.085
10 - 11	388	0	31	372.5	.000	1.000	.915	372.5	.000000	.085
11 - 12	357	5	43	335.5	.015	.985	.902	330.5	.000045	.098
12 - 13	309	4	42	288.0	.014	.986	.889	284.0	.000049	.111
13 - 14	263	2	15	255.5	.008	.992	.882	253.5	.000032	.118
14 - 15	246	1	22	235.0	.004	.996	.878	234.0	.000017	.122
15 - 16	223	3	20	213.0	.014	.986	.866	210.0	.000067	.134
16 - 17	200	0	29	185.5	.000	1.000	.866	185.5	.000000	.134
17 - 18	171	1	40	151.0	.007	.993	.860	150.0	.000047	.140
18 - 19	130	0	34	113.0	.000	1.000	.860	113.0	.000000	.140
19 - 20	96	0	40	76.0	.000	1.000	.860	76.0	.000000	.140
20 - 21	56	0	33	39.5	.000	1.000	.860	39.5	.000000	.140
21 - 22	23	0	8	19.0	.000	1.000	.860	19.0	.000000	.140
22 - 23	15	0	7	11.5	.000	1.000	.860	11.5	.000000	.140
23 - 24	8	0	8	4.0	.000	1.000	.860	4.0	.000000	.140

TABLE 19c

Cumulative Survival and Recidivism Rates For Problem Drinkers (Completions Only): Group Therapy Plus School

Months After Referral (1) t to t+1	Enrolled at Beginning of Interval (2) E_t	Recidivists During Interval (3) R_t	Withdrawn Surviving During Interval (4) W_t	Effective Number Exposed to the Risk of Recidivism (2) $-\frac{1}{2}$(4) (5) E'_t	Proportion Recidivists (3) ÷ (5) (6) q_t	Proportion Surviving 1.0 - (6) (7) p_t	Cumulative Proportion Surviving Through End of Interval $(p_1 \cdot p_2 \ldots p_t)$ (8) P_t	(5) - (3) (9) $E'_t - R_t$	(6) ÷ (9) (10) $q_t/(E'_t - R_t)$	Cumulative Proportion Recidivating Through End of Interval 1.0 - (8) (11) $1.0 - P_t$
0 - 1	221	0	0	221.0	.000	1.000	1.000	221.0	.000000	.000
1 - 2	221	0	0	221.0	.000	1.000	1.000	221.0	.000000	.000
2 - 3	221	0	0	221.0	.000	1.000	1.000	221.0	.000000	.000
3 - 4	221	0	0	221.0	.000	1.000	1.000	221.0	.000000	.000
4 - 5	221	0	0	221.0	.000	1.000	1.000	221.0	.000000	.000
5 - 6	221	1	0	221.0	.005	.995	.995	220.0	.000023	.005
6 - 7	220	0	22	209.0	.000	1.000	.995	209.0	.000000	.005
7 - 8	198	2	16	190.0	.011	.989	.984	188.0	.000059	.016
8 - 9	180	1	16	172.0	.006	.994	.978	171.0	.000035	.022
9 - 10	163	2	16	155.0	.013	.987	.965	153.0	.000085	.035
10 - 11	145	1	29	130.5	.008	.992	.958	129.5	.000062	.042
11 - 12	115	2	17	106.5	.019	.981	.940	104.5	.000182	.060
12 - 13	96	0	11	90.5	.000	1.000	.940	90.5	.000000	.060
13 - 14	85	0	12	79.0	.000	1.000	.940	79.0	.000000	.060
14 - 15	73	0	19	63.5	.000	1.000	.940	63.5	.000000	.060
15 - 16	54	0	21	43.5	.000	1.000	.940	43.5	.000000	.060
16 - 17	33	0	14	26.0	.000	1.000	.940	26.0	.000000	.060
17 - 18	19	0	19	9.5	.000	1.000	.940	9.5	.000000	.060

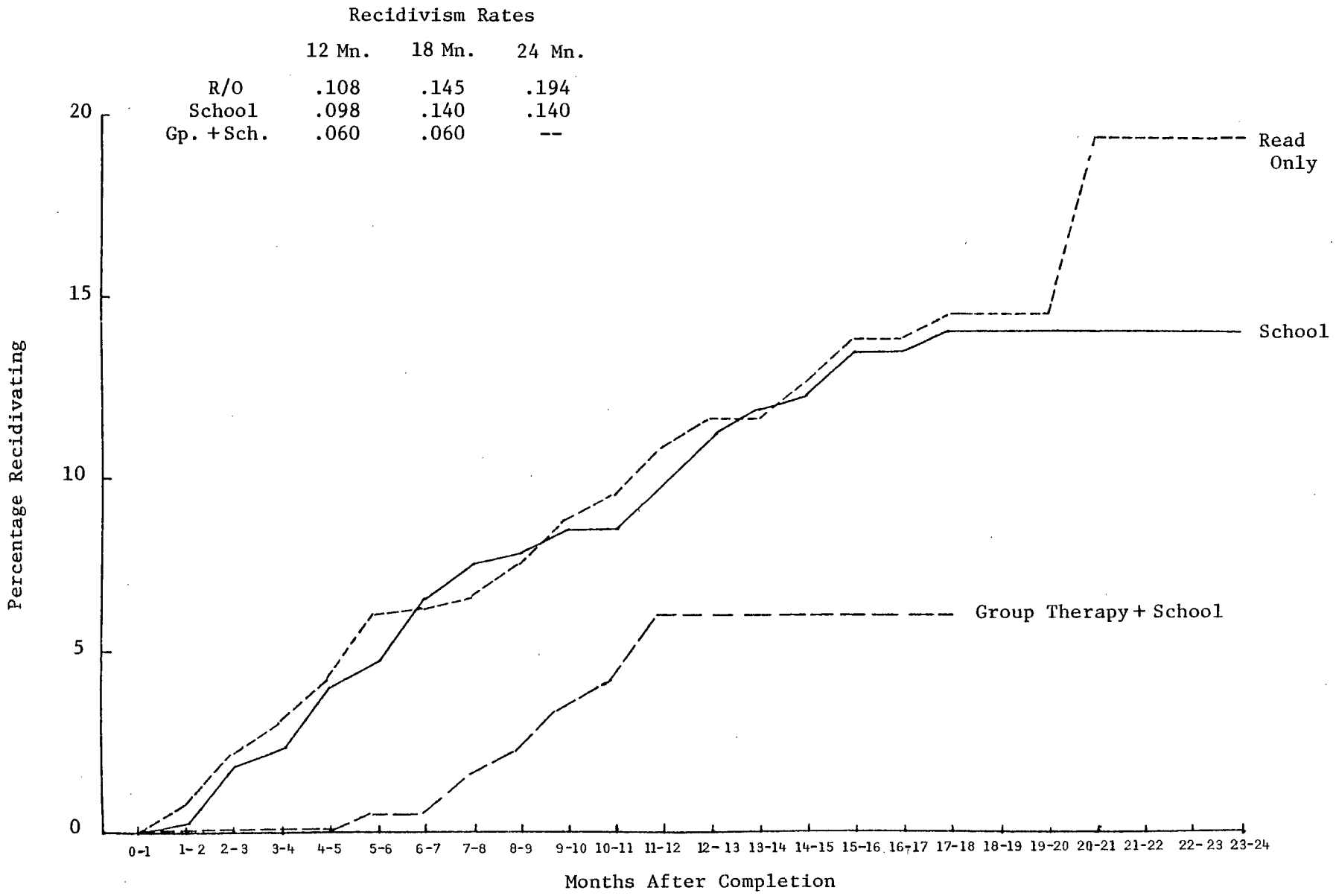


FIGURE 5

Cumulative Recidivism Rates for Problem Drinker Research Design Groups: Completions Only

TABLE 20

Summary of Survival Rate Analyses for Problem Drinker Completion Groups: Group Therapy + School vs. School

Groups (Completions):	Group Therapy + School	vs.	School
12 Month Recidivism Rate	.060		.098
12 Month Survival Rate	.940		.902
Standard Error	.0199		.0133
95% Lower Confidence Limit	.900		.875
95% Upper Confidence Limit	.980		.929
Effective Sample Size	142		500

$t = 1.588$, $p < .20$, $df = 640$

Groups (Completions):	Group Therapy + School	vs.	School
18 Month Recidivism Rate	.060		.140
18 Month Survival Rate	.940		.860
Standard Error	.0199		.0178
95% Lower Confidence Limit	.900		.824
95% Upper Confidence Limit	.980		.896
Effective Sample Size	142		380

$t = 2.996$, $p < .01$, $df = 520$

TABLE 21

Summary of Survival Rate Analyses for Problem Drinker Completion Groups: Group Therapy + School vs. Read Only

Groups (Completions):	Group Therapy + School	vs. Read Only
12 Month Recidivism Rate	.060	.108
12 Month Survival Rate	.940	.892
Standard Error	.0199	.0153
95% Lower Confidence Limit	.900	.861
95% Upper Confidence Limit	.980	.923
Effective Sample Size	142	412

$t = 1.912$, $p < .10$, $df = 552$

18 Month Recidivism Rate	.060	.145
18 Month Survival Rate	.940	.855
Standard Error	.0199	.0202
95% Lower Confidence Limit	.900	.815
95% Upper Confidence Limit	.980	.895
Effective Sample Size	142	304

$t = 2.998$, $p < .01$, $df = 444$

month recidivism rates were 6.0% for group plus school and 10.8% for read only. The probability of observing the difference was less than .10, which was not statistically significant at the .05 level set for the analyses of completion data. The eighteen-month recidivism rates were 6.0% for group plus school and 14.5% for read only, which was a statistically significant difference ($p < .01$).

3. Summary and Discussion

The Tampa ASAP rehabilitation research design involved the random assignment of 1,691 social drinkers and 1,524 problem drinkers to treatment and minimum-exposure conditions. Group profile comparisons verified that the random assignment procedure produced treatment groups with equivalent client characteristics. Social drinker and problem drinker clients assigned to DWI school or read only had a maximum of twenty-four months exposure to rearrest, while problem drinker clients assigned to group therapy plus school had a maximum of eighteen months exposure. However, very few clients were actually exposed for the maximum length of time, resulting in relatively unreliable estimates of recidivism for the longest exposure times. Consequently, the conclusions presented below were primarily based on twelve and eighteen-month recidivism data (and twelve-month data only, for the group plus school clients).

Social drinkers referred to school had a significantly lower recidivism rate at twelve months (6.3%) and eighteen months (7.9%) after referral, compared to social drinkers referred to read only (8.5% and 12.1% correspondingly).

The analysis of problem drinker referrals revealed no significant differences in recidivism among the research design groups: school vs. read only, group therapy plus school vs. school, and group therapy plus school vs. read only.

Although there was no evidence of treatment effectiveness for problem drinkers referred to treatment, only slightly more than one-half of the clients referred to the group plus school combination successfully completed. Thus, any treatment effect

for group plus school, if it existed, would be considerably weakened by the high proportion of clients who were not exposed to the full treatment program.

The analysis of treatment completion groups indicated that there were no statistically significant differences in twelve-month recidivism rates between group plus school and school only, and between group plus school and read only. However, the twelve-month rates for group plus school (6.0%) and read only (10.8%) were sufficiently different to suggest that the group therapy plus school combination may have an arrest reduction potential for persons who successfully complete both modalities. Although the comparison of completion groups was definitely quasi-experimental and the results were subject to a number of confounding factors, the problem drinker completion groups were found to be comparable on several client characteristics including arrest BAC and Mortimer-Filkins score, lending credibility to the authors' interpretation.

Considering all analyses of client recidivism, the following conclusions were warranted.

Regarding DWI Counterattack:

1. There was definite evidence that exposure to social drinker classes resulted in a lower rate of recidivism among participants, relative to the recidivism rate for social drinker read only clients.

2. There was definite evidence that exposure to problem drinker classes alone had no effect on the recidivism of problem drinker clients.

Regarding HCMHC Alcoholism Services:

3. Although there was no definite evidence of treatment effectiveness for clients referred to group plus school, the data suggested that the combination of short term didactic and group therapy plus problem drinker classes may reduce recidivism among those clients completing both modalities.

D. Effect of Treatment on Life Changes

The present section assesses the impact of Short Term Rehabilitation (STR) treatments on various aspects of the participants personal lives. The primary reason for conducting an investigation of this nature is due to the fact that the probability of arrest for a drunk driver is quite small, making a DWI arrest (or recidivism) for any one individual a rare event, which in turn renders the analysis of recidivism data relatively insensitive. The life changes analysis offers a more direct assessment of the influence STR treatments had on participants but a less direct assessment of STR treatment impact on DWI arrest recidivism and alcohol related motor vehicle accidents. However, evidence of favorable life changes would provide evidence of ASAP (STR treatment) effectiveness under the implicit assumption that favorable life changes would effect less drinking-driving behavior which in turn would bring about less DWI arrests and less alcohol related accidents. The evaluative question of interest then within this section may be stated as follows: Have persons who received STR treatments experienced favorable life changes as a result of the treatments?

1. Methodology

Beginning in November, 1975, all ASAP clients diagnosed as problem drinkers were administered the Life Activities Inventory (LAI) package immediately after receiving random assignment to one of three treatments (problem drinker school plus group therapy, problem drinker school only, or a read only control group). When initial data collection stopped in March, 1976, 353 total LAI's had been administered consisting of 144 for group plus school clients, 103 for school only clients and 106 for read only clients. Life changes resulting from the treatments were measured by re-administering the LAI package at six-month and twelve-month intervals from the date of the initial inventory. Since clients were generally not under court order to return for the six and twelve month inventories they were offered $10.00 for returning and participating in the inventories. The return rate was quite reasonable though, as 274 six month inventories were conducted and approximately 230 twelve month

inventories were conducted (twelve month follow-up information was available for 198 clients on the STR abstract file at the time of this writing). There were seven cases in which twelve-month information was available for a client with no available six-month information. For purposes of analysis then, there were 191 subjects (clients) with initial, six-month, and twelve-month data available consisting of 65 clients receiving the group plus school treatment, 59 clients receiving the school only treatment, and 67 clients receiving the read only treatment (the minimum exposure "control" group).

The group treatment consisted of the short term didactic and group therapy program conducted by the Hillsborough Community Mental Health Center. The school treatment for problem drinkers was part of and was conducted by DWI counterattack which is Tampa's Alcohol Safety School and consisted of four lecture type sessions. The read treatment was also conducted by DWI counterattack and consisted of giving the clients assigned to the treatment some educational materials to be read at home. More detailed descriptions of these treatments may be found in the introduction to this report. Clients receiving assignment to the group designated group plus school received both group treatment and school treatment. Clients assigned to the group designated school only received only the school treatment and clients assigned to the group designated read only received only the read treatment.

The LAI package was assembled by the University of South Dakota and consists of four parts: 1) Mortimer-Filkins questionnaire, 2) two self administered questionnaires, the Personality Assessment Scale (PAS) and the Current Status Questionnaire (CSQ), 3) LAI interview, and 4) records check. This study utilizes factor scores (to be discussed below) from the combined CSQ(developed by the Fort Logan Mental Health Center, Denver, Colorado as part of their ongoing treatment evaluation program) and LAI interview (developed by the University of South Dakota as part of the LAI package). The CSQ describes current behaviors, feelings and attitudes towards a number of activities such as drinking, family and social life, employment, leisure time,

etc. while the LAI interview assesses the clients behavioral activity in a number of aspects of his life during the previous six-month period--e.g. health, employment, marital/family, social/recreational, drinking activities.

The factor analytic work identifying the underlying constructs or dimensions of the CSQ and LAI interview was conducted at the University of South Dakota (Ellingstad and Struckman-Johnson, 1977). Although a number of factors (constructs) were identified for each of the measuring instruments (CSQ, LAI interview, and PAS), a set of five factors identified for the combined CSQ/LAI interview were considered the most stable estimates of underlying constructs. It should be pointed out that the factor analytic work was carried out on initial LAI data from 3681 clients including those from 10 sites other than Tampa. The present study is concerned with life changes along these five constructs which have the following interpretations: Factor I - current quantity/frequency of drinking, Factor II - employment/economic stability, Factor III - current physical health problems, Factor IV - social interaction, and Factor V - current drinking problems.

In order to provide measurement of life changes along those constructs a scale score for each client on each of the five factors for each inventory available was computed. (Ellingstad and Struckman-Johnson, 1977). Each scale was based only on the salient variables of a particular factor (those variables which are highly correlated with the construct and in fact define it) by assigning a weight of one to each salient variable and a weight of zero to non salient variables. The scores for each client on each variable which entered into the computation of a

scale score were first standardized according to

$$z_{ij} = \frac{(X_{ij} - \mu_j)}{\sigma_j}$$

where z_{ij} is the standard score for client i on variable j ;

X_{ij} is the obtained raw score for client i on variable j ;

μ_j is the mean for variable j (based on the 3681 initial cases);

σ_j is the standard deviation of variable j (based on the 3681 initial cases).

Scale scores were computed from these z scores by summing the salient variable z scores and then scaling the sums to means of 500 and standard deviations of 100 (across the 3681 initial cases). Means and standard deviations for the Tampa sample may differ somewhat from 500 and 100 respectively since the scaling was done on the 3681 initial cases. The range for each factor scale score may be from 0 to 999 but it can be safely assumed that the majority of scale scores are between 200 and 800 (± 3 standard deviations).

The scale scores for each client on each of the five LAI interview/CSQ combined factors for the initial LAI then provide measures of relative position along the life activity dimensions defined by the factors while the scale scores for the six month and twelve month follow-up LAI's provide measures of change along the five life activity dimensions. A high scale score on factor I reflects a high quantity and frequency of drinking in the recent past and relatively short periods of abstention. High scale scores on factor II indicate greater income production and stability of employment while low scale scores would be indicative of problems in this dimension. A high scale score on factor III is indicative of substantial numbers of health complaints and problems. Individuals who score high on factor IV tend to be outgoing and socially active. Factor V represents current drinking problems (blackouts, prolonged drunkenness, inability to control drinking behavior etc.) as opposed to factor I which is a measure of current <u>frequency</u> of drinking.

High scores on factor V indicate the presence of alcohol/ drinking problems.

Statistical analysis of changes in each of the five dimensions was accomplished through the use of profile analysis. A separate profile analysis was conducted for the three groups (problem drinker group plus school, problem drinker school only, and the read only control group) for each factor. The dependent variables for each profile analysis were the scale scores computed from the initial, six-month and twelve-month LAI's. As previously stated, scale scores from all three LAI's were available on 191 clients at the time of this writing and it is these 191 subjects who enter into the profile analyses (65 group plus school clients, 59 school only clients, and 67 read only clients). It should be mentioned that extensive profile (demographic) comparisons via χ^2 tests presented in a preceding section of this report failed to turn up any substantial differences between clients who appeared for six and twelve month follow-up inventories and clients who didn't, or between treatment groups with twelve month information available.

A profile analysis consists of three separate tests of significance. The first test is of the parallelism hypothesis. For this test the null hypothesis may be stated: the profiles for the three groups are parallel (have the same shape). This test is analogous to the univariate test for interaction and is the test of most importance for the comparisons being made. Significance for this test would indicate that the three STR treatment groups experienced differential life changes on the dimension (factor) being considered. The second test is for the flatness hypothesis or test for zero slope. This test tests the hypothesis that the "pooled" profile for all three groups combined is flat (has slope equal to zero). The third test is for the levels hypothesis where the null hypotheses is that the profiles of the three groups are at the same mean level or that the mean sums of the three dependent variables (factor scores) are equal for the three groups (actually, a one way ANOVA on the sums is conducted). The three tests are statistically independent,

but the last two have no real menaing when the parallelism hypothesis is rejected. Alpha was set at .05 for all tests of significance. More detail on this subject may be found in most texts on multivariate statistics, e.g., see Harris (1975).

2. Results

Table 22 presents the results of the profile analysis for scale scores on Factor I from the combined LAI interview and Current Status Questionnaire. High scores on this factor reflect a high frequency and quantity of drinking and the experimental hypothesis would be that the STR group plus school and school only treatment groups would have reduced scores six and twelve months after treatment began while the read only control group would show little or no change. The test for parallel profiles is seen to be significant and indicates that treatments did indeed differentially influence the groups. The scale score means shown in Table 22 are depicted graphically in Figure 6 and indicate the group getting group therapy plus school STR treatments had considerably lower scores at six and twelve months than they did initially. The group getting school only STR treatment also showed decreased scores at six and twelve months although not to the extent of the group plus school clients while the scores for the read only control group have remained more or less the same (actually went up slightly). Although the tests for zero slope (flatness) and equal levels were also significant, indicating that the slope of the combined profiles is not zero (it is significantly negative) and the mean levels of the profiles are different (the level for group plus school clients appears to be lower than the mean level for school only and read only clients); they are essentially irrelevant given the significance of the parallelism hypothesis.

Table 23 presents the results of the profile analysis on scale scores for LAI interview/CSQ factor II. Higher scores on this dimension reflect higher income and greater stability of employment while low scores indicate problems in this life activity area. The test of the parallelism hypothesis shown in Table 23 was not significant and inspection of the factor scale

TABLE 22

Profile Analysis: LAI Interview/CSQ Factor I
(Current Quantity/Frequency of Drinking)

Factor Scale Score Means

Group	Initial	6 Months	12 Months
Group + School	479.26	444.78	439.11
School	510.03	502.24	477.85
Read Only	486.75	495.22	492.73

Parellelism Hypothesis

Wilks λ = .9497

F = 2.446 (df = 4 and 374)

p = .045

Flatness Hypothesis

Wilks λ = .9559

F = 4.316 (df = 2 and 187)

p = .015

Levels Hypothesis

MS_{gps} = 306148.00

MS_{error} = 72717.56

F = 4.210 (df = 2 and 188)

p = .016

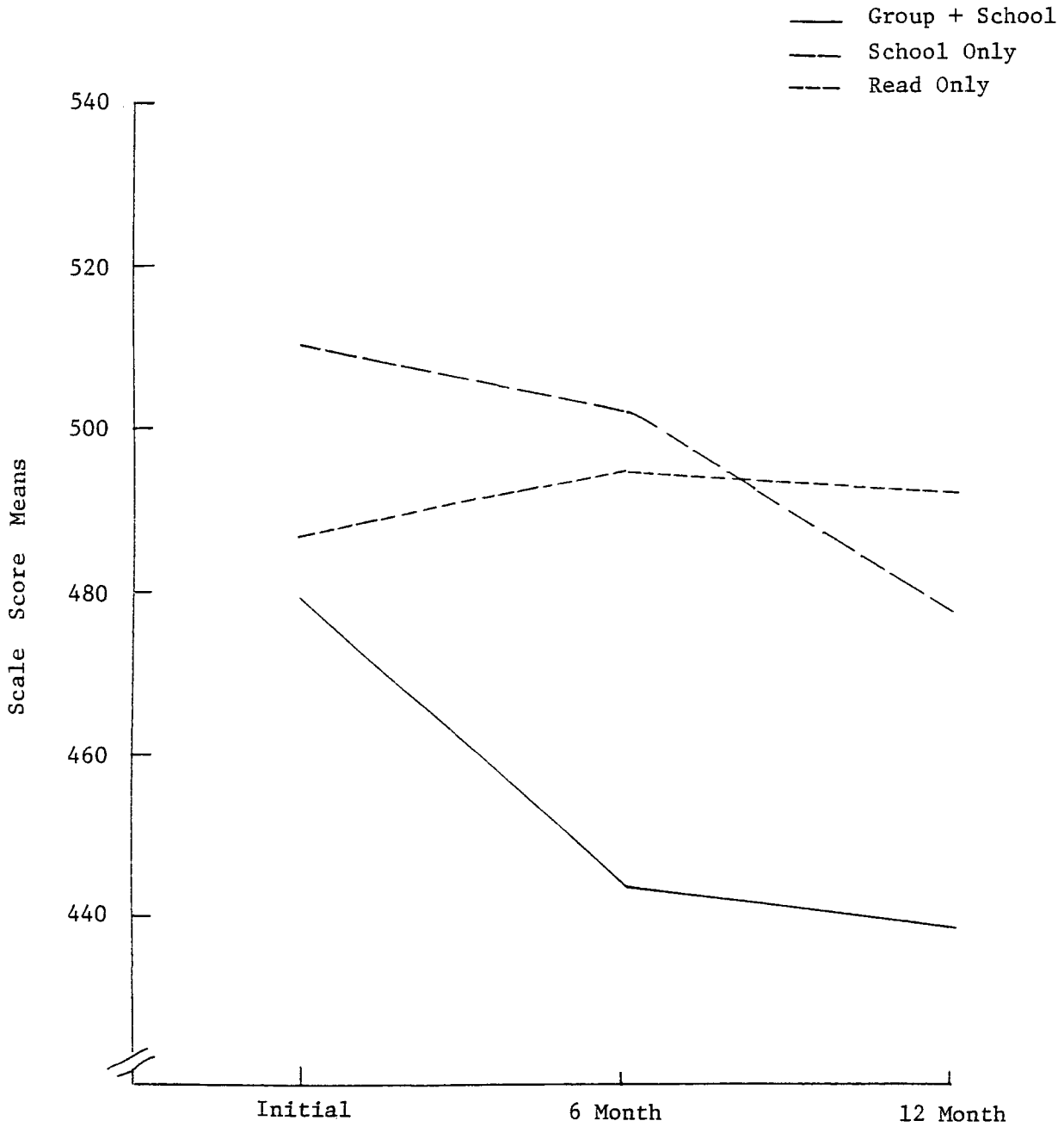


FIGURE 6

Profiles of STR Treatment Groups on LAI Interview/CSQ Factor I: Current Quantity/Frequency of Drinking

TABLE 23

Profile Analysis: LAI Interview/CSQ Factor II
(Employment/Economic Stability)

Factor Scale Score Means

Group	Initial	6 Months	12 Months
Group + School	485.89	470.02	481.00
School	467.80	487.22	475.02
Read Only	480.42	473.27	484.07

Parallelism Hypothesis

Wilks λ = .9750

F = 1.191 (df = 4 and 374)

p = .314

Flatness Hypothesis

Wilks λ = .9986

F = 0.136 (df = 2 and 187)

p = .873

Levels Hypothesis

MS_{gps} = 1100.56

MS_{error} = 79768.50

F = .014 (df = 2 and 188)

p = .987

score means given in Table 23 and presented graphically in Figure 7 confirms that there are no real differences between groups or between inventory periods.

The results of the profile analysis for factor scale scores on LAI interview/CSQ factor III are shown in Table 24. Factor III is labeled current physical health problems and high scores on this dimension are indicative of high numbers of physical health complaints and problems. Figure 8 depicts the mean scale scores on this factor for the three STR treatment groups at each of the three inventories conducted (initial, six month follow-up and twelve month follow-up). The group plus school clients have lower scores six and twelve months after the initial inventory as would be predicted, but the school only group has higher scores at the six and twelve month inventory periods. In any case, the test for parallel profiles was not significant indicating no real differences between the three groups in the shapes of their profiles. It is concluded that the STR treatments have had no effect on the life activity dimension of physical health problems.

Scale score means for factor IV of the combined LAI interview and CSQ and the profile analysis on the scale scores are presented in Table 25. The test for parallel profiles was significant and indicates that the profiles for the three groups on these scale scores across the initial, six-month, and twelve-month inventories are not equal. Inspection of the scale score means depicted in Figure 9 reveals that the profile for the group plus school clients is different from the profiles of the school only and read only groups. Since high scores on factor IV are indicative of social activity and low scores are indicative of alienation, withdrawal, and social inactivity, the higher score means at the six month and twelve month inventory periods for group plus school clients are in the expected direction. However, closer inspection of Figure 9 indicates that most of the difference in the profiles is due to the group plus school clients having a much lower mean than the school only and read only groups at the <u>initial</u> inventory.

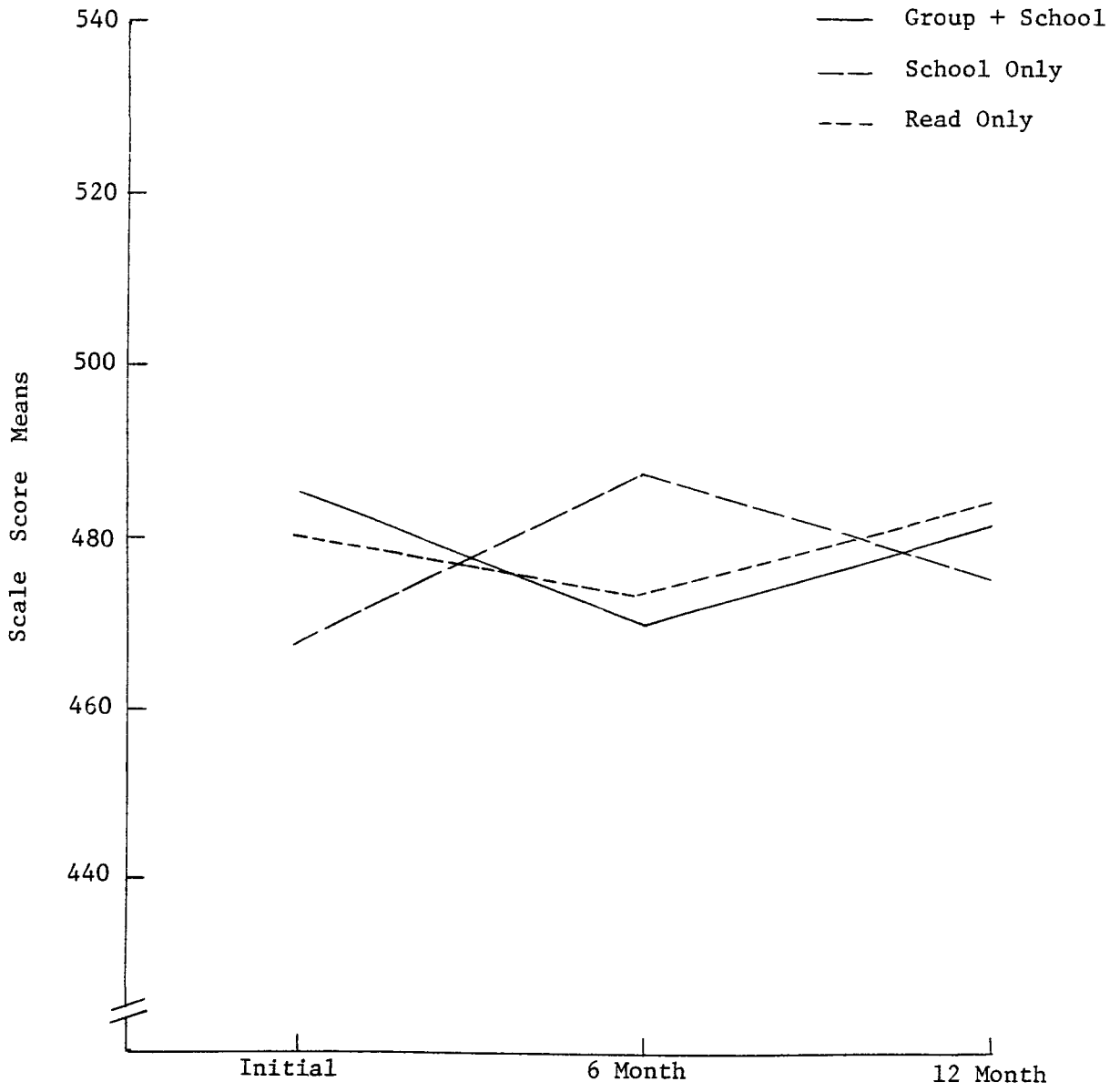


FIGURE 7

Profiles of the STR Treatment Groups
on LAI Interview/CSQ Factor II:
Employment/Economic Stability

TABLE 24

Profile Analysis: LAI Interview/CSQ Factor III
(Current Physical Health Problems)

Factor Scale Score Means

Group	Initial	6 Month	12 Month
Group + School	548.68	530.06	523.62
School	526.47	551.76	547.70
Read Only	513.28	524.07	523.46

Parallelism Hypothesis

Wilks λ = .9655
F = 1.655 (df = 4 and 374)
p = .159

Flatness Hypothesis

Wilks λ = .9980
F = .188 (df = 2 and 187)
p = .830

Levels Hypothesis

MS_{gps} = 69117.70
MS_{error} = 113854.62
F = .607 (df = 2 and 188)
p = .551

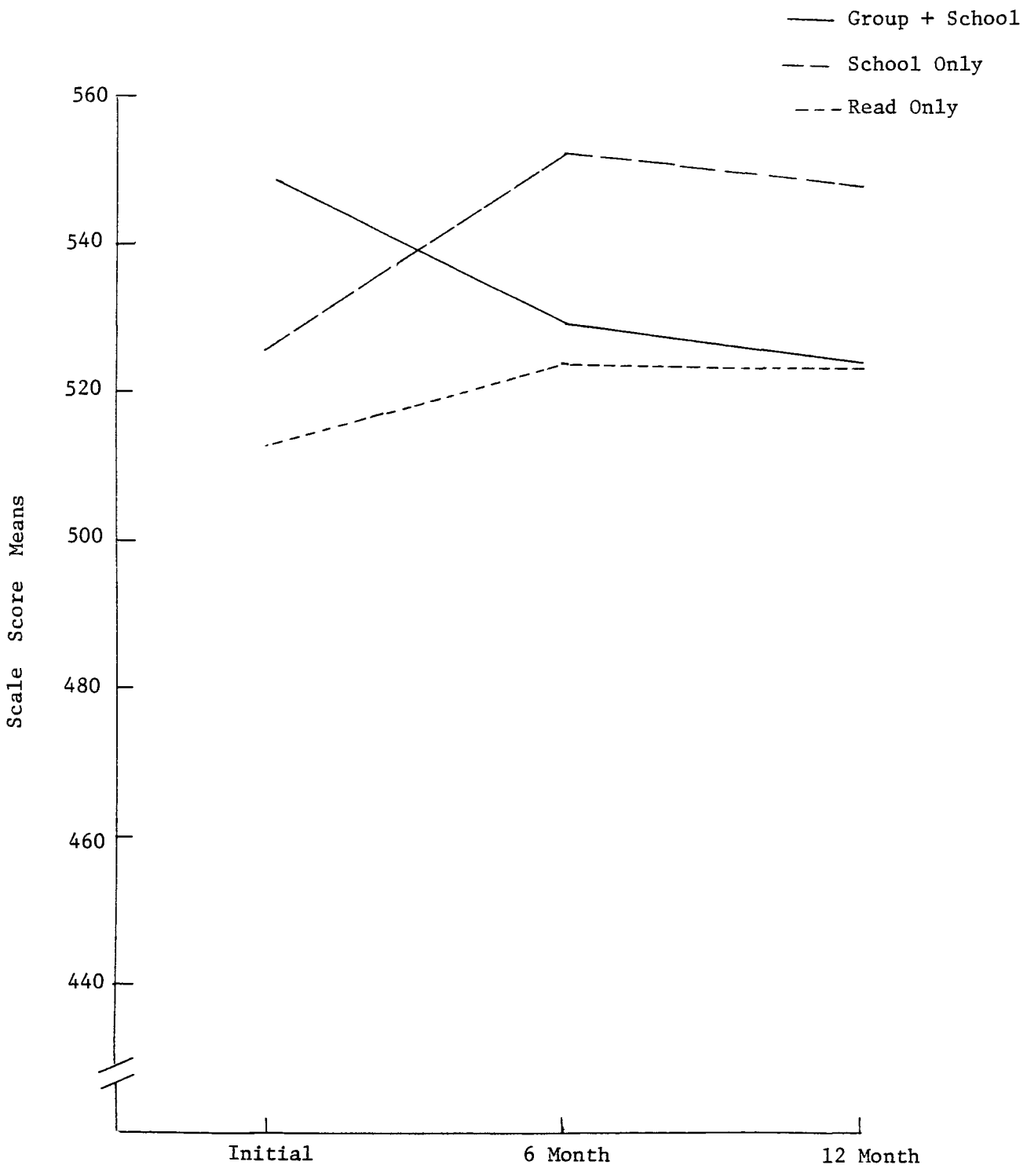


FIGURE 8

Profiles of the STR Treatment Groups
on LAI Interview/CSQ Factor III:
Current Physical Health Problems

TABLE 25

Profile Analysis: LAI Interview/CSQ Factor IV
(Social Interaction)

Factor Scale Score Means

Group	Initial	6 Month	12 Month
Group + School	467.14	507.91	515.49
School	520.78	517.76	529.05
Read Only	505.30	517.84	509.75

Parallelism Hypothesis

Wilks $\lambda = .9352$

$F = 3.183$ (df = 4 and 374)

$p = .014$

Flatness Hypothesis

Wilks $\lambda = .9425$

$F = 5.709$ (df = 2 and 187)

$p = .004$

Levels Hypothesis

$MS_{gps} = 92516.20$

$MS_{error} = 72494.25$

$F = 1.276$ (df = 2 and 188)

$p = .281$

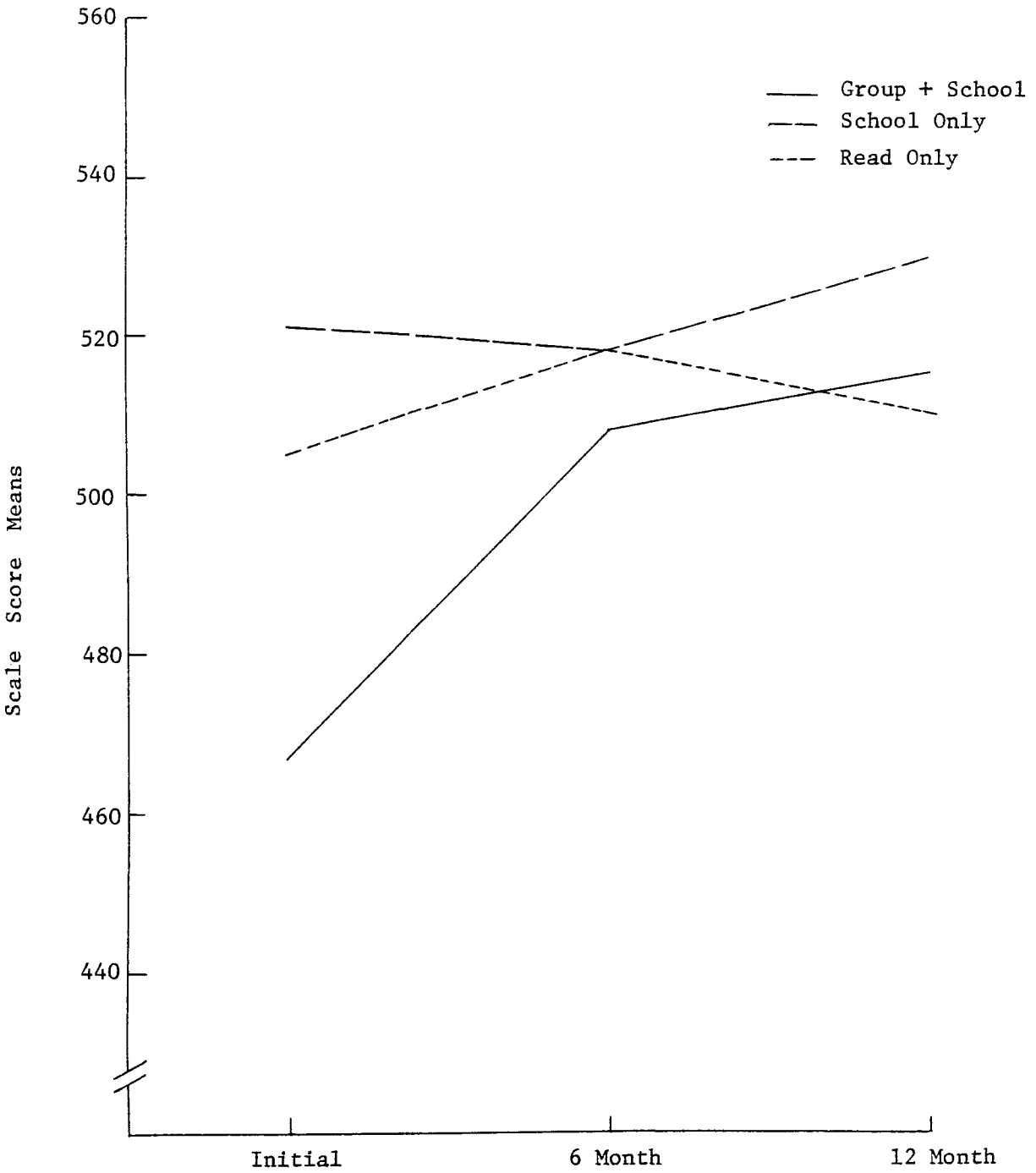


FIGURE 9

Profiles of the STR Treatment Groups
on LAI Interview/CSQ Factor IV:
Social Interaction

Since clients were initially assigned randomly to one of the STR treatments, this large initial difference must be attributed to "measurement" error. Therefore, the author feels that significance for the parallelism hypothesis is due to an artifact and concludes there were no real differences between the three groups on the life activities dimension of social interaction due to STR treatments.

Table 26 presents the results of the profile analysis on factor scale scores for factor V of the combined LAI interview and CSQ. High scores on this factor are indicative of the presence of alcohol/drinking problems while low scores would indicate the relative absence of drinking problems. Thus, the experimental hypothesis would predict lowered scores on this dimension as a result of the STR treatments. The test for parallel profiles was not significant however, indicating no differential effect of treatments on factor scale scores for the three groups. Inspection of the profiles of means depicted in Figure 10 reveals that the profiles for the three groups are quite similar. All three groups show a decrease in average score six months from the initial inventory, and then sustain their six month means at the twelve month inventory. While these results indicate no differences between the two STR treatment groups (group plus school and school only) and the read only control group, it was most encouraging to note the decrease in scores for all three groups. In fact, the test of the flatness hypothesis now has meaning (since the parallelism test was not significant) and it was highly significant, indicating a strong tendency toward lower scores at the six and twelve month inventories for the three groups combined. Despite the lack of differences between groups, these results are supportive of the findings reported for factor I (current quantity/frequency of drinking) in that both the group plus school clients and the school only clients have reduced drinking problems at the six month and twelve month inventories. If should also be kept in mind that the read only group was not a true control group but a minimum exposure group and it would not be unreasonable to expect some moderate degree of improvement in the

TABLE 26

Profile Analysis: LAI Interview/CSQ Factor V
(Current Drinking Problems)

Factor Scale Score Means

Group	Initial	6 Month	12 Month
Group + School	471.78	446.91	449.52
School	499.22	469.68	466.05
Read Only	477.72	467.64	466.70

Parallelism Hypothesis

Wilks λ = .9753
F = 1.176 (df = 4 and 374)
p = .320

Flatness Hypothesis

Wilks λ = .8726
F = 13.654 (df = 2 and 187)
p = .000

Levels Hypothesis

MS_{gps} = 72046.00
MS_{error} = 28637.96
F = 2.516 (df = 2 and 188)
p = .082

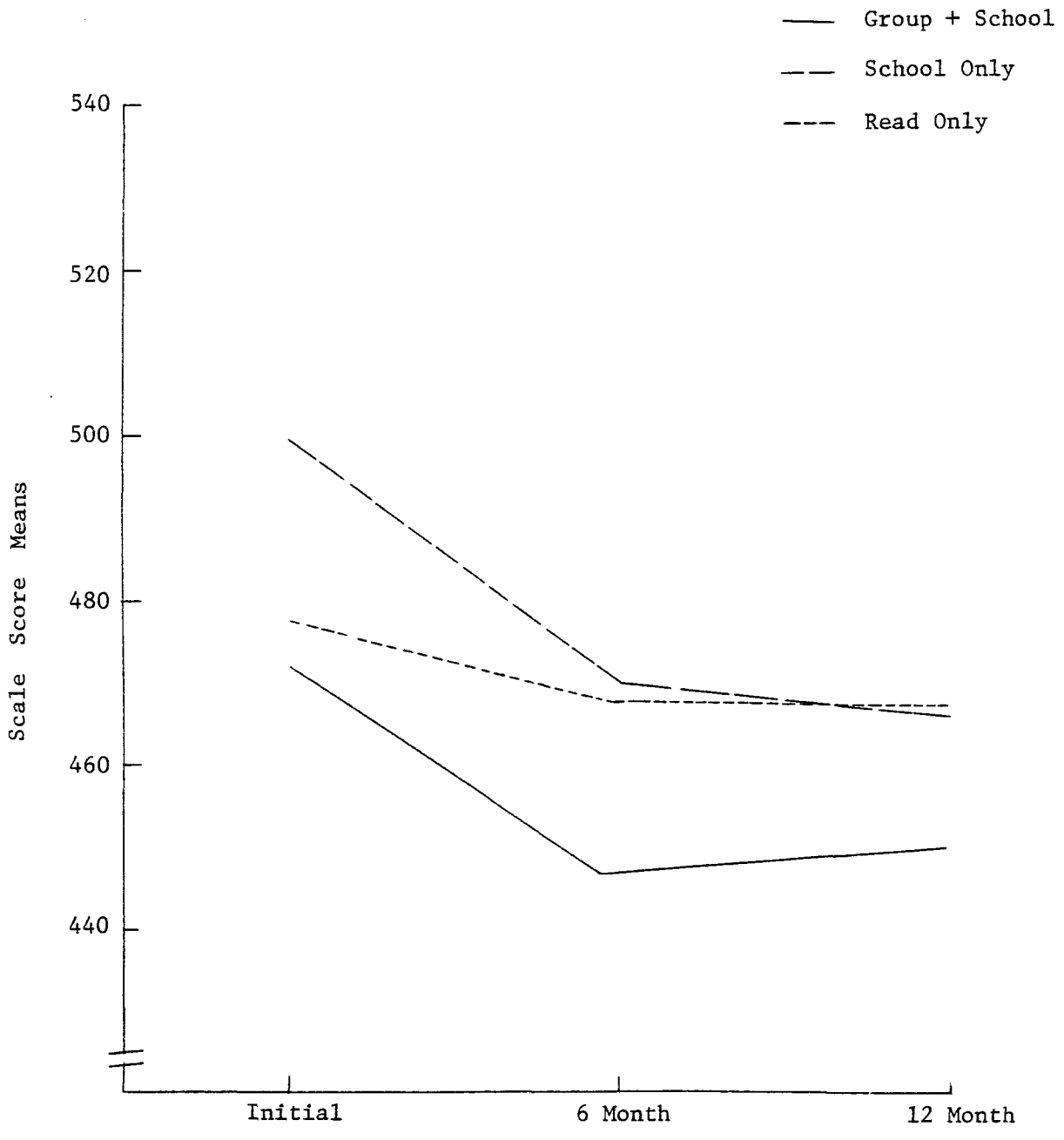


FIGURE 10

Profiles of the STR Treatment Groups
on LAI Interview/CSQ Factor V:
Current Drinking Problems

life activities dimensions for these clients. However, the author makes no conclusion regarding the effectiveness of STR treatments in improving current drinking problems since no differential effects of treatments were found. If the read only group is regarded as a control group, then the improvements noted for all groups combined may have occurred due to the simple passage of time (without treatment).

3. Summary and Discussion

The effect of STR treatments on five life activities dimensions was examined. The five dimensions (factors) were derived via factor analytic work conducted at the University of South Dakota from the Current Status Questionnaire (CSQ) and Life Activities Inventory (LAI) interview. Each STR client was assigned a score based on his responses to the CSQ and LAI interview on each factor at each administration of the LAI. The LAI was administered to each client immediately after random assignment to one of the three STR treatments, six months after entering treatment, and twelve months after entering treatment. Clients were all problem drinkers assigned to either group therapy plus school treatment, school only treatment, or to a minimum exposure read only "control" group. A profile analysis was conducted for each factor to test for treatment effects and group differences. Results of the profile analyses for each of the five factors are presented below.

Factor I (Current Quantity/Frequency of Drinking): The group plus school and school only clients showed marked improvement on this dimension (had lower mean scores at the six and twelve month inventories indicating reduced frequencies of drinking) while the read only group showed no improvement. These results were interpreted to be strongly supportive of STR treatment effectiveness.

Factor II (Employment/Economic Stability): No differences were found across time or between groups. STR treatments had no effect on this life activities dimension.

Factor III (Current Physical Health Problems): No differences due to STR treatments were found for this construct.

Factor IV (Social Interaction): Although the profile analysis indicated a significant difference in the profiles of the groups, the authors attributed this to an artifact brought about by a very low initial mean score for group plus school clients. Other than this one low initial mean score, the means for the three groups across the three inventory periods appear to be similar. It was concluded STR treatments had no effect on this life activities dimension.

Factor V (Current Drinking Problems): No differences in the profiles of the three groups were found but all three groups combined showed significant improvement in this dimension. The three groups had lower scores (indicating less drinking problems) at the six month inventory than at the initial inventory and sustained these lowered scores at the twelve month inventory.

Factors I and V would appear to be logically related to each other despite the fact that they comprise two separate factors. It was concluded that the results of the profile analyses for these two dimensions (current quantity/frequency of drinking and current drinking problems) were in basic agreement and supportive of each other. Therefore, it seems reasonable to conclude that the STR group plus school and school only treatments have effected an improvement in the alcohol related life activities of clients but not in the other three life activity dimensions examined (employment/economic stability, current physical health problems, and social interaction).

Although the results for factors I and V support each other when considered together, the lack of differential STR treatment effects on groups for factor V does cloud the interpretation somewhat when factor V is considered alone. Possibilities other than improvement due to STR treatments are not ruled out. It is possible for example that clients were agitated and hostile at the first administration of the LAI (they had just been found guilty of DWI and ordered to report to treatment) and registered higher than normal scores on factor V due to this alone. Six and twelve months later these same clients may have been less upset and consequently registered lower scale scores on factor V.

In this case the mere passage of time (without treatment) would have resulted in improvement on the dimension of current drinking problems. Since the two separate factors on alcohol/drinking were extracted during the factor analytic process, it must be assumed they are at least roughly independent. With this in mind, results for factor V should indeed be interpreted with caution as suggested above.

IV. REFERENCES

Cutler, S. J., and Ederer, F., Maximum utilization of the life table method in analyzing survival, J. Chron. Dis., Dec., 1958.

Ellingstad, V. S. and Struckman-Johnson, D. L. Short term rehabilitation (STR) study: Abstract file manual. Contract No. DOT-HS-6-01366, Human Factors Laboratory, University of South Dakota, Vermillion, S. D., 1977.

Harris, R. J. A primer of multivariate statistics. New York: Academic Press, 1975, p 106 - 108.

V. APPENDICES

APPENDIX A

ASAP REPORT TO COURT

Defendant_____Age_____Race_____Sex_____

Citation #_____Current DWI Arrest Date_____BAC_____

Court Date_____Court Room_____Time_____

DWI ARREST HISTORY	BAC

HISTORY OF COURT REFERRALS

☐ ASAP has no record of prior DWI Arrests.

☐ Prior arrest(s) exist. Referral to ASAP was not ordered.

☐ Prior arrest(s) exist. Referral to ASAP was ordered as follows:

Diagnostic Interview

☐ Ordered in 197____: Completed_____ (diagnosis) / Not Completed

DWI School

☐ Ordered in 197____: Completed / Not Completed

Additional Treatment at_____

☐ Started in 197____: Completed / Not Completed

Phase I Phase II Phase III No Recommendation

ASAP
TAMPA

APPENDIX B

Jury Trial and Appeal Procedures

ITEM I

Procedures for Obtaining Jury Trials

The procedure for obtaining a jury trial for an alcohol-related traffic offense is fairly simple in the State of Florida. Since all alcohol-related cases first go to the Traffic Division of County Court, all the defendant (or his attorney) need do is to file a petition for a jury trial. If possible, the petition is preferred in writing, but may be accepted orally by any judge currently serving in the Traffic Division. If the petition has not been filed prior to the court date, the defendant or his attorney may move for a jury trial when the defendant appears in court for the first time.

Under Florida Law (322.262 (4) F.S.), an individual's right to trial by jury is considered to be waived if his petition for jury is: 1) not made in good faith, 2) made to obtain a delay, or 3) if real harm would be done to the public by granting the petition. Thus, the judge has the prerogative of denying the motion for a jury trial under the above criteria. Both the defendant and the State have the right to appeal the judge's decision, and also have the right to petition for jury trial at the appellate level.

When a motion for jury trial is received and accepted, the case is transferred to the Criminal Misdemeanor Division of County Court and a trial date is set in that division.

County Court has three sections: Traffic, Criminal Misdemeanor, and Civil. Thus, requests for jury trials after March 15, 1976 do not leave County Court (as do appeals) but rather simply transfer from the Traffic Division to the Criminal Misdemeanor Division of County Court. Between January 1, 1975 and March 15, 1976, jury trials were held in the Traffic Division itself by the same judges who heard non-jury proceedings.

Should the decision reached at the jury trial be unacceptable to the defendant or the the prosecution, an appeal may be made following the procedure outlined in Appendix B, Item 2 of this report.

In 1975, an average of 27.5 cases were docketed for jury trial each month, with an average of one (1) actually reaching trial. Of the 318 cases where petitions for jury trials were granted but the trial in fact did not occur, all defendants were convicted of DWI or UBAC through the plea process. Of the 12 cases which were actually tried by jury, acquittals were recorded for six, the remaining six being found guilty. Thus, while petition for trial by jury occurred almost daily (4.5% of all disposed cases in 1975), an actual trial was quite rare (0.2% of all disposed cases).

Given the change in jurisdiction within County Court for jury trials (and the availability of other judges) the rate of petition and trial may increase.

ITEM II

Aspects of Appeal

Appeal to Circuit Court: All alcohol-related cases are first processed through the Traffic Division of County Court. These trials are typically of a non-jury nature. If a defendant is convicted of an alcohol-related charge, but feels that a reversible decision occurred during the trial itself, he may appeal the decision by filing a Notice of Appeal with the Criminal Appellate Division of the Circuit Court. Reversible decisions may include such items as, 1) the test was inappropriately administered, 2) the equipment was not in proper working order, 3) evidence admitted was prejudicial, etc.

The Circuit Court has three divisions: The Civil Division, the Criminal Division (and the Criminal Appellate Division within it), and the Juvenile Division. Typically, all felonies appear before the Criminal Division of Circuit Court. There are two exceptions. The first exception is the Appellate Division which honors appeals from the Criminal Misdemeanor Division of County Court, such as that described above, and is the first line of appeal from County Court.

The second exception deals with juveniles. All alcohol-related offenses where juveniles are involved are handled directly by the Juvenile Division of Circuit Court, and do not therefore, ever appear in County Court.

Appropriate grounds for appeal to the Appellate Division of the Circuit Court are many and varied. If however, an individual wishes to appeal a decision of the Appellate Division of the Circuit Court, such grounds are more limited.

To appeal beyond the Appellate Division of the Circuit Court, the individual must appeal to the Circuit District Court of Appeals located in Lakeland. In this case, grounds for appeal are scrutinized a good deal more carefully, and the Circuit District Court has every right to refuse to accept cases if in their judgment the grounds are insufficient.

In the above discussion, reference was made to the defendant who was convicted of an alcohol-related offense. Appeals are by no means limited to defendants. Prosecutors representing the State can also appeal any judicial decision from County Court using the same avenues.

In 1975 fewer than five appeals were made from County Court, including both those made by defendants as well as those made by the State. No data on the outcome of those appeals are available. This low frequency is largely due to the fact that County Courts are not courts of record. Anytime a record of the proceedings is unavailable, successfully negotiating for an appeal is much more difficult than when a record of the proceedings is available.

In order to obtain a record of the proceedings in County Court, court reporters must be brought in at the expense of either the defendant or the prosecution. Such measures are taken only when the defense or the prosecution feels that a record is necessary because the possibility of appeal is great. So far, those occasions have been few.

Direct Appeal to the Florida State Supreme Court: If the issue raised by either the defendant or the prosecution in the original case was one of a constitutional nature, the case goes directly to the Florida Supreme Court on appeal. In 1975 there were two such cases. In both cases the appeal was made by the defendant but the State was successful.

The first case (State v. Wooten) was a Tampa case where the constitutionality of the driving with an unlawful blood alcohol level [F.S. 316.028 (3)] was attacked on the grounds that the prohibition of withholding adjudication in such cases denies equal protection. The Florida Supreme Court affirmed the conviction of the lower court and rejected the challenge by defense counsel. The Supreme Court held that rather than denying equal protection, the inability of a judge to withhold adjudication in fact guaranteed equal protection.

The second case (State v. Roberts) came from Sarasota and challenged the constitutional validity of the DWI statute itself [F.S. 316.028 (3)] on the grounds that (1) it was not reasonably related to the police power of the State of Florida, and (2) that it was vague and indefinite. The second point concerns the inability of the consumer of alcohol to determine when their blood alcohol level would make it illegal for them to drive. The Florida Supreme Court again affirmed the conviction and rejected the challenge citing a Utah Supreme Court decision indicating the ability of individuals to make appropriate decisions about alcohol consumption and driving.

APPENDIX C

A S A P C O U R T O R D E R S

PHASE I

PHASE II

PHASE III

PHASE I
Court Order
Hillsborough County Court, Traffic Division

NAME_____SUBJECT #_____

DL#_____SS #_____

RACE_____SEX_____AGE_____DOB_____

ADDRESS (HOME)_____PHONE (HOME)_____

ADDRESS (BUSINESS)_____PHONE (BUSINESS)_____

DATE OF ARREST_____CITATION #_____

INTERVIEW DATE_____DIAGNOSIS_____M/F:K-1___K-2___K-3___QT___FS___

COUNSELOR_____REFERRALS_____

You are hereby placed on six (6) months probation. It is further ordered that you comply with the following conditions of Probation:

(a) Not change your residence or employment or leave the county without first procuring the consent of the Court.
(b) Use no narcotic drugs. Do not use intoxicants of any kind in excess
(c) Avoid injuries or vicious habits; avoid association with persons of harmful character or bad reputation.
(d) In all respects live honorably, work diligently at a lawful occupation, and support dependents, if any, to the best of your ability, and live within what income is available.
(e) Not carry any weapons without first securing the consent of the Court.
(f) Visit no gambling places.
(g) Live and remain at liberty without violating any law.
(h) Promptly and truthfully answer all inquiries directed by the Court.

You are hereby ordered to attend one (1) diagnostic interview at Hillsborough Community Mental Health Center Alcoholism Services at____o'clock on _____the_____of_____, 197___. (Fee: $25.00)
You are hereby ordered to attend the DWI Counterattack School at the Hillsborough Community College_____Campus, at _____o'clock on_____the_____of_____, 197___. (Fee: $40.00)

REPORT IMMEDIATELY AT THE ASAP CENTRAL BREATH TESTING LABORATORY at the south end of the Tampa Police Station, 1710 North Tampa Street, Tampa, Florida 33602 for scheduling. Additional fees will be assessed for missed appointments.

_____ _____
ASAP Scheduling Officer Client Signature

By further written Order of this Court you may be required to attend and participate in additional therapeutic programs. In this event, you are also ordered to participate in any follow-up interviews which may be required (at no charge) at six month intervals during the next year.

The Court may at any time rescind or modify any of the conditions of this probation, or may extend the period of probation as authorized by law, or may discharge you. If you violate any of the conditions of this probation, you may be arrested and the Court may revoke this probation and impose any sentence which it may have imposed before placing you on probation.

DONE AND ORDERED in open Court this_____day of_____197___.

_____
COUNTY COURT JUDGE

You are hereby further ordered to attend additional treatment described as follows:

_____
_____at____o'clock on____the___of_____197___.

_____
COUNTY COURT JUDGE

DISTRIBUTION:
White: Court of Record
Green: ASAP Phone: 223-8001/Scheduling Office 23-8005
Yellow: HCMHC Alc. Svcs. Phone: 223-7411
Pink: DWI Counterattack, Inc. Phone 872-6663
Goldenrod: Defendant

ASAP
TAMPA

PHASE II

COURT ORDER
HILLSBOROUGH COUNTY COURT, TRAFFIC DIVISION

NAME _____ SUBJECT # _____

DL# _____ SS# _____

RACE _____ SEX _____ AGE _____ DOB _____

ADDRESS (HOME) _____ PHONE (HOME) _____

ADDRESS (BUSINESS) _____ PHONE (BUSINESS) _____

DATE OF ARREST _____ CITATION # _____

INTERVIEW DATE _____ DIAGNOSIS _____ M/F:K-1 _____ K-2 _____ K-3 _____ QT _____ FS _____

Counselor _____ Referrals _____ _____ _____

You are hereby placed on six (6) months probation. It is further ordered that you shall comply with the following conditions of Probation:

(a) Not change your residence or employment or leave the county without first procuring the consent of the Court.
(b) Use no narcotic drugs. Do not use intoxicants of any kind to excess.
(c) Avoid injurious or vicious habits; avoid association with persons of harmful character or bad reputation.
(d) In all respects live honorably, work diligently at a lawful occupation, and support dependents, if any, to the best of your ability, and live within what income is available.
(e) Not carry any weapons without first securing the consent of the Court.
(f) Visit no gambling places.
(g) Live and remain at liberty without violating any law.
(h) Promptly and truthfully answer all inquiries directed by the Court.

You are hereby ordered to attend one (1) diagnostic interview at Hillsborough Community Mental Health Center Alcoholism Services at _____ o'clock on _____ the _____ of _____, 197_____. (Fee: $25.00)

You are hereby ordered to attend the DWI Counterattack School at the Hillsborough Community College, _____ Campus, at _____ o'clock on _____ the _____ of _____, 197_____. (Fee: ~~$30.00~~ $40.00)

REPORT IMMEDIATELY TO THE ASAP CENTRAL BREATH TESTING LABORATORY at the south end of the Tampa Police Station, 1710 North Tampa Street, Tampa, Florida 33602 for scheduling. Additional fees will be assessed for missed appointments.

_____ _____
ASAP SCHEDULING OFFICER CLIENT SIGNATURE

During your diagnostic interview, you may be assigned to treatment at the Hillsborough Community Mental Health Center, or at other treatment programs. You are hereby ordered to enter into and complete any program that you are referred to and to pay any fees that are charged for your treatment. You are also ordered to participate in any follow-up interviews which may be required (at no charge) at six month intervals during the next year.

You are hereby further ordered to attend additional treatment described as follows:

_____ at _____ o'clock on _____ the _____ of _____ 197 _____.

The Court may at any time rescind or modify any of the conditions of this probation, or may extend the period of probation as authorized by law, or may discharge you. If you violate any of the conditions of this probation, you may be arrested and the Court may revoke this probation and impose any sentence which it may have imposed before placing you on probation.

DONE AND ORDERED in open Court this _____ day of _____ 197_____.

_____
COUNTY COURT JUDGE

DISTRIBUTION:

White: Court of Record
Green: ASAP Phone: 223-8001
Yellow: HCMHC Alc. Svcs. Phone: 238-7411
Pink: DWI Counterattack, Inc. Phone 872-6663
Goldenrod: Defendant

asap
ALCOHOL SAFETY ACTION PROJECT TAMPA

PHASE III

COURT ORDER
HILLSBOROUGH COUNTY COURT, TRAFFIC DIVISION

NAME _____ SUBJECT # _____

DL# _____ SS# _____

RACE _____ SEX _____ AGE _____ DOB _____

ADDRESS (HOME) _____ PHONE (HOME) _____

ADDRESS (BUSINESS) _____ PHONE (BUSINESS) _____

DATE OF ARREST _____ CITATION # _____

INTERVIEW DATE _____ DIAGNOSIS _____ M/F:K-1 _____ K-2 _____ K-3 _____ QT _____ FS _____

Counselor _____ Referrals _____

You are hereby placed on two (2) years probation. It is further ordered that you shall comply with the following conditions of Probation:

(a) Not change your residence or employment or leave the county without first procuring the consent of the Court.
(b) Use no narcotic drugs. Do not use intoxicants of any kind to excess.
(c) Avoid injurious or vicious habits; avoid association with persons of harmful character or bad reputation.
(d) In all respects live honorably, work diligently at a lawful occupation, and support dependents, if any, to the best of your ability, and live within what income is available.
(e) Not carry any weapons without first securing the consent of the Court.
(f) Visit no gambling places.
(g) Live and remain at liberty without violating any law.
(h) Promptly and truthfully answer all inquiries directed by the Court.

You are hereby ordered to attend one (1) diagnostic interview at Hillsborough Community Mental Health Center Alcoholism Services at _____ o'clock on _____ the _____ of _____, 197_____. (Fee: $25.00)

You are hereby ordered to attend the DWI Counterattack School at the Hillsborough Community College, _____ Campus, at _____ o'clock on _____ the _____ of _____, 197_____. (Fee: $30.00)

REPORT IMMEDIATELY TO THE ASAP CENTRAL BREATH TESTING LABORATORY at the south end of the Tampa Police Station, 1710 North Tampa Street, Tampa, Florida 33602 for scheduling. Additional fees will be assessed for missed appointments.

_____ _____
ASAP SCHEDULING OFFICER CLIENT SIGNATURE

During your diagnostic interview, you may be assigned to treatment at the Hillsborough Community Mental Health Center in Group or Chemotherapy or at other treatment programs. You are hereby ordered to enter into and complete any program that you are referred to and to pay any fees that are charged for your treatment. You are also ordered to participate in any follow-up interviews which may be required (at no charge) at six month intervals during the next year.

You are hereby further ordered to attend additional treatment described as follows:

_____ at _____ o'clock on _____ the _____ of _____ 197 _____.

The Court may at any time rescind or modify any of the conditions of this probation, or may extend the period of this probation as authorized by law, or may discharge you. If you violate any of the conditions of this probation, you may be arrested and the Court may revoke this probation and impose any sentence which it may have imposed before placing you on probation.

DONE AND ORDERED in open Court this _____ day of _____ 197_____.

_____
COUNTY COURT JUDGE

DISTRIBUTION:

White: Court of Record
Green: ASAP Phone: 223-8001
Yellow: HCMHC Alc. Svcs. Phone: 238-7411
Pink: DWI Counterattack, Inc. Phone 872-6663
Goldenrod: Defendant

asap
ALCOHOL SAFETY ACTION PROJECT TAMPA

PHASE I

COURT ORDER
IN THE COUNTY COURT IN AND FOR
HILLSBOROUGH COUNTY, STATE OF FLORIDA

TRAFFIC DIVISION

CITATION #_____ DATE OF ARREST _____

NAME _____ AGE _____ RACE _____ SEX _____

DL# _____ SS# _____ DOB _____

ADDRESS (HOME) _____ PHONE (HOME) _____

ADDRESS (BUSINESS) _____ PHONE (BUSINESS) _____

INTERVIEW DATE _____ DIAGNOSIS _____ M/F:K-1 _____ K-2 _____ K-3 _____ QT _____ FS _____

Counselor _____ Referrals _____ _____ _____

You are hereby placed on six (6) months probation. It is further ordered that you shall comply with the following conditions of Probation:

(a) Not change your residence or employment or leave the county without first procuring the consent of the Court.
(b) Use no narcotic drugs. Do not use intoxicants of any kind to excess.
(c) Avoid injurious or vicious habits; avoid association with persons of harmful character or bad reputation.
(d) In all respects live honorably, work diligently at a lawful occupation, and support dependents, if any, to the best of your ability, and live within what income is available.
(e) Not carry any weapons without first securing the consent of the Court.
(f) Visit no gambling places.
(g) Live and remain at liberty without violating any law.
(h) Promptly and truthfully answer all inquiries directed by the Court.

You are hereby ordered to complete one diagnostic interview at _____ _____ , at _____ o'clock on _____ the _____ of _____ , 197 _____ . (Fee $ _____ .)

You are hereby ordered to complete an approved alcohol education course at _____ _____ , at _____ o'clock on _____ the _____ of _____ , 197 _____ . (Fee $ _____ .)

REPORT IMMEDIATELY TO THE SCHEDULING OFFICE at the south end of the Tampa Police Station, 1710 North Tampa Street, Tampa, Florida 33602 for scheduling. Additional fees will be assessed for missed appointments.

_____ SCHEDULING OFFICER

_____ CLIENT

After your diagnostic interview, you may be assigned to treatment. You are hereby ordered to enter into and complete any program that you are referred to and to pay any fees that are charged for your treatment.

The Court may at any time rescind or modify any of the conditions of this probation, or may extend the period of probation as authorized by law, or may discharge you. If you violate any of the conditions of this probation, you may be arrested and the Court may revoke this probation and impose any sentence which it may have imposed before placing you on probation.

DONE AND ORDERED in open Court this _____ day of _____ 197_____ .

_____ COUNTY COURT JUDGE

_____ Judge's Initials — Judicial Concurrence Requested

_____ Judge's Initials — Interview and School Only

_____ Judge's Initials — Interview Only

Your treatment is described as follows:

_____ at _____ o'clock on _____ the _____ of _____ 197 _____ .

DISTRIBUTION:

White: Court of Record
Green: Alcohol Traffic Safety Project
Yellow: Alcohol Rehabilitation/Counseling Agency
Pink: Alcohol Education Agency
Goldenrod: Defendant

PHASE II

COURT ORDER
IN THE COUNTY COURT IN AND FOR
HILLSBOROUGH COUNTY, STATE OF FLORIDA

TRAFFIC DIVISION

CITATION # _____ DATE OF ARREST _____

NAME _____ AGE _____ RACE _____ SEX _____

DL# _____ SS# _____ DOB _____

ADDRESS (HOME) _____ PHONE (HOME) _____

ADDRESS (BUSINESS) _____ PHONE (BUSINESS) _____

INTERVIEW DATE _____ DIAGNOSIS _____ M/F:K-1 _____ K-2 _____ K-3 _____ QT _____ FS _____

Counselor _____ Referrals _____

You are hereby placed on two (2) years probation. It is further ordered that you shall comply with the following conditions of Probation:

(a) Not change your residence or employment or leave the county without first procuring the consent of the Court.
(b) Use no narcotic drugs. Do not use intoxicants of any kind to excess.
(c) Avoid injurious or vicious habits; avoid association with persons of harmful character or bad reputation.
(d) In all respects live honorably, work diligently at a lawful occupation, and support dependents, if any, to the best of your ability, and live within what income is available.
(e) Not carry any weapons without first securing the consent of the Court.
(f) Visit no gambling places.
(g) Live and remain at liberty without violating any law.
(h) Promptly and truthfully answer all inquiries directed by the Court.

You are hereby ordered to complete one diagnostic interview at _____ _____, at _____ o'clock on _____ the _____ of _____, 197 _____. (Fee $ _____.)

REPORT IMMEDIATELY TO THE SCHEDULING OFFICE at the south end of the Tampa Police Station, 1710 North Tampa Street, Tampa, Florida 33602 for scheduling. Additional fees will be assessed for missed appointments.

_____ SCHEDULING OFFICER

_____ CLIENT

After your diagnostic interview, you may be assigned to treatment. You are hereby ordered to enter into and complete any program that you are referred to and to pay any fees that are charged for your treatment.

The Court may at any time rescind or modify any of the conditions of this probation, or may extend the period of probation as authorized by law, or may discharge you. If you violate any of the conditions of this probation, you may be arrested and the Court may revoke this probation and impose any sentence which it may have imposed before placing you on probation.

DONE AND ORDERED in open Court this _____ day of _____ 197_____.

_____ COUNTY COURT JUDGE

Your treatment is described as follows:

_____ at _____ o'clock on _____ the _____ of _____ 197_____

DISTRIBUTION:

White: Court of Record
Green: Alcohol Traffic Safety Project
Yellow: Alcohol Rehabilitation/Counseling Agency
Pink: Alcohol Education Agency
Goldenrod: Defendant

137 135 140

Appendix E

STR Client Follow-up Reminders

ASAP Letter

HCMHC Letter

Charles D. Dunn
PROJECT DIRECTOR

GREATER TAMPA ALCOHOL SAFETY ACTION PROJECT
PHONE (813) 223-8001

August 21, 1976

Ruth Lampl
4596 Madison Street
Tampa, Fla. 33602

Dear Ms. Lampl:

This is to inform you that you should appear for your six-month follow up interview on September 21, 1976 at 9:30 a.m. at the Community Alcoholism Services at 2905 East Henry Street. There will be NO CHARGE for this interview. It will last less than one hour and all information on your case will be kept STRICTLY CONFIDENTIAL and will not be identifiable by your name.

On January 17, 1976 you were ordered by the Hillsborough County Court into ASAP alcohol rehabilitation. About six months ago you attended a diagnostic interview at the Division of Alcoholism Services. At that time, you were informed by your interviewer, and in writing on your court order that follow-up interviews "at six-month intervals during the next year" would be required of you. If you have any questions please call Mr. John Repetosky at 238-7411 or write to Alcoholism Services.

Sincerely,

GREATER TAMPA ALCOHOL
SAFETY ACTION PROJECT

Charles D. Dunn
Project Director

CDD/dj

Mayor Wm. F. Poe

Roderick W. Scudder
PROJECT DIRECTOR

GREATER TAMPA ALCOHOL SAFETY ACTION PROJECT
• PHONE (813) 223-8001

December 3, 1976

Ms. Judy Walters
4596 Madison Street
Tampa, Florida 33602

Dear Ms. Walters:

This is to inform you that you should appear for your twelve-month follow-up interview on December 18, 1976 at 11:30 a.m. at the Community Alcoholism Services at 2905 East Henry Street. There will be NO CHARGE for this interview. It will last less than one hour and all information on your case will be kept STRICTLY CONFIDENTIAL and will not be identifiable by your name.

AFTER YOUR INTERVIEW WE WILL GIVE YOU $10 FOR YOUR COOPERATION.

On December 3, 1975 you were ordered by the Hillsborough County Court into ASAP alcohol rehabilitation. About twelve months ago you attended a diagnostic interview at the Division of Alcoholism Services. At that time, you were informed by your interviewer, and in writing on your court order that follow-up interviews "at six-month intervals during the next year" would be required of you. If you have any questions please call Ms. Michelle Leyland at 238-7411 or write to Alcoholism Services at the address mentioned in the first sentence of this letter.

Sincerely,

GREATER TAMPA ALCOHOL
SAFETY ACTION PROJECT

Ruth Lampl
Judicial/Rehabilitation
Coordinator

RL/gc

HILLSBOROUGH COMMUNITY MENTAL
HEALTH CENTER, INC.
ALCOHOLISM SERVICES N.I.A.A.A.
TELEPHONE 238-7411
2905 E. HENRY AVENUE
TAMPA, FLORIDA 33610

JERRY FLEISCHAKER, M.D.
DIRECTOR
MARIA J. MARTINROE, PhD.
CHIEF CLINICAL PSYCHOLOGIST
ANN Q. FOX, M.S.W.
CHIEF PSYCHIATRIC SOCIAL WORKER
EVE DAVIS KEITH, M.S.W.
PROGRAM DIRECTOR

REV. A. LEON LOWRY
PRESIDENT, BOARD OF DIRECTORS

Dear _____:

This is our second attempt to remind you that you should appear for your six-month follow-up interview on _____ at the Hillsborough Community Mental Health Center, Alcoholism Services at 2905 East Henry Street. There will be NO CHARGE for this interview. It will last less than one hour and all information on your case will be kept STRICTLY CONFIDENTIAL and will not be identifiable by your name.

On _____ you were ordered by the Hillsborough County Court into ASAP alcohol rehabilitation. About six months ago you attended a diagnostic interview at the Division of Alcoholism Services. At that time, you were informed by your interviewer, and in writing on your court order that follow-up interviews "at six-month intervals during the next year" would be required of you. If you have any questions please call Mr. John Repetosky or Michelle Leyland at 238-7411 or write to Alcoholism Services. I remain.

Sincerely,

John Joseph Repetosky
Deputy Director, Alcoholism Services

JJR/ml

APPENDIX F

SUMMARY OF EXPENSES FOR PROVIDING TREATMENT SERVICES

ITEM 1 DWI COUNTERATTACK INC.

ITEM 2 HILLSBOROUGH COMMUNITY MENTAL HEALTH CENTER ALCOHOLISM SERVICES

DWI COUNTERATTACK TAMPA-HILLSBOROUGH, INC.
STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS
TWELVE MONTHS ENDED APRIL 30, 1977

	APRIL	YEAR TO DATE	1976-77 BUDGET
RECEIPTS:			
DWI Student Fees	$ 9,061.60	$129,667.41	$171,240.00
Tampa Plan	--	307.90	
Interest (C.D.'s & Savings)	--	1,271.56	
Misc. Income (Tax Refund)	95.16	184.51	
	$ 9,156.76	$131,431.38	$171,240.00
EXPENSES:			
SALARIES			
Instructors	$ 4,400.00	$ 45,000.00	$ 46,400.00
Aides	980.00	12,060.00	13,920.00
Director	1,450.66	17,733.26	17,408.00
Office Manager	793.88	9,746.45	9,526.53
Executive Secretary	480.00	6,099.67	8,231.81
Cashier/Clerk	587.52	7,134.48	7,050.24
File Clerk	--	2,327.60	4,968.00
Temporary Office Help	--	1,643.60	500.00
Enforcement Coordinator	100.00	1,200.00	1,200.00
Payroll Taxes	830.50	6,460.25	8,000.00
Payroll Adjustments			
Hospitalization	--	--	6,000.00
Pension	144.59	1,859.61	3,647.40
Fire	--	3,507.71	5,613.83
Workman's Compensation	--	292.00	216.14
Liability	--	818.00	587.43
Bond	--	346.05	40.66
Bank Delivery Coverage	--	241.44	173.34
Rent	--	30.00	50.00
Telephone	--	1,617.00	5,392.00
Postage	369.70	3,810.53	3,157.00
Office Equipment Purchases	--	--	2,000.00
Classroom Equipment Purchases	--	--	1,500.00
Office Equipment (Repairs & Maintenance)	--	--	500.00
Classroom Equipment (Repairs & Maintenance)	--	184.24	400.00
Office Supplies	--	--	300.00
Printed Materials (local)	58.45	2,239.46	2,000.00
Literature	--	813.35	2,500.00
Films & Slides Purchases	651.91	2,385.75	6,000.00
Travel Expense (Meetings & Seminars)	124.00	124.00	1,000.00
Travel Expense (local)	--	733.19	1,500.00
Dues	--	375.40	500.00
Recognition Lunches	--	314.50	600.00
Annual Audit	22.40	381.00	500.00
Program Development	--	600.00	400.00
Sinking fund (mortgage retirement)	--	--	6,100.00
Building Loan	--	--	3,000.00
Custodian Service	480.00	2,414.79	--
Contingency Fund	50.00	250.00	--
	--	69.95	357.62
	$11,523.61	$132,813.28	$171,240.00
Excess Receipts (Disbursements)	(2,366.85)	(1,381.90)	--

Hillsborough Community Mental Health Center
Alcoholism Services
DWI Program
Calendar Year 1976

Income and Expense Recap

Income	
Total Income for period	$ 79,582.00
	79,582.00
Expense	
Direct Expense	
Salaries	$ 61,864.79
Health Insurance	1,707.30
Retirement	3,711.89
Payroll Taxes	3,619.12
Travel, Per Diem and Meals	589.20
Rental of Furniture and Equipment	1,559.16
Electric	1,558.20
Telephone	1,299.28
Janitorial Supplies	60.00
Office Supplies	110.72
Postage and Shipping	162.50
Legal Fees	15.00
Maintenance and Repairs - Building	34.83
Small Equipment Purchases	147.84
Other Administrative Expenses	50.00
Direct Expense Total	$ 76,496.83
Indirect Expense	
Indirect Cost (based on 16.1%)	12,315.99
Total Expense	$ 88,812.82
RECAP	
Total Income	$ 76,496.83
Total Expense	88,812.82
Net Surplus (Deficit)	($ 12,315.99)