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AN ANALYSIS OF DRINKER DIAGNOSIS AND REFERRAL ACTIVITY IN COLUMBUS GEORGIA From January, 1972 - December, 1974' Section II - Volume 5

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16. Abstract

The Columbus, Georgia Alcohol Safety Action Project (ASAP) became operational in January 1972 and continued for a three year period. Two additional years of data collection were funded through NHTSA. The ASAP area included Columbus/Muscogee County, Georgia. Richmond County, Georgia was used as a control/comparison area in measuring the extent to which Columbus ASAP achieved its primary objectives: to decrease the number and proportion of DWI crashes.

The Project reported that when data from Richmond are compared with data from Muscogee, it is clear that Columbus ASAP attained its first objective by producing a significant decrease in both the number and proportion of DUI crashes during 1972-1974. While DUI crashes significantly increased in Richmond during these two years, Muscogee DUI crashes were significantly reduced. This reduction seems directly attributable to the presence of Columbus ASAP in Muscogee, since the effects of all other confounding forces but one could be ruled out through the use of Richmond as a control area. One intriguing way in which Columbus ASAP generated this decrease may have been through its impact on the general driving public. Significantly fewer multi-vehicle DUI crashes during the 5:00 p.m. to 3:00 a.m. time period in 1972-1974 indicated increased cautiousness on the part of non-intoxicated drivers toward drivers suspected of intoxication. Thus, the general driving public was apparently attentive to Enforcement and PIE Countermeasures aimed more at the target group of intoxicated drivers, at least attentive enough to define this time period as one of peak threat to them from intoxicated drivers and thus a period in which they were more on the lookout for such drivers.

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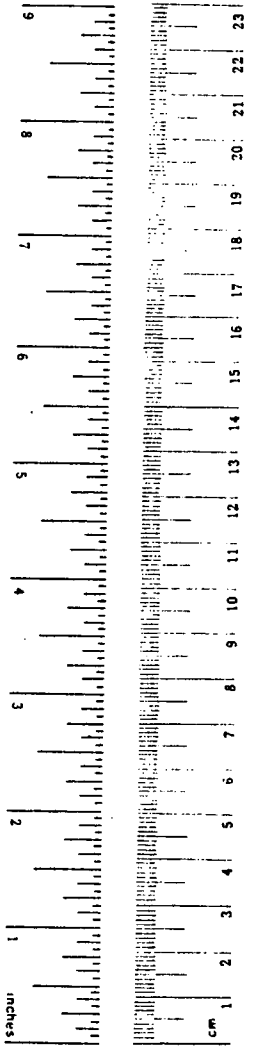
METRIC CONVERSION FACTORS

Approximate Conversions to Metric Measures

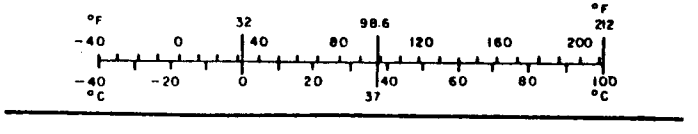
Symbol	When You Know	Multiply by	To Find	Symbol
	LENGTH			
in	inches	*2.5	centimeters	cm
ft	feet	30	centimeters	cm
yd	yards	0.9	meters	m
mi	miles	1.6	kilometers	km
	AREA			
in^2	square inches	6.5	square centimeters	cm^2
ft^2	square feet	0.09	square meters	m^2
yd^2	square yards	0.8	square meters	m^2
mi^2	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
ft^3	cubic feet	0.03	cubic meters	m^3
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			
mm	millimeters	0.04	inches	in
cm	centimeters	0.4	inches	in
m	meters	3.3	feet	ft
m	meters	1.1	yards	yd
km	kilometers	0.6	miles	mi
	AREA			
cm^2	square centimeters	0.16	square inches	in^2
m^2	square meters	1.2	square yards	yd^2
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			
ml	milliliters	0.03	fluid ounces	fl oz
l	liters	2.1	pints	pt
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



A N A L Y T I C S T U D Y 5

AN ANALYSIS OF DRINKER DIAGNOSIS AND REFERRAL ACTIVITY IN COLUMBUS, GEORGIA FROM JANUARY, 1972 - DECEMBER, 1974

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INTRODUCTION

Analytic Study Five describes the judicial/education and rehabilitation system of Columbus-Muscogee County and its relationship to referral and diagnosis activity. The disposition of DUI cases in Recorder's and State Courts are also described as they concern the use of education and treatment sentencing alternatives (referrals). The classification scheme developed and implemented by ASAP in Columbus-Muscogee County is described. The treatment and rehabilitation modalities, developed by ASAP and those which existed prior to ASAP are considered as well. Various distributions by drinking driver classification and other variables by referrals, are described and the implications of these distributions are considered.

Analytic Study Four has provided a detailed description of the judicial system. Therefore, only the salient features of the judicial system will be considered.

I. RECORDER'S COURT

Disposition of all cases involving a DUI charge begins in Recorder's Court. Here an accused can enter a plea of not guilty, guilty or nolo contendere. It is, however, only with pleas of guilty or nolo that a person might enter the education and rehabilitation system from Recorder's Court.[1] Pleas of not guilty will either be dismissed by the Recorder's judge or be bound over to State Court. If a bond forfeiture is accepted by Recorder's Court, the individual will not enter the education and rehabilitation system.[2] (Note Figure 1)

When an individual is convicted of a DUI charge in Recorder's Court, it is solely at the discretion of the judge to sentence or not to sentence the individual to an education or treatment phase.[3] Furthermore, when a Recorder's judge sentences an individual to an education or treatment modality, it is entirely at his discretion as to what phase the individual will attend. Thus, while ASAP developed criteria[4] for making distinctions for various drinking driver types or

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[1] A plea of guilty is in effect a self-conviction. A nolo plea is never (at least in the State of Georgia) accepted as conviction. However, the Recorder's Court in sentencing the individual acts as though a nolo plea were a type of self-conviction.

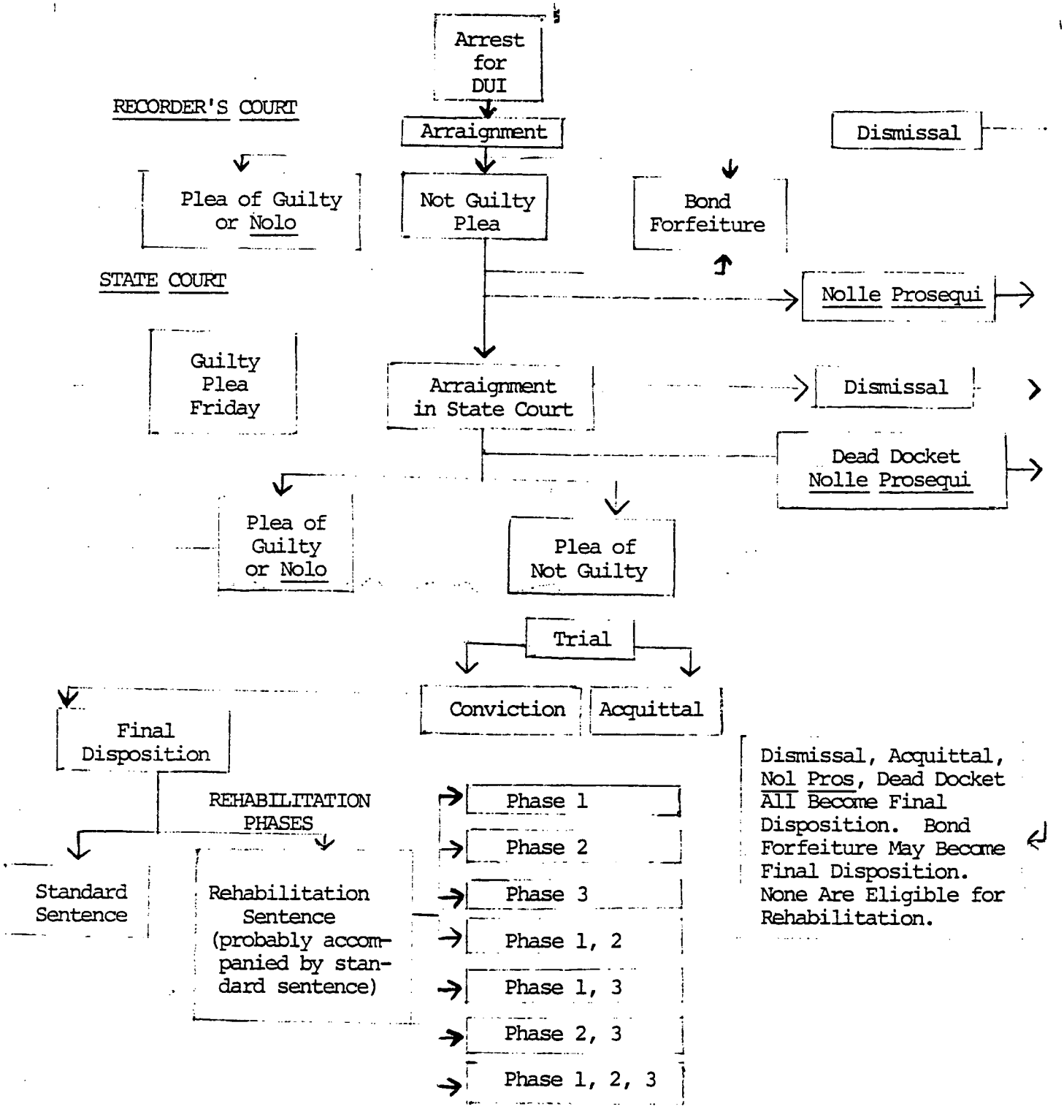
[2] As indicated in Analytic Study Four, if the bond forfeiture is not accepted by Recorder's Court, the accused is forced to enter a plea.

[3] ASAP has been responsible for development of the rehabiliation sentencing alternatives. See Analytic Study Four and subsequent sections of this report.

[4] Classification levels will be considered in a subsequent section of this report. It should be noted that classification of a drinking driver, as opposed to diagnosis, is for the most part an automatic process.

Figure 1

Flow Chart of Movement of DUI Case
Through Columbus Courts



levels, and thereby a means for deciding what education and treatment phase(s) an offender should be referred, the Recorder's judge ultimately makes this determination.[5]

The general procedure followed in Recorder's Court when an education or rehabilitation sentence is imposed is to directly sentence the individual to Phases I, II, or III or a combination of these without a pre-sentence investigation (PSI). Thus, background investigations now are completed only after sentencing, and there is no PSI. It should be noted, however, that during the ASAP operative period PSIs were completed with regard to offenders referred to treatment Phase III.

During the three years of ASAP operations ASAP counselors were responsible for conducting all PSIs and background investigations. The responsibility for all background investigations now has been assumed by Garrard Clinic counselors. It was often the case that whatever recommendations were made by the ASAP counselors as a result of the PSI would be implemented by the Recorder's judge. This, however, was true primarily with regard to rehabilitation recommendations only. It was less true with regard to recommendations that concerned the amount of fine or other punitive measures.[6] This seems still to be the case.

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[5]This is not to denigrate the influence the ASAP counselors may have on the Recorder's Court judge's decision. They may have a substantial influence on his decision. Yet, in the final analysis, it is the judge, solely, who determines what sentence the accused will receive.

[6]There are cases, however, where the court will reduce or waive the fine upon recommendation of the ASAP counselors.

The actual mechanics involved in implementing the rehabilitation sentence in Recorder's Court was and is quite simple: the Recorder's judge provides on paper where, when, and to whom the individual is to report to implement the rehabilitation sentence. This is the procedure irrespective of the phase(s) to which the individual is sentenced. The Phase I, II and III counselors are informed of all dispositions including those involving education and rehabilitation sentences in Recorder's Court. Consequently, they know what individuals to expect as well as when those individuals will report to implement the rehabilitation sentence.

As indicated in Analytic Study Four, however, while an individual can be sentenced to a rehabilitation phase, Recorder's Court has been reluctant to enforce the sentence should the individual refuse to cooperate.[7] The major reason for the Court's reluctance seems to be a concern for the logistics involved in issuing a warrant, arresting, and returning the individual to Court. Wedded to a traditional way of dealing with DUI offenders, which involves essentially a one-time confrontation between the Court and the individual charged with DUI,[8] the Court seems to be disinclined to implement pro-

[7]With regard to Phase I, letters are sent to those individuals who are delinquent in attending the Phase I Traffic Information Program (TIP) warning them of the possibility of contempt charges being brought if they do not comply with the rehabilitation sentence. In fact, however, contempt charges are rarely, if ever, actually brought.

[8]Except for those few cases continued (injury, illness, etc.), the individual is arraigned, either convicted, bounded over to State Court, or the charges are dismissed at a single Court session. This can involve as few as five to ten minutes if an individual is not represented by counsel. A bond forfeiture can often involve less than five minutes.

cedures which could involve them in repeated and extended confrontations or meetings with DUI subjects.

II. STATE COURT

All individuals who are arraigned in State Court on a DUI charge have been bound over from Recorder's Court after a plea of not guilty. An individual may be arraigned in State Court through the Guilty Plea Friday procedure, as explained in Analytic Study Four; or he may be arraigned after having been placed on the State Court's arraignment docket. Upon arraignment the individual can enter one of three pleas: not guilty, guilty, or nolo contendere.

If the plea is not guilty, the Court will either dismiss the charge or the individual will be arraigned sometime in the future for a jury trial.[9] If the individual enters a plea of guilty he, in effect, convicts himself. If a plea of nolo[10] is entered, there is no conviction. However, the State Court in sentencing the individual acts as if a conviction had been obtained. That is, the Court imposes whatever sentence it chooses. Conviction, therefore, by plea or jury, and nolo pleas are the means by which an individual may enter the education and rehabilitation system. Bond forfeitures accepted by the Court, nolle prosequi, cases dead docketed, and cases dismissed never enter this system.

With the initiation of the ASAP program, education and rehabilitation sentencing alternatives were provided State

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[9]The vast majority of trials in Recorder's Court and State Court do not involve jury trials (See Analytic Study Four).

[10]It is at the pleasure or discretion of the Court to accept or reject nolo pleas.

Court. Throughout the ASAP operative period, though, State Court often elected not to use the ASAP developed education and rehabilitation programs. From June, 1973 - March, 1974, this was the case, with few DUI cases sentenced to any ASAP provided education or rehabilitation modalities. At the end of the ASAP operational years, however, there was some indication that there has been an increased commitment in the use of education and treatment modalities by State Court (see Analytic Study Four).

It should be noted, though, that State Court, like Recorder's, is not bound to use the drinker classification criteria established by ASAP with regard to referrals. Thus, the use of the criteria is entirely at the discretion of the court. Also, like Recorder's Court, when an individual is referred there is no assurance that the individual will participate in the referral program(s). It is true, however, that if an individual is sentenced to an education or rehabilitation phase(s) and refuses to cooperate, the State Court will be inclined to impose a harsher sentence with any subsequent DUI conviction.

Once an individual has been sentenced to an educational or treatment phase(s), a counselor will be present in State Court to advise the individual where, when, and to whom he should report. State Court directly assigns individuals to Phase I, (no PSI or background investigations are conducted). However, when the Court imposes a referral sentence which involves treatment or rehabilitation phases (i.e. Phases II or III), the individual is assigned to Garrard Clinic counselors (when ASAP

was operative, ASAP counselors), who determine whether the individual should attend Phases II and/or III. The State Court procedure does not, therefore, involve continuing a case for pre-sentence investigation. Rather, the individual is sentenced at the time of conviction and a background investigation is completed later.

SUMMARY AND COMPARISON OF RECORDER'S COURT AND STATE COURT

An individual can enter the education and rehabilitation system only upon conviction. This is true for both courts. It is also the case that a nolo plea, while not technically a conviction in either court, is considered as one in both. Neither court is required to refer, and neither is required to follow the drinking driver criteria when assigning subjects to education or rehabilitation phases. When a subject is assigned to an education or treatment modality in Recorder's Court he is informed in writing to whom and where he is to report. When an individual is referred in State Court, counselors are present to inform the individual to whom he should report and where. Recorder's Court assigns subjects directly to Phase I, II, and III. State Court assigns subjects directly to Phase I only. Whether an individual attends Phase II and/or III is determined by Garrard Clinic counselors after the subject has been assigned to them for a background investigation. Neither Court has shown much inclination to prosecute those subjects who default on their education or rehabilitation sentence. Neither Court uses anything approaching a random selection process in assigning

individuals to treatment or control groups. Neither court orders PSIs, but may order background investigations.

III. DRINKING DRIVER CLASSIFICATION

With the beginning of the ASAP program, criteria were established by which the courts and those persons working directly with drinking drivers could readily classify or distinguish these into two types - problem drinking drivers and non-problem drinking drivers. Thus, an expedient means was established by which it was possible to quickly determine to which education or rehabilitation phase a driver should be assigned. It should be recognized that the classification scheme established by ASAP was never intended as a diagnostic tool. Rather it should be seen as a screening device which can be quickly learned and implemented by those concerned with the classification process. Moreover, the information needed to classify a drinking driver was and is readily available and easily interpretable.

The criteria for classifying drinking drivers was modified after being initially implemented in January, 1972. From January, 1972 - June, 1973, the following criteria were employed: if a drinking driver had a BAC of less than .20 and no DUI[11] arrest within the previous three-year period he was classified as a non-problem drinking driver (non-PDD); an individual who had a BAC greater than .19 and/or one or more DUI arrests within the previous three-year period was classified as a problem drinking driver (PDD). Note that either BAC

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[11] The Detailed Operational Plan on page 4.1 reads, "A/R arrest." However, the criterion used was DUI arrest and not A/R arrest.

or the previous DUI record could have been a sufficient condition for classifying a drinking driver as a PDD. Both conditions were not necessary.

Modified criteria was adopted July, 1973. From then to the present the following criteria has been employed: a non-problem drinking driver is classified or defined as a driver with a BAC of less than .15 and no A/R arrest[12] within the previous three-year period. A problem drinking driver is anyone with a BAC greater than .15 and/or one or more A/R arrests within the previous three-year period. However, there are two PDD classification levels. The least severe PDD is defined as having a BAC from .15 -.24 and/or two or fewer A/R arrests within the previous three-year period. The more severe PDD is defined as an individual with a BAC greater than .24 and three or more A/R arrests within the previous three year period. It should be noted that either BAC or previous arrest record may be a sufficient condition for a driver to meet the PDD criteria. Again, both are not necessary conditions.

Analogous to the classification of drinking driver as non-PDD's, less severe PDD's, or more severe PDD's, it is more common to refer to them as level I, level II or level III drinking drivers. That is, a level I drinking driver is the same as a non-PDD; a level II drinking driver is the same as a less severe PDD; and a level III drinking driver is the same

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[12] Note that the new criterion reads A/R arrest and not DUI arrest.

as a more severe PDD.[13] While there is some congruency in the classification schemes, driver levels over classification criterion are not considered to be analogous.

Using the classification scheme as intended, a level I drinking driver would be assigned to Phase I, a level II drinking driver to Phases I and II, and a level III drinking driver to Phases I, II, and III. As already indicated, however, Recorder's and State Court judges were not obliged to follow classification criterion with regard to referrals.

A drinking driver is classified as an unidentified drinking driver (UI) if his BAC and his previous DUI record are unknown. Actually, if the previous DUI record indicates no DUI offenses in the previous three-year period, and the BAC is unknown, the driver will also be classified as unidentified. Therefore, either when the previous DUI history is unknown or there are no DUI arrests in the previous three-year period and this is accompanied by an unknown BAC,[14] the drinking driver will be classified as unknown(UI). It should be noted that if BAC data is known, the drinking driver will always be classified, whether the previous DUI arrest record is available or not.

It should be recognized that prior to ASAP's inception, there was no drinking driver classification process in the Columbus court systems. ASAP not only developed such a classification process, but facilitated its use by insuring that all

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[13]It is often the case to refer to a PDD as a level II or level III PDD.

[14]A BAC may be unknown for essentially two reasons: it may have never been analyzed (i.e. the driver refused), or it may have been lost (usually a blood test).

TABLE 1

Mortimer-Filkins
Score Values

	0-59	60-85	86-114	
I	5	0	0	5
II	55	29	12	96
III	3	2	2	7
	63	31	14	108

Gamma = .548, $p < .009$

requisite information be readily available to the courts. Furthermore, to prevent any classification bias,[15] the classification scheme was designed so as to be essentially an automatic process. That is, no subjective judgement is required to classify a DUI subject.

Evaluation of the Classification Criterion

An objective attempt was made to evaluate the validity of the classification scheme second criterion in an effort to determine if it produced reliable classification results. The only objective determinate available as to the degree of the drinking problems was a few Mortimer-Filkins scores on some subjects. Unfortunately, not all subjects for which M-F scores had been obtained could be classified into drinking driver level because the requisite information was not available. Both scores and requisite classification data, though, was available for 108 subjects. Results of the test of association are indicated in Table 1.

The test of association, gamma, is significant ($p < .009$) and indicates an association between M-F scores and drinking driver levels obtained by the classification scheme second criterion. It must be noted, however, that there is a large discrepancy in drinking driver levels I and III and II. Ideally it would have been hoped that the number of drinking drivers for each level would have been the same. The trichotomization of the M-F scores

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[15] Bias means here racial, sexual, aged or occupational bias.

was suggested by M-F interpretation guidelines with the lower the score the less chance that there was a drinking problem. The score intervals were interpreted as follows: those persons in the 0-59 intervals do not have a drinking problem; those in the 60-85 interval may have a drinking problem; and those in the 86-114 interval arejudged to have a drinking problem.

Table 1 indicates that all persons classified as a drinking driver level I had a M-F score in the 0-59 interval. However, drinking drivers classified as level II had M-F scores in all of the score intervals. If it is assumed that it is acceptable to classify subjects as having a more severe drinking problem than indicated by the M-F score then those 55 subjects who fall in the level II/0-59 cell would not be considered as an error of classification. That is, the classification system would make an error, but the error would be in the conservative direction. Those twelve individuals who fall into the level II/86-114 cell, however, represent an error in the wrong direction. Here the M-F score indicates a severe drinking problem while the classification system classifies the subject as a level II drinking driver. Thus, the error here is not in an acceptable direction. It should be noted, though, that in no instances where a subject obtained a M-F score in the 60-86 or 86-114 interval was he classified as a non-PDD (i.e., level I drinking driver).

The conclusion here is that the classification system second criterion <u>may</u> provide a reliable means of rapidly classifying

drinking drivers with a reasonable degree of accuracy. Judgement would have to be reserved, however, until additional testing could be conducted especially with higher numbers of level I and level III drinking drivers. If additional testing should indicate essentially the same results, then the major error would seem to be a conservative one. Moreover, should the same results obtain, the classification system would provide a quick means of classifying drinking drivers into a dichotomy of PDD and non-PDDs. Drinking drivers classified as problem drinkers (i.e. levels II and III) could then undergo additonal evaluation and testing to ascertain if they actually had a drinking problem (i.e. check for a conservative error), and if there was a drinking problem, determine the extent of it.

IV. EDUCATION AND TREATMENT MODALITIES

Phase I

Phase I, also known as the Traffic Information Program (TIP), is appropriate for drinking drivers at all three levels, although for those drinking drivers who meet level II and/or level III criteria subsequent levels of rehabilitation should also be attended. Phase I classes meet for two hours per session, two times a week for two weeks.[16]

Phase I should be viewed as an educational rather than a treatment process. For non-PDD's and level II and level III drinking drivers, an attempt is made to acquaint the individual with the dangers associated with drinking and driving. That is, the drinking driver is informed of the increased risk he takes and dangers he subjects himself to when he drives after drinking. It is hoped that by informing the drinking driver of these, he will modify his behavior (i.e., either he will not drink and drive or he will moderate his drinking and driving behavior) such as to minimize or reduce this danger to himself and others. It is recognized that the educational process for those persons classified as level II and level III drinking drivers will very likely not be sufficient to modify behavior since these individuals probably have a drinking problem. Thus, Phase I also attempts to help these persons determine if they actually do have a problem with alcohol, and

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[16] In 1972 Phase I met four times per week, while in 1973 it met five times a week. In 1972 it met three times a week for three hour sessions.

if this is the case, advises them of the various agencies available to assist them. In addition, the level II and level III drinking driver is exposed during the process of Phase I to basic information such as terms (BAC, etc.) and definitions (social drinker, problem drinker, alcoholic, etc.) which will be helpful to him should he attend Phases II and III.

The curriculum includes the following:

1. the effect of alcohol on driver attitude
2. the relationship of alcohol to fatal accidents
3. definition of BAC
4. the presumptive level of alcohol intoxication in the state of Georgia
5. driver reaction time and its association with the amount of alcohol consumed
6. the effect of alcohol on the physiology of the body
7. experimental, social and recreational, seeking, dysfunctional and suicidal relationships to alcohol
8. definition of social, problem drinker and alcoholic and the difference between each
9. symptoms of a problem drinker and an alcoholic
10. strategies the individual may employ to avoid situations where he is likely to drink excessively

Lectures and films are the usual procedures employed in the presentation of Phase I material. This is followed by a discussion and question and answer session of the important

points of the lecture or film. Guest speakers[17] may also be invited to address the Phase I group.

Phase I sessions, as indicated above, are held at the group level. They are not segregated by drinker type nor by any other criteria. If an individual completes Phase I and is convicted on a subsequent DUI charge, it is not likely that he will be assigned to Phase I again. Appendix A provides a course outline for Phase I.

The cost presently associated with TIP school is $16 per student (note subsequent chapter of this report for cost breakdown during the ASAP operative period). In August, 1974 Columbus College, a four year state college, assumed the responsibility of Phase I. The $16 fee is to cover expenses associated with operating TIP school by the college. This cost is paid by the city of Columbus which has increased Recorder's Court fines from $127 (first offense) to $152. Since July, 1974, then, Phase I has not required NHTSA funding in order to be maintained.

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[17]Guest speakers often include staff members of the various agencies that are available to assist persons with alcohol problems.

Phase II

Phase II provides a therapy regimen for those problem drinking drivers (PDD) classified as level II drinking drivers. As previously indicated a level II PDD is judged to have a less severe drinking problem than a level III PDD.

Phase II was initiated in July, 1973 as a component of the Department of Public Health, although it was completely funded by ASAP through September, 1974. Moreover, the Columbus ASAP was completely responsible for the formulation and implementation of the Phase II program. Phase II personnel as Garrard Clinic counselors are responsible to the Director of the Garrard Clinic, a division of the Department of Public Health, but during the ASAP operative period Phase II was an entirely separate program and maintained a separate staff.[18] There was, however, some interaction between Phase II and Garrard Clinic staffs with regard to inservice training during this period. Further, Garrard Clinic personnel made use of Phase II clients' files and administered medication to Phase II clients who required it. Also, interaction occurred when a client attended Phase II and Phase III at Garrard Clinic simultaneously. Presently Phase II is a component of Garrard Clinic (not separate as during the ASAP years), and the same staff is used to operate both Phases II and III. Garrard Clinic has eleven members.

Phase II operations began in June, 1973 and the staff

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[18] Phase II staff consisted of two counselors and one secretary.

remained the same with regard to personnel and size during the ASAP operational years. Prior to the initiation of the Phase II program, the Phase II staff was essentially concerned with pre-sentence investigations (PSI) and background investigations and individual counseling. With the initiation of the Phase II program, individual counseling was largely replaced by group counseling. The Phase II staff, however, was still responsible for all PSI and background investigations. Moreover, as indicated in Analytic Study Four, it was the Phase II staff during the ASAP operative period which was ultimately responsible for deciding which of those individuals sent from State Court attended Phase II or Phase III. Garrard Clinic counselors have this responsibility now.

During the ASAP operative period the Phase II group counseling program consisted of twenty-one hours of group therapy over a seven-week period. With each session three hours in length, the general philosophy of Phase II was one of education as opposed to treatment or rehabilitation. Obviously, the primary objective of the program was to prevent or reduce the extent of drinking and driving by those individuals who completed the Phase II program. In striving to achieve this objective the following were emphasized:

(1) The individual should attempt to recognize the goals in life which he has established for himself.

(2) The individual should become aware of his relationship to alcohol and how it affects his life including, his family, his work, and his interaction with others.

(3) The individual should strive to develop an alternative coping behavior to situations of stress other than drinking and driving.

(4) The individual should develop a positive decision-making process whereby both the positive and negative consequences of his decision will be taken into account.

(5) It is hoped that the individual will, through the above, be able to increase his level of self-esteem.

(6) It is hoped that the individual will develop positive attitudes toward himself and society.

Once the individual was clear as to what his goals in life were, he was asked to look at his behavior and ascertain whether it was likely to help or prevent the achievement of his goals. Moreover, concerning goals, the individual was urged and assisted in setting realistic goals. He was confronted with his risk-taking behavior in order to determine if he had accurately assessed the risk associated with this behavior. Finally, the relationship of the individual to alcohol was examined and an effort was made to see how this relationship was viewed juxtapositioned to that of the individual's life goals. The individual was forced to view this justaposition and to see that in order to attain his life goals, his relationship to alcohol might have to be changed or modified. According to the Director of Garrard Clinic the extant Phase II regimen is essentially as it was during the ASAP period. It is now somewhat shorter, however, but according to the director the objectives and emphasis remain unchanged.

It should be noted that during the ASAP operational years if an individual attended Phase II he would have very likely attended Phase I (TIP) as well. However, as with TIP, rarely would an individual ever attend Phase II a second time.

Presently an individual who attends Phase II does not necessarily have to have also attended Phase I. Like the ASAP years, though, once a person attends Phase II he will probably not attend a second time.

Phase III

Phase III consists of a number of treatment modalities including Garrard Clinic, Benning House, Family Counseling, Alcoholics Anonymous, and Central State Hospital. Since the vast majority of Phase III drinking drivers attend Garrard Clinic, the descriptive effort here will concern Garrard Clinic. Also, a comparison will be made of Garrard Clinic and Phases I and II. Garrard Clinic, in contrast to Phase I and II, is and was not funded through ASAP,[19] although its funding is a direct result of the ASAP program in Columbus.[20] It should be noted that Phase III is essentially as it was during the ASAP operative years.

Unlike Phases I and II, fewer than one-fourth of the referrals to Garrard Clinic are DUI offenders. While the court may refer these, and individuals convicted of other types of alcohol-related offenses, in fact, the substantial portion of referrals to the Clinic are either by physicians or social agencies or are self-referrals.

In contrast to Phases I and II, which are conducted over a specific period of time, the duration of treatment at Garrard Clinic does not involve completion of a treatment regimen within a specific time interval. Treatment lasts until

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[19] Garrard Clinic is funded through the National Institute of Alcohol Abuse and Alcoholism.

[20] Garrard Clinic existed before the implementation of the ASAP program. However, the size of its operation was substantially less than its present program.

the client withdraws, or the client's behavior with regard to alcohol is modified or conforms to an acceptable level.

Treatment sessions (other than medication) are held at the group level. Initially (first two weeks), sessions are held every day for one hour. Then the number is reduced to one session a week. Most of the sessions are held during the day, although some are held in the evenings and on weekends. This contrasts with Phase I and Phase II (at least during the ASAP years) where all (Phase I) or most (Phase II) of the group sessions are or were held in the evenings. Garrard Clinic does not have in-patient facilities.

In general two types of medication comprise the drug regimen of Garrard Clinic, sedative and antiabusal. This is another difference in procedure between Garrard Clinic and Phase I and for the most part Phase II. The Phase I treatment regimen does not include medication while that of Phase II provides for its use only to a limited degree.

Determination of the degree of the drinking problem, according to the Director of Garrard Clinic, is essentially through subjective means. This is also the approach used in Phase II presently; however, Phase II during the ASAP operative period employed the Tennessee Self Concept Scale and the Mortimer-Filkins to some extent.

Garrard Clinic and Phase I and II also differ in that Garrard Clinic group sessions are open while Phases I and II sessions are closed. That is, Garrard Clinic group sessions may have a continually changing membership with some persons

added to the group and some persons dropped. Phase I and II group sessions may lose members, because of drop-outs, but new members will not be added. Perhaps it is because of the variable treatment length of the Garrard Clinic treatment regimen that they employ open-group sessions, while Phase I and II conduct closed groups because of fixed-length program.

Much of the group counseling at Garrard Clinic is conducted by individuals such as ministers, whose profession ordinarily exposes them to counseling responsibilities. These are in addition to full-time Garrard Clinic staff members. Garrard Clinic provides in-service training for these persons as well as for its own staff. Phases I and II, of course, use full-time staff members for all group counseling activities, although guest speakers are often invited to speak to group sessions.

Finally, it should be noted that all education and treatment phases extant during the ASAP operative years are still functional and available as sentencing alternatives to the court system.

V. COST OF REFERRAL AND DIAGNOSIS ACTIVITY

Cost associated with the operation of Phases I and II as well as PSIs and background investigations over the ASAP operative period was $122,245.64. No cost were involved with the operation of Phase III. Phase I accounted for $60,315.06 while Phase II, PSIs and background investigations accounted for $61,930.58.

A total of 2367 persons completed Phase I over the ASAP operative period. The cost per completion then was $25.39.

Phase II, PSIs, and background investigation cost are not easily determined because ASAP counselor's who were responsible for conducting Phase II were also responsible for PSIs and background investigations. The formula followed here in determining the cost of completing PSIs and background investigations is based upon the fact that approximately 50 percent of the ASAP counselor's time over the three year period was spent in conducting these. Thus the basic figure is 50 percent of $61,930.58 or $30,965.29 for conducting the PSIs and background investigations. The number of PSIs and background investigations was 417. Therefore, the cost associated with each PSI or background investigation was $74.26. The only other cost associated with PSIs and background investigations over the ASAP operative years was $700 for several psychological examinations. When physical examinations were required they were provided without charge.

Phase II, as previously noted, was operative only the last 18 months of the ASAP program. The operation of Phase II

required about 50 percent of the ASAP counselor's time during the last 18 months of ASAP operations. Hence the basic cost was 50 percent of the total figure for Phase II, PSIs and background investigations for the last 18 months. Total operating cost for these over the final 18 months was $28,514.50. Therefore, total cost for Phase II was $14,257.25. The number of Phase II completions was 108, hence the cost per completion was $132.01.

It is obvious that since funding for Phase I, Phase II, PSIs and background investigations was a fixed amount, the cost per completion was directly dependent upon the volume of cases. Thus, the higher the volume of cases the lower the cost would have been per case while the fewer the higher the cost would have been. Consequently, during the ASAP operative period PSIs, background investigations and Phase II completion were relatively expensive because the volume ordered or referred by the courts was low.

An alternative means of managing PSIs, background investigations and Phase II could have been to contract each case out as a specific amount per case (assuming these resources were available of course). With a relatively low number of cases this may be the preferred form of management. If the volume is high it may be just as inexpensive, however, to complete all cases with a hired staff.

Unfortunately, it is often difficult to determine before hand the court's commitment to these types of activities. Furthermore, this commitment may be highly capricious as

evidence by State Court. If some agreement and commitment level, however, could be reached with the courts before the implimentation of these activities perhaps, then, a decision could be made as to what management procedure to follow. Short of inducing the courts to refer and order PSIs and background investigations by paying them on a per case basis, there is probably no easy means of determining what the case volume would be and, consequently, no easy solution to the problem.

VI. ANALYSIS

The analysis provided in Analytic Study Five considers several distributions. These concern only the operational period of the Columbus ASAP from January, 1972 - December, 1974. The distributions in this report consider the use of alternative sentencing or referrals by phase, year, race, sex, age, BAC, civilian/military occupation, and drinking driver level by quarter. There was a total of 25 distributions considered. In general, only significant results are presented in table form, although reference is made to all of the distributions. All distributions are based upon the entire population of DUI cases for the three year operational period.

Referrals

Tables 2 and 3 show referral by phase or phase combination in Recorder's and State Courts. It is obvious from tables 2 and 3 that the bulk of referrals were made to Phase I. In the case of Recorder's Court this was the case about 90 percent of the time and in State Court about 86 percent. Thus, when alternative sentences were employed by the courts they for the most part involved Phase I only. In both Recorder's and State Courts the second most likely sentencing alternative employed was a combination of Phases I and II, but this was employed only about 5 percent of the time in both courts. As would be expected Phases II and III and combinations involving these were employed more often with PDDs than with non-PDDs.

TABLE 2

Referral
Recorder's Court
Drinker Level
By Phase
January, 1972 - December, 1974

Phase	Drinker Level PDD	Non-PDD	L/I	Total	Total
I	675 (74.9%)	1188 (98.9%)	272 (96.5%)	2135	(89.5%)
II	15 (1.7%)	2 (.2%)	1 (.3%)	18	(.8%)
III	80 (8.9%)	3 (.2%)	1 (.3%)	84	(3.5%)
I & II	113 (12.5%)	6 (.5%)	7 (2.5%)	126	(5.3%)
I & III	15 (1.7%)	2 (.2%)	1 (.3%)	18	(.8%)
II & III	2 (.2%)	0 (0 %)	0 (0 %)	2	(.1%)
I, II & III	1 (.1%)	0 (0 %)	0 (0 %)	1	(.1%)
	901	1201	282	2384	

TABLE 3

Referral
State Court
Drinker Level
By Phase
January, 1972 - December 1974

Phase*	Drinker Level PDD	Non-PDD	L/I	Total	Total
I	374 (67.6%)	861 (97.8%)	7 (63.6%)	1242	(86.0%)
II	34 (6.1%)	9 (1.0%)	3 (27.3%)	46	(3.2%)
III	43 (7.8%)	6 (.7%)	1 (9.1%)	50	(3.5%)
I & II	78 (14.1%)	1 (.1%)	0 (0 %)	79	(5.5%)
I & III	20 (3.6%)	3 (.3%)	0 (0 %)	23	(1.6%)
II & III	4 (0.7%)	0 (0 %)	0 (0 %)	4	(.3%)
	553 (99.9%)	880 (99.9%)	11 (100 %)	1444	

*There are no records of referral to Phases I, II and III in State Court.

Table 4 presents referral by year in Recorder's Court ($p < .001$). As indicated in table 4 referral activity for the last ASAP operational year declined from the first. Table 4 also indicates that 1973 was the year of greatest referral activity with a sharp decline in referrals in the final year. Table 5 indicates referral activity in State Court by years ($p < .001$). Comparing the first with the last year there was a decided lack of referrals in the final year. As opposed to Recorder's Court, however, 1973 rather than 1974 was the year of lowest referral activity in State Court. Overall comparing Recorder's with State Court, the Recorder's Court referred about 63 percent of the cases disposed of in that court while State Court referred about 40 percent of the cases it disposed of.

With regard to race, sex, and age, there were no statistically significant differences in either court concerning referral activity. In both courts, then, whites were no more likely to be referred than blacks, nor males than females, nor younger offenders than older. The overall referral rate for each of these was about 63 percent in Recorder's Court and about 40 percent in State.

Table 6 shows referral by BAC in Recorder's Court ($p < .001$). With the exception of the 01-09 category, those persons in the higher two BAC categories were less likely to be referred than those in the lower. Table 7 indicates referral by BAC in State Court ($p < .001$). The referral pattern fluctuates with regard to the various categories with the

TABLE 4

Referral
Recorder's Court
By Year
January, 1972 - December, 1974

	1972	1973	1974	Total
Referred	890 (62.5%)	916 (72.1%)	578 (52.1%)	2384 (62.7%)
Not Referred	535 (37.5%)	355 (27.9%)	531 (47.9%)	1421 (37.3%)
Total	1425 (100.0%)	1271 (100.0%)	1109 (100.0%)	3805

Chi-square = 100.777, $p < .001$ with 2 df.

TABLE 5

Referral
State Court
By Year
January, 1972 - December, 1974

	1972	1973	1974	Total
Referred	927 (60.2%)	280 (20.5%)	237 (32.9%)	1444 (39.8%)
Not Referred	612 (39.8%)	1089 (79.5%)	483 (67.1%)	2184 (60.2%)
Total	1539 (100.0%)	1369 (100.0%)	720 (100.0%)	3628

Chi-square = 496.306, $p < .001$ with 2 df.

TABLE 6

Referral
Recorder's Court
By BAC
January, 1972 - December, 1974

	01-09	10-14	15-19	20-24	25 +	Total
Referred	7 (38.9%)	1134 (61.3%)	792 (67.2%)	252 (60.0%)	65 (54.6%)	2250 (62.7%)
Not Referred	11 (61.1%)	716 (38.7%)	387 (32.8%)	168 (40.0%)	54 (45.4%)	1336 (37.3%)
Total	18 (100.0%)	1850 (100.0%)	1179 (100.0%)	420 (100.0%)	119 (100.0%)	3586

Chi-square = 20.653, $p < .001$ with 4 df.

TABLE 7

Referral
State Court
By BAC
January, 1972 - December, 1974

	.10-.14	.15-.19	.20-.24	.25+	Total
Referred	581 (41.9%)	469 (36.5%)	230 (52.6%)	70 (47.9%)	1350 (41.5%)
Not Referred	804 (58.1%)	815 (63.5%)	207 (47.4%)	76 (52.1%)	1902 (58.5%)
Total	1385 (100.0%)	1284 (100.0%)	437 (100.0%)	146 (100.0%)	3252

Chi-square = 37.999, $p < .001$ with 3 df.

greatest proportion of referrals in the 20-24 category and the lowest in the 15-19. However, table 7 does indicate that there was a propensity to refer in greater proportion those offenders in the higher two BAC categories than those in the lower two.

There was no significant differences with regard to referral by civilian/military occupation in either court. Thus, those with civilian occupations were no more likely to be referred than those with military.

Tables 8 and 9 present referrals in Recorder's Court and State Courts for drinking driver level I first criterion ($p < .001$, both tables). In Recorder's Court referral activity was greater the last two quarters than the first two. The highest referral activity, however, occurred in quarters three and four. It should be remembered that ASAP referral options were not available to the Courts until late February, 1972 so this could account for the lower referral level during quarters one and two.

Table 9 indicates that quarters one and two were the quarters of greatest referral activity in State Court which is just the opposite of Recorder's Court. However, there was a sharp decline in referral activity in quarters five and six following quarters one through four. From table 9 (and table 5) it is obvious that the first ASAP operational year was the year of maximum referral activity by State Court. If the trend continues with regard to those cases unresolved in State Court there will have been a decided decrease in referral activity in

TABLE 8

Referral
Recorder's Court
By Driver Level
By Quarter
Level I

	1-2	3-4	5-6	Total
Referred	203 (50.0%)	391 (75.0%)	210 (71.4%)	804 (65.8%)
Not Referred	203 (50.0%)	130 (25.0%)	84 (28.6%)	417 (34.2%)
Total	406 (100.0%)	521 (100.0%)	294 (100.0%)	1221

Chi-square = 69.023, $p < .001$ with 2 df.

TABLE 9

Referral
State Court
By Driver Level
By Quarter
Level I

	1-2	3-4	5-6	Total
Referred	217 (53.7%)	275 (53.6%)	95 (33.0%)	587 (48.7%)
Not Referred	187 (46.3%)	238 (46.4%)	193 (67.0%)	618 (51.3%)
Total	404 (100.0%)	513 (100.0%)	288 (100.0%)	1205

Chi-square = 37.471, $p < .001$ with 2 df.

State Court the last two ASAP operational years.

Table 10 provides referral by drinking driver level III first criterion in Recorder's Court. Referrals increased over the quarters almost exactly as with drinking driver level I (note table 8). That is, referrals increased substantially in the third and fourth quarters but declined in the fifth and sixth. Again it should be noted that the ASAP referral options did not become available to the court until the latter part of February, 1972. Referral activity by drinking driver level III first criterion was not significant in State Court.

Table 11 presents referral by drinking driver level I second criterion in Recorder's Court ($p < .001$). From table 11 it is obvious that there has been a steady erosion of the referral process in Recorder's Court over the quarters. From quarters seven and eight through quarters eleven and twelve, representing July, 1973 - December, 1974, the proportion of referrals has decreased almost 18 percent.

Table 12 presents referral activity in State Court for drinking driver level I second criterion ($p < .001$). While the overall referral rate is low there has been an increase in referral activity from quarters seven and eight through quarters eleven and twleve. This is just the opposite of Recorder's Court, yet even with the increase in referral activity in State Court the overall referral rate is still substantially lower than in Recorder's Court for drinking driver level I second criterion. Moreover, the actual number of

TABLE 10

Referral
Recorder's Court
By Driver Level
By Quarter
Level III

	1-2	3-4	5-6	Total
Referred	64 (44.8%)	155 (67.7%)	123 (61.8%)	342 (59.9%)
Not Referred	79 (55.2%)	74 (32.3%)	76 (38.2%)	229 (40.1%)
Total	143 (100.0%)	229 (100.0%)	199 (100.0%)	571

Chi-square = 19.734, $p < .001$ with 2 df.

TABLE 11

Referral
Recorder's Court
By Driver Level
By Quarter
Level I

	7-8	9-10	11-12	Total
Referred	135 (68.9%)	139 (54.9%)	119 (51.1%)	393 (57.6%)
Not Referred	61 (31.1%)	114 (45.1%)	114 (48.9%)	289 (42.4%)
Total	196 (100.0%)	253 (100.0%)	233 (100.0%)	682

Chi-square = 15.006, $p < .001$ with 2 df.

TABLE 12

Referral
State Court
By Driver Level
By Quarter
Level I

	7-8	9-10	11-12	Total
Referred	7 (5.9%)	30 (19.1%)	20 (35.7%)	57 (17.2%)
Not Referred	112 (94.1%)	127 (80.9%)	36 (64.3%)	275 (82.8%)
Total	119 (100.0%)	157 (100.0%)	56 (100.0%)	332

Chi-square = 24.619, $p < .001$ with 2 df.

TABLE 13

Referral
Recorder's Court
By Driver Level
By Quarter
Level II

	7-8	9-10	11-12	Total
Referred	226 (76.1%)	179 (57.9%)	79 (47.0%)	484 (62.5%)
Not Referred	71 (23.9%)	130 (42.1%)	89 (53.0%)	290 (37.5%)
Total	297 (100.0%)	309 (100.0%)	168 (100.0%)	774

Chi-square = 43.365, $p < .001$ with 2 df.

TABLE 14

Referral
State Court
By Driver Level
By Quarter
Level II

	7-8	9-10	11-12	Total
Referred	36 (11.7%)	81 (23.8%)	41 (48.2%)	158 (21.6%)
Not Referred	271 (88.3%)	260 (76.2%)	44 (51.8%)	575 (78.4%)
Total	307 (100.0%)	341 (100.0%)	85 (100.0%)	733

Chi-square = 54.298, $p < .001$ with 2 df.

offenders referred is much smaller than Recorder's Court.

Table 13 provides referral in Recorder's Court for drinking driver level II second criterion ($p < .001$). Again there is a steady, unmistakable decline in referral activity over the quarters. Here, however, the difference is even more pronounced than with drinking driver level I second criterion. There is a proportional decline of almost 30 percent from quarter seven and eight through quarters eleven and twelve.

Table 14 presents referral activity in State Court for drinking driver level II second criterion ($p < .001$). Of the cases disposed of in that court there has been a steady increase over the quarters which is opposite the trend in Recorder's Court. From quarters seven and eight through quarters eleven and twelve there has been a 36.5 percent increase in referrals. In addition, by the end of the ASAP operational quarters (quarters eleven and twelve) the proportional overall referral rate in State Court exceeded that of Recorder's Court for drinking driver level II second criterion. Still, however, the actual number of persons referred is much smaller than the number referred in Recorder's Court.

Tables 15 and 16 present referrals by Recorder's and State Courts for driver level III second criterion ($p < .001$, both tables). In Recorder's Court there has been again a decline in the referral activity of that court. From quarters seven and eight through quarters eleven and twelve there has been a substantial reduction in the referral rate with a 52 percent decrease. Again just the opposite is true in State

TABLE 15

Referral
Recorder's Court
By Driver Level
By Quarter
Level III

	7-8	9-10	11-12	Total
Referred	45 (71.4%)	27 (44.3%)	8 (19.0%)	80 (48.2%)
Not Referred	18 (28.6%)	34 (55.7%)	34 (81.0%)	86 (51.8%)
Total	63 (100.0%)	61 (100.0%)	42 (100.0%)	166

Chi-square = 28.290, $p < .001$ with 2 df.

TABLE 16

Referral
State Court
By Driver Level
By Quarter
Level III

	7-8	9-10	11-12	Total
Referred	20 (20.6%)	44 (41.5%)	21 (60.0%)	85 (35.7%)
Not Referred	77 (79.4%)	62 (58.5%)	14 (40.0%)	153 (64.3%)
Total	97 (100.0%)	106 (100.0%)	35 (100.0%)	238

Chi-square = 20.170, $p < .001$ with 2 df.

Court where referrals have shown a proportional increase. In State Court there has been an almost 40 percent increase in referral activity. Moreover, the actual number of referrals exceeded that of Recorder's Court.

With regard to the distribution concerning referral, there is essentially one important conclusion. It is that referral activity in Recorder's Court has declined over the years while referrals in State Court have begun to increase after a sharp decline from the first ASAP operational year to the second. It should be noted, however, that even with an increase in the referral rate after the second year, State Court referral activity is still less than Recorder's.

Referral activity in the Columbus-Muscogee county court system changed significantly over the ASAP operative years. The first year produced the highest level of referral activity by either court. The second produced an even greater level of referral activity in Recorder's Court, but in State Court the second ASAP operative year was the lowest in the proportion of referrals. In the third year opposite referral trends emerged in Recorder's and State Courts. Of the three years this was the lowest in the proportion of referrals by Recorder's Court and referral activity in there decreased over the final six quarters. In State Court referral activity increased in the third year as well as in the last six quarters, especially with regard to drinking driver levels II and III. It should be noted, however, that over the ASAP operational period Recorder's Court referred many more subjects than State.

One final note with regard to Recorder's Court and referral activity. It has been conveyed to the evaluation unit that with the cessation of ASAP activities, contact between Recorder's Court and Phase II and III counselors (Garrard Clinic) have been limited. As a result Phases II and III sentencing alternatives are being used even less frequently than even during the ASAP operative years. What steps have been taken to modify this situation are unknown at the time of this report. Recorder's Court, however, still makes referrals to Phase I.

Diagnosis Activity

Table 17 presents ASAP diagnosis activity for the ASAP operative period from January, 1972 - December, 1974. There were 417 PSIs and background investigations. This was of a total of 7430 convictions or 5.6 percent. There were no known instances where the courts did not accept the referral recommendation of ASAP. However, as related in several instances throughout this report, the courts were reluctant to enforce referral sentences. It should be noted that PSIs were never conducted in State Court during the ASAP operative period with background investigations completed only after sentencing. PSIs were conducted in Recorder's Court during the ASAP operative years, but now only background investigations.

It was planned that from 60-80 percent of those persons convicted of DUI and classified as PDDs would have PSIs or background investigations completed as well as physical

examinations and psychological testing.* Considering that there were 3001 persons classified as PDDs and essentially only two people to coordinate these activities, this was probably not a realistic goal. Of the 3001 persons classified either as level II or III drinking drivers, 398 PSIs or background investigations (13.3 percent) and 211 physical/psychological examinations (4.9 percent) were completed.

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*Note Detail Operational Plan, Countermeasures J-4 and J-5.

TABLE 17

ASAP Diagnosis Activity
January, 1972 - December, 1974

ASAP ACTIVITY	ASAP UNIT			TOTALS
	PSI AND BACKGROUND INVESTIGATIONS			
	PDD	NON-PDD	UI	
In the Unit where the diagnostic decision was made, how many drivers were PDD, Non-PDD and UI	398	19	-	417
Of those classified, how many were referred into specific rehab programs?	398	19	-	417
Of each group of referrals, how many were accepted by the court?	398	19	-	417
Total Alcohol-related Arrests				10,341
Convictions A/R*				7,430

*These include nolo contendere pleas which are not technically recognized as convictions.

VII. COUNTERMEASURES

Countermeasures associated with drinker diagnosis and referral activity in the Columbus-Muscogee county court system included J-1 through J-5.* Countermeasure J-3 provided expert intoximeter witnesses for court testimony, but as already related there were very few occasions when this was required. Four police officers were trained in the operation of the photoelectic intoximeter during the ASAP operative period, and were available when testimony was requested by State Court.

Countermeasure J-5 provided medical/psychological examinations for DUI subjects classified as problem drinking drivers. Over the ASAP operative periods 211 of these were completed. It had been hoped that 60-80 percent of those drivers classified as PDDs would have medical/psychological examinations. There were 3001 persons classified as PDDs over the three year operation of ASAP, and the hope of completing examinations on 60-80 percent of them was probably an unrealistic figure. The ordering of medical/psychological examinations for only slightly over seven percent of those classified as PDDs by the courts, however, is disappointing.

Countermeasures J-1, J-2, and J-4 were all concerned with providing sentencing alternatives for Recorder's and State Courts as well as providing the means for obtaining presentence and background investigations for convicted DUI offenders. Also J-1 and J-2 were concerned with proving a classi-

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*See Detailed Operational Plan

fication system and the requisite data required by that system whereby it was hoped that 90 percent of those persons charged with DUI could be classified into drinking driver levels.

It has already been noted that the Columbus ASAP was successful in proving sentencing alternatives for the Columbus court system as well as establishing the classification system and making provision for the requisite data needed by that system. It was and is possible to classify about 90 percent of those persons charged with DUI. In addition the Columbus ASAP provided the means for conducting PSIs and background investigations. However, while this was available these were infrequently ordered by the courts.

The degree of success in achieving the objectives established by the countermeasures, it is held, is one of perspective. ASAP established both sentencing alternatives it sought to establish. Furthermore, both of these have been continued. Prior to ASAP there was only one sentencing alternative and it was employed only occasionally. ASAP established a classification system and met the data requirements of that system. This, too, continues to operate. Prior to ASAP no such system existed. Finally, the Columbus ASAP established means by which PSIs and background investigations were provided. This also is still available and Garrard Clinic which now makes this provision was substantially expanded because of the Columbus ASAP.

The two areas where less was achieved than was hoped for was in the use of alternative sentences in both courts (and the enforcement of these), and the number of PSIs and back-

ground investigations ordered. It had been hoped that alternative sentences would be used in about 70 percent of the DUI convictions for both courts. Recorder's Court employed alternative sentences in 62.7 percent of the cases where a subject was convicted of DUI while State Court employed the sentencing alternatives only about 39.8 percent of the time. However, failure to require DUI offenders to complete the sentencing alternatives made compliance essentially a voluntary process.

Furthermore, only 417 PSIs and background investigations were ordered by the courts. It had been hoped that PSIs and background investigations would be ordered in 70 percent of the DUI convictions involving PDDs (levels II and III). There were 3001 PDDs over the ASAP operative period, and PSIs or background investigations were ordered in only about 14 percent of those cases involving levels II or III drinking drivers.

It can be concluded, then, that the Columbus ASAP was successful in those areas of the countermeasures where success depended for the most part on independent activity and action by ASAP, and in those areas where direct court involvement was not required. In those areas where the courts were directly involved (i.e. referrals, PSIs, etc.,), however, there was less success. Given the level of cooperation by the court system, it is held that the measure of success achieved was probably the best which could have been hoped for.

VIII. Conclusion

The analysis of drinker referral and diagnosis activity indicates that over the Columbus ASAP operative years referral and diagnosis activity increased from essentially nothing to substantial levels. Prior to ASAP there was virtually no referral and diagnosis activity. While it is true that referral and diagnosis levels never reached anticipated levels, 54 percent of the DUI convictions in Recorder's and State Courts were referred over the three year period. About 6 percent of these included diagnosis activity.

The major complaint raised is that even with the relatively high referral rate, the courts took little or no action to enforce referral sentences. About 30 percent of those persons referred did not complete the referral sentence. It might be the case, however, that the courts simply did not have the manpower to rearrest and bring those persons back into court. In future considerations it may be necessary to insure the courts that this manpower will be provided.

Another matter of concern was that even though Recorder's Court referred at a relatively high rate over the ASAP operative years, there was every indication that the referral rate declined over the last six quarters. State Court referrals increased the last six quarters of the ASAP program, but the overall referral rate was still less than Recorder's Court.

Also discerting was the courts infrequent use of diagnosis facilities provided by the Columbus ASAP. It is not clear why this was the case.

As noted then, the Columbus ASAP was successful in establishing those facilities necessary for implimentation of referral and diagnosis activity by the courts. Specificially ASAP established a classification system, provided for the data requirements of that system, established educational and treatment modalities, and provided diagnosis facilities. Also, ASAP was successful in generating a high level of referral activity by the court system particularly when it is considered that there was essentially none prior to ASAP. The major areas where there was a lack of success was in the enforcement of referral sentences by the courts and failure by the courts to take advantage of the diagnosis facilities provided by ASAP.