

COURT INTERVENTION:

PRE-SENTENCE INVESTIGATION TECHNIQUES FOR DRINKING/DRIVING OFFENSES

INSTRUCTOR'S GUIDE

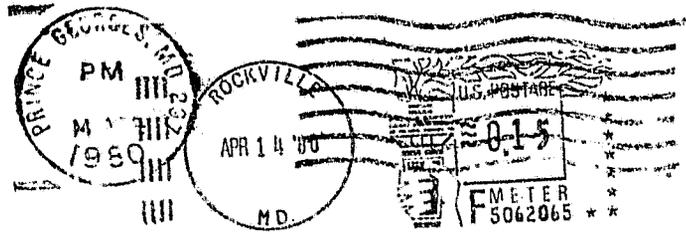
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COURT INTERVENTION - PRE-SENTENCE INVESTIGATION TECHNIQUES FOR DRINKING/DRIVING OFFENSES

U.S. National Highway Traffic Safety Administration

1980

U.S. Department of Transportation
National Highway Traffic Safety Administration
400 7th St., S.W.
Washington, D.C. 20024

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FOREWORD

Within the past five years, partially in response to the experience gained in the 35 Alcohol Safety Action Projects (ASAPs), both the legal profession and the judiciary have spoken out in favor of the use of Pre-Sentence Investigation (PSI) and probation in misdemeanor cases.

When the National Highway Traffic Safety Administration (NHTSA) formulated the concept of PSI and probation for persons convicted of Driving While Intoxicated (DWI), however, few people involved recognized how radically different the functions of the PSI personnel would become among the 35 different sites that were funded. The actual PSI screening task has been found to take a variety of forms, from a brief 10-minute interview in one large municipal court to a three-hour session of tests and interviews in another.

The principal goal of the PSI in all courts, however, is to assist the judges in their selection of appropriate sanctions. In the case of a DWI offender, the PSI process can and should include a screening system to identify the person's level of alcohol abuse, i.e., social drinker, borderline, or problem drinker. The PSI report recommendations can then be structured so that the courts can readily assign offenders to programs best suited to their levels of alcohol problems.

In 1976, NHTSA began development of a nationally-applicable training package for PSI personnel to assure fair, accurate, and comprehensive diagnosis and referral of DWI offenders to the most appropriate education and/or rehabilitation programs. Training objectives were reviewed by selected judges and probation supervisors, and the training materials were pilot tested in five locations: (1) Pittsburgh, Pennsylvania; (2) Ames, Iowa; (3) Memphis, Tennessee; (4) Boston, Massachusetts; and (5) Seattle, Washington. The materials were revised after each pilot test on the basis of the evaluations made by the project team and attendees.

The final training package for PSI personnel has been designed to acquaint them with: (1) the history of the ASAP's approaches to PSI, (2) the severity of the DWI problem, (3) the role of PSI personnel in screening, (4) the types of tests currently used and their relative worth, (5) a suggested "model" PSI report, and (6) suggested rehabilitation modes for each drinker type.

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SEMINAR

PURPOSE AND SCOPE

This training development project was sponsored by the Office of State Program Assistance, National Highway Traffic Safety Administration (NHTSA) of the U.S. Department of Transportation. Its overall objectives are:

- Definition and documentation of the task performed by PSI personnel who screen DWI offenders in representative lower court systems. This was done by means of interviews with them and their supervisors, as well as actual observations of PSI interviews in seven jurisdictions.
- Identification of the training required to produce acceptable performance of all documented PSI tasks.
- Development, pilot test and evaluation of a PSI seminar package in five locations, revising the materials after each administration in line with the evaluation results.

The resulting seminar package has been designed for use by state and local agencies as in-service training for those who conduct PSI interviews with DWI offenders.

The seminar is directed toward increasing the PSI's awareness of the necessity for, and importance of, identification of the level of alcohol abuse among the DWI offender population. It focuses on an explanation of the ASAP's health/legal approach to the DWI problem, and particularly on the "screening" procedures adopted in the most efficient ASAPs. These procedures, when systematically applied, assure that all DWI offenders receive fair treatment by the courts and contribute greatly to the efficiency of the criminal justice system.

A brief description of each day of the seminar is provided in the agenda which follows.

AGENDA

PRE-SENTENCE INVESTIGATION SEMINAR

Day One

0900-1200 1. Introduction and Overview

This unit covers: (a) introduction and administrative information, (b) information on DOT/NHTSA standards, (c) the genesis of the project, and (d) explanation of the ASAP health/legal approach.

Coffee Break

2. The Problem Drinking Driver

The national and local statistics on alcohol-related highway crashes will be reviewed, with particular emphasis on the average Blood Alcohol Concentration (BAC) at which the drinking driver is arrested, and the prior arrest records of these drivers.

1200-1300 Lunch

1300-1700 3. Alcohol and Impairment

This unit will focus on the physiological effects of alcohol and its influence on driving abilities. The group will view the film "Under the Influence," and discuss the multitude of factors which affect an individual's ability to drive at high BACs (.10 and above).

4. The Responsibilities of PSI Personnel

Using examples of the various ASAP court systems, the concept of screening and diagnosis for court referral will be covered. Preliminary diagnoses of sample cases will be requested as "homework" assignment.

Day Two

0900-1200 5. Screening Instruments

Review homework, review two systems. A brief history of the types of instruments used in screening will be presented, highlighting the CPIPD, and a videotape of the Sample CPIPD. Interview will be shown and the scoring explained. Sample interviewing techniques will also be demonstrated by means of videotape.

Coffee Break

6. Practical Application

Selected participants will demonstrate, through role-playing, their mastery of the administration of the CPIPD, and its scoring, using sample cases.

1200-1300 Lunch

1300-1700 6. Practical Application (continued)

7. Report Writing

Guidelines will be provided for a "model" referral form which contains all necessary and sufficient information for use by the courts, probation, and treatment agencies.

8. Court-Monitored Rehabilitation Programs

Reviewed here will be the results of the ASAP STR study, and suggested modes of rehabilitation for each drinker type. Guidelines will be provided for monitoring attendance/completion of court-mandated programs.

9. Summary of Recommendations

The group will be polled to obtain agreement on specific tasks they will undertake to improve their courts' programs for screening, referral, and monitoring of defendants through alcohol treatment programs.

THE INSTRUCTOR'S ROLE

The PSI seminar can easily be conducted by one person, assuming that he/she possesses the following knowledge and capabilities:

- A basic familiarity with the PSI in general, and specific knowledge of the adjudication process and the duties and responsibilities of PSI personnel in the jurisdiction where the seminar is held.
- Complete understanding of the NHTSA-sponsored ASAP demonstration projects and its subsequent research which underlie the health/legal approach to a DWI control system.
- A working knowledge of the existing state/local laws and court practices used in the jurisdiction, as well as the sanctions that are available to the court system.
- Knowledge of (or access to) data on:
 - Numbers/types of DWI arrests made monthly and yearly in the community served by the attendees.
 - Court/prosecutor policy and mandates by which the PSIs are bound, both written and unwritten.
 - Numbers/types of agency referrals typically used by the courts.
- Sufficient legal experience to permit:
 - Correct interpretation of the state's vehicle code and any/all applicable local laws.
 - Judgment of acceptability of the procedures currently followed by the court and community agencies responsible for DWI offenders' classification, education, treatment and follow-up.
 - Recommendations for improvement in the adjudication process, given existing laws and court policies.

Duties and Responsibilities

One of the instructor's primary responsibilities is to impress upon the attendees the necessity for observance of the DWI offenders' civil rights to fair and equal treatment under the law. This topic is of particular import for the PSI's future role in the DWI offense adjudication process. For this reason, all seminar units should clearly reflect the need for accuracy and consistency in observing the defendant's rights, while attempting to inform attendees about techniques that can be used to reliably assess the level of drinking problem of a DWI offender.

The instructor is expected to work closely with both court and prosecutor offices prior to seminar conduct to assure that he/she has a clear picture of the adjudication process, from arrest of the offender through the imposition of the sanction.

In addition, the instructor must be fully aware of the entire course content, sequence, and instructional methods used. It is the instructor's responsibility to control the duration of the seminar discussions and keep them on point, without appearing authoritarian. All offenders should be encouraged to participate actively in the seminar sessions to assure that their interest level remains high and their perception of themselves is of contributing participants rather than passive students.

GUIDELINES FOR PLANNING

Materials Development

This phase of seminar planning can be expected to take 30-45 days, depending upon the ease of access to local/state information required to "tailor" the seminar materials. The course administrator should work with the prosecutor's office and the court personnel responsible for record keeping to obtain the necessary data. The information required falls into three categories:

- **Statutes.** Copies of your state's motor vehicle code and penalties, plus any local ordinances pertaining to DWI offenses should be obtained.
- **Court/Prosecutor Policies.** Where these agencies' policies are documented, this will be relatively easy. Where these guidelines do not exist in written form, descriptions of the process and step-by-step procedures should be obtained from the presiding judge and/or the probation supervisor, as well as the prosecutor's office.
- **Statistics/Reports.** Records should be obtained of the number of arrests, prosecutions, and dispositions of DWI cases over the past five years.

Customizing the Unit 6 Case Materials

Nine cases are provided for use by the participants in the role-playing demonstration of CPIPD administration. Because of the differences in state vehicle codes and penalties, and the wide variety of court practices, the administrator and/or the instructor should examine each case and tailor the past records and penalties to the specific jurisdiction covered. These changes should also be made to assure that the DWI offender would actually be scheduled for a PSI and/or a screening interview, in light of local practice.

For example, some courts might well deny a fourth-time DWI offender the opportunity for a PSI. In this instance, Case No. 1 in Unit 6 will have to be changed to reflect a second offense of DWI (or something else depending upon local practice). As a practical matter, this might mean simply changing the driver's prior record to show several Reckless Driving offenses instead of DWIs.

These changes require very little time and effort, and are critical to seminar success, since all attendees must readily agree on the fact that the DWI offender would actually appear for a screening interview, be it pre-trial, post-trial, or pre-sentence.

Participants

The PSI materials provided in this package have been designed to be presented to court personnel who approximate the following profile:

- A twelfth grade level of education, or higher. (In many cases, probation officers will be attending, and are assumed to have, either a two-year or four-year college degree.)
- At least six months' experience as an employee of the courts, either as a paralegal or as a probation officer. Where community agency personnel conduct screening interviews for the courts, they should also have at least six months' work prior to attending the seminar.

- Thoroughly versed in the motor vehicle code and court policy, and highly motivated to provide referral recommendations to the courts in DWI cases.

The class size envisioned for the In-Service Seminar is a group 12-15 PSIs. This number of participants is viewed as optimum, given the two-day time period and the necessity for extensive group interaction throughout the seminar. If the class size must be increased substantially (e.g., to 20 persons), this will necessitate splitting the class into two groups for the role-playing exercise in Unit 6, since each role-play and critique can be expected to take approximately 25-30 minutes.

Instructor/Resource Persons

The criteria to be met for instructor(s) of the PSI seminar are as stated in Section 3 of the **Instructor's Guide**. Suffice to say here that instructor(s) should be very familiar with the court systems employed by the ASAPs, and the role of the PSI in DWI adjudication. The instructor(s) should be particularly knowledgeable in the areas of highway safety research, interpersonal communication skills, and the psychological factors that influence human behavior. It is important that the instructor(s) establish his/her credibility in Units 1 and 2 of the seminar, since this initial contact will greatly influence the PSIs' impressions of the information gained.

Materials, Equipment and Facilities

Only three types of materials are required for administration of the PSI Seminar: (1) overhead transparencies/projector, (2) 16mm projector and film, "Under the Influence," and (3) videotape cassettes and monitor. Only the early units use the overhead projector. Unit 5 requires the videotape monitor and cassettes. The remainder of the training materials are the **Participant's Manuals** and handouts, as noted in the **Instructor's Guide**.

A Reference Table should also be set up in the seminar meeting room, and should display copies of any/all of the reports gathered by the instructor as background reading material (see Reference section of Instructor's Lesson Plans). In addition, any relevant state or local information such as prosecutorial guidelines, judicial memoranda, etc., should also be available. The participants should be told that they can review the reference documents over night (from Day One to Day Two), but that all must be returned to the instructor at the end of the seminar.

A significant portion of the seminar material is concerned with the results of the ASAPs, and the most recent reports on the ASAP evaluations and summaries should be requested through the office of the state Governor's Representative for Highway Safety. These documents will be necessary source material for instructor preparation, and will also serve as useful references for the PSI personnel who attend the seminar.

The meeting room should be arranged to accommodate the participants in a seminar, rather than a classroom arrangement. This can take the form of a hollow square of tables, a Chevron-shape wherein the tables are staggered in two lines from a central point into a V-formation, or in a half-wheel, where the hub of the wheel is the instructor's table and the participants are seated at tables that emanate from the instructor's table as a central point. The informal atmosphere promoted by these kinds of

seating arrangements has been found to be most productive for the PSI seminar.

Evaluation

Two types of evaluation are used in the PSI seminar: (1) Pre- and Post-Seminar Questionnaires, which measure the amount of new information gained by the participants, and (2) the Materials Evaluation Form, which has been designed to assess the PSI's general impressions of the two-day training as presented. Copies of these two types of forms can be found in the **Instructor's Guide**, in the units in which they are administered (Units 1 and 9).

INSTRUCTIONAL METHODS

Three instructional methods are used in the PSI seminar, based on sound educational research data that specify these approaches for achievement of different types of behavioral objectives. The instructor will be guided entirely by the lesson plans provided in this manual, and will use:

- The lecture/visual aid approach is used in Units 1-4, primarily because of the time constraints. This method is, however, most appropriate when numerous abstract concepts and new ideas are presented.
- The videotaped interviews, CIPPD demonstration, and case studies used in Units 5-8 have been found to be extremely effective in producing behavioral changes among the participants, since imitative modeling is easy to accomplish. When strongly reinforced by their supervisors, these procedures will readily be incorporated into the PSI personnel's daily screening tasks.
- The role-playing exercise used in Unit 6 is accepted as the only demonstrable criterion by which PSI performance can be judged on the tasks in a simulated interview.
- The brief question and answer period in Unit 9 provides the PSIs with an opportunity to clarify all they have learned and to prepare them to take the **Post-Seminar Questionnaires**.

The following section presents detailed guidelines for seminar preparation and conduct.

GUIDELINES FOR CONDUCT

Use of the Manuals

The **Instructor's Lesson Plans** contained in this manual outline the major content areas to be discussed in the course of the training. The primary purpose of the **Participant's Manual** is to provide the attendees with all materials they need during the two-day seminar, and allow them to have a permanent record of the topics covered.

The overhead projections to be used in Units 1-4 may be made directly from the pages that appear after each unit in this manual. Where hand-outs are indicated (Case Studies 1-9), the pages from which they can be made are also included.

Each unit of this **Instructor's Manual** consists of two parts: (1) a summary page, indicating unit number and title, instructional methods, instructional objectives and references to be used; and (2) the actual lesson plan which outlines the content to be presented in the time allotted.

The first **Instructor's Lesson Plan** page is primarily for orientation to the unit, the equipment required, and the activities for which the instructor is responsible. The second and subsequent pages list the topics to be presented in logical sequence, with suggestions for questions to be asked, examples to be used, etc. All references to audiovisual aids provided as part of the package appear in the **Supporting Materials** column at the extreme left. References to pages in the **Participant's Manual** are listed as **PM** numbers in the middle column.

The content outline is intended for use as a starting point, to be expanded to suit the instructor's individual style. The topics listed are not to be read verbatim to the group, but should instead serve as a basis for the instructor's lectures and/or discussions.

Community-Specific Data

The course administrator and instructor (who may well be the same person), must work closely with all court personnel before the seminar to obtain copies of necessary documents (e.g., vehicle code, court procedures, prosecutor guidelines, etc.). These local inputs are critical to seminar success, since the instructor must have a clear picture of the court's authority and existing court/agency referral practices in order to structure the seminar presentations.

Specific directions for all instructional activities can be found in the pages which precede each unit in this manual. General recommendations to be followed by all instructors are:

- Carefully read the **Instructor's Lesson Plans** for each unit for which you are responsible, and review the documents recommended as background reading.
 - If necessary, contact the court personnel who are most knowledgeable about local adjudication procedures to clarify your perception of the PSI's role in the existing system.
 - Review the unit as covered in the manual and make notes on your own copy to supplement your lecture.
 - Practice your presentation of all units to assure that they will fit into the allotted times. Devote the greatest amount of time to the critical issues raised in Units 4 and 5, and to the demonstration (role-playing exercise) in Unit 6.
-

LESSON PLAN

1

Introduction and Overview

Methods/Media: Lecture/Discussion

Time Allotted: Day One 9:00-10:15 a.m.

Equipment Required: Overhead Projector/Transparencies

OBJECTIVES

- Explain the seminar background and ultimate goals.
- Orient the group to the purpose and scope of the seminar.
- Describe the instructional objectives and the expectations of the participants.
- Distribute the **Participant's Manuals**.
- Explain the Federal Standards, the ASAP program, the genesis of this training package, and the health/legal approach now being taken by the courts.
- Present the ASAP results as they apply to the court system in general, and PSI in particular.
- Review what is known about efficacy of various traffic sanctions, and explore local practices and treatment resources.
- Obtain completed copies of **Pre-Seminar Questionnaires** from all participants.

REFERENCES

- **Participant's Manual and Pre-Seminar Questionnaires**
- **Volume 1: Summary of ASAP Results.** Washington, D.C.: NHTSA, 1977
- **Court Procedures for Identifying Problem Drinkers, Volumes 1-3.**
- **Court Intervention: PSI Techniques for Drinking/Driving Offenses. Final Report.** ASA, 1978.
- **Appendix A: Alcohol Use and Abuse in America**

INTRODUCTION

- Identify the seminars in-service training for the Pre-Sentence Investigator (PSI) (explain this term as one that may describe court personnel who screen for the prosecutor pre-trial, probation officers who may screen pre-trial, pre-sentence, or post-trial, etc.).
- Introduce the seminar leader(s). Allow each person to explain his/her background, experience, and qualifications for leading the seminar.
- Ask all participants to state their names, years of experience, prior positions held, and present court responsibilities.

Manuals for all attendees

ADMINISTRATIVE INFORMATION

- Distribute **Participant's Manuals**.
- Explain seminar agenda, session times, breaks, lunch hour, rest-room locations, etc.

SEMINAR OBJECTIVES

- Describe the purpose and scope of the seminar:
 - To make the group aware of the need for and usefulness of PSI information in determining type of sanction to be imposed.
- Background on Federal Standards.
 - History of National Highway Traffic Safety Administration (NHTSA).
 - Highway Safety Act, 1966, created the Federal Highway Works Administration (FHWA) and National Highway Safety Bureau (NHTSB).
 - NHTSA and FHWA separated in 1969-70.
 - Relationship of DOT-NHTSA and 18 Federal Standards to the courts and traffic records.

[Explain that bi-level Standards are guidelines provided to the states as of July 1977. Major components are mandatory, such as uniform traffic signs and signals and data recorded on driver and vehicle licensing. The second level of the standard suggests programs which are **recommended**, but the states are not required to meet these precisely. The standard under which this program falls is Standard No. 8, **Alcohol and Highway Safety**. It recommends specific laws (such as .10 BAC as the illegal limit) and enforcement practices for DWI laws. DOT has certain funds for implementation of each standard. The development of this training package was done with money allocated to Standard No. 8.]

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Refer to Highway Safety Program Standards Book on reference table.

Overhead #1

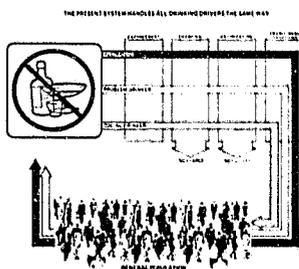


- To inform all attending of the NHTSA responsibility for the 18 standards, the rationale behind the DOT Alcohol Safety Action Projects (ASAPs), and the health-legal approach to drinking driver adjudication which has resulted from the ASAP experience.

- To make the group familiar with the extent of alcohol use and abuse in America (see Appendix A), and the impetus behind the development of these seminar materials.
- To acquaint them with the screening concept and its application to drinking drivers, with particular emphasis on the Mortimer-Filkins test to determine level of alcohol abuse.
- To provide attendees with the necessary skills and knowledges to enable them to accurately diagnose drinking problems, write acceptable reports, and make appropriate recommendations for treatment of the various levels of alcohol abuse.

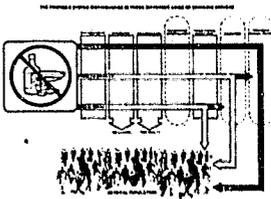
THE ASAP HEALTH/LEGAL APPROACH

Overhead #2

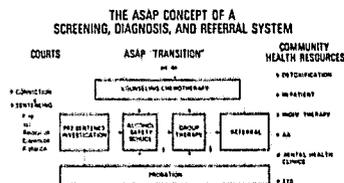


- The old approach to handling DWIs under which the above statistics were gathered is characterized by:
 - Handling all DWI offenders the same way, which includes:
 - Equal enforcement for all offenders, regardless of level of drinking problem. This is as it should be.
 - All are charged or not charged under discretion of officer or prosecutor.
 - Those charged are found guilty or not guilty as per the adjudication process.
 - All offenders, regardless of their level of drinking problem, are sanctioned the same, i.e., fine, license suspension, etc.
 - Regardless of drinking characteristics, all offenders are thrown back into the general population after their sanction.
 - No provision for rehabilitation, education, or differential treatment of drinking types.
- New approach called for on the basis of reports like Borkenstein, 1964, **The Role of The Drinking Driver and Traffic Accidents**, and DOT 1968 **Alcohol and Highway Safety Report**, which detailed the statistics reported above. NHTSA implemented the following health/legal approach in 1970 through 35 Alcohol Safety Action Programs (ASAPs).

Overhead #3



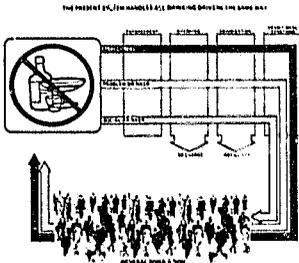
Overhead #4



CHARACTERISTICS OF THE NEW APPROACH

- Multifaceted—addressing the integration of treatment with the court system and supplementing of existing programs with new.
- Enforcement—increased through development of DWI enforcement training for police (Michigan course), increased awareness of programs for police management, and monies for special enforcement trained teams, breathalyzers, etc.
- Court—constructive coercion—adjudication measure specifically designed for DWI.
- PSI and probation—required.

Repeat
Overhead #2



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Pages 15, 16

Pages 16-18

- Rehabilitation/Treatment.
- Public Information and Education.

Compared to Old Approach

- Adds education, treatment/rehabilitation, and, reason you are here today, PSI.
- One of the primary keys is PSI. Provides diagnosis for differential treatment where needed.

Results of the Now Largely Completed ASAP Programs

- Accomplishments:
 - Feasibility of coordinated and integrated health/legal approach to processing problem drinkers into rehabilitation programs.
 - Found that implementation requires extreme degree of cooperation among highway safety system, criminal justice system, and health care delivery system.
 - States **can** be catalyzed to improve their own safety program (Vermont, Virginia, South Dakota, Utah, etc.). Approximately 50 percent of original 35 ASAP programs are in operation today in one form or another, funded out of local or state monies.
 - Can be run at minimum cost.
- Review the ASAP findings. Ask participants to comment on these three pages, indicating areas of disagreement or special interest.
- Lead group discussion on the findings regarding adjudication, with particular attention to:
 - Plea-bargaining procedures
 - The probation department's monitoring role
 - Court procedures that can be implemented to double or triple the caseload without adding more judges or prosecutors.
- Did not demonstrate:
 - An immediate and dramatic reduction in alcohol-related highway deaths. Difficult to do since our death rate per 100 million is low (3.7).
 - Has not invented education and rehabilitation modalities that would reliably prevent recidivism. Ongoing studies are being funded to provide us with more reliable systems.
 - Did not discover which sanctions by the system are most effective for which type of drinking driver. Studies are still under way to assess these effects.

Specifically, ASAP programs defined the character of the alcohol screening procedure which was to include:

- Background investigation of offender.
- Diagnosis—standardized test (MAST, CIPID).
- Recommendation to court.

- Referral to appropriate rehabilitation agency.
- Probation follow-up contact.
- More will be said about the ASAP findings regarding alcohol screening later.

REVIEW

Review pages 2-8 of Manual and have group discuss which of these two approaches is most viable in their jurisdiction.

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THE SEMINAR PACKAGE

Review the project activities which resulted in the development of these materials including:

- Data collection sites (7)
- Survey sites responding (7)

Source: Nesbitt, M.W., & McGill, D.W. *Court Intervention: PSI Techniques for Drinking/Driving Offenses*, 1978.

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SURVEY RESULTS

Explain the wide disparity in time spent on PSIs by various agency personnel responsible. Encourage group to discuss **their** local practices and amount of training given for this task.

SEMINAR EXPECTATIONS

- Explain how the units will be presented and the instructor(s) responsible for each.
- Emphasize that this is a "gathering of professionals to discuss and resolve issues," not a classroom type presentation.
- Briefly describe the CPIPD (Mortimer-Filkins) test, and its use. Explain that this will be covered thoroughly in Unit 5.
- Inform the group that they will be asked to demonstrate proficiency by conducting an administration of the interview portion of the CPIPD in Unit 6.
- Distribute the **Pre-Seminar Questionnaires**, and allow 10-15 minutes for completion.

Pages 22 , 23

Supporting Materials

BACKGROUND ON FEDERAL STANDARDS

The National Highway Traffic Safety Administration (NHTSA) was established by the Highway Safety Act of 1970 to carry out a congressional mandate to reduce the mounting number of deaths, injuries, and economic losses resulting from traffic accidents on the nation's highways.

Under the NHTSA program, Safety Standards are issued which form the foundation for state and local community safety programs. All states are expected to have federally approved safety programs in operation.

An 18-volume Highway Safety Program Manual has been issued by the Department of Transportation to assist state and local agencies in implementing the federal standards. The titles of the 18 volumes are:

1. Periodic Motor Vehicle Inspection
2. Motor Vehicle Registration
3. Motorcycle Safety
4. Driver Education
5. Driver Licensing
6. Codes and Laws
7. Traffic Courts
8. **Alcohol in Relation to Highway Safety**
9. Identification and Surveillance of Accident Locations
10. Traffic Records
11. Emergency Medical Services
12. Highway Design, Construction, and Maintenance
13. Traffic Control Devices
14. Pedestrian Safety
15. Police Traffic Services
16. Debris Hazard Control and Cleanup
17. Pupil Transportation Safety
18. Accident Investigation and Reporting

THE NATIONAL ALCOHOL SAFETY ACTION PROGRAM

National Objectives

- Demonstrate the feasibility of the systems approach for dealing with the drinking-driving problem and demonstrate that this approach saves lives.
- Evaluate the individual project countermeasures within the limits permitted by the simultaneous application of a number of different countermeasures at the same site.
- Catalyze each state into action to improve its safety program in the area of alcohol-related highway losses.

Project Objectives

- Develop the local control system to the point where it was arresting and processing large numbers of drinking drivers at minimal cost and with maximal speed and efficiency.
- Develop sanctioning packages, including supplemental alcohol education and treatment programs, which would: (a) be acceptable to the courts, and (b) be appropriate to the drinking-driving offenders.

- Improve records systems to the point where the control system actions could be measured and drinking drivers accurately tracked and monitored.
- Measure the effectiveness of a whole group of countermeasures, as well as each individual countermeasure, at the same time that the experimentation and system development took place.

SOME ASAP FINDINGS

Public Information and Education (PI&E)

- The general public responds to PI&E campaigns by changing knowledge, attitudes, and significant behaviors.
- PI&E campaigns alone do not change drinking-driving behavior, but a fear-of-arrest campaign can change drinking-driving patterns, at least on the short term.
- Campaigns with special messages for specific target-groups are more effective than general public campaigns alone.

Enforcement

- Arrest rates can be increased permanently and economically by use of specially trained selective enforcement patrols.
- Investment in special equipment is necessary for the credibility of police testimony.
- Investment in special technology can be limited. Purchase of pre-arrest breath testers, for instance, is much more cost-effective than purchase of television cameras.
- Training and motivating police management are two economical methods for improving arrest rates.
- Patrol officers will tend to cooperate with any disposition system as long as they do not see it as subverting their activities, especially in individual cases (e.g., informal plea-bargaining).

Adjudication

- Courts should concentrate more on handling cases that do not reach a full trial than on those which do (less than 10 percent in a typical jurisdiction).
- Cooperation between prosecutors and judges produces economical and fair adjudication systems.
- Plea-bargaining should be formalized, systematic, and purposeful, based on standard criteria and accurate records.
- Pre-sentence investigations can be conducted quickly and cheaply.
- Probation serves a monitoring rather than a counseling function, especially with persons in alcohol treatment programs.
- Report-back systems can be easily designed and run on the basis of good records systems.

- Sentencing should create packages of sanctions appropriate to the offenders' drinking status, yet allow the court considerable flexibility.
- Legislation affecting the courts should be enacted only after thorough investigation of probable court and prosecution responses.
- Attention to court procedures can enable handling of triple the present caseload of drinking-driving offenses without adding new prosecutors or judges.
- Sanctions should be used to provide an incentive for long-term cooperation with the court, as well as for punishment.

Education and Rehabilitation

- Lecture-oriented DWI Schools do not affect the behavior of most problem drinkers and should not be used for them.
- Problem drinkers respond better to interaction-oriented schools than to lecture-oriented schools.
- Problem drinkers respond better to comprehensive therapy programs than to briefer therapeutic modalities.
- Social drinkers sent to schools generally do better than those not sent to schools, but there may be even cheaper alternatives.
- Misdiagnosis and diagnoses that are not followed up by an appropriate referral do more harm than good.
- Experimentation should continue to define the proper modalities, curricula, and staffing for drinking-driver education and treatment.
- Persons referred and monitored by the court tend to attend and remain in treatment programs for the duration of court control, manifesting positive changes in attitude and behavior during that period.
- One-shot programs, whether educational or therapeutic, are not enough to change the behavior of many drinking drivers, especially problem drinkers.

WHAT DO WE KNOW ABOUT THE VARIOUS TRAFFIC SANCTIONS?

Sanction	Impact	Research Findings
Court Appearance Only	Uncertain	A limited study demonstrated that face-to-face contact with a judge does not necessarily result in lower recidivism than for non-appearing offenders.
Monetary Fine	Uncertain	There are no reported studies in which the amount of fine was manipulated experimentally. The few ex post facto studies are not very informative. There is some evidence, however, that heavy fines (in excess of

		\$120) are associated with subsequent decreases in accident frequency.
Jail Term	Unknown	There are no empirical data on the effectiveness of jail sentences for traffic offenders. This sanction is infrequently applied even when required by law.
License Suspension	Uncertain	Research studies have shown that driving during periods of license suspension or revocation is frequent. License suspension appears to be ineffective or negligibly effective with chronic traffic violators. There is some evidence that suspension does have an impact on less repetitive "major" traffic offenders, such as drinking drivers. These offenders had significantly fewer accidents and citations during the suspension period than before. Overall, license suspension has not proven effective in eliminating or reducing accidents.
Restricted or Occupational License	Uncertain	Findings of the limited research have not been entirely consistent. The restricted license is violated probably as often as license suspension. Restricted drinking-driving offenders have been found to have more subsequent accidents than revoked drinking drivers, but not more than the general driving population.
Traffic Schools and Group Driver Improvement Meetings	Uncertain	There is reasonably persuasive evidence that some group traffic safety meetings are effective in reducing accidents and violations, although not all authorities agree.
Effect of Graduating Sanction Severity by Number of Prior Convictions	Unknown	There is no information on the effectiveness of this procedure.
Alternative Service	Unknown	There is no information on the effectiveness of this sanction.
Court Probation and Suspended Sentence	Unknown	Little/no evidence has been gathered on the effectiveness of judicial probation and sentence suspension.

Drinking-Driver
Treatment
Programs

Uncertain

Based on early ASAP results (1973), rehabilitative efforts for drinking drivers have not been proven effective. However, poor evaluation design in many of the ASAPs precluded valid scientific conclusions being made on the initial data.

Source: John P. McGuire and Raymond C. Peck, *Traffic Offense Sentencing Processes and Highway Safety, Vol. II, Technical Report*, April, 1977.

RESULTS OF SURVEY ON PRE-SENTENCE INVESTIGATIONS (PSI)

- Project team estimates that:
 - 75-80 percent of PSIs are done by probation officers.
 - Remaining 20-25 percent of PSIs are done by various agencies serving the courts (e.g., paralegals from prosecutor's office, mental health professionals, etc.).
- Time spent on PSIs varies widely—from 10-15 minutes in large municipal court to 1-3 hours in smaller city courts.
- Training for PSI personnel is primarily on-the-job, with little/no emphasis on objective measures of alcohol abuse, except in ASAP-experienced areas.

THE ASAP RESPONSE HAS SHOWN

If a community wants to address the drinking-driving problem seriously, it should:

- Increase and improve enforcement.
- Conduct special target group and general public information and education campaigns.
- Establish a management unit for the control system.
- Introduce alcohol education and rehabilitation as supplemental sanctions.
- Standardize and routinize the sanction packages (including punitive, therapeutic and administrative sanctions).
- Improve and coordinate its records systems.
- Introduce a screening, referral, and monitoring capability (i.e., pre-sentence investigation, probation).
- Remove court processing delays by streamlining procedures.
- Evaluate the success of the system efforts.

If a community wants only to improve its present system without accomplishing a great deal more, it should:

- Increase arrests only to a level that the system can process efficiently.

- Provide some general publicity for the new program.
- Refer drinking driving offenders routinely to an alcohol safety school, but do **not** send suspected problem drinkers to large, lecture-type schools.

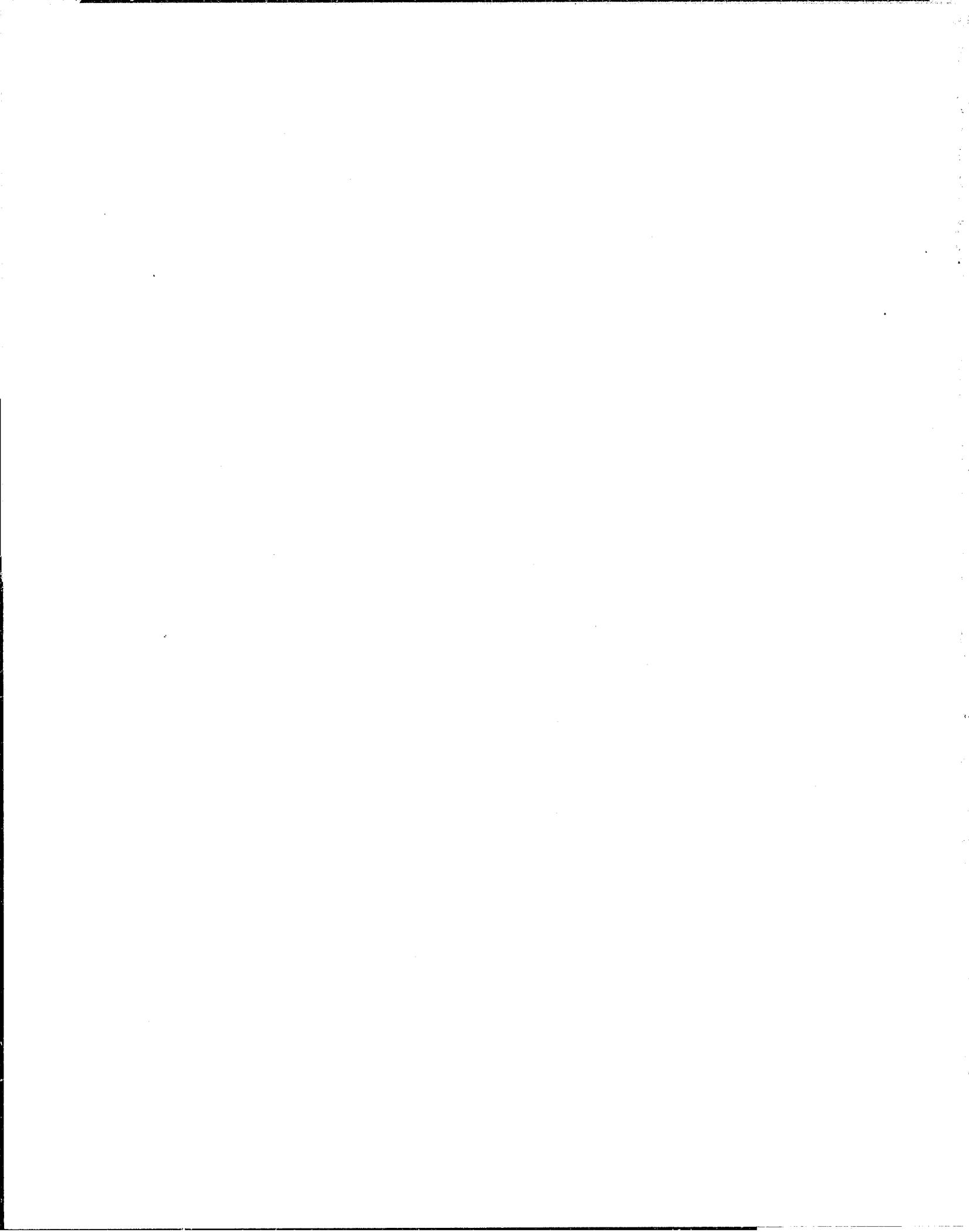
GENESIS OF THE PSI SEMINAR PACKAGE

Data Collection Sites:

- Baltimore Municipal Courts, Baltimore, Maryland
- Department of Motor Vehicles, Washington, D.C.
- Allegheny County Courts, Pittsburgh, Pennsylvania
- New Orleans and Lafayette Municipal Courts, Louisiana
- San Antonio City Courts, San Antonio, Texas
- Los Angeles Municipal and County Courts, Los Angeles, California
- Rio Hondo Court, Orange County, California

Court Survey Questionnaires Were Received From:

- Los Angeles, California
 - Denver, Colorado
 - New Orleans, Louisiana
 - Minneapolis, Minnesota
 - Raleigh, North Carolina
 - San Antonio, Texas
 - Richmond, Virginia
-



PRE-SEMINAR QUESTIONNAIRE

Name _____

Title _____

Date _____ Years in Position _____

Please check (✓) the appropriate answer.

1. How would you rate your present awareness of the national and state-level statistics on driving while intoxicated (DWI) offenses?
 - Very knowledgeable
 - Knowledgeable
 - Slight knowledge
 - Little/no awareness

2. How familiar are you with your jurisdiction's existing laws and practices governing the courts' treatment of DWI offenders?
 - Highly familiar
 - Moderately familiar
 - Minimal knowledge
 - Not at all

3. Are you familiar with the U.S. Department of Transportation's Alcohol Safety Action Projects' (ASAPs) efforts to impact the drinking driver control system?
 - Highly familiar
 - Moderately familiar
 - Minimal knowledge
 - Not at all

4. How qualified do you presently feel in screening DWI offenders for alcohol abuse and recommending appropriate treatment?
 - Very qualified
 - Qualified
 - Minimally qualified
 - Not qualified

5. Which of the following screening instruments are familiar to you?

- Alcadd Test
- Alcohol Use Questionnaire
- Iowa Alcoholic Intake Schedule
- Johns-Hopkins Questionnaire
- MacAndrew Alcoholism Scale
- Michigan Alcoholism Screening Test (MAST)
- Mortimer-Filkins Test
- NCA Criteria for Alcoholism Diagnosis

If you are aware of other tests used in screening for alcohol abuse problems, please list below:

6. How valuable do you think are these types of screening tests in assessing level of drinking problem?

- Very valuable
- Valuable
- Minimal value
- No value

7. Blood Alcohol Content (BAC) level is the usual determinant of level of impairment in a DWI arrest. Impairment of physical and mental functions and loss of judgment and inhibitions appear at which BAC level?

- .00-.04
- .00-.09
- .10-.14
- .15+

8. Typically diagnosis is based on such things as: (a) BAC at arrest; (b) prior alcohol-related offenses; (c) history of alcohol problems in family, job, etc.; and (d) interview results. Please rate each of these items on the scale below. (Be sure your weights total at 100 percent.)

Percentage that each item contributes to diagnosis of problem drinker

- % BAC
- % Priors
- % History
- % Test Score (if used)
- % Interview
- 100%

9. All of the following personal characteristics are important in one who conducts screening interviews. Please rank order the factors from 1-7 in terms of which you consider most important. (Most critical = 1, least critical = 7.)
- Empathic (i.e., exhibits concern for offender's problems)
 - Impartial/fair
 - Responsive/encouraging
 - Up-to-date on agencies/treatment available
 - Ability to put offender at ease and establish rapport
 - Effectively communicates important information (court dates, treatment appointments, etc.)
 - Reliably and consistently judges offenders' problems by standardized criteria
10. Do you recognize and/or use any of the following interviewing techniques in your present job?
- Active listening
 - Paraphrasing/clarifying
 - Perception-checking
 - Confrontation
 - Open-ended questions
 - Observation of non-verbal cues
11. Are you aware of the Federal regulations (e.g., the Privacy and Freedom of Information Acts) which may impact on your agency's records and, specifically, your own reports?
- Yes
 - No
12. Are your recommendations to the court subject to subpoena by a defense or prosecuting attorney?
- Yes
 - No
 - Don't know
13. Is the format and style of your report to the courts on the screening interview prescribed by agency practice or formal procedure?
- Yes
 - No
 - Don't know

LESSON PLAN

2

The Problem Drinking Driver

Methods/Media: Lecture/Group Discussion

Time Allotted: Day One 10:30-12:00 Noon

Equipment Required:

OBJECTIVES

- Present the national, state, and local statistics on alcohol-related highway deaths and injuries.
- Discuss the prevalence of problem drinkers among the DWI population.
- Explain the exponential increase in crash probability as BAC rises.

REFERENCES

Aarens, M., et. al. *Alcohol, casualties and crime*. Berkeley: University of California, School of Public Health, 1978.

SCOPE OF THE PROBLEM

Review **Participant's Manual** pages 9 to 12 on "Drinking and Driving Statistics." Request comments from group on their contents, particularly on epidemiology of highway deaths and absence of prior arrests in the DWI population.

- National statistics from ASAP programs 1972-1977:
 - One out of every 10 drivers found legally ($\geq .10$) drunk at voluntary roadside breath test.
 - About 40-50 percent of all fatals are alcohol-related. Of these fatals, an estimated 2/3 were problem drinker; 1/3 were young and/or social drinkers.
 - Average number of arrests for DWI was only two arrests per policeman/per year in 1976.
 - Only one out of every 2,000 legally drunk drivers are arrested.
 - Average BAC at arrest is .20. In all but two states, Maryland and Mississippi, .10 is presumptive of intoxication.
 - Predominantly males, ages 21-35.
- Latest review of alcohol involvement in traffic involvement in traffic accidents is summarized in table on page 10 . As can be seen from these data on numerous U.S. studies of traffic fatalities, between 35 percent and 59 percent of drivers killed in crashes have BACs of .10 percent or higher.

Source: Aarens, et al, Alcohol, casualties, and crime, 1978

RISK OF DRIVING AT HIGH BACs

Explain the great increase in risk at BACs of .10 or higher. Lead group discussion of this phenomenon.

IDENTIFICATION OF PROBLEM DRINKERS (PD)

Refer to page 12 of Manual which illustrates the number of PDs in the DWI population and obtain group reaction.

SUMMARY

Briefly summarize the high impact on traffic safety of the small number of PDs who are involved in the high number of crashes.

Supporting Materials

DRINKING AND DRIVING STATISTICS

Highway crashes are:

- the fourth largest cause of death (behind heart disease, cancer, and stroke).
- the leading cause of death for persons aged 1 to 38.
- the leading cause of accidental death for all Americans.

Alcohol-impaired drivers are involved in at least:

- 55 to 65 percent of single-car fatalities.
- about 50 percent of multiple-car fatalities.
- 10 to 35 percent of serious injury crashes.
- 5 to 10 percent of "run-of-the-mill" crashes and, setting aside driver impairment, 29 to 43 percent of all pedestrians killed are impaired by alcohol.

Alcohol is clearly the greatest single contributing factor in serious and fatal crashes, and a major factor in all categories of crash. However, only about 5 percent of drivers involved in fatal crashes in any given year have a record of a prior conviction for DWI.

Significant facts on DWI arrests:

- our arrest rate is too low to detect all drinking drivers who are likely to have a crash in the future.
- over 1 million known arrests for DWI are made each year, involving only about 0.5 percent of the adult driving population.
- on the average nationwide, each uniformed police officer makes only two DWI arrests per year.
- the average BAC at arrest nationwide is 0.20%. A great majority of arrested drivers have extremely high BACs (0.15% or higher).
- for every DWI arrest, 2,000 incidents of drinking and driving go undetected.

Males are higher risks because:

- males have and cause many more serious crashes than do females.
- typically, more than 90 percent of DWI arrests involve males.
- about 48 percent of men and 22 percent of women admit to driving after drinking.
- about 26 percent of men and 8 percent of women admit to driving after drinking **too much**.

The probability of causing a crash increases dramatically with BAC. See following chart)

Source: 1968 Alcohol and Highway Safety Report; Gallup polls

SUMMARY OF U.S. STUDIES REPORTING BLOOD ALCOHOL CONTENT OF PERSONS AT THE TIME OF THE ACCIDENT—PERCENT WITH BAC \geq .10%

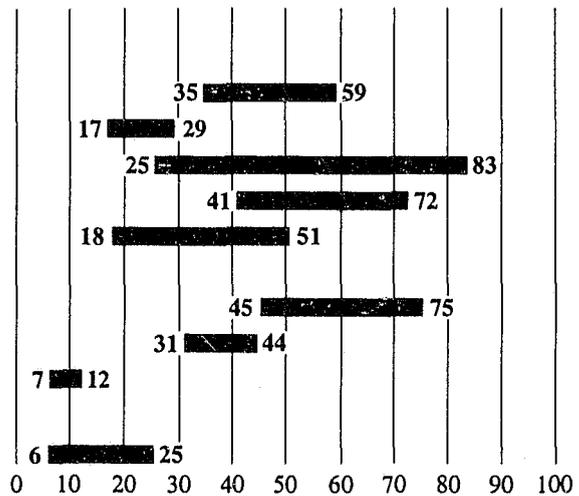
ACCIDENT CATEGORIES

Fatal Accidents

- Drivers
- Passengers
- Pedestrians
- Single-vehicle (drivers)
- Multi-vehicle (drivers)
- Responsible drivers
 - Single and multi-vehicle
 - Multi-vehicle
- Non-responsible drivers

Non-Fatal Accidents

- Drivers



PROBLEM DRINKING DRIVERS

- The Problem Drinking Driver is someone who **regularly** drives while seriously impaired.
- In the typical jurisdiction, about two-thirds of persons arrested for DWI are identifiable as Problem Drinkers, either clearly or marginally.
- Problem Drinking Drivers usually have a high BAC (0.15 percent or above) when arrested. Of course, the BAC on any occasion may be lower.
- Drivers with a high BAC (0.10 percent or above) are likely to be involved in at least
 - Twice as many crashes
 - Twice as many property damage crashes
 - Five times as many personal injury crashes
 - Twelve times as many fatal crashes
 - Twice as many traffic violations
 - Three times as many license suspensions
 as the average driver.
- Social Drinkers rarely achieve the high BAC (0.10 percent or above) which problem drinkers achieve very often.
- A person can learn to “drive while drunk” i.e., to compensate partially for the impairment caused by alcohol up to a point. The learning takes a lot of practice.

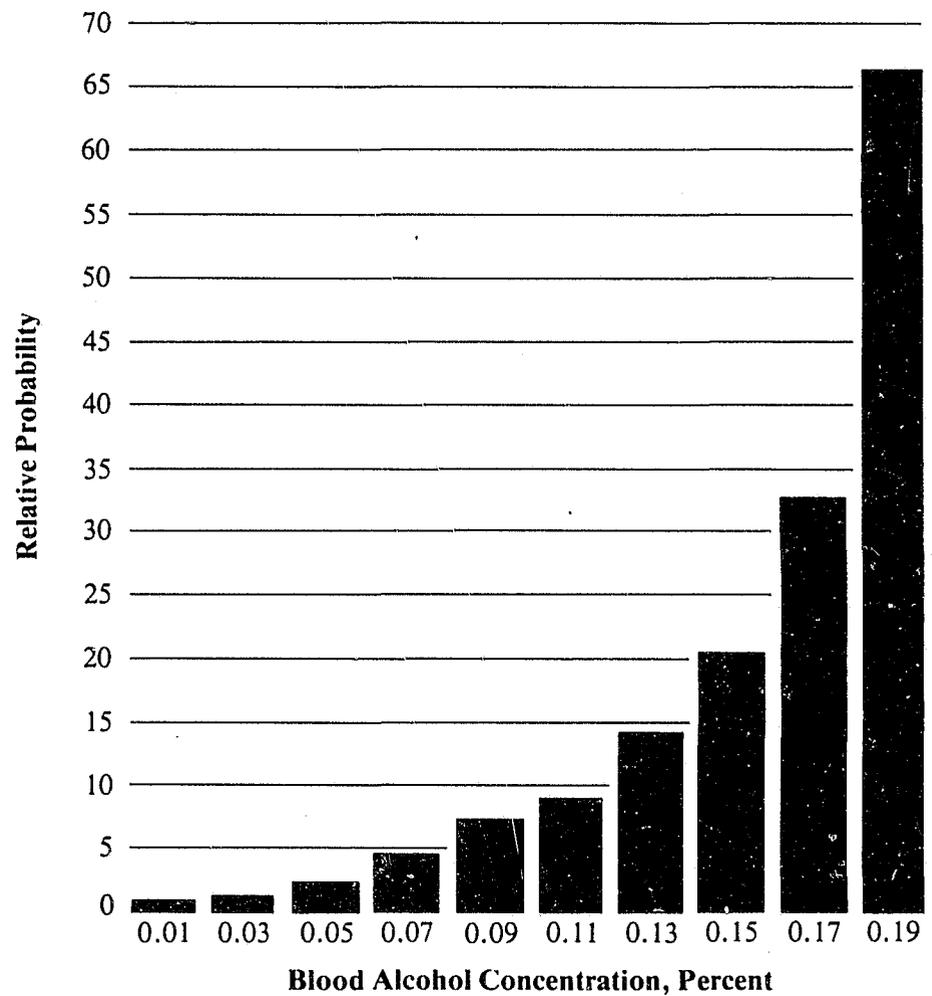
Social Drinkers don’t get that much practice. They are likely to judge themselves “too drunk to drive,” or to drive very badly at lower BACs.

Therefore, a person who drives reasonably well at a high BAC, or who can drive at all at a very high BAC (0.20 percent or above), is likely to be a Problem Drinker.

- Problem Drinking Drivers tend to lead troubled lives, as is shown in:
 - The probability of their having previous and subsequent DWI arrests.
 - The frequency of their contacts with social agencies.
 - Their emotional profiles.
 - The frequency of their family and economic problems.

This makes it possible to identify them by record checks and personality tests.

**RELATIVE
PROBABILITY OF
BEING RESPONSIBLE
FOR A FATAL CRASH
AS A FUNCTION OF
BLOOD ALCOHOL
CONCENTRATION**

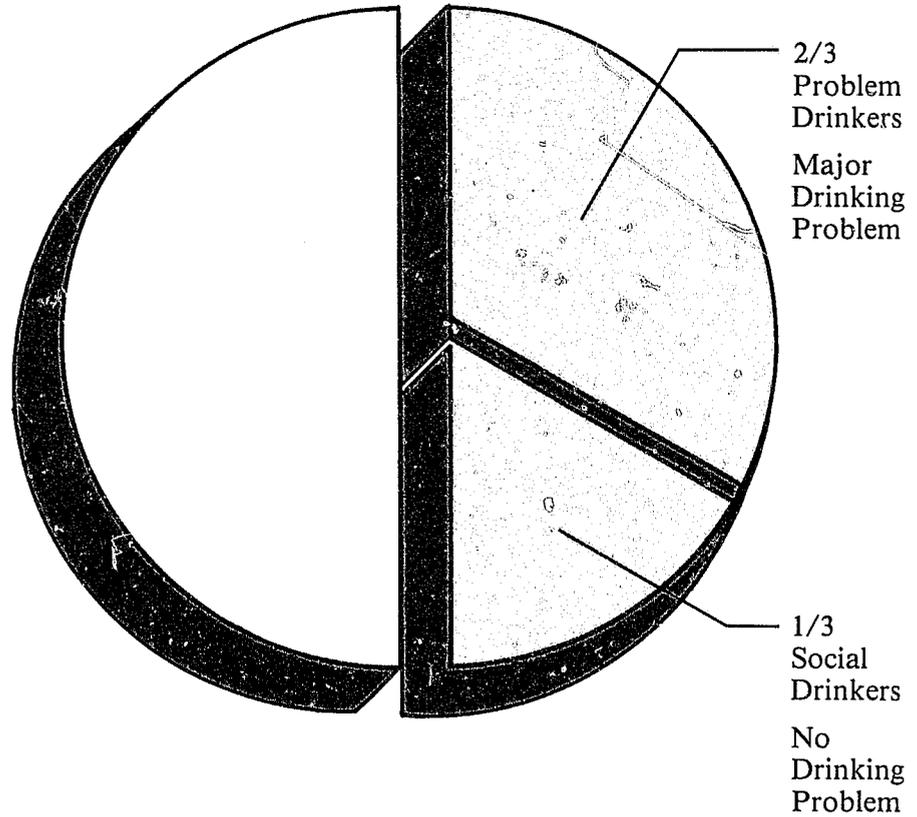


Source: Perrine et al, 1971

**IF PROBLEM
DRINKING DRIVERS
CAN BE IDENTIFIED,
APPROPRIATE
COUNTERMEASURES
CAN THEN BE
APPLIED TO THIS
HIGH-RISK
POPULATION**

50% of Fatal Crashes
Are Not Related to Alcohol

50% of Fatal Crashes
Are Alcohol-Related



Source: 1972 ASAP Evaluation of Operations, NHTSA

LESSON PLAN

3

Alcohol and Impairment

Methods/Media: Film—"Under the Influence"
Lecture/Group Discussion

Time Allotted: Day One 1:00-2:30 p.m.

Equipment Required: 16mm Projector, Screen

OBJECTIVES

- Explain the nature of the Blood Alcohol Concentration (BAC) tests and the meaning of .10 BAC.
- Describe the amount of alcohol required to reach .10 BAC, and alcohol's effects on behavior in general and driving skills in particular.
- Show the film, "Under the Influence," and lead group discussion on its content.
- Make the participants aware of the increase in probability of a driver's being **responsible** for a total accident as his/her BAC rises.
- Obtain group consensus on the validity and accuracy of BAC as a measure of impairment by alcohol.

REFERENCES

BLOOD ALCOHOL CONCENTRATION (BAC)

- What it is.
- How it is measured:
 - Breath test.
 - Blood test.
 - Urine test.
- How .10 BAC is reached. Lead discussion of page 3-2.

Source: Local toxicologist is suggested as a resource person for this unit

THE ILLEGAL LIMIT — .10 BAC

- Illegal at .10 BAC in all but two states—Mississippi and Maryland, where bi-level law says .10 is impaired, .15 is intoxicated. Utah uses .08 BAC as illegal. AMA has endorsed .10 as illegal. UVC recommends using .10 as well.
- Most European countries have .05 BAC as illegal, all United Kingdom and Canada use .08. In East Europe, .01 is illegal.

Source: Summary of ASAP Results, Vol. 1, 1976

AVERAGE BAC AT ARREST

- Nationally—varies between .18 and .20.
- (Insert site-specific data.)

Distribute samples of BAC calculator (should be available from state alcohol/safety agency)

ALCOHOL CONSUMPTION REQUIRED TO REACH .10 LEVEL

- Using Alco-Calculator and/or other scales, demonstrate:
 - For 150-lb. male—4 ounces of 100 proof over one-hour period.
 - For 170-lb. male—6 ounces over one-hour period.
 - For 120-lb. female—2 ounces over one-hour period.

16mm Film: "Under the Influence"

INTRODUCE FILM

Major points to watch for are:

- These 30 drivers were randomly chosen from among 500 volunteers who were judged to be "experienced" drinkers.
- All drivers were tested on standard reaction time tests while under the influence, and found to be able to react better than normal drivers.
- The ASAP project staff and police personnel provided eight hours of training on the driving course before these drivers were tested and scored on "dry" runs. The course represents, for the most part, typical driving behaviors, although the use of safety cones makes it appear less typical. The most critical decisions shown in the movie

must be made on the accident simulator where the driver approaches three red traffic lights from a center lane and must quickly veer into the lane on which the light turns green and then stop. This is representative of the dart-out accident or an intersection crossing where a car unexpectedly pulls out in front of the driver.

Pages 35 - 38

SHOW FILM

Ask for comments.

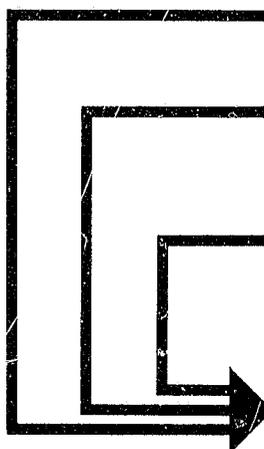
- Refer participants to page 14 of **Participant's Manual**, "Predictable Kinds of Impairment Occur at Specific BACs." Lead discussion of how alcohol depresses central nervous system, how judgment is impaired. Relate this to what was seen in film.
- Refer to page 15 of **Participant's Manual**, and discuss the marked changes in the driver's attitudes and skills at high BACs.
- Review page 16 of **Participant's Manual**, and ask participants to respond to these 14 items which list statistics on drinking drivers.
- Obtain group reaction to "Conclusion" on page 16. Lead discussion of National Safety Council's endorsement of .08 percent as impaired, rather than .10 percent.

SUMMARY

- Review to assure that all participants agree that BAC is an **accurate** measure of impairment by alcohol, and that the .10 percent BAC level impairs driving skills in **all** drivers.
 - Recap film's conclusions and ask if there are any questions.
-

Supporting Materials

THE PROBABLE DEGREE OF DRIVING IMPAIRMENT CAN BE MEASURED BY BAC



When alcohol enters the bloodstream, it acts as an anesthetic and impairs behavior in all people.

There are certain proven correlations between the amount of alcohol in the blood and the degree of impairment.

The amount of alcohol in the blood (called Blood Alcohol Concentration or BAC) can be accurately measured by chemical tests and expressed in terms of a percentage.

Therefore—if the measuring method is accurate—the BAC is an accurate measure of impairment.

THE NUMBER OF "DRINKS" CONSUMED IS NOT A RELIABLE INDICATOR OF DEGREE OF IMPAIRMENT

Concentration of Alcohol

The greater the concentration of alcohol in a beverage, the more rapid the rate of absorption and the higher the concentration of alcohol in the blood.

Amount of Alcohol

The more alcohol ingested at any one time the longer the absorption period will be.

Rate of Drinking

The rapid ingestion of beverage alcohol will likely result in elevated alcohol levels, while drinking in small, divided amounts prevents high alcohol concentrations.

Amount of Food in the Stomach

Presence of food in the stomach delays the absorption of alcohol by diluting the alcohol and causing slower absorption.

Non-Alcohol Substances in Alcoholic Beverages

Generally, the more non-alcoholic substances in a beverage the more slowly will be the absorption of alcohol. However, the carbon dioxide present in drink mixes and sparkling wines actually speeds up absorption.

Body Weight

The more a person weighs, the lower will be the blood alcohol concentration, because heavier persons have more body fluids which dilute the alcohol.

Pylorospasm

In some drinkers, the consumption of too much alcohol causes the pylorus (muscular valve between the stomach and small intestine) to contract. This spasm may retard absorption and delay intoxication or result in nausea and regurgitation.

Psychological Factors

Such phenomena as stress, anger and fear are presently recognized as factors which also influence the emptying of the stomach.

Source: Charles Carrol. *Alcohol Use, Nonuse, and Abuse*, 1970

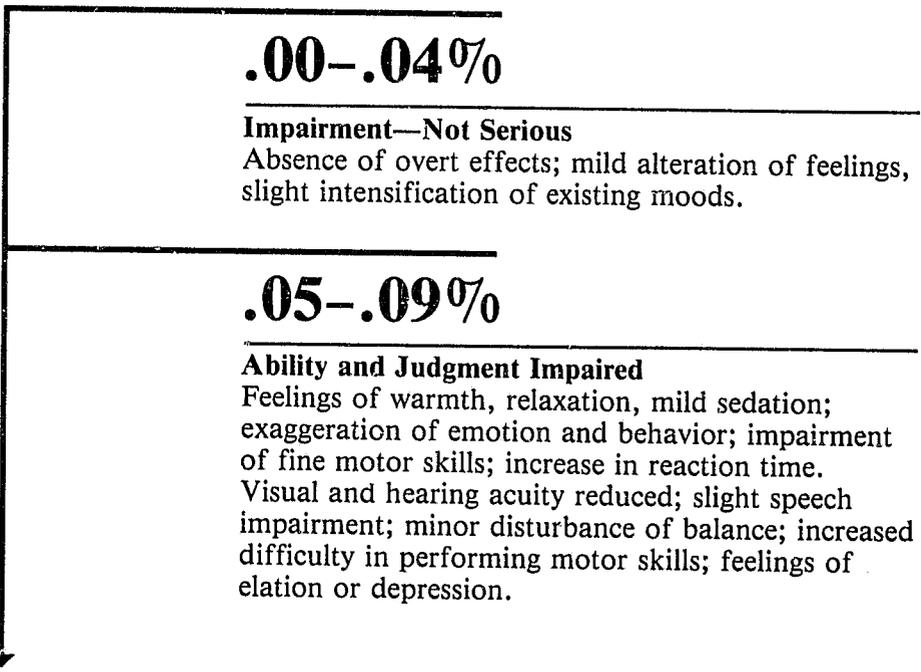
IT TAKES A LOT OF ALCOHOL TO REACH A HIGH BAC

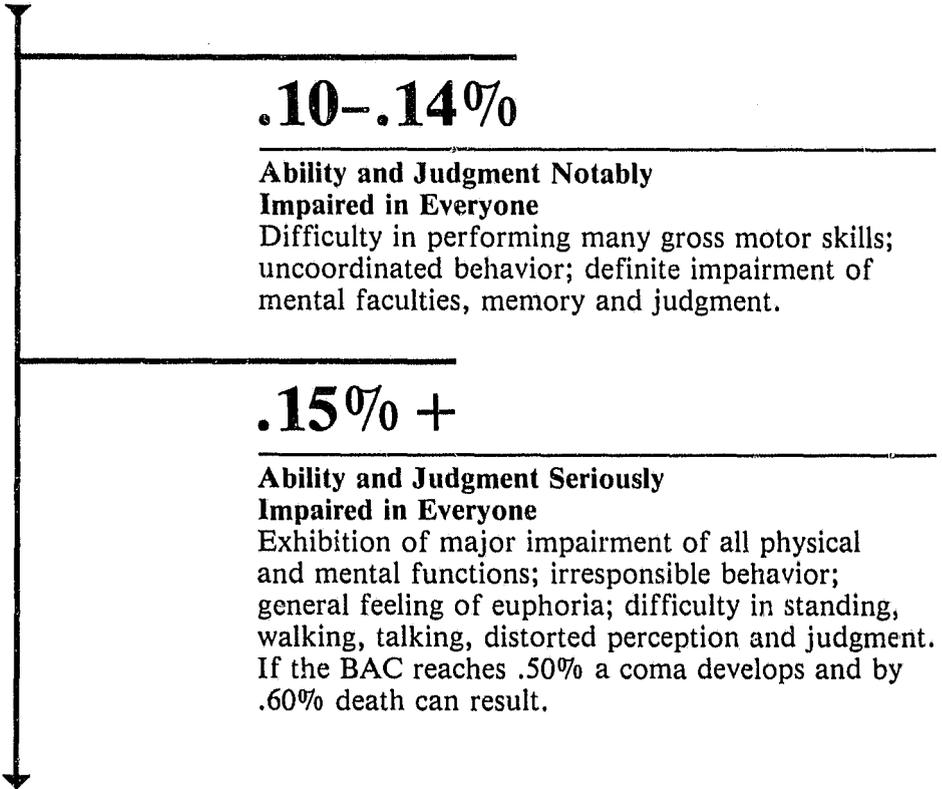
IT TAKES TIME AND ONLY TIME TO SOBER UP

	.05%	.10%	.15%
	A 160 lb. drinker (drinking 1 ounce of 86 proof alcohol per drink) needs	He needs	He needs
	4 drinks in 2 hours	6.5 drinks in 2 hours	9 drinks in 2 hours
	and he needs	and he needs	and he needs
	3.5 hours to sober up BAC = .00%	6.5 hours to sober up	10 hours to sober up

Source: Rutgers Alco-Calculator

PREDICTABLE KINDS OF IMPAIRMENT OCCUR AT SPECIFIC BACS





Source: Charles Carroll. Alcohol Use, Nonuse, and Abuse, 1970

THE DRIVERS' ATTITUDES

- There was a distinct change in attitudes toward the test.
- The drivers tended to do things they never would have done if they had been sober while driving.
- The driving attitude tended to be much more aggressive on the wet runs.

THE DRIVERS' SKILLS

- There was a decreased ability to sense change in the car's direction.
- There was a decreased ability to sense the attitude or the position of the car, particularly on curves.
- There was a decreased ability to sense speed; i.e., maintain a cruising speed.
- There was a decreased ability to cancel quickly a reaction that had been initiated.
- There was a decreased ability to control the rate of deceleration.
- The driver tended to react to the situation rather than anticipate it.

- Drivers drove up to things more quickly and then stopped too soon.
- Deep muscle sense was generally inhibited.
- Drivers reacted to visual cues where they normally reacted to a combination of sensory cues; thus, they tended to react after something had already happened or had already begun to happen. Weaving action resulted from this.

THE DRINKING DRIVER IS A PROBLEM OF MAJOR PROPORTIONS

- Drinking drivers are **responsible** for crashes four times more often than they are the **victims** of crashes.
- Over 800,000 crashes per year are alcohol-related.
- About 23,000 deaths per year result from alcohol-related auto accidents.
- One to six percent of drunk drivers (those with a BAC of .10% or higher) cause 50% of fatal single-car accidents.
- Problem drinkers account for at least 60% of alcohol-involved accidents.
- Forty-five percent of drivers killed in multi-car crashes had a BAC of .10% or higher.
- As high as 97% of drivers arrested for "driving under the influence" have a BAC of .10% or higher.
- Most alcohol-involved crashes occur between 6:00 p.m. Saturday to 6:00 a.m. Sunday.
- Between 10:00 p.m. and 2:00 a.m. on Fridays and Saturdays, one out of every 10 drivers on the road is at .10% BAC or higher.
- Eighty percent of the fatally injured drivers who were **not** at fault in all crashes had **no** alcohol in their bodies.
- Of drivers killed in single-car crashes, 41-72 percent had a BAC of .10%.
- Eighty percent of passengers killed in single-car crashes had been drinking.
- Drinking driver arrests in America average out to approximately six arrests per policeman per year in 1976.
- For every drinking driver arrest, an estimated 2,000 such offenses go unheeded.

Source: ASAP Summary Report, 1976

CONCLUSION

Driving impairment occurs at much lower BACs than most people realize.

Moderate BAC levels (.01-.07%) affect:

- Perceptual motor skills
- Risk-taking behavior
- Decision processes involved in driving

High BAC levels (.08% +) lead to:

- Erratic movement (weaving, swerving)
- Extreme caution or recklessness
- Failure to anticipate hazards
- Failure to maintain lane control
- Aggressive driving

In view of the scientific evidence on impairment at low BAC levels, the National Safety Council Committee on Alcohol and Drugs in 1971 took the position that a BAC of .08% in **any** driver of a motor vehicle is indicative of impairment in his driving performance.

ALCOHOL INFORMATION INVENTORY

Please check (✓) the appropriate answer.

1. What is the Blood Alcohol Concentration (BAC) level presumptive of legal intoxication in this state?
 - a. .05%
 - b. .08%
 - c. .10%
 - d. .15%
 - e. .20%

2. Approximately how many drinks (one-ounce shot of 86 proof whiskey, twelve-ounce can of beer, or four-ounce glass of wine) would a 175-pound man have to consume to reach this BAC? Assume that he drinks them within an hour's time and that he has not eaten for at least three hours.
 - a. Three
 - b. Six
 - c. Nine

3. Which of the methods listed below effectively sober up a person so that he will be able to drive safely? (check one or more)
 - a. Black coffee
 - b. Waiting as long as is necessary
 - c. Cold shower (or a dip in a swimming pool, lake, etc)
 - d. Hot shower, steam bath, sauna
 - e. A shock (like an auto accident, or near miss)
 - f. Exercise
 - g. Fresh air
 - h. None of the above

4. True or false: One or two drinks of alcohol sharpen your driving skills.
 - a. True
 - b. False

5. When a 175-pound man has had nine standard drinks on an empty stomach two hours before driving, what do you think his chances are of being involved in an accident?
 - a. 2 times greater than when he is sober
 - b. 5 times greater than when he is sober
 - c. 25 times greater than when he is sober

6. In most states, what proportion of the drivers arrested for driving while intoxicated do you think have had a previous arrest for DWI?
 - a. 1 in 2
 - b. 1 in 10
 - c. 1 in 25

7. In most states, what percentage of the drivers arrested for DWI do you think are already known to community service agencies for having other alcohol problems?
 - a. 10%
 - b. 50%
 - c. 80%

8. Approximately how many people were killed last year in traffic accidents in this country.
- a. 5,000
 - b. 25,000
 - c. 50,000
 - d. 100,000
9. Approximately what percentage of these deaths involved drinker-drivers or drinking pedestrians?
- a. 25%
 - b. 50%
 - c. 75%
10. What percentage of those accidents in which blameless drivers were killed were caused by drinking drivers?
- a. 15%
 - b. 45%
 - c. 75%
11. On the average, people arrested for DWI have Blood Alcohol Concentrations that would result from a 175-pound man drinking how many drinks in an hour?
- a. 3
 - b. 6
 - c. 10
12. Alcohol is medically considered:
- a. A stimulant
 - b. A depressant
 - c. Both
 - d. Neither
13. In California a study was made of the records of traffic violations of all types. What percentage of people who had had their licenses revoked were caught driving without a license?
- a. 15%
 - b. 35%
 - c. 65%
14. True or false: In most states, when a person is stopped for a DWI violation, his record is usually checked for previous violations (at least those violations which took place within the state).
- a. True
 - b. False
15. True or false: In most states alcohol is involved in more run-of-the-mill crashes than in serious crashes.
- a. True
 - b. False
16. True or false: Alcohol-related crashes typically involve drivers with BACs that are at very high levels rarely found among drivers who do not get into accidents.
- a. True
 - b. False

17. What proportion of adult pedestrians hit by vehicles are under the influence of alcohol?
- a. 10%
 - b. 40%
 - c. 80%
18. True or false: Since few alcoholics own cars, they do not contribute significantly to the drinking-driver problem.
- a. True
 - b. False
19. True or false: Very few convicted drinker-drivers have ever been involved in any crime (such as drunk and disorderly) other than DWI.
- a. True
 - b. False
20. True or false: Two-and-a-half times as many people are killed in alcohol-related automobile accidents as are killed in willful murders.
- a. True
 - b. False
21. True or false: Five times as many people are injured in alcohol-related car accidents as are hurt in crimes against persons (muggings, assaults, etc.).
- a. True
 - b. False

Source: Alcohol Highway-Traffic Safety Workshop

**ANSWER SHEET FOR
ALCOHOL INFORMATION INVENTORY**

1. .08 in Utah, .10 in all other states except Maryland and Mississippi, which have .15 BAC as illegal (1978 data).
2. Six
3. (b), waiting one hour for each drink consumed.
4. False
5. (c)
6. (c)
7. (a)
8. (c) (1978 data)
9. (b)
10. (b)
11. (c)
12. (b)
13. (c)
14. True
15. False
16. True
17. (b)
18. False
19. False
20. True
21. True

LESSON PLAN

4

The Responsibilities of PSI Personnel

Methods/Media: Lecture/Group Discussion

Time Allotted: Day One 2:45-5:00 p.m.

Equipment Required: Overhead Projector/Transparencies

OBJECTIVES

- Identify three possible points in the adjudication process where screening can take place.
- Establish the fact that all PSI personnel currently make judgments about levels of alcohol abuse, although they may or may not use the term "diagnosis."
- Identify the information used to determine levels of alcohol abuse among DWI population.
- Define the three levels of drinking problems—Social, Problem (or Borderline Problem), and Alcoholic (may be called only Problem Drinkers to avoid label of "Alcoholism").
- Request the group to make their preliminary diagnoses independently of each other to see how well they agree, and on what basis their judgments are made.

REFERENCES

SCOPE OF THE PROBLEM

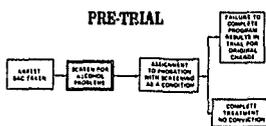
- Approximately 140 million licensed drivers in U.S. Less than five percent are arrested each year for DWI.
- Host state data:
 - Number of drivers in state.
 - Number arrested for DWI yearly: First Offense, Second, and Subsequent.
 - Drivers placed on probation = X.
 - Numbers of persons referred to community agencies by courts = X.
- Profile of DWI offender:
 - 25 to 35 year old male, either divorced or separated. (Females are only 10 percent of all DWI arrests.)
 - 65 percent Problem Drinkers (PDs), 35 percent Social Drinkers (national breakdown).

Source: State Traffic Safety Agency

WHO DOES THE SCREENING?

- ASA's site visits to seven jurisdictions (District of Columbia, Baltimore, Pittsburgh, Los Angeles, New Orleans, San Antonio, and Lafayette, Louisiana) included interviews and observations of persons who are responsible for screening, plus judges and prosecutors at each site.
- Profile of screening personnel:
 - 2-4 years of college, some with Master's degrees.
 - Agencies may be: Probation, Public Health, Mental Health, Division of Alcoholism, or ASAP.

Overhead #5



WHEN DOES SCREENING TAKE PLACE?

Review possible options that courts have for timing of the screening.

- Pre-Trial

Overhead #6



- Post-Trial

Overhead #7



- Pre-Sentence

Ask which model(s) are most applicable to court system under which participants presently work. Lead discussion of the relative merits of each model.

INTRODUCE CONCEPT OF DIAGNOSIS

- Elicit information from participants regarding the parameters they presently use to judge level of alcohol abuse. Some of these may be:
 - BAC at arrest.
 - Prior DWI arrests.
 - Other alcohol-related arrests.
 - Criminal record.
 - Marital/family problems.

Lead discussion of information page , and poll the group to obtain listing of **all** factors they currently consider when making their assessment of drinker type.

DEFINE THREE LEVELS OF DRINKING PROBLEM

- **Social Drinker**—Person who does not use alcohol to solve a problem. Quantity: 1-2 drinks per sitting. Frequency: Drinks only occasionally before dinner, at parties, or on weekends.
- **Borderline Problem Drinker**—Person whose drinking leads to problems with police, family, etc. One who has developed a psychological dependence on alcohol. Quantity: 2-4 drinks per sitting. Frequency: Two or more times/week.
- **Problem Drinker**—Shows actual signs of physiological addiction. States that he/she **WANTS** or **NEEDS** a drink at certain times. Has experienced blackouts. Has marital, job, or family problems directly related to alcohol abuse. Quantity: 4-5 drinks per sitting. Frequency: Daily or 3-4 times per week, but may only drink on weekends or days off, depending upon employment.

RESPONSIBILITIES OF SCREENING PERSONNEL

- Review model(s) chosen and describe the entire sequence of activities done by screeners, from initial interview through referral and monitoring, to exit interview (if applicable). Stress **legal** responsibility of probation department for offender's conduct during probation period. Explain that **authority** can be delegated to community agency for person's compliance with treatment program, but **responsibility** rests with probation department.

Pages 49, 50, 51

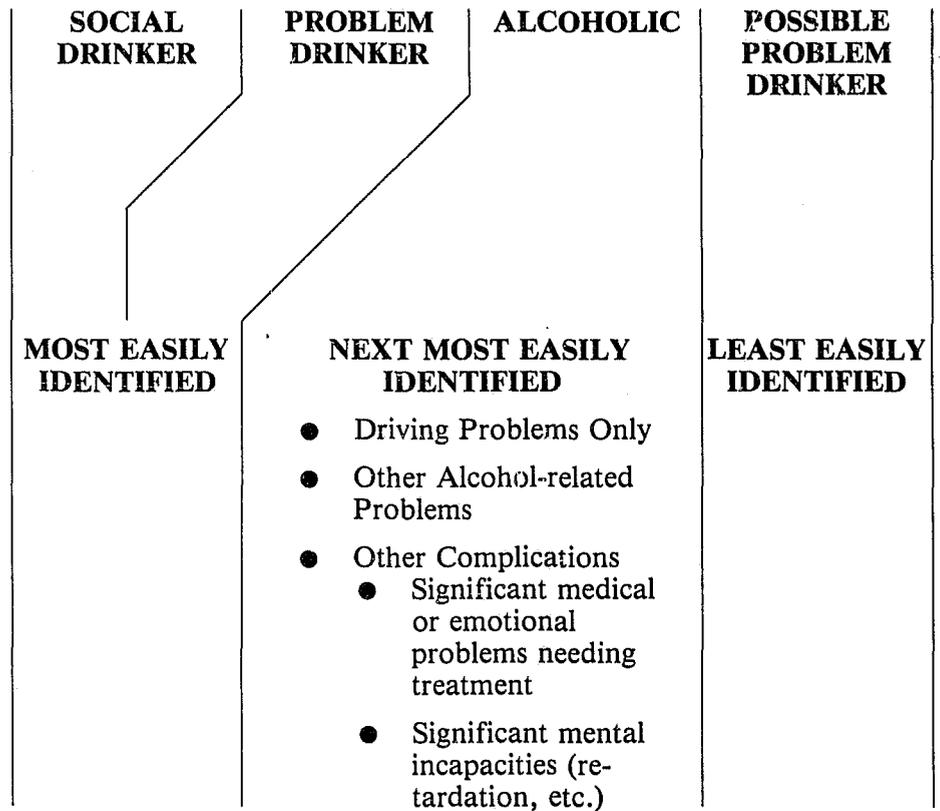
ASSIGNMENT

- Request that participants look at Cases 1-3 in Unit 4 of **Participant's Manual**. Explain that they are to decide for themselves, on basis of information given, what type of drinker the person is. Prefer no discussion/interaction among group members, since these should be **individual** decisions. **THERE ARE NO WRONG ANSWERS**. Responses will not be turned in or graded.
 - Ask if there are any questions on what is to be done. If none, adjourn for the day.
-

Supporting Materials

SCREENING MAY BE ENOUGH

The Screening Concept: Collect the least amount of information necessary for quickly sorting offenders into drinking types.



CASE NO. 1

Robert Grant, 38 Years Old

Marital Status: Separated since 1974.

Occupation: Shop Foreman at Bishop Foundry. Employed there for 16 years.

Criminal Record: DWI conviction, 1971

Driving Record: 4 July 1971 — DWI arrest and conviction, BAC of .14, no accident. License suspended for six months; paid fine/court costs.

21 Dec. 1973 — Reckless Driving arrest and conviction, accident with minor injuries to himself and passenger. Points assessed against license; paid fine/court costs.

Present Offense: 8 July 1977 — DWI arrest, BAC of .19, petitioned for diversion program, given 12 months' probation.

Observation: On brief contact with offender, interviewer observed that Mr. Grant appeared quite nervous, chain-smoking throughout the 20-minute interview. His responses to questions regarding his drinking quantity and frequency appeared guarded, but this may have been due to high anxiety. His hands are steady, but nicotine-stained. His general physical appearance is good, although his face seems flushed at the beginning of the interview. He is very reluctant to discuss his separation from his wife; answers questions in brief Yes/No manner.

Preliminary Diagnosis: _____ Social Drinker
[Check (✓) one] _____ Borderline Problem Drinker
_____ Problem Drinker

CASE NO. 2

Lewis R. Stone, 25 Years Old

Marital Status: Single.

Occupation: Truck Driver for McGraw Transport Co. Employed there for four years, immediately after discharge from U.S. Army.

Criminal Record: 18 Nov. 1968 — Arrested and convicted for Vandalism and Petty Larceny. Received six months' suspended sentence, 18 months' probation.
21 Jan 1969 — Arrested for possession of unregistered firearms and probation violation. Received 30 days in jail, but judge suspended sentence and placed him on reporting probation for 24 months. This was discontinued when he entered the U.S. Army in 1971.

Driving Record: 2 June 1969 — Speeding, 50 mph in 35 mph zone. Fine and point assessment.
14 Oct. 1969 — Speeding and Drag Racing. Fine and point assessment.
16 Mar. 1974 — Reckless Driving arrest and conviction. Fine and point assessment. License suspension was waived because of occupation.

Present Offense: 22 July 1977 — DWI arrest, BAC of .16, petitioned for diversion program, given 12 months' probation.

Observation: Mr. Stone's interview was brief because he arrived late for a 4:00 p.m. appointment. He explained that he was delayed at work, but did not apologize. His demeanor was off-hand, self-assured. When questioned about his drinking patterns and behavior while drinking, he responded that alcohol was not a problem to him, he could "take it or leave it alone." His account of the arrest is substantially different than the officer's report. He states that he was not weaving, only trying to avoid large potholes in the roadway. His appearance is excellent, he is clear-eyed and steady, although the interviewer detects a slight odor of alcohol on his breath. When asked if the RD conviction was plea-bargained down from a DWI, Mr. Stone takes offense, but does not become hostile. He contends that the RD citation was given for making an improper turn in his truck, without sufficient room to maneuver. He admits to having "a few drinks" on the night of the DWI arrest, but states that he was not drunk.

Preliminary Diagnosis: _____ Social Drinker
[Check (✓) one] _____ Borderline Problem Drinker
_____ Problem Drinker

CASE NO. 3

Daniel S. Felker, 36 Years Old

Marital Status: Married, two children.

Occupation: College Instructor. Employed at Community College for 10 years as full-time instructor.

Criminal Record: None

Driving Record: 2 Oct 1968 — Negligent Driving, resulting from accident in which his vehicle hit another from behind. Fine and point assessment.
15 Aug 1973 — Speeding, 55 mph in 45 mph zone. Fine and point assessment.

Present Offense: 20 July 1977 — DWI arrest, BAC not recorded, petitioned for diversion program, given 12 months' probation.

Observation: Mr. Felker was very nervous but most cooperative in his interview. His chief concern appeared to be that he might lose his license. After explaining that that could only happen if the probation was violated, the interviewer questioned him regarding the quantity and frequency of his drinking. Mr. Felker contended that he very rarely drinks (1-2/month), but that he'd had some personal problems the day of the arrest and drank nearly half a bottle of wine that evening at a friend's house. He then attempted to drive home, realized he was too drunk, and pulled over to the side of the road to sleep, but left his engine running. This correlates with the officer's arrest report. He said the officer told him his BAC was about .12. Other than bloodshot eyes, his physical appearance showed little evidence of alcohol abuse.

Preliminary Diagnosis: _____ Social Drinker
[Check (✓) one] _____ Borderline Problem Drinker
_____ Problem Drinker

LESSON PLAN

5

Screening Instruments

Methods/Media: Lecture/Demonstration

Time Allotted: Day Two 9:00-11:00 a.m.

Equipment Required: Three Videotapes, Playback Machine
CPIP Test Blanks and Scoring Keys

OBJECTIVES

- Review preliminary diagnoses and point out areas of disagreement among PSI personnel.
- Explain subjective nature of these diagnoses as opposed to the desirable objectivity of a screening instrument. Do the Exercise of 30 Squares to illustrate differences in people's perceptions of the same information.
- Describe briefly the history of various instruments (MAST, NCA Criteria, Johns Hopkins, CPIPD) and contrast these with one another in terms of their respective validities and reliabilities.
- Using videotapes, demonstrate administration of the CPIPD, and proper interviewing techniques.

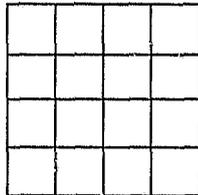
REFERENCES

- Jacobson, G. R. **The Alcoholism: Detection, Diagnosis and Assessment.** New York: Human Sciences Press, 1976.
- **Appendix B. Sample Tests in Participant's Manual.**
- Mushill, E., & Struckman-Johnson, D. **A reassessment of diagnostic screening procedures, 1977.**
- University of South Dakota. **1974 Analytic Studies Nos. 5 and 6.**

REVIEW GROUP'S DIAGNOSES

- Begin at right and ask first group member to state his/her diagnosis of Case 1, Robert Grant, and the **reason(s)** why this category was chosen. Continue with next person and ask all around the table. Answers to **why** category was chosen will be repeated after second or third participant, to eliminate repetitive answers by asking if anyone has anything to **add** to this diagnosis. If yes, allow it to be stated. If no, canvass entire class and record how many persons chose each category. Lead discussion of why different diagnosis might be made, depending upon investigator's interpretation of information.
- Ask group what **additional** information would be sought to help clarify Robert Grant's alcohol abuse problem. (Suggestions: Interview spouse, inquire about RD conviction to see if it was plea-bargained down from DWI.) Lead discussion of other avenues of information as long as group interest remains high and discussion is productive.
- With Case 2, begin at left and ask participants to state his/her diagnosis of Lewis Stone, and reasons why diagnosis was made. Continue as in Case 1.
- With Case 3, begin at middle of table where respondents have not yet had the opportunity to be first diagnostician, and move to either right or left, asking each person to respond. Proceed as in Cases 1 and 2.

Draw the figure like the one below on the board and ask the group to count the squares and write down the total, without discussion with others. Wait 5 minutes. Ask each individual to tell you the total they have, writing these on the board as they tell you. The correct answer is 30, but answers may vary from 16-30+. Explain that this is an exercise in **perception**, and different people perceive things differently. That's why subjective judgments disagree from one person to the next.



Illustrate to group the disparities in their judgments, since all are subjectively based. Ask how these differences in judgments might affect the defendants. Is the subjective judgment of one investigator the same as all others? If not, what are the consequences? Is treatment different for Borderline Problem Drinker and Problem Drinker? Isn't an objective, consistently applied diagnostic tool called for here? What are advantages/disadvantages of subjective versus objective assessments of drinking problems.

Lead discussion, but abbreviate arguments of "right" or "wrong" diagnoses, and focus the group on consistent and defensible judgments. This unit should lead to the value of the screening tools to be explored.

HISTORY OF DIAGNOSIS AND ASSESSMENT

- Prior to ASAP, there was virtually no assessment of levels because:
 - Inadequate funds
 - Lack of concept of differential treatment
 - Lack of authority to gain the offender's cooperation
 - Criteria for referral did not exist
 - Almost all PSI were done on felons and not misdemeanants
- The original concept of PSI, as formulated by NHTSA before the ASAP projects were implemented, included:
 - Background investigation, including driving and criminal records, interviews with family and associates, structured interviews and questionnaires, and medical/psychological examination.
 - This was to be a diagnosis of drinking problem severity, **NOT** rehabilitative counseling.
 - Recommendation of the most appropriate course of action based on diagnosis.
 - Referral to appropriate rehabilitation agency.
 - Probation or follow-up contact to ensure compliance.
- What ASAP personnel actually did:
 - Background data—Initially too long, expensive, time-consuming and frequently irrelevant to diagnosis. Evolved to simple, relevant, inexpensive methods.
 - Diagnosis—In-depth diagnosis not intended nor relevant to the needs of the court. Evolved from diagnosis to screening and categorization into three drinking types—Social, Borderline Problem, and Problem.
 - Recommendation—Evolved from the original lengthy descriptions (including recommendations of criminal penalty) down to two basic elements:
 - Classification of the type of drinking problem
 - Recommended choice of disposition pattern (i.e., agency and perhaps duration of court control).
 - Referral—Eventually followed routine referral patterns for certain classifications of offender, depending upon available treatment/educational resources.
 - Follow-up not adequately resolved—ASAPs have not consistently answered questions related to who is responsible for reporting offender progress, how progress is measured, etc.
- As part of the ASAP program, NHTSA established criteria for defining a problem drinker. These include:
 - Diagnosis as an alcoholic by a competent medical or treatment facility.
 - Self-admission of alcoholism or problem drinker.

- Two or more of the following:
 - BAC of $\geq .15$.
 - ≥ 1 prior.
 - Record of previous alcohol-related contacts with medical, social or community agencies.
 - Reports of marital, employment or social problems related to alcohol.
 - Diagnosis of problem drinker on the basis of an approved, written diagnostic interview instrument (i.e., MAST, CIPID, NCA and/or Johns Hopkins).
- Non-problem drinkers are defined as those who do **not** meet the above criteria.

TWO OTHER GENERAL APPROACHES WERE INVESTIGATED FOR POSSIBLE USE AS SCREENING TECHNIQUES

- The first included attempts to determine what types of demographic data are predictive of arrest for DWI. Of characteristics such as age, sex, race, occupation, education, marital status, income, etc., none were found to be predictive of re-arrest.
- The second approach used information regarding offenders' BAC at arrest, prior DWI offenses, prior criminal offenses, prior traffic offenses, and prior public intoxication offenses to predict DWI arrest. Of these variables, only BAC at arrest and prior DWI offenses were found to be predictive. We will talk more about these variables later as alternative screening techniques.

STANDARDIZED TEST SCORES

NHTSA included scores from standardized tests as part of the criterion definition of a problem drinker. We will now turn our attention to objective tests frequently used to establish level of drinking problems in a DWI offender.

To be useful, these screening tests would have to be valid, reliable, efficient, and readily implementable by court personnel. In addition, they must be legally acceptable for use in screening.

We will discuss five techniques used to screen for alcohol problems: (1) the NCA criteria, (2) the NCA 26 Revealing Questions, (3) the Johns-Hopkins University Hospital questions, (4) the MAST, and (5) the CIPID (i.e., Mortimer-Filkins). We will discuss each in terms of:

- How they were developed.
- The characteristics of the test.
- Their quality, in terms of reliability and validity.
- Explain reliability.
 - Define—Reliability is the ability of a measuring device, like a test, to indicate the same measure, or score, if one were to test

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Page 68

and then immediately retest the same person before he/she changes.

Example:

If you were to measure the width of a book with a steel tape measure twice, you would obtain nearly identical measures both times, regardless of who used the tape measure. This measuring device is reliable.

However, if you were to measure the hooks with an elastic tape measure, you would be much less likely to obtain the same measure twice, especially if two different people do the measuring.

- Explain validity.
 - Define—Validity refers to the ability of a test to measure what is supposed to measure.

Example—An accurately marked steel tape measure validly measures length; it is also reliable. However, it is not a valid measure of intelligence if one were to measure foot length. It would be very reliable, since the same result would be found upon second measure, but not at all valid.
- Numerical measures of reliability and validity:
 - Measured by a mathematical process called correlation.
 - Yields a number between 0.00 and 1.00, called correlation coefficients.
 - The closer to 1.00 the better the test, but there are differences between reliability and validity.
 - The best psychological tests yield reliabilities in the .90-.99 range. If reliabilities are lower than .90, the test needs improvement.
 - In the best psychological tests, validities up to .60 are acceptable. Useful tests, however, yield validities of .30 or better.
 - Good tests, then, will have reliabilities around .90, and validity above .30.

See Appendix B for
copies of sample tests

FIRST TECHNIQUE

The first technique of identifying a problem drinker that will be discussed is that developed by the National Council on Alcoholism (NCA); i.e., the NCA criteria, found in Appendix B. Point out:

- Generated primarily by medical personnel.
- Distinction between major and minor criteria.
- Distinction between clinical and behavioral indicators.
- Diagnostic weights: Note in particular the reference to BAC levels.
- Introductory material explains the likelihood of becoming a problem drinker as a function of personal and socioeconomic conditions.
 - Family history of alcoholism, including parents, siblings, uncles.

- History of teetotalism in the family, particularly where strong moral overtones were present. Most particularly, where social milieu of the subject has changed to an environment where drinking is encouraged or required.
- History of teetotalism or alcoholism in the spouse or the family of the spouse.
- Coming from broken home or home with much parental discord, particularly where father is absent.
- Being the last child of a large family—or last half of a large family.
- Having remale relatives of more than one generation who have had a high incidence of recurrent depressions.
- Heavy smoking (reverse not necessarily true).

Source: Jacobson, G. R., *The Alcoholisms: Detection, Diagnosis, and Assessment*, 1976.

SECOND TECHNIQUE

NCA Questionnaire—26 REVEALING QUESTIONS (See Appendix B) is the second technique to be discussed. These are frequently used by screening personnel.

- Development:
 - Questions were originally part of an industrial alcoholism pamphlet.
 - Currently printed in a pamphlet entitled "What are the Signs of Alcoholism?"
 - NCA personnel stated emphatically that the 26 questions were **not** designed as an alcohol screening test, but rather as an aid to self-diagnosis.
 - Most commonly given to people at their first attendance of AA meeting and told it is to be used as a guideline in determining whether future attendance would be beneficial.
- Characteristics:
 - 26 questions regarding use of alcohol, 10-15 minutes administration time.
 - Questions answered Yes or No.
- Scoring:
 - Yes to Questions 1-8 = early stage of alcoholism.
 - Yes to Questions 9-21 = middle stage of alcoholism.
 - Yes to Questions 22-26 = beginning of final stage.
- Assessment:
 - Validating sample = unspecified.
 - Appears to underclassify subjects, i.e., fewer people classified as problem drinker than actual.
 - Validity and reliability = unspecified; no studies performed.

JOHNS HOPKINS UNIVERSITY HOSPITAL QUESTIONS

(See Appendix B)

- Development:
 - Originally 35 Yes-No questions written by R. V. Seliger, M.D., for a 1939 publication of the magazine **Your Life**. (No Johns Hopkins personnel involved.)
 - Published again in 1945 as "Alcoholics are sick people."
 - Again, in 1955 (August), U.S. News and World Report reduced and edited it to 20 questions entitled "What you should know about drinking."
 - May appear in a number of forms. Most popular one in use uses 30 questions.
 - Not devised as a screening device.
- Characteristics:
 - 20-30 questions regarding drinking pattern/effects—10-15 minutes administration time.
 - Yes/No question format.
- Scoring:
 - Any 1 of the 30 questions answered Yes = definite warning that you may be an alcoholic.
 - Any 2 of 30 questions answered Yes = chances are that you are an alcoholic.
 - Any 3 of 30 questions answered Yes = You are definitely an alcoholic.
- Assessment:
 - No validation sample described—ever.
 - No reliability or validity studies reported.
 - Overclassifies subjects—many people classified as a problem drinker who actually are not.

MICHIGAN ALCOHOLISM SCREENING TEST (MAST), 1971

(See Appendix B)

- Development:
 - Not guided by any particular theoretical orientation, but arose out of the author's experience with medical students.
 - Developed as a quick, consistent way of identifying alcoholics by interviewing them or their families.
 - Originally 28 questionnaire items, later reduced to 24. A recent short-form has been devised, consisting of only 10 items.
- Characteristics:
 - 24 questions = 10-15 minutes administration time.
 - Yes-No question format.

- Scoring—each question may receive a score of 0–5 points, and “Yes” answers to any one of the three critical items (questions 8, 19, and 20) are considered to be diagnostic of problem drinker. Score ranges between 0–53. For some reason, the question “Have you ever attended an AA meeting because of your drinking?” and a questions on having delirium tremens only score two points each.

0–3 points = No drinking problem
 4 points = Suspicion of alcoholism
 5 points = Alcoholic

- Assessment:
 - Validating samples include: alcoholics and nonalcoholics; both hospitalized and unhospitalized; prison population; psychiatric patients; male and female; large numbers of blacks; 30–40 Mexican-Americans; some American Indians and Orientals; and large numbers of DWI offenders.
 - No reliability data presented.
 - Validity—the test will identify alcoholics, if they respond truthfully.
 - It was found to severely underclassify when applied to DWI population in ASAP locations. Of those classified as non-problem drinkers by MAST, 91 percent were problem drinkers by valid ASAP drinker classification criteria.
 - Caution in use is strongly recommended. Good substantiating evidence is needed for accurate diagnosis.

CPIPD Package

V.1 Manual

V.2 Supplementary Readings

V.3 Scoring Key and Final Report

COURT PROCEDURES FOR IDENTIFYING PROBLEM DRINKERS (CPIPD)

- Development:
 - Intended and built as a three-level screening device (i.e., social, borderline, and problem drinker).
 - Built to take into account alcohol-related offenses; building rapport; discourage faking; make inexpensive, quick, easy to use, objective, standardized, valid and reliable; and to cover specific signs and symptoms relevant to detection of alcoholism in early stages.
 - Original 135 items of questionnaire have been revised and reduced to 58 items.
 - Original 66 interview questions were increased to approximately 70 discrete items (plus subparts for some questions). Items were selected for their ability to discriminate between problem and nonproblem drinkers, rather than for any logical or theoretical reason.
 - Items tap problem drinking behavior and degree of general neuroticism (free-floating anxiety). Each is scored separately, and then combined to yield a total score indicative of level of alcohol problem.

**Volume 1.
CPIP Manual**

- Characteristics. The CPIPD is a two-part instrument, a questionnaire and an interview. [Hand out copies of questionnaire and interview if group is not using this instrument.]
 - Questionnaire = 58 items, self-administered, Yes/No True/False, or very brief response. Takes 5-10 minutes administration time. There are two scoring keys—Key A for problem drinking items, and Key B for neuroticism items. Combination of A and B scores yields a total Questionnaire score.
 - Interview = 70 items. Takes 14-15 minutes administration time, objective and subjective. Must be individually administered. Scoring key is used after offender responses are converted to Yes/No format, and yields an Interview score.
 - The CPIPD test manual provides:
 - BAC, driver and criminal record tally sheet.
 - Questionnaire and Interview summary sheet.
 - Treatment and evaluation sheet.
 - A complete questionnaire with instructions.
 - A complete set of interview questions, with instructions.
 - Manual contains complete administration and scoring procedures. Also contains references for supplementary sources, and ancillary instructions indicating:
 - Physical reactions and diseases related to intoxication and alcohol dependence.
 - Ways to find listings of treatment agencies in the community.
 - Information to be sought in each agency (i.e., purpose, type of service, cost/client and pay schedule, hospitals and days of operation, telephone, address, director, criteria for accepting client and types of clients it feels it can willingly and successfully treat).
- Administration suggest using questionnaire first since it is less threatening.
 - Questionnaire instructions see page 7-8 of CPIPD Manual. Review quickly. Page 37 gives exact instructions.
 - Interview instructions, see page 9 of CPIPD Manual. Pages 10-20 contain rationale behind individual interview questions. Read the exact instructions on pages 41-42.
 - Let the participant briefly look through the questionnaire to get a flavor of the test items.
 - Introduce the videotape. Have participants attend to:
 - The instructions.
 - The manner of questioning.
 - The nature of the answers, since they will be scoring the interview later.
 - Point out any obvious jurisdictional differences that may be on the tape.

**Videotape 1.
"Sample CPIPD"**

- Once the tape is complete, discuss participant reactions to:
 - The nature of the test.
 - The interviewing techniques.
 - The level of drinking problem of the offender.
- Give a complete explanation of the scoring of the questionnaire. It is best to score a sample questionnaire with the class.
 - Include scoring of each item.
 - Page score placement on summary sheet.
 - Complete item by content tallying.
 - Answer all questions.
- Explain the scoring procedures for the interview.
 - Include scoring of each item.
 - Page score placement on summary sheet.
 - Complete item by content tallying.
 - Answer all participant questions.
- Hand out sample interview for scoring assignment.
- Explain procedures for obtaining total score (i.e., Questionnaire and Interview) and interpretation.
 - Problem drinker = 50+. Severe—countermeasures sorely needed.
 - Presumptive problem drinker = 40-49. Highly presumptive of problem drinker. Consider subject problem drinker unless other evidence to the contrary. Be particularly suspicious of young persons under 25 who score in this range.
 - Non-problem drinker = less than 39, unless other strong evidence to the contrary is present.
 - Mention that original cut scores were higher when revised due to underclassification.
- Interpretation of partial scores (This is NOT recommended).
 - Questionnaire = ≥ 16 . Clear problem drinker. 15-12 presumptive problem drinker. Less than ≥ 11 non-problem drinker.
 - Interview = ≥ 50 . Clear problem drinker. 40-49 presumptive problem drinker. ≥ 39 non-problem drinker.
- Completing the BAC, driving and criminal record tally sheet, see page 38 of the Manual.
- Use of treatment evaluation sheet is explained on page 26 of the Manual.
- Assessment of the CIPD.
 - Validation samples—Initial validation was done on 297 control subjects and 192 problem drinkers in Michigan. Documented population in terms of age, sex and marital status, and obtained driving records of all participants.

- Control subjects were recruited from civic, religious, labor, and other organizations, and through public advertisements. Included were firemen, church members, persons seeking job counseling or collecting unemployment, and students.
- Problem drinkers were drawn from the prison population, hospitals, Salvation Army out-patient half-way houses, alcohol counseling agencies from Detroit, Annapolis, Denver, and Toledo.
- Validation studies:
 - Initial validation was a double cross-validation using the control (non-problem drinkers) and problem drinker samples described above. Each group was split into two subgroups. Sample items were given to one-half of each group, and only the discriminating items were kept. Revised tests were then administered to the remaining halves of each group to determine validity.
 - Neither Questionnaire nor Interview alone discriminated as well as the Questionnaire plus the Interview.
 - CPIP scores were compared to county alcohol traffic safety program diagnoses of problem drinker or non-problem drinker. Ended up with validity correlations of .35 for the Questionnaire and .45 for the Interview, with .45 for the two together. Remember, validities of useful tests begin at .30.
 - In three ASAPs, CPIP scores of 700 subjects were validated against composite objective criteria, including BAC, priors, other alcohol-related arrests, and subjective classification by PSI personnel and psychiatrists.
- Reliabilities. Questionnaire = .95 and .94. Interview = .90 and .97. Questionnaire and Interview together = .98.
- Validity, although acceptable, can be improved. Filkins has stated that the CPIP is:
 - Less valid with an educated offender. They are able to fake their responses to reduce the likelihood of problem drinker diagnosis.
 - Will have some loss of validity due to poor reading, confusion of meaning.
- As good as the CPIP may be, it still underclassifies 17 percent as Social rather than Problem Drinkers, due to low or high education levels, and denial.

SUMMARY OF SCREENING TESTS

- Mention that other screening tests are used, i.e., Alcadd, Alcoholism Assessment Interview, Bell Alcoholism Scale of Adjustment, Drinking Behavior Interview, Iowa Alcoholic Intake Schedule, etc. All of these are reviewed and assessed in the Jacobson book.

- Emphasize the usefulness and quality of the CPIPD as compared to all other screening tests from the perspective of:
 - Objectivity.
 - Reliability.
 - Validity.
 - The CPIPD provides a defensible criterion by which problem drinkers and borderline problem drinkers can be defined.

Source: Jacobson. *The Alcoholisms: Detection, Diagnosis and Assessment*, 1976.

RESEARCH STUDIES ON SCREENING TECHNIQUES

NHTSA has recently sought to determine the effects of time for interview versus accuracy of prediction, and ways of reducing the number of cases requiring face-to-face contact for screening. If the total number of persons requiring screening interviews can be reduced, obviously the costs of screening will go down.

- Attempted to answer the question: "What offender characteristics give us the best prediction of rearrest?" Identification of offenders with those characteristics will indicate persons who are most in need of some type of rehabilitation.
- A study performed with data from ASAP sites is summarized in a table.
 - Explain that a multiple regression study was done to isolate the individual and cumulative abilities of each variable to predict recidivism of DWI offense.
 - Identify those variables with the highest predictive capabilities [i.e., BAC at arrest, number of prior DWIs, and the CPIPD (Mortimer-Filkins) test score].
 - Indicate that:
 - Predictive power of all data, including CPIPD prediction, is .6086.
 - Predictive power of all data **except** CPIPD prediction is .4815.

Source: University of South Dakota, 1974 Analytic Study Nos. 5 & 6.

SCREENING/DIAGNOSIS APPROACHES

- Explain how some states have approached reducing the number of intensive diagnoses:
 - New Hampshire screens only first offenders.
 - San Antonio. If the offenders have no priors and BAC is less than .14, they are sent to DWI school without diagnosis.
 - Cincinnati. If BAC is more than .20, offender is sentenced as a Problem Drinker **without** background investigation.
 - Unfortunately, the accuracy of these diagnoses have not been validated.
- As explained earlier, there are two systems in the Mushill & Struckman-Johnson approach to minimizing the numbers of intensive diagnoses to be performed by using BAC at arrest, number of DWI priors, and CPIPD score as discriminators of drinker types.

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Pages 69-71

Pages 69, 70

Pages 69-71

Pages 69-71

- The types of decision systems proposed are:
 - System A, in which there is only one treatment type per drinker category.
 - System B, where there is more than one treatment type per drinker category. Treatment type is dependent upon the particular problems of the offender.
- Diagnostic screening applicable in both cases.
 - First system—Determine probable severity only on subjects unidentified by either $> .15$ BAC or one or more prior DWI arrests.
 - Second system—Where resources are available to allow all DWIs to be screened, this system could be used to restrict intensive diagnosis to only those offenders classified by the CPIPD (Mortimer-Filkins) as a drinker type for which multiple treatment modalities exist (typically Problem Drinkers).
- **System A.** Less discrimination of group rearrest rate than System B. Social drinker is BAC $\geq .15$ and 0.0 priors (32 percent).* Borderline drinker is BAC $.16+$ and 0.0 priors (48 percent).* Problem drinker is 1+ priors (20 percent).*
- **System B.** Social drinker is one with a CPIPD score of more than 40 and 0.0 priors (56 percent).* Borderline drinker is one with a CPIPD of less than 40 and 0.0 priors (24 percent).* More intensive investigation is needed in these cases. Problem Drinker is one with 1+ prior (20 percent).*

System A results in less false negatives than System B, where the Problem Drinker may be misclassified as a Social Drinker due to his low test score and lack of prior arrests.

Discuss the possible use of the above systems with respect to advantages/disadvantages of each, in light of jurisdictional budget constraints.

*Percentages indicate the percent of the population that would fall into each drinker category if the criteria were applied to ASAP data.

Source: Mushill, E. & Struchman-Johnson, D. A Reassessment of Diagnostic Screening Procedures, 1977.

INTERVIEW TECHNIQUES

Discuss the importance of effective communication to establish good rapport and promote mutual understanding in order to make accurate diagnoses and appropriate treatment recommendations.

- Emphasize the importance of a comfortable and informal setting. Some important items include:
 - Arrangement of chairs, i.e., no barrier between the investigator and the defendant that would interfere with good eye contact or cause the investigator to "sit above" the defendant, causing him to feel threatened/inferior.
 - Table top cleaned of all unnecessary papers. All required files and forms at hand.
- Discuss the use of first impression as diagnostic data.
 - Non-verbal cues; e.g., eye contact, gestures, facial expression,

eye movement, tone of voice, etc.; provide insights concerning emotional reaction to the interview; e.g., fear, anger, etc.

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- The appearance of the defendant (hair, clothing) provides information concerning a person's self-image, and quite possibly the level of drinking involvement (i.e., cigarette burns on fingers, flushed face, etc.).
- A handshake provides additional data on the degree of tension felt by the defendant, and is a good icebreaker.
- Discuss the subtleties of building rapport, while pointing out those things which tend to alienate people.
 - Maintain eye contact.
 - Treat the offender as an equal.
 - Adjust your vocabulary and terminology to the person's level—don't "talk down" to him/her.
 - When the person is talking, give him/her your full attention, don't do other things (fill out forms, etc.).
 - Demonstrate an interest in the person as an individual by asking informal questions rather than plunging into fact-finding types of questions.
 - Ask the question, "What can you do to make the offender feel more comfortable?" Answers should suggest things like offering him/her coffee or a cigarette; asking about their home town or neighborhood, etc.
 - Use a warm tone of voice to convey your interest in the offender as an individual.

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- Discuss techniques for leading and directing the conversation to the main objective of the interview, establishing the level of drinking problem and selecting a treatment program.
 - Remind the investigator that he cannot afford to ignore the court's requirements in his attempt to be informal and pleasant.
 - Stress the importance of flexibility. This does not mean the investigator should always agree with things the offender says, only that he should always project an image of open-mindedness.
- Review quickly the different types of questions used in the interview, and the kinds of responses each question type elicits.
 - Direct questions, which usually result in a specific yes/no answer, should be used only to obtain facts.
 - These often result in putting people "on the spot," and arouse a defensive attitude.
 - Direct questions should be used sparingly, and only for factfinding. Give examples.
 - Open-ended questions, which are less threatening than direct questions, allow for a variety of possible responses, and can provide unexpected information and insights.
 - Careful, objective phrasing of each question is essential.
 - Questions of this type can be used to demonstrate the

investigator's concern and open-mindedness. Ask for examples from participants.

- Clarifying or summarizing questions reiterate what has been said and help to assure there is no misunderstanding on either part.
- Discuss the use of paraphrasing/restatement to check understanding of what has been said. Point out that, while paraphrasing ascertains what has been said, it does not imply investigator's agreement with what has been said.
- Explain perception-checking, and how it can be used to determine if the investigator is being understood (i.e., does the person understand the investigator's statements, and what the potential results of the interview might be?).
- Introduce the videotapes "Sample Interview Techniques" and "Barriers to Communication" to promote and expand discussion of the importance of good communication and ways of improving communication with the offender.

Videotapes
#2 and #3

SUMMARY

- The techniques outlined in this unit, when applied to the interview setting, will go a long way toward creating a positive attitude toward the investigator and the agency which he represents, and will aid in creating changes in the offenders' views of their errant driving/drinking behaviors.
 - Explain that the skills required to apply these techniques take time to develop, and many experienced investigators already possess many of these skills. They are reviewed here to refresh the group's memories, and highlight some good/bad approaches to the screening interview.
 - The effects of applying the techniques to increase communication will be greatly enhanced when combined with the personal characteristics of warmth, honesty, acceptance, and trust. Although comprehensive training in "human relations" is beyond the scope of this training package, these characteristics can be developed through guidance that might be found in group counseling seminars, helping professions clinics, and accredited sensitivity training programs that are frequently held by many state and local agencies for their personnel.
-

Supporting Materials

NHTSA'S DEFINITION OF A PROBLEM DRINKER

A problem drinker is an individual characterized by:

- Diagnosis as an alcoholic by a competent medical or treatment facility, or
- Self-admission of alcoholism or problem drinking, or
- Two or more of the following:
 - A BAC of .15 percent or more at the time of arrest,
 - A record of one or more prior alcohol-related arrests,
 - A record of previous alcohol-related contacts with medical, social, or community agencies,
 - Reports of marital, employment or social problems related to alcohol,
- Diagnosis as a problem drinker on the basis of approved structured written diagnostic interview instrument

SCREENING METHODS

In order to be useful or usable, a screening method must be—

- Valid
- Reliable
- Efficient
- Implementable
- Acceptable

SCREENING INSTRUMENTS

- National Council on Alcoholism Questions (NCA)
- Johns Hopkins University Hospital Questions
- Michigan Alcohol Screening Test (MAST)
- Court Procedures for Identifying Problem Drinkers (CPIP)

SUMMARY OF STEP-WISE MULTIPLE REGRESSION ANALYSIS FOR FULL SET OF PREDICTOR VARIABLES ON DRINKER TYPE CRITERION

Mult. r^2	Variable Number Entered
0.0442	1. Age
0.1532	2. BAC at arrest
0.2331	3. No. prior PI convictions
0.2413	4. No. reckless driving convictions
0.2422	5. No. HVM convictions
0.2423	6. No. driver license violation convictions
0.3177	7. No. prior DWI convictions
0.3223	8. No. convictions other crimes
0.3328	9. Educational level
0.3452	10. Income class

0.4758	11. Drinking pattern
0.4794	12. Marital status
0.4815	13. Work pattern
0.6086	14. Mortimer-Filkins score

The above summary indicates the degree to which knowing each of the variables on the right cumulatively increases the accuracy of predicting recidivism for any given motorist. The increase in prediction is indicated by the numerical increase in the multiple r^2 digits in the column on the left, where totally accurate prediction would be indicated by 1.0000.

For example, knowing a driver's number of license violation convictions, variable number 6, increases prediction of recidivism negligibly if one already knows variables 1 through 5. The increase in accuracy of prediction is very small—0.2422 to 0.2423. However, knowing the driver's number of prior DWI convictions increases accuracy of prediction from 0.2423 to 0.3177, which is a substantial gain. Other variables and their importance to prediction may be similarly derived from this table.

Source: Alcohol Safety Action Projects interim analyses of drinker diagnosis, referral and rehabilitation countermeasures: 1974. Analytic Study Numbers 5 and 6.

TWO SCREENING SYSTEMS

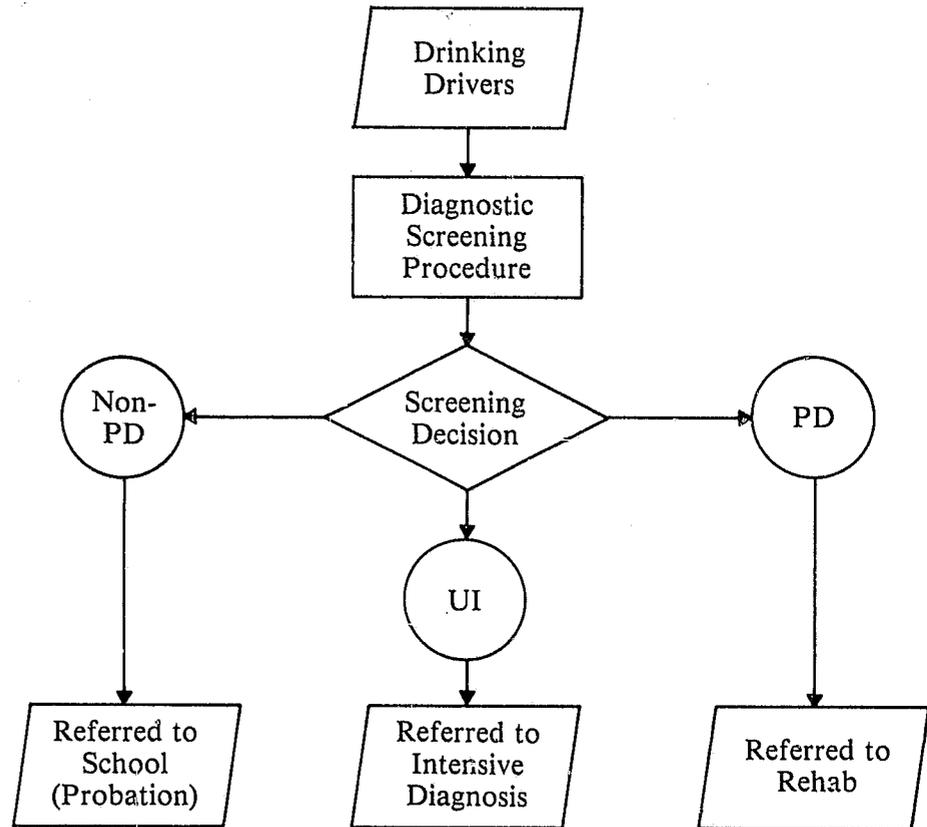
SYSTEM A

Drinker Type	BAC	No. of Priors	Percent of Population
Social Drinker	≤ .15	0	32
Borderline	> .15	0	48
Problem Drinker	N.A.	1 or more	20

SYSTEM B

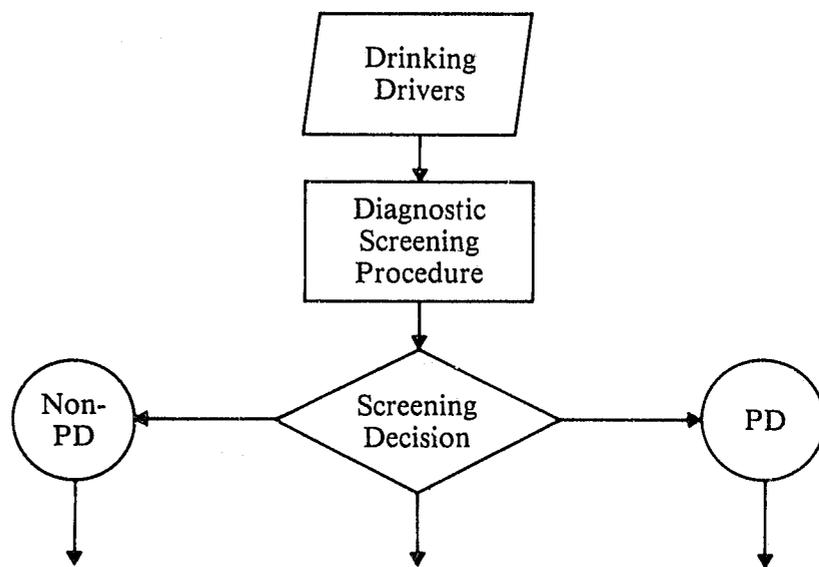
Drinker Type	MF Score	No. of Priors	Percent of Population
Social Drinker	< 40	0	56
Borderline	> 40	0	24
Problem Drinker	N.A.	1 or more	20

SCREENING SYSTEM A

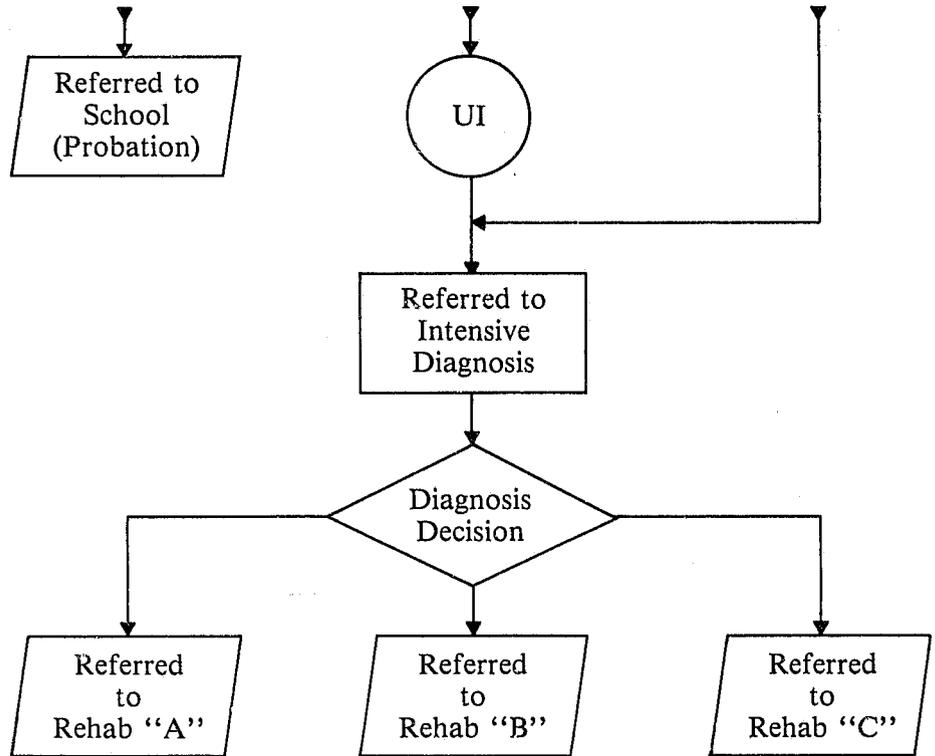


Client Flow For Systems With Unidimensional Treatment Programs
(Only One Referral Alternative Per Drinker Type)

SCREENING SYSTEM B



**SCREENING SYSTEM B
(Continued)**



**Client Flow For Systems With Multidimensional Treatment Programs
(More Than One Referral Alternative For One or Both Drinker Types)**

**INTERVIEW
TECHNIQUES**

- Questioning
- Active Listening
 - Paraphrasing
 - Perception-checking
 - Summarizing
- Confrontation
- Non-Verbal Cues

**BARRIERS TO
COMMUNICATION**

- Categorical Statements
 - Arguing
 - Sarcasm
 - Interruptions
 - Dominance
 - Poor Listening Habits
-

LESSON PLAN

6

Practical Application

Methods/Media: Role-Play/Critique

Time Allotted: Day Two 11:00-12:00, 1:00-2:30 p.m.

Equipment Required: Table and two chairs

OBJECTIVES

- Allow the participants to demonstrate their facility in interviewing DWI offenders, using the CPIPD.
- Critique the role-play and request comments and questions from the group.

REFERENCES

INTRODUCTION TO ROLE-PLAY EXERCISE

Describe the sequence of activities in a role-playing exercise:

Handouts:
Cases 1-9

- Driver's copy is given to person who will play role of offender. (One of the seminar leaders may choose to play the offender's role for the first role-play.)
- Stage is set by the person acting as the investigator. He/she should describe the most recent offenses to the group, and explain the reason for the interview.

Table and two chairs

CONDUCT ROLE-PLAYING

- The investigators will conduct the interview as they normally would, using a table/chairs off to one side of the classroom so that they can be readily observed by all.
- All participants and the seminar leaders will be asked to critique each simulated interview conducted.
- After the interview has been conducted, participants should be asked to comment **before** the leaders. Focus all discussion of the simulated interviews on the interview techniques used, the CPIPD questions, and the observance of good communication behavior.
- If time permits, request that investigators explore the different judgments they might make and sanctions they'd recommend for each case.

SUMMARY

Review the decisions made by the group regarding drinker types for all cases. Lead discussion of what types of education and/or treatment is available in their respective jurisdictions, and how these would be used for different drinker types and age groups.

Interviewer's Copy
CASE NO. 1

DWI—Fourth Offense

Interview Date: 1 September 1976
Name: Robert J. O'Malley
4529 Meridian, Center City
Date of Birth: 1 May 1929
Employment: Insurance Agent
Aetna Life and Casualty

Criminal Record:	Arrest Date	Outcome
	2 July 1968	DWI conviction, no BAC recorded, no accident. Received 12 months' probation and 30-day license suspension.
	14 Dec 1969	DWI conviction, BAC of .22, no accident. Received 18 months' probation, 90-day suspension and DWI school.
	3 Mar 1974	Reckless Driving, leaving scene of an accident. Placed on 18 months' reporting probation. Attended Mental Health alcohol treatment program for six months as part of sentence, as well as two AA meetings/week for three months.
	19 Mar 1977	DWI arrest with BAC of .26. Judge allowed him to be placed on 12 months' probation.
Driver's Record:	1945-70	Two speeding tickets, one DWI in this period.
	14 Dec 1969	DWI conviction, three months' license suspension. Attended DWI school.
	3 Mar 1974	Reckless Driving, six months' revocation.
	14 May 1974	Driving while license revoked. Two-year revocation, referral to alcohol rehabilitation agency.
	19 Mar 1977	DWI conviction. Currently awaiting DMV hearing on charge of Habitual Offender.
Present Offense:	19 Mar 1977	DWI arrest with BAC of .26.
Officer's Report:	Mr. O'Malley was observed first making an illegal turn, then proceeded to drive at 70 mph in a 45 mph zone. When stopped, he was angry and uncooperative. He fumbled for his license, his speech was slightly slurred, and he swayed standing on one foot.	
Court Status:	Mr. O'Malley is currently on 12 months' probation.	

**Interviewer's Copy
CASE NO. 2**

DWI—First Offense

Interview Date: 2 June 1977

Name: Brenda S. McHenry
5631 Semple Road, Center City

Date of Birth: 20 January 1956

Employment: Switchboard Operator
Farmingham Supply Co.

Criminal Record: None

Driver's Record: 9 June 1974 Backed into traffic from driveway onto Hill Drive
and hit 1968 Ford Brougham LTD. No injuries/
\$400 damage total.

18 Dec 1974 Hit parked car at shopping center. \$175 damage
total.

12 May 1976 Went through red light and hit bus. Minor injuries
to two bus passengers. \$1800 damages.

Present Offense: 22 Apr 1977 DWI arrest with BAC of .11.

Officer's Report: Ran STOP sign and hit pickup truck. No injuries, \$700 damage. Did
fairly well on psycho-motor tests, except for standing on one foot and
finding coins the officer dropped. Her speech was slurred and she was
in tears when stopped.

Court Status: Placed in diversion program for first offenders. Referred to probation
department for initial interview.

**Interviewer's Copy
CASE NO. 4**

Breath Test Refusal

Interview Date: 1 June 1977
Name: Alan B. King
2023 Hill Street, Center City
Date of Birth: 5 May 1938
Employment: Shop Foreman/Union Safety Officer
United Steel Works, Inc.

Criminal Record:	Arrest Date	Outcome
	22 Nov 1965	DWI conviction, BAC of .19. Entered diversion program on 12 months' probation. Attended DWI school.
	20 Oct 1974	Drunk and Disorderly. Arrested in downtown bar with two other men after a fight. Released on \$100 bond; later paid fine of \$50.
	26 Jan 1975	DWI conviction; no accident; BAC of .25. Referred to Mental Health Clinic for problem drinking. Attended four treatment sessions, then joined AA in March 1975.
Driver's Record:	26 Jan 1975	DWI, 60-day license suspension.
	7 Mar 1977	Breath Test Refusal, six months' suspension.
Present Offense:	7 Mar 1977	Refused breath test. Traveling north on Route 28, crossed centerline and collided head-on with another car. \$2200 damage, serious injuries to other driver.
Officer's Report:	Report states that when he came upon the scene of the accident, Mr. King was out of his car and giving aid to the other driver. He had been belted into his car, and only had a few bruises. The other driver was not belted and his head and chest were badly cut, so Mr. King used his first aid knowledge to help him. The officer noted the odor of alcohol on Mr. King's breath but, in the ensuing confusion didn't ask him to do any psycho-motor tests. When he did request that Mr. King take a breath test, Mr. King refused.	
Court Status:	Received suspended sentence and placed on 12 months' probation. Referred to this office for initial interview.	

Interviewer's Copy
CASE NO. 5

DWI—First Offense

Interview Date: 1 June 1977
Name: Madeline L. Quinn
3230 Jackson Hts., Center City
Date of Birth: 21 January 1946
Employment: Catering Service Manager
Hilton Hotel

Criminal Record:	Arrest Date	Outcome
	24 May 1969 New York City	DWI arrest with BAC of .12. Entered diversion program for first offenders; received 12 months' probation. Attended DWI school.
Driver's Record:	1 June 1970	Speeding, 60 mph in 45 mph zone.
	2 Nov 1972	Speeding, 70 mph in 50 mph zone
	18 Dec 1973	Reckless Driving, struck 1970 Chevrolet at an intersection after running STOP sign. No injuries. \$600 damage total.
	6 July 1974	Speeding, 65 mph in 55 mph zone. 30-day suspension; Defensive Driving School.
Present Offense:	21 April 1977	DWI arrest with BAC of .19. Her car struck a utility pole. Minor injury to herself; \$250 damage to car.
Officer's Report:	The police report that when they came upon the scene of the accident, Mrs. Quinn was slumped forward over the steering wheel, unconscious, and the odor of alcohol was very strong on her breath. She was found to have only minor injuries, but her speech was slurred, and she was extremely slow in responding to requests for her license and registration. When asked to perform psycho-motor tests, she refused saying she'd fallen asleep at the wheel and was not drunk. She was very hostile when arrested, and scratched both officers.	
Court Status:	Mrs. Quinn has been placed on probation for 12 months. Once condition of probation is to be evaluated for alcohol abuse in this interview.	

Interviewer's Copy
CASE NO. 6

DWI—First Offense

Interview Date: 1 June 1977

Name: Edward V. Scanlon
2423 Gibson Drive, Center City

Date of Birth: 3 January 1924

Employment: Self-employed as Real Estate Agent

Criminal Record: None

Driver's Record: 1940-70 Four speeding offenses, one Reckless Driving in this period.

21 Dec 1973 Reckless Driving, too fast for conditions.

14 May 1974 Reckless Driving; ran red light; struck 1966 Plymouth. Minor injuries/\$650 damage. No BAC taken. Thirty-day suspension.

Present Offense: 24 Mar 1977 DWI arrest with BAC of .21. His car struck a 1972 Ford, veered off and hit a utility pole. Minor injuries to other driver and one passenger in Ford.

Officer's Report: Officer states that Mr. Scanlon was still in the car when he arrived, and he appeared relatively calm and composed. He had only minor bruises and a lacerated finger, but resisted getting out of his car. The officer noted the strong odor of alcohol, and again requested Mr. Scanlon to step out of his car. After he did so, the officer found a half-empty flask of vodka under the front seat. Mr. Scanlon did not do badly in the psycho-motor tests—failing only to walk a straight line. His speech was slow but not slurred.

Court Status: Although the judge has noted that he feels this is probably not the driver's first offense, he placed him on 12 months' probation, and requested an investigation to determine the extent of Mr. Scanlon's alcohol abuse problem.

Interviewer's Copy
CASE NO. 7

Interview Date: 3 June 1977

Name: Anthony P. D'Amico
197 Main Ave., Center City

Date of Birth: 6 February 1942

Employment: Bricklayer
Picone Construction Co.

Criminal Record: None

Driver's Record: 17 Apr 1971 Speeding, 50 mph in 35 mph zone.
4 Aug 1974 Reckless Driving. Lane changing on freeway at high
speed. No BAC taken.
28 Jul 1976 Speeding, 65 mph in 55 mph zone.

Present Offense: 1 Apr 1977 DWI arrest with .13 BAC. Went through YIELD
sign on expressway, collided with 1974 Pontiac.
Minor damage and no injuries.

Officer's Report: Report says only that Mr. D'Amico was suspected of being under the
influence of alcohol because of his unsteady gait and slurred speech.
No psycho-motor test results are given.

Court Status: Placed in diversion program for first offenders. Referred to probation
department for initial interview.

**Interviewer's Copy
CASE NO. 8**

DWI—First Offense

Interview Date: 6 June 1977

Name: Richard L. Thompson
1502 Hillcrest Drive, Center City

Date of Birth: 14 June 1950

Employment: Truck Driver
Self-Employed

Driver's Record:	Arrest Date	Outcome
	21 Mar 1968	Speeding, 75 mph in 65 mph zone.
	2 Aug 1970	Speeding, 70 mph in 50 mph zone.
	17 Oct 1973	Speeding, 75 mph in 55 mph zone. License suspension 30 days.
	14 May 1975	Reckless Driving, too fast for conditions. Struck tree in state park and suffered minor injuries. (In own car, 1974 Oldsmobile.) No BAC taken.
	22 Sept 1975	Speeding, 70 mph in 55 mph zone.
	4 Jan 1976	Speeding 65 mph in 45 mph zone.
Present Offense:	9 Apr 1977	DWI arrest with BAC of .17. Ran red light and collided with 1970 Dodge. Serious injuries to other driver; \$2600 damage to both cars.

Officer's Report: The police report is brief, but states that Mr. Thompson's speech was unintelligible, he had difficulty finding his license, and was uncooperative in the psycho-motor tests. He repeatedly insisted that the light was yellow when he went through it, and the other driver struck him.

Court Status: The judge placed Mr. Thompson on probation for 12 months, and ordered an investigation into his drinking problem.

**Interviewer's Copy
CASE NO. 9**

DWI--Second Offense

Interview Date: 7 June 1977

Name: Robert J. Duncan
422 Rennie Street, Center City

Date of Birth: 12 October 1915

Employment: Janitor
Fuller Department Store

Criminal Record:

Arrest Date	Outcome
15 Dec 1973	Drunk in Public, spent 48 hours in jail; fined \$50.
8 Oct 1963	DWI conviction in Illinois with .18 BAC. 60-day suspension. Crossed center line after making right turn, sideswiped oncoming 1973 Dodge Station Wagon. Minor injuries to two children. \$1800 damage.

Driver's Record:

10 June 1974	Illegal turn resulted in minor accident. No injuries/\$600 damage total. No BAC taken.
4 Mar 1975	Ignoring signal. Ninety-day suspension. Went through STOP sign and hit front end of telephone maintenance truck. Minor injuries to self only. \$425 damage total.

Present Offense: 21 Apr 1977
DWI arrest. Entered freeway and failed to yield to faster moving traffic. Resulted in three-car accident, minor injuries to one driver, serious injury to one passenger in car he struck from right. \$3600 damage total to three cars. BAC reading of .23.

Officer's Report: Police report that Mr. Duncan was out of his car when they arrived, but appeared to be incoherent. His speech was slurred, he staggered, and he could not pass any of the psycho-motor tests.

Court Status: Placed on 12 months' probation. Judge requested investigation into drinking habits because of bad driving record and prior DWI.

**Driver's Copy
CASE NO. 1**

DWI—Fourth Offense

Motorist: Robert J. O'Malley
47 years old, Insurance Agent

Goal: Project image of a confirmed problem drinker who denies his alcoholism, defends his driving actions, and blames others for his problems.

Employment: Has worked as an independent agent for six insurance companies over the past 25 years, but has lost his four biggest life insurance companies within the past two years. Now writes policies only for one automobile insurance and one homeowner's company.

Personal Characteristics: Divorced from first wife in 1968. Married present wife in 1970. A large (6'2" 225-lb.) florid-faced Irishman, Mr. O'Malley earned his early reputation as a football star at the local high school and state college. After college, he became an extremely successful insurance agent, earning \$25-30,000/year by the late 1960's.

Smokes/drinks heavily. Has been trying to cut down from three to two packs/day, because his doctor has told him that he must. Admits that he had a drinking problem at one time, but thinks that he can now handle his alcohol. He maintains that his lifestyle (entertaining clients, working evenings) makes it difficult for him not to drink.

Admits to some work-related problems recently but he insists they are not because of his drinking. Many of his accounts have changed to another agent because the "young smart-ass college kids from other insurance companies sell them short on benefits or lie about the acceleration on their premiums."

When asked if his wife/friends/employers think he drinks too much, he hesitates, but then admits that he's discussed it with all of them recently. He contends that it's just because everyone knows he once had a problem so he's been "labeled" as a drunk, and no one will ever believe him now that he has improved. He maintains that he can stop anytime, and has stopped for months at a time over the past five years.

Driving Habits: On his insurance calls, he currently drives 75-100 miles/day. His years of driving experience have made him very confident of his driving ability.

Health: Recently his doctor has suggested that he cut down on eating, smoking and drinking because of a high cholesterol problem and his family history of heart disease. When questioned, he adds that doctors always tell you to quit doing all the things you enjoy, while they keep on doing them.

Attitudes: O'Malley is a typical problem drinker—perhaps a fullblown alcoholic. He denies that his liquor consumption is unusual, and doesn't consider himself addicted to alcohol. He feels that many other drivers are worse than he is, he just happened to be unlucky enough to get caught. He becomes slightly hostile at the suggestion that he might drink in the morning or hide a bottle of liquor.

With regard to the most recent DWI conviction, he says the officer was lying in wait for him outside the bar, and that the judge was unfair in believing **only** the policeman and not listening to his side of the story. He is positive that he can drive safely with 5-6 drinks, because he is a big man and a high BAC doesn't mean as much in a large person as it does in a 125- or 150-pound person.

Driver's Copy
CASE NO. 2

DWI—First Offense

Motorist: Brenda McHenry
21 years old, Switchboard Operator

Goal: Project image of a young woman who is **unaware** that her perceptual skills are poor because she is myopic and needs glasses.

Employment: Has held same job since high school graduation in 1975.

Personal Characteristics: Single; 12th grade education.

Smokes less than one pack/day.

Usually drinks 3-4 drinks/week, only on weekend dates, doesn't normally drive afterwards.

Recently she has had a few problems with her boss on-the-job, and some money worries. She finds that a drink after work relaxes her and makes her feel better.

Driving Habits: Doesn't care for driving, particularly in traffic. Hates to drive in downtown area, because it requires so much attention and decision-making about lanes, turns, etc.

Feels that many other drivers are "crazy." She **always** tries to drive very slowly and carefully, but people often pull out in front of her. She's had several "near-misses" that might have been accidents if she hadn't noticed other cars coming at the very last second.

Health: Has had some difficulty lately with split vision, migraine headaches. She attributes her headaches to sinus trouble. Does not associate her recent accident with taking sinus medicine and alcohol together.

Attitudes: She feels that police officer was unfair to her in May 1976, because "the bus pulled right out in front of her" after she was forced by traffic to go through the red light. She agrees that she'd had too much to drink. She'd had three drinks in a bar with her boyfriend between 5:00 and 6:00 p.m., and they had an argument, and she left him hurriedly. She admits that she'd taken three sinus tablets that day as well.

Driver's Copy
CASE NO. 3

DWI—First Offense

Motorist: Laura L. Goodman
49 years old, Chief Accountant

Goal: Project image of stable career woman whose confidence in her driving has been shaken by this involvement in a drinking/driving accident.

Employment: Has worked for 18 years for same firm in the accounting department, advancing to Chief Accountant in 1971.

Personal Characteristics: Married, two grown children, daughter married, son in U.S. Navy. High school diploma and one year of business school for accounting training. No marital problems, no money worries, some health-related concerns.

Non-smoker, social drinker—4-5 drinks/week. Job pressures are normal, rising at end of each month with reports due, etc.

Highly verbal, serious person, concerned about loss of license, but slightly defensive about her impairment after only "a few drinks."

Driving Habits: Normally drives only 150 miles/week, going to/from work and shopping. Wears seat belt and drives defensively since attending driver improvement school after the accident.

Health: Has had two major operations within the past three years for stomach ulcer and gall bladder removal. Still sees internist regularly for recurring ulcer symptoms.

Attitudes: Mrs. Goodman initially isn't happy about being called in for the interview. She states that the amount of rum punch she had to drink at a wedding shower was not sufficient to impair her driving. She was driving slowly because she was sleepy, not drunk.

On being questioned about the officer's report, Mrs. Goodman admits that she may have been traveling too slowly for safety, but the officer should have arrested the drivers who were speeding, not those who drive too slowly.

With regard to her drinking, Mrs. Goodman is very truthful. She usually only drinks no more than one drink except when she's at a party with her husband, when she has 2-3. She had not eaten dinner and she started drinking the rum punch at 7:00 p.m. on the night of her arrest, eating only sparingly of party foods because of her special dietary restrictions since her recent gall bladder operation. She only had 2-3 glasses of punch, but later in the interview admits that it was rather heavily laced with rum (100 proof). She finally agrees that it was probably stronger than her usual drinks, and she may well have been more impaired than she thought.

Driver's Copy
CASE NO. 4

Breath Test Refusal

Motorist: Alan B. King
38 years old, Shop Foreman

Goal: Project image of a hard-working individual who has obtained his employment goal and rewards himself for his success. A problem drinker, he has been treated at a Mental Health Clinic and has also joined AA (June 1975) but stopped going to meetings in February 1976, because he "didn't need all that religious stuff." His aim is to have the interviewer see him as a victim of injustice regarding his two DWI arrests. In the present offense, his explanation is that anyone can make an error in judgment and that he simply was in a hurry, the road was not well-lighted, the rain obscured his vision of oncoming traffic. He refused the BAC test because he wasn't drunk anyway, and he didn't know why the cop asked him to take it. He'd only had "a few beers."

Employment: Employed by United Steel Co. for the past 17 years. Started there in the shop and after 10 years became shop foreman.

Personal Characteristics: Divorced in 1975, two children, one with his wife and one in the U.S. Army. A blue collar worker, Mr. King is dedicated to his job and his employer. He has little social life, but occasionally sees his ex-wife. She still considers him an alcoholic. He feels he doesn't need AA anymore, he can control his drinking.

A cigar smoker and moderately heavy drinker (at least four or five beers each evening, and far more on weekends), Mr. King feels that he's just an average guy. He insists that he has never had a bad hangover or black-outs. States he has never been on a binge. He works hard and thinks that he is entitled to a "little relaxation."

He feels his two DWI arrests were arbitrary and that since "everyone drives after drinking" he can't understand why he is repeatedly being singled out for punishment. His attempts to control his drinking problem have been successful, as far as he is concerned, since he's "not an alcoholic after all." His one D&D arrest came about after another man "jumped him" in a bar in an argument over a bet on a football game. He contends he is not usually aggressive or angry when drinking.

Driving Habits: Drives home from the local tavern and bowling alley after his usual six or eight beers every Friday and Saturday night. He feels that he is an extremely capable driver and that "a few beers" don't affect his driving abilities. He always wears a lap belt and shoulder harness, since he's very safety conscious, on-the-job and off as well.

Health: At his yearly company-mandated physical examination, Mr. King was found to have high blood pressure for which he was given medication, and encouraged to cut down on his drinking.

Attitudes: Mr. King begins the interview by stating that he had "a few beers" before the time of the accident, but that he was **not** drunk. His error in crossing the centerline was due to a mistake in judgment and not due to alcohol. He explains that he would not agree to a breath test because he has been "framed by the cops before."

When questioned about his drinking, he lies about the amount of alcohol he consumes and justifies his daily drinking by stating that all the guys stop after work and, furthermore, that he feels he is being persecuted unjustly because of his prior history. He is, he says, in "complete control" of his drinking, or else he wouldn't have quit AA. He goes to work every day, and drinks "socially" all week. He **never** drinks before 4:30 or 5:00 p.m., and drinks alone at home only because a "six-pack is cheaper than six at a bar."

Driver's Copy
CASE NO. 5

DWI--First Offense

Motorist: Madeline L. Quinn
30 years old, Manager Catering Service

Goal: Project image of a bright, sophisticated, hardworking woman who feels embarrassed and upset by her driving record and alcohol consumption.

Employment: Has worked for the Hilton Hotel since 1970.

Personal Characteristics: Divorced for the past year, she has one eight-year old daughter living with her. Her former husband has custody of their son, five years old. Graduated from college with a degree in Nutrition Education.

Currently has a discipline problem with her daughter, and some financial worries because her husband has fallen behind in his support payments. In addition, she has recently ended an affair with a married man whom she'd expected to marry. She has begun to drink more heavily over the past two months "to forget about him." She smokes two packs of cigarettes/day, but is trying to cut down. She's also trying to quit taking tranquilizers daily, but hasn't succeeded.

She admits to drinking in the morning, on occasion, to steady her nerves. She feels that, without tranquilizers, she "needed something." Although she learned about the synergistic effects of combining alcohol and other drugs in her alcohol education in 1975, she doesn't think of herself as addicted to either substance, nor as dangerous on the highway.

Driving Habits: She drives to/from her office and to shopping centers, a total of only 200 miles/week.

Health: During the last few months of her marriage (Winter 1975), she doctored for "nerves" and headaches, and began taking 5mg Valium daily. Within two months, she was taking 10mg Valium pills daily, and became concerned about addiction. She now takes only one 5mg of a milder tranquilizer each day, but still sees her doctor frequently for migraine headaches.

Attitudes: Mrs. Quinn feels strongly that both of her DWI arrests were questionable. She did not feel intoxicated, only sleepy, and resented the officers' handling of her. She complains that they handcuffed her and treated her "like a criminal" in this most recent arrest. She resents the present suspension, and feels that if she'd had a lawyer she would not have been convicted.

With regard to her drinking, she is relatively truthful in the interview. She admits to taking a drink in the morning, when she feels nervous, and that alcohol puts her at ease. She does not admit to hangovers, blackouts, or feeling guilty about her drinking. She contends that no one she knows is bothered by her drinking. They all drink as much or more than she does.

Driver's Copy
CASE NO. 6

DWI—First Offense

Motorist: Edward V. Scanlon
52 years old, Real Estate Agent

Goal: Project image of a well-to-do businessman, a problem drinker, who had two previous convictions for Reckless Driving which may have been plea-bargained down from DWI. His statement is that he was not drunk, but did not respond readily to the officer's requests because he was ill and on medication at the time of his arrest.

Employment: Owner/operator of Scanlon Real Estate for past 12 years. Previously employed for 18 years as agent for Palmer Real Estate Agency.

Personal Characteristics: Divorced for two years, four children, all married. Mr. Scanlon is an excellent salesman whose business depends upon his good reputation in the community. He needs his car for his work, so is anxious to avoid a conviction.

A heavy smoker (2+ packs/day) and a moderately heavy drinker (at least three drinks/evening, more on weekends). Does not think he has a drinking problem. Both he and his former wife have always had a drink before dinner each night, and 1-2 after dinner. Other than this arrest, he feels that his drinking has never been a problem to him.

Driving Habits: Normally drives 6-800 miles/week taking clients to see available properties. Always drives home from clubs, bars, meetings after his usual 3-4 drinks. Feels he is a better driver after drinking, since he is more relaxed.

Health: Recent stomach problems and shortness of breath prompted him to see his doctor who recommended that he cut down on smoking and drinking. Occasional memory loss on "mornings after" a night of heavy drinking, plus some gastric distress which he attributes to "eating party food."

Attitudes: Mr. Scanlon begins interview by assuring the investigator that he was not drunk at time of the accident. His irregular driving was the result of taking both tranquilizers for his stomach upsets and antihistamines for a sinus condition. He admits to having had "a few drinks" which the officer smelled on his breath. He explains that he didn't understand the officer's request to get out of his car because he was too upset over the accident.

Upon being questioned about his drinking, Mr. Scanlon lies about his alcohol consumption, but tells the truth about his general state of health. He feels he is ulcer-prone, as was his father, who died of gastritis and liver disease. He admits that his father drank a good deal, "like all good Irishmen do." He does not admit that his drinking contributed to his divorce, since "she could drink me under the table." She's referred to often as the "real alcoholic" in the family. When questioned about the half-empty flask, Mr. Scanlon states that it was leftover from a trip he'd taken several weeks before. It was not the

vodka in the flask that he was drinking on the night of the arrest. He'd just had 1-2 drinks at a bar with a client and was on his way to a dinner engagement.

Driver's Copy
CASE NO. 8

DWI—First Offense

Motorist: Richard L. Thompson
26 years old, Truck Driver

Goal: Project image of an annoyed, impatient young man who feels as though the police and the courts are persecuting him. Answers questions very reluctantly, in a sullen manner, acts bored and impatient.

Employment: 1970-71 Acme Trucking Co.
1971-73 Tesone Trucking Inc.
1973-74 Associated Transfer Co.
1974-Present Self-employed as truck owner.

Personal Characteristics: Single and a high school dropout, Mr. Thompson is black and very hostile toward authority figures. His lifestyle is very loose and free. He drinks and smokes heavily, two packs/day. He insists that he never drinks for 12 hours before making a "run," and has never been drunk behind the wheel.

Recently, he's had trouble with his girlfriend and with his various employers, because "they all try to make me live by their rules." His income has dropped because of disagreements with his usual clients. His debts are piling up. He likes the feeling of power he gets in driving a large rig, and resents the police and the courts' interference in his life.

Driving Habits: He likes to drive, uses his car and truck to relax in. He feels he's an excellent driver, better than most other professionals. He's made some mistakes, however, in not watching out for the state police while driving his truck.

Health: Excellent, no problems.

Attitudes: Mr. Thompson is openly hostile toward the police. His general feeling is one of powerlessness against "the system."

Although Mr. Thompson never directly addresses the issue, he is obviously under the impression that he is being discriminated against by the police because he is black.

He accuses the officer who made the DWI arrest of maltreating him, and insists that the light was not red, but yellow when he went through it. He blames the other driver for the accident.

When asked about his drinking habits, he responds negatively in nearly all cases. He states that he is a social drinker who has 1-2 beers each day, and 3-4 if it's a long, hot day. He never drinks anything but beer, so he "can't be an alcoholic." On weekends he admits to having 6-7 beers at a bar or a party, but doesn't believe it interferes with his driving.

With regard to the 1975 Reckless Driving offense, Mr. Thompson contends that the only reason it was broken down from DWI was because it was a "bad arrest." He recalls that his BAC was only .11 or .12, and his attorney convinced the prosecutor not to pursue the DWI charge.

**Driver's Copy
CASE NO. 7**

DWI—First Offense

Motorist: Anthony P. D'Amico
34 years old, Bricklayer

Goal: Project image of an impatient, aggressive man who possesses adequate driving skills and drinks only on social occasions. His explanation of his drinking behavior is that he'd had a fight with his brother and was upset, so he went to the bar to cool off. He met some fellow workmen there and "just drank a little too much."

Employment: Began as an apprentice bricklayer with Baker Construction Co. in 1961. Worked for several companies until he got his union card. Has worked for Picone Construction Co. since 1970.

Personal Characteristics: Married, three children; high school diploma.

Non-smoker, drinks only beer. Never drinks during the week, only on weekends at home or at social gatherings. Has only been "drunk," by his estimate, 5-6 times in his life. No money, job, or marital problems, but recent disagreements with his two brothers over some family property have upset him.

Driving Habits: Admits to being "heavy-footed," especially when driving to work, since he's often late and trying to make up lost time. Drives 3-400 miles/week to/from construction jobs.

Health: Excellent, no problems.

Attitudes: Mr. D'Amico is polite and well-spoken. He appears anxious about losing his license. He is very respectful and compliant throughout the interview. His explanation of Reckless Driving violation in 1974 is that he was driving to the hospital to see his wife. He was not driving his own car, so was not aware of the speed at which he was traveling. Lane changing was because he was impatient in the traffic. He denies that he'd been drinking before that offense. On recent offense in July, he was late for work and did not pay attention to speedometer.

With regard to his drinking, Mr. D'Amico is quite truthful. He's had no problems until now, and he doesn't feel alcohol is something he "needs." He is slightly affronted at being asked about drinking in the morning, hiding liquor, etc. His answer is "only a real alcoholic would say 'yes' to those questions."

**Driver's Copy
CASE NO. 9**

DWI—Second Offense

Motorist: Robert J. Duncan
61 years old, Janitor

Goal: Project image of elderly black driver who only drives to/from his work place, church, and shopping center. He is confused and unhappy about his accident record, and defensive about his drinking.

Employment: Has worked as janitor part-time (30 hours/week) since 1970.

Personal Characteristics: Widower since 1973, with two married daughters; 10th grade education. Confirmed problem drinker, but denies it at first. Quiet, well-mannered and polite, but firm in his belief that he is a conscientious, careful person. Underconfident about his driving, because of his age and arthritis. Drinks regularly, but doesn't admit to himself or others that he has a problem.

Driving Habits: Never drives except to/from work, church, and shopping. (All within 25-mile radius of his home.) Daughters pick him up for visits, since they both live 40-50 miles away, and he won't drive that far. Never drives at night if he can avoid it.

Health: Under treatment for arthritis of both hands and left shoulder. Has had several attacks of irregular heartbeat and other circulatory problems recently. These sometimes produce shakiness and even temporary paralysis of arms/legs, but he has medication for this. Never drives when he's feeling bad.

Attitudes: Mr. Duncan feels as though he's being persecuted by the police because of his age. He also shows slight paranoia when talking about how the accidents happened, saying things like "In the first accident, that man just sat there in his old car and let me hit him, just to get the insurance money so he could replace his old, rusted-out car."

In explaining the most recent accident, he claims that the fault was not his because he could have gotten into the traffic opening, but the driver of the car he hit increased his speed and filled the gap too quickly. The third car in that accident also was going too fast because he should have been able to stop when he saw the original collision.

When questioned about his drinking, Mr. Duncan initially denies all health problems associated with alcohol, but then begins to admit that perhaps he has a problem. His daughters have mentioned it to him, and recently his boss has made some comments. He attributes the start of his problem to loneliness that began when his wife died in 1973. He admits to occasionally drinking in the morning, and to blackouts once or twice. He contends that he does no harm to anyone, since he usually drinks his beer at home, and doesn't drive.

LESSON PLAN

7

Report Writing

Methods/Media: Lecture/Group Discussion

Time Allotted: Day Two 2:30-3:30 p.m.

Equipment Required: Overhead Projector/Transparencies

OBJECTIVES

- Explain the necessity for clear, concise PSI report writing.
- Provide guidelines for content and format of the referral report for court use.

REFERENCES

TAILORING THE REPORT TO COURT NEEDS

- Who is the user of your PSI reports?
 - Judge
 - Prosecutor
 - Rehabilitation Agency
 - Other
- What types of information are necessary for the reports' audience?
 - Background (demographic data, arrest record, driving record, etc.)
 - Drinker type diagnosis (social, borderline PD, PD, or alcoholic).
 - Recommendation for education/treatment.
 - Recommendation for legal action.

Lead group discussion on existing reporting forms, and the types of information they currently contain. Ask for suggestions on how the forms might be changed to provide more information on drinker type.

Overhead #8

CHOOSE A SUBJECT (ONE) AND ANALYZE
THEY (THE POINTS) IN THE COURT

- 1) Personal information
- 2) Social history
- 3) Background for the court
- 4) Education
- 5) Employment
- 6) Family and relationships
- 7) Special services
- 8) Substance
- 9) Recommendations for legal actions
- 10) Information on treatment
- 11) Information on law
- 12) Other relevant data
- 13) Summary of findings
- 14) Specific recommendations

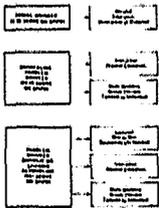
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SUGGESTED MODEL REPORT FORM

Refer participants to page 38 in Manual. Request comments and suggestions for revision in this form. Ask, "Will your judges (prosecutor, etc.) accept and be able to use this form as it is? If not, how should it be changed?"

Overhead #9

QUALITY TREATMENT/RECOMMENDATION BY DRINKER TYPE



EDUCATION/TREATMENT RECOMMENDATIONS

Review data presented on page 39 of Manual, recommending types of treatment for each drinker type based on CPIPD score. Elicit group reaction to these and lead discussion of available resources.

CONTINUED

1 OF 2

MODEL SCREENING REPORT FORM

Cover Sheet

- 1. Name
2. Case Number and Present Charge
3. Sentence Information Filing Data
4. Relevant Data for Referral
a. BAC at Arrest
b. Prior Alcohol-Related Offenses
c. Contacts with Social Agencies regarding Alcohol Problems
5. Employment Record
6. Reason for Recommendation (Brief Statement)
7. Recommendations

Interviewer's Report

Name: _____ Date: _____

Case No.: _____

To: (Agency/Court)

I hereby certify that a screening test has been administered to the above-named person, and combined with other relevant information gained in the interview conducted on _____, the above-named person has been judged to be a _____ (date) (Social, Borderline, or Problem Drinker). It is therefore recommended that as a condition of probation, this person attend the following:

Start Date

- 1. Alcohol Education (6 sessions)
2. Outpatient Therapy at Clinic (Minimum of 4 sessions, then reevaluation)
3. Inpatient Treatment (Detoxification, by agreement)
4. Private Counseling (By agreement, to be reported through personal physician)
5. Antabuse Therapy (x weeks by agreement)
6. Other

Respectfully submitted,

(Signature of Interviewer)



LESSON PLAN

8

Court-Monitored Rehabilitation Programs

Methods/Media: Lecture/Group Discussion

Time Allotted: Day Two 3:30-4:30 p.m.

Equipment Required:

OBJECTIVES

- Make the group aware of the ASAP findings regarding treatment modes for different drinker types.
- Lead discussion of the probation department's responsibility for monitoring DWI offenders throughout their treatment program.
- Explain the usual conditions of probation imposed on DWI offenders, and the monitoring process required to assure compliance with these conditions.

REFERENCES

- Description of local education and/or treatment programs, and the monitoring system employed.

PURPOSE OF ALTERNATIVE SANCTIONS

Review pages 41 of Manual for discussion of preliminary ASAP findings on desirable types of rehabilitation for each drinker type.

- Explain that the courts are aware of their performance record using traditional sanctions of jail, fines, license actions, and are seeking alternatives because of the ineffectiveness of these sanctions.
- ASAPs discovered that the DWI arrest was a **warning signal** for many Problem Drinkers (PD). May be the one opportunity for society to intervene in PD's life and make him/her aware of the extent of alcohol abuse and the danger signs.
- Courts choose rehabilitation/treatment over traditional sanctions for two reasons.
 - They recognize that traditional sanctions don't prevent recidivism.
 - First offense DWI arrests are viewed by an enlightened judiciary as a **symptom** of an underlying alcohol problem, not a crime to be punished through usual sanctions.

Source: Suggest use of person from State Division of Alcoholism Programs as a resource for this unit

THE COURT'S RESPONSIBILITY

- Identify local community resources (public or mental health, state alcoholism control programs, etc.)
- Establish criteria to be met by service providers, including reporting requirements (weekly/monthly), court conditions which must be met, etc.
- Interview/visit agency personnel to identify program type, length, and suitability for DWI offender population.
- Institute a network of reporting to insure offender's compliance with court/program mandates.
- Investigate agency and assure that staff members are safeguarding defendant's rights to privacy (locked files for reports, non-responding to telephone inquiries about defendant's court status or progress).

SUCCESSFUL COMPLETION OF COURT-MANDATED PROGRAM

Question the group:

- What is the primary purpose of the probation period?
 - To protect the community (assure that person doesn't drink abusively, get arrested again).
 - To help the offender (provide rehabilitation and/or treatment as appropriate to drinking problem).

Lead discussion on which is most important of these two, and the types of alcohol treatment programs available for court referrals.

- **Conditions of Court-Monitored Probation.**
 - **Reporting**—Maximum, moderate, or minimal supervision. (Usually minimal for DWI, unless it's a lesser-included offense.) Ask group which type of reporting is required for DWIs in their courts.
 - **Attendance at Rehabilitation/Treatment Center**—Stipulation must be made of where, when, and how many sessions the defendant must attend, and feed-back obtained from treatment agency on attendance, progress and completion.
 - **Treatment Plan**—Overall goals should be outlined for the end of the probation period, with smaller (weekly or monthly) goals set for the interim reporting times. Ask group for examples of treatment plan goals.
-

MONITORING PROCEDURES

- Explain the criticality of good rapport with treatment agency to assure that prompt, accurate notification is received when a defendant fails to appear/complete the program.
 - Ask group for examples of frequency, format, and content of the reports he/she now receives from treatment agencies. Is this monitoring sufficient? If it is not, what kinds of reports would be most durable, and how often?
-

SUMMARY

Recap unit briefly by restating the primary purpose of probation, as agreed upon by the group, and the highlights of their discussions of treatment plans, follow-up procedures, and realistic expectations.

Supporting Materials

PRELIMINARY ASAP REHABILITATION FINDINGS

EDUCATION

All Drinking-Drivers (Social and Problem Drinkers)

- Educational programs can change drinking-drivers' **knowledge** of alcohol-related problems and possibly their **attitudes** toward drinking and driving.
- Education has little or no demonstrated overall effect in reducing re-arrests or crashes.

Social Drinkers

- Social drinkers entering education programs had significantly lower re-arrest rates than social drinkers not referred.
- It made little difference what kind of educational program a social drinker was referred to. One ASAP reported that a home study course was as effective as a DWI school.

Problem Drinkers

- Problem drinkers as a whole are not helped by educational programs.
- Problem drinkers entering lecture-type DWI schools had worse re-arrest rates than those entering smaller-session size, more interactive-type schools. Lecture-type schools may be harmful for problem drinkers.
- Moderate problem drinkers reduce drinking activity for at least six months after completing an alcohol-safety school.

SHORT TERM THERAPY

All Drinking Drivers (Social and Problem Drinkers)

- Therapies characterized by a moderate number of long sessions with small groups (averaging: 8 persons) had slightly (but significantly) lower re-arrest rates than less-intensive therapies with large groups (18 persons) and shorter sessions.

Social Drinkers

- It made little difference on subsequent arrest rates which therapy program social drinkers were referred to.

Problem Drinkers

- There is some evidence that problem drinkers referred to chemotherapy (Disulfiram), especially when supplemented by other therapy, had lower subsequent re-arrest and crash rates than a control group.
- Other research indicates chemotherapy reduced drinking behavior but not driving-related effects after six months.
- Problem drinkers entering small-group therapy had lower re-arrest rates than larger-group therapies with more frequent sessions.
- Initial results from the ASAP Short-Term Rehabilitation Study indicated few positive effects for non-school therapies during the first six-month follow-up period.

**EFFECTIVENESS OF
OVERALL
REHABILITATION
EFFORTS**

- ASAP project-level studies provided some evidence of a positive effect for rehabilitation in terms of re-arrests, but not in terms of reducing crashes.
- ASAP program-level analyses suggest that rehabilitation as a whole resulted in fewer re-arrests for social drinkers, but not for problem drinkers.
- It makes little difference what kinds of programs social drinkers are exposed to, but the program makes a great deal of difference with problem drinkers. They appear to do better in non-lecture, small-group settings. In fact, large session, lecture-type courses may have a negative effect on problem drinkers.

**WHAT DO WE KNOW
ABOUT ALCOHOL-
SAFETY SCHOOLS?**

- There is no model curriculum.
- It may be desirable to have two types of schools:
 - A brief, lecture-oriented school for social drinkers.
 - A longer, more action-oriented, small-group (fewer than 12) school for problem drinkers.
- Client-paid schools should be encouraged.
- Instructors for the school need not be police, doctors, judges, or university teachers, but should be able to deal well with people.
- The subject-matter should include:
 - Alcohol as a risk factor
 - Alcohol as a health issue
 - Alcohol as legal issue
 - Ways to avoid drinking and driving situations.
- Attendance must be monitored and absentees reported.
- Flexibility in the program must be maintained, including different times, days, and locations to accommodate student needs.
- The school should not be isolated from the rest of the drinking-driver control system. Communication must be maintained with court personnel (e.g., judges and probation officers), who should also be involved in the school curriculum.

**THE APPROPRIATE
THERAPEUTIC
REFERRAL**

Program	Drinker Type	Appropriate Application
Literature	Social and Problem	All offenders should receive reading materials on alcohol/impairment/highway safety.

DWI School (6-8 Weeks)		
• Lecture-oriented	Social Only	Maximum 35
• Interaction-oriented	Social, Problem, and Potential Problem	Maximum 15
• Therapeutic	Problem Only	Maximum 10
Group Therapy	Problem or Potential Problem	Small groups only (maximum 10). Recommended duration: 3-6 months.
Chemotherapy	Problem Only	Must include medical exam, and be administered in conjunction with psychotherapy. Should probably be used only on a voluntary basis as a temporary support during an attempt to give up drinking. Offender should not be coerced into participation.
In-Patient Therapy	Problem Only	Used rarely and only for medical emergency (detoxification or other), or for physical or psychological rehabilitation at the beginning of "recovery." Recommended duration: 6-30 days.

ALCOHOL TREATMENT RESOURCES

Alcohol-Safety School

- Alcohol Education
- Counseling

Detoxification Centers

- Police
- Medical

Hospitals

- General
- Mental
- V.A.

Mental Health Clinics

- Inpatient
- Outpatient

Alcoholism Clinics

- Inpatient
- Outpatient

Social Agencies

- Public Health Dept.
- Welfare
- Information/Referral Centers

Professionals

- Private Physicians
- Psychiatrists
- Clergymen

Organizations

- Alcoholics Anonymous
- Halfway Houses

**TREATMENT
TECHNIQUES****Medical Care**

- Detoxification
- Drying out
- Nutrition/Nursing

Psychotherapy

- Individual
- Group
- Family
- Aversion Therapy

Drug Therapy

- Disulfiram
- Tranquilizers

Rehabilitation

- Participation in AA
- Milieu Therapy
- General Counseling
- Education
- Work
- Recreation

**REALISTIC
EXPECTATIONS****Problem Drinkers:**

Regardless of what we do with problem drinkers, approximately 1 of 5 will be re-arrested for a drinking-driving offense within one year, 2 of 5 in three years.

Social Drinkers:

Without rehabilitation, 3 of 10 social drinkers will be re-arrested within three years. However, only 2 of 10 entering rehabilitation of some type will be re-arrested.

Source: University of South Dakota, Program Level Evaluation of ASAP Diagnosis Referral and Rehabilitation Efforts. Sept. 1975.

LESSON PLAN

9

Summary

Methods/Media: Lecture/Group Discussion

Time Allotted: Day Two 4:30-5:00 p.m.

Equipment Required:

OBJECTIVES

- Review all principles and concepts covered in the two-day seminar.
- Answer any questions regarding the materials and references provided.
- Administer **Post-Seminar Questionnaires**.

REFERENCES

- **Post-Seminar Questionnaires**

SUMMARY

Reiterate the seminar objectives, and review the following issues:

- The screening/diagnosis concept.
- The timing of screening in the adjudication process.
- Sanctions appropriate for each drinker type.
- The importance of BAC and priors as indicators of a drinking problem.
- The necessity for a referral and monitoring system.
- Criteria for an acceptable DWI adjudication system.
- Suggestions for improvements that participants can make in their court systems.

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POST-SEMINAR QUESTIONNAIRES

- Distribute **Post-Seminar Questionnaires**.
-

Supporting Materials

A GOOD DRINKING/DRIVER ADJUDICATION SYSTEM

- Can handle a large caseload expeditiously.
 - Will impose traditional and supplemental therapeutic sanctions, as promised.
 - Ensures that a record of an alcohol-related driving offense is a result in "guilty" cases.
 - Contains effective incentives for offenders to accept rehabilitation.
 - Collects enough revenue to support most of the sanction system.
-

POST-SEMINAR QUESTIONNAIRE

Name _____

Title _____

Date _____ Years in Position _____

Please check (✓) the appropriate answer.

1. How would you rate your present awareness of the national and state-level statistics on driving while intoxicated (DWI) offenses?
 - Very knowledgeable
 - Knowledgeable
 - Slight knowledge
 - Little/no awareness

2. How familiar are you with your jurisdiction's existing laws and practices governing the courts' treatment of DWI offenders?
 - Highly familiar
 - Moderately familiar
 - Minimal knowledge
 - Not at all

3. Are you familiar with the U.S. Department of Transportation's Alcohol Safety Action Projects (ASAPs) efforts to impact the drinking driver control system?
 - Highly familiar
 - Moderately familiar
 - Minimal knowledge
 - Not at all

4. How qualified do you presently feel in screening DWI offenders for alcohol abuse and recommending appropriate treatment?
 - Very qualified
 - Qualified
 - Minimally qualified
 - Not qualified

5. Which of the following screening instruments are familiar to you?

- Alcadd Test
- Alcohol Use Questionnaire
- Iowa Alcoholic Intake Schedule
- Johns Hopkins Questionnaire
- MacAndrew Alcoholism Scale
- Michigan Alcoholism Screening Test (MAST)
- Mortimer-Filkins Test
- NCA Criteria for Alcoholism Diagnosis

6. How valuable do you think are these types of screening tests in assessing level of drinking problem?

- Very valuable
- Valuable
- Minimal value
- No value

7. Blood Alcohol Content (BAC) level is the usual determinant of level of impairment in a DWI arrest. Impairment of physical and mental functions and loss of judgment and inhibitions appear at which BAC level?

- .00-.04
- .05-.09
- .10-.14
- .15+

8. Typically diagnosis is based on such things as: (a) BAC at arrest; (b) prior alcohol-related offenses; (c) history of alcohol problems in family, job, etc.; and (d) interview results. Please rate each of these items on the scale below. (Be sure your weights total at 100 percent.)

Percentage that each item contributes
to diagnosis of problem drinker

- % BAC
- % Priors
- % History
- % Test Score (if used)
- % Interview
- 100%

9. All of the following personal characteristics are important in one who conducts screening interviews. Please rank order the factors from 1-7 in terms of which you consider most important. (Most critical = 1, least critical = 7.)

- Empathic (i.e., exhibits concern for offender's problems)
- Impartial/fair
- Responsive/encouraging
- Up-to-date on agencies/treatment available
- Ability to put offender at ease and establish rapport
- Effectively communicates important information (court dates, treatment appointments, etc.)
- Reliably and consistently judges offenders' problems by standardized criteria

10. Will you now use any of the following interview techniques in your present job?

- Active listening
- Paraphrasing/clarifying
- Perception-checking
- Confrontation
- Open-ended questions
- Observation of non-verbal cues

11. Are you aware of the Federal regulations (e.g., the Privacy and Freedom of Information Acts) which may impact on your agency's records and, specifically, your own reports?

- Yes
- No

12. Are your recommendations to the court subject to subpoena by a defense or prosecuting attorney?

- Yes
- No
- Don't know

13. Since you've attended this seminar, how will your reports to the court change as a result?

Appendix A

Alcohol Use and Abuse

ALCOHOL CONSUMPTION IN AMERICA

1. Who Drinks Alcohol?

Some 68 percent of the adult American population drink. This includes 95 million persons aged 18 or over.

2. Who Has a Problem?

Most never drink enough to have problems.

About 42 percent either abstain or drink rarely (less than once a month).

Another 31 percent are classed as light drinkers—less than 0.22 ounce absolute alcohol per day.

3. Alcohol Problems

Problems are more likely to arise in the 27 percent remaining. Of these, 9 percent can be classed as “heavy” drinkers (1.0 ounce absolute alcohol or more per day), and 18 percent as moderate drinkers (between 0.22 and 1.0 ounce per day).

4. National Averages

The average (mythical) drinker consumes 3.93 gallons *absolute* alcohol per year.

On the average, this amounts to 2.6 gallons distilled spirits; 2.2 gallons of wine; and 26.6 gallons of beer. Or, for each drinker each year, about 44 fifths of whiskey (3 ounces per day); or, 98 bottles of fortified wine; or, 157 bottles of table wine; or, 928 bottles of beer.

5. Consumption

However, averages don't count much. Heavy drinkers consume more than light drinkers can imagine.

Examples:

About 15 percent of the *drinking* population consumes about 60 percent of all alcohol.

The average alcoholic drinks about *11 times* as much as the average social drinker.

6. Sex Differences

Overdrinking is primarily a male characteristic. More than 1 out of every 5 males is a heavy drinker, compared with 1 out of 20 females.

The average male drinker consumes *three times as much* as the average female drinker.

7. Youth and Alcohol

Alcohol is the drug of preference among youths.

Some 42 percent of high school students drink once per month or more.

Some 23 percent get drunk four or more times per year (regarded as potential problem drinking).

Some 5 percent get drunk at least once per week (regarded as problem drinking).

Overdrinking is characteristic of juvenile delinquents as compared with other juveniles.

8. Socio-Economic Status

The rich drink more, and so do the better educated.

In 1974, 89 percent of those earning \$20,000 or more were drinkers, compared with 57 percent of those earning less than \$5,000. About 85 percent of all professional or business people drink.

Of those who are college-trained, 83 percent drink. Of those with high-school education, 70 percent. Of those with grade-school education, 46 percent.

ALCOHOL ABUSE

1. "Problem drinking" is less severe drinking than "alcoholism." Generally, it means drinking enough to impair one's functioning at work, in the family, or in society. It does not at all mean that one has ceased to function altogether.
2. Official estimates that the U.S. contains some 10 million alcoholics are regarded now as underestimates. At any given time, some 20 million persons are "in trouble with alcohol" but by no means all of these require "treatment" to change their behavior.
3.
 - a. Of all people questioned, 12 percent see liquor as having been a cause of "trouble in the family."
 - b. Of adult males who drink, 43 percent report one or more "problems connected with drinking" during the previous three years. The parallel figure for females is 21 percent.
 - c. Each alcohol abuser is estimated to affect adversely the lives of about four other members of society either directly or indirectly.
4.
 - a. Alcoholism and problem drinking are not primarily skid-row problems.
 - b. Some 5 to 8 percent of alcoholics are on skid-row.
 - c. Most problem drinkers have jobs, and impaired work performance is a relatively early identifier.
5.
 - a. Overdrinking is associated with almost every kind of widespread health problem: accidents, ailments and diseases.
 - b. Heavy drinkers have shorter life expectancies.
 - c. Most categories of accident fatalities show very high degrees of alcohol-involvement (traffic, boating, private plane; fires and other home accidents).
6.
 - a. Males in their middle years are most at risk from problem drinking.
 - b. The heaviest drinking is among men aged 30 to 34 and 45 to 49.
 - c. However, even children can become serious alcoholics, and problem drinking is increasing among both women and youths.
 - d. Overdrinking (whether or not a sign of alcoholism) is the riskiest activity in which most young people engage, particularly because of driving accidents.

Source: NIAAA and NHTSA Reports to Congress

ALCOHOL AND DRUG-RELATED ARRESTS

Arrest Category	Number	% of Total	% of Population
Total estimated arrests: (excluding Traffic)	9,608,500	100%	4.5%
Drunkenness	1,297,800	13.5%	0.61%
Disorderly conduct	657,500	6.9%	0.31%
DWI	1,029,300	10.6%	0.48%
Narcotics and other drugs	609,700	6.3%	0.28%
All alcohol and drugs	3,594,300	37.3%	1.68%
All alcohol	2,984,600	31.0%	1.4%

Change in Arrests from 1966 — 1976 (Estimated):

Narcotics and other drugs	up 527%
DWI	up 131%
Disorderly conduct	down 5%
Drunkenness	down 45%
All offenses	up 21%

The other high volume for arrests in 1976 was Larceny-Theft, with 1,117,300 arrests, 11.7% of the total.

Source: FBI Crime Report for 1976

COURT PROCESSING

Among persons formally charged with offenses in 1976, court action resulted in the following patterns:

Offense	Guilty as Charged	Guilty Lesser Offense	Dismissed or Acquitted	Referred to Juvenile Court
Drunkenness	85.5%	0.5%	12.0%	2.0%
DWI	75.7%	12.7%	9.9%	1.7%
Disorderly conduct	70.4%	1.3%	19.3%	9.0%
For Comparison				
Drugs	44.9%	4.1%	24.4%	26.5%
Larceny-Theft	46.3%	2.8%	14.5%	36.4%
Index offenses	40.1%	4.2%	16.1%	39.6%
All offenses	60.3%	3.4%	17.7%	18.7%

Drunkenness had the highest conviction rate of all offenses, and the second lowest rate of juvenile involvement. DWI had the third highest conviction rate of all offenses, and the lowest rate of juvenile involvement.

Conclusion: Courts handle alcohol offenses differently from other categories of arrest. The probability of conviction for the original charge is much higher. The degree of juvenile involvement is much lower.

Source: FBI Crime Report for 1976

CONCLUSIONS

1. Alcohol-use is a factor in a majority of arrests. The misdemeanor courts deal with more (non-traffic) offenses related to alcohol use than to any other factor.
2. DWI is the single most important misdemeanor, in terms of numbers, processing, and probably costs.
3. Roughly 2 percent of the nation's population (about 4 million people) are arrested each year either entirely or partly because of their use of alcohol.
4. Police officers, prosecutors, and judges see more alcohol-abusers per year than all alcoholism treatment programs.
5. Alcohol causes much more higher costs to the criminal justice system than any other drug, or than all other drugs combined.

Appendix B

Sample Tests

CRITERIA FOR THE DIAGNOSIS OF ALCOHOLISM By The Criteria Committee, National Council on Alcoholism

These criteria were compiled by a committee of medical authorities from the National Council on Alcoholism to establish guidelines for the proper diagnosis and evaluation of this disease. Criteria are weighted for diagnostic significance and assembled according to types: Physiological and Clinical (including major alcohol-associated illnesses) and Behavioral, Psychological, and Attitudinal. Because early diagnosis is helpful in treatment and recovery, manifestations are separated into their earlier and later phases. There are brief discussions of recurrent and arrested alcoholism, cross-dependence, and the types of persons at high risk of alcoholism.

The problem of alcoholism has been receiving increasing interest in the past few years. Extensive treatment programs are being mounted, hospitals are beginning to accept patients for treatment, labor-management programs are attempting to identify alcoholic employees to give them special benefits and rehabilitation, third-party payments are being afforded by insurance carriers, and courts are making special disposition for rehabilitation. Therefore, it is important to establish a set of criteria for the diagnosis of alcoholism. To this end, the National Council on Alcoholism established a committee¹ to prepare a set of criteria, to submit it for criticism and documentation by other experts, and to publish it for the guidance of those involved in the diagnosis of alcoholism.

¹Members of the committee are listed in Annex 1.

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Reprints of the Criteria are available from the National Council on Alcoholism, Publications Department, 2 Park Ave., New York, NY 10016.

At the outset, it became apparent that we had undertaken a formidable task, for, despite a great deal of work in the past, much of the literature is burdened by anecdotal material and special assumptions made priori, and there is a dearth of scientifically controlled observations on the natural course of the disease. In addition, people of many disciplines have made observations from their own points of view, which may be hard to reconcile, and there are not a few who, by their definition of disease, have eliminated alcoholism from the category of disease. But any tendency to withdraw from the field was overcome by the urgency of the task, and the committee herewith presents the results of its deliberations.

Diagnostic criteria may serve several purposes. They may be used to *ascertain the nature of a disease* from a cluster of symptoms. This was not the main goal of the committee. They may be used to promote *early detection* and provide *uniform nomenclature*, both objects of this endeavor. Criteria may be used to *prevent overdiagnosis*. This is important because of the psychological, financial, legal, and therapeutic implications in a diagnosis of alcoholism for the life of the patient. Criteria may be set for *treatment* purposes. Beyond indicating that a need for

treatment exists, the committee believes that any indication of different modalities of treatment, except in broad terms is beyond the scope of its mandate. Criteria may be set for *prognosis*; at present the prognosis for alcoholism is obscure.

Mainly, the committee expects the criteria to be used to identify individuals at multiple levels of dependence. The committee has endeavored to use objectively reproducible data that are obtainable from the patient, his immediate family, or his associates. These data have been weighted for their diagnostic significance. We have included material that would differentiate degrees of severity and that would allow for progression of the disease, where that exists, without prejudging the possibility that cases of alcoholism may exist in which progression is not a factor. All but one consultant believed that, in alcoholism, there generally is a progression of the disease, although this might not necessarily be reflected by continually increasing drinking. Many consultants have exhorted us to concentrate more on "early manifestations." The reader will note a separation into early, middle, and late effects, which is a general guide. Our first intent, however, is that the person who is diagnosed as having alcoholism surely fits into that category.

THE NATURE OF ALCOHOLISM

The committee was unanimous in defining the disease of alcoholism as a pathological dependence on ethanol, as it is classified under Section 303.2 in the *Diagnostic and Statistical Manual of Mental Disorders*, second edition, of the American Psychiatric Association.

Aside from the legal difference between the distribution of alcohol and that of other drugs, there are important scientific differences. A drug is defined in two senses: it is a substance of use in medicine, and it is a habit-forming substance. It generally produces its effect in small quantities. Although alcohol does produce an effect with small quantities, it differs from other drugs in both senses in that large quantities over a long period of time are necessary for it to become habit-forming.

Another difference between alcohol and other drugs, particularly those of the opiate class, is the relative risk of addiction. Many people drink, but less than ten per cent develop the psychological and physiological dependency on alcohol that can be categorized as alcoholism. With opiates, the risk of pharmacological addiction is considerably higher. Many alcoholics believe that they were alcoholics from their first drink, that their reaction to alcohol was different from that of others. These retrospective data are suspect until and unless a clear difference is established between these individuals and others. Family incidence of alcoholism and other factors may indicate a portion of the population at high risk.

Whether *anyone* who drinks a sufficient quantity over a sufficient period of time will develop alcoholism, whether a specific biochemical or psychological difference leads to alcoholism, or whether both conditions (with other as yet undetermined factors possible turning the balance) are necessary to cause alcoholism has not yet been established. Thus, whether there is a continuous or discontinuous progression from drinking alcoholic beverages to dependence on alcohol has not yet been clearly decided. Animal data suggest that anyone who drinks enough over a sufficiently long period of time will develop the signs of alcoholism. In the free state, however, neither all humans nor all animals choose the paths that lead to this condition. In establishing criteria for diagnosis, the committee wishes to avoid prejudging these issues of etiology.

On the other hand, once alcoholism is established there is general consensus on its manifestations, and the committee thus feels that it is appropriate to describe it as a disease, in agreement with the American College of Physicians, the American Medical Association, the American Psychiatric Association, and other bodies. Alcoholism fits the definition of disease given in *Dorland's Illustrated Medical Dictionary*, 24th edition:

A definite morbid process having a characteristic train of symptoms; it may affect the whole body or any of its parts, and its etiology, pathology, and prognosis may be known or unknown.

Partial and intermittent forms of alcoholism pose some problems that will be treated separately. Isolated episodes of inebriation, even if they generate unfortunate consequences, are eliminated.

Divisions of Data

Data are assembled according to the type of material they represent. Therefore, there are separate data "tracks"—Track I: Physiological and Clinical, and Track II: Behavioral, Psychological, and Attitudinal. The Track II data are grouped together because behavioral manifestations, the easiest to determine and most objective to recognize, imply attitudinal and psychological manifestations.

There is no rigid uniformity in the progress of the disease, but, since early diagnosis seems to be helpful in treatment and recovery, manifestations are separated into "early," "middle," and "late." In addition to identifying early and late symptoms and signs, each datum was graded according to its degree of implication for the presence of alcoholism. Of course, some of the more definite signs occur later in the course of the illness. But this does not mean that people with earlier signs may not also have alcoholism.

Various terminologies for these signs have been suggested; we propose to weight them and group them into three "diagnostic levels," with those weighted as "1" being the most significant.

Diagnostic Level 1. Classical, definite, obligatory: This criteria is clearly associated with alcoholism.

Diagnostic Level 2. Probable, frequent, indicative: This criteria lends strong suspicion of alcoholism; other corroborative evidence should be obtained.

Diagnostic Level 3. Potential, possible, incidental: These manifestations are common in people with alcoholism, but do not by themselves give a strong indication of its existence. They may arouse suspicion, but other significant evidence is needed before the diagnosis is made.

Diagnosis

It is sufficient for the diagnosis of alcoholism that one or more of the major criteria at diagnostic level 1 are satisfied, or that several of the minor criteria in Tracks I and II are present; see Tables 1 and 2. If one is making the diagnosis because of major criteria in one of the tracks, he should also make a strong search for evidence in the other track. A purely mechanical selection of items is not enough; the history, physical examination, and other observations, plus laboratory evidence, must fit into a consistent whole to ensure a proper diagnosis. Minor criteria in the physical and clinical tracks alone are not sufficient, nor are minor criteria in behavioral and psychological tracks. There must be several in *both* Track I and Track II areas.

Psychiatric Diagnosis

After a suitable evaluation, a separate psychiatric diagnosis should be made on every patient, apart from the diagnosis of alcoholism. Patients may suffer from schizophrenia, latent or overt; from manic-depressive psychosis, obsessive-compulsive neurosis, recurrent depression, anxiety neurosis, or psychopathic personality; or have no psychiatric constellation differing from normal. The diagnosis should be made after treatment for withdrawal is complete, since alcohol is anxiety-producing and can also bring out psychological mechanisms and traits that are not apparent without alcohol. In particular, the hallucinatory behavior induced by alcohol withdrawal is not to be equated with schizophrenic hallucinatory behavior.

Alcoholism With Intermittent or Recurrent Drinking

Intermittent or recurrent may represent a phase in the course of alcoholism. This pattern should be noted separately. The same criteria control the diagnosis. In some individuals there are recurring episodes of inebriation that become more frequent over a period of years until a daily drinking pattern emerges. In many individuals daily drinking increases until the individual himself slowly becomes aware that physiological and psychological dependence exist. At this point periods of "going on the wagon" may occur, with a resulting intermittent or recurrent pattern of drinking. For most drinkers, there are lesser or greater periods of time when, because of circumstances or the acute effects of alcohol, drinking is not possible. This pattern is consistent with other drug dependence situations, in which interruptions of use are commonplace and have been accepted without the necessity of making a separate category for them.

Even with a "steady" pattern of alcohol use, there are marked fluctuations in the blood alcohol level during each day. The patient with an alcohol problem, given free choice, does not, as one might assume, keep drinking to maintain a steady blood level of alcohol. It has been observed that men who were incarcerated for public intoxication for three-month periods had a total yearly alcohol intake and total time available for drinking that may have been less than that of the "normal" drinker. Yet these men reported withdrawal signs and symptoms upon cessation of each drinking spree. There is also good experimental evidence for a withdrawal syndrome upon cessation of relatively short periods of heavy drinking.

Thus, where the practitioner has a patient whose drinking pattern consists of intermittent or recurrent drinking and in whom the appropriate diagnostic criteria are satisfied, the condition should be diagnosed as alcoholism (with the qualification as to pattern added if it seems important).

Alcoholism: Recovered, Arrested, or in Remission

Since alcoholism is relapsing and chronic, there are very few authorities who claim a complete cure. But there are many patients who, after a time of complete sobriety, have reordered their lives in a rehabilitative way and are completely able to perform complex and responsible tasks. There are also a few patients who have returned to "social" drinking or who have infrequent "slips" but who still function as rehabilitated persons.

Although these diagnostic criteria are not devised as a guide to prognosis, it is the opinion of the committee that a history of alcoholism in the past, followed by a significant recovery, should be taken into account as a guide to treatment, employment, and restoration of rights and privileges

previously denied because of active alcoholism. Some members of the committee believed that total abstinence would not, in the future, turn out to be an absolute, final necessity for recovery from alcoholism. However, it was agreed that total abstinence, as a measure of recovery, arrest, or remission, was usually more easily measurable, definitive, and generally accepted than a change from "dependency" to "social" drinking. Thus, the committee agreed that the following considerations should determine the diagnosis of recovered, arrested, or remitted alcoholism:

- Duration of abstinence
- Concurrent active treatment program
- Concurrent A.A. attendance with full participation
- Concurrent self-administered and professionally guided deterrent medication
- Resumption or continuation of work without absenteeism
- No traffic violations
- No substitution of other drugs

Although the committee did not choose at this time to assign definitive time values for any of these considerations, the recovery or remission gains in its validity with a progressively longer time. For abstinence alone to be the criterion, without other therapeutic activity, there needs to be a longer time period than if abstinence is combined with other criteria.

Alcohol Use

Diagnostic terms that define conditions that fall short of alcoholism are necessary because of the effects of alcohol on behavior. Although the term *alcohol abuse* has wide currency, we prefer *alcohol use*, accompanying this term with a description of effect. This leaves the term "abuse" for such situations as child abuse, animal abuse, or self-abuse, where there is an animate object of the abuse, and does not anthropomorphize alcohol, which, after all, is a chemical (the "neutral spirit"). The term *misuse*, we believe, also carries an unnecessary normal implication.

Alcohol Use With Inebriation

Intoxication may be mild, moderate, or severe, or may lead to coma. Although alcoholics are frequently obviously intoxicated, mere intoxication is not sufficient for the diagnosis of alcoholism. Indeed the physician should be cautious in making a diagnosis of alcohol intoxication on the basis of a staggering gait, slurred speech, other neurological signs, and an odor of alcohol on the breath. In such cases, one must be sure to rule out diabetic acidosis, hypoglycemia, uremia, impending or completed stroke, and other causes of cerebral impairment. An alcohol breath test, determination of blood alcohol level, or serum osmolality measurement may assist in making a diagnosis of alcohol intoxication. A history from the patient and from family members or friends is usually helpful but must in itself be subject to evaluation. Alcohol intoxication must be thought of in any person in coma; *in addition*, barbiturate and other sedative intoxication must be investigated: cross dependence and cross tolerance are common.

Alcohol Use With Pathological Intoxication

In some individuals a small amount of alcohol will evoke violent, aberrant behavior. Pathological intoxication is a idiosyncratic response to alcohol and is separate from alcoholism.

Alcohol Use: Reactive, Secondary, or Symptomatic

Reactive, secondary, or symptomatic alcohol use should be separated from other forms of alcoholism. Alcohol as a psychoactive drug may be used for varying periods of time to mask or alleviate psychiatric or situationally induced symptoms. This may often mimic a prodromal stage of alcoholism and is difficult to differentiate from it. If the other criteria of alcoholism are not present, this diagnosis must be given. A clear relationship between the psychiatric symptom or event must be present; the period of heavy alcohol use should clearly not antedate the precipitating situational event (for example, on object loss). The patient may require treatment as for alcoholism, in addition to treatment for the precipitating psychiatric event: one may be able to confirm the diagnosis only in retrospect.

Alcohol and Anxiety

The effects of alcohol on the rising slope of the absorption curve parallel the four stages of anesthesia, and thus excited or uninhibited behavior may be shown with mild inebriation. But it also has been documented that, with large doses over a prolonged period of time, alcohol produces anxiety. Whether this bimodal effect occurs as a regular result of any amount of alcohol is currently being investigated. The progressive rise of anxiety with continued heavy drinking is responsible for many of the effects listed as minor criteria.

Cross-Dependence

Cross-dependence (or "cross-addiction") may begin iatrogenically or spontaneously with the use of any of the sedative class of drugs, barbiturates, or "minor" tranquilizers in an attempt to control the anxiety generated by heavy alcohol use or in the mistaken impression that pharmacological control of the anxiety will stop the alcohol use. Such cross-dependence is so common that it must be investigated in any person suspected of alcoholism.

In addition, the life-style of persons who seek pharmacological "highs" is associated with heavy alcohol use *pari passu* with other psychoactive chemical materials. Such persons are at risk of alcoholism, and patients being investigated for the diagnosis of alcoholism should also be evaluated for use of these materials.

Treatment programs for the use of other drugs engender a significant proportion of "instant alcoholics" who, having relinquished the other drugs, turn to alcohol and experience an unusually rapid onset of dependence. Thus, patients in this category should also be screened for alcoholism, and attempts should be made to prevent its onset.

Persons at High Risk of Alcoholism

Epidemiological and sociological studies show that the following factors indicate high risk for the development of alcoholism. There is not complete agreement on the extent of risk for each factor.

- A family history of alcoholism, including parents, siblings, grandparents, uncles, and aunts (2).
- A history of teetotalism in the family, particularly where strong moral overtones were present and, most particularly, where the social environment of the patient has changed to associations in which drinking is encouraged or required (2).
- A history of alcoholism or teetotalism in the spouse (2) or the family of the spouse (3).

- Coming from a broken home or home with much parental discord, particularly where the father was absent or rejecting but not punitive (4).
- Being the last child of a large family or in the last of the sibship in a large family (3).
- Although some cultural groups (for example, the Irish and Scandinavians) have been recorded as having a higher incidence of alcoholism than others (Jews, Chinese, and Italians) the physician should be aware that alcoholism can occur in people of any cultural derivation (5-7).
- Having female relatives of more than one generation who have had a high incidence of recurrent depressions (8).
- Heavy smoking: Heavy drinking is often associated with heavy smoking, but the reverse need not be true (9).

Recording the Diagnosis

If alcoholism as defined above is present, the diagnosis should be stated in this order:

- Alcoholism: intermittent use, recurrent use, steady use (early, moderately advanced, far advanced)
- Psychiatric diagnosis
- Physical diagnosis

If major criteria or a sufficient number of minor criteria are not met, the diagnosis should be:

- Suspected alcoholism: psychiatric diagnosis; physical diagnosis

Other diagnoses that can be made:

- Alcohol use: reactive, secondary, or symptomatic; psychiatric diagnosis; physical diagnosis.
- Alcohol use with inebriation

A description of the physical diseases associated with alcoholism and their diagnosis will be the subject of a separate communication.

TABLE 1. MAJOR CRITERIA FOR THE DIAGNOSIS OF ALCOHOLISM

Criterion	Diagnostic Level
Track I. Physiological and Clinical	
A. Physiological Dependency.	
1. Physiological dependence as manifested by evidence of a <i>withdrawal syndrome</i> * when the intake of alcohol is interrupted or decreased without substitution of other sedation.** It must be remembered that overuse of other sedative drugs can produce a similar withdrawal state, which should be differentiated from withdrawal from alcohol.	
a) Gross tremor (differentiated from other causes of tremor)	1
b) Hallucinosis (differentiated from schizophrenic hallucinations or other psychoses)	1
c) Withdrawal seizures (differentiated from epilepsy and other seizure disorders)	1

Criterion	Diagnostic Level
d) Delirium tremens. Usually starts between the first and third day after withdrawal and minimally includes tremors, disorientation, and hallucinations*	1
2. Evidence of <i>tolerance</i> to the effects of alcohol. (There may be a decrease in previously high levels of tolerance late in the course). Although the degree of tolerance to alcohol in no way matches the degree of tolerance to other psychotropic drugs, the behavioral effects of a given amount of alcohol vary greatly between alcoholic and nonalcoholic subjects.	
a) A blood alcohol level of more than 150 mg/100 ml without gross evidence of intoxication	1
b) The consumption of one-fifth of a gallon of whiskey or an equivalent amount of wine or beer daily, for a period of two or more consecutive days by a 180 lb. individual***	1
3. Alcoholic "blackout" periods (Differential diagnosis from purely psychological fugue states and psychomotor seizures.)	2
B. Clinical: Major Alcohol-Associated Illnesses. Alcoholism can be assumed to exist if major alcohol-associated illnesses develop in a person who drinks regularly. In such individuals, evidence of physiological and psychological dependence should be searched for.	
Fatty degeneration in absence of other known cause	2
Alcoholic Hepatitis	1
Laennec's cirrhosis	2
Pancreatitis in the absence of cholelithiasis	2
Chronic gastritis	3
Hematological disorders:	
Anemia: Hypochromic, normocytic, macrocytic, hemolytic with stomatocytosis, low folic acid	3
Clotting disorders: prothrombin elevation, thrombocytopenia	3
Wernicke-Korsakoff syndrome	2
Alcoholic cerebellar degeneration	1
Cerebral degeneration in absence of Alzheimer's disease or arteriosclerosis	2
Central pontine myelinolysis (diagnosis only possible post-mortem)	2
Marchiafava-Bignami's disease (diagnosis only possible post-mortem)	2
Peripheral neuropathy (see also beri-beri)	2
Toxic amblyopia	3

*See Seixas (1).

**Some authorities term this "pharmacological addiction."

***For equivalent amounts in wine and beer, See Annex 2.

Criterion	Diagnostic Level
Alcoholic myopathy	2
Alcoholic cardiomyopathy	2
Beriberi	3
Pellagra	3

Track II. Behavioral, Psychological and Attitudinal

All chronic conditions of psychological dependence occur in dynamic equilibrium with intrapsychic and interpersonal consequences. In alcoholism, similarly, there are varied effects on character and family. Like other chronic relapsing diseases, alcoholism produces vocational, social, and physical impairments. Therefore, the implications of these disruptions must be evaluated and related to the individual and his pattern of alcoholism. The following behavior patterns show psychological dependence on alcohol in alcoholism:

- | | |
|--|---|
| 1. Drinking despite strong medical contraindication known to patient | 1 |
| 2. Drinking despite strong, identified, social contraindication (job loss for intoxication, marriage disruption because of drinking, arrest for intoxication, driving while intoxicated) | 1 |
| 3. Patient's subjective complaint of loss of control of alcohol consumption | 2 |

TABLE 2. MINOR CRITERIA FOR THE DIAGNOSIS OF ALCOHOLISM

Criterion	Diagnostic Level
Track I. Physiological and Clinical	
A. Direct Effects (ascertained by examination).	
1. Early: Odor of alcohol on breath at time of medical appointment	2
2. Middle: Alcoholic facies	2
Vascular engorgement of face	2
Toxic amblyopia	3
Increased incidence of infections	3
Cardiac arrhythmias	3
Peripheral neuropathy (see also Major Criteria, Track I, B)	2
3. Late (see Major Criteria, Track I, B)	
B. Indirect Effects.	
1. Early: Tachycardia	3
Flushed face	3
Nocturnal diaphoresis	3
2. Middle: Ecchymoses on lower extremities, arms, or chest	3

Criterion	Diagnostic Level
Cigarette or other burns on hands or chest	3
Hyperreflexia, or if drinking heavily, hyporeflexia (permanent hyporeflexia may be a residuum of alcoholic poly neuritis)	3
3. Late:	
Decreased tolerance	3
C. Laboratory Tests.	
1. Major—Direct:	
Blood alcohol level at any time or more than 200 mg./100 ml.	1
Level of more than 100 mg./100 ml. in routine examination	1
2. Major—Indirect:	
Serum osmolality (reflects blood alcohol levels): every 22.4 increase over 200 mOsm/liter reflects 50 mg./100 ml. alcohol	2
3. Minor—Indirect	
Results of alcohol ingestion:	
Hypoglycemia	3
Hypochloremic alkalosis	3
Low magnesium level	2
Lactic acid elevation	3
Transient uric acid elevation	3
Potassium depletion	3
Indications of liver abnormality:	
SGPT elevation	2
SGOT elevation	3
BSP elevation	2
Bilirubin elevation	2
Urinary urobilinogen elevation	2
Serum A/G ration reversal	2
Blood and blood clotting:	
Anemia: hypochromic, normocytic, macrocytic, hemolytic with stomatocytosis, low folic acid	3
Clotting disorders: prothrombin elevation, thrombocytopenia	3
ECG abnormalities:	
Cardiac arrhythmias; tachycardia; T waves dimpled, cloven, or spinous; atrial fibrillation; ventricular premature contractions; abnormal P waves	2
EEG abnormalities:	
Decreased or increased REM sleep, depending on phase	3
Loss of delta sleep	3
Other reported findings	3
Decreased immune response	3
Decreased response to Synacthen test	3
Chromosomal damage from alcoholism	3

Criterion	Diagnostic Level
Track II. Behavioral, Psychological, and Attitudinal	
A. Behavioral.	
1. Direct effects.	
Early:	
Gulping drinks	3
Surreptitious drinking	2
Morning drinking (assess nature of peer group behavior)	2
Middle:	
Repeated conscious attempts at abstinence	2
Late:	
Blatant indiscriminate use of alcohol	2
Skid Row or equivalent social level	2
2. Indirect effects.	
Early:	
Medical excuses from work for variety of reasons	2
Shifting from one alcoholic beverage to another	2
Preference for drinking companions, bars, and taverns	2
Loss of interest in activities not directly associated with drinking	2
Late:	
Chooses employment that facilitates drinking	3
Frequent automobile accidents	
History of family members undergoing psychiatric treatment: school and behavioral problems in children	3
Frequent change of residence for poorly defined reasons	3
Anxiety-relieving mechanisms, such as telephone calls inappropriate in time, distance, person, or motive (telephonitis)	2
Outbursts of rage and suicidal gestures while drinking	2
B. Psychological and Attitudinal.	
1. Direct effects.	
Early:	
When talking freely, makes frequent reference to drinking alcohol, people being "bombed," "stoned," etc. or admits drinking more than peer group	2
Middle:	
Drinking to relieve anger, insomnia, fatigue, depression, social discomfort	2
Late:	
Psychological symptoms consistent with permanent organic brain syndrome (see Major Criteria, Track I. B)	2

Criterion	Diagnostic Level
2. Indirect effects.	
Early:	
Unexplained changes in family, social, and business relationships; complaints about wife, job, and friends	3
Spouse makes complaints about drinking behavior, reported by patient or spouse	2
Major family disruptions: separation, divorce, threats of divorce	3
Job loss (due to increasing interpersonal difficulties), frequent job changes, financial difficulties	3
Late:	
Overt expression of more regressive defense mechanisms: denial, projection, etc.	3
Resentment, jealousy, paranoid attitudes	3
Symptoms of depression: isolation, crying, suicidal preoccupation	3
Feelings that he is "losing his mind"	2

NATIONAL COUNCIL ON ALCOHOLISM QUESTIONS

NAME _____

1. Do you sometimes drink excessively when you are disappointed, argued with, or aggravated by someone? Yes _____ No _____
2. Do you drink more than usual when you are troubled or under pressure? Yes _____ No _____
3. Are you able to drink more now without feeling it than when you first started to drink? ... Yes _____ No _____
4. Do you suffer memory losses of events during the evening, and yet not pass out? Yes _____ No _____
5. Do you try to squeeze in a couple of extra drinks during the evening without other people knowing it? Yes _____ No _____
6. On some occasions, do you feel ill at ease if alcohol is not available? Yes _____ No _____
7. Are you rushing more to get that first drink than you did, say last month? Yes _____ No _____
8. Do you occasionally have feelings of guilt about your drinking? Yes _____ No _____
9. When your friends and family discuss your drinking, do you quietly resent it? Yes _____ No _____
10. Are your "blackouts" more frequent recently? Yes _____ No _____
11. Do you want to continue drinking when your friends say "enough"? Yes _____ No _____
12. Do you have a reason when you get drunk? .. Yes _____ No _____
13. Are you embarrassed by the things you say and do when drunk? Yes _____ No _____
14. Have you switched drinks or changed your pattern to control your drinking? Yes _____ No _____

15. Do you promise yourself to control your drinking and then break the promise? Yes _____ No _____
16. Have you changed jobs or moved to a new place to control your drinking? Yes _____ No _____
17. Do you avoid friends and family when drinking? Yes _____ No _____
18. Are financial and work problems increasing? Yes _____ No _____
19. Do you feel people are treating you unfairly? Yes _____ No _____
20. When drinking, do you eat irregularly and very little? Yes _____ No _____
21. Do you take another drink in the morning to quiet your "shakes"? Yes _____ No _____
22. Has your drinking capacity decreased lately? Yes _____ No _____
23. Do you occasionally stay drunk for several days? Yes _____ No _____
24. Are you sometimes depressed and feel that life isn't worth living? Yes _____ No _____
25. Do you occasionally have hallucinations after a period of drinking? Yes _____ No _____
26. Do you have vague fears after drinking heavily? Yes _____ No _____

**JOHNS HOPKINS
UNIVERSITY
HOSPITAL
QUESTIONS**

NAME _____

1. Do you require a drink the next morning? Yes _____ No _____
2. Do you prefer (or like) to drink alone? Yes _____ No _____
3. Do you lose time from work due to drinking? Yes _____ No _____
4. Is your drinking harming your family in any way? Yes _____ No _____
5. Do you crave a drink at a definite time daily? Yes _____ No _____
6. Do you get the inner shakes unless you continue drinking? Yes _____ No _____
7. Has drinking made you irritable? Yes _____ No _____
8. Does drinking make you careless of your family's welfare? Yes _____ No _____
9. Have you thought less of your husband or wife since drinking? Yes _____ No _____
10. Has drinking changed your personality? Yes _____ No _____
11. Does drinking cause you bodily complaints? Yes _____ No _____
12. Does drinking cause you to have difficulty in sleeping? Yes _____ No _____
13. Has drinking made you more impulsive? Yes _____ No _____
14. Have you less self-control since drinking? Yes _____ No _____
15. Has your initiative decreased since drinking? Yes _____ No _____
16. Has your ambition decreased since drinking? Yes _____ No _____
17. Do you drink to obtain social ease? (in shy, timid, self-conscious individuals) Yes _____ No _____
18. Do you drink for self-encouragement or to relieve marked feeling or inadequacy? (In persons with feelings of inferiority) Yes _____ No _____
19. Has your sexual potency suffered since drinking? Yes _____ No _____
20. Do you show marked dislikes and hatreds since drinking? Yes _____ No _____

21. Has your jealousy, in general, increased since drinking? Yes_____No_____
22. Do you show marked moodiness as a result of drinking? Yes_____No_____
23. Has your efficiency decreased since drinking? Yes_____No_____
24. Are you harder to get along with since drinking?..... Yes_____No_____
25. Do you turn to an inferior environment since drinking? Yes_____No_____
26. Is drinking endangering your health? Yes_____No_____
27. Is drinking affecting your peace of mind? Yes_____No_____
28. Is drinking jeopardizing your business? Yes_____No_____
29. Is drinking clouding your reputation? Yes_____No_____
30. Have you ever had a complete loss of memory while, or after drinking? (Blackouts) Yes_____No_____

**MICHIGAN
ALCOHOLISM
SCREENING TEST**

	Answer	Points*
1. Do you feel you are a normal drinker? (By normal we mean you drink less than or as much as most other people.)	No	2
2. Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of the evening?	Yes	2
3. Does your wife, husband, a parent, or other near relative ever worry or complain about your drinking?	Yes	1
4. Can you stop drinking without a struggle after one or two drinks?	No	2
5. Do you ever feel guilty about your drinking?	Yes	1
6. Do friends or relatives think you are a normal drinker?	No	2
7. Are you able to stop drinking when you want to?	No	2
8. Have you ever attended a meeting of Alcoholics Anonymous?	Yes	5
9. Have you ever gotten into physical fights when drinking?	Yes	1
10. Has drinking ever created problems between you and your wife, husband, a parent, or other near relative?	Yes	2
11. Has your wife, husband, a parent, or other near relative ever gone to anyone for help about your drinking?	Yes	2
12. Have you ever lost friends or girl friends because of your drinking?	Yes	2
13. Have you ever gotten into trouble at work because of your drinking?	Yes	2

14. Have you ever lost a job because of drinking?	Yes	2
15. Have you ever neglected your obligations, your family or your work for two or more days in a row because you were drinking?	Yes	2
16. Do you drink before noon fairly often?	Yes	1
17. Have you ever been told you have liver trouble? Cirrhosis?	Yes	2
18. After heavy drinking have you ever had delirium tremens (DTS) or severe shaking, or heard voices or seen things that weren't really there?	Yes	2
19. Have you ever gone to anyone for help about your drinking?	Yes	5
20. Have you ever been in a hospital because of drinking?	Yes	5
21. Have you ever been a patient in a psychiatric hospital or on a psychiatric ward of a general hospital where drinking was part of the problem that resulted in hospitalization?	Yes	2
22. Have you ever been seen at a psychiatric or mental health clinic or gone to any doctor, social worker, or clergyman for help with any emotional problem, where drinking was part of the problem?	Yes	2
23. Have you ever been arrested for drunken driving, driving while intoxicated, or driving under the influence of alcoholic beverages?	Yes	2
24. Have you ever been arrested, even for a few hours, because of other drunken behavior?	Yes	2

Source: University of Michigan, 1975

*Total of 5 points indicates alcohol problem

DOT HS 900 035
January 1980

END