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APPENDIX C12
REHABILITATION OF THE PERSISTENT DRINKING/DRUGGING DRIVER

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INTRODUCTION

Results from a comprehensive meta-analytic review of treatment efficacy for DUI offenders suggested the following points that are relevant to treatment of the persistent offender. (Wells-Parker, et al, 1994):

A. As compared to standard sanctions such as jail or fines or no treatment, rehabilitation showed a generally small but positive influence (7-9 percent reduction) on reducing incidence of alcohol-related driving recidivism and crashes, when averaged across all types of offenders and rehabilitation.

B. Treatments that combined strategies - i.e. education plus therapy plus follow-up (contact monitoring or probation, aftercare, etc.) were most effective for multiple, as well as "first" offenders. These combination strategies were superior to educational programs alone and to contact probation alone in reducing subsequent drinking and driving. Rehabilitation

tended to reduce alcohol-related crashes while licensing actions tended to reduce non-alcohol related crashes: combining rehabilitation with licensing actions produced the most effective reduction in all crashes.

C. In the set of evaluated studies, "severe" or "high-problem" offenders (the definition of which varied across studies) appeared to show a smaller response (i.e. smaller reduction in drinking driving) to treatment than did offenders with more moderate risk levels; however, some of these high-risk groups also tended to receive less effective single focus strategies and programs that focused on abstinence alone rather than broad spectrum goals.

These results suggest the following research needs:

a. A clearer definition of the "high-risk" or "severe problem" offender is needed. It is acknowledged that substantial problems may exist in a unitary definition of risk or problem severity, especially across gender, age, and ethnically diverse sub-groups. Indeed, more than one "profile" may be associated with elevated risk or "persistence" given the diversity of personality, as well as drinking variables, that are likely to contribute to elevated crash risk in the DUI population.

b. A significant need is the evaluation of programs - programs that will likely involve a combination of elements including significant psychotherapeutic intervention, after care/monitoring and incapacitation sanctions - that are tailored to prevent characteristics of high risk profiles.

An intervention that combines the suggested components should be evaluated for "persistent" offenders since most of the components that are suggested have not been evaluated either alone or in combination for DUI offenders.

The remainder of the paper draws on both extensive clinical experience; research and theory on DUI offender characteristics, and evaluation of strategies from the more general alcohol treatment literature to develop components of a treatment model tailored to general characteristics of one offender profile that is likely to be associated with "persistence" in high risk driving, especially driving after drinking.

Background for model:

The persistent offender is much more likely to have been through several mandated treatment programs, been involved in others types of criminal behavior and is more likely to have been involved in a serious crash. (Simpson & Mayhew, 1991)

Treatment for this population has largely aimed to separate drinking and driving behaviors, and has been based primarily on the Minnesota Model of Chemical Dependence which has, in addition to it's disease orientation, the notion that treatment needs to be based only on the level of drinking or use severity.

In addition to the use of a model which has not been demonstrated to be efficacious, the problem has been exacerbated by inadequate assessment. Such assessments have usually dealt with substance use and largely have ignored personality variables and risk taking behaviors. Assessment information has rarely been incorporated into treatment plans. The result has been non-individualized treatment presented in cookie-cutter fashion.

Compounding matters has been the quality of personnel. The majority of people providing treatment have only been schooled in the disease model. The lack of understanding of other models has been complicated by the lack of training in techniques which both the alcohol and Criminal Justice literature have shown to be efficacious. (ADAD, 1993), (Miller & Hester, 1986), (Beck, et al.1993), & (Andrews and Bonta, 1994) In addition, interventions have generally been of too short duration and too low a level of intensity. (Nichols, 1990)

There has been an historical evolution in the conceptualization and treatment of the DUI offender. Research shows that the persistent offender is a distinct subset of the total population of drinking drivers, characterized by a number of deviant behaviors that increase risk of involvement in driving fatalities and risk of re-offending. (Donovan & Marlatt, 1982) A number of theories have attempted to explain the behavior of the high-risk driver. The most parsimonious seems to be that of problem-behavior theory. It suggests that the multiple offender's drinking behavior is only one of a subset of deviant behaviors that occur within a lifestyle context. (Jessor, 1987) Treatment that aims only to separate drinking/driving behaviors may produce limited outcomes. (Kunkel, 1983) An effective treatment paradigm must address the critical lifestyle and personality variables that create, shape, perpetuate and maintain the behavior of this population. The variables include the offender's lifestyle and its environmental context, the offender's driving/related attitudes, their personality system and their substance abuse patterns.

Model:

A. Process-oriented assessment:

Traditional assessment that focuses primarily on drivers' drinking is not sufficient. The research on multiple DUI offenders suggests that social, environmental, interpersonal and individual factors combine to shape the offender's high-risk behaviors. Offenders who evidence interrelated problem

behaviors are frequently characterized by lack of social stability, conceptual rigidity, external locus of control and poor problem-solving skills and in general tend to lack the skills necessary for adaptive functioning. (Institute of Medicine, 1990) Their deficits are cognitive, interpersonal and social. Cognitive factors include their driving-related attitudes, attitudes toward law enforcement and their cognitive set: the manner in which they view their lives, themselves and others. Interpersonal factors include poor social relationships, some of which are characterized by high levels of aggression and risk-taking. Social factors include lifestyle, social network, occupational and leisure functioning.

Assessment would be an integral part of the model program, and comprehensive assessment should be sensitive enough to identify the alcohol and non-alcohol related problems of the offender. In addition to being multifaceted and comprehensive, assessment would also be process-oriented. This type of assessment evaluates offender status throughout treatment in the areas of motivation for change, behavioral coping skills and psychopathology. Assessment data needs to be used as a continuous feedback loop, providing program personnel with information that guides and helps individualize the course of treatment. Assessment needs to be re-iterative in nature. Assessment-as-intervention has been shown to increase motivation in drug/alcohol populations, and shows promise for improving the level and nature of the offender's involvement in treatment. (Miller & Rollnick, 1991)

B. Focus on motivation for change:

Motivation for change has traditionally been considered to be a major obstacle to effective treatment of this population. The work of Prochaska and DiClemente on stages of readiness-for-change (1992) and the work of William Miller on motivational interviewing (1991) (Miller, et al, 1993) are applicable. Miller's work shows that traditional confrontational strategies produce poorer outcomes when compared to motivational strategies and that the more counselors confront, the more clients have been shown to be drinking at follow-up. Retention of these clients in treatment has also been a factor. The research on motivational interviewing shows that it increases the rate of client retention in treatment, client compliance with treatment objectives and client outcomes. Cognitive-behavioral interventions such as the highly-structured Reasoning and Rehabilitation (R&R) 35-session model developed by Ross and Fabiano has been shown to be highly effective at engaging the client in the treatment process. This suggests that the lack of motivation traditionally attributed to this population has been a function of poor counselor skills and lack of a treatment paradigm that addresses the characteristics and needs of this population. (Ross & Fabiano, 1985) (Ross, et al, 1986)

C. Length, intensity and setting:

The length of this ideal program would be one year. Experience suggests that many judges are sentencing persistent offenders to 6-12 month jail sentences with no treatment. The judicial system is frustrated by the lack of viable and effective treatment options for this population. Although brief-treatment models may be applicable to the general DUI population in which there is considerable diversity as to level and types of problems, the proposed model focuses on a more prescribed group of offenders who are likely to be characterized by heavy consumption of alcohol, repeated instances of criminally involved behavior and high-risk driving incidents. Clinical experience suggests that the particular DUI offenders for whom the program is modeled after are characterized by behavior that is ego syntonic, with an external locus of control and tremendous difficulty forming a relationship of trust. (Donovan, et al, 1986)(Donovan, et al, 1989) (Donovan, 1990) (Donovan & Rosengren, 1992) For this reason, a structured situation is needed at treatment initiation so that the individual becomes "hooked" to participate in an active and involved manner. Jail or a work-release setting would be optimal settings for beginning treatment. Sentences can be modified if the offender successfully completes the first phase. Treatment on an outpatient basis would need to maintain high levels of structure including BAC monitoring. Optimal program length, as well as setting for treatment initiation could be explicitly evaluated in outcome and process evaluation.

D. Goals:

Treatment goals should include (1) increasing motivation for change in the offender's lifestyle and substance-abuse pattern; (2) use of environmental and social interventions to increase motivation for change and reinforce behavior change once it occurs; and (3) develop offender self-efficacy in the areas of problem-solving, communication-skills, conflict-management skills, stress management skills and conceptual flexibility that are linked to the maintenance of pro-social behaviors. The following therapeutic components are targeted toward these goals.

E. Therapeutic components:

1. Cognitive-Behavioral Skills Training:

The component of cognitive-behavioral skills training addresses the driving-related variables and personality factors that combine to shape the offender's drinking-and-driving behavior. The driving-related attitudes of this population include sensation-seeking and thrill-seeking behaviors, positive evaluation of risk-taking, competitive speeding while driving, driving as a means of reducing psychological tensions and as a means of increasing the perception of personal efficacy, status and power. (Donovan, et al, 1983 (Donovan, 1988) Other variables include low respect for the law, an aggressive attitude while driving, through which acute and chronic anger and resentment are expressed, and attribution of the cause of accidents to factors beyond one's personal control. Skills training is based on the evidence that lack of coping skills contributes more to risky driving than anything else. (Chaney, et al. 1978) The impulse-control problems noted in the research make abundantly clear that this population is suffering from skills-deficits and that the latter result in the self-defeating behavioral strategies.

2. Reasoning and Rehabilitation Component:

The Reasoning and Rehabilitation model consists of ten interrelated modules that address the following topic areas: problem-solving skills, creative thinking, social skills, emotion management techniques, values, and critical reasoning. The sequence of sessions has been adjusted for optimal performance based on empirical trials and evaluation. The sessions are experiential, generally non-didactic and expressly designed to be engaging and practical. High levels of participant energy and attention are required to facilitate performance gains in the basic cognitive and self regulation skills. (Ross & Fabiano, 1985)

3. Relapse Prevention:

Relapse Prevention addresses the substance abuse problem with a series of interventions. It focuses on building client-specific coping behaviors designed to inoculate against the use of old strategies. At this phase of treatment offenders who continue to be Pre-Contemplators (Prochaska & DiClemente, 1992) are screened out and placed in a group focusing on motivational interventions designed to identify and resolve obstacles to movement to the next stage of readiness for change. The goals of Relapse Prevention are to (1) increase the range and flexibility of client coping strategies and (2) to increase client self-efficacy.

4. Community Reinforcement Component:

Community Reinforcement is part of a wider intervention strategy that expands the focus beyond attention on the persistent offender's drinking and personality deficits to include lifestyle and community adjustment. (Azrin, et al, 1982) High relapse rates for this population are related to the post-treatment environment. Persistent drinking drivers are field-dependent and have external locus of control. Clients with these characteristics have been found to be unlikely to use positive supportive resources in the community.

The Community Reinforcement model will focus on those lifestyle factors that can reduce the risk of re-involvement in risky-driving: poor social stability, high levels of job dissatisfaction, lack of family satisfaction, lack of leisure-time satisfaction, and high degree of negative peer influence. The goals of this phase are to (1) significantly impact the style and pattern of drinking by increasing the levels of community involvement and satisfaction; (2) reduce negative peer influence as a function of an increase in satisfaction in all three areas of life functioning: occupational, interpersonal and use of leisure time; (3) managing the reinforcements in the offender's environment in a way that will further reinforce the prosocial values and behavior training that occur in the first two phases of treatment.

These components of treatment overlap in a manner that ensures cohesiveness, congruence and reinforcement of learning from previous sections.

F. Adjunctive components:

In addition to the primary components, the ideal treatment program must have an array of adjuncts. Treatment could be combined with incarceration in different degrees of intensity and various settings, and serious efforts must be made to keep the offender off alcohol and other drugs. Where there is no valid medical contraindication, Antabuse should be used in conjunction with treatment throughout the entire program. Random breath testing can be utilized in cases in which Antabuse can not be used, and when there is evidence of other drugs being used, the offender should be on a random urine testing schedule.

Additional risks associated with the persistent offender indicate the program should include off site monitoring. Random, periodic observation and other types of checks on the offender while at work, school, and home need to be done in order to reinforce expected behaviors as well as to check program compliance. Because of the high risk of illegal driving, a model program should also require that vehicle

immobilization devices be placed on all vehicles over which the offender has control and that interlocks be placed in the vehicles if the offender is to be granted any type of driving privileges.

Potential impediments and possible avenues to solutions:

As with any new, comprehensive program there are bound to be a number of potential impediments. The financial aspects of an intense comprehensive program ideally would be largely borne by the offender. If tax dollars are to be used, they must be kept to a minimum and the entire program should be designed to be self-sufficient. If the National Health Insurance Plan is enacted with the provision that offender treatment is all or in part included, then partnership linkages need to be strengthened between treatment providers and criminal justice agencies so that the systems can better cooperate in providing the needed long term and more intense treatment for this subset of offenders.

Current belief systems of the treatment and criminal justice constituencies, as well as the public will need to be challenged with a goal toward change since many treatment personnel have been schooled exclusively in the disease model, with little training about other approaches and techniques that both the alcohol and criminal justice literature have shown to be effective. (ADAD, 1993), (Miller & Hester, 1986), (Beck, Wright, Newman and Liese, 1993) and (Andrews & Bonta, 1994). Public education and training for treatment and criminal justice agency personnel will need to be modified. Current models of addiction must be taught along with empirically based treatment techniques. The implementation of such a program may well take legislative action. It is important that not only as an educational package for law and police makers be developed but that a broad base of support be developed involving both political parties at the local as well as state and national levels.

Evaluation:

The implementation of an extensive outcome and process evaluation is needed to ensure fidelity of the treatment model. Indeed, well designed outcome measures will need to be made part of the overall program design. In addition to determination of the efficacy of such a comprehensive program as compared to standard sanctions or traditional interventions of similar length and intensity, it would be useful for an evaluation to identify optimally effective and least costly combination of components. For example, comparisons of treatments initiated in facilities such as jails, as compared to initiation in out-patient settings or comparisons of combinations with similar components but different number of hours would be important.

Summary Recommendations:

Assessment should be process oriented, reiterative in nature and include mental health issues, cognitive functioning and risk taking behaviors as well as substance misuse.

Treatment should combine strategies, i.e., education, therapy, and case management.

Treatment should be provided over time, i.e., a minimum of nine - twelve months.

Treatment should be combined with Antabuse or random breath testing, random urine screens, vehicle immobilization, ignition interlocks, and various alternatives to standard incarceration.

Treatment programs such as outlined in this paper which address driving related variables, lifestyle, and personality factors as well as substance abuse should be thoroughly evaluated.

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APPENDIX C13
CITIZEN ACTIVISTS' ASSESSMENTS OF THE DUI PROBLEM, PUBLIC ATTITUDES AND SELECTED RESPONSES TO THE PERSISTENT DRINKING DRIVER

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INTRODUCTION

Traffic crashes have long had a major impact on highway safety, representing the greatest single cause of death for Americans aged 6 to 33[4]; alcohol has been involved in approximately half of these deaths in recent decades. Both total traffic fatalities and alcohol involvement in these deaths peaked in the early 1980s, after which deaths began to decline. Except for a period in the mid-1980s, the trend in alcohol involvement has been rather steadily downward.

Since the late 1970s, the impaired driving problem has been the focus not only of federal, state and local highway safety and law enforcement officials, but also of the public. In 1978 a citizen-activist group called Remove Intoxicated Drivers (RID) was started in New York; Mothers Against Drunk Driving was begun in 1980; and various other groups have been formed as well. These groups have played an important role in generating momentum for legislative change and other programs to reduce the involvement of alcohol in traffic crashes. As recently as April 1 of this year, U.S.

[4] National Highway Traffic Safety Administration, Fatal Accident Reporting System, 1993