

# **Management of the High-Risk DUI Offender**

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## Introduction

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The state of Illinois invests considerable resources to prevent and contain the threat to public safety posed by alcohol- and other drug-impaired drivers. Those resources have produced significant changes in legislation and a multi-agency system that seeks to further reduce impaired driving and to respond aggressively to contain, rehabilitate and monitor those convicted of driving under the influence (DUI). Between 1982 and 2001, the efforts of these agencies have reduced the alcohol-related fatalities per 100 million miles of travel in Illinois by more than 60 percent (National Highway Traffic Safety Administration, 2002).

One important initiative has been the design and delivery of DUI-related training by the Illinois Department of Human Services Office of Alcoholism and Substance Abuse, the Administrative Office of the Illinois Courts, the Secretary of State, and the Illinois Department of Transportation. For the past fourteen years, the author has worked with these agencies to update judges, prosecutors, evaluators, probation officers, treatment personnel, and administrative hearing officers on the latest findings about what we are learning about impaired driving, the profile of the DUI offender and the most effective approaches to prevention, rehabilitation and containment. The purpose of this monograph is to capture the information provided through that training in writing so that it may reach a larger audience. It is hoped this information will help orient new personnel filling these roles and aid in the development of new trainers who will continue this work in the future.

This monograph has been written with six specific audiences in mind: state's attorney staff who prosecute DUI cases, judges who hear DUI cases, the evaluators who assess DUI offenders and report their findings to the courts, the probation officers who monitor and supervise DUI offenders, the treatment personnel called upon to counsel DUI offenders, and the Secretary of State administrative hearing officers who decide if and when to reinstate driving privileges for persons convicted of DUI.

The monograph will cover the following content areas:

- Substance use trends and their implication for public safety.
- The changing perception of the DUI offender.
- Subpopulations of DUI offenders.

- The high risk DUI offender profile.
- The role of addiction treatment and mutual aid resources in managing and rehabilitating the DUI offender.
- Principles and strategies for managing the DUI offender in the local community.

This monograph incorporates and updates two earlier works: *Evaluation of the DUI Offender* (White, 1997) and *An Ethnographic Profile of the Higher Risk DUI Offender* (White, 2001).

It has been a great privilege to work with the personnel and agencies that have contributed to the dramatic reduction of alcohol-related crashes and deaths in Illinois during my lifetime. I hope this monograph will help further this trend into the future.

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## **Chapter One**

### **Substance Use Trends and Public Safety**

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Monitoring trends in alcohol and other licit and illicit psychoactive drugs is a challenging task. Popular reports of such trends are plagued by underreporting of stakeholders wishing to deny local substance-related problems and by the exaggerated reporting of those who have financial or political interests tied to substance-related problems. Fortunately, several systems exist that scientifically monitor alcohol and other drug use trends and their implications. At the national level, the most significant of these include:

- The National Household Survey on Drug Abuse (NHSDA) and specialized surveys related to substance use and driving conducted by the Substance Abuse and Mental Health Services Administration/National Institute on Drug Abuse (NIDA) and the National Highway Traffic Safety Administration (NHTSA).
- The NIDA-sponsored Monitoring the Future Survey that annually samples 43,000 8<sup>th</sup>, 10<sup>th</sup>, and 12<sup>th</sup> graders from 394 schools (<http://www.monitoringthefuture.org>).
- The Drug Abuse Warning Network (DAWN) that monitors drug-related emergency room admissions and fatalities on behalf of NIDA and the Drug Enforcement Administration.
- Systems for monitoring per capita alcohol consumption, alcohol-related problems and alcohol-related arrests and crash fatalities on behalf of the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the NHTSA.
- Drug-related arrests reported by the Federal Bureau of Investigation (FBI).
- Drug-related disease transmission reported by the Center for Disease Control and Prevention (CDC).
- Reports on the demand for addiction treatment and changes in the characteristics of those seeking treatment prepared by the Substance Abuse and Mental Health Services Administration.

This first chapter identifies eight trends related to substance use in the United States using data from these monitoring systems. Each of these trends is



accompanied by a discussion of its implications for those charged with protecting the public safety of Illinois citizens.

### **Trend # 1: Moderated Alcohol Consumption / Deviant Binge and Heavy Drinking**

Annual per capita alcohol *consumption* has declined in recent decades. Such consumption declined 17.4 percent between 1977 and 1999 and further declined 11 percent between 1990 and 1997. Much of this decline is attributable to reduced consumption of distilled spirits, which in 1997 was at its lowest level since 1934. Annual per capita consumption of alcohol in Illinois declined from 2.87 gallons in 1977 to 2.32 gallons in 1997 — still above the 1997 national average of 2.19 gallons (Nephew, et al., 1999). Even among high school seniors, reported lifetime, annual, past 30-day, and daily alcohol use declined between 1975 and 2001 (<http://niaaa.nih.gov/databases/dkpat10.htm>, accessed 2003).

Alcohol-related *problems* are also declining in the United States and in Illinois. The rate (per 100,000 population) of deaths from alcohol-related medical disorders has declined from 42.2 in 1979 to 32.3 in 1996 — from 40.3 to 31.5 in Illinois (Stinson, et al., 1996), and liver cirrhosis fatality rates are at an all-time low in American history, half of what they were in 1910 (Yoon, et al., 2002). Alcohol-related crash fatalities have similarly declined from 17,414 in 1977 to 13,050 in 2000, with the percentage of alcohol-related crash fatalities dropping from 43.5 percent of total crash fatalities in 1986 to 31.1 percent in 2000 (Yi, Williams, & Dufour, 2002). The decline in alcohol consumption and alcohol-related problems is a product of what some have christened an era of “new temperance” in the United States (Wagner, 1997).

In spite of this decline, Americans continue to consume more than 482 million gallons of alcohol per year, with Illinois citizens consuming 22.3 million gallons of that total (<http://www.niaaa.nih.gov/databases/consum01.htm>, 2003b). Forty-eight percent of Americans aged 12 or older are current drinkers (consuming at least one drink in the past thirty days). Current drinking rises with developmental age, e.g., 67.5 percent of those age 21 (National Household Survey on Drug Abuse, 2001). As Table 1 shows, levels of recent alcohol intoxication reported by youth have remained relatively stable for the past ten years.

Of greatest concern to public safety is the fact that one fifth — 20.5 percent — of the total population 12 or older report current binge drinking (5 or more drinks at a single setting during the past 30 days) and 5.7 percent report heavy drinking (5 or more drinks on the same occasion on at least 5 different days in the past 30 days). Young adults aged 18-25 report the highest prevalence of heavy drinking and binge drinking of all age groups (NHSDA, 2001). According to the latest

household survey, 10.1 million persons aged 12-20 reported drinking in past month — 28.5 percent of this age group. Of this age group, 6.8 million — or 19 percent — are binge drinkers and 2.1 million — or 6 percent — are heavy drinkers (NHSDA, 2001). Young people ages 12-20 consume one fifth of the nation’s alcohol — \$22.5 billion of the \$116.2 billion total spent on alcohol per year (National Center on Addiction and Substance Abuse, 2003).

There are few geographical differences in drinking patterns among adults but some differences among youth. The rate of heavy drinking for all persons over age 12 varies little from metropolitan to non-metropolitan areas. Among youth aged 12-17, rates of past-month alcohol use and heavy drinking are higher in rural areas than in large metropolitan areas (NHSDA, 2001).

Implications:

- Reduced alcohol consumption by the majority of Americans increases the visibility of the smaller population of binge and heavy drinkers who consume most of the alcohol ingested in this country.
- Binge drinking and heavy drinking by a minority of drinkers poses significant threats to public safety as the percentage of “social drinkers” within the total pool of DUI offenders shrinks.

<b>Grade Level</b>	<b>1991</b>	<b>2001</b>
8 <sup>th</sup> graders	7.6 percent	7.7 percent
10 <sup>th</sup> graders	20.5 percent	21.9 percent
12 <sup>th</sup> graders	31.6 percent	32.7 percent

**Source:** *Monitoring the Future*, 2001

**Trend #2: Increased Illicit Drug Consumption**

The illicit psychoactive menu has expanded and become more accessible to American citizens. In 2001, 15.9 million Americans — 7.1 percent of the population over age 12 — self-reported current illicit drug use (NHSDA, 2001). Like alcohol, lifetime illicit drug use rises with developmental age, with past-month use peaking in the years between 16 and 26. Following a decline in illicit drug use in the 1980s, such use rose again in the 1990s, reflecting three interacting patterns:

1. A youthful polydrug phenomenon not unlike the 1960s and early 1970s with marked increases in the use of marijuana (37 percent of high school seniors reporting use in the past year), hallucinogens (LSD), sedatives (rohypnol, GHB), and so-called “designer drugs” (e.g., MDMA/ “Ecstasy”).
2. Changing patterns of stimulant use marked by increased use of methamphetamine and a new generation of young cocaine users.
3. A surge in opiate addiction among adolescents and young adults sparked by the intranasal ingestion of high potency heroin and the misuse of prescription opiates such as oxycodone and hydrocodone.

**Table 2: Lifetime Prevalence Rates: 1991-2001**

Any Drug	1991	2001
8 <sup>th</sup> grade	18.7 percent	26.8 percent
10 <sup>th</sup> grade	30.6 percent	45.6 percent
12 <sup>th</sup> grade	44.1 percent	53.9 percent

**Source:** *Monitoring the Future*, 2001

Collectively, these trends impacted both lifetime and past-month trends in illicit drug consumption.

The rate of current illicit drug use is highest in New England — 9.2 percent, and the West — 8.3 percent, and lowest in the South — 6.2 percent, and Midwest — 6.8 percent. Rates of illicit drug use are higher in metropolitan areas than in non-metropolitan areas except among youth aged 12-17, for

whom illicit drug use is higher in rural areas — 14.4 percent — than in metropolitan areas — 10.4 percent (NHSDA, 2001).

College graduates have higher rates of lifetime illicit drug use, compared to those with less than a high school education, but have the lowest rate of current illicit drug use — only 4.3 percent (NHSDA, 2001). This suggests that college attendance is a risk factor for illicit drug experimentation but a protective factor for sustained drug use and dependence.

There is also considerable correlation between tobacco, alcohol and illicit drug use. The rate of illicit drug use is 9 times higher for youth who smoke cigarettes — 48.0 percent, compared to youth who do not — 5.3 percent. Sixty-five percent of youth who are heavy drinkers report illicit drug use, compared to 5.3 percent of youth who report illicit drug use but do not drink.

The increased substance use among youth during the past decade is evident in many data sources. Drug-related juvenile arrests rose from 93,300 in 1970 to

202,500 in 2001, compared to drug-related adult arrests over the same period from 322,300 to 1,384,400. Increased juvenile arrests were driven by the rise in marijuana-related arrests, where adult arrests were driven by arrests related to marijuana, cocaine and other controlled substances. Juvenile drug arrests rose in the 1990s, going from 8 percent of total juvenile arrests in 1990 to 13 percent of total juvenile arrests in 2001(FBI, *Crime in the U.S.*, 2001). Drug-related emergency room visits also increased for juveniles during the 1990s and continued to increase between 1999 and 2000 for patients aged 12-17 — a 20 percent increase, and for patients aged 18-25 — a 13 percent increase (*NIDA Info Facts*, [www.drugabuse.gov](http://www.drugabuse.gov), accessed 2003).

Implications:

- Concerns about drug-impaired driving will increase in tandem with rising illicit drug consumption. This will stir calls for legislation aimed at drivers impaired with non-alcoholic drugs. Eight states, including Illinois, currently have such laws.
- Rising polydrug use also reinforces the need for more sophisticated evaluation instruments that assess drug use other than alcohol as well as more sophisticated monitoring tools, e.g., urine surveillance.

**Trend #3: Multiple Drug Use**

There is a shift from single drug use to multiple drug use (concurrent and sequential patterns of alcohol and other drug use). Alcohol in combination with other drugs is the most frequent cause of drug-related emergency room visits (*NIDA Info Facts*, [www.drugabuse.gov](http://www.drugabuse.gov), accessed 2003). Most people entering treatment for alcohol or

other drug-related problems report more than one drug of choice; of the 72,007 admissions to addiction treatment in Illinois in 2001, only 15,363 — 21 percent — presented in the “alcohol only” category (*Substance Abuse Treatment...*, 2001).

<b>Any Drug</b>	<b>1991</b>	<b>2001</b>
8 <sup>th</sup> grade	5.7 percent	11.7 percent
10 <sup>th</sup> grade	11.6 percent	22.7 percent
12 <sup>th</sup> grade	16.4 percent	25.7 percent

**Source:** *Monitoring the Future*, 2001

Implications:

- More DUI events will involve persons using alcohol in combination with other drugs, drugs other than alcohol, and persons whose primary drug of choice is not alcohol.

- This will require assessment instruments and interview protocols that encompass a review of drugs other than alcohol and an expansion of treatment options to encompass drug-specific treatment interventions, e.g., the use of methadone and buprenorphine in the treatment of opiate addiction.
- Law enforcement agencies will be under increasing pressure to add Drug Recognition Expert (DRE) training for their officers.

#### **Trend #4: Increased Drug Potency and Altered Methods of Administration**

There is evidence of increased drug potency via increased purity of heroin, new and more potent forms of cocaine, increased THC content of marijuana, and a growing number of alcohol products with higher ethanol content (premium brand liquors, fortified wines, malt liquors and “ice” and “dry” beers) accompanied by an expanded definition of unit dose, e.g., 40 ounce bottles of beer and serving alcohol in pitchers and “bird bath” (size) glasses. There are also more efficient and less stigmatized methods of drug ingestion, e.g., from intranasal ingestion of cocaine to smoking cocaine, inhaling or smoking rather than injecting heroin.

#### Implications:

- Impaired driving rises in tandem with the speed and intensity of drug intoxication.
- Drug-impaired driving will become increasingly evident as more drivers are stopped for gross impairment who evidence minimal or no alcohol intoxication.
- Heightened potency is causing an expansion and redefinition of who is vulnerable to addiction.
- Increased potency and ingestion efficiency is creating more intractable patterns of drug addiction that require interventions of greater intensity and duration.
- The need for education related to drugged driving is intensifying within the culture.

#### **Trend #5: Lowered Age of Onset**

There is a significant trend toward lowered age of onset of regular alcohol and other drug use. In the past four decades, substance experimentation has moved

from being a symbolic rite of passage from late adolescence into adulthood to a rite of passage from childhood into adolescence (White, 1999; Dennis, Babor, Roebuck, & Donaldson, 2002). This lowered age of onset of drug exposure is particularly pronounced in populations of adolescents entering the criminal justice system and addiction treatment programs. Thirty-eight percent of drug-using youth incarcerated within state-operated juvenile facilities reported onset of drug use before age 12 — 19 percent before age 10 (U.S. Department of Justice, 1994). In the just-completed Cannabis Youth Treatment Study, more than 80 percent of the 600 youth admitted to the study began regular substance use between the ages of 12 and 14 (Dennis, Titus, et al., 2002).

#### Implications:

- Lowered age of onset of alcohol and other drug use (onset before age 15) has been linked to increased risks of adult substance use disorders, faster development of drug dependence, greater problem severity, the development of comorbid physical disorders and psychiatric disorders, and poor intervention outcomes (White, Godley, & Dennis, in press). Lowered age of onset of drinking has also been linked to increased lifetime risk of drinking and driving, and involvement in motor vehicle crashes while under the influence of alcohol (Hingson, Heeren, Jananka, & Howland, 2000).
- An increasing number of young (adolescent and young adult) DUI offenders will already be in late stages of problem development due to the telescoping, or condensed problem progression, that results from early age of onset.

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*Females will be showing up in increasing numbers as DUI offenders and recidivists.*

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Comment [COMMENT1]: mld These rates are very different because originally we divided by everyone but several people criticized us for this so in the 2002 article we subsetted only those people who had tried a given substance before calculating the rates of problems and odds ratio.

#### **Trend #6: Greater Gender Parity**

In 1939, the percentage of men and women who reported at least occasional use of alcohol was 70 percent and 45 percent respectively; by the mid-1990s, those percentages remained at 70 percent for men but had risen to 61 percent for women (<http://www.niaaa.nih.gov/databases/dkpat1.htm>, 2003c). For young people aged 12-17, reports of current alcohol use are comparable for males and females — 17.2 percent of males and 17.3 percent of females — while rates of binge drinking and heavy drinking continue to be higher for males than females in all age groups (NHSDA, 2001). The rate of current illicit drug use among youth aged 12-17 is higher for boys — 11.4 percent, than girls — 10.2 percent (NHSDA, 2001), but this gender gap is closing. A review of impaired-driving arrests among women found that such arrests were increasing, as was impaired-driving recidivism

among women, though significantly lower than for men (Shore, McCoy, Martin, & Kuntz, 1988).

In Illinois, women now make up 16 percent of those arrested for DUI (White, 2003).

Implications:

- Females will be showing up in increasing numbers as DUI offenders and recidivists.
- Screening, assessment and treatment and monitoring strategies must meet the test of gender appropriateness and effectiveness.

**Trend #7: Changes in Ethnicity**

Caucasian Americans use alcohol and illicit drugs at higher rates than ethnic minorities, but ethnic minorities are over-represented among substance-related casualty data. For example, African Americans have an alcoholism-related death rate that is three times that of Caucasian Americans. Native Americans and Hispanics of Mexican origin suffer higher rates of alcohol-related traffic fatalities while Asian-Pacific Islander Americans experience a very low rate of such fatalities (Voas, Tippetts, & Fisher, 2000; <http://www.health.org/newsroom/rep/107.aspx>). In reviewing the literature on the characteristics of DUI offenders, Ross and colleagues (1991) found that African Americans and Hispanics were over-represented in DUI arrests.

In Illinois, there is significant ethnic minority representation in admissions to addiction treatment — 44.7 percent of Illinois admissions are African American and 9.3 percent are Hispanic (*Substance Abuse Treatment...*, 2001) — and there is growing concern about the increased representation of Hispanics among DUI offenders. Caetano and Raspberry (2001) note that the over-representation of Hispanics in DUI arrests may be related to Hispanic drinking patterns, which include lower frequency of use but higher levels of consumption when use does occur. Roadside surveys have found decreases in the percentages of white drivers with BACs over 0.10 percent, but these decreases were not noted for African American and Hispanic drivers (Lund & Wolf, 1991). It may be that the media vehicles used to change attitudes toward drinking and driving in the 1970s and 1980s did not penetrate communities of color.

Implications:

- Changing attitudes and behaviors related to drinking and driving in ethnic communities may require different strategies than those that have proved successful in the larger American culture.
- Evaluators must be familiar with cultural patterns of drinking, culturally-specific patterns of alcohol-related problems, and culturally-prescribed pathways of problem resolution.
- There is a growing need for culturally congenial approaches to treating African American, Hispanic and Native American DUI offenders with significant alcohol problems.

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*Evaluators must be familiar with cultural patterns of drinking.*

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**Trend #8: Alcohol/Drug-impaired Driving**

The prevalence of driving after drinking and alcohol-related crash fatalities has significantly declined in recent decades (Lund & Wolf, 1991). In spite of this success, recent surveys reveal one in ten Americans aged 12 or older — 25.1 million persons — reporting driving under the influence of alcohol in the past year. In 2001, 16,653 Americans died in alcohol-related crashes and another 275,000 individuals were injured (NHSDA, 2001).

Drinking drivers aged 21 or younger involved in fatal crashes decreased by 61 percent between 1982 — 4,393 — and 1998 — 1,714 (Hedlund, et al., 2001), but survey figures continue to raise alarm. Among young adults aged 18-25, 22.8 percent drove under the influence of alcohol in 2001 (NHSDA, 2001). More 19-year-olds in the U.S. die in alcohol-related crashes than any other single age. A third of 21-24-year-old drivers who died in fatal crashes were intoxicated. Seventy-nine percent of young drivers who died in alcohol-related fatal crashes were unrestrained (NHTSA, 1996b).

In Illinois, 620 people were killed in alcohol-related crashes in 2001, 44 percent of total crash fatalities). That same year, there were 49,676 DUI arrests in Illinois, 18 percent of whom had prior DUI offenses. For the past ten years, Illinois has arrested each year from .58 percent to .66 percent of its 8.5 million licensed drivers for driving while impaired (White, 2002; White, 2003). Under age 21 DUI violations have risen from 2,829 in 1993 to 4,399 in 2001. “Use it & lose it” violations have increased from 2,844 in 1995 to 3,012 in 2001. A total of 20,145 drivers under the age of 21 have lost their driving privileges since the “use it & lose it” policy was implemented (White, 2003). Those aged 16-20 are three times



more likely than those over age 21 to have consumed five or more drinks on their most recent occasion of drinking and driving, and are twice as likely to report driving after using alcohol and other drugs in combination (NHSDA, 2001).

Concern about impairment of driving resulting from drugs other than alcohol increased in the mid-1980s (Simpson, 1985; Cowart & Kandela, 1985) and has continued to grow (Brookoff, et al., 1994). A 1993 study of 1,882 fatally injured drivers found that 52 percent had been drinking and 18 percent had consumed drugs other than alcohol; 64 percent of the latter involved combinations of drugs and alcohol. In this study, illicit drug use was most common in young drivers; prescription drug use was most common in drivers over age 55 (NHTSA, 1993).

In 2001, over 8 million persons aged 12 or older reported driving under the influence of illegal drugs. Sixteen percent of those age 16-20 reported drugged driving compared to 5 percent for those over 20, but rates of drugged driving among those 18-34 increased between 2000 and 2001 (NHSDA, 2001). Impairment from drugs other than alcohol is a factor in as many as 18 percent of drivers involved in vehicular crashes (NHTSA, 1993).

According to the National Household Survey on Drug Abuse (2001), the person most likely to drive within two hours of consuming a drug other than alcohol is a white, unmarried male under 21 years of age who is unemployed or makes less than ten thousand dollars per year, has had prior contact with the criminal justice system, and is most likely to drive impaired on weekends between the hours of 6:00 p.m. and 6:00 a.m. These individuals also perceive themselves as capable of driving while under the influence of drugs and believe they are no more likely to be stopped by police after smoking marijuana than on other occasions.

Public safety responses to driving impairment related to drugs other than alcohol are plagued by several factors.

1. Testing for drugs other than alcohol is more invasive (e.g., requiring blood or urine analysis rather than breath analysis) and its instrumentation is more expensive and less portable.
2. The relationship between other drug concentrations and impairment are more complex and less linear than for alcohol; BAC equivalents do not exist for other drugs.
3. There is no technology to effectively test impairment resulting from drug interactions.

On the other hand, considerable progress has been made in creating the equivalent of the field sobriety test for drugs other than alcohol. The Drug Recognition

Expert (DRE) Program provides law enforcement officers forty hours of structured training followed by field supervision. DRE-trained officers conduct a field evaluation of drug-related impairment and prepare the Standard Drug Evaluation Report based on appearance, manner, attitude, behavioral test performance, vital signs (blood pressure, pulse rate, body temperature), eye signs (nystagmus, strabismus, dilation/constriction, speed of response), and physical signs of ingestion (marks, debris, residue).

Implications:

- As rates of drinking and driving diminish in America, we are left with overlapping groups of youthful, high-risk drinking drivers and hard-core drinking driving recidivists.
- Impairment related to intoxication with drugs other than and in addition to alcohol will become an increasingly visible threat to public safety.

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*Impairment related to intoxication with drugs other than alcohol will become an increasingly visible threat to public safety.*

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**Trend Summary and Implications**

Per capita alcohol consumption has declined and has been accompanied by growing concerns about a subpopulation of binge and heavy drinkers who pose significant threats to public safety. The prevalence of illicit drug use rose in the 1960s and 1970s, peaked between 1979 and 1981, declined from 1982 to 1991, rose during the mid-1990s, crested between 1998 and 2001, and then showed a slight decline in 2002. The most significant changes in the patterns of substance use over the past three decades include an expanded drug menu, changes in drug potency, more efficient methods of drug administration, and the use of alcohol and other drugs in combination. Changing characteristics of alcohol and other drug users are evident in lowered age of onset of use, new patterns of late onset alcohol problems among older adults (see Chapter 4 discussion of special populations), and increased representation of women and ethnic minorities in alcohol- and drug-related casualty data. These trends call for:

1. Efforts to sustain the progress in reducing alcohol-related problems and alcohol-related crashes.
2. A more sophisticated process of assessing impaired drivers across the points of arrest, evaluation, prosecution, sentencing, treatment, probation monitoring, and license reinstatement or denial.

3. Expanded sentencing options that reflect the changing demographic characteristics of DUI offenders.
4. A wider menu of treatment options that reflect the broadened drug choices of impaired drivers in Illinois.

## **Chapter Two**

### **The Myth of the Social Drinking DUI Offender**

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The Alcohol Safety Action Program (ASAP) emerged more than three decades ago as the dominant programmatic model aimed at reducing risks to public safety posed by the alcohol-impaired driver. Pioneered in 35 local projects funded by the National Highway Traffic Safety Administration, the ASAP was designed to 1) distinguish problem drinkers from social drinkers within the total pool of individuals arrested for driving under the influence of alcohol, and 2) link the former group to treatment and the latter to remedial education. The ASAP program was widely replicated throughout the United States (White, 1998).

While this system provided an efficient means of processing hundreds of thousands of DUI offenders through the criminal justice system, it came under increasing criticism by the mid-1980s from judicial leaders, victim advocacy groups such as Mothers Against Drunk Drivers (MADD), Blacks Against Drunk Driving (BADD) and Remove Intoxicated Motorists (RID), and from social scientists who evaluated DUI intervention programs. Evaluations revealed that the ASAP programs were lowering recidivism among the less problematic drinkers but were not producing reductions in rates of alcohol-related crashes (Nichols, 1990).

In seeking to explain the limitation of the ASAP model, some suggested that the model was based on the following three myths:

1. The DUI offender is generally a law-abiding citizen; he or she is one of “us.”
2. The majority of DUI offenders are not alcoholics or problem drinkers, but social drinkers whose driving while intoxicated represents an isolated error of good judgment.
3. DUI offenders can be educated to moderate their drinking patterns to reduce risks to public safety via future drinking and driving.

Two seminal papers challenged these myths. In 1986, Judge Albert Kramer called for a change in how Americans were viewing and responding to the impaired driver:

*From a criminal justice point of view, we must face the reality that we in the courts are failing to alter the destructive behavior of the hundreds of thousands of drunk drivers who come before us each*

*year.... Worse still we must face the grim prospect that these offenders will continue their flagrant misconduct ... before we get a chance to catch them again. It is critical that we take a hard look at what we are doing, or more appropriately, what we are not doing, and make the needed changes without delay. (Kramer, 1986, p. 26)*

Kramer went on to challenge the view of the DUI offender as a non-criminal and educable social drinker and argued that there was a growing body of empirical evidence suggesting that this view was “completely fallacious.”

In a similar vein, Alfred Crancer presented a paper in 1986 that similarly challenged what he called the “myth of the social drinking DUI offender.” Crancer provided evidence that DUI offenders “are not social drinkers but persons with moderate to serious drinking problems — maybe as high as 90 percent” who, following their first arrest, “repeatedly drive drunk” (p.11). The Kramer and Crancer papers marked a watershed in changed thinking about the DUI offender. The ASAP assumptions came under increasing challenge.

The assumption that the DUI offender was a family member or friend rather than a dangerous criminal allowed the culture to address the problem of impaired driving without stigmatizing the impaired driver. This assumption began to be challenged by studies of DUI offenders that painted a quite different portrait. These studies revealed that 40-70 percent of first-time DUI offenders had prior alcohol- or drug-related criminal offenses, e.g., illegal possession of alcohol or controlled substances, illegal transportation of alcohol, disorderly conduct, larceny, criminal damage to property, resisting arrest, public urination, and assault and battery. One study found that 63 percent of DUI offenders had at least one prior criminal arrest compared to 11 percent of licensed drivers without an arrest for DUI (Taxman & Piquero, 1998). Chang and Lapham (1996) compared prior arrests reported by DUI offenders against official criminal records and found that 65 percent of DUI offenders underreported their prior arrests. There were other studies that revealed striking similarities between the profiles of DUI offenders and persons convicted of other criminal offenses (Kochis, 1997). Collectively, these studies portrayed the DUI offender as anything but a model citizen, and as a significant threat to public safety.

The myth that most DUI offenders are social drinkers who experienced a rare lapse in judgment on the occasion of their DUI arrest was similarly challenged. First, while social drinkers do make rare errors in judgment and drive while intoxicated (see Chapter One), they rarely ever get arrested. The reason for this is found in the number of times an average person must drive intoxicated to generate an arrest for impaired driving. Numerous roadside safety surveys comparing the number of intoxicated drivers with the number of DUI arrests in the U.S. have

concluded that a driver would have to commit between 300 and 2000 repetitions of impaired driving violations to statistically generate one arrest (Borkenstein, 1975; Jones & Joscelyn, 1978; Voas & Hause, 1987). The most conservative estimate by the National Highway Traffic Safety Administration is that only one percent of episodes of impaired driving result in arrest (NHTSA, 2001a). This is perhaps most evident in the fact that most — about two-thirds — of alcohol-related fatal crashes involve drivers with no prior arrest for DUI. In one study, 49 percent of DUI offenders reported driving at least once a week after having consumed two or more drinks (Pollack, 1969). In a 1993 NHTSA study, 52 percent of DUI recidivists reported driving 13 or more times in the past month after drinking (Hedlund, 1995).

The percentage of drivers registering a detectable amount of alcohol in their bloodstream in roadside safety checks dropped from 36 percent to 17 percent between 1973 and 1996, while the number of deaths from alcohol-related traffic crashes dropped 32 percent between 1982 and 1996, from 25,165 to 17,126 (NHTSA, 1997). Studies in the 1980s found a dramatic reduction in fatally injured drivers

with BACs of 0.10-0.19 percent and above 0.20 percent while those with lower (0.01-0.09 percent) BACs increased (Perrine, Peck, & Fell, 1989). Since then, studies have shown that the percentage of lower BAC drinking drivers — the true social drinkers — is shrinking while the percentage of the higher BAC drinking drivers is not (beginning with Lund & Wolf, 1991), suggesting that we are now left with a residual pool of “hard core drinking drivers” (Simpson & Mayhew, 1991).

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*In one study, 52 percent of  
DUI recidivists reported driving  
13 or more times in the past  
month after drinking.*

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In a study comparing binge-drinking drivers with other drivers, it was found that the binge drinking drivers:

- Drank more days per week.
- Believed they could drink large amounts of alcohol and drive safely; 68 percent thought they could drive safely after 6 or more drinks and 28 percent thought they could drive safely after 10 or more drinks.
- Reported a much higher frequency of driving after any consumption of alcohol; 57 percent reporting driving after drinking three or more times in the past month).

- Were twice as likely to have experienced a vehicular crash after they had been drinking (Nelson, Kennedy, Isaac, & Graham, 1998).

More than one third of those arrested for DUI have elevated enzyme (glutamyltranspeptidase) levels indicating chronic excessive alcohol consumption (Dunbar, et al., 1985).

When the author was first trained to evaluate DUI offenders in the early 1970s, I was told that my job was to find the hidden minority of alcoholic DUI offenders — estimated at about 15 percent — camouflaged within a sea of social drinking drivers. By the mid-1980s, the estimate of the percentage of DUI offenders who met diagnostic criteria for alcohol abuse or dependence had climbed to 30-50 percent and some researchers (Miller, et al., 1986) reported that three quarters of DUI offenders met diagnostic criteria for alcohol abuse or alcohol dependence. There is growing evidence that the majority — most studies now suggesting between 70-80 percent — of DUI offenders are experiencing significant problems in their relationship with alcohol and/or other drugs (Timken, 1999; Lapham, et al., 2001). My experience confirms that the majority of DUI offenders already have a serious problem in their relationship with alcohol or other drugs, are in the process of developing such a problem at the time of their arrest, or will go on to develop such a problem in the years following their first arrest.

The percentage of social drinkers in the DUI pool is shrinking as more people choose to abstain from drinking, as American drinking patterns moderate and as drinking and driving becomes increasingly stigmatized within the culture (Yi, et al., 2002a). The percentage of late-night weekend drivers with blood alcohol concentrations of 0.10 percent or greater declined significantly between 1973 and 1986 and has continued to decline in the intervening years as the use of “designated drivers” has increased (Lund & Wolf, 1991). The percentage of Illinois citizens who reported driving after consuming alcohol dropped from seven percent in 1984 to two percent in 1999 (Center for Disease Control and Prevention, 1999) — a percentage consistent with national levels of reported drinking and driving obtained in health surveys of the American public (Liu, et al., 1997).

The assumption that the risk DUI offenders pose to public safety could be eliminated via a brief intervention (10-12 hours of remedial education in the ASAP model) also was challenged. The most methodologically rigorous evaluation of the early ASAP programs concluded that remedial education provided no measurable reductions in DUI recidivism or crashes when compared to persons who did not participate in remedial education (Nichols & Ellingstad, 1978; Nichols, Ellingstad, & Reis, 1980). Remedial education increased measurable levels of knowledge about the effects of drinking and driving but there was no evidence that this increased knowledge resulted in reductions in

drinking and driving, re-arrest and alcohol-related crashes (Golden, 1979). The changing view of the DUI offender has helped explain why remedial education approaches have not been found in controlled studies to be effective in altering the drinking behavior of those DUI offenders (the majority) with significant alcohol or other drug-related problems.

In short, there is growing evidence that our 30-year experiment of DUI intervention has been based on what Crancer has called the “myth of the social drinking DUI offender.” If the majority of DUI offenders are experiencing serious substance use disorders, as a growing number of studies reveal, then how could so many of these individuals have been assessed through community substance abuse agencies and determined to not be “alcoholic?” The problem appears to have been in the misapplication of traditional alcoholism assessment technology.

During the early 1970s, a well-developed assessment and treatment technology evolved to address the needs of the traditional alcoholic clients who found their way to self-help groups and/or alcoholism treatment. Like software written for unique capacities and characteristics of a particular brand of computer, this technology (assessment and treatment software) was based on clients who shared a fixed set of characteristics. They were male. They were white. They began significant drinking in early- to mid-adolescence, experienced a progressive loss of control over their relationship with alcohol, and entered recovery in their forties and fifties. They were drawn from the working and professional classes. They were literate and sometimes highly educated. They used alcohol as their primary, and most often exclusive, drug of choice. They did not have significant psychiatric impairment that predated the onset of alcoholism. They represented the dominant pattern of alcoholism in the United States. And they consistently presented themselves to self-help or treatment in very late stages of alcoholism. Assessment instruments and treatment protocols were designed to fit these characteristics, and when applied to clients who shared these characteristics, were quite effective at identifying alcohol problems. However, when this technology was applied to DUI offenders with very different characteristics, that effectiveness was compromised.

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*New assessment and treatment technologies are emerging to respond to different populations of DUI offenders.*

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There is a growing awareness that the majority of DUI offenders have significant problems in their relationship with alcohol and/or other drugs. There is further recognition that within this total population of offenders can be found numerous and diverse patterns of alcoholism and drug addiction and patterns of alcohol- and drug-related problems that can significantly impair life functioning and pose



threats to public safety via alcohol- and drug-impaired driving. New assessment and treatment technologies are emerging to respond to these different populations of DUI offenders and reduce their threat to the health and safety of others. The next chapter will explore the nature of these subpopulations, the various patterns of substance use with which they are involved and the different treatment approaches that may be required to address their problems and lower their threat to public safety.

## **Chapter Three**

### **The Varieties of Substance Disorders and Public Safety**

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*There is not one alcoholism but a whole variety.*  
Dr. E. M. Jellinek, in *The Disease Concept of Alcoholism*, 1960.

This chapter will identify and describe eight major subpopulations of DUI offenders based on differences in the driving forces (etiological pathways) behind the onset of excessive alcohol and other drug use. Appropriate treatment interventions and settings applicable to each will also be described. For judges, prosecutors and probation officers, the chapter will convey the distinct personalities and patterns behind what seems like an endless stream of DUI offenders and will emphasize the importance of individualized approaches to sentencing and case supervision. For evaluators and treatment personnel, this chapter will provide a detailed guide to assessment, treatment planning and recovery planning (the plan for post-treatment recovery support services).

#### **A Multiple Pathway Model of Alcohol and Other Drug Problems**

Traditional alcoholism assessment technology assumes that alcoholism springs from a single etiological cause, presents itself in a consistently and narrowly defined profile of clinical characteristics (you either have it or you don't), responds to a narrow treatment approach (philosophy and techniques), and is characterized by a single pathway of long term recovery. In contrast to this view, multiple pathway models are based on the following propositions:

- There are numerous etiological pathways that form the motivating forces behind the onset of excessive alcohol consumption, in general, and the act of driving under the influence of alcohol, in particular.
- These etiological pathways lead to subpopulations of persons with serious alcohol problems (and subpopulations of DUI offenders) who present with very different patterns and profiles.
- These profiles encompass persons with primary addictive diseases (alcoholisms and other drug addictions) and persons with patterns of alcohol and other drug-related problems whose intensity and duration pose threats to public safety but which do not constitute addiction as it is traditionally defined. The evaluation of DUI offenders must extend alcoholism assessment technology to patterns of excessive, problematic and life-threatening alcohol and other drug problems.

- DUI offender evaluation technology must go beyond alcoholism assessment to identify areas of comorbidity (dimensions of psychopathology, e.g., depression, anxiety, hostility, risk-taking behavior, antisocial behavior) that increase the risk of future drinking and driving and future alcohol- and other drug-related crashes.
- The recommendation of treatment modality and setting must take into account the differential needs of these subpopulations.
- The distinguishing characteristics of all patterns of excessive alcohol use begin to diminish with chronic use, as issues of physiology begin to dominate other etiological influences. The multiple pathway model is particularly apt in guiding interventions with individuals at early and middle stages of problem development.

The following sections will briefly outline an approach to differential diagnosis, treatment planning and criminal justice management of different DUI offenders. There is no single cause of excessive alcohol use and alcoholism. Factors of physiology, psychology, culture and economics constantly interact to influence drinking patterns and drinking consequences. What is needed and what this model attempts to show is how specific etiological factors, when dominant, shape particular clinical and criminal profiles and how such profiles can be modified through combinations of particular treatment approaches and criminal justice sanctions.

### **Species I: Physiopathological Vulnerability**

*A. Etiology and Patterns.* DUI offenders within Species I share an abnormal biological relationship with alcohol or other drugs. The driving force behind the onset of excessive alcohol use is rooted in an aberrant response that makes alcohol more physically reinforcing or more impairing than it is to other humans possessing a normal physical response to the drug. The magic and poison of the person-drug relationship in this species occurs at the cellular and metabolic level. This pattern has been referred to as “gamma species alcoholism” (Jellinek, 1960), “Type B” alcoholism (Babor, et al., 1992), “Type II alcoholism,” “male-limited alcoholism” (Cloninger, 1987), and “primary alcoholism” (White, 1996). This pattern, described by Cloninger (1987) as male-limited or Type II alcoholism is characterized by earlier onset of alcohol use and alcohol problems and is thought to be more genetically influenced.

This pattern is characterized by heritability (revealed by extensive family histories of alcohol and other drug-related problems), early onset, high problem severity and early failed attempts at self-resolution. There are also persons who were not

genetically high risk for addiction, who once maintained a normal nonproblematic relationship with alcohol but who, following illness or trauma, experienced an altered and increasingly problematic relationship with alcohol. These two populations whose vulnerability is of physiological origin look quite different in the DUI incident. The gamma species alcoholic can demonstrate an extremely high BAC without gross signs of intoxication (including passing field sobriety tests) while the physically traumatized person may show profound levels of intoxication with a very low BAC. One has atypically high tolerance, the other atypically low tolerance. There are also persons who experience a toxic, allergic reaction to alcohol — a very rare condition called idiosyncratic intoxication in which small amounts of alcohol in a neophyte drinker can produce a toxic organic psychosis characterized by explosive violence or self-injury, with subsequent amnesia of the drinking event.

The pattern of excessive drinking called “gamma species alcoholism,” of all the patterns described below, warrants the moniker “alcoholism” and the descriptor “disease.” Its etiology is primarily physiological. It is chronic and progressive.

There are biological markers and medical sequelae that mark its advancement and frequently cause premature death. It is marked by severe psychological, legal, social, family and occupational complications.

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*The very definition of alcoholism in the United States is a depiction of gamma species alcoholism.*

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*B. Assessment Indicators.* The very definition of alcoholism in the United States is a depiction of gamma species alcoholism, as is the pattern of alcoholism identified through nearly all of the traditional alcoholism assessment instruments. The major descriptors of this pattern include the following:

- A family history of heavy alcohol use and related drug problems spanning multiple generations.
- Teetotalism (alcoholism in one generation spawning radical abstinence in the following and alcoholics stopping drinking at an early stage in the progression of alcoholism).
- Intergenerational patterns of accidental deaths and deaths by suicide.
- Intergenerational history of alcohol related medical illnesses, e.g., gastritis, pancreatitis, and liver disease.
- Family history of psychiatric illness (primarily affective disorders).

- Developmental markers preceding drinking, e.g., diagnosis of attention deficit disorder or hyperkinesis in childhood, mild sociopathy.
- Early onset of drinking.
- Euphoric recall of first drink.
- Atypically high alcohol tolerance from onset enhanced by acquired tolerance, e.g., high BAC without signs of gross intoxication.
- Minimal early drinking consequences, e.g., hangovers.
- Physical craving for alcohol.
- Loss of control over alcohol (inability to predict the quantity to be consumed once drinking begins).
- Radical personality change while drinking (Dr. Jekyll/Mr. Hyde).
- High risk-taking, sensation-seeking, aggression.
- Predictable progression of symptomatology, e.g., increased frequency/duration of blackouts, failed efforts to control drinking, failed promises and resolutions, attempts at geographical escapes.
- An elaborate cognitive defense structure (denial, minimization, rationalization, projection) designed to sustain drinking and escape the consequences of drinking.
- Increased intensity of guilt and remorse.
- Fear of insanity.
- Pervasive impairment across areas of life functioning, e.g., deteriorations in physical and emotional health, intimate and social relationships, vocational functioning.

*C. Intervention and Treatment Principles.* The major components of the alcoholism treatment system in the United States have been erected specifically in response to, and out of experience with, gamma species alcoholics. The framework of Alcoholics Anonymous (AA) and the assessment and treatment technology of traditional AA-oriented inpatient and outpatient alcoholism treatment programs, although they have come to embrace numerous patterns of alcoholism, were designed specifically to fit the needs and characteristics of

gamma species alcoholics. And this technology works remarkably well! There are hundreds of thousands of persons who are in long term, stable recovery from alcoholism as a result of their experience in AA and traditional alcoholism treatment. When persons fit the dominant pattern of alcoholism in the United States, they should be provided access to the treatment structures that have proved successful with its treatment.

Gamma species alcoholism can be successfully treated in both outpatient and inpatient treatment modalities with the latter generally indicated under the following circumstances:

- The client presents a history of prior unsuccessful treatment in outpatient treatment settings.
- The client requires detoxification or presents concurrent acute medical and/or psychiatric problems that require medical supervision in an inpatient setting.
- The client demonstrates no prior history in his or her ability to maintain even short periods of self-imposed sobriety.
- The client is in a family and/or social milieu that has a history of undermining and sabotaging efforts at sustained abstinence.
- The client needs to be removed from the current environment for his or her own physical protection.

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*There are hundreds of thousands of persons who are in long term, stable recovery from alcoholism as a result of their experience in A.A.*

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The major elements of traditional outpatient or inpatient treatment of gamma species alcoholism include:

- Neutralization of enabling behaviors in the family and social network that have prevented the alcoholic from experiencing the full consequences of his or her drinking.
- Exposure to hope-instilling and empowering relationships, including exposure to recovering role models.
- Therapeutic weakening of the cognitive defense structure to reduce denial, minimization, projection, etc., and create acceptance of alcoholism as a personal reality.

- A three-stage shift in identity from denial of alcohol problems to that of alcoholic and finally to that of recovering alcoholic.
- Focus of all treatment efforts on total abstinence, with recognition of risks of abuse for secondary drugs.
- Linkage and encouragement for long-term affiliation with a self-help structure, e.g., Alcoholics Anonymous.
- Utilization of early steps of AA to create acceptance of disease, generation of hope, and reduction of guilt and remorse.
- Reorganization of pathology-shaped family roles and rules and reduction of family pain.
- Detachment of client from alcohol-dominated social network and reconstruction of client's social, vocational and leisure rituals.
- Development of an active plan for relapse prevention and external monitoring of recovery progress, e.g., probation supervision with breath/urine testing.

This traditional, mainstream treatment technology should be used heavily in our response to the impaired driver because gamma species alcoholics are heavily represented in the total population of DUI offenders. As we shall see shortly, however, there are other patterns of alcoholism and alcohol-related problems for which this traditional technology is less effective.

### **Species II: Self-Medication of a Diagnosed or Undiagnosed Physical Illness**

*A. Etiology and Patterns.* The onset of excessive alcohol and drug use of DUI offenders within Species II is tied to the self-medication of painful or otherwise discomforting symptoms of diagnosed or undiagnosed medical problems. While such self-medication can produce a transient relief of symptoms, the cumulative effect of this pattern may be serious alcohol-drug related problems in the lives of these clients. At the earliest stages, this is clearly a pattern of alcohol/drug abuse. In its most extreme forms, this pattern can take on the characteristics of a primary addictive disorder, particularly when alcohol is combined with other prescribed sedatives and narcotic analgesics.

Subpopulations found within this species of substance abuse include:

- Persons experiencing severe and painful medical illness or trauma who were introduced to analgesic drugs through legitimate medical treatment but who

eventually began a pattern of compulsive drug seeking and drug using behavior in search of symptom relief.

- Aged persons experiencing chronic intractable pain from a variety of debilitating illnesses.
- Women who experience severe physical and emotional discomfort related to PMS. (Women may be at increased risk within this species due to their increased propensity in this culture to receive prescriptions for sedative and analgesic medications.)
- Persons with unusual, and often undiagnosed, medical disorders who discover the effects of alcohol or drugs to be normalizing or performance enhancing.

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*There are other patterns of alcoholism and alcohol-related problems for which traditional technology is less effective.*

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*B. Assessment Indicators.* The indicators of this pattern of alcohol abuse in DUI offenders include the following:

- The presence of alcohol-related problems in the absence of core symptoms of gamma species alcoholism, e.g., family history, loss of control.
- The consumption of prescribed and/or over-the-counter drugs in addition to alcohol in the DUI incident.
- A medical history revealing presence of chronic (or acute at time of DUI incident) pain from illness or injury.
- Atypical drug choices, atypical drug combinations, atypical tolerance (e.g., extended use of amphetamines without escalating dosage), and atypical patterns (timing, frequency, setting of use).
- Marked absence of euphoric effects from drug use.
- Propensity to use in isolation from other users and outside normal social rituals of use.
- Marked absence of denial related to use. (Users consciously aware of the self-medication process may defend their use with an air of self-righteousness and anger at the failure of traditional medicine to relieve their symptoms.)
- Emotional regression produced not by the alcohol/drug use but as a



consequence of chronic intractable pain.

- Atypical symptoms in detox — emergence and escalation of symptoms of the primary disorder or injury.

*C. Intervention and Treatment Principles.* Assessment and treatment approaches to DUI offenders reflecting the Species II pattern include the following:

- Given the likelihood of a number of mood-altering medications, often received from different physicians, a single physician may need to be involved to assess the total pattern of drug consumption as part of the DUI assessment to determine whether the offender is a high risk to public safety even if they don't drink while driving.
- This client is best referred to a medically based treatment program where the history and current status of the physical illnesses/injuries and the intensity and chronicity of substance abuse can be adequately assessed. The treatment foci in early to middle stage patterns of abuse is on developing alternative and more effective methods of symptom management and substance use/abuse education; in late stages, clients may be appropriate for primary addictive disease models of treatment.
- Aborting the pattern of dysfunctional alcohol and drug use is contingent on effective treatment or at least symptom management of the primary medical illness.
- Effective treatment regimes often involve traditional (exploration of nonsteroidal anti-inflammatory alternatives to narcotics, stretching and toning exercises, transcutaneous electrical muscle stimulation) and nontraditional (acupuncture, acupressure, hypnosis, visualization, muscle relaxation, breathing techniques) methods of pain management or referral to specialized pain control programs in conjunction with substance abuse education. The medical condition of many of these individuals would make abstinence from all mood-altering medication unrealistic.
- Specialized support groups, focusing on pain management as the primary issue, and support from treatment staff may be essential to encourage the client to explore non-drug alternatives to pain management and to prevent relapse. The relapse prevention plan must incorporate pathways of contact and support when medical symptoms worsen and pose risks of return to abusive patterns of drug consumption.
- Prevention of DUI recidivism entails not only primary treatment, but also specific education focusing on the effects of prescribed medications on

driving performance. “Knowing when to say when” for this client must encompass prescribed and over-the-counter medications in addition to alcohol.

### **Species III: Substance Abuse and Psychiatric Illness**

*A. Etiology and Patterns.* There are three distinct relationships between primary psychiatric disorders and secondary patterns of excessive substance use, all of which can result in a DUI offense. In the first relationship, excessive alcohol and drug use serves to mask or hide the existence of a psychiatric illness. The function of the drug use is more symbolic (identity and esteem salvaging) than pharmacological. In the second relationship, excessive alcohol or drug use is simply one element within a cluster of symptoms that reflect the presence of a primary psychiatric disorder, e.g., excessive alcohol use as a symptom of a broader pattern of sensation-seeking and risk-taking. In the third and most common relationship, excessive alcohol and drug use serves to self-medicate discomforting symptoms of a primary psychiatric disorder.

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*There are three distinct relationships between primary psychiatric disorders and secondary patterns of excessive substance use.*

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Typical subpopulations found within the self-medicating population of DUI offenders include the following:

- *Unipolar and Bipolar Disorders.* Persons self-medicate both mania and depression with alcohol. The disinhibiting and judgment impairing effects of alcohol interact with dimensions of the psychiatric illness (sensation-seeking, risk-taking, increased aggressiveness) to elevate risks of drinking and driving and potential risks of using an automobile for suicide.
- *Schizophrenia.* Community mental health centers have long noted the propensity of the chronically mentally ill to supplement their psychotropic medication with alcohol and cannabis. Many clients with schizophrenia have learned to titrate doses of alcohol and cannabis as a supplement or alternative to their prescribed medication to relieve anxiety and fear and to sedate themselves into sleep.

- *Anxiety and Phobic Disorders.* Alcohol and cannabis have both been used by anxiety-ridden and phobic persons for their tranquilizing and disinhibiting effects.

*B. Assessment Indicators.* The indicators of this pattern of excessive substance use in DUI offenders include:

- A family history of psychiatric (serious mental illness) rather than substance use disorders.
- A history of psychiatric impairment that predates the onset of excessive alcohol or drug use.
- A history of psychiatric treatment, psychiatric hospitalizations and prescribed psychotropic medication.
- A weak or brittle cognitive defense structure to deny or justify use; flamboyant exaggeration of alcohol and drug use present among those masking psychiatric impairment.
- Alcohol and drug use not governed by social norms.
- Evidence of compromised mental status at time of the DUI evaluation.

*C. Intervention and Treatment Principles.* Assessment and treatment approaches to DUI offenders reflecting the Species III pattern include:

- Assessment and treatment is best conducted by an interdisciplinary team involving psychiatric and addiction specialists.
- Treatment at a center specializing in treating dually diagnosed clients or concurrent referral for addiction and psychiatric treatment is recommended.
- The risks to public safety must be assessed separately and distinct from the issue of diagnosable alcoholism, e.g., extent of driving impairment produced by medication, frequency and intensity of risk-taking behavior, potential use of vehicle in suicide.
- Appropriate medication and social support systems may be essential in removing the pattern of self-medication.
- Alternatives to nontraditional self-help structures should be explored, e.g., Dual Diagnosis Anonymous, Double Trouble in Recovery, GROW, etc. (See appendix and [www.bhrm.org](http://www.bhrm.org) for a directory of recovery support groups.)

The potential impact of recognizing co-occurring disorders within the DUI offender population is indicated by a study by Wells-Parker and Williams (2002) in which they were able to lower DUI recidivism 35 percent by screening for depression and adding an enhanced program (individual counseling).

#### **Species IV: Substance Abuse and Personality Disorders**

*A. Etiology and Patterns.* Excessive alcohol and drug use for Species IV DUI offenders emerges out of a broader pattern of antisocial behavior. Excessive alcohol and drug use is simply one element within an excitement-seeking, authority-challenging and high risk-taking lifestyle.

*B. Assessment Indicators.* The indicators of this pattern of excessive alcohol and drug use in DUI offenders include the following:

- Personality and behavioral profile characterized by high impulsivity, excessive risk-taking, excitement seeking, superficial charm, inability to sustain non-exploitive relationships, marked absence of guilt and remorse, disdain for authority, and propensity for aggressive and violent behavior.
- History of antisocial and criminal behavior that predates onset of substance use.
- Predatory behavior unrelated to the need for drug supply or drug intoxication.
- Legal and driving history that often reflects many non-alcohol related offenses indicative of risk-taking behavior, e.g., fleeing an officer, resisting arrest, excessive speeding tickets, running red lights, driving too fast for conditions, driving without a license.

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*Excessive alcohol and drug use for Species IV DUI offenders emerges out of a broader pattern of antisocial behavior.*

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*C. Intervention and Treatment Principles.* Assessment and intervention approaches to Species IV patterns of alcohol and drug use include the following:

- Use of strong and sustained external controls, e.g., two-years-plus of court supervision.
- High frequency and high visibility monitoring systems, e.g., frequent urine drops, unannounced home visits by the probation officer, high frequency of reporting, intensive forms of probation for recidivist in the community.

- High intensity and sustained duration of treatment as opposed to traditional short term treatment interventions; use of therapeutic community treatment as alternative to incarceration for recidivist.
- There is some evidence of maturing out or decreasing intensity of this style with aging; for many, our task is to minimize the risk to public safety posed by these individuals from ages 14-35.

### **Species V: Self-Medication of Emotional Pain**

*A. Etiology and Patterns.* For the Species V DUI offender, the onset of excessive alcohol and drug use (and often the DUI incident) is tied to the self-medication of emotional pain related to a major developmental crisis. This subpopulation is indicated by studies noting that DUI offenders experience particular stressors in the year prior to their DUI arrest not experienced by the general population (Veneziano, Veneziano, & Fichter, 1994). Crises that have been linked to a gradual or sudden escalation of alcohol and drug consumption include the death of a parent, child, sibling, or close friend; breakup of marriage or other intimate relationship; physical loss (mastectomy, hysterectomy, onset of physical disability); sudden unemployment; or loss of land (for farmers). In most of these occurrences, alcohol and drugs are used to self-medicate the emotional pain of unresolved grief. In other cases, alcohol is used to self-medicate anxiety produced by the experience of multiple stressors within a short time frame.

Species V is a pattern of problematic alcohol use at its earliest stages that, when sustained over time, can take on many of the characteristics of a primary addictive disease, e.g., late stage gamma species alcoholism.

*B. Assessment Indicators.* The indicators of this pattern of alcohol and drug problems among DUI offenders include the following:

- A pattern of heavy drinking superimposed on a history of minimal and/or non-problematic alcohol use (no evidence of progression).
- Identifiable traumatizing life events that are concurrent to the onset of excessive alcohol/drug use.
- Stress-related medical problems present at the onset of self-medication, e.g., headaches, skeletal-muscular pain, chronic fatigue, disordered sleep, gastro-intestinal disorders, sudden weight changes.
- DUI event is concurrent with or shortly following a period of emotional crisis.

- A weakened defense structure, e.g., minimal efforts to hide, minimize, or rationalize use.
- Evidence of poor judgment and deterioration of overall cognitive functioning, e.g., impaired memory and concentration, increased confusion and disorientation.
- High severity when losses leave the survivor emotionally and socially isolated.

*C. Intervention and Treatment Principles.*

Assessment and treatment approaches to Species V substance use problems include the following:

- Where the client has experienced significant loss, e.g., death of child or spouse, the evaluator should assess the intensity and duration of depression in the client and identify the presence and intensity of suicidal ideation.
- The intervention must focus on the resolution of emotional pain. Referral to an outpatient therapist with concurrent referral for substance education would be highly appropriate for clients in early stages of this pattern.
- An essential component of the treatment intervention is an environmental manipulation to increase social supports and decrease the stressors being experienced by the client.
- The treatment strategy in addition to the resolution of grief focuses on teaching the client healthier patterns of managing stress and loss. The formal teaching of stress management techniques may be appropriate to incorporate into this treatment process.
- The role of substance education is to inform and to stigmatize drinking (and drinking and driving) as a method of problem solving.
- Alternative self-help groups are warranted when available, e.g., Parents Without Partners, SHARE.

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*Intervention with Species V  
substance use problems  
must focus on the resolution  
of emotional pain.*

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## **Species VI: Family-Oriented Substance Problems**

*A. Etiology and Patterns.* Initiating factors in the onset of substance problems among Species VI DUI offenders are rooted in family system dynamics rather than physical or psychological pathology. The driving forces and rewards for alcohol/drug misuse rest not within the individual but with the meaning and function such behavior has for the family system. Alcohol and drug problems in this species emerge from a dynamic in which the family needs symptomatic behavior (e.g., excessive substance use) to serve as a diversion from a much more painful and potentially destabilizing issue.

This pattern is particularly prevalent among adolescents, who have long been known for their proclivity to act out family system disturbances. In such cases, the misuse of alcohol does not represent a primary addictive disease process but instead represents a red flag for help for the family and a pressure valve to discharge toxic energy from the family system. Primary family system disturbances that typically create explosive adolescent substance abuse of this variety include: addiction of one or both parents, an acute medical or psychiatric illness of a key family member, sexual infidelities of one or both parents, the impending breakup of the marital dyad, family violence, and incest.

*B. Assessment Indicators.* The indicators of this pattern of alcohol abuse in DUI offenders include the following:

- The intensity of the alcohol/drug use pattern is in direct proportion to the intensity of family dynamics that demand symptomatic behavior: where dysfunction is extreme, alcohol and drug use behaviors can be excessive and life-threatening, e.g., overdose, DUI related accident.
- A pattern of exaggerated and flamboyant use rather than denied or minimized use.
- Explosive onset and rapid family/community visibility, without progression or historical context.
- Emotional pain of the client is usually tied to family dynamics rather than as a consequence of alcohol/drug use.
- Alcohol and drug use may be accompanied by other acting out behaviors unrelated to the drug use, e.g., runaway behavior, sexual promiscuity, antisocial behavior.

*C. Intervention and Treatment Principles.* Assessment and treatment approaches to Species VI patterns of alcohol/drug abuse include the following:

- Family assessment of all DUI offenders under 18 and all DUI offenders living with their family of origin is recommended to potentially identify this pattern.
- The treatment of choice is concurrent family counseling and substance education.
- Where family pathology prevents effective engagement, focus of client counseling should be on detaching the client from his or her role in family pathology; when this strategy is used, the service agency or self-help groups may have to perform a role of surrogate family for the client.
- Family centered support groups may be particularly helpful in the long-term emotional health of these clients and families.

**Species VII: Peer-Oriented Abuse**

*A. Etiology and Patterns.* The onset of excessive alcohol and drug use among DUI offenders in Species VII is tied to affiliation with a peer culture that promotes excessive drinking and/or drug use as a primary group ritual. The needs met by the excessive use of intoxicants relate to social rewards of approval, status, identity, esteem, and a sense of acceptance and belonging. Subcultures in the U.S. that have often spawned peer-oriented patterns of use include adolescent subcultures, colleges and universities, the military, and occupational or neighborhood networks that promote excessive alcohol and drug use as a group norm. Some may promote drinking but stigmatize drinking and driving, while others promote both excessive drinking as well as drinking and driving. Due to the repetitions of drinking and driving, individuals in the latter group are likely to enter the DUI offender pool.

*B. Assessment Indicators.* The indicators of this pattern of alcohol abuse in DUI offenders include the following:

- Use occurs in and is sustained by group rituals.
- The DUI event is often associated with a group-related drinking event.
- Periods of absence from the group or exit from the group, e.g., military discharge or graduation, are accompanied by reduction or cessation of alcohol/drug use. The frequency and intensity of drug use are shaped by the social environment rather than by physical or psychological need.

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*Emotional pain of the Species VI client is usually tied to family dynamics rather than as a consequence of alcohol or drug use.*

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*C. Intervention and Treatment Principles.* Assessment and treatment approaches to Species VII patterns of substance abuse include the following:

- Group-oriented education and treatment activities.
- Stigmatization via education about drinking-driving.
- Ego-strengthening activities, e.g., values clarification and transmission and assertiveness training.

### **Species VIII: Culture-Oriented Abuse**

*A. Etiology and Patterns.* The onset and maintenance of excessive drinking for DUI offenders in Species VIII are tied to membership in, and participation in, drinking rituals of a particular ethnic or cultural group. This pattern of alcoholism is the dominant one in many European countries, e.g., Northern Italy, France, and Germany and constitutes a subcultural pattern of alcoholism in the U.S.

*B. Assessment Indicators.* Indicators of this pattern of drinking among DUI offenders include the following:

- Daily alcohol consumption interspersed with explosive “fiesta drinking,” e.g., weddings, funerals, holidays.
- No pattern of progression.
- Inability to abstain rather than loss of control.
- Most areas of life functioning remain intact, e.g., vocational functioning.
- Marked absence of cognitive and affective defense structure, e.g., denial and guilt.
- Marked absence of key gamma species symptoms, e.g., failed efforts to control, failed promises and resolutions, geographical escapes.

Two of the most frequent problems bringing attention to this pattern are DUI arrest and the onset of serious alcohol-related medical problems.

*C. Intervention and Treatment Principles.* Assessment and treatment approaches to DUI offenders reflecting Species VIII patterns include the following:

- The critical questions in the treatment of cultural patterns of alcoholism are:

How does the client in his or her culture maintain status and esteem as a nondrinker? How does the culture provide permission not to drink?

- Culturally sanctioned pathways (rationales) to abstinence can vary widely, e.g., medical, religious beliefs, political beliefs.
- Educational and treatment interventions must utilize and reinforce culturally approved pathways to abstinence or at a minimum intensely stigmatize the connection between drinking and driving.

### **Implications of Multiple Pathway Research**

This chapter has outlined a typology of DUI offenders based on the etiological roots and drinking patterns of each group. It is hoped that it conveys to the reader the diversity of profiles that make up the total pool of DUI offenders. States often undergo three stages in their understanding and response to such diversity.

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*It is hoped that this chapter conveys to the reader the diversity of profiles that make up the total pool of DUI offenders.*

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In the first stage, which most states went through in the 1960s and 1970s, DUI offenders were viewed as a dichotomous population of social drinkers and alcoholics. The evaluation task was to identify and segregate the latter group for special sentencing and rehabilitative strategies.

The lack of uniformity of evaluation tools, the high variability of evaluator competence, and ethical abuses related to a low level of problem identification for the financial profit of the evaluator led to a second stage of system standardization. This stage was marked by state-generated requirements to use a particular assessment instrument, standardized reporting formats, evaluator licensing and training requirements, and complaint and investigation processes related to unethical or incompetent conduct by evaluators. Most states experienced this standardization process in the 1980s and 1990s.

While this stage of standardization eliminated some of the earlier problems, it generated its own criticisms. Judges complained that report summaries had become so standardized that they didn't provide an adequate picture of who was being sentenced. There were concerns that problem levels were being based on one or two benchmarks (e.g., number of prior DUI arrests or BAC) rather than a comprehensive evaluation of the offender. There were concerns that the system of independent evaluators had inadvertently resulted in a decline in the rigor of

evaluations, as the most competent and rigorous evaluators were punished by decreased referrals whereas some of the least competent evaluators financially thrived in what amounted to their employment by defense attorneys.

The DUI assessment instruments gave some indication of the existence or intensity of alcohol problems but did not: 1) address drugs other than alcohol, 2) adequately identify other related problems, 3) assess future threat to public safety, and 4) provide clear recommendations for sentencing or type of treatment intervention. There were also concerns about the growing fragmentation of the DUI system and calls to create a more sophisticated system of evaluation that brought together the multiple agencies and parties charged with responding to the DUI offender.

This call for greater sophistication and coordination that most states are currently experiencing has resulted in parallel calls for more sophisticated evaluation instruments, enhanced competency of evaluators, and an integrated system that combines the resources of multiple state and private agencies to prevent and respond to alcohol- and drug-impaired driving. As states call for subtyping and more individualized approaches to prevent recidivism, it is important to note what such subtyping can and cannot achieve.

Subtyping of DUI offenders into clinical subpopulations is helpful in understanding the development and course of alcohol and other drug problems and in planning appropriate interventions (Saltstone & Poudrier, 1989), but subgroupings like the “species” outlined above do not in themselves predict DUI recidivism (Donovan, et al., 1986). Risk factors for recidivism, which we will discuss later, cross these subpopulations. As Voas (2000) suggests,

*...individuals with one or more DUI offenses are not a homogenous group but vary from those with clear alcohol problems (high risk drinkers who drive) to those who are principally bad or reckless drivers (high-risk drivers who drink). (p. 125)*

Where we seem to be going in the United States is a growing recognition of DUI first offender subpopulations and an understanding across those populations of the factors that are most predictive of future re-arrest or involvement in a future alcohol-related crash. There is an effort to both expand the menu of DUI sentencing/intervention options and to match particular types of interventions to particular subpopulations while creating a database to evaluate the impact (recidivism rates) of these interventions on various subpopulations of offenders. This desire to provide a more sophisticated response to all DUI offenders is being joined by an emerging consensus on the need to define and contain the highest risk DUI offender. Before profiling this high-risk offender, we will examine a few other special populations of DUI offenders.

## **Chapter Four**

### **Special Populations of DUI Offenders**

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As the last chapter noted, there are many subpopulations of DUI offenders who present with different patterns of substance abuse and who may require specialized approaches to sentencing, treatment and monitoring. In this chapter, we will briefly discuss six subpopulations of DUI offenders who can present special challenges for the DUI evaluator, the courts and treatment personnel. These subpopulations include:

- Women.
- Youthful offenders.
- Aging offenders.
- Ethnic minorities.
- Persons with medical/psychiatric disorders.
- Veterans with PTSD (Post Traumatic Stress Disorder).

#### **Women**

The increasing number of women being arrested for DUI in Illinois requires that DUI evaluators have an understanding of unique aspects of substance use disorders in women and the special needs they bring to treatment. This is particularly true in light of the fact that traditional assessment and treatment technology was based almost exclusively on experiences with men. A recent review of the literature on substance use problems among women (White, Woll, & Webber, 2003) underscores the differences in substance use problems in men and women.

- Reach higher peak blood alcohol levels than men even when weight differences are considered.
- Experience different blood alcohol levels across their menstrual cycle (women report becoming most intoxicated before onset of menstrual flow and least intoxicated immediately after onset).
- Report drinking binges beginning or drinking increasing during the premenstrual phase.
- Develop complications of alcoholism, e.g., liver disease, after shorter periods of drinking and at lower levels of alcohol intake than men.

- Are more likely than men to be using other drugs in conjunction with beverage alcohol.
- Have patterns of alcoholism different from those exhibited by men. Phases of alcoholism for women are less distinct, begin at a later age, take less time, and are different — some early stage symptoms for men are late stage symptoms for women.
- Are much more likely to have the onset of alcoholism associated with a particular event, e.g., childbirth, breast removal, hysterectomy, family problems, death of a family member.

It is important for the DUI evaluator to understand that women may present with serious problems in their relationship with alcohol and yet the pattern of their alcohol use may look very different from traditionally defined alcoholism. Not all alcoholic women, for example, exhibit loss of control or radical personality change while drinking. Many traditionally defined symptoms of alcoholism — grandiose and aggressive behavior, geographical escapes, increased preoccupation with power and control — may be culturally shaped male adaptations to decreasing competence rather than symptoms of a disorder shared by both men and women. The focus for the evaluator should be on the consequences of drinking and drug use, rather than the frequency or quantity of drinking or congruence with a preconceived style of problem drinking.

The dominant profile of the female DUI offender is a woman between the ages of 20 and 39, single or divorced, and either employed in a service occupation or unemployed at the time of the arrest. The arrest most likely occurs between midnight and 4 a.m. and is more likely than for men to occur on a weekday rather than a weekend (Shore, McCoy, Martin, & Kuntz, 1988). Studies of female DUI offenders reveal high substance use severity and a high incidence of co-occurring psychiatric disorders (Parks, et al., 1996).

In discussing referrals for treatment services for women, the evaluator should be cognizant of the many treatment barriers for women: family enabling, financial dependence, lack of adequate childcare resources, transportation, and discomfort with male-oriented treatment philosophies and approaches. In identifying treatment resources for women, preference should be given to programs which:

- Provide case management services to address treatment obstacles, e.g., daycare, transportation, acute medical problems.
- Offer gender specific treatment and aftercare groups.
- Have treatment protocols designed to address issues of codependency and

posttraumatic stress disorder (PTSD) related to childhood sexual abuse. From 50 to 75 percent of alcoholic women report parental alcoholism; many are involved intimately with an alcoholic or addict at the time they enter treatment; and as high as 95 percent of alcoholic women report being sexually abused in childhood. (White, Woll and Webber, 2003).

- Are well-linked to women's self-help groups, e.g., women's groups in AA, Women for Sobriety.
- Provide strong family- and children-oriented services. Many authors have also noted the high incidence of depression and anxiety in alcoholic women and have proposed a self-medication of affective disorder hypothesis as the etiology of alcoholism for such women. Where concurrent psychiatric symptoms and alcohol abuse exist, referral to a program with expertise in dual disorders or simultaneous referral for substance and psychiatric evaluation would be warranted.

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*Women have a lower prevalence of alcoholism than men and enhanced prospects of natural or professionally assisted recoveries.*

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Women have a lower prevalence of alcoholism than men (*Alcohol and Health*, 1997) and, when they develop alcoholism, have enhanced prospects of natural or professionally-assisted recoveries (Anthony & Helzer, 1991; Copeland, 1988). Humphreys and his colleagues found in a follow-up study of clients eight years following discharge that the female clients were 1.63 times more likely than male clients to be in stable recovery (Humphreys, et al., 1997).

### **Youthful Offenders**

The rise in youthful drug experimentation during the 1990s led to a dramatic increase in the number of adolescents entering treatment. Although less than 10 percent of substance dependent adolescents currently receive treatment, addiction treatment admissions for adolescents in the United States increased 53 percent between 1992 and 1998, from 96,787 to 147,899 admissions (Dennis, et al., under review; Hser, et al., 2001; OAS, 2000).

The evaluation of adolescent DUI offenders can be particularly difficult. As a culture, we have an idea of what problematic (deviant) drinking is for adults because we have social norms that prescribe such drinking in terms of timing, location, frequency and quantity and we have experience with most adults who maintain an episodic, non-problematic relationship with alcohol. Adult deviant

drinking becomes easier to identify because our picture of normal drinking is a clear one. But when we turn attention to adolescents, we are faced with the question: “What is ‘normal’ drinking for a 17-year-old?” While most adults would say that no drinking is normal, we are left with data in Chapter One confirming that a large percentage of adolescents do consume alcohol and yet not all of these young people have a substance use disorder or need alcoholism treatment. It is this ambiguity, and the broad range of etiologies that can produce excessive drinking (and driving) in adolescents, that pose special problems in the evaluation process.

Alcohol-related problems among adolescent DUI offenders can reflect peer-oriented patterns of abuse, can reflect family scapegoat behavior (acting out problems of family dysfunction), can emerge in response to psychiatric illness, or may indicate signs of a primary addictive disease process. Treatment interventions for all of the above patterns may be appropriate, but it is the last pattern for which we have the best-developed treatment resources. Are there warning signs that would indicate that a 17- or 19-year-old DUI offender is high risk for, and in the earliest stages of, a primary addictive disease? The author has found the following indicators predictive of this risk:

- A family history (3-5 generations) of: alcohol, drug abuse, and teetotalism; alcohol related medical problems; disproportionate number of deaths by accident and suicide; and proclivity for female family members to marry alcoholics.
- Atypically high tolerance from the onset of drinking; consistent ability to maintain a high BAC without gross signs of intoxication; atypical absence of severe hangovers during early drinking career.
- Euphoric recall of the first contact with alcohol.
- Physical attraction to a broad variety of psychoactive drugs.
- Early episodes of loss of control and radical personality change while drinking (particularly evident with early age of onset of drinking).
- Drinking outside the boundaries and rituals of the peer culture.
- The development of an elaborate cognitive defense structure (denial, rationalization, projection, etc.) to justify and minimize consequences related to drinking behavior.

Where such symptoms are evident, referral to formal 12-step oriented addiction treatment programs is highly warranted even for a young adolescent. Where the

above symptoms do not exist, the pattern of excessive alcohol use may be more appropriately addressed within the framework of substance education, affective education (activities that focus on values clarification, self-esteem enhancement, assertiveness training, etc.), or group or family counseling that includes but is not totally focused upon substance abuse.

Two recent reviews of adolescent treatment (White & Dennis, 2002; Risberg & White, 2003) drew several lessons that underscore the import and difficulty of working with the adolescent DUI offender.

- *Substance-related disorders interact synergistically with other problems of youth and families.* The co-occurrence of substance use and other personal and family problems is the norm among adolescent DUI offenders. The two primary implications of such problem co-occurrence are the need for global assessment instruments and processes and the need for treatment that can address multiple problems.

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*The co-occurrence of substance use and other personal and family problems is the norm among adolescent DUI offenders.*

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- *Many adolescents mature out of substance-related problems in the transition into adult role responsibilities.* The line between volitional substance experimentation and the emergence of a serious substance use disorder characterized by compulsivity and chronicity is not well understood, making it difficult for the evaluator and the courts to determine which youthful offenders would most benefit from treatment-oriented interventions.
- *For other adolescents, excessive substance use constitutes a chronic, debilitating disorder whose resolution will require multiple interventions over time.*
- *What distinguishes youth who mature out of substance use and those who go on to develop significant and prolonged substance-related problems is that the latter exhibit greater personal vulnerability (e.g., family history of substance problems, lower age of onset), experience greater problem severity, have significant co-occurring problems, and have lower levels of positive family and peer support.* In the presence of these factors, substance-involved adolescents may need significant and ongoing support to initiate and sustain recovery.
- *The earlier the intervention (in terms of age and months/years of use) with a substance use disorder, the better the clinical outcomes and the shorter the*



*addiction career.* These research findings suggest the potential utility of early identification and treatment of substance-related problems via the DUI evaluation process.

- *There are evidence-based, brief therapies that are effective for many substance-involved adolescents, but responses to treatment are highly variable.* Post-treatment adjustment measured by substance use patterns includes five subgroups:
  - a. Continued post-treatment abstinence.
  - b. Continued use at same or accelerated level.
  - c. Early abstinence followed by sustained relapse.
  - d. Early relapse followed by sustained recovery.
  - e. Vacillation between recovery and relapse.
- *Viewed as a whole, the most common outcomes of adolescent treatment are enhancements in global functioning (increased emotional health and improved functioning in the family, school, and community) and reduced substance use (to approximately 50 percent of pre-treatment levels) rather than complete and enduring cessation of alcohol and other drug use.* The implication of these findings is not that treatment is ineffective for the majority of adolescents, but that, like other chronic disorders, multiple episodes of intervention may be required to resolve severe and persistent substance use disorders.
- *Most adolescents are precariously balanced between recovery and relapse in the months following treatment.* The period of greatest vulnerability for relapse is in the first 30 days following treatment; the adolescents' status at 90 days following treatment is highly predictive of their status at one year following treatment. The stability of recovery is enhanced by post-treatment monitoring and periodic recovery checkups.
- *The adolescent's post-treatment peer adjustment is a major determinant of treatment outcome.* Adolescents who experience major relapse have the highest density of drug users in their post-treatment social milieu.
- *The post-treatment home environment also plays a significant role in recovery /relapse outcomes.*
- *All treatment programs are not the same.* Those programs with the best clinical outcomes:
  - a. Treat a larger number of adolescents.
  - b. Have a larger budget.
  - c. Use evidence-based therapies.
  - d. Offer specialized educational, vocational, and psychiatric services.

- e. Employ counselors with two or more years of experience working with adolescents.
  - f. Offer a larger menu of youth-specific services, e.g., art therapy, recreational services.
  - g. Are perceived by clients as empathic allies in the recovery process.
- *Recovery mutual aid networks (AA, NA, etc.) can offer considerable support for long-term recovery, but they suffer from low teen participation rates and their effect is dependent upon intensity and duration of participation.*

## **The Elderly**

Many signs of alcoholism among older adults are interpreted as normal aging, e.g., cognitive impairment, depression, poor nutrition, neglect of hygiene, and impaired balance. As a result, life-threatening substance use problems are often “underestimated, underidentified, underdiagnosed, and undertreated.”

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*Many signs of alcoholism among older adults are interpreted as normal aging.*

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In general, volume of alcohol consumption declines with advancing age, but alcohol exposure remains high. Community surveys reveal that more than 60 percent of adults between 60 and 94 consume alcohol. Heavy drinking is reported in 13 percent of men and 2 percent of women over 60. Some 15 percent of older alcoholics also suffer from concurrent drug dependence, e.g., benzodiazepines (Rigler, 2000). Heightened alcohol sensitivity — NIAAA recommends no more than one ounce of alcohol a day for persons over 65 — and the resulting alcohol-related injuries, e.g., vehicular accidents, hip fractures from alcohol-related falls, suicide attempts, synergistic drug interactions, antagonist drug interactions, and neutralized effectiveness of crucial medication are all hazards faced by the older alcoholic (National Institute on Alcohol Abuse and Alcoholism, 1998).

About two-thirds of elderly DUI offenders are aging alcoholics whose DUI arrest is simply one of many symptoms signaling the advanced progression of a disease process that has probably been occurring over several decades. Most of the offenders in this group began drinking at an early age and their alcohol-related problems have increased with time. Such persons often exhibit classic symptoms of alcoholism that are easily identifiable using traditional assessment instruments and procedures (Rigler, 2000). There are, however, other populations of aging DUI offenders (about one-third of older problem drinkers) who do not fit this pattern. What they share in common is a lack of risk factors (family history of alcoholism), a non-problematic relationship with alcohol through early and midlife, and the emergence of identifiable problems and consequences related to

drinking late in life (Rigler, 2000). Sometimes referred to as “late onset alcoholism,” these patterns of problematic drinking vary greatly from the dominant pattern of alcoholism in the United States. Four subpopulations of aging DUI offenders are described below.

The physical capacity to metabolize alcohol and other drugs can diminish with the aging process, creating idiosyncratic or paradoxical effects. This changing tolerance to alcohol may be exacerbated if the individual is also consuming other prescribed and over-the-counter medications. The aging person’s decreased efficiency in metabolizing alcohol and drugs can lead to a toxic buildup of drugs in the body, unexplained synergistic reactions between drugs and alcohol, and the sudden onset of altered alcohol tolerance, e.g., small amounts of alcohol producing profound intoxication. This person may be a long-time social drinker who suddenly finds himself or herself — in spite of the lack of change in the frequency or quantity of alcohol consumption — experiencing problems related to drinking, e.g., DUI arrest. This person’s lack of a problematic drinking history, lack of prior DUI arrests and frequently low BAC will probably result — very appropriately — in placement in a remedial education program where hopefully specialized information can be provided on alcohol and aging.

The next three populations are in need of more intense intervention. With the first of these, we have individuals who are often managing chronic progressive and painful illnesses or are managing pain related to recovery from physical trauma who discover that an increase in alcohol consumption decreases their physical discomfort. This self-medication of diagnosed or undiagnosed physical illnesses with alcohol, which was described in Chapter Three, can be particularly problematic with the elderly. Changing capacities to detoxify alcohol, life-threatening synergistic drug interactions, increased vulnerability for alcohol-related medical illnesses, and the reinforcing effects of pain reduction all can create significant problems in the life of the physically impaired elderly.

Another group of high-risk elderly begin a pattern of excessive drinking to self-medicate the emotional pain of developmental losses. The onset of this pattern can be tied to the death of a spouse, the loss of children, the loss of identity via loss of employment or retirement, or the loss of one’s intimate social network through death, retirement or relocation. This excessive drinking may be tied to a pathological grief and mourning reaction or may provide solace for the pain and loneliness of social isolation.

A third variation of this pattern can be seen in the socially isolated elderly who fill this social vacuum by participation in a heavy drinking subculture, e.g., local bars. These persons, who may have had little drinking history through most of their lives, may seek out drinking late in life in a bar culture or other drinking social group that fills the void of loss and loneliness. Individuals in all three groups may

find themselves in a DUI incident or experiencing other problems and consequences related to their alcohol use.

The evaluation interview should ascertain whether the pattern of alcohol problems in the elderly offender is characterized by chronicity and progression or whether the onset is of relatively recent origin. With the latter, it may be necessary to broaden the focus of the evaluation process to include a determination of the appropriate service interventions that can address both the pattern of alcohol misuse or alcoholism and the individual's risk to public safety via future drinking and driving. The following principles related to treatment of alcohol abuse and alcoholism among the elderly should help shape appropriate treatment recommendations.

- Assume and evaluate the presence of physical and psychiatric comorbidity (physical signs include gastrointestinal disease and bleeding, immunosuppression, elevated risk of stroke and cancer — the latter magnified by high smoking rates).
- Assess the degree of alcohol-related and age-related cognitive impairment. Older problem drinkers may require a longer duration of treatment contact due to alcohol-induced cognitive deficits.
- Look for unresolved grief and social isolation.
- Assess problems related to housing, transportation, or lack of financial resources, and evaluate expertise in self-advocacy related to health and human service systems (e.g., needs for case management).
- Try to create service integration utilizing formal and informal helping agencies and persons.
- Don't forget the critical role of the primary health care physician in long-term recovery management.
- Use pharmacotherapy, where indicated, e.g., neuroleptics in the treatment of delirium, anxiolytics and antidepressants for affective disorders, anti-craving agents (i.e., naltrexone) to reduce risk and duration of relapse.

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*The good news is that  
treatment outcomes for  
persons over 60 are as good  
as for those under 60.*

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- Utilize nutritional and megavitamin therapies to reverse malnutrition and speed reversal of alcohol-related physical pathologies.
- Like other adults, assess the family and peer social support network. Construction of an age-appropriate, sobriety-based social network is an essential element of treatment interventions for the elderly.

The good news is that treatment outcomes for persons over 60 are as good as for those under 60. Outcomes are more favorable for persons with shorter drinking histories and there is some evidence for enhanced outcomes with specialized treatment with elder focus (NIAAA, 1998).

### **Ethnic Minorities**

There are several points that are important when working with DUI offenders who are members of an ethnic minority group. First, the DUI event must be evaluated in terms of the cultural context in which it occurs. Drinking practices and alcohol-related problems vary widely across ethnic groups (NIAAA, 2002). This drinking behavior surrounding a DUI event can reflect an ethnic pattern of drinking (e.g., what Jellinek called “fiesta drinking”) or mark a break from subcultural drinking norms. Evaluating a DUI offender of Asian descent, for example, is best done with an awareness that excessive drinking, drinking problems and drinking and driving are much more rare (but increasing) among Asians than all other ethnic groups. Recognizing unique factors that may contribute to alcohol problems among ethnic minorities (e.g., acculturation stress, high density of alcohol outlets in minority neighborhoods) adds an important dimension to the evaluation of the DUI offender.

Second, ethnic minority status (and primary language and legal status) of the person being evaluated interacts with the ethnic background of the evaluator to enhance or inhibit the evaluation process. Being aware of how cultural differences can influence the interview process and using culturally congruent interview techniques will enhance the quality and outcome of the interview process.

Third, and perhaps most important, is the recognition of cultural pathways for resolving alcohol- and drug-related problems. Most cultures have evolved indigenous healers and institutions to provide aid for such problems and have evolved cultural prescriptions on how such problems can best be resolved. There is, for example, a long history of abstinence-based religious and cultural revitalization movements that have served as a conceptual framework and sobriety-based support structure for Native American alcoholics. Studies in Illinois (White, Woll, & Webber, 2003) have similarly documented the role of the church as a sobriety-based support structure for addicted African American women. For the person facing serious problems in their relationship with alcohol

and other drugs, the evaluator needs to ask, “What cultural pathways would legitimize abstinence from alcohol and other drugs for this person and allow them to maintain their membership and identity within this social world?” In some ethnic cultures, the physician can play an enormously influential role in the shift from addictive drinking to abstinence-based recovery while in other cultures their influence on this problem is negligible. Intervention and treatment outcomes will be enhanced to the extent we can align ourselves with these natural sources and styles of problem resolution.

### **Veterans with PTSD**

DUI evaluators have long observed the over-representation of Vietnam veterans within the total pool of DUI offenders. While some veterans have substance-related problems whose etiological roots and progression are unrelated to and unaltered by their wartime experiences, other veterans may present a pattern of substance-related problems whose origin is tied to the physical and emotional trauma of war. The former group will quite likely respond to traditional intervention and treatment; the latter group may need some specialized treatment interventions. The diagnostic question for the evaluator is whether the veteran DUI offender has a pattern of chronic or delayed posttraumatic stress disorder (PTSD) that fuels excessive alcohol or drug use and/or poses a significant obstacle to treatment responsiveness and long-term recovery. Signs of PTSD that may emerge from the DUI evaluation interview include the following:

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*DUI evaluators have long observed the over-representation of Vietnam veterans within the total pool of DUI offenders.*

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- The existence of emotional trauma experienced during the war and/or upon one’s re-entry into civilian life.
- A chronic recapitulation of the emotional trauma through intrusive recollections, nightmares, or flashbacks (fleeting feelings that one is back in the wartime environment) triggered by sensory or emotional cues.
- Social and emotional disengagement, psychic numbing, and constricted affect.
- Hyper-alertness and exaggerated startle responses.
- Guilt about having survived war.

- Unprovoked incidents of aggressive and violent behavior.
- Impulsive behavior, impairment of ability to sustain intimate relationships.
- Deterioration in cognitive and vocational functioning.

Many veterans with PTSD have developed a pattern of self-medicating symptoms of this disorder with excessive alcohol and drug use. When such a pattern exists, it can lead to unpredictable and ill-timed episodes of excessive drug use and personality change that resemble but are quite different from the dominant pattern of alcoholism in the United States. This pattern of PTSD self-medication is not the “loss of control” and “radical personality change while drinking” associated with “gamma species” alcoholism. In individuals who have developed this pattern of self-medication, symptoms of PTSD may escalate with sustained sobriety, increasing the likelihood of relapse. Without specialized supports to find non-drug mechanisms of symptom management, the long-term prognosis for sustained sobriety is poor.

Where patterns of PTSD exist, the DUI evaluator may wish to:

- Recommend a formal assessment of the potential existence of PTSD as a component of the DUI evaluation.
- Recommend placement in a substance abuse treatment environment that has experience working with Vietnam veterans.
- Recommend concurrent substance abuse and psychiatric treatment.
- Recommend concurrent involvement in 12-step support structures and support groups for veterans with PTSD.

### **Persons with Medical or Psychiatric Disorders**

Occasionally a DUI evaluator interviews an offender whose medical and/or psychiatric symptoms or history are so complicated that they feel additional assessment data is essential for the court to make an informed adjudication of the pending DUI case. As noted in Chapter Three, there are clients who self-medicate symptoms of acute medical and psychiatric illnesses with alcohol and other psychoactive drugs who do not fit the traditional pattern and criteria of alcoholism, but who do pose a significant threat to public safety via driving under the influence of intoxicants. In such cases, it may be appropriate to arrange for a physical or psychiatric evaluation to accompany the evaluator’s report to the court or Secretary of State. Signs that would raise the potential need for such additional evaluation would include the following:

- The offender presents a complicated medical and/or psychiatric history that raises the possibility that a pattern of self-medication exists that is not within the rational control of the offender.
- The offender presents at the time of the interview symptoms of severe physical or psychiatric illness that have not been appropriately evaluated or treated.
- There is evidence of atypical drug choices and atypical drug consumption patterns.
- The offender was medicated at the time of the DUI offense and is maintained on medication that, alone or in combination with even small quantities of alcohol, severely impair driving performance. (Cases exist in which DUI offenders are maintained on such high doses of mood altering drugs — often several concurrent prescriptions from different physicians — that these individuals are a threat to public safety while driving even if they don't drink. The evaluator must sound a warning bell in such cases.)
- The physical, emotional, and social functioning of the client deteriorates rather than improves during episodes of sustained sobriety.
- There is a marked absence of denial and evidence of grandiosity and the potential for fabrication related to self-reported drug history.

Where such signs exist, additional evaluation data may be essential to the formulation of appropriate sentencing and treatment recommendations. There are a growing number of referral sources around the country designed specifically for persons with substance-related problems that have developed out of or in tandem with physical and psychiatric illnesses.

The next chapter will discuss what is known about the most difficult DUI offender population: the multiple DUI recidivist.



## **Chapter Five**

### **The Highest Risk DUI Offender**

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Nationally, about one-third of those arrested for DUI have a prior DUI arrest (NHTSA, 1997). Put another way, one-third of first time DUI offenders will continue to drink and drive and be re-arrested in the future. This has raised concerns about how to contain the “hard-core drinking driver” and how this high-risk individual might be identified and provided more intensive intervention the first time he or she passes through the criminal justice system on a DUI charge (Voas & Fisher, 2001).

All individuals who drive under the influence of alcohol and other drugs are “high risk” in the sense that they pose a threat to public safety, but a subgroup of these individuals pose particular high risks due to the frequency (number of repetitions of drinking and driving) and intensity (combining drinking with aggressive and reckless driving) of such behavior. In this chapter, we will try to explore the profile of this highest risk DUI offender: defining risk in terms of probability for future drinking and driving, future re-arrest for DUI and future involvement in an alcohol/drug-related crash involving injury or fatality.

The first point we should make here is that DUI recidivists and those involved in alcohol-related fatal crashes share many characteristics with DUI first offenders. Some investigators have even suggested that there are no distinguishable differences, that first offenders are simply problem drinking drivers who have not yet had a second offense and who pose as great a risk to public safety as the identified recidivist (Arstein-Kerslake & Peck, 1985). What separates single versus multiple offenders is not a set of characteristics present in one but not the other, but characteristics that exist in different degrees. For example, both groups may exhibit greater risk taking than the general population, but the recidivist may exhibit this characteristic to a much higher degree than the offender arrested for DUI who does not recidivate. Shope and Bingham (2002) have concluded that impaired driving is not an isolated behavior but is a behavior imbedded within a larger cluster of high-risk behavior (drinking driving, drugged driving, risky driving) and interlinked problems.

The profile outlined below is based on a review of the available literature. The following sources were particularly helpful in the construction of this profile: Kennedy, 1993; Hedlund, 1995; NHTSA, 2000; Timken, 1999; Perrine, Peck, & Fell, 1989; Caviola & Wuth, 2002. Items listed below without citation come from these sources or are drawn from the author’s own experience over the past 30 years.

## Demographic Profile

*Gender.* The DUI recidivist is overwhelmingly male (90-95 percent). It has been suggested that women find the legal process much more shaming than do men and thus have lower recidivism rates across most crimes (Shore, et al., 1988). Having stated this, it is important to note that the representation of women in this population has grown during the past decade. We need to discover if risk factors for women entering the recidivist pool are different from those risk factors for men.

*Age.* Most DUI recidivists range in age from 21 to 45; more than 75 percent are under age 40 and only 10 percent over age 50. This pattern of natural attrition or maturing out suggests strategies of containment during peak years of threat to public safety and raises the need to identify what factors lead to movement into and out of this population.

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*Most DUI recidivists range in age from 21 to 45; more than 75 percent are under age 40 and only 10 percent over age 50.*

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*Education.* DUI recidivists have less education (nearly half have less than a 12<sup>th</sup> grade education) than their non-recidivist counterparts. This may not be a function of lower intelligence as much as their inability to tolerate structure and authority.

*Employment.* DUI recidivists are more likely than their non-recidivist counterparts to present with histories of occupational impairment, e.g., patterns of unemployment, frequent job change, or seasonal or self-employment that preclude sustained supervision by others. DUI recidivists are more likely to work in non-white collar occupations; more than 70 percent have annual incomes of less than \$25,000. Like education, this is not a reflection of lack of skill as much as recurring problems with authority figures. Lower educational levels also reflect lower annual income.

*Marital Status.* DUI recidivists are more likely than their non-recidivist counterparts to present with a history of impaired intimate relationships, e.g., inability to sustain friendships and intimate relationships as well as a pattern of conflict in such relationships. Although more than 60 percent of DUI recidivists have children, 75 to 80 percent are unmarried (single, separated, divorced or widowed) at the time of their arrest. Single, divorced and widowed offenders have higher re-arrest rates than those who are married (Lapham, Skipper, Hunt, & Chang, 2000). The pattern of failed and strained intimate relationships is also evident in some overlap between DUI recidivist and domestic battery recidivists.

*Social Network.* Binge-drinking drivers tend to socialize with individuals who also drink frequently and heavily (Nelson, et al., 1998).

### **Driving and Criminal Justice History**

*Prior Criminal Record.* DUI recidivists have a higher percentage of prior criminal records (exclusive of impaired driving arrests) than do non-recidivists. Between 20-25 percent of prior convictions for DUI recidivists are for crimes against persons. A study of DUI recidivism in the state of New York found that prior criminal history other than prior DUI offenses was a predictor of future DUI recidivism (Nochajski, Miller, & Wieczorek, 1989).

*Prior AOD-related Arrests.* DUI recidivists are more likely than their non-recidivist counterparts to have prior alcohol- or other drug-related arrests that predate their first DUI arrest, e.g., illegal consumption, illegal possession, illegal transportation, criminal damage to property, disorderly conduct, public urination, assault, etc.

*Number of Prior DUIs.* The risk of DUI recidivism goes up in tandem with the number of prior DUI arrests (NHTSA, 1996b). Adult drivers ages 35 and older who have been arrested for impaired driving are 11 to 12 times more likely than those who have never been arrested to die eventually in crashes involving alcohol (Brewer, et al., 1994).

*Driving Record.* DUI recidivists are more likely than their non-recidivist counterparts to have high-risk driving records (e.g., moving violations, accidents involving personal injury or property damage, loss of insurance) and to be involved in more traffic crashes than other drivers in general and non-recidivist impaired drivers (“Drivers with,” 1994). DUI recidivists are over-represented among drivers involved in fatal crashes. (The driving profile indicates a general disregard for community norms and a high degree of sensation-seeking, risk-taking, competitive speed, and driving-related hostility.) Recidivism increases with the number of DUI arrests and with the number of moving violations. There is growing evidence of an overlap between the pool of DUI recidivists and the larger pool of high-risk drivers (Wells-Parker, et al., 1986; Taxman & Piquero, 1998).

*Driving on a Suspended License.* DUI recidivists are more likely than their non-recidivist counterparts to not just drive on a suspended/revoked license, but to do so in ways that indicate a disregard for community norms and a high degree of sensation-seeking, risk-taking, and interpersonal aggression.

*Community Response to Prior DUI.* DUI recidivists are more likely to have had prior cases of arrest for DUI that resulted in long processing time before disposition and were disposed of without a conviction (Yu & Williford, 1995).

Multiple offenders are often very “system sophisticated.” They have learned how to manipulate both the criminal justice system and the treatment system to avoid the consequences of their drinking and driving behavior.

### **Drinking and Driving Beliefs**

DUI recidivists are more likely than those who do not drink and drive or one-time offenders to:

- Believe they can drive safely after consuming large quantities of alcohol as long as they drive more carefully (Caudill, et al., 1990; Nelson, et al., 1998). Those who believe they can drive safely after heavy drinking are 61 percent more likely to be re-arrested for DUI (Hingson, Hereen, & Winter, 1998).
- Underestimate their level of intoxication (Beriness, Foss, & Voas, 1993).
- Make no alternative transportation arrangements before drinking (Nelson, et al., 1998).
- Experience less social disapproval from friends related to drinking and driving (Nelson, et al., 1998).
- Disagree that penalties for impaired driving should be more severe (Nelson, et al., 1998).
- See their DUI arrest as a function of bad luck or victimization by the police rather than a consequence of their own irresponsible decision to drive after drinking.

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*DUI recidivists are more likely to believe they can drive after consuming large quantities of alcohol as long as they drive more carefully.*

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### **The Arrest Event**

*Perception of Driving Capability.* Both first time and recidivist DUI offenders believed they were “okay” to drive at the time of their arrest for DUI (NHTSA, 1996).

*Time of Arrest.* DUI recidivists are more likely to be arrested during the day and on a weekday than their non-recidivist counterparts. Some studies have found no difference between one-time and multiple offenders on time of arrest (Yu & Williford, 1995).

*Activity Prior to Arrest.* DUI recidivists are more likely than their non-recidivist counterparts to be drinking alone or in groups of men and to be driving alone at the time of the arrest. Most DUI recidivists are on their way home at the time of the arrest.

*Collateral Charges.* DUI recidivists are more likely than their non-recidivist counterparts to have collateral charges tied to their DUI arrest, e.g., fleeing, resisting arrest, drug possession.

*Blood Alcohol Content.* DUI recidivists are more likely than their non-recidivist counterparts to have excessively high blood alcohol content (BAC) — .25 or greater — at the time of the arrest (*National Commission Against Drunk Driving*, 1986). The average BAC for the DUI recidivist is .20 compared to a BAC of .17 for first offenders. More than half of fatally injured DUI recidivists have a BAC of .20 or greater. Higher BAC has been shown to be a risk factor in recidivism (Simpson & Mayhew, 1991; “Drivers with,” 1994) in most studies, although the difference between the BAC in first offenders and recidivists is slight in more recent studies. In a study by Davignon (2001), the average BAC for first offenders was 0.148 percent and for multiple offenders was 0.158 percent. (The mixed findings suggest the potential benefit but also the potential limitations of establishing separate sentencing sanctions and other intervention strategies for people who reach these high BACs.) What does seem to be clear is the relationship between high BAC at the time of arrest and subsequent diagnosis of alcoholism. In a study of 327 alcohol-impaired drivers, Brinkmann and colleagues (2002) found that 80 percent of those with BACs of 0.19 percent or greater met diagnostic criteria for alcohol dependence.

*BAC and Signs of Intoxication.* DUI recidivists are more likely than their non-recidivist counterparts to exhibit high BACs without gross signs of intoxication, e.g., less impairment in field sobriety tests in relationship to their BAC.

*Refusal.* DUI recidivists are more likely than their non-recidivist counterparts to refuse a Breathalyzer test and to exhibit a high degree of knowledge (or pseudo-knowledge) regarding DUI laws. Refusals increase with the number of DUI arrests and those refusing chemical testing are more likely to be re-arrested for DUI in the future. This reveals involvement in what might be called a DUI subculture through which methods of avoiding apprehension reach a remarkable degree of sophistication. The multiple offender is likely to be a member of an elaborate culture of addiction whose collective knowledge of judicial and treatment systems can be tapped to produce a well-coached performance in the evaluation interview, in the courtroom, or the treatment center.

## Clinical Profile

*Family History.* DUI recidivists are more likely than their non-recidivist counterparts to have family trees indicating a high degree of alcohol/drug pathology, e.g., high rates of parental alcoholism, higher numbers/percentages of family members with identifiable alcohol-drug problems, and greater propensity for accidents, suicides and alcohol/drug-related medical problems as causes of death within the family tree. DUI recidivists are more likely than their non-recidivist counterparts to exhibit family histories marked by patterns of abuse and abandonment or patterns of overindulgence and overprotection.

*Age of Onset.* DUI recidivists are more likely than their non-recidivist counterparts to exhibit early age of onset of alcohol/drug use, euphoric recall of their first contact with alcohol/drugs, and higher tolerance from onset of use.

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*DUI recidivists are more likely to be involved in multiple drug use.*

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*Alcohol Consumption.* DUI recidivists are more likely than those without a DUI conviction or only one DUI conviction to drink more frequently, consume more alcohol per drinking episode, report having more problems related to drinking, and report that they need to cut down their drinking (Hedlund, 1995). DUI recidivists are more likely than their non-recidivist counterparts to be involved in a daily social lifestyle of male-based bar drinking.

*Beer/Spirits.* Most DUI recidivists prefer beer as their primary alcoholic beverage, but are more likely than the general population and their non-recidivist counterparts to consume distilled spirits as either their primary or secondary drug of choice. This preference reflects their high tissue tolerance and the need to use products with high alcohol concentrations to maintain cellular/psychological comfort.

*Other Drug Use.* DUI recidivists are more likely than their non-recidivist counterparts to be involved in multiple drug use — licit recreational drugs, prescribed psychoactive drugs, and illicit drugs (Osborn, 1997). While the vast majority of all DUI offenders smoke (Taxman & Piquero, 1998), the recidivist may be marked by the early onset of smoking, the amount of smoking (more than 30 cigarettes per day), high intensity of nicotine craving, smoking within five minutes of waking up, and lack of attempts to cut down or quit (John, et al., 2003). This pattern of multiple drug use suggests that the recidivists' risk to public safety is even greater than their BACs would indicate and opens the potential for the selective use of drug screens (urine) as a surveillance device for the multiple DUI offender.

*Alcohol/Drug Problems.* DUI recidivists are more likely to have problems with alcohol and other drugs and to have more severe problems than non-recidivists (Perrine 1990).

*Prior Substance Abuse Treatment.* DUI recidivists are more likely to have had prior treatment for alcohol or other drug problems, to have been noncompliant with that treatment (Peck, Arstein-Kerslake, & Helander, 1994; Nochajski, et al., 1994), and to have viewed such treatment as a “waste of time” (Timken, 1999).

*Psychiatric Status/Treatment.* DUI recidivists are more likely than their non-recidivist counterparts to have mental health problems and to have had some (often coerced) contact with mental health authorities. The most frequent diagnoses reflected in these histories include affective disorders (depression and bipolar disorder) and personality disorders (Cluster B: antisocial personality, borderline personality, narcissistic personality, and histrionic personality). Female DUI recidivists exhibit significant alcohol/drug and psychiatric pathology; women DUI recidivists have inordinately high representations of sexual abuse in their developmental histories — histories marked by numerous traumagenic factors (an early onset, long duration, multiple perpetrators, etc.). Such histories raise the possibility that the female DUI recidivist’s excessive alcohol consumption may be tied in part to self-medication of posttraumatic stress disorder (PTSD). If confirmed, this finding would also suggest the need for more gender-specific intervention strategies.

*Medical History.* DUI recidivists are more likely than their non-recidivist counterparts to present with medical histories reflecting accidents, higher frequency of emergency room visits, worker compensation and disability claims.

*Personality (Characterological Risks).* DUI recidivists, like the entire pool of first-time DUI offenders, are made up of numerous subpopulations, but there are some shared characteristics that are over-represented in the recidivist group. The most prominent of these characteristics include:

- Diminished capacity for empathy, rendering this person inappropriate for sanctions such as a victim impact panel.
- Diminished capacity for self-observation and insight.
- Diminished capacity for emotional expression.
- An elaborate cognitive defense structure characterized by denial, minimization, rationalization, resentment, projection of blame and aggression (Caviola & Wuth, 2002).

- Impaired problem-solving, e.g., limited capacity to generate choices, diminished capacity to analyze — project outcomes and select from multiple options.
- High impulsivity combined with sensation and risk-seeking, e.g., fatalities of impaired drivers is high in part to their failure to wear seat belts (Hedlund & Fell, 1995; Caviola & Wuth, 2002).
- Minimal goal orientation.
- Diminished capacity for guilt and remorse (Farrow, 1989; Reynolds, et al., 1991).

### **Impaired Drivers Involved in Fatal Crashes**

Profiles of drivers with prior DUI convictions who were later involved in fatal crashes reveal similarities to the DUI recidivist in numerous areas, e.g., gender (91 percent male), age (59 percent between 21 and 34; 28 percent between 35 and 54), BAC (63 percent had a BAC of 0.10 percent or higher), vehicles (older cars and trucks), type of crash (55 percent single-car crashes), timing of crash (42 percent on weekend nights), and failure to use seatbelts (75 percent) (Hedlund, 1995).

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*Profiles of drivers with prior DUI convictions who were later involved in fatal crashes reveal similarities to the DUI recidivist in numerous areas.*

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There is growing consensus that more sophisticated approaches are needed to examine how particular risk factors interact to predict DUI recidivism and future involvement in alcohol-related crashes (C’de Baca, Miller, & Lapham, 2001). This is triggering growing calls for more sophisticated evaluation instruments and processes used to evaluate DUI offenders.

The multiple offender brings not only severe alcohol problems but also a chronic self-defeating style of avoiding drinking consequences that is likely to sabotage forced attempts at rehabilitation. The goal is that the evaluation can result in an appropriate intervention that can disrupt such self-defeating styles of “doing treatment,” alter the developmental trajectory of the client’s alcohol and other drug problems, and eliminate the client’s risk to public safety. Some key suggestions related to framing treatment recommendations for repeat offenders would include the following:

- Avoid placing the repeat offender in treatment modalities or settings that have already proven unsuccessful.



- The choice of treatment site should be made by the evaluator or court, not the offender. Offenders given a choice will “treatment shop” to find the setting that has the least potential to alter their life and lifestyle.
- Make sure that the duration and intensity of recommended treatment has a reasonable chance of success given the chronicity and intensity of the offender’s pattern of substance use.
- Recommend placement in treatment settings in which staff have substantial experience and success in confronting self-defeating styles of “doing treatment.”
- Communicate via your reporting that this offender needs strong external controls and monitoring to have any reasonable chance at successful treatment and to prevent future DUI offenses. (A reasonable time frame spanning movement through progressively less restrictive treatment environments and external monitoring via the court should be framed in years rather than weeks or months.)

An expanded discussion of principles for managing the high risk DUI offender can be found in Chapter Seven.

## **Chapter Six**

### **Treatment and Recovery Resources and Effectiveness Research**

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The purpose of this chapter is to provide a brief overview of treatment and mutual aid resources that can aid in the rehabilitation of those DUI offenders who are experiencing severe problems in their relationship with alcohol and other drugs. The chapter answers some of the most frequent questions the author receives from the criminal justice, clinical and administrative personnel involved with DUI offenders.

*Won't some offenders simply mature out of substance use without the aid of professional treatment or self-help groups?*

Only a small portion (less than 25 percent) of those who recover from addiction do so through the vehicle of professionally-directed treatment (Knupfer, 1972; Vaillant, 1979; Sobell, et al., 1996), but there are significant differences between those who experience natural recovery (resolve these problems on their own) and those who require significant involvement with professional treatment and mutual aid groups. Natural recovery is most common in individuals with shorter and less severe drinking careers and those with higher incomes and more stable social and occupational supports (Sobell, et al., 1993; Sobell et al., 1996; Larimer & Kilmer, 2000). Treatment and mutual aid populations are distinguished by greater personal vulnerability (family history of substance-related problems, lower age of onset), greater problem severity and chronicity, co-occurring medical and psychiatric disorders, and lower "recovery capital" — internal and external resources that can help initiate and sustain sobriety (Room, 1989; Weisner, 1993; Bischof, et al., 2001; Granfield & Cloud, 1996, 1999; Tucker & Gladsjo, 1993). In summary, the greater the level of problem severity, the greater the likelihood that a DUI offender will need professional treatment and mutual aid resources to sustain sobriety and lower his or her threat to public safety.

*What types of treatment are provided to persons experiencing alcohol and other drug problems?*

There are more than 11,000 addiction treatment programs in the United States that specialize in the treatment of persons with alcohol and other drug problems. These programs provide services in different settings (hospitals, free-standing residential programs, outpatient clinics) and through a wide variety of methods.

The placement of individuals in different types of programs is influenced by two diagnostic and placement schemes.

Substance use disorders are catalogued in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*. By defining the diagnostic criteria for various substance use disorders, the DSM-IV forms the basis for determining whether an individual has a substance use disorder and the type and severity of that disorder. Treatment approaches to these disorders are defined in the American Society of Addiction Medicine's *ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders*. The ASAM Placement Criteria define five levels of care in addiction treatment:

- Level 0.5, Early Intervention.
- Level I, Outpatient Treatment.
- Level II, Intensive Outpatient/Partial Hospitalization
- Level III, Residential/Inpatient Treatment.
- Level IV, Medically-Managed Intensive Inpatient Treatment.

Within these broad levels of service is a range of specific levels of care. Admission criteria are defined for each level of care based on the following dimensions: acute intoxication/withdrawal potential; biomedical conditions and complications; emotional, behavioral or cognitive conditions and complications; readiness to change; relapse, continued use or continued problem potential; and recovery environment.

Addiction treatment exists on a continuum from high structure and intensity (inpatient medical detoxification) to low structure and intensity (weekly outpatient counseling) and from brief interventions that span a few hours of professional contact to interventions that may last for years (methadone maintenance). Inpatient services are generally indicated for those individuals who present with:

- Substance use disorders of great intensity and/or chronicity.
- Acute medical/psychological problems that require close monitoring or care during detox and early recovery.
- A family/social environment that inhibits the initiation of sobriety, or
- A prior history of failure in outpatient addiction treatment modalities.

### ***What occurs in treatment?***

Treatment activities often consist of monitored detoxification; treatment of substance-related medical problems; nutritional and activity therapies; client and family education; individual, group and family counseling; treatment of co-occurring psychiatric disorders; linkage to community mutual aid groups such as Alcoholics Anonymous or Narcotics Anonymous; abstinence monitoring (via drug testing) and development of relapse prevention and recovery promotion plans.

### ***What supports exist when treatment ends?***

Most treatment programs offer formal aftercare groups and participation in alumni associations and also encourage continued support through local recovery mutual aid societies. There are also halfway houses, recovery homes and sober houses that help clients sustain their sobriety during the early months and years of recovery. Participation in continuing care following primary treatment is associated with improved outcomes at follow-up (Ornstein & Cherepon, 1985; Walker, et al., 1983; Cross, et al., 1990; Hawkins & Catalano, 1985; Ito & Donovan, 1986; Johnson & Herringer, 1993), but participation in aftercare groups is very low — about 20 percent of those discharged from treatment. New approaches to assertive continuing care are being pioneered that place a greater emphasis on post-treatment monitoring and recovery support services. (See later discussion.)

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*New approaches to continuing care are being pioneered that place a greater emphasis on post-treatment monitoring and recovery support.*

### ***What drugs are used in the treatment of addiction?***

There are a growing number of pharmacological adjuncts in the treatment of addiction. These include aids in detoxification (benzodiazepines), stabilization agents (methadone, LAAM, buprenorphine), aversive agents (Antabuse-disulfiram), neutralizing agents (naltrexone in the treatment of opiate addiction), anti-craving agents (naltrexone [ReVia] and acamprosate) and a variety of agents used to treat co-occurring psychiatric disorders.

### ***How effective is addiction treatment?***

Studies evaluating the effectiveness of addiction treatment have consistently found the following treatment outcomes:

- Cessation or reduction in alcohol and other drug use.
- Reduction in alcohol- and other-drug-related medical problems.
- Cessation or reduction in alcohol- and drug-related criminal activity.
- Improvements in educational and vocational functioning.
- Improvements in parental and family functioning.

This summary, however, obscures the fact that responses to treatment are highly variable. As noted in our earlier discussion of adolescent treatment outcomes, there are several distinct effects of treatment. Treatment follow-up studies find multiple outcome groupings, including those who:

- Remain continually abstinent following treatment (sustained abstinence effect).
- Remain continually abstinent and function at levels superior to those preceding onset of substance use disorder (amplified effect).
- Immediately return to pre-treatment levels of substance use (no effect).
- Decrease their use to subclinical levels (moderated effect) or experience less severe problems than before treatment (partial effect).
- Abstain initially but return to pre-treatment levels of substance use (transient effect).
- Relapse following treatment but migrate to a pattern of stable recovery (delayed effect).
- Recycle between periods of recovery and periods of relapse (ambivalent effect).
- Accelerate substance use following treatment (iatrogenic effect).

The National Institute on Drug Abuse recently released the following thirteen research-based principles of effective addiction treatment:

1. No single treatment is appropriate for all individuals.
2. Treatment needs to be readily available.

3. Effective treatment attends to multiple needs of the individual, not just his or her drug use.
4. An individual's treatment and service plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs. It is critical that the treatment approach be appropriate to the individual's age, gender, ethnicity, and culture.
5. Remaining in treatment for an adequate period of time is critical for treatment effectiveness. Research indicates that for most patients, the threshold of significant improvement is reached at about 3 months in treatment.
6. Counseling (individual and/or group) and other behavioral therapies are critical components of effective treatment for addiction.
7. Medications (methadone, naltrexone) are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.
8. Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.
9. Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.
10. Treatment does not need to be voluntary to be effective. Strong motivation can facilitate the treatment process. Sanctions or enticements in the family, employment setting, or criminal justice system can increase significantly both treatment entry and retention rates and the success of drug treatment interventions.
11. Possible drug use during treatment must be monitored continuously. Lapses to drug use can occur during treatment.
12. Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases, and counseling to help patients modify or change behaviors that place themselves or others at risk of infection.

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*Remaining in treatment  
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treatment effectiveness.*

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13. Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment. As with other chronic illnesses, relapses to drug use can occur during or after successful treatment episodes. Addicted individuals may require prolonged treatment and multiple episodes of treatment to achieve long-term abstinence and fully restored functioning. Participation in self-help support programs during and following treatment often is helpful in maintaining abstinence.

***How can the quality of a treatment program be evaluated?***

There are several benchmarks that indicate quality in the provision of addiction treatment services. Some of the most significant of these include:

- State licensure.
- Joint Commission on Accreditation of Health Organizations (JCAHO) accreditation.
- Medical/psychiatric services or linkage.
- Multidisciplinary staff; direct service staff certified as addiction counselors; supervising staff trained at M.A. to Ph.D. level.
- Prior experience with drug choice, age, ethnicity, clinical profile of client being referred.
- Use of global assessment instruments and processes.
- Diversity of treatment modalities (full continuum of care).
- Intensity of family involvement.
- Intensity of linkage to mutual aid groups and other recovery support services.
- Intensity and duration of aftercare program; presence and strength of alumni association.
- Specialized services for clients with special needs, e.g., adolescents, women, clients of color, dually diagnosed, relapsed clients.

*What can the criminal justice system do to improve treatment outcomes?*

The criminal justice system can exert its influence in a number of ways to improve treatment outcomes for the DUI offender. The most significant of these include:

- Using external coercion to engage the DUI offender in an assessment and treatment process.
- Monitoring treatment engagement to insure an adequate dose of treatment and to enhance the probability of successful completion of a primary course of treatment.
- Encouraging and facilitating family involvement in the treatment process.
- Monitoring and encouraging participation in a structured program of aftercare following services.
- Encouraging the development of a sobriety-based social support system.
- Monitoring post-treatment functioning and providing feedback, linkage to recovery supports and, when needed, early re-intervention.

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*The criminal justice system can exert its influence in a number of ways to improve treatment outcomes for the DUI offender.*

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Several reviews (e.g., Westermeyer, 1989) of factors affecting treatment outcome make special note of the potential role of monitoring in long-term outcomes. Such sustained monitoring takes on added significance in light of “treatment careers” research (Hser, et al., 1997), new recovery management models (White, Boyle, & Loveland, 2002), and recent studies on the potential value of post-treatment monitoring and recovery support services. These innovative studies underscore several key points:

- A single, acute intervention rarely has sufficient effect to initiate stable and enduring recovery in those with severe and persistent alcohol and other drug problems.
- Multiple episodes of treatment may be viewed not as failures but as incremental steps in the developmental process of recovery.
- Treatment effects not visible following a single episode become discernable when viewed over the longer history of treatment and recovery.



- Treatment episodes may have effects that are incremental and cumulative.
- The treatment of individuals with severe substance use disorders needs to shift from serial episodes of brief intervention to a model of sustained recovery management, e.g., active engagement, motivational enhancement, support for treatment retention, post-treatment monitoring and recovery support services, stage appropriate recovery education, active linkage to local communities of recovery, recovery checkups, and, when needed, early re-intervention and re-engagement in treatment.

***What role do mutual aid societies play in the recovery process?***

Alcoholics Anonymous is the most widely used community resource in the United States for the resolution of alcohol-related problems (Room, 1989; Room & Greenfield, 1993; Weisner, Greenfield, & Room, 1995). In a 1990 household survey, 3.1 percent of those interviewed reported having attended AA sometime in their life for an alcohol problem and, of those, 1.5 percent reported having attended AA in the past year — a figure that far exceeds AA’s report of its current membership (Room & Greenfield, 1993). Mutual aid involvement can play a significant role in the movement from addiction to recovery for both adults (Timko, et al., 1994; Fiorentine, 1999; Fiorentine & Hillhouse, 2000; Timko, et al., 1999; McCrady & Miller, 1993; Emrick, et al., 1993; Tucker, et al., 1994; Morgenstern, et al., 1997) and adolescents (Johnsen & Herringer, 1993; Margolis, Kilpatrick, & Mooney, 2000).

The positive effect of mutual aid comes not from exposure alone (e.g., mandated AA attendance), but by what might be called an intensity effect. Recovery outcomes improve with the number of meetings attended in the first three years of recovery (Hoffmann, Harrison, & Belille, 1983; Humphreys, Moos, & Cohen, 1997; Chappel, 1993; Snow, 1992). This dose effect is significant in light of the fact that dropout rates in AA are reported to be in the range of 35-68 percent (Emrick, 1989). Other measures of intensity of involvement include active application of program concepts (e.g., “working the steps”), meeting participation (attendance, speaking, interacting, leading, having a home group), participation in pre- and post-meeting rituals, use of mutual aid network for fellowship and leisure, reading program literature, being sponsored, sponsoring others and involvement in other service work (Sheeren, 1988; Cross, et al., 1990; Johnson & Herringer, 1993; Emrick, et al., 1993; Caldwell & Cutter, 1998; Montgomery, Miller, & Tonigan, 1995; Humphreys, Moos, & Cohen, 1997). This intensity effect of mutual aid involvement has been found to apply to adolescents as well as adults (Margolis, Kilpatrick, & Mooney, 2000).

*Aren't AA and other Twelve Step groups less effective for special populations, e.g., women, ethnic minorities?*

While the original membership of AA during its formative years (1935-1939) was almost exclusively white, middle-aged men, criticisms that AA/NA and other 12-step groups are not appropriate for women, ethnic minorities, and other special populations have not held up under scientific investigation (Gilbert, 1991). Women and cultural minorities affiliate with AA/NA at the same rates as white men (Humphreys, et al., 1994) and at least one report suggests women may have an easier time affiliating with 12-step groups than men (Denzin, 1987). Recent surveys of 12-step group participation reveal no racial differences in levels of affiliation or participation (Kessler, et al., 1997; Winzelberg & Humphreys, 1999). Population surveys have revealed that AA is widely known in minority communities and recommended as a resource for alcohol problems (Caetano, 1993). AA membership surveys reveal that four percent of AA members are Hispanic and five percent of AA members are African American (Alcoholics Anonymous, 1997).

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*Specialized recovery mutual aid resources may enhance recovery for those who bring special obstacles or vulnerabilities to their attempts to initiate recovery.*

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Specialized recovery mutual aid resources may enhance recovery for those who bring special obstacles or vulnerabilities to their attempts to initiate recovery (Laudet, et al., 2000). Double Trouble in Recovery (DTR) groups or professionally directed support groups may enhance recovery for the dually diagnosed who may not be comfortable or welcomed in regular AA/NA meetings (Noordsy, et al., 1996). There is, however, recent survey evidence to suggest that individuals with comorbid psychiatric illness do affiliate with AA and that participation in AA is positively associated with stable recovery (Quimette, et al., 2001).

The assumption that the those with no or low religious orientation would not do well in 12-step programs — a practice that has led to decreased referrals of atheists and agnostics to AA (Winzelberg & Humphreys, 1999) — has been challenged by research revealing that those with low religious orientation affiliate with AA at rates similar to those with high religious orientation (Winzelberg & Humphreys, 1999) and, in some studies, do not seek out non-spiritually-based alternatives to AA/NA/CA even when available (Weiss, et al., 2000). In contrast to these findings, Tonigan, Miller, and Schermer (2002) found that atheists and agnostics were less likely to attend AA and more likely to disaffiliate from AA following initial exposure.

Kelly, Myers, and Brown (2002) conducted a study of 12-Step group affiliation among adolescents. They found that 71.6 percent of youth completing a Minnesota Model treatment program attended at least one 12-Step meeting in the first three months following treatment. It was concluded that affiliation and the positive effects from such affiliation were linked to youth with more severe AOD problems.

***What about people who don't feel comfortable in AA or other 12-Step groups?***

There is a growing variety of adjuncts and alternatives to 12-Step recovery groups in the United States. These include religious frameworks (Alcoholics Victorious, Mountain Movers, Alcoholics for Christ, various recovery ministries), secular frameworks (Secular Organization for Sobriety, LifeRing Secular Recovery), gender-specific support (Women for Sobriety), culturally nuanced frameworks (the Red Road, Free N' One) and moderated recovery frameworks (Moderation Management) of problem resolution. The appendix includes a guide to these mutual aid resources that is regularly updated and posted at [www.bhrm.org](http://www.bhrm.org).

***Are there support services or special support meetings for particular occupational groups?***

Yes. Most of these are for professions in which individuals would face special stigma if it were known that they had an alcohol or other drug problem. These groups include the Impaired Nurse Network (National Nurses Society on Addiction), Peer Assistance Network for Nurses (Illinois Nurses Association), Dentists Concerned for Dentists, Lawyers Assistance Program, Lawyers Concerned for Lawyers, International Lawyers in Alcoholics Anonymous, International Pharmacists Anonymous, Illinois State Medical Society Impaired Physician Program, and International Doctors in Alcoholics Anonymous. (See Appendix.)

***What is known about the process of addiction recovery?***

Recovery can reflect a process of sudden transformation or a process of incremental change. Most people resolve severe and persistent AOD problems through multiple efforts — self-resolutions, mutual aid support, and professionally directed treatment — spanning an extended period of time before final resolution is achieved (Vaillant & Milofsky, 1982). But there are individuals (as many as one-third in surveys of recovered people) whose abstinence decision occurred “immediately” rather than incrementally (Sobell, et al., 1993; Burman, 1997). Miller and C’de Baca (2001) found that this type of “quantum change” or “transformative change” is usually marked by high vividness (intensity), suddenness (unintentional), positiveness, and permanence of effect. Some of these “spontaneous” recoveries reflected quite extraordinary conversion-like exper-

iences, while others represented a seemingly insignificant experience that was the proverbial “straw that broke the camel’s back.” It is clear that the priming dose of negative consequences and hope-infusing experiences necessary to ignite recovery can come climactically or incrementally.

Addiction recovery often involves stages of change, processes (strategies/mechanisms) of change, and levels (arenas, e.g., cognitive, relational) of change (DiClemente, et al., 1992). Klingemann’s (1991) three-stage recovery model (motivation, action, maintenance) and Prochaska and colleagues’ (1994) six-stage recovery model (precontemplation, contemplation, planning, action, maintenance, and termination) underscore the fact that the process of recovery begins *before* AOD use is moderated or terminated. They further contend that while a single, linear movement through these stages is possible, the more common pattern is a spiral pattern of repeated movements through these stages before permanent recovery is achieved.

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*The stability and durability of addiction recovery increases with the length of continuous sobriety.*

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***When is a pattern of sobriety permanently sustainable?***

Short periods of sobriety are not predictive of sustained sobriety. The stability and durability of addiction recovery increases with length of continuous sobriety (Vaillant, 1983). A growing number of studies are suggesting that the point at which most recoveries become fully stabilized is between four and five years (Vaillant, 1996; Nathan & Skinstad, 1987; De Soto, et al., 1989; Dawson, 1996; and Jin, et al., 1998). While relapses can and sometimes do occur in those with five or more years of sobriety, the rate of relapse is low — below 15 percent — after the achievement of five years of stable recovery.

Recovery durability differs by drug choice. Studies of heroin addicts have confirmed the instability of periods of abstinence. Studies of recovered heroin addicts found that while five years of abstinence significantly reduced the risk of future relapse, the subsequent relapse rate was higher with heroin addiction than the rates reported for alcoholism (Duvall, et al., 1963; Maddux & Desmond, 1981; Hser, et al., 2001). Those at greatest risk of relapse following the achievement of five or more years of sobriety are those with the greatest characterological problems and adverse drinking-related social consequences (Jin, et al., 1998). Once attained, recovery is more durable for those with late onset alcohol problems compared to those with early onset alcohol problems (Schutte, et al., 1994).

The best indicators of recovery stability are time, reconstruction of personal identity (presence of a 3-part story style, e.g., my life before, what happened to change it, my life now), and reconstruction of one's social network.

***Won't some DUI offenders resolve their drinking problems and related legal problems without having to permanently abstain from drinking?***

The ability to resolve alcohol problems through moderation rather than abstinence strategies is highly influenced by problem severity. As problem severity increases, the likelihood of a successful, sustained moderated resolution declines. A recent review (Larimer, et al., 1998) of the research on moderated outcomes for alcohol problems drew the following four conclusions:

1. Even in traditional abstinence-oriented treatment programs, some alcohol-dependent clients choose and achieve moderation goals.
2. Even when they are trained in controlled drinking, many alcohol-dependent individuals choose abstinence. Over time, rates of abstinence (as compared to controlled drinking) tend to increase.
3. Offering a choice of goals tends to result in greater treatment retention and recruitment of a broader range of problem drinkers, without increasing the risk of relapse to uncontrolled-drinking states.
4. Client characteristics, goal choice, and severity of dependence may all be related to treatment outcome (abstinence, moderation, or relapse); when given a choice, individuals tend to choose the goal that is most appropriate for them.

The fact that those who resolve alcohol problems through moderation differ from those who resolve such problems through abstinence is a crucial point further confirmed by studies of Moderation Management (MM). Klaw and Humphreys (2000) found that one-third of MM membership would not meet diagnostic criteria for an alcohol use disorder, and that of those who did, nearly all met the criteria for alcohol abuse rather than alcohol dependence. Given the earlier data presented on the level of problem severity among most DUI offenders, abstinence goals would seem most indicated for those offenders whose history indicates a significant problem with alcohol or other drugs. Individuals seeking reinstatement of driving privileges through the Secretary of State bear the burden of proof that their resolution goal (abstinence or moderation) is congruent with the intensity and duration of their drinking history/problems and that this resolution (abstinence or moderation) marks a sustainable pattern of stability rather than a brief, externally posed hiatus in their drinking career.

## **Chapter Seven**

### **Managing the DUI Offender: Intervention Principles and Practices**

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The purpose of this last chapter is to summarize the intervention principles that the author has presented this past decade within Illinois' training programs for DUI prosecutors, judges, probation officers, evaluators and Secretary of State hearing officers. The chapter will:

- Review a large menu of strategies being used to prevent impaired driving and lower DUI recidivism and alcohol-related crashes.
- Summarize the research on the effectiveness of such strategies.
- Detail principles that can guide sentencing and monitoring, with a particular emphasis on the high-risk offender.

Unless otherwise indicated by citation, the principles are drawn from the author's own experience and the NHTSA's 2000 report, *Research on Repeat DWI Offenders* (2000b).

DUI-related public policy initiatives; public education campaigns; law enforcement, judicial, and correctional interventions; and offender-focused educational and rehabilitation approaches have multiple goals. The sentencing of DUI offenders, for example, serves multiple and different functions with different offenders: punishment, incapacitation, specific deterrence (reduction of DUI recidivism), and general deterrence (prevention of DUI offenses by the general public), and rehabilitation (NHTSA, 1996). Below is a brief summary of some of the strategies that have been used to address the threat to personal and public safety posed by alcohol- and drug-impaired driving and what research reveals about the relative effectiveness of these strategies.

#### **I. Social Policy and Environmental Interventions**

*A. Alcohol Taxation.* There is evidence that increases in alcohol taxes decrease traffic deaths by lowering gross alcohol consumption (Cook, 1981; Saffer & Grossman, 1987; Chaloupka, et al., 1993).

*B. Density of Alcohol Sales.* There is some evidence that the greater the number of per capita alcohol outlets within a community or neighborhood, the greater the

rate of alcohol-impaired driving. One study calculated that a city of 50,000 residents in Los Angeles County with 100 alcohol outlets would experience an additional 2.7 crashes for each new alcohol outlet opened (Scribner, et al., 1994).

*C. Minimum Drinking Age Laws.* By 1988, all states, under considerable federal encouragement, had laws declaring the legal drinking age to be 21. This reversed a trend toward the lowering of legal drinking age in the 1970s. Studies of the effect of these laws have consistently shown that raising the drinking age was accompanied by significant reductions in underage alcohol use (more than 50 percent), underage purchasing of alcohol (as much as 70 percent), and progressive reductions in impaired driving by those under age 21 (Yu & Schaket, 1998). Minimum drinking age laws that moved the legal drinking age to 21 have prevented more than 16,500 traffic deaths since 1976 (NHTSA, 1996).

*D. Criminal Per Se Laws.* Criminal per se laws state that it is a criminal offense to drive with a BAC above the state's legal limit. Per se laws decrease the rate of alcohol-related traffic deaths, especially when combined with administrative license revocation laws (Hingson, 1996; Rogers, 1994).

*E. Zero Tolerance Laws.* Laws making it illegal for individuals under age 21 to drive with any level of alcohol in their system have been passed in 49 states. A study of the effects of the first 12 states implementing zero tolerance laws found that the fatality rate for drivers between the ages of 15 and 20 dropped in comparison to neighboring states that had not implemented such laws (Hingson, et al., 1994). Overall, zero tolerance laws have produced a 20 percent reduction in the fatalities of young drivers (NIAAA, 2002).

*F. Graduated Licensing.* Phased assumption of full driving privileges has been used as a strategy to lower alcohol- and non-alcohol-related crashes among young people. Few systematic evaluations of graduated licensing have been conducted, but preliminary studies reveal a 5 percent to 10 percent reduction in crashes involving young drivers following state adoption of graduated licensing (Jones and Lacey, 1991; McNight, et al., 1990; Frith, et al., 1989).

*G. .08 BAC Laws.* Recent laws lowering the legal level of intoxication from 0.10 percent to 0.08 percent have been found to lower alcohol-related crash deaths by six percent in the years following the change in law (Hingson, 1996, Johnson & Fell, 1995; Hingson, Hereen, & Winter, 2000).

*H. Penalties for Higher BACs.* Some states are passing legislation that enhances the penalties for DUI offenders who are found to be driving with high BAC levels. Little research exists yet on the effects of such legislation.

*I. Public Education Campaigns.* Major public education campaigns were launched in the 1970s and 1980s to alter American views about drinking and driving. The success of these campaigns is indicated in the data summarized in chapter one noting the reduction in the percentage of drivers stopped at sobriety checkpoints who have been drinking, the increased use of designated drivers, and the dramatic decline in alcohol-related crashes and fatalities. Programs that involve multiple strategies focused on an entire community are a promising means for reducing alcohol-related problems. For example, fatal crashes involving alcohol dropped by 42 percent and fatal crashes in which the driver was legally intoxicated declined by 47 percent in the six Massachusetts cities participating in the Saving Lives Program, compared to the rest of the state (Hingson, et al., 1996).

*J. Sobriety Checkpoints.* Sobriety checkpoints have been found to reduce alcohol-related traffic crashes (Stuster & Blowers, 1995; Lacey, et al., 1997), but their effectiveness seems to hinge on the amount of publicity surrounding the checkpoint program (Lacey, et al., 1997). A sobriety checkpoint program in Tennessee decreased alcohol-related fatal crashes by 20 percent.

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*The effectiveness of sobriety checkpoints seems to hinge on the amount of publicity surrounding the checkpoint system.*

*K. "Dram Shop" Laws.* Laws making it illegal to serve alcohol to patrons of bars and restaurants who are intoxicated can reduce alcohol-related crashes (Wagenaar & Holder, 1991). More than 40 states currently have such laws. These laws have spurred another strategy, server training, which is aimed at preventing intoxicated patrons from being provided additional amounts of alcohol and dissuading intoxicated patrons from driving.

*L. Server Intervention Training.* Field evaluations of server training have found that trained servers can generate the following results when compared to untrained servers: 1) greater number of interventions to reduce impaired driving, 2) a reduction in the number of intoxicated patrons, and 3) a reduction in overall alcohol consumption at the server site (Geller & Lehman, 1988; Saltz, 1986). Nighttime, single-vehicle crashes decreased 11 percent in the year following Oregon legislation that mandated server training (Holder & Wagenaar, 1994).

*M. BAC Feedback.* Providing drinkers with education and feedback about their BAC levels while they are drinking via trained interventionists and portable breathalyzers has been found to exert no influence on drinking decisions —



moderation in use — or decisions to drink and drive even when BAC levels exceeded legal limits and alternative transportation is available (Leland, 1989).

*N. Controlling the Location and Quantity of Alcohol Consumption.* Some states and municipalities have experimented with bans on selling cold beer at gasoline stations and bans on happy hour sales of alcohol (Hingson, 1995).

## **II. Interventions Aimed at Driving Privileges**

*A. License Suspension.* States suspend the driving privileges of DUI offenders in two ways: administratively — confiscation by the arresting officer on behalf of the state license authority — or civilly — via judicial order following conviction (NHTSA, 1996). Administrative license suspension — confiscation of the driver's license of individuals arrested for impaired driving through an administrative rather than criminal process — has been found to lower DUI recidivism and alcohol-related crash fatalities (NIAAA, 2002). Administrative license suspension combined with treatment has been found to reduce recidivism by as much as 50 percent (NHTSA, 2000). The NHTSA (1996b) reports that the optimum period for suspension of driving privileges is 12 to 18 months. License suspension is *the* most effective means of reducing DUI recidivism (DeJong, et al., 1998; Voas, 2000). License suspension is more effective than license restriction or treatment, but suspension plus treatment is more effective than suspension alone.

The argument that license suspension/revocation is ineffective because “everyone drives on a suspended license” doesn't hold up under close analysis. While a majority of offenders with suspended/revoked licenses do drive sometime during their suspension, there is evidence to suggest that they do so with a heightened degree of caution to avoid detection — an action that also decreases the threat to public safety (Ross & Gonzales, 1988; Jacobs, 1989; Ross, 1992; Williams, et al., 1984).

*B. Partial Driver's License Suspension.* The use of daytime-only driving permits for convicted DUI offenders, combined with addiction treatment, have been found to be more effective in preventing future alcohol-related crashes than full driver's license suspensions (Wells-Parker, et al., 1995).

## **III. Vehicular Interventions**

*A. Automobile Immobilization, Impoundment or Seizure.* Voas and colleagues (1996) found that impoundment and immobilization reduced DUI recidivism in Ohio both during and following the period of impoundment. When combined with license suspension, vehicle impoundment can reduce DUI recidivism by as much as 50 percent (Voas, 2000). Impoundment may have particularly enhanced effects on lowered recidivism of the multiple DUI offender (Voas & DeYoung, 2002).

*B. License Plate Stickers.* The author found no studies on the practice of issuing DUI offenders special license plates, but studies of Washington's and Oregon's "Zebra Tag" laws showed a deterrent effect in Oregon but not in Washington (Voas, & DeYoung, 2002).

*C. Registration and License Plate Seizure.* Plate confiscation and destruction at the time of arrest has been found to reduce recidivism by multiple DUI offenders (Rodgers, 1994), but recent studies note that there are numerous problems related to its implementation and use, e.g., legal questions regarding DUI offenders arrested driving vehicles that belong to someone else — 32 percent of DUI offenders in a study in Minnesota (Ross, Simon, & Clearly, 2003).

*D. Breath Ignition Interlock Devices.* Ignition interlock is an effective deterrent to drinking and driving while the interlock device remains on the vehicle of the DUI offender (Beck, et al., 1997; Cohen and Larkin, 1998) and has enhanced effectiveness when combined with other interventions such as treatment (Marques & Voas, 1995; Timken, 1999). Implementation of interlock programs has been plagued by low use as a sentencing option, failure of those sentenced to get interlock devices installed, the use of multiple, undeclared vehicles by the repeat offender, and reduced deterrent effects once the device is removed (DeYoung, 2002).

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*Many states have enhanced penalties for impaired driving with a recent focus on penalty enhancement for multiple offenders.*

#### **IV. Interventions (Containment and Rehabilitation) of the DUI Offender**

*A. Enhanced Penalties.* Many states have enhanced penalties for impaired driving with a recent focus on penalty enhancement for multiple offenders.

*B. Lower BAC Laws for DUI Offenders.* An evaluation of Maine's law reducing legal level of intoxication to 0.05 percent for convicted DUI offenders resulted in reduced alcohol-related fatalities in this group (NIAAA, 2002).

*C. Dedicated Prosecutors, Judges and Probation Officers.* There is a clear trend in Illinois to supervise a larger number of DUI offenders within the framework of a specialized probation caseload — nearly 30 percent of DUI offenders in 1997 were monitored by a probation officer with a specialized DUI caseload (Olson, 1999b). Overall, DUI offenders are good candidates for probation. They have the lowest rate of probation revocation and re-arrest of any category of criminal

offense. An Illinois study to identify risk factors to predict recidivism and re-arrest found only one factor — prior criminal offense — predictive of probation failure for DUI (Olson, 1999a).

*D. Intensified Probation.* Programs in which DUI offenders are rigorously evaluated, linked to treatment and provided sustained, high intensity monitoring by addiction-trained probation officers have been found to reduce recidivism by nearly 50 percent (Jones, et al., 1996). Where the frequency and intensity of contact is low, there is no effect on recidivism (Voas & Truppets, 1990). In some studies, rigorous monitoring has had an effect almost equal to that of treatment in reducing recidivism (Voas & Tippetts, 1990). While short-term follow-ups of probation supervision for DUI offenders sometimes reveals no effect, the longer-term — 6-9 years — evaluations do show an effect on lowering recidivism (Landrum, et al., 1982).

*E. Fines.* In spite of the widespread use of fines to punish DUI offenders, little research exists to measure the effect of the amount of the fine on DUI recidivism (Voas & Fisher, 2001). In one study, Yu (1994) concluded that the poor enforcement of fine collection has eroded the potential effect of fines as a sanction in DUI cases.

*F. Electronically Monitored House Arrest.* Containment of DUI offenders in their own homes except to go to work and participate in treatment and mutual aid groups has been found to reduce DUI recidivism (Baumer & Mendelsohn, 1992). Some jurisdictions are experimenting with house arrest and electronic monitoring with a remote Breathalyzer to enforce no drinking probation orders.

*G. Jail.* Jail has been shown to have little impact on reducing DUI recidivism (Voas, 2000; Voas & Fisher, 2002) but may serve two other functions: 1) protecting the community from high-risk offender behavior for a prescribed period of time, and 2) creating a broader deterrent effect among drinking drivers not yet arrested for DUI. When jail and comparable periods of residential treatment are compared, the jail-only group has twice the recidivism rate of the treatment group (McCarty & Argeriou, 1988).

*H. Victim Impact Panels.* Studies of the effect of victim impact panels (VIPs) on DUI offender recidivism have produced mixed results (NIAAA, 2002), with some studies showing cost-effective changes in attitudes and intentions and lowered rates of recidivism (Badovinac, 1994; Fors & Rojek, 1999) and other studies showing minimal or no effect (Shinar & Compton, 1995). Where effects on recidivism have been shown, they are for persons with lower problem severity without prior DUIs (Timken, 1999). One recent study suggests that VIPs may have a negative effect in terms of recidivism risk in female repeat offenders (C'de Baca, et al., 2001).

*I. Intensified Assessment/Intervention.* The Weekend Intervention Program (WIP) in Ohio uses an intensive assessment process and an individualized remediation/treatment plan developed over the course of a weekend. For offenders with serious substance-related problems, the weekend is followed by linkage to more extensive treatment. WIP participants have been found to have lower recidivism rates than matched control groups (Siegel, 1985).

*J. Remedial Education.* The NHTSA, in its review of the effectiveness of remedial education in lowering DUI recidivism, concluded that remedial education can reduce recidivism — by about 10 percent — among those social drinkers least likely to re-offend but that remedial education has no significant impact on the majority of DUI offenders who have alcohol or other drug problems (NHTSA, 1996b). In the most vigorous evaluation of early remedial education programs, it was discovered that there were no significant reductions in re-arrest rates compared to offenders who did not have remedial education (Nichols & Ellingstad, 1978). Educational interventions are much more appropriate for low-problem offenders than high-problem offenders (Foon, 1988).

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*Educational interventions  
are much more appropriate for  
low-problem offenders than  
high-problem offenders.*

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*K. Treatment.* Wells-Parker and colleagues (1985) conducted a meta-analysis of 225 DUI treatment outcome studies and concluded that treatment could reduce the recidivism rate of DUI offenders by about seven to nine percent. While there is growing interest in dedicated detention or rehabilitative confinement (treatment while incarcerated) of the multiple DUI offender, few studies exist to measure the effectiveness of such a combination. Treatment has a greater effect on first offenders with alcohol problems than on multiple offenders. What effect treatment does exert on multiple offenders is also less sustained than the effects on first offenders (Voas & Tippetts, 1990), leading reviewers such as Taxman & Piquero (1998) to conclude that remedial education and treatment have little effect on reducing DUI recidivism and future alcohol-related crash involvement.

*L. Mandated Exposure to a Recovery Mutual Aid Group.* There have been several studies of the effects of mandated AA attendance for DUI offenders. A 1991 New Jersey study found that mandated AA was a cost-effective means of lowering DUI recidivism and that its effect on recidivism was equal to that of treatment (Green, et al., 1991). Mandated AA exposure should be selective rather than

indiscriminate to both enhance the probability of rehabilitative effect and to prevent potential disruption of local AA meetings (NHTSA, 1996).

*M. Alcohol and other Drug Testing.* Drug testing is viewed as an effective monitoring tool but studies are lacking regarding its precise effect on recidivism and crashes.

*N. Public Shaming.* Several efforts have been undertaken to try to shame individuals out of certain behaviors by publicly exposing their breach in social etiquette. While printing the names or photographs of those arrested for certain crimes — e.g., shoplifting, prostitution — has been linked to decreased offenses, no such decrease has been reported when the names or photographs of those arrested for DUI are printed in local newspapers (Ross & White, 1987).

*O. “Scared Straight.”* There are no evaluations of programs that try to scare offenders out of drinking and driving via such sanctions as mandated time in an emergency trauma center.

*P. Community Service.* Studies of the effectiveness of community service programs have not found any direct effects on reductions in DUI recidivism (Popkin & Wells-Parker, 1994).

*Q. Victim Restitution.* There are no controlled studies of the effects of having DUI offenders pay financial restitution to the victims of their offense (Popkin & Wells-Parker, 1994).

### **The High Risk Offender: Intervention Principles**

The *1996 Guide to Sentencing DUI Offenders* prepared by the NHTSA listed five keys to lowering DUI recidivism:

1. Evaluating offenders for alcohol-related problems and recidivism risk.
2. Selecting appropriate sanctions and remedies for each offender.
3. Including provisions for appropriate alcoholism treatment in the sentencing order for offenders who require treatment.
4. Monitoring the offender’s compliance with treatment.
5. Acting swiftly to correct noncompliance.

These keys are crucial for all DUI offenders but there are additional principles that may be helpful to those working with high-risk DUI offenders — defined as

those most likely to be re-arrested or involved in future alcohol-related crashes involving injuries or fatalities. The author would like to leave the reader with some final thoughts on such principles.

### **Visibility Principle (Re-engineering Community Norms)**

The effectiveness of DUI-related social policy changes is often linked to the intense publicity surrounding the change and the subsequent intensification of public disapproval of drinking and driving. Intensified or new approaches (e.g., sobriety checkpoints) to enforcement seem to be effective (impacting DUI incidence and alcohol-related crash and fatality rates) only to the degree extensive publicity changes the perception of likelihood of arrest for drinking and driving and further shifts community norms against drinking and driving. With this in mind, prosecutors, judges and other court personnel, treatment personnel and Secretary of State personnel should take every opportunity to stigmatize drinking and driving at the level of the media.

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*The intensity and duration of sanctions and rehabilitation activities need to reflect the severity and duration of the substance-related problem.*

### **Dose Principle**

The intensity and duration of sanctions and rehabilitation activities need to reflect the severity and/or duration of the substance-related problem (NHTSA, 1996). Treatment effectiveness — like antibiotic treatment — is dependent on achieving a baseline dose. For those presenting with high problem severity, the treatment and monitoring process should reflect high structure, high intensity (frequency of contact), and long duration of active treatment and post-treatment monitoring.

### **Intensity Principle**

Remedial education programs are most effective at reducing recidivism with educated, social drinkers. Lecture-type educational programs are not effective with problem drinkers. Behavioral change often occurs in context of a crisis of emotional intensity in which there is a fundamental redefinition of the person-drug relationship. These crises usually involve aspects of both pain and hope. Our job with the DUI offender with serious substance use problems is to help provoke just such a crisis and to create interventions that demand a high level of personal participation by the offender. At all costs, we must avoid palliatives that allow the serious offender to “do treatment” via superficial compliance.

### **Combination Principle**

I am frequently asked variations on the following question: “Which is the most effective sentence for a DUI offender: licensure suspension, a fine, a jail sentence, probation, treatment, community service or a victim impact panel?” I usually respond, “Any combination of those.” The reason is that DUI offenders and DUI recidivists are not homogenous populations and that different approaches work better with different offenders. The problem is that we have yet to develop effective technology that scientifically matches each offender to the ideal sentence and rehabilitative strategy. As a result, combinations of interventions are always more effective in the long run than single interventions. Recommended approaches to multiple offenders involve a combination of license suspension/revocation, treatment, and criminal sanctions. Mandated and monitored treatment should be viewed as an adjunct to, not a replacement for, other court sanctions. Remember, combinations of interventions generate better outcomes than any single intervention.

### **Motivation Principle**

Popular wisdom says that people must want to change before change can occur. There is little research support for requiring expressed motivation as a precondition for entry into treatment. The presence or absence of such motivation is not a predictor of treatment outcome. Many studies have found that those who were “forced” into treatment had outcomes similar to those who supposedly “volunteered” for treatment. Motivation is important for recovery but it is something that can emerge out of the treatment process rather than be a requirement for treatment admission.

An environmental context for recovery can be set by refusing to tolerate or dismiss consequences of irresponsible behavior — a refusal to enable by protecting or rescuing — while keeping a doorway of hope open by making the length and severity of consequences contingent upon pro-recovery and pro-social behaviors. We can provide meaningful consequences while continuing to express an expectation for change, express confidence in the offender’s ability to change, monitor the presence or absence of significant change and, where necessary, re-intervene with rewards contingent upon recovery adherence.

### **Multiple Points of Accountability**

One of the most effective methods of managing higher risk DUI offenders in the community is through a system that requires multiple points of accountability with rewards and punishments contingent on clearly defined behavioral objectives, e.g., drug test results, aftercare meeting attendance, employment,

restitution payments, etc. Most high-risk offenders have little internal locus of control of their behavior, due to their impaired decision-making abilities, impulsivity and propensity for risk-taking and sensation-seeking. Multiple points of accountability provide strong and sustained “external locus of control.” This can be provided via “multiple call-backs or assignment to intensive probation” — a strategy not needed for all DUI offenders but one that is recommended for the highest risk offenders being supervised in the community.

### **Drinking Relapse versus Drinking and Driving Relapse**

Managing relapse is a difficult process for both court personnel and treatment personnel. Here are some brief thoughts on this subject. First, most people in successful recovery from alcohol and other drug problems experienced one or more episodes of relapse before achieving stable sobriety. Recovery is a long-term process that for many involves reduced number, frequency, intensity and duration of relapse episodes that precede continuous sobriety. At the

same time, the court cannot tolerate clients who continue to defy its orders and pose a threat to community safety. Given these dual realities, I suggest the following. Consider differential consequences between a drinking relapse and a drinking and driving relapse. The former can be responded to with minor consequences and admonitions to reactivate and strengthen recovery activities, where a clear “no tolerance” message should accompany the latter. The goal is to drive a wedge between the act of drinking and the act of drinking and driving. Where the latter may require the courts’ most immediate and severe sanctions, the former can be responded to via: 1) sentence with portion to be served or dropped contingent upon recovery activities and results of urine drops, 2) increased urine surveillance, 3) more intense monitoring and support, 4) progressive discipline (announcing next consequence ahead of time), 5) requiring a drug-free living environment, and 6) recommending a higher level of care in treatment.

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*Managing relapse is a difficult process for both court personnel and treatment personnel.*

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### **Containment Principle**

The final principle is based on the recognition that there are some DUI offenders for whom no rehabilitative strategies will reduce the frequency or intensity of their alcohol or drug use and their related threats to public safety. The goal for this group is to contain them for the maximum periods of time with no illusion of rehabilitative effect. The goal is to protect the community for the longest period of time with the hopes that such high-risk behavior will dissipate with age and accumulating consequences. When jail is used under these circumstances, it is



used with the understanding that the offender's threat to public safety will be just as great or greater on the day that he/she re-enters the community as when he/she left it. Some judges are finding creative ways to construct sentences so that there is actually external monitoring that begins at this point of community re-entry, e.g., combining jail and probation sentences for different offenses.

For high-risk offenders in the community, the goal is to combine interventions to reduce the frequency and quantity of alcohol and drug use (e.g., urine testing, remote Breathalyzers), contain where drinking occurs (house arrest), reduce the risk of drinking and driving (e.g., vehicle seizure, interlock devices), and reduce larger threats to community safety (e.g., intensive probation).

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## **Appendix**

### **The Kurtz Guide to Mutual Aid Resources**

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*Note: The following Guide was retrieved from the Behavioral Health Recovery Management Web site ([www.bhrm.org](http://www.bhrm.org)) on May 7, 2004, and is reprinted here in its entirety with permission from the authors. The information in the Guide is updated periodically.*

#### **Guide to the Development of Mutual Aid Groups**

##### **Acknowledgement**

This guide to utilizing mutual aid groups was developed by Linda and Ernie Kurtz for the Behavioral Health Recovery Management project. Linda Kurtz, D.P.A., is the author of *Self-help and Support Groups: A Handbook for Practitioners*; Ernest Kurtz, Ph.D., authored *Not God: A History of Alcoholics Anonymous* and is co-author of *The Spirituality of Imperfection*.

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*Problems at the time of the last update:* None

##### **Worth special notice:**

- On Dr. John Grohol's site [Grohol](http://Grohol) there is an excellent specialized search engine, Enpsychlopedia, that offers a Google-based search interface to Psych Central, as well as a dozen other mental health and psychology Web sites. It allows for easy, targeted queries on specific health topics, such as narrowing a search to only symptoms or treatments.
- Women for Sobriety announce their Annual Weekend Conference to be held at DeSales University, Center Valley, PA, the weekend of June 4-6, 2000. See [WFS Site](#).
- The Methadone Anonymous site, run by the Advocates for the Integration of Recovery and Methadone [A.F.I.R.M.](#) currently features a letter from founder Fredrick W. Christie. Meanwhile a new group, the National Alliance of Methadone Advocates has begun a website: [National Alliance of Methadone](#)

[Advocates](#) As its name indicates, "The primary objective of NAMA is to advocate for the patient in treatment by destigmatizing and empowering methadone patients." As these are relatively new groups to us, we ask for comments on anyone's experience with these groups. <mailto:kurtzern@umich.edu>

- The J.A.C.S. site currently offers "New Statistics about Addiction in the Jewish Community" [New Statistics about Addiction in the Jewish Community](#)

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- [Internet-Focused Mutual Aid Resources](#)
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- [Indicators of Mutual Help Involvement](#)
- [Aids to Working With Mutual-Aid Groups](#)
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## **Group-Based Mutual Aid Resources**

### **Al-Anon Family Groups**

International. 32,000 + groups. Fellowship of men, women and children whose lives have been affected by the compulsive drinking of a family member or friend. Contact: Al-Anon Family Groups, Inc., 1600 Corporate Landing Parkway, Virginia Beach, VA 23454-5617. Call (757)563-1600 or (888)-4ALANON (meeting information, M-F, 8 AM-6 PM ET) FAX: (757)563-1655. Web: Online <http://www.al-anon.alateen.org>. **Refer:** In general Al-Anon groups prefer that only family and friends of alcoholics attend their meetings. In Al-Anon, the focus is on the participant, not the alcoholic. All family members children, spouses, parents and friends or employers are welcome.

### **Alcoholics Anonymous**

International. 98,710 groups. Founded 1935. Fellowship of men and women who come together to share their experience strength and hope. General Service Office, P.O. Box 459, Grand Central Station, New York, NY 10163. Call (212)870-3400; FAX: (212)870-3003. Web: <http://www.aa.org>. **Refer:** Despite much research, there have never been reliable guidelines about which people do well in AA. Those with higher group affiliation needs have an easier time bonding; referring a less group-oriented person requires extra effort on the clinician's part. Always refer to a person rather than sending to a meeting,

especially those who have low needs for group membership.

### **Deaf and Hard of Hearing 12 Step Recovery Resources**

A web site rather than a group, this site provides information on AA groups and activities that offer American Sign Language services for the deaf and hard of hearing. It links to online meetings, offers information on how to construct a meeting for deaf and hard of hearing persons, provides an information packet, and suggests guidelines and literature on alcoholics with special needs . It may be found at <http://www.dhh12s.com/index.htm>.

### **Cocaine Anonymous**

International, with an estimated (1996) 30,000 members in over 2,000 groups. "Cocaine Anonymous is a fellowship of men and women who share their experience, strength and hope with each other so that they may solve their common problem and help others to recover from addiction. The only requirement for membership is a desire to stop using cocaine and all other mind-altering substances." The same guidelines apply to CA as to AA when making referrals Further information is available at <http://www.ca.org/>

### **Depression and Bi-Polar Support Alliance**

National. 275 chapters. Founded 1986. Mutual support and information for persons with depressive and manic-depressive illness and their families. Public education on the nature of depressive illnesses. Annual conferences, chapter development guidelines. Quarterly newsletter. Bookstore, catalog, mail orders. Contact: Depression and Bipolar Support Alliance, 730 N. Franklin, Suite 501, Chicago, IL 60610. Dues \$20 for client; \$100 for professional. 60610. Call (800)826-3632 or (312)642-0049; FAX: (312)642-7243. Web: <http://www.dbsalliance.org/>. The home page of this web site offers screening tools for Bipolar Disorder and Depression. **Refer:** The Alliance's membership includes patients with the diagnosis, family members, and professionals. Anyone with a diagnosis of Affective Disorder (Manic Depressive, Major Depression) is eligible as are families and concerned professionals. Although persons currently not stable on medications are allowed, referral should be limited to those who are relatively stable.

### **Double Trouble in Recovery**

Founded in 1993 and with groups in seven states, Double Trouble in Recovery (DTR), "a recovery group for the dually diagnosed," is a twelve-step fellowship of men and women who share their experience, strength and hope with each other so that they may solve their common problems and help others to recover from their particular addiction(s) and manage their mental disorder(s). **Contact:** <http://www.doubletroubleinrecovery.org/>. This site is rich in resources, including a "Pamphlet for Professionals" and some excellent material on sponsorship in recovery. This group may also be reached at Double Trouble in Recovery, Inc.,

261 Central Avenue, Albany, New York 12206, 1-866-836-7251. **Refer:** "... those recovering from mental disorders and addiction problems. . .[they] also address the problems and benefits associated with psychiatric medication."

### **Dual Recovery Anonymous**

International. 312 chapters listed on website. Founded in 1989 in Kansas City, Missouri. DRA is an independent, twelve step, self-help organization for people with a dual diagnosis. Contact Dual Recovery Anonymous World Service Central Office, P.O. Box 218232, Nashville, TN 37221-8232. Toll Free 1-877-883-2332. Web: <http://draonline.org> Local meetings are listed on the website by state. Refer: People who are chemically dependent and also affected by an emotional or psychiatric illness.

### **Emotions Anonymous**

International. 1200 chapters. Founded in 1971. 12-Step fellowship of people who come together for the purpose of working toward recovery from emotional difficulties. Contact: E.A., PO Box 4245, St. Paul, MN 55104. Phone: (651)647-9712. Web: <http://www.EmotionsAnonymous.org>. **Refer:** EA is most suitable for clients who are dually diagnosed and already attend AA or NA and clients who want to use the 12 steps for emotional concerns not limited by diagnosis. It is not the best group for people with serious and persistent mental illness, but EA groups are accepting of these clients if they are stable.

### **Families Anonymous**

International, over 500 groups, founded in 1971 and headquartered in Culver City, CA, "Families Anonymous (FA) is a Twelve-Step, self help, recovery program and fellowship of support groups for relatives and friends of those who have alcohol, drug or behavioral problems." **Contact:** Its literature is available from FA, Inc., P.O. Box 3475, Culver City, CA 90231-3475, and its World Service Office can be reached at 1-800-736-9805, between 10 AM and 4 PM PST, or by e-mail at [famanon@FamiliesAnonymous.org](mailto:famanon@FamiliesAnonymous.org). The Families Anonymous website, <http://www.familiesanonymous.org/>, offers information on meetings, literature, and an e-meeting. **Refer:** Parents concerned with drug and alcohol abuse to minor behavioral problems, runaways, hostility, delinquency, truancy, low self-esteem, and other related topics.

### **Gamblers Anonymous**

International. Approximately 1200 chapters. Founded 1957. Fellowship of men and women who share experience, strength and hope with each other to recover from compulsive gambling by following a 12-step program. Chapter development kit. Monthly bulletin for members. Contact: G.A., P.O. Box 17173, Los Angeles, CA 90017. Call (213)386-8789; FAX: (213)386-0030. Web: <http://www.gamblersanonymous.org>. **Refer:** The same guidelines apply to GA as to AA in making referrals.

**Gam-Anon Family Groups**

International. 500 groups. Founded 1960. 12-step fellowship for men and women who are husbands, wives, relatives or close friends of compulsive gamblers who have been affected by the gambling problem. Purpose is to learn acceptance and understanding of the gambling illness, and to use the program to rebuild lives, and give assistance to those who suffer. Contact: Gam-Anon, P.O. Box 157, Whitestone, NY 11357. Call (718)352-1671 (Tues. and Thurs., 9am-5pm); FAX: (718)746-2571. Web: <http://www.gam-anon.org/> **Refer:** Follow same guidelines as Al-Anon Family Groups.

**GROW, Inc.**

GROW, Inc. International. 143 groups in IL, NJ and RI. Founded in 1957. 12-step (not the same steps as AA) mutual help program to provide know-how for avoiding and recovering from depression, anxiety and other mental health problems. Caring and sharing community to attain emotional maturity, personal responsibility, and recovery from mental illness. GROW, International was organized in Australia; it has no official website for the international organization, however, there is a website for GROW in Australia at <http://www.growint.org.au/> Leadership training and consultation to develop new groups. Contact: GROW, Inc., 2403 W. Springfield Ave., Box 3667, Champaign, IL 61826. Call (217)352-6989; FAX: (217)352-8530. Refer: GROW was organized for seriously mentally ill people and if you are in an area where there are groups, this is probably the self-help group most adapted to serving the client with serious mental illness and most difficulty with community living. GROW uses some paid organizers who are committed to developing a supportive community for members.

**J.A.C.S.**

Jewish Alcoholics, Chemically Dependent Persons and Significant Others. International. c. 50 groups. Aims to help Jews understand alcoholism and especially how to integrate Alcoholics Anonymous with their Judaism. Contact J.A.C.S., 850 Seventh Avenue, New York, NY 10010. Phone: 212-397-4197; Fax: 212-489-6229; Web: <http://www.jacsweb.org>. **Refer:** Jewish clients with alcohol and/or drug problems, especially if they have difficulty with the spirituality of A.A. or N.A.

**LifeRing Secular Recovery**

International; c. 50 groups; split off from Secular Organizations for Sobriety (see below) in 1997; LifeRing offers meetings in many States as well as Canada and Europe. Web: <http://www.unhooked.com>, which contains explanations of LifeRing's basic philosophy, the three "S" of Sobriety, Secularity, Self-Help. "LifeRing Secular Recovery (LifeRing or LSR) is a non-religious self-help recovery network for individuals who seek group support to achieve abstinence from alcohol and other addictive drugs, or who are in relationships where chemical dependency is a problem." **Refer:** Those dissatisfied with more classic

modalities of recovery. LifeRing encourages crosstalk and direct feedback at meetings.

### **Moderation Management**

National. 50 groups. Founded 1993. Support for problem drinkers who want to reduce their drinking and make other positive lifestyle changes. For those who have experienced mild to moderate levels of alcohol-related problems. Literature, support group meetings, on-line support group and handbook available. Assistance in starting new groups. Contact: Moderation Management Network Inc., PO Box 3055, Point Pleasant NJ 08742, Phone: 732-295-0949, E-mail: moderation@moderation.org. Web: <http://moderation.org>. **Refer:** MM is for people who want to limit their alcohol intake without total abstinence. Refer anyone who chooses this goal. MM requires that participants begin with abstinence for 30 days and recommends AA or another abstinence program for those who cannot fulfill this requirement. It is not intended for use by alcoholics. MM has few groups nationwide and is more available on line.

### **N.A.M.I. (National Alliance for the Mentally Ill)**

National. Over 1200 affiliates. Founded 1979. Network of self-help groups for relatives and individuals affected by mental illness. Emotional and educational support. Bi-monthly newsletter, affiliate development guidelines. Anti-discrimination campaign. Contact: National Alliance for the Mentally Ill, Colonial Place Three, 2107 Wilson Blvd., Suite 300, Arlington, VA 22201-3042; Toll Free HelpLine-1-800-950-NAMI (6264); Front Desk-(703)524-7600; FAX-(703)524-9094; TDD 703/516-7227; Web: <http://www.nami.org> **Refer:** NAMI is composed of parents and other family members of persons with serious mental illness (Schizophrenia, Affective Disorders, Borderline Personality) and of persons with mental illness. Most members (80 %) are parents of adult children with mental illness. This organization is primarily oriented to support and advocacy and is most effective with parents of newly diagnosed individuals. They receive needed information, support, and advocacy in obtaining the best treatment available.

### **Narcotics Anonymous**

International. 21,000+ groups. Founded 1953. Fellowship of men and women who come together for the purpose of sharing their recovery from drug abuse. There are no dues, fees, or registration requirements. The only requirement for membership is the desire to stop using drugs. Uses 12-Step program adapted from AA. Information is available in several languages, on audio tapes and in Braille. Contact: N.A., P.O. Box 9999, Van Nuys, CA 91409. Call (818)773-9999; FAX: (818)700-0700 Web: <http://www.na.org>. **Refer:** Anyone who abuses alcohol or other drugs is welcome in NA. In general, the NA membership is younger and more diverse than is AA, but otherwise the same guidelines apply to NA as to AA in making referrals.



**Nicotine Anonymous**

"Nicotine Anonymous is a fellowship of men and women helping each other to live our lives free of nicotine. . . . The only requirement for membership is the desire to stop using nicotine." What information is available on this group may be obtained from <http://www.nicotine-anonymous.org/> or by contacting Nicotine Anonymous World Services, 419 Main Street, PMB#370, Huntington Beach, CA 92648. (415) 750-0328 or by e-mail at [info@nicotine-anonymous.org](mailto:info@nicotine-anonymous.org).

**Obsessive-Compulsive Foundation, Inc.**

International. 8 chapters. Founded 1986. Support and education for people with obsessive-compulsive disorder (OCD) and related disorders, their families, friends and professionals. Supports research into the causes and effective treatments of these disorders. Bi-monthly newsletter, free packets with treatment and support group information, annual conference, books, audio and video tapes. Trains mental health professionals in the latest treatment techniques. Contact: Obsessive-Compulsive Foundation, Inc., 337 Notch Hill Road, North Branford, CT 06471; Voice: 203:315-2190; Fax: 203:315-2196; E-mail: [info@ocfoundation.org](mailto:info@ocfoundation.org). Web: <http://ocfoundation.org>. **Refer:** The OC Foundation maintains a wide variety of group types; some are 12-Step, some mutual help, some professionally facilitated. They are for clients with obsessive-compulsive disorders of any kind, however, some groups are specific to a particular type of obsession/compulsion. It is best to consult with the online directory for the closest group and then to check if that group is appropriate for your client.

**Recovery, Inc.**

International. 700+ groups. Founded 1937. A community mental health organization that offers a self-help method of will training; a system of techniques for controlling temperamental behavior and changing attitudes toward nervous symptoms, anxiety, depression, anger and fears. Publication for members. Information on starting groups. Leadership training. Contact: Recovery, Inc., 802 N. Dearborn St., Chicago, IL 60610. Call (312)337- 5661; FAX: (312)337-5756. Web: <http://www.recovery-inc.com>. Recovery offers a special site with links to literature for professionals at <http://www.recovery-inc.com/professionals.html> **Refer:** Recovery, Inc. is most suitable for people who have high anxiety, depressed mood, a problem with anger or with irrational fear. Clients should be able to read aloud. This association is effective with all diagnostic categories.

**Schizophrenics Anonymous**

International. 70+ chapters. Founded in 1985. Offers fellowship, support and information for people with schizophrenia using a 6-step program. Contact: Schizophrenics Anonymous c/o MHA in Michigan, 15920 W. Twelve Mile, Southfield, MI 48076. Call: (810) 557-6777 OR (800) 482-9534; FAX: (810)557-5995. Web: <http://www.schizophrenia.com/help/Schizanon.html> . **Refer:** Refer anyone with a diagnosis of schizophrenia. It is best if the client is stable on

medications and/or non-psychotic. Meetings are structured and focus on six steps. Meetings are supportive, non-demanding, and educational. Press the "Home" button at the bottom of this page for more information and groups.

### **Secular Organization for Sobriety/Save Our Selves (S.O.S.)**

International. c. 750 groups. Founded (as Secular Sobriety Groups) in 1985. Web: <http://www.cfiwest.org/sos/> Contact: SOS, 5521 Grosvenor Blvd., Los Angeles, CA 90066; Call: (310)821-8430; FAX (310)821-2610; E-mail: SOS@CFIWest.org. **Refer:** Alcoholics who have difficulty with the spirituality or "religion" of Alcoholics Anonymous. "Secular Organization for Sobriety/Save Our Selves (SOS) is a nonprofit network of autonomous, non-professional local groups dedicated solely to helping individuals achieve and maintain sobriety. SOS takes a self-empowerment approach to recovery and maintains sobriety is a separate issue from all else."

### **SmartRecovery®**

International. c. 100 groups. SmartRecovery split off from Rational Recovery (see also A.V.R.T) in 1994. Contact: SMART Recovery, 7537 Mentor Avenue, Suite #306, Mentor, Ohio 44060. Phone: 440-951-5357. FAX: 440-951-5358. Web: <http://www.smartrecovery.org/>. "SMART Recovery is an abstinence-based, not-for-profit organization offering a self-help program for people having problems with drinking and using. No one will label you an "alcoholic" or an addict. You are neither diseased nor powerless, and if you do not believe in a religion or spirituality, that's fine, too. We teach common sense self-help procedures designed to empower you to abstain and to develop a more positive lifestyle." **Refer:** Those who have difficulty with "spirituality" who might benefit from a Rational Emotive Behavior Therapy approach.

### **Women for Sobriety**

National. Founded 1976. c. 200 groups. Contact: WFS, Inc., P.O. Box 618, Quakertown, PA 18951-0618, Phone/fax: (215)536-8026; Web: <http://www.womenforsobriety.org/>. "Based upon a Thirteen Statement Program of positivity that encourages emotional and spiritual growth, the 'New Life' Program has been extremely effective in helping women to overcome their alcoholism and learn a wholly new lifestyle." Many online groups. **Refer:** Women put off by the sexism of many AA and other meetings. Many WFS members also attend AA, using WFS for their "women's issues."

### **Internet-Focused Mutual Aid Resources**

#### **Online Intergroup of Alcoholics Anonymous**

Internet only. The Online Intergroup of Alcoholics Anonymous was formed to serve all online AA Groups in the rapidly growing online Fellowship. It offers links to international sites in several languages and sponsors real time meetings,

email meetings, events calendar, information and links to other sites and groups.

**Contact:** <http://aa-intergroup.org/> **Refer:** Membership in the Intergroup is open to all online AA groups and all AA members. There are no dues or fees for membership.

### **A.V.R.T. (Addictive Voice Recognition Training) -- also known as Rational Recovery**

International. No groups: sees groups of addicted people as the problem. Founded 1986 as "Rational Recovery." Web: <http://www.rational.org/>. **Refer:** People incapable of participating in groups. Reach the RR main office at (530)621-4374, or (530)621-2667, weekdays, 8 AM - 4 PM, PST. Write to Rational Recovery Systems, Inc., Box 800, Lotus CA 95651 FAX: (530)622-4296."

### **Bi-Polar Disorder -- also known as Manic-Depression**

Harbor of Refuge Organization, Inc. -- Peer to Peer Support for People with Bipolar disorder and those that care about them. "Philosophy: Harbor of Refuge members believe in the principle that each member must find and adhere to an effective plan of treatment for herself or himself that includes qualified medical care, regular and proper rest, and moderate exercise. Additionally, we believe that in helping others to navigate the sometimes stormy waters of this illness, we also help ourselves.

"The Harbor of Refuge strives to provide a safe refuge for interaction between bipolar, their families, and close friends -- without judgment, condemnation, or outside enforcement. We encourage and nurture each other as we seek to overcome this illness through good medical and self-care strategies. However, we know that each one of us must be responsible for our own actions and their impact on our emotional and physical well-being." <http://www.harbor-of-refuge.org/>

### **Bi-Polar Significant Others**

Internet only. "The information presented on this site is intended to provide information and support to the families, friends and loved ones of those who suffer from bipolar disorder (manic-depression). These resources have helped many of us inform ourselves, cope with behaviors that sometimes arise from the illness, better understand our own reactions, and determine how we may best support our loved ones in their efforts to understand and live with this often terrible disease." **Contact:** To Subscribe to the BPSO List, send an e-mail message to: majordomo@lugdunum.net with this message: subscribe bpso. Do not include anything else in the message. This message will be forwarded to the BPSO list manager, who will contact you as soon as possible. Go to web site at: <http://www.bpsos.org/>. **Refer:** BPSO is a private, closed and unmoderated internet mailing list for those who are involved in a loving, caring, intimate and/or nurturing relationship with someone suffering from bipolar affective disorder (manic-depression). Unlike internet newsgroups, BPSO is accessible only to

members.

### **Bipolar World**

"A website for individuals diagnosed with Bipolar Disorder (Manic Depression) and for the families and friends who care for them. 'We have walked many miles in your moccasins' and understand the need for information and support."

This net-only, virtual group can be found at <http://www.bipolarworld.net/> In addition to offering News and good information on Diagnosis, Treatment, etc., it offers an opportunity to "Ask the Doctor" and offers links to Message Boards and Chat Rooms on such topics as Dual Diagnosis, Veterans with PTSD, Teens, and Parents of Bipolar Children.

As this site notes, "Many individuals who have been diagnosed with Bipolar Disorder have no one to turn to, to discuss their feelings about the illness. Many have questions that they feel are 'silly' and they don't want to bother their psychiatrist with. The internet has proven to be a wonderful resource for meeting with others with the same diagnosis."

### **Depressed Anonymous**

"A 12 Step Program of Recovery": "Depressed Anonymous was formed to provide therapeutic resources for depressed individuals of all ages. We work with the chronically depressed and those recently discharged from health facilities who were treated for depression.

"We also seek to prevent depression through education and by creating a supportive and caring community through support groups that successfully keep individuals from relapsing into depression."

<http://www.depressedanon.com/index.html>

### **Dissociative Identity Disorder -- also known as Multiple Personality Disorder**

17 online forums, divided into three areas. "MosaicMinds Interactive Community Forums are considered 'self-help' and community support networks. MosaicMinds employs no professionals to monitor or interact in these forums."

<http://www.mosaicminds.org/Community/index.shtml>

More information may be found at <http://www.mosaicminds.org/inside-mm.shtml>

### **Methadone Anonymous**

International. Founded 1991. Self-help group for, and led by, current and former methadone maintenance treatment patients. "Have you ever attended a 12-step meeting and were not allowed to 'share' because you are a methadone patient? Have you ever gone to one of these meetings and felt like you could not be honest about being a methadone patient because there were things you needed to talk about? If so, Methadone Anonymous may be for you." Phone: (516) 897-1330 (days); (516) 889-8142 (evenings); Fax: (516) 897-1149. Web:

<http://www.charityadvantage.com/AFIRMFWC/Home.asp> **Refer:** Recovering

addicts who wish to follow a 12-Step program while on methadone maintenance.

#### **National Alliance of Methadone Advocates**

We have little information on this group beyond what may be found at its website: [National Alliance of Methadone Advocates](#)

#### **Prescription Anonymous**

Founded 1998 in Atlanta, Georgia. "Rx Anonymous is a voluntary fellowship of men and women who have taken a pledge of responsibility to carry our message of hope to the millions of people who suffer from prescription addiction and/or other mood-altering substances. Our primary focus is to learn how to stop our abuse and to successfully create a life of peace and understanding. We listen to others and feel relieved to know that someone else can identify. We learn how to let go of our fears, cry when the moment comes and share our stories without judgement or criticism. We are not therapists or doctors. Our qualifications are only that we have successfully stopped abusing prescription medications and mood-altering substances. Our hope is to share with others our way of life."

<http://www.prescriptionanonymous.org/>

#### **Rational Recovery**

See **A.V.R.T.**, above.

#### **Self-Injury: You are NOT the only one**

Internet only. Seven weekly moderated chats on topics ranging from issues facing men and women who self-harm to support for families and friends to how faith affects the experience of self-harm. The site includes numerous informative links to aspects of self harm, types, diagnosis, therapy, reading lists etc. There are self tests for diagnosis and links to frequently asked questions. A desire to stop self injury is **not** a requirement for membership. **Refer:** Those who injure themselves intentionally and who want more information and support from fellow sufferers. Contact: <http://www.palace.net/~llama/psych/injury.html> Use of the site is free; it belongs to Deb Martinson and is based in Seattle, WA. E-mail:

<mailto:llama@palace.net>

#### **Sober 24**

Internet only. "12 step support groups combined with 'Virtual Fellowship' and recovery management tools make Sober 24 a safe, anonymous recovery environment for those suffering from alcoholism and drug addiction. The site contains "bulletin boards and chat rooms where you can get support when you need it, and offer your own support to those who can benefit from it. They offer virtual meetings on a regular basis. . . ." The site also offers reading material and lists local meetings. **Contact:** <http://www.sober24.com/>. **Refer:** Those in recovery from alcohol and drug abuse and their friends and family. The site is password

protected and charges a \$32 membership fee after a free trial period of 24 days.

### **SoberDykes Hope Page**

This web-only site, located at <http://www.soberdykes.org/> aims at "women in recovery for substance abuse" and focuses on Dual Diagnosis: "Those of us who have a dual diagnosis often have our mental health issues disregarded by mental health professionals because they think that our drinking/using is the cause of our problems. Our brothers and sisters in recovery often tell us to give ourselves to the recovery program we attend and, when we still don't get "well", we are told that we just aren't doing a good enough job."

This site may be of special use to lesbian women in rural or other areas where they find it difficult to find "community." Its goal and hope is "that here, with other women in recovery, you will find a safe home."

Among resources offered are treatments on Self-Medicating, Finding Support, and On-line Dual Diagnosis Meetings on SoberDykes. There is also a link to many resources on "Gay/lesbian recovery resources."

### **Evidence of Mutual Support Group Effectiveness**

It is not easy to capture the value of self-help groups through quantitative, empirical studies. But some researchers have partnered with self-help groups to find appropriate methods of evaluation. What follows summarizes the extant research.

Extensive evaluations using before-after measures, comparison groups, and time-series designs, have found that more intense and longer term participation in a wide variety of self-help/mutual-aid groups contributes to better outcomes. These outcomes include reduced psychiatric symptoms, reduced use of professional services, increased coping skills, increased life satisfaction, and shorter hospital stays. Members of health-related groups reported better adjustment, more effective coping skills, higher self-esteem, and improved acceptance of the illness than self-assessments of less active and nonmembers (Kyrouz, Humphreys and Loomis (2002) [Kyrouz, Humphreys and Loomis](#) (This article is in Adobe Acrobat. Acrobat Reader can be obtained, free, at [Emotions Anonymous.](#)) For specifics, see this study, the results of which are summarized in the next five paragraphs:

1. Patients DISCHARGED FROM A PSYCHIATRIC HOSPITAL who participated in a Community Network Development (CND) Program required one-half as much rehospitalization, ten months after discharge, as a comparable group of non-participating ex-patients. CND ex-patients also required one-third as many patient days of rehospitalization (7 vs 25 days) and a significantly smaller percentage of them needed to continue to attend Community Mental Health Centers and other mental health agencies for services (48% vs 74%).

2. VOLUNTEER LEADERS IN RECOVERY, INC., a self-help group for people who have been treated for mental health problems (half of whom had been hospitalized for mental illness) rate their overall satisfaction with life and health, as well as their satisfaction with work, leisure, and community as high, equivalent to the general public's levels of satisfaction.

3. CHILDREN OF PARENTS WITH DRINKING PROBLEMS who participated in Alateen, a self-help group sponsored by Al-Anon, suffered less emotional and social disturbance than peers who did not belong.

4. Participants in a national self-help group for parents of young drug and alcohol abusers -- (PRIDE - Parent Resources Institute for Drug Education) -- reported that their participation was associated with improvement in their children's DRUG PROBLEM. A majority of the participants also reported improvements in their children's general discipline problems and in adjustment outside the home.

5. Participating in a self-help group for FAMILIES OF PSYCHIATRIC PATIENTS reduced the family's sense of burden. Members found the group helpful because it provided them with information about schizophrenia and coping strategies that professionals did not provide. Participation also helped parents to develop supportive social bonds with others who were experiencing similar problems.

Recent studies by reputable researchers have supported 12-STEP GROUP effectiveness (Project Match Research Group, 1997). A multi-state, rigorous research project funded by the NIAAA contrasted outcomes of three treatment conditions, one of which was 12-Step facilitation. The sole objective of 12- Step facilitation was to connect with and reinforce use of community AA. Findings showed that persons who received this treatment approach were as successful in reaching treatment goals as those who received the two other professional treatments. Another study found that individuals treated in a 12-Step-oriented program have higher levels of engagement with 12-Step programs and 64% lower utilization of professional mental health services than patients treated where there was little emphasis on 12-Step principles and involvement. (Humphreys, K. & Moos, R. (2001). Can encouraging substance abuse patients to participate in self-help group reduce demand for health care? A quasi-experimental study. *Alcoholism: Clinical and Experimental Research*, 25 [5] (May 2001), 711-716.)

All studies suggest that success in any program correlates with more intense mutual help involvement. Therefore, encourage your client to become as active as possible. A listing of indicators of involvement intensity appears below and can be reached directly from the "Contents" list.

## **Encouraging Local Group Development**

### **1. Don't Re-invent the Wheel**

Find a national group that already exists and request a starter packet or "how to" guide. Ask nearby group leaders to help. Attend meetings of that association in other locations to get a feel for how they operate; borrow from their successful techniques.

### **2. Find a Suitable Meeting Place and Time**

Try to obtain free meeting space at a local church, library, community center, hospital, or social service agency. Chairs should be arranged in a circle; avoid a lecture set-up. Consider holding initial meetings in members' homes. Also, try to set a convenient time for people to remember the meeting, e.g., the first Tuesday of the month or every Tuesday at 7:30 p.m.

### **3. Publicize and Run your First Public Meeting**

To reach potential members, consider where they might go to seek help and get the word out to those persons and places. Don't start before you have a core group of committed founders. The first meeting should be arranged so that there will be ample time for you and other core group members to describe your interest and work, while allowing others the opportunity to share their view of how they would like to see the group function. Identify common needs the group can address. Make plans for the next meeting; have an opportunity for people to talk and socialize informally after the meeting.

### **4. Future Meeting Tasks**

Establish the purpose of the group. Is the purpose clear? Groups often focus upon providing emotional support, practical information, education, and sometimes advocacy.

Also determine any basic guidelines your group will have for meetings (e.g., insure that group discussions are confidential, non-judgmental, and informative).

*Membership:* Who can attend meetings and who cannot? Do you want membership limited to those with the problem? Will there be membership dues? If so, how much?

*Meeting Format:* How will the meeting be structured? How much time will be devoted to business affairs, discussion, planning future meetings, socializing? What topics will be selected? Can guest speakers be invited? If the group grows too large, consider breaking down into smaller sub-groups of 7 to 12.

*Roles and Responsibilities:* Continue to share and delegate the work and responsibilities in the group. Who will be the phone contact for the group? Do you want officers? Consider additional roles members can play in making the



group work. In asking for volunteers, it is sometimes easier to first ask the group what specific tasks they think would be helpful.

*Phone Network:* Many groups encourage the exchange of telephone numbers or an internal phone list to provide help to members between meetings. Ask your membership if they would like this arrangement.

*Use of Professionals:* Consider using professionals as advisors, consultants, or speakers to your groups, and as sources of continued referrals and information.

*Projects:* Always begin with small projects, then work your way up to more difficult tasks.

### **Problems and Pitfalls In Working With Mutual-Aid Groups**

#### **1. Taking Over the Peer Helper Role**

Do not do for the client what the community can do. Assist your clients to find peers who can help them instead of keeping clients dependent on you. Think of your role as one of linking your clients to a life of continuing growth, not as merely a treatment provider who will produce a finished product at the end of your treatment plan.

#### **2. Over-identification with Resistance**

Beware of over-identifying with your client's resistance to attending meetings. You must be firm in insisting that the need for lifestyle change includes finding a new support system.

#### **3. Problems with Religion**

One common problem with AA/NA affiliation is objection to the religious atmosphere in some 12-Step groups. It is important to be knowledgeable about the differences between spiritual and religious and to read the chapter in the Big Book, "We Agnostics" (AA, 1976). Some groups are more openly religious than others. AA's beginnings were rooted in evangelical Protestantism, but its teachings are compatible with Catholicism, Judaism, and Islam. For example, there is an organization called JACS (Jewish Alcoholics, Chemically Dependent Persons and Significant Others) headquartered in New York City that helps Jewish addicts understand the 12-Step program as compatible with Judaism. They can be contacted at JACS, 850 Seventh Ave., New York, NY 10019. Phone: (212)397-4197. Web: <http://www.jacsweb.org>

#### **4. Gender Issues**

Women often express discomfort about AA/NA groups, although this difficulty is diminishing as more women are becoming AA members. The most recent survey indicates that one-third of members are women (AA, 1999). One way to help a woman client adjust to AA is to link her to an all-women's group or

to a group with a large number of women in attendance. It is also appropriate to help the client learn to deal with male prejudice and sexist comments.

#### 5. Discomfort in groups

An important characteristic of successful members is capacity for group dependency. One researcher found that people with high affiliation needs bond quickly with groups, whereas those with low affiliation needs do not. Some people described themselves as "loners" or "misfits." For such people integration into the mutual-aid social world can be more difficult. Those who pay attention to what is said in meetings and read the literature are able to participate more and to engage in dyadic relationships within groups. Continued attendance allows the less extroverted members to become involved and develop a sense of belonging. A dyadic relationship is often required before the less sociable person is able to be involved in an AA group.

#### 6. Lack of transportation and other logistical barriers

Such things as no transportation and other barriers to attendance need to be considered and resolved. Rides can be obtained to deal with transportation problems. One definition of an AA meeting is simply "one drunk talking to another." Anywhere you can find one other person who has a story to tell, you can find a meeting. Thus, your client might find someone who he or she can talk to in person or by telephone at times when a regular meeting is not available.

#### 7. Working at Cross Purposes With the Group

One of the biggest problems that can occur when a professional's client belongs to a peer support group is the possibility that what you are doing with your client may be undermined by peer helpers. This happens most often with the issue of the use of medication for psychiatric disorders. While it is true that addicts tend to use chemicals to solve their problems, it is also true that some addicts need medications of various kinds. An AA pamphlet states, "It becomes clear that just as it is wrong to enable or support any alcoholic to become re-addicted to any drug, it's equally wrong to deprive an alcoholic of medication which can alleviate or control other disabling physical and/or emotional problems" (AA, 1984, p. 13). Despite this warning in AA's own literature, some newcomers may be instructed by peer helpers not to use their medications. You can do two things to remedy this. First, you can obtain the AA brochure quoted above and share it with your clients. Secondly, you can recommend to your clients that they not discuss medications in their groups or informally with the friends they meet in AA or NA.

### **Indicators of Mutual Help Involvement**

- Meeting attendance
- Participation in social activities

- Service roles: elected to office, contributions of refreshments, setting up meeting rooms, etc.
- Telephone calls to members
- Friendships with members
- Reading literature
- Following group recommendations written exercises, taking inventories, prayer and meditation
- Having a sponsor
- Being a sponsor.

### **Aids to Working With Mutual-Aid Groups**

There exist a vast variety of resource aids, many of them available online or easily ordered online. Virtually all the web sites listed above contain many articles and recommend other readings. Many of these sites also offer links to chat-rooms and virtual meetings as well as further detailed information. Below are some resources that we have found especially helpful.

#### ***General***

American Self Help Clearinghouse Self-help Sourcebook online:  
<http://mentalhelp.net/selfhelp/>

Champaign, IL, area: <http://www.prairienet.org/selfhelp/homepage.phtml>. Note: This site may have to be "Reloaded" or "Refreshed" in order to appear properly in some browsers.

National Mental Health Consumers' Self-Help Clearinghouse:  
<http://www.mhselfhelp.org/>

This is a consumer-run technical assistance center. It provides training materials for advocacy and starting new groups. It disseminates information on legislation, provides links to government resources and to other related organizations. Links on this site provide an amazing amount of free training materials.

#### ***Chemical Dependency***

AA: AA World Services publishes books, pamphlets, videos, periodicals, and workbooks. Periodicals include a newsletter, BOX 459 (News and Notes from the General Service Office of A.A.); About AA: A Newsletter for Professionals; and the AA Grapevine ("our meeting in print"). The first offers news about the AA organization such as number of members and groups, decisions made in conferences, and the like. About AA contains information about the fellowship that might be of interest to professionals, such as results of member surveys, information about AA's history, available literature and other products. The AA

Grapevine contains writings by members that reveal aspects of their spiritual journeys in recovery. AA's General Service Office can be reached by mail at A.A. World Services, P.O. Box 459, Grand Central Station, New York, NY 10163. Phone: (212) 870-3400. See <http://www.aa.org/> We suggest also checking out "Your First AA Meeting: An Unofficial Guide For the Perplexed" at [http://www.bma-wellness.com/papers/First\\_AA\\_Meeting.html](http://www.bma-wellness.com/papers/First_AA_Meeting.html)

NA:Narcotics Anonymous World Services is headquartered in Van Nuys, California. It also publishes literature: books, booklets, pamphlets, handbooks and guides, directories, audio cassettes and one video, Just For Today. NA also publishes The NA Way Magazine: The International Journal of Narcotics Anonymous. The magazine's mission is to provide service information, recovery-related entertainment related to current issues and events relevant to and written by members. You can order from NA at their address: N.A., P.O. Box 9999, Van Nuys, CA 91409. Call: (818)773-9999.

### ***Mental Illness***

EA: EA publishes a text, Emotions Anonymous, and numerous pamphlets. A catalog of its publications may be found at <http://www.mtn.org/ea/catalog1.html>

Grohol, J.M.: PsychCentral and other resources: <http://www.grohol.com/>

GROW: Publishes numerous books and pamphlets. Contact their headquarters for informational packets and assistance in developing groups.

NAMI: Publishes local and state newsletters as well as the NAMI Advocate, a bi-monthly newsletter that reports on national mental health policy news, organizational news, book reviews, order forms for NAMI publications. Available to all dues-paying members.

NDMDA: Publishes the National DMDA Newsletter containing news of national public policy and organizational news and sells brochures and articles with information on manic depressive illness. See web site to order.

Obsessive-Compulsive Foundation, Inc.: Publishes a bi-monthly newsletter, free packets with treatment and support group information, annual conference, books, audio and video tapes. Trains mental health professionals in the latest treatment techniques. See <http://ocfoundation.org/ocf1100a.htm>

Recovery, Inc.: Publishes a basic text, Mental Health Through Will Training by founder Abraham Low, Selections from Dr. Low's Works, Peace Versus Power in the Family. Also a bi-monthly publication, The Recovery Reporter, containing many examples of recovery practice. There are also pamphlets, a group directory, and other aids to Recovery leaders. The headquarters office has videos for helping new groups get started. Recovery offers a special site with

links to literature for professionals at <http://www.recovery-inc.com/professionals.html>

### **The Question of Responsibility**

Some have asked questions concerning the responsibility of a professional for what happens to people one has referred to a non-professional site or group. We suggest the following principles:

- (1) The professional is responsible for being knowledgeable about the group or the website so that harm is unlikely to occur;
- (2) the professional should make it clear to the person being referred that the group is a non-professional, mutual aid group made up of non-professionals with similar problems;
- (3) the professional should remain available to the person if something potentially harmful happens.

When possible, this Guide provides group mission statements and suggestions about whom to refer to groups. One of the most harmful things we have seen professionals do is to refer someone to a group for which they were not really qualified; i.e., they did not share the problem with which the group deals. We have seen this happen often in Al-Anon when someone who was depressed came in referred by a professional who thought Al-Anon was a nice group of supportive people and did not know of a group for people with depression. The innocent person, who is in pain, goes to the group and is asked to leave. The group is also harmed because they have had to struggle with whether to include someone for whom they have nothing to offer or reject them thus increasing the level of pain for the newcomer. When this occurs, a group member usually takes the person aside and tried to soften the rejection, but the harm is done.

As noted elsewhere in this Guide, there is no credible evidence that any of the groups listed here have been harmful to any person or category of persons. It is, however, important to monitor your referee's experience. Any individual group could develop destructive group dynamics that could be harmful to individual members.

The groups listed above as "Group-Based" generally have proven track records and are generally well-known. Those listed above as "Internet-Focused" are in general newer, or are geographically limited, and we have less information about them and no direct experience with them. We nevertheless think that they are likely to be helpful. We ask that you inform us if your experience with these groups provides information you deem helpful to others.

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## **Recommended Reading**

- Grohol, J.M. (2002). The insider's guide to mental health resources online: 2002/2003 edition. New York: Guilford Press.
- Kurtz, E. (1991 ed.). Not-God: A history of Alcoholics Anonymous. Center City, MN: Hazelden.
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- Humphreys, K. & Moos, R. Can encouraging substance abuse patients to participate in self help groups reduce demand for health care? A quasi-experimental study. *Alcoholism: Clinical and Experimental Research*. Special Issue: Vol 25(5), 711-716, May 2001.
- Kyrouz, E.M., Humphreys, K. and Loomis, C.L. (2002). A review of research on the effectiveness of self-help mutual aid groups; expanded and updated. [Kyrouz, Humphreys and Loomis](#)
- Project Match Research Group. (1997). Matching alcoholism treatments to client heterogeneity: Project MATCH post-treatment drinking outcomes. *Journal of Studies on Alcohol*, 59, 513-522.
- White, B.J. & Madara, E.J. (Eds.). (2002). The self-help sourcebook: Your guide to community and online support groups (7th ed.). Cedar Knolls, NJ: American Self-Help Group Clearinghouse.

## About the Author

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The Lighthouse Institute is the research, training, consulting and publishing branch of Chestnut Health Systems ([www.chestnut.org](http://www.chestnut.org)) in Bloomington, Illinois. The institute conducts addiction-related research and conducts advanced professional education for individuals working directly with those impacted by alcoholism and other addictions.