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Recognizing, Managing and Containing the “Hard Core Drinking Driver”*

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The 1.5 million persons arrested each year for driving under the influence of alcohol or other drugs (DUI) constitute a growing portion of the caseloads of the nation’s probation officers (Federal Bureau of Investigation, 2002). The sheer volume of these cases poses the challenge of determining which DUI offenders pose the greatest threat to public safety and require more rigorous monitoring and case management. 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 article responds to that challenge by reviewing the research on the highest risk DUI offenders, introducing the Hard Core Drinking Driver Checklist, and discussing principles probation officers can utilize to effectively manage the hard core drinking driver (HCDD).

Changing Perceptions of the DUI Offender

During the mid-twentieth century, both the American public and service professionals viewed the DUI offender as an otherwise law-abiding social drinker who made an isolated error in judgment that could be permanently corrected through brief remedial education. According to this view, the challenge for the criminal justice system was to identify and manage the small percentage of alcoholic DUI offenders who constitute a high recidivism risk (Vingilis, 1983). This “needle in the haystack” view of the high risk DUI offender was subsequently challenged by judicial activists (Kramer, 1986) and researchers (Crancer, 1986) who suggested that the entire system of reducing alcohol impaired driving rested on a mythical

conception of the social drinking DUI offender. Further studies of the DUI offender have challenged this myth.

- Between 40-70% of first-time DUI offenders have prior alcohol- or drug-related criminal offenses (Taxman & Piquero, 1998; Chang and Lapham, 1996; Kochis, 1997).
- A driver would have to commit between 200 and 2000 repetitions of impaired driving violations to statistically generate one arrest (Borkenstein, 1975; Jones & Joscelyn, 1978; Voas & Hause, 1987; Beitel, Sharp, & Glauz, 2000).
- Most alcohol-impaired drivers treated in hospital emergency departments are not arrested and convicted of the impaired driving that produced their injuries (Soderstrom, Ballesteros, Dischinger, Kerns, Flint, & Smith, 2001).
- The percentage of non-problematic, social drinkers within the DUI arrest pool has declined due to the cumulative effects of successful DUI educational campaigns (NHTSA, 1997; Lund & Wolf, 1991; Yi, et al., 2002).
- Significant problems exist with the accuracy of diagnosis of alcohol use disorders among DUI offenders, with the rate of retrospective alcohol dependence diagnoses tripling in five-year follow-up studies (Lapham, C'de Baca, McMillan, & Hunt, 2004).
- More than 80% of DUI offenders have a significant problem in their relationship with alcohol and/or other drugs (Timken, 1999; Lapham, et al., 2001; Brinkmann, Beike, Köhler, Heinecke, & Bajanowski, 2002; See Lapham, et al, 2004 for a review). A five-year follow-up study of convicted DUI offenders revealed that 85% of the female offenders and 91% of the male offenders met lifetime criteria for alcohol abuse or alcohol dependence and that 32% of females and 38% of males met lifetime criteria for a non-alcohol related substance use disorder (Lapham, Smith, C'de Baca, Chang, Skipper, Baum, & Hunt, 2001).

Seen as a whole, most DUI offenders have, are developing, or will go on to develop a serious substance-related problem. Within this larger pool of DUI offenders exists a subpopulation of drinking drivers who pose inordinate threats to public safety based on their frequency of drinking and driving and their levels of debilitation when drinking and driving. These individuals have been christened “hard core drinking drivers.”

The “Hard Core Drinking Driver”

The emerging definition of the hard core drinking driver (HCDD) is an individual who, despite education, threats, and punishments, drives frequently (at least monthly) at high BAC levels (above 0.15%) (Simpson, Beirness, Robertson, Mayhew, & Hedlund, 2004). Recent surveys reveal that 3% of licensed drivers account for 80% of the total number of impaired driving trips (Beirness, Simpson, & Desmond, 2002, 2003). HCDDs pose exceptionally high threats to public safety due to their frequency of drinking and driving and their high level of intoxication while driving. Because of these twin threats, HCDDs are at high risk for re-arrest for driving while impaired and for future involvement in a drinking-related crash. The challenge for the probation officer is to identify individuals in this highest risk category and develop special monitoring and management strategies based on their unique characteristics (Voas & Fisher, 2001).

The Hard Core Drinking Driver Profile

Hard core drinking drivers share many characteristics with the larger pool of DUI offenders (Arstein-Kerslake & Peck, 1985) but exhibit these characteristics to a much higher degree than non-recidivating offenders. HCDDs also reflect characteristics that distinguish them from impaired drivers who are arrested once but who are neither re-arrested for DUI nor involved in a future alcohol-related crash.

Demographic Profile

The general profile of the HCDD is that of a male (90-95 percent), aged 25 to 45 (more than 75 percent are under age 40 and only 10 percent over age 50), with 12 grades or less education employed in a non-white-collar occupation (with a history of occupational instability), and lower socioeconomic status (Simpson, et al, 2004). Most HCDDs have a history of impaired intimate relationships, e.g., the inability to sustain friendships and intimate relationships as well as a pattern of conflict in such relationships (e.g., domestic violence). DUI recidivists are more likely to have prior domestic violence offenses than first time DUI offenders (Syrclé & White, 2006). More than 60 percent of DUI recidivists have children, but 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). Many HCDDs socialize with individuals who also drink frequently and heavily and who also drink and drive (Nelson, et al., 1998).

Substance Use History

HCDDs, when compared to the larger pool of DUI offenders, are more likely to present with a family history of alcohol and other drug problems, including family modeling of drinking and driving (Jessor, 1987; Gulliver & Begg, 2004). They report an early age of onset of alcohol/drug use (Hingson, Heeren, Levenson, Jamanka, & Voas, 2002), euphoric recall of their first contact with alcohol/drugs, atypically high tolerance from the onset of drinking (White, 2004), and a pattern of high school binge drinking (Wechsler, Lee, Nelson, & Lee, 2003). Individuals reporting onset of drinking before age 14 are seven times more likely to be in an alcohol-related crash than those who begin drinking after age 21 (Hingson, et al, 2002). Most HCDDs are involved in frequent, heavy drinking and prefer drinking in venues outside their homes (e.g., bars/restaurants) that are accessible by car (Gruenewald, Johnson, & Treno, 2002). They may also exhibit patterns of drinking in automobiles (Snow & Wells-Parker, 2001), which is reflected in early charges for illegal possession of alcohol, illegal transportation of alcohol, or an open bottle or can at the time of the DUI arrest. They show signs of severe drinking-related problems (half meet diagnostic criteria for alcohol dependence)(Simpson, Mayhew, & Beirness, 1996) and self-report a need to cut down on their drinking (Hedlund, 1995; Perrine, 1990).

Most HCDDs report beer as their primary beverage of choice (Gruenewald, Johnson, Millar, & Mitchell, 2000), however, supplementation with distilled spirits is common, particularly as alcohol tolerance increases (White, 2004). HCDDs are more likely than others to report a sustained pattern of multiple drug use including alcohol and tobacco, prescribed psychoactive drugs, and illicit drugs (Osborn, 1997). While the vast majority of DUI offenders smoke (Taxman & Piquero, 1998), the HCDD is often 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). HCDDs often report prior treatment for alcohol or other drug problems, but records reveal noncompliance with sentencing conditions and treatment (Peck, Arstein-Kerslake, & Helander, 1994; Nochajski, et al., 1994). Interviews with HCDDs reveal the perception that treatment was a “waste of time” (Timken, 1999).

Driving and Criminal Justice History

HCDDs have a higher percentage of prior criminal records (exclusive of impaired driving arrests) than the larger pool of DUI offenders (Syrle & White, 2006). Between 20-25 percent of prior convictions for DUI recidivists are for crimes against persons. At least one study found that prior criminal history other than DUI offenses was a predictor of future DUI recidivism (Nochajski, Miller, & Wieczorek, 1989). HCDDs 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, or assault. The risk of future DUI arrest rises in tandem with the number of prior DUI arrests (NHTSA, 1996a). 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 eventually die in crashes involving alcohol (Brewer, Morris, Cole, Watkins, Patetta, & Popkin, 1994).

HCDDs are more likely to have high-risk driving records (e.g., moving violations, failure to wear seat belts, accidents involving personal injury or property damage, loss of insurance) and to be involved in more traffic crashes than other drivers in general as well as non-recidivist impaired drivers (Baum, 2000; Begg, Langley, & Stephenson, 2003; "Drivers with...", 1994). There is growing evidence of an overlap between the HCDD and the larger pool of high-risk drivers (Wells-Parker, Landrum, & Cosby, 1985; Taxman & Piquero, 1998). HCDDs commonly drive on a suspended/revoked license and do so in ways that indicate a disregard for community norms and a high degree of sensation-seeking, risk-taking, and interpersonal aggression. A study by Simpson and Mayhew (1991) revealed that 21% of drivers who were killed at a time they had a BAC over 0.20% did not have a valid drivers license at the time of the crash.

HCDDs are more likely to have had prior cases of arrest for DUI that resulted in long processing time before disposition and the avoidance of DUI conviction (Yu & Williford, 1995). HCDDs are often characterized as "system sophisticated" due to their ability to manipulate both the criminal justice system and the treatment system in order to avoid the consequences of their drinking and driving behavior as well as the consequences for their non-compliance with sentencing conditions (Robertson & Simpson, 2003; Simpson, et al., 2004).

Drinking and Driving Beliefs

HCDDs 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 (Caudill, Kantor, & Ungerleider, 1990; Nelson, et al., 1998; Hingson, Hereen, & Winter, 1998). They fail to make alternative transportation arrangements before drinking (Nelson, et al., 1998) and underestimate their level of intoxication at the time they decide to drive (Beirness, Foss, & Voas, 1993). HCDDs trivialize drinking and driving in part because they are often enmeshed in heavy drinking subcultures that provide little social disapproval for drinking and driving (Nelson, et al., 1998). HCDDs do not support severe penalties for impaired driving (Nelson, et al., 1998) and tend to see their DUI arrest as a function of bad luck or victimization by the police rather than as a consequence of their poor decision-making.

The Arrest Event

In comparing the arrests of the HCDD to that of the larger pool of DUI offenders, the HCDD is more likely to be drinking alone or in groups of men prior to the arrest and to be driving alone at the time of the arrest. They are more likely to have collateral charges tied to their DUI arrest, e.g., fleeing, resisting arrest, drug possession. They are also more likely to have an excessively high BAC — .25 or greater — at the time of their arrest (National Commission Against Drunk Driving, 1986). More than half of fatally injured DUI recidivists have a BAC of .20 or greater, which in itself is a risk factor for recidivism (Simpson & Mayhew, 1991; “Drivers with...”, 1994) and a predictor of alcoholism (Brinkmann, Beike, Köhler, Heinecke, & Bajonowski, 2002). The high alcohol tolerance developed from prolonged heavy drinking can also result in high BACs without gross signs of intoxication, e.g., less impairment in field sobriety tests than one would expect from their BAC levels. HCDDs are also more likely to refuse a Breathalyzer test (Syrle & White, 2006) and to exhibit a high degree of knowledge (or pseudo-knowledge) regarding DUI laws.

Broader Clinical Profile

Clinical assessment of the HCDD reveals a broader pattern of problems and a characterological profile that contributes to their risk for recidivism. HCDDs frequently report a history of co-occurring psychiatric

problems (e.g., depression, posttraumatic stress disorder, antisocial personality)(C'de Baca, Lapham, Skipper, & Hunt, 2004) as well as complex medical histories marked by accidents, emergency room visits, workers' compensation claims and disability claims (Soderstron, et al, 2001). HCDDs often reflect minimal goal orientation; diminished capacity for empathy, guilt, and remorse; an elaborate cognitive defense structure characterized by denial, minimization, rationalization, resentment, projection of blame, hostility, and aggression (Caviola & Wuth, 2002; Farrow, 1989; Reynolds, Kunce, & Cope, 1991; Simpson, et al, 1996); impaired problem-solving skills; and impulsivity, sensation-seeking, and risk-taking (Yu & Williford, 1993; Hedlund & Fell, 1995; Caviola & Wuth, 2002).

It is this overarching characterological profile that seems to link alcohol-impaired driving, drugged driving, and risky driving (Donovan, 1993). It is this same profile that produces high follow-up mortality rates, particularly among drivers arrested with high BACs (Mann, Anglin, Wilkins, Vingilis, & MacDonald, 1993; Skurtveit, Christophersen, Grung, & Mørland, 2002). The high auto fatality rate of HCDDs is related to both their risk-taking behavior while intoxicated and their failure to wear seat belts. A recent Illinois study comparing first-time DUI offenders and multiple DUI offenders found a driving risk-taking cluster among the latter as indicated by higher rates of prior arrests for speeding, improper lane usage, failure to stop/yield, seat belt and child safety violations, and prior collisions (Syrle & White, 2006).

Individuals arrested for DUI before age 18 have been found to experience high rates of psychiatric illness as well as high rates of arrest for violent crimes (Rasanen, Hakko, & Jarvelin, 1999). Regarding the latter, some studies have found that aggressiveness at age 18 combined with alcohol dependence at age 21 constitute a predictor of future involvement in an alcohol-related crash (Begg, Langley, & Stephenson, 2003). Aggression as a risk factor for future DUI recidivism and other public safety risks is further indicated by recent findings of alcohol problems among those involved in road rage incidents (Mann, Smart, Stoduto, Adlaf, & Ialomiteanu, 2004).

Profile Implications

There are a number of important implications for probation officers that could be drawn from the emerging profile of the HCDD.

System Sophistication: The studies reviewed here portray a subgroup of HCDDs who are quite knowledgeable about DUI enforcement,

evaluation, and adjudication and who seek to manipulate that system (e.g., underreporting their substance use histories and their prior criminal histories)(Chang and Lapham, 1996). One of the most significant flaws in the current system of evaluating DUI offenders is its over-reliance on data self-reported by the offender. The probation officer would be well advised to base his or her assessment of the level of risk of a DUI offender on data sources other than the offender's self-disclosure (e.g., criminal record, driving record, arrest report, BAC, drug tests, laboratory reports, and collateral interviews).

Age of Onset: The early age of onset of drinking among HCDDs creates a twofold trajectory. First, such early onset of drinking increases the risk, severity, and complexity of adult substance use disorders (Grant, 1998) and is a predictor of future driving after any drinking, driving after five or more drinks, riding with an intoxicated driver, and involvement in alcohol-related crashes (Hingson, Heeren, Levenson, Jamanka, & Voas, 2002; Hingson, Heeren, Zakocs, Winter, & Wechsler, 2003). Second, early onset prevents the HCDD from developing internal and external assets that can later serve as the foundation of sustained recovery. This shortage of "recovery capital" (assets/hope) suggests the need for greater habilitative resources that could make up for these deficits, e.g., a focus on social and technical skills development, the development of pro-recovery social networks, and remedial approaches to education and occupational opportunities.

Co-occurring psychiatric and medical problems: The HCDD's use of drinking to manage negative emotional states suggests interventions that include the assessment and treatment of these problems as well as improved problem solving and stress management skills (Woldt & Bradley, 2002). Psychiatric and medical evaluations as well as involvement of psychiatric and medical personnel in a multi-disciplinary, multi-agency case management team are clearly indicated for some of the highest risk HCDDs.

Criminal profile: The criminal histories of HCDDs suggest a need for the criminal justice system to rethink how these individuals are perceived. It is clear that many HCDDs present a threat to public safety that far transcends their drinking and driving behavior. Clearly recognizing this broader pattern will help avoid/diminish the tendency to not see the DUI offender as a "real criminal." The HCDD is a real criminal and needs to be viewed and managed as such.

Aging Out: One of the most provocative findings in recent DUI research is the apparent aging out of the HCDD profile beginning at age 35 and rising sharply between age 40-50 (Shope & Bingham, 2002). This

would suggest that the long-term role of the probation department (and the larger criminal justice system) is to provide sustained periods of external supervision until the majority of HCDDs mature out of this pattern. Given the seeming intractability of the HCDD pattern in late adolescence and young adulthood, it will be important to experiment with and evaluate combinations and sequences of sanctions and interventions that can speed up this maturing out process.

Social Network Reconstruction: The fact that many HCDDs are not nested in families and are enmeshed in alcohol/drug-saturated social networks has special implications for the probation officers and treatment personnel who are involved with them. The challenge is to remove alcohol and other drugs from the life of the HCDD and to remove the HCDD from a milieu that reinforces anti-social behavior and replace that milieu with one that supports pro-social behavior. Recovery mutual aid societies and new recovery support services (e.g., recovery homes, recovery support centers) can play a particularly helpful role in the habilitation of the HCDD because of the pathways of entry they provide to pro-recovery social networks and activities.

Multiple Drug Use: The propensity for multiple drug use among HCDDs suggests the potential use of random chemical testing as an effective monitoring tool for this group of DUI offenders. We suspect that the number of DUI offenders whose primary drug of choice is something other than alcohol has been grossly underestimated. This is confirmed by a study of DUI offenders reporting that only 6% of DUI offenders were diagnosed with drug abuse or dependence at the point of initial screening, but that 28% retrospectively reported drug abuse or dependence at the time of initial screening when interviewed five years later (Lapham, C'de Baca, Chang, Hunt, & Berger, 2002). Recent studies in Cook County, Illinois showing 18-26% of DUI offenders testing positive for drugs other than alcohol at the time of their evaluation offer some confirmation of this suspicion (Central States Institute of Addiction, 2003). Further confirmation comes from Illinois treatment admission data noting that 9% of DUI offenders entering the treatment system identified a primary drug other than alcohol (Illinois Division of Alcoholism and Substance Abuse, 2004).

Errors in Thinking: It is obvious from the data presented here that HCDDs inaccurately perceive themselves and their relationship to the world. Treatment approaches that focus on exposing faulty thinking and improving problem solving are clearly indicated for HCDDs. Repeated episodes of impaired driving rest upon a foundation of faulty assumptions that must be revised if the behaviors that flow from them are to be altered. Cognitive

behavioral approaches currently in vogue within probation departments around the country may be particularly well-suited for the HCDD, as some preliminary studies suggest (Little, Robinson, & Burnette, 1990; Ross, 1995).

Characterological Profile: Research paints a picture of the HCDD as a person lacking internal locus of control and suffering from impulsivity, aggression, and an attraction to sensation-seeking and risk-taking—all of which are amplified under the influence of alcohol. This profile alone would suggest the need for strong systems of external monitoring and control. The volume of DUI arrests in this country would preclude the use of specialized DUI courts for all DUI offenders, but aggressive judicial case management combined with intensified probation services, appropriate treatment services, and periodic incarceration (in response to non-compliance) may constitute a potent rehabilitative combination for HCDDs. The profile outlined in this paper would also preclude the use of certain interventions for the HCDD, e.g., remedial education programs, victim impact panels.

Treatment: HCDDs have significant alcohol and other drug problems but may be ill-suited for acute models of addiction treatment that are characterized by brief, psycho-educational experiences. The characterological profile of the HCDD would indicate a style of treatment that is much more behaviorally focused and involves rigorous and sustained post-treatment monitoring and support, assertive linkage to local communities of recovery, and early re-intervention in response to any substance use. We envision a future in which integrated teams of judges, specialized probation officers, and treatment professionals will be involved in such sustained safety monitoring and recovery management. Such models would resemble the “containment model” currently used in the supervision of sex offenders (English, 1998).

Substance Relapse versus Impaired Driving Relapse: The severity of substance use problems among the HCDD population makes some episodes of relapse likely following primary treatment. Some short lapses are not unusual on the way to achieving stable recovery, but it is very important that the community and its representatives send a message of zero tolerance of drinking and driving to the HCDD. The goal is to drive a wedge between the act of drinking and the act of drinking and driving. While the former can be managed in the context of a recovery process, punishment for the latter must be certain, immediate, and severe.

Strategies and Principles

The National Highway Traffic Safety Administration's *Guide to Sentencing DUI Offenders* (1996b) lists 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.

We concur with these points, but would note several additional principles that may be helpful to those working with high-risk DUI offenders (White, 2004).

Visibility Principle: The HCDD's trivialization of drinking and driving must be challenged via an unequivocal and highly visible cultural/community message of zero tolerance for alcohol and drug impaired driving. Representatives of criminal justice and treatment agencies must be consistent carriers of this message and enlist media resources to help transmit this message visibly and repeatedly. This principle is grounded in findings that heightened perception of risk for future accidents or police stops reduces future risk of DUI recidivism (Greenberg, Morral & Jain, 2004).

Dose/Intensity Principle: Clinical treatment of the HCDD must be characterized by high intensity of personal involvement and a minimal dose below which outcomes are compromised. Such services may involve multiple levels of care (inpatient, outpatient, continuing care), but extend, in total, over at least three months time (NIDA, 1999).

Combination Principle: Combining multiple interventions—e.g., combining license suspension/revocation, treatment, and criminal sanctions—is more effective than any single intervention used in isolation in containing the HCDD. The goals are to combine interventions to reduce the frequency and quantity of alcohol and drug use (e.g., urine testing, remote alcohol monitoring, treatment, mutual aid groups), contain where drinking occurs (e.g., house arrest), reduce the risk of drinking and driving (e.g., vehicle seizure, interlock devices), and reduce larger threats to community safety (e.g., monitoring via DUI court and intensive probation).

Motivation/Behavior Principle: Those who are “forced” into addiction treatment have similar outcomes to those who “volunteer” for treatment.

The lack of initial motivation for change does not preclude long-term positive outcomes from treatment services.

Accountability Principle: Effective methods of managing the HCDD rely on multiple points of accountability with rewards and punishments contingent on clearly defined behavioral objectives, e.g., drug test results, aftercare meeting attendance, employment, restitution payment schedule. Many HCDDs do change their behavior when the punishment for continued drinking and driving is certain, severe, and quick (Wiliszowski, Murphy, Jones, & Lacey, 1996). We expect this principle to be integrated into a significant expansion of specialized DUI courts in the coming decade.

Containment Principle: There are HCDDs for whom no rehabilitative strategies will work, leaving a confinement strategy to protect the community via incarceration for the longest period of time with the hopes that such high-risk behavior will dissipate with age and accumulating consequences.

Summary

There is growing recognition of a subgroup of hard core drinking drivers that pose significant and sustained threats to public safety. Probation officers play a critical role in identifying and supervising this group of offenders. This article has summarized research on the hard core drinking driver, provided a checklist to aid identification of this high risk profile, and offered principles that can help probation officers supervise this high risk group of offenders.

The instrument below has been designed as a tool to help judges and probation officers quickly identify which DUI offenders pose the highest risk for re-arrest and future threat to public safety via impaired driving. Each item below has been identified as a risk factor in studies of DUI recidivism and through clinical observation of DUI recidivists. Those items in bold type in each area are those that seem to be the best predictors of recidivism.

Many of the items in this checklist have been confirmed in studies of Illinois DUI offenders, including the recent ASUDS-RI Pilot Study (Syrle & White, 2006). It is our hope that the continued follow-up of those re-arrested for DUI in the ASUDS-RI pilot study will allow us to rank and numerically score the risk factors contained in this checklist.

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Hard Core Drinking Driver Profile Checklist

Demographic/Social Profile

- Male (90-95% of recidivists)**
- Age 25-45 (75% of recidivists under age 40)**
- Education (half of recidivists have less than 12 years)
- Non-white-collar employment
- Occupational instability
- Lower socioeconomic status (annual income less than \$25,000)
- Impaired intimate relationships (75-80% divorced)**
- Social network containing other heavy drinkers and drinking drivers**

Substance Use/Treatment History

- Family history of AOD problems**
- Exposure to drinking and driving by parent and peer models**
- Early age of onset of regular drinking (age 14 or earlier)**
- Frequent, heavy drinking at venues accessible by car**
- History of drinking in automobiles
- Past year consumption of drugs other than alcohol**
- Early onset of smoking, heavy smoking, no effort or failed efforts to stop smoking**
- Meets DSM-IV criteria for substance abuse or substance dependence**
- Prior addiction treatment or involvement in addiction recovery mutual aid group
- Prior failure to comply with terms of sentencing (e.g., failure to complete mandated treatment, community service, etc.)**

Driving & Criminal Justice History

- Prior (often AOD-related) criminal arrests predating first DUI arrest**
- Prior crimes against persons
- Prior DUIs (Risk of recidivism rises with number of prior DUIs)**
- High-risk driving record (moving violations, prior crashes, prior loss of driving privileges, or high risk insurance or lack of insurance)**
- Prior aggravated driving without a valid license (e.g., high speed/recklessness, DUI, crash)

___ Prior DUI arrests in which consequences were avoided, delayed, or minimized

Drinking/Driving Beliefs

___ **Believes he or she can drive safely after consuming large amounts of alcohol**

___ **Underestimates his/her level of intoxication**

___ Makes no alternative transportation arrangements before drinking

___ Expresses likelihood of drinking and driving in the future

___ Believes penalties for impaired driving should be less severe

___ Perceives DUI arrest as product of bad luck or targeting by police

Arrest Event

___ **BAC greater than .15**

___ **High BAC without gross signs of intoxication**

___ Collateral charges with DUI

___ Current or past history of refusal of Breathalyzer test

___ Not wearing a seat belt at time of arrest; does not generally use seat belts

Broader Clinical Profile

___ **Symptoms of, and/or prior treatment of, psychiatric illness (depression, PTSD)**

___ **Medical/criminal history reflecting injury to self and others**

___ **Personality characteristics that include diminished capacity for empathy, guilt and remorse, failure to take personal responsibility (e.g., projection of blame), impulsivity, risk-taking, and aggression)**

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