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Changing Profile of the Drinking/Drugged Driver: Implications for Clinical Assessment

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Problems arising from acute and chronic alcohol and other drug intoxication constitute significant public health and safety issues in America. Of particular concern is the role alcohol and other drug impairment continues to play in traffic fatalities on the nation's highways. The rate of alcohol-related fatalities per vehicle miles traveled has dropped dramatically in the past two decades (from 1.64 in 1982 to 0.59 in 2003), but alcohol-related traffic fatalities continue to constitute 40% of all traffic fatalities—more than 17,000 persons killed per year (NHTSA, 2005). At the same time, new understandings about the profile of the drinking driver challenge many long-standing assumptions upon which intervention programs have been built. This article describes the evolution in our understanding of the drinking driver, highlights current research on the "hard core drinking driver," and discusses the clinical implications of these research findings.

Early History

Concerns about alcohol, drugs, and public safety have a long history. Early nineteenth century temperance literature is filled with images of bottle waving, drunken young men careening through city streets in horse-drawn carriages. Such threats led to drinking and driving laws that predate the invention of the automobile. Prohibition promised to end growing concerns about intoxicated drivers, but Repeal brought a new wave of drinking and driving problems in the 1930s as well as regulations aimed at reducing them. It wasn't until the Alcohol Safety Action Program (ASAP) emerged in the 1970s that America launched a comprehensive approach to reducing risks to public safety posed by the alcohol-impaired driver.

Funded by the National Highway Traffic Safety Administration, the ASAP was first piloted within 35 local projects and then widely replicated throughout the United States. The ASAP created local assessment centers whose staff determined if impaired drivers were problem drinkers or social drinkers, linking the former to treatment and the latter to brief remedial education (White, 2004). This system provided an efficient means of

processing hundreds of thousands of offenders arrested for driving under the influence (DUI), but came under increasing criticism in the mid-1980s (Kramer, 1986). 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). It turns out the ASAP model was based on the "myth of the social drinking DUI offender" (Crancer, 1986)—a myth that continues to influence arrest, evaluation, sentencing, and treatment decisions. This myth is historically rooted in three flawed assumptions.

The first assumption was that the DUI offender is generally a law-abiding citizen—he or she is not a criminal. This assumption was challenged by studies revealing that 40-70% of first-time DUI offenders had prior criminal offenses, most of them alcohol and drug related, 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 (Taxman & Piquero, 1998; Chang & Lapham, 1996). Collectively, these studies portrayed the DUI offender as anything but an otherwise model citizen and a significant threat to public safety.

The second assumption was that the majority of DUI offenders are not alcoholics or problem drinkers, but social drinkers whose impaired driving represented an isolated error in judgment. This assumption was challenged by studies finding that:

- It takes between 100 and 2000 repetitions of impaired driving violations to statistically generate one arrest (Borkenstein, 1975; Jones & Joscelyn, 1978; Voas & Hause, 1987; NHTSA, 2001).
- The accuracy of alcohol use disorder diagnoses among DUI offenders is seriously compromised by reliance on self-report data, with the rate of retrospective alcohol dependence diagnoses tripling in five-year follow-up studies (Lapham, C'de Baca, McMillan, & Hunt, 2004).
- The majority (most studies now suggesting between 70-80%) of DUI offenders are experiencing significant problems in their relationship with alcohol and/or other drugs (Timken, 1999; Lapham, Smith, C'de Baca et al., 2001).
- The percentage of drivers registering a detectable amount of alcohol in their bloodstream has dropped significantly since the mid-1970s (Yi, Williams, & Dufour, 2002), indicating that the number of social drinking drivers are shrinking, leaving in their

The third flawed assumption was that DUI offenders could be educated to moderate their drinking patterns and reduce their threat to public safety. The most methodologically rigorous evaluation of the early ASAP programs concluded that remedial education produced increased knowledge about the effects of drinking and driving but did not reduce rates of drinking and driving, re-arrest, or involvement in future alcohol-related crashes (Nichols & Ellingstad, 1978; Nichols, Ellingstad, & Reis, 1980).

The "Hard Core Drinking Driver"

The total pool of drinking/drugged drivers represents millions of American citizens, but recent studies confirm that the majority of total impaired driving trips are committed by a much smaller core of "hard core drinking/drugged drivers" (HCDD). This group is made up of individuals who, despite education, threats, and punishments, continue to drive frequently (at least monthly) at high BAC levels (above 0.15%) (Simpson, Beirness, Robertson, Mayhew, & Hedlund, 2004). Two recent studies highlight the profile of the hard core drinking driver (White & Gasperin, in press; Syrcle & White, 2006). HCDDs (those at highest risk for re-arrest for DUI and/or future involvement in an alcohol-related crash) are predominately single, separated and divorced males between the ages of 25-45 with 12 or fewer years of education transiently employed in non-white collar positions and who are enmeshed in a social network of heavy drinkers and drinking drivers. HCDDs are distinguished from non-recidivist offenders by greater family histories of AOD problems; prior exposure to drinking and driving by parent and peer role models; early age of onset of regular drinking (age 14 or earlier); early onset smoking, heavy smoking, and failed efforts to stop smoking; and past year use of drugs other than alcohol. Their first DUI arrest was likely to be characterized by a high BAC (greater than .15) without gross signs of intoxication, collateral charges, and refusal to take a Breathalyzer test. HCDDs believe they can drive safely after consuming large amounts of alcohol, believe penalties for impaired driving should be less severe, and perceive their arrest for impaired driving is a product of bad luck or targeting by police. They are more likely than non-recidivists to have criminal arrests predating their first DUI arrest; have prior DUI arrests in which consequences were avoided, delayed, or minimized; and to have high-risk driving records (e.g., multiple moving violations, prior crashes). In terms of clinical history, HCDDs are more

likely to report symptoms of, and/or prior treatment of, psychiatric illness; medical/criminal histories reflecting injury to self and others; and are more likely to exhibit diminished capacity for empathy, guilt, remorse, failure to take personal responsibility, impulsivity, risk-taking, and aggression.

Clinical Implications

The majority of those arrested for impaired driving either already have, are in the process of developing, or will go on to develop a significant problem in their relationship with alcohol and/or other drugs. Traditionally, addiction professionals were asked to answer two questions related to the impaired driver: 1) Does he or she have an alcohol problem and if so, how severe? 2) How can this problem be best resolved, e.g., recommendations that could influence judicial sentencing or probation supervision. It was assumed that answers to these questions would address the larger question of threat to public safety and how that threat could be minimized. But data on HCDDs suggests that effectively evaluating of the degree of the future threat to public safety and containing that threat require a far more comprehensive assessment process and more sophisticated intervention technologies than those traditionally offered.

The changing profile of the alcohol/drug impaired driver and growing recognition of the inordinate role HCDDs play in the total volume of impaired driving trips suggest the need for sophisticated global assessment instruments and advanced interviewing protocol whose conclusions can be used to guide evaluation, prosecution, sentencing, treatment, probation monitoring, and license reinstatement/denial decisions. The growing presence of drugs other than alcohol as threats to highway safety suggests the need for 1) better technologies for the identification, field evaluation, and arrest of drug-impaired drivers, 2) assessment instruments that evaluate the whole spectrum of psychoactive drug use, 3) an expanded menu of treatment options for impaired drivers whose primary dependence is upon a drug other than alcohol, and 4) increased use of drug testing as a monitoring tool for the DUI offender. The clinical profile of the HCDD further warrants more comprehensive assessment protocol (focused on broader driving, criminal, and psychiatric histories), more intense and enduring treatment options, and sustained monitoring of post-treatment status and assertive early re-intervention strategies.

The development of public safety measures to address the threats posed by alcohol- and drug-impaired drivers must be dynamic and accommodate changes in global patterns of substance use, changes in the

profile of the American drinking driver, and changes in the characteristics of those increasingly recognized as "hard core drinking/drugged drivers".

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