COURT INTERVENTION:

PRE-SENTENCE INVESTIGATION TECHNIQUES FOR DRINKING/DRIVING OFFENSES

PARTICIPANT'S MANUAL

U.S. Department of Transportation
National Highway Traffic Safety Administration
Washington, D.C. 20590

CONTENTS

SEMINAR

AGENDA

PRE-SENTENCE INVESTIGATION SEMINAR

Day One

0900–1200 **1. Introduction and Overview**
This unit covers: (a) introduction and administrative information, (b) information on DOT/NHTSA standards, (c) the genesis of the project, and (d) explanation of the ASAP health/legal approach.

Coffee Break

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

1200–1300 **Lunch**

1300–1700 **3. Alcohol and Impairment**
This unit will focus on the physiological effects of alcohol and its influence on driving abilities. The group will view the film "Under the Influence," and discuss the multitude of factors which affect an individual's ability to drive at high BACs (.10 and above).

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

Day Two

0900–1200 **5. Screening Instruments**
Review homework, review two systems. A brief history of the types of instruments used in screening will be presented, highlighting the CPIPD, and a videotape of the Sample CPIPD. Interview will be shown and the scoring explained. Sample interviewing techniques will also be demonstrated by means of videotape.

Coffee Break

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

1200–1300 **Lunch**

1300–1700 **6. Practical Application *(continued)***

7. Report Writing
Guidelines will be provided for a "model" referral form

which contains all necessary and sufficient information for use by the courts, probation, and treatment agencies.

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

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

Unit 1

Introduction and Overview

OBJECTIVES

- Acquaint the group with the instructor(s), the seminar purpose and scope, and expectations of the participants.
- Become familiar with the relationships between DOT, NHTSA, and the applicable standards (7 and 8).
- Be aware of the results of the five-year ASAP experience, and their implications for court treatment of DWI offenders.
- Recognize the court system changes that have been introduced as a result of the ASAP community action programs.
- Understand the nature and the purpose of the screening task.

BACKGROUND ON FEDERAL STANDARDS

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

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

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

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

17. Pupil Transportation Safety
18. Accident Investigation and Reporting

THE NATIONAL ALCOHOL SAFETY ACTION PROGRAM

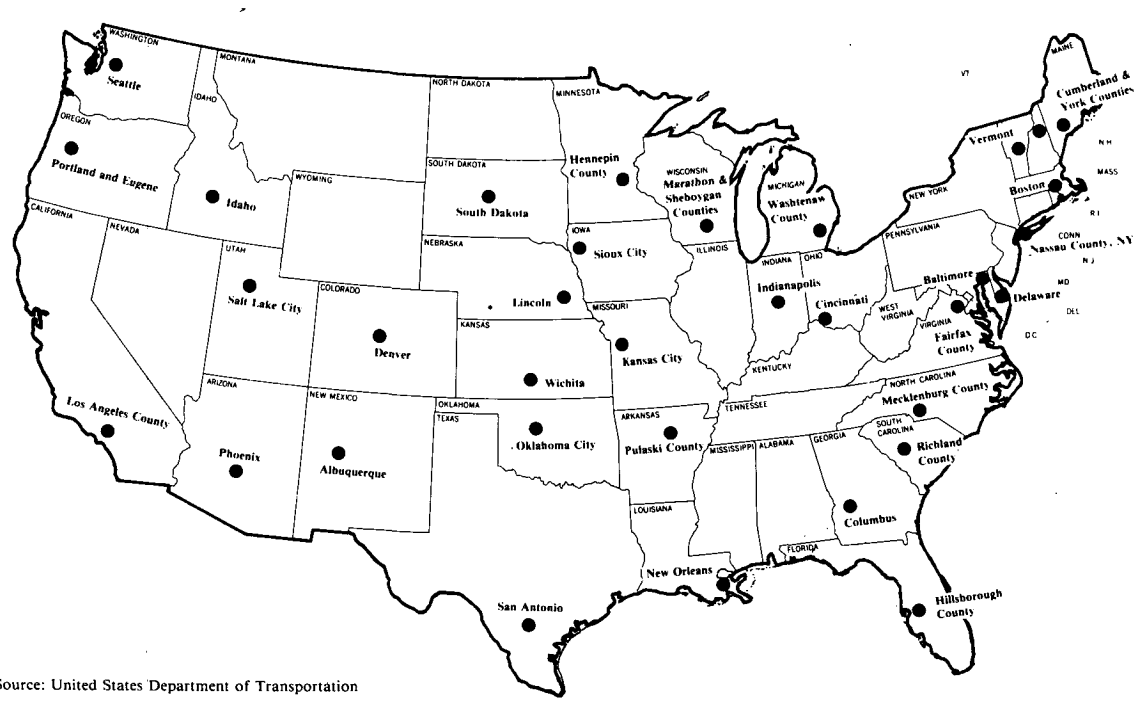
National Objectives

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

Project Objectives

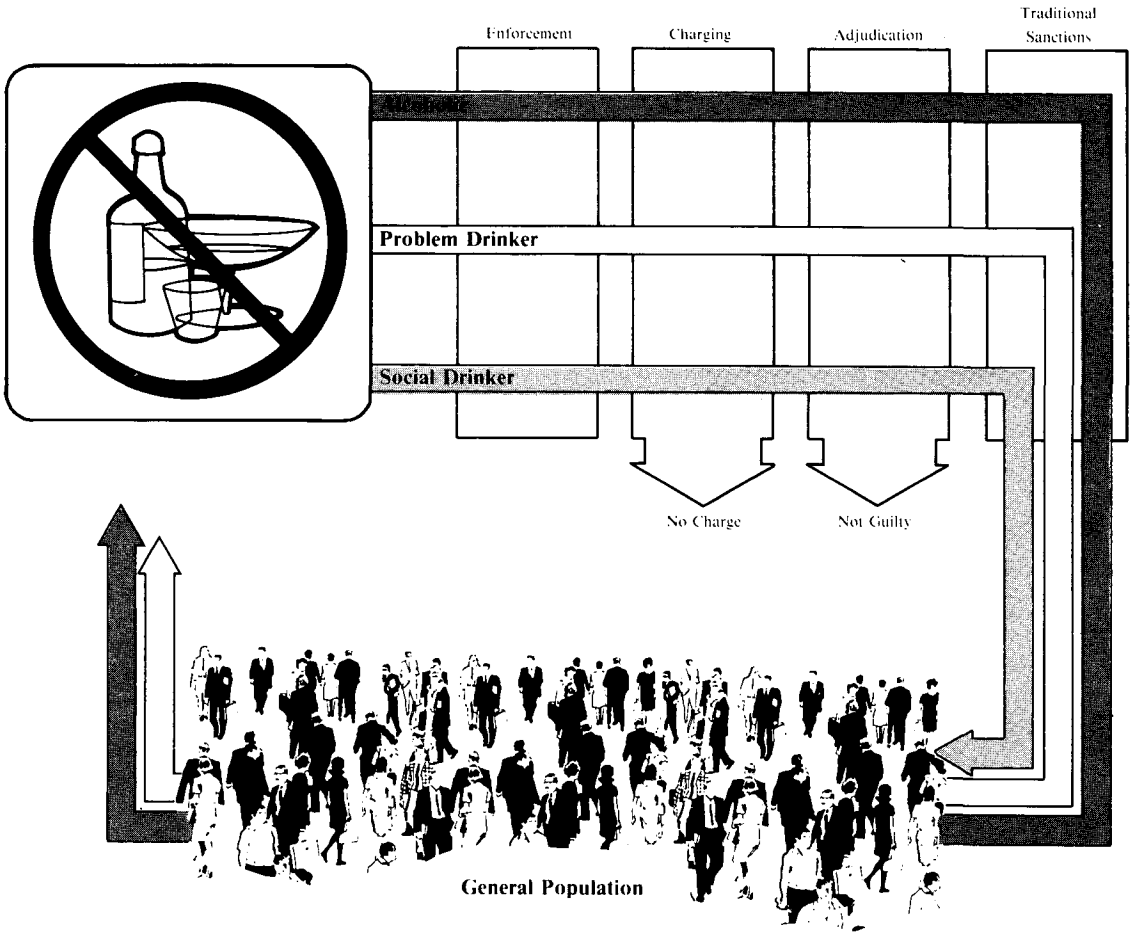
- Develop the local control system to the point where it was arresting and processing large numbers of drinking drivers at minimal cost and with maximal speed and efficiency.
- Develop sanctioning packages, including supplemental alcohol education and treatment programs, which would: (a) be acceptable to the courts, and (b) be appropriate to the drinking-driving offenders.
- Improve records systems to the point where the control system actions could be measured and drinking drivers accurately tracked and monitored.
- Measure the effectiveness of a whole group of countermeasures, as well as each individual countermeasure, at the same time that the experimentation and system development took place.

35 ALCOHOL SAFETY ACTION PROJECTS

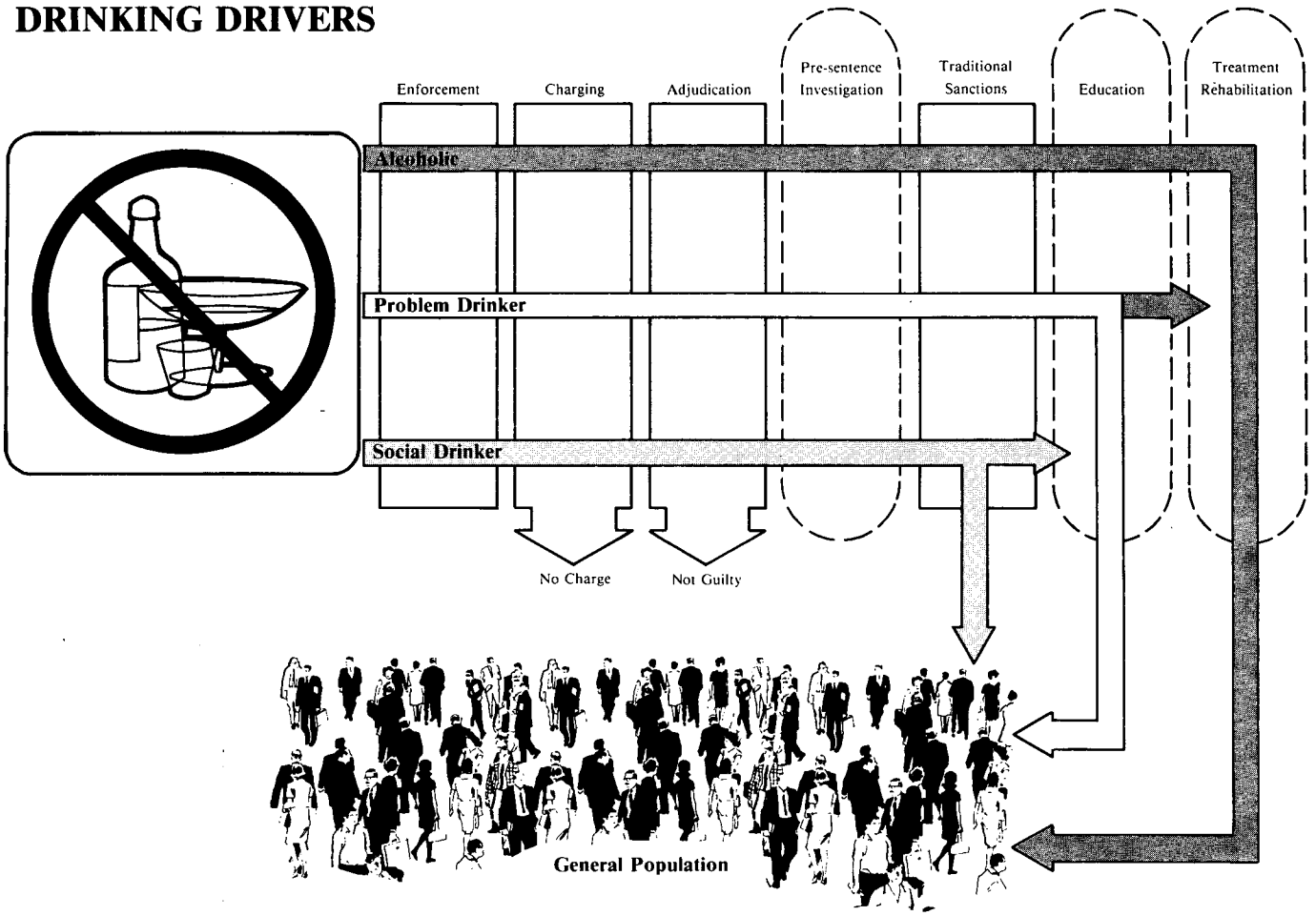


Source: United States Department of Transportation

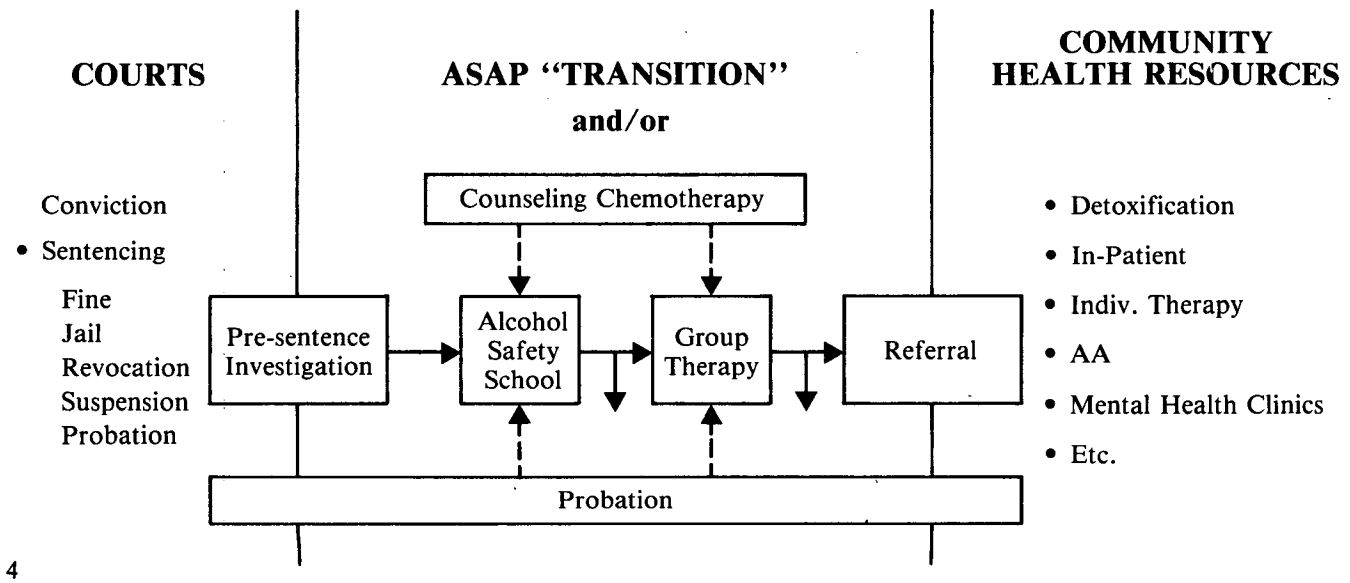
THE PRESENT SYSTEM HANDLES ALL DRINKING DRIVERS THE SAME WAY



THE PROPOSED SYSTEM DISTINGUISHES BETWEEN DIFFERENT KINDS OF DRINKING DRIVERS



THE ASAP CONCEPT OF A SCREENING, DIAGNOSIS, AND REFERRAL SYSTEM



SOME ASAP FINDINGS

Public Information and Education (PI&E)

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

Enforcement

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

Adjudication

- Courts should concentrate more on handling cases that do not reach a full trial than on those which do (less than 10 percent in a typical jurisdiction).
- Cooperation between prosecutors and judges produces economical and fair adjudication systems.
- Plea-bargaining should be formalized, systematic, and purposeful, based on standard criteria and accurate records.
- Pre-sentence investigations can be conducted quickly and cheaply.
- Probation serves a monitoring rather than a counseling function, especially with persons in alcohol treatment programs.
- Report-back systems can be easily designed and run on the basis of good records systems.
- Sentencing should create packages of sanctions appropriate to the offenders' drinking status, yet allow the court considerable flexibility.
- Legislation affecting the courts should be enacted only after thorough investigation of probable court and prosecution responses.
- Attention to court procedures can enable handling of triple the present caseload of drinking-driving offenses without adding new prosecutors or judges.
- Sanctions should be used to provide an incentive for long-term cooperation with the court, as well as for punishment.

Education and Rehabilitation

- Lecture-oriented DWI Schools do not affect the behavior of most problem drinkers and should not be used for them.

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

WHAT DO WE KNOW ABOUT THE VARIOUS TRAFFIC SANCTIONS?

Sanction	Impact	Research Findings
Court Appearance Only	Uncertain	A limited study demonstrated that face-to-face contact with a judge does **not** necessarily result in lower recividism than for non-appearing offenders.
Monetary Fine	Uncertain	There are no reported studies in which the amount of fine was manipulated experimentally. The few **ex post facto** studies are not very informative. There is some evidence, however, that heavy fines (in excess of $120) are associated with subsequent decreases in accident frequency.
Jail Term	Unknown	There are no empirical data on the effectiveness of jail sentences for traffic offenders. This sanction is infrequently applied even when required by law.
License Suspension	Uncertain	Research studies have shown that driving during periods of license suspension or revocation is frequent. License suspension appears to be ineffective or negligibly effective with chronic traffic violators. There is some evidence that suspension does have an impact on less repetitive "major" traffic offenders, such as drinking drivers. These offenders had significantly fewer accidents and citations during the suspension period than before. Overall, license

		suspension has not proven effective in eliminating or reducing accidents.
Restricted or Occupational License	Uncertain	Findings of the limited research have not been entirely consistent. The restricted license is violated probably as often as license suspension. Restricted drinking-driving offenders have been found to have more subsequent accidents than revoked drinking drivers, but not more than the general driving population.
Traffic Schools and Group Driver Improvement Meetings	Uncertain	There is reasonably persuasive evidence that some group traffic safety meetings are effective in reducing accidents and violations, although not all authorities agree.
Effect of Graduating Sanction Severity by Number of Prior Convictions	Unknown	There is no information on the effectiveness of this procedure.
Alternative Service	Unknown	There is no information on the effectiveness of this sanction.
Court Probation and Suspended Sentence	Unknown	Little/no evidence has been gathered on the effectiveness of judicial probation and sentence suspension.
Drinking-Driver Treatment Programs	Uncertain	Based on early ASAP results (1973), rehabilitative efforts for drinking drivers have not been proven effective. However, poor evaluation design in many of the ASAPs precluded valid scientific conclusions being made on the initial data.

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

THE ASAP RESPONSE HAS SHOWN

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

- Increase and improve enforcement.
- Conduct special target group and general public information and education campaigns.
- Establish a management unit for the control system.
- Introduce alcohol education and rehabilitation as supplemental sanctions.
- Standardize and routinize the sanction packages (including punitive, therapeutic and administrative sanctions).
- Improve and coordinate its records systems.
- Introduce a screening, referral, and monitoring capability (i.e., presentence investigation, probation).

- Remove court processing delays by streamlining procedures.
- Evaluate the success of the system efforts.

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

- Increase arrests only to a level that the system can process efficiently.
- Provide some general publicity for the new program.
- Refer drinking driving offenders routinely to an alcohol safety school, but do **not** send suspected problem drinkers to large, lecture-type schools.

GENESIS OF THE PSI SEMINAR PACKAGE

Data Collection Sites:

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

Court Survey Questionnaires Were Received From:

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

RESULTS OF SURVEY ON PRE-SENTENCE INVESTIGATIONS (PSI)

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

Unit 2

The Problem Drinking Driver

OBJECTIVES

- Be aware of the national, state, and local statistics on alcohol involvement in highway crashes.
- Recognize the prevalence of Problem Drinkers in the DWI population.
- Understand the increase in probability of responsibility for an accident with high BACs.

DRINKING AND DRIVING STATISTICS

Highway crashes are:

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

Alcohol-impaired drivers are involved in at least:

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

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

Significant facts on DWI arrests:

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

Males are higher risks because:

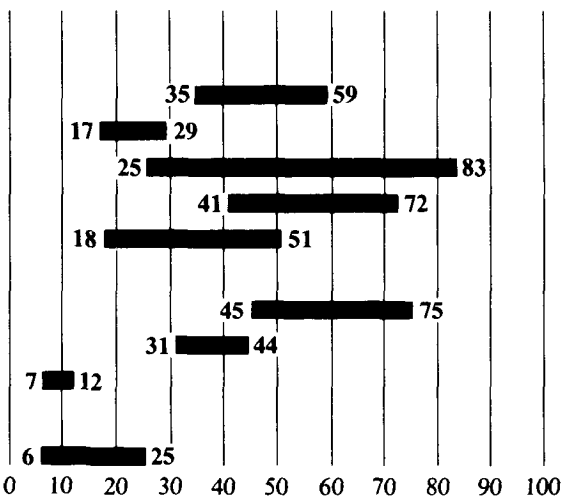
- males have and cause many more serious crashes than do females.
- typically, more than 90 percent of DWI arrests involve males.
- about 48 percent of men and 22 percent of women admit to driving after drinking.

- about 26 percent of men and 8 percent of women admit to driving after drinking **too much.**

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

Source: 1968 Alcohol and Highway Safety Report; Gallup polls

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



PROBLEM DRINKING DRIVERS

- The Problem Drinking Driver is someone who **regularly** drives while seriously impaired.
- In the typical jurisdiction, about two-thirds of persons arrested for DWI are identifiable as Problem Drinkers, either clearly or marginally.
- Problem Drinking Drivers usually have a high BAC (0.15 percent or above) when arrested. Of course, the BAC on any occasion may be lower.
- Drivers with a high BAC (0.10 percent or above) are likely to be involved in at least
  - Twice as many crashes
  - Twice as many property damage crashes
  - Five times as many personal injury crashes
  - Twelve times as many fatal crashes
  - Twice as many traffic violations
  - Three times as many license suspensions

  as the average driver.
- Social Drinkers rarely achieve the high BAC (0.10 percent or above) which problem drinkers achieve very often.
- A person can learn to "drive while drunk" i.e., to compensate partially for the impairment caused by alcohol up to a point. The learning takes a lot of practice.

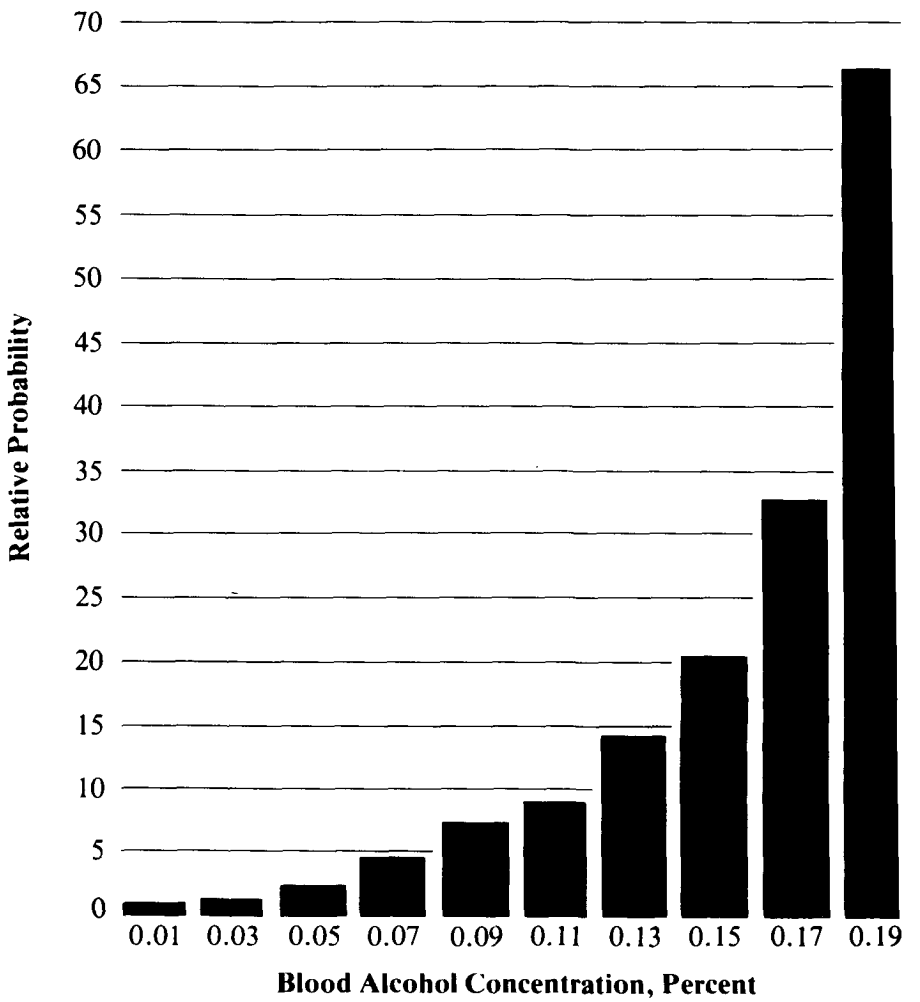
Social Drinkers don't get that much practice. They are likely to judge themselves "too drunk to drive," or to drive very badly at lower BACs.

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

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

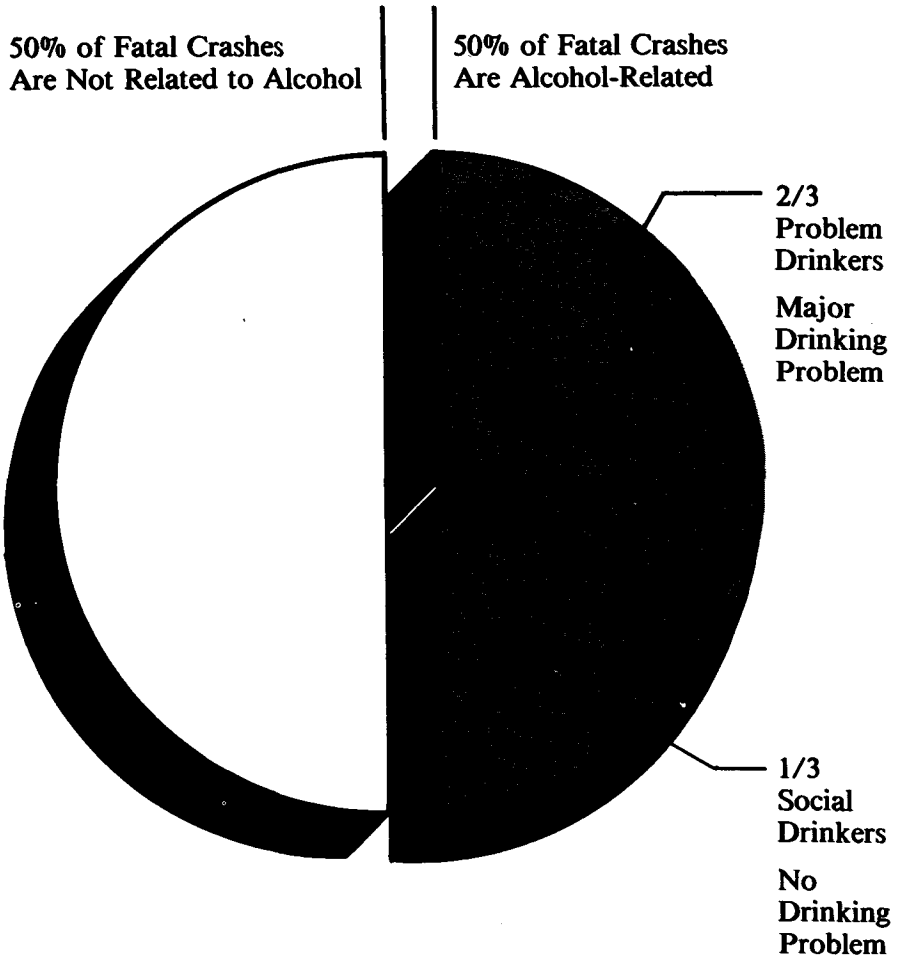
  This makes it possible to identify them by record checks and personality tests.

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



Source: Perrine et al, 1971

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



Source: 1972 ASAP Evaluation of Operations, NHTSA

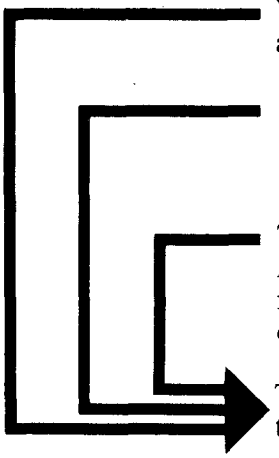
Unit 3

Alcohol and Impairment

OBJECTIVES

- Accept the BAC as an accurate measure of driving impairment.
- Be able to determine the amount of alcohol that must be ingested to achieve specific BACs.
- Identify the behavioral and attitudinal changes that occur in drivers who are under the influence of alcohol.
- Accept the premise that BACs of .08 and higher substantially impair driving skills in all persons regardless of their age, sex, or habituation level.

THE PROBABLE DEGREE OF DRIVING IMPAIRMENT CAN BE MEASURED BY BAC



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

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

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

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

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

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

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

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

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

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

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

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

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

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

IT TAKES A LOT OF ALCOHOL TO REACH A HIGH BAC

IT TAKES TIME AND ONLY TIME TO SOBER UP

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

Source: Rutgers Alco-Calculator

PREDICTABLE KINDS OF IMPAIRMENT OCCUR AT SPECIFIC BACS

.00–.04%

Impairment—Not Serious
Absence of overt effects; mild alteration of feelings, slight intensification of existing moods.

.05–.09%

Ability and Judgment Impaired
Feelings of warmth, relaxation, mild sedation;

exaggeration of emotion and behavior; impairment of fine motor skills; increase in reaction time. Visual and hearing acuity reduced; slight speech impairment; minor disturbance of balance; increased difficulty in performing motor skills; feelings of elation or depression.

.10–.14%

Ability and Judgment Notably Impaired in Everyone
Difficulty in performing many gross motor skills; uncoordinated behavior; definite impairment of mental faculties, memory and judgment.

.15% +

Ability and Judgment Seriously Impaired in Everyone
Exhibition of major impairment of all physical and mental functions; irresponsible behavior; general feeling of euphoria; difficulty in standing, walking, talking, distorted perception and judgment. If the BAC reaches .50% a coma develops and by .60% death can result.

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

THE DRIVERS' ATTITUDES

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

THE DRIVERS' SKILLS

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

- Deep muscle sense was generally inhibited.
- Drivers reacted to visual cues where they normally reacted to a combination of sensory cues; thus, they tended to react after something had already happened or had already begun to happen. Weaving action resulted from this.

THE DRINKING DRIVER IS A PROBLEM OF MAJOR PROPORTIONS

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

Source: **ASAP Summary Report**, 1976

CONCLUSION

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

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

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

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

- Erratic movement (weaving, swerving)

- Extreme caution or recklessness
- Failure to anticipate hazards
- Failure to maintain lane control
- Aggressive driving

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

ALCOHOL INFORMATION INVENTORY

Please check (✓) the appropriate answer.

1. **What is the Blood Alcohol Concentration (BAC) level presumptive of legal intoxication in this state?**

   ___ a. .05%
   ___ b. .08%
   ___ c. .10%
   ___ d. .15%
   ___ e. .20%

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

   ___ a. Three
   ___ b. Six
   ___ c. Nine

3. **Which of the methods listed below effectively sober up a person so that he will be able to drive safely? (check one or more)**

   ___ a. Black coffee
   ___ b. Waiting as long as is necessary
   ___ c. Cold shower (or a dip in a swimming pool, lake, etc)
   ___ d. Hot shower, steam bath, sauna
   ___ e. A shock (like an auto accident, or near miss)
   ___ f. Exercise
   ___ g. Fresh air
   ___ h. None of the above

4. **True or false: One or two drinks of alcohol sharpen your driving skills.**

   ___ a. True
   ___ b. False

5. **When a 175-pound man has had nine standard drinks on an empty stomach two hours before driving, what do you think his chances are of being involved in an accident?**

   ___ a. 2 times greater than when he is sober
   ___ b. 5 times greater than when he is sober
   ___ c. 25 times greater than when he is sober

6. **In most states, what proportion of the drivers arrested for driving while intoxicated do you think have had a previous arrest for DWI?**

___ a. 1 in 2
___ b. 1 in 10
___ c. 1 in 25

7. **In most states, what percentage of the drivers arrested for DWI do you think are already known to community service agencies for having other alcohol problems?**

___ a. 10%
___ b. 50%
___ c. 80%

8. **Approximately how many people were killed last year in traffic accidents in this country.**

___ a. 5,000
___ b. 25,000
___ c. 50,000
___ d. 100,000

9. **Approximately what percentage of these deaths involved drinker-drivers or drinking pedestrians?**

___ a. 25%
___ b. 50%
___ c. 75%

10. **What percentage of those accidents in which blameless drivers were killed were caused by drinking drivers?**

___ a. 15%
___ b. 45%
___ c. 75%

11. **On the average, people arrested for DWI have Blood Alcohol Concentrations that would result from a 175-pound man drinking how many drinks in an hour?**

___ a. 3
___ b. 6
___ c. 10

12. **Alcohol is medically considered:**

___ a. A stimulant
___ b. A depressant
___ c. Both
___ d. Neither

13. **In California a study was made of the records of traffic violations of all types. What percentage of people who had had their licenses revoked were caught driving without a license?**

___ a. 15%
___ b. 35%
___ c. 65%

14. **True or false: In most states, when a person is stopped for a DWI violation, his record is usually checked for previous violations (at least those violations which took place within the state).**

___ a. True
___ b. False

15. **True or false: In most states alcohol is involved in more run-of-the-mill crashes than in serious crashes.**

___ a. True
___ b. False

16. **True or false: Alcohol-related crashes typically involve drivers with BACs that are at very high levels rarely found among drivers who do not get into accidents.**

___ a. True
___ b. False

17. **What proportion of adult pedestrians hit by vehicles are under the influence of alcohol?**

___ a. 10%
___ b. 40%
___ c. 80%

18. **True or false: Since few alcoholics own cars, they do not contribute significantly to the drinking-driver problem.**

___ a. True
___ b. False

19. **True or false: Very few convicted drinker-drivers have ever been involved in any crime (such as drunk and disorderly) other than DWI.**

___ a. True
___ b. False

20. **True or false: Two-and-a-half times as many people are killed in alcohol-related automobile accidents as are killed in willful murders.**

___ a. True
___ b. False

21. **True or false: Five times as many people are injured in alcohol-related car accidents as are hurt in crimes against persons (muggings, assaults, etc.).**

___ a. True
___ b. False

Source: Alcohol Highway-Traffic Safety Workshop

ANSWER SHEET FOR ALCOHOL INFORMATION INVENTORY

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

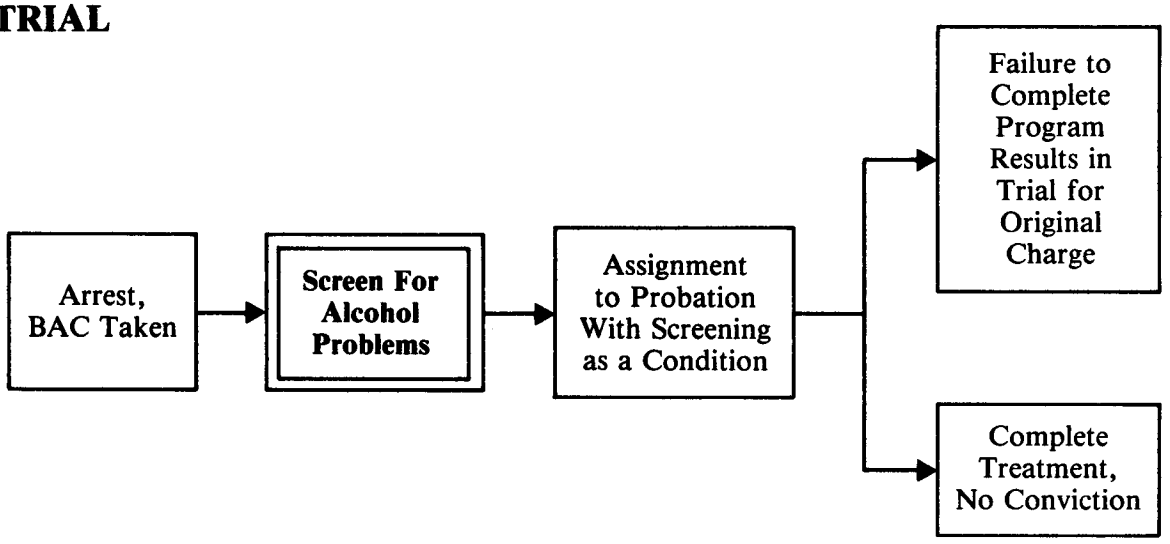
Unit 4

The Responsibilities of PSI Personnel

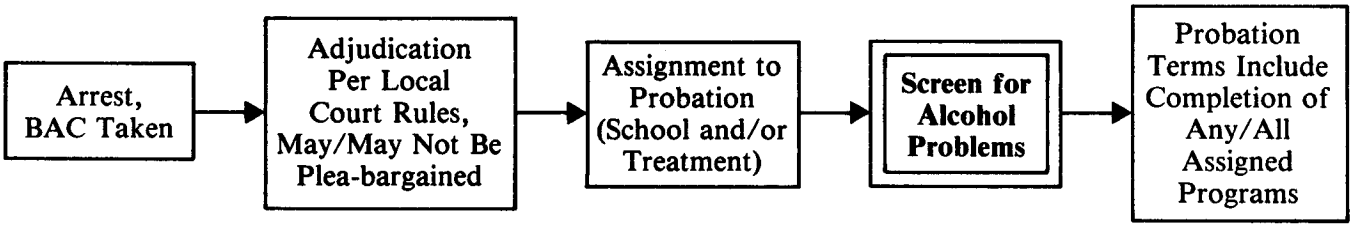
OBJECTIVES

- Recognize the screening techniques and timing used in various court systems, both ASAP and non-ASAP.
- Attempt to diagnose the levels of drinking problems in sample cases provided.

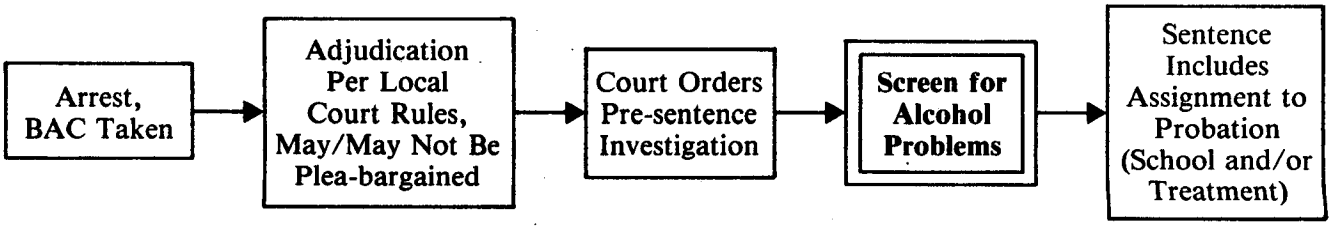
PRE-TRIAL



POST-TRIAL

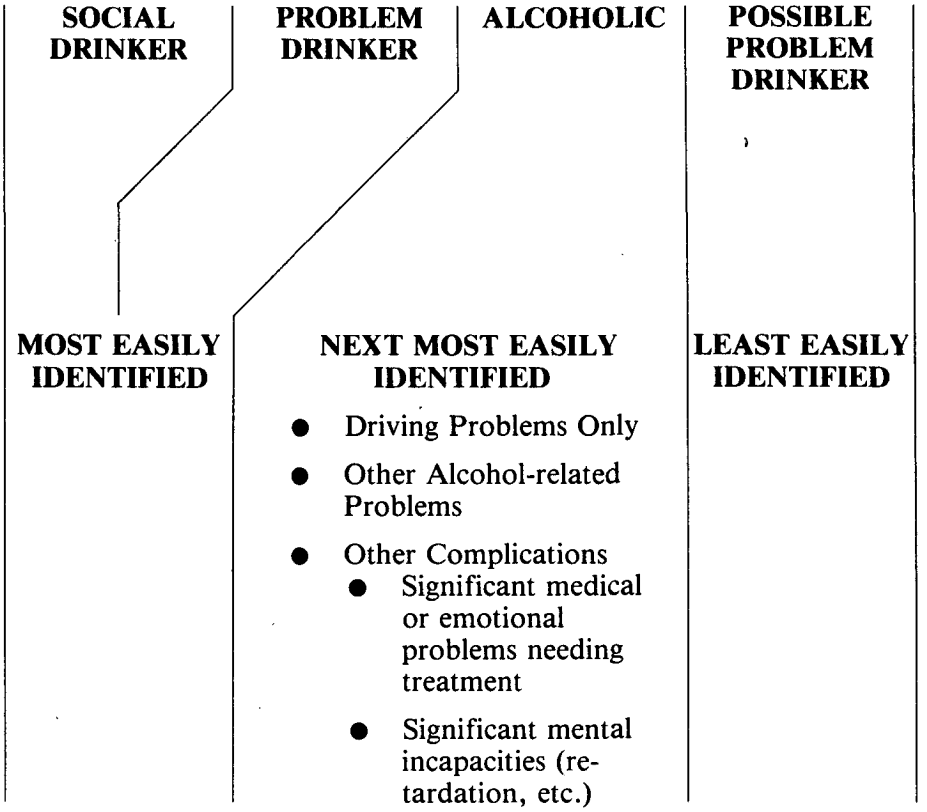


PRE-SENTENCE



SCREENING MAY BE ENOUGH

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



CASE NO. 1

Robert Grant, 38 Years Old

Marital Status: Separated since 1974.

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

Criminal Record: DWI conviction, 1971

Driving Record:

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

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

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

Observation: On brief contact with offender, interviewer observed that Mr. Grant appeared quite nervous, chain-smoking throughout the 20-minute interview. His responses to questions regarding his drinking quantity and frequency appeared guarded, but this may have been due to high anxiety. His hands are steady, but nicotine-stained. His general physi-

cal appearance is good, although his face seems flushed at the beginning of the interview. He is very reluctant to discuss his separation from his wife; answers questions in brief Yes/No manner.

Preliminary Diagnosis: [Check (✓) one]

_____ Social Drinker

_____ Borderline Problem Drinker

_____ Problem Drinker

CASE NO. 2

Lewis R. Stone, 25 Years Old

Marital Status: Single.

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

Criminal Record:

18 Nov. 1968 – Arrested and convicted for Vandalism and Petty Larceny. Received six months' suspended sentence, 18 months' probation.

21 Jan 1969 – Arrested for possession of unregistered firearms and probation violation. Received 30 days in jail, but judge suspended sentence and placed him on reporting probation for 24 months. This was discontinued when he entered the U.S. Army in 1971.

Driving Record:

2 June 1969 – Speeding, 50 mph in 35 mph zone. Fine and point assessment.

14 Oct. 1969 – Speeding and Drag Racing. Fine and point assessment.

16 Mar. 1974 – Reckless Driving arrest and conviction. Fine and point assessment. License suspension was waived because of occupation.

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

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

Preliminary Diagnosis: [Check (✓) one]

_____ Social Drinker

_____ Borderline Problem Drinker

_____ Problem Drinker

CASE NO. 3

Daniel S. Felker, 36 Years Old

Marital Status: Married, two children.

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

Criminal Record: None

Driving Record:

2 Oct 1968 – Negligent Driving, resulting from accident in which his vehicle hit another from behind. Fine and point assessment.

15 Aug 1973 – Speeding, 55 mph in 45 mph zone. Fine and point assessment.

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

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

Preliminary Diagnosis: [Check (✓) one]

_____ Social Drinker

_____ Borderline Problem Drinker

_____ Problem Drinker

Unit 5

Screening Instruments

OBJECTIVES

- Understand the need for an *objective* measure of level of drinking problem.
- Be aware of the types of screening instruments used, and their relative worth.
- Recognize the importance of good interviewing and communication skills for screening personnel.
- Be able to administer and score the CPIPD test, and interpret the results.

NHTSA'S DEFINITION OF A PROBLEM DRINKER

A problem drinker is an individual characterized by:

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

SCREENING METHODS

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

- Valid
- Reliable
- Efficient
- Implementable
- Acceptable

SCREENING INSTRUMENTS

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

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

Mult. r^2	Variable Number Entered
0.0442	1. Age
0.1532	2. BAC at arrest
0.2331	3. No. prior PI convictions
0.2413	4. No. reckless driving convictions
0.2422	5. No. HMV convictions
0.2423	6. No. driver license violation convictions
0.3177	7. No. prior DWI convictions
0.3223	8. No. convictions other crimes
0.3328	9. Educational level
0.3452	10. Income class
0.4758	11. Drinking pattern
0.4794	12. Marital status
0.4815	13. Work pattern
0.6086	14. Mortimer-Filkins score

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

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

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

TWO SCREENING SYSTEMS

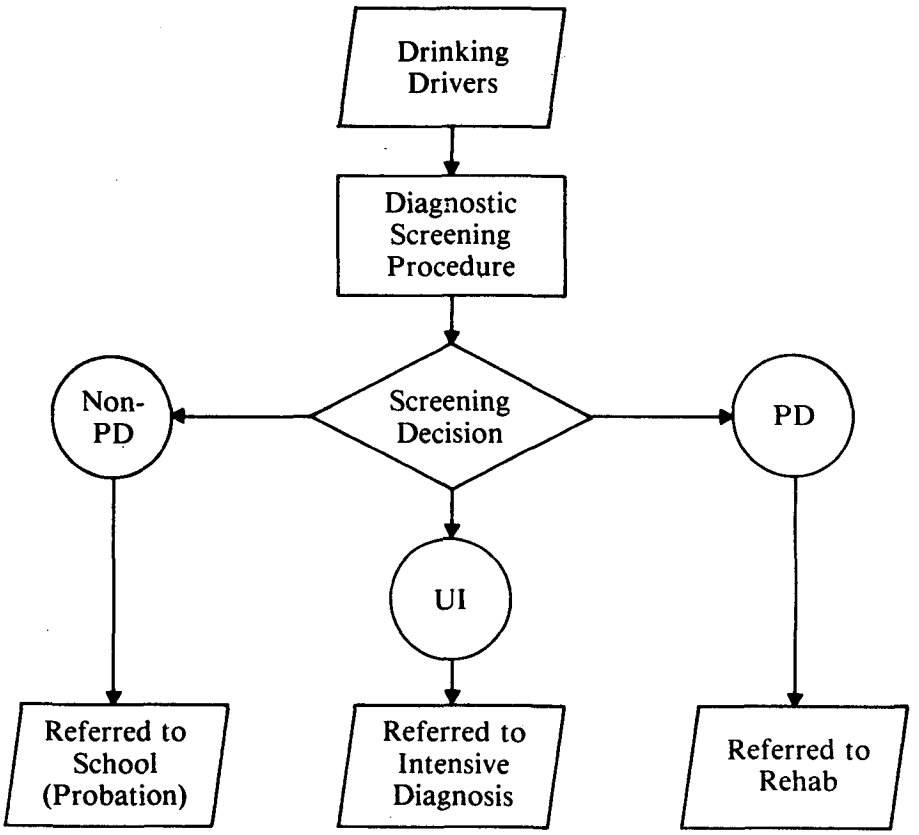
SYSTEM A

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

SYSTEM B

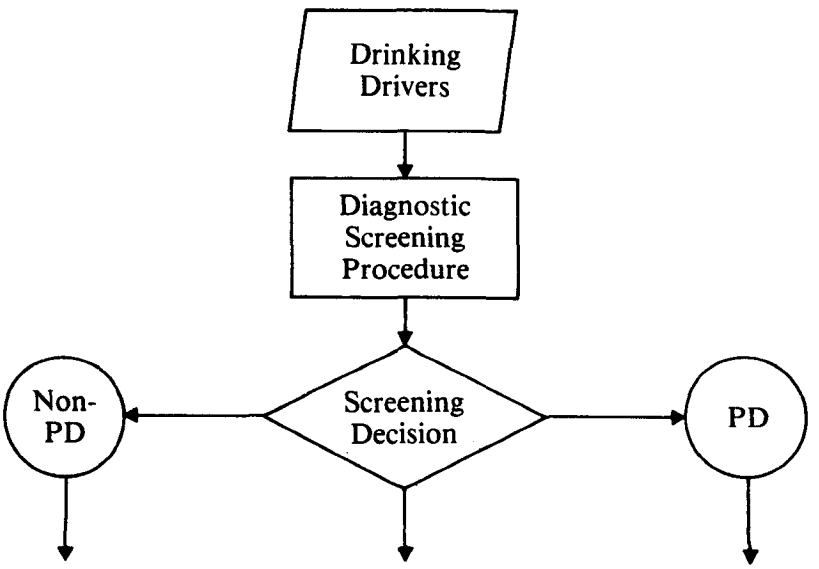
Drinker Type	MF Score	No. of Priors	Percent of Population
Social Drinker	< 40	0	56
Borderline	> 40	0	24
Problem Drinker	N.A.	1 or more	20

SCREENING SYSTEM A

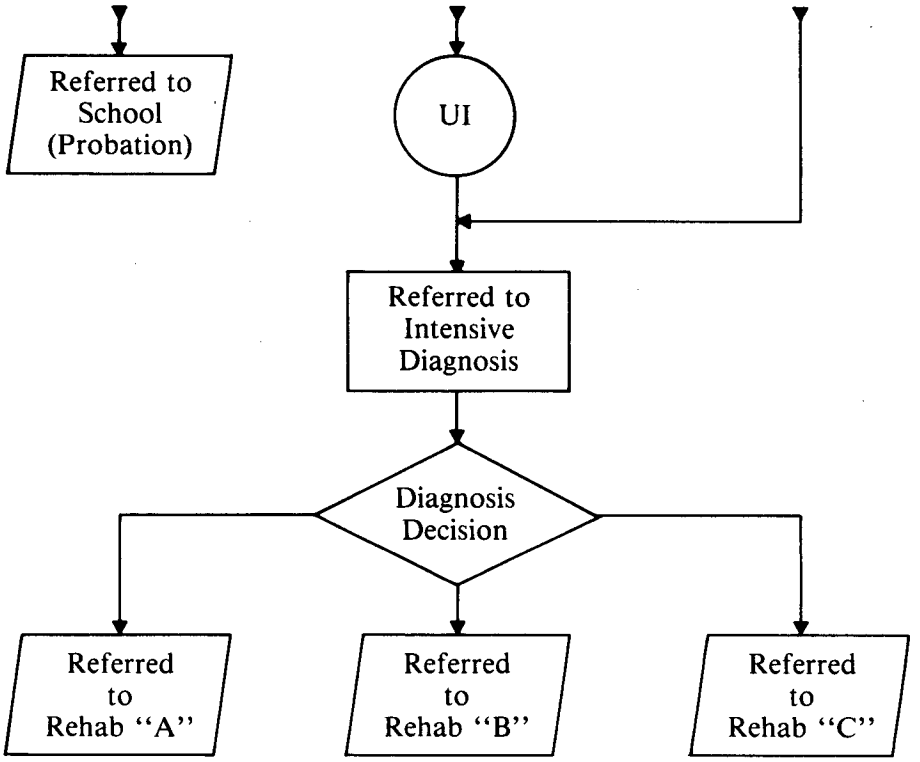


Client Flow For Systems With Unidimensional Treatment Programs (Only One Referral Alternative Per Drinker Type)

SCREENING SYSTEM B



SCREENING SYSTEM B (Continued)



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

INTERVIEW TECHNIQUES

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

BARRIERS TO COMMUNICATION

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

Unit 6 Practical Application

OBJECTIVE

- Be able to administer the CPIPD interview in a role-playing situation, and assess the level of drinking problem represented by each case.

Interviewer's Copy
CASE NO. 1

DWI–Fourth Offense

Interview Date: 1 September 1976

Name: Robert J. O'Malley
4529 Meridian, Center City

Date of Birth: 1 May 1929

Employment: Insurance Agent
Aetna Life and Casualty

	Arrest Date	Outcome
Criminal Record:	2 July 1968	DWI conviction, no BAC recorded, no accident. Received 12 months' probation and 30-day license suspension.
	14 Dec 1969	DWI conviction, BAC of .22, no accident. Received 18 months' probation, 90-day suspension and DWI school.
	3 Mar 1974	Reckless Driving, leaving scene of an accident. Placed on 18 months' reporting probation. Attended Mental Health alcohol treatment program for six months as part of sentence, as well as two AA meetings/week for three months.
	19 Mar 1977	DWI arrest with BAC of .26. Judge allowed him to be placed on 12 months' probation.
Driver's Record:	1945–70	Two speeding tickets, one DWI in this period.
	14 Dec 1969	DWI conviction, three months' license suspension. Attended DWI school.
	3 Mar 1974	Reckless Driving, six months' revocation.
	14 May 1974	Driving while license revoked. Two-year revocation, referral to alcohol rehabilitation agency.
	19 Mar 1977	DWI conviction. Currently awaiting DMV hearing on charge of Habitual Offender.
Present Offense:	19 Mar 1977	DWI arrest with BAC of .26.

Officer's Report: Mr. O'Malley was observed first making an illegal turn, then proceeded to drive at 70 mph in a 45 mph zone. When stopped, he was angry and

uncooperative. He fumbled for his license, his speech was slightly slurred, and he swayed standing on one foot.

Court Status: Mr. O'Malley is currently on 12 months' probation.

Interviewer's Copy
CASE NO. 2

DWI–First Offense

Interview Date: 2 June 1977

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

Date of Birth: 20 January 1956

Employment: Switchboard Operator
Farmingham Supply Co.

Criminal Record: None

Driver's Record:

9 June 1974	Backed into traffic from driveway onto Hill Drive and hit 1968 Ford Brougham LTD. No injuries/ $400 damage total.
18 Dec 1974	Hit parked car at shopping center. $175 damage total.
12 May 1976	Went through red light and hit bus. Minor injuries to two bus passengers. $1800 damages.

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

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

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

Interviewer's Copy
CASE NO. 3

DWI–First Offense

Interview Date: 1 June 1977

Name: Laura L. Goodman
Apt G, Fillmore Apts., Center City

Date of Birth: 4 September 1928

Employment: Chief Accountant
Artcraft Printing Co.

Criminal Record: None

Driver's Record:	1948-72	Only two moving violations—one illegal turn, one speeding offense.
	1 Mar 1977	Lost control on icy road and struck 1968 Pontiac. Minor injuries. $850 damage.
Present Offense:	14 Mar 1977	DWI arrest with BAC of .11, no accident.

Officer's Report: The officer observed her weaving and then driving very slowly (25-30 mph) on four-lane, high-speed toll road. She did very poorly on all psycho-motor tests. Was unable to walk a line or stand on one foot without swaying.

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

Interviewer's Copy
CASE NO. 4

Breath Test Refusal

Interview Date: 1 June 1977

Name: Alan B. King
2023 Hill Street, Center City

Date of Birth: 5 May 1938

Employment: Shop Foreman/Union Safety Officer
United Steel Works, Inc.

Criminal Record:	**Arrest Date**	**Outcome**
	22 Nov 1965	DWI conviction, BAC of .19. Entered diversion program on 12 months' probation. Attended DWI school.
	20 Oct 1974	Drunk and Disorderly. Arrested in downtown bar with two other men after a fight. Released on $100 bond; later paid fine of $50.
	26 Jan 1975	DWI conviction; no accident; BAC of .25. Referred to Mental Health Clinic for problem drinking. Attended four treatment sessions, then joined AA in March 1975.
Driver's Record:	26 Jan 1975	DWI, 60-day license suspension.
	7 Mar 1977	Breath Test Refusal, six months' suspension.
Present Offense:	7 Mar 1977	Refused breath test. Traveling north on Route 28, crossed centerline and collided head-on with another car. $2200 damage, serious injuries to other driver.

Officer's Report: Report states that when he came upon the scene of the accident, Mr. King was out of his car and giving aid to the other driver. He had been belted into his car, and only had a few bruises. The other driver was not belted and his head and chest were badly cut, so Mr. King used his first aid knowledge to help him. The officer noted the odor of

alcohol on Mr. King's breath but, in the ensuing confusion didn't ask him to do any psycho-motor tests. When he did request that Mr. King take a breath test, Mr. King refused.

Court Status: Received suspended sentence and placed on 12 months' probation. Referred to this office for initial interview.

Interviewer's Copy
CASE NO. 5

DWI—First Offense

Interview Date: 1 June 1977

Name: Madeline L. Quinn
3230 Jackson Hts., Center City

Date of Birth: 21 January 1946

Employment: Catering Service Manager
Hilton Hotel

	Arrest Date	**Outcome**
Criminal Record:	24 May 1969 New York City	DWI arrest with BAC of .12. Entered diversion program for first offenders; received 12 months' probation. Attended DWI school.
Driver's Record:	1 June 1970	Speeding, 60 mph in 45 mph zone.
	2 Nov 1972	Speeding, 70 mph in 50 mph zone
	18 Dec 1973	Reckless Driving, struck 1970 Chevrolet at an intersection after running STOP sign. No injuries. $600 damage total.
	6 July 1974	Speeding, 65 mph in 55 mph zone. 30-day suspension; Defensive Driving School.
Present Offense:	21 April 1977	DWI arrest with BAC of .19. Her car struck a utility pole. Minor injury to herself; $250 damage to car.

Officer's Report: The police report that when they came upon the scene of the accident, Mrs. Quinn was slumped forward over the steering wheel, unconscious, and the odor of alcohol was very strong on her breath. She was found to have only minor injuries, but her speech was slurred, and she was extremely slow in responding to requests for her license and registration. When asked to perform psycho-motor tests, she refused saying she'd fallen asleep at the wheel and was not drunk. She was very hostile when arrested, and scratched both officers.

Court Status: Mrs. Quinn has been placed on probation for 12 months. Once condition of probation is to be evaluated for alcohol abuse in this interview.

Interviewer's Copy
CASE NO. 6

DWI–First Offense

Interview Date: 1 June 1977

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

Date of Birth: 3 January 1924

Employment: Self-employed as Real Estate Agent

Criminal Record: None

Driver's Record:

1940–70	Four speeding offenses, one Reckless Driving in this period.
21 Dec 1973	Reckless Driving, too fast for conditions.
14 May 1974	Reckless Driving; ran red light; struck 1966 Plymouth. Minor injuries/$650 damage. No BAC taken. Thirty-day suspension.

Present Offense:

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

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

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

Interviewer's Copy
CASE NO. 7

Interview Date: 3 June 1977

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

Date of Birth: 6 February 1942

Employment: Bricklayer
Picone Construction Co.

Criminal Record: None

Driver's Record:

17 Apr 1971	Speeding, 50 mph in 35 mph zone.

	4 Aug 1974	Reckless Driving. Lane changing on freeway at high speed. No BAC taken.
	28 Jul 1976	Speeding, 65 mph in 55 mph zone.
Present Offense:	1 Apr 1977	DWI arrest with .13 BAC. Went through YIELD sign on expressway, collided with 1974 Pontiac. Minor damage and no injuries.

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

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

Interviewer's Copy
CASE NO. 8

DWI–First Offense

Interview Date: 6 June 1977

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

Date of Birth: 14 June 1950

Employment: Truck Driver
Self-Employed

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

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

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

Interviewer's Copy
CASE NO. 9

DWI–Second Offense

Interview Date: 7 June 1977

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

Date of Birth: 12 October 1915

Employment: Janitor
Fuller Department Store

Criminal Record:

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

Driver's Record:

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

Present Offense:

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

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

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

Unit 7

Report Writing

OBJECTIVE

- Be able to write a clear, concise report for court system use in deciding upon referrals to education or treatment for alcohol problems.

CHOOSING A SANCTION—WHAT INFORMATION DOES THE JUDGE NEED AND WANT?

- Background information only
- Drinker type only
- Recommendation for therapeutic referral to another agency
  - ASAP
  - Diagnosis
  - Treatment and rehabilitation
  - Social services agency
  - Supervision
- Recommendation for Legal disposition
  - Imposition of incarceration
  - Imposition of fine
  - Driver licensing action
  - Granting of probation
  - Specific conditions of probation

Cover Sheet

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

Interviewer's Report

Name:_____ Date:_____

Case No.:_____

To: (Agency/Court)

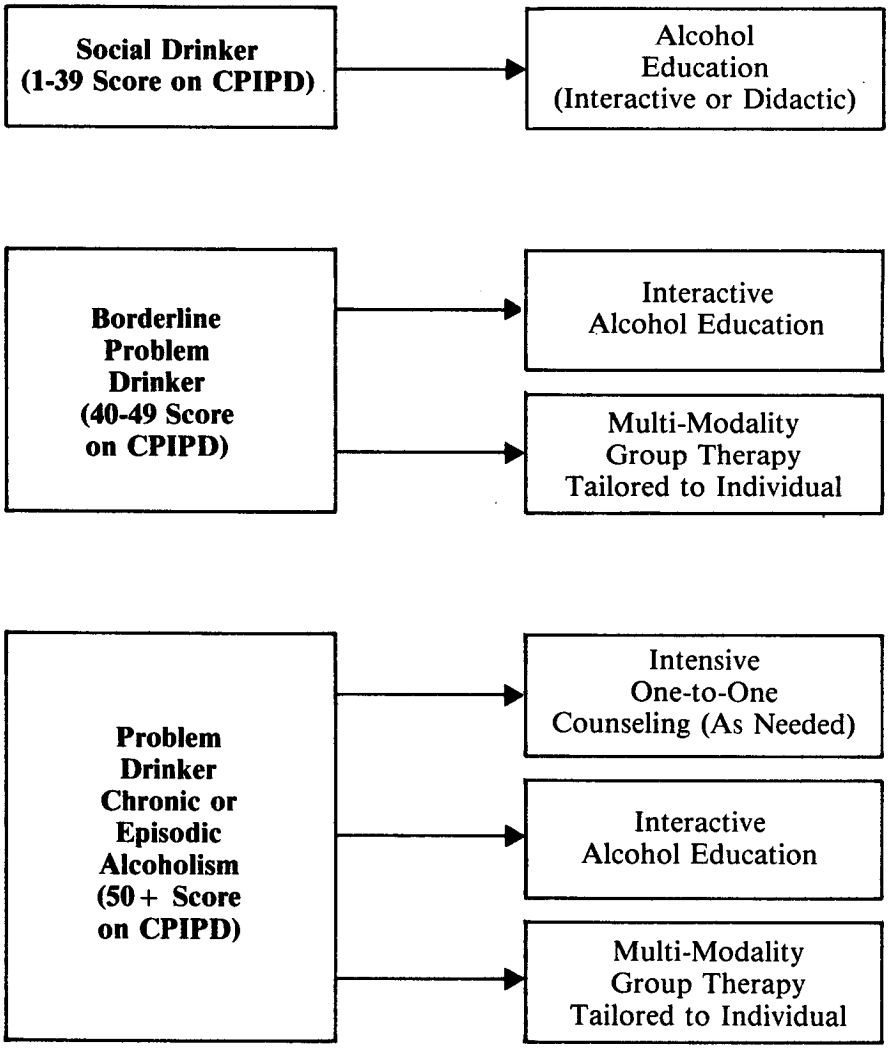
I hereby certify that a screening test has been administered to the above-named person, and combined with other relevant information gained in the interview conducted on _____ (date), the above-named person has been judged to be a _____ (Social, Borderline, or Problem Drinker). It is therefore recommended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

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

Respectfully submitted,

_____
(Signature of Interviewer)

SUGGESTED EDUCATION/ TREATMENT BY DRINKER TYPE



Unit 8

Court-Monitored Rehabilitation Programs

OBJECTIVE

- Recognize and make provisions for the need to provide a reliable monitoring system to assure that offenders comply with all aspects of court-mandated referrals.

PRELIMINARY ASAP REHABILITATION FINDINGS

EDUCATION

All Drinking-Drivers (Social and Problem Drinkers)

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

Social Drinkers

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

Problem Drinkers

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

SHORT TERM THERAPY

All Drinking Drivers (Social and Problem Drinkers)

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

Social Drinkers

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

Problem Drinkers

- There is some evidence that problem drinkers referred to chemotherapy (Disulfiram), especially when supplemented by other therapy, had lower subsequent re-arrest and crash rates than a control group.
- Other research indicates chemotherapy reduced drinking behavior but not driving-related effects after six months.

- Problem drinkers entering small-group therapy had lower re-arrest rates than larger-group therapies with more frequent sessions.
- Initial results from the ASAP Short-Term Rehabilitation Study indicated few positive effects for non-school therapies during the first six-month follow-up period.

EFFECTIVENESS OF OVERALL REHABILITATION EFFORTS

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

WHAT DO WE KNOW ABOUT ALCOHOL-SAFETY SCHOOLS?

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

THE APPROPRIATE THERAPEUTIC REFERRAL

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

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

ALCOHOL TREATMENT RESOURCES

Alcohol-Safety School
- Alcohol Education
- Counseling

Detoxification Centers
- Police
- Medical

Hospitals
- General
- Mental
- V.A.

Mental Health Clinics
- Inpatient
- Outpatient

Alcoholism Clinics
- Inpatient
- Outpatient

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

Professionals
- Private Physicians
- Psychiatrists
- Clergymen

Organizations
- Alcoholics Anonymous
- Halfway Houses

TREATMENT TECHNIQUES

Medical Care
- Detoxification
- Drying out
- Nutrition/Nursing

Psychotherapy
- Individual
- Group
- Family
- Aversion Therapy

Drug Therapy
- Disulfiram
- Tranquilizers

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

REALISTIC EXPECTATIONS

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

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

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

Unit 9

Summary of Recommendations

OBJECTIVE

- Review all screening procedures and court-based programs introduced in the seminar, and select the one most readily applied to your jurisdiction.
- Formulate a plan for submission to the judges and/or prosecutor to implement a referral system for DWI offenders.

A GOOD DRINKING/DRIVER ADJUDICATION SYSTEM

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

Appendix A

Alcohol Use and Abuse

ALCOHOL CONSUMPTION IN AMERICA

1. Who Drinks Alcohol?

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

2. Who Has a Problem?

Most never drink enough to have problems.

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

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

3. Alcohol Problems

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

4. National Averages

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

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

5. Consumption

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

Examples:

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

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

6. Sex Differences

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

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

7. Youth and Alcohol

Alcohol is the drug of preference among youths.

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

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

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

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

8. Socio-Economic Status

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

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

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

ALCOHOL ABUSE

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

Source: NIAAA and NHTSA Reports to Congress

ALCOHOL AND DRUG-RELATED ARRESTS

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

Change in Arrests from 1966 — 1976 (Estimated):

Narcotics and other drugs	up 527%
DWI	up 131%
Disorderly conduct	down 8%
Drunkenness	down 45%
All offenses	up 21%

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

Source: FBI Crime Report for 1976

COURT PROCESSING

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

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

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

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

Source: FBI Crime Report for 1976

CONCLUSIONS

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

Appendix B

Sample Tests

CRITERIA FOR THE DIAGNOSIS OF ALCOHOLISM

By The Criteria Committee, National Council on Alcoholism

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

The problem of alcoholism has been receiving increasing interest in the past few years. Extensive treatment programs are being mounted, hospitals are beginning to accept patients for treatment, labor-management programs are attempting to identify alcoholic employees to give them special benefits and rehabilitation, third-party payments are being afforded by insurance carriers, and courts are making special disposition for rehabilitation. Therefore, it is important to establish a set of criteria for the diagnosis of alcoholism. To this end, the National Council on Alcoholism established a committee[1] to prepare a set of criteria, to submit it for criticism and documentation by other experts, and to publish it for the guidance of those involved in the diagnosis of alcoholism.

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[1]Members of the committee are listed in Annex 1.

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

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

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

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

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

THE NATURE OF ALCOHOLISM

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

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

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

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

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

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

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

Divisions of Data

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

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

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

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

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

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

Diagnosis

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

Psychiatric Diagnosis

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

Alcoholism With Intermittent or Recurrent Drinking

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

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

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

Alcoholism: Recovered, Arrested, or in Remission

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

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

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

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

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

Alcohol Use

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

Alcohol Use With Inebriation

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

Alcohol Use With Pathological Intoxication

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

Alcohol Use: Reactive, Secondary, or Symptomatic

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

Alcohol and Anxiety

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

Cross-Dependence

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

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

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

Persons at High Risk of Alcoholism

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

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

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

Recording the Diagnosis

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

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

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

- Suspected alcoholism: psychiatric diagnosis; physical diagnosis

Other diagnoses that can be made:

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

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

TABLE 1. MAJOR CRITERIA FOR THE DIAGNOSIS OF ALCOHOLISM

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

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

*See Seixas (1).
**Some authorities term this "pharmacological addiction."
***For equivalent amounts in wine and beer, See Annex 2.

Criterion	Diagnostic Level
Alcoholic myopathy	2
Alcoholic cardiomyopathy	2
Beriberi	3
Pellagra	3
Track II. Behavioral, Psychological and Attitudinal	
All chronic conditions of psychological dependence occur in dynamic equilibrium with intrapsychic and interpersonal consequences. In alcoholism, similarly, there are varied effects on character and family. Like other chronic relapsing diseases, alcoholism produces vocational, social, and physical impairments. Therefore, the implications of these disruptions must be evaluated and related to the individual and his pattern of alcoholism. The following behavior patterns show psychological dependence on alcohol in alcoholism:	
1. Drinking despite strong medical contraindication known to patient	1
2. Drinking despite strong, identified, social contraindication (job loss for intoxication, marriage disruption because of drinking, arrest for intoxication, driving while intoxicated)	1
3. Patient's subjective complaint of loss of control of alcohol consumption	2

TABLE 2. MINOR CRITERIA FOR THE DIAGNOSIS OF ALCOHOLISM

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

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

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

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

NATIONAL COUNCIL ON ALCOHOLISM QUESTIONS

NAME _____

1. Do you sometimes drink excessively when you are disappointed, argued with, or aggravated by someone? ..... Yes_____No_____
2. Do you drink more than usual when you are troubled or under pressure? ..... Yes_____No_____
3. Are you able to drink more now without feeling it than when you first started to drink? ... Yes_____No_____
4. Do you suffer memory losses of events during the evening, and yet not pass out? ..... Yes_____No_____
5. Do you try to squeeze in a couple of extra drinks during the evening without other people knowing it? ..... Yes_____No_____
6. On some occasions, do you feel ill at ease if alcohol is not available? ..... Yes_____No_____
7. Are you rushing more to get that first drink than you did, say last month? ..... Yes_____No_____
8. Do you occasionally have feelings of guilt about your drinking? ..... Yes_____No_____
9. When your friends and family discuss your drinking, do you quietly resent it? ..... Yes_____No_____
10. Are your "blackouts" more frequent recently? ..... Yes_____No_____
11. Do you want to continue drinking when your friends say "enough"? ..... Yes_____No_____
12. Do you have a reason when you get drunk? .. Yes_____No_____
13. Are you embarrassed by the things you say and do when drunk? ..... Yes_____No_____
14. Have you switched drinks or changed your pattern to control your drinking? ..... Yes_____No_____

15. Do you promise yourself to control your drinking and then break the promise? ..... Yes_____No_____
16. Have you changed jobs or moved to a new place to control your drinking? ..... Yes_____No_____
17. Do you avoid friends and family when drinking? ..... Yes_____No_____
18. Are financial and work problems increasing? . Yes_____No_____
19. Do you feel people are treating you unfairly? . Yes_____No_____
20. When drinking, do you eat irregularly and very little? ..... Yes_____No_____
21. Do you take another drink in the morning to quiet your "shakes"? ..... Yes_____No_____
22. Has your drinking capacity decreased lately? . Yes_____No_____
23. Do you occasionally stay drunk for several days? ..... Yes_____No_____
24. Are you sometimes depressed and feel that life isn't worth living? ..... Yes_____No_____
25. Do you occasionally have hallucinations after a period of drinking? ..... Yes_____No_____
26. Do you have vague fears after drinking heavily? ..... Yes_____No_____

JOHNS HOPKINS UNIVERSITY HOSPITAL QUESTIONS

NAME _____

1. Do you require a drink the next morning? .... Yes_____No_____
2. Do you prefer (or like) to drink alone? ..... Yes_____No_____
3. Do you lose time from work due to drinking? Yes_____No_____
4. Is your drinking harming your family in any way? ..... Yes_____No_____
5. Do you crave a drink at a definite time daily? . Yes_____No_____
6. Do you get the inner shakes unless you continue drinking? ..... Yes_____No_____
7. Has drinking made you irritable? ..... Yes_____No_____
8. Does drinking make you careless of your family's welfare? ..... Yes_____No_____
9. Have you thought less of your husband or wife since drinking? ..... Yes_____No_____
10. Has drinking changed your personality? ..... Yes_____No_____
11. Does drinking cause you bodily complaints? . Yes_____No_____
12. Does drinking cause you to have difficulty in sleeping? ..... Yes_____No_____
13. Has drinking made you more impulsive? .... Yes_____No_____
14. Have you less self-control since drinking? .... Yes_____No_____
15. Has your initiative decreased since drinking? . Yes_____No_____
16. Has your ambition decreased since drinking? . Yes_____No_____
17. Do you drink to obtain social ease? (in shy, timid, self-conscious individuals) ..... Yes_____No_____
18. Do you drink for self-encouragement or to relieve marked feeling or inadequacy? (In persons with feelings of inferiority) ..... Yes_____No_____
19. Has your sexual potency suffered since drinking? ..... Yes_____No_____
20. Do you show marked dislikes and hatreds since drinking? ..... Yes_____No_____

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

MICHIGAN ALCOHOLISM SCREENING TEST

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

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

Source: University of Michigan, 1975
*Total of 5 points indicates alcohol problem

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