FINAL REPORT

AN ANALYSIS OF PROBLEM DRINKER DIAGNOSIS AND REFERRAL WITHIN THE FAIRFAX ALCOHOL SAFETY ACTION PROJECT, 1972

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PURPOSE AND SCOPE

This report is one of a series, developed in conformance with annual reporting requirements contained within Alcohol Safety Action Projects: Evaluation.[1/] In February 1972, operations of the Fairfax Alcohol Safety Action Project began and these federally financed activities will be continued as a three-year demonstration project. The goal of the project is to remove the problem drinker from the highway. This report examines how those persons arrested for driving while intoxicated (DWI) are diagnosed and referred for treatment or rehabilitation. Development of this analytical study will provide an opportunity to examine the degree of success associated with getting ASAP's DWI defendants into appropriate treatment programs.

In the report emphasis is placed upon the route of the DWI defendant from the post-arrest meeting with the prosecutor to enrollment in ASAP treatment modalities. Also, in accordance with the aforementioned annual reporting requirements, the analysis is confined to ASAP activities occurring during 1972, which encompasses the first eleven months of ASAP countermeasure operations.

DESCRIPTION OF THE PROBLEM DRINKER DIAGNOSIS AND REFERRAL SYSTEM

Once ASAP countermeasure units became operational, an organizational scheme was created for processing those persons apprehended for driving while intoxicated. There are many agencies and institutions participating in ASAP operations;

1/ Alcohol Safety Action Projects: Evaluation, U. S. Department of Transportation, National Highway Traffic and Safety Administration, Office of Alcohol Countermeasures, January 1972.

therefore a description of the problem drinker diagnosis and referral system should start with a few basic elements. Key functions managed by the judicial/ rehabilitative system are listed and described below.

(1) Following arrest, drivers are formally charged with violation of driving while intoxicated statutes.

(2) Defendants meet with the court prosecutor to review the status of their cases.

(3) Drivers referred to ASAP then meet with probation officers for diagnostic interviews.

(4) Drivers not referred to ASAP, due to more serious offenses or recurring recidivism (arrests for driving while intoxicated) are referred back to the courts for prosecution.

(5) Probation officers and other ASAP staff members meet to decide upon treatment referrals.

(6) Defendants enroll in one or more treatment programs.

(7) Certain treatment units perform secondary diagnostic evaluations to guide the course of rehabilitation.

(8) In special cases, defendants are referred to community institutions or military treatment resources.

(9) Defendants complete various treatment sessions.

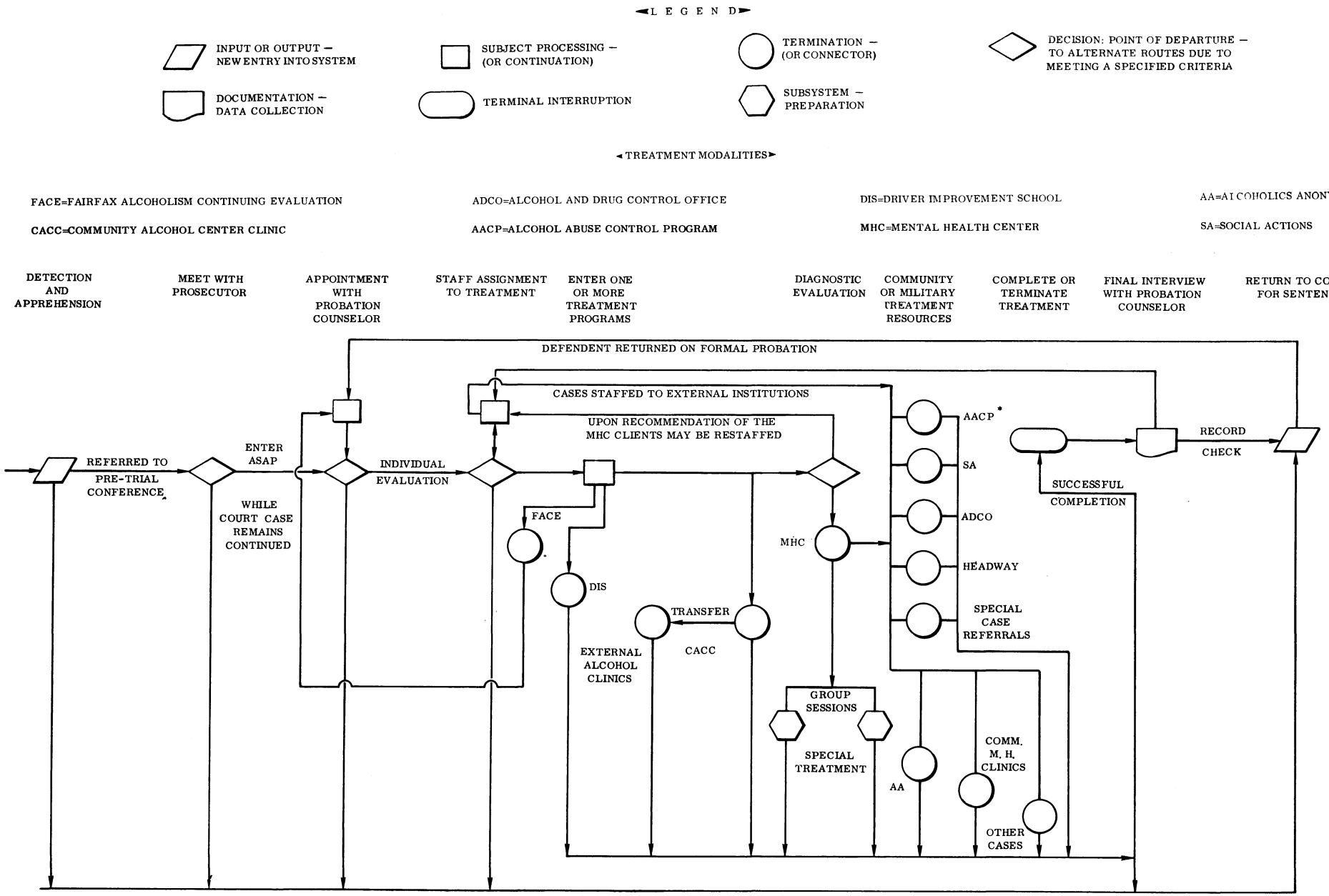
(10) Probation officers arrange for final interviews and individual evaluations.

(11) Defendants are returned to court on the alcohol-related traffic charges. Upon completion of treatment, or receipt of probationary recommendations, the judge may reduce the charges.

These functions are shown in an organizational flow chart, along with the many related channels through which defendants are processed, in Figure 1.

Explanation of the organizational flow chart concentrates upon the four primary treatment modalities. These major treatment programs and their rehabilitative objectives are listed below.

(1) Alcohol Safety School (Driver Improvement School) — Those persons diagnosed as social, or non-problem drinkers, are referred to this educationally based program. Eight 2-hour class sessions are designed to improve the knowledge and attitude of those persons having relatively minor drinking problems.



*MILITARY INSTALLATIONS IN THIS AREA PROVIDE TREATMENT CENTERS FOR THEIR OWN PERSONNEL. THE SOCIAL ACTIONS PROGRAM IS RUN BY THE AIRFORCE, BOTH HEADWAY AND ADCO BY THE ARMY AND THE AACP BY THE NAVY.

FIGURE 1

OUTLINE OF THE KEY ELEMENTS OF A MANAGEMENT INFORMATION SYSTEM FOR INCREASING THE EFFECTIVENESS OF JUDICIAL COUNTERMEASURE CONTROLS

(2) Fairfax Alcoholism Continuing Evaluation (FACE) — The management of the Fairfax ASAP has prescribed that this treatment program should be used only in conjunction with participation in other treatment modalities. Those referred to this supplemental treatment are unclassified drinkers, and the purpose of the FACE sessions have not been adequately defined. In general though, the goals of the FACE sessions have been to help each defendant evaluate the degree of his drinking problem.

(3) Mental Health Clinic (Diagnostic and Psychiatric Evaluation Unit) — Those defendants who appear to have both drinking and emotional problems are referred to this unit by the probation office. Staff members then arrange secondary interviews to perform detailed evaluations of each case brought to the clinic.

(4) Alcohol Center Clinic — This counselling and therapeutic unit is responsible for the treatment of those classified in the problem drinker, or the most severe, category.

From an overview of the system, there are two critical decision areas within the sequence of activities shown in the rehabilitative flow chart. The first of these begins with the meeting between the defendant and the prosecutor. At that session, the alcohol-related traffic offender will be screened for entry or exclusion from the ASAP program. A second critical decision area centers around the initial diagnostic interview and referral to treatment by the probation staff. The personal interview in the probation office is the key to the determination of individual drinking classification and the selection of treatment programs. Each of the above critical decision areas will be reviewed in detail within the following sections of this analysis.

JUDICIAL SCREENING CRITERIA

Several matters are routinely considered in the process of screening DWI defendants into ASAP treatment programs. Judicial officials orient their screening decisions with the intent of placing every suitable driver into the ASAP system. Concurrently, they also stand responsible for upholding ASAP treatment entry standards.

In brief, screening criteria are utilized to exclude some defendants from entry into ASAP treatment modalities. Some unsuitable driver types and characteristics which often disqualify potential ASAP clients are:

(1) Drivers who have recently accumulated a number of serious traffic violations. These serious problem, or habitual traffic offenders are expected to receive severe judicial sentences, often including jail terms.

(2) Residents of areas beyond practical commuting range from ASAP treatment centers.

(3) Drivers who do not expressly agree to participate in ASAP programs.

(4) Recidivists who have previously completed ASAP treatment sessions. In these cases, evidence of rehabilitation cannot be used to justify and guide the course of continued treatment sessions.

(5) Individuals presenting evidence of a strong legal defense against the DWI charge. 2/

In calendar year 1972, more than 3,000 persons were arrested for alcohol-related traffic offenses in the ASAP study area. More than 90% of the DWI defendants entered the ASAP rehabilitation and treatment countermeasure system, while less than 10% were barred from entering the system for the reasons listed above. Because of two primary factors, more than 2,900 were referred to ASAP treatment programs. At the outset of ASAP operations, a backlog of 300 alcohol-related traffic offenders who had been arrested prior to ASAP were immediately placed into the new countermeasure programs. In addition, traffic court judges from non-ASAP jurisdictions have requested the referral of special cases to ASAP treatment countermeasures.

THE PROCEDURE FOR DIAGNOSIS AND ASSIGNMENT OF DRINKING CLASSIFICATIONS

From the initial phase of ASAP operations, through 1972, the policy of the judicial countermeasure has been to utilize the Mortimer-Filkins Test 3/ for the diagnosis of drinking problems. Each person referred to ASAP has personally received an initial screening interview with an appointed probation officer. Prior to the 90 minute to two hour interview, each DWI offender fills out a background information questionnaire. Next the probation officer reviews that material and administers a client interview form.

2/ A small number of drivers are able to obtain legal recourse because of incorrect arrest procedure as in cases where a defendant's blood samples are damaged through mail shipment. The prosecution must then act on some lesser traffic violation.

3/ "Court Procedures for Identifying Problem Drinkers;" DOT 800 630, The University of Michigan, Highway Safety Research Institute, July 1971.

Evaluative Screening Criteria

The probation officer then develops a treatment referral recommendation based upon:

(1) The numerical score recorded from a review of the Mortimer-Filkins Questionnaire and Interview

(2) A review of the individual drinking behavior which produced the blood-alcohol concentration at the time of arrest.

(3) Detection of any valid self-admission of uncontrollable drinking problems.

(4) The revelation of any medical evidence that could be indicative of alcohol-related problems.

(5) A review of the driver's traffic and criminal records.

(6) An evaluation of the defendant's attitude or receptiveness toward participation in treatment programs.

(7) The interviewer's overall subjective estimate of the client's drinking problems and treatment needs.

Classification of Drinking Behavior

The probation officer assigned to screen the client then classifies the defendant as either:

(1) A "problem drinker"

(2) A "social drinker"

(3) An "unidentified drinker"

Finally, the probation officer managing the client's case presents his recommendations to a group of ASAP staff members, who discuss the diagnostic information and agree upon a drinking classification and treatment referral for each case.

METHODOLOGY

Sources of Data

The diagnosis and referral of problem drinkers is an extremely complex and difficult task. Because of this, an analysis of the effectiveness of this diagnosis and referral activity must examine many facets of activity and must utilize a variety of data sources in order to provide a balanced perspective of the issues involved. It would be simplistic and improper to use only a single source of data to draw any conclusions concerning the effectiveness of the activity when the activity itself is so complex. As a result, the basic data sources selected for use in this analysis are a combination of quantitative and qualitiative judgements. One of the quantitative sources is Appendix H, Table 11* dealing with the judicial and probation operations. The other quantitative source is a computer print-out of the cross tabulations of the demographic characteristics of 821 of the first DWI offenders who were arrested in 1972. The qualitative sources of data consist of the opinions of professionals on the ASAP staff. When taken separately, neither the quantitative nor qualitative assessment of the effectiveness of problem drinker diagnosis and referral is adequate to draw valid conclusions. But when taken together, both the quantitative and qualitiative assessments seem to provide a more accurate and complete measure of the effectiveness of the diagnosis and referral activity during the first year of the Fairfax ASAP.

Appendix H Tables

Data were taken from Table 11 of Appendix H for the four quarterly ASAP reports which dealt with the judicial pre-trial investigation activity. The data which were extracted were the classifications of drinkers into the three basic categories of problem drinkers, social drinkers, and unidentified drinkers (no final determination). These categories will be compared across quarters to depict the trends which occurred in drinking classification.

Cross-tabulations of Demographic Data

In order to summarize the information available on DWI offenders, a Probation Office Data Analysis form was devised. A copy of this form is shown in Exhibit 1. It consists of coded information about a defendant's demographic characteristics, driving record, criminal arrest record, blood alcohol concentration (BAC) level at the time of his arrest, diagnostic screening test score, and his referral to a treatment program. These categories of information were cross-tabulated so that it was possible to examine characteristics of various subgroups of all the DWI defendants. This part of the analysis will be primarily limited to examining the sub-

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* Appendix H tables consist of a set of input forms (17 tables) which will be used by each ASAP in the submission of evaluation and performance data to the Office of Alcohol Countermeasures, National Highway Traffic Safety Administration.

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EXHIBIT 1

PROBATION OFFICE
DATA ANALYSIS

1. NAME: _____ _____ _____
(Last) (First) (Middle Initial)

2. CASE NO: _ _ _ _ _

3. SEX /__/
Code
1- M
2- F

4. RACE /__/
Code
1- White
2- Black
3- Other

5. AGE /__/
Code
1- 16-18
2- 19-24
3- 25-34
4- 35-44
5- 45-54
6- 55-65
7- Over 65

6. EDUCATION /__/
Code
1- 8th Grade or Less
2- High School (Complete)
3- High School (Incomplete)
4- Vocational Training
5- College (1-3 Yrs.)
6- College (Complete)
7- Post Graduate

7. OCCUPATION /__/
Code
1- Student
2- Professional
3- Business
4- Craftsman
5- Laborer
6- Clerical
7- Military
8- Housewife
9- Retired
10- Unemployed

8. RESIDENCE /__/
Code
1- ASAP Area
2- Other Va.
3- Maryland
4- D.C.
5- Other

9. MARITAL STATUS /__/
Code
1- Married
2- Single
3- Widowed
4- Separated
5- Divorced

10. NO. TIMES MARRIED /__/
Code
1- None
2- One
3- Two
4- Three or More

11. FAMILY INCOME /__/
Code
1- Under $5,999
2- 6-9,999
3- 10-14,999
4- 15-24,999
5- Over $25,000

12. PREVIOUS DWI ARREST (DMV) /__/
Code
1- One
2- Two
3- Three or More

13. PREVIOUS RECKLESS ARREST (DMV) /__/
Code
1- One
2- Two
3- Three or More

14. OTHER MOVING VIOLATIONS LAST 3 YRS. (DMV) /__/
Code
1- None
2- One
3- Two
4- Three or More

15. LICENSE REVOKED (DMV) /__/
Code
1- One
2- Two
3- Three or More

16. REPORTABLE ACCIDENTS IN LAST 3 YRS. (DMV) /__/
Code
1- One
2- Two
3- Three or More

17. ARREST RECORD LAST 5 YRS. (CCRE) /__/
Code
1- One
2- Two
3- Three or More

18. BAC /__/
Code
1- Under .10
2- .10-.15
3- .16-.25
4- Over .25

19. TEST SCORE /__/
Code
1. Under 60
2. 60-85
3. Over 85

20. REFERRAL /__/
Code
1- No. Va. C.C.
2- FACE
3- FFCMHC
4- AC
5- COURT
6- OTHER

21. CLASSIFICATION /__/
Code
1- Social Drinker
2- Problem Drinker
3- Undetermined

REVISED 8/12/72

groups of defendants who were referred to the Driver Improvement School as social drinkers. The analysis of these cross-tabulations is further limited because the cross-tabs represent the characteristics of 821 of the first persons arrested for DWI in 1972. Therefore the demographic data analysis will deal strictly with the first two quarters of the project and must be interpreted in conjunction with other sources of data which reflect the entire year of operation.

Professional Opinions

Opinions were sought from the Director of the Community Alcohol Center Clinic, the Head of the Psychiatric Diagnostic Evaluation Unit, and the Probation Office Supervisor. These opinions are used in conjunction with the quantifiable data to provide qualitative insights into the effectiveness of problem drinker diagnosis and referral.

Group Intake Experience

The probation office has recently revised its methods concerning the intake of clients from its previous procedure of individual interviews of $1\frac{1}{2}$ to 2 hours with each client to a group intake concept in which two probation officers lead a group discussion with eight clients. This concept is still in the experimental stage, but the results it has achieved merit attention and assist in measuring the effectiveness of the old system.

DISCUSSION OF FINDINGS

The Distribution of ASAP Participants Among Diagnostic Categories

An analysis of the distribution of ASAP defendants in the three diagnostic categories dramatically illustrates trends in evaluative classifications across quarters. Data previously reported in Table 11 of Appendix H of the quarterly reports were converted to percentages and graphically represented in Figure 2. Discrete points were plotted for each drinking category and interpolated into a continuous curve. While the percentage of social drinkers in the sample remained relatively constant across quarters (about 50%), both the problem drinker and undiagnosed categories fluctuated radically. The percentage of problem drinkers dropped significantly each quarter, from a high of 39.9% in quarter 1 to a low of 11.3% in quarter 4. The curve representing the undiagnosed drinker classification ascended from 5.3% in quarter 1 to 38.0% in quarter 4. The problem and unclassified drinkers curves form a near mirror image, acting almost as reciprocals. A chi square was calculated for these data and found to be significant at the .001 level (see Table 2).

TABLE 2

THE DISTRIBUTION OF ASAP PARTICIPANTS AMONG DIAGNOSTIC CATEGORIES

	Problem Drinkers	Undiagnosed Drinkers	Social Drinkers	Total
Quarter 1	83	11	114	208
Quarter 2	175	159	321	655
Quarter 3	99	194	276	569
Quarter 4	106	355	474	935

The chi-square value of 167.73, $p < .001$.

From these data, it is obvious that probation officers have become increasingly hesitant to assign subjects to the problem drinker category. This may be due to several factors. Diagnosis in any form is a difficult task, especially when it involves as complex a problem as alcohol abuse. Many human factors, both psychological and social in nature, may intercede with the evaluator. While some personal involvement is necessary to effectively counsel the participant, it may become a hinderance when applied to objective diagnosis. Informing the subject of the evaluator's decision also becomes more difficult as personal involvement increases. While all of these put emotional pressure on the probation officer to avoid actual problem drinker classification, the development and expansion of the probation sponsored FACE program facilitiated "non-referral" on a practical level. Unexpected demands placed upon rehabilitation by increased DWI arrests made the establishment of a "holding area" necessary. This was especially true in the cases of problem drinkers, since those more complex modalities specifically developed for them were not as easily expanded as were those for social drinkers. A probation officer might also be more inclinded to assign a participant to a modality with which he had first hand experience or to one which was taught by other probation officers, like FACE. The FACE program, while it did serve its "catch-all" purpose, was not as effective as other rehabilitation methods since those participants attending FACE had a higher true annual rate of recidivism than any other modality, 4/ including the traditional court system.

Analysis of Probation Office Data Cross-tabulations

Exhibit 1 is a copy of the Probation Office Data Analysis form used in recording information on DWI defendants. A total of 821 of these forms, which covered approximately the first six months of probation office operation, were keypunched and cross-tabulated. The basic distributions of characteristics are

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4/ Lynn, C. "Recidivism Rates as a Measure of the Effectiveness of the Rehabilitation and Treatment Countermeasure of the Fairfax, Virginia ASAP, 1972 " Virginia Highway Research Council, Charlottesville, Virginia, November 1973.

shown in Exhibit 2. The last item on the second page of Exhibit 2 is the distribution of referrals. Only 7% of the defendants were referred directly to the Alcohol Clinic, which was originally intended to handle all of the problem drinkers. A low referral rate to the Alcohol Clinic was primarily a result of the low capacity for handling ASAP cases at the clinic rather than an inability to diagnose problem drinkers. Thus only the more severe drinking problems were referred to the clinic in 1972, and many problem drinkers were referred to less extensive treatment agencies such as FACE and DIS.

At the other end of the treatment spectrum was the Driver Improvement School, which was designed to handle the social drinkers or non-problem drinkers. Instead of examining the characteristics of the more severe cases who were referred to the Alcohol Clinic, this part of the analysis is limited to examining the subgroup of defendants who were classified as social drinkers and referred to the Driver Improvement School. Of the 821 defendants whose records were cross-tabulated, a total of 405 were referred to the DIS. The traffic and arrest records, BAC levels, and diagnostic test scores will serve as the basis for examining the defendants in the Driver Improvement School. These cross-tabs offer evidence that there existed considerable underclassification of drinkers during the first half of 1972.

The definition of a problem drinker is listed in the NHTSA's Evaluation Manual for the Alcohol Safety Action Projects as follows:

"Problem Drinker — A drinker defined by any one of the following:

(1) Diagnosis as an alcoholic by a competent medical or treatment facility, or

(2) Self admission of Alcoholism or Problem Drinking, or

(3) Two or more of the following:

(a) A BAC of .15 percent or more at the time of arrest,

(b) A record of one or more prior alcohol-related arrest,

(c) A record of previous alcohol-related contacts with medical, social, or community agencies,

(d) Reports of marital, employment or social problems related to alcohol,

(e) Diagnosis of problem drinker on the basis of approved structured written diagnostic interview instruments. Examples: (MAST, Mortimer-Filkins, NCA, and John Hopkins diagnostic tests)." 5/

5/ Alcohol Safety Action Projects, Evaluation, NHTSA, Office of Alcohol Countermeasures, January 1973, Section C, p. 31.

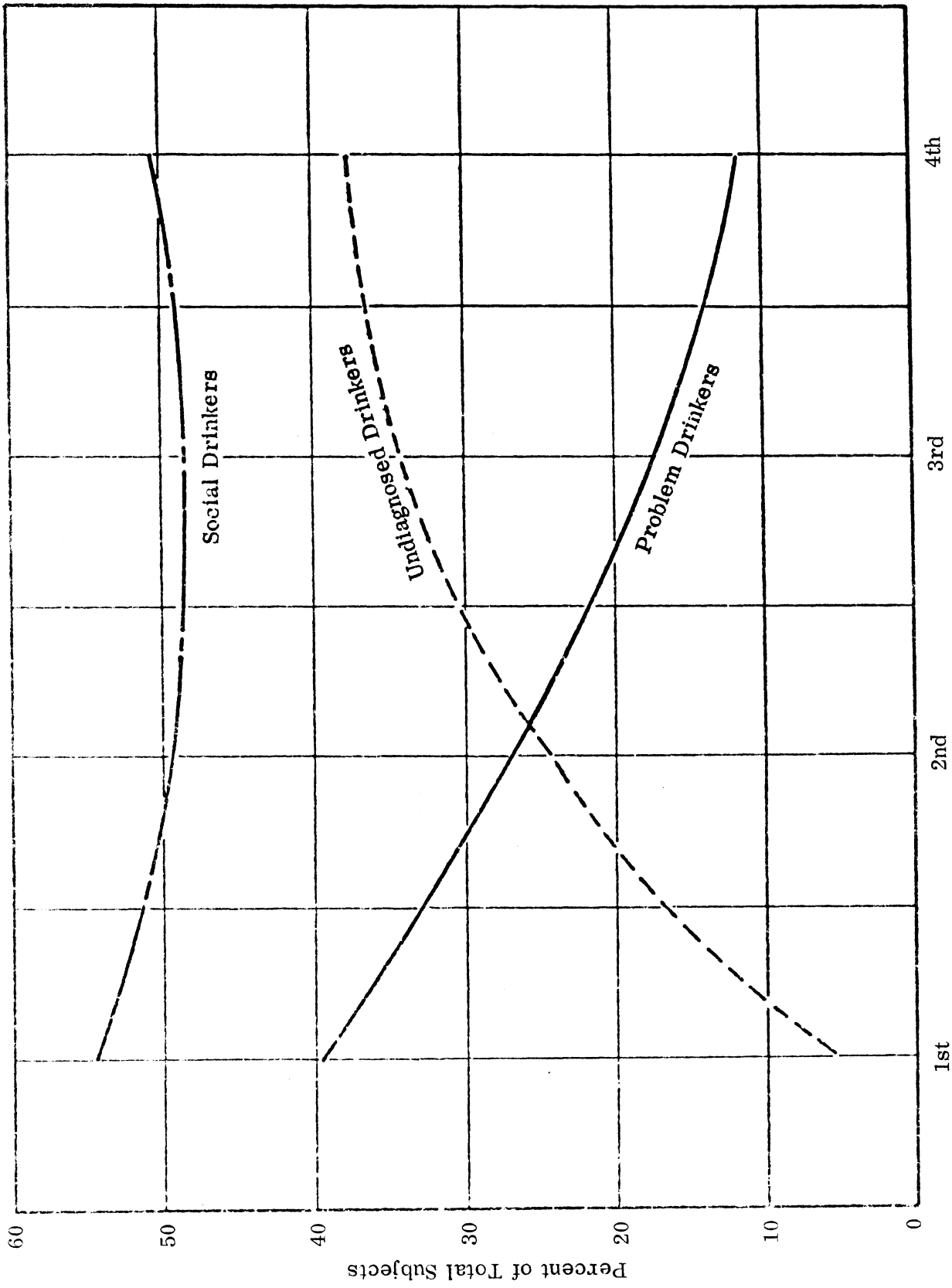

Figure 2. Distribution of ASAP cases into drinking categories by quarterly time intervals.

EXHIBIT 2

PROBATION OFFICE
DATA ANALYSIS,

First 821 Cases

SEX

Male	93%
Female	7%

RACE

White	94%
Black	6%
Other	0%

AGE

16-18	2%
19-24	15%
25-34	30%
35-44	29%
45-54	18%
Over 55	6%

EDUCATION

8th Grade or Less	13%
High School (Complete)	30%
High School (Incomplete)	20%
Vocational Training	6%
College (1-3 Yrs.)	17%
College (Complete)	8%
Post Graduate	6%

OCCUPATION

Student	3%
Professional	13%
Business	16%
Craftsman	22%
Laborer	27%
Clerical	4%
Military	8%
Other	7%

RESIDENCE

ASAP Area	54%
Other VA.	39%
Maryland	5%
D.C.	2%

MARITAL STATUS

Married	61%
Single	20%
Widowed	2%
Separated	9%
Divorced	8%

NO. TIMES MARRIED

None	20%
One	65%
Two	13%
Three or More	2%

FAMILY INCOME

Under $5,999	14%
6-$9,999	24%
10-$14,999	24%
15-$24,999	22%
Over $25,000	11%
No Income	5%

PREVIOUS DWI ARREST

One	11%
Two	2%
Three or More	1%
None	86%

PREVIOUS RECKLESS ARREST

One	27%
Two	8%
Three or More	2%
None	63%

Exhibit 2 (continued)

OTHER MOVING VIOLATIONS
LAST THREE YEARS

None	58%
One	20%
Two	12%
Three or More	10%

BAC (Blood Alcohol Concentration)

Under .10	5%
.10 - .15	23%
.16 - .25	60%
Over .25	12%

LICENSE REVOKED

One	26%
Two	8%
Three or More	4%
None	62%

TEST SCORE

Under 60	57%
60 - 85	19%
Over 85	24%

REPORTABLE ACCIDENTS
IN LAST THREE YEARS

One	18%
Two	5%
Three or More	2%
None	75%

ARREST RECORD
LAST 5 YEARS

One	7%
Two	2%
Three or More	3%
None	88%

REFERRAL

Northern Virginia Community College	49%
Fairfax Alcoholism Continuing Evaluation	19%
Mental Health Center	15%
Alcohol Clinic	7%
Court	9%
Other	1%

Among the 405 defendants in the DIS, 21 had had a previous DWI conviction. Out of the total of 821 defendants, 115 had had previous DWI convictions, and 21 of these were referred to DIS and another 42 to the FACE program. A previous alcohol-related arrest is one of the criteria of the Office of Alcohol Countermeasures, NHTSA, for the definition of a problem drinker, when this criterion can be combined with another criterion from the list. Because of the extremely low rate of enforcement and conviction of DWI cases prior to the Fairfax ASAP, it appears that any person with a previous DWI conviction would more likely be a problem drinker than a social drinker. It is probable that some of those with previous DWI convictions were underclassified by the probation office.

There were 27% of the DIS students who had had previous reckless driving convictions, and 6.4% of them had had two or more prior reckless driving convictions. The driving-oriented DIS would appear to be a good place to improve their driving skills, but the question must be raised as to whether or not these reckless driving convictions involved alcohol, and secondly, if these convictions were discussed with the defendants.

Of the DIS students, 40.5% had had convictions for violations other than reckless driving in the preceding 3 years. There may be a large overlap among these groups, but it is apparent that the DIS group generally had a poor driving record. Poor driving records combined with the DWI arrest which brought them into ASAP and a high BAC would indicate that some of these people were more than social drinkers. There is no way to even estimate the number of people who fell into this category on the basis of the cross-tabs, but it should be pointed out that the likelihood exists that there were a considerable number who fitted this category.

Another characteristic of the DIS student was that 28% had had their drivers license revoked. Intuitively, this percentage seems high for the average population of drivers. Twenty-five percent had had reportable accidents in the preceding three years with 7% having had two or more accidents. Seven percent of the DIS students had had criminal arrests in the preceding five years with 3% having had tow or more arrests. Again it seems that some of the people referred to the DIS were not average drivers or average people. Some of them seem to have been underclassified.

One of the OAC (Office of Alcohol Countermeasures) criteria for a problem drinker is a BAC of .15% or more at the time of arrest. There were only 30% of the DIS students who had BAC's of .15% or less, while fully 70% of the students had BAC's of .16% or more. Thus this group consisting of 70% of all DIS students satisfied at least one of the two criteria necessary for classification as a problem drinker. Combined with the poor driving records previously described, it appeared that a considerable number of this group merited a higher classification than that of a social drinker.

Classification on the Mortimer-Filkins screening test showed that 11.5% of the DIS students scored higher than 60 on the test. This relatively high test score combined with any other evidence of poor driving or alcohol-related problems would seem to indicate more than just social drinking.

Professional Opinions

Ralph T. Paton, Director of the Community Alcohol Center Clinic, has stated that all of the ASAP referrals to that clinic have proven to belong to the "problem drinker" category. 5/ Thus he believes that there has not been any overclassification of social drinkers to the degree that they were improperly referred to the Alcohol Clinic.

Bette Ann Weinstein, Head of the Psychiatric and Diagnostic Evaluation Unit of the Mental Health Center, has also stated that she believes that there is a tendency to underclassify a person's drinking problem rather than overclassifying it. An overclassification would be an extremely rare occurrence. 6/

Richard Rocchio, Probation Officer Supervisor, has stated that he thinks there has been a tendency to underclassify the severity of a person's drinking problem. Mr. Rocchio very recently initiated a group intake procedure in which two or more probation officers interview a group of eight defendants. He has stated that the early experience with the group intake procedure has given his probation officers much better insight into a person's drinking problem, and it allows the probation officers to monitor their cases better by field investigation of certain cases which warrant such investigation. 7/

Analysis of the Preliminary Effects of Group Intake Experience

The group intake experience is probably the most encouraging aspect of the diagnosis and referral problem in the Fairfax ASAP. Not only have its procedures made the evaluative operation more efficient, but they have also resulted in what seems to be a more accurate diagnosis.

Under the traditional procedures used by the probation office, one probation officer would interview one ASAP participant, often for as long as two to three hours. Thus, the probation officer could see only three or four subjects in one day, and since this individual interview method is psychologically and physically exhausting, he might not be able to maintain a high quality of classification

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5/ Conversation with Mr. Ralph T. Paton in his office in Fairfax on May 7, 1973.

6/ Interview with Mrs. Bette Ann Weinstein in her office in Fairfax on May 24, 1973.

7/ Conversation with Mr. Richard Rocchio on May 16, 1973.

throughout each day. Also, the individual interviewer would be under a certain psychological pressure to avoid the problem drinker category, as previously discussed and as illustrated by the data.

For the group intake experience, basic procedure entails bringing two probation officers and an average of eight subjects together on an informal basis, for from two to three hours. After this discussion session the probation officers meet alone to make their decisions and they return to the group, where they announce the results of the "interviews". This method is designed to specifically provide positive reinforcement for both the subjects and the interviewers. Participants are encouraged to discuss problems freely and develop a certain amount of reassurances from other group members. Often similar experiences are discussed within the group, allowing self-comparisons among the subjects and forming what could be thought of as a temporary reference group. The group intake procedure is more effective for the interviewers in that it allows for greater depth of individual analysis, since participants are often more candid, and since more than one observer is present, occurrences that might have passed unnoticed by one interviewer may be detected by the other. The interviewers also have more confidence in the validity and reliability of their decisions, since conclusions were drawn from two different frames of reference. From an administrative point of view, this method is much more efficient. A diagnostic team can see as many as 24 subjects in one day and maintain a higher standard of classification, since the presence of two interviewers reduces some of the exhausting psychological burdens of the more traditional method.

Early trends in the classification of drinkers using the group intake method substantiate the hypothesis that under more traditional diagnostic methods, problem drinkers were underclassified. In the first set of participants (n = 110), about 25% were classified as social drinkers, as compared with a constant figure of 50% in that category in 1972. More subjects are being classified as problem drinkers and sent directly to more extensive treatment groups. More importantly, as a result of this procedure, the undiagnosed category is being redefined as to the nature of subjects thus classified. The undiagnosed group seems to encompass a second group of problem drinkers, less serious than the already existing group, but more serious than the social drinker category. Since alcoholism is a progressive disease, these subjects can be thought of as early problem drinkers whose habits are not as strongly entrenched as those of the chronic drinker. It is essential to recognize that this group does exist and to institute some type of modality to specifically head off further problems and modify their existing drinking/driving behavior.

CONCLUSIONS AND RECOMMENDATIONS

Both qualitative and quantitative research data available to the evaluators for the key analytic study in diagnosis and referral of problem drinkers indicate a tendency to underclassify the drinking problems of DWI defendants. Therefore, ASAP defendants who are inappropriately diagnosed and classified are also inappropriately referred to treatment. It follows that defendants who are inappropriately referred to treatment are less likely to benefit from that rehabilitation program than are persons properly classified. Even though court officials firmly support all treatment programs, they have not as yet questioned the accuracy of the referrals. Thus, inappropriate referrals threaten the relationship that ASAP has enjoyed with the court system.

Therefore, the following recommendations are offered to ASAP management.

1. Establish a consolidated form for recording case management information important to the long-term surveillance of ASAP defendant processing. The probation office data analysis card would be replaced and supplemented by one consolidated information sheet. The new form should be designed using a format compatible with automated data processing systems. Then elements of case management information could be keypunched along with other related material comprising the proposed ASAP court defendant tracking system. Then a set of key variables can be monitored, including defendant characteristics, prior driving and criminal records, and diagnostic interview test scores. These variables for classifying problem drinkers and referring them to treatment can also be matched with post-treatment followup, final case evaluations, court dispositions, and recidivism. The evaluation team will promptly develop a consolidated form, suitable for inclusion with individual probation case files.

2. Project management, the probation staff, rehabilitation counselors, and the evaluation staff should cooperate in the development of a standardized model for cross-checking diagnostic and referral decisions. Extensive experience gained through ASAP countermeasure operations should be applied to the development of a set of guideline criteria.

   Under present conditions a number of key variables are reviewed as input for defendant diagnostic and treatment referral decisions; these variables and other potential indicators have not been weighted or interrelated in a consistent manner. In the early phase of ASAP operations the determination of drinking classifications and corresponding treatment recommendations were subjectively formulated, without the benefit of reference to a formally structured set of interrelated criteria.

The proposed decision model, when calibrated to the norm of ASAP diagnostic and referral patterns, would provide a cross-check upon the consistency of decisions, matching defendants with corresponding rehabilitative programs. In concept the model would supplement existing OAC drinking classification criteria by interrelating definitive variables such as interview and questionnaire responses, level of intoxication following arrest, and a systematic review of previous traffic and criminal convictions. It is anticipated that the standardized model will be available for inclusion with the second annual evaluation of diagnostic and referral activities.

3. Continue experimentation with the techniques used for managing diagnostic interviews and guiding recommendations for treatment. Recently the probation staff has initiated procedures for conducting "group intake" interview sessions. This "encounter group" approach shows immediate benefits in the area of time and manpower resources, and individual evaluations obtained from group intake sessions have significantly altered the underclassification pattern typical of individual interview procedures.

Certainly, the "group intake" strategy must be methodically analyzed before treating it as a universal cure-all for a complex problem area. Progress must be continued with the search for techniques that can streamline interview procedures and increase the effectiveness of the diagnostic and referral process. For example, system efficiency can be augmented by such actions as:

(a) Schedule time for follow-up studies on every ASAP probation case. The probation staff should provide for a re-examination of each defendant's post-treatment drinking problems. Course instructors, the staff of the diagnostic and evaluation unit, family investigation checks, and the defendant could be used as sources of information concerning individual response to treatment or the need for more exposure to rehabilitative programs.

(b) Until the recidivism problem in the FACE program is diminished, the practice of referring defendants to multiple treatment modalities should be emphasized to a greater extent. After a large proportion of defendants receive greater exposure to rehabilitation programs, the total rate of recidivism would be expected to decline.

(c) A small sample of ASAP defendants could be selected for participation in a clinical study consisting of in-depth interviews with both the subjects and their families as well as close associates.