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Evaluating the "Hard Core Drinking Driver"

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Alcohol-related fatalities have significantly decreased over the past 25 years, but alcohol-impaired driving continues to kill more than 17,000 individuals per year—40% of all traffic fatalities (NHTSA, 2005). Sustained public education campaigns and toughened laws have led to dramatic decreases in the number of social drinking drivers. As the pool of social drinking drivers decreases, "hard core drinking drivers" constitute a larger portion of the impaired driving offender population (Simpson & Mayhew, 1991). States have called upon addiction professionals to evaluate those arrested for impaired driving to identify such high risk drivers, but the accuracy of these evaluations has often been compromised by reliance on self-report data and imperfect evaluation instruments. Particularly troublesome is the fact that the percentage of retrospective alcohol dependence diagnoses triples when impaired drivers are re-evaluated five years following their first arrest (Lapham, C'de Baca, McMillan, & Hunt, 2004). This article describes efforts in the State of Illinois to enhance the quality of such evaluations and highlights a recent study that sheds light on the profile of the hard core drinking driver.

Impaired Driving: One State's Response

Illinois has a long history of collaboration across multiple agencies to reduce alcohol-related driving fatalities. Between 1982 and 2001, toughened laws, assertive law enforcement and prosecution, an informed judiciary, assertive monitoring by probation officers, rigorous gatekeeping of licensure re-instatement by Secretary of State administrative hearing officers, as well as mandated professional evaluation and treatment contributed to a 60% reduction in Illinois' alcohol-related fatalities (National Highway Traffic Safety Administration, 2002). Even in the face of such success, calls grew for a more sophisticated approach to the evaluation and management of the state's driving under the influence (DUI) offenders.

Historically, evaluators have been asked to answer three questions related to the DUI offender: 1) Does this offender have a problem in his or her relationship with alcohol and/or other drugs? 2) If so, what is the duration and level of severity of this problem? 3) What combination of educational and treatment services has the greatest probability of resolving these problems? While such questions are appropriate in the context of addiction

treatment, they do not, in and of themselves, answer two broader questions: 1) What degree of risk does this offender pose to the safety of the public (risk defined as DUI recidivism and future involvement in alcohol-related crashes involving damage to property, personal injury, and death)? 2) What community strategies can be best combined to lower the threat to public safety posed by this offender?

In an effort to provide better answers to these questions, the Illinois Department of Transportation, in collaboration with the Administrative Office of Illinois Courts, the Division of Alcoholism and Substance Abuse, and the Illinois Secretary of State, created a DUI Task Force and a Risk Reduction Work Group. The latter group was charged in 2000 with the responsibility of examining the DUI evaluation process in Illinois. The work of this committee was performed under the direction of the Institute for Legal and Policy Studies at the University of Illinois. Over the ensuing years, the Risk Reduction Work Group: 1) conducted a literature review of the DUI evaluation process (White, 2004), 2) created a scientific advisory panel, 3) conducted a 2001 national survey of state DUI evaluation processes/instruments (47 states provided survey responses), and 4) conducted focus groups with Illinois' prosecutors, judges, probation officers, evaluators, treatment specialists, and administrative hearing officers.

There were two major findings from these early steps. First, we found that states varied widely in their evaluation protocol. There were differences in which state agency was responsible for alcohol-related public safety, who conducted the evaluation of DUI offenders (e.g., private contractor versus probation officer), and DUI evaluation instruments. Twenty-three of 47 states mandated use of one or more instruments, with DRI-II and the Mortimer-Filkins being the most commonly mandated evaluation tools. In the national survey, we found a total of 33 evaluation instruments in use with only half the states reporting that they were satisfied with the instrument they were using.

Second, multiple stakeholders shared with us concerns that the integrity of DUI evaluations was being compromised by reliance on self-report, inconsistent access to criminal and driving/insurance records, and instruments that did not collect critical areas of information (e.g., histories of drug use other than alcohol). There was also concern in those states in which DUI evaluation was the province of the private sector that competition for defense attorney referrals downgraded the rigor of the evaluation process (i.e., those agencies with reputations for rigorous assessment not getting referrals). There was a particular concern that existing evaluation instruments/processes did not identify those offenders who posed the greatest threat to public safety and who should receive the greatest intensity of supervision resources. This led the Work Group to identify those qualities of an ideal evaluation instrument and to explore whether any existing instrument met those criteria.

When the Risk Reduction Work Group found no instruments that met all the desired criteria for an evaluation instrument, the group identified the instrument—The Adult Substance Use and Driving Survey (ASUDS)—that met the most of such criteria and contracted with its developers (Drs. Ken Wanberg and David Timken) to modify the instrument to include additional data collection elements desired by Illinois DUI stakeholders. The revised instrument (ASUDS-RI) (Revised for Illinois) was then piloted in 2004 with 486 offenders in 10 different evaluation sites.

The ASUDS-RI (Revised for Illinois) is a self-administered assessment instrument composed of 113 questions arranged into 15 scales and sub-scales. The scales are designed based on research related to DUI risk and risk prediction. Scales related to drug use and criminal history were added or modified for the Illinois version of the instrument based on the feedback received from multiple DUI constituency groups. The scales include the following:

- *Alcohol Involvement*: Measures the extent of alcohol use.
- *Driving Risk*: Evaluates general risk-taking behavior while driving.

- *Antisocial*: Assesses antisocial behavior and attitudes.
- *Mood Disruption*: Measures depression, anger, and/or anxiety problems.
- *Alcohol/Drug Involvement*: Measures drug use across 10 major categories.
- *Disruption*: Measures the problems/consequences encountered by the respondent as a result of drugs or alcohol; identifies symptoms of abuse or dependence.
- *Involvement/Disruption One-Year*: Measures the scope and intensity of alcohol and drug use and negative consequences related to such use in the past 12 months.
- *Global*: A composite of Involvement, Disruption, Anti-social, and Mood Disruption scales that provides an overall risk profile for each offender.
- *Motivation*: Measures the degree to which the respondent is willing to make necessary changes related to alcohol or drug use.
- *Benefits*: Utilizes components of the Involvement scales to measure social or psychological benefits gained from use and self-treatment of depression or anxiety.
- *Antisocial (community)*: Sub-scale of Antisocial. Identifies general attitudes linked to anti-social behavior.
- *Antisocial (criminal justice)*: Sub-scale of Antisocial. Measures past and current involvement with the criminal justice system.
- *Psycho-social Disruption*: Sub-scale of Disruption. Measures physical and psychological problems related to alcohol or drug use.
- *Social-behavioral Disruption*: Sub-scale of Disruption. Identifies social problems such as inability to work and problems with family resulting from use.
- *Defensiveness*: Measures the degree to which the respondent is willing to disclose sensitive information.

The output from the instrument provides a raw score for each scale and a percentile rank showing where the respondent falls in relation to other DUI offenders and a composite score with cut points indicating the level of service needed.

A major goal in refining the ASUDS-RI was to develop an instrument that could differentiate first time DUI offenders who are unlikely to be involved in future DUI offenses from the first time DUI offender whose problems are likely to escalate into increased risk of DUI recidivism and alcohol/drug-related crashes. We will use this Phase One pilot data from Illinois to illustrate growing understanding of the Hard Core Drinking Driver (Syrcle & White, 2006).

The Hard Core Drinking Driver

The hard core drinking driver (HCDD) is an individual who, following repeated sanctions, continues to drive at least once a month with a BAC of 0.15% or greater (Simpson, Beirness, Robertson, Mayhew, & Hedlund, 2004). Such drivers make up a small subset (about 3%) of licensed drivers, but contribute 80% of the total impaired driving trips (Beirness, Simpson, & Desmond, 2003). Due to the frequency with which they drive while impaired and the degree of that impairment, HCDDs pose a very significant threat to public safety. One of the tasks of the addiction professional serving as a DUI evaluator is to recognize the HCDD and recommend interventions that can lower this threat to public safety.

An emerging HCDD profile is emerging from multiple studies that compare DUI non-recidivists with DUI recidivists (Summary data below is from White & Gasperin, in press). Several components dominate that profile and are illustrated by the Illinois ASUDS-RI data.

Recidivist Demographic Profile: As a group, DUI recidivists are predominately single, separated, or divorced Caucasian or Hispanic males between the ages of 25-45. They have less than 12 years of education, are transiently employed in blue collar jobs, and are part of social groups whose members are heavy drinkers and drinking drivers. In the Illinois pilot study, repeat offending peaked between the ages of 31-

35, and the repeat offenders were more likely than non-recidivists to be married or divorced. The fact that recidivism risk declines with age suggests the need to mobilize community resources to contain the HCDD until they age out of this high-risk pattern.

Driving Attitudes / History: Compared to the non-recidivist, the DUI recidivist is more likely to believe that he or she can drive safely after drinking and to see his or her DUI arrest as a function of bad luck or police harassment. They are also more likely to have past histories of high risk driving (e.g., failure to wear seatbelts, moving violations, accidents, injuries) (Begg, Langley, & Stephenson, 2003). In the Illinois pilot, recidivists were more likely to have prior arrests for speeding, failure to yield/stop, improper lane usage, seat belt, or child safety violations as well as being nearly twice as likely as first-time offenders to have at least one prior collision on their driving record.

Substance Use / Treatment History: DUI recidivists are distinguished from non-recidivist offenders by an increased propensity for family histories of alcohol- and other drug-related problems. Many recidivists reported early exposure to drinking and driving by their parents and adolescent exposure to drinking and driving within their peer social group. They are also more likely to report early age of onset of alcohol, tobacco, and other drug use. In the Illinois pilot, recidivists were more like to be heavy smokers (1-2 packs a day), less likely to have successfully quit smoking, and reported greater number of episodes of past illicit drug use. Multiple offenders were substantially more likely to have previously attended treatment and, to a lesser extent, self-help groups—a factor likely influenced by mandated treatment or Alcoholics Anonymous exposure linked to earlier DUI arrests. Although not tested in the Illinois pilot, research reviews note that recidivists are more likely to have dropped out of prior treatment and to have failed to complete earlier court-ordered services (White & Gasperin, in press).

Arrest Event: DUI arrests of recidivists, when compared to non-recidivists, were more likely to be characterized by a high BAC (greater than .15) without gross signs of intoxication, collateral charges, and refusal to take a Breathalyzer test. Over half (55.6%) of the DUI recidivists in the Illinois pilot study refused the breathalyzer test, compared to only 30% of first-time offenders. Even with this high rate of refusal, the remaining recidivists still had a significantly higher BAC (mean of .159) (as well as self-reports of drinking more hours and more drinks) than first time offenders. Recidivists were also more likely to have been arrested on Monday, Wednesday, and Thursday. It is unclear why the trend toward an increased likelihood for repeat offender arrests during non-weekend nights does not hold true for Tuesday, unless this reflects a pattern of brief reprieve among daily, heavy drinkers whose consumption peaks over the course of extended weekend drinking episodes.

Criminal History: Those with one or more prior DUI offenses are significantly more likely to have a prior non-DUI arrest on their criminal history report than first-time DUI offenders. Nearly half of the multiple offenders have two or more prior non-DUI arrests, compared to less than 20% for first-time offenders. Nine percent of repeat offenders have five or more previous non-DUI arrests. Multiple offenders had a history of crimes against persons at a rate twice that of the first-time offenders; 30% and 15% respectively. In addition, the person crimes of repeat offenders were more likely to be domestic violence related, with 56% of the person crimes for multiple offenders being for domestic violence. The difference between first-time and repeat offenders is less pronounced in terms of previous charges related to controlled substances, with rates of 11% and 19% respectively. The over-representation of cannabis and controlled substance violations in the multiple offender group is consistent with the finding that multiple offenders are almost three times more likely to have a collateral charge of cannabis possession at their DUI

arrest than are first offenders (9% compared to 3.2% respectively).

Characterological Profile**:** DUI recidivists are more likely than non-recidivists to have prior treatment for psychiatric illness as well as medical treatment reflecting injury to self via risk-taking. Recidivists are also distinguished by diminished capacity for empathy, a marked absence of guilt and remorse, a failure to take personal responsibility for decisions and their outcomes, and a general pattern of impulsivity and risk-taking (White & Gasperin, in press). Evaluation instruments like the ASUDS-RI that focus on global assessment will increase our ability to identify such characterological risk factors and tailor particular interventions to address them.

The Future

The ASUDS-RI pilot study was able to obtain completed evaluations on 486 individuals and analyze the evaluation data to establish Illinois norms for the ASUDS-RI. The pilot study also added information on the profile of the Illinois DUI offender and DUI recidivist population. This preliminary study confirms a number of risk factors for DUI recidivism that have been noted in the national profile literature: gender (male), age (21-45), marital status (never married or divorced), less stable employment, prior treatment, prior non-DUI criminal history, prior criminal history of violent aggression, prior non-DUI traffic offenses, breathalyzer refusal or high BAC, and more likely to be arrested for DUI on a Monday, Wednesday or Thursday. Of the 16 ASUDS-RI scales, 14 of these scales revealed significant differences between the fist-time DUI offender and the multiple-DUI offender.

Continued follow-up of this and other populations of DUI offenders will reveal increasingly precise delineations of those factors that predict DUI recidivism and broader threats to public safety. Once we have defined this highest risk population of impaired drivers, it may be possible to develop specialized treatment protocols designed to enhance their recovery rates and lower their threat to communities across the country.

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