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ABSTRACT

These participant and administrator manuals are designed for a seminar on alcohol and safety. This seminar is intended to be a small-group, intensive planning session dealing with the problems of handling people charged with drinking-driving offenses. The participants should be enforcement, judicial, presentence, prosecution, probation, rehabilitation, or other treatment personnel, with a group maximum of 20 people. All participants should be engaged professionally on a daily basis with drinking-driver cases. The purpose of the seminar is to encourage participants to act as more effective members of the whole alcohol-safety system. Another purpose is to break down misunderstandings and hostilities between traffic-law and treatment personnel. The seminar provides information about alcoholism, alcohol safety, and problem drinkers, but it is not intended for the well-trained probation officer or psychologist. The technical and professional skills needed for job performance are assumed; in fact, a strength of the seminar is the structure interchange of ideas and information among a group of experienced professionals.

(Author/PC)

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seminar on alcohol and safety

**training for social
and health care personnel—
curriculum development,
evaluation and conducting
a pilot test**

participant's manual

U.S. Department of Transportation
National Highway Traffic Safety Administration

November 1974

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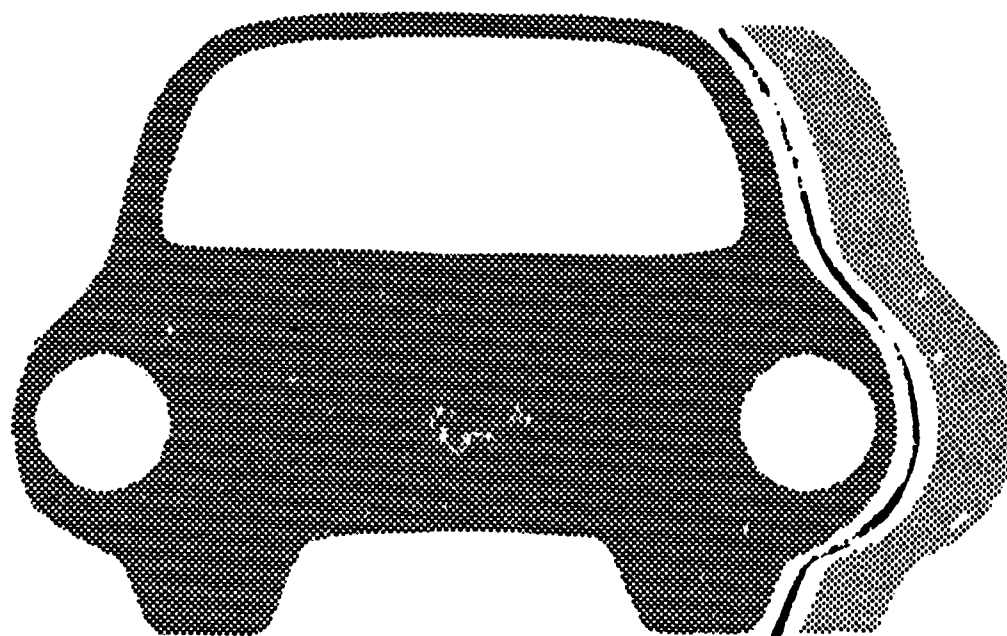
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INTRODUCTION



**This session is designed to explain
the contents of the seminar, meet
the leaders and fellow participants.**

OBJECTIVES OF THE SEMINAR

The primary objectives of this seminar are two-fold. One is to increase the knowledge and understanding of participants with regard to highway safety as it is affected by alcohol and alcohol abuse.

A second purpose is to increase coordination and cooperation between personnel involved in highway safety and those involved in the treatment aspects of alcohol and alcohol abuse.

The seminar may be judged a success if, at the end, both participants and leaders agree that:

They realize that alcohol treatment professionals and members of other professional disciplines involved in alcohol safety (judges, prosecutors, probation officers, enforcement officers, etc.) share many of the same goals.

The treatment professionals and those in the highway safety disciplines recognize each other's special difficulties in the countermeasures area and have identified where they can be of assistance to each other.

They have identified specific improvements that can be made at once in their operation and the local drinking driver control system.

INSTRUCTIONAL STRATEGIES

The instructional strategies used in this seminar are designed to produce mutual problem-solving among a group of specialists. Participants should contribute their own expertise primarily, with supplemental expertise from local resource people and one or two small-group leaders. Sessions are designed deliberately to alternate between large and small groups, with two goals:

- (1) to help participants solve their own problems and be true participants, not just receptors of lectures, and
- (2) to enliven the seminar format by giving it variety.

The manual provides simplified visual materials that can be added to or eliminated entirely in the whole-group sessions or small-group discussions. The information session of the second day, for example, may be altered or shortened if participants are sophisticated. This is the only session where resource speakers are specifically suggested, but they may be brought in for other sessions or during meals.

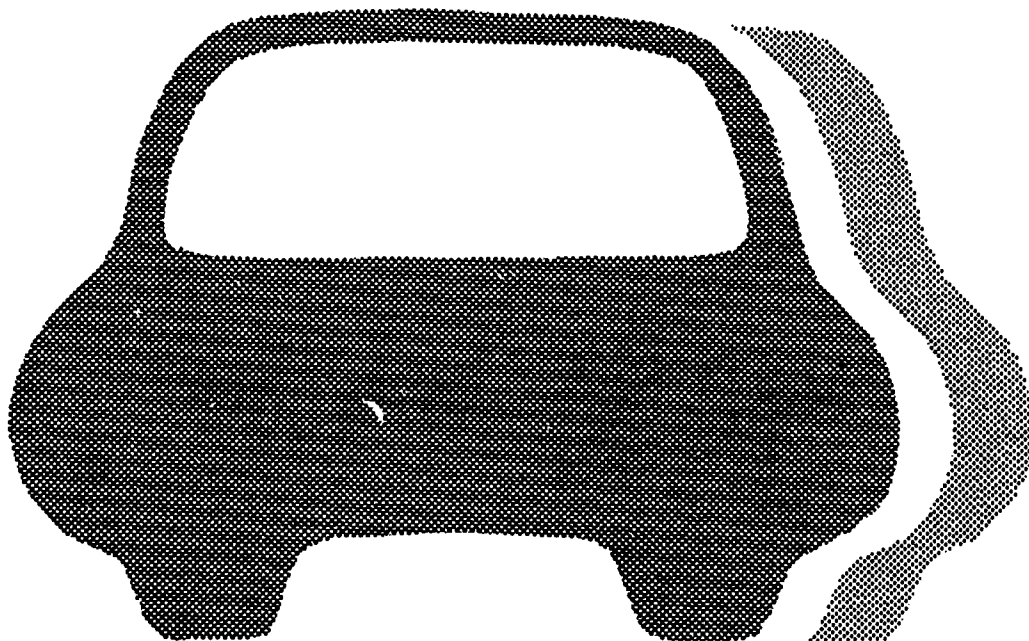
Another basic strategy is to maintain a relaxed, informal working and learning atmosphere in which participants will feel less constraint than the formalities of their jobs usually require.

A final strategy is to use research information, reference materials and a film to provide instructional authority, allowing the leaders to remain uncommitted to special viewpoints.

SUGGESTED SEMINAR SCHEDULE

T I M E	DAY I	DAY II	DAY III
<p>MORNING</p> <p>9:00</p> <p>10:00</p> <p>11:00</p> <p>12:00</p>		<p>BREAKFAST Seminar Expectations (Small Groups)</p> <p>The Problem Drinking-Driver (Optional)</p> <p>BREAK</p> <p>How Are We Coping?</p> <p>LUNCH -- Brief Descriptions of Agency Functions</p>	<p>BREAKFAST A Plan for this Community</p> <p>BREAK</p> <p>LUNCH</p>
<p>AFTERNOON</p> <p>1:00</p> <p>2:00</p> <p>3:00</p> <p>4:00</p>		<p>Telephone Assignment (Optional)</p> <p>The Interface (Small Groups)</p> <p>BREAK</p>	<p>Discussing the Model</p> <p>BREAK</p> <p>What Have You Learned? (Small Groups)</p> <p>SEMINAR ENDS</p>
<p>EVENING</p> <p>5:00</p> <p>6:00</p> <p>7:30</p> <p>10:00</p>	<p>Registration</p> <p>DINNER -- Seminar Introductions</p> <p>BREAK</p> <p>Value Exploration</p> <p>Agenda for Tomorrow</p>	<p>Informal Get-Together</p> <p>DINNER</p> <p>Free Evening</p>	

VALUE EXPLORATION



This session is designed to develop awareness and understanding of differing values pertaining to alcohol and safety.

VALUE EXPLORATION

RECORD SHEET

NAME _____

TYPE OF WORK: _____ **Alcohol Countermeasure**
_____ **Alcohol Treatment**
_____ **Judiciary**
_____ **Law Enforcement**

NUMBER OF YEARS IN THE FIELD _____

1. Value cards drawn _____

2. Value cards traded: **Traded away** _____
Received _____

3. Value cards turned in _____

4. Value cards finally held _____

5. Value cards held by community:

Major values _____

Minor values _____

LIST OF VALUES

1. A legal requirement that all alcoholic beverages carry a warning similar to that on cigarettes would have no effect on the consumption of such beverages.
2. Consumption of alcohol would drop if there were a legal requirement that all alcoholic beverages carry a warning similar to that on cigarettes.
3. An alcoholic cannot learn to drink in a controlled way. Total abstinence is the only road an alcoholic can take.
4. An alcoholic can learn to drink in a controlled way. Setting a goal of total abstinence is unnecessary.
5. Requiring drivers with two or more DWI convictions to display special license plates or bumper decals as a warning to other drivers would be illegal because of invasion of privacy.
6. Drivers with two or more DWI convictions should be required to display special license plates or bumper decals. This would warn other drivers to drive defensively when a car so labeled is on the road.
7. The disease, alcoholism, is not caused by underlying psychological problems.
8. Alcoholism is a disease that is caused by underlying psychological problems.
9. Drivers convicted for the first time of DWI should be fined, assigned to well-supervised probation, and alcohol safety school, but be allowed to retain their drivers' licenses.
10. There should be no difference between the court treatment of drivers convicted of DWI whether it is their first time or their fourth.

11. Government rehabilitation programs for drivers convicted of DWI have to be focused on the total drinking problems of the individual rather than just the problem of "drinking and driving."
12. Government rehabilitation program for drivers convicted DWI should be aimed at "drinking and driving" rather than at the total drinking problem of the individual.
13. The country-wide reduction of the speed limit to 50 miles per hour will probably increase the number of drinking/driving charges since the drinking driver's lack of control will be more obvious.
14. The country-wide reduction of the speed limit to 50 miles per hour will reduce the number of drinking/driving charges since even drinking drivers will have better control at that speed.
15. Since alcoholism has been officially declared a disease and DWI defendants are considered sick people, judges are obligated to go easy on sentencing.
16. Even though alcoholism has been officially declared a disease and DWI defendants are considered sick people, judges have no obligation to treat them differently than they do other law breakers.
17. "Scare films" showing the blood and gore of highway crashes are amateurish and ineffective in promoting safe driving habits.
18. "Scare films" showing the blood and gore of highway crashes are effective in promoting safe driving habits.
19. The disease of alcoholism creates special problems that can be treated only by alcoholism specialists in controlled rehabilitative settings.
20. The disease of alcoholism involves basic psychological functioning and should be treated in comprehensive mental health settings.
21. Alcohol/driving safety school has value for the social drinker but not for the problem drinker.
22. Alcohol/driving safety school has value for problem drinkers as well as social drinkers.

23. A drinking-driver rehabilitation program should concentrate on the specific problems of the individual rather than on observable behavior modification ("Don't drink and you will recover").
24. A drinking-driver rehabilitation program should concentrate on observable behavior modification ("Don't drink and you will recover") rather than on the specific problems of the individual.
25. Social drinkers are as likely to be picked up for DWI as problem drinkers.
26. Since social drinkers do not drink to get drunk, they are unlikely to be arrested for DWI.
27. In the drinking driving area, the courts should waive their traditional sanction of fine and/or imprisonment in favor of rehabilitation. It is more important to prevent recurrences than to punish offenders.
28. In the drinking driving area, the courts should not give up their traditional sanctions of fine and/or imprisonment. Although the court may provide some medical and psychological help, rehabilitation is primarily the responsibility of other agencies.
29. It is wrong to charge fees for the treatment of drivers who have committed alcohol related offenses. Since the offender remains in the court's jurisdiction, this practice amounts to charging a fee for the meting out of justice.
30. Fees should be charged for treatment of drivers who have committed alcohol related offenses. A fee would be more appropriate than a fine and the money could be used to improve treatment programs.
31. The reason very few women are picked up for DWI is that their drinking and driving patterns are different from those of men.
32. The reason very few women are picked up for DWI is that relatively few women are problem drinkers.
33. Alcoholism counselors should be recovered alcoholics; the only person who can understand and help people with alcohol problems is someone who "has been there."

34. Alcoholism counselors should be trained persons who understand human behavior and can relate to people in a helpful way. The recovered alcoholic may or may not possess these attributes.
35. The liquor industry should be made to pay part of the costs of rehabilitation of drinking drivers since the advertising of alcoholic beverages encouraged many of the drivers to start drinking in the first place.
36. The liquor industry cannot be held responsible for problem drinkers or alcoholics since people have a choice and can refuse to buy alcoholic beverages if they want to.
37. People who classify "problem drinkers" as a group between social drinkers and alcoholics are only fooling themselves. Anyone with a drinking problem is an alcoholic and needs to be treated as one.
38. There is a large group of people who can be classified as "problem drinkers" who are somewhere between social drinkers and alcoholics. They possess some of the tell-tale signs of alcoholics but do not have the disease.
39. Publishing the names of drivers convicted of DWI in the newspaper will have no effect on drivers' drinking and will cause unwarranted embarrassment for the drivers' families.
40. Publishing the names of drivers convicted of DWI in the newspaper is a useful device to reduce drinking driving. Since exposure is what the alcoholic and problem drinker fear most, it will make them think twice before doing it again.
41. People in highway safety programs don't seem to realize that problem drinkers didn't get that way in a few weeks or months and, therefore, cannot be rehabilitated in a short period of time either.
42. People concerned with highway safety programs are not against the rehabilitation of drunk drivers, but they are concerned that rehabilitation programs don't seem to be producing sober drivers in a reasonable period of time.

43. A judge now has the legal option to sentence a drunk driver to treatment as a new and effective way to improve highway safety while at the same time providing benefits to the driver.
44. It is acceptable for the court to get an alcoholic into treatment by suspending his sentence for drunk driving, but of questionable legality for the court to directly sentence the driver to treatment.
45. The real secret to cutting down on alcohol related accidents lies in rehabilitation of the drinking driver.
46. The real secret to cutting down on alcohol-related accidents lies in well-publicized and strict law enforcement.
47. A drinking driver's driving privileges should not be suspended during the time he is being rehabilitated. Rehabilitation requires a positive attitude which is impossible while the driver has the additional problem of trying to conduct daily business without a car.
48. A drinking driver's driving privileges should be suspended during the time he is being rehabilitated. The important issue is to keep him off the road until he is rehabilitated.
49. The most important goal for our highway safety system in relation to alcohol is to identify and treat drinking drivers.
50. The most important goal for our highway safety system in relation to alcohol is to keep drinking drivers off the road.
51. Teenagers and social drinkers convicted of DWI should have treatment separately from problem drinkers and alcoholics.
52. All drivers convicted of DWI should receive treatment together, whether they are teenagers, social drinkers, or problem drinkers.
53. Stiff fines, jail sentences and/or suspension or revocation of drivers' licenses are not effective control measures for problem drinkers, though they may be for social drinkers.

54. **Stiff fines, jail sentences and/or suspension or revocation of drivers' licenses are effective control measures for both problem drinkers and social drinkers.**
55. **On-the-spot roadside checks (stopping cars to determine the number of drinking drivers) is a worthwhile project for highway safety since it provides information not available from any other source.**
56. **On-the-spot roadside checks (stopping cars to determine the number of drinking drivers) is not only irritating to non-drinking drivers but wastes time and money that could be better spent in apprehending DWI's in a larger area.**
57. **In entering the field of drunk-driver rehabilitation, the federal government is assuming a public health stance -- that alcoholism is a disease that is dangerous to the common good and, therefore, needs to be treated.**
58. **In entering the field of drunk-driver rehabilitation, the federal government is imposing moral values on society.**
59. **Jail sentences should be eliminated for DWI cases unless the driver has been involved in an accident.**
60. **Jail sentences should not be eliminated for most DWI cases, even though not involving an accident. An automobile with a drunk driver is as much a lethal weapon as a gun.**

VALUE EXPLORATION NOTES

Although there may be no "right" values, these notes are intended to provide some accepted definitions, facts and research results that bear directly on the value statements in the Value Game. They are divided into four areas: Drinking, the Alcoholic and the Problem Drinker; Punishment and Sanctions; Treatment; and Miscellaneous.

DRINKING, THE ALCOHOLIC AND THE PROBLEM DRINKER

The first special report to Congress from the Secretary of Health, Education and Welfare (December, 1971) had this to say about the etiology of alcoholism:

"The causes of alcoholism are so many and appear in such differing constellations from person to person that one cannot consider treating alcoholism as if it were a single illness with an identifiable and specific etiology, a known cause, and a proven response to a particular chemical agent or medical treatment. Alcoholism is the result of complex and interacting factors. About the only characteristic shared by most of the alcoholic population is some pattern of repeated alcohol abuse that acts as a form of 'self-treatment' for the sufferer."

Some definitions of alcoholism are medically complex. Others are relatively simple. The Florida Bureau of Alcoholic Rehabilitation says alcoholism is "an illness characterized by uncontrolled, compulsive drinking."

Between 6 1/2 and 7 million Americans are believed to be victims of this illness. Whether there is a class of "problem drinkers" who are not alcoholics is debatable. In its alcohol countermeasures programs, the federal government has attempted to identify "problem drinking drivers" -- those whose drinking constitutes a threat to highway safety. They may not be alcoholics, just as alcoholics may not be problem drinking drivers.

Problem drinking drivers may be identified even in the absence of insights into their psychological makeup. The traditional technique, explained and discussed later in the seminar, has been to gather information on each possible subject concerning previous contacts with community agencies, arrests involving drinking and previous accidents.

The problem drinking driver is believed to constitute about seven per cent of all drivers and to cause 60 per cent of alcohol-related highway accidents. Since there are more than 108 million American drivers, this means that more than 7 million drivers today are a primary hazard in terms of alcohol-related deaths and serious injuries.

When the federally supported Alcohol Safety Action Projects were established more than three years ago, they at first served about half "problem" drinkers and half social drinkers. However, the proportion of problem drinkers increased significantly in almost every program as time went by.

The populations in nearly every study of problem drinking drivers are predominantly male -- from 88 to 95 per cent. Until the 1950's, it was estimated that there were five or six male alcoholics in the U.S. for every female alcoholic. In the 1960's, this ratio reportedly had dropped to four-to-one, or even lower.

Many students of the problem have suggested that the (apparent) increase in the number of female alcoholics noted during recent years is primarily due to the growing willingness of such women to seek treatment and may, therefore, be more apparent than real.

A number of factors may account for the small number of women arrest for Driving While Intoxicated (DWI). Among them are the fact that women tend to be passengers and the fact that the majority of driving by women occurs between 7:00 A.M. and 7:00 P.M., when there is less chance of detection and police apprehension.

Other characteristics of drivers involved in fatal and serious-injury highway crashes were disclosed in a study conducted for the Department of Transportation by the Department of Psychology at the University of Vermont, published in 1971.

Drivers involved in serious crashes were compared with drivers: (1) using the same roads at similar times, but without crash involvement; (2) with recent drunk driving arrests; (3) with arrests for other serious traffic violations; and (4) with no crashes or citations in the prior five years.

Among driver fatalities, 54 per cent had alcohol in their blood, 42 per cent had Blood Alcohol Contents (BAC) of .10 or higher. Those with alcohol tended to be young to middle-aged males with histories of medium to heavy drinking and with fatty degeneration of the liver. Those without alcohol tended to be older and to be light drinkers.

Among roadblock drivers -- those stopped at the accident sites several weeks later but under similar conditions -- 14 per cent had alcohol and 2 per cent had BACs of .10 or greater. Twelve per cent were heavy drinkers, and these were overrepresented among those who had alcohol when stopped, and who had prior crashes or citations on their records. Among clear-record drivers, 2 per cent had alcohol and none had .10 or higher BACs.

Almost all drunk drivers in the study were males; most were heavy drinkers with excessive numbers of prior crashes and citations; many were laborers; and many were unmarried.

PUNISHMENT AND SANCTIONS

License revocation or suspension is common practice in all states upon DWI conviction. Furthermore, all states, as of the fall of 1972, had implied consent laws which require drivers arrested for drinking and driving to take a chemical test or surrender their license.

A number of procedures -- probation before verdict, for example -- make it possible for a judge to avoid lifting of driving privileges. In many cases, rehabilitation is seen as a means of avoiding the removal of driving privileges.

According to the National Highway Traffic Safety Administration, there is little empirical evidence as to the effectiveness of publishing the names of convicted drunk drivers. Many alcohol countermeasures programs do publish names, and the practice may be effective, but its effectiveness awaits research verification.

With chronic offenders, there is reasonable evidence that traditional penal sanctions (fines and imprisonment) do not change drinking and driving habits. Research has shown that many problem drinking drivers drive after the suspension and/or revocation of their licenses and that many are arrested or involved in alcohol-related crashes during or immediately following suspension or revocation.

Traditionally, the law has considered driving a privilege, not a right, in America. However, a few court decisions in the past year have declared that a person's access to employment is a right that cannot be removed by the courts.

It is true that actually sentencing a defendant to treatment may not be legal in some states, but generally such sanctioning methods are expressly authorized by statute.

- Some methods, however, may be considered to derive from statute by implication or from inherent judicial authority. These methods may be formal or informal.**
- The informal methods, such as a "recommendation" or a "suggestion" to a DWI may be as effective as direct sentencing to achieve the desired result.**

Even such severe probationary conditions as the prohibition of drinking have been upheld by the courts.

TREATMENT

"Scare films" have been used for some time in driver training and highway safety programs largely unrelated to alcohol. Studies have shown that the scare technique results in safer driving habits in the short run but appears to have no effect in the long run.

In most countermeasures programs directed at the alcohol problem, scare techniques are minimized. The films commonly used in alcohol safety schools are usually sophisticated dramatizations of alcohol problems or, like the Canadian "Point Zero Eight," they provide visual proof of the dangers of combining drinking and driving.

Psychotherapists do not agree whether total abstinence is an absolutely necessary goal and the only measure of success in the treatment of alcoholism. Abstinence has long been deemed the first essential step in psychological rehabilitation, but opinions keep appearing to suggest that some alcoholic persons can become normal drinkers while, at the same time, increasing their psychological and interpersonal health in other areas. In a recent study conducted at Patton State Hospital, near Santa Ana, California, subjects treated by individualized behavioral therapy with a treatment goal of controlled drinking were found to function significantly better over a two-year duration than did control subjects treated by a conventional program oriented toward abstinence. This viewpoint bothers many therapists and Alcoholics Anonymous people who fear that each alcoholic will see himself as the exception who can become a controlled drinker.

Treatment under coercion -- either the threat of court-ordered punishment or the loss of employment -- has been proven effective in a number of studies. According to a 1972 study by the Public Systems Research Institute at the University of Southern California, there has been a reversal in recent years of the philosophy that enforced treatment does more harm than good.

It seems that many alcoholics and problem drinkers refuse to recognize their problem, and that enforced attendance at rehabilitation sessions creates favorable conditions for such recognition. A 1967 study found that enforced treatment actually decreased the recidivism of those who went through probationary educational classes in alcoholism.

On the other side of the coin stand several findings that there appeared to be no significant difference in recidivism not only between individuals going through enforced treatment and those given regular sentencing by the court but also between those given enforced treatment and those given none at all.

Some feel that an alcoholic person who has recovered from the illness is best qualified to treat it, since he has a deep personal understanding of the problem. Others disagree. They concede that the recovered alcoholic may have an initial advantage in establishing rapport, but they fear that the depth of understanding will be limited by the blind spots and prejudices of his own battle with the illness.

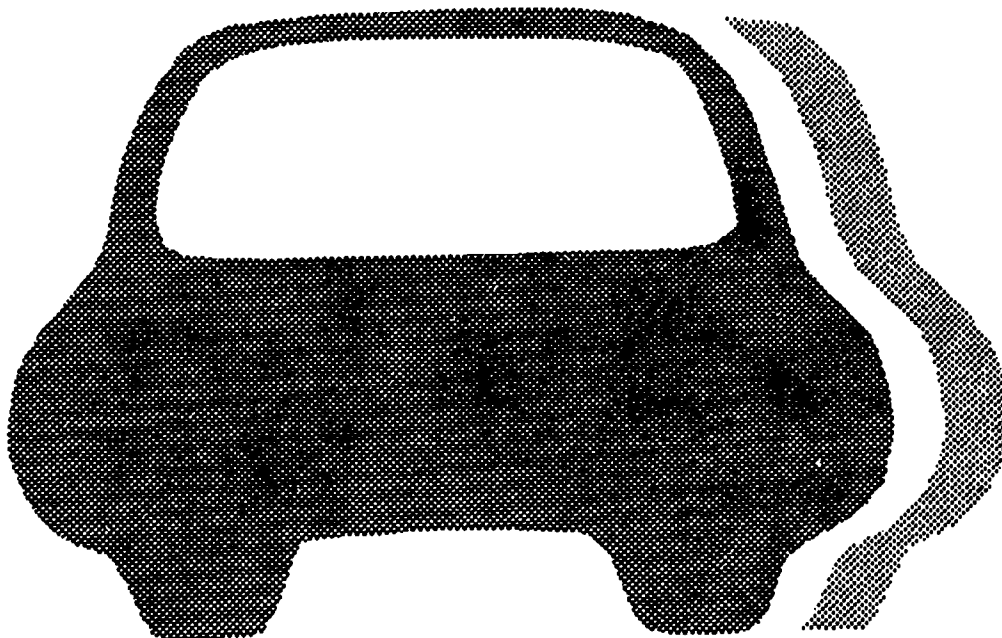
The critical need for alcoholism counselors and others to help problem drinkers has rendered this old controversy less partisan today than it was formerly. According to the HEW secretary's 1971 report: "The therapeutic disciplines and Alcoholics Anonymous have met, heard and learned from each other."

MISCELLANEOUS

The primary objective of the National Alcohol Safety Countermeasures program is "to get problem drinkers off America's highways and to keep them off until their problem is alleviated." The major approaches are: (1) identification of the problem drinker, (2) a decision on a course of action, based on a pre-sentence investigation after the individual's guilt is determined and (3) "action to assure a follow-up to carry out the decisions concerning the most appropriate procedures to reduce the drinking-driving problem, and to assure that drivers who drink excessively do not operate a vehicle on the highways."

In a field that desperately needs accurate research, on-the-spot field surveys like those employed in the previously mentioned Vermont research are considered the most accurate. Those conducting such surveys have encountered surprisingly little resistance, even from alcohol-impaired drivers. In the University of Vermont roadblock tests, 93 per cent of the drivers cooperated, and only 1.3 per cent of the respondents refused to give a breath sample.

SEMINAR EXPECTATIONS



DISCUSSION AND LISTING OF SEMINAR EXPECTATIONS

This session is designed to develop and outline individual and professional objectives for the seminar.

Why are you here?

What are you bringing here?

What do you expect to take away from the seminar?

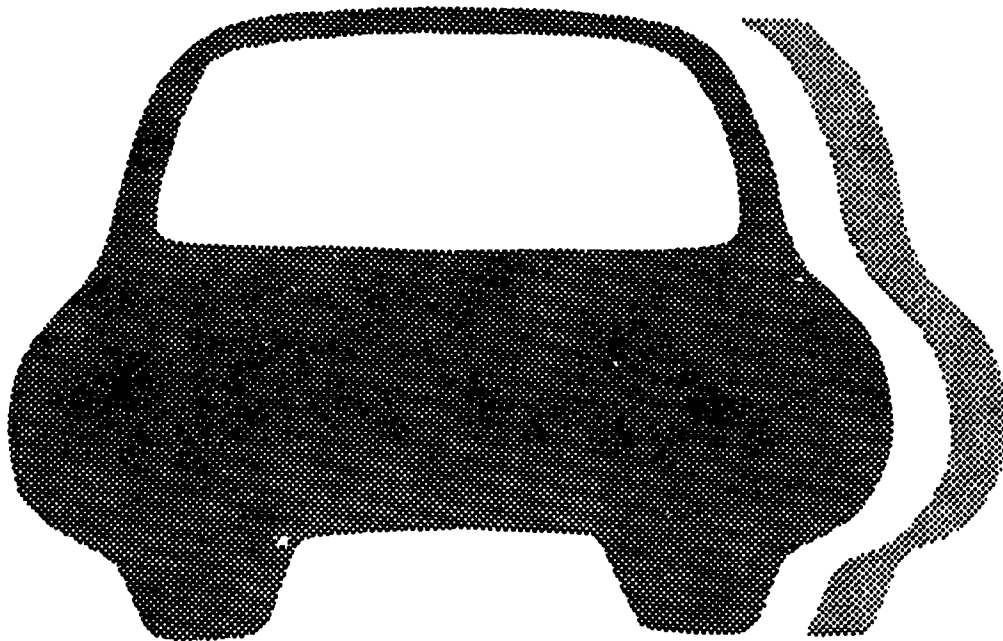
SEMINAR EXPECTATIONS

This session is to give you the opportunity to list your expectations for this seminar. What do you hope to learn in these two days?

List the expectations on the following page. Do not worry about duplication or repetition. Your individual objectives will be synthesized and summarized during the conference. You will have the opportunity to review these objectives with this same group before the conference ends.

Please list two or three expectations you would realistically like to accomplish during this seminar.

THE PROBLEM DRINKING DRIVER



NATIONAL PROBLEMS POSED BY PROBLEM DRINKERS WHO DRIVE

This session is designed to develop awareness and understanding of alcohol and highway safety.

Three subsections review alcohol and safety, alcohol and impairment, and the problem drinking driver.

ALCOHOL AND SAFETY

4.)

USE AND EFFECTS OF ALCOHOL

In 1970 the "average American drinker" (ages fifteen or older) consumed:

**44 fifths of whiskey, or
90 bottles of fortified wine, or
157 bottles of table wine, or
928 bottles of beer.**

After consumption:

Alcohol travels to the stomach and is absorbed into the bloodstream.

Absorption rate varies with:

Rate at which drinks are consumed.

Make-up of drink (more diluted - slower absorption)

Amount of food present in stomach (more food - slower absorption)

Prior presence of alcohol in bloodstream.

Blood carries alcohol to tissues and brain.

Effects of alcohol in blood:

A few drinks (approximate level reached in an average 160 lbs. person consuming three one-ounce drinks of whiskey) may:

Dull consciousness

Remove inhibitions

Increase self-confidence

Act as a depressant rather than a stimulant

Lower body temperature

A larger amount of alcohol (1/2 pint or more) absorbed into the bloodstream may:

Cause loss of memory

Cause unconsciousness and possible paralysis

Removal of effects of alcohol:

Time - it takes time to sober up.

**Time is required for oxidation to take place.
Alcohol eventually changes to carbon dioxide and water.**

Amount of time needed to sober up varies:

Time for oxidation varies according to amount of alcohol consumed.

Approximately one hour to burn up 2/3 ounce of whiskey.

Effects cannot be removed by:

Fresh air, black coffee, cold shower, etc.

BEHAVIOR PATTERNS -- SOCIAL DRINKERS

A person who can control the amount he drinks

A person for whom alcohol has not caused a problem in any area of his life

A person who follows the generally accepted behavior for a drinking occasion

A person who is a low volume alcohol consumer

A person with an average BAC (blood alcohol content) of .03 to .05 when drinking

A person with a sense of responsibility to community in awareness of drinking and driving hazards

BEHAVIOR PATTERNS -- PROBLEM DRINKERS

A person with an average BAC (blood alcohol content) of .10 and higher when drinking.

A person for whom alcohol has caused a problem in any area of his life, job, health, family, community, etc.

A person who cannot control the number of drinks he takes at a given time.

A person who frequently has a hangover and/or takes a drink to get rid of a hangover.

A person who rationalizes his or her drinking.

A person who drinks to get rid of his or her social or sexual inhibitions.

A person who gets drunk only on weekends so it doesn't interfere with his work.

A person who goes beyond the accepted behavior for a drinking occasion.

A person who hides his drinking or never drinks in a bar so no one sees him.

A person who will not admit to or seek help for his drinking habits if his drinking has caused problems in any area of his life.

BEHAVIOR PATTERNS -- ALCOHOLIC

Alcoholism is a disease.

Symptoms seen in problem drinkers are often seen in early stages of alcoholism.

There is no such thing as a typical alcoholic.

Less than 3% are found on skid row -- there are 6 to 6 1/2 million alcoholics in this country.

Some symptoms of chronic stages of alcoholism are:

- A. Drinks in morning.
- B. Experiences blackouts.
- C. Needs alcohol.

During periods of abstinence -- nervous, tense, irritable, resentful, lonely.

Alcoholic's power of reason and judgment are seriously affected.

The alcoholic consumes rather than drinks.

An alcoholic cannot drink.

Final stages of alcoholism can lead to rejection of reality, physical tremors, paranoia, collapse of all former social status and early death.

An alcoholic's average life span is 12 years less than that of the non-alcoholic.

SOCIAL DRINKING OR PROBLEM DRINKING?

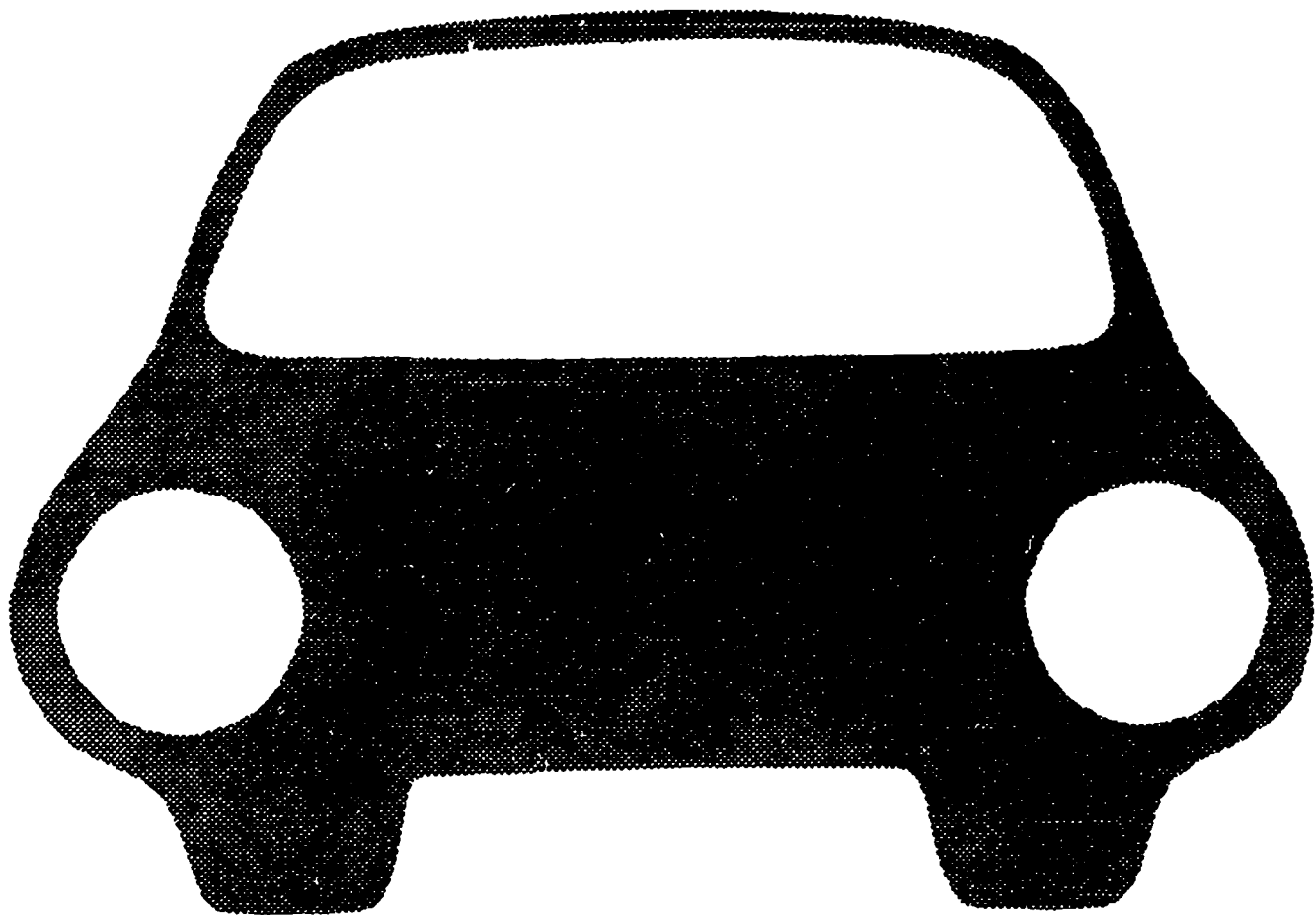
Which of the traits and practices on this page do you think indicate a social drinker, and which a problem drinker?

A PERSON WHO:

- 1. Frequently has a hangover.**
- 2. Takes a drink to get rid of a hangover.**
- 3. Takes a drink in the morning.**
- 4. Hasn't had a drink for three months.**
- 5. Goes on a binge one or two nights a year.**
- 6. Thinks liquor makes sex more enjoyable.**
- 7. Drinks in order to become sexually less inhibited.**
- 8. Never drinks in a bar.**
- 9. Has a drink at work.**
- 10. Only gets drunk with his or her spouse or family.**
- 11. Drinks only beer.**
- 12. Has to have a martini every night before dinner.**
- 13. Is accused by his or her spouse of drinking too much.**
- 14. Is accused by his or her boss of drinking too much.**
- 15. Drinks at lunch time.**
- 16. Gets drunk only on weekends.**

17. Never has more than three drinks at a sitting.
18. Sometimes misses work on Monday because of a hangover.
19. Frequently cannot remember what he or she was doing while drinking.
20. Was arrested once for being drunk.
21. Drinks while in a car.
22. Holds his liquor well.

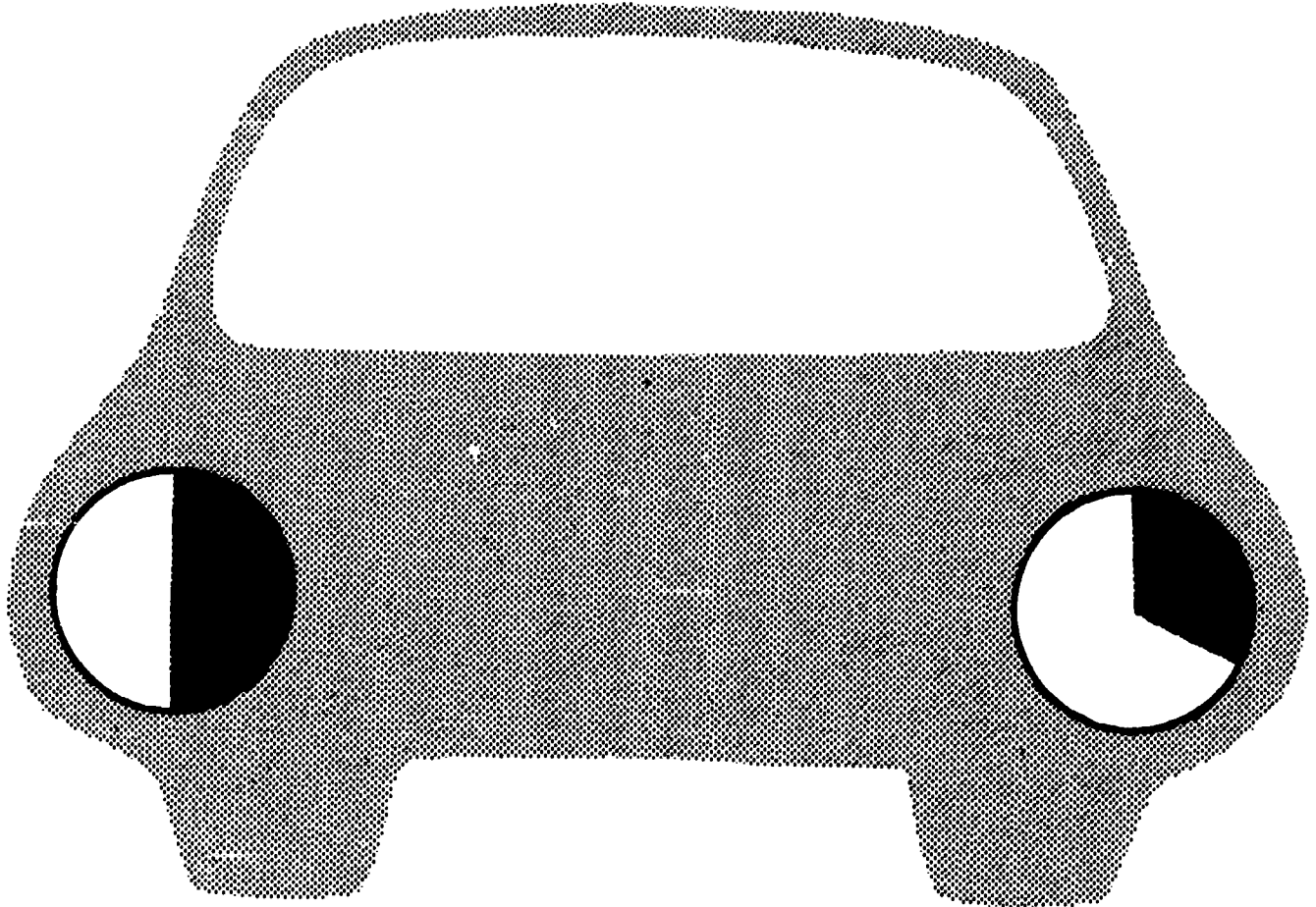
**If you have been drinking
don't drive**



If you have been drinking, don't drive. In 1970 there were 54,800 fatalities from various types of crashes. It is estimated that better than 50% of these fatalities were alcohol related.

If you have been drinking, don't drive. Combat deaths are fewer than alcohol related auto deaths. Ten years of the Vietnam war caused 54,000 deaths. Two years of alcohol related auto accidents resulted in 55,000 deaths.

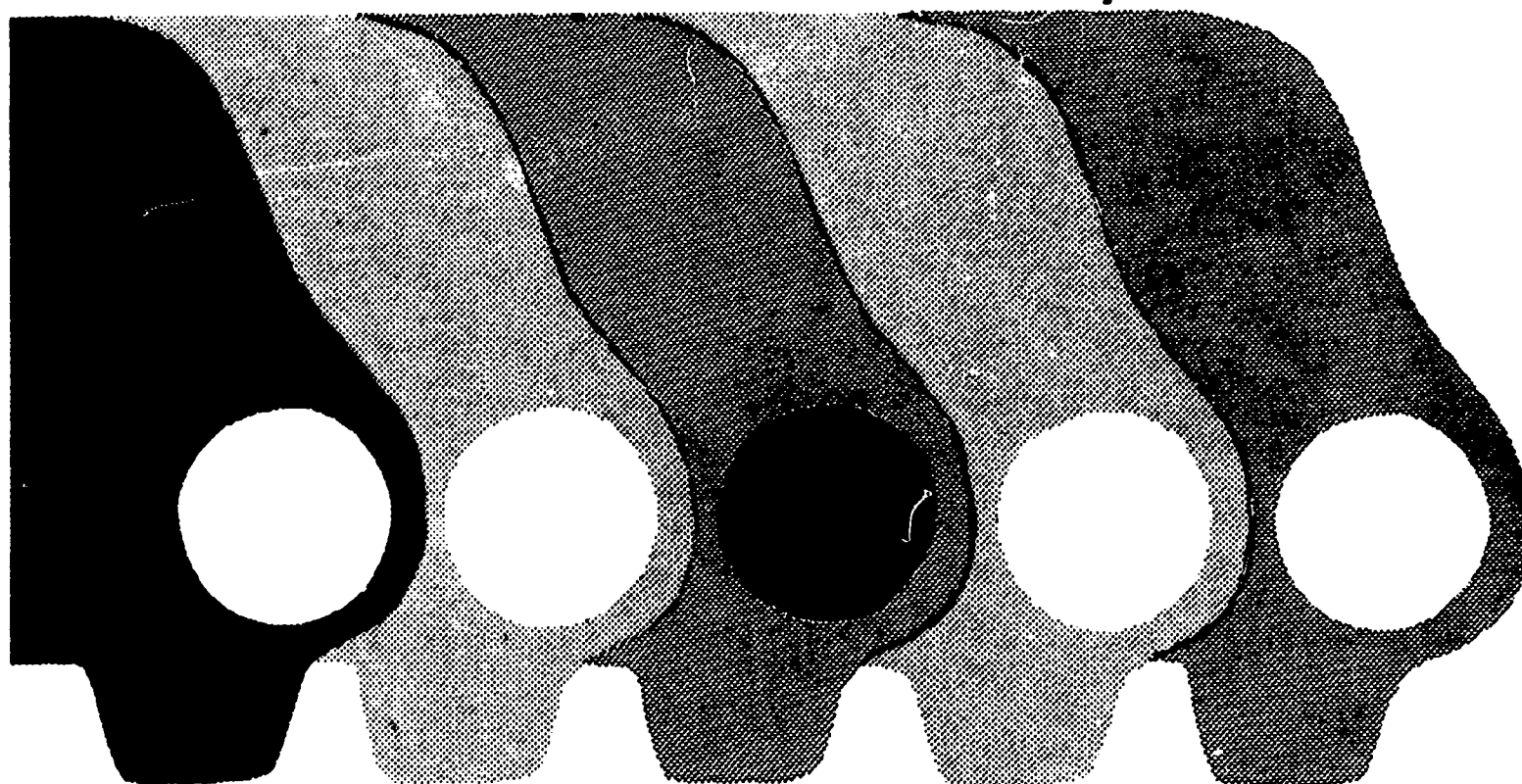
Alcohol-related auto accidents kill about twice as many people yearly as criminal homicides



Every 30 minutes a
homicide in the U.S.

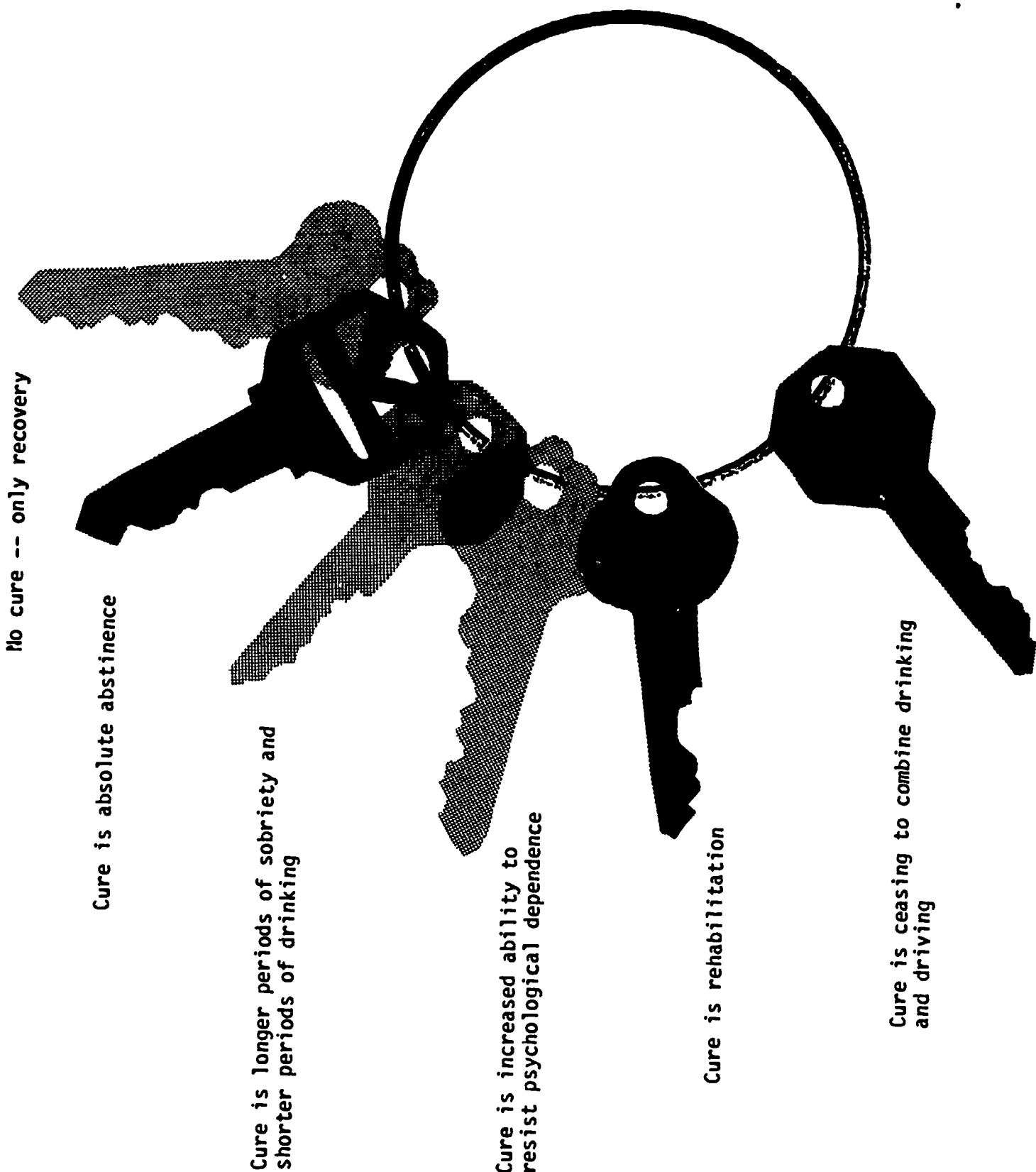
Every 19 minutes an
alcohol-related auto
fatality in the U.S.

Each year alcohol-related auto accidents are the third largest accident cost to our economy



Work Accidents	Non-Alcohol- Related	ALCOHOL-RELATED	Home Accidents	Public Non-Auto Accidents
\$9,300,000,000	Auto Accidents	AUTO ACCIDENTS	\$2,000,000,000	\$1,700,000,000
	\$8,500,000,000	\$7,300,000,000		

Which "cure" is the key?



No cure -- only recovery

Cure is absolute abstinence

Cure is longer periods of sobriety and shorter periods of drinking

Cure is increased ability to resist psychological dependence

Cure is rehabilitation

Cure is ceasing to combine drinking and driving

•
•

ALCOHOL AND IMPAIRMENT

61

B A C

B L O O D

A L C O H O L

C O N C E N T R A T I O N

The most common statutory method for expressing the concentration of alcohol in the blood is percent by weight. This usually means percentage weight by volume (w/v) based on the number of grams of alcohol per 100 milliliters (or 100 cubic centimeters) of blood.

DEFINITION

Blood alcohol concentrations are measured through chemical tests which involve:

Collection and measurement of breath or body fluid sample.

Separation of alcohol from the biological material.

Quantification of the separated alcohol.

Identification of the substance as alcohol.

MEASUREMENT

COMMON CHEMICAL TESTS FOR ALCOHOL

BLOOD ANALYSIS

POSITIVE

Cooperation of subject not required.

Most accurate of the tests for predicting brain alcohol.

Most direct for determining BAC.

Method for determining BAC usable with unconscious or dead subjects.

Generally less time consuming than other methods.

NEGATIVE

Collection procedure probably objectionable to subject.

Inconvenient specimen collection and identity control.

Costly.

Results may be delayed.

Laboratory equipment, facility and technician required.

BREATH ANALYSIS

POSITIVE

Accurately reflects BAC.

Results prompt.

Specimen collection convenient.

Collection procedure not likely to be objectionable.

Relatively less costly than other methods.

Laboratory facility not required.

NEGATIVE

Cooperation of subject required.

Generally not applicable to unconscious or dead subjects.

URINE ANALYSIS

NEGATIVE

Specimen collection and identity control inconvenient.

Results difficult to interpret.

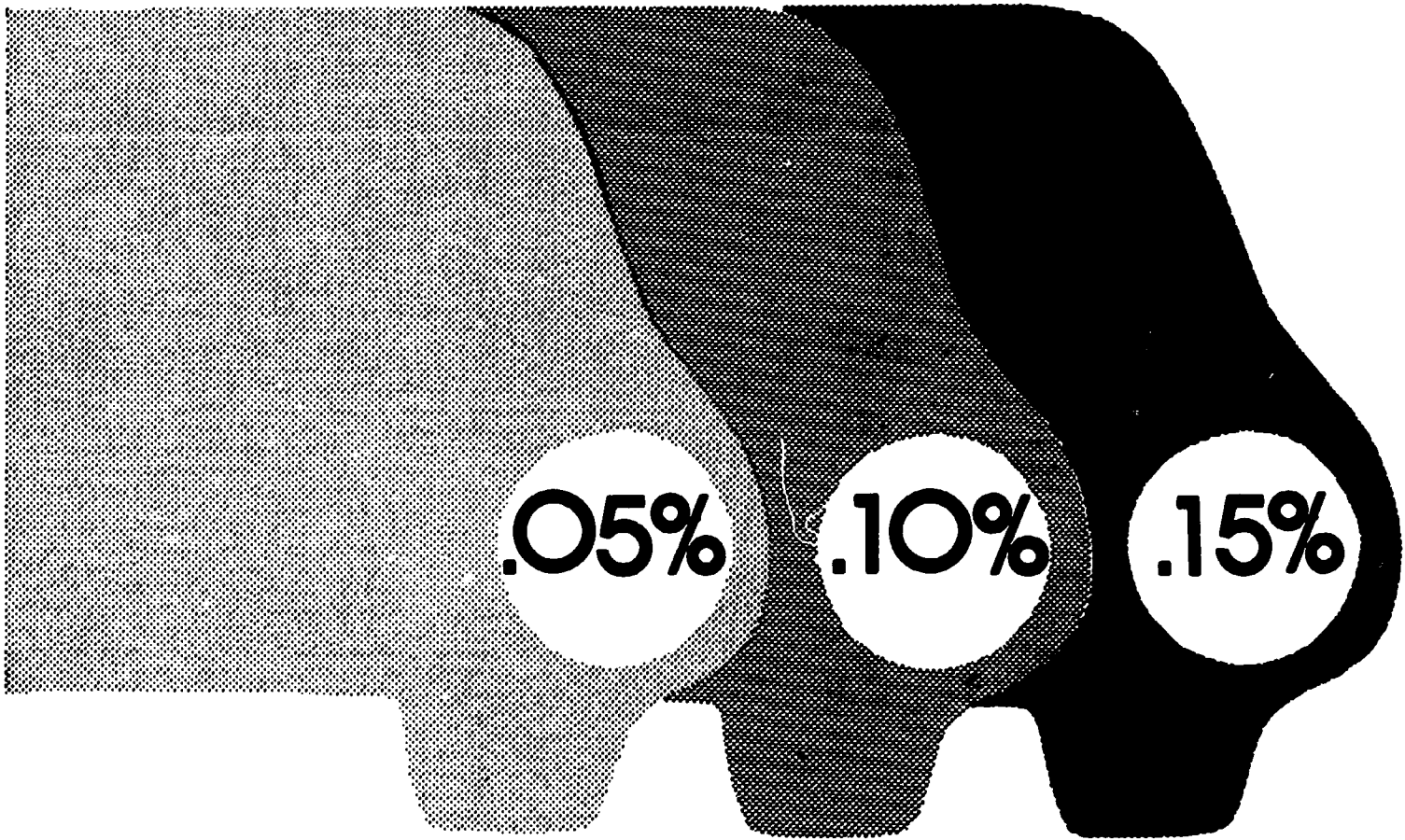
Results may be delayed.

Costly.

Cooperation of subject required,

Laboratory equipment, facility and technician required.

**It takes a lot of drinks
to reach a high BAC.
It takes time to sober up.**



**A 160 lb. drinker
(drinking 1 ounce
of 86 proof alcohol
per drink) needs**

4 drinks in 2 hours

and he needs

**3.5 hours to sober
up. BAC=.00%**

He needs

**6.5 drinks in
2 hours**

and he needs

**6.5 hours to
sober up.**

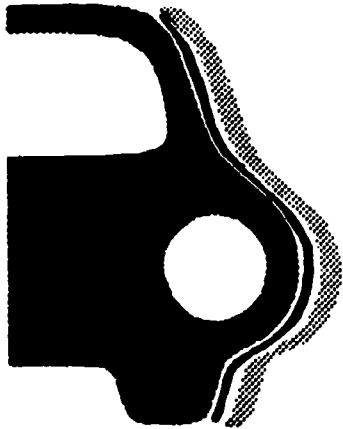
He needs

**9 drinks in
2 hours**

and he needs

**10 hours to
sober up**

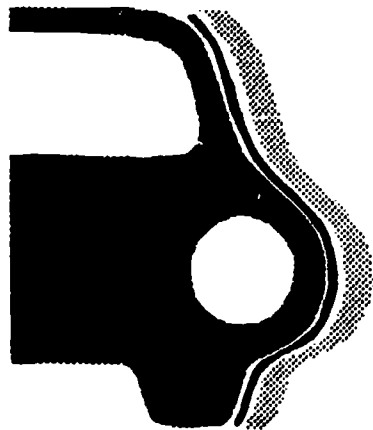
Predictable kinds of impairment occur at specific BACs



.00 - .04%

IMPAIRMENT - NOT SERIOUS

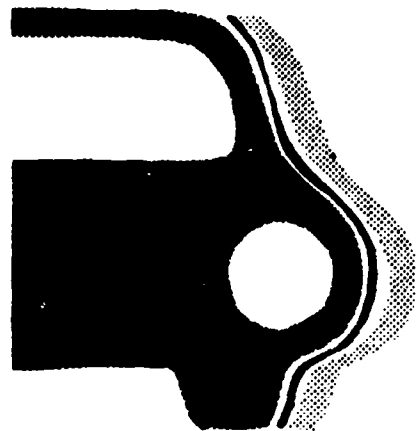
Absence of overt efforts; mild alteration of feelings, slight intensification of existing moods.



.05 - .09%

ABILITY AND JUDGMENT IMPAIRED

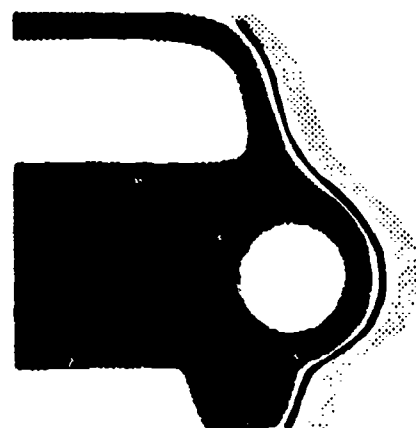
Feelings of warmth, relaxation, mild sedation; exaggeration of emotion and behavior; impairment of fine motor skills; increase in reaction time. Visual and hearing acuity reduced; slight speech impairment; minor disturbance of balance; increased difficulty in performing motor skills; feelings of elation 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.



.01 - .04%

Loss of lane control (crossing center line).
Increase in driving speed.

A BAC of .08% is too high for safe driving




.05 - .09%

Increase in roughness of car handling.
Increase in speed.
Marked loss of lane control.
Marked increase of error generally.
Marked increase in speed.
Erratic car handling.
Panic stopping.



.10 - .14%

Five times the number of errors committed.
Loss of lane control.
Very rough car handling.
Reliance upon ability rather than caution.



.15% +

Aggressive behavior.
Exhibitionist-type driving.
Ignoring speed zones.
Excessively fast driving.
Skidding.
Uncontrolled braking.
Loss of lane control.
Running traffic light.

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

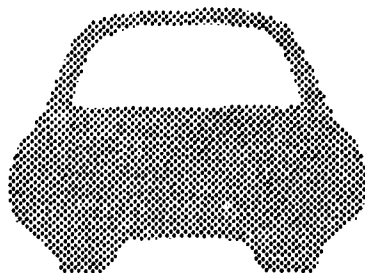
- Erratic movement (weaving, swerving)
- Extreme caution or recklessness
- Failure to anticipate hazards
- Failure to maintain lane control
- Aggressive driving

Tests show that both heavy and moderate drinkers are impaired

THE TESTS:

Vision Test
Standing Test
Coordination Test
Concentration Test
Comprehension Test

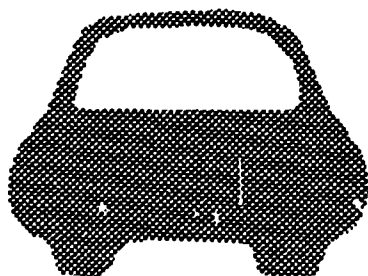
THE IMPAIRMENT:



.00 - .05%

18% of Moderate Drinkers were impaired

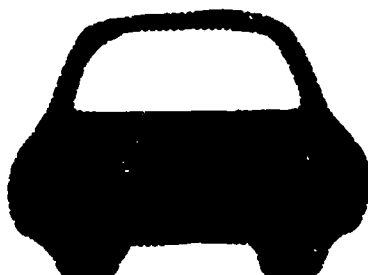
6% of Heavy Drinkers were impaired



.05 - .10%

95% of Moderate Drinkers were impaired

57% of Heavy Drinkers were impaired



.10 - .15%

100% of Moderate Drinkers were impaired

100% of Heavy Drinkers were impaired

THE PROBLEM DRINKING DRIVER

50

SOME IMPRESSIVE STATISTICS ON THE DRINKING DRIVER

Drinking drivers are responsible for crashes 4 times more often than they are the victims of crashes.

Over 800,000 run-of-the-mill crashes per year are alcohol-related.

About 28,000 deaths per year result from alcohol-related auto accidents.

1 to 4% 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.

Alcoholics in fatal accidents often have histories of personal violence, depression, strong suicidal drives and paranoia.

80% of fatally injured drivers who were not at fault in all crashes had no alcohol in their bodies.

48% to 57% of drivers killed in multi-car crashes had a BAC of .10 or higher.

80% of passengers killed in single car crashes had been drinking.

40% of pedestrians killed have a BAC of .10 or higher.

Most alcohol-involved crashes occur between 6:00 P.M. and 6:00 A.M. on Saturday night.

As high as 97% of drivers arrested for "driving under the influence" have a BAC of .10 or higher.

Drinking driver arrests in America average out to two arrests per policeman per year.

For every drinking driver arrest, 2,000 such offenses go unheeded.

Of the drinking drivers involved in 1,000 fatal drunk-driving accidents (California, 1961) 25% were convicted and only 5% (50 drivers) were jailed.

52

WHY DO PEOPLE DRINK?

As far back as historical records go, beverages containing alcohol have been made and used by mankind. Such beverages are part of the cultures of people throughout the world. A recent survey in the United States shows that 68 per cent of American adults drink at least occasionally. The other 32 per cent have exercised their freedom of choice not to drink.

People drink for a variety of social, cultural, religious or medical reasons. They drink at parties and celebrations with friends and relatives. They drink in religious ceremonies. Some drink wine to complement the taste of their dinners. Some drink to relax. Some drink to increase their appetites.

The drinking of most people is "integrative" drinking; that is, the use of alcohol is an adjunct to other activities, such as meals, family and religious feasts or an evening with friends.

Among Orthodox Jews, native Italians, and other groups where alcohol is part of religious or social traditions, there is a low incidence of problem drinking, though there is almost universal use of alcoholic beverages.

Some people, however, use alcohol for its own sake, for the anesthetizing effect it has on the mind and the body. Some of these are the people who cannot do without alcohol; who drink to get drunk; who drink for courage; who use alcohol as an escape from life; who drink to forget their worries; who cannot have fun without alcohol; who use alcohol as a drug. These uses of alcoholic beverages often lead to drinking problems.

ONE DEFINITION OF A PROBLEM DRINKING DRIVER

Diagnosis 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 or more at the time of arrest.

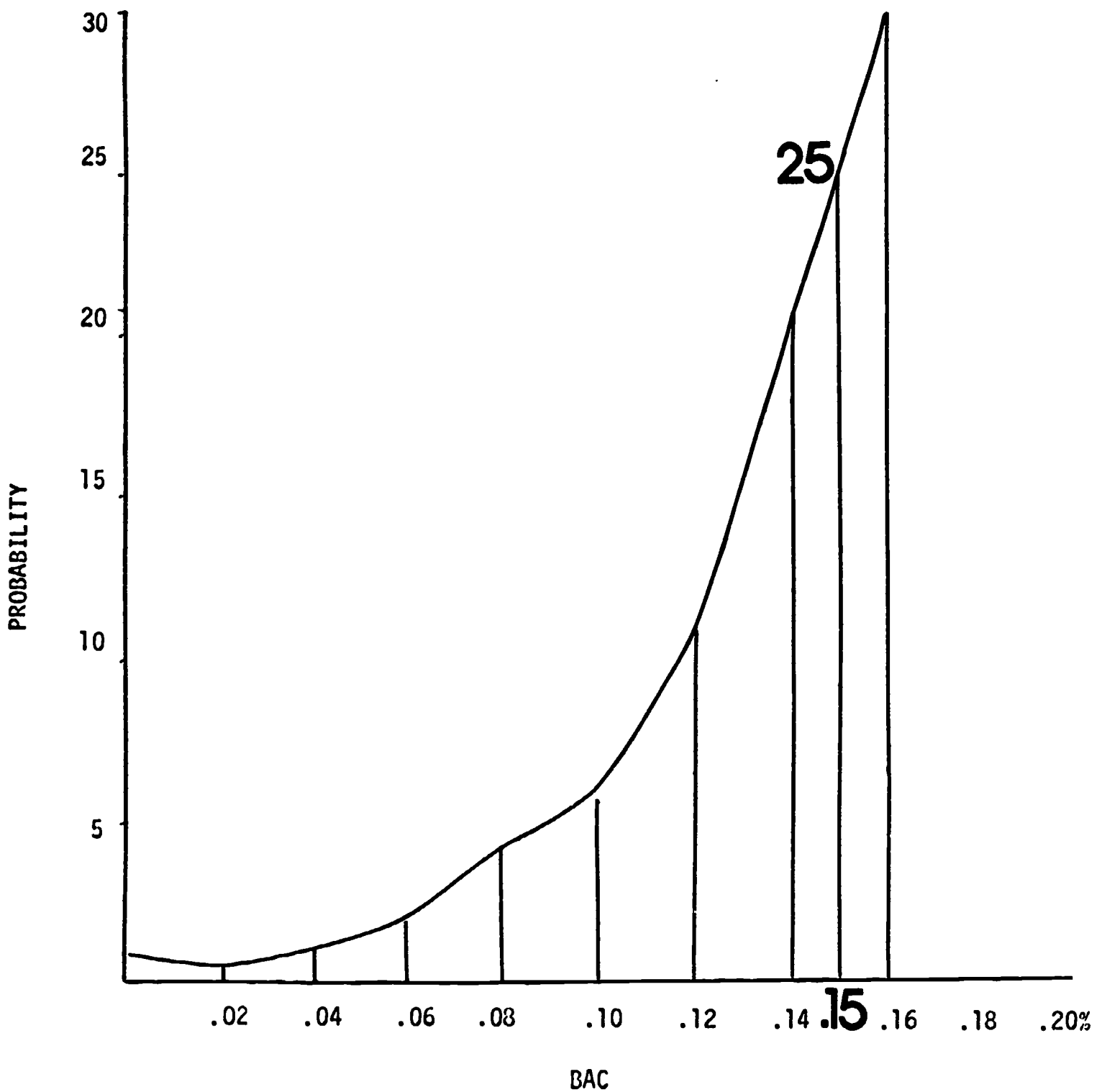
A record of one or more prior alcohol-related arrests.

A record of previous alcohol-related contacts with medical, social, or community agencies.

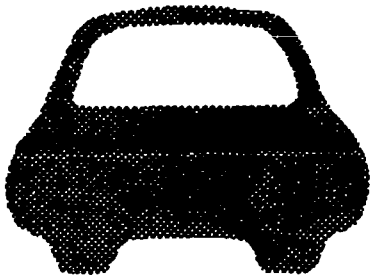
Reports of marital, employment or social problems related to alcohol.

Diagnosis as problem drinker on the basis of approved structured written diagnostic interview instruments.

Drivers with a .15 BAC
are 25 times as likely to CAUSE
an accident as drivers with a
.00 BAC

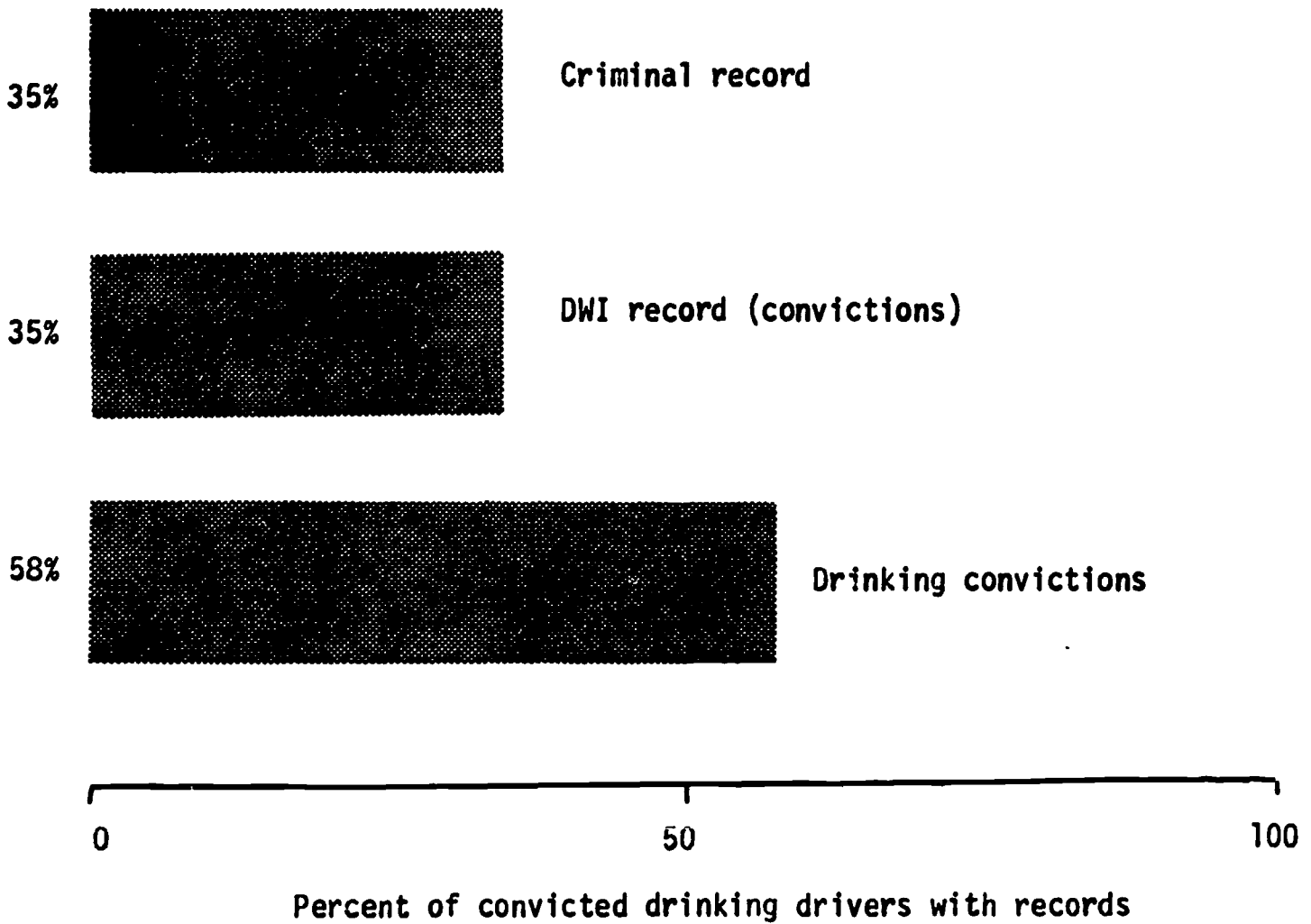


THE PROBLEM DRINKING DRIVER IS IDENTIFIABLE BY:

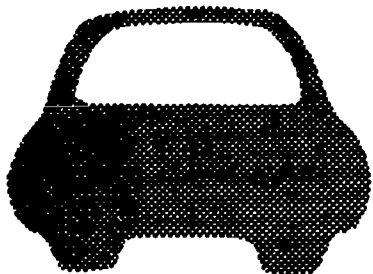


His criminal and traffic record

Men convicted of drunk driving often have a record of criminal, traffic, and drinking offenses.

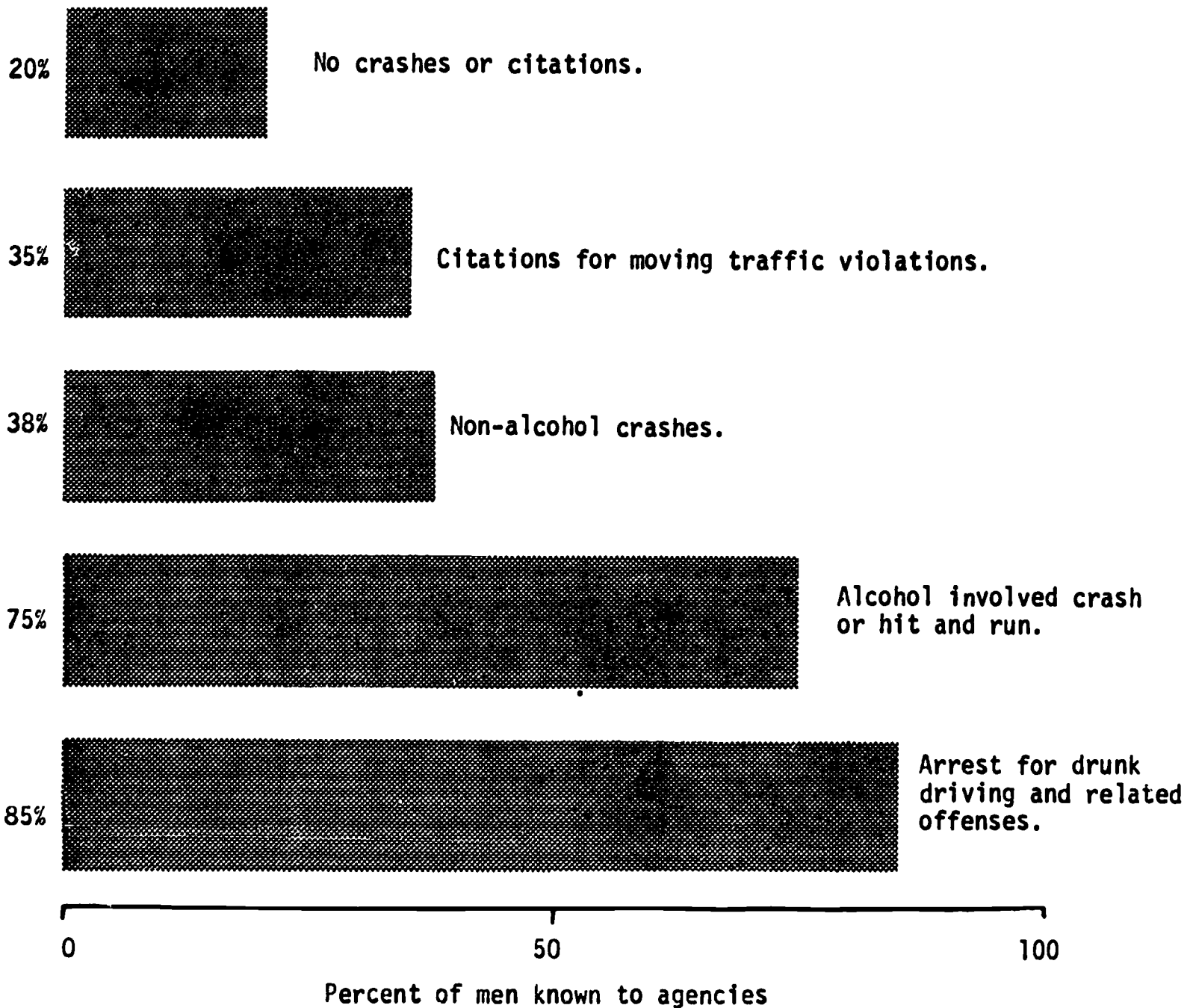


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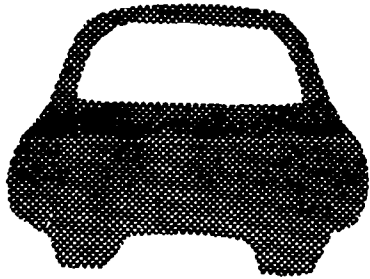


His community agency record

Men known to community agencies often have records of motor vehicle crashes and violations.



THE PROBLEM DRINKING DRIVER IS IDENTIFIABLE BY:



His continuing involvement with the system

ADJUDICATION

ENFORCEMENT
PROSECUTION
JUDGE
DEFENSE

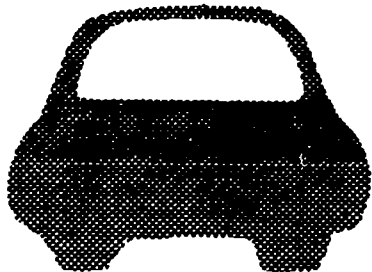
PRE-SENTENCE
INVESTIGATION

PROBATION
DIAGNOSIS
ENFORCEMENT
MOTOR VEHICLE DEPARTMENT
COMMUNITY SERVICE AGENCIES

SANCTIONS

PROBATION
REHABILITATION
TREATMENT
MOTOR VEHICLE DEPARTMENT
CORRECTIONAL INSTITUTIONS

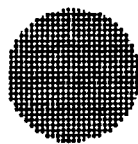
THE PROBLEM DRINKING DRIVER IS IDENTIFIABLE BY:



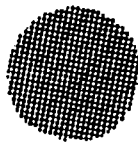
His driving performance

The consequences of drinking driving may be the most valid indicator of impairment by alcohol.

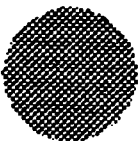
Drivers with a BAC of .10% or above (1-4% of drivers on the road) are involved in at least



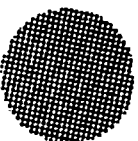
TWICE as many auto accidents of all kinds.



TWICE as many property damage accidents.



FIVE TIMES as many personal injury accidents.



TWELVE TIMES as many fatal accidents.

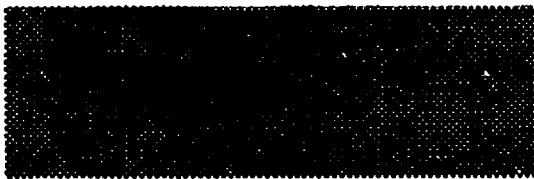
as is statistically probable.

A STATISTICAL EXERCISE

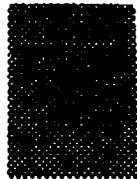


In 50 years the statistical probability is that a legally drunk driver will have at least one serious crash -- there's a 50% chance someone will die in it.

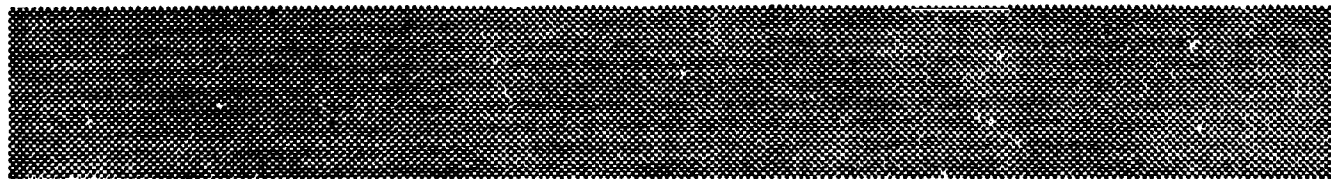
IN 50 YEARS OF DRIVING:



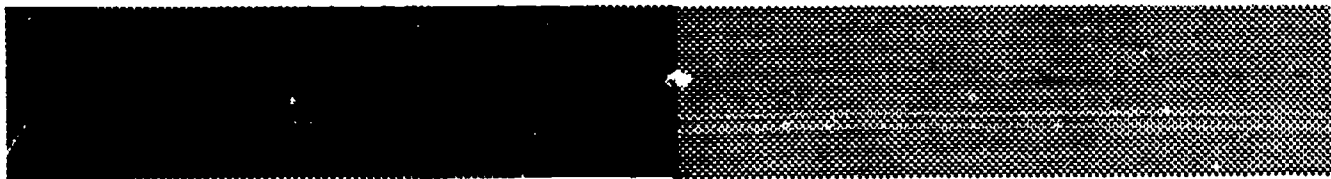
4 of 10 sober drivers will crash with another sober driver.



And 1 of those 10 drivers will crash with a legally drunk driver (BAC = .10 +)



A drunk driver (BAC = .10 +) will have at least one serious crash.



And half of those legally drunk drivers will be in a fatal crash.



Problem drinking drivers merit special attention because of:

THEIR CRIMINAL AND TRAFFIC RECORD

1. Comprise 35% of people who are having "run-of-mill" crashes.
2. Have nearly twice as many crashes and traffic violations as non-problem drinking drivers.
3. Have three times more suspensions of driver's license than non-problem drinking drivers.

THEIR COMMUNITY AGENCY RECORD

1. Tend to have problems with rage, depression, uncontrollable violent impulses, and paranoid reactions.
2. Commonly have psychiatric problems.
3. Tend to have marital and family problems.
4. Tend to have financial and employment problems.
5. Frequently are alcoholics, but are undetected as such.

THEIR HIGH BAC AT THE TIME OF ARREST

1. Usually have a BAC of .15 or higher at the time of arrest.

THEIR DRIVING PERFORMANCE

1. Cause 50% of alcohol-related auto fatalities.
2. Represent 60% of drivers killed in single-car accidents.
3. Represent 45% of drivers killed in multi-car accidents.
4. Represent 45% of drivers killed and responsible for vehicle crashes.
5. Represent 45% of fatal injuries to adult pedestrians.
6. Represent 45% of drivers responsible for pedestrian fatalities.
7. Tend to be apathetic about theirs and others' safety.

STATEMENTS - TRUE OR FALSE

1. Alcohol is a drug.
2. Alcohol is a food.
3. In the body, alcohol is digested just as food is.
4. In the body, alcohol is burned up just as food is.
5. Because it is a stimulant, alcohol tends to pep a person up.
6. Everyone's body reacts the same way to the same amount of alcohol.
7. Alcoholic beverages can be fattening.
8. Alcohol in any quantity will damage organs in the human body.
9. A person can die of alcohol poisoning.
10. All alcoholic beverages are equally strong.
11. Liquor taken straight will affect you faster than liquor mixed with water or soda in a highball.
12. You'll get drunker on vodka or gin or rum than on the same amount of whiskey.
13. Switching drinks will make you drunker than staying with one kind of alcoholic beverage.
14. You can sober up quickly by drinking black coffee and dousing your head in cold water.
15. It's risky to drive a car right after having a drink.
16. Drunkenness and alcoholism are the same thing.
17. Anyone who drinks at all is likely to become an alcoholic person.
18. Alcoholic individuals can be helped.
19. There are certain symptoms to warn people that their drinking may be leading to alcoholism.

1. **TRUE** - Alcohol is a special type of drug; it affects the nervous system.
2. **TRUE** - Alcohol is called a food because it contains calories. But it is not a proper substitute for the usual foods in a balanced diet since it is almost completely lacking in the many other nutrients needed for growth and maintenance of good health.
3. **FALSE** - Alcohol does not have to be digested slowly, as most other foods must be, before reaching the blood stream. Alcohol is immediately absorbed into the blood, passing directly through the walls of the stomach and the small intestine. The blood rapidly carries it to the brain. That is why alcohol may affect a drinker so quickly.
4. **TRUE** - The body burns up alcohol through the process of oxidation - a series of chemical changes that enables food to release energy. Oxidation takes place mostly in the liver, which needs about one hour to burn up 1/2 ounce of alcohol; this is the amount contained in one average highball, one glass of wine, or one can of beer. Meanwhile, the unoxidized alcohol remains in the blood stream and continues to have an effect on the brain.
5. **FALSE** - Alcohol is generally a depressant, not a stimulant; but sometimes a drinker imagines that he is being pepped up. This is why: Alcohol's first effect on the brain is to slow down the brain area that controls judgment and thought. Thus, alcohol may interfere with a person's normal ability to do certain mental tasks: to remember; to understand; to reason; to make decisions. In slowing down this area, alcohol releases the drinker's inhibitions which usually guard him from dangerous behavior. Since he is less inhibited, more relaxed, he may at first feel unusually free and easy and gay. But his nervous system is being depressed, not stimulated; and this depressant action increases if the person continues to drink.

Alcohol also tends to slow down the brain area that controls muscular coordination. Thus, alcohol may also interfere with a person's normal ability to do certain physical tasks: to coordinate movement of his arms and legs; to speak clearly; to balance himself.

If a person takes in alcohol faster than his body can oxidize it, the alcohol concentration in his blood will increase. As the alcohol concentration builds up, his reactions become less and less dependable when he tries to reason, to remember, to coordinate the muscles that help him to stand, move, drive. With the depressant action increasing, relaxation may give way to feeling high, drunk, and finally, if he continues to drink, to passing out.

6. FALSE - Reactions to alcohol vary tremendously. Different people react differently to the same amount of alcohol. Even the same person may react differently to the same amount of alcohol under different circumstances.

Reactions depend on many complex factors. A person may be influenced by physical factors: how fast he drinks; whether he has eaten; the type of beverage; his body weight; his body chemistry. He may also be influenced by psychological factors: the situation he's in; his mood; his attitude toward drinking; his drinking experience.

7. TRUE - Alcohol is higher in calories than sugars and starches, although lower than fats. An ounce of liquor contains about 70 calories, the equal of a fried chicken drumstick. A 12 ounce can of beer contains about 150 calories, the equal of one frankfurter. The calories in alcohol can contribute to overweight. However, if alcohol is substituted for a balanced diet, the person may suffer from malnutrition.

8. **FALSE** - Moderate amounts of alcohol usually do not harm body organs in the well-nourished person. But large amounts and high concentration of alcohol may lead to irritation or inflammation of parts of the digestive system; prolonged and heavy drinking may seriously affect the heart, liver, stomach and other organs.
9. **TRUE** - If a person rapidly gulps down an unusually large amount of alcohol (more than a pint), it may kill him.
10. **FALSE** - Alcoholic beverages are made by two different processes, fermentation and distillation. Distillation creates beverages containing higher concentrations of alcohol.

Wine and beers are fermented beverages. Most beer made in the United States contains about 4 per cent pure alcohol. Ordinary table wines (such as burgundies, sauternes) contain up to 14 per cent pure alcohol. Dessert or cocktail wines (ports and sherries, for instance) are fortified with extra alcohol, increasing the alcohol content to 18 per cent or 21 per cent.

Liquors are distilled beverages: rum, gin, vodka, brandy, and whiskey (rye, bourbon, scotch). Liquors usually contain between 40 per cent and 50 per cent pure alcohol. In this country, a liquor is labeled by its "proof," which is double its alcoholic strength: "80 per cent proof" means 40 per cent alcohol, while "100 per cent proof" means 50 per cent alcohol.

11. **TRUE** - Straight liquor reaches the brain faster because it is absorbed into the blood stream faster than liquor which is diluted.

But when liquor is diluted, what you use as a mixer has an influence on absorption of the alcohol. The carbonation in soda or ginger ale will speed the passage of the alcohol through the stomach. Thus, the alcohol in liquor diluted with water is absorbed most slowly; the alcohol in liquor diluted with soda is absorbed somewhat faster; and the alcohol in straight liquor is absorbed fastest of all.

12. FALSE - The flavor of the liquor does not affect the drinker. It's the alcohol content that affects him. Each liquor has a different flavor because each is made from different ingredients. Whiskey is made from grain such as corn, barley, rye; vodka from corn, other cereals and potatoes; rum from molasses; gin from alcohol flavored with juniper berries.

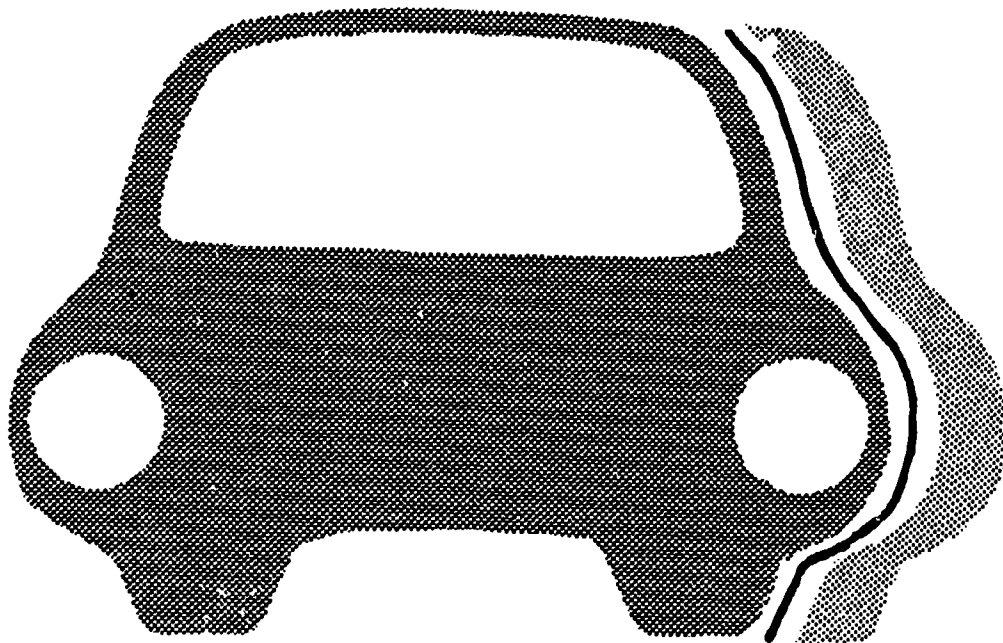
But all ordinary liquors have roughly the same alcohol content. With most vodkas, gins, whiskies, rums, one ounce contains about 1/2 ounce pure alcohol.

13. FALSE - Switching, or mixing, won't make you drunker because the degree of drunkenness is determined by the total amount of alcohol your blood absorbs, not by the flavor of the beverage. However, for some people switching is more likely to cause nausea and vomiting, possibly because of the different flavorings and mixers used.
14. FALSE - Nothing can speed the sobering-up process because your body oxidizes alcohol at a steady rate. Coffee can help keep you awake, but it won't improve your judgment or sharpen your reactions. A person who is drunk can only wait for his liver to burn up the alcohol, at the rate of about one hour for every 1/2 ounce of alcohol he has drunk.
15. TRUE - Under certain circumstances, one drink may affect a driver's judgment, may interfere with his normal alertness, especially if he is an inexperienced driver or an inexperienced drinker. He may become overconfident, careless, more likely to take chances, running through a red light, passing a curve, speeding. To be absolutely safe, anyone should wait at least an hour, after having a drink, before he drives. If he cannot wait, he should find a nondrinker to take the wheel.

16. **FALSE** - Drunkenness is temporary loss of control over one's reactions and behavior while drinking alcohol. Anyone who drinks immoderately at one time or another may become drunk. Alcoholism is a serious illness. The alcoholic person loses control of his drinking. He is dependent on alcohol; and his drinking interferes with some vital part of his life, his work, his family, his emotional or physical health. He may feel that drinking offers him not only escape, but actually the only satisfaction he can find in life.
17. **FALSE** - Out of about 80 million people in the United States who use alcohol, 9 million are estimated to be alcoholic persons. Doctors do not know why some people become alcoholic; most experts believe that it is a combination of physical, psychological, and sociological causes. The person who drinks to escape from his emotional problems and the pressures of everyday living is probably more likely to become an alcoholic individual.
18. **TRUE** - In many cases. Medicines and psychiatric treatment are used by doctors to help the alcoholic person stay sober and learn to handle his problems effectively without alcohol. Many people have also been helped by Alcoholics Anonymous, by religious guidance, by vocational rehabilitation workers and other counselors who specialize in working with alcohol problems. But no single method of treatment works for everyone.
19. **TRUE** - These signs may be warnings: The person's drinking increases, especially his drinking alone. He may seek excuses to drink, or drink on the sly, or need to drink early in the morning. He may gulp drink after drink. He may "black-out." (This is temporary loss of memory, not loss of consciousness.)

At this point, a person may be treated effectively if he consults his physician or minister, or a counselor, psychologist, or psychiatrist. Without treatment, he faces uncontrolled drinking, frequent drunkenness, and addiction to alcohol.

HOW ARE WE COPING?



This session is designed to develop the operation of the enforcement, judicial and health care sectors in both the old and new drinking driver control systems.

AN HISTORICAL OVERVIEW

Years ago, if a man suffered from alcoholism, he had few places to turn for help. Except in rare instances, he was considered a moral degenerate. Doctors and hospitals wanted nothing to do with him. Churches offered what help they could, but usually, the alcoholic or problem drinker was faced with sobering-up in jail. This was true whether he had been arrested for public drunkenness or drunk driving.

Drunkenness was a punishable offense in the American colonies. Virginia in 1619 decreed that any person found drunk for the first time was to be reprovved privately by his minister, the second time publicly, and the third time he would "lye in halter" for 12 hours and pay a fine. Yet in the same year the Virginia Assembly passed legislation encouraging production of wines and distilled spirits. In the Massachusetts Bay Colony, occasional drunkenness was punished by whipping, fines, and confinement in stocks.

The temperance movement emerged in the early 19th century as a reaction against the gross excesses of drinking on the frontier and in the cities. By the end of the century, temperance had taken on an air of religious evangelism and had become a major force in the social and political life of the nation. After 1900, the movement shifted from moral persuasion against drunkenness to proposals for legal enforcement of total abstinence. Led by the Anti-Saloon League and the Woman's Christian Temperance Union, and supported by a substantial bloc of Protestant churches, the movement culminated in the ratification of the 18th Amendment in 1919, making it illegal to manufacture or sell alcoholic beverages.

That amendment was not repealed until 1933 with the passage of the 21st Amendment, and during those years, the automobile came into its own as a staple of American life. Thirty-three years after repeal, public drunkenness was considered a criminal offense in all United States jurisdictions, but the concept of alcoholism as a treatable disease was taking root. It grew slowly, no doubt influenced by Alcoholics Anonymous and modern psychiatry. There was disagreement over the nature and causes of alcoholism, but the main belief was that a person with an alcohol problem could be treated and restored to normal life.

Full professional acceptance of the medical nature of alcoholism came in 1956, when the American Medical Association approved a statement placing "alcoholic symptomatology... within the scope of medical practice." The AMA suggested that hospitals develop facilities for detoxification, noting the "changed viewpoint and attitude which places the alcoholic in the category of a sick individual."

The growing acceptance of the disease concept of alcoholism raised questions about the legal status of intoxication and alcoholism. Offenses directly associated with alcohol accounted for a third of the arrests recorded by police in 1972, according to statistics compiled by the Federal Bureau of Investigation. The vast majority were for public intoxication. Drunk driving was a distant second but gaining recognition as a major national health problem.

A campaign to change the legal status of intoxication began in the mid-1960s at about the time of growing momentum for increased federal action. The legal challenges relied on a fundamental principle of criminal responsibility -- that criminal sanctions may be applied only to voluntary action. It was argued that as a result of his disease, an alcoholic drinks involuntarily and, therefore, cannot be criminally punished for his intoxication. This concept was upheld by the U.S. Circuit Court of Appeals for the District of Columbia in 1966. The same year, a Fourth Circuit (Richmond) ruling held that the Eighth Amendment prohibition against cruel and inhuman punishment precluded convicting a homeless alcoholic for public intoxication.

In a health message to Congress, also in 1966, President Johnson recommended establishment of a center to conduct research on the causes, prevention and treatment of alcoholism. The request led to the formation in October, 1966 of the National Center for Prevention and Control of Alcoholism within the National Institute of Mental Health.

The next year, Congress passed the District of Columbia Alcoholic Rehabilitation Act of 1967. The new statute, the first of many to follow across the country, directed that "all public officials in the District of Columbia shall take cognizance of the fact that public intoxication shall be handled as a public health problem rather than as a criminal offense..." The principles of the 1967 act were applied nationally with the Alcoholism Rehabilitation Act of 1968, and an act in 1970 created the National Institute on Alcohol Abuse and Alcoholism to coordinate all federal activities in the field.

To receive its share of formula grants under the 1970 act, each state is required to develop a comprehensive alcoholism plan. States also are required to submit highway safety plans, including plans for alcohol safety, to the Department of Transportation. DOT and the National Institute on Alcohol Abuse and Alcoholism have been cooperating in the attack on alcohol abuse on the highways. In 1972, they launched an advertising and publicity campaign to attack the problem. In March, 1973 the National Commission on Marijuana and Drug Abuse declared, "Alcohol dependence is without question the most serious drug problem in this country today," and the nation appeared to be moving toward that realization.

THE DRINKING DRIVER CONTROL SYSTEM

Because drinking drivers long have been a danger on the highways, society long ago developed a network or system of agencies aimed at controlling their behavior. We call it the drinking driver control system.

The principal agencies and personnel who control drinking drivers make up the traffic-law subsystem. This consists of those units of government involved in the generation, implementation and enforcement of traffic laws, in the adjudication of the guilt of alleged violators and in the imposition of sanctions against those found guilty.

Since alcoholism has come to be recognized as a social and medical problem, a loose-knit collection of helping agencies, both public and private, concerned with the treatment and rehabilitation of the problem drinker and alcoholic, has developed which might be termed the alcoholism treatment subsystem.

Distinctions between the subsystems are arbitrary, and so are the names we might ascribe to them. We might call the former the enforcement-identification subsystem and the latter the education-treatment subsystem. Educating a problem drinking driver about the extent of his problem is a part of his rehabilitation.

THE NEW SYSTEM AND THE OLD

Until education and treatment entered the scene, the drinking driver control system -- the "old" one -- treated all Driving While Intoxicated (DWI) cases the same.

Adjudication flowed immediately into sanctioning. Drinking drivers, whether social drinkers, problem drinkers or alcoholics, were declared guilty, fined or jailed. Usually, their privileges were suspended or revoked, as well.

All three types of drinkers returned to the general population. The social drinker probably would never return to the system. But the other two types probably would return -- either as repeat offenders or as highway crash statistics.

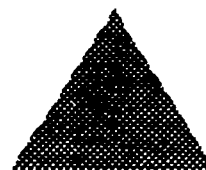
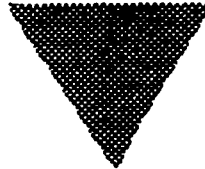
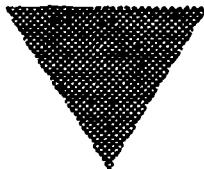
One problem with the old system was that adjudicators did not have at their disposal information that would identify a problem drinker or alcoholic; there was no reason to have such information if all sanctions were to be virtually identical.

The new system separates the adjudication and sanctioning functions, giving time for a pre-sentence investigation and allowing the judge, if he chooses, to prescribe a sentence on the basis of the diagnosis provided by the pre-sentence investigation.

The new system also provides alcohol safety education for social drinkers and medical and psychological services for problem drinkers and alcoholics.

We speak of the old system in the past tense, but actually it prevails through much of the nation. The new way has been tried in a scattering of Alcohol Safety Action Projects financed by the federal government and in local projects financed through states and localities. Results so far are inconclusive, although there are some encouraging signs. What is known for certain is that the old system has failed to keep drunk drivers from returning to the road while under the influence of alcohol; alcohol-related deaths and injuries on the highways continue to pose a national health problem.

GENERAL POPULATION



TRAFFIC LAW SYSTEM

General Laws

Enforce

Adjudicate

Sanction

ALCOHOLISM CONTROL SYSTEM

Treat and

Rehabilitate

THE TRAFFIC-LAW SUBSYSTEM AND THE TREATMENT SUBSYSTEM: SOME POINTS

Both systems are controlled by law. However, unless they are acquitted, violators who enter the traffic-law subsystem are subject to criminal sanctions.

The traffic-law subsystem has the responsibility for public safety and the mandate to enforce procedures to produce safety beyond the interests or motivation of any specific individual.

The tradition of a large component of the treatment subsystem is that of the voluntary seeking of help by the patient. In the drinking driver control system, however, the violator often approaches treatment involuntarily.

The traffic-law assumption that its responsibility is to enforce safety procedures beyond the interests or motivation of any specific individual may not be shared by the treatment subsystem, which takes patients individually, voluntarily and confidentially.

The treatment subsystem is a relative newcomer to the large drinking driver control system because alcoholism has only recently been regarded as a treatable disease.

A primary goal of the drinking driver control system is to keep people from combining drinking and driving. The approach is soft on drinking but hard on the combination of drinking and driving.

The drinking driver control system does not have the objective of removing all drinking drivers permanently from the highway. The public does not desire this, nor are there resources to do so. The system's objectives actually are very modest. They attempt to balance the social and economic utility to the public of drinking as a pleasure and the automobile as a convenience against the social and economic disutility of crashes cause by the drinking driver.

In the drinking driver control system, the treatment subsystem is supplemental to, not a substitute for, the traffic-law subsystem.

FUNCTIONS OF THE SYSTEM

Insofar as they join together to act against the drinking driver, the traffic-law subsystem and the alcoholism treatment subsystem perform five basic functions.

LAW GENERATION -- the legislation designed to control the undesirable behavior of the alcohol-impaired driver.

ENFORCEMENT -- identification and apprehension of law violators

ADJUDICATION -- the official determination of guilt or innocence for those accused of violating the laws.

SANCTIONS -- the imposition of legal punishment against those found guilty of disobeying those laws.

TREATMENT -- the medical and psychological procedures to alleviate the alcohol problem underlying the prohibited behavior.

In this seminar, we are concerned with the interfacing of the first four functions as a group (particularly adjudication and sanctioning) and the treatment function.

EVALUATION

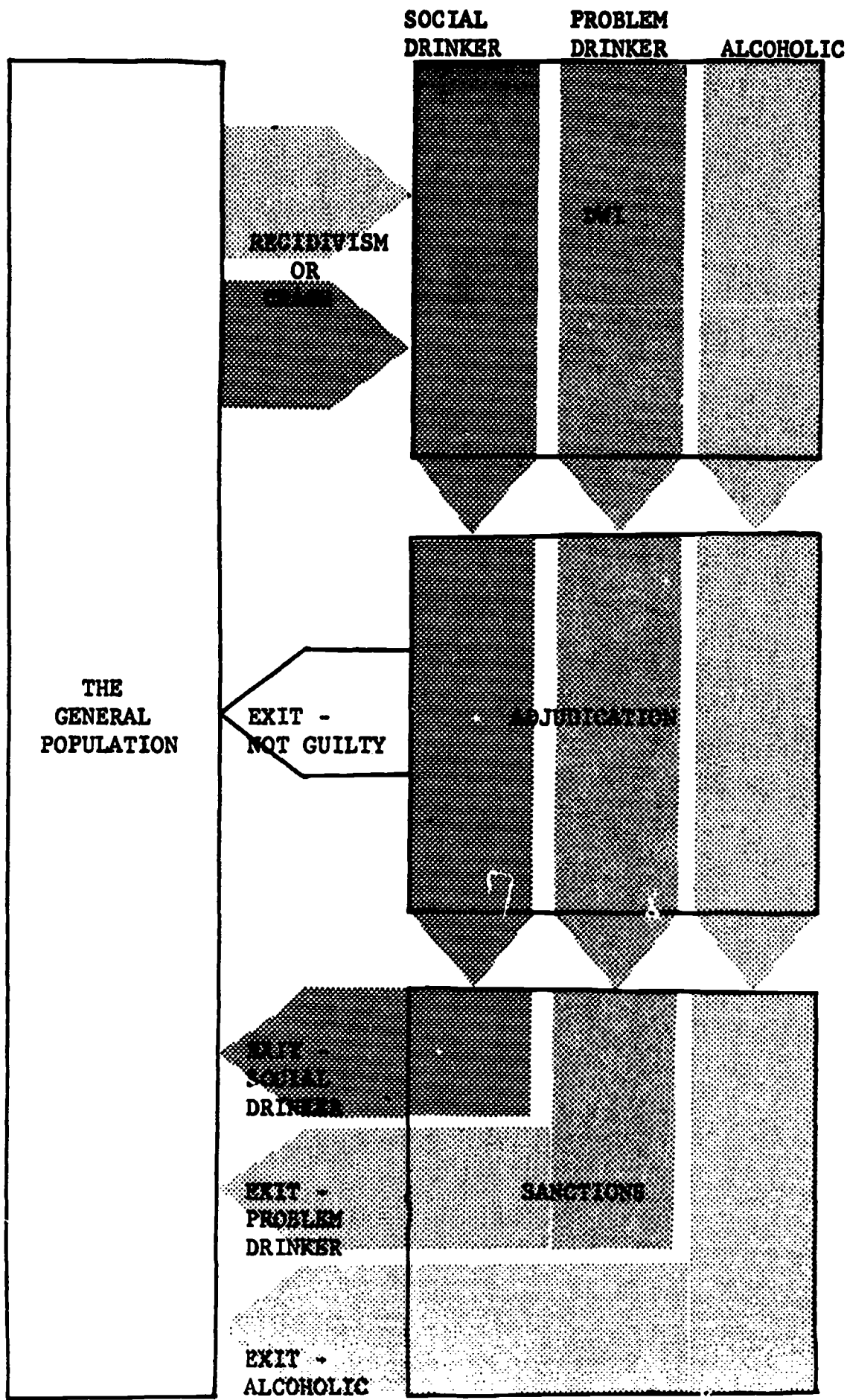
The entire drinking driver control system suffers from a lack of evaluation of its effectiveness. So lacking is an ongoing evaluation, in fact, that a number of the system's parts are designed largely on hypothesis.

We do not know for certain that the traditional sanctions do not have the desired effects on problem drinking-drivers and alcoholics. We do not have enough data to determine the probability that a person will cease driving if his license is suspended. When several sanctions are applied at the same time, we do not know which is having an effect, if any. Finally, we do not know the probable success of various treatment techniques.

Because of the nature of past enforcement activity, most published information on the effectiveness of various sanctions deals only with severe problem drinkers and alcoholics. The majority of people in the category of "problem drinker" have not yet received innovative sanctions, so that the effectiveness of these sanctions has not been evaluated.

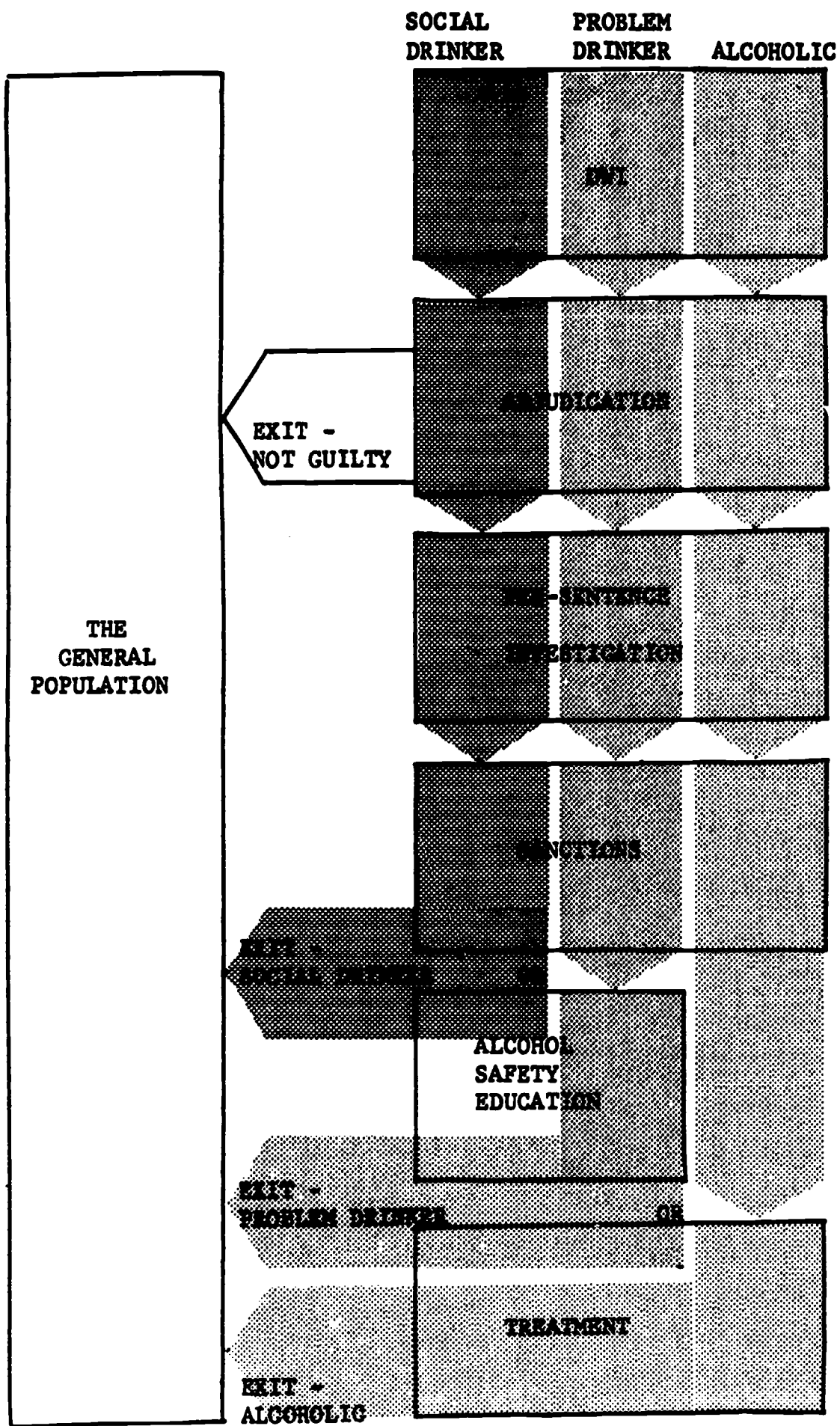
Ongoing evaluation should be built into the entire drinking driver control system. At least minimal data on each case should be maintained. The results of the monitoring and evaluation of each case contribute to the cumulative data required for periodic program assessment. When programs are proven effective in this way, the court's confidence in the referral program increases -- and vice versa.

THE OLD SYSTEM



BEST COPY AVAILABLE

THE NEW SYSTEM



LAW GENERATION

The generation of laws relating to DWI offenders is vitally important to the drinking driver control system at every point. The findings of the social and medical sciences would seem to indicate that distinctions should be made between the alcoholic or problem drinker whose excessive use of alcohol results from his illness and the individual whose excessive use is voluntary. For years, scientific evidence has pointed to the need for distinguishing between these two types of drinking drivers, but only recently has the distinction begun to appear in legal literature. To date, not all state statutes have isolated the alcoholic or problem drinker as the major threat to highway safety, although in most cases existing laws do provide a basis for police initiative in this area.

The Uniform Vehicle Code (National Committee on Uniform Traffic Laws and Ordinances) reads:

"It is unlawful and punishable as provided in section 11-902.2 for any person who is under the influence of intoxicating liquor to drive or be in actual physical control of any vehicle within this state."

But not all states use the broad and inclusive expression "under the influence of intoxicating liquor" in their code, and in a handful, degrees of drinking-driving violations are recognized.

There are literally hundreds of other variances in existing statutory law, judicial interpretation and administrative regulation. The "point system" is an example of one of the most nonuniform laws in existence. Many states have no pre-arrest breath test legislation, although all now have implied consent laws that require drivers arrested for drinking and driving to take a chemical test or surrender their licenses for up to six months.

But laws regulating everything from auto safety inspections to post mortem examinations to the closing hour of taverns are a hodgepodge both among the states and within individual states and communities.

And while new legislation can provide the ways and means of curbing the activities of the problem drinker who drives, legislation alone is inadequate without the active support of the public in general, police agencies, social groups, service organizations and medical groups.

This is why a strong public information program is one of the countermeasures in the federally supported drinking driver control systems.

ENFORCEMENT

The police officer, the primary agent of the enforcement subsystem, has one of the hardest and least appreciated jobs in the drinking driver control system. His is the job most visible to the public, and, of course, without him, the system could not function.

His functions are three:

Prevention of drunk driving, detection of drunk driving and apprehension of the drunk driver.

He must have a thorough knowledge of the alcohol-driving problem, be able to detect erratic drunk driving, make efficient and legal arrests, be equipped with breathalizers and other specialized equipment and know how to use them and follow his cases into the courts. All of this requires a fundamental knowledge of the laws in his state related to drinking and driving. In states that allow hearings in cases of chemical test refusal, the police officer must weigh legal issues vital to his multiple roles as party, witness, counsel and advocate -- all at the same hearing!

PREVENTION

The problem of identifying the problem drinker must be solved before preventive measures can be designed.

The police officer is the first person in the system to begin the post-arrest job of identifying the problem drinking driver. The violator's BAC at the time of arrest is one indicator, as are his records of contacts with health and social agencies, his previous driving records, the results of a medical examination or of interviews with family, employer and associates.

Some police departments, as a preventive measure, regularly publish statistics on the number of intoxicated persons arrested in a night or in a week. A few have established "crisis intervention centers," which provide transportation for drivers who are intoxicated in public places. Usually, their cars are driven home for them.

DETECTION

Many police forces have specially trained units to spot the tell-tale signs of drunk driving -- opening car windows in the winter, for example. Roadblocks and checklanes have been used, though some DWI's can slip through them and many citizens resent them as nuisances, if not an invasion of privacy.

Breath, blood and urine tests, along with the long-established tests of coin pick-up, finger-to-nose, balance, walking and turning are the usual detection devices. But even with these devices at hand, the officer must be careful. The National Safety Council estimates that more than 60 clinically recognized disabilities have symptoms the same as or similar to those of alcoholic intoxication. And the effects of the combination of alcohol and other drugs may be synergistic; that is, combined, they have a greater effect than the sum of their individual effects.

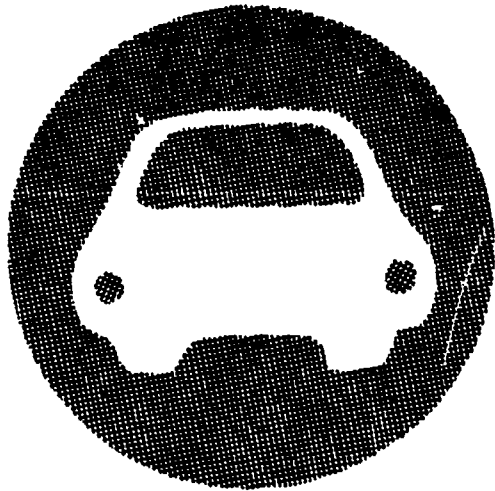
APPREHENSION

Apprehension of DWI offenders is limited, to a degree, by the availability of police officers. The greatest number of DWI offenses occur in the late night hours, between 9:00 P.M. and 3:00 A.M., which are those hours of the day when demands for police services in a community are at their highest.

The International Association of Chiefs of Police recommends that "hot pursuits" of DWI offenders should be avoided whenever possible. The probability that they will crash is high under ordinary circumstances.

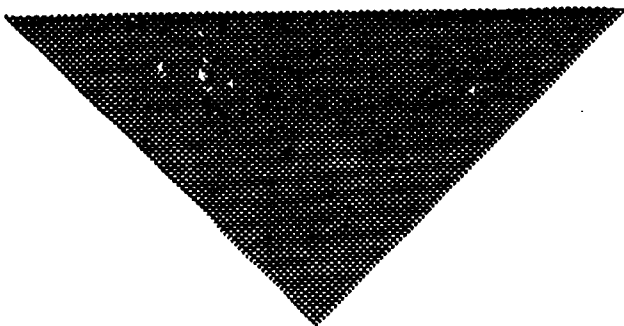
The association also notes that "the professional character of the arresting officer must be impervious to verbal assaults from DWI offenders."

With the common use of chemical tests, the police officer's job may only have begun with the arrest. And a single arrest may cause him to spend a whole day in court as a prosecution witness.

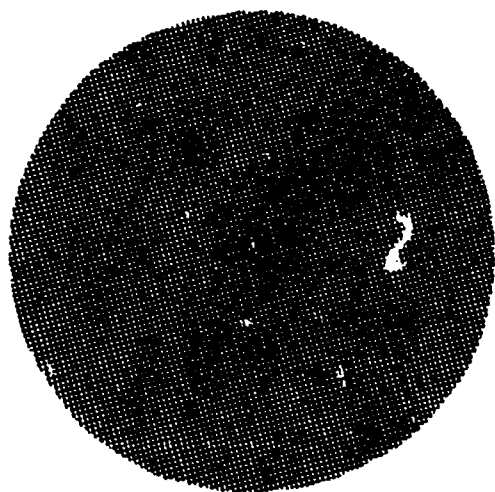


DWI POLICE FUNCTIONS

**Detection
Prevention
Apprehension**



PROSECUTION



ADJUDICATION

THE PROSECUTION

Once the drinking driver has been arrested for DWI, the first responsibility for further action in the case rests with the prosecutor. At the pre-adjudicative phase, he represents the first opportunity for the control system to identify the problem drinking driver. Before choosing a course of action the prosecutor should desirably procure and review the available information to determine whether the drinking driver is a problem drinker or alcoholic rather than a social drinker. Official and unofficial sources of information include:

DWI arrest information

Enforcement records

State motor vehicle department records

Community agency records (hospitals, welfare department, medical and social agencies)

Family

Employer

Friends and associates

The prosecutor must suggest what action will be taken by the courts against the drinking driver, including whether he should be brought to trial, and if so, on what charge. There are several courses of action open to him:

No prosecution; dismissal of charge (nolle prosequi)

Deferment of prosecution

Reduction of charge and prosecution on a lesser offense

Prosecution for DWI

Initiation of proceedings for civil commitment

In choosing the best action, the prosecutor will take into account the same considerations as in any criminal case; sufficiency and strength of evidence, reliability and availability of witnesses, amount of time involved, availability of staff. The various courses of action are not mutually exclusive. For instance, the prosecutor may decide to prosecute for DWI (or a reduced charge) and have the violator committed to a treatment agency.

If the defendant pleads guilty, the plea is presented to the judge in open court. If he pleads not guilty, the DWI charge is prosecuted in what most authorities agree is a difficult case for prosecutors to win.

PLEA BARGAINING

Although plea bargaining has been discouraged by some authorities and deemed arguably unconstitutional by others, some sort of plea negotiating is common in DWI cases. Most typical is the reduction of a charge of driving under alcoholic influence to a charge of reckless driving, even though reckless driving is not necessarily an element of DWI. The issue boils down to how much leniency an offender will be given in return for a guilty plea.

Understandably, certain minimum standards for plea bargaining have been set by such organizations as the American Bar Association.

These include allowing only voluntary, open court pleas; allowing the plea to be withdrawn for good cause and restricting plea discussion participants to the prosecutor and defense counsel.

The guilty plea, whether negotiated or not, provides a means of disposing of DWI cases at a minimal cost, allows everyone concerned to avoid the inevitable risks and uncertainties of a trial, and avoids harsh, mandatory sentences.

But there are serious disadvantages to plea-bargaining, especially if the judge does not know the extent of a violator's drinking problem. This makes referral for treatment unlikely, and if the involvement of alcohol in the case does not appear on the record because of plea-bargaining, the identification of the offender as a problem drinker in subsequent offenses is more difficult.

A recent study in Denver found that DWI defendants represented by lawyers were more likely to have had poorer previous records than those not represented, to have their charges reduced through plea-bargaining and to have poorer subsequent records. The same study recommended that plea-bargaining be eliminated on DWI charges on an experimental basis as a means of increasing the certainty of sanctions.

CIVIL COMMITMENT

At some point before the final decision to criminally prosecute, consideration is sometimes given to civil commitment to a treatment agency if statutory authority exists.

The commitment might be voluntary or involuntary. If voluntary, the act should not preempt prosecution, but it may cause the prosecutor to assess the practicality or necessity of continuing with the prosecution of the DWI charge.

Procedures governing the commitment of persons with mental disabilities are almost entirely statutory. Statutes dealing with the civil commitment of alcoholics range from those specifically dealing with alcoholics to those that group the mentally ill, drug addicts and alcoholics together in a single statute. Commitments must not violate a violator's rights to due process under the 14th Amendment.

Institutionalization, however, must be looked upon as a limited, perhaps outdated, treatment method in the 1970's. Once a common practice in mental health, commitment today is looked upon as simple incarceration, as a possible violation of a patient's rights and as an inadequate way to deal with disease. Unfortunately, as we shall see, the "involuntary" aspects of the traffic-law sub-system create major problems when the violator reaches the treatment sub-system.

THE PROSECUTOR'S ROLE

The ABA recommends:

The office of prosecutor, as the chief law enforcement official of his jurisdiction, is an agency of the executive branch of government which is charged with the duty to see that the laws are faithfully executed and enforced in order to maintain the rules of law.

The prosecutor is both an administrator of justice and advocate; he must exercise sound discretion in the performance of his function.

The duty of the prosecutor is to seek justice, not merely to convict.

Other Recommendations:

He is firm, but not inflexible, in dealing with defendants.

He is convinced of the efficacy of drunk-driver rehabilitation.

He is willing to recommend flexible and imaginative probationary terms and sanctions.

ADJUDICATION

The prosecutor's function flows directly into the adjudication function, the determination of guilt or innocence by a judge or jury.

In the old drinking driver control system, this was a routine matter. The new system, however, allows for innovative approaches to handle the drinking driver along with an opportunity to provide uniformity in sanctions. However, the use of these innovative approaches and the continuance of present legislation and practices provide flexibility in the court process on one hand, and a dilemma for the judge on the other.

If the adjudicator declares a defendant not guilty, then the control system has no further authority. If the adjudicator declares him guilty, then the subsequent elements of the system, that is, sanctions and treatment, can be brought to bear.

A drinking driver may be arrested two or three times for drinking driver offenses. If the judge bypasses a conviction, the arrest information will not appear on his driving record. A drinking driver is arrested for a drinking driver offense; if license revocation is the judge's only available course of action, he may attempt to circumvent the guilty decision and, thus, the arrest information will not appear on the driving record of the arrested drinking driver.

If the defendant is a drinking driver, speed in obtaining treatment is better than delay, and a decision of guilty is better than a decision of not guilty, not just from the viewpoint of the defendant but from the viewpoint of highway safety. With treatment and other innovative sanctions available to the judge, there is a chance that the problem drinking driver will be helped rather than simply punished.

The judge has at least six roles in adjudication and sentencing. He may:

Adjudicate without trial.

Preside over adjudication with trial.

In sentencing, he:

Collects and considers sentencing information.

Selects a sanction.

Monitors the disposition of the sanction.

Monitors the following-up of the sanction.

THE ABA RECOMMENDATIONS

ADJUDICATION WITHOUT TRIAL

Role of the judge in charge reduction

Reduction of charges in traffic cases should be a judicial power and exercisable only by the judge.

Role of the judge in plea discussions and plea agreements.

The trial judge should not be involved with plea discussions before the parties have reached an agreement other than to facilitate fulfillment of the obligation of the prosecutor and defense counsel to explore with each other the possibility of disposition without trial.

The trial judge should not accept a plea of guilty or nolo contendere without first inquiring whether there is a plea agreement, and if there is one, requiring that it be disclosed on the record.

If the plea agreement contemplates the granting of charge or sentence concessions by the trial judge, he should:

unless he then and there grants such concessions, inform the defendant as to the role of the judge with respect to such agreements;

give the agreement due consideration, but notwithstanding its existence reach an independent decision on whether to grant charge or sentence concessions; and

permit withdrawal of the plea (or, if it has not yet been accepted, withdrawal of the tender of the plea) in any case in which the judge determines not to grant the charge or sentence concessions contemplated by the agreement.

The trial judge may decline to give consideration to a plea agreement until after completion of a pre-sentence investigation or may indicate his conditional concurrence prior thereto.

THE ABA RECOMMENDATIONS

ADJUDICATION WITH TRIAL

Pre-Trial Procedures

The trial court should establish, by court rule or otherwise, efficient procedures for dealing with pre-trial matters, including such features as:

broad discovery to be conducted between the prosecutor and defense counsel without the need for application to the court;

submission of motions without papers, at least initially, at a single hearing, using a check list or similar means to assure that all issues have been raised as early as possible in the proceedings, and requiring submission thereafter only of such papers as the court deems necessary or helpful.

Responsibility for Court Time

The trial court has the ultimate responsibility for proper management of the calendar and should take measures to insure that cases are listed on the calendar and disposed of as promptly as circumstances permit.

Whenever feasible, there should be individual dockets for each trial judge, with the judge having continuing responsibility for cases on his docket from the filing of the indictment or information.

The trial judge has the obligation to avoid delays, continuances and extended recesses, except for good cause.

**JUDGE AND JURY IN THE NEW DRINKING DRIVER
CONTROL SYSTEM**

**Should believe the court can play a role
in alcohol safety.**

**Should understand the balance, delicate as
it is, between the needs of society and of
the individual.**

**Need realistic, flexible state highway
safety laws.**

**Need to understand the difference between
adjudication and sanction.**

Should know community-treatment resources.

**Should believe in the efficacy of drunk-
driver rehabilitation.**

**Are willing to refer drinking drivers to
treatment before verdict or sanction.**

**Are willing to impose flexible and imaginative
sanctions or probationary terms.**

**Should receive records of drinking-driving
defendants.**

Need realistic caseloads.

PRE-SENTENCE INVESTIGATION

Under the new drinking driver control system, the process of pre-sentencing investigation is included between adjudication and sanctions, enabling the sentencing judge to make the appropriate decision when selecting a sanction.

For the social drinker, the traditional sanctions may be sufficient. For the problem drinker, the judge may add alcohol safety education to the traditional sanctions. For the alcoholic, treatment may be recommended. The operative principle guiding the judge's determination of the sanction to be applied should be the "concept of the appropriate decision."

The judge must consider four things:

- 1. The law -- His decision must be within the possibilities and constraints presented by the law and must be appropriate to what the court considers its proper function to be in relation to that law.**
- 2. The individual -- The sanction selected must be appropriate to the needs, but not necessarily to the desires, of the offender.**
- 3. Alcohol safety -- The sanction selected should enhance the probability and likelihood that the offender will not in the future couple heavy drinking with the driving of an auto.**
- 4. Cost effectiveness -- The sanction should not place an unrealistic financial burden on the court system or the individual. Charging a fee for the administering of some sanctions is a recent development that is proving effective.**

But before the "appropriate decision" can be reached, the pre-sentence investigation must provide the court with enough factual and diagnostic information to help it determine whether the individual is, or may become, a problem drinker.

Usually this job falls to the probation officer, special pre-sentence investigators or court counselors or to the judge himself.

Among the sources and methods for collecting information which may indicate a drinking problem:

Measurement of BAC and behavior at arrest.

In-court interview.

Criminal and traffic records -- police and motor vehicle departments.

Psychological tests and interviews.

Community agency records.

Diagnostic reports by a probation officer.

Reports from family and friends.

The concept of the appropriate decision

The possibilities and constraints of the law.

The best interest of alcohol safety.

The best interest of the offender.

Cost effectiveness.



APPROPRIATE DECISION

INFORMATION FLOW DURING THE SENTENCING PROCESS

Prosecutor (case history).

Enforcement agency (criminal history).

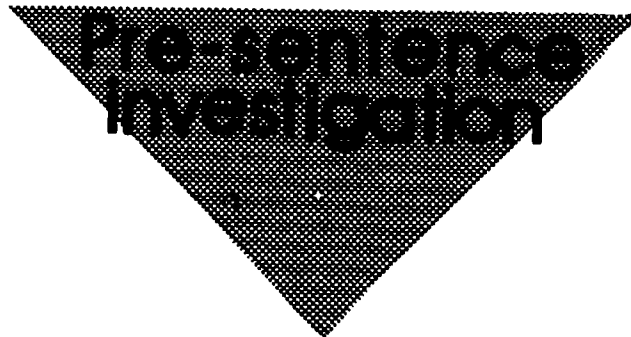
Motor vehicle department (driving history).

Community agencies (social history).

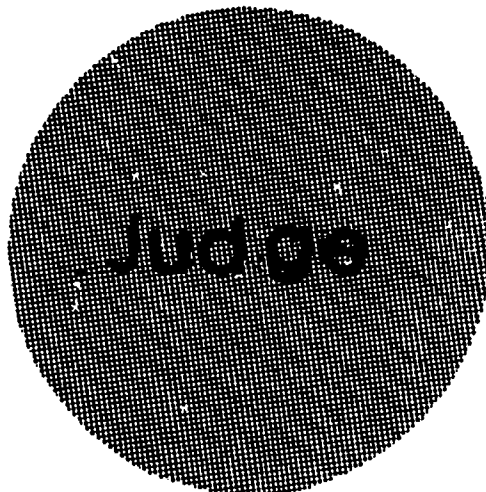
Diagnostic services (diagnosis).

Defendant's family, friends, employers (personal history).

Drinking driver (personal information).



TRIAL INFORMATION (BAC AND CIRCUMSTANCES OF THE ARREST)



SANCTIONING

The imposition of legal sanctions against those people convicted of DWI is one of the main functions of the drinking driver control system.

The objectives of the sanctions applied by the system are fairly straightforward:

Modification of the future behavior of individuals who have been convicted of DWI

Deterrence of DWI behavior on the part of any individual.

With the advice of the prosecutor and the aid of the pre-sentence investigation, the court may, upon a plea of guilty or a finding of guilty:

Impose sanctions authorized by legislation.

Impose penalties or conditions not specifically mandated or authorized by statute but rather resulting from discretion vested in the court.

Mix the above two sanctions, giving the court its greatest leverage in determining the future behavior of the drinking driver.

SANCTIONING ALTERNATIVES

TRADITIONAL:

Fine

Imprisonment

License withdrawal

The Uniform Vehicle Code provides for the sanctions of imprisonment for ten days to one year, and/or a fine of \$100 to \$1,000, and mandatory driver's license revocation. License withdrawal is the most popular sanction but also very questionable; studies have shown that though the loss of driving privileges may deter the social drinker, the problem drinkers and alcoholics continue to drive after withdrawal of the license.

CONDITIONS ON BEHAVIOR:

Forbidding driving or drinking during a period of probation. This is a traditional method whose constitutionality has been upheld in several states.

INNOVATIVE SANCTIONS:

Alcohol-safety education.

These programs, such as the Phoenix DWI Course, are used to provide information on the consequences of drinking and driving and to promote self-assessment by the DWI of the ramifications of continuing his drinking-driving behavior. These educational programs are generally conducted by the court or court-associated agency, Alcohol Safety Action Project (ASAP), motor vehicle department, alcohol treatment or other health agency, independent agency (that may charge a fee for the program) or educational institution. They are directed primarily at youthful and first-time offenders.

Alcohol safety schools can be nothing but the old, familiar driver education schools dressed up with indoctrination about alcohol and its effects. Or they can be sophisticated education centers involving a complete review of alcohol and its relation to driving, with films, outside speakers and a strong emphasis on motivating the drinking driver to stop driving after drinking or to seek further treatment or rehabilitation.

Occasionally, all DWIs are referred to an alcohol safety school, and a procedure for screening problem drinkers and determining the need for more intense therapy is built in. This, however, is usually an informal function carried out during the course of the school, usually six to ten weeks.

Individual and group therapy can be a part of the alcohol safety school. In some instances, several sessions of classroom training are followed by group sessions, also of several weeks' duration. Social drinkers might not be required to attend, reserving problem drinkers and alcoholics for the more intense therapy.

Whatever the approach, the alcohol safety school can be seen as a transitional device between the enforcement and treatment subsystem. And it is of the utmost importance that the details of the school's operation be worked out prior to its beginning -- what makes up the criteria for court referral and school acceptance, who will conduct and pay for the classes, what happens in the school and the degree of control exercised by the court.

TREATMENT:

Requiring medical treatment under threat of sanction has been upheld as long as evidence presented at the trial indicates the defendant is in need of such treatment. Medical treatment is an important alternative to punitive and deterrent types of sanctions. A recent evaluation of a number of court-related

alcoholic treatment programs indicated that such programs were successful for over one-half of the participating offenders. These programs apply a combination of the short-term and long-term, therapeutic approaches to resolution of the drinking problem and, thus, increase the chances for successful rehabilitation.

Voluntary enrollment: The offender is required to enroll and continue contact with an outpatient treatment facility as a condition of probation.

Voluntary commitment: Under certain conditions commitment to treatment is appropriate.

SANCTIONING METHODS

Generally, the sanctioning methods are expressly authorized by statute, although some methods may be considered to derive by implication or from inherent judicial authority. The informal methods, such as a "recommendation" or "suggestion" to a DWI may be as effective as direct sentencing to achieve the desired result. Some of the sanction-imposition methods presently used are:

Deferment of prosecution accepted by the court subject to compliance with conditions (probation).

Holding of the case under advisement pending compliance with "recommendations."

Withholding of judgment subject to compliance with conditions.

Acquittal with "recommendation" as to subsequent action.

Deferment of sentencing subject to compliance with conditions.

Direct sentencing.

Suspension of execution of sentence subject to compliance with conditions (probation).

Initiation of civil commitment proceedings.

THE ALCOHOLISM TREATMENT SUBSYSTEM

As a result of the recognition that many drivers responsible for crashes are problem drinkers or alcoholics and that traditional sanctions have not deterred these people from drinking and driving, the drinking driver control system has begun to use the tools of the alcoholism treatment subsystem -- treatment and rehabilitation. Under this approach, the traffic-law subsystem regards the problem drinking driver as a patient as well as an offender.

In establishing a court-referral program, the first step is an assessment of the treatment resources available in the community. This information should be sought:

Type of therapy.

Cost of therapy.

Number and types of professional and support staff.

Type of agency (e.g., public/private; state/local/federal; inpatient/outpatient; hospital/clinic/other).

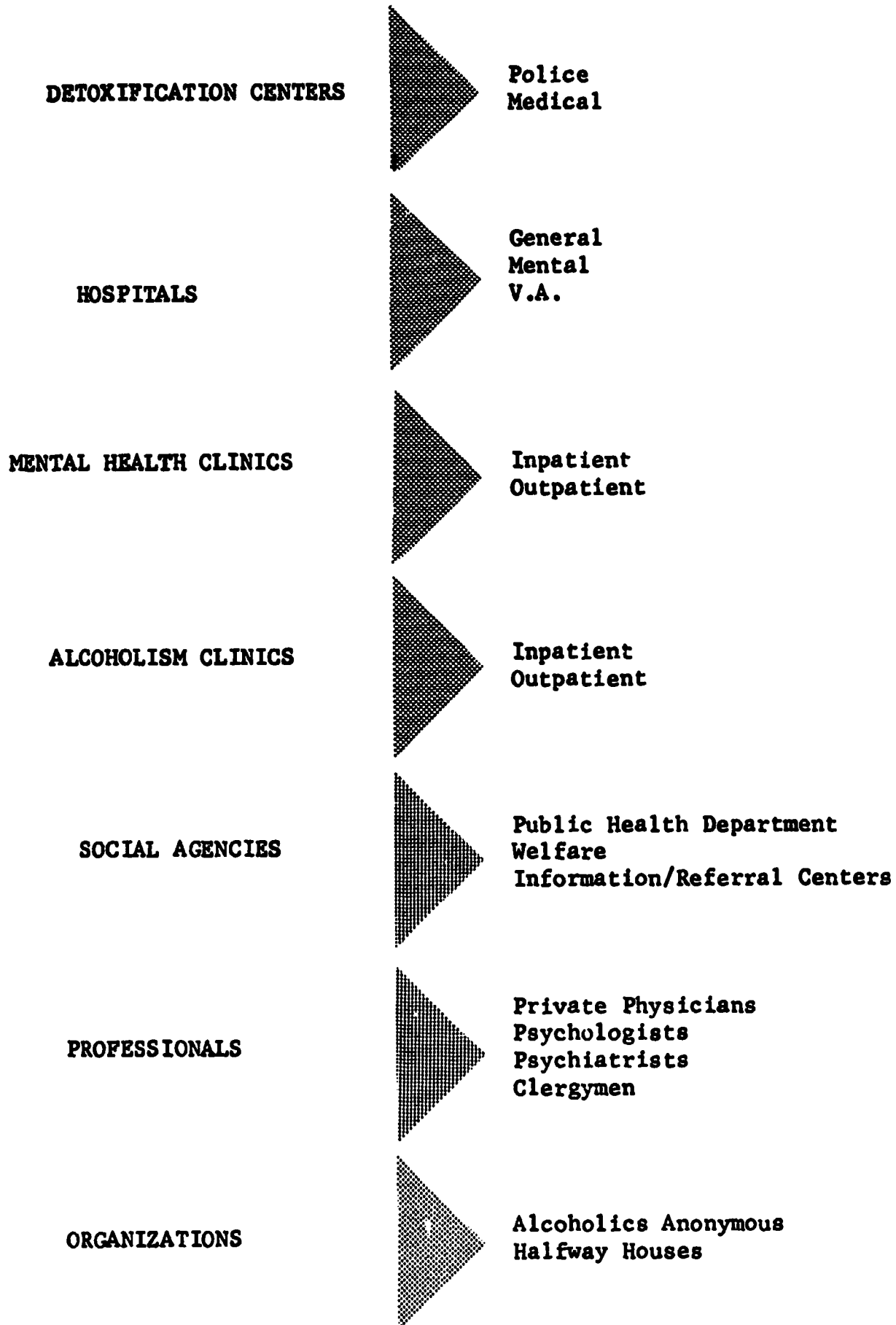
Requirements for admission.

Capacity.

Location and accessibility.

Willingness of facility to treat alcoholism and to participate in a court-referral program.

TREATMENT FACILITIES



THE COMPREHENSIVE APPROACH

The problem drinker and alcoholic cannot be treated as though they had a single illness with an identifiable and specific cause. Nor do they respond similarly to a particular chemical agent or medical or psychological treatment. The variety of people afflicted with alcoholism is probably as varied as humanity itself, and a variety of treatment techniques have been developed and, hopefully, are waiting to be developed for this field.

What is important for the drinking driver control system, as well as for any other system involving health care, is that treatment be comprehensive. This means that each of the basic services is available and organized so that an individual can move between them without duplication and with continuity of care.

With the drinking driver control system, this is a huge task. The subject population here is drawn from municipal court referrals and is undergoing what amounts to enforced treatment. The course of individual alcoholism treatment is perilous enough, without the coercive element. Studies have shown, for example, that the alcoholic patient's repeated and intensive testing of his relationship with his therapist can result in the fulfillment of the patient's fear that no one can be trusted.

Furthermore, although the drinking driver control system uses the traditional methods of treating alcoholism, probably most of the court referrals are problem drinkers, not alcoholics. Referral of a person diagnosed as a problem drinker to Alcoholics Anonymous, for example, has proven an unwise move both from the viewpoint of the patient and the organization. The establishment of the treatment elements of a drinking driver control system in a community inevitably will lead to the mixing of problem drinkers, alcoholics and perhaps some social drinkers.

A third element that is not unique to the drinking driver control system, but which must be carefully considered, is cost-effectiveness. The long-term value to society of comprehensive community treatment programs may render all of

the costs worthwhile. But the fact is that most local judicial systems are strapped for operating money, and a professional group leader may command anywhere between \$50 to \$150 for a two-hour session. A 1972 report to the Department of Transportation from the University of Southern California's Public Systems Research Institute had this to say about the cost of therapeutic programs:

"... insistence upon only the most highly qualified types of professionals, such as those with M.D. or Ph.D. training, may over-tax the manpower resources of many communities. The spread of costs is vast, ranging from, say, \$30 per hour per subject in individual therapy -- which is clearly prohibitive for a public program -- to somewhere between \$5 to \$10 per person per session in professionally-conducted groups -- to roughly \$1 per person per session for paraprofessionals or non-professionals. Here we have a great range of costs where public pressure will probably be very great to get maximum therapy per dollar for community programs."

A fourth problem is establishing a drinking driver control system in a community with limited mental health resources. While many large cities have an array of treatment types and facilities, small cities and rural communities may not be able to offer them.

There is hope in all of these areas, however, and mounting evidence that comprehensive treatment programs for problem drinking drivers can be established in communities of all sizes.

ENFORCED TREATMENT

A general consensus appears to be growing that court enforced, or company enforced, programs tend to increase the percentage of alcoholics and problem drinkers who apparently benefit from treatment. Many problem drinkers refuse to recognize their problem and a number of studies have shown that the coercive nature of treatment helps them recognize that problem. One finding by alcoholic program research has been the fact that court-enforced programs compel the incipient

alcoholic to seek treatment before he has reached "bottom." (A necessary part of a court-enforced program, of course, is that offenders be compelled to attend sessions upon penalty of the loss of their probation.)

PROBLEM DRINKERS AND ALCOHOLICS

While there may be a fine distinction between the two, the entire philosophy behind the comprehensive approach is the treating of the "whole" alcohol-abusing person, be he a problem drinker or alcoholic, with all of his psychological, medical, social and employment difficulties. That a comprehensive approach is necessary is evidenced by the numerous studies that indicate the presence of more than one type of alcoholic and more than one type of problem drinker. A thorough review of existing programs may indicate that some are not being used or that one agency does not know the other exists. The problem, in short, may be that there has been no formal organization for coordinating existing services to the problem drinker and alcoholic or for coordinating the judicial system and the welfare and community action centers.

COST-EFFECTIVENESS

Little solid research is available, particularly on the long-term cost effectiveness of a drinking driver control system. However, a number of approaches have been taken by existing community programs to contain costs. One is the use of existing community referral and treatment services, including medical and psychiatric units, social welfare, outpatient-inpatient services of existing state and veterans hospitals, probation and social welfare services and vocational programs. Another approach is the use of specially trained paraprofessional counselors or voluntary counselors. The use of follow-ups on missed appointments may increase the effectiveness of the program and hence the cost-effectiveness over the long run. In order to reduce the public burden, fees may be charged for particular treatment modes, especially psychotherapy.

THE SMALL COMMUNITY

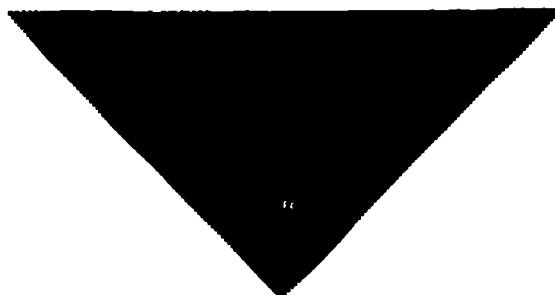
Far from feeling frustrated, those implementing a drinking driver control system in a small or rural community might take advantage of their smallness to organize an effective program. Too often, an urban program suffers from the normal problems of large bureaucracies.

The small community especially may not be able to establish new treatment agencies, but it will have hospitals and clinics and, of course, a police force and judicial system. Individuals may have to "double up" in function. The judge may have to act as an alcoholism counselor (and he does in many existing smaller programs). And the small community has one further advantage:

Without so many agencies and causes competing for public attention, the smaller community is able to launch an effective public information program on the problems of alcohol and driving and what the community is trying to do about them.

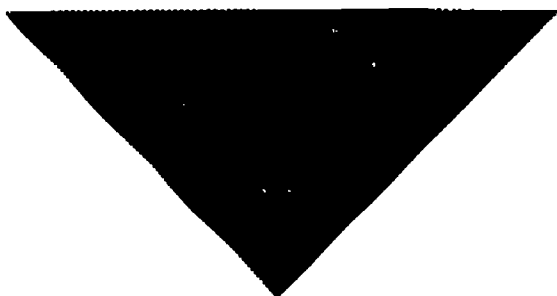
Objectives of the alcoholism treatment system

MEDICAL CARE



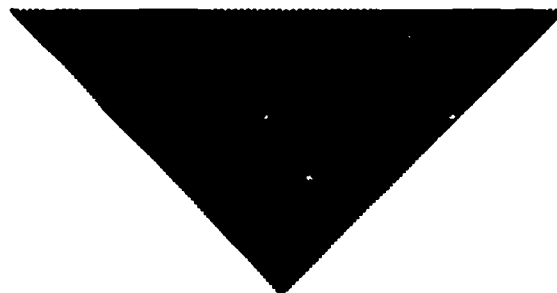
Restoration of physical well being.

PSYCHOTHERAPY



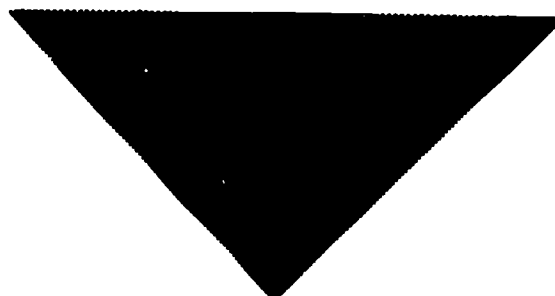
Restoration of mental well being.

DRUG THERAPY



Physical and mental support.

REHABILITATION



Restoration to Society

TREATMENT APPROACHES

MEDICAL CARE

Medical care may be divided into two general areas. One is detoxification, or the medical management of withdrawal symptoms. The other is the treatment of the deleterious effects of the long use of alcohol on the heart, pancreas, liver, peripheral nerves, brain and body cells in general.

DETOXIFICATION

The usual procedure is to use anticonvulsant drugs and sedative compounds to prevent seizures and delirium tremens (d.t.'s) during the period when alcohol-withdrawal symptoms are present.

Hospitals that accept alcoholic patients for detoxification are reducing both illness and death following acute alcoholic episodes. Despite positions taken by the American Medical Association, however, some hospitals and physicians still avoid the responsibility of detoxification, and health insurance is often inadequate to cover its costs.

GENERAL MEDICAL TREATMENT

The general social and physical deterioration of the alcoholic person finally results in the "skid row" bum caricature. Only a small minority of alcoholic individuals ever reaches this level, but it has been observed that large amounts of money have been spent in their incarceration and arrest and comparatively little in their rehabilitation.

The great majority of alcohol abusers, by contrast, are not on skid row. For them, treatment begins with the cessation of drinking and nutritional rehabilitation. Then specific medical problems can be addressed. It has been estimated that failure to provide adequate medical care may result in premature death, possibly by ten to twelve years.

PSYCHOTHERAPY, DRUG THERAPY AND REHABILITATION

"Alcohol and Health," a special report to Congress by the Department of Health, Education, and Welfare in December, 1971, distinguished between therapy that is "interpersonal," "social" and "societal."

Intrapsychic therapy deals with emotional or unconsciously motivated factors in alcohol addiction. According to the report, "This view that alcoholism is an intrapsychic disorder is involved in the same debate as those surrounding the typology of emotional and mental disorders, and is subject to the same degree of criticism by many persons who object to seeing it thus classified."

A vital part of this therapy is the opportunity offered the alcoholic person to develop trust in someone. He appears generally to be lonely and guilt-ridden and, beneath a facade of conviviality, yearns for a trusting and non-judgmental helping person upon whom to become dependent. But having experienced many disappointments, he will challenge the new-found helper to see if this caregiver will be found wanting -- like all others who came before.

Interpersonal therapy focuses on marital and family disorders and how they relate to the alcoholic person's marital partner or family member. Increasingly, alcoholism is seen as a family problem. Spouses and children of alcoholics may have serious psychological problems. Large proportions of teen-age suicides and juvenile delinquents have one or two alcoholic parents.

The partner of an alcoholic may contribute to this alcohol abuse by unconsciously enjoying his or her dominant role in the family. The nonalcoholic spouse may unconsciously resist attempts of the alcoholic partner to recover. This therapy helps restructure the family interaction and helps the family see how its life contributes to the problem.

Social therapy helps the alcohol addict to renew ties with small social groups such as friends, acquaintances, clubs, neighbors, work colleagues and interest groups that extend outside his family. Unfortunately, the slow progression to alcoholism usually results in a loss of such contacts. The alcoholic may project responsibility upon others for his social rejection, but within himself, he knows where the responsibility lies, thus confirming the worst of his already low self-appraisal.

The prime example today of treatment provided within small group settings that take these factors into account is Alcoholics Anonymous, the major influence for the past 30-odd years in gaining acceptance of the disease concept of alcoholism.

The aim of AA members is to help each other gain and maintain their sobriety, and to share their recovery experience freely with anyone who has an alcohol-related problem. The AA program basically consists of "Twelve Suggested Steps" designed for personal recovery from alcoholism.

Founded in 1935 by two hopeless alcoholics -- a stockbroker and a surgeon -- AA keeps no membership records and provides no hard statistics, but it is estimated that several hundred thousand people have achieved sobriety through AA. There are no dues, no fees. It is a fellowship whose only requirement for membership is a sincere desire to stay sober.

Restoration to society -- "rehabilitation," in this context -- actually incorporates all of the other forms of therapy.

An overall coordinating agency for services is needed in most communities. Otherwise, gaps in service will exist through which many alcoholic persons will fall, or costly duplications will occur. This coordination can be accomplished under the umbrella of a public health department, a comprehensive health or mental health organization, or some similar group.

All kinds of alcohol-related services are included in this category:

The drinking driver control programs, Alcoholics Anonymous, the community programs of the National Institute on Alcohol Abuse and Alcoholism and the education and referral services of the National Council on Alcoholism.

To broaden availability of treatment, a number of major hurdles must be overcome. Services must be provided the medically indigent patient, for example, that are comparable to those provided patients who can pay. And health insurance carriers must be forced to remove clauses in their policies that discriminate against alcoholism.

A system providing a full range of services and continuity of care would favorably influence the outcome of treatment and rehabilitation and, thus, increase the ranks of the patients who show marked improvement. According to the 1971 report to Congress, at any given time, a cross-section of alcoholic patients shows one-third much improved (not only in alcohol-related behavior but in general living comfort), one-third experiencing some lesser benefit and one-third unchanged.

PSYCHOTHERAPY AND COUNSELING

Since an important component of alcoholism appears to be psychological, psychologically oriented treatment approaches seem appropriate for alcoholics, and in many cases, problem drinkers who drive.

Four major categories of such treatment are individual psychotherapy, hypnosis and post-hypnotic suggestion, aversion therapy and group counseling and therapy.

INDIVIDUAL PSYCHOTHERAPY

This classical approach examines the personal meanings and origins of drinking so that by understanding his problem, the alcohol addict can develop alternative ways to achieve personal satisfaction. This method is the most costly and time-consuming.

HYPNOSIS OR POST-HYPNOTIC SUGGESTION

Hypnosis can be used to explore feelings and memories that are not readily available to conscious experience but play an important role in precipitating drinking episodes. Post-hypnotic suggestions can be given that make abstinence seem pleasurable and drinking painful. Again, this is a costly and time-consuming process.

AVERSION THERAPY

This is a training program similar to hypnosis in which the alcoholic is conditioned to associate the sight, smell and taste of alcohol beverages with an unpleasant reaction caused by such drugs as apomorphine, emetine or disulfiram (Antabuse), or with a painful event such as electric shock. Surveys of hospital-based programs have shown that aversion therapy, hypnosis and other programs, such as the use of LSD, are not widely practiced.

GROUP COUNSELING

Alcoholic patients experience therapeutic interactions as part of a "group" of individuals. The experience for each alcoholic helps clarify the nature of his illness and makes him realize that it is shared. He becomes aware of the personal situation that leads him to drink and learns ways he can conduct his life in abstinence.

A therapist trained in psychiatry, psychology, or social work need not necessarily conduct this form of group discussion session. Alcoholism Counselors, often specially trained paraprofessionals, are coming into their own as providers of services in this field.

Group therapy can be in a number of formats, including:

INPATIENT COUNSELING, where the individual lives with a group and discusses with it at periodic intervals problems which have arisen in the course of daily living.

OUTPATIENT GROUP COUNSELING, scheduled discussion groups about personal adjustment.

ENCOUNTER GROUPS, where groups of patients participate in discussion and non-verbal exercises with professional direction to become more aware of personal feelings as these are stimulated by interaction with other people and of the impact of these feelings on the course of their lives.

MARATHON SESSIONS, where encounter groups meet continuously for a prolonged period, lasting up to 40 hours. This promotes the breakdown of defenses and the expression of feelings which influence behavior.

ALCOHOLICS ANONYMOUS (AA), probably the best known treatment group for alcoholism. AA meetings may involve open general discussion, in-depth discussion of drinking problems by old members or even purely social events. Emphasis is on total abstinence.

FAMILY THERAPY, in which entire families participate in group discussion and encounter exercises to clarify how family adjustment patterns may have unintended undesirable effects.

THE SALVATION ARMY, which provides extensive programs for the rehabilitation of chronic alcoholics, including the provision of food, shelter and clothing.

HALFWAY HOUSES

Originally instituted for individuals with various types of problems and needs, the halfway house probably performs its greatest service for the alcoholic patient. The halfway house is for individuals whose drinking has so disorganized their life socially that they need supportive maintenance in an organized lifestyle during readjustment. The alcoholic on the road to recovery may remain from several weeks to several months. He has an opportunity to continue confrontation group therapy, obtain proper nutrition, and take a "breathing spell" while he job hunts or undertakes a vocational rehabilitation program. Very often, the halfway house has a strong Alcoholics Anonymous or spiritual orientation.

Halfway houses may be a part of a public network of rehabilitation services, or operated by non-profit voluntary groups. They are almost always run by recovered alcoholics and almost always exclusively male.

EXTENDED CARE FACILITIES

Institutions have been established primarily for alcoholics whose family life and work life have been so disorganized that they must withdraw to reorganize for the return to usual daily routines. A wide variety of alcoholism treatment services is provided. These institutions tend to be proprietary and expensive, thus excluding indigent alcoholics.

DRUG THERAPY

DIRECT

This approach exploits the fact that chemical compounds which inhibit the enzyme aldehyde dehydrogenase will cause the metabolic degradation of alcohol in the body and cause an unpleasant toxic reaction to ingestion of alcohol. Disulfiram, which goes under the brand name Antabuse, is a drug with the potential for severe reaction if taken while alcohol is in the body. Antabuse must be administered under supervision of competent medical personnel. Patient motivation appears to play an important role in successful use of the drug. Reported "recovery" rates range from 35 to 80 per cent.

INDIRECT

Various pharmacological agents, such as major tranquilizers, antidepressants, anti-anxiety agents, LSD and nutritional supplements have been used with modest success to alleviate other psychological and medical conditions which stimulate the use of alcohol.

COMBINATION THERAPY

The best therapy for problem drinkers may not be a single approach but a combination of several. The combination of a suitable drug, for instance, with the right kind of counseling will often bring success where neither would succeed separately.

The proper procedure for treatment of problem drinking should involve two stages:

1. an initial effort to motivate the patient to undertake a prolonged course of therapy; and
2. follow-up using combination therapy.

CRISIS INTERVENTION

A number of communities have attempted to help the problem drinker when he experiences a crisis with alcohol. At least two approaches have been used:

A "hotline," or special telephone number, where a problem drinker can get instant counseling 24 hours a day.

A taxicab service for problem drinkers who become intoxicated at a bar or other location from which they must drive home. The taxi, whose fare is paid by the agency, may be obtained by calling a special number. Usually, the drinker's car is picked up and driven home.

Evaluation of such crisis intervention has shown it to be of limited success. Problem drinkers seem reluctant to use the service, and it is costly. However, crisis intervention has undergone only limited evaluation, and what is a failure in one community may be a success in another.

One idea with untried possibilities is a volunteer driving service to perform the same function as the taxicab service. It might be staffed by Alcoholics Anonymous members or other recovered alcoholics.

CONFOUNDING THE DRUNK DRIVER

Devices to keep drunks from starting their cars have been developed by a number of companies and researchers. One is a mind-boggling 30-second test that is controlled by an electronic box under the car's front hood.

To get a car started when it is equipped with this experimental device, the driver must perform the following tasks in order in 30 seconds: Fasten the seat belts. Turn the ignition on. Turn the hazard lights on and off. Depress and release the brake pedal. Turn parking lights on and off. Turn wipers on and off. Flick right turn signal on and off. Pull out headlight switch and turn lights on high and low beam, then turn headlights off. Switch on left turn signal, then switch it off.

If the driver accomplishes all of these tasks in sequence within the allotted time, the car starts. If not, he can only try again.

University of Michigan engineering students have devised another type of system. With this device, if a driver fails three consecutive reflex-timing tests, which consist of responding accurately to a series of digits that light up on the instrument panel, the car becomes inoperable. However, foreseeing exceptional situations, the students installed a switch that will allow the car to be driven even if the test is flunked -- but only with all the emergency lights flashing and at a top speed of 20 miles per hour.

Such things as the 30-second test have been criticized on a number of counts. For one thing, they may confound people who are genuinely absent-minded but safe drivers. And they may themselves be unsafe. What if a car equipped with the device stalls on a railroad track?

TREATMENT ESSENTIALS

Seven points are essential in psychological and medical care services for problem drinkers:

They must be designed to provide a full range of services: inpatient, outpatient, emergency and transitional.

They must be equipped to deal with the behavioral as well as the medical aspects of alcohol problems.

They must be available to a wide economic range of patients.

They must be coordinated with and closely related to other major care-giving services; mental health, public health, medical care and public welfare.

They must be organized so as to ensure continuity of care between various elements.

They must be guaranteed continuing support by legislative bodies and professional groups.

THE ARRAY OF SERVICES

Following is a general description of the treatment facilities for alcohol abusers, including a description of each facility's treatment approaches and characteristics.*

*** SOURCES: Sidney Cahn, Treatment of Alcoholics, Oxford University Press, 1971. Also Indiana University Institute for Research in Public Safety.**

GENERAL MENTAL HEALTH AGENCIES

GENERAL STATEMENT

Often in the past such facilities have been unrelated to other community services.

Alcoholics are often reluctant to use mental health facilities for fear of being labelled "crazy."

CHARACTERISTICS

GENERAL PSYCHIATRIC CLINICS

Do not as a rule treat alcoholics unless other psychiatric disorders are involved.

GENERAL HOSPITAL PSYCHIATRIC CLINICS

May offer short-term medical treatment for alcohol toxicity.

TEACHING AND UNIVERSITY-AFFILIATED FACILITIES

Training of personnel in the treatment and handling of alcohol patients is limited and highly restrictive.

Often treat only cases in which alcohol problems are symptomatic of or closely allied to other psychiatric conditions of interest as teaching material.

V.A. HOSPITALS

Currently developing alcoholism treatment programs throughout the nation.

Important because number of alcoholic problems in WW II veterans will remain high for the next few years.

PRIVATE PRACTITIONERS

Significant numbers offer some form of help to alcoholics.

Some doctors, feeling that recovered alcoholics would have a closer rapport with a patient diagnosed to be an alcoholic (usually enlist the help of a recovered alcoholic, a member of AA) in the treatment of their active alcoholic patients.

FAMILY SOCIAL AGENCIES

Emphasize understanding and working with the family as a social unit.

Similar to treatment programs of psychiatric clinics.

INFORMATION AND REFERRAL CENTERS

May offer diagnostic and screening services.

Often act merely as referral agency.

STATE MENTAL HOSPITALS

GENERAL STATEMENT

State mental hospitals are the most widely used inpatient service for alcoholic cases of all kinds and have been termed "the heart of inpatient treatment for alcoholic behavior in the U.S."

CHARACTERISTICS

Varying admissions policies..

Lack of professional staff (former problem drinkers are often used).

Tendency to carry more stigma than private mental treatment.

TREATMENT APPROACHES

A therapeutic community composed of:

An informally structured ward, but a structured social system.

A therapeutic team.

Meaningful work (this may result in the problems of patient exploitation and friction created by the patient work status structure).

Group therapy including a wide range of activities from the discussion of AA's 12 steps to professional leadership of group activity.

Individual treatment (there is only limited use of individual therapy because of the lack of trained personnel and a belief in the superiority of group methods).

Didactic instruction (usually patients' attendance is compulsory).

Some form of ward government.

**Drug treatment using disulfiram, tranquilizers,
and energizers.**

Recreation.

Participation in A.A.

**Discharge planning which aims at preparing the
patient psychologically for his return to the
community.**

**After-care services (often these are not avail-
able to alcoholic patients).**

SPECIALIZED ALCOHOLISM CLINICS

GENERAL STATEMENT

Specialized alcoholism clinics are usually supported by public funds under state alcoholism or mental health authorities. The primary referral sources to such clinics are voluntary application, family, service agencies, and legal-police-penal establishments.

CHARACTERISTICS

Professional staffing (former problem drinkers are sometimes employed as treatment personnel).

A multidisciplinary approach.

Goals which include the better control of the person's drinking and secondarily, a change in the total life style and personal interrelationships.

Concentration first on the drinking behavior rather than underlying psychological problems.

Emphasis on the patient's verbal ability, motivation, and family stability.

An initial orientation lecture series to screen out unmotivated persons.

TREATMENT APPROACHES

Individual psychotherapy.

Group therapy (not extensively used).

Behavior therapies (including aversion therapy and positive reinforcement).

Crisis therapy, i.e., an attempt to discover the "trigger" for binges and to correct the reaction.

Indirect therapy with the wives of the alcoholics.

AA involvement (minimal due to indifference or hostility).

Conjoint therapy, i.e., treatment of the husband and wife together at therapeutic sessions.

GENERAL HOSPITALS

CHARACTERISTICS

Proprietary hospitals:

Often do not have hospital license due to limited services.

Demand payment in advance unless individual has acceptable insurance.

Specialized medical wards in general hospitals:

Demand payment in advance unless individual has acceptable insurance.

Emergency service in general hospitals:

Practices vary widely.

Not always sympathetic to or interested in persons with alcohol toxicity.

Failure to provide adequate care has led to development of specialized detoxification centers.

HALFWAY HOUSES

GENERAL STATEMENT

Limit admissions to certain social types.

Prohibit those still under the influence.

Expel those who drink while in residence.

Have complete abstinence as the treatment goal.

Have the manager as the key person in the intake process.

Have source of funds as an important determinant of the institution's stability.

Often in the past such facilities have been unrelated to other community services.

Alcoholics are often reluctant to use mental health facilities for fear of being labelled "crazy."

TREATMENT APPROACHES

Internal anti-drinking culture.

All residents are expected to find work.

May require attendance at alcoholism clinic.

Extensively use AA.

Encourage residents to form discussion groups for "self-help" therapy.

Generally have no medical program.

CHARACTERISTICS

Voluntary

Usually AA oriented.

Always managed by former problem drinker.

Generally financially dependent on contributions and payment of residents.

Church-affiliated

Organized by Protestant denominations, primarily Episcopalian.

Usually managed by ministers.

Financed by church groups.

Quasi-public

Organized under voluntary auspices, but with public funds.

Offer broader spectrum of services.

Maintain closer relationship with alcoholism clinics and professional treatment services.

Public

Municipally organized and publicly financed.

Governed by public administrators.

Program similar to voluntary halfway houses.

Professionalized

Voluntary associations

Generally managed by former alcoholic for the house.

Accept only cases referred by official treatment agencies.

Dependent on contributions.

ALCOHOLICS ANONYMOUS

GENERAL STATEMENT

The stated purpose of AA is "to stay sober and help other alcoholics to achieve sobriety." Any person who calls himself a member is considered a member.

CHARACTERISTICS

Minimum amount of formal organization.

Meetings often take form similar to group therapy.

Belief that only an alcoholic can really understand and help another alcoholic.

Stress individual responsibility and strong moral and spiritual elements.

Inculcates positive sense of "specialness" in members.

Generally fear drug treatments because of addictive potential.

Actively involved in professionally oriented and directed programs in many state hospitals.

Universally available.

Costs little.

Successful for numerous individuals.

May be beneficial to alcoholics in:

Providing hope through examples of recovered alcoholics.

Accepting the alcoholic as human.

Helping alcoholic to recognize his condition and confront his problem.

Helping alcoholic to accept his strengths and weaknesses.

Orientation and attitudes often in conflict with professional approaches to alcoholism.

PUBLIC WELFARE

GENERAL STATEMENT

The significance of public welfare in the total alcoholism-helping structure is in the scope of its coverage and in its function to relieve economic stress.

PUBLIC WELFARE CAPABILITIES

Old age assistance.

Aid to dependent children.

General assistance.

Aid to the disabled.

Vocational rehabilitation.

APPLICABLE WELFARE PROGRAMS

Purchase treatment services for problem drinkers.

Provide individual casework.

TREATMENT IN THE DRINKING DRIVER CONTROL SYSTEM

Although all of these treatment modalities are open to the drinking driver control system in theory, in practice a few of them will be more appropriate than others. These are group sessions oriented to helping the problem drinking-driver work on the problems that motivate him to continue drinking (and the problems he experiences in stopping drinking); treatment groups for a patient and his family; individual counseling and medically supervised use of Antabuse.

The medical and psychological approaches of the treatment agencies are aimed at helping individuals reduce the problems that got them in trouble with the law in the first place. During treatment, the patient is to be confronted with the fact that he is having problems with the legal system and that the treatment staff is willing to help work out those problems. If working out those problems requires abstinence, fine; the treatment staff can help the patient stop drinking. But neither the law nor the treatment agency has as its primary concern the stopping of drinking. Thus, the distinction between the "problem drinker" and the "alcoholic" is not that important in the treatment subsystem. Both tend to get in trouble with the law.

The treatment agencies should not be required to report detailed medical information to the courts, prosecutors and probation officers. However, regular reports should be filed with the probation department indicating whether the patient is attending sessions and cooperating in the treatment.

The patient, before beginning treatment, should sign an agreement setting forth the conditions attached to the treatment, the length and type of treatment and the penalties for failure to complete the program.

AGREEMENT

A written agreement on the procedures of the drinking driver control system enhances cooperation and helps prevent misunderstanding. It should be drawn up and signed by all parties.

The agreement should include the following:

The proper authority and responsibility for monitoring violators as they move through the courts and treatment agencies.

The channels of communication for coordinating both the flow of referrals to the treatment agency and the release of violators for treatment.

The procedures for referring violators from the courts.

The procedures for handling "no-shows" -- those who fail to report for treatment or who fail to complete prescribed treatment.

Any other procedural agreements between agencies; for example, plea negotiation procedures, case preparation and case presentation procedures.

The criteria for admission to treatment and/or alcohol education programs.

Prerequisite examinations -- physical or written -- for admission to treatment.

The kinds of information to be gathered in the pre-sentence investigation and who should gather it.

The usual length of the course of treatment.

The schedule of fees that will be charged by the treatment facility or any other agency in the program.

The way confidential information on patients will be handled without compromising the treatment agencies.

The nature and form of reports that will be made by all agencies in the system.

ALCOHOL SAFETY ACTION PROJECT

The Federal Government, for many years, had been involved in programs designed to get the problem drinking driver off the road, but at the turn of the 1970's it began a series of fully funded community level demonstration projects known as Alcohol Safety Action Projects (ASAP). Each project was funded for three years to provide evidence at the community level of the feasibility of the countermeasures concepts. Then the shift was to be made to state financial assistance on a matching arrangement. There were 35 such ASAP's in operation in 1973, with the first group already being phased out of full federal funding.

The ASAP efforts relate to ten basic areas. Many of the individual countermeasures employed are experimental and innovative. They have to be tested in the field before there are sufficient, valid data to support further application nationwide.

The following ten objectives are condensed from a 1971 pamphlet of the National Highway Traffic Safety Administration.

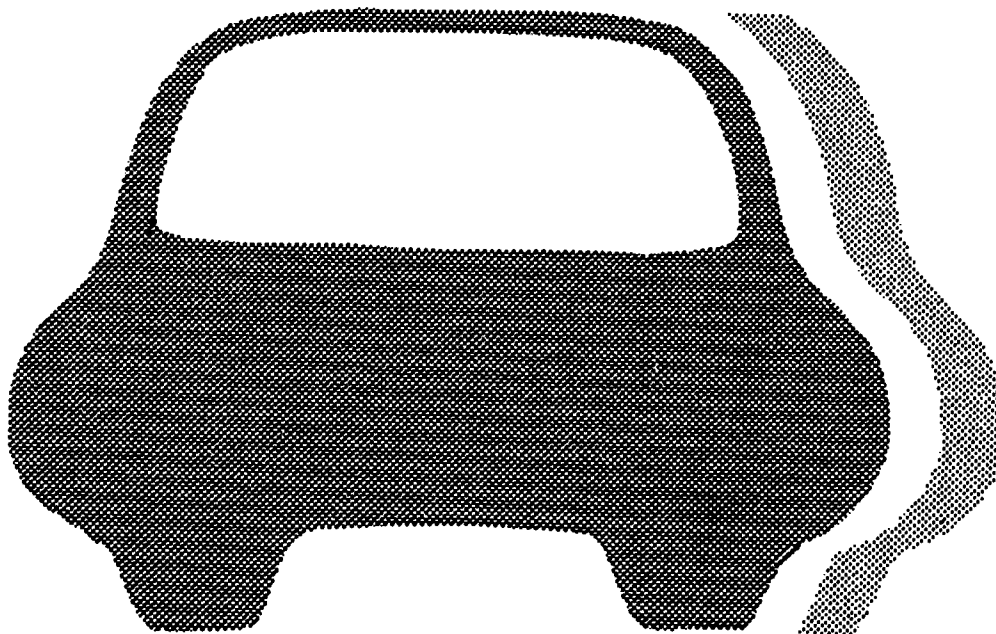
THE TEN BASIC ASAP OBJECTIVES:

1. Official support -- The initial step for a community undertaking an ASAP encourages the support of all the agencies in carrying out countermeasures activity.
2. Public support -- The initiation of an educational campaign to gain widespread public acceptance is essential to augment official support.
3. Identification of problem drinking drivers -- before they get on the road while intoxicated. The most practical method is by improving record systems so that convictions for alcohol-involved non-traffic arrests appear on the driving record, together with records of treatment by public social and health agencies.

4. Enforcement -- Problem drinkers for whom no record exists must be apprehended through more intensive enforcement at the time and places where a drunk-driving offense occurs. There also must be more adequate enforcement against driving with revoked or suspended licenses.
5. Court action -- Following apprehension and conviction, a pre-sentence investigation should be instituted to insure objective sentencing; referral to treatment for those who need it; the use of preventive drugs under medical supervision where indicated.
6. Required treatment -- Just as industrial organizations motivate employees identified as problem drinkers to take treatment under warning of dismissal, so the courts may induce convicted problem-drinker-drivers to take treatment as a prerequisite for reinstatement of their driver's license. If this option is to be available to the courts, communities must provide expanded treatment facilities. The National Institute on Alcohol Abuse and Alcoholism, the Public Health Service, the Veterans Administration and others work with the federal Alcohol Safety Countermeasures Program administrators to ensure that combined efforts "dove-tail" in the interest of the rehabilitation of those who need it.
7. Licensing actions -- by authorities generally empowered to suspend or revoke driver licenses. Legal safeguards must be used in this use of authority. Medical review board should determine eligibility for a driver's license of every individual who shows evidence that he has a drinking problem.
8. Driver assistance -- Enforcement efforts are supplemented by assisting the restricted driver through car pools or "hot lines" for the individual heavy drinker to call for help when he is intoxicated and unable to drive.

9. Driver training -- special instruction directed at the drinking problem within traditional driver improvement programs that are operated by the courts and motor vehicle departments.
10. Program evaluation -- the surveying of experience gained from application of the objectives.

THE INTERFACE



This session is designed to discuss problems in the transition from the traffic-law subsystem to the treatment subsystem.

What situations are most likely to create these problems? What are some alternative solutions?

THE INTERFACE

This session deals with that part of the drinking driver control system where things most often go wrong -- the interface, or that important link between the court, its related agencies and the treatment agencies.

In the following pages are a number of situations and problems in local drinking driver control systems. You will find some of them familiar. Most are real situations encountered in real local programs.

In your groups, discuss the problems, using the questions that follow as discussion guides. Don't spend too much time on those situations that do not apply. Offer realistic solutions where you can. Perhaps your own program has addressed some of these problems in ways we have not considered.

Then see how your discussion jibes with the notes at the end of the section. These are presented not as the only solutions but as suggested ways to deal with the problems.

In your discussion, note how often attitudes and conflicting values about driving and alcohol hinder the smooth functioning of the system. The solutions to these problems are complex. Usually, we suggest that a good start is for the parties to meet and do their best to resolve their differences.

Procedural problems are quite another thing. Many of these difficulties would not have occurred had all agencies in the system subscribed to a written agreement on procedures.

A

SITUATION Motivation plays an important -- possibly the most important -- role in the successful use of disulfiram (or Antabuse). Many patients are not motivated to use Antabuse, in spite of the fact that some studies have shown that recovery rates of alcoholics who are treated with the drug may be better than those who are not.

PROBLEM Many times, patients referred involuntarily to a treatment facility view Antabuse as unnecessary and harmful and refuse to take it. Occasionally, the medical community support this view.

QUESTIONS What are some ways to create positive attitudes toward Antabuse among patients and in the medical community?

What efforts can be made to better inform the medical community about Antabuse, its effects and the latest research findings about the drug?

If a patient refuses Antabuse treatment, what alternative treatment modes are available?

B

SITUATION Those concerned primarily with highway safety believe printing the names of convicted drunk drivers in the newspapers is an effective way to prevent repetition and to alert the community to the dangers of drinking and driving. Health professionals disdain the practice. They maintain that publishing the name of a person who possibly suffers a disease is hardly a way to help him.

PROBLEM The director of an alcoholism clinic makes a public complaint that the printing of the names of convicted drunk drivers in the local newspaper is an invasion of privacy, does little good and probably is unconstitutional.

QUESTIONS What are the common grounds and objectives in a program that seeks to promote public safety while respecting the rights of individuals?

How can those goals that are shared be highlighted for traffic enforcement people and treatment people?

Is there a way to measure the effectiveness, in terms of future highway safety, of name-publishing?

Is there a tendency to "blow up" minor issues like name-publishing to the detriment of broader issues?

141

C

PROBLEM A new community alcohol safety action project is causing strain throughout the judicial and rehabilitative sectors because of the increased volume of offenders. Particularly strained is the probation department, whose job it is to screen offenders entering the program. The probation officers find it difficult to give individual interviews to offenders.

QUESTIONS What procedures would expedite the flow of information through the various agencies to ease the workload of the probation department?

Would it help to have an alcohol safety probation officer and an alcoholism counselor on a screening team? If this proves successful, what other kinds of group meetings and scheduling also might help?

Should a fee be charged for group screening?

D

PROBLEM In a community Alcohol Safety Action Project the probation department is bitter to the last man. The officers complain that they are trained as counselors, that their expertise lies in working with people, conducting interviews. Yet, they say, the program has been set up in such a way that their only function is processing warrants for violators who have "dropped out." "We're treated as dog catchers," says one probation officer.

QUESTIONS If one important department is excluded in the planning of an alcohol safety program, what steps should be taken to overcome the negative attitudes that inevitably will result?

When there is a great increase in the number of violators requiring probation services, what can be done to improve the self-image and productivity of the probation officer?

In an alcohol program, who has the responsibility for investigation, patient referral and counseling? Should these functions be assigned an order of priority?

E

SITUATION Health agencies are accustomed to being approached by patients voluntarily. They also are accustomed to rendering services voluntarily. They are not accustomed to a system that sends them patients under "involuntary coercion" or that leaves them no option to refuse the patient.

PROBLEM In setting up a drinking driver control program in a large city, the organizers ask 32 health agencies to accept problem drinking drivers on referral. All but four decline.

QUESTIONS What steps can be taken to expand the services of existing agencies for the problem drinker and alcoholic?

Is the problem here one of changing attitudes, or is it the treatment agencies' lack of competence in treating alcohol problems?

Will educational programs on alcoholism for mental health and social workers change their attitudes toward working with "involuntary" patients?

F

SITUATION When an alcohol countermeasures program is established, the differing objectives of the health professionals and the enforcement professionals are not thoroughly discussed and problems are not ironed out.

PROBLEM Enforcement people are impatient with treatment people because they refuse to set a fixed amount of time for rehabilitation. For their part, treatment people say that it is difficult to set standard time limits, since no two patients are alike and all require different time lengths for treatment.

QUESTIONS Is it possible and desirable to "standardize" the time needed for treating court referrals in an alcohol safety program?

Are there various treatment patterns that would "standardize" the flow of patients through treatment while still satisfying the health professionals' concern for individual care?

What are some ways to make the patient move from the courts to the health agencies more efficiently?

Given limited time and resources, what is the "average" time needed to treat a problem drinking driver? A social drinker?

G

SITUATION In many instances, the alcohol safety school is a johnny-come-lately to the system and is not yet trusted by local judges or even recognized by the motor vehicle department.

PROBLEM An alcoholism counselor in a newly designated alcohol safety school says he feels "lost" in the system, never hears from the motor vehicle department and seldom from the court. His only contact, he says, is the probation office.

QUESTIONS Would this be a unique problem in your local setting?

In an alcohol safety program, motor vehicle personnel, judges and alcoholism counselors have certain formal and informal relationships. What should they be?

What steps can any official in a program take to "advertise" his role both to the public and to other departments?

H

PROBLEM Local judges are referring DWI's to the treatment subsystem but with a doubtful, even cynical attitude. Most of them make no secret of their belief that the traditional sanctions are more effective.

QUESTIONS Are the new treatment approaches to the problem drinking driver meant to replace the traditional, punitive ones?

Does research indicate that "involuntary coercion" is effective in treating problem drinkers and alcoholics?

PROBLEM The police officer views the alcoholism treatment and DWI school approaches as weak substitutes for punitive sanctions. Too many times, he says, after hard work and risk the "judge will only ease off on the guy and send him to school." The result of this attitude is a tendency to "look the other way" when observing alcohol-related traffic offenses.

QUESTIONS What are some ways to instill a police officer's confidence in new, rehabilitative approaches to the problem drinking driver?

 Is the drinking driver control system a substitute for, or a supplement to, the traditional, punitive system?

 Is "treatment" really "easing off?" Which may be considered harsher to the violator -- treatment or traditional punishment? Would a defendant agree with the policeman in this case?

J

PROBLEM A police officer has made some assumptions in arresting a drunk driver. When the defendant is brought into court, however, the officer cannot support these assumptions with technical evidence. His department has been given inadequate financial aid to secure technical equipment to assist the officer.

QUESTIONS Assuming increased financial aid is not available, what additional resources can be used to support a policeman's evidentiary material in court?

 If the actions of the police officer temporarily remove the drinking driver from the highway, has he effectively performed a part of his job?

K

PROBLEM The community is beginning to view the DWI school as a "place to put in time." Local judges are referring all defendants to the school, and the school is so crowded that violators are moved through quickly. The judges blame their own heavy caseload, but a short-term relief in the court causes a long-term burden in the school.

QUESTIONS What are some ways to improve the credibility of the DWI school in the community?

Should a school use flexible scheduling during times of increased caseloads to bide it over emergencies?

Should all violators be referred to the DWI school?

L

SITUATION The head of an ASAP counseling service, a reformed alcoholic, believes that only a reformed alcoholic can work effectively with the problem drinker. "The only way to do it well is to have been there," he says.

PROBLEM The counseling director's attitude creates a crisis of confidence among employees of the program. They feel some antagonism toward the head counselor, and some feel uncertain as to the counselor's judgment of their work.

QUESTIONS What criteria should be used in judging a good counselor?

If one treatment modality is effective with some patients, does it assure success with all patients?

M

PROBLEM Statistics show that there is considerable advantage to having a lawyer in a DWI case. In a particular county court, defendants in DWI cases who are represented by lawyers are more likely than those without lawyers to have dispositions of their charges delayed, to be found not guilty, to have their charges reduced or dismissed and to pay smaller fines. Furthermore, the defendants who hire lawyers are more likely to have poor prior driving records than those who do not.

QUESTIONS If it is as advantageous to be represented by a lawyer in traffic court as it is in criminal court, should legal representation be guaranteed everyone appearing in traffic court?

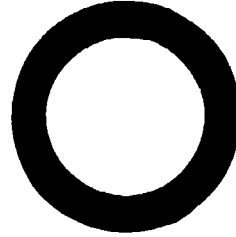
What are the pros and cons of eliminating plea-bargaining in traffic court?

N

PROBLEM In a large, metropolitan county with an alcohol safety countermeasures program, a lack of coordination results simply from the fact that the various offices and departments are miles apart. The telephone helps, of course, but there is value in being able to walk down the hall to see the boss.

QUESTIONS What are the advantages of having all departments in the same location?

If consolidation of offices is impossible, what are some other ways of making an alcohol safety program more efficient?



PROBLEM In an alcohol safety program, delays between arrest and conviction are caused by heavy caseloads in the judiciary. A similar workload in the motor vehicle department causes long delays between conviction and the removal of license.

QUESTIONS What measures or administrative procedures will overcome the delays caused by heavy caseloads?

How can the roles of existing personnel be expanded to expedite case flow?

Besides the sheer number of cases, does anything else cause delays?

P

SITUATION When a local drinking driver control system is set up, rules are not established for the effective monitoring of violators as they move through the system. Although license revocation is automatic upon DWI conviction, restoration of driving privileges is automatic after a set time period; it does not depend upon successful completion of the program.

PROBLEM "No-shows" becomes a major problem for an alcohol safety school because word has gotten out that nothing will happen to those who don't attend. There is a high percentage of dropouts and of those who attend occasionally. This is especially worrisome to the project managers because most of the "no-shows" are problem drinkers.

QUESTIONS What kinds of information should follow the violator through the system?

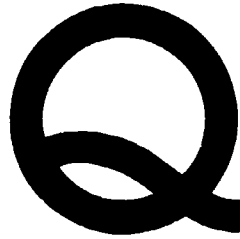
Who should collect the information and for what purpose, should it be used?

If there are public misconceptions about the "new" system replacing the "old," what publicity for "no-shows" would increase respect for the program?

Should someone be assigned specifically to trigger punitive measures for "no-shows?"

What enforcement measures could a judge use to assure that "no-shows" continue in the program?

Should violators receive a "contract" setting forth the conditions attached to their punishment?



PROBLEM An inexperienced traffic patrolman calls in about 7:00 A.M., shortly before the end of his shift. He says he has picked up a driver who is obviously heavily intoxicated and who appears to be showing the symptoms of alcohol withdrawal. The officer has attempted without success to get medical help at three hospitals -- two public and one private. One of the public hospitals has said it has no room for people from outside its area. The other has no detoxification facilities. The private hospital (with excellent detoxification facilities) will not accept a patient who cannot pay in advance or guarantee payment. The arrested man is in the squad car, and the officer is near the end of his shift. He wants to know what to do.

QUESTIONS Should the officer have known ahead of time where there were detoxification units that would accept the patient?

What can be done in a community to expand emergency medical services and make them available to the indigent? Which medical institutions should provide these services?

How can police officers be made aware of the array of community treatment facilities?

Whose responsibility is it to keep an up-to-date list of such facilities and to keep the police department informed of which are available?

Are hospital personnel, particularly those in emergency rooms, trained adequately to receive and treat emergency alcoholic patients?

Is detoxification covered under hospital insurance plans?

R

SITUATION The prosecutor is confronted with a man who has been arrested three times for alcohol-related driving offenses, but because of past judicial reluctance to impose criminal sanctions, there is nothing on the record to show the prior arrests were alcohol-related.

PROBLEM Developing evidence in cases involving habitual drunk drivers is difficult because the state historically has considered these violators to be criminals -- not persons with medical or psychological disorders. Sympathetic judges in recent years have avoided the imposition of criminal sanctions by accepting negotiated pleas or by reducing and suspending sentences.

QUESTIONS How can prosecutors obtain medical information about a defendant without violating his right to privacy?

Are there sources of such information, other than criminal or driving records, that are readily accessible to the prosecutor?

In cases where plea-bargaining results in reduced sentences such as reckless driving, is it feasible to note the alcohol relation on the driving record?

S

PROBLEM A DWI defendant referred by the court for treatment is proving an obstinate patient. He manages to perform efficiently enough at work, but at home he drinks 10 to 12 beers every night while watching television. He barely communicates with his wife and children, but he vehemently declares that he has no drinking problem and defies anyone to prove that he has one. This classic example of the "denier" has already missed two of his first three group sessions and is about to be sent back to the court for punitive action.

QUESTION Within the limits of staff size, time and financial resources, what is the best way for the treatment agency to approach the "denier?"

A

Both the medical community and individual patients need accurate information on the benefits, side effects and relative risks involved in Antabuse. A growing body of positive research is available, including reports from some of the original federally supported Alcohol Safety Action Projects.

Patients should know that the relative risk of Antabuse treatment is very low when the drug is properly administered.

A person who has been helped by Antabuse treatment might testify as to its effectiveness as a regular part of the rehabilitation program.

But Antabuse treatment should be only one of many ways of helping the problem drinker. The community should develop an array of treatment resources and a number of treatment modalities.

B

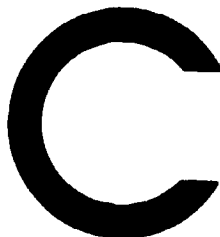
Perhaps the complaining clinic director is misunderstanding the purpose of the name-publishing, which is at least threefold. One is to be punitive of the individuals whose names are published. Another is to alert the community to the extent of the problem; people's neighbors are involved. A third is to point out that no one is exempt from punishment, no matter how influential. (Usually, the names are published long after the actual conviction and after time has run out for an appeal.)

After a meeting between program officials and the clinic director, a compromise may be struck, with the former agreeing to publish only statistics on DWI arrests or the names of third-time, instead of second-time, offenders.

There are any number of other ways to dramatize the extent of the problem of alcohol and driving. Alcohol-related fatal accidents, for example, can be analyzed and the results of such analysis published. While local police and newsmen are keeping the annual "highway death count," the local alcohol safety program could keep its own poll of alcohol-related fatalities -- and publish it.

The project officials should be evaluating the name-publishing to see if they can isolate any benefits. This is a difficult and time-consuming process. There is only a small body of research on the value of "scare" techniques in driver education programs and, according to the National Highway Traffic Safety Administration, there is presently little evidence to show that name-publishing is an effective deterrent to future drinking-driving or that it hurts or helps the individual's attitude toward rehabilitation.

The overriding objective is to keep drinking drivers off the road, while still respecting their rights. This may involve increasing court-imposed punishments rather than name-publishing.



The problem is to individualize the screening process as much as possible while, at the same time, developing routine procedures that will facilitate the flow of violators through the screening process. Methods should be developed for personnel to gather information routinely and to present it in a standard format.

Initially, perhaps the probation department should get together with the motor vehicle department to facilitate the rapid gathering of a defendant's driving record. Maybe the two departments are using different forms. Some states now have computer links between the courts and the motor vehicle agency so judges can obtain information instantly.

Perhaps a representative of the licensing department can be assigned to court to help speed the process.

It may be possible to institute group screening, a technique being used in Fairfax, Virginia. Participants occasionally are less reluctant to admit to an alcohol problem if they see another in the group has the same problem. At least part of an alcoholism screening test can be administered in the group setting.

If the probation department needs more personnel, has it considered charging a fee for its services? This money might be used to expand the staff.

D

If any one professional's job is closest to the "interface," it may be the probation officer. On the one hand, as the delegate of the judge, he represents the authority of the state. On the other hand, he is the natural ally of the violators he counsels. At one and the same time, he may be the only person in an alcohol safety program fully trusted by both the judge and the violator.

In this case, the probation department apparently wasn't consulted thoroughly or made a part of the planning process that set up the program. An immediate solution might be found in a meeting to determine which department has the responsibility for providing counseling services. The probation officer might be convinced that he does not need that responsibility in addition to his other jobs as pre-sentence investigator, monitor of cases and observer of violators after they leave the program.

The program might launch a public information campaign to acquaint the public with the role of the probation officer. His is a misunderstood job. Children want to grow up to be policemen or firemen but seldom probation officers.

E

Here is an attitude-changing problem for which, we well know, there's no overnight solution. It is also a competence-building problem, for we are dealing with two deficiencies. One is the reluctance of the health agencies to deal with problem drinking drivers; the other is their lack of competence in treating alcoholism.

Fortunately, attitudes and competencies are beginning to change. Most mental health clinics are refocusing their programs to approach the involuntary patient with firmness yet understanding. Lincoln, Nebraska reports good results with what it calls a "tough love" program. Moreover, recent studies have shown that the involuntary patient who is in danger of losing something -- his job, in the case of an industrial alcoholism program, his license, in the case of the drinking driver control system -- is by no means untreatable. In fact, it appears that the involuntary nature of these programs isn't the obstacle it was regarded in the past.

But how to approach the immediate problem? One approach is an educational program for the health agency staff that is jointly sponsored by the treatment agencies and the alcohol safety project. Consultants might be brought in from, say, the Nebraska program.

Training programs also might be established to develop competence in the treatment of problem drinking drivers and alcoholics. Scholarships might be provided for the training. If possible, federal and state funds might be sought for developing new alcoholism treatment agencies.

F

The courts are accustomed to a relatively high volume of defendants who can be processed in terms of broad classifications such as "DWI." Not only are health professionals reluctant to predict the time needed for an individual's treatment; they also are unaccustomed to the heavy flow of violators, and they may have difficulties in scheduling treatment.

The health professionals will need to standardize treatment as much as possible as they gain experience and learn from similar programs elsewhere. The courts must understand, however, that the length of an individual's treatment might vary from the "average."

Treatment can be structured in at least two patterns. One is to make a careful diagnosis of each violator's alcohol problem, then match individual treatment with results of the diagnosis. The other is to give all violators the same minimum treatment for a set time period (usually in an alcohol safety school) and to select from this group the problem drinkers who need more intensive treatment. The route chosen will depend on the resources available for the diagnostic process.

G

Normally, just the opposite is the case; the judiciary or motor vehicle department help initiate an alcohol safety school. In this case, the new school should have been advertised throughout the system. Now is the time for improved communications on all sides. There should be a meeting of all parties involved immediately. The counselor in this case needn't be a wallflower. His role is not limited to counseling. He might make appointments to visit local agencies to learn about their

function. In the course of such visits, he will be asked to explain his role. In addition, he might join formal and informal organizations related to his field: the area council on alcoholism, the mental health association, social work and counseling groups. Leads to these agencies can be obtained from the faculties of local colleges.

H

Here the problem is to convince the judiciary of the efficacy of a new, innovative method when there is not a great deal of research to support it. But there is something to be said for trying a program that is new and different. The change itself, with the enthusiasm that accompanies it, sometimes is good. It is the judges, in fact, who in many parts of the country have initiated innovative court-referral programs.

Furthermore, not all of the research is negative. We have evidence in industrial alcoholism programs that the combination of coercion and rehabilitation is effective in a high percentage of cases. The goal here is not to replace an old program with a new but to use the new to supplement the old. In the community education program that should precede the launching of a drinking driver control system, it should be stressed that traditional punitive measures aren't being abandoned.

Perhaps the problem here is that the enforcement agency, as the program began, was not made to feel an important part of the system. Of course, the role of the police is crucial, for without arrests and the evidence to back up convictions, the system will not work.

In most larger drinking driver control systems, the officers on patrol during the crucial drunk driving hours constitute a separate unit specially trained to spot drunk driving, to administer breath tests and to prepare cases for court. Morale is often high in these units, as the officers take pride in their expertise and occasionally go out of their way to perform extra service -- comforting a violator's family after his arrest, for example. Perhaps the officer in this case could be assigned temporarily to such a unit.

The officer's superior plays a key role. If the superior spots the attitude described here, perhaps he could invite the officer to observe a treatment program in operation or arrange a conference between the officer and a health professional.

Some DWI schools -- the one in Tampa, Florida, is an example -- use police officers in civilian clothes as aides in the education sessions. The offenders might see the policeman in a different light. Such an approach might have a positive effect on both the police officer and the violator.

It should be mentioned that the attitude cited in this example probably is the exception rather than the rule. In fact, the current trend in correctional circles is toward rehabilitation, not away from it.

The policeman probably understands the human problems of alcohol on the road more than any other participant in the system. He sees the drunk driver at his worst at the time of arrest, then follows him through the court appearance. More often than not, as the cornerstone of the punitive system, the police officer is a strong proponent of the alternatives -- simple because he understands the weaknesses of the traditional, punitive methods. He knows without having to read weighty reports that irresponsible drivers (drinking drivers among them) continue to drive after they have lost their licenses.

J

It is easy to say that the community and state must be willing to give financial assistance for updating records and technical equipment as well as support for the training of the police force in drunk driver apprehension. But such may not be the case in this instance, at least in the short run.

Although this may be very discouraging to the officer, officers are generally aware of the need for evidence in court. Such evidence doesn't necessarily have to be of a technical nature requiring financial assistance. Witnesses can be produced, for example, from the scene of the arrest, the hospital emergency room, a private physician's office, or a witness could be a fellow police officer.

When the policeman can't produce "evidence," he can't expect a judgment against the person he has arrested. But he can take comfort in the fact that he has taken "off the road," at least temporarily, a drunk driver. In the case of a social drinker, the arrest itself may have amounted to instant rehabilitation.

K

Some way needs to be found to dispel the growing public opinion of the DWI school as a "dumping ground." A public relations campaign might be launched to help inform the public of the real purpose of the school -- to help violators become safe, sober drivers while earning the restoration of their driving privileges.

A conference might be held between the judges and the directors of the DWI school. While there may be no immediate way to ease the caseload in both the courts and the school, a number of steps might be taken to expedite the case flow. Perhaps for a short time the courts should use traditional, punitive sentencing. At the same time, the school might shorten its required number of sessions for a few weeks. If problem drinkers can be referred to treatment directly from the courts, this might ease the school's burden. It should be emphasized all along, however, that completion of the prescribed treatment is absolutely necessary for the restoration of driving privileges.

L

A public program cannot subscribe to a specific treatment modality. No one theory can be applied because there is no research to support the head counselor's claim. An individual's commitment to his job, his training and background, his interest in the patient and his almost intangible ability to relate to people -- all combine to make him an effective counselor, regardless of whether or not he is a recovered alcoholic. If alcoholism is to be treated as an illness, then it must be treated by professionals. Those other professionals in this particular program who are secure in their roles might try to convince the head counselor, by persuasion and example, that the issue is not whether a counselor is a recovered alcoholic but whether he is a good counselor. The counseling staff, ideally, should be a mix of recovered alcoholics and professionals who have never had a drinking problem.

M

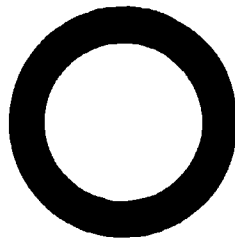
That judges give preferred sanctions to legally represented defendants was documented in a recent study in Denver, Colorado, and it may be a widespread problem. If the judges in this case will not alter the practice, at least two approaches might be tried experimentally. Plea-bargaining of DWI charges might be eliminated for a short period to study the effects. And, if there are funds available, legal representation should be provided to all defendants required to appear in traffic court.

N

Programs seem to work better when the component departments are under as few roofs as possible. It might help to consolidate, but finances and other considerations might make this impossible.

Coordination is aided by open lines of communication, strong supervision and leadership, regularly scheduled staff conferences and ongoing evaluation whose results are made available to all. The departments should be required to make regular written and oral reports on their activities.

A newsletter might be published for internal circulation. It would serve not only as a means of communication but also as one way to keep morale high.



A number of factors can influence delays in the traffic court system. They include a shortage of staff, an inefficient organization, a lack of equipment needed to transmit information and poor scheduling of time in the various departments.

Such delays can be ruinous. In the case of the problem drinking driver, the delays may be detrimental to health. And studies have shown that people have a tendency to forget, to minimize guilt or to dismiss a drinking problem with the passage of time.

A thorough analysis of the system and how it is breaking down might pinpoint some of these deficiencies. A "court master" or other officer could perform much of the administrative work so that the judges would not have to examine each case in detail. The judge, it should be pointed out, does not have to wait for the motor vehicle department to remove licenses. He can do it himself from the bench or authorize the court clerk to do it.

A representative of the motor vehicle department might be assigned to the court on a permanent basis.

In many states, computerized access to state motor vehicle records is providing judges with instant information at the bench.

P

There seem to be two problems here. One is that information is not flowing smoothly and not being brought to the attention of the appropriate officials and officers. Court officials and probation officers might meet with those in charge of the alcohol school to determine where the information is being held up and what can be done to get it flowing again.

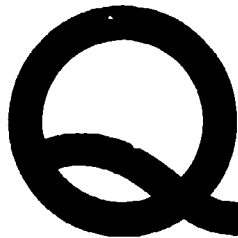
Another problem is that the traditional punitive sanctions are not being brought to bear on those who do not complete the program. Completion of the alcohol school sessions should be a prerequisite to the return of driving privileges. Studies of industrial alcoholism programs and of driving improvement programs have shown that such "involuntary coercion" is effective. Importantly, some individual or office must act as the triggering mechanism for invoking sanctions in the case of "no-shows."

A short-run solution in this case might be a well-publicized crackdown with some heavy fines and/or jail sentences to convince the "no-shows" that the program means business.

It also might help to designate a liaison person from the court and treatment agencies, or from an outside organization like the local public health office, to help the program function more smoothly.

It is not necessarily bad - or realistic -- in a large alcohol safety program for the judge to follow through on every case. What is important is that the violator understand that he has been accused (or convicted) of a crime and that there are certain conditions he must meet before his driving privileges will be restored. He should be presented with a written statement of the sanction imposed in his case and the conditions attached to it. It should be made clear that if he does not cooperate, then he will be brought back to court.

If there is widespread misunderstanding of the program in the community, perhaps a booklet could be prepared and widely distributed that describes the program in detail.



This scenario actually took place recently in a large East Coast city. The officer did not know that at least two municipal hospitals in his city were designated, by law, as detoxification centers. A number of states, since the mid-1960's, have repealed laws making criminal offenses of public intoxication and have required that persons found intoxicated in public either be taken home (an alternative the officer in this case might have chosen) or be given detoxification or emergency medical care.

However, adequate detoxification facilities are missing in many communities, or, if they are there, they are unattractive and need improvement. Moreover, in general, persons who need medical insurance coverage and health and social resources as a result of their alcoholism do not have the same services available -- either from the private or public sectors -- as persons with other illnesses.

A number of measures appear necessary in this instance. Both the police department and those who receive and treat patients in detoxification facilities need training in the nature of alcoholism, the medical approaches to detoxification and the laws and regulations regarding the hospital admission of intoxicated patients. A surprising number of those who work in hospital emergency rooms have had no training in alcoholism, and as a result do not know how to diagnose alcoholism. To help each side fully understand the other's problems, the training in this case might be given jointly for police officers and medical personnel.

This community also appears to lack a roster of public and private alcoholism services that should be widely distributed. The police department also needs a set of procedures for turning intoxicated persons over to detoxification units, including a priority list of hospitals and clinics.

Patients admitted to hospitals for emergency medical care are covered under many hospital insurance plans, but very often the patient is not so informed. This is a possible violation of the law and should be reported to the state insurance regulatory body.

R

This problem gets at the heart of the drinking driver control system, for without the authority to obtain personal information about a defendant, the prosecutor and judge cannot make intelligent judgments about needed treatment.

The prosecutor obtains information from various sources. One is the record of the arrest itself, particularly the BAC of the defendant. If it is extremely high, this is one indication the defendant is a problem drinker. The prosecutor would be assisted in preparing his case if there were procedures agreed upon with the police department for the processing of evidence in drunk driving cases.

A pre-sentence investigation, of course, should disclose a defendant's past abuse of alcohol -- either through his medical records or the testimony of family, friends and employers. The prosecutor, however, may not have the luxury of a pre-sentence investigator or probation officer assigned that task.

The third source of information is the defendant himself. Interview techniques and alcoholism screening tests have become more sophisticated and diagnostically accurate. They may not be sufficient in and of themselves, but the combination of arrest information, interview, screening test and medical-employment records should provide an accurate picture of a problem drinker.

At several points along the way, confidentiality becomes a problem. To obtain medical records, the prosecutor may have to obtain the written consent of the defendant.

A potential danger is that the innovative sanctions recommended in the drinking driver control system will themselves be used to avoid convictions. The intent, however, is not to avoid convictions that would appear on a driving record but to avoid criminal disposition by diverting offenders to community treatment resources. Perhaps what is needed in this community is an education program for judges to impress upon them the necessity of putting alcohol-related convictions on the record.

S

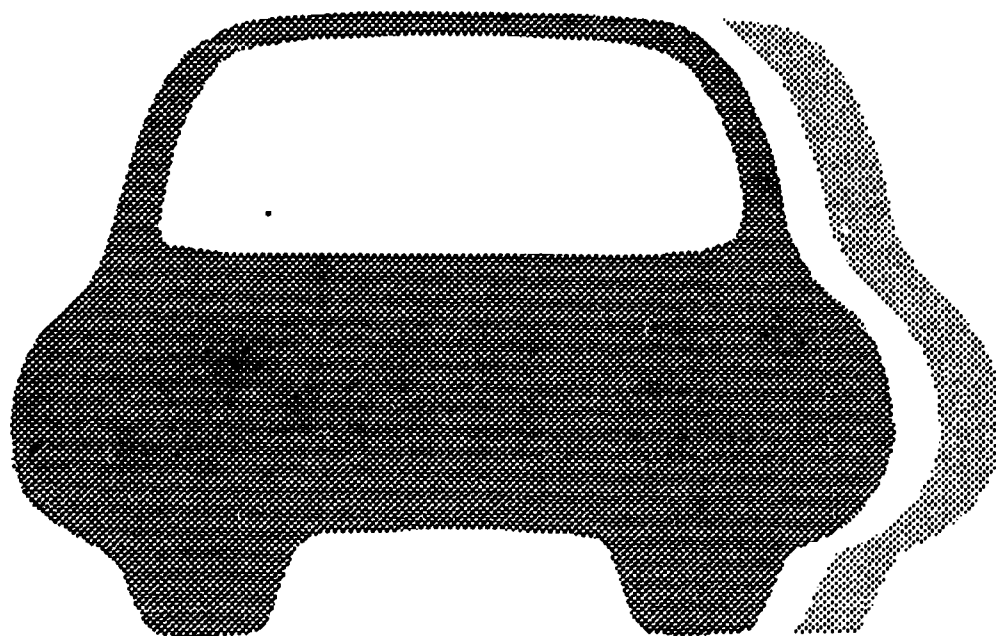
The patient has been referred to a treatment agency because he got into trouble with the legal system, and the best approach to treatment is to help him solve those personal and social problems that led to his legal difficulties. In this context, whether or not he considers himself an alcoholic is unimportant, and to dwell on that question in treatment may be unproductive. What is important is that he has been experiencing difficulties directly related to his drinking practices, for example he has been arrested, probably two or three times, for driving while intoxicated or he may be having marital or family problems related to his drinking. He should be confronted with these facts such as the details of each arrest, which probably included BAC's well above .10. A screening test, administered through a questionnaire, might spot some signs of problem drinking, and the patient should be confronted with those signs so that he says, at least to himself, "Yes, I do some of those things." He should be invited to discuss the circumstances of his arrest,

his feelings about the arrest, the reactions of his family members and others, his feelings about previous arrests and his experiences with police, judges and jails.

If the circumstances are right, the patient might be confronted by members of his family who, in the case in point, have been having a bad time of it. If such a session cannot be held "downtown," perhaps a well-trained counselor could visit the patient and his family at home. The treatment staff has to learn how to undercut a series of denying arguments, or, as one director of an alcoholism clinic put it, "to drive a wedge into the denial."

Throughout the treatment of the problem drinking driver, the approach should be to explore alternatives to behavior that leads inevitably to trouble.

A PLAN FOR THIS COMMUNITY



**This session is designed to build a
locally appropriate drinking driver
control model.**

**What are some major local problems?
What local and state resources are
available for this program?**

A PLAN FOR THIS COMMUNITY

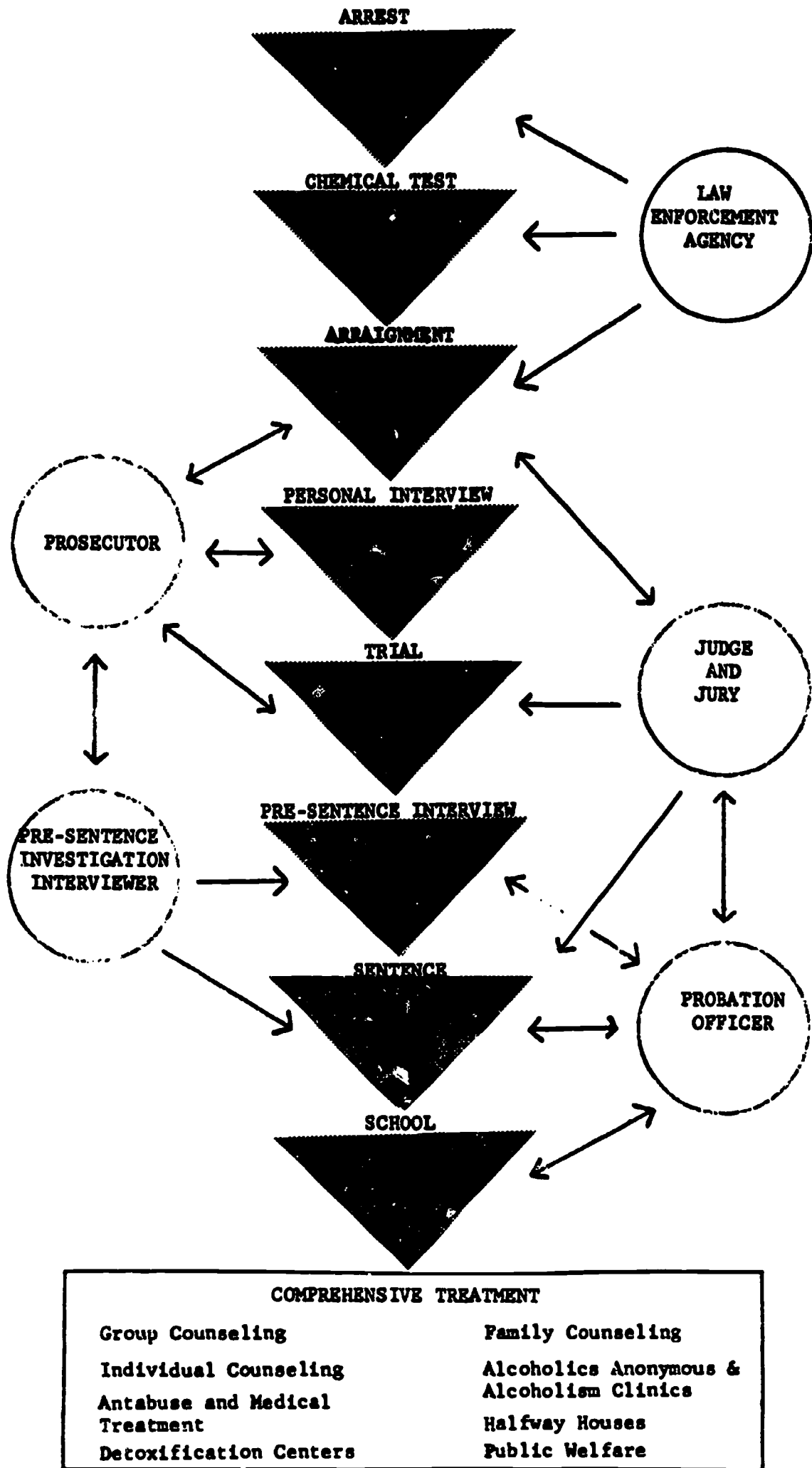
The seminar so far has covered three basic areas:

- 1. The nature of alcohol, its effects on the body and the highway safety problems caused by problem-drinking drivers.**
- 2. A description of the "old" and "new" drinking driver control systems.**
- 3. A discussion of how things go wrong in alcohol safety programs, particularly at the "interface" between the traffic-law subsystem and the treatment subsystem.**

The next exercise is to create your own locally appropriate models. You will know, as no one else, the particular needs of your community and the departures from the "ideal" that will have to be made to accommodate reality. Take into account those limitations of budget and staff as you work. Your leader will help get you on the way, and easels are provided for your use.

In the next few pages an overall picture is provided of a model drinking driver control system. It contains the basic elements of a plan for apprehending, identifying and treating problem drinking drivers. You may disagree with this approach or find it inappropriate in your local situation.

A MODEL DRINKING DRIVER CONTROL SYSTEM



TRAFFIC LAW ENFORCEMENT

There should be regular educational programs for all police and training of at least six weeks for police officers assigned to special drinking driver apprehension units.

Special police units should be used at critical times when drunk driving occurs.

There should be written agreement with prosecutors and the court covering the type of evidence, particularly chemical tests, that will be acceptable.

There should be central laboratories that provide police with evidence to be used in court.

The state should have implied consent laws, and drivers with a blood alcohol content of .08 or above should be charged with DWI.

Police should have the authority to administer pre-arrest chemical tests.

PROSECUTION

There should be regular educational programs for all prosecutors and special orientation for prosecutors assigned to drunk driving cases.

The prosecutors should have established guidelines of evidence which, when followed, will obviate the necessity for plea-bargaining.

The prosecutor should begin the pre-sentence investigation and may seek medical records of a defendant with his written permission.

The prosecutor should have standardized forms for information about arrest and prosecution. These should be forwarded to the pre-sentence investigators.

THE COURT

There should be regular orientation for all judges and special orientation for judges assigned to traffic court.

All cases should be tried in traffic court, but judges should be rotated regularly.

Judges and juries should evaluate each case individually, without anticipating the consequences of driver's license revocation.

Judges should be aware of the treatment alternatives made possible through various types of disposition; e.g., deferment of sentence, withholding of judgment, probation before verdict and probation with suspended sentence.

There should be a system for ensuring the judge that his order is carried out.

There should be a standard procedure for imposing sanctions on those who fail to comply with prescribed treatment.

PRE-SENTENCE INVESTIGATION

Specially trained individuals should be assigned to pre-sentence investigation, in order to free prosecutors and probation officers for their main tasks.

There should be routine procedures and standardized forms for gathering data -- both about the driving and arrest records of an individual and about his personal alcohol problems.

There should be a record search for a violator's prior contacts with courts and any failures to carry out prior treatment commitments.

SENTENCING

The court should have a series of graded sanctions it can apply to individuals to motivate them to improve their driving behavior. These include fines, various periods of license revocation and jail sentences.

The court alone makes the decision as to whether a violator has manifested enough signs of serious problem drinking-driving to warrant treatment.

Unless there is immediate evidence of problem drinking or alcoholism, all first offenders should be sent to the alcohol safety school.

ALCOHOL SAFETY SCHOOL

Everyone convicted of DWI should attend the school, unless he is among the few referred directly to treatment.

The school should have an appropriate record-keeping system so that the judges and probation officers can be officially informed whether violators appear regularly and so that "no-shows" will be signaled immediately to the court.

Violators should attend the school at least one evening a week for eight weeks.

The curriculum should cover the following:

The effects of alcohol on the human body and human behavior as it affects driving.

Information about the course of development of alcohol problems in people and how one identifies the extent to which alcohol has become a problem in his life.

The violator's personal feelings about his arrest, arraignment and court appearance.

The array of treatment facilities in the community, including their function, staffing and cost.

Discussion of the consequences of another apprehension for DWI.

Some of the discussion in the school should be carried out in small groups.

The staff of the school should be capable of recognizing and helping individuals with their alcohol-related problems.

The staff should be aware of voluntary and involuntary referrals so that they can recommend referrals to the probation department, since the staff should not have the authority to make referrals.

The school should be open to the public; however, those who attend should participate, not simply observe.

A small fee of no more than \$50 should be charged of all school participants, the proceeds to be used to operate the school.

PROBATION

There should be instruction in alcohol matters for all probation officers and special instruction for those assigned to drunk driving cases.

The probation officer should be aware of the treatment and rehabilitative agencies in his community, the requisites for admission, fees and waiting time for admission (if any).

Although the ultimate authority for referring violators to treatment rests with the judge, he assigns that authority to the probation officer, who should report regularly to the judge.

The probation officer should monitor the progress of the violators under his supervision, and he should refer those violators who fail to cooperate with school or treatment programs back to the court for further disposition. The probation officer also should have the authority to refer to treatment those identified as problem drinkers in the school.

The probation department should do an annual analysis of the recidivism rates of those individuals assigned to the school and treatment programs.

TREATMENT

There should be a treatment contract handed the violator for his signature prior to his first treatment session. It specifies the reasons for the treatment, including the benefits to the violator. It informs him of the length and type of treatment and of the consequences of his failure to attend sessions or otherwise to cooperate in treatment.

Medical and psychological treatment should be focused on helping the violator understand the problems that led him to drink and drive as well as helping him reduce those problems or learn to cope with them.

There should be four treatment modalities available:

1. Group counseling -- oriented to helping problem drinking drivers work on the personal problem that led them to drink and drive.
2. Group therapy for patients and their families, aimed at reducing family problems that led to drinking and driving.
3. Individual counseling.
4. Counseling combined with medically supervised use of Antabuse.

A small number of patients may need detoxification facilities, halfway houses and residential facilities.

The treatment process should include recording of attendance, which should be made available to the probation officer monitoring the cases.

The treatment agency may refer a patient to another mental health or psychiatric facility, or to Alcoholics Anonymous, with proper notification to the monitoring probation officer.

COORDINATION

Decisions about the drinking driver control system should be made by a coordinating committee or agency sponsored jointly by all the participating departments and facilities.

Each agency head should designate a person to serve on the committee. It will meet regularly, probably as frequently as once a week at the outset of the program.

Prior to the establishment of the program, the departments and agencies involved should subscribe to a written agreement on the procedures to be used. Based on experience with programs over time, necessary changes can be made with ratification of the coordinating committee.

PUBLIC RELATIONS AND EVALUATION

The coordinating committee should employ a public relations person whose primary duty is to inform the public of how the drinking driver control system works, of the dangers of drunk driving, and so on.

The public relations office would work in cooperation with existing councils on alcoholism and other agencies with alcohol-related public information functions.

Among pamphlets that might be prepared by the public relations office, whose financing ideally should be the joint responsibility of the participating agencies, might be one on Antabuse, one giving local alcohol-related highway crash statistics and one listing the types of available treatment agencies and how to contact them.

Besides the annual report on recidivism required of the probation department, the coordinating committee will maintain quantitative data on the volume of patients and their retention in treatment.

STAFFING QUALIFICATIONS -- FREQUENTLY USED STANDARDS

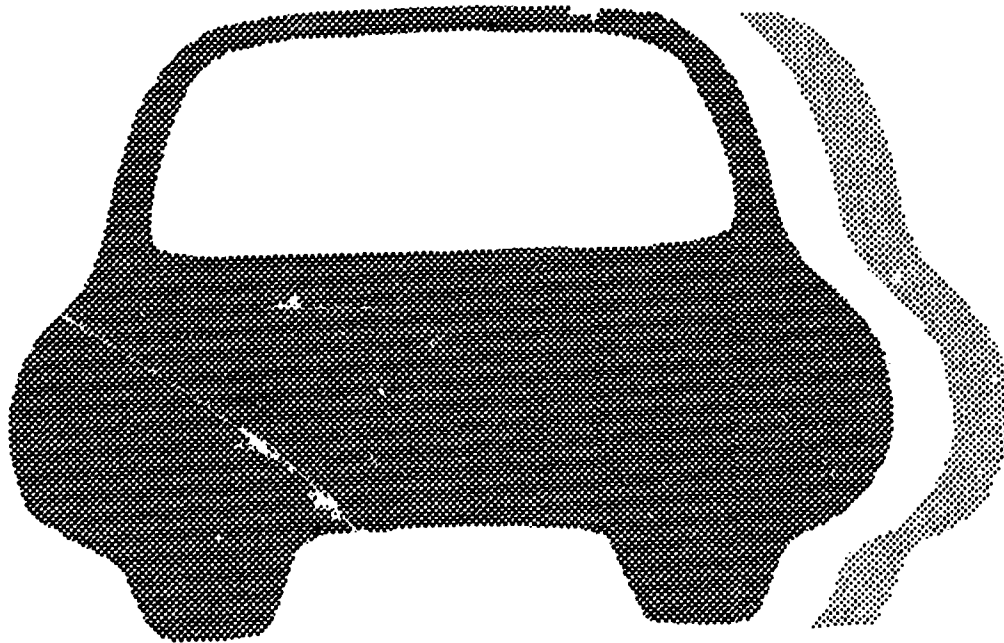
Probation officers and prosecutors: Individuals should have at least three days (twenty hours) of training in alcohol and alcohol-related problems. These individuals, on the basis of experience, should be sympathetic to the problem of alcoholism.

Counselors: Every community should work toward having alcoholism counselors, with specialized training in a recognized training program for alcoholism counselors.

School staff: These should be alcoholism counselors.

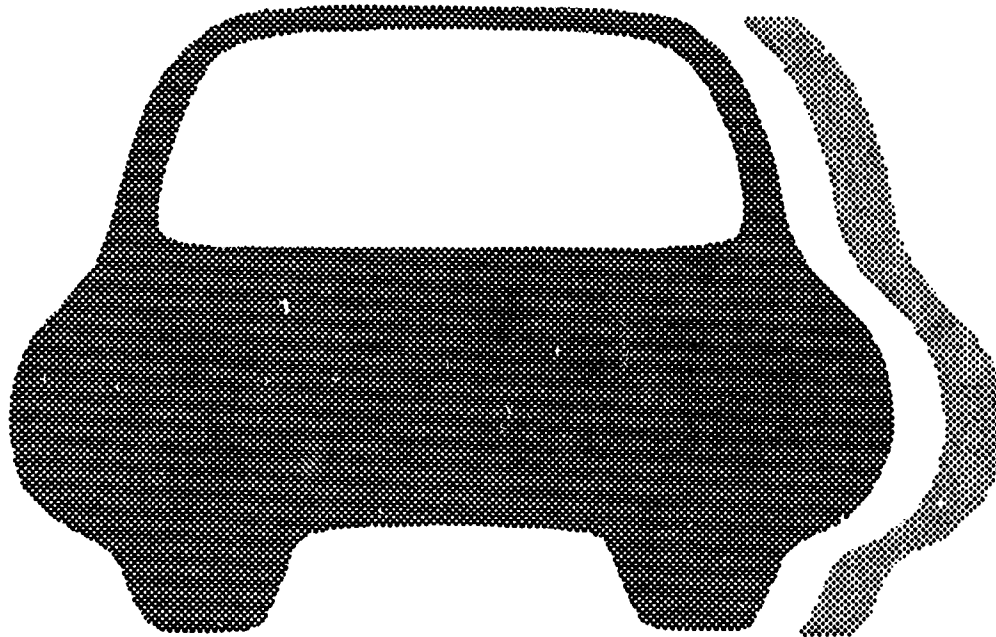
Treatment staff: Every treatment program should be under the supervision of a person with at least two years of special training, education and experience. One year should be academic work in alcoholism services, psychological and social counseling or vocational rehabilitation counseling. A clinical staff should have a psychiatrist or psychologist to provide professional supervision as appropriate.

DISCUSSING THE MODEL



This session is designed to discuss
and combine features of the models
developed in the previous session.

WHAT HAVE YOU LEARNED?



This session is designed to review the individual objectives elicited at the opening of the seminar.

Should they be rewritten?

Have your expectations for the seminar been realized?

Are the expectations for what a community can achieve realistic?

INDIVIDUAL OBJECTIVES

In front of you are the individual expectations you listed in the beginning of the conference.

Now that the seminar is concluding, should they be rewritten? Are there greater areas of agreement between highway safety personnel and treatment personnel than you were aware of before the conference? Have your expectations for the seminar been realized? Are your expectations for what your community can achieve realistic?

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administrator's manual

U.S. Department of Transportation
National Highway Traffic Safety Administration

November 1974

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INTRODUCTION

This Manual is for the use of anyone intending to conduct the Seminar on Alcohol and Safety. It should be read in conjunction with the Participants' Manual and the Leaders' Manual for the seminar.

The seminar has been designed as far as possible to be given by persons thoroughly familiar with the local and state enforcement, judicial or treatment agencies that deal with the problem-drinking driver. These persons should be familiar with both traffic-law and treatment operations. A familiarity with the Alcohol Safety Action Project would be helpful but not necessary. A familiarity with group dynamics also would be helpful. Some of the techniques for handling groups are described in this Manual and the Leaders' Manual. Further information may be obtained from the staff of the Johns Hopkins University School of Hygiene and Public Health or from the Office of Alcohol Countermeasures, National Highway Traffic Safety Administration, U.S. Department of Transportation.

The Seminar on Alcohol and Safety is a small-group, intensive planning session, dealing with the problems of handling people charged with drinking-driving offenses.

The participants are enforcement, judicial, pre-sentence, prosecution, probation, rehabilitation and other treatment personnel, both from ASAP (where the seminar is conducted in an ASAP location) and other local agencies, up to a maximum of 20 people. All participants should be engaged professionally on a daily basis with drinking-driver cases.

The seminar's purpose is to encourage participants to act as more effective members of the whole alcohol-safety system. Another purpose is to break down misunderstandings and hostilities between traffic-law and treatment personnel. The seminar provides information about alcoholism, alcohol safety and problem drinkers, but it is not intended for the well trained probation officers or psychologists. The technical and professional skills needed for job performance are assumed; in fact, a strength of the seminar is the structured interchange of ideas and information among a group of experienced professionals, not beginners.

The seminar produces a learning atmosphere well suited for mature professionals. For 2 1/2 days, the participants work intensively to solve the detailed problems of planning and implementing an improved system for handling drinking-driver cases. Carefully designed materials help them, but the most productive subject matter comes from the expertise of the group itself.

The group is small. Its members share some common interests, but some participants are likely to hold punitive views and some therapeutic views about highway safety. The participants will bring to the seminar different experiences and different answers as to what properly should be done with a person with alcohol-related problems. It should be kept in mind that alcoholism has been considered a treatable disorder for only a short time and that some seminar participants are likely to have grown up in the era of "drunk tanks."

The seminar sets common objectives for the participants. Though information is conveyed and people get to know each other better, the real results should be very specific and pragmatic improvements in the local alcohol safety programs.

The seminar was designed under the joint sponsorship of the National Highway Traffic Safety Administration, U.S. Department of Transportation, and the National Institute on Alcohol Abuse and Alcoholism, U.S. Department of Health, Education and Welfare. It requires careful preparation, but the effort is usually repaid by much better working attitudes and relationships and improved procedures for handling drinking-driver cases.

This Administrators' Manual should be read in detail, since it is the basis for successful organization and operation of the seminar experience. The Introduction to the Leaders' Manual gives further information about how the seminar works and should also be read carefully.

PURPOSES AND OBJECTIVES OF THE SEMINAR

The primary purpose of this seminar is two-fold. One is to increase the knowledge and understanding of participants with regard to highway safety as it is affected by alcohol and alcohol abuse.

A second purpose is to increase coordination and cooperation between personnel involved in highway safety and those involved in the treatment aspects of alcohol and alcohol abuse.

The objectives of the seminar are:

To realize that alcohol treatment professionals and members of other professional disciplines involved in alcohol safety (judges, prosecutors, probation officers, enforcement officers, etc.) share many of the same goals.

That treatment professionals and those in the highway safety disciplines recognize each other's special difficulties in the countermeasures area and have identified where they can be of assistance to each other.

To identify specific improvements that can be made at once in their operation and the local drinking-driver control system.

SUGGESTED SEMINAR SCHEDULE

T I M E	DAY I	DAY II	DAY III
<p align="center">MORNING</p> <p>9:00</p> <p>10:00</p> <p>11:00</p> <p>12:00</p>		<p>BREAKFAST Seminar Expectations (Small Groups) The Problem Drinking-Driver (Optional)</p> <p>BREAK</p> <p>How Are We Coping? ↓ LUNCH -- Brief Descriptions of Agency Functions</p>	<p>BREAKFAST A Plan for this Community</p> <p>↓</p> <p>BREAK →</p> <p>LUNCH</p>
<p align="center">AFTERNOON</p> <p>1:00</p> <p>2:00</p> <p>3:00</p> <p>4:00</p>		<p>Telephone Assignment (Optional)</p> <p>The Interface (Small Groups)</p> <p>BREAK →</p>	<p>Discussing the Model</p> <p>BREAK ↓</p> <p>What Have You Learned? (Small Groups)</p> <p>SEMINAR ENDS</p>
<p align="center">EVENING</p> <p>5:00</p> <p>6:00</p> <p>7:30</p> <p>10:00</p>	<p>Registration</p> <p>DINNER -- Seminar Introductions</p> <p>BREAK</p> <p>Value Exploration</p> <p>↓</p> <p>Agenda for Tomorrow</p>	<p>Informal Get-Together</p> <p>DINNER</p> <p>Free Evening</p>	

NATURE OF THE SEMINAR

The main assumption of the seminar is that the participants themselves possess the knowledge and ability to provide most of the seminar's subject matter. It is designed to be an organized working session in which the professional-level participants define measurable improvements in the alcohol-safety system which they themselves make, starting right away.

The other elements of the seminar allow this to happen. They provide support, direction, information and organization. In no way do they attempt to provide authoritative instruction as to the way local problems ought to be solved, but they have been carefully structured to encourage change to occur and to suggest ways that change might occur.

The seminar may be said to consist of four elements:

1. **The Participants.** Everyone should be aware that the seminar belongs to them. It is basically their responsibility to ensure its success. They do most of the talking and the decision-making. Leaders are present only to help them by providing information, stimulus, or commitment to further action.
2. **Leaders.** The seminar depends very heavily on small-group interaction. The leaders provide direction, information, stimulation, order. They arbitrate disputes or insure that the right people talk. The leaders must not dominate or manage the discussions. They also provide special alcohol-safety expertise.
3. **The Manual.** The Manual provided to all participants acts both as an information source and as the main structure for the seminar. It is not intended to be used rigidly or dogmatically; in fact, one section is designed to be reduced or eliminated if participants are sophisticated enough. The Manual contains a series of units which may be re-emphasized or re-ordered to fit the local situation, as determined by the leaders. All sections of the Manual except the listing of values and notes for the value exploration session, as well as the printed "discussion" section designed to follow the interface session, should be distributed at the time of registration. We suggest that the sections designed for later distribution be printed on paper of a different color.

4. Visual Aids and Resource Speaker. Slides have been designed to illustrate one unit; a film has been suggested as a visual aid for another unit. In addition, at the suggested time, a key person from the criminal justice or alcohol treatment fields may be invited as a resource speaker. As experts in their own areas, resource speakers contribute substantially to enabling participants to develop a coordinated, system-wide viewpoint. (Resource personnel also benefit from the direct communication set up in the seminar, and their participation often provides them with unexpected dividends.) Every effort should be made to keep the meeting from slipping back into a tone of a social problem -- rather than a disease.

These elements are intended to produce a learning atmosphere well suited to mature professionals. The atmosphere is informal and the seminar seems lightly structured. It is non-authoritarian. There should be no dreary dinner speeches or outside observers. All people present at any time will be engaged. A facility removed from the working locations of most participants and pleasant in atmosphere is recommended so that an uninterrupted working atmosphere may be maintained. The 2 1/2 days are busy and intense. The objective is a set of clearly definable commitments to action, not just words.

This learning situation is unusual because in most localities the participants do not normally meet regularly or as a small, professional group with a common mission. They have not usually met to deal with any specific problem area (such as alcohol safety). They rarely meet formally with people from other elements of the criminal justice and alcohol treatment systems. Used to being bored at seminars and conferences, they tend to find this seminar a positive and productive experience.

SEMINAR DATES

It normally takes two months from the initial decision to hold the seminar before it can be held. This lag is due mostly to the need to clear the schedules of the local participants far enough in advance, partly to the lead time needed to reserve a facility, and partly to the time needed to rent films or invite resource speakers. The Schedule Checklist at the end of this Manual is based on eight weeks' notice.

The dates for the seminar will be chosen as soon as possible after a decision to hold the seminar is made. It may be held on any days of the week, although starting days of Sunday, Monday, Tuesday or Wednesday are recommended. The seminar should not run through a weekend. It starts with dinner of Day I and continues through the afternoon of Day III. Participants should stay overnight at the facility. It is difficult to compress the seminar into a shorter period of time. The evening of Day II is left free and may be used to shorten Day III. These variations, however, should be avoided if possible.

SEMINAR PARTICIPANTS

The participants selected to attend the seminar will be those from an alcohol-safety program who handle alcohol-related drinking-driving cases. The optimal number of participants is 15 to 20.

Because traffic-law and alcohol-treatment staffs include people very different in status, experience and age, decisions on who should attend must be individual. In all localities, agency personnel who actually handle drinking-driving cases, be they police officers or alcoholism counselors, are of first priority. Other agency personnel may or may not be of value. It is recommended that two or three chief administrative officers be invited, although a particular problem arises from their participation, partly because they may be too busy to attend the full seminar, partly because they may stifle the discussion of subordinates, partly because some will never find alcohol safety an important subject. These invitations, therefore, must be handled with care. It is recommended that half of the 20 participants be from the traffic-law agencies, including policemen, prosecutors, probation officers, judges and pre-sentence investigators. The other half should be from the treatment fields, including counselors, therapists, clinicians, psychiatrists and psychologists.

LEADERS

The seminar uses two leaders, one of whom will act as the primary leader of the seminar, welcoming participants at the opening session. Three leaders, if there are financial resources for them, would be even better for a seminar of 20. The groups would then be of a more manageable size, making the leaders' job easier. The leaders may handle different units of the seminar, but each should be versed in group dynamics. One will take each group of approximately 10 participants when the seminar breaks into "small groups." The leaders need not be trained educators. They must not be authoritarian in personality. They must preserve a difficult balance between monitoring and encouraging the discussions without stifling or dominating them. During the seminar, considerable tact must be exercised, but the leaders also have the responsibility for asking difficult questions, identifying problem areas, and pinning all participants down to specific commitments, so they should avoid being bland. They are not "teachers," "instructors" or "trainers" but a combination of the best of each.

ADMINISTRATION

The seminar organizer or a member of his staff should be assigned the task of planning and coordinating the seminar, acting as administrator. The administrator will ensure the performance of all pre-seminar administrative activities using the Schedule Checklist provided in the back of the Administrators' Manual. Since the seminar schedule is tight, it is important that all deadlines be met. Calendars must be cleared and commitments to attend obtained. The success of the pre-seminar planning will in large measure determine the probable success of the seminar.

The administrator also ensures that any additional administrative assistance necessary at the seminar is provided: the details of distributing materials, preparing badges, assigning rooms, paying bills, seeing that coffee is provided, attending to lighting and ventilation, etc., should be handled by the administrator or his designate so that leaders are free to concentrate on the seminar itself. A projectionist also may be necessary.

RESOURCE PERSONNEL

A resource speaker is suggested for the "Information" unit of the seminar, but this does not preclude the use of resource personnel at other times during the seminar. Each attends only those portions of the seminar which are relevant to his knowledge. The kind of expert who likes to lecture should be avoided.

Suggested resource speakers for the "Information" session should be those who can provide first-hand knowledge of the nature and effects of alcohol. Among possibilities are traffic policemen, representatives of Alcoholics Anonymous, toxicologists or pharmacologists and medical examiners or coroners.

Other resource personnel, including the Governor's Highway Safety Representative, a legislator, a judge, an assistant attorney general, the director of the local ASAP, if there is one, a psychologist or psychiatrist, a clinic director, the director of a halfway house or an alcoholism counselor might be invited to participate, where appropriate, in the seminar.

ADMINISTRATIVE INFORMATION

LOCATION

The choice of a location is very important. It should be attractive. It is preferable to choose a place out of the city and away from the participants' working environment. This emphasizes the participants' commitment to spend two and one-half full days, uninterrupted by routine, working on alcohol safety -- rather than attending for just those sessions they can manage. The geographical distance from participants' homes, however, should not be a major hindrance. Usually an area within an hour's drive will provide a choice of facilities. A motel, preferably away from the center city, may be ideal, but a college campus may be rented cheaply, especially if the seminar is held in summer. The area should not be such as to encourage a "party" atmosphere, since all seminar hours are working hours.

The facility should be small or medium in size, capable of providing rooms to all participants and leaders, along with a room for the seminar sessions. Large hotels are less desirable. The facility should also provide meals, along with coffee and cold drinks in the meeting room.

THE SEMINAR ROOM

The meeting room should not be a schoolroom or a lounge. Its atmosphere should be relaxed and comfortable, neither too casual nor too instructional. A room 35 feet by 20 feet serves for a group of 18 to 20 people. It must be capable of being darkened for the showing of films during daylight. It should be well lit, since the participants use the manuals throughout the seminar. It should be well ventilated, and the chairs should be comfortable and numerous. A separate room or anteroom for coffee breaks is desirable, as is a separate area for storing materials.

The best arrangement of tables and chairs is a rectangular conference-table shape that can be easily re-arranged for the small-group sessions.

EQUIPMENT

Little equipment is needed for the seminar. The administrator should provide a 16 mm sound projector, an extra projector bulb, an outsize (1600-foot) take-up reel, a carousel slide projector with an extra bulb and possible external speakers with Y-cord and adapter. Three stand-up easels with pads of large paper also are necessary. Scratch pads and pens are desirable but not essential, since most writing will be done in the Manual. Name-tags for participants and leaders also should be provided at the beginning of the seminar and worn throughout. Also needed are two boxes of regular crayons.

THE SEMINAR MANUALS

All participants will receive a copy of the Seminar Manual, which is theirs to keep. The Manual contains all the printed materials needed to convey the subject matter of the seminar. It is intended to be easy to handle and comprehend. It comes in the form of a loose-leaf notebook, to which pages or sections can be added. The pages have been designed to be read easily, except for some reference pages. The pages will be used as necessary by the leaders, and the Manual will provide the timing and structure for the discussions. The Manual has been designed as a series of units, not all of which will be used at any one seminar.

The Leaders' Manual is the Participants' Manual with special pages added for leaders. These pages contain details as to special objectives and strategies with individual units.

The Administrators' Manual is designed for use by the administrator of the seminar.

SEMINAR ACTIVITIES

This section describes how the seminar should be planned and run by the administrator and leaders. It is a narrative of the Schedule Checklist (printed at the end of the Manual).

PRE-SEMINAR PREPARATION

Pre-seminar activities begin with the decision of the sponsors to conduct the seminar. This decision should not be made until a copy of the Administrators' Manual has been obtained and it has been determined that there is a need for such an event. When a decision has been made to "go" with the seminar, a minimum of eight weeks' preparation is required before the seminar can be held.

At least eight weeks before the seminar, the sponsor and/or administrator should:

1. Identify and reserve facilities for the seminar.
2. Order or commence to assemble one complete reference set.
3. Order a sufficient number of manuals for participants, resource personnel and leaders.

By the end of the seventh week before the seminar, dates for the event must be selected. Ample lead time must be allowed to ensure all attendees can adjust their work calendars. It is inadvisable to attempt to rush the scheduling of the seminar. Resource speakers will be difficult to secure if given much less than two months' notice. Local conditions and relationships, however, will permit tight scheduling in some cases.

Also required for completion by the seventh week are:

1. Identification, briefing and informal invitation of resource speakers.
2. Identification and informal invitation of participants.

The timing of the invitations will depend very much on local circumstances. The invitations to the chief administrative officials of participating agencies should be made in the first place orally. A formal letter may be sent later (by the end of the fifth week) if it is felt the situation requires such formality. Whether individual invitations to specific potential participants should be made without proceeding through their administrative superiors is a function of local protocol. Invitations to resource speakers should also be made orally and informally initially, with the opportunity being taken to brief the resource speakers on the local traffic safety program, the seminar and their role. Formal invitations may also be desirable with certain resource speakers. If so, they should be sent no later than five weeks before the seminar.

Acceptances and commitments to attend by participants and resource speakers should be monitored. It is desirable that the seminar roster be completed by the fourth week prior to the seminar. Follow-up phone calls or personal contacts may be necessary to ensure attendance by key participants. Some potential attendees may be unwilling to commit themselves too far in advance. By the second week before the seminar or as soon thereafter as commitment to attend has been obtained, a follow-up letter confirming their acceptance and attendance (and reminding them of time and dates) should be sent. Manuals should be delivered or sent to resource speakers to allow at least a week for them to review contents. Preparation of the manuals can be done during the final two weeks.

SEMINAR OPERATIONS

It is recommended that the seminar start on a Wednesday evening and finish on Friday mid-afternoon. There will be attendance problems with any days chosen, since apart from the demands of their private lives, participants' schedules are often controlled by the duration of a court session or by other duties. The desirability of their attending from the first to the last session should be emphasized when the invitation is extended. The presence of spouses is not permitted at the seminar and is not desirable at the facility. Care should be taken to begin and end the sessions on time. Since the schedule given to the participants does not state time-periods for the sessions, the seminar staff has enough latitude to allow fruitful discussions to continue uninterrupted. It is better, however, to be punctual to whatever hour is selected for the beginning and end of sessions, especially since much useful work is also accomplished at the meal-breaks. Normally, a coffee break is desirable in the middle of each three-hour session. This should not extend beyond 15 minutes.

The seminar staff should arrive at the facility around lunch-time on Day I in order to set up the room, equipment, etc. The leaders will arrange the room.

The room should be arranged with two large tables surrounded by enough chairs to seat all the participants, resource speakers, if any, and leaders. Numerous other chairs should be available around the room away from the tables. The Participants' Manuals should be placed on the table at the locations where the participants should sit. Leaders and resource speakers, if any, should be interspersed among the participants rather than grouped in one place. If the opening evening meal is served in the same room where discussions will take place, the room will have to be arranged after the dishes are cleared away. Manuals, in this case, should be placed on the dinner tables. There is no seating order for the opening dinner, although leaders should mix with participants, not stick together, throughout the seminar. Formation of the seminar small groups is discussed in the Leaders' Manual.

The room should look as comfortable and spacious as possible. Serve-yourself coffee and cold drinks should be nearby. Name-tags should be set out.

The seminar-room should be arranged by 5:30 P.M. It may then be used to greet the arriving participants, though it is better for this process to occur in another room. The leaders should greet people as they arrive (and see them through check-in if necessary). The seminar leaders should be formally introduced at dinner, and the evening session on Day I should begin at 7:30 P.M. at the latest.

The evening session should formally end by 10:30 P.M., even at the expense of cutting short any discussion. Normally, the participants will want to socialize in small groups, but this activity should also be ended by midnight or fatigue will occur during the next day's lengthy sessions.

Two-hour breaks between three-hour sessions is the normal pattern for Day II. Within each of these breaks one hour is allocated for meals. This schedule should be adhered to loosely, and it is the responsibility of the leaders to judge when to break or when to continue. No social activities that will encourage late attendance or absence should occur.

It is very important that a relaxed and open atmosphere exist throughout the seminar. There should be no banquets or visiting dignitaries. The atmosphere must be that of a group of experts working through discussion toward the practical solution of an identifiable problem: a combination of informality with efficiency. Every endeavor must be made to keep the participants working rather than passively listening. Overly dominant participants should be quieted and overly quiet participants should be actively brought to express their views, especially during the problem-solving session of Day II. Opinions and reactions from the groups should be solicited at every point, and the reactions of the seminar staff should be honest and forthright (see Leaders' Manual).

SAMPLE LETTER OF INVITATION

The attached invitation is a sample of the letter sent to participants. It is a recommendation only and, of course, may be changed as desired to suit the sponsor of the seminar. In some cases, depending on local protocol, the administrative official of a participating agency may have to approve invitations in advance. Normally, invitations should be followed within three days by a follow-up telephone call, and another call of confirmation should be made two weeks before the seminar.

Dear _____:

As a person who deals professionally with the problem of the drinking driver, you have been recommended as a participant in a select Seminar in Alcohol Safety to be held in _____ on _____.

The knowledge and background that you can bring to the seminar is an important part of the content. The particular experiences of the other nineteen persons invited will help you gain a better understanding of the (location) alcohol-safety program and how it might be improved. You will be able to share your ideas through group discussion.

Seminar participants will examine their attitudes toward alcohol, alcoholism and the drinking driver. They will evaluate alcohol-safety programs and solve typical problems that arise in offering such services. They will develop a model for a comprehensive alcohol-safety and rehabilitation program for the _____ area. The atmosphere of the seminar will be informal with an avoidance of lectures and maximum attention given to small group meetings and open discussion.

Among those invited are policy makers and those working at the operational level of alcohol-traffic safety and alcohol treatment programs. An important objective of the seminar is to enable traffic-law professionals and treatment professionals to understand and appreciate each other's roles in dealing with drivers with alcohol related problems. We believe that improved enforcement, adjudication and rehabilitation will result from the pooling of resources in _____.

The seminar will take place at the (facility), (address), (dates). It will open with registration and a dinner meeting on (Wednesday) evening, (date) at 5:30 P.M. Sessions will be held at the (motel) between 9:00 A.M. and 5:00 P.M. (Thursday) and (Friday).

Single room accommodations will be provided, as will all meals. (Participants will be reimbursed for travel to and from the seminar at the rate of _____.)

(Name), of the (Sponsor) staff, will be contacting you by telephone within a few days to answer any questions you may have about the seminar and to confirm your participation.

We hope that you will join us in this cooperative effort.

Sincerely,

The following is a sample letter of confirmation to be sent to invited resource speakers after an oral invitation has been made:

Dear _____:

This is to confirm the invitation I extended to you to participate as a resource person in the Seminar in Alcohol Safety on _____. The seminar is being held at _____, and all accommodation and meal expenses will be paid by us. The session in which your expertise is most relevant will be held the (afternoon) (evening) (morning) of (date) starting at _____. We have reserved a room in your name for (Thursday night), and I hope you will join us for (dinner).

We appreciate your giving time and energy to the seminar. It does not require any special preparation on your part, since there are no formal speeches or presentations. The small size of the group -- about 20 -- encourages informality, and discussions can get lively. The Manual provides structure to the course, and I am sending it to you under separate cover so that you will know what we hope to accomplish. I would like to draw your attention particularly to the Introduction. Most of the work at the seminar is done by the participants themselves, and the primary function of the resource person at each session is to stimulate them (by facts or ideas) to define their problems in the alcohol-safety area and to assist in devising solutions.

In order to plan properly, we would appreciate confirmation of your attendance at the earliest convenience. I will be happy to answer any questions you may have (telephone _____).

I look forward to working with you at the seminar.

Sincerely,

SCHEDULE CHECKLIST

The following Schedule Checklist is the main working document for the seminar. It lists all the major activities to be performed by the sponsor, administrator and leaders. Responsibility for the completion of the Schedule Checklist rests with the administrator.

The Schedule covers a period of approximately eight weeks from the initial decision to hold the seminar until the seminar has been concluded. The numbers in parentheses represent weeks, counting backwards from the date on which the seminar will be conducted. Activities should be completed before the indicated date.

SCHEDULE CHECKLIST

Date Scheduled **Date Performed**

PRE-SEMINAR PREPARATION

- | | | |
|-------|-------|---|
| _____ | _____ | Administrators' Manual obtained (-8) |
| _____ | _____ | Identify possible facilities (-8) |
| _____ | _____ | Order Reference Set (-8) |
| _____ | _____ | Order Manuals (-8) |
| _____ | _____ | Select dates for Seminar (-7) |
| _____ | _____ | Invite participants formally (-7) |
| _____ | _____ | Make follow-up calls to participants (-7) |
| _____ | _____ | Invite resource personnel informally (-7) |
| _____ | _____ | Inspect and reserve facility (-6) |
| _____ | _____ | Invite resource personnel officially (-5) |
| _____ | _____ | Monitor acceptance of invitations (-4) |
| _____ | _____ | Reserve equipment (-3) |
| _____ | _____ | Confirm attendance (-2) |
| _____ | _____ | Prepare Manuals for Seminar (-1) |
| _____ | _____ | Mail/deliver Manuals to resource personnel (-1) |
| _____ | _____ | Prepare final roster of participants, resource personnel and leaders (-1) |
| _____ | _____ | Assemble Manuals, equipment, films, name tags, and administrative supplies (-1) |

REFERENCE MATERIALS

There is a substantial research library in the area of drinking-driver control and rehabilitation. A bibliography of the references and resources is included in the Participants' Manual.

The books, periodicals, pamphlets and other literature comprising these references and resources can be secured from the sources listed below:

Community Program to Assist and Re-Educate Drinking Drivers, by Public Systems Research Institute, University of Southern California, 1972. Three-volume report to the National Highway Traffic Safety Administration; \$3.00 per volume. Obtain from: National Technical Information Service, 5385 Port Royal Road, Springfield, Virginia 22151.

Court Procedures for Identifying Problem Drinkers, Volume I: Manual and Volume 2: Supplementary Readings, June, 1971 (Report to the National Highway Traffic Safety Administration, DOT, by the Highway Safety Research Institute, University of Michigan.) Obtain from: Highway Safety Research Institute, University of Michigan, Huron Parkway and Baxter Road, Ann Arbor, Michigan 48105, \$5.00 per set; or, National Technical Information Service, 5385 Port Royal Road, Springfield, Virginia, 22151. \$3.00 per volume.

Standards Relating to Probation, by American Bar Association Project on Standards for Criminal Justice, Approved draft, 1970. \$2.00 for single volume; \$1.00 per volume for orders of ten or more. Obtain from: American Bar Association, 1155 East 60th Street, Chicago, Illinois 60631.

Alcohol and the Impaired Driver: A Manual on the Medico-Legal Aspects of Chemical Tests for Intoxication, by the Committee on Medico-Legal Problems, American Medical Association, 1970. (Book, maximum \$1.50 each, less with bulk order). Obtain from: American Medical Association, 535 North Dearborn, Chicago, Illinois 60610.

The Treatment of Alcoholics, by Sidney Cahn, 1970. (Book, \$7.50 each) Obtain from: Oxford University Press, Inc., 1600 Pollitt Drive, Fairlawn, New Jersey 07410.

Drink/Driver Calculator, Illinois Governor's Traffic Safety Coordinating Committee. (Small number free, otherwise 5¢ each.) Obtain from: Governor's Traffic Safety Coordinating Committee, Springfield, Illinois.

A Survey of Court Procedures for Handling Problem Drinkers Convicted of Driving While Intoxicated. Six volumes, 1971. (Report to the National Highway Traffic Safety Administration, DOT, by the Institute of Research in Public Safety (IRPS), Indiana University). Obtain from: IRPS, Indiana University, 400 East Seventh Street, Room 519, Bloomington, Indiana 47401, \$3.00 per volume; or National Technical Information Service, 5385 Port Royal Road, Springfield, Virginia 22151, \$3.00 per volume.

The Alcoholic American, National Association of Blue Shield Plans, 1970. (Free Pamphlet) Obtain from: Local Blue Shield Office.

Catalogs of publications on alcoholism, National Council on Alcoholism. (Free). Obtain from: National Council on Alcoholism, Suite 1720, 2 Park Avenue, New York, New York 10016.

Alcohol Safety Countermeasures Program, National Highway Traffic Safety Administration, April, 1971. (Free pamphlet). Obtain from: National Highway Traffic Safety Administration, 400 Seventh Street, S.W., Washington, D.C.

Alcohol: Use, Nonuse and Abuse, by Charles R. Carroll. (Book, 95¢ each). Obtain from: Wm. C. Brown Company, Publishers, 135 South Locust Street, Dubuque, Iowa 52001.

Alcohol and Highway Safety, August, 1968, by Secretary of Transportation. (Report, 50¢ each). Obtain from: Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., 20402.

The Killer Drunk: Now We Can Slow His Slaughter, by Edwin W. Brown, a reprint from Saturday Evening Post, Fall, 1971. (Cost 25¢.) Obtain from: Saturday Evening Post, 1100 Waterway Boulevard, Indianapolis, Indiana.

First Special Report to the United States Congress on Alcohol and Health. Department of Health, Education, and Welfare, December, 1971. (Report, \$1.50). Obtain from: Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 21402.

Parole and Probation? Selected Readings, by Robert M. Carter and Leslie T. Wilkins, 1970. (Book, \$12.95). Obtain from: John Wiley and Sons, 605 Third Avenue, New York, New York 10016.

Imaginative Programming in Probation and Parole, by Paul Keve, 1967. (Book, \$7.95).
Obtain from: University of Minnesota Press, 2037 University Avenue, S.E.,
Minneapolis, Minnesota 55455.

The Probation Officer Investigates, by Paul W. Keve, 1960. (Out of print).
Obtain from local library.

Elements of a Combined Health-Legal Approach to the Control of the Problem-
Drinking Driver, by Lyle D. Filkins, from Proceedings of a Conference on
Community Response to Alcoholism and Highway Crashes, Highway Safety
Research Institute, University of Michigan: Ann Arbor, 1970. Obtain from:
Distribution Service, University of Michigan, E. University Avenue, Ann
Arbor, Michigan 48104. (\$6.50 for Proceedings). Permission to reproduce
article may be sought from author.

FILMS

The films needed for the Seminar may be available on loan from the National Highway Traffic Safety Administration. If necessary, new copies of the films may be obtained through the following sources:

"Point Zero Eight," (\$125.00 plus additional \$25.00 shipping, handling and customs). Order from: Cable Television, 42 Charles Street, W. Toronto, Canada.

"The Drinking American," (\$240.00). Order from: National Educational Television, 317 East Second Street, Indiana University, Bloomington, Indiana 47401.