

IMPAIRED DRIVING PROGRAMS -
A REVIEW OF THE CANADIAN EXPERIENCE:

"WHAT MAKES FOR AN EFFECTIVE INTERVENTION?"

CENTRE FOR NEWFOUNDLAND STUDIES

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B. WAYNE SMITH



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Submitted by B. Wayne Smith

B.A.; B.S.W.

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ABSTRACT

Driving while impaired (DWI) continues to present a serious problem, both nationally and internationally, and current countermeasures in prevention, intervention and rehabilitation have had questionable impact in the reduction of DWI incidents and recidivism. Various national and provincial initiatives have recently been implemented, centered around primary prevention, however the re-education and rehabilitation efforts aimed at the second and subsequent offenders have not received the same public attention. This study looks at the past and current programming related to DWI intervention programs and has identified, through a literature review and an explanation of existing evaluations, essential components that need to be present in the construct of an "effective" DWI intervention. Using these components, which include psychosocial assessment, qualification of personnel, and course content, a questionnaire was developed and administered to 11 existing programs across Canada. The results of the questionnaire indicate that many programs are deficient in several of the components and substantial efforts would be required in order to advance many of the programs to a stage where these components are established and maintained. The study contends that without these improvements, programs would continue to have mixed outcomes, would be difficult to evaluate in terms of measuring impact, and of greater importance, be able to demonstrate to key stakeholders that DWI programming warrants the attention and support of the public sector.

TABLE OF CONTENTS

ACKNOWLEDGEMENT	i
ABSTRACT	ii
CHAPTER I	
Impaired Driving Programs - A Review of the Canadian Experience	02
Historical and Social Context of Problem	05
CHAPTER II	
Who are the Impaired Drivers	08
CHAPTER III	
History of Driving While Impaired Intervention Program	12
CHAPTER IV	
The Role of Social Worker in DWI Programming	18
Acceptance of Problem	22
Appropriateness of Behaviour	23

Early Identification	24
Prevention	25

CHAPTER V

Types of DWI Programming	
Four Programming Models	27
The Phoenix Driving While Impaired Program	28
The Crash Program, Vermont	30
The Cooke county, Illinois Program (A.D.A.S)	32
The St. Louis Impaired Driving Treatment Program, Saskatchewan	35

CHAPTER VI

Evaluation of DWI Programmes	39
------------------------------------	----

CHAPTER VII

Problems Related to DWI Evaluations	51
---	----

CHAPTER VIII

Essential Components and Criteria for an "Effective" DWI

Program	56
---------------	----

CHAPTER IX

Focus of this Study and Method of Inquiry	70
---	----

CHAPTER X

Design, Method and Procedures	73
-------------------------------------	----

CHAPTER XI

Results and Discussion of Survey Questionnaire:

History	79
Opposition to the Program	81
Sponsoring Body for the Program	83
Changes and Current Programming	87
Assessment	97
Time, Setting and Qualifications of Assessor	104
The Program	108
Use of Audio Visual Material	115

Differentiation of Rehabilitative and Educational Models	116
Records and Informational Data	120
Personnel	125
Follow-up	129
Evaluation	131

CHAPTER XII

Summary, Conclusion and Recommendations	
Psychosocial Assessment	136
Sustained Inter-Agency Communication	138
Structure and Approach of Intervention	140
Receptiveness to Evaluation	143
Program Comprehensiveness	145
Qualification of Personnel	146
Effective Tracking of Clients	150
Responsiveness to Change	151
Top Level Management	153
Conclusion	155

REFERENCES	157
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LIST OF APPENDICES

APPENDIX A - Criminal Code of Canada	166
APPENDIX B - Description of the Study	168
APPENDIX C - Consent to Participate in Research	170
APPENDIX D - Structural Interview Guide Canadians	
DWI Survey	173
APPENDIX E - Correspondence	189

CHAPTER I

IMPAIRED DRIVING PROGRAMS - A REVIEW OF THE CANADIAN EXPERIENCE

"WHAT MAKES FOR AN EFFECTIVE INTERVENTION"

INTRODUCTION

Driving while impaired (DWI) is one of the most costly social, legal and safety problems in society, both in financial and in human terms. As will be demonstrated, it is a major source of accidents, injuries and fatalities. To address this problem situation, many countermeasures have been developed and implemented over the years. These actions include road side checks, increased and stricter penalties and sentencing options, community and media campaigns, and re-education and rehabilitation programs. The latter countermeasure is aimed at addressing one of the more problematic offenders: the recidivist. He/she is the individual who, in spite of penalties imposed for a previous conviction of DWI, continues to drive after drinking, endangering both his/her own life and the lives of others. (For the purposes of this study Driving While Impaired is as described in the Criminal Code, Section 253. This section lays out the terms and conditions under which a person would be charged with this offence. See appendix A.)

DWI psychosocial education, treatment, and rehabilitation programs have yielded

mixed outcomes, but are believed to have the potential to reduce this most serious aspect of DWI. Unfortunately, many programs have suffered from inadequate planning, ineffective instructional material and delivery, and inadequate follow-up policies. While these factors make evaluation of issues difficult, issues such as the lack of randomized assignment of participants to treatment and control groups, inadequate pre-intervention data, and the general lack of scientific rigor, further obstruct efforts to measure effectiveness. This study reviewed and analyzed DWI programming from the mid 1960's to the present within the context of policy and implementation, and examine the results of the evaluation of such programs on the recidivist DWI offender and inform social work practice with this population. While evaluations have not produced definitive answers for improving DWI programs, they have identified elements that are essential to improved and more promising programming. Using these elements (ie, policy implementation and evaluation), DWI programs currently operating in Canada will be reviewed and described. Program directors and staff were asked to participate in a telephone interview covering all aspects of programming, from assessment to follow-up. As well, a review of the printed material relevant to the program such as policy, legislation, curriculum, assessment instruments is be integrated into the analysis. It is hoped that the study can serve to provide sound guidance for the improvement and enhancement of such programs in their efforts to impact on the recidivist DWI offender.

The purpose of this study is to review and analyze DWI policy and programs in Canada within the context of the intervention that is re-education, treatment and rehabilitation. The conceptual perspectives applied will draw on concepts from the social administration school of thought which includes policy development and evaluation and program development. In achieving these purposes, the methods utilized are best considered as multiple methods and include the following: (1) documents received and analyzed, (2) key informant interviews, (3) structured survey instrument, (4) limited direct observation and (5) examination of program goals and objectives.

HISTORICAL AND SOCIAL CONTEXT OF THE PROBLEM

About 4,000 persons are killed in automobile accidents in Canada each year (Transport Canada, 1987). Conservative estimates indicate that at least 30% of fatally injured drivers have a blood alcohol concentration (BAC) in excess of the legal limit (TIRF, 1983). It should be noted that the legal limit is set arbitrarily and any BAC elevation increases accident risk, especially under complex and/or high speed driving conditions. Transport Canada (1987) however, estimates that the figure approaches 45%. The contribution of alcohol to traffic fatalities is even greater when drinking drivers with BAC below the legal limit are also included in the figures. According to Donelson et al (1985) as many as 60% of all driving fatalities involve alcohol. Similar results were reported by Vingilis (1983) Allaby (1982) and Stroh (1973) - they claim 55% of fatalities were alcohol related with the majority over .08 blood alcohol level (BAC).

The Traffic Injury Research Foundation (TIRF) (1983) fatality data base provides information on alcohol involved drivers who were fatally injured in motor vehicle accidents in seven provinces from 1972 to 1982 inclusive. In 1982, 42% of drivers tested for BAC had .08 or higher. The percentage of fatally injured drivers who were impaired has remained relatively stable for the past ten years, fluctuating between 45% and 51%

but exhibiting no particular trend with respect to significant changes.

Investigations conducted in British Columbia (Mercer, 1986) and New Brunswick (Allaby, Decourcey, and Doucet, 1982) indicated that approximately 20% of injured drivers reporting to emergency wards had BAC in excess of .08 and 10% had BAC exceeding 15%. Although available data sources for Canada do not provide exact measures of the magnitude of the impaired driving problem, they do indicate that it is both substantial and persistent. Furthermore, considering that available estimates are conservative, they are likely to be larger than first indicated.

It is worth noting that the figures from the United States are comparable. Of the approximate 50,000 road deaths in the U.S. in 1982, 30,000 were alcohol related and of these, 40% of the drivers were in excess of .10 BAC (N.H.T.S.A., 1979). As well, between 58% and 78% exhibited symptoms of alcoholism or problem drinking (Reid, 1978). The jarring fact that an alcohol related fatality occurs in the U.S. every 20 minutes is worthy of report. (Landstreet, 1977).

In spite of imprecise measurements in DWI research, the enormous costs of impaired driving to society cannot be overlooked. Arguably, impaired driving causes more harm to, and extracts more cost from, society than does any other single behaviour

(Mercer, 1986). A earlier study compared the incidence and economic costs of cancer, motor vehicle accidents, coronary heart disease and stroke (Transport Canada, 1987). It was found that the number of new cases of cancer plus coronary heart disease and stroke came to a little over 1/2 million cases each year in the U.S. For motor vehicle injuries it was 4 million. In terms of economic costs, vehicle accidents rank second only to cancer. The range of cost areas include health care, property damages, escalating insurance rates.

Property damage resulting from alcohol related traffic accidents is estimated to cost Canadian society in excess of \$6 billion annually (TIRF, 1983). To this should be added the cost of the criminal justice processing of impaired driving offenses which amounts to an additional \$600 million annually. These figures represent only a part of the total alcohol problem which is estimated to cost Canadian society \$8.4 billion in 1986.

CHAPTER II

WHO ARE THE IMPAIRED DRIVERS?

While individuals from all sectors of society are apprehended for impaired driving, characteristically the greatest number are males (90%) who most often fall between the ages of 30 and 50, have blue collar jobs with high school education or less. In a study commissioned by Health and Welfare Canada (1988) it was revealed that despite public education and enforcement efforts, the frequency of drinking and driving is increasing at an alarming rate. Research in the U.S. and Australia (Mookheysee et al, 1980) reported that involvement in other criminal activity and less resistance to negative peer influence are also common characteristics of the DWI population.

Males age 20 to 29 are being apprehended at an increasing rate (TIRF, 1983). Of particular concern is the fact that a disproportionate number of impaired drivers are 16 to 24 year of age. While they represent only 16% of the total population, 36% of all impaired drivers are in that age group. More alarming is the fact that over 36% of impaired drivers demonstrate serious alcohol dependence, as determined by their respective addiction agencies, with beverage alcohol (McGuire, 1982). Saltstone and Poudrier (1989) in their identification of four sub-groups of Ontario DWI offenders, determined that the

"worse case" offenders, that is the recidivist, suffered from levels of alcohol dependency that rivalled levels found in samples of alcoholics in treatment. The need for a treatment model for recidivists was reinforced by Kline et, al (1988) who examined the profile of multiple offenders participating in non-drinking drivers alcohol treatment programs.

Despite the incidence of problem drinking drivers, the majority of DWI offenders do not necessarily occupy the far end of the spectrum. In fact most of them are not alcoholics and programs for the alcoholic population do not meet their needs. To design appropriate psycho-social programs it is necessary to recognize DWI offenders in terms of their presenting behaviour (Pisani, 1986). Brown (1981) found that most DWI offenders are mid-way between social drinkers and problems drinkers in their drinking behaviour. Scoles, Fine and Steer (1984) found that nearly 50% did not have alcohol problems. Scoles and Fine (1977) noted the diversity of the DWI offenders as being a major obstacle to successful intervention. McGuire, (1982) points out that the programs which have favourable impact on light drinkers can be unsuitable for heavy drinkers. In fact Steer (1979) was able to distinguish seven types of DWI offenders, each of which require different forms of intervention.

Early efforts at addressing the problem of impaired driving concentrated on enforcement, e.g. sporadic, intense roadside checks, and periodic legislative and judicial

crack-downs with severe penalties (Malfetti, 1983). Such measures have not produced the result expected. In the long run these measures were neither affordable nor tolerable in the North American system of jurisprudence, and in fact there appeared to be an inverse relationship between the severity of penalties and conviction rates. Internationally, there is a wide variation in levels of law enforcement. However, these measures have met with disappointing results (Ross, 1982). As an example of the range of penalties related to alcohol and driving offenses, South Africa has a penalty of up to 10 years in jail for second offenders and in Bulgaria the death penalty has been handed down for the same offense. These extreme practices contrast with the U.S. where no imprisonment for second offence was possible in 40 states up to 1986. Some research has indicated that it is the probability of being apprehended, not the penalty which is the main deterrent affect. (Smart, 1983, ARF)

It is clear in the literature (Brown, 1980; Mann, et al.,1983) that one single approach to address the problem is not to be found. As Saunders (1979) points out, the tragic consequences of drunk driving defy a single solution. Stricter law enforcement, stiffer fines and tougher driver license suspension are only partial solutions. Research in the area of impaired driving strongly suggests that strategies such as amendments to the criminal codes will not in and of themselves reduce the impaired driving problem. Legislation alone does not have any long term impact on reducing the drunk driving

problem because the perceived risk of being apprehended for this offense is at present 1 in 2000.

When one adds together drinking practices, community attitudes, apprehension probability, and the apparent ineffectiveness of legislative initiatives, the challenge of impaired driving reduction becomes very difficult. And, any program which hopes to be effective, must address all of these. In fact there is strong evidence to demonstrate a contradiction between people's attitudes about driving while impaired and their behaviour. Public opinion polls (Health and Welfare, 1988) indicate that while 4 out of 5 Canadians express disapproval of drunk driving, more than half of them admit to this behaviour at some frequency. This conflict between what people say and what they do reflects the social acceptability of the behaviour in the face of attitudinal sanctions. People pay lip service to the admonition "don't drink and drive" and then do otherwise. This gap between public definition of social responsibility and personal responsibility-taking greatly complicates efforts to decrease the actions that represent the DWI phenomena of drinking and driving. The goal of intervention, then, becomes that of closing the gap between belief and behaviour! The past, present and future of these efforts will be addressed next.

CHAPTER III

HISTORY OF DRIVING WHILE IMPAIRED INTERVENTION PROGRAM

In the years prior to 1970, in North America, a growing awareness of the seriousness of the drinking and driving problem was developing (Main et al., 1983). Several ways to deal with the problem were being suggested (Hurst, 1970; and Schmidt et al., 1963). However, in terms of tertiary intervention programs, the work undertaken in Phoenix, Arizona (Malfetti, 1974) and the Alcohol Safety Actions Projects (A.S.A.P.) throughout the U.S. paved the way for rehabilitative programs for DWI offenders, as we know them today.

The many rehabilitation programs that emerged during the 1970's clustered around two broad approaches: education and treatment (Ennis, 1977). Education programs were described as those in which information was provided, however, the participants' drinking problems were not the direct focus of the program. In contrast, the treatment approach squarely placed the drinking problem of the participant as the direct focus of the program.

The re-education format which was modelled after the Phoenix, Arizona program (Malfetti, 1974) (a more psychosocial model) normally involved four consecutive 2 1/2 to

3 hour sessions where participants were given information on the effects of alcohol, driving skills, alcohol's effects on driving, problem drinking and avoidance of future problems (Stewart and Malfetti, 1971). Using the Phoenix program as their basis, A.S.A.P. developed 400 programs in the U.S. and Canada, during the period from 1970 to 1975. The work of Malfetti and Stewart in Phoenix continues to serve as the cornerstone for most contemporary programs and its conceptual base has continuing validity. Once the impaired driver reeducation movement (Schmidt et al, 1963) got underway, it gathered incredible momentum, and was not halted by negative evaluative findings. The commitment of the staff, the public, and the government for the program, in spite of the mixed evaluation outcomes, usually meant the programs continued in the face of questionable results (Israelstam, 1975). Then in 1969, in recognition of the seriousness of the impaired driving problem, the U.S. government launched a nationwide program to provide financial and technical assistance to communities to develop and implement a systematic program to combat drinking and driving (Waller et al, 1982). These were called Alcohol Safety Action Projects (A.S.A.P.). The programs focused on three major areas: the identification of drunk drivers on the road; informed decision as to the nature of the drunk driving problem; and the determination of the most effective action to prevent future incidents. A.S.A.P. was born and five categories of countermeasures were developed: enforcement; judicial and legislative initiatives; pre-sentence investigation and probation; rehabilitation; and public information and education (Jones and Jocelyn,

1978). Among the categories of the A.S.A.P. program there was a rehabilitation countermeasure, with diagnostic measures to discriminate between problem and non-problem drinkers. As well, the A.S.A.P. programs utilized a broad range of alcohol treatment countermeasures including alcohol safety schools, group therapy, and chemotherapy.

The fundamental assumption of the A.S.A.P. programs was that a large proportion of the DWI offenders were problem drinkers whose control over their drinking behaviour was limited. Accordingly, practically all the A.S.A.P. programs employed re-education programs to accommodate all DWI referrals but invariably utilized the rehabilitation services through the local alcohol rehabilitation centres. Ennis (1977) observed that most alcohol safety schools were, in fact, treatment countermeasures for problem drinkers. In reality most prevention efforts particularly in the U.S. over the initial 10-15 yrs. had focused on tertiary interventions (Mann et al, 1983).

The Introduction of DWI Programs to Canada

The introduction of impaired driving programs to Canada came, in the majority of cases, through the provincial addiction agencies. It was the addiction agencies' belief that

the DWI programs for second offenders allowed for the early identification of persons with alcohol problems, offering a better prognosis for recovery. However given that apprehension is a fairly random event, this assumption is somewhat weak. They saw it as an excellent means for detecting persons who, although dependant, are in the earlier and therefore, most treatable stage. Based on the fact that over 30% of convicted impaired drivers are alcohol dependent, addiction agencies felt that their role, as change agent was legitimate, and that DWI convictions can act as an identification and engagement mechanism for initiating treatment.

Initially, Canadian programs, designed to rehabilitate and educate convicted impaired drivers, were patterned after the DWI Phoenix Program (Clay,1977). At the outset, these programs are oriented more to education than to treatment. The assumption was that participants would make a rational decision not to drink and drive based on the awareness of the consequences imparted to them through the programs. However, the problem of alcohol dependent drivers was not effectively addressed by this approach as it lacked adequate diagnostic and counselling/referrals processes (Malfetti,1974).

A significant change in the approach of Canadian agencies in the treatment of alcohol dependent offenders occurred with the introduction of the A.S.A.P. program in the U.S. in the early 1970's. As described earlier A.S.A.P. employed a multiple strategy

approach which involved classifying and placing the offender in suitable programs. Since that time the Canadian programs have increasingly taken on a treatment orientation. This evolution was prompted by data which suggested that many impaired drivers are alcohol dependent and among recidivists, the proportion is significantly greater. Also it was believed that without treatment, it is highly probable that the alcohol dependent offender will continue to drive while impaired and to be a subject of higher accident risk.

With these facts in mind, some Canadian jurisdictions have concentrated their efforts on programming for persons with two or more impaired driving convictions. This involves, in most cases, agreement between the province's registry of motor vehicles and the additions agencies to have repeat offenders referred to determine whether or not dependency is present. As in the U.S., Canadian researchers posed the question of program effectiveness. Unfortunately, undue attention was paid to the question of whether the programs reduce recidivism, a difficult outcome measure to verify. Results were inconclusive and many jurisdictions became discouraged. Consequently, the enthusiasm for DWI programs has fluctuated from 1975 to the present. However, with the increased recent attention around fatalities on the highway and the emergence of the many advocacy programs i.e., MADD, SADD, TADD, DWI initiatives have once again surfaced during the past three years. Tertiary intervention is just one of these. Given the political climate against "drunk driving", this author would argue that it is now opportune to re-establish

dormant DWI programs and to review and improve programs that may have been unchanged since their inception and may have suffered from deterioration.

CHAPTER IV

THE ROLE OF SOCIAL WORK IN DWI PROGRAMMING

The relationship of social work to intervention programs for impaired drivers originated primarily from two sources: a) the probation system and b) the addictions field. This includes a wide variety of other services which encounter addiction problems in the course of helping a variety of populations. When one looks at the history of the Canadian programs for impaired driving it is noted that these two forces influenced the establishment of such programs. The probation system as a servant of the court, performs the role of a referral service, while the addictions agencies develop and deliver both the re-education programs and the rehabilitation programs. The probation system is brought back into the picture at some point to provide to the participants an overview of the legal implications of a DWI offense. Both social service agencies employ social workers for their various programs and it is the skills and generic abilities of the social worker that enable these agencies to carry out the functions of the driving while impaired program. It is recognized de facto that social workers are best suited for this field as evidenced by the credentials of agency staff involved in driving while impaired programs. For example, a sound grounding in contemporary group counselling techniques has been identified as necessary, especially when one considers the involuntary nature of the population being

served (Berliner, 1987). As well the rehabilitative functions within the driving while impaired program require the most exacting skills and experience that a social worker can bring. It must be remembered that a DWI client may be experiencing significant dependency problems when entering the program that are grounded in emotional problems or related to other social situations in his/her life.

The anxiety, isolation and alienation that the clients bring with them can be significantly reduced by the personal relationship established with social work personnel. In his examination of personality factors associated with DWI offenders, Farrow (1988) found that feelings of powerlessness and stressful life events were more evident when compared to the control group. DWI staff must also be prepared to deal with the denial and rationalization that may be firmly established in the client, and at the same time be able to portray an attitude of hope and positive expectations. As with the social worker involved in the mental health field or in health service delivery, acute care needs of the client must be recognized and assessed, and the appropriate referral made. This is critically important when physical withdrawal, which requires immediate treatment, is observed.

From one perspective, the client entering the driving while impaired program displays many stages of resistance. These are manifested in emotional states such as anger

and fear, and patterns which include testing limits, eventual compliance, then anger again, self-depreciation, surrender and acceptance (Berliner 1987). The counsellor should be trained and prepared to cope with these reactions from clients. The resistance identified in some driving while impaired clients may limit the acceptance of the program content. Therefore, the counsellor must be skilled in providing motivation and therapy in the forms of cognitive restructuring, development of social skills, behaviorally oriented programs, and the more traditional psychotherapy. These various abilities have been identified and supported by Collins (1982) and Reis (1982), who recommend that assertiveness training can be a useful technique to a DWI counsellor. Most of these approaches reflect the theory that a significant cause of excessive drinking is inadequate social skills. Panepinto et al (1982), recommends treatment that is founded on situational crisis theory, adjustment demand theory and treatment contracts. Miller (1984) has developed an effective approach to motivational interviewing. The DWI instructor must also recognize various levels of self-esteem among his clients as it has been demonstrated (Annis et al, 1983) that low self-esteem among clients may indicate need for an institutional setting, while offenders showing a high degree of self-esteem do better in intensive out-patient therapy. These observations by researchers looking at driving while impaired programs all consistently support the need for trained social work personnel in the assessment, development, and delivery of driving while impaired programs. Without such competencies in social interventions, the effect might be reduced possibilities for effective interventions and

increased recidivism rates. It can be said that while competency of staff is only one of the criteria for a successful DWI program, it should be ranked as one of the more important.

It is not surprising that the DWI staff handle similar problems faced by social workers in the health care field, the correction field as well as other areas of social work. Saunders (1979) draws the analogy under such client issues as:

- a) acceptance of problems;
- b) appropriateness of behaviour;
- c) early identification;
- d) prevention.

Each of these will be briefly discussed.

a) ACCEPTANCE OF PROBLEM

Saunders (1979) points out that whether it is the driving while impaired problem or other social issues, the situation is influenced both by the way the affected individual views the problem and the manner in which the helping person handles it. The person arrested for a driving while impaired offense usually claims that he is a social drinker who had too many and merely got caught. He inevitably focuses on the arrest and not the alcohol abuse. Similarly when alcohol is the agent in family disruption, problem drinkers resist the notion that the presenting problem may be the symptom of underlying disturbance. It may also be the presenting problem! In the majority of cases, alcohol dependence is the problem with or without related disturbance. The social worker in both situations can be caught up in this dynamic. The ill-prepared DWI instructor may fail to recognize the underlying dependency problem and the dynamics of this problem. In many cases a client is genuinely not "aware" of the problem.

In many ways the social worker who performs the role of a DWI instructor is assisted in reaching the client by several motivational factors. Trauma of arrest, risk to other person's safety, and the court mandated sanction, all limit the ability of the driving while impaired offender to resist treatment. These factors, among others, can force a client to come to grips with his alcohol dependence and reduce the opportunity for denial.

Court directed treatment for child abuse, and E.A.P. referral for treatment represent similar constructive coercion measures employed in other social work settings. Social workers are able to bring with them skills and techniques used in other settings where constructive coercion is utilized. Client strengths and resources are even more powerful motivators -- typically promoting change based on functional behaviour patterns in other areas of the clients life.

b) APPROPRIATENESS OF BEHAVIOUR

For the DWI offender the examination of current drinking and driving behaviour and its subsequent modification is essential to resolve the problem. This pattern is like that used for resolution of most social work mediated situations. Realistic goals must be set, and deviations from those goals must be understood to be inappropriate and counter productive. However, in setting the behaviour change, the counsellor must recognize the cultural milieu and appreciate the pressure placed on the offender back in his community. As well he must recognize situations that might trigger the resumption of this high risk drinking including unachievable objectives.

c) EARLY IDENTIFICATION

In many settings the social worker is unable to reach the potential client for early identification or intervention. However, like E.A.P., driving while impaired programs, through a built-in referral system, permit some early identification. This is probably one of the most important attributes of DWI programs. Research has shown that clients referred for treatment of problem drinking through DWI were usually in an earlier stage of the "disease" than those referred through other sources. One study (Kissako, 1976) reveals that of 36,000-clients treated in federally-funded alcoholism centres 28% were referred through driving while impaired programs. These clients, when compared to the remaining 72%, were younger, had fewer years of heavy drinking, were more often employed, had better incomes, were less impaired physically and mentally, and generally profited more from treatment. Thus it is apparent that DWI programs by the nature of their referral process can help achieve intervention for emerging alcohol dependence -- under conditions where the client is likely to have more strengths and more social support. Under these conditions DWI programs could be used as early brief interventions relative to emerging alcohol problems.

d) PREVENTION

The fashion with which services are delivered in most social work settings is reflective of the reality that most social workers address as crises or in the serious latter stage, such as chronic alcoholism. Few social workers are deployed to carry out other social work functions such as preventative education or community consultation. (Bloom, 1981). In contrast, the DWI program allows the social worker to interact with public agencies involved with enforcement, the judiciary, rehabilitation and public information components. Coordination between various agencies in preventive and rehabilitative modes makes DWI programs promising for prevention of other alcohol related problems and motivation to treatment.

Scoles et al (1984) points out that the drinking and driving phenomenon is a classic example of a social health issue that defies traditional solutions and single agency response. Historically, intervention with the drinking driver was a police and legislative matter, whereas treatment of alcohol abuse was in the domain of rehabilitation programs. However, the driving while impaired program did not conveniently fit into either category, but rather represented a combination of both legal and health arenas. The complexity of the problem demanded the development of a viable working relationship between systems, and the skills of the social worker in establishing cooperation among social agencies played

a major part. This allowed the social worker to look at the total picture and then examine ways to reduce or prevent further incidents.

Upon reflection, the DWI initiatives introduced to the alcoholism and social work fields a social control system that promoted a better working relationship between the criminal justice system and the health and social care network. Experience in certain jurisdictions (Ennis, 1977; Malfetti, 1983) indicated that cooperation between courts and alcohol treatment agencies is both feasible and highly productive. Without the possibility of a referral to a driving while impaired program, the courts have little reason to change their traditional sentencing practices and little reason to consider rehabilitation as an alternative. On the other hand, without the leverage of the criminal justice system to entice cooperation, rehabilitation programs for alcoholism do not have the power to attract and retain as many clients. With cooperation, one system supports and enhances the work of the other. Moreover each shares in a mutually beneficial "goal sharing" process that serves to reduce duplication of efforts. The social worker is well equipped to work within this relationship and foster its progress.

CHAPTER V

TYPES OF DWI PROGRAMMING. FOUR PROGRAM MODELS

The current DWI Programs operating in the U.S. and Canada vary in approach, philosophy, structure and duration. As was referenced earlier, the general categories are education and rehabilitation, however under those two approaches the programs differ widely. To acquaint the reader with DWI approaches, four programs have been selected for discussion. This is, by no means, an exhaustive listing of approaches but serves to illustrate the continuum ranging from information dissemination to intensive treatment. The programs selected are (1) the Phoenix Program -- primarily secondary prevention education; (2) the C.R.A.S.H. Program, Vermont -- a combination of preventative education with some brief intervention counselling; (3) the Cooke County Program A.D.A.S., Illinois -- a combination of counselling and therapy with some preventative education, and (4) the St. Louis Impaired Driving Program, Saskatchewan -- primarily an intensive residential treatment program.

At the one extreme is the original Phoenix Program which exemplifies the informational approach and places less emphasis on matching client to program and the referral to treatment. The C.R.A.S.H. Program of Vermont, while essentially an educational model, is part of a larger community effort and recognizes the rehabilitation

component. The Cooke County Program pays particular attention to the repeat offender and provides a variety of re-education and rehabilitation options. The St. Louis Model of Saskatchewan provides an inpatient program which is aimed at the recovery aspect of alcohol dependence, denoting the disease concept of alcoholism.

At this point, only one Canadian program is being presented. Later in the paper, a comprehensive description of the Canadian models will form part of the analysis.

THE PHOENIX DRIVING WHILE IMPAIRED PROGRAM

This course was developed in Arizona by J.L. Malfetti in 1971 and served as a prototype or guide for some 500 corrective DWI programs throughout the U.S. and Canada. In preparing the DWI course, program personnel examined DWI arrests and looked at the files of over 1,000 DWI violations, examining such variables as age, sex, race, education, employment, details of arrest, number and type of prior arrests and history of drinking problems. The number of sessions, program content, and method were planned with both the needs and characteristics of the DWI offenders in mind (Malfetti, 1984).

The course sessions were held once each week for four consecutive weeks. Each

session lasted 2 1/2 hours and was taught by professionals. The aims of the course were: 1) to provide information on the consequences of drinking and driving and, 2) to consider why people drink and drive and what countermeasures can be taken. The attendees were encouraged to examine and analyze their own habits and determine ways to modify the behaviour which brought them to the program. Tests were administered to measure the extent of the problem and trained counsellors were present for participants who wished additional help. Participants paid \$15.00 registration fee meaning that not only was the program self-supporting, but the clients/offenders were required to demonstrate responsibility by paying for their program.

The sessions were arranged as follows:

1st session - Presentation of statistics and visual aids to indicate the extent of the problem. A film was then shown of actual accidents caused by impairment.

2nd session - BAC and driving skills were examined in terms of demonstrated abilities at various levels of alcohol intake. This included response time to braking, steering etc.

3rd session - Problem drinking was discussed. Comprehensive data was collected

and various alcoholism inventories were administered to help participants judge for themselves the extent of their problem.

4th session - Individual plans were developed to avoid future drunken driving. Myths were debunked. Options and alternatives to drinking and driving were provided. Verbal commitments were given and honesty was encouraged. The strength of the course was believed to be the opportunity for frank discussion and full dialogue among the participants. At this session, counsellors with special training in alcoholism and DWI were present to facilitate this process and arrange, if indicated, a more intensive involvement.

THE C.R.A.S.H. PROGRAM, VERMONT

The C.R.A.S.H. (Countermeasures Related to Alcohol Safety on the Highways) originated in Vermont in 1970. It was one of the original nine demonstration projects funded under the National Highway and Transport Administration- Alcohol Safety Awareness Programs. Like the other ASAP projects, the re-education and rehabilitation initiatives represented one segment of the larger A.S.A.P. In the case of the Vermont experience, the response to convicted DWI offenders was the provision of a Drinking Driver Education School (Clay, 1977).

The C.R.A.S.H. School worked in cooperation with the court system and utilized a tactic of reduced license suspension as a "carrot" to attract offenders to the program. However, as the researchers with the N.H.T.S.A. (1979) lament, the cooperation with the courts became unreliable in terms of the license suspension policy and the coercive element was lost. On a positive note, without mandatory referral, the offenders choosing voluntarily to attend, created a positive atmosphere in the DWI School.

The C.R.A.S.H. School operated on the belief that every participant:

- a) will take responsibility for his actions when given the facts about alcohol, alcohol dependence and driving;
- b) will assimilate these facts and make changes in his/her drinking habits as necessary.

In retrospect, such a belief system would be perceived as naive and unrealistic, in that it failed to look at the contradictory and competing behaviour of alcohol dependence even when exposed to information.

The objectives of the C.R.A.S.H. School were: a) to provide information on

alcohol impairment, driving skills, etc. b) to provide the participant with insights on drinking through the use of various audio visual material; c) to inform the participant of help available for dependency.

These objectives were accomplished by: a) gaining student's confidence and trust; b) providing an atmosphere that allowed an opportunity for the participant to evaluate his behaviour; c) allowing the student to design his own control program.

THE COOKE COUNTY, ILLINOIS PROGRAM (A.D.A.S.)

(The Alcohol and Drug Assessment Services)

The A.D.A.S. was an attempt to deal with the problem of DWI through varied forms of intervention designed to meet the individual offender's needs. The approach that is followed includes education and guidance, monitoring, deterrence, referral to counselling or therapy. It is based on a holistic, modified punitive framework. The program is conducted in cooperation with the court system, however there can be voluntary referral as well. Typically, clients are contacted before trial, and participation in A.D.A.S. is presented to them as an alternative to the traditional attempt to avoid conviction, an arrangement with which the courts are prepared to cooperate. Since the

penalties for DWI range as high as 364 days in jail and \$1,000 fine this alternative is generally attractive (Clay, 1977).

The availability of A.D.A.S. does not preclude the use of more traditional penalties for DWI offenders. Judges retain the option of imposing fines, jail sentences, and suspension of license. But A.D.A.S. gives the judge the opportunity to offer a wider array of options than a strictly punitive sentence.

The basic purpose of the program is to change the client's behaviour by changing his or her attitudes and motives. An attempt is made to convince the client that driving after consuming any significant amounts of alcohol is simply unacceptable behaviour. (Note: this, of course, would run contrary to a program aimed at the alcohol dependant, where the program's philosophy is based on the disease concept of alcoholism).

The initial step in the program is assessment which utilized:

(a) a Personal Data Form, (b) an attitudinal study, (c) the Michigan Alcohol Screening Test, (d) the A.D.A.S. Substance Abuse Assessment, (e) Behaviour Assessment Scale (B.A.S.). Based on these assessments, appropriate interventions are selected. Two levels of programming are provided. The first level is provided by the A.D.A.S. for 'milder problems' and the second level is provided by outside agencies, for offenders exhibiting

more profound behavioral problems.

Level I clients attend four, 2 hour sessions devoted to lectures, films, and discussion groups, which provide information on the effects of alcohol, the factors that trigger its use, the methods of gaining improved control over alcohol use, and the laws regulating alcohol consumption. Within Level I are several tracks to respond to the characteristics of the offenders among which are included youthful offenders, a woman's program and a poly-drug group.

Level II clients are referred to appropriate collaborating agencies for the development of an intervention or treatment plan. Therefore options exist for clients with mild or severe alcohol problems; for clients with other drug problems; for clients with difficulties in learning; and for clients with special social, psychological or physical needs. This diversity is central to the design of A.D.A.S. and a quality that should be present in contemporary Canadian programs. Pisani (1986) maintains that A.D.A.S. is unique in its use of a holistic, modified punitive approach with multiple levels of intervention.

THE ST. LOUIS IMPAIRED DRIVING TREATMENT PROGRAM, SASKATCHEWAN.

(An in-patient treatment centre for the DWI offender)

This program is aimed at persons convicted of second and subsequent impaired driving offenses, as part of the sentence of imprisonment. The program is of a 14 day duration which replaces the 14 day jail term on second conviction. The primary aim of the program is alcoholism recovery (Read, 1978)

Assessment and Referral

Preliminary screening and referral are provided to the courts by the probation division by means of a pre-sentence report which advises whether the offender is suitable for transfer to St. Louis. For those amenable to treatment the transfer to St. Louis will replace the 14 day jail term.

The purposes of this program are: 1) To provide information on the consequences of drinking and driving, with specific focus on individual differences in tolerance to alcohol; 2) To consider both the reasons why people drink and drive and to induce

offenders to develop countermeasures to the problem.

Treatment

The St. Louis program consists of: individual assessment and treatment planning - education and information regarding chemical dependency; individual and group counselling. A maximum of 15 clients are admitted each week. Once admitted, the client enters into an intensive program aimed at providing a foundation for ongoing recovery. Clients are expected to actively participate in the recovery program.

The program design presents clients with information about the illness of alcoholism, its signs and symptoms and its effects on themselves and others in their life. Extensive reference is made to the relationship between drinking and driving, with two days devoted exclusively to the Driving Without Impairment Program.

The Driving Without Impairment program is designed for eight sessions as follows:

- I Outline of course content, and dealing with initial denial and hostility.

- II Legal Information
- III Impairing effects of alcohol on human functioning; effects of alcohol on driving ability.
- IV Impairing effects of other drugs; rules of the road; defensive driving techniques.
- V Alcoholism information
- VI Assessing the impact of impaired driving on their lives.
- VII Feedback to participants; explore ways of separating the acts of drinking and driving.
- VIII Commitment stated and course evaluation

Follow up

Clients are expected to arrange for follow up for a six month period with addiction

agency staff in their home community.

CHAPTER VI

EVALUATIONS OF DWI PROGRAMMING

An extensive body of research exists on Driving While Impaired Programs. Some evaluators have adopted the quasiexperimental approach while others have attempted to use an experimental design. Much of this research has limitations due to factors inherent in the DWI program. An in-depth look at problems in evaluation will be taken in a later chapter. At this point a review of the most pertinent research will be presented.

The traffic safety impact of education and rehabilitation programs was first studied under controlled experimental conditions in the A.S.A.P. programs in the early seventies. The findings suggested that for drunk drivers who did not evidence drinking problems, referral to an in-class program reduced re-arrests, but did not affect subsequent accident involvement. For drunk drivers with moderate to severe drinking problems, the A.S.A.P. findings suggest that the rehabilitation programs had little or no effect on drunk driving behaviour or accident involvement (Hawkins, 1976)

Waller (1982) reports that virtually all of the efforts to evaluate impact of DWI programs have suffered from insufficient information or lack of control over variables. While early studies looked promising when measuring knowledge and attitudes, the most

rigorous evaluations that focus only on those studies meeting stringent design criteria, have found that the re-education and rehabilitation components of A.S.A.P.'s fail to show an impact on subsequent auto accidents.

Israelstam and Lambert (1975) states that programs such as A.S.A.P., Phoenix and the Alberta Impaired Driving Program (A.I.D.P.) appear to have marginal impact when recidivism is used as a program objective. In other evaluations of the Alberta Program, which was originally modelled after the Phoenix program, Israelstam and Lambert (1975) found no reliable reduction in recidivism but did find reduced convictions for other highway offenses. Zelhart (1975), in his evaluation of the Alberta Program for the Ministry of Transportation, reported that it had little effect on recidivism but did affect change in other areas. The A.I.D.P. participants for example expressed a greater willingness to seek professional help with problems associated with their charge of impaired driving. Additionally he maintained that the program may improve responses to attitude and information measures. Other positive observations reported were improved records for other Criminal Code convictions and lower conviction rate of offenders based on pre- and post- program data. In conclusion, Zelhart recommends A.I.D.P. as an effective referral service for individuals with alcohol dependency problems.

Malfetti, the founder of the Phoenix Program in 1966, undertook an extensive

evaluation in 1974. A study was made of repeat DWI offenders. The first 500 persons (experimental) convicted of DWI who took the Phoenix course were matched against 500 (control) who were convicted of the same charge at about the same time but did not take the program. Matching was on the basis of age, sex and race. Driving records for both groups were searched for 3 years before and after the DWI conviction. Post-baseline citation data showed significantly in favour of the experimental group on DWI citations. (Malfetti et al, 1974).

Caution must be exercised in interpreting this evaluation; it was an after-the-fact study and the assignment to treatment group could have been biased where problem drinkers could have been disproportionately placed in either group. Besides, at that time, records were poorly kept and vulnerable to error. For these reasons, Malfetti (1974) cautions that generalizations should be tempered. Prior to Malfetti's results, Crabbe et al (1971) also found that graduates of the Phoenix program had significantly better driving records than controls.

Reis (1988) examined the Comprehensive Driving Under the Influence Program (C.D.U.I.). This program, which began in 1977, used several incentives for offenders such as allowing participants to plead down their offense to reckless driving and the retention of their driving privileges. The evaluation showed a mild improvement in the

first offender involved in the four session program. The most significant observation was the reduced recidivism for offenders who participated in the program's year long group-educational/counselling option. The finding of the C.D.U.I. suggests that the most effective length of time for follow up evaluation is greater than 6 months and probably close to one year duration. Reis also reported that, unless the group counselling techniques in DWI programs are of high quality, it will prove no more effective than brief individual interventions. In his conclusion, Reis stated, "a properly designed rehabilitation program can make at least a limited contribution to traffic safety". However, unless there is a high level of specificity in the treatment modality, it should continue to be used in conjunction with traditional punitive sanctions, particularly license suspension. He goes on to state that the criminal justice system represents a tremendous case finding mechanism for early alcohol intervention.

Connery, (1983) undertook an evaluation of the U.C.L.A. Driving While Impaired Demonstration Program, a program which focuses on the educational needs of first-time offenders. It was assumed that this group could engage in self examination and assume control of their drinking and driving decisions. This pilot 12 hour program was comprised of two didactically-taught information sessions separated by two small group discussion sessions.

Although a strictly controlled recidivism study was not contemplated, citation records for 320 (95 %) offenders who participated, reported, after one year, an 18% lower rate when compared with a cohort of non-participants. The process evaluation of the course by participants and instructors was consistently high. Connery, while praising the pioneer efforts of Malfetti, maintains that there is a continuing need for curriculum study and development which reflect changing needs and circumstances of the problem and the participants.

There have been two large scale evaluations of the A.S.A.P. programs. Both involved a longitudinal study of re-convicted offenders in areas where A.S.A.P programs were operated as compared with those regions where no programs were provided. The first of these, by the Comptroller General of the U.S. (1979) was based on examination of 35 A.S.A.P.'s conducted in 1971-1978. It reveals mixed results. While no reduction in the number of highway deaths was evident, improvements were apparent in the number of drunk drivers and the number of problem drinkers referred to rehabilitation. The second study, by Saunders (1979) examining 25 A.S.A.P. pilot projects, notes as their advantages both early identification of problem drinkers and encouragement of treatment acceptance. But Pinsani (1986), in his review of evaluation of A.S.A.P., points out that many of the A.S.A.P. programs were poorly designed, weak in content and often lacked planning and follow through.

Several other studies of the A.S.A.P. format described mixed success levels. Swanson et al(1981) reporting on a program in Arizona, found little evidence for the effectiveness of short term treatment in a sample of midrange drinkers. Hogan, (1978) comparing license revocation or suspension, of participants in a one year alcohol abuse treatment program in California, found no significant favourable effects of program participation, and one unfavourable effect. Similarly, Michelson (1979) describing a Florida program sending DWI offenders to an alcohol safety school, found no statistically significant differences between subjects and controls over a three year follow-up.

Holden (1983) observed many combined DWI interventions, such as probation and education programs, therapy and probation period, and found it difficult to isolate, if any, the effective intervention. He generally found the current intervention outcomes discouraging. Even more discouraging were the results of a study by Salzberg and Klineberg (1988) which compared DWI offenders who received deferred prosecution and alcoholism treatment to offenders who received normal judicial sanctions. They found higher rates of alcohol-related traffic violations in the treatment group.

There have, however, been more encouraging findings on DWI programs in later years. Reis (1982) reviewed a year long educational counselling program, with or without, chemotherapy. This study, involving 5,700 DWI offenders, found that the results

were no more positive than brief but personal counselling. This should not be considered negative but points to the need for individual treatment as part of the overall DWI intervention. In a comparison of DWI offenders referred to six programs of treatment with offenders not referred, McGuire (1982) found favourable effects on light drinkers, but not on heavy drinkers. This study looked at changes in alcohol-related and general traffic violations and accidents over a two year period. Snowden (1984) analyzed treatment results of 178 problem drinking drivers and reports that factor analysis revealed two factors in client characteristics: a general improvement factor linked to psychopathology, and a resistance factor (expressed in continued drinking) linked to alcohol use. Both of these factors were linked to involvement in the program as well.

Mann et. al, (1983) undertook an extensive review of past and current evaluation of drinking driving programs. They were able to summarize the results of these studies under the categories of quasi-experimental and experimental studies and whether the outcome measure utilized was recidivism, knowledge and attitudes, or treatment lifestyle measures. In total 34 studies was reviewed and improvement in attitude and knowledge was noted.

In terms of educational DWI approaches several quasi-experimental evaluations have appeared. Of these studies, eleven have reported positive program effects, while one

has reported negative program effects. With knowledge and attitude change as an outcome measure, Coghlan (1979) examined an educational program, a brief jail term and a combination of both. A positive impact was observed for the education and the education plus jail term. Similarly Holt (1979) examined an education program alone, and in combination with other treatments, and a control group, and found positive effects for the education and the education plus other conditions.

With traffic safety as the outcome measure, quasi-experimental studies such as Crabbe et al Phoenix evaluation (1971) were identified, with positive results on driving records. Using pre-conviction measures as covariates, analyses of post-conviction data indicated that program graduates had significantly better driving records than controls. Similarly, Michelson (1979) comparing the driving records of individuals assigned to a control group or an educational program based on the Phoenix model, found that the group did not differ over the three years of follow-up, but suggested a positive program effect based on the finding that program participants had significantly worse records prior to the course. Ginnett and Whitbeck (1979) examined the New York program which was also modelled after the Phoenix model. Graduates had a better pre-and-post driving records than controls.

Using an experimental design, encouraging results were found related to knowledge

and attitudes (Brown, 1981; Vingilis, 1983; Swanson et al, 1981). They identified significant attitude and knowledge improvement with participants in Out-based DWI re-education programs. However Scoles, Fine and Steer (1984) randomly assigned first offenders to a four session educational program or a control group. After the program, measures of self reported alcohol consumption and symptoms of heavy drinking revealed no significant differences.

With traffic safety (recidivism) as the measure, the effects of educational programs appear minimal when subjected to the scientific rigor of the experimental design. Preusser (1976), studying a 13 session educational program, revealed a significantly higher accident rate in the educational group, which disappeared once the variable of differential length of license suspension for the two groups (treatment and control) was controlled. Vingilis et. al, (1979) found, after three and a half years of follow up of the Oshawa program, no significant differences between groups on traffic safety measures existed. However Siegal (1987) in his examination of the Weekend Intervention Program (WIP) in Ohio, revealed that the recidivism rate of first time offenders in the WIP group was lower than that of first time offenders receiving other sanctions i.e., jail term, suspended sentence/fine.

Mann et. al, (1983), has concluded that the usefulness of educational programs is unclear, and while they appear to positively affect knowledge and attitudes, their effects

on alcohol consumption and drinking problems appear minimal.

Treatment approaches aimed at reducing an individual's drinking problem have been extensively evaluated using both quasi-experimental and experimented approaches and using traffic safety as the outcome measure. About 50% of the evaluations reviewed by Mann et al (1983) demonstrated some beneficial impact of treatment.

Seixas and Hopson (1974) compared pre-and post- treatment driving records of participants in a job-related rehabilitation program with control groups. They found fewer DWI convictions, reckless driving incidents and collision among the treatment group. McGuire (1982) compared three forms of treatment (Alcoholics Anonymous, alcoholism counselling, and combined lecture and small group discussion) with three educational groups and a control group. For light drinkers each of the treatment programs had a positive effect on at least the traffic safety measure. For heavy drinkers, the A.A. and combination lecture and group discussion had a positive effect on accidents.

The Saskatchewan Department of Education (Read, 1978) reviewed the St. Louis Impaired Driver Treatment Program (described earlier in the paper) and looked at both process and outcome in their evaluation. The process evaluation showed positive results in that St. Louis was considered a highly supportive environment. They reported that

residents demonstrated a high level of understanding of alcohol dependency and drug misuse.

In terms of outcome measures, the results were encouraging when knowledge and attitude were examined. But once again the evaluation failed to show an impact on recidivism, although there was a significant reduction in other driving offenses. It should be noted that the profile of the offender was not described, but one might speculate that if they were classified an alcoholic, the 14 day program would have only a marginal impact on many participants.

Using experimental design to examine treatment/rehabilitation effects on knowledge and attitudes and traffic safety, the results are, once again, mixed and inconclusive (Brown, 1980; Coghlan, 1979; Clay, 1977; and Nichols et al, 1978). Treatment programs for drinking driving as yet provide no definitive indication of their effectiveness. Knowledge/attitude measures seem to be beneficially influenced by treatment. However, traffic safety measures do demonstrate sufficient positive program effects to warrant further study (Mann et. al, 1983) the need for improved intervention techniques is indicated in recent literature reviews. Donovan (1989), in a comprehensive review of DWI literature, concluded that efforts must be undertaken to improve the effectiveness of rehabilitation programs. This recommendation was made often examining all 3 levels of

preventive programming addressing the DWI population. In this authors opinion, the community needs multiple levels of DWI programming, each designed to address the specific stage of alcohol use demonstrated by the client\offender.

CHAPTER VII

PROBLEMS RELATED TO DWI EVALUATIONS

Many attempts at external evaluations of DWI programs have been plagued with serious methodological problems such as: small sample size, lack of random control/treatment assignments, the weakness of measures used to assess results, the short follow-up period for observation, the inability to equate groups prior to treatment and most notably the inability to compensate for the extent of the pre-treatment drinking problem (Nichols, Ellingstad and Struckman-Johnson, 1979; Mann et al. 1983). Of equal importance, some failures to demonstrate positive outcomes of DWI programs have been credited to the choice of the dependant variable used to measure outcome, i.e., subsequent driving while impaired offenses: recidivism. While certain programs appear to reduce recidivism (Vingilis, 1983) such program evaluations need to be replicated in a well controlled study.

Waller (1982) has identified in point form many of the barriers to sound evaluative studies. These are: 1) The problem of assigned treatment groups because of the integrity of the program and the agency undertaking the program. In many cases, random assignment to control and treatment groups was not possible. The courts and probation and addiction agencies strongly felt that if the program was available, any individuals who

might benefit from such a process should not be excluded. Therefore evaluation was hindered from the outset. 2) Drunk driver arrests are relatively rare events so evaluations suffer from insufficient data. 3) Drunk drivers are not a homogeneous group. Malfetti, (1983) has identified at least 5 categories of DWI offenders. The most obvious dichotomy involves the social versus the problem drinker. It has been clearly pointed out in the evaluation to date that these groups react quite differently to interventions; 4) Evaluations are often an afterthought and consequently assignment to control and treatment groups are not possible even when the professional integrity issue has been overcome; 5) Evaluation studies must be as independent from the program as possible. There is pressure to prove the program effective by staff, agency officials, and the community. Therefore the evaluation team must resist manipulation of the design by individuals who are unable to be objective about the evaluation process. 6) In many cases the evaluations have not been permitted as the findings may create political problems for the proponents of the programs. This is most prevalent in a period of restraint when addiction agencies and the courts have to justify expenditures based on evaluation studies. 7) In many evaluations, poor methodology is used and many times, results do not support the conclusions reported. 8) Evaluations, in many cases, are based on what the program is supposed to cover or transmit to the participant. It cannot be assumed that just because the information and procedures are in the teaching guide that they are actually being utilized. It is extremely important that prior to evaluation, an evaluability assessment be completed and a clear idea

of what is being communicated through the curriculum should be documented. Kenashito (1983), observed that previous attempts to evaluate impaired driving programs were methodologically flawed in many ways. Among these are the inadequacy of re-arrest data such as recidivism measures, the need for its self help report data, the diverse aims of programs being assessed, and finally the fact that attitudinal change may not underlie behavioural change.

Throughout the evaluation literature, recidivism continues to be the major criterion for success. However, as Ennis (1977) points out, this outcome measure restricts the assessment of rehabilitation programs' effectiveness through the measurement of behaviour change in a relatively small portion of a problem drinker's life situation. In other words, no attempt is made to observe and consider other changes in this person's lifestyle around the alcohol consumption. We do know from previous evaluations of DWI programs (Malfetti, 1975) that there is significantly increased knowledge about alcohol and driving and that more positive attitudes towards alcohol and drunk driving are observed.

Another explanation put forth for the problems in using recidivism as an outcome measure centres around the assignment of the individuals to DWI programs. In many U.S. studies it was observed that, if individuals agreed to participate in the DWI programs, their licenses were reinstated during the program period. Hence, the person attending the

program was driving more and therefore had greater exposure to the risk of detection. In other words, the treatment and control groups did not recommence driving at the same time for observation purposes. Unfortunately, most DWI rehabilitation programs save DWI offenders from license suspension rather than using the education/rehabilitation experience in conjunction with the license suspension as has been recommended in the current literature (Schmidt et al, 1963; Whitehead, 1984).

In conclusion, it seems that, before the scientific evaluations with significant rigor can be undertaken, it is necessary to create more uniform and systematic programs in re-education or rehabilitation for impaired drivers. However, given the practical realities of the genesis of DWI programs in any particular community and the agenda of the stakeholders in such programs, this may not be possible. This is not to say that the evaluation should be abandoned but that precise and conclusive outcome measures may not be realistic. However, these evaluations may serve to provide strong indications as to how to improve DWI programs. In this paper several observations have been made based on the literature that will be used as a basis of comparison for the existing Canadian programs for DWI. These observations were based on evaluations completed in the past, however, such former evaluations were done using as much scientific rigor as was deemed possible at the time of the studies. The reliability of such observations is improved when other independent evaluations have yielded similar findings. These components which the writer

feels are necessary for a successful program, may also serve to assist program developers in articulating state-of-the-art DWI programs.

CHAPTER VIII

ESSENTIAL COMPONENTS AND CRITERIA FOR AN "EFFECTIVE" DRIVING WHILE IMPAIRED PROGRAM

While evaluation of rehabilitation programs has been hindered by methodological difficulties, there are indicators that certain programs may reduce recidivism in driving while impaired offenders. Driving while impaired re-education and rehabilitation programs have had a checkered past and in fact some have been motivated by community interest and commitment rather than based on sound scientific principles. However, there is evidence that such programs can have a significant impact on knowledge, attitudes and subsequently driving behaviour for offenders who participate in these programs. The evaluations described in this paper of the various United States and Canadian-based programs have revealed that certain deficiencies, such as weaknesses and gaps in programming, staffing and referral, have created an atmosphere of instability and uncertainty. In many of the evaluations of driving while impaired programs the authors have put forward observations about problematic program components that can also serve as a guide for improving future programs. Based on these observations the following guidelines have been formulated which can be used in the review of Canadian driving while impaired programs.

It can be stated with some confidence that, for maximum effectiveness, programs for driving while impaired offenders, whether they be re-education or rehabilitation, should adhere to the guidelines describe below.

Psychosocial Assessment

Driving while impaired programs should utilize effective methods for assessing individual participants on the extent of their drinking problem, which will then form the basis for deciding which intervention will be the most beneficial, i.e., re-education, counselling, or intensive treatment. In the past, individuals arrested for DWI were often inappropriately targeted for preventive intervention. However, the high rate of diagnosed alcoholism among DWI offender group suggests a need to identify individuals at risk much earlier in the process. For example, Donovan, (1990) has in fact identified a program called "Bad Drivers" which is comprised of drivers with several non-alcohol offenses. In this group, are a significant number of individuals demonstrating early alcohol dependence. Accordingly, the assessment should begin early, possibly at or near apprehension, but certainly at the pre-sentence level, and be continued throughout the driving while impaired intervention. This would serve not only to assign to the appropriate program but would identify modifications if and when there are necessary, and may result in referral to outside agencies or a redesigning of the remainder of the program. Accurate and reliable

assessments can also prove to be a cost saving measure by avoiding the assigning of inappropriate treatment modalities to referred offenders. As an example, low risk drinkers have benefited from a relatively short assessment instrument entitled "Lifestyle Inventory Assessment". Neff and Landrum (1983), in administering pretests, included Lifestyle Inventory Assessment which showed a marked reduction in subsequent violations among low risk groups. This test looked at the extant life routines in relation to the families and personal life. The authors assert that this component, namely self reflection, is the operative factor in the DWI intervention. On the other hand, during this diagnostic phase, testing may identify individuals who manifest all signs and symptoms of alcoholism, for which most conventional DWI programs would have little effect. In fact mis-matching alcoholics with educational programs can result in counter-effective results (Horowitz et al. 1981).

Unfortunately, many DWI programs have neglected the assessment phase of the program and made general assumptions about the offender population. Mann et al (1983) determined that many DWI programs have assumed that the drinking and driving offender's problem is always an alcohol problem and have labelled or diagnosed him accordingly. This assumption has proven to be problematic as there is evidence to suggest that many first time DWI offenders do not manifest signs of alcohol dependence and instead would benefit from a driving re-education and information program instead of the

rehabilitative model so popular in DWI programming.

To properly assess the DWI offender, various assessment instruments should be utilized. However, as Vingilis (1983) points out, many of the assessment tools must be treated with some reservation. The most popular assessment tools in DWI programming are the Mortimer Filkins Test and the Michigan Alcoholism Screening Tests (M.A.S.T.). Vingilis points out that the Mortimer Filkins's validity as a test for alcohol dependency is open to question and has demonstrated that it is only of marginal utility in predicting alcohol impaired recidivism. On the other hand the M.A.S.T. was found to be a better indicator for abstinence, controlled drinking or heavy drinking outcomes following self control training in the alcohol client population. However, the M.A.S.T. also continues to have validity problems. Without looking at such other factors as BAC upon apprehension, and family and social problems in concert with the Mortimer Filkins and the M.A.S.T., there is high probability of classification errors and therefore mis-matching of client to treatment.

It must also be remembered that many DWI offenses are caused by poor drinking and/or poor driving habits. Traditionally, literature around the DWI offenses assumes that there is an alcohol problem when in fact the offender has problems in both areas. There is significant heterogeneity in the DWI population, in fact five sub-types have been

identified (Donovan 1989). In addition to an assessment instrument that involves questions of drinking behaviour, further assessment should look for other problems that may impinge on the client's lifestyle. Scoles (1980), in his review of standardized assessment approaches, reported that in most programs the assessment fails to give a comprehensive profile of the client's lifestyle and future needs and readiness to change.

With comprehensive assessment as a guide, the agency, operating the DWI program, should then develop a multi-referral capacity to deal with these lifestyle needs, be they vocational, financial, medical, marital or any other problems that may face the DWI client. Given the problems that DWI participants present at the outset of the program, the community resources available through the DWI program should be similar to those accessible to traditional in- or out-patient treatment centres.

Sustained Interagency Communication

There should be formal arrangements between the DWI program and the community referral agencies to ensure reliable feedback is obtained on the client's progress. It is not enough to merely assign a client to an outside treatment system or other professional service, e.g., marital, financial, etc., and assume that something positive has occurred. It is essential that continuity and information sharing take place throughout the

entire process. An assessment and frequent reporting from other referral agencies can help determine the future programming for individual participants, and may serve to identify mis-matching of clients through the outside agencies interpretation of the client's problems and progress.

Structure and Approach of Intervention

There is evidence to suggest that the small group session size that employs an interaction-oriented approach, is the most promising compared to programs with a combination of interaction and lecture, and programs utilizing large group size with only the lecture approach. Nichols et al (1978), suggested that small group session size was associated with the least recidivism, while the large groups size was associated with the most recidivism.

The usefulness of educational programs for drinking and driving offenders seems at present unclear. These programs appear to improve knowledge about and an attitude towards drinking and driving, but their effects on a person's alcohol consumption and drinking problems appears minimal. There is evidence, however, (Seixas and Hopson, 1974) that alcoholism treatment can affect recidivism. Again, intervention has to be matched to the offender's level of dependence. Additionally there is evidence to suggest

that combination programs of information and rehabilitation may not work with problem drinkers especially when they include driver education (Horowitz et al. 1981). Driving while impaired programs must employ rigorous review to ensure that effective programming and program components match individuals to ensure that the participants receive the most benefit from those programs.

Issues such as degree of drinking problem, ethnic, urban/rural, age and education, and as well as other factors should help in assigning driving while impaired offenders to the program that will provide relevant information and appropriate countermeasures. Programs specifically tailored to offenders would more likely positively influence their subsequent behaviour. It must be remembered that the client after intervention will be returning to certain settings that could support or obstruct his desire to reform.

The program and its presentation should be organized for an effective, 'informative and challenging presentation. Didactic and lecture formats weaken the overall impact of the program and whenever possible, should be avoided. The only legitimate place for lecture style is in the transmission of quantitative data around legislation and blood alcohol. By far the majority of the format should be aimed at drawing from the participants their comments, concerns, and feeling around the offense, their alcohol consumption and their options for the future (Berliner, 1987). The objectives of the

program should be declared at the outset. These should be clear and specific and comparable with the program resources and curriculum. Conflicting messages in the materials should be avoided and continuity among speakers should be assured.

Receptiveness to Evaluation

The program format and materials used should, wherever possible, be "evaluation friendly", so that both formative and summative evaluations can be undertaken. It may not be necessary or suitable to select traffic safety impact (driving record after treatment) as an evaluation outcome. Although positive traffic safety impact of DWI reeducation and rehabilitation programs has been reported, these are too costly to be administered as part of an individual DWI program process. Evaluation, however, should be built into the program and designed to measure knowledge and attitude change and be formative in design and aimed at improving the existing programs.

Although there is a strong temptation to look at traffic safety as an outcome measure, it requires a high level of confidence beyond most programs, and, if the outcome is inconclusive because of shoddy evaluation techniques, this information might inadvertently assist cynics and those concerned with financing DWI programs. Unless the program is well articulated and the evaluation professionally undertaken the exercise might

negatively mislead the practitioner, the courts, the community and, more importantly, the funding source. However, it may be possible to develop other observable, objective measures of outcome. This is highly desirable and ultimately essential.

Program Comprehensiveness

To qualify as a legitimate driving while impaired reeducation or rehabilitation program, it must meet certain requirements, namely: a) programs should have specific educational functions which makes it undeniably clear to participants as to the risk of driving while impaired; b) it should include examination of the participant's drinking behaviour; and c) it should prepare participants to accept whatever changes that are necessary to avoid future problems with alcohol. The latter may mean accepting forced treatment. This requirement is extremely important for it is recognized that 50% of driving while impaired offenders are problem drinkers or alcoholics, who need to deal with this drinking behaviour before addressing the issues around drinking and driving. It should be noted that in some treatment programs abstinence is considered the desirable goal. Consequently drinking and driving would technically no longer be an issue for the curriculum, when abstinence is the only goal. However, this goal needs to be objectively verified.

As pointed out earlier in this paper, driving while impaired community based programs are the single largest identifier of persons who would benefit from early intervention, and possesses the leverage to get them there. Driving while impaired programs should be geared to emphasize this fact and motivate these individuals into acceptance that treatment is required. Programs with a significant therapeutic group counselling "emphasis" would facilitate the transition for that dependent group of clients needing more extensive treatment. The effectiveness of the therapeutic model for this high risk group should be monitored in terms of referrals to treatment.

Qualification of Personnel

The qualifications of the program personnel should be clearly specified. It has been reported that a climate of caring is an important element to a program success. Personnel must be capable of empathic warmth. They must be able to see things from the perspective of the driving while impaired offender and help him to re-establish his dignity by treating him as a fellow human being worth their time and effort (Anderson et al. 1980). The allocation of personnel should be examined in terms of their ability to conduct the program effectively, understand the dynamics of alcohol dependence and their proficiency in group dynamics. Program personnel may have to possess a mix of skills in adult education, group process, and social work counselling. Family counselling may

also be an effective skill set.

The question of whether or not recovering alcoholics be used as instructors and counsellors in DWI programs continues to be an issue. There is no simple answer. The question is important given that the use of alcoholics is common occurrence in Canadian programming. Most reviewers suggest that being an alcoholic should of itself be neither a requirement nor a disqualification. All else being equal, a person having a personal experience with alcoholism can be more credible than one without it. (This question will be explored in more detail in the paper, as it will be a critical issue in terms of the message communicated to the participants.) Traditionally alcoholics recovering through the A.A. program have a very rigid philosophy of addictions and it is important that, if they are chosen to be the program instructors, their personal objectives and treatment goals be consistent with the program.

There is agreement, however, that instructors should be competent in facilitating interaction among participants, and between the instructor and participants. Any evaluation of course content must also contain a procedure for evaluating the personnel's ability to deliver, and to assess their strengths and weaknesses. This may include assessments from participants, administrators and instructor's self evaluation. When indicated, in-service training should be a fixed component of the driving while impaired

program.

Effective Tracking of Clients

The ability to monitor clients outside the program activities should be built into DWI process. Tracking of clients should begin at the outset of the program and continue through all the sub-systems, i.e., assessment, education program, treatment if indicated, and in the reporting process back to the criminal justice/probation system. It must be remembered that the re-education or rehabilitation program is just one part of a larger network which involves family enforcement officials, the judiciary, motor vehicle departments personnel and community agencies. A secondary but equally important effect of this tracking and reporting process, can be a reminder to the larger judicial system that the driving while impaired program is a serious intervention using sophisticated methods of supervision, review and follow-up. All too often once an individual is referred to a DWI program, the other components step to one side and feel that their role is completed. A cursory look at current DWI programs in Canada suggests that in some jurisdictions the programs do not receive the respect they deserve and this may be sensed by the participants (T.I.R.F. 1983). If this occurs it can seriously jeopardize the credibility and overall effectiveness of individual DWI programs.

Responsiveness to Change

The program should be structured in such a way as to make it receptive to new ideas for improvement. Sometimes a successful program over a long period gets "stale" or "runs out of gas" (Reis 1982). It loses its motivation for improvement. Some ideas recently identified might include; a) review of the spacing of the sessions that would allow more time for the participants to integrate newly established experiences and patterns of behaviour, before moving into other new challenges; b) the use of outside assignments to be completed between sessions; c) a review of community based activities of which participants may avail; d) an examination of the pressures of lifestyle images in the advertising of the beverage alcohol; e) the use of contracting with participants, similar to contracts utilized in other social work settings; and f) more innovative uses of community agencies and other resources.

Top Level Management

Finally, one of the most important elements for a successful DWI program identified by Martinson (1983) is the overall administration of DWI program. It is his feeling, based on his research of the A.S.A.P. programs in the United States, that the administration and approval mechanism should be located at the highest level of

government and should be, wherever possible, in a neutral locale. While enforcement and treatment people form the team for the delivery of the DWI program, neither camp should take overall administrative responsibility for deciding whether the DWI program should continue and in what form.

CHAPTER IX

FOCUS OF THIS STUDY AND METHOD OF INQUIRY

It has long been recognized that the better a program matches the actual characteristics of the target population, the more success it will attain (McGuire, 1982). The mismatch of a person's needs and program delivery can result in no effects or may even be counterproductive (e.g. putting a chronic alcoholic into a basic re-education program). A too narrowly conceived program will aid a sub-group of clients while failing with other sub-groups. It may be speculated that these two problems account for the reported unsatisfactory results of some DWI programming. A promising program does not assume that all clients are of the same type or have the same needs; it would provide varied paths of intervention and seek to assign clients optimally to them. Most specifically, it does not define all impaired drivers as "alcoholics", nor offer treatment suited to alcoholics to all of them. It would provide a program specifically designed for the characteristics of various sub-groups of the DWI offender. The use of a multiple intervention and comprehensive holistic approach, which seeks to meet all of each client's unique and individual needs in one comprehensive framework, appears to be the approach best suited to the complex realities of DWI behaviour (Landstreet, 1977).

Punitive and rehabilitative measures for DWI offenders are not only compatible but, when combined, may be the most effective deterrent to DWI behaviour by preventing recidivism. When treatment or education is court-mandated and imposed along with legal sanctions, it can provide both beneficial effects in itself as well as an incentive to change behaviour in the future. These less severe but more prudent penalties have a far greater likelihood of being imposed and thus be more effective in lowering recidivism among DWI offenders than the more stringent standards currently being imposed ie. long term incarceration, extended license suspensions.

The evaluations, completed to date, have been mixed. What has been learned from the many evaluations that have taken place? First, it is apparent that many programs are loosely structured and have not clearly defined their objectives and means of achieving those objectives. Secondly, assessment procedures are, in many cases unreliable and inconsistent. Thirdly, offenders may be inappropriately placed in re-education or rehabilitation sessions and little attention is paid to the degree of dependence or the dynamic of alcoholism. And finally, the duration, content and follow-up, lack the quality control to improve reliability of the program.

This lack of reliable program development, delivery and follow-up, created obvious difficulty for evaluators to determine with any certainty whether the program produces

changes to knowledge, attitudes and behaviour. Additionally many of the evaluative studies have been methodologically flawed, or have been undertaken for politically driven motives, either to justify or scuttle the program. In all the programs evaluated to date, deficiencies in the program or weaknesses in the evaluation were identified which served to throw into question, "proof" of program effectiveness.

CHAPTER X

DESIGN, METHOD AND PROCEDURES

The purpose of this study is to:

1. Describe the philosophies, policies, procedures, content and intervention processes of DWI programs in Canada, aimed at first and subsequent offenders;
2. To critically evaluate the philosophies, content, policies, procedures and processes found in the selected DWI programs - in part in relation to existing research and practice wisdom;
3. Based on these results, to propose policies and programs that increase the likelihood of comprehensive and meaningful interventions.

Translated into the terminology of social research, the **Question** for this study is:

What are the philosophies, policies and procedures, content and intervention

processes that govern the DWI programs in Canada aimed at first and/or subsequent offenders? Current program review suggests they are inadequate and there is room for improvement.

DESIGN

The design of this study is multiple method. Specifically:

1. A critical review was made of all public documents related to the philosophy, policies and procedures, content and intervention processes that govern the selected DWI programs;
2. A combination of face-to-face interviews (where economically feasible) and telephone interviews were used (to ensure representative coverage of the nation), in a semi-structured interview format, that includes many open-ended questions;
3. Follow-up with key informant interviews was employed to clarify points of discrepancy and to consult on the researcher's interpretations of the findings.

PROCEDURES

1. **A Non-Random Sample** of twenty persons employed in the intervention process in Canadian DWI programs for first or subsequent offenders were contacted by telephone between April and September 1992. In selecting key informants, the size of the program determined the number of persons invited to act as key informants. Where possible, at least two persons per program were selected. Each person contacted were informed of the purpose and procedures (See Appendix A), and be invited to participate in this national survey, as a key informant.
2. Each person who agreed to participate was sent a package which includes:
 - a. A written statement of the purpose and procedures and an informed consent release (See Appendix B);
 - b. Given that some of the respondents had to review agency materials in order to give a complete response, the package also included a copy of the semi-structured interview guide (See Appendix C);

- c. The package contained letter a request to provide written information/documentation, selected by the respondent, that addressed questions of philosophy, policy, procedures, content and processes.
3. Each person who returned a consent to participate form was to be contacted by telephone within two weeks and a time arranged for either a face-to-face interview or a telephone interview. [It should be noted that the researcher travels to many provinces to meet professionals in the addictions field and that it was possible for about one half of the interviews will be completed in person and the other half by telephone.]
4. Face-to-face or telephone interviews were conducted at the rate of three or four per week, with an approximate interview time of 45 to 60 minutes.
5. The qualitative data was be transposed to a text data base and will be analyzed for commonalities, variations, trends, weaknesses based on past studies and/or the scholarship on practice wisdom in the areas of DWI problems, needs, opportunities and programming.

6. Selected key-informants were re-contacted for purposes of clarification of information, apparent discrepancies, and feedback on the researcher's preliminary interpretations of the data.

The elements or observations listed and discussed in the previous section form the basis of the inquiry. From these essential elements, the author developed a questionnaire to be applied against existing Canadian DWI programs. Selected staff employed in the DWI program in each jurisdiction were requested to respond to a telephone questionnaire in a candid and realistic fashion. In total, 20 interviews were undertaken covering 11 DWI programs across Canada.

The next phase of the investigation was be the actual review of the material, policies, data, and legislation used in each jurisdiction. This may provide a balance to the subjectivity anticipated in the responses to the questionnaire. Finally, an analysis was undertaken of Canadian Programs to determine to what extent they have incorporated the essential elements identified in the previous section. In a sense, this review could serve as 1) an evaluability assessment that could be of benefit for the future evaluation of Canadian Programs; 2) as a constructive feedback for possible program modification in any given jurisdiction. Hopefully it will assist DWI programmers in future examinations and promote improvement where indicated.

Based on the above analysis and content a set of questions was formulated and translated into a semi-structured questionnaire with largely open-ended questions [See Appendix A.]. This is the instrument that was used to survey key informants in the six Provinces that have clear and established DWI offender intervention programs, with special reference to first or second offenders.

CHAPTER XI

RESULTS AND DISCUSSION OF SURVEY QUESTIONNAIRE

HISTORY

In the majority of jurisdictions examined, the programs commenced in the late 70s or early 80s and, in most cases (7 of 11), were established by their respective provincial addictions agency. However, it became evident that in order to sustain momentum and public support for DWI programs, other non-governmental organizations had to be engaged in a more active role. Of particular note was the role carried out by advocacy groups, including victims' groups such as "Mothers Against Drunk Drivers". Without the active involvement by government and non-governmental organizations the issue may have receded into the background of the policy agenda - only to regain its place when a local tragedy occurred that would rekindle attention. As this review will argue, there were key individuals who took a significant interest who, for a variety of reasons expressed a certain outrage and believed that DWI programs were at least a partial answer to the problem. Furthermore, they believed that programming could achieve the desired result - a positive change in recidivism or at least a change in attitude and in the use of alcohol while driving.

In all the jurisdictions, the primary reason for the establishment of a DWI program was the growing public awareness and public outrage at the DWI problem (substantiated by convincing data). It was recognized by all involved in the health and safety fields during the late seventies that the data clearly showed an alarming increase in DWI related offenses, injuries and deaths. Armed with this information, the media also played significant role in prompting civic and political leaders to take action. With the mandate from government the challenge was taken up, initially by provincial addiction agencies in particular Alberta Alcohol and Drug Addiction Commission, Alcoholism Foundation of Manitoba and Addiction Research Foundation. A number of researchers emerged as pioneers in DWI research and program development. Perhaps the most celebrated were Mann and Vingilis who stressed the need for well-controlled programs including identification, assessment, and follow-up. During the pioneer period of developing programs and innovative approaches, and up to the present time, another organization, The Traffic Injury Research Foundation contributed greatly to the increase in public awareness. They were quoted widely in the media both nationally and by local advocacy groups; this functionally kept the issue alive. The history of DWI programs owe much to these early programmers and researchers; and, not surprisingly, they are referenced by many respondents in this study.

Opposition to the Program

Respondents perceived that there was no overt opposition to the establishment of DWI policies and programs. In an apparent contradiction to public support was the perception that governments minimized the problem as represented in inadequate resource allotment. For example, respondents noted that per diem and the per course allowances were meagre and in some cases inadequate to attract the attention of professionals to deliver programs in the fashion that policy and program formulators intended. Of the exceptions, the most notable were the programs established and currently operated by Alcoholism Foundation of Manitoba and the IMPACT program in Alberta. In both cases the offender must pay fee for course participation. However, even with this sense of secure funding, respondents indicated that there were times when the programs' future was less than certain. Additionally, there were no market force attractions as there were no "fortunes" made on ventures undertaken by private consultants as business enterprises. In fact quite the opposite. An argument could be made that without the sustained enthusiasm and personal commitment demonstrated by many respondents many programs may have been abandoned many years ago.

While there was public support for both punishment and mandatory education or treatment, there were some who appeared to be more concerned with the rights of the

offender. Specifically, many respondents complained, and with cause, that in some jurisdictions, judges continue to display sentencing behaviour that strongly suggests that they do not consider the act of DWI to be of sufficient risk to justify that they "inflict" a DWI program on offenders. Some respondents believed that judges too often considered the attendance at such a program to be "cruel and unusual punishment".

There were reports of other cases where judges would use the program as an alternative to sentencing, but unfortunately for the wrong reason. They sometimes would use the program as a way to justify the avoidance of incarceration as a disposition. Additionally, respondents complained of judges in rural regions who were reluctant to take much effective action - suggesting that he/she would not want to offend friends, neighbours and acquaintances by placing them in a program that in all likelihood would take place in the local community centre or other equally conspicuous places.

SPONSORING BODY FOR THE PROGRAM

The sponsoring organization for provincial DWI programs in the majority of cases (9 of 11) have essentially remained unchanged since the inception of the policy and program. In many jurisdictions (7 of 11) the program was operated as a joint effort by the respective addiction agency and the registry of motor vehicles. The addiction agencies normally received the official mandate to develop policy related to DWI from the provincial government. In many respects these agencies were the most appropriate to perform this task as they had the staff resources and of course the addiction knowledge base to plan and implement programs.

Even when a given policy was translated into legislation, commitment to effective action varied greatly. Only two of the eleven programs reported ambitious and elaborate policy and program action that involved formative as well as summative evaluations. Perhaps the most sophisticated program was one that was sponsored by the respective addiction agency and was contracted out to a private consultant who operated on fee basis. Other addiction organizations carried out modest programs that generally targeted the first offender; these efforts reflected activities that the offender could complete with little investment of either time or effort.

As referenced earlier, the drinking and driving issue was prompted by public pressure and using DWI statistics. In some cases, the advocacy group sustained the interest and in fact went on to create and deliver the program. In two provinces the program was developed and delivered by one individual who had cultivated an expertise in the DWI area and, quite clearly had a real commitment to this problem area. For example, one program was created by a young professional who had only just completed a masters degree with a thesis in that subject area.

Three of the programs were established by non-governmental organizations whose primary interest was in the alcohol abuse and prevention field; they were able to adapt their focus and refine their programming to provide intervention in the DWI area. These organizations did not have a clear mandate or supporting legislation; each relied heavily on professional and para-professional services (e.g. addictions counsellors and parole services personnel) for various levels of support, input and referrals. They did not have a supporting infrastructure - not even their own space. Invariably they would rely on the free material from addiction agencies to augment their own offerings. These austere programs operated on a very modest budget but this limitation was more than compensated for by commitment and enthusiasm that translated into credible projects.

Respondents, in this study, indicated that the trend in recent history suggests a

significant decline in political support (defined as "political will"); media attention; organizational profile and some decline in public support - displaced by other issues such as AIDS and youth and drugs.

Sponsoring bodies, themselves suffering from grossly inadequate funding, maintained the per course support at the base year level or provided only modest increases, but continued to expect the success of the program to rest on the personal concern and resourcefulness of the program providers (the continuation of the "more with less" mythology that governments have promoted since about 1989).

Responses to the study question on the original budgets were somewhat vague, in part because of the respondents unfamiliarity with that aspect of the history but also probably because of a traditional sense of secrecy with respect to financial matters. Respondents were reluctant to disclose exact figures and instead gave reference to the fact that costs were contained in the overall budget of the agencies. Accordingly the responses were of little value in developing a baseline from which to assess current support within the context of earlier levels of support. Some of the smaller NGOs, were quite candid about their situations - perceived as surviving from DWI course to course, based on direct income on a per course basis - with no sustaining support. Most programs, governmental or non-governmental implied or by direct reference, gave the message that current levels

of support are non-sustaining at best and threatening at worst.

More specifically, in one case, the provider was allotted \$5000 per course which on average were of three month duration - with a schedule of two nights a week. Another was provided \$15,000 for an eight week, twice a week program, but in both cases the entire costs were contained in this amount. That is there were no sustaining funds. As one respondent reported, there was a general unwillingness to financially support the rhetoric, while another referred to the budget as 'fragile'. This situation is in sharp contrast to the situation of one program sponsored by an addiction agency which employed nearly twenty staff and charges over \$200 per person, per course. It is obvious that some programs, a minority, benefit from a sense of security that permits them to get on with their work rather than channelling excessive energy into survival. The one program which was contracted out to a private consultant provided no financial analysis or information.

Given the responses to historical items, this authors concludes:

1. After an initial commitment by governments and NGO's, based on public support and political will to deal with a problems of major social impact, there was a general decline in functional support while the rhetoric of political support was maintained. The general downward trend was

mediated briefly by the Federal announcement in 1987 to reduce impaired driving through the "National Impaired Driving" strategy.

2. After an initial commitment or sharing of resources, that current financial or in-kind support for DWI programs put some in the category of "threatened species" and others in the category of being marginalized.
3. That sponsorship still reflects an agenda of secondary prevention, early brief intervention and mild levels of punishment.

With respect to the importance of public perception and media mania in promoting social responsibility in needed areas, one respondent cynically and cryptically stated: "the DWI field needs a (boys name)" in reference to a tragic drug related drowning in Toronto which sparked public outrage that prompted significant funding in Ontario to address the drug problem.

CHANGES AND CURRENT PROGRAMMING

In all cases the earlier programs have undergone changes, however in the majority of cases the modifications have been minor in the overall program design, duration and

educational philosophy. The changes were in many instances additions to course content or changes to audio-visual materials, or small changes to duration - often economically driven.

There was however two programs that underwent significant alterations. At the beginning, the initial efforts resulted in a didactic educational course consisting of four consecutive weekly sessions which were subsequently changed to one day formats. In both cases after almost a decade of operation, it became apparent that the number of repeat offenders were unacceptably high. Their data indicated that over one third of the course participants reported previous impaired driving convictions. The implications were that the previous course that they attended was not deriving the desired results for some offenders and an additional course was required. The concept of a repeat impaired drivers program was introduced in 1984 in two jurisdictions. The decision in both provinces were guided by the following assumptions and analysis:

A one day educational course is insufficient as a rehabilitative measure for repeat offenders. A substantial proportion of these individuals experience alcohol and drug use problems at such a level that more intensive intervention is required if an impact is to be likely.

Recidivist impaired drivers are not a homogeneous group and no single approach is viable. As a result, in one province a entirely new program was born where the other the existing program was augmented by a second stream which involved a more intensive intervention some of which went beyond psychosocial education to be mildly therapeutically oriented.

An optimal program must be designed to permit the impaired driver to explore personal issues from an individualistic perspective. Personal self awareness and insight serve to break down resistance and to influence motivation to make lifestyle changes, and if necessary seek treatment (Klap and Whitehead 1988). To those who had significant experience in the field it became apparent that brief assessment interviews were not likely to induce insight or motivation.

As supported by clinical research in addictions, early intervention, before an offender has lost social supports, is associated with successful outcomes. The early brief intervention model of treatment is seen as being a minimum in terms of what is needed (Vingilis, 1983).

It is difficult to determine whether there was consultation between the two jurisdictions because both created a new approach and philosophy at approximately the

same time. What seems to have been recognized was that a superficial approach that relied only on psychoeducation was inadequate to have an impact on those offenders that demonstrate alcohol dependence. In one of those jurisdictions they created an innovative approach which was neither an educational nor a therapy program. The goals of the program focused on enabling the offender to arrive at an assessment and sufficient insight with respect to alcohol involvement to either change or to use the program as a step toward engagement in treatment. Differential assessment and active participant involvement were the cornerstones of the program. This philosophy was reflected the goals, which may be reduced to the following essential elements:

to establish conditions that lead participants to look at the consequences of their mood alternating drug use;

to differentially assess participants' level and pattern of drug use and the extent of the effects of that use in major life areas;

to identify the future needs of the participants and to formulate appropriate plans for change and maintenance thereof;

to establish conditions that lead participants to accept responsibility for their

offenses, their actions and commitment to these plans;

within the "treatment sample" to reduce the incidence of alcohol related problems, particularly DWI.

The approach is very different from a specific DWI "educational" bias and looks at the whole person in relation to their alcohol and drug intake. Other programs continued in a psychoeducational mode with many being envious of the resources that others had that would enable a richer and more effective program that transcended the superficial. It must be recognized though that in some of the fledging programs, even with programmatic deficiencies, their limitations appear to have been overcome by the personal nature of the delivery and the missionary enthusiasm with which their work accomplished. In some cases the impact may be considered to be "therapeutic". It would be an interesting exercise to complete a comparative evaluation of the therapeutic value of "missionary zeal" in comparison with the therapeutic value of more formal early brief intervention.

The method by which the offender is referred to a DWI program often reflects the level of commitment given by the authorities towards the successful delivery of the program. More importantly it sends a signal to the program and policy designers and deliverers that this is a program worthy of attention and detail. Therefore referral is

regarded as an important functional as well as symbolic step in the overall program.

As the majority of programs address the second or subsequent offender, both the courts and probation or parole play a role in the referral process. An important dynamic in the referral process is the degree to which legislation guides the referral process. For example, 4 of the 11 programs have provincial highway regulations which recognize the respective DWI program. In another jurisdiction, a section of the Criminal Code is invoked (section 238(b)) which allows the provincial court to refer offenders to 'restorative treatment'. Finally there are two jurisdictions which treat the program as a voluntary option.

For administrators of a DWI program, the mandatory route of referral appears to be the preferred choice. On the one hand, it legitimizes the program in terms of the courts' obligation to take the program seriously. On the other hand, it allows for an administrative process that is facilitated by the court record system. Finally it has a "constructive coercion" element in that the offender must complete the course as determined by the course instructors, or face further involvement with the court system. This would be either with the probation agency or the judge who originally sentenced the offender.

Two exceptions are worthy of mention in the review of DWI programs. Specifically, the referral by the Registrar of Motor Vehicles and the referral by addictions agencies. As referenced in the history section, the Registrar has, in most jurisdictions, "sentencing power" greater than the judiciary in that he/she can withhold licence re-instatement until intervention measures are taken. Therefore, with the support of the Registrar, even a smaller program can assume some legitimacy in the eyes of the offender and can maintain a strategic relationship with at least one level of authority. In discussions with respondents, this connection was viewed as very important especially in light of the mixed reaction from the courts and exceptionally limited budgets.

The completion of the course in the majority of programs (7 of 11), however, was not determined by the courts to be a requirement for licence re-instatement. In all those cases, the Registrar was not consulted or involved, and licence re-instatement occurred upon completion of a probation period whether or not the course was successfully completed. Given that it is known that, typically, licence re-instatement is considered to be very important to offenders, it seems regrettable that this factor could not be utilized more creatively or strategically. It could serve as an incentive to complete the program and not require any additional cost on behalf of the funding body. One might suspect that this is one more indicator of the reluctance of judges to be 'overly' oppressive in their sentencing practices. Of the seven programs that do not have course completion as a

requirement for licence re-instatement, six of them were those where the respondents reported a reluctance by judges to refer offenders to the program or use it in lieu of incarceration.

There were two instances where the addictions agencies were the chief referral agent and in both cases the program was underfunded and had not received the full support of the courts. The addiction agency filled a very supportive role in that it nurtured the program, encouraged its development, and could be relied on for continuous intake. On the other hand addiction agencies could receive referrals when addiction problems were identified. This relationship was very evident in one particular province where there was not one specific program but rather a variety of small and apparently uncoordinated efforts. Connection with the provincial addiction agency served as a stabilizing factor in that it provided some continuity of approach, and some preliminary assessment and profile on offenders. The macro programs in other jurisdictions had the capacity to ensure this consistency among their many regional efforts.

The respondents were also asked questions about course accessibility and, as expected, the answers varied greatly. The responses ranged from one site only to a comprehensive network covering the respective province. However with the one site programs there was no intent to be able to provide program to anyone other than the

offenders in the immediate area. The program was not court directed or mandatory and the instructors were understanding of legitimate absences. On the other hand, the province wide programs were less able to accommodate the unique problems and needs of individual participants. Respondents in those jurisdictions viewed part of the program organization as being geographically rationalized. In these attendance was mandatory with limited excuses permitted. Based on the espoused program theory, based on the personal and resource investment in the model, there appeared to be little tolerance for individual differences and needs. As well the programs decision rules appeared to emphasize the punitive-rehabilitation dimension rather than the educational-rehabilitative dimension.

In seven of eleven jurisdictions, the program is recognized in provincial legislation. However, the strength of the regulation varies significantly in its weight and usefulness to program effectiveness. In four of the seven jurisdictions, the term 'may' is utilized making the program optional. In these discretionary jurisdictions, attendance rules were matters for the court or probation to prescribe to each offender. Not surprisingly, these are the same jurisdictions where the programs were poorly funded, and received mixed support from the judicial system. Within the context of lack of support and lack of the leverage of constructive coercion, the success of these programs was seen as being dependent upon the degree of industry and enthusiasm of the instructors.

In a jurisdiction where a macro program was offered, one of the options was participation in a condensed version of the larger program. This option was offered only to those offenders who were originally sentenced to a jail term and was offered in lieu of sentence. As the respondent reported, "this option was prompted by jail overcrowding", not by practice wisdom related to psychosocial education or rehabilitation. The option was not offered to those who lived long distances away and were prepared to overnight in the location of the mini-program. It may be the case that people who elected this option were highly motivated and could still benefit from a reduced program. Without some outcome analysis or evaluation, one must conclude that the policy was clearly not related to program effectiveness but was driven by institutional expediency.

Given the reality of denial or low awareness present in alcohol and drug dependency, and given presence of stigma attached to the involvement with the law, it is doubtful that the offender would comply without this constructive coercion. It appears from the literature and consistent in the interviews that the legal overlay in DWI programming is in fact a necessary component to successful referral and completion of the DWI course. This mandatory "lever" can take many forms from the restorative treatment as described in the Criminal Code or through the use of the power rested with the registrar of motor vehicles.

ASSESSMENT

In terms of the need for assessment as identified in the essential components for an effective DWI intervention, the review of programs that were operational in 1990-91, indicated a serious lack of well-defined, reliable and consistent assessment components. At the time of this survey, six of the eleven programs did not administer assessment instruments or to complete a detailed clinical assessment at sentencing or at any of the other milestones facing the offender before entering the program. The addiction literature is very consistent in recommending that assessment be completed early. Baseline assessments should be completed at or near apprehension, and at the very least at the presentence level. Of the many reasons reported, obtaining a baseline measure of substance use involvement and matching the program to the offender, were defined as of prime importance.

Of the 11 programs reviewed, five may be considered to demonstrate a level of sophistication in terms of assessment - specifically, the deliberate use of recognized assessment tools to support decisions with respect to disposition and/or the type and intensity of course required for that offender. Other respondents (6 of 11) described any assessment process as "informal" with the use of assessment tools not being consistent. When one considers that many programs accepted both first and second offenders, and also did not utilize assessment instruments on a regular basis, the likelihood of planned goal

attainment or any measurable change was unlikely.

Of the programs with a routine assessment process prior to the offender commencing the course, recognized testing instruments were employed. In four of the five, the Mortimer-Filkner was included among the battery of tests. Even in jurisdictions where assessments were sporadic, the Mortimer-Filkner was an accepted and valued instrument. Another credible assessment that was reported in some programs was the M.A.S.T. (The Michigan Alcohol Screening Test) (Wendling and Kolody, 1982); it was utilized in three of the programs where testing was consistently used and was also identified in three others where assessment was irregular.

Given the lack of predictable use of assessment tools during the initial phase of apprehension and processing, erroneous assumptions could have been made about the offender population. In fact, Mann et al (1983) determined that many DWI offender programs have assumed that the drinking and driving problem is always associated with an alcohol problem. This is not the case and erroneous assessments have resulted in offenders being compelled to undergo rehabilitation when simple short term and less costly education is sufficient - e.g. the interaction between one drink and diabetic medication. While the two macro programs did, for the most part, recognize the importance of assessment and by doing so matched the offender to an appropriate level of intervention,

there was a tendency to err on the side of the treatment stream - that is the most invasive alternative. In one case, this commitment to the most invasive action was due, in part, to the sponsoring body's AA history and related philosophy. As for the remainder of the programs reviewed, the value of an effective assessment was recognized, but due to time constraints and budgetary limitations effective assessments were often bypassed. Some respondents believed that the assessment of the offender's problem and subsequent needs would be "picked up" (informally) by the instructor or counsellor, during the actual sessions. All respondents recognized the need for the comprehensive assessment which would identify problems other than DWI that could impact negatively on the client's lifestyle.

Notwithstanding the above, either formal or informal assessments may not be of sufficient depth and complexity to give clear direction to an individualized plan for education or counselling. In this regard, Scoles (1980) reported that in most programs the assessment failed to give a comprehensive profile of the client's lifestyle and future needs.

Of particular note is the use of an assessment called SALCE (the Substance Abuse/Life Circumstance Evaluation) (AFM,1990). It is a printed, substance abuse assessment based upon computer analysis of respondent answers to a 94 item, self-administered questionnaire. The SALCE questionnaire takes approximately 20 minutes

to complete. It approaches assessment by examining a broad range of behaviour and attempts to replicate a personal interview process. It has a somewhat unique feature in that it focuses on, and examines patterns of respondents' answers rather than relying primarily upon answers to individual questions as a means of formulating the evaluation.

The SALCE includes the following:

1. attitude towards test taking
2. life circumstances evaluation
3. drinking evaluation category
4. alcohol addiction evaluation
5. recommended interventions
6. important symptoms
7. BAC and driving record.

The respondents from this program felt strongly that the SALCE was able to measure several areas of life circumstance and stressed the accuracy of the alcohol abuse assessment. The respondent from the agency which uses this instrument remarked on the short period of time required to administer it and the high level of confidence given to the findings making it cost beneficial and also very useful during the actual treatment phase.

However psychometric properties such as reliability/validity were not discussed. When one considers that the offender must pay in excess of \$200 for this assessment, the popularity of this instrument among addiction agencies becomes all the more understandable. Given the fact that the setting, the professional credentials, and the instruments used, were strategically planned in only two of the programs with any level of consistency would obviously result in a high probability of mis-matching in many programs reviewed. The cost, the staffing, the course duration are but a few of the practical implications that are affected by this deficiency in programming. And at the outcome side of programming, the potential mis-matching due to inaccurate assessments would probably result in an ineffective intervention and an offender who could when the occasion presented itself repeat a DWI offence.

To summarize the range of assessment procedures used in the eleven programs examined, a brief synopsis is provided:

- Program 1 Clinical assessment
 - Mortimer-Filkner
 - Co-lateral interview (spouse)
 - Overall lifestyle assessment (no elaboration given)

- Program 2 "Personality Thumbnail Sketch"
Self administration assessment
- Program 3 Assessment modelled after #2 as program was offered in the same province and a close relationship existed between the two programs
- Program 4 A Sixteen item knowledge test developed by Malfetti in Phoenix in 1977
Michigan Alcohol Screening Test (MAST)
- Program 5 Informal assessment (not described) at outset of program. Assessment is not considered essential as offenders are second and subsequent and are all considered high risk and alcohol dependant.
- Program 6 No assessment is completed as all participants are incarcerated and are second and subsequent offenders. The classification officer at the jail may provide some background to the course instructor on any particular offender for guidance purposes.
- Program 7 No recognized assessment instruments are utilized however if

dependence is obvious at the outset, the offender is referred to the addiction agency where assessment is done for treatment purposes. For those offenders in whom dependency is not obvious, the course coordinator administers an untitled assessment which is described by the respondent as 'cognitive approach, intense in nature'.

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- Program 8 First time offender program. Short duration and no assessment is taken.
- Program 9 SALCE, a computer administered program (see description above) BAC at time of arrest is considered. Life circumstances and client perception are recorded and incorporated into the overall assessment.
- Program 10 The Mortimer-Filkner and a comprehensive screening is completed at a cost to the offender of \$240. This assessment is used throughout the intervention phase.
- Program 11 No assessment is done prior to the offender entering the program that the respondent considered to be a 'preliminary' screening as

such. Rather, the respondents considered the entire program to be the assessment. During the program, group disclosures, clinical impressions and the Alcohol Dependency Scale (ADS) serve as assessment tools.

TIME, SETTING AND QUALIFICATIONS OF ASSESSOR

In response to the questions relating to the time at which the assessment was completed, there were once again varied responses. In no instance was the assessment administered following the arrest and no clinical observations were possible except for the BAC reading in jurisdictions where BAC data was released to the DWI program. In all cases the assessment was completed after sentencing. In many instances, this was several months later due to court waiting lists or at times strategic planning by the offender's lawyer. This delay is unfortunate for, as the literature suggests, the preferred choice was early assessment ideally shortly after apprehension to capture the early signs of dependency and to establish a more reliable baseline assessment.

In terms of the setting, care was taken by some programs to create a favourable atmosphere in which to carry out the assessment procedure. In three instances, an office was used that, in the opinion of the respondents, created a climate for discussion and

exploring of issues. In these cases the setting was described as similar to that used in a social work or similar clinical setting (ie. a comfortable chair and no noise that might disrupt). However in the great majority of assessment situations (8 of 11) the setting was typically whatever was available at the time. Probation offices and waiting areas, and classrooms were the most often reported with no apparent regard for an atmosphere conducive to a valid or reliable assessment. The impression was that the assessment was completed when the opportunity arose in a setting that was available at that time. The larger programs appeared to have a more standardized format where a deliberate procedure was put in place with a designated setting and a scheduled time period.

In the literature, the qualifications of assessors has been considered to be a significant variable with respect to depth, complexity and reliable or valid interpretation of results of psychosocial assessments. The respondents in this survey indicated varied levels of expertise or lack thereof in the person who completed the assessment. In the macro programs, a team of professionals was identified to conduct assessments as its primary function. Such a function was part of the larger plan in an organization that had the time and resources to undertake a variety of services. On the other extreme, in the fledgling programs, which in many cases, were one person operations, the sole employee performed the role of assessor, clinician, administrator, educator, and evaluator - three of eleven programs used staff without benefit of any professional preparation.

Of the larger programs (2), the assessors can be divided into two categories. In one program, all assessors had post secondary degrees. Their backgrounds encompassed areas such as social work, psychology, educational psychology, addictions counselling, and nursing. However in the other programs, academic credentials were lower. In this case the sponsoring body has a strong Alcoholic Anonymous history. There was less importance placed on post secondary degrees and rather a ready acceptance of a recovered alcoholic as assessor and instructor. In most cases the assessors had 300 hours of on-site training at the provincial treatment centre where the disease model (AA) is used as the basis for rehabilitation.

Of the remaining programs, there were wide variations even within the same program. Qualifications ranged from high school education to a Masters in Social Work. The respondent in one program would only refer to 'trained administrators' as the description of their assessors. In another program, a one person operation, the assessor had baccalaureate degree religious studies and was completing a professional masters degree. And finally there was one operation which was administered by an individual who had a background in a health discipline.

The qualifications of personnel, whether they deliver the program or administer the

assessment, is an important factor in the quality of the program. It was the evaluation of two respondents that in their experience a recovering alcoholic administering the assessment is likely to determine that the person is in need of a more intense level of intervention than if the assessment was delivered by a helping "professional" with the objectivity that academic training would bring. On the other hand, the two programs that had strong AA philosophical underpinnings maintained that the recovering alcoholic is best suited to administer the assessment because of his capacity to identify and confront the subtleties of denial that are present in individuals with developing alcohol dependence. Of course, this battle between the professional and the recovered alcoholic is not confined to DWI programming but is evident throughout the addiction treatment community and in all likelihood will continue as long as the 'disease model' vs 'controlled drinking' debate is sustained.

As with the other elements of DWI programming, the issue of qualifications revealed no consistent trend. Qualifications varied widely and there was a relationship with economic factors and availability of personnel. In the fledgling programs, the deliverer also had the responsibility for assessment and became proficient in applying a limited and non-comprehensive approach to assessment. Given this reality, and the absence of formative evaluation during the assessment phase, there is no way of knowing whether the offenders were appropriately matched to program and, therefore, given an

intervention that would result in lasting behaviour or attitude change which would include a reduction or elimination of drinking and driving. The skills required for assessment may have been developed in these individuals and the selection of certain assessment tools may have been appropriate, but unfortunately little direction can be given in terms of standards of practice as the practices are varied and unproven. Even if the assessments are not as effective as they might be, it is possible that the supportive milieu created by some of the program personnel may be sufficient to engage offenders in some type of helpful process.

THE PROGRAM

In analysing categories of programs, it was found that some programs were exclusive in the type of offender that they accepted: first offender programs (2); those targeted for second and subsequent offenders only (6); and programs that accepted both levels of offenders (3). While the respondents described their programs as indicated in the above breakdown, the demarcation requires some clarification and discussion. For example, the programs reported as second and subsequent offender programs had, in some instances, been further sub-divided depending on the extent of alcohol dependence. One program which was designed for the second offender, had three classifications, (a) assessment only, (b) traditional awareness group, and (c) ongoing counselling. In still another, the program was divided into two categories: for some offenders (not necessarily

first offenders) a one day educational workshop was offered and, for those who were displaying dependency (high risk), six, two hour sessions were offered with a continuing one on one counselling phase when no change was apparent after the sessions.

There were some programs that were specifically targeted for first or second offenders and the sessions were designed with the unique offender needs in mind. For example, in a macro program the audience was second time offenders with the same program being delivered to all. A weekend experience of 20 hours duration was offered in an in-residence setting. The program consisted of an individual interview, an AA presentation, questionnaires, films, lectures and small group experiences. The respondent reported that this format allowed participants to explore their life situations and identify new ways to cope.

In contrast, in programs that were less structured and accepted a more diverse and less homogeneous group, the flexibility and willingness to modify according to the participant's immediate needs. This flexible approach is more consistent with adult learning theory and clinical practice with respect to the relative likelihood of changing knowledge, attitudes, feelings or behaviour patterns of the offenders.

With respect to program duration, the programs in all categories varied widely.

In first offender programs (2), there was a 2.5 hour program and an eight week, two hour per session program. There was no way of knowing whether the short program was too short or whether the second was clearly excessive. It is interesting to note that in one program identified in the research (Neff and Landrum, 1983), it was shown that the administration of a particular assessment tool (ie. Lifestyle Inventory Assessment - LIA) proved to be a major variable accounting for much of the program's success. That assessment tool took 35 minutes to administer and was the operative factor with first time offenders. Therefore early brief intervention might work with this population. Given the lack of empirical support for long and short programs, about the most that one could suggest is a series of demonstration studies that examine knowledge, attitude and behaviour change under conditions of assessment, psychosocial education, and/or counselling - controlling for the first or repeat offender dynamic.

The second offender programs also varied in duration from six, seven, and eight week programs consisting of one night sessions per week to two weekend programs of 20 and 25 hours duration respectively. The programs that were described as accepting both first and second offender populations ('hybrid') were typically six week programs consisting of one session per week of two to three hours.

While program length in itself is not an indicator of the quality of the program, a

series of six weekly sessions of two hour duration or a concentrated weekend experience appears to be sufficient to communicate the necessary information and create the positive atmosphere for change. Accordingly, the majority of programs meet this criteria. The programs that were of the 2-3 hour length used essentially an educational approach and if the offender group was low risk in terms of alcohol involvement, there would have been sufficient opportunity to communicate fundamental information on alcohol and driving. Any attempt to create a therapeutic milieu in that time period would be a fruitless exercise.

The respondents were also asked about the size of the group sessions. In the literature it has been clearly demonstrated that the size of groups, whether they are educational or rehabilitative, is extremely important to the overall success of the process. Some interesting responses were received. The majority reported that the average number of participants was between 10-15 and in two instances 15-20. In terms of manageability the numbers appear within the desired range for psychosocial education but are beyond the normally acceptable range for effective group therapy. In one of those examples two staff formed a team teaching approach and were both present in the session at all times.

In two programs the number of participants per course appeared undesirable, ranging from 30-50 participants. With these numbers, it would be very difficult to effectively transmit sensitive and sometimes subtle messages to specific individuals, or to

create an atmosphere that would allow for the effective monitoring of individual offender progress. Most educators and therapists would argue that it would be problematic to deliver even basic information on DWI issues and expect anything beyond superficial knowledge change in such a setting. The opportunity to surface and share life experiences and personal life circumstances in other than incomplete and superficial ways is unlikely in this context. To further exacerbate the large intake of offenders to each course, the setting was also problematic. The sessions took place in standard classroom settings with the traditional rows of desks, an arrangement that has long been proven to be unsatisfactory as a learning environment, especially with adult learners. Under such circumstances the creation of a therapeutic atmosphere is highly unlikely.

The remaining programs appeared to have recognized the importance of setting and the benefits to be gained. Typically, the respondents described the setting as a room which lent itself to a warm atmosphere. The room was small and the seating was in a semi-circle where eye contact was possible among participants and rapport was facilitated. In other programs, a round table was utilized which achieved the same effect. And, in at least one program, the format was varied: a classroom for the educational/informational sessions and a round table for the in-depth intervention. Finally there were programs (2) where the setting would depend on availability of space in the addiction agency. In these situations, the size of the group and the quality of space were factors that were of constant

concern. Once again the programs in question were the fledgling operations.

In terms of the intervention approach used, the respondents reported that both didactic and experiential styles to psychosocial education, or counselling experiences, effected a change in knowledge, attitudes, self-awareness, depending on the aspect of the program being utilized. It should be noted that a major concern expressed by researchers in this field is that there is an arbitrary use of approaches without due regard for the type of offender group. The general consensus is that the didactic/lecture style weakens the impact on knowledge, attitude change or self-awareness and should be avoided. Research suggests that the only legitimate place for this approach is in the transmission of specific finite information such as legal information and Blood Alcohol Concentration facts. It is generally accepted that the most effective processes are aimed at drawing out the opinions and beliefs of the participants and using this "here-and-now" information as the basis for change and for insight by group members. The lecture approach is unlikely to do this.

In the review of the responses there was evidence that there was inappropriate matching of approach to offender group. In four programs where the group were second and subsequent offenders the intervention was heavily weighted in the lecture style. Given that the research strongly indicates that the second offender is developing alcohol dependence, a deeper, and more dynamic approach is required. In three of these

programs, little or no assessments of offenders were utilized which further indicates the importance of a program decision rule that supports the rehabilitative process. In other words one would be wise to err on the side of rehabilitative measures. This would stress client participation. In one of these programs the format and approach was clearly informational and there was much reliance on the use of audio-visual material. The program also depended on some didactic lectures supplemented by printed handouts and films. In that particular example, of the six nights, three were taken up with films. This is not to suggest that the films chosen were not appropriate or effective but the dependence on such aids reduces the probability that a therapeutic or otherwise rehabilitative attitude will be created. The aids can be used to prompt discussion but, especially with repeat offenders, must be considered as an aid and not as the main activity of the program.

The remainder of the programs appear to have recognized the importance of matching intervention approach to offender type - where the second offender group has participation as dominant and lecture or aid materials as secondary. For the first offender groups (2) there was a greater emphasis on an informational model where there appears to less need for depth in the exploration of values and attitudes. It could be argued though with respect to the latter that early-brief intervention theory applies to the extent that EBI interventions may be delivered by suitably-trained personnel.

USE OF AUDIO-VISUAL MATERIAL.

Eight of the eleven programs utilized audio-visual aids and in several jurisdictions, the titles of films, tapes and brochures were similar. Of particular note were the films "Make Sure It Isn't You", and "The Party's Over". These films were used in three programs. Other films included "Missing You" and "Just Another Friday Night". The theme of all of these films is exclusively driving while impaired without an emphasis on alcohol dependence. These films were used in the educational models as well as the rehabilitative programs, however the rehabilitation model also included audio-visuals which were clearly related to dependency. One example is the film, "I'll Quit Tomorrow" - a three-part presentation which demonstrates the progressive nature of alcoholism and is intended to elicit discussion on dependency. In one program, the instructor found some value in using a well known motion picture "Days Of Wine And Roses" which depicts individuals moving in and out of alcohol dependence. The instructor was of the opinion that, although the movie is now dated, it remains one of the best dramatizations on the subject. She went on to say that given the resistant attitude of many offenders, this film maintains their attention and therefore increases the possibility of communicating important messages on alcohol dependency.

Of the programs that did not utilize audio-visual materials, only one offered an

explanation. The respondent reported that the program was designed in such a way that the use of such material would distract from the interactive climate created by the program and therefore any value generated by audio-visuals would be counter productive in that setting.

DIFFERENTIATION OF REHABILITATION AND EDUCATIONAL MODELS

When asked to discuss the rationale for adopting a rehabilitative or an educational model, in most instances the respondents were cognisant of the importance of matching of offender to program as argued in the literature. However, as further information was volunteered, it was clear that some of the programs had not translated their espoused theory into consistent action. For example, in two of the first offender programs there was a distinct emphasis on a rehabilitative approach - the default position assuming alcohol dependence until otherwise proven. These same two programs used audio-visual messages that clearly communicated the disease model of alcoholism. While not suggesting that the offender group would not benefit from this type of messaging, the fact remains that this was not the original purpose of the course for first offenders. The original intent was to communicate information about DWI in a relatively short period of time. Instead the program undertook a far more challenging task of introducing alcohol dependence material to first offender programming.

The other possible inconsistency occurred in a program that was designed for the second and subsequent offender. The program consisted of a variety of components that were aimed at providing information about DWI and suggested that a behaviour change was expected - separating the drinking behaviour from driving. This strategy, however, runs contrary to the second part of the program which clearly communicates information based on the AA model of alcohol dependence. The message in that philosophy is that when alcohol interferes with an important life experience or when alcohol creates conflict (legal or otherwise) then a dependency is forming. Dependency in the AA framework is a very structured and well defined concept and therefore the 'treatment' is a commitment to abstinence. The agency which operated the program was grounded in the AA philosophy and would not deviate from the intervention that they deemed necessary. A corrective measure for this inconsistency would be to commence with the dependency model (AA) and guide the offender through that process. For if the offender is developing a dependency (and the literature supports this position) then denial is one of its manifestations, and the very reference to a possibility of returning to 'controlled' drinking presents the opportunity for manipulation. It is believed the alcoholic in denial would welcome any reference to the possibility of returning to any form of drinking. The latter is a problem only if the offender is problematically dependent.

Conversely, another major program which specialized in second and subsequent

offenders has taken a 'middle of the road' approach to alcohol dependence and was clearly not from the AA school of alcohol dependence. The approach was intended to enhance the offender's understanding of his/her alcohol use and the emphasis was on creating conditions through which participants could learn about themselves. The belief system of the course developers was that increased self awareness and insight serve to break down resistance and influence motivation to make lifestyle changes. The most telling evidence of their open approach was the reference in their manual 'Most repeat impaired drivers experience alcohol problems and therefore behavioral change is required (be it reduced consumption or abstinence)'. In this program the process is paramount and the insight that may evolve from the intervention will depend on the offender's insight into his alcohol use. This program was based on the premise that recidivist impaired drivers are not a homogenous group but have a continuum of problem (impairment to dependence) and needs (information and attitude change to self-awareness and behavioral pattern modification). The program is structured to accommodate abstinence as well as controlled drinking goals.

Notwithstanding the above, there also appears to be a pragmatic reason for respecting the AA philosophy which is described in the policy manual. It states that good relations with AA serve to enhance the program's reputation in the community.

The philosophical underpinnings and program approaches used in the remaining programs were not well defined nor are they as revealing in their strength of position. They used a combination of approaches and program material that were in part, determined by the availability of resource material and guest lecturers. It must be remembered that these small courses did not have the benefit of careful planning and development and in many cases did not question the possible contradiction in messages. Perhaps in retrospect, they were attempting to create a "broad brush" approach in the hopes of bringing each offender to a certain level of understanding of his/her respective problems. In three of the smaller programs, the respondents reported that the program would change 'midway' as the offender population was better understood in terms of the level of alcohol dependence. In one case the decision to bring in an AA speaker would depend largely on the number of offenders exhibiting significant levels of alcohol abuse.

The importance of matching the offender to the appropriate model is well supported in the literature. However, the approaches taken reveal some inconsistencies. When asked for which group the program was designed, it was reported that two specialized in first offenders, six in second offenders, and three accommodated both groups. But when asked to categorize the program as educational or rehabilitative, the responses indicated some inconsistencies. Five programs were described as educational, three were described as rehabilitative, and three were regarded as hybrids. Based on these category

determinations, some second offenders were receiving solely an educational model and were unlikely to benefit from this type of programming.

RECORDS AND INFORMATIONAL DATA

In the majority of jurisdictions reviewed (8 of 11), no records were kept in a systematic fashion. Some, in fact, had no records on which to assess whether or not there was any marked change in the problem and whether the program had been the agent for change. Five jurisdictions maintained arrest records but given that the catchment areas varied widely in size, demographics and density, no conclusions could be drawn on the seriousness of the problem in one area as compared with another. For those who did report, the frequency ranged from 800 per year to 4,500 per year - all of these being second and subsequent offenders.

Given that statistical records were not kept, there exist real problems in judging the effects of the DWI program. Any evaluation attempts would be frustrated by the lack of consistent data that could be used for comparison across jurisdictions or in a control/experimental study. This fact will be discussed in the evaluation section of the study. It does however indicate the lack of importance placed on record keeping by police and court systems and the apparent absence of collaborative effort between the programs

and such officials. Given that it is not probable that a combination of information and analysis resources are likely to converge, there is a functional inability to assess impact. One might wonder whether governments are, in fact, genuinely interested in quality of program relative to the amount being spent.

In terms of sentencing trends the majority of respondents (8 of 11) observed that sentences were becoming more severe and the personal opinions of respondents were that the courts were taking the problem seriously. It should be noted that the opinions were given in the absence of supporting empirical data. The opinions expressed made reference to improved police reporting and a general willingness to appreciate the importance of proper record keeping that could result in an offender participating in a DWI program. Of the remaining three respondents, two expressed marked cynicism about the sentencing practices and generally felt that the courts continued to show a lack of real concern. They believed that some judges especially in the rural areas were sensitive to 'offending' the sensibilities of the citizens.

One respondent provided data on sentencing that serves to show how offenders are manipulating the judicial system in order to minimize the suspension time, and by doing so create a data trend that would suggest that the DWI problem was declining. The respondent was referring to an increase in plea bargaining from impaired driving to the

lesser charge of 'dangerous driving'. This seemed to become more common after suspension times for DWI were increased. An analysis of data before and after the suspension increase showed a 9% reduction in first time DWI offenses, a 19% reduction in second time DWI offenses and a 13% reduction in third time DWI offenses. At the same time there was a 42% increase in dangerous driving. Thus, while it would appear that DWI is on the decline, in reality the magnitude of the problem remains the same.

For the eight programs that one might consider small and under resourced, the respondents were not that knowledgeable about the police and courts' ability and capacity to maintain data and statistics that could prove useful in program improvement and effectiveness. Their concern was confined to the data that would insure adequate class sizes. This is not meant as a criticism of the respondents but is intended to demonstrate that given the limited time and resources this is in fact the amount of attention that they can afford to this subject. The majority recognized the importance of record keeping and data analysis of arrest trends, and saw the evaluation potential of such data gathering. Regretfully, a reliable data bank was not kept and has hindered the evaluation of DWI programming.

In terms of community understanding of the DWI problem, the responses were highly consistent and encouraging. All respondents concluded that the general public was

becoming less tolerant of drinking and driving and felt that a significant change in attitude had occurred among the young driver population. All respondents identified the rise in the strength of the advocacy and victim groups as being a major factor in increased public awareness. Eight of the eleven participants identified such groups as MADD and SADD, and the parent group PRIDE as significant pioneers in the DWI movement and many of the respondents expressed the opinion that without such public advocate support, their DWI program would have suffered financially or would have possibly disappeared. They were encouraged by later statistics which indicated a reduction in BAC readings over .08 and a decrease in DWI arrests. Two respondents did however note that the public awareness did not extend to the older driver and this was reflected in arrest data. They expressed regret that the older driver seemed immune to positive messaging and continued to drink inappropriate amount and create high risk situations.

One final observation that was expressed by two respondents was the apparent irony in the profile of the offenders that enter the first and second offender programs. The majority of participants in first offender programs are young. The explanation put forth by respondents is that they are over represented due to arresting practices of police and that the older population are not always the focal point of police efforts. The respondents maintain that the time of day of police DWI efforts and conspicuousness of the young drivers' defective automobiles and the general attitude of police towards youth are the most

prominent reasons for apprehensions.

On the other hand the older driver had somehow avoided the first offender programs and usually displayed a different profile. At the time of arrest and BAC reading and the drinking patterns of the older repeat offender are in great contrast to the younger offender population. The arrest information suggests that the older drinker has learned very little from the public awareness campaigns and at best will change venue only. If transportation is required, the spouse will cover off this responsibility, while not necessarily recognizing the growing dependency. No fundamental change has occurred in the drinking culture for those offenders and the health promotion field has recognized that the conventional primary prevention programming will have little or no impact on this population. The contention, made by Ross (1982), that fear of apprehension is the only effective deterrent appears to have some validity with this age group. The majority of respondents agreed with this observation but were equally determined to 'make' their program have a beneficial impact on this population. This determination was most evident with the respondents from the smaller programs. It would be unmeasurable from an evaluative standpoint but is probably the most significant operative factor in the 'success' of these programs. Throughout the interviews this enthusiasm prevailed and, judging from the feedback forms completed by course participants, this factor was recognized and considered important in the overall impact of the course. Conversely the same was not

necessarily identified by participants in the larger, province wide programs. This willingness to over compensate for the material shortcomings of their small programs may result in equalizing the overall quality.

Notwithstanding the problems addressing the older offender group, the majority of respondents agreed that there has been an increased awareness of the drinking-driving problem among the general public, and by some estimates, there has been a growing trend for repeat offenders to receive jail time for their offence. The respondents indicated that while they appreciated the educational and rehabilitative process, that the general public was more punishment oriented and had little appreciation for the rehabilitation process and what effective treatment entails.

PERSONNEL

The literature indicates that the qualifications of the staff are significant in creating a climate of caring and concern and in developing a professional milieu. As well the staff must possess the ability to conduct the program effectively, be competent in adult education, group process, and social work counselling, and lastly understand the dynamics of alcohol dependence. For evaluation purposes, the qualifications of instructors must be examined in relation with course content and offender profile. Without a reliable

intervention expertise, little can be compared across programs. Unfortunately, the level of formal preparation and related credentials vary significantly across programs and there appears to be little attention paid to the careful selection and matching of offender type to staff expertise. The one exception is the hiring of recovering alcoholics in the program where it is clear that the "treatment" is based on the disease notion of alcoholism and A.A. belief systems. It is also interesting to note that it is the latter programs in which a social work appears least valued. In fact, one respondent from this type of program said that the social worker does not have the practical experience and is too weighted in theory. He felt that the hiring of social workers was generally counterproductive to the effectiveness of the overall goals and strategies of their specifically focused program.

Below is listed by program the credentials of the staff as reported by the respondents:

Program 1: In total three staff, ranging from a Masters in Education, a Registered Nurse and an individual with Grade 12. Two of the individuals were recovered alcoholics with additional experience in the drug dependency field.

Program 2: A one person operation who has some university education (not described). No recovered alcoholics are used in the program.

Program 3: Community college graduates are used. Currently, a qualified teacher is administering the program and recovering alcoholics are utilized.

Program 4: A one-person operation is currently filled by individual with a BA in religious studies. No further information was provided.

Program 5: A course currently operated by individual with some university background who is a recovering alcoholic.

Program 6: Any university credentials would be acceptable, as the major importance is placed on sobriety. It is their strong belief that recovering alcoholics show the compassion that is 'proven' effective in DWI programming.

Program 7: Four individuals currently operate the program, none of which possess a university degree.

Program 8: A variety staff from the provincial commission operate the program which has an educational approach. No significant importance is placed on qualifications and it was pointed out that the staff range from an

MSW to individuals whose recovery process are their main qualification.

Program 9: The limited information that was forthcoming indicated that the program is an educational approach and does not use recovered alcoholics.

Program 10: Two types of individuals are employed: 50% recovered alcoholics, 50% instructors with credentials in psychology (but could also be recovered alcoholics). There was little expressed tolerance for other professional groups. Not surprisingly the program has a firm commitment to the medical-disease model of alcoholism.

Program 11: All staff have post secondary degrees in the social sciences and clinical skills are considered of significant importance. Additionally, addictions background, especially related to small group dynamics, is highly valued.

FOLLOW UP

The follow up policies for the majority of programs are, to say the least, lacking. In fact, only two of the programs had any technique to track the offender after the completion of the course. The responses ranged from absolutely no undertaking of responsibility to maintain contact to a recognition of this program weakness. In some programs (4) the list of 'graduates' was kept by the registry of Motor Vehicles but there was no apparent practical use made of this data by the course operators. Others reported that the police tracking system (CPHX) also maintained some similar information but that it too was not utilized.

In areas where the program is small and where the geographic area is confined, there was a form of informal follow up that consisted of actually meeting offenders during the process of daily business activities. Repeaters were generally well known by virtue of the common knowledge of the small community. While this may sound quaint by some standards, it does represent a form of follow-up intervention where the instructor can actually carry out a post-program monitoring and support session. In some jurisdictions, participants are encouraged to return after completion of the course and, in fact, do. Once again these experiences apply to the smaller more parochial programs where familiarity is the operative term. In its own way, this informal follow up is a form of recovery that

may reinforce relapse prevention for some offenders. Both of the larger programs had no such follow up process and the only time the offender was seen was when convicted for a subsequent DWI offence.

In the two programs where follow up was attempted it was primarily for evaluation purposes as opposed to reinforcing relapse prevention. The follow-up usually took the form of a summary review of annual statistical data with special reference to re-offenses. In one case the follow up was prompted by a staff person who was using the data as the basis for a thesis. These data were used to evaluate certain components of the program.

One final conclusion based on the summary of the findings is that once again the ability and motivation to develop and carry out a follow up procedure was related to the size of the programs and support they received. The poorly funded did not tend to undertake this process while the more affluent made more efforts to maintain some follow up record keeping. It is safe to conclude that typically programs do not undertake an active commitment to follow-up.

EVALUATION

Of the eleven programs, seven had, at some point, participated in an evaluation exercise, though the quality and depth varied widely. Five involved an internal exercise where the staff would administer a questionnaire to participants. The questionnaire would consist of items aimed at determining whether or not the participants found the course informative and if it would have an effect on future driving behaviour and drinking attitudes. Participant responses did serve to give direction to changes in course content.

In one of the larger programs, evaluations, both formative and summative, were carried out. Eight formative studies were completed over a three year period and a summative evaluation was undertaken in 1990. The overall purpose of the studies was to assess the outcome results of the program. This author was impressed with the level of detail, complexity and rigor in methodology - within the context of DWI studies. However, there was a recognition of the limitations and potential biases associated with some of the evaluation results.

Notwithstanding the limitations identified, these studies did reach certain conclusions:

- a) The program did have a significant positive effect on impaired driving recidivism. It was also reported that recidivism was more likely to occur within the first year after program attendance.
- b) Participants' mood altering drug use and functioning in major life areas improved significantly during the follow up period.
- c) Participants reported taking action to avoid impaired driving; taking a taxi and asking someone else to drive were the most common strategies. Going to bars less often and following up on referrals to other help agencies were other examples of positive changes. It is obvious that for some the impaired driving problem may be under control but one cannot conclude that disinhibition or impairment in social situations is under control.
- d) The vast majority of participants were satisfied with the program and thought the program helped them to some degree.

In conclusion, it was recommended that the program continue, but of note was the recommendation for an active follow-up component. More in-depth support for impaired drivers who were alcohol dependent was recommended as well as informal supports to

encourage offenders to achieve lifestyle changes.

The results of the evaluation of the second large program were not as definitive or as encouraging. The core of the evaluation was an outcome study, following the client for a period after the completion of the course. This study was accompanied by a control group selected randomly. The aim of the study was to determine whether the DWI program had a measurable impact on any of its various client groups. The study involved the administration of a questionnaire to formerly registered participants. The findings, based on respondents from both the control group and program participant group, were as follows:

- improvements in job or school related behaviour;
- improvements in relationships;
- inconsistencies in attitudes towards drinking and driving; specifically, while respondents significantly reduced their estimate of the number of drinks required to become impaired, their estimates were still in the risk zone;
- a sizable number of respondents reported continuing to drive after drinking.

The conclusion was that the program appeared to have a definite impact on clients but that "more clients should receive more education". The findings suggest that, as a group, DWI clients made a number of changes for the better on a number of important variables. Relevant to the improvement of the program was the mixed outcome of the attitudinal variables. Moreover, while changes for the better occurred in knowledge and behavioral measures, it could be argued that these did not go far enough, since many continued relatively risk filled behaviour. It is the conclusion of this author that one of the dynamics that may have been operating was that the staff were more committed to the treatment-counselling program than to the re-education program.

Essentially, only the two programs identified above undertook a structured or formal evaluation. While there was evidence of positive change, it is also possible that all of the programs studies had some impact - though the nature and depth of change remain unknown. While there was a definite sense of haphazardness to many of the programs and a paucity of resources, the level of commitment appeared to be of such an intensity that equally positive results are likely. There was in many cases a real understanding of the dynamics of alcohol dependency and its relationship to DWI behaviour, a clear appreciation of the components of a DWI program, and in some programs, recognition of the need to match client to treatment modality. If these aspects were operative, then it is quite possible that equal success could be achieved. Perhaps of

greater importance is whether these austere programs could achieve the same results or whether an individual component of a program could be sufficient to reduce the recidivism rate.

CHAPTER XII

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Driving while impaired has been identified as a problem in much of the world, nationally in Canada, and provincially, as evidenced by provincial programs aimed at assessment, prevention, early intervention and/or rehabilitation. Helping professionals such as social workers and recovering people who have been trained to undertake some basic assessment, education or counselling, may both help the DWI offender.

PSYCHOSOCIAL ASSESSMENT

The literature which addresses addiction and DWI programming, stresses the need to conduct a valid assessment on each offender to ensure a clear understanding of the offense problem, the extent of alcohol dependence, concomitant problems and to match the individual to a program that would be most beneficial. Unfortunately, in the majority of programs this was not the case. The instruments or clinical processes used, the time, locations and settings cannot be regarded as consistent and supportive of reliable assessments. The assessment process using standardized measures must be strengthened in terms of both depth and comprehensiveness to guide psychosocial education and/or counselling. Assessments also provide some of the baseline data that might be useful to

support outcome evaluations. From a clinical perspective, weak assessments may ensure inappropriate matching of the offender to the service.

This author recommends:

1. That each DWI program design an assessment process of optimal depth and complexity to give direction to service and to establish a baseline for each offender.
2. That the staff be trained to complete the assessment process in a fashion that will ensure optimal validity and reliability of results.
3. That assessments not be used as an end in themselves but as a means to give direction to service in the course of the entire intervention process - at a minimum.
4. That assessments be sufficiently comprehensive to: understand the offense cycle and its risks; establish the likelihood, or not, of a substance abuse or dependency problem that transcends disinhibition and impairment.

5. To the extent feasible that standardized tests of known reliability, validity and utility be used in the assessment process and that instruments of unknown value not be used for the sake of having instruments.

SUSTAINED INTER-AGENCY COMMUNICATION

The results of the survey indicated that there was an underutilization of the knowledge and skills available in related agencies and that the DWI programs had infrequent communication with related services. The profile of the offender that is described in the literature strongly suggests the need for the utilization of a more diverse group of agencies. Utilization of related services appears to be much less than could be expected. Even where a referral link was described there was evidence that there was little two-way communication or feedback thereafter. The exceptions were in the programs that had a historical or organizational tie to the addiction agency or were actually sponsored within the addiction agency.

The common theme that is carried throughout the review of DWI programming is the tendency for the issue to fade from public attention and consequently place program

support from the political masters and the community in jeopardy. Interagency cooperation in tracking of the offender would provide a data base to guide policy and programming as well as support a stronger case with politicians. To mitigate against the possibility of losing public and government support, tracking, inter-agency communication and active interrelationships among top level management must be constantly kept in the forefront. Accordingly, these component must be strengthened, especially the inter-agency communication, with the view to develop a public relations strategy. The primary focus would be the development of an approach to ensure that long range planning that includes the appropriate communications-interagency component as an integral part of such planning. It is clear from the interviews held with the programmers and observations contained in the literature, that DWI services run the risk of continuing to slip from the upper reaches of political agenda. Advocates for DWI programming must undertake to ongoing coordination, development and communication if the needs of the offenders are to be met.

Accordingly, the author recommends:

1. that DWI programs set into place a mechanism to strengthen a system of inter-agency support that can respond to the needs of the DWI offender that are not addressed by the current re-education or

rehabilitation program - community consultation and organization development;

2. that DWI programs and related services undertake coordinated tracking in a manner that ensures better service and continued political, community and inter-agency support.

STRUCTURE AND APPROACH OF INTERVENTION

The results of the review revealed that the quality, specificity, content, duration, matching of clients to program model or component, in most of the programs, are not pulled together in a synthesis that enables meeting the individualistic needs of the offender within the context of a class of offenders. The net result is that the service is program-driven rather than need-driven (evidence of goal displacement). This problem is partially due to the thin financial base that many must operate under. The net result though is that the DWI field may be subject to being used to ensure that there is at least the image that something is being done with offenders, even if the results are not likely to be as expected, because the services are typically program driven based on a belief that offender needs are basically homogeneous.

There is also no real evidence that the judicial system is utilized in a way so as to strengthen the DWI programs or to enable constructive coercion to work in the interest of the offender.

The literature and the key informant feedback in this consultative study indicates that a combined legal-therapeutic model is preferred. It acknowledges the value of rehabilitation but contends that it must be complemented by legal sanctions. The judgement of many was that the Criminal Code has progressed to the stage that it can actually help in the rehabilitative process. For example, the court can require individuals found guilty of a drinking and driving offence to undergo 'curative treatment'. The treatment option may be either in addition to or, in some cases, instead of a fine or imprisonment. And while this legal dimension can be abused (as was observed in one of the provinces with a macro-program), there is clearly an advantage to collaboration between the criminal justice system and re-education and rehabilitation programs.

As well, the addictions community appears to support this model and its policies. The Addiction Research Foundation (1985) argues that legal sanctions have an important positive impact on driving behaviour which might be increased by the rehabilitation program but which could not be achieved by the program alone. The rehabilitation program in a legal-therapeutic milieu can generate positive results if it contains the

necessary combination of components tailored to the needs of the client and the etiology of alcohol dependence. Rehabilitation programs can be shown to produce positive results when sensitive measures of change in attitude and knowledge are employed, and it can be speculated that such programs may produce beneficial impacts on future driving behaviour of the offender (Mann et al. 1983).

The author recommends:

1. That the various components of DWI intervention be re-examined to insure that they are reflective of diverse client needs for assessment, psychosocial education, counselling and/or therapy - including mutual aid groups and family involvement for the alcohol-dependent. That within this context that process and intermediate outcome evaluations be completed on all programs to ensure that service is not just input oriented but that the programs have real outcomes.
2. That a legal-therapeutic model, with a dynamic balance between constructive coercion and rehabilitation be promoted - one that ensures cooperation, integration and coordination among systems devoted to: justice, assessment, psychosocial education, counselling and more in-

depth therapy.

3. That DWI programming pay attention to matching client sub-groups to programming based on their profile such that the service goals do not result in goal displacement such that the client is over programmed (inefficient) or under-programmed (ineffective).
4. That a federal-provincial consultation be put in place to review fifteen years of DWI programming with the intention of affirming commitment to reducing offenses and the risk and increasing constructive coercion, and rehabilitation in the interest of reducing risk in a known risky population.

RECEPTIVENESS TO EVALUATION

An important element in the implementation of educational and treatment programs for impaired drivers is the determination of their effectiveness through program evaluation. According to Hogan (1978) program evaluation should be an integral part of any impaired driver program. That is, evaluations designed to assess the extent to which a program

fulfils its goal (outcome evaluations) can provide necessary information which can lead to program improvements.

With respect to the programs under review in this study, formal evaluation took place in two jurisdiction only. Five others had a form of evaluation but nothing definite to date. The evaluations revealed an increased knowledge by participants and a significant positive effect on self esteem and future behavioral intentions related to impaired driving. The results on recidivism are inconclusive, however, most researchers would agree that given the slim chance of conviction on a second offence, the use of rearrest or conviction as accurate measures of subsequent drinking and driving episodes would require a very large sample.

The author recommends:

1. That DWI programming put in place an evaluability assessment procedure that be determine whether or not the specific program has the capacity to sustain critical questions on its effectiveness.
2. That process and intermediate outcome evaluations be undertaken, not to decide whether a program lives or dies but to enable progressive

improvements that increase the likelihood of both client service effect and reduced public risk.

PROGRAM COMPREHENSIVENESS

The results of this consultation indicate that there are various levels of comprehensiveness or lack thereof within existing programs. At one level there may be comprehensiveness within a program, such as the duration, content and complexity of a psychosocial education program. The difficulty arises when one considers that the comprehensive psychoeducational program may be sufficient for the offender who is not highly dependent but, in itself, will likely be insufficient and ineffective with the offender who has a history of severe alcohol dependence. There is a belief among key informants and some support in the literature for the notion that second offenders often require more than assessment and psychoeducation.

Most of the key informants had a clear idea of what a comprehensive and effective program would look like. On the other hand, the majority pointed to the lack of resources and support to ensure the most effective service; financial, demographic, and personnel factors continued to set the agenda in many jurisdictions.

The author recommends that:

- 1. A review of current programming be undertaken with the intent of improving the alignment of program to client needs.**
- 2. Any such review recognize the differences in first and second offender client groups and that every attempt be made to ensure a clear options to meet the differentiate needs and risks.**

QUALIFICATION OF PERSONNEL

This review revealed no agreement with respect to key informant opinion about the ideal qualifications of personnel. In fact, there was a wide divergence in hiring practices, ranging from a strong preference for selecting the recovering alcoholic, with academic credentials being secondary, to a mandatory requirement of a post secondary degree. The other significant observation relates to the programs that had no particular personnel preference but merely accepted the credentials of the willing instructor. These were grass roots programs, on limited budgets that welcomed interested instructors and counsellors. In the opinion of this author these instructors displayed much enthusiasm and energy that

seemed to more than compensate for a possibly weak academic background. It is important though, given the highly technical nature of some of the material that staff at least be trained if the goals of assessment, prevention, early intervention, and more in-depth counselling are to be met.

Social work did not surface in the review as being a common requirement for the administrators of DWI programs. This would appear to be a weakness in the selection of personnel as it was demonstrated in the literature that individuals with a social work background can bring to a DWI program many useful and effective skills related to assessment, prevention, early brief intervention and more in-depth counselling. These skills would include group counselling techniques necessary to deal with the identified characteristics of a DWI offender including denial, aggressiveness, and resistance. The social worker would also bring to a DWI program the community development strategies that would be needed to mobilize the community support systems necessary to sustain interest in this problem area and solicit financial support and official sanction from the regulatory bodies. As well, the social worker would be familiar with other intervention programs that may be tied into the DWI problem that could augment the components of the program, i.e. addiction services, family and marital counselling and mental health services.

Unfortunately, the programs reviewed, with few exceptions, did not develop their hiring practises with these more complex considerations in mind. This has, at times, resulted in the hiring of individuals with only some of the necessary skills, consequently affecting professional programming and on occasion necessitating the acquisition of additional staff. The DWI offender, especially the second and subsequent type, brings to the legal and program development systems a complex and diverse problem, a situation that requires the skills of the social worker. Given the findings of this report, this area requires further consideration in the future development of intervention programs. It would be an effective and efficient method of maximizing human resources and limited budgets while bringing quality program delivery to the DWI field. In audit terms, there is an economy of scale in the acquisition of social workers. Particularly in programs that were based on the disease concept of addiction, there needs to be a reconciliation of the social work field and the recovering community in the interest of the DWI offender. Both systems can play a valuable role towards a successful intervention. There is no evidence that this reconciliation is occurring based on this inquiry. Both stakeholder groups must consider the impact of their biases and limitations on the clients they are supposed to serve.

This author recommends that:

1. the relative success of both professional counselling-education staff and recovering non-professional staff be studied with respect to undertaking: optimal psychosocial assessments; preventative psychosocial education; early brief intervention; and more in-depth counselling.
2. the broad general practice strengths that professional social workers may bring to a DWI program be acknowledged, not only with respect to the undertakings described in 1. above but also with respect to community consultation skills and evaluation skills.
3. the staff, professionally prepared and credentialed or not be trained to criterion with respect to any of the undertakings in 1., unless they possess such knowledge and skills at the point of hiring.

EFFECTIVE TRACKING OF CLIENTS

The results of this study indicated no evidence that there was a systematic method of tracking offenders either after the intervention or during the various phases of the program period, i.e. apprehension to course completion. It is only with a systematic method of tracking that evaluation can be effectively undertaken and lessons learned on possible program weaknesses. The literature also identified another practical reason for tracking; it serves to remind the other systems that the program is operating and expects the judicial, police and treatment systems to appreciate the role played by the DWI re-education/rehabilitation process (T.I.R.F. 1983). In instances where tracking was evident, the effort was modest and no strategic plan was adopted for the exercise - an opportunity to re-visit former offenders in a casual fashion. This was only possible in the small programs delivered in the rural settings. With the larger programs (province wide), the tracking only took place after course completion and was primarily for statistical purposes - such as recording recidivism rates. Tracking is necessary and does not have to be an expensive proposition. It requires the cooperation of the police and motor vehicle division, requesting that a system be put in place that identifies the offender early in the process and can continue into the post intervention period.

The author recommends that:

1. Record keeping of existing program be improved in terms of quality and depth of information gathering.
2. Tracking procedures should be primarily concerned with service continuity, program improvement and facilitation of evaluation.
3. The tracking should be two tiered with the judicial system tracking the offender and with the DWI program tracking the offender (ex-offender) in an integrated fashion.

RESPONSIVENESS TO CHANGE

The literature which examined the essential components of DWI programming (Reis, 1982) stresses the importance of the program's ability to modify as the need arises. In this review, many programs recognized the need to modify course content, duration and other program elements based on feedback received from the participants. The majority of the programs gradually evolved from their original form. However, the fledgling

organizations could only change within certain fiscal constraints, often necessitating innovation and resourcefulness. The net result is that the history of some program changes are more consistent with disjointed incrementalism than with strategic planning.

The conclusion reached from this review is that, for the most part, programs are "evolving" over time. Change appears to be based in part on participants' feedback, review by instructors of current literature, and dialogue with counterparts in other programs. For the smaller programs, while flexibility for change may be present, actual change was often prohibited by lack of resources.

The author recommends that:

1. Increased dialogue across servicers be initiated or strengthened such that progress in the field of DWI benefit from the collective wisdom.
2. That program change be based on strategic planning as opposed to disjointed incrementalism with due respect to political work, community consultation and organization development that must take place. In addition, the program supporters must ensure improved public and financial support so that the job to be done is undertaken in an optimal

fashion.

3. While there is some attention to the feedback from participants with respect to program improvement, more systematic attention to collective feedback (reflecting a class of problems, needs or opportunities) should be balanced against a range of predictable individualized needs.

TOP LEVEL MANAGEMENT

The overall administration of the DWI program is considered to be very important in the success and endurance of any program. Sanction and approval should rest at the highest level of government possible.

The findings of this review indicate that this was not happening in any of the programs, even the ones described as province wide and recognized in legislation. In most programs (8 of 11), there was a real sense that once the program was operational, government policy makers would step aside removing themselves from further involvement unless a deliberate policy or financial decision was indicated. The distance between the actual program and the decision makers was, in many instances, substantial. This factor

was identified by many of the respondents as problematic with respect to accountability and continued personal support at the management levels of government.

The relationship with other administrative bodies was also identified in the literature as being important to the overall success of the program (Vingilis 1983; Mann et al, 1983). Of particular note is the relationship with the Registrar of Motor Vehicles as reinstatement of licence is an important factor in rehabilitation and recidivism. Vingilis, (1983) and Mann et al (1983) point out that reinstatement of licence during treatment can decrease the period of time before recidivism occurs. In all programs under discussion, the registrar had the authority to control the reinstatement. The relationship of the rehabilitation program personnel to the registrar can be useful in a therapeutic sense. And, where financing has been a critical problem, this relationship is very much a value added consideration.

Accordingly, the author recommends:

1. That contact with the administrative and funding bodies be strengthened, and the development of a cooperative relationship with the Registry of Motor Vehicles be viewed as essential to the enhancement of existing programs, the potential success of emerging

initiatives, and the development of a data gathering capacity for evaluation purposes. The maintaining of the DWI problem as a key issue with policy and budget planners must be foremost in the promotional activities of DWI programmers.

2. That a concerted alliance be formed with advocacy and victim groups be established to keep the DWI in the forefront of media attention and policy makers.

CONCLUSION

At the time of writing, DWI programming was in a state of uncertainty with respect to funding - public policy and political support being constantly in jeopardy. The issue appears to have slipped from public attention and other, albeit serious, phenomena are capturing media and resources. There is an irony in this current situation in that the Federal Government, through its Canada Drug strategy, is attempting to address the needs of the convicted DWI offender in a climate where the issue is lower on the public agenda.

Long term funding is available and expertise can be engaged to explore in some

depth all aspects of the intervention process. What is now required by citizen advocacy groups and DWI programmers is an concerted effort to maximize these funds to bring the problem back on the agenda and put in place programming that can withstand the critics of the re-education/rehabilitation approach to the DWI offender. At this point in the evolution of DWI programming across Canada, the quality, comprehensiveness, client matching to program, and evaluation effort will be always subject to the criticism by those who believe that incarceration and stricter penalties are the only answer to this pervasive problem. On the other hand those who undertake assessment, education and clinical intervention know that incarceration does not change behaviour - especially in the drug dependent sub-group.

We have sufficient experience, practice wisdom and research at this time to construct a normative, comprehensive set of policies and sub-programs to reduce risk. The issue is, do we have the public and political will and the motivational energy?

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APPENDIX A**DEFINITION OF IMPAIRMENT AS DESCRIBED IN THE CRIMINAL CODE OF CANADA (1992).****SECTION 253****OPERATING WHILE IMPAIRED.**

253. Every one commits an offence who operates a motor vehicle or vessel or operates or assists in the operation of an aircraft or of railway equipment or has the care or control of a motor vehicle, vessel, aircraft or railway equipment, whether it is in motion or not,

- (a) while the person's ability to operate the vehicle, vessel, aircraft or railway equipment is impaired by alcohol or a drug; or

- (b) having consumed alcohol in such a quantity that the concentration in the person's blood exceeds eighty milligrams of alcohol in one hundred millilitres of blood. R.S.C. 1985, c. 27 (1st. Supp.), s. 36; c.32 (4th Supp.), s. 59.

Appendix B

Description of the Study to be Given Orally in Telephone Contact with Potential Respondents

The purpose of this study is to examine the current programming in addressing the recidivist impaired driver. Selected programmes have been identified and staff of these programmes are being asked to respond to a series of questions that cover the entire intervention process starting from the initial identification to eventual follow up. The questionnaire format of approximately 45 minutes duration was completed after extensive review of the literature in the area of DWI intervention. This research has identified 10 essential components that would be present in order to form a comprehensive program. The questionnaire to be used in this study is based on these components.

The results of this consultation will hopefully assist those involved in DWI programming to examine the operations and identify possible gaps that may be affecting a positive intervention.

As is pointed out in the consent form, the information will be kept confidential and the actual responses destroyed once the study is submitted to the university. A copy of the

report will be available to you at that time.

I very much appreciate your participation in this study. Should you agree, I will send you an official letter acknowledging your interest as well as a letter of consent for your signature. I am also requesting that you forward relevant material used in your program including informational items designed for general public and agreements with outside agencies. This material will help form a comprehensive picture of your service.

Should you wish to reach me, I can be contacted at
613-954-8520.

Thank you.

Appendix C

Consent to Participate in Research

In signing below, I acknowledge that I have read and understand the following information regarding this study. I understand that this study is part of the requirement for Mr. Smith's Master of Social Work Degree.

1. I understand that the purpose of this study is to assess the current policies, administration and practices of existing driving while impaired intervention programs with the view to identifying key elements that make for an effective intervention.
2. I understand that my responses in the study will be kept confidential and only the final results of the research will be shared with my agency so as to ensure that I will not be identifiable. The final results will not identify the specific location or the source of specific information. I understand that my agency has consented to assist in the study and will not require the names of the agency participants.
3. I understand that my participation in this study is voluntary and that I may withdraw without prejudice at any time.

4. I understand that any known risks to me associated with my participation in this study, will be mitigated by the procedure used in the presentation of the results.

5. I understand that Mr. Smith hopes that the results will be of benefit in giving direction to agencies involved in the delivery of driving while impaired intervention programs.

6. I understand that upon submission of the research paper by Memorial University, that the recording of the interview will be destroyed. The research paper will be placed on file in the School of Social Work at Memorial University, St. John's, Newfoundland. Mr. Smith may reduce some of the material for publication in a professional journal. The names of participants will not be disclosed in any written reports on the project. As well, the information and recording of interview will be stored by number rather than by the name of participant.

7. I understand that Mr. Smith, the researcher, is a professional social worker. This research will serve as part of the requirement for his Masters of Social Work Degree. The actual interview is to be of 45-60 minute duration.

Signature

Witness

Date

Date

Appendix D

Structured Interview Guide

Canadian DWI Survey

A. History

- 1) When was your DWI program established?
- 2) Who were the principle architects of the DWI program and what role did each individual or agency play in its development?
- 3) What prompted or motivated your community to establish a DWI program? Please elaborate.
- 4) Please describe the support that was received from the following community agencies:
 - a) police (enforcement), b) community advocacy group c) addiction agencies d) courts, e) probation

- 5) Has the course content and procedures changed since inception? If so, in what way and to what extent?
- 6) Were there any early evaluations or formative reviews completed?
- 7) Was there opposition to the establishing of the program, both from within the agency or from external agencies? Explain.
- 8) Has the sponsoring body changed over time? If so, explain the reason for the change and its impact on program philosophy, program and procedures.
- 9) What was the original budget for the DWI Program and how has it changed over time? Please provide budget details and staffing allotments.

B.1 Current Program

Intake and Assessment

B.1 INTAKE

- 1) Please describe the procedures for identifying individuals to be candidates for the DWI program. If court directed, please describe the process involved, from apprehension to actual enrolment.
- 2) Is the Program mandatory for all DWI offenders? If not, who is exempt and why?
- 3) If certain DWI offenders are excluded from participating in the Program, who makes this determination and how is the determination made?
- 4) Is the DWI Program referred to in your Provincial legislation? Does such legislation override discretion in program implementation? If so, explain.
- 5) Are other sentencing options considered instead of or in conjunction with the DWI Program? i.e., license revocation, incarcerations, fines, probation? Explain.

6) Does attendance at the DWI Program allow participants to retain their license? If not, is 'successful' completion of your DWI Program a condition of license reinstatement? Is there a written policy of the Motor Vehicles Department in this issue?

7) Are such factors as geographic distance from the DWI Program, accessibility problems, and special circumstances i.e., family disruption, considered during the selection phase?

B.2 ASSESSMENT

1) Is an assessment procedure employed in the referral of offenders to the DWI Program? If yes, please describe and give history and rationale for this requirement.

2) What assessment and screening instruments are utilized? Please elaborate, explaining why certain instruments were selected and what they are intended to measure. What information do they provide about the offender?

3) At what point after arrest does the assessment occur? Are assessments completed prior to sentencing or after the offender is ordered to participate in the DWI Program? What was the rationale for your particular policy in this regard?

- 4) In what way is the information that is obtained from the assessment utilized in guiding subsequent treatment of this offender?
- 5) Who is responsible for administering the assessment? What position does he/she hold in the agency and what % of his time is engaged by this procedure? What educational credentials does this individual possess?
- 6) What setting is employed to carry out the assessment procedure, i.e., physical setting, duration of assessment, interaction before, during, and after the procedure? Are the results of the assessment communicated to the offender at that time?
- 7) Is your agency satisfied with the instruments employed and the quality of the information gathered? If not, to what extent is the assessor's experience and training a factor?
- 8) How is the assessment used? Does it serve to determine the type and extent of intervention to be chosen? Does it serve as a formal pre-test or baseline data for a post evaluation and follow-up?

9) Are the BAC reading and other presenting symptoms considered in the assessment process?

10) Is a social and family history part of the assessment? Describe its level of comprehensiveness.

11) Is there an opportunity to continue to assessment during the actual intervention program? If so, how is this achieved?

12) What other agencies are involved in the assessment procedure? Elaborate and explain.

13) Is the assessment shared with other agencies involved with the offenders, i.e., police, probation, court, jail, lawyers (defense and prosecution), family, employer. If so, what is the basis for this policy?

C. The Program

C.1 a) For what category of DWI offender is your program designed? i.e., 1st offender, 2nd and subsequent offenders, both categories?

b) Do you offer more than one type of program? Please explain.

c) What is the duration of your program? Please elaborate i.e., number and length of sessions, over what period of time? (time of day, week, etc.) Are absentees accommodated at other times?

d) What is the usual number of participants in each program? Why was this size chosen?

e) In what type of setting is the program offered? Please describe the physical setting; seating arrangement, room size and characteristics; area of the city or town, other uses of the building etc...

f) What method of instruction is employed in your program? Please elaborate (a) didactic (b) participant involvement (c) both, if so, what (d) other methods, please explain.

g) Is the program's primary emphasis the transmission of information regarding drunk driving or is it designed in a rehabilitative/counselling mode? Or both? Please elaborate and explain the rationale for your particular approach.

h) Please list the audio-visual material and collaterals employed and why they were selected?

i) Is your program based on a previously developed model e.g., Phoenix DWI Program, the ASAP model, etc. Why was it chosen?

C.2 Information/Re-education Programs:

If your DWI program is essentially informational, please answer the following question:

a) What issues are conveyed in your program? Please indicate the % of course time for each issue.

Yes	No	% of course time
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B.A.C

Legislation on DWI

Effects of alcohol on
driving skills

Insurance implications

Alcohol dependence

Other (specify)

Please state the rationale for choosing the above topics and the reason for the relative importance (%) of each subject area.

- b) Why was this model chosen for your DWI program?
- c) Is this informational program offered to all participants in your DWI program? If so, is it augmented by additional techniques for any particular sub-group?

C.3 The Rehabilitation Model

If you utilize the rehabilitation model, please address the following questions:

- a) What methods and techniques are utilized as the basis for your rehabilitation model and to what extent are they employed? Please elaborate on the rationale for electing to use

these particular techniques and what basic assumptions are made about the target audience.

b) What issues are covered in the rehabilitation model and how are they delivered? What % of time is allocated on each component and why?

c) What outside agencies are used in the program and why were they chosen?

d) What philosophical underpinnings of alcoholism rehabilitation form the basis of your program? (Abstinence model, behavioural approach, moderation goal?) Please elaborate on why a particular philosophy was adopted.

e) Is the rehabilitation approach given to all participants in your DWI program?

f) Is the program modified in any way to respond to the differing levels of alcohol use or dependence?

C.4 Combined Re-education and Rehabilitation Model

If your jurisdiction offers a combined program or both programs separately, please answer the following questions:

- a) Why was the combined model of the two separate program models chosen?
- b) What selection criteria are used for placing individuals in a particular program?
- c) Are these two distinct programs offered or is one a further elaboration of the other. For example, does the rehabilitation program build on the topics contained in the re-education model? Please elaborate and identify components used in both programs and the rationale therein.

D. Records and Informational Data

- a) How many individuals are apprehended and convicted of DWI related offenses in the catchment area where the DWI program is offered? What % are referred to your program?
- b) What are the sentencing trends for DWI offenses in your geographic area? Objective data as well as subjective analysis would be helpful here.

c) Describe the importance (or lack thereof) that your police and court system places on the DWI problem. Is your DWI program part of a larger intervention/prevention program? Where other initiatives are underway in your area?

d) What changes have been observed in the past 5-15 years in your community's understanding and response to the problem of DWI?

e) Is the data collection system of your courts, police and DWI program systems adequate for the purpose of planning, evaluation and follow-up? Please describe the systems in place. Is retrieval of information reliable and of value to your program? Please explain how such data is used.

E. Personnel

a) What is the required educational background and experience for instructors in your program?

b) Is social work a relevant, desired or mandatory qualification? If so, what does a social worker bring to the DWI program? Elaborate.

c) Are 'recovered' alcoholics used as presenters/instructors/counsellors in your DWI program. Why or why not?

d) Are the instructors observed and evaluated on a regular basis?

e) What has been your experience in staffing. Issues in the D.W.I. program?

F. Follow-up

a) Does your DWI program have a follow-up policy to track former participants? If so, how is it operationalized?

b) Are repeat offenders who were former participants in the DWI program offered the same program as before?

c) Are participants encouraged to maintain involvement in the course? How is this done and what has been the experience?

d) Is there a formal follow-up report to the police and court system? Is there a general policy or only under special circumstances? Is the report utilized in the further court

disposition of the offender?

G. Evaluation

a) Has your program ever been evaluated, either formally (external) or in internal review and examination? If so, when and under whose decision and direction?

b) What type of program evaluation was employed i.e., formative, summative, both? Please elaborate.

c) What design formed the basis of the evaluation, i.e., experimental, or quasi experimental. What importance was given to factors such as control/treatment group, randomization of participants, sampling, and other scientifically rigorous considerations.

d) Who was the audience for the evaluation results, i.e., internal, government, media, public?

e) What were the limiting factors in carrying out the evaluation?

f) In your evaluation, what outcome measures were looked at, i.e., knowledge, attitudes,

subsequent drinking/driving behaviour. Was recidivism used as a specific measure?

g) What would you consider a 'success' in relation to your DWI program?

h) If no evaluation was done, state reason for this decision. Is an evaluation contemplated? If so, when and what method will be employed?

Thank you for your cooperation and commitment to this exercise.

Appendix E

Correspondence

1. Covering Letter:

describes the project

requests written material

thanks them for their interest

notes that you will follow up by phone, with those who return consent

describe what is in package

2. Follow-up Letter

Thank you for your continued interest

this is to confirm arrangements

either face to face for One hour or telephone interview

3. Thank You Letter

Thank you for participating

I will telephone for any further clarification of consultation.



