AN ANALYSIS OF PROBLEM DRINKER DIAGNOSIS AND REFERRAL IN THE FAIRFAX ALCOHOL SAFETY ACTION PROJECT, 1973

by

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ABSTRACT

This report provides an analysis of the diagnosis and referral activities of the Fairfax, Virginia, Alcohol Safety Action Project (ASAP), a $2.3 million demonstration program for combatting the drinking driver problem. The exploratory nature of ASAP countermeasure operations necessitates research for validating the procedures used to match individual client needs and available treatment resources. This study identifies key decision points and priority variables essential for the control of diagnostic and referral activities.

Unique among the 35 community based ASAP programs funded by the National Highway Traffic Safety Administration, the Probation Office and Mental Health units of the Fairfax ASAP use group interview techniques to diagnose and classify drunken drivers. Also unique to the Fairfax ASAP is a case management strategy whereby defendants are frequently referred to a series of separate treatment programs. These are intended to provide exposure to a number of rehabilitative approaches. However, in developing administrative policy, a limitation upon the number (now often three) of treatment modalities assigned an individual should be dependent upon a trade-off of two considerations: likely incremental program benefits versus economic and psychological costs to the client of multiple rehabilitative courses having fees from $30 to $60 each.

Because of the costs of the detailed and intensive diagnostic procedures in Fairfax and the need to develop a less sophisticated and lower cost procedure for use in the mini-ASAP's in other communities in Virginia, it was concluded that preliminary classification based upon the BAC (blood alcohol content) at the time of arrest, previous traffic records, and problem drinking symptoms should be used for all defendants. Those defendants who couldn't be classified on the basis of their records could then be scheduled for group interviews. A model which interrelates the number of problem drinking characteristics, BAC at time of arrest, and previous traffic violations was developed to supplement diagnostic decisions made in Fairfax by serving as a quick cross-check on all diagnostic decisions.

FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

Office of Alcohol Countermeasures Findings and Conclusions

1. An experimental model simulating ASAP diagnostic decisions was developed which interrelates three key elements: number of drinking characteristic variables, BAC level at the time of arrest, and prior traffic violations. This model is consistent with OAC criteria for three drinking categories and possibly could be used to replace, or at least supplement, the current costly diagnostic procedures.

2. A check of drinking classification and subsequent referral to treatment indicated that there is no clear-cut procedure for matching the results of the diagnosis to the eventual referral. Of a random sample of 75 ASAP defendants controlled for drinker category, it was found that 20 were referred to treatment modalities inappropriate for their diagnosis.

3. Since July 1973, Fairfax ASAP management policy has been to staff all defendants to a Driver Improvement School. Yet the data in the Probation Office files indicated that 36 of the 75 sampled defendants had not been staffed to Driver Improvement School. Because of the management's policy, multiple treatment is now a common practice, including many referrals to as many as three treatment programs. From the two basic treatment programs at the start of ASAP operations in 1972, there are now at least 19 major combinations of treatment, which must be reported on Appendix H tables.

4. Quarterly data indicate great disparities in the diagnoses of defendants into the three drinking categories. The percentage of problem drinkers ranged from a low of 12% in quarter 4 to a high of 54% in quarter 7. Non-problem drinkers ranged from a low of 14% in quarter 8 to a high of 55% in quarter 1. The category of drinkers who were not classified ranged from a low of 7% in quarter 1 to a high of 37% in quarter 4. While it is possible that the characteristics of the defendants exhibited differences over time, it is much more likely that policy and procedural changes in the Probation Office accounted for these fluctuations.

5. Much data sought from ASAP probation folders for analysis of the time necessary for entry into rehabilitation were found to be invalid for use in this study. A large number of administrative procedures are prerequisite for scheduling treatment. Hence, some doubt is cast upon the accuracy of the file records, which indicate that more than one-third of the sampled cases entered treatment within two days of referral.

6. The average cost per defendant diagnosis, referral, and probation was calculated to be approximately $82. Defendant diagnosis and referral were estimated to be in excess of $60 per defendant. In view of these high costs and wide fluctuations in diagnostic decisions over time, it was concluded that alternatives to this costly, yet erratic procedure should be sought.

Recommendations

1. The Fairfax ASAP management staff should consider using the model developed in this report for preliminary diagnostic screening of all defendants. Those defendants for whom no classification could be made from the model could then be scheduled for more extensive diagnostic work.

2. The proposed model, or another similar to it and based upon the OAC criteria for problem drinking classification, should be considered as a means for reducing costs by preliminary screening of all defendants on the basis of records. For those cases for which the records are not sufficient for classification, the model could be supplemented with group intake techniques.

3. The management staff should consider the alternative of reducing the number of multiple referrals to reduce the work load on the treatment agencies as well as balancing the increased costs to the defendants against the incremental benefits accruing from multiple treatment programs. Without a significant increase in the arrest rate, apparently an increasing percentage of defendants are precluded from entering any ASAP treatment program. It is not clear if the increasing use of multiple treatment so overloaded the community treatment resources that the decision was made to deny an increasing percentage of defendants from entering rehabilitation programs. If that is the case, then it appears that the management staff has lost sight of the original ASAP goal of making rehabilitation services available to every suitable defendant and should reconsider its decision regarding the use of multiple treatment programs.

4. The record-keeping deficiencies in the probation files which made almost impossible an assessment of the recidivism rates of defendants should be corrected. Hopefully, the Office of Alcohol Countermeasures of NHTSA will not change the format again for the recording of recidivism data on Table 15 of Appendix H, and the Probation Office should develop a plan to record and compile in a timely fashion in the data necessary for Table 15.

5. Streamlining the Fairfax ASAP case management system is a necessity because it should serve as the prototype system for a series of mini-ASAP's sponsored by the Highway Safety Division of Virginia.

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BACKGROUND

The Fairfax Alcohol Safety Action Project is one of 35 federally funded demonstration programs organized to confront the drinking driver problem. For each ASAP, a series of key analytic studies are required annually; specific research problems which must be investigated by the series of evaluation reports are described in Alcohol Safety Action Projects: Evaluation.[1/]

This report reviews the techniques whereby those persons arrested for drunken driving are diagnosed as to their degree of problem with alcohol control and are referred to treatment programs. Because of the exploratory nature of the ASAP countermeasures, detailed research is needed to validate diagnostic and referral procedures. In Fairfax these are functions of a special ASAP Probation Office. Specifically, the needed research must identify key decision points and priority variables integral to case management operations. These should form the basis for developing standardized criteria useful to diagnostic and referral activities. This analytical study also evaluates the degree of success associated with getting ASAP's driving while intoxicated (DWI) defendants into appropriate programs.

A companion report evaluating 1972 case management operations identified tendencies to underclassify the drinking problems of DWI defendants in Fairfax.[2/] That analytical study recommended improving administrative records, development of a model for cross-checking diagnostic and referral decisions, and continued experimentation with the "group intake" interview techniques.

PURPOSE AND SCOPE

Objectives

The objective of the diagnosis and referral system is to establish matches between individual needs and available treatment resources. It should be recognized that the total ASAP system is comprised of four countermeasure activities; however, this research is confined in scope to concentrate exclusively upon the diagnostic and referral system in Fairfax. There are corresponding key analytic studies wherein closely related ASAP countermeasure functions are described in separately bound reports.

The route of the DWI defendant begins with the pre-trial court appearance. Defendants then begin the referral process, which was designed to ensure transfer into appropriate ASAP treatment modalities. The time frame for the analysis presented here covers 1973, the second year of operations for the Fairfax ASAP. For purposes of comparison, the 1972 year of operations and the preceding base year era are used.

Description of DWI Diagnosis and Referral System

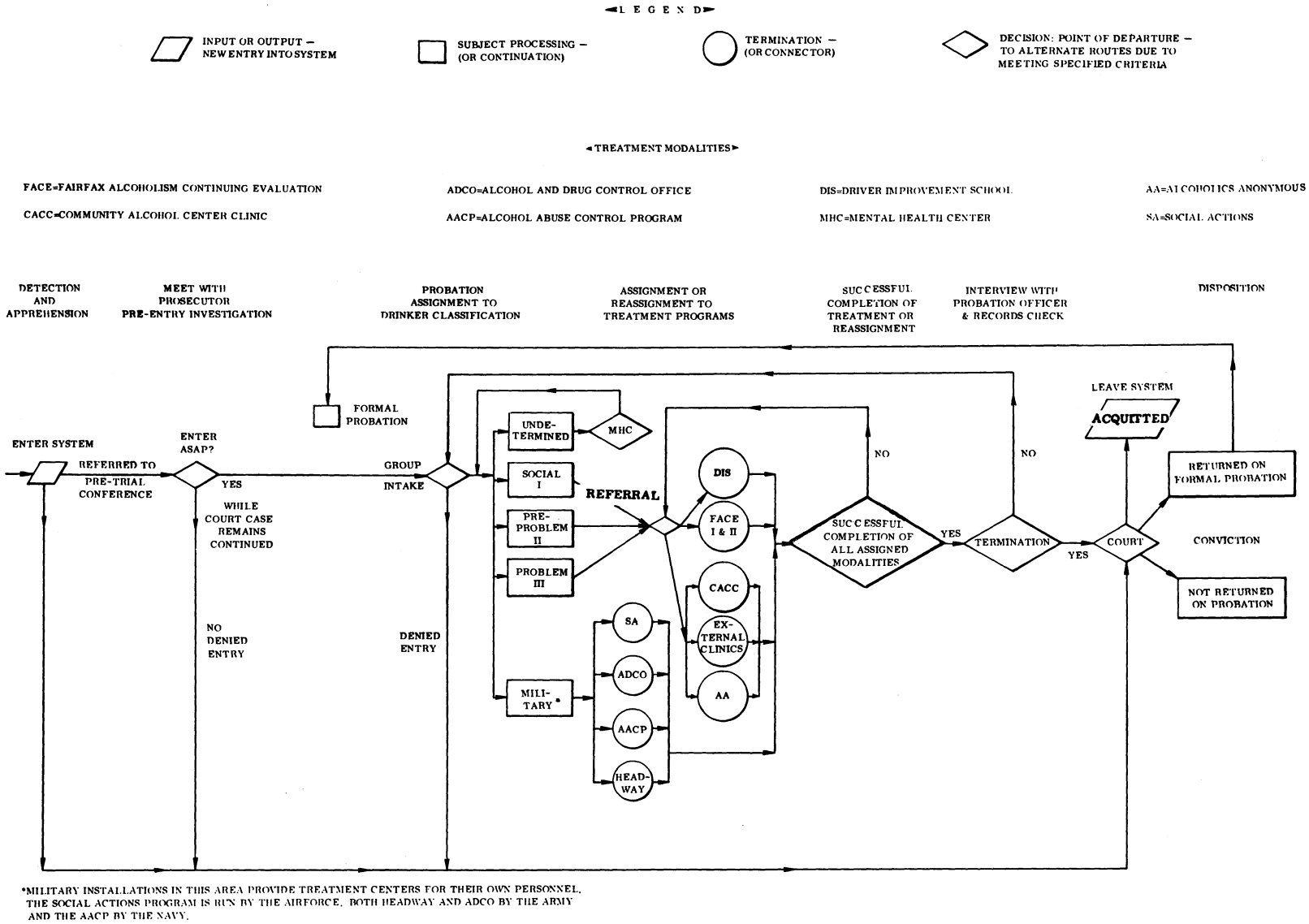
The complete cycle for diagnosing and referring DWI cases encompasses a complicated chain of events. In the interest of clarification an overview of the main elements of the system are listed in outline form.

(1) Arrest for driving while intoxicated.
(2) Pre-trial court hearing and continuance of case.
(3) Diagnostic interview.
(4) Incompatible DWI cases are screened and return directly to court.
(5) Probation staff determines treatment referrals.
(6) Defendant enrolls in treatment programs.
(7) Secondary diagnostic evaluations may be utilized.
(8) Special cases can be assigned to external community treatment programs.
(9) Individual successfully completes treatment courses.
(10) Final interview with probation office.
(11) Court trial.
(12) Defendant sentencing keyed to probationary recommendation.

The above listed functions are described in greater detail in an earlier report entitled "An Analysis of Problem Drinker Diagnosis and Referral Within the Fairfax ASAP, 1972."[3] The interrelations of these functions are diagrammed within an organization flow chart in Figure 1. To facilitate interpretation of the chart it is important to describe the treatment programs. Concise descriptions of the primary treatment courses along with their corresponding rehabilitative goals are as follows:

(1) Alcohol Safety School (Driver Improvement School) — An educationally based 16-hour program for improving driver behavior by increasing knowledge and building positive attitudes. A companion report in the 1973 analytic studies will give a detailed review of the types of Driver Improvement Schools in Fairfax.

(2) Fairfax Alcohol Community Education (FACE)— A supplemental 20-hour treatment in which a defendant is asked to assess the effects of drinking on his lifestyle.[4]



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

Figure 1. System operation within the rehabilitation and treatment countermeasure of the Fairfax ASAP—1973.

(3) Mental Health Center (Diagnostic and Evaluation Unit) — The primary role is to perform secondary evaluation of individual drinking problem diagnoses. This office of the Fairfax-Falls Church Mental Health Center has begun conducting group therapy for FACE Information Group courses. 5/

(4) Community Alcohol Center Clinic — This Clinic uses counseling and therapeutic techniques to treat persons having severe drinking problems. It is the only local treatment program authorized to administer chemotherapy, even though this capability has been utilized infrequently.

Referring again to the rehabilitative flow chart shown in Figure 1, there are two critical decision points meriting close attention. These key phases of the probation cycle are the pre-trial meeting with the court prosecutor and the diagnostic interviews managed by the Probation Office.

At the first key phase, prosecutors screen DWI offenders for entry or exclusion from the ASAP rehabilitation programs. The second key phase encompasses the tasks of performing diagnostic interviews and referral to appropriate treatment programs. Previously, the basic technique for accomplishing these probationary functions was centered around personal interviews for all ASAP clients. By the second quarter of 1973, the Fairfax ASAP Probation Office converted that system into one using "group intake" methods.

Judicial Screening Criteria

A series of factors are reviewed during the DWI defendant screening process. The intention of the judicial screening established by court judges and prosecutors was to have every suitable driver permitted entry into the ASAP probation system. Selected criteria are used to screen certain types of DWI offenders from entry into the ASAP pre-trial probation program. Prominent among the factors which tend to disqualify 10% or more of all potential probationary applicants are the following:

(1) DWI offenders having a series of major traffic violations. Judges prefer to impose severe sanctions upon the habitual traffic offenders. Often such offenders are convicted of DWI and placed on formal court probation with ASAP.

(2) Drivers residing outside a reasonable commuting distance from ASAP rehabilitation and probation facilities.

(3) Uncooperative DWI cases who will not agree to comply with the terms of ASAP probation.

(4) DWI recidivists (those arrested a second time for DWI) who may have successfully completed all phases of the ASAP rehabilitation programs assigned following their first alcohol-related traffic offense.

(5) There are exceptional cases where drivers have legal recourse against erroneous arrest procedures -- e.g., a DWI case in which the defendant's blood sample was misplaced or tested below the presumptive limits.

Throughout 1973, 3,777 arrests for DWI were reported; 2,688 defendants were initially admitted into the ASAP probation system. Among those returned to court, 581 were returned on formal probation and were referred to ASAP treatment programs.

Diagnostic Criteria

Until May 1973, the special Probation Office performed individual diagnostic interviews using the Mortimer-Filkins Test[6] to classify ASAP clients into three categories. Then each defendant was referred to the treatment program designed to handle his drinking category. Following reorganization, this procedure of using a validated instrument for diagnostic interviews along with singular treatment referrals was abolished because of its expense and slowness. Now each defendant participates in group diagnostic interview sessions designed to identify his drinking category. Starting with one group intake interview session, eventually all clients are assigned into one of three groups.

The respective drinking classifications are the following:

(a) Problem drinker.
(b) Non-problem drinker.
(c) Unidentified (pre- or potential problem drinker).

Corresponding definitions for these classifications center around the criteria for a problem drinker.[7]

"Problem drinker" -- a drinker defined by any one of the following:

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

(2) Self-admission of alcoholism or problem drinking,

(3) Two or more of the following:

(a) A BAC of .15 percent or more at the time of arrest,
(b) A record of one or more prior alcohol-related arrests,

(c) A record of previous alcohol-related contacts with medical, social or community agencies,
(d) Reports of marital, employment or social problems related to alcohol,
(e) Diagnosis of problem drinker on the basis of approved structured written diagnostic interview instruments. Examples: (MAST, Mortimer-Filkins, NCA or Johns Hopkins Diagnostic Tests).

"Non-problem drinker" — any drinker not classified as a problem drinker.

"Unidentified drinker" — after the (diagnostic) investigation has been completed and no decision can be made to classify a person as a problem or non-problem drinker he should then be classified "unidentified."

In July 1973, the staff of the Safety Section of the Virginia Highway & Transportation Research Council conducted a review of ASAP operations in Fairfax. The two members of the ASAP probation office who were interviewed explained that they were unfamiliar with and did not use the above definitions, which were provided by the Office of Alcohol Countermeasures.[8/]

Referral to Treatment

Since May 1973, the Probation Office has used a process relying upon group interview sessions for obtaining diagnostic information. In short, one probation officer conducts a group session with 8-10 defendants; after 2-3 hours, two other ASAP staff members are called in to review the facts collected by the "group intake". From the collected facts on drinking behavior, the three jointly agree to drinking classifications and treatment referrals in the presence of the 8-10 defendants.

METHODOLOGY

Sources of Data

Several sources of diagnosis and referral information must be drawn upon to achieve an adequate analysis of the DWI diagnosis and referral. Available quantitative data for the analysis are compiled from the following:

(1) ASAP form 7, shown in Exhibit 1, and completed for each pre-sentence investigation case, includes 21 specific symptoms of problem drinking. It would be anticipated that DWI defendants having equal numbers of problem drinking symptoms would be grouped into identical drinking categories, and that the presence of extensive overlaps would provide evidence of inconsistent interpretation of data.

EXHIBIT 1

ASAP-7 (Rev. 8/73)

ALCOHOL SAFETY ACTION PROJECT

ASAP CASE # _____ COURT _____ COURT DATE _____ BAC _____

NAME _____ ARREST DATE _____

SEX _____ RACE _____ SOCIAL SECURITY NUMBER _____ AGE _____

DOB _____ POB _____ LEVEL OF EDUCATION _____

ADDRESS _____ APT. NO. _____

CITY _____ COUNTY _____ STATE _____ ZIP _____

TELEPHONE – HOME _____ WORK _____ SPOUSE'S WORK PHONE _____

MARITAL STATUS _____ NO. OF DEPENDENTS _____ PREVIOUS MARRIAGES _____

MILITARY SERVICE – BRANCH _____ DISCHARGE DATE OR ACTIVE _____ HIGHEST RANK _____

EMPLOYMENT _____ LENGTH OF TIME HERE _____

JOB TITLE _____ SALARY $ _____ ☐ CIVIL SERVICE ☐ MILITARY

HEALTH PHYSICAL _____ MENTAL _____ SPOUSE'S _____

LAST PHYSICAL EXAM _____ UNDER PROFESSIONAL CARE _____

☐ VA DISABILITY ☐ OTHER DISABILITY _____

☐ HEALTH INSURANCE _____

OPERATOR'S LICENSE – STATE _____ NO. _____ ☐ VALID ☐ REV. OR SUSP.

PRIOR RECORD – DWI _____ DIP _____ OTHER _____

COMMENT _____ ☐ ALCOHOL RELATED ☐ FAMILY RELATED

THE ABOVE INFORMATION IS TRUE AND CORRECT _____

THE FOLLOWING SYMPTOMS OF PROBLEM DRINKING WERE OBSERVED DURING INTERVIEW:

___ DAILY DRINKING	___ GUILT ABOUT DRINKING	___ USING MEDICATION
___ OFTEN DRINKS TO EXCESS	___ HAS SOUGHT OR OBTAINED TREATMENT	___ ILLNESS DUE TO DRINKING
___ BAR DRINKING	___ ONE OR MORE BLACKOUTS	___ PERSONALITY CHANGES WHILE DRINKING
___ DRINKS ALONE	___ MISSED WORK DUE TO DRINKING	___ MARRIAGE / HOME PROBLEMS
___ BINGE DRINKING	___ SHAKING OR TREMORS	___ SELF ADMISSION OF DRINKING PROBLEM
___ DRINKS FOR REASONS	___ MORNING SICKNESS	___ AA CONTACT
___ HIDING LIQUOR	___ DRINKS IN MORNING	___ _____
___ ATTEMPTS TO CONTROL DRINKING		

INTERVIEWER'S IMPRESSIONS AND RECOMMENDATIONS:

INTERVIEWED BY _____ DATE _____

PROBATION OFFICER _____

☐ PROBLEM DRINKER
☐ NON-PROBLEM
☐ UNDETERMINED

☐ TRIAL PENDING – COURT DATE _____ ☐ PROBATION – EXPIRATION DATE _____

	REFERRAL DATE	COMPLETION DATE
PROGRAM REFERRAL (FIRST) _____		
PROGRAM REFERRAL (SECOND) _____		
PROGRAM REFERRAL (THIRD) _____		
PROGRAM REFERRAL (FOURTH) _____		

(2) Either ASAP form 7, or ASAP form 1, the Probation Office data analysis card shown in Exhibit 2, should establish the relationship between the individual drinking classification and corresponding treatment program referrals. It is important to determine how often individuals placed in particular drinking problem categories are referred to the same combination of treatments.

(3) ASAP form 7 and ASAP form 10 (refer to Exhibit 3), the Court Data Card, should serve as a check on the time frames associated with each phase of the probation process. Comparisons of the time intervals between the dates for DWI arrest, pre-trial hearing court appearance, case continuance period, Probation Office investigative interview, treatment program referral, completion of rehabilitation courses, and final court trial can uncover process delay points or backlogs of activity.

(4) A VHRC-ASAP evaluation form entitled Recidivist Fact Sheet (refer to Exhibit 4) provides information concerning those DWI offenders who have multiple alcohol-related traffic arrests. These forms show which combinations of rehabilitation treatment programs are most frequently associated with DWI recidivists — a proven ASAP system failure.

(5) The coded information items in ASAP form 1 (refer to Exhibit 2) can be key punched and cross-tabulated to examine characteristics of various subgroups of all DWI defendants. This same type of analysis is performed in companion reports on 1973 judicial, rehabilitative, and recidivist activity. To avoid redundancy this source of research input will not be emphasized here.

(6) Appendix H Tables 11 and 14, available for each quarter of ASAP operations, contain aggregate summaries of defendant drinking classifications and rehabilitation program enrollments. These ASAP activity summaries can be charted in a time series fashion to detect trends within classification and enrollment.

Data Analysis

Diagnostic Criteria

The case records for 75 probation defendants entering the ASAP system since August 1973 are reviewed to compile material on the 21 drinking characteristic variables. The number of symptoms of problem drinking checked for each probation case is compared with corresponding diagnostic classifications. By summing the number of checked variables for 25 DWI cases diagnosed in each of three drinking levels, sample means and 95% confidence intervals for each category can be established.

EXHIBIT 2

PROBATION OFFICE
DATA ANALYSIS

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

2. CASE NO: ___ ___ ___ ___ ___ ___ ARREST DATE:_____

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

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

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

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

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

8. RESIDENCE /__/
Code
1- ASAP Area
2- Other Va.
3- Maryland
4- D.C.
5- Other
8- Not Known

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

10. NO. TIMES MARRIED /__/
Code
0- None
1- One
2- Two
3- Three
4- Four
5- Five
6- Six
7- Seven or more
8- Unknown

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

12. PREVIOUS DWI ARREST (DMV) /__/

13. PREVIOUS RECKLESS ARREST (DMV) /__/

14. OTHER MOVING VIOLATIONS LAST 3 YRS. (DMV) /__/

Codes for DMV Record Items 12-16 & CCRE Items 17-18
0- None
1- One
2- Two
3- Three
4- Four
5- Five
6- Six
7- Seven or more
8- Unknown because record (DMV or CCRE) not available

15. LICENSE /__/ REVOKED (DMV)

16. REPORTABLE /__/ ACCIDENTS IN LAST 3 YRS.(DMV)

17. ALCOHOL OFFENSES /__/ LAST 5 YRS. (CCRE)

18. OTHER OFFENSES /__/ LAST 5 YRS. (CCRE)

19. BAC /__/ __ __
Code
1- Under .10
2- .10-.15
3- .16-.25
4- Over .25
5- Refused Test
8- Unknown

20. TEST SCORE /__/ T:__ __ __
Code
1- Under 60 Q:__ __ __
2- 60-85
3- Over 85 I:__ __ __
8- Unknown

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

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

Date this form initially completed_____

24. Completed by ___ ___
Code - Enter 2-digit Fx staff Code

ASAP FORM #1 1/12/73

EXHIBIT 3

ASAP COURT DATA CARD

DEFENDANT_____ COURT_____

Warrant or Summons No._____ County_____Municipal_____Cir._____

ASAP #_____ Docket #_____ Referred to ASAP Yes_____ No_____

Arrest Date_____ Continuance Date_____

Initial Court Date_____ Date Tried_____

Arresting Officer_____ BAC_____

CHARGES: DWI_____ Refusal_____ Reckless Driving_____ No O.L. in Poss._____

Other charges_____

DISPOSITION: Plea to DWI_____

Plea to a lesser charge_____

Convicted of_____

SENTENCE: Jail_____ Suspended_____Imposed_____

Fine_____ Suspended_____Imposed_____

Court Costs_____

Operators License_____ Suspended_____Revoked_____

Probation_____ Active to ASAP_____

Good behavior only_____

Probation Expires_____ Report desired_____

If Nolle Prossed, reason: _____

If Dismissed, reason: _____

Date Released from Probation_____

If Probation Revoked, date:_____Sentence Imposed_____

Judge_____

Prosecutor_____

Clerk_____
(Or other person completing this form)

ASAP Form 10
May 15, 1973

EXHIBIT 4

RECIDIVIST FACT SHEET

Name and Age of Recidivist _____

Date of Initial Arrest/ BAC _____ Inclusive ASAP Quarterly Periods _____

Date of Subsequent Arrest/ BAC

_____ _____
_____ _____
_____ _____
_____ _____

Dates of Current Traffic Convictions (1967 to date, excluding above arrests) _____ Description of Charges _____

_____ _____
_____ _____
_____ _____

Score on MAST _____ Drinking Category _____

Recommended Treatments _____ Time Frame for Sessions _____

_____ _____
_____ _____
_____ _____

Type and Percent of Treatments Completed, prior to Subsequent Arrests (2) _____ (3) _____

_____ _____
_____ _____
_____ _____

Probation Officer _____ Place of Residence _____

Data for quarterly ASAP diagnostic decisions are charted on Figure 4. It is assumed that any major cycles in quarter-to-quarter distribution patterns would be attributable to ASAP Probation Office policy changes rather than actual changes in the characteristics of the defendants.

Referral Criteria

Using the above set of 75 cases, with 25 case files representing each of the three drinking categories, a graphical scheme is structured to depict the distribution of treatment referrals into combinations of treatment programs for each category. This technique should detect any overlapping areas where persons diagnosed in different drinking categories receive similar treatment referrals or those in the same category are assigned different levels of treatment combinations.

Economic Costs

Costs of diagnosis and referral activities are estimated by the Probation Office and are not examined.

Recidivism

The VHRC-ASAP evaluation forms for all 1973 recidivists (ASAP cases having multiple DWI arrests) are summarized in tabular form. This material comprises the only available information for complying with two NHTSA guidelines for key analytic studies.[9] It is expected that this limited research input will fall short of either specifying "the effectiveness of ASAP referral activity in reducing recidivism" or showing "the effects of probation follow-up on recidivism."[10] A cursory analysis can describe which combinations of treatment programs — controlled for the three classifications of drinkers — are most frequently associated with recidivism.

Here, the methodology for the research could have yielded significant facts, provided data collection limitations were removed. Restricting obstacles resulted from the fact that the data needed to complete Appendix H Table 15 are not available. In attempting to remedy this deficiency, the Fairfax ASAP Probation Office was asked to provide quarterly enrollment data by drinking classification for all combinations of treatment programs on a timely basis.

ANALYSIS

Data for the first phases of the analysis outlined by the research methodology are tabulated in the Appendix. Included are the diagnostic and referral characteristics of 75 ASAP clients, randomly drawn in accord with criteria specified in the methodology. Sample cases are grouped with 25 in each of the three drinking categories. Viewing the tabulation from left to right, column one lists the Fairfax ASAP Probation Office reference file number for each case drawn for the sample. The second column identifies the diagnosed drinking category for individual ASAP clients. Column three specifies the BAC of each defendant at the time of arrest for drunken driving. A fourth column lists the number and type of problem drinking symptoms detected during intake interviews. Column five specifies the number and type of prior traffic convictions for each individual. The sixth column shows the combination of ASAP treatment programs assigned. The last three columns form a set of time frames for the intervals between DWI arrest, probation intake interviews, and enrollment in the first assigned ASAP treatment program.

Diagnostic Criteria

The data were organized to establish the statistical means and 95% confidence intervals corresponding with the number of problem drinking characteristics for each drinking category. The results of these statistical calculations are illustrated in Figure 2. It was determined that the means for non-problem, unidentified (pre- or potential problem drinkers) and problem drinkers are 1, 3, 4 and 9, respectively. Corresponding 95% confidence intervals are listed and graphically illustrated in Figure 2. The 95% confidence interval is the range within which all but 5% of the sample values should be contained.

An experimental model which simulates ASAP diagnostic decisions was empirically constructed by interrelating three key elements: number of problem drinking characteristic variables, BAC level at time of arrest, and prior traffic violations. Figure 3 provides a graphic model caliabrated with the input data and corresponding decisions tabulated in the Appendix. For clarification, a separate set of instructions for chart utilization are attached on the page preceding the model (see Instructional Guidelines for Figure 3).

Through application of the model it was found that more than 75% of the diagnostic decisions tabulated in the Appendix are in agreement with the parameters of the model. Because a significant proportion of similar cases were diagnosed into different drinking categories, further restructuring of the model would not appreciably improve sharpness.

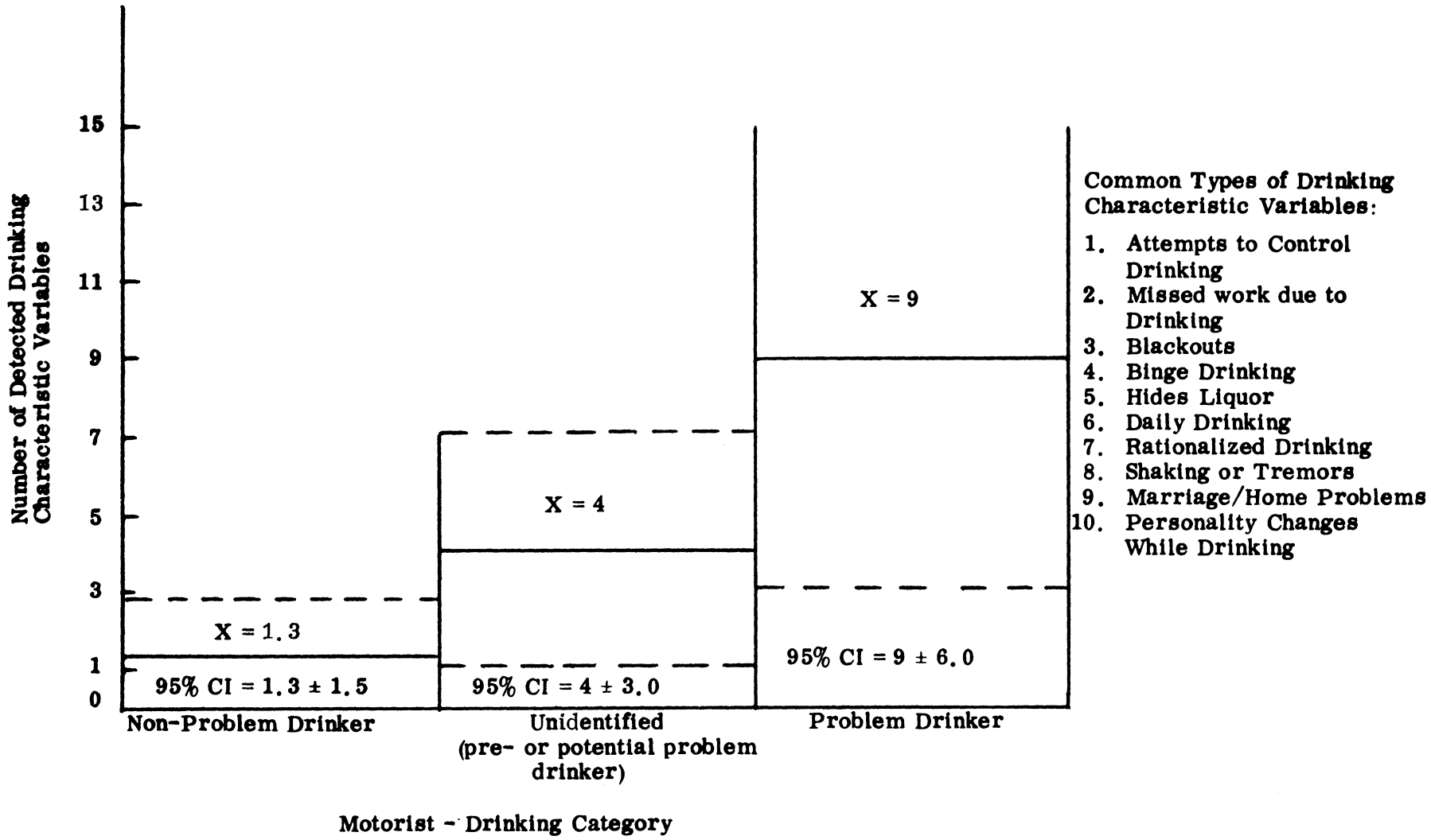


Figure 2. Statistical means and 95% confidence intervals for symptoms of problem drinking: 75 cases, Fairfax ASAP, 1973.

(Instructional Guidelines for Figure 3)

Refer to the diagrammatic model to cross-check each diagnostic decision. The model provides a comparison with a representative sample of previous probation staff decisions.

1. Start by establishing a point on the scale at the upper left corner of the model. The number of detected drinking characteristic variables checked on ASAP form 7 determines that point on the scale. By special note, those cases with more than 10 checked variables exceed the immediate parameters of the model so that it might be worthwhile to extend parts of the graph on the same scale. It was anticipated that the abbreviated graph would be adequate for the majority of cases and using fewer values in a larger scale would facilitate accuracy.

2. From the point established for the first key variable draw a horizontal line until it reaches intersection with the client's BAC level at time of arrest. That intersection with the BAC level establishes a second point on the graph.

3. Proceeding from the second point, draw a perpendicular line downward until it reaches intersection with the defendant's traffic conviction index. To avoid confusion, a simplistic technique provides that the traffic conviction index is assumed equal to the number of prior traffic convictions—irrespective of the type of violation. If the situation merits further refinement, a more sophisticated chart could be devised to have severe violations read progressively higher on the traffic conviction index—e.g., a conviction for reckless driving coincident with an accident should yield a very high value on the index scale.

By this procedure a third point is established at the above described intersection. It must be noted that the traffic conviction index lines for values of zero and one were graphically interrupted. This alteration was deliberate so that for cases where planned intersections with index lines zero and one are not obtainable, the client should be placed in the next higher group—i.e., the unidentified category. The effect of this empirical procedure is to ensure that cases having combinations of both borderline (nearly significant) numbers of drinking variables and BAC levels are not frequently underclassified and inappropriately placed in lesser categories on the basis of negative traffic violation records.

4. From the third point, draw another horizontal line over to a final intersection with the calculated drinking category. Thus a cross-check is established for each diagnostic decision.

Certainly if stronger evidence concerning ASAP client drinking behavior is available, utilization of the model can be superceded. The methodology for this study purposefully excluded the following types of cases:

(a) Persons with physical deterioration due to long-term alcohol consumption.
(b) Cases where there are family/employment descriptions of alcohol problems.
(c) Those arrested for DWI during unusual times such as daylight-weekdays.

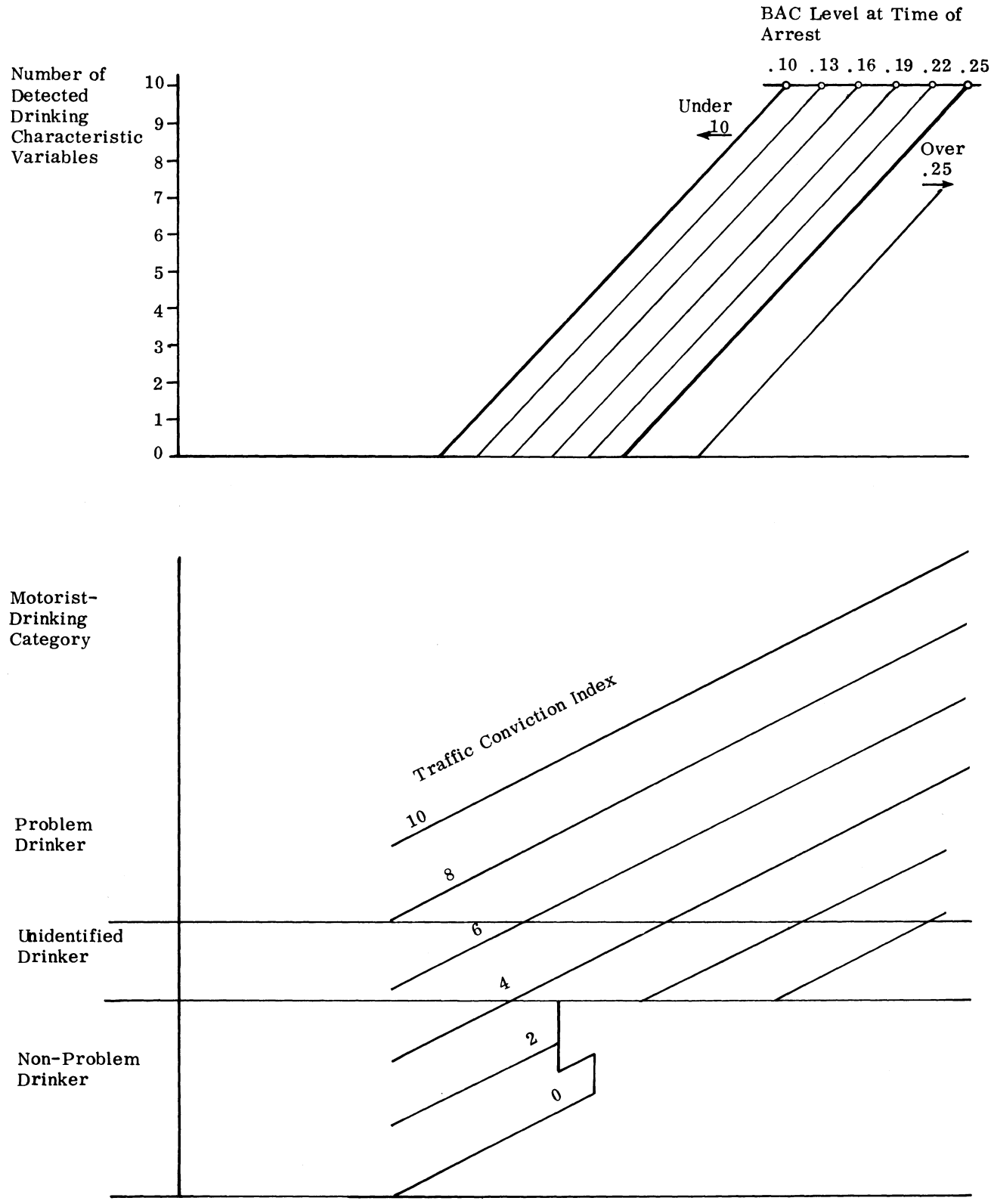


Figure 3. Diagrammatic model for interrelating key variables to determine motorist drinking categories.

It is the opinion of the author that 15-20% of diagnostic decisions in the test sample sharply differed from the mainstream of diagnostic patterns. The intended use of the model provides a capability of identifying these "exceptional case" diagnostic decisions. Once a number of these non-predictable cases are separated from others by measurable criteria, they should be reviewed in detail to explain what criteria are associated with the inconsistent assignment of clients into various categories. Any attempt to validate the new group intake process would prove ineffective as long as the proportion of untypical decisions remains significant and unexplained. This topic would merit further study if probation management policies are modified to reduce the frequency of unsystematic diagnostic decisions.

It is important to review the impact of the 1972-73 diagnostic policy upon all ASAP probation clients. Towards this objective, time-series data pertinent to the quarterly distribution of diagnostic decisions are examined.

The chart shown in Figure 4 displays the distribution of ASAP clients into the three drinking categories by quarterly reporting intervals. Attention is immediately drawn to the extreme degree of variance in the pattern for diagnostic decisions. At the start of 1972, about 40% were diagnosed as problem drinkers; by quarter 4 only 12% were classified as problem drinkers, and by quarter 7 more than 50% were so classified. In the absence of positive policy controls, the pattern of Fairfax ASAP diagnostic decisions has vacillated almost to a pinnacle of inconsistency at times. The 75 probation case samples for the diagnostic decision model were taken in September 1973.

Referral Criteria

In order to conform with sound principles of case management, each client must be accurately diagnosed and referred into a suitable combination of ASAP treatment modalities. The preceding phase of this study established that 75% of the sample ASAP cases were diagnosed using a systematic and predictable pattern. The actual effectiveness of these diagnostic decisions should be measured during the process of validating the group intake system recommended for 1974. The next phase of the probation case management system involves follow-through referral decisions. Defendants should be assigned into treatment combinations corresponding with their respective drinking classifications.

For the Fairfax ASAP, an extensive series of treatment referral combinations has evolved. The most frequently encountered single or multiple treatment combinations can be considered to correspond with three treatment levels.

1. Level I — Treatment programs were structured to deal with "non-problem" drinkers.

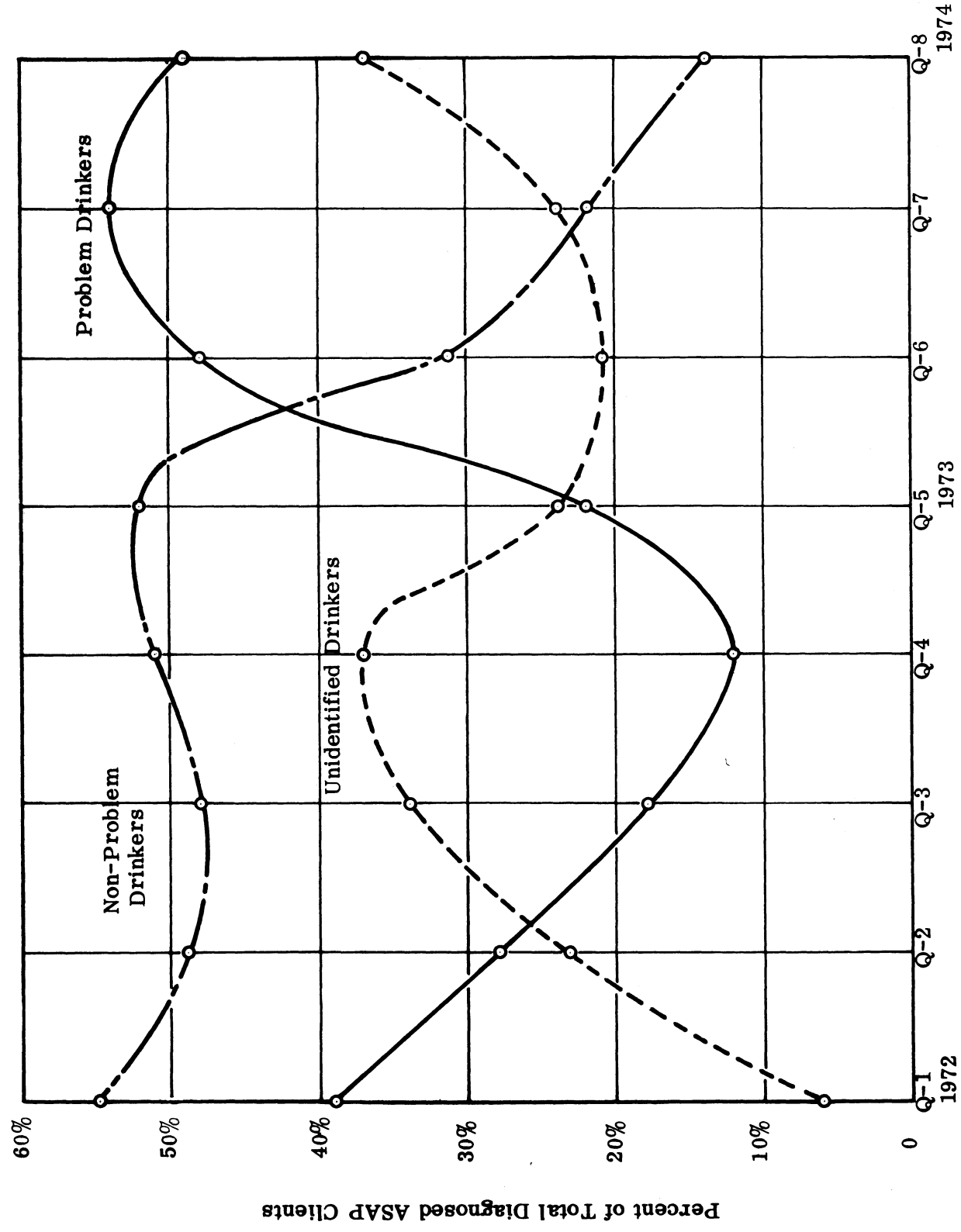


Figure 4. Time series chart illustrating the distribution of Fairfax ASAP clients into motorist drinking categories.

2. Actual usage of the level II treatment scheme is administratively complicated; however, in basic terms it was organized to manage unidentified clients, who are ultimately classified as "pre-problem drinkers".

3. Level III, the extreme (most severe) end of the scale for those with alcohol lifestyle problems, includes the final treatment alternatives for problem drinkers.

The chart shown in Figure 5 illustrates the distribution of treatment referrals for the previously described sample of 75 ASAP probation cases. In reference to the diagram, the vertical axis separates areas to correspond with a series of ASAP treatment program combinations. The horizontal axis is graphically segmented into the three drinking categories. All treatment referral combinations can be identified by use of the abbreviation code — i.e., FACE + MHC is a dual combination of sessions with the Fairfax Alcohol Community Education course and the Mental Health Center's ASAP Diagnostic Unit.

When first glancing at Figure 5 one might wonder how 75 ASAP clients, initially grouped 25 into each of three categories, were ultimately referred into 19 different diagnosis-referral treatment combinations. Moreover, 11 clients were referred into treatment combinations levels above those geared to their respective levels of problem with alcohol. Likewise the chart shows that 9 of the sample cases were referred to treatment combinations below their diagnosed level of need. A partial explanation is offered for the 9 sample cases. All 75 cases were reviewed while "active" and the apparently "under-treated 9" might be ultimately reassigned to more intensive treatment programs. Yet their respective administrative files for both the "under-treated 9" and the "over-treated 11" did not include explanations for their assignments into extra-category treatment combinations.

Definitive administrative policies are needed to guide the referral of Fairfax ASAP clients following their diagnosis into three drinking categories. In retrospect, the Probation Office policy in 1972 simply established that "non-problem" drinkers attend driver improvement school, "unidentified" (the pre- or potential problem drinker terms had not been associated with the category) clients enroll in FACE (Fairfax Alcohol Continuing Evaluation — 1972 term) and "problem drinkers" should be referred to community alcohol clinics or comparable programs sponsored by military institutions.

Now that multiple treatment is the alternative most frequently selected by individual probation officers, there is a need to develop specific treatment referral guidelines. For example, it is especially important to have mechanisms that will ensure that cases such as the "under-treated 9" are ultimately matched with the correct level of treatment. In this example, the 9 cases sent to extra-treatment referral combinations should be followed up. The progress reports from instructors in their initial treatment programs must be detailed enough to explain whether "untypically referred" individuals proved to be in correct treatment modalities.

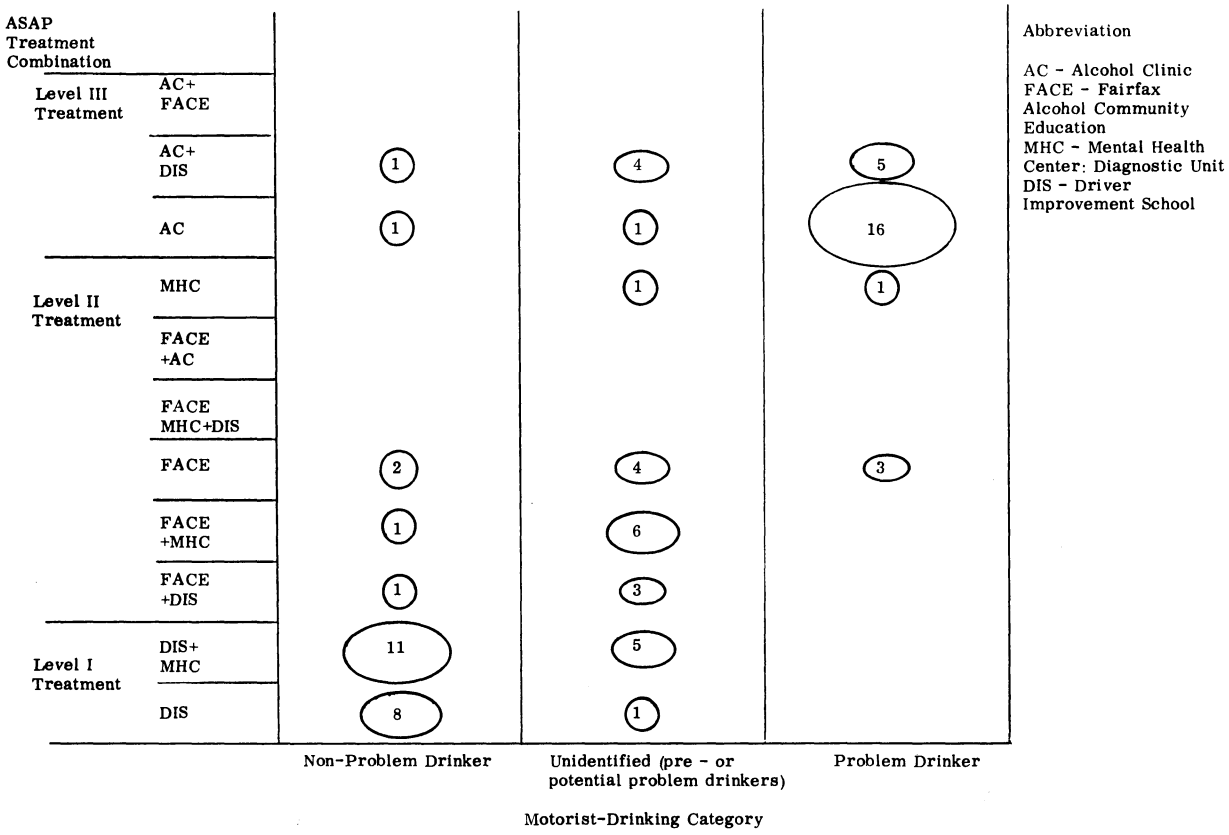


Figure 5. Frequency of ASAP treatment referrals by motorists — drinking categories.

At present there are no systematic administrative guidelines listing the criteria for referring ASAP clients into the 11 combinations of treatments shown in Figure 5. Following the 1972 referral policy, a supplementary policy provided that "all Fairfax ASAP probation cases are to attend DIS."[11/] Yet the chart in Figure 5 indicates that 36 of the 75 sample cases were not administratively scheduled for DIS. It might be conceded that these 36 should not have been referred to DIS until they completed initial program referrals. Yet the fact emerges that there were no administrative file notes indicating that the "everyone to DIS" policy will be adhered to for these "active" cases.

The diagram shown in Figure 6 shows the corresponding impact of referrals on enrollment in primary ASAP treatment modalities. It was previously concluded that there is little correlation between diagnostic classification and subsequent referral to treatment. Hence the diagram in Figure 6 serves only to verify a long-term growth of quarterly enrollment for each of the primary treatment modalities. It is believed that the sustained growth in enrollment was due to multi-treatment referrals rather than a meaningful increase in DWI apprehensions, and was sustained in spite of recent increases in the volume of DWI offenders who do not participate in the voluntary rehabilitation program.

Cost Analysis

Data from Appendix H tables indicated that 2,696 defendants were diagnosed and referred in 1973 by the Probation Office. The breakdown by classification of drinking is as follows:

Annual Number Classified and Referred

Problem Drinkers	1,144
Non-problem Drinkers	869
Unidentified Drinkers	683

In order to calculate the unit costs for diagnosis and referral, the total costs of the Probation Office and the Diagnostic Unit of the Mental Health Center were used. Treatment at the Mental Health Center is handled separately through the use of a fee system. The costs in 1973 for the Probation Office were $149,820 and were $72,652 for the Diagnostic Unit for a total of $222,472. Dividing the total costs by the number of defendants diagnosed and referred yielded a unit cost of $82,51. Even using a conservative estimate that only 60% of the Probation Office costs should be allocated to diagnosis and referral, the unit costs would still be in excess of $60.00.

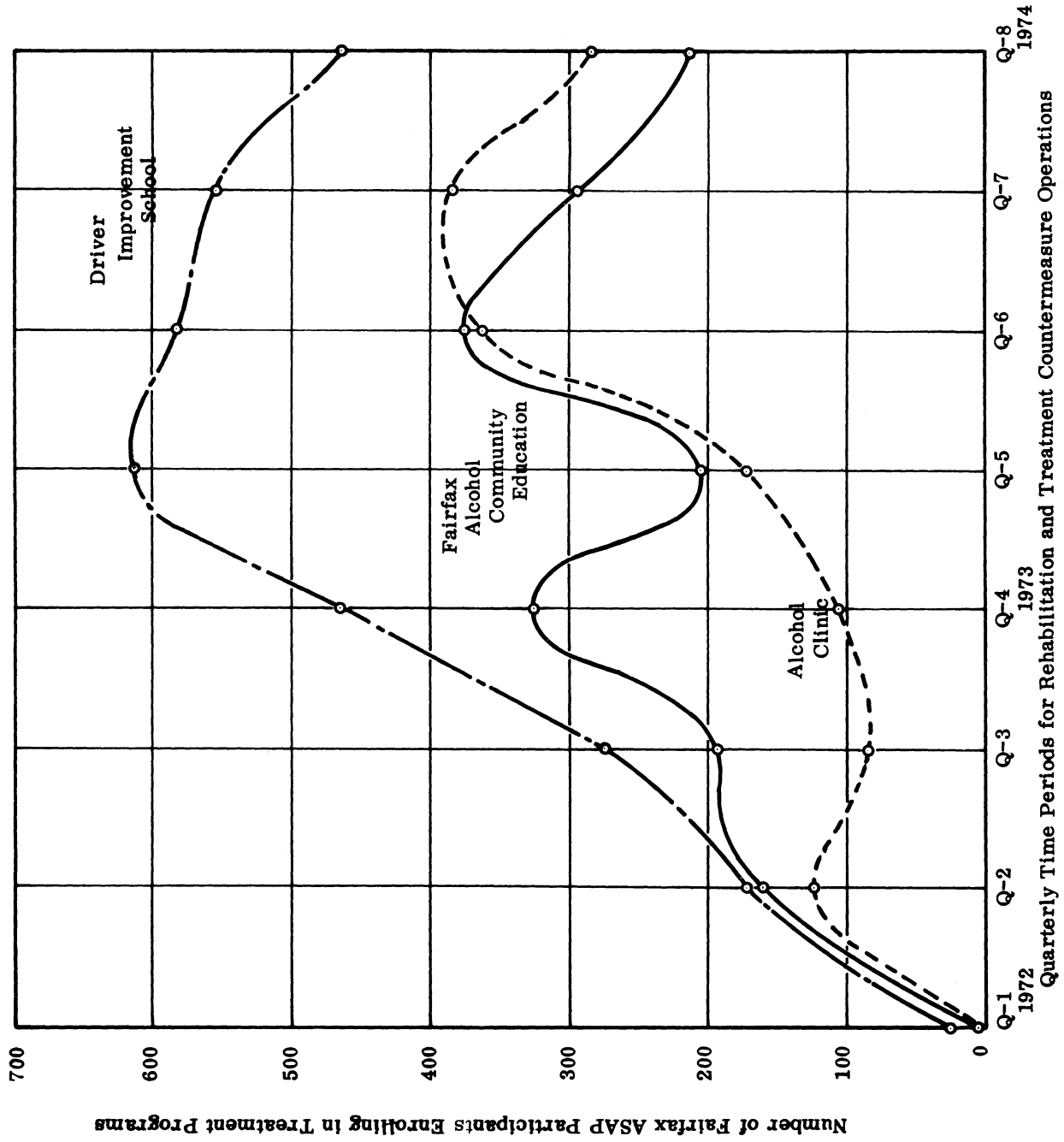


Figure 6. Graphical plot of quarterly enrollments for each primary treatment modality in the Fairfax ASAP.

Information provided by the Office of Alcohol Countermeasures, NHTSA, indicates that intensive and costly programs of defendant diagnosis and referral are common in the ASAP program. In a recent report on project operations, OAC evaluation had this to say: "Based on the experience of these 29 projects, it is OAC's opinion that the use of intensive, in-depth presentence investigation is too expensive and time-consuming for most sites. This is especially true when a large volume of cases moves through the system."[12]

This conclusion was based on average cost figures from the 29 projects of from $20 to $50.

At the beginning of project operations, it is possible that intensive and in-depth diagnostic procedures were warranted based upon the idea that proper referral was critical to successful rehabilitation. It was not then contemplated that defendants would be referred to multiple treatment programs. Thus the current situation in the Fairfax ASAP is an anomaly. An intensive, detailed, and costly diagnostic procedure is usually followed by multiple referrals to a variety of treatment programs. In fact, it has been documented previously in this report that diagnosis and referral to treatment are not based on criteria established by the Office of Alcohol Countermeasures of NHTSA, and moreover, the referral to treatment does not always match the drinker classification established by the diagnosis. Considering that the costs of diagnosis and referral are frequently greater than the costs of an individual's rehabilitation, it does not seem that such costly intake procedures are a reasonable management strategy in view of limited project resources. Diagnostic decisions based on the model developed in this report and based largely on OAC criteria matched more than 75% of the diagnoses developed in the current intake procedures. Thus an alternative to the current costly intake of all individuals would be to use the proposed model for making the diagnostic and referral decisions which are clearly defined by the model and supplementing this with group intake of the borderline cases.

Time Analysis

Returning briefly to the 75 sample cases, the methodology proposed a review of the distribution of time frames for ASAP clients to identify any extensive delays between referral and actual enrollment in treatment. For the sample cases the parameters for these time frames are tabulated in the Appendix. A check of those data indicated that it would not be productive to perform the time-series analysis. It appears that the information, taken from individual probation files, is largely invalid for research purposes.

The administrative files for the 75 cases show that 12 clients attended treatment sessions the same day of referral (one actually listed as the day before referral), six within 24 hours, and eight within 48 hours. Given the large number of administrative procedures required to schedule treatment groups, it is highly doubtful that more than one-third of the sample entered treatment within 48 hours. Concluding that present time-frame data are most

unreliable, it is suggested that attention should be concentrated upon the need to administratively designate specifically when ASAP clients attend their first treatment session.

Recidivism

In order to develop an adequate methodology, there should be an attempt to review the effectiveness of referral activity towards reducing recidivism. Previously described data collection limitations restricted the opportunity to perform a detailed analysis of those arrested on a second DWI subsequent to their diagnosis and referral to ASAP treatment modalities. There are plans to compile the missing diagnosis and treatment combination enrollment for all 1973 DWI cases.

Once this extensive inventory is completed and summarized in Appendix H, Table 15 for the ASAP annual report, it should serve as input to a pair of needed analytical studies closely related to diagnosis and referral activity. The first of these key analytic studies will cover the topic of recidivist characteristics in the Fairfax ASAP, 1973.

Matching Diagnosis and Referral Decisions

It is possible that the "everyone to DIS" policy and preference for the "combination alternative," whereby the typical client is referred to a series of treatment programs, are both reasonable strategies. Yet referral criteria need to be structured into policy guidelines. During the development of subsequent administrative policy, care should be taken to limit the number of programs assigned to any one individual. Certainly a person with complicated alcohol problems should benefit from continued exposure to a succession of treatments. On the side of caution, the proliferation of new ASAP treatment programs leaves each client vulnerable to a chain of time-consuming and costly (fees) treatments; his only protection comes from efficient referral decisions whereby diagnostic decisions are systematically related to subsequent referral decisions.

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3/ Ibid.

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7/ Alcohol Safety Action Projects: Evaluation, U. S. Department of Transportation NHTSA, Office of Alcohol Countermeasures, January 1972, Section C, p. 31.

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9/ "Guidelines for Key Analytic Studies, Revised 12/12/73," A supplement to Section G of Alcohol Safety Action Projects: Evaluation, U. S. Department of Transportation, NHTSA, Office of Alcohol Countermeasures, January 1973.

10/ Ibid.

11/ Rocchio, Richard, "Instructions mentioned in staff meeting and interview with VHRC staff members," August 1973.

12/ U. S. Department of Transportation, NHTSA, Alcohol Safety Action Projects: Evaluation of Operations — 1972, Volume II, Chapter 5, pp. 17-18 (1974).

APPENDIX

DIAGNOSTIC AND REFERRAL CHARACTERISTICS OF ASAP CLIENTS

Case Number	Diagnosed Drinking Category	BAC Level	Number and Type of Problem Drinking Symptoms	Number and Type of Prior Traffic Convictions	ASAP Treatment Referrals	DWI Arrest Date	Probation Interview Date	First Treatment Enrollment Date
	Non-Problem							
5831	"	.18	(1) Reason Drinking	(1) Speeding	DIS MHC Op End	9/5/73	9/26/73	9/27/73
5848	"	.22	(2) Excess, Control	(0)	DIS	9/8/73	10/4/73	10/4/73
5910	"	.10	(2) For Reasons, Guilt	(1) Speeding	DIS	9/16/73	10/10/73	12/3/73
6056	"	.15	(1) Marriage Problems	(1) Reckless	DIS MHC Op end	9/24/73	12/5/73	12/5/73
6053	"	.24	(2) For Reasons, Job Stress	(0)	DIS MHC Op end	9/24/73	10/24/73	12/3/73
5973	"	.10	(2) Attempts Control, Blackouts	(3) Speeding, Fail to keep control	DIS	9/18/73	10/17/73	10/25/73
5941	"	.13	(0)	(0)	DIS	9/16/73	10/18/73	10/25/73
5872	"	.10	(2) Missed School, Shaking	(4) Speeding, Reckless, No co. tag	Ind Int w/PO DIS	9/8/73	1/24/73	1/23/74
6066	"	.16	(2) Attempts Control, Blackouts	(0)	ADCO	9/27/73	10/24/73	11/12/73
5968	"	.12	(1) Shaking	(3) Speeding, No OL Improper Lane Chge	DIS MHC O-e	9/19/73	10/18/73	10/25/73 12/15/73
6068	"	.23	(2) Drinks to Excess, Personality Changes	(6) Speeding, Imp Equip Op Overweight veh Reckless	FACE	9/27/73	10/30/73	11/5/73
5857	"	.19	(2) Attempts Control Personality Changes	(0)	DIS, MHC O-e	9/9/73	10/4/73	12/1/73 2/20/74
6099	"	.10	(0)	(1) Fail to Obey Highway Signs	MHC O-e FACE	9/29/73	10/24/73	11/7/73
6041	"	.10	(1) Reason Drinking	(0)	DIS, MHC	9/25/73	10/30/73	2/12/74 11/5/74
5902	"	.15	(1) Attempts Control	(0)	DIS, MHC	9/15/73	10/9/73	11/1/74
5815	"	.11	(1) Marriage Problems	(0)	Mont. Co. DWI School	9/5/73	10/30/73	11/5/73
6045	"	.11	(1) Blackouts	(0)	FACE, DIS	9/25/73	10/24/73	10/25/73 3/14/74
6042	"	.20	(2) Excess, Attempts Control	(1) Speeding	FACE	9/26/73	10/30/73	11/5/73
5933	"	.10	(0)	(0)	DIS	9/13/73	10/10/73	10/10/73
5928	"	.17	(1) Excess	(0)	HEADWAY-Info DIS	9/10/73	10/17/73	10/19/73 11/4/73

Case Number	Diagnosed Drinking Category	BAC Level	Number and Type of Problem Drinking Symptoms	Number and Type of Prior Traffic Convictions	ASAP Treatment Referrals	DWI Arrest Date	Probation Interview Date	First Treatment Enrollment Date
	Non-problem							
5979	"	.15	(0)	(3) Speeding, Obstr Traffic, Fail to Obey	DIS, MHC O-e	9/20/73	10/18/73	10/25/73
5916	"	.14	(1) Blackouts	(0)	DIS, MHC O-e	9/16/73	10/9/73	10/12/73 1/31/74
6023	"	.14	(1) Personality Changes	(8) Speeding, Reckless Operation in Violation of Restr Lic	DIS	9/22/73	10/17/73	10/25/73
6044	"	.15	(3) Attempts Control, Blackouts Heart and Cholesterol	(0)	DIS, MHC O-e	9/25/73	10/24/73	11/28/73 2/14/74
6033	"	.18	(1) Excess	(0)	DIS, MHC O-ed	9/23/73	10/17/73	10/25/73
	Undetermined							
5851	"	.17	(5) Reason Drinking, Control, Medical Illness Due, Marriage Prob.	(1) Speeding	FACE	9/8/73	10/4/73	10/4/73
5992	"	.18	(4) Excess, Alone, Attempts Control, Guilt	(1) Speeding	Arl A/C	9/21/73	10/16/73	11/28/73
5883	"	.09	(5) Daily, Alone, Attempts Control Morning, Home Problems	(6) Speeding, Impr Lane, Vio Traf. Sign.	MHC Op end R/DIS	9/3/73	9/27/73	11/1/73
5900	"	.25	(5) Excess, Reasons, Use Medic., Illness Due To, Marriage Prob.	(0)	FACE DIS	9/15/73	11/6/73	11/8/73
5982	"	.13	(5) Excess, For Reasons, Guilt, Marriage Probl., Self-Admit	(0)	MHC FACE	9/20/73	10/16/73	11/26/73
5855	"	.16	(5) Daily, Alone, For Reason, Use medic, Marriage Prob.	(1) Speeding	FACE, DIS Woman's Cr. Grp.	9/6/73	10/5/73	11/20/73
5998	"	.10	(5) Excess, Alone, For Reason Missed Wrk, Pers. Changes	(1) Fail to Obey Hi-way Markings	MHC Op End DIS	9/23/73	10/9/73	10/18/73
5849	"	.14	(5) Binge, Attempts To Control, Use Medic, Illness Due To, Denial	(1) Op. Uninsp. Veh.	MHC Op-end FACE	9/9/73	10/4/73	10/11/73
6014	"	.15	(3) For Reasons, Use Medication Marriage Problems	(0)	MHC Indiv Woman's Grp	9/22/73	10/16/73	10/16/73
5870	"	.13	(4) Daily, Alone, Attempts to Control, Blackouts	(0)	ADCO, DIS	9/9/73	10/10/73	10/10/73
6003	"	.22	(5) Daily, Excess, For Reasons Attempts to Control	(2) Impr Brakes Impr Control	MHC Op-end Woman's Level II Grp	9/3/73	10/16/73	10/16/73

Case Number	Diagnosed Drinking Category	BAC Level	Number and Type of Problem Drinking Symptoms	Number and Type of Prior Traffic Convictions	ASAP Treatment Referrals	DWI Arrest Date	Probation Interview Date	First Treatment Enrollment Date
	Undetermined							
5863	"	.10	(3) Attempt to Control, Use Medic, Pers Changes	(3) Speeding, Impr Equip	MHC O-e DIS	9/3/73	10/8/73	10/18/73
5981	"	.15	(2) Attempts Control, Blackouts	(0)	MHC O-e DIS	9/20/73	10/16/73	10/30/73
5856	"	.29	(5) Excess, Bar, Attempts Contr Blackouts, Denial	(1) Improper Passing	MHC O-e FACE	9/9/73	10/3/73	10/23/73
5885	"	.15	(4) Excess, Attempts Control Medication, Minimizes	(0)	FACE DIS	8/31/73	9/20/73	11/19/73
5890	"	.22	(6) Excess, Bar, Alone, Attempts Control, Mar. prob. Switched Brands	(1) Reckless	P/O Interview FACE	9/9/73	11/30/73	12/3/73
5906	"	.22	(3) Excess, Attempts Control, Missed Work	(0)	ADCO DIS	9/15/73	10/10/73	10/10/73
5897	"	.16	(5) Excess, Alone, Medication, Illness Due, Home Prob.	(0)	MHC O-e FACE	9/15/73	10/16/73	12/6/73
5878	"	.21	(3) Excess, Attempts Control, Self-admit	(2) Speeding	Headway, DIS	9/10/73	9/27/73	10/3/73 3/18/74
5818	"	.20	(5) Excess, Binge, Blackouts, Missed Work, Shaking, Past Arrest	(3) Speeding, Impaired Driving, Fail To Obey Sign	MHC FACE	9/13/73	10/10/73	10/12/73 12/12/73
6018	"	.17	(4) Attempts Control, Missed Work, Shaking	(1) Fail to obey sign	FACE	9/21/73	10/18/73	12/10/73
5898	"	.14	(5) Excess, Binge, Attempts Control Morning Sickness, Marriage Prob.	(6) Defect Equip, Impr. Dr., Reckless, Fail To Obey, Highway Sign, Op Uninsp. Veh.	FACE	9/10/73	10/31/73	11/5/73
6049	"	.10	(1) Marriage Problems	(1) Speeding	DIS DC Traf. School	9/24/73	10/30/73	10/30/73 12/4/73
5951	"	.21	(0)	(0)	MHC O-e DIS	9/17/73	10/18/73	10/19/73 1/14/74
5824	"	.18	(2) Bar, Attempts Control	(0)	ADCO, DIS	9/1/73	10/4/73	10/10/73
	Problem							
5807	"	.36	(11) Daily, Excess, Binge, Reason, Control, Guilt, Morning Drinking, Blackout, Shaking, Personality Change, Family Problems	(2) Reckless (Accident In One)	AC, DIS	9/2/73	9/26/73	11/1/73

Case Number	Diagnosed Drinking Category	BAC Level	Number and Type of Problem Drinking Symptoms	Number and Type of Prior Traffic Convictions	ASAP Treatment Referrals	DWI Arrest Date	Probation Interview Date	First Treatment Enrollment Date
	Problem							
5841	"	.16	(9) Excess, bar, Reason, Control, Guilt, Personality Changes, Home Problem, Self Admt., Personal Concern	(5) Speeding, Improper Driving	AC	9/7/73	10/4/73	10/5/73
5804	"	.16	(6) Bar Drinking, Blackout, Shaking, Missed Work, Illness, Medication for Drinking	(4) Reckless, Speeding	AC Washington DIS Center	9/1/73	9/26/73	10/31/73
5817	"	.19	(8) Daily, Excess, Reasons, Morning Blackouts, Miss Work, Shaking, Self Admit	(0)	AC Alexandria	9/2/73	10/16/73	11/1/73
6011	"	.15	(5) Excess, Guilt, Sought Treatment, Blackouts, Shaking	(3) Speeding, Improperly Mounted Lic Plates, Failure to Yield	MHC ind. int.	9/22/73	10/30/73	11/19/73
5920	"	.20	(12) Excess, Binge, Attempts Control Sought Treatment, Blackouts Missed Work, Shaking, Medication Illness Due, Personality, Self Admit AA/	(6) No OL, Reckless, Op Unlic MV, Improper stop on Highway	WashHospCenter	9/11/73	10/10/73	10/12/73
5858	"	.26	(9) Daily, Excess, Bar, Binge, Reasons, Attempts Control, Guilt, Blackouts, Concern/	(0)	MHC, Alcohol Clinic, Dallas, TX	9/5/73	10/4/73	10/4/73 3/4/74
5909	"	.17	(9) Often Drinks Excess, Bar, Binge, Attempts Control, Blackouts, Missed Work, Shaking, Marriage Prob., Self-Admit	(8) Reckless, Defective Equip, Impr Muffl, Fail Obey, NoOL, Dr Under Revoc.	BASR - Alex.	9/14/73	10/10/73	10/12/73
5847	"	.28	(11) Daily, Often, Binge, Reasons, Blackouts, Missed Work, Shaking Morning, Medic, Mar Prob., AA	(0)	AC-CACC	9/7/73	10/8/73	10/10/73
5875	"	.21	(7) Daily, Excess, Bar, For Reasons Attempts Control, Guilt, Self-Admit	(2) No OL Driv While Susp	AC-CACC	8/25/73	9/18/73	9/25/73
5861	"	.20	(13) Daily, Excess, Bar, For Reasons, Attempts Control, Guilt, Obtain Treat, Blackouts, Shaking, Medic, Marr. Prob., Self Admit, Family Health Stress	(1) Speeding	HEADWAY, DIS	9/9/73	10/4/73	10/17/73
5888	"	.15	(8) Daily, Often, Attempts Control, Guilt, Blackouts, Shaking, Personality Changes, Marriage Prob.	(2) Reckless, Speeding	FACE	9/8/73	10/9/73	10/10/73
6015	"	.15	(2) Excess, Bar	(2) Improper Control Fail To Obey Sign	FACE	9/22/73	10/16/73	11/18/73

Case Number	Diagnosed Drinking Category	BAC Level	Number and Type of Problem Drinking Symptoms	Number and Type of Prior Traffic Convictions	ASAP Treatment Referrals	DWI Arrest Date	Probation Interview Date	First Treatment Enrollment Date
	Problem							
5958	"	.20	(4) Excess, Blackouts, Shaking in Morning	(1) Improper Turn	FACE	9/16/73	10/17/73	11/18/73
5835	"	.09	(4) Attempts Control, Obtained Treatment, Illness Due To, Self-Admit, AA Contact	(1) Speed	CACC	8/29/73	9/20/73	9/25/73
6004	"	.18	(8) Daily, Excess, Alone, Attempts to Hide, Sought Treatment	(1) Fail to Obey a Highway Sign	Wash. Hops. Cen. NOVA Clinic	9/23/73	10/4/73	11/15/73 2/27/74
5935	"	.19	(10) Excess, Bar, Attempts Control Guilt, Blackouts, Shaking, Pers Changes, Marriage Prob, Self Admit, AA	(4) Speeding	BASR-Alex	9/14/73	10/10/73	10/12/73
5927	"	.38	(10) Excess, Binge, Attempts Contr, Sought Treat., Blackouts, Shaking in Morning, Medication, Self-Admit, AA	(3) Speeding, OperImpr Control, Fail To Obey Traffic Signals	ADCO	9/10/73	10/10/73	10/18/73
5918	"	.19	(9) Bar, Attempts Control, Blackouts, Missed Work, Shaking, Medication Marriage Problems, Self-Admit, AA	(4) Speeding, Impr Equip Run Red Light, Speeding	Baltimore ASAP	9/16/73	10/9/73	11/5/73
6034	"	.31	(11) Daily, Bar, Control, Blackouts, Missed Work, Shaking, Drinks In Morning, Illness, Mar. Probl., Self-Admit, AA.	(0)	ADCO DIS	9/23/73	10/24/73	11/2/73
5914	"	.21	(17) Daily, Excess, Bar, Alone, Binge, For Reasons, Hiding, Guilt, Blackouts, Shaking, Morning Sick, Drinking in Morning, Personality Changes, Self-Admit, AA, Wants To Stop.	(7) Speeding, Reckless Driv Under Revoc. Speeding Fail to Obey Highway Sign.	CACC	9/15/73	10/10/73	10/10/73
5929	"	.17	(10) Daily, Excess, Attempts Contr. Guilt, Sought Treatment, Blackouts, Shaking, In Morning, AA, Severe Business Pressure	(3) Reckless	CACC	9/10/73	10/12/73	10/18/73
5886	"	.29	(8) Alone, For Reasons, Blackouts, Missed Work, Shaking, Drink In Morning, Marriage Problems, AA	(12) Op Uninsp Veh., Fail to Give Full Time, Operate Unlicense MV, Operate Uninsp Veh., DWI, NoOL	RCA&Ind Interv. AC, CACC	9/5/73	11/14/73	11/15/73 1/4/74
5950	"	.30	(12) Daily, Excess, Bar, Alone, Binge, Reasons, Attempts Control, Guilt, Blackouts, Shaking, Personality Change, AA	(5) Revoked permit, reckless, hit & run	BASR-Alex	9/16/73	10/18/73	11/1/73
5860	"	.25	(11) Excess, Reasons, Control, Guilt, Sought Treat, Blackouts, Morning Sick, Drunk in Morning, Medic, Personality Changes, Concern Switched To Beer.	(0)	HEADWAY	9/8/73	10/4/73	10/15/73