THE ILLINOIS DUI ASSESSMENT INSTRUMENT PROJECT

A PROJECT TO IDENTIFY EFFECTIVE DUI ASSESSMENT INSTRUMENTS AND EXAMINE CRITERIA THAT WILL HELP THE ILLINOIS COURTS AND TREATMENT PROVIDERS IDENTIFY AND ASSESS HIGH RISK DUI OFFENDERS SHOWING THE GREATEST RISK AND CONTINUED THREAT TO PUBLIC SAFETY

This is an active project funded by the Illinois Department of Transportation, Division of Traffic Safety and supported by members of the DUI Risk Reduction Work Group, a group of state agencies and organizations interested in increasing public safety on Illinois' roads and decreasing the risk to the public by individuals who continue to drink and drive.

Prepared by
Institute for Legal, Administrative, and Policy Studies
University of Illinois at Springfield
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PREFACE

The authority to respond to threats to public safety posed by alcohol and other drug-impaired drivers has throughout American history rested primarily with the states. Within each state, overlapping agency responsibilities and a growing citizens advocacy movement have involved multiple parties in this issue. While the interplay of these organizations has created a high degree of variation in state responses to alcohol and drug-impaired driving, there are some predictable stages that states have gone through in the past three decades related to the evaluation of those arrested for driving under the influence of alcohol or other drugs.

During the 1960s and 1970s, states sought a more systematic response to the problem of impaired driving. One element of this response was the emerging expectation that DUI offenders would be evaluated for alcohol-related problems. In response, a new industry was birthed to perform this function. Existing treatment programs and a new breed of clinical entrepreneurs conducted evaluations. While this stage constituted a needed improvement, problems quickly arose related to the lack of standardization of the evaluation process, inconsistency in the rigor and competence with which the evaluation was conducted, allegations of ethical abuses related to the conduct of evaluations, and widely varying practices related to the use or non-use of this information within the criminal justice system.

By the 1980s, states were calling for a standardization and professionalization of the DUI evaluation process. More specifically, DUI evaluators were required to meet certain education and training requirements, certain elements or instruments were mandated to be included in all evaluations, levels of risk were codified (usually based on prior arrest histories and BAC at the time of arrest), and prosecutors, judges and probation offers were provided training about the DUI offender. This second stage solved some of the earlier problems but created new ones in their wake.

There are concerns that the evaluation process has become too codified – that the required instruments do not meet the needs of the multiple parties called upon to make decisions regarding the DUI offender and that a lack of consistent competence compromises the integrity of the evaluation as a tool of case management for prosecutors, judges, probation offers, treatment providers, and Illinois Secretary of State hearing officers. Some court jurisdictions have become so dissatisfied that they are generating their own court rules related to how the DUI evaluations will be conducted. Such court rules often create a single preferred provider and demand a higher level of sophistication in the screening process and in the recommendations made to the court.

What is emerging around the country is a growing consensus that earlier responses were stage-appropriate advancements, but that there is a need for increased sophistication in our

approach to identifying and managing the high-risk offender. Illinois has reached that stage and the report that follows is a reflection of this readiness.

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

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

The inability of the current system to adequately answer these questions has led to a call for changes in the way DUI offenders are evaluated in Illinois. In the report that follows you will be introduced to the work of the Risk Reduction Work Group created by the Illinois Department of Transportation to examine the DUI evaluation process in Illinois and to make recommendations related to the future of this process. The work of this group and its preliminary report could become simply one more unread, dust-accumulating study, or it could mark a significant milestone in the evolution of how the State of Illinois protects its citizens from alcohol and drug-impaired drivers.

The report is a call for change in our response to one facet of this problem. If pursued, it will open the door to evaluate the larger system of which the evaluation process is a component. The report and its recommendations constitute a call to push Illinois to a much higher level of sophistication in evaluating and managing the risks posed by impaired drivers. There is from all indications an emerging state of readiness to make this move, but it is a move that will require moving beyond personal and institutional interests. Achieving the recommendations in this report will require an unprecedented level of inter-agency collaboration and will require, at key points, personal and institutional courage on the part of those involved. It is time for us to make this move into the future. The citizens of Illinois deserve nothing less than our very best effort on this issue.

I. BACKGROUND AND HISTORY

In the fall of 1999, the Administrative Office of the Illinois Courts (AOIC), Division of Probation Services, initiated a study of Illinois' current DUI assessment process. Although initially working independently, the AOIC hoped that key state and federal agencies charged with handling DUI offenders and cases would join them in their efforts.

Impetus for Study

Since 1991, the Division of Traffic Safety, Illinois Department of Transportation, has funded training opportunities for court personnel. These training sessions and multi-day

seminars provide opportunities for judges, state's attorneys, and probation officers to examine Illinois' system of handling DUI offenders. Statewide participation in the sessions allows for the discussion of a full range of DUI issues facing court personnel in Illinois. At each session, the participants offer suggestions and observations.

Over the years, issues relating to the DUI assessment process were noted. Specifically, it was stressed that assisting court personnel in identifying high-risk drivers in the initial screening and evaluation of the DUI offender after arrest can provide important information to the judges and prosecutors in matching offenders to the most effective combinations of sanctions and treatments to protect the public from drinking drivers. It also has been mentioned that judges, prosecutors, and probation officers recognize the importance of receiving credible and useful evaluations from DUI service providers. While court personnel and service providers from many systems and agencies are increasingly encountering recidivist DUI offenders, instruments currently used in the state do not identify high-risk offenders.

The Formation of the DUI Risk Reduction Work Group

According to the AOIC, the mission of the Division of Probation Services is to partner with local jurisdictions for purposes of securing resources for Illinois probation and court services. It strives to improve the quality of the administration and delivery of such services by developing, establishing, promulgating, monitoring, and enforcing uniform standards for practice and programs. With this mission, staff members are in a position to foster initiatives that have the potential to enhance services needed by judges and probation officers who routinely work with DUI offenders.

As the study of the Illinois assessment system proceeded through the initial steps, it became obvious that key agencies and individuals involved with the DUI system in Illinois needed to be involved at the beginning of the initiative, and that these agencies and organizations must work together.

As a beginning step, AOIC reached out to the Illinois Department of Transportation, Division of Traffic Safety for advice and possible interest in this issue. The Division of Traffic Safety had a proven history of support, demonstrated by active participation in promoting projects that address public safety issues with a concerted and pragmatic approach.

With the input and guidance from IDOT, the DUI Risk Reduction Work Group was convened. The group is comprised of members of the following agencies and organizations:

- Administrative Office of the Illinois Courts (AOIC), Division of Probation Services
- Chestnut Health Systems, Bloomington, Illinois
- Secretary of State (SOS), Driver Services, Policy and Programs
- Secretary of State, Administrative Hearings Division
- Illinois State Police
- Illinois Department of Human Services, Office of Alcoholism and Substance Abuse (OASA)
- Central States Institute of Addiction (added in 2001)
- DuPage County Probation Services (added in 2001)

- Illinois Department of Transportation, Division of Traffic Safety (DTS)
- University of Illinois at Springfield, Institute for Legal, Administrative and Policy Studies

The Development of Project Goals

On September 20, 2000, members of the DUI Risk Reduction Work Group drafted a resolution and vision statement. Prior to doing so, the following facts were discussed by the group: 1) motor vehicle crashes are the leading cause of death among Americans ages 4 to 33 years old; 2) approximately 50,000 DUI citations are issued annually in Illinois; 3) the DUI offender comprises approximately 20% of all cases under probation supervision in the State; 4) the DUI offender evaluation tool currently used by Office of Alcohol and Substance Abuse (OASA)-licensed evaluators has not proven adequate in the assessment of an offender's level of potential risk to public safety; 5) judges require accurate and meaningful reports to properly sentence DUI offenders; 6) OASA-licensed DUI treatment providers could benefit from information that would help them incorporate into their treatment interventions a specific focus on drinking-driving public safety threats; and, 7) Secretary of State administrators need accurate meaningful reports to decide whether to reinstate driving privileges. In consideration of these facts and needs, the DUI Risk Reduction Work Group identified three primary goals:

1. Establish a subcommittee of the DUI Advisory Council to examine how the financial and technical resources of the multiple agencies can best be coordinated to identify the highest risk alcohol/drug impaired drivers and to contain the threats such individuals pose to the safety of the citizens of Illinois;

2. Support the cross-agency reforms required to respond to the DUI offender and the DUI recidivist; and,

3. Pool resources necessary to: 1) develop a comprehensive assessment instrument that would meet the varied needs of OASA evaluators, prosecuting attorneys, judges, probation officers, and SOS hearing officers; 2) implement and refine this instrument, and 3) systematically evaluate which sentences, interventions, strategies, etc. prove most successful in rehabilitating/containing the high risk offenders.

The full committee of the Illinois DUI Advisory Council accepted the signed resolution in November 2000.

II. INFORMATION GATHERING

Since its formation, the DUI Risk Reduction Work Group has been involved in a variety of information gathering tasks. The tasks include commissioning a review of the relevant literature, conducting statewide focus groups, funding a national survey, and hosting a panel meeting of DUI researchers. Each of these efforts provided the DUI Risk Reduction Work Group members with valuable information for the development of a comprehensive assessment instrument.

Literature Review

Illinois State University was commissioned to complete a review of the relevant literature surrounding the issue of the DUI recidivist offender. The main subject areas included in the review were: Classification and Prediction of the DUI Offender, Profile of the DUI Offender, Probation and Supervision Programs, Treating the DUI Offender, and Evaluation of DUI Treatment and Programs.

One commonality among DUI recidivists found in the literature was that they are often young male problem drinkers or alcoholics. It was also found that DUI offenders frequently had poor driving and criminal histories, with first arrest occurring at a young age. The literature also stressed the importance of a focus on treatment rather than a more punitive sanction, citing specifically the value of a pre-trial intervention and deferred prosecution programs. Using a combination of sanctions, such as electronic monitoring and intensive probation supervision, were found to be most effective with this offender population. (See Appendix A – Executive Summary, The DUI Offender: A Review of the Literature, Illinois State University.)

Statewide Focus Groups

Based on the goals established by the DUI Risk Reduction Work Group, the Institute for Legal, Administrative, and Policy Studies, University of Illinois at Springfield, the Division of Traffic Safety, Illinois Department of Transportation, and the AOIC coordinated and hosted three statewide focus groups. The group participants, who included veteran specialized probation officers who handle DUI caseloads, provided valuable field information and impressions on current DUI assessment practices in Illinois. William L. White, Senior Research Consultant, Lighthouse Institute, assumed a lead role in organizing the project and facilitating the focus group meetings. Focus groups were held in Joliet, Springfield, and Chicago to encourage the widest geographic participation possible, with a total of 105 specialized probation officers attending the focus group meetings.

From the Administrative Office of the Illinois Courts: Specialized DUI Probation Officers Focus Groups (June - July, 2000)

By consensus, the focus groups agreed that communication between the parties involved with the DUI offender in the court system is a crucial component for consistency in following the dictates of the court order. Court orders that require compliance and completion of treatment recommended in the DUI evaluation result in more successful supervision outcomes.

Criminal arrest records are not routinely considered by DUI evaluators when completing the evaluation and assessment of the DUI offender, resulting in an incomplete assessment for the court. In many counties DUI evaluators do not have access to criminal records, so they must rely solely on the examination of the driving record or on self-reporting from the offender. Additionally, the evaluation report received by probation departments can vary widely in format and depth of provided information about the offender.

The current DUI assessment tools indicate the severity of alcohol problems with accuracy, but are not equipped to report on the offender's possible criminal tendencies or record, drug use, or threat to public safety. The focus groups suggest looking carefully at developing or finding a DUI assessment tool that will effectively screen the DUI offender and identify indicators for DUI recidivist behavior. Using a more comprehensive DUI assessment tool will

serve as an important aid for probation officers, judges, and state's attorneys when dealing with sentencing and case management issues with DUI offenders. An assessment tool that will help probation officers and members of the court match offenders to particular intervention strategies is more likely to have the greatest chance for a successful outcome.

Recommendations suggested by the focus groups centered on several areas of concentration with an emphasis toward development of more comprehensive assessment and screening instruments for the DUI offender and especially for the recidivist drinking driver.

Probation officers recognize the importance of receiving valid and accurate assessment information on DUI offenders, as they must routinely provide supervision services to high-risk individuals in their caseloads. Information needed includes but is not limited to the following elements:

- ✓ OASA DUI evaluation screening information;
- ✓ A criminal history of the offender;
- ✓ A driving/insurance history;
- ✓ A driving risk and character logical profile; and,
- ✓ The level of personal and environmental chaos of the offender.

In addition, the instrument must be realistically affordable and fall within acceptable standards of affordability and ease of administration.

A summary consensus of the focus groups recommends that an instrument be developed that will identify that group of offenders who pose the greatest risk to public safety, who are at the highest risk for recidivism, and who should receive the highest intensity of supervision and allocation of community resources.

The focus groups examined the sanctions imposed on DUI offenders and sanction options including retribution, incapacitation, special deterrence, general deterrence, and rehabilitation. In addition, restitution and program financial considerations could be considered as objectives in sentencing and supervision decisions.

General observations of the group with specific suggestions on use of sanctions that would help probation officers include:

- Use of jail sentences up to 90 days that could serve as leverage for treatment and probation compliance through periodic status reviews;
- Immediate consequences for DUI offenders who arrive for probation visits or other services under the influence of alcohol or other drugs, such as use of incarceration;
- Increased use of alternative sentencing such as electronic monitoring, community service, stayed sentences to jail, ignition interlock devices, etc; and,
- A concerted effort to address the language and cultural barriers of offenders and resources available in the community.

Many of the focus group participants were DUI specialized officers and agreed to offer their perspectives when working with DUI offenders. Suggestions offered in the key area of sentencing and supervision include the following:

- Expand the range of sentencing and supervision options used for DUI offenders and recidivists with combinations of sanctions being preferred;
- Sanctions and supervision options should be tailored to individual offenders on the basis of an evaluation of offender characteristics and recidivism risk;
- Provision of appropriate training and educational opportunities for specialized probation officers;
- Recruitment of bilingual probation officers with incentives for other officers to acquire skills in languages other than English;

Since 1991, the Division of Traffic Safety, Illinois Department of Transportation, has funded training opportunities for court personnel. These training sessions and multi-day seminars provided opportunities for judges, state's attorneys, and probation officers to focus on a single topic area, *Driving Under the Influence*, while examining the strengths and weaknesses of the DUI system. Statewide participation in the sessions allows discussion of a full range of DUI issues facing court personnel in Illinois. At each session, suggestions and observations are offered by the participants, which are intended to support and brace up the DUI system in Illinois. The suggestions and observations offered by hundreds of men and women working with DUI offenders and representing a majority of downstate judicial circuits and counties are summarized as suggestions for further discussion and examination and cover a ten-year span of time beginning in 1991.

From the Judicial, State's Attorney and Probation Officer Seminars

- Linking services and improving communication between agencies involved with the DUI offender continues to be identified as vital to promote success in deterring drinking and driving on Illinois roads. The collection and sharing of information needs to begin at the time of the DUI arrest with continuity of tracking of the DUI offender through all of the DUI systems. These systems include the law enforcement officer, the assessment evaluator, the treatment provider, the Secretary of State, the Department of Alcoholism and Substance Abuse, the state's attorney, the judge, and probation officer.

- Suggestions by participants at the seminars included beginning a DUI Task Force for all stakeholders in the DUI system to share information and work together to close communication gaps. Within the last five years regional DUI task forces and joint community efforts have been initiated in a number of circuits to address mutual DUI issues, however, the communication between all parties continues to be viewed as problematic.

- Judges and state's attorneys are interested in receiving current information on any changes in DUI rule including subsequent procedures that impact on ruling and sanction options. Judicial and state's attorney seminars as well as related training events are viewed as an essential service to officers of the court.

- Each member of the DUI court system needs to understand the differences between the real and perceived roles of each member. These parties include the judiciary, the substance abuse provider agencies, the prosecutors, the probation officers, and the state agencies involved in providing services and oversight of the DUI system.

- Judges, prosecutors, and probation officers recognize the importance of receiving credible and useful evaluations from DUI service providers. Court personnel and service providers from many systems and agencies are increasingly encountering recidivist DUI offenders. Service providers need evaluation tools to identify the high risk DUI offender and report these findings to the court.

- Assisting court personnel in identifying high-risk drivers in the initial screening and evaluation of the DUI offender after arrest can provide important information to the judges and prosecutors in matching offenders to the most effective combinations of sanctions and treatments to protect the public from drinking drivers.

Focus group participants stressed that judges will benefit by receiving updated DUI information and training with respect to DUI offenders on an ongoing basis. For example, it was recommended the state (i.e., AOIC) continue its involvement in and support of DUI-related judicial training and that a DUI orientation and bench manual to be compiled for new personnel. Additionally, training for all court personnel could be available as easily accessible videocassettes and/or CD ROMs. Furthermore, there needs to be enhanced lines of communication between the probation officers and DUI judges, especially with high risk offenders, such as providing pre-sentencing evaluation reports.

It was recommended to enhance the recruitment of bilingual probation officers, including incentives for current officers to acquire skills in languages other than English. Also, additional training and educational opportunities could be offered to officers with specialized DUI caseloads.

From the Illinois Secretary of State DUI Administrative Hearing Officers

The Illinois Secretary of State, Department of Administrative Hearings conducts ongoing training opportunities for administrative hearing officers responsible for holding informal and formal hearings for DUI offenders. SOS Hearing Officers must make sensitive and difficult decisions that create immediate and long-term effects on the ability for Illinois citizens to drive safely on our roads and highways. The most important issues are listed as follows:

- Establishing ongoing official and unofficial lines of communication with OASA on mutual issues;

- Hearing Officers consistently require comprehensive reports from DUI service providers to adequately address the issues presented at the hearings. The officers report that many reports received do not contain detailed case histories;

- Development of an updated investigative report form to be completed by DUI service providers;

- The Hearing Officer must rely on the assessment to determine if the petitioner will continue to be a risk to public safety. More information is often needed to make that determination, including reports on other major life problems, drug and criminal histories, and records of unstable behavior.

- Many officers do not have direct contact with the courts and probation departments and must rely on the reports from the petitioners. This lack of communication does create misunderstanding between SOS and the courts;

- Hearing Officers' report that some DUI provider agencies have developed close relationships with defense attorneys. At the time of the hearing this relationship is revealed with inconsistencies in the assessment reports and emergence of errors in reporting blood alcohol contents (BACs) or number of DUI convictions; and,

- Hearing Officers can be placed in the role of completing "independent" assessment at the time of the hearing. This role emerges when the Hearing Officer must challenge inconsistencies in behavior and the assessments.

From the DUI Service Providers

DUI substance abuse providers that attended DUI training programs offered by the UIS Institute for Legal, Administrative, and Policy Studies (2001 to 2002) have identified a number of issues that impact on their ability to obtain necessary information for doing evaluations and interventions with the DUI offender. The issues and comments are listed below. Most of the staff that participated delivers evaluation and risk education services, and intervention services to DUI offenders that are court ordered to these services.

- DUI evaluators and other substance abuse providers state that one of their most difficult issues has been to rely on the DUI offender to supply reliable and accurate information for the assessment;

- The DUI service provider, in many counties, is not able to access the criminal records for the DUI offender seeking an assessment or treatment and again, must rely on self-reporting from the offender;

- Communication and networking between DUI service providers is limited. Service providers seek resources to connect with each other on a regular basis;

- Service providers working with the high-risk offender seek regular contact with other agencies and the courts in their counties;

- DUI evaluators are seeking updated assessment tools for use in completing the initial assessments; and,

- The DUI service provider system must police its own members and eliminate those providers abusing the system with unethical behavior.

The DUI Risk Reduction Work Group appointed a subcommittee to initiate an action plan to complete three major tasks identified on March 14, 200l. The tasks identified were:

- Complete a DUI Assessment Tool National Survey through the summer of 200l and identify the assessment instruments being used by all 50 states;

- Convene a national Scientific Advisory Panel of national research consultants to meet with the DUI subcommittee in September, 200l and review results gathered in the National Survey. The University of Illinois at Springfield will conduct the survey and collect DUI assessment instruments for discussion for review by the DUI Assessment Committee and Scientific Advisory Panel; and,

- Develop an Assessment Instrument Matrix that contains general criteria desired for a new or adapted assessment instrument in Illinois. The criteria will be instrumental in reviewing and evaluating the assessment tools requested from various states participating in the national survey.

DUI Assessment Tool National Survey

It is usually deemed wise to examine carefully programs that are currently implemented by colleagues in other areas of the country, especially when a new initiative is launched to amend or change a current statewide program. In many cases, the research will uncover facts that show the strengths of the current program as well as the weaknesses. At its third information-gathering event, the DUI Risk Reduction Work Group commissioned a national study on the assessment of DUI offenders.

Methodology

First, in order to gather information regarding DUI assessment tools, it was necessary to understand how DUI offenders are assessed in each of the 50 states. To this end, the Institute for Legal, Administrative, and Policy Studies evaluation team concluded that the administration of a survey would be the most efficient and effective data collection technique to employ. Information regarding the survey instrument, the survey respondents, and the stages of survey administration are described below.

Survey Design

The primary focus of the survey instrument was to elicit information regarding the DUI assessment process being conducted in each state. Specifically, respondents were asked to describe their state's DUI offender assessment process for purposes of determining:

- who performs the assessment;
- what tools are used;
- whether any tools are mandated, and if so, under whose authority;
- why specific tools were selected;
- how long the state has used a particular tool(s);
- whether those using the tool generally are satisfied with the assessment process, including the assessment tools being used; and,
- if there are any efforts underway to revise or develop a new assessment tool(s).

For states not having a standardized process for assessing DUI offenders, survey respondents were asked why the process was not standardized, if there were any efforts underway to standardize it, and if so, were there any impediments toward these efforts.

To a lesser degree, additional information relating to: 1) how the DUI assessment information gathered is used; 2) what specialized DUI programs exist; and, 3) what research has been conducted regarding DUI offenders and their impact on our nation's roads and highways also was asked of survey respondents. Copies of all assessment tools used and evaluative reports conducted were requested. (See Appendix B – DUI "Best Practices" Assessment Tools: A National Survey.)

Survey Respondents

To increase the likelihood that complete information about each state's assessment process would be obtained, a "multiple perspectives" data collection approach was employed (Sabath & Cowles, 1995). When using this technique, a variety of potential survey or interview subjects with differing orientations are identified, with the premise that each offers a unique perspective of the question at hand. For the current study, three potential survey respondents initially were identified for each state. These individuals were overwhelmingly state-level employees working in a core area relating to the incidence of DUI and included: 1) the state coordinator of the National Association of Governors' Highway Safety Representatives (NAGHSR); 2) employees from each state's court/probation system (e.g., Alaska Department of Corrections, Arkansas Board of Correction and Community Punishment, Office of the State Court Administrator for the State of Colorado, etc.); and, 3) an administrator from each state's alcohol and drug abuse agency (e.g., Alaska Department of Health and Social Service, Division of Alcoholism and Drug Abuse; Colorado Department of Human Services, Alcohol and Drug Abuse Division; Georgia Department of Human Resources, Division of Mental Health, Mental Retardation, and Substance Abuse, etc.).

The pool of potential survey respondents was expanded, but refined, during the data collection process through the use of a "snowball sampling" technique. That is, each survey respondent was asked to identify other persons in their state who may have information relating to the DUI offender assessment process. This technique was particularly helpful in those states where none of the initial respondents had the requested information. Contact information for potential survey respondents was obtained from the IDOT Division of Traffic Safety, AOIC, and OASA.

Survey Administration

Data collection commenced in July 2001 and continued through August 2001. As an initial contact, a cover letter explaining the study was e-mailed or faxed to all persons for whom such technology was available and/or known by the evaluation team. The information requested was gathered primarily through telephone conversations held between the survey respondent and an evaluation team member, although a small number of survey respondents completed the survey independently and mailed, e-mailed, or faxed their responses back.

Summary of the Findings

Interviews were completed for 47 states, including Illinois. At least one person from each state was interviewed, while in some states multiple interviews were conducted. The three states for which interviews were not obtained were Tennessee, Virginia, and Wyoming. The assessment process varied greatly, making generalizations across states very difficult.

It was necessary to determine which department in each state had administrative rule over its DUI system (see Table 1.1). In approximately two-thirds of the states, the Departments of Health or Human Services or some combination thereof held primary responsibility. The Departments of Transportation or Highway Safety were the next most common program administrators, with approximately 15% of the responding states. New Mexico indicated that their DUI program is an inter-agency mission administered through the Local Government Division of the Department of Finance and Administration possibly due to the payment of fines being used to track DUI offenders. Kansas does not currently have a standardized DUI program and the primary department was not clear from the information received.

Table 1.1: Departments Administering the DUI Programs

	N
Department of Health, Public Health, Mental Health, Human Services, Human Resources, or Social Services	31
Department of Transportation, Highway Safety or Department of Motor Vehicles	7
Department of Alcohol and Drug Abuse	3
Administrative Office of Courts or Judicial Committee	2
Department of Corrections, Probation or Parole	2
Department of Finance and Administration	1
Administration Unclear	1
Total	47

The research found that, in most states (approximately 45%), the DUI assessments are conducted by contract treatment providers, including both public and private agencies (see Table 1.2). Nine states have a treatment/education program designed specifically for DUI offenders. In these states, individuals in that program complete assessments. For example, DUI offenders in New Jersey are referred to an Intoxicated Driver Resource Center (IDRC). While at an IDRC, offenders must attend a series of educational sessions, complete an assessment questionnaire, and meet with a counselor for a personal interview. The Division of Addiction Services at the New Jersey Department of Health and Senior Services must certify these counselors. Probation officers completed all DUI assessments in four states, while an additional eight states utilize a combination of probation officers and either contract providers or DUI program officers. Five states, including Illinois, allow assessments to be completed by individuals from variety of professional fields. It is required by rule that assessors in Illinois be certified substance abuse counselors.

Table 1.2: Individual or Agency Conducting DUI Assessments

	N
Contract Providers (Includes both public and private agencies)	21
Statewide designated DUI program officers	9

Probation Officers	4
Both probation officers and contract providers	6
Both probation officers and DUI program officers	2
Varies (a number of persons are authorized to perform the assessment in the given state)	5
Total	47

Table 1.3 lists each state and the assessment tools that are either required or are frequently used. Those that are mandated are indicated in bold. Twenty-three states have a specific tool or combination of tools that are required by either state law or administrative rule. An additional four states have a list of two or more approved tools that an assessor may choose from, while the remaining twenty states have no statewide mandate in terms of the tools used. The DRI-II and the Mortimer-Filkins were the two most commonly mandated tools. The DRI-II is currently mandated for solo use in 5 states, while it may be chosen from a list of other tools in Illinois and Arizona. In Hawaii, DUI assessors must use both the DRI-II and the Mortimer-Filkins. The Mortimer-Filkins is mandated alone in two states, it may be chosen in four states and must be used in combination with other tools in four additional states. Other tools that are state mandated include the ASI, mandated in three states, the NEEDS, required in two states, and the SALCE and the ASUDS, each currently used in one state.

Table 1.3: Tools Used, by State

Alabama	DRI-II, SALCE, Mortimer-Filkins	Missouri	DRI-II
Alaska	Mortimer-Filkins	Montana	Providers may choose from a list of 33 tools
Arizona*	DRI-II, MAST, MMPI, MAC, Mortimer-Filkins, SASI, CAGE	Nebraska	DRI-II
Arkansas	Providers may choose	Nevada	DRI-II, SASSI, Mortimer-Filkins
California	CAGE, MAST, Mortimer-Filkins	New Hampshire***	DRI-II, MAST, CAGE, SAG, SALCE, ASI, Mortimer-Filkins
Colorado	ASUDS	New Jersey	Intoxicated Driving Program Questionnaire
Connecticut	Mortimer-Filkins	New Mexico	NEEDS
Delaware	DRI-II, SAI, Mortimer-Filkins	New York	RAISI
Florida	DRI-II	North Carolina	SASSI, NEEDS, MACH
Georgia	SALCE	North Dakota	ASI
Hawaii	DRI-II, Mortimer-Filkins	Ohio	ASI, ODADAS
Idaho**	ASI, MAST, DSM-IV, SASSI, Mortimer-Filkins, SUDDS, Compu-13 and 7, Compu-15	Oklahoma	LSI-r, ASUS
Illinois***	DRI-II, Mortimer-Filkins	Oregon	Mortimer-Filkins, Drinking History Questionnaire, Drug Use Inventory
Indiana	SASSI, SALCE	Pennsylvania	Court Reporting Network (combination of tools)
Iowa	SASSI	Rhode Island	Mortimer-Filkins, In-House tool
Kansas	SASSI, MAST, SUDDS, Mortimer-Filkins, Western Personality Inventory	South Carolina	DRI-II
Kentucky	AUDIT, DAST	South Dakota	SASSE
Louisiana	SMAST, Mortimer-Filkins	Texas	SASSE, SAUSI, and other state-specific tools

Maine	NEEDS, DAST	Utah	SASSI, MAST, ASI, SALCE, DRI-II, CAGE, Mortimer-Filkins
Maryland	MAST	Vermont	CAGE, MAST, SALCE
Massachusetts	ASUDS	Washington	Providers may choose
Michigan	ASI, NEEDS	West Virginia	ASI, MAST, SASSI
Minnesota	Mortimer-Filkins, Jelnik	Wisconsin*	ADOA, WAID, UNCOPE (all state specific tools)
Mississippi	MASEP (combination of the MMPI, Mortimer-Filkins, and AUDIT)		

* Mandated use of one or more of these instruments.
** Assessors required to administer two of these instruments.
*** Either test is acceptable.

Approximately half of the states with a specific tool(s) currently required reported they are satisfied with the tool. Only five states responded that they were unsatisfied with their current system. The remaining respondents were unclear as to how the parties in their state felt about the tools used. Only four of the states, including one that stated they were satisfied with their current process, reported they were in the process of revising their system. All five states using the DRI-II as a statewide assessment tool reported they are satisfied with the tool (see Table 1.4). Of the states without a mandated tool, Ohio was the only one to report that efforts are underway to standardize the process in their state. Ohio is currently conducting a pilot test of a statewide tool, which is an adaptation of the ASI.

Table 1.4: Satisfaction with Mandated Tool(s) by Tool

Tool	Satisfied	Not Satisfied	Mixed Reactions	Unknown	Total
DRI-II	5	0	0	0	5
ASI	1	0	1	1	3
NEEDS	1	0	0	1	2
Mortimer-Filkins	0	1	0	1	2
SALCE	1	0	0	0	1
ASUDS	1	0	0	0	1
RIA Self Inventory	0	0	1	0	1
Intoxicated Driver Program Questionnaire	1	0	0	0	1
Combination Tool or Choose from a List	3	3	0	2	8
Use of more than one tool	1	1	0	1	3

In slightly more than a third of the states the assessors have access to an offender's criminal history (see Table 1.5). Six additional states reported there was limited access or access varied based on the individual conducting the assessment or the county in which it takes place. For example, a probation officer conducting a DUI assessment would have access to the offender's entire criminal record, while a contract treatment provider may not.

Table 1.5: Access to Criminal History

	N
Yes	16

No	15
Varies based on who is conducting the assessment	3
Limited access	2
Varies by county	1
Unclear	10
Total	47

It was more common for an assessor to have access to the offender's driving record, as was found in more than half of the responding states (see Table 1.6). In five states the assessor's access to the driving record was limited or based on who is conducting the assessment.

Table 1.6: Access to Driving Record

	N
Yes	25
No	9
Varies based on who is conducting the assessment	3
Limited access	2
Unclear	8
Total	47

Nearly every state compiled basic DUI crash statistics; however, few submitted evaluative reports. Examples of evaluative reports that were received include, *The Effectiveness of Education and Treatment in Reducing Recidivism Among Convicted Drinking Drivers* (Colorado), *Georgia DUI Alcohol/Drug Risk Reduction Program 1992-1996*, and *Alcohol Program Completion: Does it Matter for DWI Recidivism?*

Scientific Advisory Panel Meeting

As a fourth and final information gathering event, the DUI Risk Reduction Work Group contracted with the Institute for Legal, Administrative, and Policy Studies, University of Illinois at Springfield to hold a Scientific Advisory Panel meeting. The goals of the meeting were to identify any existing instruments that might meet and/or could be modified to meet Illinois' assessment needs.

Prior to the meeting, the members of the DUI Risk Reduction Work Group agreed to the following guidelines regarding the incorporation or development of a new assessment instrument. First, the new assessment instrument would not serve as a tool from which a clinical diagnosis would be made. Rather, this assessment would attempt to measure whether key areas of the target problem are present in an individual referred for a DUI assessment. Second, the purpose of the DUI assessment is to conduct an initial screening to obtain significant and relevant information from a DUI offender about the nature and extent of their use of alcohol or other drugs in order to identify the offender's risk to public safety for the circuit court of venue or the Office of the Secretary of State, and to recommend an initial intervention to the DUI offender and to the court or the Office of the Secretary of State. Third, the instrument's measurement scope is ideally to include the ability to provide screening capability to differentiate between DUI offenders who represent minimal risk to driver safety on the roads and those high-risk offenders most likely to be recidivists. This measurement is not now possible with the current assessment instruments being used for DUI assessments. It also was agreed that

the effective and appropriate implementation of a new or adapted assessment instrument would increase if its use and purpose were clearly understood by those involved in the process.

To prepare for the meeting with the expert panel, the DUI Risk Reduction Work Group developed a DUI Assessment Matrix. (See Appendix C – Matrix I.) This matrix was created to easily identify the criteria desired in the tool and would allow participants to evaluate and compare the various assessment instruments. Included in that matrix were the following questions:

- Is the instrument capable to be used by multiple parties: DUI evaluators, prosecutors, judges, probation officers, treatment providers, Secretary of State Hearing Officers?
- Has the instrument been tested for validity across gender, ethnicity, and age?
- Does the instrument have the ability to be administered and interpreted by individuals with educational/certification required by IAODAPCA and OASA?
- Does the instrument have the capability to be computer scored to set levels of risk?
- Does the instrument contain an open-ended written summary that addresses two questions: "Does the individual have an AOD-related problem and the extent/severity of the problem" and, " Does the individual pose a threat to public safety and the severity of the threat?"
- Does the instrument have the capability to recommend rehabilitative interventions and social sanctions?
- Is the instrument capable of being administered multiple times with flexibility for follow-up services?
- Does the instrument assess use of drugs other than alcohol?
- Does the instrument address any other issues related to co-morbid psychiatric conditions?
- Does the instrument assess the driving risk history?
- Does the instrument assess any prior service history?
- Does the instrument incorporate data other than self-reporting information?
- Does the instrument assess issues of criminality?

Members of the expert panel were asked to complete the matrix for each assessment test prior to the meeting. Copies of the following assessment tools were obtained through the survey process and were evaluated for their appropriateness for use in Illinois based on the above criteria outlined by the committee: ASI, ASUDS, AUDIT-DAST, CAGE, CSI, DRI-II, Drinking History Questionnaire (Oregon), JASAE, MASEP, MAST, Mortimer-Filkins, NEEDS, New

Jersey Intoxicated Driver Program Questionnaire, Numerical Drinking Profile (Texas), ODADAS, RIA Self Inventory, SALCE, and the SASSI.

The individuals, each nationally recognized for their contributions in the field of addictions and assessment, who participated in the meeting held in Springfield, Illinois on September 25, 200l, are listed below.

Elizabeth N. Wells-Parker
Ph.D., Psychology, Duke University
Associate Director and Research Fellow/Scientist, SSRC; Professor of Psychology, MSU

Dr. Wells-Parker's research areas and interest deal with alcohol, drugs, and transportation. Her grants include funding by such agencies as the National Institute on Alcohol Abuse and Alcoholism, National Highway Traffic Safety Administration, National Institutes of Health, Mississippi Governor's Highway Safety Program, and the NRTA/AARP Andrus Foundation. Along with her work with such agencies, she serves on the Alcohol, Drugs, and Transportation Committee of the Transportation Research Board and the Executive Council of the International Council on Alcohol, Drugs, and Traffic Safety (ICADTS). Some of her most recent publications include "Final Results from a Meta-analysis of Remedial Interventions with Drink/Drive Offenders," Addiction; "States of Change and Self-efficacy for Controlling Drinking and Driving," Addictive Behaviors; "The Science of Prevention: Methodological Advances from Alcohol and Substance Abuse Research," American Psychological Association; Drinking and Driving Among Women: and Gender Trends, Gender Difference," Women and Alcohol: Issues for Prevention Research. Along with her many publications, Dr. Wells-Parker has been an invited addressee for the International Council of Alcohol and Alcoholism, Circuit Court of Cook County, Il, the Annual Meeting of the Transportation Research Board, NIH/NHTSA Workshops, and Southeastern Regional DUI Systems Conferences. She has also served as member/consultant of grant review panels for the National Institute on Alcohol Abuse and Alcoholism, the National Institutes of Health, The National Commission Against Drunk Driving, The Department of Defense, and The Medical Research Board of Canada, as well as a consultant for Yale University's School of Medicine. Dr. Wells-Parker is a Co-Investigator for the Rural Health, Safety, and Security Institute. In this role, she is developing a number of health related projects in the areas of patient safety, health service delivery, and applied cognitive issues in medical settings. She is liaison to North Mississippi Health Services for joint research projects.

Harvey Siegal
Ph.D., Yale University
Director, Center for Interventions, Treatment and Addictions Research
Wright State University School of Medicine, Dayton, Ohio
Professor, Department of Community Health and Department of Sociology and Anthropology; Wright State University

Dr. Siegal created the Weekend Intervention Program. In developing the program, he worked closely with government agencies, the criminal justice system and the substance abuse treatment community to integrate into the community an effective educational, assessment and

referral program for individuals convicted of a legal offense involving the abuse of alcohol or other drugs, usually involving driving while intoxicated. The program became a prototype for others across the country, and is the centerpiece of Siegal's subsequent efforts to develop and demonstrate the effectiveness of programs that provide early intervention and education on substance abuse and AIDS. He also created a Caring Clergy substance program for seminary students at United Theological Seminary in Dayton and Hebrew Union College in Cincinnati.

Dr. Siegal is the author of the book, *Outposts of the Forgotten: Lifeways of Socially Terminal People in Slum Hotels and Single Room Occupancy Tenements*, and co-author of six others on social and drug use issues. During the past three years, he has had 14 articles or chapters published, with seven more in press. Since 1988, he has been the principal investigator for major grants from the National Institutes of Health totaling more than $13,000,000. He has been appointed to several posts of national prominence, and serves on local boards and committees as well. He is a member of the Drug Abuse Epidemiology and Prevention Research Review Committee at the NIH's National Institute on Drug Abuse, and Division of the National Safety Council. His honors and awards include Wright State's Presidential Award for Faculty Excellence in Community Service, which he received in 1989. Because of his service to the university and the community, and his outstanding accomplishments in scholarship, teaching, and service, the Board of Trustees of Wright State University bestowed Dr. Siegal its Award for Faculty Excellence in 1994.

Ronald Snow
Ph.D., Geography, University of Illinois at Urbana
Research Fellow/Scientist, SSRC, Adjunct Professor of Sociology, MSU

Dr. Snow has served as Coordinator of the Research and Program Development Unit of the Mississippi Alcohol Safety Education Program (MASEP), Social Science Research Center, since 1983. Before coming to Mississippi, he held academic positions at Georgia Southern College and Michigan State University. He has directed several projects related to drinking and driving, which include The Mississippi Project: A Problem Oriented Approach to Curriculum and Assessment in First Offender DUI Education/Rehabilitation Programs; DUI System Analysis Project: Arrests, Adjudication, Referral, and Public Awareness; The MASEP Judicial Education and Public Awareness Project: Court Referral Procedures, Judicial Workshops, and Traffic Safety Poll; and Tracking the Mississippi DUI Offender: Improving the Utility of Existing Mississippi Data Bases for Studying DUI Recidivism. Recent research has focused on predicting recidivism among convicted drinking drivers, and on the attitudes and opinions of Americans with respect to highway safety issues. Dr. Snow has served on several committees of professional organizations, including the steering committee of the Southeastern Division of the Division of the Association of American Geographers. His research has been published in *Mississippi Geographer, Southeastern Geographer, Perspectives on the American South, Addiction Deviant Behavior, Sociology and Social Research, International Journal of the Addictions, American Journal of Drug and Alcohol Abuse, British Journal of Addiction, and Addictive Behaviors.* In 1990, he accepted a Distinguished Service Award from the National Commission Against Drunk Driving on behalf of the Mississippi Alcohol Safety Education Program.

Assessment Instruments Reviewed

Addiction Severity Index (ASI)

The ASI was developed by the Veterans Administration Center for the Studies of Addiction at the University of Pennsylvania as a research tool to measure changes in problem areas over time for individuals in a treatment program. Given that it was developed as a research tool, the ASI has been extensively studied and is valued for validity and reliability. It is frequently used by drug courts or as the intake interview for individuals entering treatment.

The ASI is public domain; however, it has been adapted and computerized by private companies. As designed, the test relies on the interviewer's ability to probe for answers and to evaluate the integrity of the responses given. The authors, therefore, feel strongly that it is important that the test be administered by an interviewer and do not endorse the computerized versions. Computerized scoring programs are also available, typically for a one-time flat fee for the purchase of the program or site license.

This tool has seven scales, including scales specifically related to drug and alcohol use, legal problems, family and social issues, and psychiatric status. The ASI was lacking only in the fact that it does not assess driving risk history. This is, however, a lengthy test to administer, requiring up to an hour for completion and another hour to score and write the associated narrative summary.

Irene Dowling of Recovery Consultants in Poughkeepsie, NY, a company that markets training programs for the ASI and other tools, was contacted during the tool review process. Ms. Dowling feels strongly that the ASI is not suited for mandated populations such as DUI offenders. She stated that she believes the ASI is an excellent tool, but only for those willing to participate in treatment. Ideally it should be used in the treatment intake process to determine the areas in which treatment most needs to be directed.

Research has shown the ASI to be an inappropriate evaluation for the following subgroups: 1) some older substance abuse patients (generally alcoholics) presenting overt evidence of cognitive impairment, 2) younger, generally drug addicted, patients often having a history of criminal involvement, and 3) adolescents younger than 16 who are supported by their families.

Adult Substance Use and Driving Survey (ASUDS)

ASUDS, a privately owned test developed by Dr. David Timken in Boulder, CO, has been mandated for use in Colorado since 1999. The cost, if selected, would be negotiable. It has been tested for validity across gender, ethnicity, and age.

This test is computer scored and can be used in sanctioning; however, it is not designed for multiple administrations nor does it take into account objective information or prior service history. Both driving risk history and use of drugs other than alcohol are addressed extensively by the ASUDS, with criminality being the only area lacking in the

test. Dr. Timken has agreed to add a criminality scale if the ASUDS is selected for use in Illinois.

Alcohol Use Disorders Identification Test (AUDIT)-Drug Abuse Screening Test (DAST)

The AUDIT was developed by the World Health Organization to identify individuals whose alcohol consumption had risen to a level that was harmful to their health. The DAST, typically used in conjunction with the AUDIT, was designed to determine a level of chemical dependency for drugs other than alcohol. The AUDIT-DAST combination met few of the criteria established by the committee. It is not capable of meeting the needs of all involved parties, is not designed to be administered multiple times, is not computer scored, has no open-ended questions, and does not address any criminal, driving, or service history. Given its inability to meet the defined needs, it was eliminated from consideration.

CAGE

CAGE is a set of additional questions that, when administered, are to be included as part of the MAST and is not designed to be given as a separate evaluation. This test was, therefore, not considered for use in Illinois.

Central States Institute (CSI

This tool also was created by the Central States Institute of Addiction and is currently being piloted in the First and Fifth Municipal Courts in Chicago. This test is very different from all the other tools, with a stronger focus on knowledge and attitude, making it very difficult for an offender's responses to be coached.

The CSI is a lengthy test to administer, taking approximately 90 minutes to complete; however, it is computer scored and results in an extensive computer generated report. Criminality and prior service history are both assessed in the CSI, including the utilization of collateral information. Use of drugs other than alcohol is evaluated, along with co-morbid psychiatric conditions. There is limited analysis of driving risk history. While the test does establish levels of risk, it is incapable of being used to recommend rehabilitative interventions or sanctions. The CSI was not designed for multiple administration.

DRI-II

The DRI-II was designed for use by evaluators and service providers. It is one of two mandated assessment instruments in Illinois, along with the Mortimer-Filkins. This test is privately owned by Behavior Data Systems, Ltd of Phoenix, AZ and costs $5 per test.

An assessment of driving risk behavior is included in the DRI-II; however, it does not address issues of risk to public safety or criminality. It is computer scored and can be administered multiple times. Questions dealing with abuse of drugs other than alcohol are asked in general terms without a clear distinction between alcohol abuse and other drug abuse. Psychological and medical issues as well as prior service history are addressed by the DRI-II, although it relies solely on self-report.

The main problem identified with the DRI-II surrounds the lack of availability of peer review literature. All data from the test is returned to Behavior Data Systems, Ltd and independent analysis is not allowed.

Drinking History Questionnaire (Oregon)

The State of Oregon uses this questionnaire in addition to the Mortimer-Filkins and a Drug Use Inventory. While this questionnaire does meet some of the desired criteria, such as the ability to be administered multiple times and validity across gender, age and ethnicity, it was discarded because it deals only with alcohol abuse and does not have the capacity to recommend rehabilitative interventions or sanctions.

Juvenile Automated Substance Abuse Evaluation (JASAE)

The JASAE was designed by ADE Incorporated to specifically target the juvenile population. This test was eliminated because it was not applicable to adult offenders.

Mississippi Alcohol Safety Education Program Assessment (MASEP)

In Mississippi, all first-time DUI offenders are required to attend a 12-hour educational program (MASEP). The assessment tool designed for the program is a combination of the MMPI, the Mortimer-Filkins, and the AUDIT. Upon discussion of the MASEP, the committee determined that this combination of tests would not be transferable to Illinois.

Michigan Alcohol Screening Test (MAST)

The MAST is a 25-item, pubic domain questionnaire used to measure alcohol abuse. It does not have the capability to be administered multiple times, does not deal with drugs other than alcohol, and does not include open-ended questions. It was felt that another test would better suit the needs in Illinois.

Mortimer-Filkins

The Mortimer-Filkins, the other mandated assessment test in Illinois, is a public domain tool and has been in circulation for more than 30 years. This test was designed for use by evaluators and service providers and was not originally intended to be used by the courts and prosecutors, which is the case in Illinois.

While the Mortimer-Filkins has more peer-review articles for the DUI population than the other tests and it is considered to be useful in the prediction of recidivism, it has not been tested for validity and may not be relevant to some ethnic populations. This test is weak in addressing drugs other than alcohol, psychological problems, service history and criminality. It relies solely on self-reporting and is not designed for multiple use. Many court officials in Illinois are not convinced that the Mortimer-Filkins is helpful to them in determining sanctions for the DUI offender. It is not used to trigger risk level determination.

NEEDS

The NEEDS was developed by ADE Incorporated and is an outgrowth of the SALCE. The cost is $6 per test. It is used extensively in Harvey Siegal's Weekend Intervention

Program in Dayton, Ohio and has been tested for validity across gender, ethnicity, and age.

Both psychological problems and criminality are addressed by the NEEDS; however, prior service information is limited. There is extensive analysis of drugs other than alcohol and an individual's threat to public safety. The NEEDS is reportedly easy to administer, requiring only 15 to 20 minutes. It is computer scored and is written to facilitate multiple test administrations. While the NEEDS includes a severity index, it has limited use in recommending sanctions. The report of the results is a customized statement on each individual and the test highlights areas that counselors may need to focus on during an interview process.

New Jersey Intoxicated Driver Program Questionnaire

The New Jersey Intoxicated Driver Program Questionnaire is a combination of the RIA Self Inventory and two additional subscales based on DSM IV criteria. New Jersey underwent a six-year revision process similar to the one we are currently involved in, and determined that this tool would best meet their needs. However, for reasons identified in the discussion of the RIA Self Inventory (see below) this test is no longer being considered for use in Illinois.

Numerical Drinking Profile (NDP)

The Numerical Drinking Profile is one of the tests that may be used in Texas. It is typically used in combination with the MAST. The committee eliminated this questionnaire because it is not a stand-alone tool.

Ohio Department of Alcohol and Drug Addiction Services Test (ODADAS)

During the time the survey was administered no assessment tool was mandated for use in the State of Ohio. They were however, in the process of creating an instrument for statewide use. The result of this process, the ODADAS, is a modification of the ASI and is currently in the pilot phase. It was decided that Illinois should not adopt a test that is currently being piloted elsewhere.

RIA Self Inventory

The State of New York commissioned Dr. Thomas Nochajski of the Research Institute on Addictions in Buffalo, NY to develop this assessment tool for use in their Drinking Driver Program. The RIA Self Inventory is public domain, but must be scored manually. The authors are currently in the process of evaluating the use of additional subscales; however, the test, in its original form, was found to be lacking in questions dealing with driving risk and drugs other than alcohol and lacks the capability for multiple administrations over time.

Substance Abuse/ Life Circumstances Evaluation (SALCE)

As previously mentioned, the SALCE was revised by ADE Incorporated and is currently marketed as the NEEDS. The SALCE, therefore, was eliminated for consideration.

Substance Abuse Subtle Screening Instrument (SASSI)

The SASSI is a one-page screening tool to determine chemical dependence. It was felt by the committee that, given the SASSI is a screening tool and not used for assessment purposes; it would not meet the needs defined for Illinois.

Overall Observations and Best Practice Recommendations

In addition to reviewing each of the instruments, the three members of the scientific advisory panel offered a variety of recommendations. These experts noted that the instrument should be developed for the persons who will use the results, whether they be the courts, the service provider, OASA, or the SOS. However, the DUI Risk Reduction Work Group should be realistic in its expectations from the instrument. The group should be very specific in what the instrument is to measure.

Non-confrontational motivational interviewing is proving to be successful when combined with the use of the assessment instrument. Those performing assessments should view working with the DUI offender as a developmental process with the responsibility of success or failure resting with the offender. It should be noted, however, that some offenders have become sophisticated in their approach to dealing with DUI offenses and the assessment process.

With respect to the instrument itself, the panel members recommended that the DUI Risk Reduction Work Group consider only tools that can be mechanically scored within a reasonable time frame (60 to 90 minutes) and that can be scored using statistical methods. Furthermore, it is important to combine the testing with the clinical observations.

By consensus, the panel also recommended that the DUI evaluator have access to the criminal record and driving record of the offender.

DUI Service Provider Survey

While information had been obtained from service providers during DUI trainings, the Risk Reduction Committee believed it was necessary to obtain more in-depth information from the individuals who work most closely with the assessment process. The decision was made to conduct a survey and hold focus groups of licensed DUI service providers in the state. A complete listing of agencies licensed to provide DUI services was obtained from the Department of Human Services, Office of Alcoholism and Substance Abuse. A random sample of 158 providers (approximately 38%) was chosen from the list. Surveys and focus group invitations were then sent to the selected agencies. Thirty-eight surveys were completed, resulting in a 24% response rate.

The survey questions were divided into sections to obtain general agency information, general multiple offender characteristics, opinions of the current DUI assessment tools, and a critique of the DUI service delivery system. A copy of the survey can be found in Appendix D.

Please see Appendix E for a complete summary of the survey results.

DUI Service Provider Focus Groups

Following completion of the provider survey, focus groups were held with providers to further discuss issues surrounding DUI assessment in Illinois. All providers included in the random sample for the survey were invited to attend a focus group near their geographical location. Focus group meetings were held in Tinley Park, Chicago, Lyle-Naperville, and Springfield. Bill White, Chestnut Health Services; Dave Gasprin, AOIC; Judi Nystrom, AOIC; Susan Baltusevich, IDOT; Carol Esarey, UIS and Joy Syrcle, UIS served as facilitators for the focus groups. A total of 53 service providers participated in the meetings. For a list of agencies represented at the focus groups see Appendix F.

The meetings provided project staff the opportunity to delve deeper into the issues raised by the survey. Focus group discussions were divided into three topical areas: characteristics that distinguish the low risk from the high risk offender, a critique of the current assessment instruments used in Illinois, and a critique of the Illinois DUI system as a whole. Each main topical area then was divided into more specific questions and the participants were provided with worksheets to assist in the discussion.

The participants found it difficult to reach a consensus regarding the high-risk offender profile. The Caucasian male between the ages of 18 and 40 was still considered to be the typical high-risk offender by most participants; however, there is a reported increase in Hispanic and female offenders. Typically the high-risk offender is unemployed or underemployed; however, some providers from the suburban areas felt strongly that their typical recidivist is a professional, educated male in a high stress occupation. Similarly, those who reported the high-risk offender is blue-collar, stated they are often in dangerous jobs, such as coal mining or construction work. The connection was then made between these occupations and general risk taking behavior. Many of the occupational differences were found between geographic regions, which lends itself to the suggestion that population characteristics of a given area should be part of the discussion when choosing or designing an assessment tool.

Overall, the providers believe the typical high-risk DUI client also uses marijuana and, to a lesser extent, cocaine. Meth-amphetamine usage is also a growing concern in more rural areas. Recidivists are likely to have a BAC of .17 or higher. Beer is seen as the drink of choice for the male offender, while women are more likely to drink mixed drinks. For the high-risk offender, drinking is part of a lifestyle. They typically drink two or more times a week. There is typically a high tolerance for alcohol and the offender is likely to deny intoxication resulting in discrepancies between BAC and self-report. Most are arrested before 6 p.m. or after midnight. It was noted that is it is of particular concern when an offender is arrested on a weekday.

One obvious red flag of a high-risk offender is presenting at the evaluation under the influence. While all providers could see the benefit of pre-evaluation drug and alcohol screening, very few providers do this. Most believe this should be a mandatory component of the evaluation process; however, there were concerns regarding funding for these tests and the actual mechanics of obtaining and testing the sample.

The providers report it is common for a high-risk offender to have an extensive history of other moving violations, specifically, speeding, driving while revoked, and illegal transportation. There is often a resisting arrest charge in conjunction with the DUI. Younger

high-risk drivers are also more likely to have been involved in serious single vehicle accidents. It was noted that many who may report having only one DUI are likely to have past DUIs that have been reduced to reckless driving.

In terms of a broader clinical profile, the providers noted that high-risk offenders are likely to have anger issues, are defensive and have a negative attitude toward treatment. One example is a resistance to pay for treatment. Some differences were noted between the male and female offenders. Men may have more anxiety problems, may be isolated and have problems with impulse control. The question on the DRI that states, " I have difficulty expressing my thoughts and feelings" was thought to be an important indicator for risk in males. It was noted that the men are more likely to drink alone or in the home, while the women are more likely to drink in a social setting. Women were seen as more likely to have diagnosable co-morbid psychiatric disorders. They often have a history of depression and general trauma in their lives. Another commonality found among the high-risk female offenders is their higher rate of involvement with the Department of Children and Family Services compared to their low-risk female counterparts.

Both male and female high-risk offenders typically have relationship problems, having had multiple significant relationships and often divorces. Those that are currently married are likely to have small children. The relationships are also often reportedly unhealthy, with a history of domestic violence being common. Women frequently report being victims of abuse, while the male offenders often have domestic violence charges on their criminal records.

The issue of domestic violence prompted a discussion regarding the significant other interviews. There was extreme disagreement as to the need to mandate this interview. Some felt it was problematic due to the nature of what is possibly a violent relationship. It was discussed that, if the offender is male, significant other responses could be coerced or the respondent could suffer repercussions as a result. If the offender is female, there was concern that the significant other could exaggerate the drinking problem in order to further punish the female offender. Further, some providers indicated that often the offender brings an individual with whom they may not have a significant relationship, such as a friend or co-worker. In these cases the information obtained from these interviews is of little help. Despite these issues, some providers believe that there is always potential of receiving useful information from these interviews and they should be a mandatory part of the assessment process. A more common opinion is that it should be at the providers discretion to complete a significant other interview.

Discussions surrounding the criminal history of the offenders were difficult in that this information is generally self-report. The provider's receipt of an official criminal history is dependent on the practice in their specific county. The charges reported to be most likely found in the high-risk offender's criminal history included assault and battery, burglary, drug possession and, as previously discussed, domestic violence. While most providers believed having an official criminal history could be helpful, it was also felt that information regarding charges in which the crime was not related to substance abuse could be prejudicial.

When asked to critique the assessment tools currently used in Illinois, the providers reported the Mortimer-Filkens is inexpensive and easy to use. It is thorough for alcohol and

yields a helpful score. The providers also appreciated that, for knowledgeable clinicians, certain questions on the Mortimer-Filkens could be used to probe for further information and data gathered from the evaluation is helpful in treatment. Another common strength of the Mortimer-Filkens is that it is a face-to-face interview and does not require a computer.

The main weakness identified for the Mortimer-Filkens is its failure to address drugs other than alcohol. It also is felt that it is easy for defense attorneys to coach their clients regarding how to answer questions on this evaluation. The lack of a link between the evaluation and a treatment plan also was noted as problematic. The age of the Mortimer-Filkens was mentioned a weakness.

Two of the most commonly identified strengths of the DRI-II were the truthfulness scale and the high-risk driving scale. Also, unlike the Mortimer-Filkens, the DRI-II contains questions regarding use of drugs other than alcohol. Most provides also appreciated the tagged questions for you to go over with the client following the computerized evaluation.

Consistently, the providers believed the cost of the DRI-II to be the biggest weakness. Discounting priors that occurred more than ten years ago was seen as flaw in this evaluation. Although the rating provided by the DRI-II was considered a strength, there was disagreement in that some providers believed the test bases the rating solely on BAC. The BAC is required to use the DRI-II, making it invalid when the offender refused. Also, seen as problematic, are questions on the DRI-II that combine alcohol and other drugs; which can be upsetting to non-drug users. The Spanish versions of both the Mortimer-Filkens and the DRI-II were considered weak.

Overall, the providers believed any new tools that are added to the list of acceptable tools should include a criminal scale and a socio-pathic scale, including some adjustment for defensiveness. The providers agreed that regardless of the tool used, interviews should always be required. It was also a common belief that, while not always necessary, providers need easier access to offender's criminal histories. As mentioned above, it also was recommended that pre-evaluation urinalysis be implemented.

There also was discussion, though not consensus, on eliminating the mandated number of treatment hours and letting treatment be at the discretion of the providers. This was not intended to lower the number of hours spent in treatment, rather to give the provider the power to keep an offender in treatment longer than the minimum requirement if necessary.

The focus group attendants believed the Illinois DUI system is generally a uniform, well-established system. The objective criteria for classification and requirements makes the system fair and consistent throughout the state. The free-market system for DUI services also was viewed as a strength.

One weakness of the system discussed by the attendants surrounded the issue of treatment compliance. Some providers feel the judges in their area do not hold the offender accountable for completing all treatment recommendations, only the minimum number of treatment hours under the law. As previously mentioned, many of the providers believe DUI

should be more treatment focused, allowing treatment providers to establish treatment criteria based on the needs of the individual. The participants also expressed the need to re-evaluate an offender during treatment.

Many providers believe there is a need for a more clearly defined mission/purpose statement for DUI evaluators. There is some confusion as to "who is their customer," given that the evaluations are used for judges decisions, treatment plans, OASA reporting and SOS hearings. Each of these require different sets of information. Along with the mission statement, evaluators would like a standardized reporting form to be used for all parties utilizing the evaluation information.

In addition, the participants felt the lack of a professional organization for evaluators was a weakness in the system. They consistently expressed a desire to have a peer where they could meet to discuss current issues in the field. While some local jurisdictions have created these groups, no statewide organization currently exists. Many participants felt the focus groups were helpful for this purpose. Similarly, the providers believed there is a need for better communication between providers and other entities in the DUI system, such as judges, state's attorneys, probation officers, and SOS hearing officers.

The providers also repeatedly express problems with reading the driving abstracts received from the SOS. Specific areas of OASA reporting also are problematic for providers. They have difficulty using and finding compatible hardware for the DOS-based system. It is the understanding of the committee that the DSRS is currently being updated to a Windows-based system.

In terms of a priority of recommendations for improving the system in Illinois, the participants agreed that levels of care should be adjusted to fit the .08 law. It is also felt judges and hearing officers need to put more focus on continuing care than is currently the case. In addition, the providers recommend an increased in the usage of BAID, victim impact panels, and toxicology screenings at the time of evaluation. Allowing the providers access to non-driving criminal records was also a priority.

Other recommendations made by the evaluators include an improvement in evaluations for offenders who do not speak English. The Spanish translations of the instruments currently used are reportedly poor.

III. ANALYSIS OF INFORMATION

Following the end of the information gathering stage, members of the DUI Risk Reduction Work Group met to discuss what had been learned and to determine their future efforts. One of the first tasks completed was to reduce the number of instruments considered to the NEEDS, the ASUDS, the ASI, and the CSI. To further differentiate these instruments, additional elements were added. These additions included clinical scales and issues related to the assessment process. (See Appendix G – Matrix II.)

Upon completion of the revised matrix, the DUI Risk Reduction Work Group met with researchers from UIS to discuss a series of research-oriented approaches to the identification and selection of an assessment instrument. During this meeting, it was stressed that any instrument must meet high standards of validation to be viewed as credible in the eyes of the court and when meeting standards of scrutiny for possible court challenges and respect within the substance abuse community. Additional questions and issues discussed at the meeting included the following:

- What exactly do we want this instrument to measure? Have we identified all of the elements necessary to determine what we want to know? As the instrument is developed, it will be important to specifically identify instrument questions to match the criteria. For instance, the identification of high-risk offenders and the use of an offenders' criminal history were identified as critical measurements.

- Does one of the existing instruments measure all of the elements in which we are interested? If the answer is no, what is missing from the instrument (such as addressing gender and ethnicity issues, setting of levels of care, criminality, and determining risk level)?

- Is it feasible to include everything wanted or needed in the instrument? It was suggested that the criteria be prioritized according to importance and need. One instrument may not be able to address all of the issues noted in the list of criteria.

- What happens if a public domain instrument is selected and new scales are added to it? Issues to study with this scenario include identifying a content expert to develop new scales for the instrument. This will be the point of identification of an entity to validate the instrument and conduct concurrent evaluation studies.

- What must be done if a privately owned instrument is used and new scales are developed with the instrument authors? The issue of validation of the instrument will need to be addressed if significant changes are made to the instrument. Copyright and ownership of the new instrument must be resolved. Costs and lengths of time for development will require negotiation with the authors.

- What is involved if more than one instrument (public or private) is combined to create a new instrument or add new scales? Again, the issues of ownership and copyright, validation, development costs and time involved will need to be examined in this scenario.

Based on the work completed to date, the DUI Risk Reduction Work Group concluded that Illinois contains a highly fragmented collection of "mini" systems dealing with DUI issues that creates difficulty in communication and implementation of policies and laws. However, those involved recognize that parts of the current DUI system need to be changed. Particularly, there is a "missing piece" in the evaluation process as it relates to the ability of current instruments to predict an offender's future risk to public safety. At the present time, there is no

dominant assessment tool available that meets 100% of the identified assessment tool criteria for Illinois.

Upon further review it was determined that the ASUDS, with the addition of new scales, is the tool closest to meeting the criteria established by the Committee. While not in the public domain, the authors of the ASUDS will allow usage through a site license for the State of Illinois for a very minimal fee. There would be no restrictions regarding utilizing the test for research purposes. The test authors are willing to work with the Committee regarding the addition of subscales to complete any of the areas in which the test could be lacking in its present form. The Committee agreed to further explore the possibility of piloting this tool for use in Illinois.

Illinois DUI Studies

The Committee further recommended that the UIS research team complete a series of mini studies utilizing Illinois DUI system data. Topics suggested included, but were not limited to: 1) youthful offenders; 2) "older" recidivists; 3) the development of an offender profile related to driving records and history; 4) an examination of race, gender, and other demographic issues; 5) a study of criminal history and predications for recidivism; 6) BAC refusal and recidivism patterns; and 7) a study of recidivist rates and profiles developed from substance abuse agencies and other agencies involved with DUI issues.

A number of state agencies were listed as potential sources of data, including the Secretary of State, the Office of Alcoholism and Substance Abuse, the State Police, and the Department of Transportation. Requests were made to each of these agencies for data on DIU offenders between the years 1997 and 2001, with the intention that the files could be linked by driver's license number for a more complete history on each driver.

The research team has encountered multiple roadblocks to this research. Much of the data has either been stalled or unable to be linked. A CD containing the data files from each DUI stop and arrest between 1997 and 2001 made by the State Police was received. This data, however, contained no identifying information and could, therefore, not be linked to other files.

In order to address the issues of confidential information, the Secretary of State drafted a confidentiality agreement which was signed by UIS research staff. A file was then provided to the research staff by the Secretary of State containing the requested data. This data file did include driver's license numbers allowing for data linkage.

A similar confidentiality agreement was presented to the Department of Transportation in order to obtain alcohol related crash information. As of last contact with the traffic records division, this agreement was being reviewed by the legal counsel for the Department.

Multiple requests for data were made to the Office of Alcoholism and Substance Abuse. However, the research staff received no response and has been unable to obtain any information regarding the status of this request.

Recommended Actions:

The following recommended actions were approved by the DUI Risk Reduction Work Group:

- Include a DUI system wide review as the DUI instrument continues through the development and piloting phases in selected jurisdictions.
    - While not part of this review, the committee recommends the following areas for future study: 1) judicial and prosecutor turnover; 2) evaluator competency and certification; 3) inconsistencies in court representative competencies; 4) the relative importance of DUI cases as viewed by the courts and law enforcement officers; 5) the role, real and perceived, of the law enforcement officer in the DUI system; 6) the impact of changes on the Secretary of State and administrative hearing process; and, 7) a need for treatment interventions specific to DUI offender;

- Proceed with the development of an improved DUI assessment instrument for the DUI evaluation that could also serve to meet the needs of other users, such as the Secretary of State and the courts;

- Utilize the contract with the University of Illinois at Springfield to proceed with modifying, developing and piloting a new instrument, possibly incorporating new subscales and norming the test to the Illinois population;

- Plan for a phased implementation process that includes instrument design and piloting of the instrument;

- Continue use of the Scientific Advisory Committee during development and piloting of the assessment instrument;

- Expand the Illinois DUI Advisory Committee to include end users for implementation. The Committee should continue to review and evaluate the assessment instrument on an on-going basis; and,

- The reconstituted Committee should proceed with attempts to complete the mini studies and multiple-offender profile. Alternate methods of acquiring information will be explored.

THE ILLINOIS DUI ASSESSMENT
INSTRUMENT PROJECT

APPENDICES

Appendix A
Executive Summary, The DUI Offender: A Review of the Literature
prepared by Illinois State University

Appendix B
DUI "Best Practices" Assessment Tools: A National Survey
prepared by University of Illinois at Springfield, Institute for Legal Administrative and Policy Studies

Appendix C
Matrix I

Appendix D
Illinois DUI Service Provider Survey

Appendix E
Illinois DUI Service Provider Survey Results

Appendix F
DUI Provider Agency Focus Group Attendees

Appendix G
Matrix II

The Driving Under the Influence Offender: A Review of the Literature

Prepared by
Illinois State University, Department of Criminal Justice
Jordan Hays, Principal Investigator
Thomas Ellsworth, Ph.D., Project Director
August 15, 2000

EXECUTIVE SUMMARY

The Sensation Seeking Scale developed by Marvin Zuckerman was prevalent in much of this research, used as an instrument to measure and determine the types of expectancies held for alcohol consumption. Alcoholics and drug abusers would score higher on measures of sensation seeking, risk-taking, and impulsivity (Creighton, Solkol). Deery and Love (1996) proposed that those individuals convicted while driving impaired in comparison with other drunk drivers not convicted, were found to possess a poor driving record.

The Mortimer-Filkins Test was found to be a qualified instrument in identifying DUI problem offenders (Reardon, 1996). Repeat offenders were less expressive emotionally, less flexible in ways of finding stimulation, and neither scores on the Michigan Alcohol Screening Test or sex differentiated first time offenders from repeat offenders (Reynolds, Kuntz, Cope, 1991). Marowitz (1996) said that blood alcohol concentration is not an efficient predictor of DUI recidivism. He also reported that offenders in the military were almost three times (2.46) as likely to reoffend than non-military personnel.

Alcoholics and recidivists had more alcohol problems than first time offenders. On the Sensation Seeking Scale, however, recidivists had the lowest score (Astley, 1994). Belenko, (1999) emphasized that treatment programs in Portland, Oregon, were very willing to give defendants several chances because they realized that relapses were part of the recovery process. Christiansen (1992) found that young, problem drinkers were at the highest risk for a future DUI/DWI. Davidsottir (1998) reported that DUI was very hard to predict but said the most significant predictor was self-efficacy. The National Highway Transportation and Safety Administration (1994) reported that the percentage of drivers with previous DUI convictions who were at risk for repeat arrests are males, usually younger, with previous traffic violations, high blood alcohol concentration level at the time of arrest, and a history of alcohol problems.

According to Illinois Secretary of State data from 1999, .08 is the current standard that is used to classify those offenders as being under the influence. Latham, Skipper, and Simpson (1997) hypothesized and found that the MacAndrews Scale of the Minnesota Multi-Phasic Personality Inventory was the best predictor of recidivism when the offender had a score of 23 or higher. Lucker and Osti (1997) found that when offenders did not complete the pre-trial intervention program, they had a 47% greater risk of being rearrested for a DUI than did those who completed the program.

Short-term residential treatment may provide an effective intervention among repeat offender drunken drivers (McCarty and Argeriou, 1988). Manilla-Hook (1994) reported that repeat offenders include a greater proportion of men who are first arrested at an earlier age, and have a poorer driving and criminal record, as compared to non-recidivists. Repeat offenders reported higher self-concept scores than alcoholics and first offenders (Myatt, 1990). Peck, Arstein-Kerslake, and Halander (1994) found that compliance to treatment programs was a much more predictable and significant factor in subsequent DUI recidivism. The offenders having a high probability of being non-compliant were much more likely to recidivate and have accidents than those with favorable compliance expectancies.

Pisani and O'Shea, (1987) reported that multiple DUI offenders differed from single offenders in that they scored higher on the Behavioral Assessment Scale in anxiety, hostility, cumulative and psychopathology scores. In reviewing and reading several bibliographies, articles, and dissertations, the biggest factor in prediction of a future DUI is being male. Sandowsky (1990) found that the closer to the time of arrest the offender entered into a treatment attitudes toward alcohol use, parental figures, and close friends tended to be problem drinkers, and these adolescents had their first drink at an early age (Forney, Forney, Ripley, 1988). Hedlund and Fell, (1995) found that DUI offenders involved in fatal car accidents were usually not repeat offenders. They were overwhelmingly male, between the ages of 21 and 34, drove a passenger vehicle without wearing a seatbelt, and were primarily involved in weekend crashes.

Repeat offenders in this analysis were 25 to 40 years old. This study found that repeat offenders had a high school education or less, worked in a blue-collar field, and tended to be aggressive and hostile with a prior criminal history. This study also addressed those drinkers who were merely persistent drinking drivers, not yet caught. Miller and Cervantes (1997) examined gender differences of alcoholic men and women and found that women drank wine more than beer and reported more negative emotional effects from consumption of alcohol.

The utilization of the Interactive Workbook has become more prevalent within treatment and diversion programs for the DUI offender. This workbook is valuable because it leads the client through a somewhat arduous process of either alcohol treatment or probation. This workbook can be used as the foundation of a treatment program or just one of the many tools used in conjunction with other treatment or probationary programs (Resource Workbook for DUI/SWI). According to Broome, Knight, Hiller, and Simpson (1996) the extent to which probation client report high self-esteem and high satisfaction with interaction among their counselors, other clients, and themselves, reflects their investment in the treatment and the ultimate benefit of the treatment or diversion program.

After careful analysis of this hypothesis, a direct relationship was found to exist between those clients who reported poor relationships with themselves and other and their increased rates of recidivism. The continuity of offender treatment for substance abuse disorders is key to a successful outcome and eventual recovery of the recidivist DUI offender. The treatment providers must collaborate with parole and probation officers to ensure quality supervision of problematic DUI offenders (Field, 1998). Haddock and Beto (1988) proposed that until a single, dominant theory of causation for abuse and addiction emerges; the safest and most practical

approach to assessment is to use a multi-dimensional system which draws from the best each theory has to offer.

Policy makers should rethink the "get tough" legislation, as harsh sanctions may ultimately do little to improve crime control or recidivism by the drunk driver (Kinkade, Leone, Wacker, 1992). Lucker and Osti (1997) speaking in general terms, said utility of a pre-trial intervention is extremely high, and offenders who are convicted of DWI and are put on probation had a 47% greater risk of a rearrest for DWI then did individuals who completed the pre-trial intervention program. According to Mumola and Bunczar (1998) over one fifth of probationers had experience with drug treatment, and forty-one percent had received treatment for alcohol abuse. This has wide-ranging implications for the treatment community and its value.

Baxter, Salzberg, Kleyn (1993) measured the effectiveness of deferred prosecution in reducing DWI recidivism is valid. The drivers given deferred prosecution had significantly less recidivism for the first, second, and fourth years after the deferred prosecution. However, there was no significant intergroup difference during the third year of evaluation. Borkman, Kaskutas, Room, Bryan, Barrows (1998) described SMP, which stand for Social Model Programs. SMP's are staffed exclusively by recovering alcoholics and the range of services include social setting detoxification, residential recovery homes, and sober living houses. The structure is based on the 12 step traditional AA, which emphasize democratic group processes. These have been found to be more cost effective than other residential approaches, averaging $2700 per day versus $4400 while offering similar outcomes.

Courtright, Mutchnick, and Berg (1997) studied the cost effectiveness of using house arrest with electronic monitoring for convicted drunk drivers. These programs are generally more cost effective because the offender pays most of the fees associated with the monitoring, and the recidivism rate was 98.2 percent successful after the first year. Fiorentine (1999) questioned the effectiveness of 12 step programs in maintaining abstinence. It was determined that weekly or more frequent 12 step participation is associated with drug and alcohol abstinence. Fors, Rojek (1999) studied the effect of victim impact panels on DWI/DUI recidivism rates. They found that rearrest rates were lower for the VIP group than the comparison group in all categories.

According to Jones, Wiliszowski, Lacey (1996), evaluated the alternative programs for DUI offenders. The effectiveness of two alternative programs, intensive supervision and electronic monitoring, were studied. Both of these programs significantly reduced DUI recidivism as compared to the traditional sanctions and programs. The recidivism rate was studied for one year after the initial offense, and were lower than the traditional sanctions. In summary, the majority of probation programs, and eventual evaluations of these programs dictate a minimum treatment or probationary period of 9 to 12 months for the DUI recidivist offender.

DUI "BEST PRACTICES" ASSESSMENT TOOLS:
A NATIONAL SURVEY

Summer 2001

Date of Interview: ___/___/___ State: _____

Contact Person: _____

Title: _____

Agency: _____

Address: _____ Zip:_____

Phone Number: ( ) _____ Fax: ( ) _____

e-mail address: _____

Section I: Assessment Tools

1. Please describe the assessment process for DUI offenders in your state.

_____

_____

_____

_____

_____

2. Who conducts your DUI assessments to DUI offenders?

_____

_____

3. What DUI assessment tool(s) are used in your state?

_____

_____

4. Is usage of this particular tool(s) mandated?

a. No (if not, skip to question #5)
b. Yes (if yes, finish question #4, then skip to question #7)
c. Unknown (if unknown, skip to question #4b)

Explanation: _____

_____

4a. Under whose authority has usage of this tool(s) been mandated?

_____

4b. Do you know why this particular tool was selected?

1) No
2) Yes

4b(1). If yes, please explain.

_____

_____

4c. How long has your state been using this/these tools(s)?

_____

4d. Overall, are people satisfied with the assessment tool(s)?

a. No
b. Yes
c. Unknown

4d(1). If no, are efforts underway to revise or develop a new tool?

a. No
b. Yes
c. Unknown

4d(1)a. If yes, please describe those efforts.

_____

_____

_____

5. If usage of a particular tool or tools is not mandated, what factors affect why the DUI assessment process is not standardized throughout your state?

_____

_____

6. Are there any efforts underway to standardize the process?

a. No
b. Yes
c. Unknown

6a. If yes, who is involved in this process?

_____

_____

_____

6b. If yes, have you aware of any impediments toward these efforts?

a. No
b. yes

6b(1). If yes, please describe those impediments.

_____

_____

7. Would it be possible for you to send us a copy of each DUI assessment tool used in your state?

a. No
b. Yes

If no, why not? _____

7a. Is there someone else who could send us copies?

a. No
b. Yes

7a(1). If yes, who is it and what is his/her telephone number and address?

_____

_____

II. USAGE OF ASSESSMENT INFORMATION

8. Do DUI evaluators have access to the client's criminal and driving records?

a. No
b. Yes

8a. If yes, how does the evaluator obtain this information?

_____

_____

_____

III. SPECIALIZED DUI PROGRAMS

9. Are you aware of any specialized programs designed for high risk/recidivistic DUI offenders in your state?

a. No
b. Yes

9a. If yes, please describe these specialized programs. (Use an attached sheet.)

IV. STATE EVALUATIVE EFFORTS

10. Are you aware of any descriptive reports that have been compiled regarding first offenders and/or recidivists (i.e., multiple offenders)?

a. No
b. Yes

10a. If yes, how could I receive a copy of these reports?

_____

_____

11. Are you aware of any descriptive reports that have been compiled regarding crashes/facilities/property damage?

a. No
b. Yes

11a. If yes, how could I receive a copy of these reports?

_____

_____

IV. SUMMARY

12. Other contact persons for DUI information. Please include each individual's name, address, phone number, e-mail). Use an attached sheet.

13. Is there anything I haven't asked that you think is important for us to know regarding how your state handles DUI assessments?

_____

_____

The Illinois DUI Assessment Instrument Project – Matrix I

	AUDIT-DAST	ODADAS (Ohio)	SASSI	Pre-sentencing Screening Report (Arkansas)	Numerical Drinking Profile (Texas)	MASEP-MASEP (handout #11)	Intoxicated Driver Program Questionnaire (New Jersey)	Drinking History Questionnaire (Oregon)	DUII (Oregon)
Capability to be used by multiple parties - DUI evaluators, prosecutors, judges, probation officers, treatment providers, SOS hearing officers	No	Yes			No	Yes	Yes		
Tested for validity across gender, ethnicity and age	?	Yes, limited			Yes		Yes	Yes	
Ability to be administered and interpreted by individuals with educational/certification required by IAODAPCA & OASA	Yes	Yes			Yes		Yes	Yes	
Capability to be computer scored to set levels of risk	No	?			Yes (possible)		Yes	Yes	
Open-ended written summary that addresses two questions; "Does individual have an AOD-related problem and extent/severity of problem?" And, "Does individual pose a threat to public safety and severity of threat?"	No No	Yes Yes					Yes Yes	? ?	
Capability to recommend rehabilitative interventions and social sanctions	No	Yes			No		Yes	No	

	AUDIT-DAST	ODADAS (Ohio)	SASSI	Pre-sentencing Screening Report (Arkansas)	Numerical Drinking Profile (Texas)	MASEP-MASEP (handout #11)	Intoxicated Driver Program Questionnaire (New Jersey)	Drinking History Questionnaire (Oregon)	DUII (Oregon)
Ability to be administered multiple times, flexibility for follow-up purposes.	No	Yes			Yes (limited)		No	Yes	
Does instrument assess use of drugs other than alcohol?	Yes	Yes			No		Yes	No	
Does the instrument address any other issues related to co-morbid psychiatric conditions?	No	Yes			No		Yes (limited)	Yes (minimal)	
Does instrument assess issues of criminality?	No	Yes			One question		Yes (limited)	No	
Can the instrument assess the driving risk history?	No	No			No		Yes (limited)	No	
Does the instrument assess any prior service history?	No	Yes			Limited		Yes	Yes (minimal)	
Does the instrument incorporate data other than self-reporting information?	?	Yes			No?		?	?	

	DRI II	M-F	ASI	NEEDS	SALCE	JASAE	ASUDS	MAST	CAGE	RIA Self Inventory
Capability to be used by multiple parties - DUI evaluators, prosecutors, judges, probation officers, treatment providers, SOS hearing officers	For use by DUI evaluators	For use by DUI evaluators	Can be used by multiple parties	Limited use			Yes			?
Tested for validity across gender, ethnicity and age.	?	No	Yes	?			Yes			?
Ability to be administered and interpreted by individuals with educational/certification required by IAODAPCA and OASA	Yes	Yes	Yes	Yes			Yes			?
Capability to be computer scored to set levels of risk	Yes	Yes (first half)	Yes	Yes			Yes			?
Open-ended written summary that addresses two questions; "Does individual have an AOD-related problem and extent/severity of problem?" And, "Does individual pose a threat to public safety and severity of threat?"	No No	Yes No	Yes Yes	Yes (widely used) Yes			?			?
Capability to recommend rehabilitative interventions and social sanctions	No	No	Yes	Yes, some for level of care			Yes			?
Ability to be administered multiple times, flexibility for follow-up purposes.	Yes	No	Yes	Yes			No			No

	DRI II	M-F	ASI	NEEDS	SALCE	JASAE	ASUDS	MAST	CAGE	RIA Self Inventory
Does instrument assess use of drugs other than alcohol?	In general, yes	No	Yes							?
Does the instrument address any other issues related to co-morbid psychiatric conditions?	Yes	Yes (qualified)	Yes (has all components)							?
Does instrument assess issues of criminality?	No	No	Yes							Yes
Can the instrument assess the driving risk history?	In general, yes	No	No							?
Does the instrument assess any prior service history?	Yes	Yes (but no detail)	Yes (limited)							?
Does the instrument incorporate data other than self-reporting information?	No	No	?							No

PLEASE COMPLETE AND RETURN BY DECEMBER 13

ILLINOIS DUI SERVICE PROVIDER SURVEY

This project has been reviewed and approved by the UIS Human Subjects Review Officer. Your participation is voluntary and your responses will kept confidential. If you have any questions regarding your rights as a research subject, please call the UIS Human Subjects Officer, Associate Vice-Chancellor Dr. Harry Berman. He can be reached at 217-206-7411. If you have any questions concerning this project, please call Ms. Joy Syrcle at 217-206-6345, e-mail syrcle.joy@uis.edu at the University of Illinois at Springfield.

Illinois DUI Service Provider Survey

AS PART OF A LARGER PROJECT, THE DUI RISK REDUCTION COMMITTEE IS ASKING FOR INFORMATION FROM VARIOUS GROUPS INVOLVED IN THE DUI EVALUATION PROCESS. AMONG THOSE BEING ASKED TO PARTICIPATE ARE THE DUI SERVICE PROVIDERS. STATES ATTORNEY'S AND PROBATION OFFICERS HAVE ALSO BEEN INCLUDED IN THE PROCESS. WE ARE SPECIFICALLY LOOKING FOR INFORMATION REGARDING THE EVALUATION INSTRUMENTS. YOUR OPINIONS AND IDEAS ARE IMPORTANT TO THIS PROCESS. YOUR PARTICIPATION IS VOLUNTARY AND YOUR RESPONSES ARE CONFIDENTIAL. PLEASE TAKE A FEW MINUTES TO COMPLETE THE FOLLOWING SURVEY.

Name : _____

Company/Agency:_____

Job Title:_____

Phone:_____

Fax: _____

E-mail Address (if applicable): _____

County(ies) Served by Agency: _____

OASA Certification Held by Agency (Please list all): _____

_____

Please complete the following survey and return it, along with your DUI Service Provider Focus Group Registration Form by December 13, 2002 in the enclosed self-addressed stamped envelope to:

Marilyn Beveridge
PAC 451B
One University Plaza, MS 451
Springfield, IL 62703-5407
Fax: (217) 206-7397

If you have any questions or need additional information, please feel free to contact:
Joy Syrcle (217) 206-6345; syrcle.joy@uis.edu
Carol Esarey (217) 206-6097; esarey.carol@uis.edu
Marilyn Beveridge (217) 206-6097; beveridge.marilyn@uis.edu

Please contact Joy Syrcle if you would like an electronic version of the survey that can be returned by e-mail.

ILLINOIS DUI SERVICE PROVIDER SURVEY

Your Agency:

1. Which of the following describes your agency affiliations for delivery of DUI services? Please check all that apply.

_____DUI Treatment

_____ DUI Evaluation

_____DUI Risk Education

_____Other Substance Abuse Treatment

_____Health Services Agency, Hospital

_____Probation Services

_____Mental Health Services Provider

_____Other: _____

2. How many years has your agency been licensed to provide DUI services? _____

3. Approximately how many DUI offenders receive the following services from your agency in a year?

_____DUI Evaluation

_____DUI Risk Education

_____DUI Treatment

4. Does your agency formally test offenders for the presence of alcohol in their system at the time of DUI evaluation (e.g. breath or blood tests)?

_____Yes

_____No

5. Does your agency formally test offenders for the presence of other drugs in their system at the time of DUI evaluation (e.g. urine test)?

_____Yes

_____No

6. Approximately what percentage of the offenders you serve is determined to be under the influence of drugs or alcohol at the time of evaluation?

_____Drugs

_____Alcohol

_____Both

_____Not applicable (Answered "No" to Questions 4 and 5)

7. If your agency does test for drugs or alcohol at the time of evaluation, please explain how you handle offenders who test positive.

_____

_____

Multiple Offenders:

8. Have you noticed changes over the past two years in the percentage of offenders you serve who have multiple DUI offenses?

_____Increased Percentage of Multiple Offenders

_____Decreased Percentage of Multiple Offenders

_____No Change in the Percentage of Multiple Offenders

9. Please indicate the frequency with which the following characteristics are true of DUI offenders served by your agency using the following scale:

1=Never 2=Rarely 3=Unknown 4=Frequently 5=Very Frequently

Characteristic	First-Time Offenders	Multiple Offenders
a. History of poly-drug use		
b. History of substance abuse treatment		
c. History of depression		
d. Exhibits anti-social behavior		
e. Presence of co-morbid psychiatric conditions		
f. Extensive criminal history		
g. History of domestic violence		
h. Unstable marital history		
i. Unstable employment history		
j. Extensive driving offense history		
k. Frequently exhibits risk taking behavior		
l. Have been victims of crimes		
m. BAC .17 or greater		
n. Arrive for the evaluation under the influence of alcohol or other drugs		

10. Are there other characteristics not listed above that you have found to differentiate repeat DUI offenders from first-time offenders? Please describe in as much detail as possible.

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

Evaluation Process:

11. What assessment tool(s) does your agency use for DUI evaluation?

_____Mortimer-Filkins

_____DRI-II

_____Other (please list): _____

12. Are you satisfied with the assessment tools you are currently using?

_____Yes

_____No

_____Somewhat

13. Please rate the ability of the Mortimer-Filkins and the DRI-II in each of the following categories using a scale of 1 to 5.

1=Not at all 2=Poor 3=Neutral 4=Good 5=Exceptional

Ability	Mortimer-Filkins	DRI-II	Other (from #11)
a. Identifies the presence of an alcohol problem			
b. Identifies the presence of a problem with drugs other than alcohol			
c. Identifies the severity of an alcohol problem			
d. Identifies the severity of a problem with drugs other than alcohol			
e. Identifies the need for treatment			
f. Identifies the type or level of treatment needed			
g. Provides data for the preparation of a treatment plan			
h. Evaluates the risk of recidivism (re-arrest for DUI)			
i. Assesses the threat to public safety via drinking or drugged driving			
j. Assesses threat to public safety via broader patterns of criminality or violence			
k. Identifies the need for intensive court probation supervision/ monitoring			
l. Assesses whether the individual is a good candidate for driving relief			
m. Assesses potential for rehabilitation			
n. Assesses strengths and personal, familial, and social resources			

14. What percentage of the time do you use the following additional sources of information in your assessment of DUI Offenders?

_____Offender's criminal record

_____Offender's driving record

_____Interviews with offender's family members

_____Assessment of usage of drugs other than alcohol

_____Prior substance abuse service history

_____Discussions with offender's probation officer

_____Other (please list): _____

15. What improvements could be made in the evaluation process used in Illinois? Please include any information not currently available to you that would be helpful in evaluation.

_____

_____

_____

_____

General:

16. What are the strengths of the DUI service delivery system?

17. What about the DUI service delivery system could be improved?

Any additional comments:

ILLINOIS DUI SERVICE PROVIDER SURVEY RESULTS

Prepared by the
Institute for Legal, Administrative and Policy Studies
University of Illinois at Springfield

January, 2003

ILLINOIS DUI SERVICE PROVIDER SURVEY RESULTS
Section 1

Agency Information:

In October of 2002 a complete listing of agencies licensed to provide DUI services was obtained from the Department of Human Services, Office of Alcoholism and Substance Abuse. A random sample of 158 providers (approximately 38%) was chosen from the list. Surveys and focus group invitations were then sent to the selected agencies. Thirty-eight surveys have been received, resulting in a 24% return rate. It should be noted that, given the low response rate, the survey can not claim to be fully representative of all agencies. The responding agencies were located throughout the state, with over half of the surveys coming from Cook and Collar counties (See Table 1.1).

Table 1.1: Responding Agencies by Geographical Area

Geographical Area	Number of Agencies	Percentage
Cook/Collar Counties	23	60.5
Downstate Counties	15	39.5
Total	38	100.0

The agencies surveyed provide a variety of DUI related services. Table 1.2 displays the number of respondents providing each DUI service. The majority of the agencies provide multiple services and are, therefore, included in each category. Some agencies also reported providing additional services such as domestic batterer counseling, anger management and parenting classes.

Table 1.2: Responding Agencies by Services Provided

Type of Service	Number of Agencies	Percentage
DUI Evaluation	36	94.7
DUI Risk Education	36	94.7
DUI Treatment	32	84.2
Other Substance Abuse Treatment	28	73.7
Mental Health Services	19	50.0
Probation Services	4	10.5
Health Services (Hospital)	2	5.3

The responding agencies also varied in the length of time they have been licensed DUI service providers, with the average length being slightly over 11 years (see Table 1.3).

Table 1.3: Length of Licensure

Number of Years	Number of Agencies	Percentage
0-5	9	23.7
6-10	6	15.8
11-15	7	18.4
16-25	11	28.9
Missing (No response)	5	13.2
Total	38	100.0
Mean: 11.4 Median: 12.0 SD: 7.6		

The majority of the responding agencies serve less than 100 clients per year for each type of service. Only 8 of the agencies provide evaluation services for more than 200 offenders each year (see Table 1.4).

Table 1.4: Number of Offenders Receiving Services

Number of Offenders Served	Number of Agencies	Percentage
DUI Evaluation		
0-50	16	42.1
51-100	5	13.2
101-150	5	13.2
151-200	2	5.3
Over 200	8	21.1
Missing (No response)	2	5.3
Total	38	100.2[1]
Mean: 139.9 Median: 62.5 SD: 181.7		
DUI Risk Education		
0-50	12	31.6
51-100	9	23.7
101-150	5	13.2
151-200	5	13.2
Over 200	5	13.2
Missing (No response)	2	5.3
Total	38	100.2[1]
Mean: 122.3 Median: 100 SD: 132.1		
DUI Treatment		
0-50	13	34.2
51-100	10	26.3
101-150	2	5.3
151-200	4	10.5
Over 200	7	18.4
Missing (No response)	2	5.3
Total	38	100.0
Mean: 124.5 Median: 77.5 SD: 135.8		

The majority of respondents indicated that their agency does not test for the presence of drugs or alcohol at the time of the DUI evaluation. Table 1.5 shows that only approximately 20% of responding agencies administer these tests. The agencies that do test for drugs and/or alcohol most indicated that less than 5% test positive for alcohol and between 2% and 10% test positive for drugs. One agency, however, reported that 20% of their clients test positive for alcohol and/or drugs. Typically agencies reported when a client tests positive for alcohol the evaluation is rescheduled and the client is assessed for the need for detox or in-patient treatment.

Table 1.5: Drug and Alcohol Test at Time of Evaluation

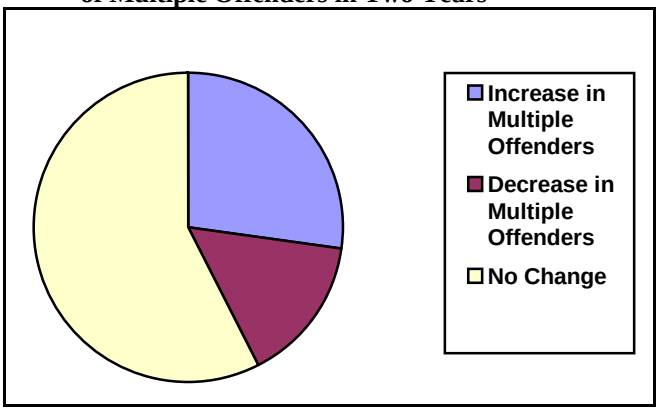
Test Given	Number of Agencies	Percentage
Clients Tested for Presence of Alcohol	7	18.4
Clients Tests for Presence of Other Drugs	6	15.8

Multiple Offenders:

One of the primary focuses of the survey was to gain information from providers regarding the high-risk, multiple DUI offender. Slightly over half of the respondents indicated there has been no change in the past two years in the percentage of their clients who have multiple DUI offenses. Approximately a fourth of the agencies believed the

percentage of recidivists they serve has increased, while 15% felt multiple offenders now make up a smaller percentage of their clients (See Figure 1.1).

Figure 1.1: Change in the Percentage of Multiple Offenders in Two Years



In order to help determine what information could be pertinent in identifying high risk drivers, the providers were asked the frequency with which a series of characteristics are true of first-time and repeat offenders. Some characteristics were identified as being more often true of recidivists (see Table 1.6). For example, over 80% of respondents reported multiple offenders frequently have a history of poly-substance use, while only 37% found this to be frequently true of first-time offenders. Multiple offenders were also more likely to be identified as having an unstable marital history, an extensive driving offense history, and a BAC at time of arrest of .17 or greater.

Table 1.6: Characteristics of First-Time Vs. Multiple DUI Offenders

	Rarely[1]		Unknown		Frequently[2]		Total[3]	
Characteristic	N	%	N	%	N	%	N	%
History of poly-drug use								
First-Time Offenders	15	40.5	8	21.6	14	37.8	37	99.9[4]
Multiple Offenders	3	9.4	3	9.4	29	81.2	35	100.0
History of substance abuse treatment								
First-time Offenders	31	86.1	1	2.8	4	11.1	36	100.0
Multiple Offenders	3	8.3	2	5.6	31	86.1	36	100.0
History of Depression								
First-Time Offenders	25	67.6	10	27.0	2	5.4	37	100.0
Multiple Offenders	14	41.2	7	20.6	13	38.2	34	100.0
Exhibits anti-social behavior								
First-time Offenders	23	62.2	11	29.7	3	8.1	37	100.0
Multiple Offenders	12	33.3	8	23.5	14	41.2	34	100.0
Presence of co-morbid psychiatric conditions								
First-time Offenders	29	73.3	9	23.7	0	0.0	38	100.0
Multiple Offenders	19	54.3	11	31.4	5	14.3	35	100.0
Extensive criminal history								
First-time Offenders	28	75.7	5	13.5	4	10.8	37	100.0
Multiple Offenders	14	41.2	4	11.8	16	47.1	34	100.1[4]
History of domestic violence								
First-time Offenders	22	59.5	11	29.7	4	10.8	37	100.0
Multiple Offenders	9	26.5	13	38.2	12	35.3	34	100.0

Table 1.6 Continued

Characteristic	Rarely[1]		Unknown		Frequently[2]		Total[3]	
	N	%	N	%	N	%	N	%
Unstable marital history								
First-time Offenders	21	56.8	5	13.5	11	29.7	37	100.0
Multiple Offenders	4	11.8	4	11.8	26	76.5	34	100.1[4]
Unstable employment history								
First-time Offenders	24	67.9	6	16.2	7	18.9	37	100.0
Multiple Offenders	8	23.5	5	14.7	21	61.8	34	100.0
Extensive Driving History								
First-time Offenders	24	64.9	3	8.1	10	27.0	37	100.0
Multiple Offenders	4	11.4	1	2.9	30	85.7	35	100.0
Frequently exhibits risk taking behavior								
First-time Offenders	15	39.5	10	26.3	13	34.2	38	100.0
Multiple Offenders	3	8.3	7	19.4	26	72.2	36	100.0
Have been victims of crimes								
First-time Offenders	14	40.0	16	45.7	5	14.3	35	100.0
Multiple Offenders	19	50.0	1	2.6	18	47.4	38	100.0
BAC of .17 or greater								
First-time Offenders	17	44.7	1	2.6	20	52.6	38	99.9[4]
Multiple Offenders	0	0.0	1	2.9	34	97.1	35	100.0
Arrive for evaluation under the influence								
First-time Offenders	33	86.8	3	7.9	2	5.3	38	100.0
Multiple Offenders	31	88.6	3	8.6	1	2.9	35	100.1[4]

[1]Numbers included responses "never" or "rarely".
[2]Numbers included responses "frequently" or "very frequently".
[3]Not all respondents answered all questions. Total number of responses may vary.
[4]Totals not equaling 100.0 are due to rounding.

The following other characteristics were identified by the respondents as differentiating first-time and repeat offenders:

- Attitudinal differences: repeat offenders are more likely to be defensive and minimize symptoms;
- Multiple offenders are more likely to have driven on suspended or revoked licenses;
- Multiple offenders had a lack of parental guidance or support while growing up, now have a lack of connectedness with family
- Multiple offenders have multiple marriages/significant relationships;
- Multiple offenders are often first generation immigrants;
- Multiple offenders are often unemployed;
- Multiple offenders tend to be older.

ILLINOIS DUI SERVICE PROVIDER SURVEY RESULTS
Section 2

Evaluation Instrument:

Another focus of the survey was to gain a better understanding of the assessment tools currently used in Illinois, through the opinions of the service provides, who have the best first hand knowledge of these instruments. More than 60% of the respondents reported using the Mortimer-Filkens, while slightly more than half reported using the DRI-II; therefore a number of agencies use both tools (see Table 2.1). Additional instrument reportedly used by some agencies included the SASSI, SUDDS, Helmuth and MAPP.

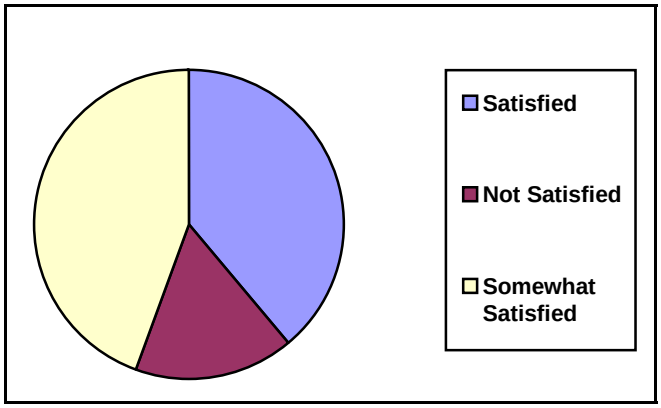
Table 2.1: Assessment Tools Used by Responding Agencies

Assessment Tool	Number of Agencies	Percentage[1]
Mortimer-Filkens	23	60.5
DRI-II	19	50.0

[1]Two agencies did not respond to these questions. Percentages based on 36 respondents.

A primary purpose of this project was to determine how well the current DUI assessment tools used in Illinois were meeting the needs of the system. Slightly under 40% of the respondents reported being satisfied with the tools they currently use. The remaining nearly 60% were only somewhat satisfied or unsatisfied (see Figure 2.1).

Figure 2.1: Respondent Satisfaction with Assessment Tools



When asked to rate the strengths of the two assessment tools used in Illinois, survey respondents consistently rated the DRI II as the more effective tool (see Table 2.2). While both scored high in identifying an alcohol problem, the DRI II was reported to be a better tool in identifying a problem with drugs other than alcohol and determining the severity of the problem. Neither tool was reported to be very effective in identifying the risk of recidivism, the need for intensive supervision, or determining if the offender is a good candidate for driving relief.

Table 2.2 Assessment Tool Ability Ratings

	Poor[1]		Neutral		Good[2]		Total[3]	
Ability	N	%	N	%	N	%	N	%
Identifies the presence of an alcohol problem								
Mortimer-Filkens	3	11.1	5	18.5	19	70.4	27	100.0
DRI-II	1	5.0	3	15.0	16	80.0	20	100.0
Identifies the presence of a problem with other drugs								
Mortimer-Filkens	17	63.0	6	22.2	4	14.8	27	100.0
DRI-II	1	4.8	3	14.3	17	81.0	21	100.1[4]
Identifies the severity of an alcohol problem								
Mortimer-Filkens	5	18.5	10	37.0	12	44.4	27	99.9[4]
DRI-II	3	15.0	3	15.0	14	70.0	20	100.0
Identifies the severity of a drug problem								
Mortimer-Filkens	20	74.1	4	14.8	3	11.1	24	100.0
DRI-II	3	15.0	3	15.0	14	70.0	20	100.0
Identifies the need for treatment								
Mortimer-Filkens	12	44.4	7	25.9	8	29.6	27	99.9[4]
DRI-II	3	15.0	4	20.0	13	65.0	20	100.0
Identifies the type or level of treatment needed								
Mortimer-Filkens	15	55.5	8	29.6	4	14.8	27	100.0
DRI-II	6	30.0	4	20.0	10	50.0	20	100.0
Provides data for the preparation of a treatment plan								
Mortimer-Filkens	12	46.2	8	30.8	6	23.1	26	100.1[4]
DRI-II	3	15.0	11	55.0	6	30.0	20	100.0
Evaluates the risk of recidivism								
Mortimer-Filkens	14	51.9	6	22.2	7	25.9	27	100.0
DRI-II	7	35.0	5	25.0	8	40.0	20	100.0
Assesses the threat to public safety via drinking or drugged driving								
Mortimer-Filkens	12	44.4	11	40.1	4	14.8	27	99.9[4]
DRI-II	4	20.0	6	30.0	10	50.0	20	100.0
Assesses the threat to public safety via broader patterns of criminality								
Mortimer-Filkens	15	55.6	9	33.3	3	11.1	27	100.0
DRI-II	9	45.0	6	30.0	5	25.0	20	100.0
Identifies the need for intensive court probation supervision/monitoring								
Mortimer-Filkens	18	66.7	7	25.9	2	7.4	27	100.0
DRI-II	11	55.0	6	30.0	3	15.0	20	100.0
Assesses whether the individual is a good candidate for driving relief								
Morimer-Filkens	17	63.0	9	33.3	1	3.7	27	100.0
DRI-II	10	50.0	10	50.0	0	0.0	20	100.0

Table 2.2 Continued

Ability	Poor[1]		Neutral		Good[2]		Total[3]	
	N	%	N	%	N	%	N	%
Assesses potential for rehabilitation								
Mortimer-Filkens	15	55.5	9	33.3	3	11.1	27	99.9[4]
DRI-II	8	40.0	7	35.0	5	25.0	20	100.0
Assesses strengths and personal, familial, and social resources								
Mortimer-Filkens	17	63.0	7	25.9	3	11.1	27	100.0
DRI-II	11	55.0	6	30.0	3	15.0	20	100.0

[1]Numbers included responses "not at all" or "poor".
[2]Numbers included responses "good" or "exceptional".
[3]Not all respondents answered all questions. Total number of responses may vary.
[4]Totals not equaling 100.0 are due to rounding.

When asked about the frequency with which their agencies use certain additional sources of information, most providers reported always using the offender's driving abstracts and prior substance use/treatment history (see Table 2.3). However, criminal history information and discussions with probation officers were used less often.

Table 2.3 Access to Additional Sources of Information for Evaluation

Percentage of Time Information is Available	Number of Agencies	Percentage
Offender's Criminal Record		
0%-25%	24	64.9
26%-50%	5	13.5
51%-75%	1	2.9
76%-100%	7	19.9
Total	3	100.0
Mean: 29.5 Median: 5.0 SD: 38.9		
Offenders Driving Record		
0%-25%	3	8.1
26%-50%	2	5.4
51%-75%	2	5.4
76%-100%	30	81.1
Total	37	100.0
Mean: 85.1 Median: 100.0 SD: 29.9		
Interview with Offender's Family Members		
0%-25%	12	32.4
26%-50%	7	18.9
51%-75%	5	13.5
76%-100%	13	35.1
Total	37	99.9[1]
Mean: 54.7 Median: 50.0 SD: 37.6		

Table 2.3 Continued

Percentage of Time Information is Available	Number of Agencies	Percentage
Assessment of Drugs Other Than Alcohol		
0%-25%	4	10.8
26%-50%	2	5.4
51%-75%	2	5.4
76%-100%	29	78.4
Total	37	100.0
Mean: 82.8 Median: 100.0 SD: 32.8		
Prior Substance Abuse Service History		
0%-25%	4	10.8
26%-50%	1	2.7
51%-75%	2	5.4
76%-100%	30	81.1
Total	37	100.1[1]
Mean: 84.3 Median: 100.0 SD: 31.5		
Discussions with Offender's Probation Officer		
0%-25%	20	54.1
26%-50%	9	24.3
51%-75%	1	2.7
76%-100%	7	18.9
Total	37	100.0
Mean: 33.1 Median: 20.0 SD: 35.9		

[1]Totals not equaling 100.0 are due to rounding.

ILLINOIS DUI SERVICE PROVIDER SURVEY RESULTS
Section 3

Strengths of the DUI Service Delivery System

The following are some of the strengths of the DUI service delivery system identified by the respondents:

- Allows for early identification of a problem and subsequent intervention;
- Forces offenders to correct their behavior;
- Evaluations are consistent across different evaluators;
- Accurate/appropriate placement of offenders based on risk;
- Minimum requirements are appropriate;
- Accurate information provided to evaluators regarding BAC and arrest information;
- Victim impact panels are very helpful;
- Court actions or threat of punitive measures are very persuasive in motivating offenders;
- Uniformity across the state;
- SOS hearing officers are well trained.

Improvements Needed in the DUI Evaluation/Service Delivery System

The responding agencies also provided a variety of suggestions for improvements to the DUI evaluation and service delivery system. Some of these ideas include:

- Allow evaluators to make recommendations for increased treatment level or other types of treatment such as mental health services, anger management, grief or domestic violence counseling based on the needs of individual clients;
- On-line access to read-only SOS and ISP databases for retrieval of driving and criminal history information.
- Better assessment tool, including an assessment of drugs other than alcohol, and include questions regarding overall substance use history, not just the past 12 months;
- Better coordination between the courts, probation, providers, and hearing officers;
- Improved public information regarding the DUI process and penalties, possibly including a mandatory course for drivers prior to receiving a license;
- Improved method of obtaining copies of past evaluations and treatment verification;
- Make the driving abstracts more clear, include page numbers so it is clear when a page is missing;
- Make the DSRS more user friendly and provide it in multiple languages;
- Provide a standardized assessment tool for use with offender's corroborative witness/significant other. Make these interviews mandatory.
- Requiring screening for presence of alcohol or other drugs in the offender's system at the time of evaluation;
- Provide more training from OASA;
- Offenders need to be held more accountable. They may attend sporadically or not at all with little or no consequences;
- Set stricter penalties for driving while revoked;
- Provide brochures and other forms from OASA in multiple languages;
- Include services for hearing impaired in those that are paid for by the state;
- Spanish version of the DRI-II seems like a poor translation;
- Better court cooperation with reclassification during treatment.

DUI FOCUS GROUP ATTENDEES

Provider Agencies	**County**
Alpha Counseling Center, Inc	Will
Association House of Chicago	Cook
Ben Gordon Center	Dekalb
Catholic Charities of the Archdiocese of Chicago	Cook
Comgraph, Inc	Cook
Community Counseling Center of the Fox Valley, Inc.	Kane
Community Service Council of Northern Will County	Will
Corporate Health Resource Center, PC	Cook
Counseling Associates, Inc.	Will
Counseling Center Inc.	McHenry
Crossmont & Associates, Inc.	Cook
Diagnostic Services Associates, Ltd.	Will
DUI Services	Macon
Dupage County Department of Human Resources	Dupage
Egyptian Public and Mental Health Department	Gallatin
Erie Family Health Center, Inc.	Cook
Hauck, Paul A., Ph.D. Ltd.	Rock Island
Heartland Human Services	Effingham
Intervention Instruction, Inc.	Cook
Kathi Cullop, Counselor	Champaign
L.W.'s Place Inc.	Champaign
Latino Intervention Center	Cook
Norcare, Inc.	Carroll
Paramo's Counseling Center	Will
Pro-Health Advocates, Inc.	Cook
Professional Consultations, Inc.	Dekalb
Provena Hospitals	Will
Renz Addiction Counseling Center	Cook
T.R.A.P.P. Services, Inc.	Bureau
Tap Resources, Inc.	Peoria
The Fellowship House	Union
Traffic School of Behavioral Change, Inc.	Will
Triangle Center	Sangamon
Tricon Counseling Centers, Inc.	Dupage
State Agencies	
Department of Human Services- Office of Alcoholism and Substance Abuse	

The Illinois DUI Assessment Instrument Project – Matrix II

QUESTIONS	DUI ASSESSMENT INSTRUMENTS			
	NEEDS	**ASUDS**	**ASI**	**CSI**
Capability to be used by multiple parties: DUI evaluators, prosecutors, judges, probation officers, treatment providers, SOS hearing officers.	Limited Use	Yes	Yes	Some
Tested for validity across gender, ethnicity and age.		Yes	Yes	No
Ability to be administered and interpreted by individuals with educational/certification required by IAODAPCA and OASA.	Yes	Yes	Yes	Yes
Capability to be computer scored to set levels of risk	Yes	Yes	Yes	Yes
Open-ended written summary that addresses two questions: “does the individual have an AOD-related problem and extent/severity of problem “ And, “Does the individual pose a threat to public safety and severity of threat ”	Yes	Yes, some	Yes	Yes
Capability to recommend rehabilitative interventions and social sanctions.	*Yes*	Yes	Yes	No
Ability to be administered multiple times with flexibility for follow-up purposes.	Yes	No	Yes	No
Does the instrument assess use of drugs other than alcohol?	Yes	Yes	Yes	Yes, but not pattern
Does the instrument address any other issues related to co-morbid psychiatric conditions?	Yes	Yes	Yes	Yes
Does the instrument assess the driving risk history?	Yes	Yes	No	Limited

QUESTIONS	DUI ASSESSMENT INSTRUMENTS			
	NEEDS	ASUDS	ASI	CSI
Does the instrument assess any prior service history?	Yes	Yes	Yes	Yes, limited
Does the instrument incorporate data other than self-reporting information?	No	Driving record/third party/official documentation	No	Yes
Does the instrument assess issues of criminality?	Yes - some	No	Yes	Yes, limited
CLINICAL PROFILE SCALES	**DUI ASSESSMENT INSTRUMENTS**			
	NEEDS	**ASUDS**	**ASI**	**CSI**
S/R Life problems	Yes	Yes	Yes	Some
DSM IV diagnosis	Yes	Yes	Yes+	Yes, limited
SA	Yes	Yes	Yes	Yes
Psychiatric		Yes	Yes	Yes, limited
Prior TX history	No	Yes+	Yes	Some
Risk Taking	No	Yes	No	Yes
Sensation Seeking	No	No	No	Yes
Aggression	No	Yes	No	Yes
Anti-social behavior	Yes	Yes	No	No
Empathy	Yes	No	No	No
Depression	Yes	Yes	Yes	Yes
Victimization	Yes	No	Yes	No

Criminal Record	*Yes*	No	Yes+	No
BAC	Yes	Yes	No	Yes
DUI ASSESSMENT PROCESS ISSUES	**DUI ASSESSMENT INSTRUMENTS**			
	NEEDS	**ASUDS**	**ASI**	**CSI**
Is the test self-administered?	Yes	Yes	See attached	Initial and interview
Does the instrument use collateral verification?	No	Yes	See attached	No
Objective verification -- are official records used in the review?	No	Yes	See attached	Yes
How is the test used to set levels of risk?	See attached	See attached	See attached	Yes (see notes)
How is the test used to set levels of care?	See attached	See attached	See attached	Available, but not used
How much time does it take the client to complete the test?	26 minutes	7 minutes	45 – 60 minutes	90 min. test 30 min. interview
How much time does it take to complete the data entry of the results?	5 minutes	5 minutes	See attached	5 min.
How much time does it take to score the test?	5 minutes	5 minutes	See attached	5 min.
What is the cost of the test?	$40 start-up $6 scoring	See attached	See attached	
Is the test in computerized form?	Yes	No	See attached	Yes – for both applicant and assessor

DUI ASSESSMENT PROCESS ISSUES	DUI ASSESSMENT INSTRUMENTS			
	NEEDS	ASUDS	ASI	CSI
How is the driving record used?	Yes	See attached	See attached	Yes, linked from Sec. Of States Office
Who sees and uses the test?	See attached	See attached	See attached	CSI Staff – evaluators and clinicians
Who has access to the test?	See attached	See attached	See attached	CSI Staff

ADDITIONAL DUI ASSESSMENT INSTRUMENT INFORMATION

NEEDS

Does the instrument assess any prior service history? Yes – mental health and other alcohol related histories.

Does the instrument assess issues of criminality? Yes – some. The instrument also assesses psychiatric issues.

Does the instrument use collateral verification? No – counselors collect the information.

How is the test used to set levels of risk? Counselors use the test to determine levels of risks.

How is the test used to set levels of care? Yes – some. The NEEDS evaluator makes recommendations. The clinician makes the final recommendations.

How much time does it take to score the test? 5 minutes – the test is scored by support staff.

How is the driving record used? Yes – the original driving record is used.

Who sees and uses the test? – Counselors and other relevant staff

Who has access to the test? Counselors

ASUDS

How is the test used to set levels of risk? -- It was designed specifically for DUI offenders – all scales except motivation – higher scale scores, the greater the level of risk.

How is the test used to set levels of care? -- The revisions they made do a better job – certain scale scores give a prescription based on model ASAM – certain scores shows that an individual person should be in a certain level of care or continuing treatment, residential, OP or a combination. The test itself is combined with an interview.

How much time does it take the client to complete the test? -- On average about 7 minutes. If it takes longer than 20 minutes, they ask them to step aside and have the professional recheck to see if the person is literate.

What is the cost of the test? -- They do not sell the test separately. If they were selling it to a state it would depend on the volume. A contract would be drawn up for a period of time (i.e. fiscal year) for X amount of dollars and they would be able to make as many copies as they want. Can build in money for conference calls with Dr. Timken. If we would want him to develop norms on our population, that could be built into the contract as well.

The approximate cost to pilot this test in 3 Illinois counties would be in the $700.00 range, if we do not want the data "massaged".

How is the driving record used? -- They try to get the offenders past driving record as well as current one so that all prior arrests would show.

Who sees and uses the test? -- Properly trained personnel. He does 1 ½ days of training to teach the use of the instrument, background, motivational interviewing techniques, the way they want the interview conducted, experiential exercises, etc. He has done classes for as many as 30-35 but does not want to do them for less than 6-8. He could come here or he could do a train the trainers class out in Colorado.

Who has access to the test? -- Just the professionals. He doesn't want the test divulged to other people such as defense attorneys.

Addiction Severity Index (ASI)

DUI Assessment Process Issues

Is the test self-administered? -- The ASI was developed as an interview. The original authors feel that it is very important that the interview process be maintained to provide the opportunity for the interviewer to evaluate the integrity of the responses. The test is, however, public domain and has been computerized and marketed by private companies. At least one of the computerized versions is self-administered.

Use of collateral verification? -- The instrument itself includes only self-report. At the end of each section there is an opportunity for the interviewer to state if they believe the respondent is misrepresenting him/herself. If collateral information were available it would be used to assist the interviewer in making that determination. This would not be applicable to computerized versions.

Objective verification (are official records used in the review)? -- As in the previous question, official records, if available to the interviewer, would be used to assist the interviewer in determining if the respondent is misrepresenting him/herself. This would not be applicable to computerized versions.

How is the test used to set levels of risk? -- The ASI can generate two different scores: a composite score and a severity rating. Composite scores are used for research purposes to measure change over time but have no value to clinicians as indications of current status in problem areas. Severity ratings are generated for each of the seven potential problem areas and are used to determine the need for additional treatment in that area. The authors make available an excel program for computing the composite score.

How is the test used to set levels of care? -- Severity ratings can be used to determine the level of care necessary for the respondent.

How much time does it take the client to complete the test? -- 45 to 60 minutes

How much time does it take to complete data entry of the results? -- Data entry time varies based on the skills of the individual doing the data entry. At least one computerized version of the test requires no data entry.

How much time does it take to score the test? -- Scoring of the test includes a Narrative Summary. Computerized versions of the test generate the summary almost immediately. Narratives written by an interviewer, however, may require up to an hour to complete.

What is the cost of the test? -- The original versions of the test are public domain. Computerized versions range from $5 to $8 per test. A scoring program can be purchased for a one-time fee.

Is the test in computerized form? -- The test was created as an interview; however, has been computerized by private companies. There is also a program available to score the test.

How is the driving record used? -- If driving records were available they would be used to assist the interviewer in determining if the respondent is misrepresenting him/herself.

Who sees and uses the test? -- A counselor or others who have been trained to administer the test are the primary users of the test. The Narrative Summary, the results, would also be given to judges or other court personnel.
The test was developed for research purposes and is used by researchers to measure change over time. It is also often used as an intake interview for those entering a treatment program.

Who has access to the test? -- The test is public domain.

CSI

Does the instrument assess the use of drugs other than alcohol? – Yes, there is drug language but not drug specific language.

Does the instrument address any other issues related to co-morbid psychiatric conditions? – Yes, but the revised/new instrument developed from this project needs to be able to generate a DSM IV component.

How is the test used to set levels of risk? The questions are "weighted" to determine level of risk and the court interprets the level of risk and uses empirical studies.