EFFECTIVENESS

OF THE

MINNESOTA

ALCOHOL SAFETY PROGRAMS

FINAL REPORT

1990

PREPARED BY:
Department of Public Safety
State Planning Agency
Department of Human Services

REPORT TO THE LEGISLATURE
AS REQUIRED UNDER
MINNESOTA STATUTE 169.126, SUBD. 4b

REPORT AUTHORS
(in alphabetical order):

David Anderson
Kathy Guthrie
Ray Lewis
Kathy Swanson
Marlene Swanson
Cindy Turnure

Prepared by the Department of Public Safety, in cooperation with the Department of Human Services and the State Planning Agency. The Department of Public Safety wishes to acknowledge the DWI Task Force and the following members of the Alcohol Problem Assessment Task Force for their assistance in the preparation of data for this report:

Mark Barta
Roxanne Bartch
Phil Brekken
Jeff Bruce
John Cassidy
Angel Catania
Cami Dirnberger
Bob Feifarke
Lee Gartner
Shirley Goetz
Kathy Guthrie
Steve Holmquist
Beverly Holt
Jim Kincannon
Wayne Krefting
Ray Lewis
Chuck Maas
Rob McDonough
Mike McGuire
David Pingry
Joanne Pohl
Alan Rodgers
Dr. Ralph Scheer
Jerry Soma
Bill Strusinski
Kathy Swanson
Ed Vennewitz

TABLE OF CONTENTS

APPENDICES

CHARTS AND DIAGRAMS APPEARING IN THIS REPORT

CHAPTER 1

MAJOR FINDINGS AND RECOMMENDATIONS

In 1987, the Minnesota Legislature mandated that the Department of Public Safety, together with the Department of Human Services and the State Planning Agency, prepare a report evaluating the implementation and effects of the Alcohol Safety Programs required in Minnesota Statutes 169.124 to 169.126. The purpose of these programs is to identify the severity of the driver's chemical abuse problem, and to recommend the appropriate level of education or treatment needed to resolve the problem and prevent subsequent offenses.

The objective of the changes enacted by the 1987 legislature (Chapter 315) was to improve the accuracy of chemical use problem assessments by reimbursing the county at a higher rate for the longer time it would take to do a better assessment.

In response to the legislative mandate, the Department of Public Safety created the Alcohol Problem Assessment (APA) Task Force to study the issues. It consists of professionals from state and county agencies and private organizations concerned with the DWI problem.

The Task Force conducted a survey of certified alcohol use assessors and screeners. In that survey, 62% responded that the program has been working "all right" since the legislative changes of 1987 were made effective.

While 77% of the respondents felt that their agency's ability to identify alcohol problems has only "increased somewhat" due to the law change, 12% feel that the law change has actually made it more difficult to identify these problems.

Furthermore, 57% responded that their agency's ability to obtain appropriate rehabilitation treatment has only "increased somewhat", and 29% feel that the law change has created more problems in getting the proper level of care for their clients.

THE PROBLEM:

Many respondents felt that it takes just as long to assess a "no problem" drinker as a problem drinker, so the state should not differentiate between them when reimbursing the counties. In some counties, the client must undergo two separate interviews, sometimes repeating the screening process before an assessment can be completed. Also, the differences between a screening and an assessment is not clear in many jurisdictions.

RECOMMENDATION: Combine the screening and assessment procedures into a single interview. This would result in better information for education and rehabilitation referrals, less duplication of efforts, and a more streamlined reimbursement process. Counties could be reimbursed on a per case basis.

ACTION: Legislative changes to Minnesota Statutes, Sections 169.124 and 169.126 would be required. Language has been drafted to be considered by the 1990 Legislature.

THE PROBLEM:

The Driver and Vehicle Services Division found that reports of screenings and assessments are often inconsistent and incomplete. The Task Force felt that if the assessors understood the full usage of these reports, they would be more complete and accurate.

RECOMMENDATION: Revise the form used for reporting the results of screenings and assessments completed. Review the information currently collected for the Alcohol Safety Program. Coordinate this information for both Rule 25 and Chapter 315 requirements.

ACTION: A subcommittee of the Task Force is currently proceeding with this recommendation. Their report is due July 1, 1990.

THE PROBLEM:

The Task Force recognized the fact that DWI arrests are continuing on a downward trend after a high in 1986. (See TRENDS later in this summary.) It appears that while recent awareness efforts have altered the behavior of many social drinkers, we have yet to reach the problem drinker.

RECOMMENDATION: Determine the recidivism rate for chemically impaired driving offenders, using the database from the Driver and Vehicle Services Division. This could provide information regarding the target audience of educational and behavioral programs.

ACTION: The Department of Public Safety has begun the research for this study. A preliminary report is expected in early 1990.

THE PROBLEM:

Under Rule 25, there is no provision for treatment other than traditional in- or out- patient chemical dependency treatment. Alternatives to such treatments have been effective for chemically abusing drivers in the past, but are no longer available within the guidelines of this system. 24% of the survey respondents indicated that offenders are "almost always" or "often" denied needed treatment because they do not qualify under Rule 25.

One of the problems with jail as an alternative to treatment, according to Judge Bernard E. Boland, is that almost 100% of the people jailed or imprisoned eventually get out -- still untreated and even more antisocial. Yet 71% of the respondents to the survey stated that a jail sentence is the most frequent sentencing recommendation for offenders who are found in assessment to be not amenable to treatment.

RECOMMENDATION: Study the "at risk" abuser, and the repeat offender programs and services available, particularly in the greater Minnesota area. Also re-think prevention efforts in terms of more successful methods of treatment, and explore alternatives to traditional in- and out- patient treatment qualifying under Rule 25.

ACTION: A subcommittee of the Task Force is currently studying this recommendation. Their report is due October 1, 1990.

THE PROBLEM:

A major problem identified by the Task Force is that Section 9 of Chapter 315 requires that assessments done for driver licensing decisions be consistent with Rule 25 criteria. However, Rule 25 was not drafted with driver licensing decisions in mind.

RECOMMENDATION: Re-examine Rule 25, and coordinate with Chapter 315 and the Department of Public Safety's rules regarding the individual's ability to re-obtain a driver license.

ACTION: The Department of Human Services has agreed to begin the rule process in January 1991. During this process, the Task Force will assist in improving the compatibility of the rule with Chapter 315 and driver license rules.

THE PROBLEM:

67% of the respondents to the survey stated that they "seldom" or "never" notify the Department of Public Safety when a DWI offenders are convicted of violating the treatment/education requirements of their probation.

RECOMMENDATION: Clarify the need for the Department of Public Safety to be notified of the probation violations of multiple offenders.

ACTION: Language has been drafted to amend Minnesota Statutes, Section 171.16, allowing the courts to recommend suspension of driving privileges of those persons who do not comply with the requirements of a chemical use assessment. This will be introduced in the 1991 session.

THE PROBLEM:

The Task Force's percieved that there is clearly a lack of understanding in several areas of the process of assessing the chemically impaired driver. This was supported by many of the comments in the survey.

RECOMMENDATION: Develop a procedure manual and provide additional training. Document the program procedures and polices. Address the issues and questions mentioned in the survey and the Task Force meetings. For example:

- The $75 program fee
- Rule 25 criteria for treatment:
  - policies for abstinence
  - budget considerations
- How to obtain and read a traffic record
- What elements are required in an assessment
- County reciprocity procedures
- Qualification and certification of assessors
- Driver License revocation and reinstatement procedures
- Reimbursement criteria & requirements

ACTION: A subcommittee of the Task Force is currently studying this recommendation.

There were several other ideas which developed during the Task Force meetings. These are long-term considerations, and as such, no action plan has been developed at this time. These ideas include:

Encourage adoption of screening and assessment tools specifically designed for juveniles.

Examine the feasibility of requiring all counties to use a computerized case management and classification system.

Examine the computerized Minnesota Assessment of Chemical Health (MACH) system for conducting assessments. Is it feasible and realistic to extend to all counties for assessments?

Examine the feasibility of automating the reporting of all screenings and assessments, through the Trial Court Information System (TCIS).

Explore whether health insurance providers are authorizing treatment at the appropriate levels. Review the standards which health providers use for treatment, compared to Chapter 315 and Rule 25 criteria.

Evaluate the assessment reports filed on repeat offenders to look for discrepancies and inconsistencies. (Over half of the respondents to the survey admitted that they at least sometimes use assessments from private agencies that do not meet Chapter 315 requirements.)

Examine the validity of the 30-day abstinence period and its use in the screening and assessment process. (According the survey, many respondents felt that it is relatively easy for a client to abstain for 30 days, which changes the level of treatment available under Rule 25.)

DECLINING TRENDS

According to statistics gathered by the Department of Public Safety, some important trends seem to be developing. Figure 1 shows that the number of first and repeat DWI offenders has been decreasing. However, it is not clear whether this is due to fewer impaired drivers or a decrease in arrest activities.

Figure 1

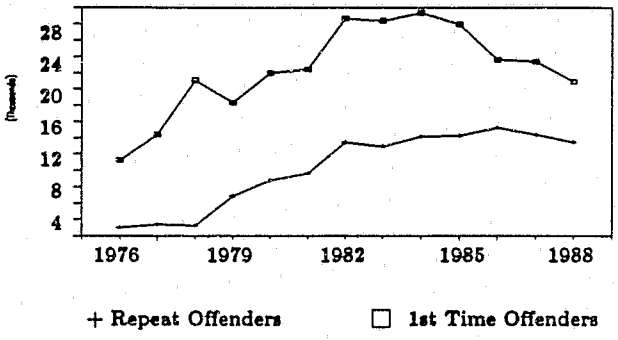
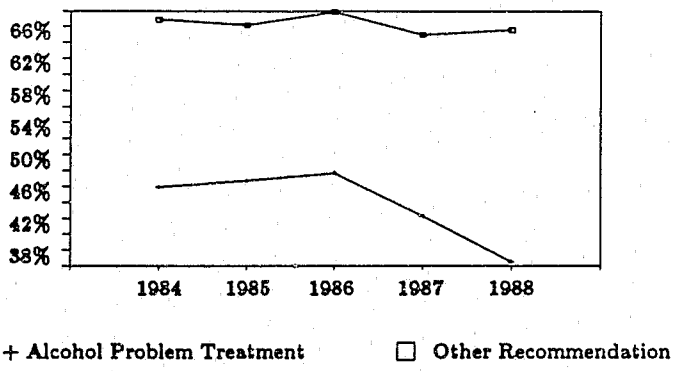


Figure 2 shows the declining percentage of defendants being recommended for alcohol problem treatment.

Figure 2



A final trend worth considering is the demographics of the impaired driver. Increasingly over the past several years, this driver has been male. Consistently, he has been primarily between the ages of 21 and 25, with the second largest group being aged 26-30. These two groups account for nearly half of the impaired driving population. This is important to note, since this age group will increase over the next ten years, which could increase the DWI problem.

Analysis by: Driver & Vehicle Services Division
Data Source: Department of Public Safety Driving Records

SEVERE PROBLEM REFERRAL RECOMMENDATIONS

For Calendar Year 1988

Number of DWI Arrests	32,827	
Number of DWI Assessments	19,744	
Of those Assessed:		
Number Determined to have a Severe Problem	3,691	
Of those with Severe Problems:		
Court recommended to In-Patient Treatment	654	(18%)
Court recommended to Out-Patient Treatment	1322	(36%)

CHAPTER 2

BACKGROUND AND HISTORY

AN OVERVIEW OF MINNESOTA CRIMINAL AND ADMINISTRATIVE SANCTIONS FOR DWI OFFENDERS

Minnesota's DWI laws and associated administrative rules are continually evolving as problems arise. The forces behind the legal changes are numerous--examples of drunk drivers who were "beating the system", heavy media involvement, closer cooperation among agencies in the criminal justice system, the efforts by MADD, and favorable decisions by the state's courts. Minnesota does not attempt to enact the strictest possible laws for punishing convicted DWI offenders. The state legislature balances the costs and threats to the public with a sense of fairness and has tried to develop laws whereby many offenders will lose their driving privileges with certainty and swiftness. Rather than severely punishing a few DWI offenders to use as examples, we have tried to affect the largest number of offenders and prevent offenses by the vast majority who are never apprehended.

The Minnesota state legislature first addressed the DWI problem in 1911 when it passed a bill making it a misdemeanor to operate a motor vehicle "while in an intoxicated condition." Since then, a more complete set of laws and administrative rules have evolved to address the problem of drinking and driving. This "double barrelled" approach assures that drivers apprehended by law enforcement agencies will face quick and certain repercussions for their dangerous and illegal behavior. In the discussion which follows, criminal sanctions or penalties (e.g., fines, incarceration) are decided by the courts. Administrative penalties (e.g., driver license revocation) are handled by the Commissioner of Public Safety.

Currently, when an individual is stopped and suspected of driving while under the influence of alcohol or drugs, the driver must submit to an alcohol concentration test or face a mandatory one year administrative license revocation. If the driver takes the test but fails by recording an alcohol concentration of .10 or more, the state administratively revokes the license for 90 days. Both of these suspensions are automatic regardless of whether or not the individual is convicted of the criminal charges of DWI.

The Administrative Track

If a first time offender pleads guilty or is found guilty of the misdemeanor DWI criminal charge, the license revocation time will be reduced to thirty days following the guilty finding. The reduced license revocation period is an incentive for guilty findings on the DWI charge. A prior DWI conviction is one of the elements which must be proved to serve as the basis for enhancing subsequent offenses to gross misdemeanors.

A first offender is faced with two choices. One choice is to plead guilty to the misdemeanor DWI offense. By doing so, the offender loses the driver license for a shorter period than if he/she were to plead "not guilty." However, subsequent offenses would carry heavier penalties because the offender will have two offenses on her/her record. Another option for the DWI offender is to attempt to have the criminal DWI charges reduced to a non-alcohol related charge such as careless driving. This option carries a longer license revocation period. In both options, the administrative license revocation will remain on the driver license record. This eliminates the effect of plea bargaining the criminal charge down to an offense which does not require a license revocation and insures that a repeat DWI offender will be identified as a repeater.

The individual's driver license is taken by the law enforcement officer at the time the driver refuses or fails the evidential test. The officer, acting on behalf of the Commissioner of Public Safety, issues a "Notice of Revocation" in exchange for the driver license. The notice serves as a temporary license and expires after seven days.

The driver may apply for a judicial and/or administrative hearing of the administrative implied consent revocation, but the revocation is not stayed pending the outcome of the review. The Attorney General's office represents the Commissioner of Public Safety at all judicial implied consent hearings, while the Driver Evaluation Service of DPS handles the administrative reviews.

The Criminal Track

A driver charged with DWI faces possible criminal penalties in addition to the automatic license revocation. A first conviction of the DWI laws is a misdemeanor punishable by a maximum $700 fine and ninety days in jail. A driver convicted of a DWI violation within five years of a prior DWI conviction or within ten years of two or more convictions is guilty of a gross misdemeanor and is subject to a maximum $3,000 fine and one year in jail. Recent legislation has mandated a 30 day jail sentence (or community service) and license plate impoundment for repeat DWI offenders. A driver convicted of killing or seriously injuring a person through gross negligence or a DWI violation is guilty of Criminal Vehicular Operation which is a felony. For violations resulting in death, the maximum fine is $10,000 and five years in prison. For violations resulting in great bodily harm, the maximum penalty is a $5,000 fine and three years in prison.

Alcohol problem assessments are required for all offenders convicted of violating the DWI laws. Offenders who have their criminal charges reduced to non-alcohol offenses are also ordered to have an assessment. Drivers with two alcohol related incidents are required to meet with a driver evaluator to discuss consequences of future involvement in drinking and driving, and their court ordered remedial action is monitored and driving privileges cancelled if action is not completed.

Drivers with three or more alcohol-related incidents are required by the Department of Public Safety to complete a rehabilitation program that usually follows, but may be separate from, court required treatment requirements. The Department's rules for rehabilitation include: 1) successful completion of treatment, i.e., traditional chemical dependency treatment, or counseling for specific problems related to use of chemicals; 2) participation in a generally recognized, ongoing chemical awareness program; 3) abstinence from alcohol use, substantiated by letters from acquaintances and the statement of the driver; and 4) an interview with a driver safety analyst.

THE HISTORY OF DWI ASSESSMENT LAWS AND PROGRAMS IN MINNESOTA

The 1976 Minnesota legislature enacted a law requiring "presentence investigations" in drunken driving cases. The impetus for this law was the federally funded Alcohol Safety Action Projects (ASAP) established in Hennepin County in the early 1970s. One of the main goals of this project was to remove the problem drinker from the road and provide treatment. In order to achieve this goal, the courts attempt to identify problem drinkers prior to sentencing and recommend treatment as part of their sentence. The terminology for this identification process was changed to "alcohol problem assessment" in 1978 to allow some courts to conduct the investigation post-sentence. The 1987 legislature amended M.S. 169.124 to require all counties to establish alcohol safety programs designed to provide "alcohol problem screenings" and "chemical use assessments". Although the terminology has changed since adoption of the requirement, the purpose remains the same; i.e, to identify the severity of the driver's chemical abuse problem, and to recommend the appropriate level of education or treatment needed to resolve the problem and prevent subsequent offenses.

In 1980, the Department of Public Safety's Office of Traffic Safety issued a "Report on Minnesota Alcohol Problem Assessments: July 1, 1976-June 30, 1979". The Alcohol Problem Assessment (APA) Law was optional for counties with less than 10,000 population, and did not apply to juveniles nor out of state drivers. The Department of Public Safety (DPS) was to provide the courts with information and assistance in establishing programs. Training workshops were presented around the state in 1976 to explain how to establish alcohol assessment programs and implement the new implied consent law.

DPS was to reimburse counties up to 50 percent of the cost of each investigation, up to $25 in each case. The APA report submitted to DPS contained an evaluation of the defendant's prior traffic record, characteristics and history of alcohol problems and amenability to rehabilitation, as well as a recommendation for treatment and rehabilitation.

In Fiscal Year 1979, 14,441 Alcohol Problem Assessment reports were submitted to DPS for reimbursement. No drinking problem was identified in 54% of cases reported. Questions were raised about the validity of assessments when 40 drivers with an alcohol concentration higher than .30 were assessed as not having a drinking problem. The average alcohol concentration for all drivers arrested was .18. Some inconsistencies between assessments and referrals were also noted. Of the 7,000 "problem" or "severe problem" drinkers, 1,000 did not enter any rehabilitation program and another 1,000 were referred to DWI classes. Although these anomalies in the system were documented, the overall program was seen as sound since over 12,000 drinking drivers were referred to a treatment or educational program. The drunken driving arrest became the biggest single channel into treatment.

The law originally did not mandate who should conduct assessments, what criteria to use, or how they should be conducted. It was left to the court to deem who was qualified to do the assessment and the routine to be followed. The law took into account the different size, style, circumstances and capabilities of the different courts. Since 1987 the municipal and county levels of Minnesota trial courts have been unified into district courts.

In 1982, the Minnesota Institute of Public Health conducted a brief survey regarding the alcohol problem assessment process. The survey was returned by 43 assessors covering 49% of the counties in the state. They found some counties that were satisfied with the assessment methods and procedures while others requested more training and funding. The number of assessments and amount of time allowed per assessment varied by county. A greater number of assessments resulted in a shorter time frame per assessment. The assessments typically involved a half-hour to two hour interview, but 28 different instruments were used to determine chemical abuse problems. The lack of standardized instruments or protocols indicated a wide variation of characteristics and criteria used among municipal and county courts to determine the level of problems and appropriate referrals. The system was characterized as unhealthy and unprofessional in that referrals were directed to whatever treatment resources were available within the county without regard for the individual needs of the driver.

In 1983, the Hazelden Foundation received a grant from the state to review the statewide alcohol problem assessment system. Hazelden was to develop and implement a training program to upgrade the quality and consistency of assessments, increase judicial awareness of alcohol problems, and to identify problems in the assessment system and recommend strategies for resolution. Hazelden attempted to meet these objectives through phone calls, surveys, interviews with court appointed alcohol-drug assessors, and 14 training workshops around the state.

One hundred ninety-seven assessors, representing seventy-nine (91%) of the counties, returned the DWI Assessment survey. Profiles of the assessors indicated that college educated probation officers or assessment counselors were the norm, but that they had a wide variety of training in chemical dependency. Only 17% were certified chemical dependency counselors, but 45% had completed requirements for certification, were county certified, or had completed formal course work in chemical dependency.

The assessment process, instruments, and criteria varied between counties. The average time required to complete an assessment was one hour, but ranged from ten minutes to 12 hours.

The Jellinek Signs and Symptoms were the most frequently used assessment tools, but many others were also mentioned. Several assessors reported routine use of more than one instrument. The most frequently mentioned need was for information regarding specific assessment tools, skills for assessing non-cooperative clients, and the legal liability of the assessor.

Hazelden's final report on statewide training on alcohol and/or drug problem assessments included several recommendations. Training of assessors should include information on drugs other than alcohol, assessment of juvenile DWI offenders, the role and resources provided by the Department of Public Safety, and follow-up training for new assessment procedures. They also recommended training for chemical dependency professionals who occasionally conduct DWI assessments, and for governmental decision makers who mandate procedures and allocate resources.

Hazelden also recommended standardized instruments throughout the state to promote uniformity. They have provided training workshops on the use of the Mortimer-Filkens Test which has an estimated 80-85% accuracy. They recommended 1-1/2 hours to conduct the assessment and substantiate the assessment through collateral contacts, traffic and criminal records, and suggested that uniform procedures be developed to ensure compliance with the court's sentencing. They also recommended further networking and improved communication as well as exploration of certification for court-appointed assessors.

Another survey of alcohol problem assessors was sent by the Minnesota Criminal Justice System DWI Task Force in 1986. A low response rate of 30 counties limits the generalizability of the survey. Most of the APA's were done presentence by probation or court service personnel within a one to two hour time frame. The Mortimer-Filkens Test was the most frequently mentioned assessment instrument. Less than 5% of DWI offenders requested a second assessment or had an independent assessment. Reasons given for additional assessments include: disagreement with treatment recommendation, at attorney's suggestion, or for further evaluation by a certified assessor.

Most assessors who returned the survey favored more standardized assessments statewide, but raised concerns about local characteristics and resources. One stressed that the standardized instrument was only one tool to be taken into context and interpreted by a trained assessor. Judges were reported to be following the assessors recommendations for treatment or education for the vast majority of cases. Deviations from the recommendations occur because of plea agreements to a reduced charge, changes in the clients circumstances between the evaluation and sentencing, o imposition of a jail sentence rather than treatment.

Additional training or information needs included: assessing adolescents and the elderly, dealing with families of alcoholics, community based alternatives, and continued updating of new techniques and methods. One assessor wrote: "Information isn't the problem. There must be agreement by the judges across the state and DPS and the treatment industry on the questions: 1) How do you know a person's problems are serious enough to indicate treatment?, and 2) Which form of treatment is appropriate for a person with a given set of problem characteristics? There is plenty of information available but little agreement on how to interpret and apply the information."

A 1986 DPS report by the Driver and Vehicle Services Division, "Description and Analysis of the Minnesota Driver Rehabilitation Program for Multiple DWI Offenders", included information on the prior APA results of 9,224 third-time DWI offenders arrested between July 1978 and January 1986. Assessors classified about three-fourths of DWI offenders as identifiable (52%) or severe (23%) problem drinkers after their first or second DWI arrest. However only 32% of these DWI offenders were sent to inpatient or outpatient treatment before the driver's third arrest. After the third arrest, 90% were classified as problem or severe problem drinkers on the alcohol problem assessment, but only 46% were sent to treatment.

In 1987, the Alcohol Problem Assessment Task Force was formed to discuss increasing the consistency of the use of a standardized assessment tool and the qualifications of assessors. The task force felt that the DPS reimbursement rules were the appropriate place to address these issues. Based on input from the task force, changes to the rules were adopted in January 1988.

FUTURE SCREENING TOOLS

The Minnesota Assessment of Chemical Health (MACH) is a computer based assessment procedure which insures internal and external validity among assessments. The MACH is an interactive program in which an assessor and client enter data directly into the computer. The MACH analyzes the data according to several diagnostic criteria for alcohol and drug problems. The criteria include the Mortimer-Filkens, Blue Cross/Blue Shield, MAST, DSM- III, and Rule 25. The information can be quickly analyzed and a printout generated for discussion with the client. The program provides a referral grid in the form of a display of options suggested by different combinations of problem severity and environmental obstacles to recovery. Many counties are currently using the MACH program for assessments.

The Chemical Dependency Adolescent Assessment Project has developed a standardized package for screening and assessment that has been empirically validated for 12-18 year olds. The assessment battery consists of three separate tools: a drug abuse screening questionnaire, Personal Experience Screen Questionnaire (PESQ), a multidimensional questionnaire Personal Experience Inventory (PEI), and a DSM-III-R diagnostic interview, Adolescent Diagnostic Interview (ADI). Each comes with a user's manual and appropriate scoring materials.

The PESQ is useful for pre-assessment or short-intake settings to determine if a more complete assessment is needed. The PEI and/or ADI should then be used for the follow-up comprehensive assessment. The developers recommend the ADI be used as the initial instrument to determine if the client meets the diagnostic criteria for substance use disorders and insurance reimbursement. If treatment is warranted, the PEI should be used to determine specific characteristics of chemical involvement, treatment responsiveness, and psycho-social factors relevant to treatment tailoring.

The Personal Experience Screen Questionnaire (PESQ) is a 38- item self-report questionnaire that can be administered to individuals or groups in about 15 minutes. It can be scored and interpreted in just a few minutes. It is appropriate for schools, courts, juvenile detention centers, and mental health and medical clinics which assess teenagers for alcohol and drug problems. The PESQ is highly predictive of the problem severity scales on the Personal Experience Inventory (PEI).

The Personal Experience Inventory is a 300 item self- administered questionnaire that can be completed in 45-60 minutes. The PEI determines the extent of substance use and abuse through several clinical scales and a detailed history of drug use frequency and onset. The PEI can be either scored at the testing site using a microcomputer or mailed to the publisher for scoring and interpretation. The PEI has been normed on both chemical dependency treatment and normal high school populations.

The project is nearing completion of a structured diagnostic interview organized around DSM-III-R criteria for substance use disorders. It is expected to be published by Western Psychological Services by mid-1989. The 45-60 minute interview also evaluates level of functioning, severity of psychosocial stressors, and screens for some mental disorders and reading/memory/orientation problems.

CHAPTER 3

CHANGES TO THE ALCOHOL SAFETY PROGRAM AND THEIR IMPACT

THE PURPOSE OF THE CHANGES TO THE ALCOHOL SAFETY PROGRAMS

The objective of the changes enacted by the 1987 legislature was to improve the accuracy of chemical use problem assessment by reimbursing the county at a higher rate for the longer time it would take to do a better assessment.

Alcohol Problem Screenings

In 1987, the legislature acted to improve identification and subsequent referral of problem drinkers to chemical dependency treatment. All 87 counties are now required to establish an alcohol safety program designed to provide preliminary alcohol problem screening for all drivers arrested for MS 169.121 or 169.129 violations, and later convicted of that or a similar offense. County boards may still contract with other counties and agencies to provide screening and assessment services. The court may approve any assessor having the knowledge and skills for screening alcohol problems to complete the screening phase and provide a report to the court.

The commissioner of public safety reimburses up to 50 percent of the cost of an alcohol problem screening, not to exceed $25. The average reimbursement in 1987 was $15.37 (See Reimbursement Payments, below).

Chemical Use Assessments

When an alcohol problem screening shows that the defendant has an identifiable chemical use problem, the court shall require them to undergo a comprehensive chemical use assessment by an assessor who has met the same qualifications as required under DHS Rule 25. If an appointment is made within a week of the court appearance and the assessment completed within two weeks of the appointment, the state shall reimburse the entire cost of the assessment, not to exceed $100.

If the same assessor conducts both the screening and assessment, the state may not require another chemical use assessment. The county will be reimbursed only for the cost of the chemical use assessment (not the screening) so long as it meets the time and recommendations for care requirements.

Funding

A drinking and driving repeat offense prevention account is established in the state treasury to reimburse counties for the cost of chemical use assessments and reports. By statute, when a court sentences a person convicted of an alcohol related driving offense, it imposes a $75 fee, which is deposited into this account. The fee may only be waived for indigency.

The appropriation enacted by the legislature in 1976, and amended in 1983 for reimbursement of screening costs is still in effect.

IMPLEMENTATION OF THE LEGISLATIVE CHANGES

Under MS, Sections 169.124 to 169.126, the qualification of assessors and guidelines for treatment referrals became subject to DHS Rule 25. Because of this, it was determined that the Chemical Dependency Program Division of DHS was best qualified to disseminate the pertinent information regarding these changes to the court systems, social service agencies, and local human services agencies.

That division has conducted 14 training sessions during the past several years, each providing 30 hours of chemical dependency assessment training. Over 1,000 individuals have been trained through this process, with about 800 from social services, 150 from court services, and 50 from chemical dependency service agencies.

They have also sent out information in their "Issues and Answers" to all counties regarding issues related to Rule 25 assessments, DWI offenders, and the courts. (For an example, see Appendix 4.) Presentations on Rule 25 have also been made to a number of groups of court services and probation officers, and at the annual judges conference in 1987.

The Department of Public Safety was not involved in the training process, except regarding the reimbursement of expenses incurred by the counties. Reimbursement information was distributed to the agencies responsible for filing the claim for annual reimbursements. Each county received a letter explaining how the statutory changes would affect their reimbursements, and a reminder of these changes was included in the request for the semiannual filing of the claim.

Even with the best efforts of both departments, there appeared to be some confusion among the counties and the courts regarding Rule 25 and the amended statutes. It was decided by DPS to recall the Alcohol Problem Assessment Task Force to address these issues and assist in preparing this report to the legislature. The task force consisted of representatives of the Departments of Public Safety and Human Services, the State Planning Agency, the Minnesota Criminal Justice System, county Court Services and Social Services, Community Corrections, and independent chemical dependency centers.

The initial concerns of the task force included:

the certification of the qualifications of assessors,
the availability of training for assessors, and
the collection of the $75 fee.

The task force recommended to DPS that a self-certification process be used regarding the qualifications of assessors. This recommendation was followed. On an annual basis, each county is requested to certify the names of the individuals who have met the training standards as outlined in Rule 25. Sixty-one counties have certified personnel from court services, and 21 counties have certified personnel from human services. All 87 counties have certified personnel to DPS.

Upon the task force recommendation, a letter was sent to all court services agencies by DPS, explaining the changes in the statute. The letter discussed the qualifications of assessors, and the continuance from screening to assessment if the client is found to have an identifiable problem. However, more significantly, it addressed the importance of using the driving record in conducting and reporting the alcohol problem screening, and the fact that the screenings and assessments are used for more than determining whether or not the client qualifies for treatment under Rule 25. It is also used to determine the reinstatement of driving privileges. It was felt that if the screeners and assessors understood the full usage of their reports, they would be more complete and accurate.

By the May 6, 1988 meeting, the general consensus of the task force was that Chapter 315 had resulted in a reduction in the percentage of DWI offenders obtaining proper treatment. Another major concern was that there was no reliable uniform way in which the screenings and assessments were being conducted and the reports completed, even though the above letter had been send in March of 1988. It was apparent that the assessors were relying heavily on self-reporting, and therefore the clients were learning how to manipulate the system. The task force felt that this may have been due to confusion regarding the law.

One of the major problems is that Section 9 of Chapter 315 requires that assessments done for driver licensing decisions be consistent with Rule 25 criteria. Rule 25 was not drafted with driver licensing decisions in mind. Under Rule 25, there is no provision for treatment other than traditional in- or out-patient chemical dependency treatment. Alternatives to treatment (such as support groups and educational programs) have been effective for chemical abusing drivers in the past, but are no longer available within the guidelines of Rule 25. Furthermore, traditional treatment has been proven ineffective for some patients, and there is a concern that in order to circumvent the system, some assessor will find "no problem" for these individuals, and they will not get the help they need. Also, many assessors do not have the information they need to make determinations that can be used for driver licensing decisions (such as past driving records).

Forst Lowery, Management Analyst for DPS addressed his concerns regarding Chapter 315 and Rule 25 to Representative Randy Kelly in a memo dated November 12, 1987. In it, he raised the concerns of county reciprocity, the waiver of the $75 fee, and the possibility that a $100 reimbursement for an assessment instead of $25 for a screening would induce some systems to initiate a full blown Chemical Use Assessment when one is not necessary. Attached to his memo was a copy of the September 10, 1987 meeting minutes of the Criminal Justice System DWI Task Force addressing major concerns regarding problems with the changes in the system. These concerns are included in this report as Appendix 5.

In an address given by the Honorable Bernard E. Boland, Judge of District Court, Seventh Judicial District, he cited an incident where an individual was denied treatment by the county, and sent to jail to serve his sentence. The judge in the case (Judge Roger Klaphake) stated that he thought the rule had become a money-saving

device, rather than a way of determining who should receive treatment. Furthermore, it limits the judge's options.

A rules coordinator for the Department of Human Services, said that the tension between judges and social service agencies is because Rule 25 does not consider public safety or punishment. However, she felt that the rule worked in the case cited by Judge Boland. Unfortunately, 22 days after that individual's release from prison, he was arrested again for DWI and Fleeing a Police Officer.

One of the problems with jail as an alternative to treatment, according to Judge Boland, is that almost 100% of the people jailed or imprisoned eventually get out--still untreated and even more antisocial. Furthermore, he cites the 1987 analysis of public opinion prepared by the Public Agenda Foundation, stating:

> . . .with virtual unanimity the American public strongly favors the use of alternatives to incarceration, including restitution, community service and mandatory treatment for drug and alcohol abuse. The study also reported . . . that Americans believe that the primary purpose of the criminal justice system should be to deter future crimes.

Wayne Krefting, in an article in CD Professional called Rule 25 a double-edged sword. Although not intended to be a diagnostic tool, DWI statutes incorporate Rule 25 as the basis for diagnostic reports for assessments and for the qualifications of assessments and assessors. Mr. Krefting states:

> The application of Rule 25 denies people access to chemical dependency treatment on the basis that they do not qualify for financial assistance. The criteria used to determine this appears much too restrictive in deciding who does and who does not qualify for treatment. Through the DWI statutes, this rule is being applied even to those not in need of financial assistance. This use of Rule 25, as required by law, as a diagnostic tool is wrong and needs to be corrected.

In summary:

In spite of the training and communication to the counties, there exists dissatisfaction with the implementation of APA changes. Among the major concerns are:

> Rule 25 does not include options (other than in- or out-patient treatment) such as driver education, AA, etc.
>
> Rule 25 assessors do not always have access to previous traffic records and therefore cannot make decisions regarding driver license reinstatement.
>
> The reimbursement process is not providing the proper incentive for conducting quality assessments.
>
> Rule 25 is too restrictive and denies treatment because the county does not have the funds to pay for treatment.

ISSUES IDENTIFIED BY ALCOHOL SAFETY PRACTITIONERS

In the summer of 1988, the Alcohol Problem Assessment Task Force determined that assessors in Minnesota should be surveyed and the results incorporated into this report. The Task Force set out the issues the survey should address, and a subcommittee put these issues into a list of specific questions. The survey format and questions suggested by the subcommittee were reviewed by the Task Force, the Department of Public Safety and the Department of Human Services.

The survey was sent to 390 registered certified chemical use assessors in all 87 counties of Minnesota. Additional surveys were sent to the counties for other agencies and individuals involved in the process, such as those who only do the alcohol problem screenings.

Responding to the survey were 159 individuals from 74 counties (85% of the 87 counties contacted). Of the responses received, 35% were from the seven metro area counties, and 65% of the responses were from 84% of the out state counties. The results of these responses are summarized below.

Major Concerns

Only 6% of respondents feel that the Alcohol Safety Program is working "poorly" or "very poorly" since the changes. Only 11% did not respond, and the remainder (83%) feel it is working "very well" or "all right."

Weaknesses cited tend to focus on the lack of communication and coordination between the agencies. There are several comments about the lack of time to do proper/thorough screenings and assessments; many stated that it is difficult to get the collateral contacts in a timely manner. There are also comments about the lack of consistency from county to county.

There seems to be considerable concern that the Rule 25 criteria are too restrictive -- not all people fit into the categories. There is also concern that placement in treatment is more influenced by money than it had been before the changes. ("Rule 25 hardly leaves anyone eligible for treatment. Rule 25 saves money, not people.")

Over half of the respondents (55%) stated that a screening is almost always conducted before the assessment. Nearly a fifth of the respondents (20%) said that a screening is "seldom" or "almost never" conducted before the assessment.

For the screenings, 82% of the respondents indicated that they always obtain information about the individual's prior traffic record, and 67% indicated that they always obtain a history of the individual's chemical problems.

For the assessments, 77% stated that they always obtain a record of the individual's blood alcohol content (BAC) at the time of the arrest; 60% indicated that they receive the individual's screening report.

Over 30% indicated that too much time elapses between a client's arrest and assessment. Over 20% stated that it is relatively easy for the client to abstain for 30 days -- which changes the level of treatment available through Rule 25.

Although only 8% of the respondents indicated that their agency's ability to identify alcohol problems has "decreased somewhat" or "decreased greatly" since August of 1987 (when changes were made to the statutes governing the Alcohol Safety Program), 22% indicated that their ability to obtain rehabilitation treatment had "decreased somewhat" or "decreased greatly."

Over 20% of the respondents indicated that offenders are "almost always" or "often" denied needed treatment because they do not qualify under Rule 25. Many indicated that if the offender has been sober for a certain period of time he or she is not eligible for treatment under Rule 25.

Over 80% of the respondents rate the qualifications of persons doing the assessments as excellent or good; nearly 75% rate those doing the screenings as excellent or good. Despite this, many respondents cited a need for more training for the people doing the alcohol problem assessments.

Additional Concerns

Over 60% of the respondents feel that the average screening takes an hour or less to complete. Over 80% feel that an assessment takes an hour or more to complete, and 30% feel that the average assessment takes two or more hours to complete. Approximately 18% of the respondents feel that there is insufficient time to conduct the screenings, and 29% feel that there is not enough time to conduct the assessments.

Many respondents stated that they are under pressure from the courts to conduct the screenings and assessments in as short a time as possible. ("Our court accepts the plea and sentences the same day. Since we do both the screening and assessment we are always working against the clock.") Many feel that the quality of the assessments and screenings suffers as a result.

Ten percent of the respondents said that they "frequently" or "sometimes" accept assessments from private agencies that do not meet Chapter 315 requirements. Less than half (42%) indicated that they never accept such assessments.

Over 20% of the respondents indicated that the $75 fee is waived more often than it is collected. Of those respondents that offered more explanation, over 50% indicated that the fee is waived when the client is indigent; and nearly 30% indicated that the fee collection depends on the judge. ("Some judges always order it, but some refuse to! Very few are indigent, so I don't understand why they waive the fee, except that they may feel sorry for the guy and all the hoops they have to jump through because of the DWI arrest.")

Less than 10% of the respondents stated that the judges often deviate from the assessment recommendations.

Results Not Related to the Change in Statute

Most of the screenings (66%) are done at the pre-sentence phase; most of the assessments are also done at this stage (60%). Although many of the respondents (approximately 30%) felt that the truthfulness of their clients was not influenced by the point at which the screening or assessment was done, those who saw differences most often felt that the client was most truthful during the presentence phase.

Over 70% indicated that the sentencing recommendation for offenders who are found to be not amenable to treatment is most likely to be jail.

In listing their preferences for new facilities or programs, many respondents cited a need for more half-way houses and facilities for women. Several indicated a need for new programs between the DWI classes and treatment programs. There was also considerable concern about the need for more programs for adolescents.

Over half of the respondents (59%) indicated that they "seldom" or "never" notify the Department of Public Safety when a repeat DWI offender violates the treatment or education requirements of probation.

Nearly 50% of the respondents rate the state's process of reimbursing counties for screenings and alcohol use assessments as "good" or "excellent." Of the complaints noted, many were related to reimbursement being received only once a year. Several complained about the difference in reimbursement amounts for clients with "identifiable problems" versus those with "no problem."

CHAPTER 4

TRENDS

CRIMINAL JUSTICE RESPONSE TO DWI:
Tougher Laws, Tougher Sentences, Fewer Arrests

It is impossible to identify the exact causes behind DWI trends; however, DWI arrests decreased and court activity increased during a time when major changes were made to the DWI laws. DWI trends in legislation, arrests, and court activity are described next. For a brief review of these events refer to Figure 3.

Figure 3

Summary of Major DWI Trends

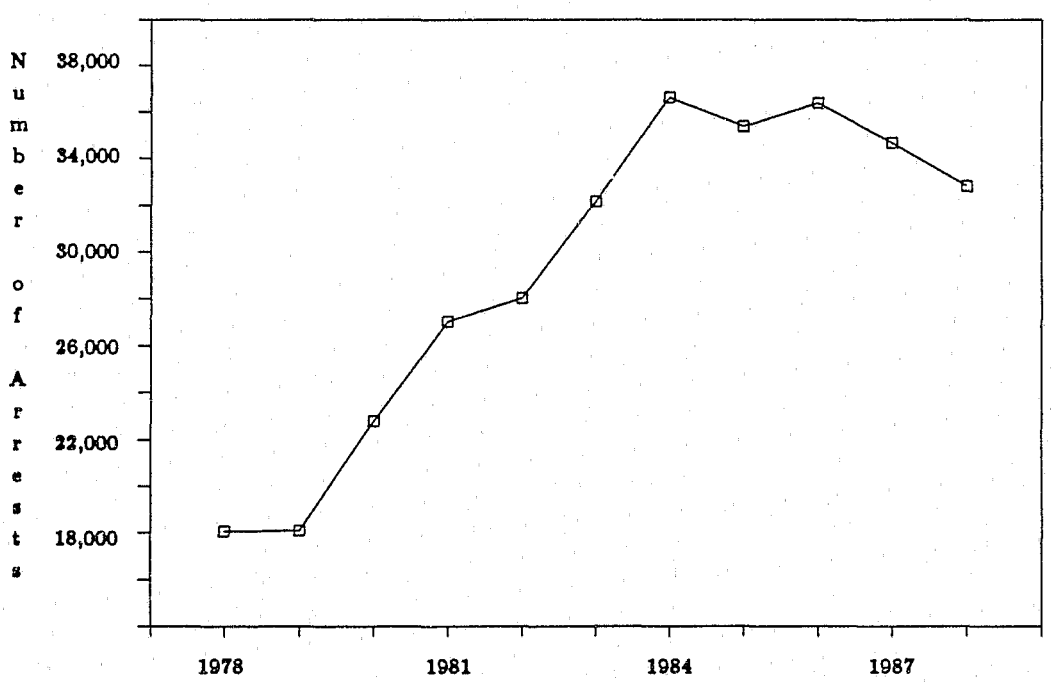
Laws, Arrests, Courts

1981	DWI arrests increased 18% -- the largest increase between 1978 and 1987.
1982	Repeat DWI offenses become a gross misdemeanor.
1983	A 15% increase occurred in DWI arrests over the previous year. Second largest increase between 1978 and 1987.
	Gross misdemeanor jail sentences increased by 62% (1,622 cases) over the previous year. This is the largest increase since the data has been available in 1981. Note that the average number of days sentenced to jail decreased from 60 to 40 during this same year.
1984	Mandatory testing for DWI.
	First decrease in DWI arrests (1,255) since 1978.
1985	Trend began toward longer jail sentences (average).
1986	Legal drinking age increased from 18 to 21 years.
	Largest annual increase in juvenile arrests (29%) since 1980 (also 29%).
1988	Mandatory sentence for repeat DWI offenders--30 days in jail or 240 hours of community service.
	An 8% decrease in total DWI arrests.

Major shifts in DWI trends were experienced during 1981 and 1984. DWI arrests increased by 18% in 1981 -- the largest increase in the last ten years (Figure 4). During 1982, the Minnesota Legislature toughened laws regarding DWI offenders. It became a gross misdemeanor for repeat DWI violations. Law enforcement and court activity continued this momentum into 1983. Arrests increased by 15% over 1982, the second largest increase in the last ten years. The courts experienced their largest increase in gross misdemeanor jail sentences. During 1983, 1,622 cases received jail sentences. This represents a 62% increase over 1982 (Figure 5). Interpretation of court data should be cautious, because approximately one-third of the DWI cases are not included. If a fingerprint card is not submitted for the criminal history file, then the case is not recorded. Many DWI cases are without fingerprint cards.

Figure 4

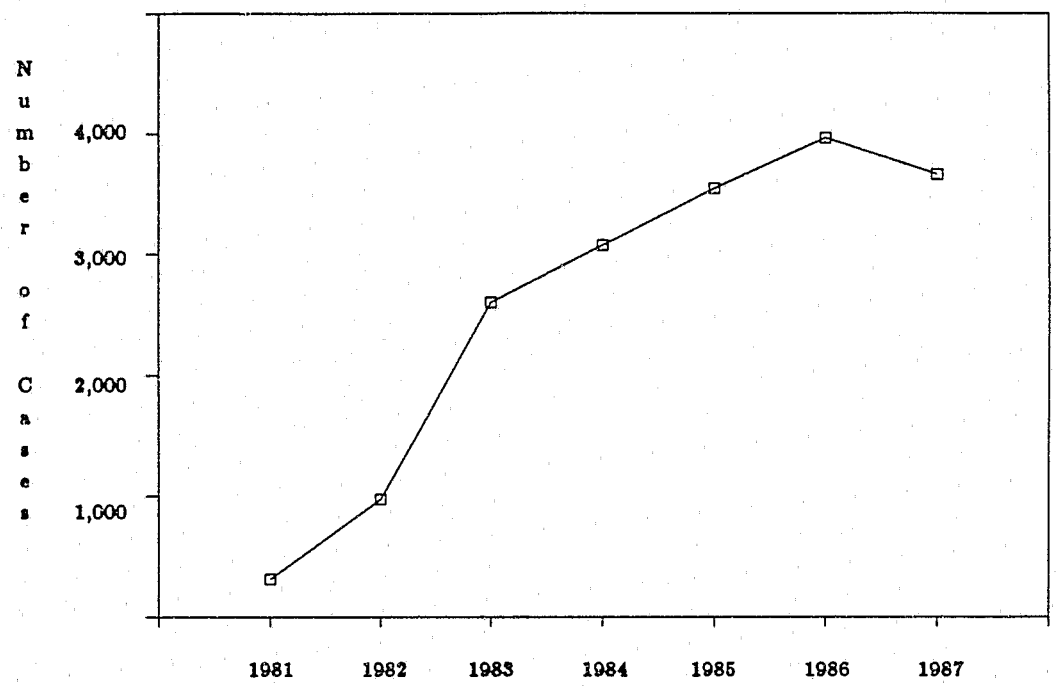
Total DWI Arrests in Minnesota



Analysis by: Statistical Analysis Center, State Planning Agency
Data Source: Uniform Crime Reports, Bureau of Criminal Apprehension

Figure 5

DWI Gross Misdemeanors*
Jail Incarceration



Analysis by: Statistical Analysis Center, State Planning Agency
Data Source: Offender Based Transaction Statistics, Minnesota Criminal History File, Bureau of Criminal Apprehension

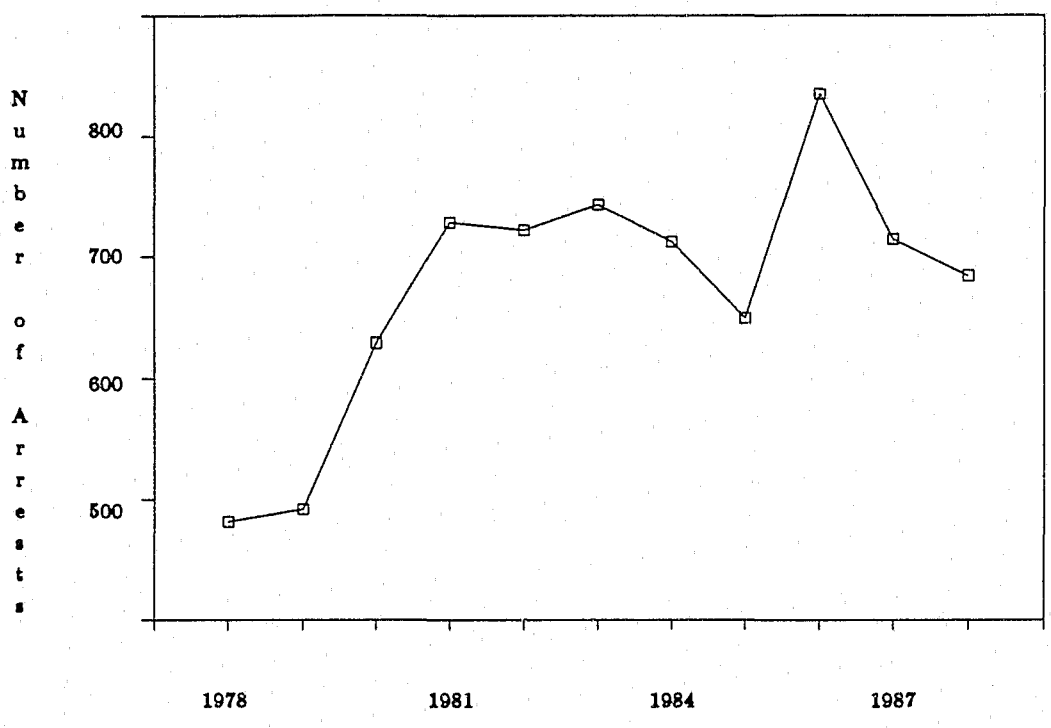
**NOTE: It is estimated that one-third to one-half of the DWI gross misdemeanors are missing from this criminal history file because fingerprint cards are not submitted for DWI offenders.*

Another shift occurred in 1984 with the passage of new legislation which required tests for DWI. Refusal to test would result in a one-year revocation of the driver license (a six month increase over previous law). For the first time since 1978, DWI arrests began to decrease.

The change in 1984 DWI laws coincide with a decrease in juvenile arrests as well (Figure 6). During this year, legislation was passed that revoked a juvenile's license for twice the time as an adult with similar DWI convictions and refusals. Juveniles tend to represent a small portion of the total arrests (2% in 1988).

Figure 6

Juvenile DWI Arrests in Minnesota
(17 Years Old and Under)



Analysis by: Statistical Analysis Center, State Planning Agency
Data Source: Uniform Crime Reports, Bureau of Criminal Apprehension

The courts responded most harshly to DWI offenders in 1983. The 1983 increase in the number of cases sentenced to jail has been unsurpassed in seven years. However, jail sentences as a proportion of total convictions continue to climb. In 1987, jail sentences represented 85% of total DWI convictions (Figure 7). In addition, the length of the average jail sentence has increased steadily since 1983 (Figures 8 & 9). The prosecution and conviction data is limited to three years and therefore, it is hard to distinguish any trends.

Figure 7

Court Processing of DWI Offenders*

Charge at Arrest	1985	1986	1987
	CASES PROSECUTED		
Felony	32	9	14
Gross Misdemeanor	4,741	5,100	4,489
	CASES CONVICTED		
Felony	31	8	12
Gross Misdemeanor	4,513	4,899	4,313
	CASES TO PRISON		
Felony	2	0	1
Gross Misdemeanor	4#	15#	23#
	CASES TO JAIL		
Felony	24	8	9
Gross Misdemeanor	3,545	3,964	3,659

#Possibly changed to felony level after arrest or sentenced for another crime.

Analysis by: Statistical Analysis Center, State Planning Agency
Data Source: Offender Based Processing Statistics, Minnesota Criminal History File, Bureau of Criminal Apprehension

**NOTE: It is estimated that one-third to one-half of the DWI gross misdemeanors are missing from this criminal history file because fingerprint cards are not submitted for DWI offenders.*

DWI Gross Misdemeanors - Jail Time Sentenced*

Figure 8

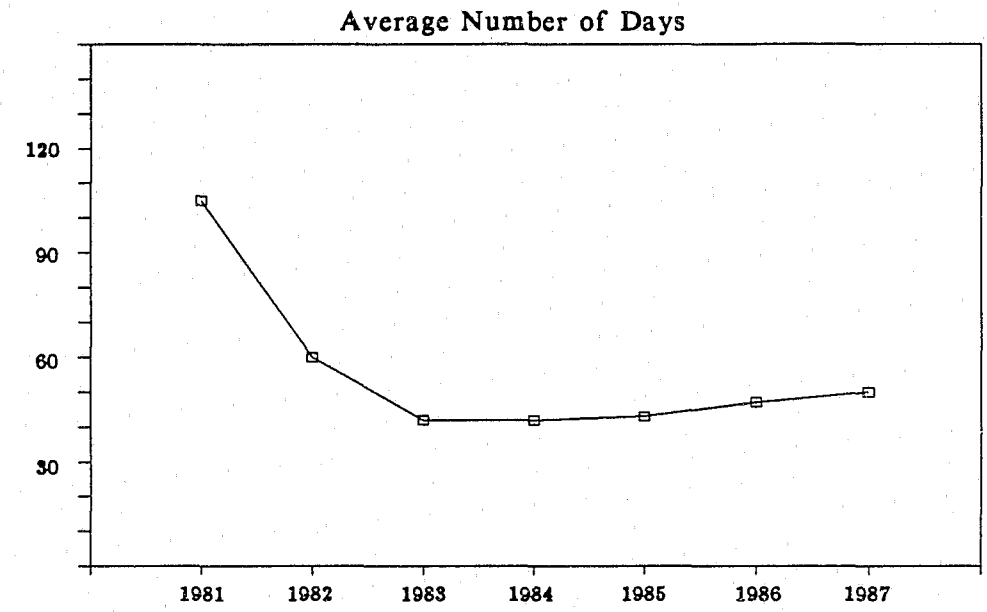
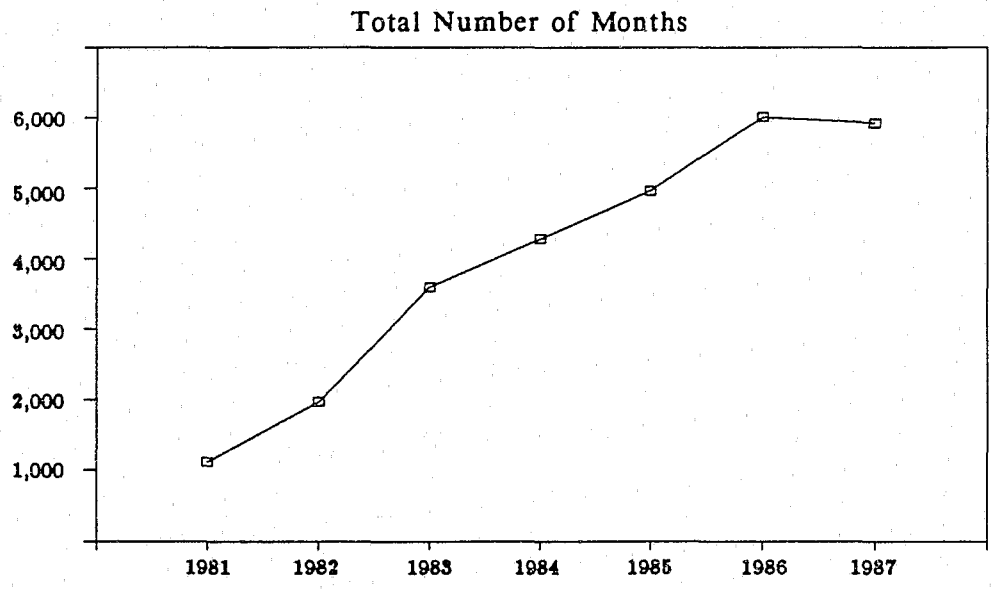


Figure 9



**NOTE: It is estimated that one-third to one-half of the DWI gross misdemeanors are missing from this criminal history file because fingerprint cards are not submitted for DWI offenders.*

WHO ARE THE DRUNK DRIVERS?

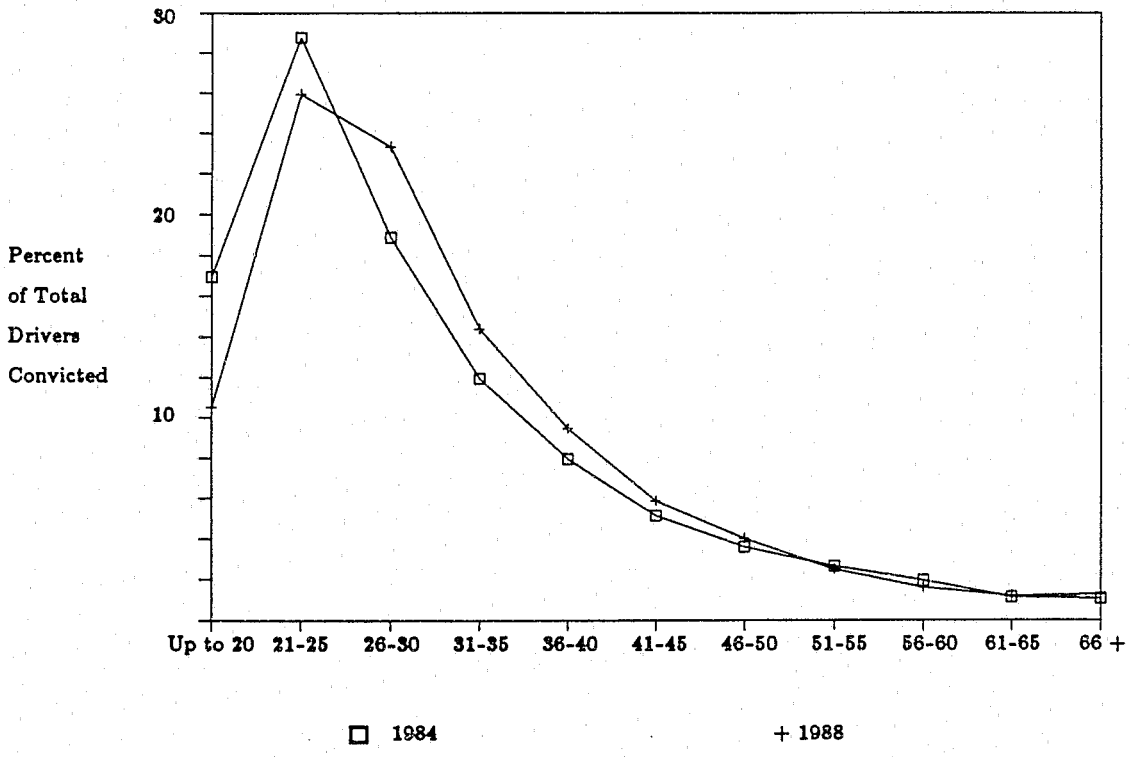
Age Distribution of Offenders

The distribution curve of the age of drivers convicted of an alcohol related offense (Figure 10) shows that the largest group is between the ages of 21 and 25, and the second largest group is between the ages of 26 and 30. The mean age of these drivers is slightly higher, and has remained relatively constant:

1984	-	30.3	Years
1985	-	31.4	Years
1986	-	31.5	Years
1987	-	31.4	Years
1988	-	31.6	Years

Figure 10

Age Distribution of Convicted Drivers



Analysis by: Driver & Vehicle Services Division
Data Source: Department of Public Safety Driving Records

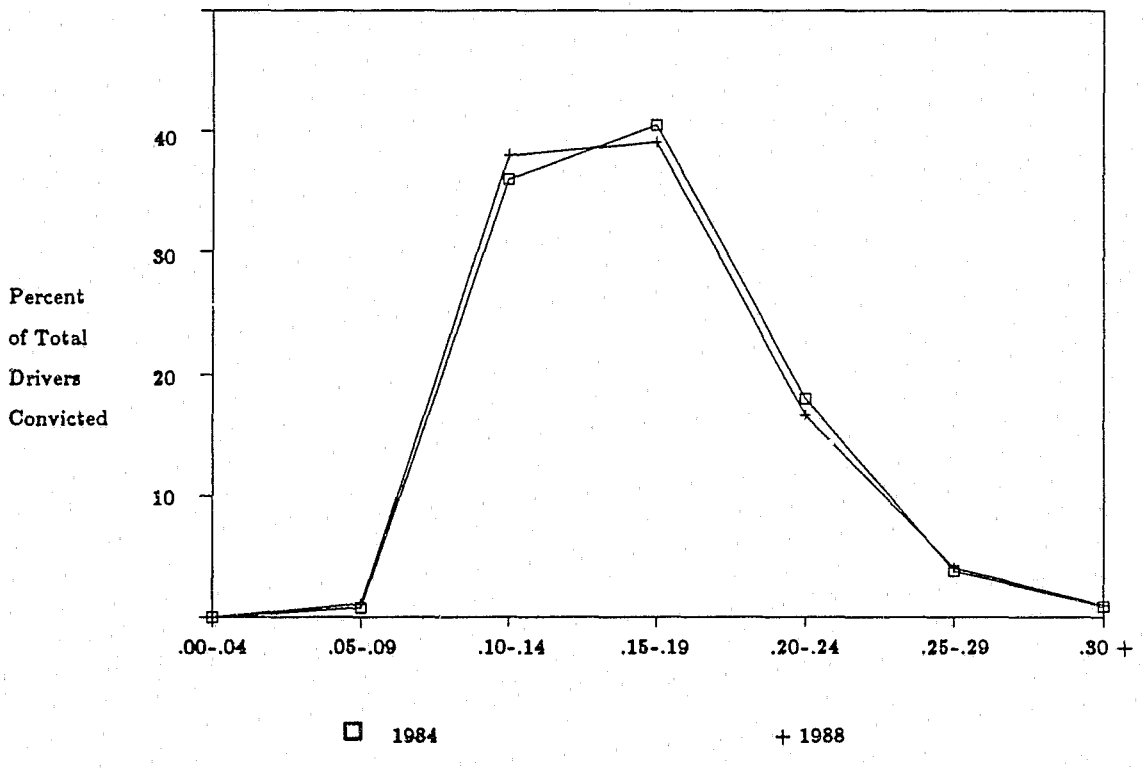
Blood Alcohol Concentration (BAC) of Offenders

The distribution curve of the BAC of drivers convicted of an alcohol related offense (Figure 11) shows the largest group to have a BAC of .15 to .19 percent, and the second largest group to have a BAC of .10 to .14 percent. The mean was relatively constant:

1984	-	.1702	percent
1985	-	.1702	percent
1986	-	.1703	percent
1987	-	.1683	percent
1988	-	.1685	percent

Figure 11

Blood Alcohol Concentration of Convicted Drivers



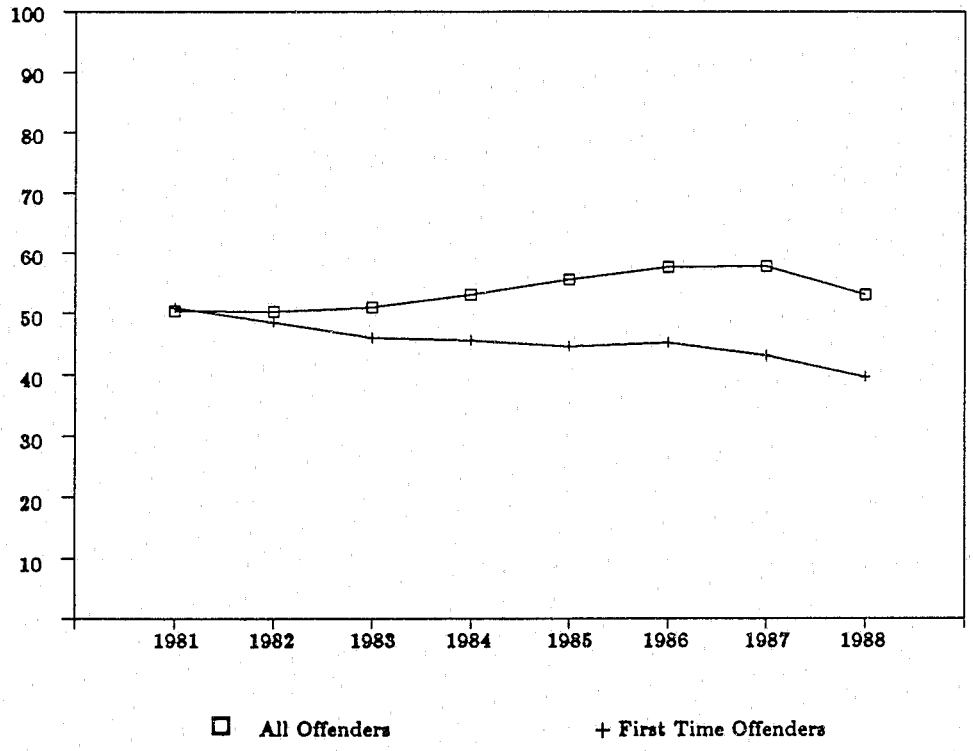
Analysis by: Driver & Vehicle Services Division
Data Source: Department of Public Safety Driving Records

Problem Offenders

Figure 12 shows that, while the percentage of all offenders determined to have an identifiable problem has increased slightly from 1981, the percentage of first-time offenders with an identifiable problem has decreased over the same time period.

Figure 12

Percentage of Offenders with an Identifiable Problem



Analysis by: Driver & Vehicle Services Division
Data Source: Department of Public Safety Driving Records

TREATMENT RESPONSE:

Fewer Problems, Less Treatment

Court Recommendations for Treatment of Offenders

The Alcohol Problem Assessment report completed by the assessor lists several options for recommended treatment of the offender. The same options are open to the courts for their recommendations. These treatments may be categorized as follows:

Miscellaneous Remedial Action:
- Driver Improvement Clinics
- Further Assessment
- Counselling
- Follow-up Investigations

Moderate Remedial Action:
- DWI Clinics
- Alcohol Problem Lectures

Alcohol Problem Treatment:
- In-Patient Programs
- Out-Patient Programs
- Support Group Affiliations

The significant change to note is the drop in Alcohol Problem Treatment recommendations, particularly between 1987 and 1988. The rates for other types of recommendations are fairly constant. (Because a court may recommend more than one type of treatment for an individual for a given incident, the percentages presented always exceed 100%.)

Miscellaneous Remedial Action Recommended:

1984	-	18.8 %
1985	-	19.4 %
1986	-	20.5 %
1987	-	20.3 %
1988	-	21.6 %

Moderate Remedial Action Recommended:

1984	-	48.1 %
1985	-	46.8 %
1986	-	47.4 %
1987	-	44.7 %
1988	-	44.0 %

Alcohol Problem Treatment Recommended:

1984	-	45.9 %
1985	-	46.7 %
1986	-	47.7 %
1987	-	42.3 %
1988	-	36.5 %

Analysis by: Driver & Vehicle Services Division
Data Source: Department of Public Safety Driving Records

CHAPTER 5

REIMBURSEMENT PAYMENTS

SCREENINGS AND ASSESSMENTS CLAIMED FOR REIMBURSEMENT

The number of alcohol problem interviews conducted that were claimed for reimbursement also remained fairly constant until Fiscal Year 1988 when there was a significant drop:

1984 - 30,545
1985 - 31,435
1986 - 30,062
1987 - 30,671
1988 - 24,565

Of this total of 24,565 interviews conducted during Fiscal Year 1988, 15,716 individuals (63.9%) were determined to have no alcohol problem and, therefore, no chemical use assessment was conducted. Of the remaining 8,849 cases, 5,727 clients (23.3% of the total) were determined to have an identifiable problem, and 3,114 individuals (12.7% of the total) were determined to have a severe problem.

FUNDING

The 1976 legislature appropriated an annual fund of $250,000 to be reimbursed to the counties which conducted alcohol problem screenings. The State was to pay up to half of the cost of the screening, not to exceed $25, at the end of the fiscal year. Claims submitted by the counties totalled only $317,223.28 in fiscal year 1977. Since 50% of that total (the maximum allowable reimbursement) was less than the appropriation, counties were paid the full allowance on their claim.

However, beginning the next fiscal year, claims increased in number and dollar amount, resulting in proration of payment to all counties. In Fiscal Year 1983, this percentage decreased to a low of 41% of eligible payment (or $8.78 per assessment reimbursed).

The legislature doubled the appropriation beginning in fiscal year 1984, which brought the payment percentage up to 75% ($16.37 per assessment reimbursed).

Due to across-the-board budget cuts, this appropriation was reduced to $471,400 for the 1986-1987 biennium. This, combined with still increasing numbers and costs, resulted in average payments between $15 and $16 per assessment.

With the legislative changes enacted in 1987, particularly the reimbursement of only an assessment when the screening and assessment are conducted by the same person, the number of reimbursable screenings in Fiscal Year 1988 was reduced by nearly 50%, which allowed the State to reimburse the full 50% of the costs claimed, at an average payment of $23.30, even though the appropriation was again cut, this time to $431,400.

According to the Alcohol Problem Assessment Reimbursement Claims submitted by the counties, of the 8,849 clients who underwent chemical use assessments in Fiscal Year 1988, 8,554 (97%) had their assessments conducted by the same person who did their screening.

In those cases where the alcohol problem screening and the chemical use assessment were conducted by the same person, the county received payment of $100 for each claim for reimbursement.

When the screening and assessment were conducted by different people, the county received payment of $100 for each assessment, plus an average payment of $23.30 for each screening claimed for reimbursement. (The screening payment ranged from $6.25 to $25.00 per case.)

COLLECTION OF THE $75 FEE

The legislative changes of 1987 included the imposition of a mandatory $75 fee to be collected by the courts from everyone convicted of alcohol related offenses. This is in addition to any fines, penalties, or assessment fees already imposed.

Figure 13 lists by county the following information:

- The number of clients seen for which a reimbursement claim was made during Fiscal Year 1988.
- The dollar amount that should have been deposited if they had collected the $75 from each individual.
- The dollar amount that was actually deposited in the Drinking and Driving Repeat Offense Prevention Account.
- The reimbursements made out of that account for each county.
- The difference between the deposits made and the reimbursements paid.

The Department of Public Safety had estimated that 20% of the individuals would be determined to be indigent, and would have this fee waived. The original allotment was estimated at $1,344,000. The amounts shown in Figure 11 do <u>not</u> reflect this 20% adjustment. Taking this into account, the total collected statewide should have been $1,473,900. Even considering this, the account is over $500,000 short. Apparently the number of the statutory $75 fees waived is closer to 50%.

Figure 13

Assessment Reimbursements, Fiscal Year 1988

County	Clients Seen	@ $75 Each	Actual Deposits	Percent	Assessment Reimbursement	Difference: Deposits less Reimbursement
Aitkin	35	$2,625	$1,575.00	60.00%	$900	$675.00
Anoka	1630	$122,250	$63,033.00	51.56%	$36,800	$26,233.00
Becker	167	$12,525	$13,750.60	109.79%	$7,400	$6,350.60
Beltrami	241	$18,075	$11,410.00	63.13%	$3,300	$8,110.00
Benton	140	$10,500	$4,854.50	46.23%	$3,500	$1,354.50
Big Stone	10	$750	$150.00	20.00%	$400	($250.00)
Blue Earth	451	$33,825	$14,515.50	42.91%	$10,300	$4,215.50
Brown	117	$8,775	$5,076.00	57.85%	$2,200	$2,876.00
Carlton	122	$9,150	$175.00	1.91%	$4,500	($4,325.00)
Carver	187	$14,025	$11,221.00	80.01%	$7,800	$3,421.00
Cass	81	$6,075	$1,925.00	31.69%	$2,500	($575.00)
Chippewa	49	$3,675	$625.00	17.01%	$200	$425.00
Chisago	289	$21,675	$7,554.00	34.85%	$2,200	$5,354.00
Clay	531	$39,825	$21,895.00	54.98%	$16,800	$5,095.00
Clearwater	31	$2,325	$1,753.17	75.41%	$500	$1,253.17
Cook	19	$1,425	$975.00	68.42%	$700	$275.00
Cottonwood	25	$1,875	$1,076.00	57.39%	$2,000	($924.00)
Crow Wing	121	$9,075	$8,083.00	89.07%	$2,600	$5,483.00
Dakota	1606	$120,450	$33,640.75	27.93%	$69,100	($35,459.25)
Dodge	69	$5,175	$2,722.00	52.60%	$2,300	$422.00
Douglas	191	$14,325	$6,810.64	47.54%	$3,600	$3,210.64
Faribault	42	$3,150	$2,175.00	69.05%	$700	$1,475.00
Fillmore	146	$10,950	$7,672.25	70.07%	$5,600	$2,072.25
Freeborn	227	$17,025	$9,225.00	54.19%	$13,000	($3,775.00)
Goodhue	344	$25,800	$10,905.00	42.27%	$4,300	$6,605.00
Grant	18	$1,350	$925.00	68.52%	$1,000	($75.00)
Hennepin	5767	$432,525	$258,895.00	59.86%	$324,800	($65,905.00)
Houston	96	$7,200	$5,625.00	78.13%	$2,100	$3,525.00
Hubbard	52	$3,900	$2,025.00	51.92%	$600	$1,425.00
Isanti	90	$6,750	$3,388.50	50.20%	$2,700	$688.50
Itasca	242	$18,150	$11,706.00	64.50%	$10,500	$1,206.00
Jackson	54	$4,050	$1,943.00	47.98%	$3,000	($1,057.00)
Kanabec	118	$8,850	$3,568.00	40.32%	$3,600	($32.00)
Kandiyohi	256	$19,200	$9,762.00	50.84%	$4,100	$5,662.00
Kittson	38	$2,850	$2,325.00	81.58%	$1,200	$1,125.00
Koochiching	33	$2,475	$1,500.00	60.61%	$0	$1,500.00
Lac Qui Parle	8	$600	$450.00	75.00%	$100	$350.00
Lake	36	$2,700	$1,445.00	53.52%	$400	$1,045.00
Lake of the Woods	20	$1,500	$1,350.00	90.00%	$200	$1,150.00
LeSueur	115	$8,625	$2,350.00	27.25%	$3,900	($1,550.00)
Lincoln	21	$1,575	$300.00	19.05%	$400	($100.00)
Lyon	104	$7,800	$3,718.75	47.68%	$700	$3,018.75
McLeod	250	$18,750	$13,730.00	73.23%	$4,900	$8,830.00
Mahnomen	48	$3,600	$1,375.00	38.19%	$1,100	$275.00
Marshall	39	$2,925	$1,710.00	58.46%	$1,300	$410.00
Martin	0	$0	$2,903.70	ERR	$0	$2,903.70
Meeker	137	$10,275	$5,571.00	54.22%	$500	$5,071.00
Mille Lacs	143	$10,725	$4,808.00	44.83%	$5,200	($392.00)
Morrison	105	$7,875	$10,158.25	128.99%	$7,200	$2,958.25
Mower	172	$12,900	$5,950.00	46.12%	$4,100	$1,850.00

Figure 13, continued

County	Clients Seen	@ $75 Each	Actual Deposits	Percent	Assessment Reimbursement	Difference: Deposits less Reimbursement
Murray	21	$1,575	$1,650.00	104.76%	$1,000	$650.00
Nicollet	160	$12,000	$7,325.00	61.04%	$5,600	$1,725.00
Nobles	130	$9,750	$6,785.00	69.59%	$4,500	$2,285.00
Norman	23	$1,725	$975.00	56.52%	$200	$775.00
Olmsted	671	$50,325	$36,188.75	71.91%	$19,800	$16,388.75
Ottertail	308	$23,100	$13,417.00	58.08%	$8,500	$4,917.00
Pennington	78	$5,850	$3,475.00	59.40%	$900	$2,575.00
Pine	98	$7,350	$1,887.50	25.68%	$3,600	($1,712.50)
Pipestone	64	$4,800	$4,508.00	93.92%	$1,500	$3,008.00
Polk	269	$20,175	$7,815.00	38.74%	$2,900	$4,915.00
Pope	77	$5,775	$1,955.00	33.85%	$1,100	$855.00
Ramsey	2234	$167,550	$51,675.00	30.84%	$77,200	($25,525.00)
Red Lake	20	$1,500	$975.00	65.00%	$100	$875.00
Redwood	43	$3,225	$1,410.00	43.72%	$1,000	$410.00
Renville	42	$3,150	$3,600.00	114.29%	$2,000	$1,600.00
Rice	293	$21,975	$10,674.00	48.57%	$5,400	$5,274.00
Rock	49	$3,675	$1,499.00	40.79%	$2,400	($901.00)
Roseau	85	$6,375	$4,450.00	69.80%	$800	$3,650.00
St. Louis	858	$64,350	$33,175.00	51.55%	$39,200	($6,025.00)
Scott	453	$33,975	$11,100.00	32.67%	$7,200	$3,900.00
Sherburne	434	$32,550	$17,307.50	53.17%	$13,600	$3,707.50
Sibley	41	$3,075	$1,575.00	51.22%	$900	$675.00
Stearns	913	$68,475	$23,266.70	33.98%	$18,400	$4,866.70
Steele	58	$4,350	$1,500.00	34.48%	$700	$800.00
Stevens	16	$1,200	$450.00	37.50%	$300	$150.00
Swift	57	$4,275	$3,345.00	78.25%	$400	$2,945.00
Todd	168	$12,600	$7,154.65	56.78%	$1,300	$5,854.65
Traverse	20	$1,500	$600.00	40.00%	$900	($300.00)
Wabasha	96	$7,200	$4,950.00	68.75%	$2,200	$2,750.00
Wadena	50	$3,750	$356.00	9.49%	$200	$156.00
Waseca	37	$2,775	$1,425.00	51.35%	$1,000	$425.00
Washington	1025	$76,875	$18,838.78	24.51%	$47,300	($28,461.22)
Watonwan	60	$4,500	$1,950.00	43.33%	$1,800	$150.00
Wilkin	23	$1,725	$750.00	43.48%	$900	($150.00)
Winona	306	$22,950	$13,075.00	56.97%	$8,400	$4,675.00
Wright	428	$32,100	$20,803.23	64.81%	$14,300	$6,503.23
Yellow Medicine	24	$1,800	$1,085.00	60.28%	$600	$485.00
TOTALS	24,565	$1,842,375	$923,250.72	50.11%	$884,900	$38,350.72
Public Safety			$2,550.00		$0	$0.00
			$925,800.72		$884,900	$38,350.72

NOTES:

"Clients Seen" refers to the total number of clients listed by each county for reimbursement for screening, assessment, or both.

"@ $75 each" does NOT take into account indigent drivers. This figure should be reduced by the percentage of indigent DWI offenders in each county to be more accurate.

Appendix 1

DWI ISSUES

Q.8: If a person has been sober for 30 days, they don't need treatment even if they meet the other criteria for outpatient treatment, right?

A: Not necessarily. Determining the need for treatment after a period of abstinence requires clinical judgment. There are certainly people who, at 30 days have gotten involved in a support group such as AA, are examining their behavior and changing their lifestyle in ways that support their new sobriety. There are others who are just hanging on until the pressure is off. When determining the need for treatment, no hard and fast rule will apply. The following factors should be considered:

1. What motivates the individual? Is it a circumstance which will continue? A person awaiting a court date for DWI may not maintain sobriety once his or her driver's license is secure.

2. Is the person finding alternatives to the situations in which he or she used chemicals? The person who is used to using with a group of people regularly for socialization will not sit at home alone for long.

3. Is the individual involved in a group or counseling situation which supports sobriety? Our data show that involvement in AA or other support groups is the best predictor of sobriety at 6 months.

4. If the client has had previous treatment experiences or attempts at sobriety, how is this different?

There are undoubtedly other factors which can be added to the list and none of them will provide a clear answer to the questions.

Q.9: My "gut" tells me a person needs treatment, but I can't gather enough information to support a placement. What do I do?

A: An assessor's "gut feeling" is not sufficient to authorize a placement. However, "gut feelings" are frequently based on things the assessor has learned through experience. The first thing to do is think about what prompted your feeling. It may be useful to set up a second appointment to give you a chance to review the assessment interview.

Another strategy used by some assessors is to choose the collateral contact yourself, rather than, or in addition to, contacting the person suggested by the client.

Q.10: Court and Department of Public Safety (DPS) ordered assessments are causing a problem. They don't like to accept assessments which result in no referral to treatment. Our clients get caught in the middle. What can we do?

A: Relationships between social services and the courts must be worked out on the local level.

However, there are some things assessors can do to ease the tension (these will also help with DPS):

1. When assessing a driving related offender, always review the driving record and arrest report before the interview. Insist on it. These will tell you things about pattern, behavior changes, and tolerance (high blood alcohol content).

2. If the individual does not meet the criteria for treatment, make recommendations concerning things the client should do to support and reinforce behaviors that will reduce the likelihood of a repeat offense. These might include counseling, regular participation in a support group such as AA, or an education program with an intensive focus on recognizing and changing problem behaviors.

3. Remember that an individual who drives while intoxicated has a problem. While Rule 25 may state "no problem," it means "no problem which requires chemical abuse or dependency treatment at this time." The latter language leaves the court or DPS free to order conditions other than participation in treatment as appropriate or necessary.

Appendix 2

TAKEN FROM THE MINUTES OF THE AUGUST 21, 1987 MEETING OF THE MINNESOTA CRIMINAL JUSTICE SYSTEM DWI TASK FORCE

II. Rule 25 conflicts with the criminal justice system.

1. The initial problem with Department of Human Service's Rule 25 criteria is that its purpose and implementation is not uniformly understood by judges, probation officers and attorneys. Presently, the state criminal justice system provides limited ways for dispersing information to increase understanding. Presentation at the state judges' conference will aid in increasing understanding, but its utility is hampered by factors such as attendance.

The conflict which Rule 25 creates is that judges may want to send some indigent or working poor DWI offenders to a level of treatment that Rule 25 criteria do not support, and consequently, the state will not pay for the costs of treatment. Minnesota law requires that repeat offenders be subject to a chemical dependency assessment.

2. The Task Force proposed to document ten concepts where the interpretation or application of Rule 25 may be unclear.

a. Rule 25 is a cost containment measure for the Department of Human Services that objectively ties levels of alcohol problems to appropriate levels of treatment. This provision is adequate in most cases. There is more flexibility in terms of funding treatment if the individual has health insurance. If the offender has no insurance or no appropriate insurance coverage they are limited to state funded treatment and can only obtain a level of care supported by Rule 25 criteria. Insurance companies have refused to pay for inpatient chemical dependency even after a Rule 25 assessment indicates it is needed. The insurance companies' refusal to cover costs may be negotiable if the client could substitute outpatient treatment or a care process like AA.

b. Rule 25 applies only to an indigent DWI offender who is in need of treatment for alcohol abuse. Statewide, about 10% of offenders are indigent. Estimates range from 10% in Stearns County to 15-20% in Minneapolis, to 10% in suburban Hennepin County. Although a high percentage of repeat offenders have serious chemical dependency problems, not all of the indigent DWI offenders are problem drinkers in need of treatment.

A problem area is the moderate income person who does not qualify for financial assistance under Rule 25 criteria, but who has no health insurance or personal funds to pay for treatment. A sliding scale will be set up in the Consolidated Treatment fund beginning July 1, 1988 with a ceiling of 115% of the median income.

c. Funding - Until January 1988, chemical dependency treatment will continue to be funded by the County Social Service Agencies (CSSA) using monies from a variety of sources such as General Assistance and Medical Assistance. Until the Consolidated Treatment Fund and statewide criteria go into effect, local treatment guidelines and funds will be applied.

This presents some overlap between Rule 25 and local treatment procedures. In some instances this may deny funding to an offender who originally qualified for assistance under Rule 25. For example, Medical Assistance will deny funds for a second attempt at treatment if the first attempt was aborted during the same year. Starting in January 1988, no treatment funds can be denied based on prior treatment experience.

d. MACH - Many jurisdictions are using a computer program, Minnesota Assessment of Chemical Health, as an assessment tool to document alcohol problems and to generate referrals to proper treatment programs. This spring, an update version was mailed to MACH users which integrated the Rule 25 criteria with treatment referrals.

e. Pilot Programs - Some of the problems in applying Rule 25 were identified and resolved by counties which served in the DHS/Rule 25 pilot program. Problems identified by these counties involved financing and assessment procedures. Counties must resolve the funding conflict when inpatient treatment is ordered by the court, but the county social services will only cover outpatient treatment. Counties should unify their assessment procedures. Instead of assigning all court ordered assessments to the probation department while leaving treatment placement with the county welfare department, counties should have the same person assessing offenders and placing them for treatment.

f. Judicial Education about Rule 25 - In the planning of Rule 25, the judiciary and court system were not included in its development but are still required to follow the criteria when placing indigent offenders into treatment. Judges who are used to having some discretion in 'diagnosing' and placing offenders in treatment may resist Rule 25 criteria as an infringement on their decision-making. Newer judges may not feel that Rule 25 constrains them because they are accustomed to relying on the recommendation made by the alcohol problem assessors.

Much of the education about Rule 25 criteria has been made on a case-by-case basis as each judge learns how the criteria apply to offenders. The Department of Human Services (DHS) has sent to all judges copies of the Rule and cover letters explaining its use. Rule 25 was also presented for discussion at the spring judicial conference. The difficulty lies in bringing together all the judges, DHS personnel, and corrections people to receive uniform training.

g. Miscellaneous Cases

1) Appeal - Appeals to the DHS may be made, but they are costly in time and in complexity. Offenders may not be able to make use of a lengthy appeals process if they must remain in jail until a treatment referral is approved. A 'fast-track' appeals process is included in the Consolidated Treatment fund starting in January.

Offenders who are not motivated to go through the appeals process may acquiesce to a referral to outpatient treatment. If the offenders have a chemical dependency problem more difficult than outpatient treatment can adequately address, then these offenders are being set up for failure by a deficiency in the system. An intoxicated driver who cannot restrain from drinking in an unsupervised environment may be a greater problem for the public than finding funding within the Rule 25 criteria. This is probably an unanticipated difficulty in the context of Rule 25 development.

2) Abstinence time - If an offender's drinking pattern has been interrupted by a jail sentence or hospitalization, this abstinence time should be deducted when diagnosing the length of time of dependency. Similarly, a mentally ill or chemically dependent person should have time spent in a mental health facility deducted.

h. Documentation - DHS is doing a survey to determine the rate of reimbursement for chemical dependency evaluations. When the survey is completed, jurisdiction will have more accurate information regarding the reimbursement for full dependency assessment, and the documentation required to prove assessor qualifications and adequate processing of offenders.

A list of qualified screening and assessment personnel should be formulated within each jurisdiction. The jurisdictions should keep track of the personnel processing each screening and assessment. Although the policy is unclear, if the same

assessor gives both the screening and he assessment, the court may only be eligible for the chemical use problem assessment reimbursement. If two different people do the screening and the assessment, the court may qualify for both reimbursements.

Acceptable collateral contacts to verify alcohol related problems should include family, friends, employers, as well as driver's license records.

i. Fees - The $75 assessment fee is required for all offenders who are convicted for an offense described in Minn. Stat. 169.126, if it arose after August 1. The state court administrator sent out a letter to all court administrators clarifying whether the fee was required for arrest or sentences handed down after August 1.

Some judges are routinely waiving the $75 fee for assessments for offenders who receive a public defender. Other judges collect the fee from all offenders. Some counties give the offender up to 30 days to pay the fee.

The assessment fee was not added to the relicensing fee which had already been increased from $150 to $200 this year. The price increase is going to enhance probation reimbursements for giving the alcohol problem screening. The current level of the reimbursement is up to half the cost to the court or a maximum of $25. However, the statewide reimbursement in 1986 was only $15. In addition, nearly one third of the drivers who lose their license due to an alcohol related offense do not get their licenses back.

Statewide uniformity is needed to implement Rule 25 criteria in the court system. Given the volume of DWI cases in the state, problems and breakdowns in the system become evident very rapidly.

Appendix 3

CHRONOLOGY OF HIGHLIGHTS OF MINNESOTA DRUNKEN DRIVING LAWS

1911	"Whoever operates a motor vehicle while in an intoxicated condition shall be guilty of a misdemeanor."
1925	Three months driver license "forfeit" upon conviction.
1927	"Under the influence of intoxicating liquor" terminology replaced "in an intoxicated condition." Offense made gross misdemeanor, imprisonment mandatory.
1937	Back to misdemeanor. (No need to offer jury trial under law at that time.)
1955	Chemical test (voluntary) presumption standards for results of tests of blood, breath, urine or saliva. Prima facie at 0.15.
1957	"Alcohol beverage" replaced term "intoxicating liquor."
1961	Implied consent: take test when arrested for DWI or lose driver license for six months.
1967	Prima facie reduced from 0.15 to 0.10.
1971	Preliminary screening breath test (PBT) authorized.
	Illegal per se at 0.10.
	Invoke implied consent without necessarily having person under arrest.
1976	Presentence alcohol problem assessment required.
	"Aggravated DWI" gross misdemeanor. (DWI while license under revocation for previous alcohol related offense.)
	Authorize administrative revocation of driver license for either refusing to take test or for testing 0.10 or more.
1978	Police officer acts as agent of Commissioner, giving notice of revocation and picking up plastic license.
	"Alcohol concentration" term (rather than "blood alcohol concentration") adopted and defined in statute by ratios to blood, breath, and urine.
1980	Admit test results without in-person testimony of chemist.

1982	Police officer choice of test.
	Second and subsequent offenses, gross misdemeanor.
	Administrative revocation effective in 7 days. Not stayed pending review.
1983	Evidence of refusal admissible in trial.
	Felony "criminal vehicular operation" if ordinary negligence, DWI resulting in death or injury.
	Felony hit-run if death or injury. (Not necessarily DWI.)
1984	Mandatory test; no "right" to refuse. One year revocation for refusing.
1986	Age 21 legal drink age.
1988	Mandatory minimum sentence for repeat offenders increased to 30 days in jail or 240 hours of community service.

Source: DWI Task Force

Appendix 4

DWI GROSS MISDEMEANORS

JAIL TIME SENTENCED

	Cases Sentenced to Jail	Average Number of Days Sentenced	Total Months
1981	318	105	1,113
1982	977	60	1,966
1983	2,599	42	3,597
1984	Missing	Missing	Missing
1985	3,545	43	4,969
1986	3,964	47	6,018
1987	3,659	50	5,932

JAIL TIME BREAKDOWN

% RECEIVING SENTENCE

Sentence Days:	1 - 30	31 - 1 Year
1983	72%	28%
1984	Missing	Missing
1985	71%	29%
1986	69%	30%
1987	66%	34%

Analysis by: Statistical Analysis Center, State Planning Agency

Data Source: Offender Based Transaction Statistics (OBTS),
Minnesota Criminal History File

Appendix 5

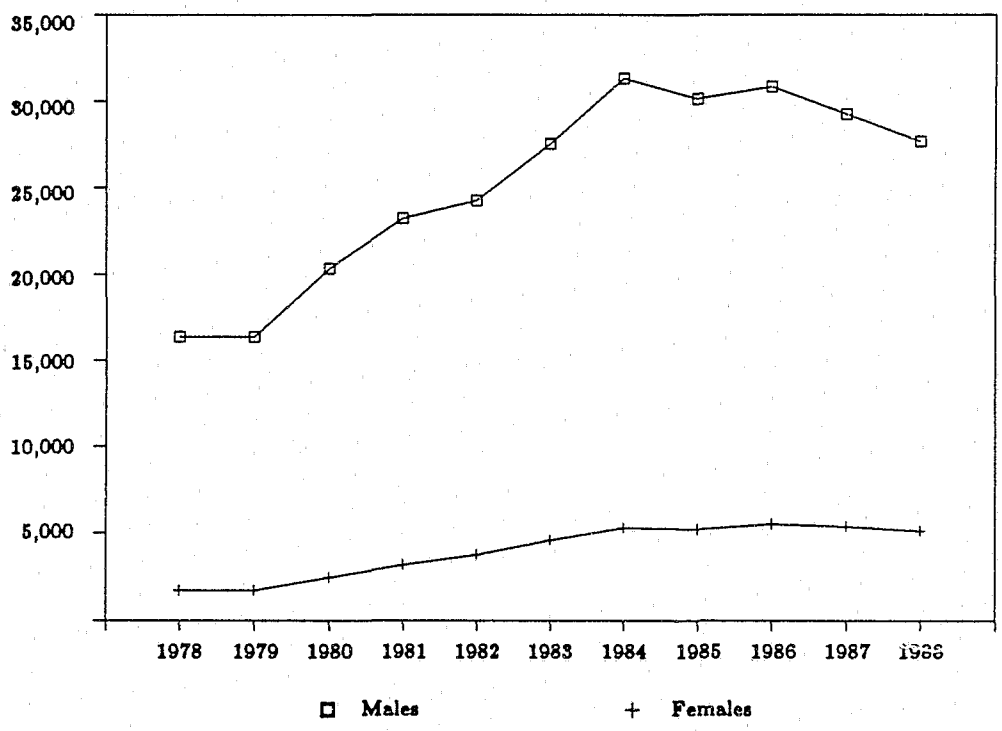
MINNESOTA DWI ARRESTS BY SEX

	TOTAL	MALE	FEMALE	17 & UNDER
1978	18,078	16,358	1,720	482
1979	18,092	16,370	1,722	492
1980	22,788	20,326	2,462	629
1981	27,034	23,230	3,181	728
1982	28,048	24,264	3,784	722
1983	32,155	27,521	4,634	743
1984	36,638	31,327	5,311	712
1985	35,383	30,135	5,248	649
1986	36,390	30,836	5,554	835
1987	34,664	29,266	5,398	714
1988	32,827	27,686	5,141	684

Data Source: Uniform Crime Reports, Bureau of Criminal Apprehension

DWI Arrests by Sex

(Number of Arrests)



Analysis by: Statistical Analysis Center, State Planning Agency
Data Source: Uniform Crime Reports, Bureau of Criminal Apprehension

PRELIMINARY REPORT ON DWI RECIDIVISM FROM THE VANHON DATABASE: TRENDS FROM THE UPDATE OF THE 1983 STUDY

This is a summary of the January 1990 preliminary report by Alan Rodgers, Research Analyst from the Minnesota Department of Public Safety, Office of Traffic Safety. The purpose of this report is to quantify the dimension of the DWI problem by giving benchmarks about the scope of the problem. These benchmarks can be compared against others calculated previously and ones to be calculated in the future to measure how the DWI problem is evolving in response to countermeasures and social change.

The Vanhon database contains a record of all drivers who had an alcohol related driver's license revocation reported to the Department of Public Safety. The database contained information on 195,000 drinking drivers in early 1986 when it was created by Tom Vanhon for the Driver and Vehicle Services Division. It was updated in late 1988 and now contains data on 269,626 drivers including 12,231 out of state residents and 9,828 Minnesota drivers included because of an "alcohol content report" or involvement in a fatal traffic crash. The records of drivers who incurred only a single alcohol related driving offense during the 1970's were purged from the main driver's license database prior to the creation of the Vanhon database. Therefore the database contains a record for every driver who's license was revoked since 1980 and some multiple offenders whose revocations occurred in the 1970's.

At the end of 1988, 3,127,029 people held Minnesota driver's licenses. In early December of that year, 247,711, or eight percent, had one or more DWI law violations on their driving record. Among the 247,711 drivers who were arrested for DWI at least once as of late 1988, 155,895 (or 63%) were arrested only once, 54,931 (22%) were arrested twice, and 36,885 (15%) were arrested three or more times. The table below compares the 1986 and 1988 DWI offender statistics from the Vanhon databases.

NUMBER AND PERCENT OF MINNESOTA DRIVERS WITH ONE OR MORE ALCOHOL INCIDENTS ON THEIR DRIVING RECORD

	1986	%	1988	%	Increase
Licensed drivers	3,066,245		3,127,029		2%
1 or more incidents	194,896	(6.4%)	247,711	(7.9%)	27%
3 or more incidents	25,964	(0.8%)	36,885	(1.2%)	42%
6 or more incidents	1,728		2,796		62%
10 or more incidents	106		192		81%

DWI RECIDIVISM

A ten percent sample of DWI violators was selected to determine the percentage of repeat offenders within each year of the 1980's. Recidivism rates in the nine cohorts, beginning in 1980 were: 29.9%, 34.4%, 32.2%, 34.9% 38.2%, 38.6%, 38.3%, 41.6%, and 41.4%. The proportion of repeat to total violators rose somewhat unevenly during the 1980's, from about 30% in 1980, to about 41% in 1988.

This database provides more accurate reports of DWI recidivism than revocation statistics provided by Driver and Vehicles Services and reported in "Crash Facts". The revocation statistics represent a measure of the DVS workload and serve primarily as

a management tool. One example of the differences is that total alcohol related license revocations count multiple offenders twice when they have their license revoked twice under separate statutes. In another instance, the 1982 peak in alcohol related license revocations resulted from a 1982 law change that permitted a large backlog to be processed rapidly, giving the appearance of a large increase in the number of violators.

DWI RECIDIVISM IN FATAL CRASHES: AN UPDATE OF THE 1986 STUDY "ESTIMATES OF DWI DRIVER RECIDIVISM IN MINNESOTA FATAL CRASHES".

The study of DWI recidivism in 1984 Minnesota fatal crashes found that one quarter of drinking drivers involved in fatal crashes had a prior DWI conviction or implied consent violation in the previous eight years. Although this rate was nearly three times the national estimate of DWI recidivism in fatal crashes, the primary reasons for this finding were better identification of repeat offenders using implied consent revocations and a longer time period for counting prior DWI offenses.

This study was cited in the Background Papers to the Surgeon General's Workshop on Drunk Driving as supporting the need for policies that have a general deterrent impact for the entire driving population since the majority of drinking drivers involved in fatal crashes have not been previously apprehended for DWI. A current study by the Department of Public Safety is replicating the study for alcohol related fatal crashes that occurred in 1988 and 1989. Preliminary comparisons are shown in the table below.

DWI RECIDIVISM IN MINNESOTA FATAL CRASHES: 1984, 1988, 1989

	1984	1988	1989
Drivers in fatal crashes	810	852	836
Drinking drivers with DL records	273	242	224
Drinking drivers with prior DWI's	64	66	77
Percent of drinking drivers with priors	24.6%	27.2%	34.4%

Appendix 7

REFERENCES USED IN THE PREPARATION OF THIS REPORT

Report on Minnesota Alcohol Problem Assessments: July 1, 1976 - June 30, 1979; Office of Traffic Safety, Minnesota Department of Public Safety

Minnesota's DWI Assessment System; Minnesota Institute of Public Health, 1982

Statewide Training on Alcohol/Drug Problem Assessments; Hazelden Foundation, 1983

Minnesota Criminal Justice System DWI Task Force Survey, 1986

Description and Analysis of the Minnesota Driver Rehabilitation Program for Multiple DWI Offenders; Minnesota Department of Public Safety, 1986

Analysis of Public Opinion; Public Agenda Foundation, 1987

Alcohol Problem Assessment Task Force Survey; Minnesota Department of Public Safety, Minnesota Department of Human Services, State Planning Agency, 1988

Estimates of DWI Driver Recidivism in Minnesota Fatal Crashes; Minnesota Criminal Justice System DWI Task Force, 1986

*Minnesota Statutes, Sections 169.124 - 169.126

*Minnesota Rules, Chapter 7408, Department of Public Safety, Alcohol Assessment Reimbursement

*Minnesota Rules, Chapter 9530, Part .6660, Department of Human Services, Chemical Dependency Care for Public Assistance Recipients

*Copies of Minnesota Statutes and Rules may be purchased from the Print Communications Division of the Minnesota Department of Administration at (612)297-3000.