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Presented at the Conference on Rehabilitating DWI Offenders: A Progress Report on Treatment and Education Systems, Albuquerque, NM, August 1991

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Evaluation of Educational Programs:
What should be evaluated and how?

by Carol L. Popkin

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Alcohol related crashes are one of the most significant public health problems in this country. Forty percent of fatally injured drivers have BAC levels at .10 or above. Furthermore, there is a growing recognition of the large number of people who are repeat DWI offenders, and there is concern about the large proportion of them who drive when their licenses have been revoked. Therefore, we need treatment programs that are effective in reducing recidivism and especially programs that reduce the likelihood of alcohol-related crashes. By treatment I mean the process of affording the client a reasonable chance to acquire and maintain those skills necessary to cope with a drinking problem and separate drinking from driving. The primary goal of DWI treatment programs should be to stop alcohol-related crashes.

Are the programs that we now have effective? Can we sped our dollars more effectively? These are the questions we are being increasingly asked. We have usually tried three different countermeasures in dealing with DWI offenders these include licensing sanctions, alcohol drug education and more intensive rehabilitation treatments.

During the late 1960's and early 1970's the National Highway Traffic Safety Administration sponsored several Alcohol Safety Action Projects (ASAPs) to combat the drinking driver problem. Their countermeasures focused on five areas: enforcement, judicial and legislative, pre sentence investigation and probation, rehabilitation, and public information and education. Many evaluations were conducted to assess the of education/rehab. programs. These reported:

1. Social drinkers experienced a beneficial effect of these educational type programs in terms of recidivism.
2. Problem drinkers did not benefit in terms of reduced DWI recidivism from such programs.
3. Positive impact in terms of knowledge gains and improved attitudes.
4. Neither group tended to benefit in terms of reduced crash involvement.

There have been several recent studies which have compared the beneficial effects of education/rehabilitation vs. licensing sanctions. Ray Peck recently completed a study comparing the effectiveness of alcohol education and rehabilitation programs with that of licensing sanctions and found these programs to be more effective than license suspension in reducing DWI recidivism.

McKnight and Voas recently reviewed literature comparing suspension vs. remediation (education/treatment). Their study of several programs found that license suspension has an positive effect on A/R crashes -- primarily due to limiting drinking and driving through the reduced driving exposure. On the other hand they found that suspension is less effective than remedial programs as a as a selective deterrent for alcohol-involved convictions. Remedial programs when combined with some type of driving restriction, appear to be more effective in deterring drinking driving behavior itself.

Thus, we see that while remediation appears to have some beneficial effect, it to date it has not been shown to be effective in terms of our goal of reduction in A/R crashes.

In summary, we don't know very much about the treatments that work and what we know is at best vague. Our knowledge is vague for maybe three basic reasons. Number 1 -- we don't know because we've done poor evaluations. Number 2 -- programs may not work because they're designed poorly. Number 3 -- they don't work well enough to overcome other societal factors.

Now let's talk about each of the three. Programs may be very successful and yet we don't know this because they've been poorly evaluated. Virtually all of the

evaluations of ASAP programs were severely criticized because they suffered from many methodological problems such as insufficient information or inadequate control over the variables of concern.

In an ideal situation a program has an evaluation component built into the program from the beginning. The key is identical (or near identical) groups of drivers --some treated and some not-treated. There is random assignment by the courts to each program, study and control groups are compared on important variables, course providers are monitored to be certain they are precisely following the protocol. Track is kept of additional confounding factors such as drop outs, other motor vehicle infractions which might incapacitate the persons time driving. In the end comparison are made controlling for differences between the groups. Trends in the general driving population are also evaluated to make certain that some extraneous factors are not contributing to a lowered DWI recidivism rate. - Sounds easy to do. It's not.

There are lots of real world obstacles to conducting good evaluations in this field.

1. Outcome measures. Should we be measuring knowledge gains, improved attitudes, effect on DWI recidivism or A/R crashes? The goal of all our programs should be to reduce A/R crashes but using this as an outcome measure may be difficult and inefficient. Unfortunately, AR crashes are rare events so all but very large evaluations are likely to suffer from insufficient data. Because they are rare events the follow up period must be sufficient to enable an evaluation of the enduring effect. Similarly, a DWI arrest is an unlikely occurrence. Estimates are that a drinking driver's chances of getting picked up is anywhere from 1 in 500 to 1 in 1000. It seems logical to use DWI recidivism as a measure of program success and yet it may be too imprecise a measure.

2. One of the most frequently mentioned difficulties encountered with evaluations is defining what program we are testing, and comparing it to

a 'no treatment' group. Unfortunately we are often comparing our new treatment to a treatment we already know has the strongest effect--license sanctions. Participation in our new treatment often results in the removal or lessening of licensing sanctions normally imposed. Thus, comparisons between those attending schools and those not are often comparing the effect of the school with license sanctions, rather than with 'no school' (or treatment).

3. Random assignment is a difficult concept for the courts to deal with--good research design is often frowned upon because it is contradictory to legal concerns about disposition of cases-it's hard to assign people who have obvious problems into the no-treatment modality which might be required by random assignment. This is complicated by the possibility of third party liability --a concern to many states. This is a Catch 22 situation. If we think it might work, we're afraid not to treat everyone. But if we treat everyone, we'll never know if it works.

4. Another reason many of us have problems with evaluating our programs is that many of our programs have added an evaluation component as a second thought--after the program has been underway for several years. Thus, evaluation design was not integral to the program design, and we are left with trying to conduct a good evaluation without having the necessary materials or study groups to do it. This is complicated by the fact that many programs don't have the resources in terms of expertise, money and manpower to do a good evaluation. (These groups should be able to turn to some "agencies for direction and expertise.")

5. Many programs are vested in the current solution to the problem. Thus, rather than focusing on the problem and finding a solution, administrators are understandably hooked into the programs that are in

place. They are scared that if they find that their programs are ineffective that they will not be given a chance to change them or try different ideas. Thus, there is a very real emphasis on maintaining the status quo and proving that the current program is effective. This does not result in sound evaluation and certainly has implications in terms of program development.

So here we have cases in which we may have an effective program and yet for several reasons we are not able to show that it is effective.

Another reason that we have not been able to show that our programs are effective may be due to having poor programs--programs so poorly designed that they may not work. Let me explain:

1. The problem is complicated by the fact that while we know that there are several types of DWI offenders (Donovan and Marlot)--this is not a homogeneous group we're working with. and yet we try to direct offenders into one or two programs. It would seem logical that some ed and rehab would work with some and not with others. But we still don't know which is best and most states don't even have guidelines attempting to direct those found to have problems into appropriate treatment.
2. It is difficult to measure small effects.

3. It may be true that we have had to sell programs to the legislature and have had to promise unrealistic outcomes. This will make it even more difficult to introduce program modifications that may have small benefits.
4. Changing human behavior is difficult. Motivating people to any change is difficult-especially when it comes to drinking problems.
5. When we have adopted 'so called' good programs from other places, we have failed to make adjustments for differences in our jurisdictions. These programs

need to be tailored to meet our needs. There are also enormous variations in populations served. In the SW there will be large subpopulations such as Indians and Spanish Americans. Each of these cultures has a different pattern of drinking and may respond differently to treatment modalities.

6. We may be vested in the solution to the problem rather than dealing with the problem and looking for better solutions. So we may be so vested in the program that we're not willing to change it or throw it out and start again. We may miss out on really innovative programs.
7. We don't do an effective job in assessing the impact of the treatment on the offender. Many licensing agencies reinstate licenses upon completion of rehabilitation. This is a problem because many people just go and sit in the group or class until it is over; and we don't have any idea if we have had an impact. Here is a part of program design that we've thought very little about -- when not to give the license back. DMV needs the power to bar a high risk individual from driving and treatment providers need to be able to provide them with feedback.

Finally we may have good programs but these programs may not be strong enough to offset societies messages to us. There are so many social factors working against program success. There are thousands of dollars of advertising money spent on pro alcohol advertising and for each dollar spent of public service ads. Research has shown very clearly that the price influences consumption. Alcohol beverages are getting relatively cheaper. It is almost cheaper to buy a beer than a soft drink.

In addition, how realistic is it to expect that years of social training as to the acceptability of alcohol and its importance in social functions is going to be offset by 8 two hour groups.

Now given that we don't know much, and that it will take alot of good evaluations and research before we will have answers to our questions, what are we going to do? We know that the trend in this country is to assess everyone

convicted of DWI. This is going to put enormous strain on our assessment rehabilitation services. This trends will probably continue for some of the following reasons:

1. A DWI may be one of the first signs that an individual is having a problem with alcohol and the societal costs of alcoholism are enormous.
2. Current countermeasures while having some impact are still not containing the DWI problem.
3. States are frustrated with the effects of some of their punitive measures. Treatment seems like a positive approach.

We see now that we know very little of what works with which type of offender. Given that most effective treatment is still unknown. Given that we will be screening and treating more offenders, what can we do? We can do a better job of assessing the offender, and we can certainly do a better job of keeping them in the system. It makes it particularly important that we make all the improvements that we can in the process. That is, we do the best job assessing the type of problem the individual has, sending them into what we think is the best treatment and at the end of the treatment process assessing what sort of a driving risk is left.

The ideal outcome of the assessment process should be accurate classification of the nature and degree of the substance abuse problem and direction into appropriate treatment . We can do the following to be more effective:

- Have an overview of the program and a plan.

- Determine the goals of the program--make certain to include the judiciary in this.

- Determine the number of cases you can anticipate and determine what the case

load should be.

- Determine what information is vital to the assessor and decide whether there is an instrument which can help you do a better job identifying problem drinkers. There aren't many good instruments out there that are any good so do a good job selecting one. Be certain that you weight the costs vs the benefits of the program.

- Instruments should have qualified versions for adolescents or foreign language speakers.

- Have a set of guidelines available for treatment and referral.

- Have a guide available to the DWI convictee that describes what is expected and the consequences of non-completion.

Implementation. Encourage post-trial assessment or at least try to separate the assessment from sanctions imposed. Try to make certain that the assessor is not the treatment provider. If a problem is identified send the results of your assessment to the treatment agency.

TRACKING. Using the guide for the convictee. Guide the person through the system always keeping track of drop outs or system failures. Following the DWI offender. This is a highly mobile group. If your jurisdiction doesn't have a tracking system contact a jurisdictions which you know does. See how much the software for this costs. In many cases you may be able to offset some of the costs of the system by eliminating personnel costs and time. For example, the Alaska system uses its tracking system to issue bench warrants for non-complyers. These are issued weekly and all the courts have to do are sign the forms. This reduces one of the most frequently mentioned problem-dropouts. Part of this tracking system

should involved keeping all members of the system informed through better coordination and communication.

In summary, the improvements I've just suggested will have a positive outcome impact. However, we can't realistically expect to do as much as we would like to reduce the problem. We need to know what works and in order to do this we need well designed treatments and well conducted evaluations. In addition, if we want to add consistency to the screening process, we need to know more about the assessment instruments we use and we need to assess to offender upon completion of a program to be certain that we keep high risk drivers off the road.

There are additional factors working against positive program outcomes. These have a profound impact on all we do. First of all, we continue to have to sell our programs by promising unrealistic outcomes. We need to know what types of treatments work best with some of the subtypes of offenders.

Rehabilitation is an important part of an overall program to combat DWI, but it is not realistic to expect that it will have a large impact on the total problem. In the first place most DWI trips go undetected and if the probability for detection is low and when systematic biases in conviction exist, those who enter the rehab program are only a small part of the problem. When we speak about realistic expectations, we must remember how difficult it is to change human behavior and motivate people to change. DWI rehabilitation programs will be most effective when we realize that the messages which society gives are contributing to the problem. The fact remains that driving after drinking is widely accepted in our country . We are spending too little on this problem to expect to have a meaningful impact or to counteract the problem. Until society makes the tough choices needed, those in DWI rehab and education will have plenty of work.