

Characteristics of OWI Offenders

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Characteristics

- First-Time Offender?
- Scratching the Surface.
- Recidivist Characteristics.
- Who Are They?
- How We Think Is How We Act.

First Time Offender?

- A low risk offender... or then again, maybe not.
 - 40-70 percent of first time OWI offenders have a history of non-driving alcohol-related arrests.
 - National studies demonstrate the OWI offender drives intoxicated 300-2,000 times before being arrested.

Scratching the Surface

- 32 percent of women and 38 percent of men convicted of OWI have a drug use disorder as well (General Population: 16% & 21% respectively).
- For offenders with alcohol use disorders, 50 percent of women and 33 percent of men have at least one psychological disorder, mainly PTSD or depression.
- OWI Recidivists: 60 percent have a mental health disorder.

Recidivists Characteristics

- The best predictor of the future is the past!
 - One-third of those arrested for OWI have a prior OWI arrest.
 - One-third of first-time OWI offenders will continue to drink and drive.
- Overwhelmingly male: 90 percent!
- Ages: Primarily 21-40
 - 75 percent under age 40
 - 10 percent over age 50
- Studies suggest significant under-diagnosis occurs at the time of the offense. Under-diagnosis might be as significant as 40 percent.

Who Are They?

5 Types of Alcoholics: Subtypes

- Young Adult
- Young Antisocial
- Functional
- Intermediate Familial
- Chronic Severe

Young Adult Subtype

- 32 percent of US alcoholics.
- Relatively low rate of co-occurring disorders.
- Low rate of family alcoholism.
- About 24 years of age, becoming alcoholic by age 20 on average.
- Rarely seek help.
- Drink less frequently, but tend to binge drink.
- Largest subtype.

Young Antisocial Subtype

- 21 percent of alcoholics.
- Average age of 26 years.
- Tend to start drinking at age 15 and alcoholic by 18-earlier than other subtypes.
- More than half have been diagnosed with antisocial personality disorder. Many are depressed, anxious, or have been diagnosed with bipolar disorder.
- More than half have a family history of alcoholism.
- More likely to smoke marijuana and tobacco (75%), and many also abuse cocaine and opiates.
- More than one-third seek help.

Functional Subtype

- 20 percent of alcoholics.
- Generally middle-aged, working adults who tend to have stable relationships, more education, and higher incomes than other alcoholics.
- One-third have multigenerational family history of alcoholism.
- 50 percent smoke cigarettes.
- 25 percent have been diagnosed with major depressive disorder at some point in their life.
- Drink every other day on average, often consuming five or more drinks per sitting.

Intermediate Familial Subtype

- 19 percent of alcoholics.
- Middle-aged and about half have multigenerational family history of alcoholism.
- Typically begin drinking by age 17 and are alcoholic by their early 30s.
- Half are clinically depressed, and 20 percent are bipolar.
- Most smoke cigarettes, and nearly one in five use marijuana and/or cocaine.
- 25 percent seek help.

Chronic Severe Subtype

- 9 percent of alcoholics.
- Most middle-aged with early onset drinking problem.
- High rate of antisocial personality disorder and criminality.
- Almost 80 percent come from families with multigenerational alcoholism.
- Highest rate of mental illness.
- Mostly men.
- Highest divorce rate.
- Frequently includes illicit drug use.
- Two-thirds seek help.

How We Think Is How We Act: Common Thinking Errors

- **All-or-Nothing Thinking:** This happens when things are seen as black or white. Things are either all good or all bad. “The entire system is messed up.”
- **Discounting or Disqualifying the Positive or Negative:** A rejection of certain experiences by insisting they "don't count" for some reason or another. In this way, one maintains an unhealthy belief that is contradicted by everyday experiences. “My parents are blowing my behavior out of proportion. I’m a good person.”
- **Mind Reading:** An arbitrary conclusion that someone is reacting negatively without bothering to check this out. “My probation officer doesn’t listen to me. He doesn’t like me.”
- **Fortune Telling:** An anticipation that things will turn out badly, and feeling convinced a prediction is an already established fact. “I know I’ll hate AA. The people there don’t care about me.”
- **Catastrophizing:** An exaggeration of the importance of things, making it sound worse than it is. “This offense has ruined my life.”
- **Minimization:** Downplaying a behavior. “Drinking and driving is not as serious as people make it out to be.”
- **"Should" Statements:** An expectation that others “should/should not” behave in certain ways . “My wife should support my decision to quit drinking.”
- **Labeling or Name-Calling:** Instead of saying, "I made a mistake," one verbally attacks another to avoid accountability.
- **Emotional Reasoning:** Assuming your feelings reflect the way things are."I think this rule is unfair.”

How Do We Use This Information?

- The Assessment Process
 - Substance Use Risk vs. Criminal Risk
 - Risk vs. Needs
 - Responsivity (capacity plus motivation for change)
 - Are there other issues to consider?
 - What Works: Making a Treatment Referral

How Do We Use This Information?

- Community Supervision
 - Intensity
 - Limited Resources: Getting the Biggest Bang
 - FID of Good and Bad Behavior
 - Catch Them Doing Something Right Too!
 - Responding to Violations
 - Rewards/Incentives vs. Sanctions

The Assessment Process

- Substance Use Risk vs. Criminal Risk (8 Criminogenic Risk Areas)
 - Substance Abuse, of course
 - Employment
 - Peer Influence
 - Leisure/Recreation Activities
 - Family
 - Attitude
 - Personality
 - Criminal History (static risk)
- Helps determine necessary interventions and supervision level

The Assessment Process: Risk vs. Needs

- Needs: What intervention(s) has the best chance to lower risk level?
- Substance abuse or other treatment
- Employment services
- Pro-social activities

The Assessment Process: What Works?

- Intervention intensity and duration consistent with risk level
- Positive reinforcement
- Cognitive Behavioral Therapy
- Avoid mixing risk levels (if possible)
- Treatment consistent with client responsivity
- Address criminogenic risk
- Structured treatment and skill-building

AP: Responsivity & Other Considerations

- Motivation Level (Stages of Change)
 - Pre-Contemplation
 - Contemplation
 - Preparation
 - Action
 - Maintenance (Action stage for 6+ months)
- Capacity: IQ, Severe Mental Health, Severe Medical Issues, Personality Disorders, etc.

AP: Referring for Treatment

- Research-supported interventions
- Intensity consistent with severity of issues
- Treatment programs should be responsive to court expectations: don't allow the tail to wag the dog
 - regular communication
 - provides appropriate treatment
 - responds to concerns

Community Supervision

- Intensity
 - frequency of reporting
 - frequency of drug and alcohol testing
 - Drug Courts: Judicial review or not to judicial review?

CS: Getting The Biggest Bang

- High risk offenders have the biggest room for improvement
- Moderate risk offenders have the best chance for improvement
- Low risk offenders have the least room for improvement (remember, are they truly low risk?)
- So, how to manage your time and resources?

CS: FID

- Frequency, Intensity, and Duration of behavior
 - Frequency: how often
 - Intensity: how much
 - Duration: how long
- The Probation FID should be consistent with the Behavior FID
- Catch them doing something right!

CS: Responding to Violations

- Rewards/Incentives vs. Sanctions
 - Tangible rewards and verbal praise (positive reinforcement): at least 4 to 1 over negative
 - Reducing requirements (negative reinforcement)
 - Sanctions in isolation actually **INCREASES** recidivism

Case Examples:

Practicing Your Decision Making

Defendant One (John):

- 23 year old male
- 2 prior MIPs, A&B, and RTF
- 1 prior failed probation and treatment
- Abusive, alcoholic father
- Early onset alcohol and marijuana use
- In addition to alcohol, regularly smokes marijuana (diagnosed alcohol dependent and cannabis abuse)
- Moderately depressed and anxious
- Denies need for treatment
- Impulsive, blaming, and minimizing his behavior
- Unemployed with a history of employment difficulties

Questions:

- What subtype is John?
- Thinking errors?
- Probation intensity and structure?
- Treatment/interventions?
- Other?

Case Examples:

Practicing Your Decision Making

Defendant Two (Mary):

- 28 years old
- No prior offenses or treatment
- Reports healthy childhood, but was sexually abused by a babysitter at age nine
- No familial history of alcohol or drug dependency
- Weekend binge drinker, rarely smokes marijuana (alcohol abuse- rule out dependency)
- Reports a history of depression and anxiety; one suicide attempt at age 17
- Open to treatment, but not convinced it's needed
- Repeatedly says she "ruined [her] life."

Questions:

- What subtype is Mary?
- Thinking errors?
- Probation intensity and structure?
- Treatment/interventions?
- Other?

Case Examples:

Practicing Your Decision Making

Defendant Three (Mike)

- 48 years old
- 2 prior OWI (current BAC: .23 percent)
- 2 prior probation and treatment completions
- Previously attended AA
- Mildly depressed
- Drinks nearly everyday and chain-smokes
- Full-time employed at same job for 24 years
- Married with three children
- Somewhat negative toward the system and references his past PO, who he didn't like
- Admits alcoholism and knows he should quit, but not interested in more treatment or AA

Questions:

- What subtype is Mike?
- Thinking errors?
- Probation intensity and structure?
- Treatment/interventions?
- Other?

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