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This Issue in Brief

Public Policy and Sentencing Reform: The Politics of Corrections.—Author Peter J. Benekos focuses on the politicalization of corrections and presents a public policy critique of correctional reform. As fear of crime and victimization have generated retributive rhetoric and get-tough crime control policies, the consequences of these policies—high incarceration rates and prison crowding—have now become their own public policy issues with critical implications for corrections. A review of one state's legislative reform efforts suggests that sentencing policies can be proposed with the get-tough rhetoric but are ostensibly more responsive to correctional needs, i.e., overcrowding and cost, than to the issues of crime, criminals, or crime control.

The Costliest Punishment—A Corrections Administrator Contemplates the Death Penalty.—According to author Paul W. Keve, the United States—going contrary to the general trend among nations—is maintaining its death penalty, with growing numbers of prisoners on its death rows, while at the same time showing a general reluctance actually to execute. Meanwhile, the public is mostly unaware that maintenance of the death penalty is far more costly than use of life imprisonment and has no proven deterrent effect. The author cautions that the interest in expediting executions by limiting appeals must be resisted because even with all the presumed safeguards, there are still repeated instances of wrongful convictions. He adds that the death penalty as respectful of the feelings of victim families is a defective concept because it actually puts families through prolonged anguish with the years of appeals and successive execution dates.

The Refocused Probation Home Visit: A Subtle But Revolutionary Change.—Home visits have historically been used in the control/law enforcement function of probation work, as well as in the treatment/service function. However, the current state of probation—dramatically affected by burgeoning caseloads, increased numbers of "difficult" clients, and emerging issues of officer safety—has made it necessary to rethink the concept of home visits. Now, many agencies are limiting home visits to high risk cases and using such visits solely for control—an approach which may be consistent with a shift in probation practice towards a law enforcement orientation. In an article reprinted from the *Journal of Contemporary Criminal Justice*, author Charles Lindner looks at the

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The Ideal Meets the Real With the D.U.I. Offender

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SINCE THE mid-1980's, the Social Service Department of the Circuit Court of Cook County has been the agency targeted to provide service to high risk offenders found guilty of D.U.I. (driving under the influence).[1] Early on—in December 1981—the D.U.I. reporting caseload was approximately 250 of a total 5,000 reporting cases, or 5 percent.[2] By December 1985, the D.U.I. reporting caseload was approximately 1,500 of a total 9,000 reporting cases, or 17 percent.[3] By November 1990, the D.U.I. reporting caseload rose to approximately 6,400 of a total 13,700 reporting cases, or 47 percent.[4] Such rapid growth placed the Department in the position of juggling a professional ideal of service with the reality of insufficient resources and ever-increasing numbers of offenders requiring service.

The intent of this article is to share the experience and perceptions of the Social Service Department regarding its responsibility to provide service to the D.U.I. offender. The article discusses the Department's approach which integrates the criminal justice and the mental health systems.[5] The Department's intent has been to close the gap between these two systems and to provide service to those defendants who, in the past, have been missed by one or both systems. The article focuses on the Department's point of view regarding treatment, the authority on which the Department's D.U.I. Intervention Program is based, the structure of the program, the value of court intervention with the D.U.I. offender, the types of offenders in the program, and related issues.[6]

Point of View

The Department views alcoholism as a disease. This is not to say that every D.U.I. offender is an alcoholic. In reality, some D.U.I. offenders are addicted, some indicate problematic use, and others indicate nonproblematic use except for, perhaps, the incident which has brought them before the court. In the Department's view, a purely punitive approach is ineffective. Instead, what every D.U.I. offender needs is either education or treatment, or both, as well as casework intervention. A response to the treatment needs of the offender is absolutely essential if recidivism is to be prevented. That is, if the problematic drinking and/or the dependency/addiction is not addressed, the offender will be back in the criminal justice system.

The Department is supported in such point of view by Marshall (1988) who, as an educator and administrator in the field of traffic safety, is convinced that a systems approach (a comprehensive program touching on all facets of traffic and highway safety) to highway safety and drunk driving is paying dividends:

> I am equally convinced that the systems approach must include strong provisions for treatment for those drivers who repeatedly drink to excess, and education for *all* drivers. The systems approach offers strategic potential for effecting substantive reductions in drunk driving and traffic crashes in general (p. 1).

Marshall (1988) cites Pisani (1986) in emphasizing the need for treatment and that it should not be a substitute for other sanctions, but an indispensable complement.

The Department contends that individuals who drink and drive have a lethal weapon in their hands when they drive. Those who drink lower their threshold of suppression and increase the possibility of acting out in a number of different ways. Their thinking is blurred, and their reactions are slowed down. They become impaired and dangerous when behind the wheel of an automobile.

The Department's point of view is supported by statute, by state rules and regulations, and by county circuit court rules. These rules and regulations pave the way for an approach which includes treatment as well as punishment. They provide the platform from which to integrate the criminal justice system and the mental health system. The goal is to prevent further breaking of the law and, subsequently, prevent further injury and death. The bottom line is to keep those who drink from driving.

Authorization

The Illinois Vehicle Code requires that a defendant be assessed by a licensed agency "to determine if an alcohol or other drug abuse problem exists and the extent of such a problem" and that the assessment be

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He also wishes to thank Chelsea A. Pollock, Jr., director of the Social Service Department, Circuit Court of Cook County, as well as Linda Bravo, district supervisor, Judi Atkins, casework supervisor, and Edith Nolan, casework supervisor—all with the D.U.I. Intervention Program.

available to the court at the time the disposition is entered (Chapter 95 1/2: 11-501[e]). The State of Illinois' Department of Alcohol and Substance Abuse (DASA) was established to monitor programs, assessment/education/treatment, which provide service to the D.U.I. offender (Title 77, Chapter X, Subchapter D, Part 2056). In addition, DASA has developed a classification system to define the levels of impairment due to alcohol and substance abuse (Section 2056.310). The risk levels are set forth in table 1, below.

TABLE 1. CRITERIA AND RECOMMENDED TREATMENT FOR EACH RISK LEVEL

Risk Level I, Minimal Risk, indicates non-problematic use. The individual must have: 1) no prior convictions or court-ordered supervision(s) for D.U.I. and, 2) a blood alcohol concentration (BAC) at the time of arrest of less than .20 and, 3) no other symptoms of alcohol or drug abuse or dependence within the past twelve months.

Treatment: Completion of a minimum of ten hours of alcohol and drug remedial education.

Risk Level II, Moderate Risk, indicates problematic use. The individual must have: 1) no prior conviction or court-ordered supervision for D.U.I. and, 2) a blood alcohol concentration (BAC) of .20 or higher at the time of arrest and, 3) no other symptoms of alcohol or drug abuse within the past twelve months.

Treatment: Completion of a minimum of ten hours of alcohol and drug remedial education and a minimum of twelve hours of alcohol and drug treatment (group or individual).

Risk Level II, Significant Risk, also indicates problematic use. An individual must have: 1) prior conviction(s) or court-ordered supervision(s) for D.U.I. and/or, 2) a blood alcohol concentration (BAC) of .20 or higher as a result of the most current arrest for D.U.I. and/or, 3) other symptoms of alcohol or drug abuse.

Treatment: Completion of a minimum of ten hours of alcohol and drug remedial education and a minimum of twenty hours of outpatient alcohol and drug treatment (group or individual) followed by a minimum of fourteen hours of follow-up services.

Risk Level III indicates dependence and high risk. Defendants classified at this level must have symptoms of alcohol and drug dependence.

Treatment: Completion of an intensive outpatient program (minimum of 75 hours) followed by a minimum of 22 hours of follow-up services or, completion of residential or inpatient program followed by a minimum of 22 hours of follow-up services.

The Circuit Court of Cook County, through a subcommittee formed at the direction of the chief judge, has adopted circuit court rules to further implement the intent of the statute and of the regulatory department (Circuit Court of Cook County Rule 11.4, adopted May 16, 1986, to become effective June 1, 1986; amended April 16, 1990). The Circuit Court has set standards, including those established by DASA, for assessment/education/treatment agencies to whom D.U.I. referrals will be made. In addition to requiring that an assessment be completed, the Circuit Court requires that "the assessment agency or court designated monitoring agency shall monitor each defendant in a treatment and/or educational program on a regular basis and report to the court as to the client's progress when required (Rule 11.4[b] [22])." The Circuit Court, by administrative approval of the chief judge's office, has designated the Social Service Department to supervise cases in which the defendant has been assessed at Risk Levels II or III and has designated the Central States Institute of Addiction, a private agency providing assessment and education services to the D.U.I. offender, to monitor cases in which the defendant has been assessed at Risk Level I.[7]

Structure of D.U.I. Intervention Program

The enactment of the D.U.I. statute, the rules and regulations of DASA, and the policy of the Circuit Court all helped set the stage for the development of the Deparment's D.U.I. Intervention Program. In addition, three threads of experience also contributed to this development. The first was the realization that, for the type of defendant coming before the court, alcoholism and substance abuse are integrally connected to the commission of the majority of crimes. Such point of view was also expressed by Gropper (1985):

> The psychopharmacological and behavioral sciences have not established any drugs (or combination of drugs) as inherently or directly "criminologic" in the simple sense that they compel users to commit crime. But, the overall cumulative evidence is clear and persuasive that the consistently demonstrated patterns of correlations between drug abuse and crime reflect real, albeit indirect, causal links (p. 2).

In order to increase expertise to deal with substance-abusing defendants, the Department stepped up its training efforts for professional staff. Training the existing staff and hiring new employees with experience in substance abuse treatment allowed the Department to develop a structure out of experience.

The second factor influencing the structure of the D.U.I. Intervention Program was the anticipated number of offenders who would be channelled into the program. The estimated figures provided by Central States Institute of Addiction were staggering. Eighteen thousand D.U.I. assessments were completed in 1984—9,000 of which were expected to be at Risk Levels II or III. Whether the courts would actually make such number of referrals to the Social Service Department remained to be seen.

The Probation Division of the Administrative Office of the Illinois Courts—the monitoring agency for funds directed at the probation and court services population—had orignally established workload standards to be 40 cases per caseworker assigned to handle defendants determined to have Risk Levels II or III. Establishing 40 cases as the maximum workload emphasized the seriousness with which the Probation Division was responding to the needs of D.U.I. offend-

ers. It also presented staffing problems. Though limited human resources were provided initially, the Social Service Department was not optimistic that it would acquire sufficient staff to meet the demands of the new D.U.I. law. Later, when it was obvious that, based on the actual referral rate, the number of cases referred that met the criteria for assignment to the intensive caseloads was far above the number expected, the criteria became more stringent. Not only did D.U.I. offenders have to be assessed at Risk Levels II or III, but they had to be multiple offenders within the past 5 years. Even with such restrictions on the numbers assigned to intensive caseloads, staffing issues were not completely resolved.

The third factor affecting the implementation of the D.U.I. program was that since the inception of the D.U.I. law on January 1, 1986, the referrals continued at a steady and increasing rate until they leveled off in 1989. This necessitated requesting new staff and deploying available staff to meet the increasing demands. These developments did not allow for program development in other areas nor for fully meeting the needs of those referred.

The program was developed to differentiate D.U.I. cases based on the experience and perception of staff regarding the degree of risk, using DASA standards as a guide. This development was in response to the "numbers" and not to the identified need/risk as assessed by the Department's previously developed classification instrument (Caseload Management Assessment).[8] The structure comprised four different types of cases that were determined through negotiation with the Probation Division. Table 2 outlines the structure.

TABLE 2. D.U.I. INTERVENTION PROGRAM*
SOCIAL SERVICE DEPARTMENT
CIRCUIT COURT OF COOK COUNTY

D.U.I. - Intensive:

- All Risk Level 3 defendants and all Risk Level 2 defendants with prior D.U.I. conviction within five years
- Repeat D.U.I. offenders within five years
- Contact standards are face-to-face contact every two weeks and phone contact on an as needed basis
- At least two collateral contacts are to be made every month, one of which is to be with a significant other
- Caseload limit is set at 40 per caseworker
- A goal is that 100% are to be transferred out of this caseload to the After-Care Caseload (see below) at the end of 6 months based on an evaluation—the reality has been that 60% have been transferred; this process is currently under review
- Treatment, usually part of the court order, at an approved facility is closely monitored

D.U.I. Non-Intensive - After-Care:

- A goal of 100% of cases from the Intensive Caseload are to be transferred to this caseload—60% have been transferred
- Contact standards are to be every 6 weeks
- Caseloads are set at 120 per caseworker

D.U.I. Non-Intensive - Post Assessment (DPACL):

- First-time D.U.I. offenders
- Risk Level determined to be 2
- *No* criminal history background
- Contact standards have been set at a minimal level—every three months
- Close monitoring of treatment at an approved facility
- Caseloads set at 240 per caseworker; 200 has been set as a goal to strive for

Diversified Caseload (i.e., Regular Reporting Caseload (Reverse of Post Assessment (DPACL):

- First-time D.U.I. offenders
- Risk Level determined to be 2
- With *criminal history background*
- Contact standards established by Caseload Management Assessment

*The structure provided reflects current criteria, not original.

Value of Court Intervention

Authorization from statute, state rules and regulations, and circuit court rules provided a platform supportive of the Department's point of view. Substance abuse training for staff, a conflicting dilemma regarding funding (i.e., providing ideally needed service versus the reality of the number of referrals and available monetary resources), and an acceleration in referrals established a reality-based perspective on which to build the program. The resulting structure, although not the full embodiment of the ideal, does at least approach the ideal to some degree. The structure provides the opportunity for court intervention to be of value, therapeutic value.

What is meant by court intervention is that the court can order a variety of conditions, including substance abuse or mental health treatment, depending on the individual before the court. Several authors have affirmed the therapeutic value of court intervention in general, as well as for specific types of offenders. Brennan et al. (1986) generally support court intervention; Giarretto (1976), Cohen and Zaglifa (1983), and Bulkley (1982) support court intervention for sexual abuse cases; and Dreas et al. (1982) support court intervention for domestic violence cases.[9]

The notion that court intervention can be therapeutic is controversial. On the one hand, the aura and authority of the courts can be blinding and intimidating, especially for those who do not understand how the law and the system operate. On the other hand, the court's authority can be used to good advantage if it is used to direct offenders to mental health treatment. Many (or most) of the defendants who come before the courts need mental health services but are not motivated to seek out those services on their own. Knowing that the authority of the court is in the background helps set parameters for offenders who do

not have the motivation or internal control to change their behavior.

Court intervention with D.U.I. offenders is essential if a long-term solution to the problem of drinking and driving is to be found. The public (through MADD and other similar organizations), political leaders (through their leadership), the legislature (through its enactment of laws), the judiciary (by its support and enactment of guidelines and sentencing of defendants), and the state police (by their enforcement of the law), as well as the mental health/substance abuse communities (through rules and regulations and provisions of primary care), have all responded in an integrated fashion. This presents a tremendous challenge, fraught with conflict, for the court social service worker whose task is to walk between the systems, responding with balanced service, and to focus on the needs of the defendant in the context of the community. In working with D.U.I. offenders, the Social Service Department's caseworkers have noted at least six benefits which have resulted from court intervention.

First, court intervention can "break the cycle" whereby the drinking increases the feelings which lead to drinking. Generally, individuals with alcohol problems, and this includes D.U.I. offenders, experience a great deal of ambivalence, wanting help and not wanting help. "The resistance is further reinforced by deeper conflicts between the wish to be taken care of and defenses against that wish which produce massive anxiety that may be responded to by increased alcohol consumption" (Chernus, 1985, p. 70, cites Zimberg, 1978, p. 8). The image of the "silent scream" for help, coupled with overwhelming inertia, aptly describes the problematic drinker.

Second, it really doesn't matter that the court is the entity which forces the offender to obtain help. The situation is similar to that of a person who finds himself or herself in a detox program—whether it is a result of intervention by an employer, a family member, or a friend—it really doesn't matter how he or she got there. The crucial issue is whether the individual finds the help he or she so desperately needs.[10] What is important is what happens once the individual is in a helping atmosphere. For some, it takes the threat of, or the actual experience of, jail to break through the system of denial so that the individual recognizes the seriousness of his or her behavior.

Which leads to the third point of value: The level of "hitting bottom" has been raised. It is no longer necessarily the skid row derelict who is homeless, indigent, and disheveled. The "straw that broke the camel's back" isn't necessarily the experience of ending up in the gutter. Instead, such experience may be the inevitable destination of jail, the actual or inevitable loss of license for increasingly longer periods of time, or the knowledge that the next offense will cost several thousand dollars in fines and costs, in attorney's fees, in assessment and treatment fees. The Department, fortified by the authority of the court, facilitates an offender "hitting bottom" through a hard-line approach that "digs in," combined with a provision for treatment. The D.U.I. offender has to pay the price for any sanction, whether punitive or rehabilitative in nature, if intervention is to be effective. Violation of a case due to failure to comply with conditions of the court order— which include reporting to the Department or following through with treatment at an outpatient facility, as well as not being convicted of another charge—can be an effective tool in this endeavor.

Fourth, caseworkers are in a position to monitor the behavior of defendants. They serve as a constant reminder to offenders that they have a serious problem. Many times, defendants have never been told that they have a serious problem (at least so that they are able to "hear" it), that severe consequences will occur as a result of the drinking problem. Caseworkers are able, at a bare minimum, to educate defendants and to reinforce the idea that a serious problem exists. Spending time with a caseworker can help a defendant move from a pattern of "thoughtless action" to "actionless thought" (Matek, 1981). The fact that a defendant has to sit for, and hopefully participate in, sessions with a caseworker can alone be of value. Defendants are reminded by the mere fact of being present that they have a problem—this is "actionless thought." Ideally, then, the impulsive and uncontrolled behavior to drink and drive—"thoughtless action"—can be prevented.

Fifth, one of the goals of outpatient treatment is to help a "client tolerate experiencing the pain covered over by her or his defenses of denial and rationalization so that she or he can increasingly have the motivation to try sobriety" (Chernus, 1985, pp. 69-70). Whether this help comes from a primary care-giver or a caseworker is not at issue. The caseworker provides a very valuable function in this regard; the caseworker becomes one more individual in a support system.

Sixth, in some situations, it is important that the "arm of the court" be visible in order for treatment to be effective. The fact that caseworkers represent the court places them in a position to be the "enforcer" of the court order which can enable the primary caregiver, whether in an inpatient or outpatient setting, to effectively provide the necessary treatment. As Chernus (1985) states:

> Initially, [therapists] may have to utilize clients' tendency toward denial and rationalization as well as their reliance on external structure as a tool or ally in the treatment process. Such an

> approach may be necessary at times because changing this defensive style may take months or years of therapy, while the clients need help in the present with the goal of achieving and maintaining sobriety (p. 68).

Taking the role of "enforcer" is especially important for some at the beginning of treatment to ensure compliance.

The court order can be the external structure or ally in the treatment process. It is similar to prescribing medication. There is a "loading dose" at the beginning, and then the dosage is adjusted to the particular client. It is like "90 days—90 meetings" for the recovering alcoholic. It is essential that the defendant comply with the "loading dose." Many D.U.I. defendants, as is true for male batterers and incest perpetrators, indicate that they would not go through or endure the treatment if it were not for the court order. In such cases, the court order which requires treatment may certainly be considered therapeutic.

Types of Clients and Related Issues

The majority of referrals to the program fall in one of four categories, each requiring a slightly different approach to treatment. First, there is the client who has had no previous treatment, or who has not had treatment for a number of years, and who has been ordered to participate in outpatient or inpatient treatment at an approved facility. With this type of client, a great deal of preliminary work is necessary in order to break through the denial so that the treatment can be effective. The fact of court intervention and its value certainly facilitates this process.

The second type of client is the one who is in need of treatment but for whom treatment has not been ordered by the court. The caseworker is, perhaps, the only treatment-oriented person with whom the client has contact. The goal is to facilitate a referral to a primary care-giver within 6 months. Given the extensive denial of these clients, this is no easy task. The third type of client is the one who has finished inpatient treatment at an approved facility prior to referral by the court (such situation is possible because there is a period of time between assessment and final disposition of the case). When treatment is finished, the hard work begins for the caseworker. The situation is difficult both for the caseworker, who must work with the client who is without the support structure of an inpatient setting, and for the client, who is in a period of major adjustment. The fourth type of client is the individual who has been in and out of treatment several times in a "revolving door" manner. The challenge here is to have intervention sink in and make an impact.

Another way of looking at the type of client referred is by compliance or noncompliance. There are, certainly, some clients who are not compliant with the court order for treatment. These cases are returned to court on a violation of the court order. However, it has been the experience of caseworkers that, for the most part, defendants are compliant with the court order.

At the beginning, caseworkers expected clients to resist biweekly appointments with them, but this has not been the case. The issue is, then, the degree to which clients are engaged in treatment/casework. There is, upon occasion, not only the compliant client, but the fully engaged and cooperative client. Although caseworkers are not formally the primary care-giver, their work takes no less clinical expertise in assessment and intervention. Once a client is off alcohol, caseworkers are able to provide sobriety counseling, thus supporting the client's choice for health and reinforcing the structure of the client's new lifestyle.

There are a number of issues with which clients need help, whether or not they are currently receiving treatment from approved primary facilities:

1. how to survive without a driver's license;
2. how to deal with the bureaucratic maze of the Secretary of State's Office in having the client's license reinstated;
3. what to do instead of drinking;
4. how to stabilize the client's physical health, including dealing with hypertension, migraine headaches, and diet; and
5. how to deal with family issues, with the Department of Children and Family Services, with being homeless, with unemployment, etc.

Certainly, there are a wide variety of other issues that surface, whether they are related directly to the client's personality and feelings or to the client's relationships with other people or systems.

The caseworkers have noted a similarity among both the D.U.I. and criminal offenders. Cook County is made up of the City of Chicago and surrounding municipalities. Generally, clients from the city are more disadvantaged, with more medical problems, more unemployment, more family and marital problems, and more illiteracy. They tend to have more problems with compliance, and caseworkers find it necessary to go over things again and again to ensure understanding.

Occasionally, clients are dually diagnosed as mentally ill, as well as addicted to, or dependent upon, alcohol. The fact that this type of client happens to be a D.U.I. offender does not make the client necessarily any different. Both disorders need to be dealt with. It is incumbent upon caseworkers to be *aware* of the points of view of the mental health counselor as well

as the substance abuse counselor (Daley et al., 1987, pp. 1-2), *aware* of both primary and secondary alcoholism as they relate to psychiatric disorders (Schuckit, 1983), and *aware* of how addictive diseases can mimic psychiatric diseases (Wanck, 1986). Primary alcoholism can mimic almost any psychiatric disorder, and secondary alcohol abuse can exacerbate any psychiatric symptoms. Wanck (1986) asserts that "the most important test for making the diagnosis is time—symptoms due to addiction fade with abstinence, while symptoms due to mental illness persist." Frequently, caseworkers are placed in the position of balancing a polarized point of view in order to ensure that the defendant/patient is provided with appropriate and full care.

The traditional stereotypic view of the AA model and the traditional stereotypic view of the mental health/medical model conflict. As a result, in some situations it may be necessary for the caseworker to confront a psychiatrist who believes that drinking is a symptom of an underlying psychiatric disorder, when actually the drinking has to be treated in its own right and separately from, but concurrently with, the underlying psychiatric disorder. In other situations, it may be important for the caseworker to point out to the substance abuse counselor that it is not enough for the client to just stop drinking and go to meetings (i.e., AA meetings). In fact, ongoing psychotherapy, and perhaps psychiatric intervention with medication, may be called for in order to prevent a client's relapse. Because both points of view can be strongly presented and come from professionally qualified individuals, a review by the court may be appropriate. In this situation, it is crucial for the caseworker to provide a complete perspective to the court so that the case may be reviewed. Expertise in dealing with both points of view, and assertiveness in making a recommendation to the court, are essential.

Discussion/Research

The workload, and face-to-face contact standards for the intensive caseloads, were set at 40 clients and 2 weeks respectively to enable a caseworker to stay on top of all cases. The Department's goal in setting such standards was to allow for effective focus of energy which would result, ideally, in quality service. It is appropriate here to discuss the Department's processing of cases through the established structure. Experience has given the Department insight from which new developments and directions have emerged—and continue to emerge.

Two factors have contributed to a less-than-easy transfer of cases from intensive to aftercare caseloads after 6 months. First, the caseworker builds a rapport with the client, and then the relationship is terminated. Satisfying work can be done after a client has given up drinking, chosen a healthy lifestyle, and is in the process of developing and stabilizing that lifestyle. It is at this time that clients are ready to look at their lives in a growth-producing way. Transferring cases at 6 months increases the likelihood that transference and countertransference issues will be more intense and difficult to manage. This creates a challenge for caseworkers to keep their focus on the needs of the client population and not necessarily on their own need to enjoy the satisfaction of a motivated defendant on the right track.

Second, many cases are violated for noncompliance with the court order—for not following through on a treatment order or for committing a new offense. In such situations, transferring a case to another caseload which provides less intensive intervention is inappropriate. Transfer may be inappropriate in other situations because of defendants' physical/medical problems, because they may be dually diagnosed, or because of other critical needs which require intensive intervention. Three departmental internal reports[11] regarding the transfer rate indicated that the range of transfer from the intensive to aftercare caseloads was 55 to 61 percent. A more recent but less detailed analysis indicated a lower rate of transfer. As a result, an audit form to monitor this decision making is being developed. With the first analysis, the data indicated that approximately 25 to 30 percent have not been transferred due to violations and return to court. Such rate does not indicate that the Department has been unsuccessful—quite the contrary. It may mean that the caseworkers are on top of their cases and are following through; however, it is important to remember that their clients—D.U.I. offenders—are among the most recalcitrant.

The phenomenon of not transferring cases at 6 months challenges established structure/standards which allow little room for the dysfunctional defendant who is incapable of moving through the system in an efficient and predictable fashion. Contined effort needs to be focused on providing service/treatment to these recalcitrant individuals. Certainly, there comes a time when one may have to say that a particular defendant is unreachable or that any further extension of service would be ineffective or beyond the point of diminishing returns. However, this issue needs careful consideration. Too often, a decision is made to pull back and withdraw services, not because the situation calls for it, but because the particular worker or system is unwilling to expend the effort to persist.

How to provide service to one particular type of client is still being analyzed. This defendant falls into the Risk Level II-Significant category with no prior D.U.I. convictions within 5 years and no Criminal

History Record Information (C.H.R.I.)—what the Department has called a "clean D.U.I." In the established structure, this defendant is assigned automatically to the post-assessment caseloads which provide only minimal supervision. Some of these defendants, however, need more intensive supervision. They may be dually diagnosed, have very critical family/personal situations, or have continued serious struggles with relapse. The Department cannot depend only upon the primary care given to help these individuals close the gap between addiction and health. These individuals need the intensive supervision provided by the intensive caseloads or by the diversified caseloads.

Recently, a change in the structure was negotiated for these clients, who were an estimated 5 percent of the post-assessment caseload. Now, should one of these "clean" D.U.I.'s have a drinking problem that is out of control or an unstable mental health condition, the case may be assigned to or transferred to the diversified caseloads where more indepth service can be provided. While the Department believes that most of these cases should be assigned to the intensive caseloads where even more intensive service can be provided, providing such service would have serious ramifications for funding.

What remains to be done is to prove the effectiveness of this program. Central States Institute of Addiction has been compiling data on the D.U.I. offender for over 15 years. Based on a 10-year study of Cook County records, the Institute found that 9.1 percent of the D.U.I. population were recidivists (Cook County Research and Evaluation Project, 1987, p. 48, Table IV). Such figure seems encouraging, but should be considered with caution. The study was limited in that the recidivist check was completed in 1 year, not after, and that the cases studied were only Risk Level I cases, not the more difficult Risk Levels II and III. Study of the D.U.I. offender will continue, however. The Social Service Department has entered into an agreement with the Central States Institute of Addiction, as part of the Cook County Research and Evaluation Project, under the direction and authorization of the Circuit Court D.U.I. Subcommittee and the chief judge's office, to evaluate the Circuit Court impact on D.U.I. offenders. The study will include both Risk Levels II and III offenders. Its results will no doubt contribute to future development of D.U.I. intervention in Cook County.

Conclusion

The services provided by the Social Service Department rise above the polarities of law enforcement and social service, are an artistic expression of balance, coupled with a grounded commitment, and contribute to solving the problem of drinking and driving. Court intervention can be and is therapeutic. The ideal has met the real to some degree—combining treatment with court intervention points up the integration of two systems, mental health and criminal justice. The program is indeed on the right track.

NOTES

[1]The Department provides correctional social services to misdemeanor cases referred to it by the courts. Cases are referred either because defendants are placed on Supervision or sentenced to Conditional Discharge and the period of time has usually been for 1 year. The statute now provides the alternative of a 2-year sentence/disposition for D.U.I., Conditional Discharge or Supervision. Defendants, whether placed on Supervision or sentenced to Conditional Discharge, are found guilty. If the conditions are fulfilled, the Supervision order will not result in a conviction and consequent criminal record. On the other hand, the Conditional Discharge Sentence is a conviction and does result in a criminal record. In general, Conditional Discharge is used interchangeably in the statute with Probation. A defendant can be ordered to report to a person or agency by the court and ordered to comply with specific conditions.

[2]Taken from two reports: departmental internal report, "Statistical Report for 1981—Status of Case at Opening April 1st, 1981 through November 30th, 1981," dated 11/22/82; and Fourth Quarterly Report for FY '81 submitted to Cook County Budget and Management Services.

[3]Monthly Statistical Report for December 1985, submitted to the Probation Division, Administrative Office of the Illinois Courts, State of Illinois.

[4]Same type of report as in Note #3 except for November 1990.

[5]Further articulation of this vision and practice is provided by Brennan et al. in their article "Forensic Social Work: Practice and Vision" (1986, 1987).

[6]An assumption is made that it would be redundant to cite statistics regarding the D.U.I. offender and the effects of drinking and driving. MADD has publicized these statistics well (e.g., *Chicago Tribune*, 1987). The problem of alcoholism has been a national concern as determined by the U.S. Congress in Alcohol and Health (1983). The Illinois Alcoholism Counselor Certification Board provides a thorough introduction to the D.U.I. phenomenon, including an historical overview as well as a brief overview of alcoholism, problem drinking, and chemical dependence (1985). The Office of the Secretary of State, Illinois, published updated information showing progress in the *1990 DUI Fact Book* (1991).

[7]A booklet, *Circuit Court of Cook County, Illinois: D.U.I. Process—Network*, was published for distribution at the 11th International Conference: Alcohol, Drugs & Traffic Safety, Chicago, Illinois, October 1989. It has since been revised (March 1990) with minor changes. The Honorable Anthony J. Montelione, chairman, Circuit Court of Cook County D.U.I. Subcommittee, coordinated the publication. It provides an overview of the process in Cook County coupled with a policy statement regarding the D.U.I. offender.

[8]The instrument is comprised of 13 factors (for example, Prior Arrests, Support System, Employment and Residence Stability, Mental Health, Substance Abuse) based on the defendant's needs. These factors are believed to predict the defendant's likelihood of reentering the criminal justice system. They are also related to the amount of time required for contact, since every defendant does not require the same amount of time. The instrument thus serves to guide caseworkers in structuring their time.

[9]Two of these articles are based on the experience of the Social Service Department: Brennan et al. and Dreas et al.

[10]Brennan et al. (1986) provide a perspective as well as sources in the literature on the involuntary or coerced client. Also, Rooney, 1988.

[11]Three internal departmental reports covering different periods of time regarding the occurence of and reason for transfer or not when a case comes up for 6-month assessment. Those results were available in March 1988, June 1988, and March 1989.

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