The treatment of drunken drivers in Finland*

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1. Introduction

Although drunken driving in Finland is by international standards a rather small problem, it is taken seriously. The number of arrested DWI's is high - approx. 30000 yearly - but it tells first of all about the effectiveness of police activities. The police control really is effective, as for example over one million breath tests are made every year in a country with five million inhabitants. Long-term roadside surveys, however, show that only 0.2% to 0.4% of all drivers have BAC-values over 0.5% (the legislative limit for drunken driving in Finland) while driving (Pikkarainen & Penttilä 1989). This percentage is among the lowest in industrialized countries.

Side by side with punishment of DWI's, their treatment has lately become an issue. In 1990-91 A-Clinic Foundation conducted a study aimed at improving the treatment of DWI's at A-Clinics (A-Clinics in Finland are voluntary outpatient units for alcohol abusers, the Foundation itself was established in the early fifties).

In the project we tried a) to improve working methods with DWI's at A-Clinics, b) to evaluate how many DWI's in general seek help for their alcohol problems and c) to motivate DWI's to seek help directly in the arrest situation.

2. Findings

We found that 35% of the clients of the A-Clinics had at some time during their lives been arrested for drunken driving. In the whole country there are 11000-13000 DWI's as clients during one year. DWI's at Clinics are not as chronic abusers as the average clients, and the results of their treatment may thus be better than average. For example, their socioeconomic status is a bit better and their treatment relationships are shorter but more intensive than average. On the other hand, those DWI's at A-Clinics are obviously the most chronic part of the whole DWI-population. The percentage of recidivists in this group was 51.

* This project was carried out at A-Clinic Foundation and financed by the Ministry of Social Welfare and Health. Conclusions presented here are those of author. The project report is published in the serie of the ministry by name "Rattijuoppojen hoidon mahdollisuuksista (About the possibilities to treat drunken drivers)" STM 1991:8, Helsinki 1991.
The success of the treatment is limited by the fact that in various studies only 30% to 50% of DWI's have been diagnosed as alcoholics (Vingilis 1983). The same percentage was also found in a Finnish study (Roine et al 1987). Consequently, treatment can be given only to this sub-population. If you offer treatment, you must have people who fill treatment diagnostic criteria. To this group almost everything is offered from Antabus to inpatient treatment in psychiatric hospitals, but the results described in the literature are often poor.

In Finland the treatment programs of the A-Clinics did not pay much attention to DWI's. In spite of the generality of problems concerning drinking and driving, only few clinics told in their information about drunken driving as a possible reason for seeking treatment.

Our second aim was to investigate the former treatment histories of DWI's. In some experimental regions we tried to include into this project all DWI's arrested during a certain time. This information we got from police registers. Then we read through the registers of the local A-Clinic, health care centre and social welfare office seeking alcohol-related visits (visits where alcohol problems were clearly written down). As can be seen below, almost half of DWI's had sought help voluntarily from those offices already before their arrest. The most chronic DWI's also seemed to seek help most often. This finding was against our expectations; we believed that the great majority of DWI's are outside treatment and that the first task is to motivate them into services.

We also found that male DWI's in general have two or three times more visits to medical doctors in health care centres than the male population on average. The youngest DWI's have more visits than older DWI's-groups.

Our third aim was to guide drunken drivers to treatment (either at A-Clinic or in health care centre) directly from the arrest situation. Arrested DWI's got a short guidance in the health care centres, where BAC-tests were made. Only few DWI's (11%) accepted the offer of treatment. The same tendency was also seen with DWI's at A-Clinics; their treatment relationships started independently of the time of arrest. Many DWI's seek help, but the decision to go for treatment seems to be the result of many factors.
A-Clinic, health care centre and social welfare office

DWI's, who during one year before arrest have alcohol-related visits

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average 47 25 (N=245)

3. Discussion

One of our conclusions was that drunken driving is not a primary problem, and can therefore be impossible to solve as such. In many cases drunken driving can be a symptom of a larger set of problems, and it is questionable to concentrate interventions only on this specific area. Our findings, especially in health care centres, suggest that many DWI's have adopted a multi-dimensional "high-risk life-style" where drunken driving is not their main problem.

The project did not recommend establishment of separate education or treatment programs for DWI's. Treatment should be promoted in those places where a significant part of DWI's already seek help voluntarily. Instead of separate programs, DWI's should have the opportunity for deeper study of their abuse, with drunken driving considered as one element of their alcohol problems.

Treatment institutions in Finland have neglected drunken driving. Changes in professional training courses and treatment methods are now discussed.
Seeking treatment could also be promoted in Finland by refocusing the information concerning drunken driving. At the moment information is mainly concentrated on the legal consequences of drunken driving and the risks it causes in traffic. It should also tell about the need for treatment that is often related to drunken driving, and about the possibilities to get help.

References

