The hard core drinking driver revisited

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INTRODUCTION

At the 1992 ICADTS meeting (Simpson and Mayhew 1993) we summarized the findings of a major study (Simpson and Mayhew 1991) that examined the issue of the hard core drinking driver -- individuals who repeatedly drive after drinking, especially with high blood alcohol concentrations (BAC) and who seem relatively resistant to changing this behaviour. Since then, the hard core drinking driver has become widely recognized as an important segment of the drinking-driving problem and the focus of a diversity of countermeasure initiatives (Wilson 1993; Sweedler 1995).

This paper provides a contemporary analysis of the problem of the hard core drinking driver in Canada and the United States. It examines the magnitude and characteristics of the problem and determines if changes have occurred in recent years. The paper also considers the implications of these findings for programs and policies to deal effectively with the hard core drinking driver.

MAGNITUDE OF THE PROBLEM

As suggested above, “hard core” drinking drivers have several defining characteristics or key attributes, principal of which are that they repeatedly drive after drinking and they often do so with high BACs -- i.e., .15 or .20 and over. Not surprisingly, given these characteristics, they have a history of drinking-driving offences. As well, many are alcohol dependent and, therefore, relatively resistant to traditional drinking-driving countermeasures.

In the present paper, the “hard core” drinking driver is operationalized in terms of BAC. It has been shown (Simpson 1995; Simpson, Mayhew and Beirness 1996) that driving with a BAC of .15 or greater is a valid surrogate measure because of the strong relationship between repeat offences and high BACs, two of the defining characteristics of the hard core drinking driver.

In this paper, we focus on high BACs in fatal crashes which represent the most serious consequences of the hard core drinking driver problem. The major report on which the present paper is based (Simpson, Mayhew and Beirness 1996) examined the magnitude of the problem
using data on drivers killed and injured in crashes, convicted DWI offenders, self-reported drinking drivers and drinking drivers identified in roadside surveys.

**United States**

Figure 1 shows the percent of fatally injured drivers who were positive for alcohol in 1988 and 1995 (illustrated in the pie chart on the left of each segment of the figure) and, among those who had been drinking, the percent who had BACs in four categories: <.10, .10 to .14, .15 to .19 and .20[^1] and above (illustrated in the bar on the right side).

As can be seen, the incidence of alcohol use among fatally injured drivers decreased from 46% in 1988 to 41% in 1995. Despite this decline in the proportion of fatally injured drivers who were drinking, there has been no change in the distribution of alcohol found among them. The overwhelming majority of drinking drivers continue to have high BACs. In 1988, 64% of fatally injured drinking drivers had a BAC in excess of .15; in 1995 the figure was 65%. In 1988, 40% of the drinking drivers had a BAC of .20 or over; in 1995, the comparable figure was 43%.

Given these results, it is not surprising that the average BAC among fatally injured drinking drivers in 1988 and 1995 was very similar -- .17 and .18 respectively, nearly twice the legal limit in most states.

These data underscore the fact that among fatally injured drivers high BACs predominate and that there has been no major change in this situation over the past seven years.

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[^1]: BAC values are in percent.
The findings for Canada are very comparable to those for the U.S. To illustrate, Figure 2 provides information on alcohol detected among fatally injured drivers in Canada in 1988 and 1995. The proportion who tested positive for alcohol is shown in the pie chart for each year and the distribution of BACs among the positive cases is shown by the bar to the right of the pie.

As can be seen, in 1988, 51% of fatally injured drivers in Canada had been drinking; in 1995, this figure had decreased to 43%. In both years, among those who had been drinking, high BACs were by far the most common. In 1988, 61% of fatally injured drinking drivers had a BAC in excess of .15 (almost twice the statutory limit of .08); the corresponding figure in 1995 was 64%. In 1988, 36% had a BAC of .20 or over; in 1995, the comparable figure was 39%.

These data illustrate that in Canada as well high BACs predominate and the situation appears to have changed only slightly over the past seven years. Indeed, if there has been a change, it has been an increase in the proportion of fatally injured drinking drivers with high BACs.

Other countries
Similar data from other countries indicate that the problem of the high-BAC driver is not unique to the United States and Canada. For example, Holubowycz et al. (1994) reported that the mean BAC of fatally injured drivers and motorcycle riders in South Australia was .17, identical to the mean BAC in the United States and Canada and well beyond their legal blood alcohol limit of .05. Among fatally injured drivers who tested positive for alcohol, 65% had a BAC of .15 or over -- again, a figure that is very comparable to the United States and Canada. Similar findings have been reported for other countries (see Ross 1993; Bailey 1993).
CHARACTERISTICS OF THE PROBLEM

The findings in the previous section clearly establish the need for action to address the problem of the hard core drinking driver. Effective targeted interventions, however, can be established only in the presence of more refined information about the characteristics of this group. In this regard, an examination of contemporary information produces a profile that is consistent with previous findings by the present authors (Simpson and Mayhew 1991). As we recently reported (Simpson, Mayhew and Beimess 1996), the hard core have numerous psychosocial and behavioural characteristics that distinguish them from the general driving population. For example, they: often exhibit a variety of antisocial and deviant tendencies, such as aggression, hostility, and thrill-seeking; are more likely than non-drinking drivers and drivers with lower BACs to have a criminal history, to use drugs, and to have poor driving records; and more frequently consume greater quantities of alcohol per occasion, experience more alcohol-related problems and are more likely to meet the criteria for a diagnosis of alcohol dependence -- these characteristics are even more pronounced among multiple DWI offenders.

Although this profile has some descriptive advantages, it is an average that obscures the substantial variability found among this group -- the hard core are not a homogeneous target group. They are diverse, with different backgrounds, problems, and most likely different reasons for engaging in DWI behaviour. Accordingly, to the extent possible, interventions should be designed to match the specific problems presented by the offender to maximize effectiveness.

PROGRAM AND POLICY IMPLICATIONS

Given these characteristics of the hard core drinking driver, several tertiary prevention measures offer promise for dealing efficiently and effectively with offenders already in the system as well as those who will enter it, to ensure that they do not repeat the offence. Such measures are needed because most jurisdictions are faced with a simple, practical reality -- their system is overloaded and much of the burden is attributable to repeat DWI offenders, who are being processed through the system with relentless monotony. The efficiency and effectiveness of identifying and processing offenders could be increased, for example, by the introduction of a tiered-BAC system, which uses the BAC at the time of arrest as a criterion for determining the sanctions imposed. In addition, assessment -- or at least some type of screening -- should be required of all DWI offenders. In practice, however, it may be more efficient to require assessment only of repeat offenders and first offenders with high BACs -- i.e., those most likely to be harmfully involved with alcohol and at greatest risk of committing a subsequent DWI offence. Treatment and rehabilitation programs should also be viewed as an essential and viable part of any strategy designed to deal with the problem of the hard core drinking driver.
Finally, programs are needed to prevent or limit the opportunity of the "hard core" to drink and drive prior to, during, and even following treatment. Some of these programs -- such as licence suspension, electronically monitored home confinement, intensive supervised probation -- can be targeted directly at the offender; others can be directed at the offender's vehicle -- e.g., alcohol ignition interlocks, administrative impoundment and immobilization, license plate stickers.

REFERENCES


