Published in final edited form as:

Alcohol Treat Q. 2017 ; 35(2): 113–129. doi:10.1080/07347324.2017.1288484.

Bringing alcohol treatment to driving under the influence programs: Perceptions from first-time offenders

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Abstract

Alcohol use disorders (AUDs) are common among first-time driving under the influence (DUI) offenders. Individuals with a DUI arrest may attend a DUI alcohol education program for license reinstatement. We evaluated the acceptability of cognitive behavioral treatment (CBT) for AUDs adapted for DUI programs. Participants (N=35) were enrolled in one of two DUI programs in Los Angeles and were an average of 34.5 (SD=11.9) years old; 66% male; 37.1% African American, 34.2% Hispanic/Latino(a), and 20% non-Hispanic White. We analyzed data from ten focus groups and 35 self-report surveys that evaluated the nine-session CBT group protocol. Overall, participants stated that the CBT philosophy was acceptable and helpful in thinking about how to prevent future DUIs. They also found the coping skills in the sessions relevant to other life events and decisions. Participants valued the personal disclosure and interactive role-play and group exercises embedded within each session stating that these exercises helped with group cohesion and self-disclosure. Data from satisfaction surveys showed that participants reported high satisfaction ratings on the overall session, session content, and session facilitator. Future studies are needed to evaluate whether evidence-based treatment within DUI programs may increase access to evidence-base care among at-risk individuals who may not otherwise seek treatment for their AUDs.

Keywords

cognitive behavioral therapy; alcohol use disorders; driving under the influence

Introduction

Driving under the influence of alcohol (DUI) is a large public health concern and efforts to prevent DUI recidivism are sorely needed. Both national and state-specific data suggests that rates of recidivism remain high. For instance, in California, about 24% of individuals with a first-time offense and 36% of individuals with three or more offenses recidivate within ten years (California Department of Motor Vehicles, 2014). In California, about 8% of alcohol-related fatal crashes involved a driver with a previous DUI conviction (National Highway

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Traffic Safety Administration, 2000). These statistics underscore the need to intervene among individuals with a DUI offense to effectively reduce the chances of future drinking and driving behaviors.

Most individuals arrested for a DUI are mandated to attend a DUI alcohol education program to reinstate their driver's license and/or satisfy court sentencing. These programs consist of education classes and process groups that may be didactic in nature (e.g., lectures or films about the consequences of drinking and driving) and may not effectively treat alcohol use disorders (AUDs) and related consequences (Davis, Thomson, Oxman, & Haynes, 1995; Kaminer, Burleson, & Goldberger, 2002; Miller, Wilbourne, & Hettema, 2003). Individuals with a DUI commonly do not access AUD treatment (Osilla et al., 2015) and may require more intensive services. Compared to first-time DUI offenders, repeat offenders are more likely to suffer from psychological distress, and to have higher levels of alcohol use-related problem severity (McCutcheon et al., 2009; Nochajski & Stasiewicz, 2006; Schell, Chan, & Morral, 2006). Also, there is evidence that the risk for AUDs remains elevated even 15 years after a first DUI (Lapham, Stout, Laxton, & Skipper, 2011). Hence, more intensive behavioral approaches may be needed to address these underlying characteristics and prevent future DUI recidivism (Nochajski & Stasiewicz, 2006; Wells-Parker, Bangert-Drowns, McMillen, & Williams, 1995).

Few rigorous intervention trials have been conducted in DUI programs and there is insufficient evidence for any single type of intervention in reducing recidivism (Miller, Curtis, Sonderlund, Day, & Droste, 2015). However, studies providing multi-component interventions that combine licensing sanctions, alcohol education, and AUD treatment, have shown some promise in lowering DUI recidivism rates (Dill & Wells-Parker, 2006; Miller et al., 2015; Wells-Parker et al., 1995). Providing evidence-based AUD treatment within a DUI program that provides education and process groups for individuals already undergoing sanctions would therefore be appropriate, timely, and may help reduce AUD-related consequences including DUI recidivism.

Implementing CBT for DUI offenders may be promising for reducing DUI recidivism. First, CBT is an effective treatment for AUDs. CBT is a treatment that utilizes coping skills, problem solving, and cognitive restructuring to address how individuals' thoughts, actions/behaviors, and feelings influence each other (Dobson, 2010). Likewise, the conceptual framework behind CBT for AUDs posits that an individual's lack of coping skills can increase the person's likelihood of drinking when confronted with high-risk scenarios such as feeling stressed or going to a party where alcohol is served (Abrams et al., 1991; Marlatt & Donovan, 2005; Monti et al., 1999). Thus, rather than targeting drinking behavior directly, CBT targets individual's skills deficit by increasing his/her ability to cope with high risk situations (i.e. negative emotional state, attending events/functions likely leading to alcohol consumption, etc.) that might put him/her at risk for drinking. Numerous randomized controlled trials and meta-analyses have demonstrated that CBT is an effective treatment for individuals with AUDs (Kaminer et al., 2002; Longabaugh & Morgenstern, 1999; Moore, Harrison, Young, & Ochsorn, 2008; Morgenstern, Blanchard, Morgan, Labouvie, & Hayaki, 2001; Project MATCH Research Group, 1998) and those with less severe problems (Kleber et al., 2007). Further, there is robust support for CBT across methods of delivery,

including both group and individual formats (Drake, O'Neal, & Wallach, 2008; Marques & Formigoni, 2001; Weiss, Jaffee, de Menil, & Cogley, 2004).

Second, there is preliminary evidence that CBT for AUD may be beneficial for reducing recidivism among individuals with first-time DUI offenses (Donovan, Salzborg, Chaney, & Queisser, 1990) as well as those with multiple DUIs (Moore, Harrison, Young, & Ochshorn, 2008). Specifically, Donovan and colleagues (1990) randomized 557 first-time DUI clients between 18-35 years old to: a 4-session CBT alcohol skills training intervention, alcohol and driving education, and no treatment. Participants in the CBT condition reported significantly greater alcohol reduction at 12-month follow-up compared to the two other groups (Donovan et al., 1990). Further, albeit non-significant, participants in the CBT condition were less likely to have another DUI episode at the 3-year follow-up (Donovan et al., 1990). There is also preliminary support that CBT for AUD might reduce recidivism rates among repeat DUI offenders (Moore, Harrison, Young, & Ochshorn, 2008). Specifically, Moore and colleagues (2008) conducted a pre-post evaluation of a 2-month DUI program consisting of weekly alcohol education groups and individual CBT for AUD. At 21-month follow-up, program completers reported lower DUI recidivism rates (13%) compared to non-completers (75%) (Moore, Harrison, Young, & Ochshorn, 2008). These studies provide preliminary evidence that CBT can be helpful in reducing DUI recidivism rates. However, more research using rigorous, experimental methodologies is needed (Miller et al., 2015). We will contribute to addressing this significant gap in the literature by evaluating our adapted CBT intervention described here, in a future randomized controlled trial.

Lastly, there is mixed support for other types of alcohol interventions, such as motivational interviewing (MI) in addressing AUD and preventing DUI recidivism (Miller et al., 2015). Specifically, out of three MI interventions included in the literature review of DUI recidivism prevention strategies, only one was associated with significantly lower rates of DUI recidivism 3 years after the intervention (Miller et al., 2015). Likewise, our own work has shown that MI is not an effective strategy to prevent future alcohol-related consequences among first-time DUI offenders when compared to usual care (Osilla et al., 2015).

The current study adapts an existing, evidence-based, manualized CBT treatment for AUDs (Monti, Kadden, Rohsenow, Cooney, & Abrams, 2002) to this specialized population of individuals with first-time DUI conviction. Given the dearth of research evaluating efficacy of CBT for AUD among first-time DUI offenders, we deemed imperative that we work closely with relevant stakeholders during the adaptation process. Specifically, we recruited individuals representing our target population to gather suggestions for making an existing treatment protocol a better fit for the DUI offender population.

In sum, our study simultaneously addresses a major public health problem (i.e. DUI-related deaths) as well as disparities in AUD treatment access among an underserved population of DUI offenders. Specifically, we address barriers to AUD treatment by providing evidence-based CBT treatment as part of a program that individuals convicted of a DUI are required to attend. We posit that by effectively addressing underlying issues related to AUD among first-time DUI offenders, we will contribute to lower rates of recidivism.

Methods

Setting

We recruited clients from two DUI programs in Los Angeles County that provide English and Spanish-speaking services to diverse clientele according to California's Title 9 requirements (California Department of Alcohol & Drug Programs, 2012). In Los Angeles County, when an adult is arrested for DUI for the first time, in addition to having a suspended driver's license and other sanctions, the individual also attends a 3, 6, or 9-month DUI program that meets Title 9 requirements for license reinstatement. At the participating programs, the average cost for attending a 3-month program is about \$500, which includes an hour of intake, 12 education classes, 18 process group sessions, 6 Alcoholic Anonymous (AA) meetings, and an individual session midway and at the end of their program. Program costs are variable across the state. For example, we have worked with programs that cost almost \$850. When a client is interested in services, they call to schedule an intake appointment where they meet with a staff member who reviews their requirements and then the client typically attends education and process group sessions one to two weeks later. According to Title 9, clients are not allowed to miss more than five absences unless they are granted a leave of absence for less than 21 days (California Code of Regulations).

Educational classes and process groups focus on the effects of alcohol and other drugs; nature of addiction to alcohol and drugs; impairment of driving abilities, skills, and judgment caused by consumption of alcohol or drugs; alternatives to the use of alcohol and drugs; and the effects of alcohol or drug use on the individual, family, and society. Individual sessions occur at the beginning, midpoint, and end of the program and are administrative in nature (e.g., filling/submitting paperwork). The current study is named *REthinking Avenues for Change* (REACH) and is part of a formative assessment leading up to a randomized controlled trial, examining the effects of CBT in DUI programs compared to existing DUI group counseling for participants with a first-time offense.

Participants and Recruitment

The study protocol was approved by RAND's institutional review board. We also received a Department of Health and Human Services (DHHS) Certificate of Confidentiality (CC-AA-15-122). Participants were clients with a DUI offense attending one of two DUI programs. They were asked to participate in a two-hour meeting that consisted of a CBT session demonstration for an hour and then a debriefing focus group in the second hour. Participants were paid a \$25 gift card for their participation.

Procedures

We used purposive sampling to specifically recruit clients who were already enrolled in the program. DUI counselors recruited clients from their existing classes. At the end of DUI classes, counselors briefly described the focus groups, stated this would not impact any of their existing services, and gave clients a consent-to-contact form to complete if interested. Counselors stepped out of the room, and then clients put these forms in an opaque envelope. Counselors gave the envelope to a DUI administrator staff member. The administrator faxed signed consent-to-contact forms to research staff via secure fax located in a locked office

only accessible to the research staff involved in this study. Research staff called clients who consented, described the study, and scheduled them for an in-person two-hour meeting at their DUI program. Participants who consented in this study attended 1-2 meetings and their involvement did not affect their DUI program attendance. Each meeting had two components: an hour CBT demonstration and an hour of focus group. A team of four research staff members led the meetings. One staff member would lead one of the nine CBT demonstrations for the first hour as an actual CBT group, and then step out during the second hour when a different staff member would debrief with the group. Hence, each focus group was different in content given the unique content of the CBT session demonstrated during the first half of the meeting. Nine participants attended two focus groups and were asked to give their feedback about two different CBT sessions. All groups were audio taped, lasted about two hours, and followed a written protocol of open-ended questions.

Intervention Adaptation

We followed Barrera and Castro's (Barrera & Castro, 2006) framework for adapting the CBT treatment, which included information gathering with key informants (i.e., DUI clients, counselors), preliminary adaptation of the CBT manual, preliminary adaptation tests through focus groups with DUI clients, and adaptation refinement that includes integrating feedback from clients. Our goal was to ensure that the CBT treatment was compatible with the client's cultural patterns, meanings, and values (Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009) and that we maintain fidelity to the core elements of CBT (Falicov, 2009).

In all, 9 CBT group sessions were developed to satisfy California's Title 9 requirements of 18 hour of group curricula in a 3-month program. The intervention was designed to accommodate rolling admission such that new clients could enroll at any session. The intervention was primarily adapted from *Treatment for Alcohol Dependence* (Monti et al., 2002). This CBT manual has been effective in reducing drinking and improving coping skills in an outpatient setting (Holder, Longabaugh, Miller, & Rubonis, 1991; Monti et al., 1990; Monti et al., 2002; Rohsenow et al., 1991; Rohsenow et al., 2001; Sannibale et al., 2003), and was adapted as an individualized treatment for AUDs in Project MATCH (Kadden et al., 2003). In addition, two sessions that were focused on identifying thoughts and cognitive restructuring (sessions 3 and 4) were adapted from *Building Recovery by Improving Goals, Habits, and Thoughts* (BRIGHT; (Hepner et al., 2011) a 9-session manualized CBT group curriculum to treat depression in individuals with substance use problems. Finally, one session that focused on harm reduction and self-management skills was adapted from Brief Alcohol Screening and Intervention for College Students (BASICS) (Dimeff, 1999). BASICS is a secondary prevention program for young adult heavy drinkers and consists of the following core elements: cognitive-behavioral techniques aimed at enhancing self-management strategies (i.e. setting drinking limits and monitoring one's drinking), motivational enhancement, discussion of expectancies and placebo effects of alcohol, harm reduction (planning safe transportation) and normative feedback; (Dimeff, 1999). In all, 9 CBT group sessions were developed and tested for acceptability.

The intervention adaptation team consisted of three clinical psychologists with expertise in cognitive behavioral therapy, substance use, and co-occurring disorders. Important

adaptations throughout the intervention included focus on preventing future drinking and driving and changing drinking behaviors (e.g., goal of treatment is to not drink and drive, which may also include changing drinking patterns; discussing skills to not drive in high risk situations), and inclusion of examples for diverse clientele (e.g., emphasis on family, common feelings of shame, and framing sessions as skills training versus treatment). Each session began with a description of the CBT circle and then a review of the previous session's practice. Group members then introduced themselves and shared how they received their DUI. After this discussion, the group counselor facilitated the session topic.

Intervention Content

Each session started with a rationale for how the session content would be helpful in reducing risk for future drinking and driving. Session 1, *Making Informed Choices about Drinking*, focused on education about alcohol's effects on our body (i.e., blood alcohol content), decision-making (i.e., alcohol myopia), and social interactions (i.e., balanced placebo design) in order to help group members in making informed choices about drinking thus minimizing alcohol-related harm such as DUI. Session 2, *Navigating Risky Situations*, focused on identifying and learning how to cope with high risk situations that can lead to drinking and driving. Group members discussed how to avoid risky events and change their thoughts about drinking and driving. Session 3, *Connecting Situation, Thoughts, and Feelings*, focused on defining thoughts and feelings, and discussing how harmful thoughts, behaviors, and thoughts are interconnected. Group members completed a chaining exercise showing that helpful thoughts can lead to healthy behaviors, while harmful thoughts could spiral down and increase the likelihood of unhealthy behaviors such as DUI. Session 4, *Identifying and Changing Unhelpful Thoughts*, focused on cognitive restructuring. Group members participated in an exercise called "Catch it, check it change it" (Hepner et al., 2011) to manage harmful thoughts. Session 5, *Coping with Criticism*, focused on learning how to receive, respond, and cope with criticism, whether DUI-specific or general criticism to reduce risk for future DUI. Session 6, *Everyday Choices Can Lead to DUI*, focused on seemingly irrelevant decisions and the importance of planning ahead by discussing how decisions made prior to drinking and driving are important. Group members reflected on their last DUI, and discussed the ten choices leading up to their decision to drink and drive. Session 7, *Communicating in Difficult Situations*, focused on the different types of communication and the steps for assertive communication. Session 8, *Establishing Supportive Relationships*, focused on learning new strategies to ensure group members have adequate support in stressful times. Group members discussed how their networks have changed since they received their DUI and encouraged them to explore what types of support people they needed in their lives. Lastly, Session 9, *Increasing Enjoyable Activities*, focused on how group members can increase their involvement in rewarding, healthy, and fun activities. In each session, group members participated in an exercise with a partner to practice the session content (e.g., role-play to practice assertive communication).

Measures

Focus Group Protocol—There were two versions of the focus group protocol. The first version was conducted with only the first focus group prior to adapting the sessions. This protocol was designed to elicit information prior to the adaptation process and asked open-

ended questions about their existing DUI program (helpful/unhelpful), the new program we were developing (reactions to CBT circle and proposed topics), and other general questions about what was important to consider in preventing future drinking and driving. The second focus group protocol was used in the remaining nine focus groups and was designed to assess participant feedback about the CBT demonstration they just attended. For example, we specifically asked their feedback regarding how CBT was helpful in reducing future DUI. With exception to one focus group that conducted two sessions (Sessions 2 and 6) in one group, research staff conducted one of the nine CBT sessions as they normally would in a live group. Afterwards, a different research staff member administered a debriefing protocol asked about overall reactions to the session and CBT model (helpful/unhelpful), feedback on specific topics within the session, and ideas for improvement.

Satisfaction Survey—At the end of each focus group, participants completed a self-report measure asking about their demographics and satisfaction with the CBT session. Participants completed one item on session quality by indicating, on a 4-point Likert scale (i.e. 1=poor; 4=excellent), their overall judgment about each session. In addition, participants reported their satisfaction with each session by ranking each of the 11 items on a 5-point Likert scale ranging from '1=Strongly Disagree' to '5=Strongly Agree'. Please see Table 3 for exact wording of all 11 items. Similar satisfaction questions were used in prior research (D'Amico, Osilla, & Hunter, 2010; Marlatt et al., 1998; Osilla, Zellmer, Larimer, Neighbors, & Marlatt, 2008).

Data Analyses

After the completion of the focus groups, the first and second authors independently reviewed audio recordings and notes, and independently transcribed quotes that were potentially relevant to the acceptability of the CBT intervention. The purpose of this review was to identify, label, and group together key points that spoke to the intervention's acceptability. Following grounded theory analyses (Strauss & Corbin, 1998), key points with similar themes were grouped together into a category if they were said several times (e.g. connection between thoughts, mood, behavior was helpful (Ryan & Bernard, 2003). The first and second authors then discussed each of the categories and generated underlying themes from the data (e.g., CBT was applicable to preventing DUI). After themes were extracted, classic content analysis was used to identify quotes that fit each of the themes (Krippendorff, 1980; Weber, 1990). Each author independently sorted quotes by theme and then together reached a consensus on any discrepancies. Themes were aggregated to assess client feedback to the CBT intervention.

We also conducted descriptive analyses of the satisfaction data examining descriptively how participants rated the facilitators, were generally satisfied with the sessions, and how sessions were helpful.

Results

Participants

A total of ten focus groups were conducted with 35 participants enrolled in one of the two DUI programs (n=19 and 16, respectively). The sample size is appropriate for collecting in-depth feedback from potential users about the acceptability of the intervention (Carlsen & Glenton, 2011). Table 1 lists the demographic characteristics for the sample, which included 66% male and 34.2% Hispanic or Latino(a). Of the 26 that provided program information, all had a first-time DUI: 19 participants were enrolled in a 3-month program, 6 participants in a 9-month program, and 1 participant in a 12-hour program.

Focus groups

Table 2 summarizes the four underlying themes and respective quotes from individuals in the focus groups. First, we asked participants for feedback about how the CBT model fit in preventing future DUI behaviors. They reported that the connection between thoughts, feelings, and behaviors was very applicable to their lives and preventing future DUI. They stated that the CBT circle was “common-sense” and that “If you can get people to think differently, they aren't gonna put themselves into a position to drink and drive.” One participant said that identifying these harmful thoughts helped him “self-diagnose” how he could prevent a future DUI, and that the session helped him “talk back to himself.” Participants reported that it was helpful to change these thoughts and replace them with more balanced helpful thoughts that did not increase the risk of a DUI. In fact, some participants reported that this cognitive restructuring was important in planning ahead (e.g., before going out) because if they did not have a plan, they would have a difficult time restructuring thoughts in the moment and were more likely to drink and drive again. Participants also reported that the sessions would help them prevent a future DUI. One participant stated “Honestly, I might walk out today and put this in the back of my head. But, the next time I drink, I may think about this stuff.” Thus, the sessions seemed to be helpful in helping participants find ways to prevent a future DUI.

Second, several participants commented that the focus of the sessions should be on preventing future drinking and driving, and not only on abstinence. Participants reported that they were all enrolled in the program because of the DUI experience, and that not all of them felt their drinking was a problem. Often, participants would report that they were at the “wrong place at the wrong time” and just happened to be caught. In other instances, participants reported that they had been drinking and driving many times, and that their DUI triggered them to re-evaluate their drinking, their social networks, and to reduce or stop accordingly. Several participants felt they would never want to experience the legal sanctions associated with a DUI again (e.g., jail, fines, classes), and thus learning how to prevent a future DUI was important. Participants reacted negatively to the existing Alcoholics Anonymous (AA) groups they were required to attend that focused on alcoholism stating they felt they were out of place. One client said “Those people are serious alcoholics; some of them take offense [to us], they think we're a fraud.” In fact, there was a consensus among many participants that there should be an AA group devoted specifically to individuals who

have a DUI. Thus, participants reported the sessions would be more useful to them if they were focused on preventing drinking and driving.

Third, several participants valued the personal disclosure in the sessions. They stated they appreciated how others shared about their DUI experience, the interaction during session topics with the counselor and fellow group members, and the group exercises where they role-played or discussed with another partner a specific topic. One participant stated “Good to talk about what in my life has changed [since the DUI]...[it was an] eye opener, I start realizing ‘Oh I don’t do that anymore’ [hanging out with other drinkers], good to hear other people’s stories.” Participants reported that the interaction in sessions helped the session go by quickly and helped them get to know fellow group members.

Finally, several participants stated that the sessions were more applicable to preventing DUI than existing sessions they were going to in the program because the existing sessions tended to focus on watching videos rather than offering them opportunities to talk about their experiences. They appreciated that the sessions were interactive and practical to their lives. For example, one participant stated “Better than any class I’ve taken in the program here...relevant to life, to help us make better decisions.” This theme was consistent throughout the sessions as many participants reported how helpful the skills were to their daily lives and more interactive than existing classes.

Satisfaction

The majority of participants rated highly the single-item about overall session quality across all CBT sessions ($M= 3.03$, $SD= 1.83$) and expressed similarly high satisfaction across all sessions ($M= 4.89$, $SD= 0.17$). Both of these indicators were significantly correlated such that the more highly satisfied participants ranked the overall quality of the sessions higher, $r= .46$, $p<.01$.

We report participants’ satisfaction ratings for each CBT session on all 11 satisfaction items in Table 3. Specifically, data clearly indicates that the majority of participants were very satisfied with group CBT sessions presented to them, with exception to Session 8. Overall, the session-specific ratings suggest that, the majority (i.e. 67% and more) of participants “strongly agreed” that the session presented to them was easy to understand, useful, thorough and complete, and that they “could use information from the session” in the future. Further, the majority of participants (i.e. 60% or more) “strongly agreed” that they “would recommend this type of session to a friend.” Second, participants endorsed favorable facilitator-specific ratings. For instance, across all sessions, the majority (i.e. 67% or more) of participants “strongly agreed” that the facilitator was respectful, competent, well-trained, warm, understanding, and helpful and “strongly agreed” that “The facilitator valued my opinion.”

Discussion

Individuals with a DUI arrest may attend a DUI education program for license reinstatement, but often do not seek specific treatment for their AUDs. Providing treatment within DUI programs has the potential to increase access for at-risk individuals who may not otherwise

seek help. To fill this clinical gap, we adapted a CBT treatment that aims to reduce drinking and alcohol-related consequences including drinking and driving among clients enrolled in a DUI program and evaluated its acceptability.

Based on participant's feedback, we altered the CBT intervention in two main ways. First, we revised our materials to emphasize DUI prevention more explicitly rather than focusing on abstinence. When we asked participants about this adaptation, participants reported the connection between thoughts, feelings, and behaviors as helpful to preventing future DUI. Second, because participants valued the personal disclosure in our sessions, we added open-ended questions throughout the manual to encourage clients to interact and participate. As part of the larger trial, we trained our counselors in motivational interviewing (Miller & Rollnick, 2013) so that they could practice a collaborative style that focuses on building the clients' self-efficacy and intrinsic motivation to change.

Although these results provide important information on adapting and implementing CBT in a DUI program setting, our sample size was small and the clients from these DUI programs may not be generalizable to clients in other DUI programs because clients self-selected into the study. While we did not assess what characteristics are associated with self-selection, clients who volunteered for the study may be more motivated to express their points of views and possibly have more insights on how their DUI experience has changed them. Further, we recruited in a small area of Los Angeles where the demographics may not represent other areas in California and the United States. Also, we were sensitive to participant burden and did not collect additional information regarding participants' drinking habits, which may have been helpful in understanding our sample. Focus group sessions were not fully transcribed. Instead, only relevant portions related to the intervention's acceptability were transcribed by each coder. Finally, our facilitators were experts in CBT and further research is needed to examine whether DUI counselors can deliver the sessions with high ratings of participant satisfaction. We currently have a randomized controlled trial underway to examine this CBT protocol to existing program services.

This study addresses an important policy question by examining whether individuals with a first-time DUI offense perceive our adaptation of CBT in a DUI setting acceptable. Providing treatment in DUI programs addresses an important public health problem: AUDs among individuals with a DUI conviction. If treatment is effective in these settings, these services can benefit a large population of vulnerable individuals with AUDs who are at high risk of DUI recidivism and develops a new model of care that increases access to treatment. Future studies are needed to evaluate whether evidence-based treatment within DUI programs may increase access to evidence-base care among at-risk individuals who may not otherwise seek help for their AUDs.

Acknowledgments

The current study was funded by the National Institute on Minority Health and Health Disparities (NIMHD; R01MD007762, Principal Investigator: Karen Chan Osilla). The content is solely the responsibility of the authors and does not necessarily represent the official views of NIMHD or the National Institutes of Health. The authors would like to thank James Gilmore for his consultation and guidance securing the DUI programs in this study.

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Table 1**Sample demographics (N=35)**

	Mean (SD)/%
Age	34.5 (11.9)
Male	66
Race	
Hispanic/Latino(a)	34.2
White	20.0
African American	37.1
Bi-racial/Other	8.7
Employment Status	
Student	28.6
Unemployed	17.1
Works full-time	40.0
Works part-time	8.6
Other	5.7
Education	
Less than High School	28.6
High School Diploma	2.9
Some College	17.1
Associates Degree or higher	51.4
Relationship Status	
Single	37.1
Dating	51.5
Married/Committed Partners	11.4
Current DUI Program	
3-month	54.3
9-month	17.1
Other	2.9
Missing	25.7

Table 2
Themes from Client Focus Groups

Theme	Participant Quotes
CBT is applicable for preventing future DUI	<ul style="list-style-type: none"> • “You’re having a conversation with yourself on how to deal with something harmful.” • “If you can get people to think differently, they aren't gonna put themselves into a position to drink and drive.”
Intervention should focus on prevention of future DUI not abstinence	<ul style="list-style-type: none"> • “I’m there [at AA] because I have to be there, not because I’m an alcoholic.” • “There needs to be more focus on before. Planning before you leave. If you don't have a plan, you are setting yourself up.”
Personal disclosure was valuable	<ul style="list-style-type: none"> • “I like the interaction, and that everyone has something to say.” • “Good to open with your story and say why you're here; gets you started, juices flowing, brainstorm and figure out different ways to cope with things that happened.”
CBT sessions were better than existing classes	<ul style="list-style-type: none"> • “I like this more than the actual class, I’m not even checking my watch, it’s more give and take.” • “I thought it was better than any class I have ever taken.”

Note: AA=Alcoholics Anonymous; CBT=Cognitive behavioral therapy; DUI=Driving under the influence

Table 3

Percent of participants endorsing “strongly agree” with each of the satisfaction items for all cognitive behavioral therapy (CBT) sessions.

	CBT Sessions (number of participants)								
	1 (5)	2+6 (4)	3 (8)	4 (2)	5 (7)	7 (3)	8 (5)	9 (6)	
Ratings about the Facilitator									
The facilitator seemed competent and well trained.	100	100	88	100	100	100	40	100	
The facilitator seemed warm and understanding.	100	100	100	100	100	100	80	100	
The facilitator valued my opinion.	80	100	100	100	71	100	50	100	
The facilitator was helpful.	80	100	88	100	86	67	50	100	
The facilitator and I respected each other.	100	100	100	100	86	100	50	100	
Ratings about the Session									
Generally, I'm satisfied with the session.	80	100	75	100	83	100	40	100	
This session was thorough and complete.	80	100	75	100	83	67	20	100	
I would recommend this type of session to a friend.	60	100	75	100	83	100	40	100	
I could understand the information from the session.	80	100	100	100	86	67	50	100	
I could use information from the session in my daily life.	60	100	63	100	80	67	50	100	
The different activities we did in the session were helpful.	80	100	86	100	86	67	50	100	

NOTE: Of the 35 unique participants, 9 attended two focus groups, which totals 44 observations. Four observations were missing from the satisfaction analyses.