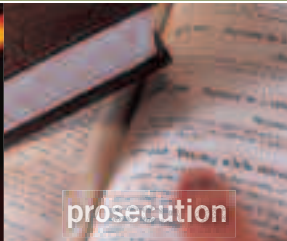


enforcement



prosecution



sanctioning



monitoring

SCREENING, ASSESSMENT AND TREATMENT OF DWI OFFENDERS:

A Guide for Justice Professionals and Policy Makers



Screening, Assessment and Treatment of DWI Offenders: A Guide for Justice Professionals and Policy Makers

Based on Discussions at the 4th Annual Meeting
of the Working Group on
DWI System Improvements

This initiative was made possible
by a charitable contribution from
The Anheuser-Busch Companies

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The Traffic Injury Research Foundation

The mission of the Traffic Injury Research Foundation (TIRF) is to reduce traffic-related deaths and injuries.

TIRF is a national, independent, charitable road safety institute. Since its inception in 1964, TIRF has become internationally recognized for its accomplishments in a wide range of subject areas related to identifying the causes of road crashes and developing programs and policies to address them effectively.

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List of Abbreviations Used in the Report

| | |
|---------|---|
| AA | Alcoholics Anonymous |
| APPA | American Probation and Parole Association |
| APA | American Psychiatric Association |
| ASAM | American Society of Addiction Medicine |
| ATTC | Addiction Technology Transfer Center Network |
| AW | Alcohol Withdrawal |
| AOD | Alcohol and Other Drugs |
| ASI | Addiction Severity Index |
| AUD | Alcohol-use Disorder/Drug-use Disorder |
| BAC | Blood Alcohol Content |
| CBT | Cognitive Behavioral Therapy |
| CLA | Computerized Lifestyle Assessment |
| CSAT | Center for Substance Abuse Treatment |
| DASIS | Drug and Alcohol Services Information System |
| DUI | Driving Under the Influence |
| DRI | Driver Risk Inventory |
| DWI | Driving While Impaired |
| GAIN | Global Appraisal of Individual Needs |
| HIPAA | Health Insurance Portability and Accountability Act |
| MAST | Michigan Alcoholism Screening Test |
| MF | Mortimer Filkins |
| N-SSATS | The National Survey of Substance Abuse Treatment Services |
| NASADAD | National Association of State Alcohol Drug Abuse Directors |
| NCIC | National Crime Information Center |
| NESARC | National Epidemiologic Survey of Alcohol and Related Conditions |
| NIAAA | National Institute for Alcohol Abuse and Alcoholism |
| NIDA | National Institute on Drug Abuse |
| NHTSA | National Highway Traffic Safety Association |
| NSDUH | National Survey on Drug Use Health |
| SAMHSA | Substance Abuse and Mental Health Services Administration |
| SALCE | Substance Abuse Life Circumstances Evaluation |
| RANT | Risk and Needs Triage |
| TASC | Treatment Accountability for Safer Communities |
| TIP 42 | Treatment Improvement Protocol |
| TRI | Treatment and Research Institute |
| VA | Veteran Affairs |

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Table of Contents

- Executive Summary ix
- 1.0 Purpose..... 1**
 - 1.1 Rationale 1
- 2.0 Background 3**
- 3.0 Introduction 5**
- 4.0 Screening, Assessment and Treatment..... 7**
 - 4.1 Screening 7
 - 4.1.1 Who is involved in the screening process? 9
 - 4.1.2 Who needs the information gathered during the screening process? 10
 - 4.2 Assessment..... 11
 - 4.2.1 Who is involved in the assessment process? 13
 - 4.2.2 Who needs the information gathered during the assessment process? 14
 - 4.2.3 Providing feedback 14
 - 4.3 Screening and Assessment Instruments..... 15
 - 4.4 Referral 20
 - 4.5 Treatment 21
 - 4.5.1 What is the purpose of treatment? 21
 - 4.5.2 Who needs to be treated? 21
 - 4.5.3 When are offenders treated? 21
 - 4.5.4 Treatment options 22
 - 4.5.5 Voluntary versus mandatory treatment 26
 - 4.5.6 Co-morbidity 27
 - 4.5.7 Who needs the information gathered during the treatment process? 29
 - 4.5.8 Other issues 30
- 5.0 Barriers to Screening, Assessment and Treatment..... 31**
 - 5.1 Resources 31
 - 5.1.1 Cost of screening 31
 - 5.1.2 Quality of the screening..... 32
 - 5.1.3 Staffing..... 33
 - 5.1.4 Availability of treatment 33

| | | |
|------------|--|-----------|
| 5.1.5 | Lack of aftercare for treatment..... | 34 |
| 5.2 | Research | 34 |
| 5.2.1 | Methodological weaknesses | 34 |
| 5.2.2 | Validation of instruments..... | 35 |
| 5.2.3 | Treatment matching | 35 |
| 5.3 | Myths and Misconceptions | 36 |
| 5.3.1 | Screening is a time-consuming and resource-heavy process | 36 |
| 5.3.2 | Screening and/or treatment is expensive | 51 |
| 5.3.3 | Coercive treatment is ineffective | 37 |
| 5.3.4 | Self-help programs qualify as treatment..... | 37 |
| 5.4 | Concerns | 38 |
| 5.4.1 | Treatment is “soft on crime” | 38 |
| 5.4.2 | Offenders participate in treatment to avoid tougher sanctions..... | 38 |
| 5.4.3 | The use of medications to treat substance abuse..... | 39 |
| 5.4.4 | The “one-size-fits-all” approach to treatment | 39 |
| 5.4.5 | Support for treatment in rural communities..... | 40 |
| 5.5 | Legislation | 40 |
| 5.5.1 | Screening and/or treatment is not a sentencing priority | 40 |
| 5.5.2 | Information-sharing is a challenge..... | 41 |
| 5.6 | Implementation | 41 |
| 5.6.1 | Inconsistent implementation | 41 |
| 5.6.2 | Lack of accountability | 42 |
| 5.6.3 | Institutional approaches | 43 |
| 5.6.4 | Obstacles to early identification | 43 |
| 6.0 | Recommendations | 45 |
| 6.1 | Good research to guide decision-making..... | 45 |
| 6.2 | Education and cross-professional training..... | 45 |
| 6.3 | Resource allocation | 46 |
| 6.4 | Comprehensive services | 46 |
| 6.5 | Consistent identification of appropriate offenders..... | 46 |
| 6.6 | Streamlined policies and practices..... | 47 |
| 6.7 | Information-sharing protocols | 47 |
| 6.8 | Accountability and aftercare | 48 |
| 7.0 | References..... | 49 |

Executive Summary

Purpose

This report is based upon discussions at the 4th Annual Meeting of the Working Group on DWI¹ System Improvements, held at the Kingsmill Resort and Spa, Williamsburg, Virginia, March 4-6, 2007. It seeks to inform justice professionals and policy makers about the importance of screening, assessment and treatment of DWI offenders, examines the strengths and limitations of the process and issues related to it, and identifies a number of priority recommendations for improving the application of quality screening, assessment and treatment to DWI offenders.

Rationale

Despite the growing interest in, and acceptance of, treatment as a key component in the array of countermeasures needed to deal effectively with convicted drunk drivers, many policy makers and practitioners remain skeptical about the value of substance abuse treatment. Those who do recognize the value of treatment are often unfamiliar with research on the effectiveness of various treatment modalities for alcohol addiction, or how to appropriately apply such approaches to offenders.

Accordingly, there is a need to provide justice professionals and policy makers with a resource document that contains practical information about the value of the treatment process for impaired driving offenders, how it fits within the justice system, and provides insights into some of the barriers to this approach and how these can be surmounted. That is the purpose of this document.

Background

Within the last decade, progress in reducing drunk driving has stalled and nominal gains have been achieved. A disproportionate part of the problem is believed to result from the persistent behavior of hard core drinking drivers – offenders who drink and drive frequently, often at high blood alcohol concentrations (BACs), and who may have a history of prior convictions and/or alcohol abuse (Simpson et al. 2004).

Of equal concern, a comprehensive review of the justice system conducted by the Traffic Injury Research Foundation – TIRF (Robertson and Simpson 2002a; 2002b; 2003a; Simpson and Robertson 2001) revealed that the persistent nature of some offenders in combination with inadequacies in the justice system were allowing these offenders to avoid detection, arrest, prosecution, conviction, and sanctioning. Indeed, this study showed that not only that many of the system problems were cross-cutting and affected all segments of it, but also underscored the fact that improvements to one part of the system could have positive benefits throughout it. More importantly, the justice professionals involved in the research also identified practical solutions to address the systemic issues and complement legislative efforts by ensuring that

¹ The abbreviation DWI (driving while impaired, or intoxicated) is used throughout this report as a convenient descriptive label, even though some states use other terms such as OUI (operating under the influence) and DUI (driving under the influence), and in some cases these terms refer to the severity of the offense. We have used DWI not only to maintain consistency throughout the report but also because it is more descriptive of the offense usually associated with hard core drunk drivers.

offenders were subject to the programs and penalties put in place to protect the public and change problem behavior. Solutions from the research were grouped according to six key areas: communication and cooperation; training and education; technologies; record systems, legislation, and resources.

Based on these research findings, TIRF created in 2004 a coalition of 14 criminal justice agencies to form the “Working Group on DWI System Improvements” to provide leadership, guidance and practical strategies that practitioners can use to improve the efficiency and effectiveness of the justice system. Since then, the Working Group has produced a series of reports examining initiatives to address impaired driving, and describing programs that represent promising practices. It has produced reports on priority issues including a guide to streamlining and simplifying DWI legislation, and a report to illustrate what is needed by practitioners to improve the delivery of ignition interlocks to offenders.

In 2007, the Working Group focused its attention on the need for more training and education for practitioners, particularly in relation to the importance of substance abuse treatment as a means of changing behavior.

Introduction

For more than 150 years, there have been two primary goals of the justice system – to protect the public and to change offending behavior. These two important, albeit often conflicting, goals are necessary to enhance long-term risk reduction. The relative importance assigned to these strategies has varied over time as a function of: 1) how criminal behavior is understood and, 2) prevalent social norms.

Of some concern, the paradigm shift from rehabilitation in the 1970s to “tough on crime” in the 1980s led governments to implement legislation and programs which placed a greater emphasis on protecting the public through the use of increased penalties and harsher and longer sentences, including incarceration. Not surprisingly, these policies resulted in a population explosion within correctional institutions and the rapid expansion of community corrections. As a result, many agencies were required to “do more with less”, so rehabilitative goals often became secondary and compliance with sentencing conditions waned.

Today, the effects of this punitive approach are still evident as justice agencies routinely cope with unmanageable caseloads and workloads, significant delays in case processing, overcrowded programs, and extended wait times for interventions. Of greater concern, this increased demand for a punitive approach has substantially eroded the ability of practitioners to encourage and reinforce behavior change using various rehabilitative techniques, including substance abuse treatment.

More recently, the limitations of a solely punitive approach have been clearly recognized by both researchers and practitioners, although there is still not widespread acceptance or understanding of these limitations at a political or public level – the “get tough” philosophy still dominates much of the application of justice. To this end, many justice practitioners now recognize that a combined approach incorporating punishment, surveillance, and treatment are essential to protecting the public while simultaneously changing the behavior of drunk-driving offenders.

Screening, Assessment and Treatment

Screening

Screening is normally a precursor to assessment and treatment. It is a process designed to identify who can be excluded from a more detailed examination for the presence of substance abuse issues, and who needs to be included for further examination or assessment. It is usually based on the results of specific testing instruments given to offenders to establish whether they have an alcohol-use disorder (AUD) and/or a drug-use disorder that requires some form of intervention.

Screening is not designed to explain the nature and severity of alcohol use problems, but rather to “raise suspicion” of them (Connors and Volk 2003) and determine whether or not further assessment is warranted. As such, screening is an important first step in the broader process of substance abuse treatment. Depending on the nature of screening that occurs (i.e., formal vs. informal) and the type of instruments that are used, screening may be administered by criminal justice practitioners or by a variety of addictions professionals who may fall along a continuum with regard to ability, interest, and accuracy.

Formal screening can involve testing and interviewing (Chang et al. 2001) which may take place in a variety of settings (e.g., probation office, health care setting) and may or may not require additional training. Increasingly, however, screening is also based on less formal methods and data collected from case files to more easily gain vital information about an offender’s substance use, abuse, or lack thereof. It warrants mentioning that the use of formal actuarial-based tests almost always greatly outperforms intuitive judgment based on informal methods when it comes to screening and assessment. Moreover, while both self-administered and interview-based assessments are common in a criminal justice setting, it should be noted that interview-based assessments are a more rigorous approach.

The characteristics of screening have changed somewhat over the past few years, so the distinction between it and assessment has become blurred. In some cases the results from the screening instruments are actually used to make the final determination of whether an offender receives treatment – i.e., screening per se is used as an assessment (Chang et al. 2001). Screening has also evolved from an initial guiding function to a process that occurs repeatedly during the subsequent treatment phase as a means of monitoring offender progress and compliance. (Chang et al. 2001; Gallant 2007). However, this does not represent best practice.

Today, the screening process may even be considered a form of treatment or brief intervention since exposure to the screening process can have therapeutic benefits (D’Onofrio and Degutis 2002; Wilk et al. 1997; Wells-Parker and Williams 2002). The key point is that screening, once regarded as a quick and relatively simple method of ascertaining who needs additional assessment to determine the nature and extent of their alcohol/drug problems, has been expanded to occur at several points in the treatment process to monitor progress, and may be considered an inherent part of the process itself because of its therapeutic potential. To maximize effectiveness, screening is used to identify potential eligibility and the assessment provides confirmation.

Screening professionals may include: police officers, prosecutors, magistrates or judges, court assessors, counselors, clinicians, offenders themselves, city and county jail employees, hearing officers or probation officers, and pre-trial staff. Who delivers the screening is often a function of which setting or point in the justice system that the screening takes place and whether informal or formal methods are used. The majority of available screening instruments can be administered by clinical, administrative or clerical staff with a minimal degree of training, and many instruments can be self-administered (Connors and Volk 2003).

Although some screenings can be administered and scored without significant training, referral decisions for assessment and/or treatment are greatly improved when they are made by professionally trained staff (SAMHSA 2005). Practitioners at various stages of the justice system may require information gathered during the screening process to inform decision-making. These include: prosecutors, judges, assessors and treatment providers, probation and pre-trial officers, prison and jail staff, and defendants/offenders.

Assessment

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines assessment as “a process for defining the nature of a problem and developing specific treatment recommendations for addressing the problem” (2005, p. 7-8). Its purpose is to confirm the presence and severity of the “problems” and identify the appropriate level of care needed to address them. Traditionally, the need for more detailed assessment of alcohol use disorders (and other related problems) is determined by the results of the preliminary screening.

Assessments are designed to:

- determine the extent and severity of a person’s substance abuse problems;
- determine the offender’s level of maturation and readiness for treatment;
- ascertain related (co-morbid) problems, such as mental illness;
- determine the type of intervention necessary to address the problems;
- evaluate the resources offenders can assemble to help solve the problem(s), (i.e. family support, social support, educational and vocational attainment, and personal qualities such as motivation); and,
- engage the offender in the proposed treatment process (SAMHSA 2005).

The assessment process typically involves a combination of paper and pencil testing, clinical interviews with the offender, personal history taking, and biological testing (CSAT 1994). Key information is gathered about the offender to help the counselor identify problem areas, disabilities, strengths and weaknesses; determine the offender’s readiness for change; and, in some cases, reach one or more diagnoses (CSAT 1994; SAMHSA 2005).

In contrast to screening, assessments are more formal, comprehensive, require specially trained practitioners, generally take place in mental health or health care settings, and may take longer, especially when additional in-depth assessments are needed.

Assessments serve to establish a definitive diagnosis of a disorder. Offenders may also be continuously re-screened and re-assessed during and following treatment to monitor for positive progress towards treatment goals (Gallant 2007). If offenders are “off track”, such measures can help identify problem areas that may be affecting treatment success and treatment plans may be adjusted accordingly to ensure that goals are met and to prevent opportunities for relapse.

Different titles may be used when referring to those who administer assessments (e.g., health care/service professionals, counselors, clinicians, service providers, etc.) but these professionals usually possess specific qualifications (Chang et al. 2002; CSAT 1994; Kerwin et al. 2006; SAMHSA 2005).

Qualifications of assessment professionals may include:

- competence in alcohol and other drug programs (i.e., addiction counselling, licensed social worker);
- credentials and/or certification as alcoholism, substance abuse, or chemical dependency counselors; and/or
- special training in basic counseling techniques (i.e., rapport building, reflective listening) in preparation for interviewing offenders.

Assessments can be done by independent assessment groups (such as a system-wide central intake unit or an independent program) or by the same professionals who will be providing treatment depending on the jurisdiction, and if it is determined that the type of intervention they provide is appropriate for the client (CSAT 1994). The Treatment Alternatives for Safer Communities in Illinois is a good example of an independent screening and assessment program that works closely with the justice system for referral to treatment and case management.²

Screening and assessment can include both less formal and formal measures/indicators that will assist in identifying the nature and extent of alcohol, drug and other problems.

Less formal factors to consider during assessment include:

- alcohol related problems (including frequent and heavy consumption);
- driving-related problems (prior moving convictions, collisions, license suspensions, reckless driving convictions);
- criminal history;
- high BAC at time of arrest;
- refusal to provide a breath or blood sample;
- prior DWI convictions (beyond a five-year window);
- arrest during daytime hours;
- marital status;
- frequent job changes; and
- socially deviant personality traits (high levels of aggression, hostility, recklessness, thrill seeking).

² For more information, please visit www.tasc.org/preview/abouttasc.html.

Various professionals at different points in the justice system need the information derived from assessing DWI offenders. This includes judges, probation officers, treatment providers, jail and prison staff, and the offenders themselves. The ability of these practitioners to access this information may be constrained due to the Health Insurance Portability and Accountability Act (HIPAA) and confidentiality issues. In some instances, these issues can be addressed through the use of consent forms, privacy releases, and agreement of specific data elements that can be shared as opposed to complete assessment results.

The Center for Substance Abuse Treatment (1994) has also offered suggestions regarding how to present assessment findings. The results should be presented in a valid, reliable, simple document, one that can be replicated, and contains data that will be relevant in treatment. A good assessment avoids excessively simplistic formulations that reduce an offender to a number, a score, a check list, or a label. The data backing up the assessment should be presented in language that is jargon-free and can be understood by all relevant personnel, including the offender and their attorney.

Screening and Assessment Instruments

A test instrument that has good sensitivity and specificity is important because it enables practitioners to minimize the identification of false positives and false negatives. A false positive is someone who tests positive but who is actually negative (e.g., the test shows the person is alcohol dependent but in fact they are not). A false negative is someone who tests negative but is in fact positive (e.g., the test shows the person is not alcohol dependent when in fact they are). Therefore, false positives mean that limited resources are wasted on offenders who do not need treatment while false negatives mean that offenders that need treatment do not receive it.

The number and variety of formal instruments/tests used in screening and assessment is quite extensive and a review of them is beyond the scope of this report. The reader is referred to several recent reviews for detailed evaluations of the more popular ones (see Chang et al. 2001; Lacey et al. 1999).³ It is generally accepted that no screening or assessment tool currently available has been tested or validated specifically on a DWI population (Lacey et al. 1999). However, many of the available instruments have adequate sensitivity and specificity for reasonably identifying alcohol use disorders (Stewart and Connors 2004/2005) and can be used with confidence for this purpose (Lacey et al. 1999).

It must be noted, however, that instruments are generally more effective once they have been adapted and are more suited to a particular population (e.g., DWI offenders, female offenders, juvenile offenders, and minority populations). Promising assessment tools include the Addiction Severity Index (ASI), Global Appraisal of Industrial Needs (GAINS) and Texas Christian University (TCU) instruments which are multi-dimensional and equally well-validated and well-studied. For a comprehensive list of alcohol and substance abuse measurement instruments, and links to many available instruments please visit the University of Texas at Austin, Center for Social Work Research.⁴

³ www.aaafoundation.org/pdf/dwiscreeningreport/pdf

⁴ www.utexas.edu/research/cswr/nids/instrumentListing.html

More recently, the Treatment Research Institute (TRI) that developed the ASI has released a Risk and Needs Triage (RANT), a decision support tool for judges and other justice decision makers to assist in matching drug-involved offenders to the community corrections program best suited to their needs for supervision and treatment.⁵ Efforts are underway to develop a similar tool that is designed for a DWI offender population (Marlowe 2008).⁶

An integrated approach to screening and assessing DWI offenders is needed in order to overcome under-reporting and deception of substance abuse issues and other limitations of assessment procedures. For example, self-report results can be used alongside face-to-face interviews as well as collateral data to help determine under-reporting as a means of gaining a more holistic understanding of the offender's drinking habits and its consequences (Chang et al. 2001).

Referral

The outcome of assessment may be a referral to a treatment program. Justice professionals provide more referrals for treatment than any other source. Owing to a number of factors many more offenders are referred to treatment than those who actually receive it – e.g. no treatment program is currently available, or offenders choose not to seek out the recommended treatment. It is important that either the Court, probation agency or service provider monitor the flow of referrals to ensure that adequate programs and staff are in place to manage the volume of referrals received, and close communication between the courts and treatment agencies can ensure offenders receive appropriate treatment.

It is also critical that justice agencies track referrals so they can share and analyze important information to better understand the effectiveness and impact of the referral process in providing needed services to offenders. The analysis of this data by skilled justice professionals is vital to understanding the quality of available programs and identifying and delivering needed technical assistance to improve the quality of the referral process.

Treatment

The treatment of DWI offenders for at least alcohol use disorders is a critical element in reducing recidivism. Accordingly, there is a growing recognition that treatment must be an essential component of the rehabilitative mix. The purpose of treating DWI offenders is to help alleviate identified problems with substance abuse that they may have, or be at risk of developing. Treatment is designed to lessen and prevent negative consequences of substance abuse (e.g., DWI) and also to support the offender during times of relapse, and to get them “back on track.”

The bottom-line realistic goal of treatment should be risk reduction (Taxman 2007). However, one of the practical limitations at this point is the burden on the system – it has been suggested (Taxman 2007) that the current treatment capacity would have to be increased four-fold to accommodate all the offenders referred for treatment. Not all offenders require placement in treatment services, and resource limitations do not allow

⁵ For more information, visit www.trirant.org.

⁶ This tool has not yet been validated.

all offenders to be treated. According to the Working Group, offenders found to possess moderate to serious alcohol issues and pose a high-risk of DWI recidivism are most in need of controlling their drinking behavior. These offenders should be prioritized for referrals to treatment services that are tailored to their individual needs (SAMHSA 2005; Williams et al. 2000). Proactively speaking, the Working Group further notes that offenders who are found to be at risk of developing a severe alcohol problem should be prioritized as well.

Overall, when and where offenders receive treatment depends on screening and assessment results, an offender's readiness for change, available programs and services, waiting times, cost of treatment and available finances. Depending on the offender's screening and assessment results, and the subsequent treatment referrals, substance abuse treatment may involve different techniques (e.g., brief interventions, motivational interviewing, treatment-matching, counseling, detoxification, medication, etc.), delivered under different models (i.e., harm reduction, behavioral model, etc.), and take place within three main types of care: outpatient, non-hospital residential, and hospital inpatient (DSAIS 2005; SAMHSA 2005).

There are a variety of forms of treatment with DWI offenders, including:

- motivational interviewing or motivational enhancement therapy;
- cognitive behavioral therapy;
- brief interventions;
- counseling/therapy (patient-centered or group);
- pharmacological intervention;
- detoxification; and,
- multi-program agencies.

Assessment results and available resources ultimately have an impact on which treatment techniques or approaches are provided for offenders, where the services are administered, and by whom.

Offenders may enter treatment programs voluntarily or as mandated by law. It should be noted that while some offenders may freely choose to enter treatment, (Young et al. 2004) argue that "voluntary" clients are rarely self-referred, but instead, enter treatment under some external pressures (e.g., from family, peers, and employers). Treatment may also be compulsory and mandated by law and offenders may have no choice but to attend. In 2002, justice referrals accounted for 655,000 substance abuse treatment admissions – an estimated 34 percent of the 1.9 million admissions in the Treatment Episode Data Set (DASIS 2004).

Findings from a longer-term study co-funded by NIDA and Veterans Affairs (VA) affirm the results of shorter term studies that have shown similar therapeutic outcomes for voluntary and legally mandated patients (Whitten 2006). Of interest, while references to constructs such as "therapeutic reactance" (Brehm 1966) are quite common in the criminal justice literature on treatment, they are less popular in the treatment community and such theories have never been empirically demonstrated, meaning that the debate regarding voluntary versus mandated treatment protocols maybe a moot point.⁶

⁶ For more information please see http://www.nida.nih.gov/NIDA_notes/NNvol20N6/Court.html.

Co-morbidity refers to the co-occurrence of two or more psychiatric disorders. Screening and assessment can also identify additional co-occurring problems associated with alcohol use that may also require treatment in order to alleviate an offender's problem behavior and prevent negative consequences. Several studies have demonstrated that alcohol use and drug use disorders are quite likely to co-occur at a higher rate among DWI offenders, particularly those with a diagnosis of lifetime use disorder. As a consequence "understanding the psychiatric profiles of repeat DUI offenders is important for developing and delivering effective treatment" (The Dram 2007, p. 1).⁷

Various entities throughout an offender's justice processing need the information derived from treating DWI offenders, and for different reasons. These include: judges, offenders, justice professionals, staff, and agencies, and policy makers. As mentioned earlier, treatment programs need to be sensitive to the unique needs (problems) of the offender. Accordingly, programs need to be sensitive to other differences among offenders, particularly socio-economic status, culture, and gender. For this reason, there has been an increasing recognition of the need for gender sensitive and competent treatment programs (e.g., Hennessey 2005).

Barriers to Screening, Assessment and Treatment

Justice practitioners may encounter a variety of barriers to applying screening, assessment and treatment opportunities to effect change among drunk driving offenders in need of substance abuse intervention. The source of these barriers can vary widely; some are more amenable to change than others. Common barriers include issues relating to: insufficient resources, research limitations, myths and misconceptions, practical concerns, challenges due to legislation, and implementation of interventions.

Resources: The amount of resources allocated towards screening, assessment and treatment in a given jurisdiction determines the number of DWI offenders who can be properly diagnosed and treated. Challenges in this area that are discussed include: the cost of screening, the quality of available screening instruments, the availability of staff to screen offenders, the availability of treatment interventions, and the lack of aftercare following treatment.

Research: The quality and quantity of research relating to the screening, assessment and treatment of DWI offenders is insufficient and/or inaccessible to allow practitioners to:

- a) identify and select reliable and accurate instruments that can identify and diagnose offenders with substance abuse issues;
- b) ascertain which interventions or strategies are most appropriate to apply to this group; and,
- c) select appropriate measures of effectiveness by which to evaluate success.

Challenges in this area that are discussed include methodological weaknesses in existing research, the validation of testing instruments, and the use of treatment matching.

⁷ For more information, visit <http://www.basisonline.org/2007/11/the-dram-vol-31.html>

Myths and misconceptions: There are a range of common myths and misconceptions relating to screening, assessment and treatment that can discourage justice practitioners from routinely applying these techniques as part of effective sentencing practices. This has occurred in part because much of the research in this area is not widely known to practitioners in the field, and also because much of this literature can be time-consuming to review and challenging to access and understand. These myths and misconceptions can be overcome with proper information. Issues discussed in this section include: the belief that screening is a time-consuming and resource heavy process; screening or treatment is expensive, coercive treatment is ineffective, and self-help programs qualify as treatment.

Concerns: There are a number of concerns about treatment that can discourage justice practitioners from incorporating treatment as a standard consideration of sentencing for DWI offenders. The concerns discussed in this section include: treatment is “soft on crime”, offenders participate in treatment to avoid tougher sanctions, the use of medications to treat substance abuse, the “one-size-fits-all” approach to treatment, and support for treatment options in rural communities.

Legislation: References to or support for screening, assessment and treatment are not consistently included as part of the sanctions for DWI offenses. In some instances, legislation pertaining to health and privacy may actually impede the effective delivery of treatment. Two priority issues discussed with regard to legislation include: treatment is not a sentencing priority and the challenges associated with information-sharing needed to apply effective treatment interventions.

Implementation: The implementation and delivery of screening, assessment, and treatment protocols is inconsistent within and across jurisdictions. The identification of those offenders in need of screening, assessment and treatment is challenging, and it is difficult to hold offenders accountable for their participation in and completion of mandated sanctions. Challenges in this area that are discussed include: inconsistent implementation, lack of accountability, institutional approaches, and obstacles to early identification.

Recommendations

Good research to guide decision-making: There is a substantial need for more definitive research relating to the screening, assessment and treatment of DWI offenders that can be relied upon by justice practitioners as a basis for the development of sound processing and sentencing strategies, and to guide the early identification of offenders in need of these forms of interventions. Many interventions require more rigorous evaluation, and require evaluation in combination with other strategies.

Practitioners need more information regarding what interventions can be combined to increase effectiveness. In addition, it is important that interventions that show promise are evaluated for both effectiveness in reducing alcohol problems and reducing impaired driving among a DWI offender population.

Greater efforts are needed to evaluate screening assessment and treatment interventions. More methodologically rigorous evaluations are needed, and more research is needed to

identify what combinations or packages of interventions have the greatest effect with which offenders.

It is critical that this research is clearly articulated in meaningful terms and made accessible to professionals to inform practice.

Education and cross-professional training: Education and cross-professional training opportunities are needed to assist practitioners in understanding evidence-based practices and promising practices as they relate to screening, assessment and treatment of DWI offenders. This knowledge can allow practitioners to make more informed decisions regarding what strategies are most likely to be effective with certain groups of offenders, and provide a better understanding of how offenders can benefit from various strategies.

Resource allocation: There is profound diversity within and across jurisdictions regarding how resources are applied to impaired driving offenders. More importantly, the agencies involved in the justice system, the role they play, and their level of influence can vary substantially. For this reason, it is challenging to develop a standard mechanism at a national or state level for incorporating screening, assessment and treatment in an effective manner.

Ideally, it may be more appropriate for the inclusion of such interventions for DWI offenders to occur as a function of community decision-making among local justice professionals who have the empirical knowledge of effective interventions and best understanding of how their system works. These practitioners are well-suited to identify the impact that impaired driving is having on their local communities and budgets beyond the justice system. More importantly, they are well-positioned to understand local operations and apply such interventions and strategies in a way that works and fits the needs of their locality.

Comprehensive services: Research has consistently shown that combinations of interventions have better outcomes than single interventions alone. “Combining strategies may be more effective, regardless of treatment length or intensity, because DUI offenders have diverse and complex problems, and offering varied approaches may help address this range of problems” (Dill and Wells-Parker 2006, p.43).

At the same time, there is a need for wraparound services to be partnered with interventions. The National Institute on Drug Abuse has identified a set of research-based core addiction treatment services that should be supported by wraparound services to enhance treatment retention and outcomes. (Ducharme et al. 2007). To date, few treatment interventions provide such comprehensive interventions or wraparound services, but this is slowly changing.

Consistent identification of appropriate offenders: Practitioners require simple strategies to consistently identify offenders in need of screening, assessment and treatment for alcohol abuse and related issues. Agencies should be encouraged, at a minimum, to use informal methods at every phase of the system and formal methods where appropriate and practicable.

Streamlined policies and practices: Practitioners require streamlined and effective strategies to apply screening, assessment and treatment. Such practices should provide them with more and comprehensive information to improve decision-making throughout the processing of offenders so they can use it to effectuate the goal of reducing the rate of recidivism and changing the behavior of the offender. Such practices should also require limited time and be easily applied to facilitate an increase in screening, assessment and treatment.

Information-sharing protocols: There is a critical need to share information from screening/assessment and treatment with offenders. By sharing this information, offenders may be moved towards readiness for change and it can allow offenders to recognize the effects of their drinking and create a sense of legitimacy and fairness for the sanctions imposed (procedural justice).

There is also a need for information-sharing across agencies (e.g., courts, probation, treatment, service providers) to increase accountability among offenders and to ensure that interventions are effectively and appropriately applied. Increased information-sharing can reduce opportunities for offenders to fail to appear or “opt-out” of programs and increase the level of monitoring, which has been shown to improve treatment outcomes (Hon 2004).

Accountability and aftercare: It is important for practitioners and policymakers to recognize that relapse is normal and does occur with some frequency. This is not to suggest that treatment does not work. It merely reflects the intensity of addiction that some offenders struggle to overcome. In legitimate treatment settings the expectation is that a person will relapse rather than not.

Two important elements that can reduce the risk of relapse are accountability and aftercare. During any intervention, monitoring of offender behavior can improve outcomes by ensuring that offenders are accountable for their behavior and that successes are positively reinforced and further encouraged. Similarly, aftercare to provide offenders with ongoing support to maintain behavior changes and reduce opportunities for offenders to return to old habits can have tremendous benefits.

1.0 Purpose

This report is based upon discussions at the 4th Annual Meeting of the Working Group on DWI⁸ System Improvements, held at the Kingsmill Resort and Spa, Williamsburg, Virginia, March 4-6, 2007.

It seeks to inform justice professionals and policy makers about the importance of screening, assessment and treatment of DWI offenders, examines the strengths and limitations of the process and issues related to it, and identifies a number of priority recommendations for improving the application of quality screening, assessment and treatment to DWI offenders.

1.1 Rationale

Research has consistently demonstrated that a significant percentage of DWI offenders are known to be alcohol dependent or have issues related to alcohol abuse (Baker et al. 2002; Maruschak 1999), so an efficient and effective method is needed to determine the nature and extent of such problems, and referral to effective treatment is critical for those who need it. Of equal concern, according to the Centre for Substance Abuse Treatment (CSAT), approximately 95 percent of those assessed as needing treatment do not feel the need to participate in treatment (Robertson 2007). The relevance of this for justice professionals is underscored by the fact that they provide more referrals to treatment than any other source, so they should be well informed about the screening and assessment process and treatment itself (Gallant 2007).

Despite the growing interest in, and acceptance of, treatment as a key component in the array of countermeasures needed to deal effectively with convicted drunk drivers, many policy makers and practitioners remain skeptical about the value of substance abuse treatment. As testimony to this, less than 1 percent of the incarcerated population in the U.S. is in therapeutic care (Taxman 2007). Those who do recognize the value of treatment are often unfamiliar with research on the effectiveness of various treatment modalities for alcohol addiction, or how to appropriately apply such approaches to offenders.

Without adequate information to guide decision-making in impaired driving cases, traditional and popular short-term solutions, such as incarceration and the enforcement of probation supervision, are relied upon to address the impaired driving problem. This despite the fact it is estimated that some 16 percent of the jail population have mental health disorders and some 40 percent of people on probation have alcohol or drug problems (Robertson 2007). Of particular significance, impaired driving offenders account for almost 20 percent of the probation population – an estimated 3.9 million offenders (DOJ 2001).

⁸ The abbreviation DWI (driving while impaired, or intoxicated) is used throughout this report as a convenient descriptive label, even though some states use other terms such as OUI (operating under the influence) and DUI (driving under the influence), and in some cases these terms refer to the severity of the offense. We have used DWI not only to maintain consistency throughout the report but also because it is more descriptive of the offense usually associated with hard core drunk drivers.

These statistics underscore the fact that traditional approaches or approaches that do not address alcohol and other related problems will be limited in their effectiveness.

Accordingly, there is a need to provide justice professionals and policy makers with a resource document that contains practical information about the value of the treatment process for impaired driving offenders, how it fits within the justice system, and provides insights into some of the barriers to this approach and how these can be surmounted. That is the purpose of this document. It is designed to provide justice professionals and policy makers with practical information about the screening, assessment and treatment of impaired driving offenders and share the concerns of practitioners regarding some of the barriers they face in applying these approaches.

2.0 Background

Drunk driving has been a prominent public concern and social issue in the U.S. for almost three decades. During this time, governments, private sector agencies, and health and safety organizations developed a wide range of initiatives to discourage and reduce impaired driving. Consistent with this collective action, and in conjunction with improvements in vehicle design and road infrastructure, significant reductions in the number of alcohol-related fatalities and injuries were achieved in the 1980s and early 1990s.

However, within the last decade, progress has stalled and, in some instances, been eroded. In 2006, 13,470 people were killed in crashes involving a drunk driver. A disproportionate part of the problem is believed to result from the persistent behavior of hard core drinking drivers – offenders who drink and drive frequently, often at high blood alcohol concentrations (BACs), and who may have a history of prior convictions and/or alcohol abuse (Simpson et al. 2004). This group of offenders has been widely recognized by government, traffic safety, justice, research agencies and not-for-profit organizations as posing a substantial threat on the roadways. And, commensurate with this recognition has been the development of primarily policies and to some degree programs to address this dangerous group.

At the same time, informal evidence suggested that impaired driving offenders in general, and hard core drunk drivers in particular, are not consistently subjected to the very programs and policies that were implemented to protect the public and change problem behavior. In essence, the persistent nature of some offenders in combination with inadequacies in the justice system were allowing these offenders to avoid detection, arrest, prosecution, conviction, and sanctioning.

Hard evidence that this was indeed the case came from a comprehensive review of the justice system conducted by the Traffic Injury Research Foundation – TIRF (Robertson and Simpson 2002a; 2002b; 2003a; Simpson and Robertson 2001). This series of studies involved more than 5,000 justice practitioners who pinpointed problems at all phases of the DWI system (enforcement, prosecution, sanctioning, monitoring) that impeded the efficiency and effectiveness of the system for dealing with hard core drinking drivers. Police officers, prosecutors, judges, and probation officers identified priority problems in the system (e.g., evidentiary issues, inadequate or inaccessible records, complex laws, failure to appear) that enabled offenders to avoid the very sanctions put in place to prevent repeat offending. Of added importance, this research suggested that, as a result of the weaknesses in the system, many offenders were able to avoid identification as “repeat” offenders and the penalties often associated with this status.

On a more optimistic note, this research revealed that many of the system problems were cross-cutting and affected all segments of it, underscoring the fact that improvements to just one part of the system could have positive reverberations throughout. In this context, the justice professionals involved in the research identified practical solutions designed to address the systemic issues and complement legislative efforts by ensuring that offenders were subject to the programs and penalties put in place to protect the public and change problem behavior.

Solutions were grouped according to six key recommendations:

- improve communication and cooperation within and between professional groups as well as among other key stakeholders;
- enhance training and education for all professional groups, especially cross-training initiatives that bring together professionals whose work is intimately connected in the system;
- prioritize the expanded, uniform use of new products and technologies that can improve the identification, processing, and supervision of hard core repeat offenders;
- simplify and streamline existing DWI statutes;
- develop, improve and evaluate record systems to promote integration and to coordinate data-sharing capabilities among agencies that will ensure timely access to appropriate, accurate, and current information; and,
- enhance resources and/or allocate them more effectively to ensure agencies and professionals can achieve their goals and objectives.

Since the completion of this research in 2003, the findings and practical recommendations flowing from it have been embraced by government, not-for profit, research, traffic safety and justice agencies across the country. To advance the recommendations, TIRF subsequently formed an action coalition in 2004 in cooperation with fourteen justice organizations representing police, prosecutors, judges, probation officers, and treatment professionals. This “Working Group on DWI System Improvements” was created to provide leadership, guidance and practical strategies that practitioners can use to improve the efficiency and effectiveness of the justice system for dealing with hard core offenders. For more information about the Working Group, please see www.tirf.org.

Since 2004, the Working Group has produced a series of reports examining available and needed initiatives to address impaired driving, and describing programs that represent promising practices. It has also provided reports on priority issues including a guide to streamlining and simplifying DWI legislation, and a report that illustrated what justice practitioners need at each phase of the system to improve the delivery of ignition interlocks to offenders.

In 2007, the Working Group focused its attention on the need for more training and education for practitioners, particularly in relation to the importance of substance abuse interventions as a means of changing behavior. Although many practitioners believe that treatment of an offender’s drinking problem is an important component of sentencing and is necessary to achieve long-term risk reduction and enhance public safety, they acknowledge having limited information about how to identify appropriate offenders, or what strategies are best-applied to whom. The present report was designed to address this need and provide practitioners and policy makers with an overview of how screening, assessment and treatment for impaired driving offenders functions within the DWI system, and illustrate some of the barriers that can impede the effective implementation of this process as well as ways they can be addressed.

3.0 Introduction

For more than 150 years, there have been two primary goals of the justice system – to protect the public and to change offending behavior. These two important, albeit sometimes conflicting, goals are necessary to promote and enhance long-term risk reduction. They are most often achieved using a combination of strategies based on deterrence, incapacitation (including incarceration as well as other control strategies), punishment and rehabilitation to reduce and prevent criminal behavior and increase public safety.

The relative importance assigned to these strategies has varied over time as a function of such things as: 1) how criminal behavior is understood and, 2) prevalent social norms. For example, following a period in the 1970s during which rehabilitative approaches designed to change behavior were widely supported and endorsed, the 1980s heralded a “tough on crime” philosophy. This paradigm shift occurred due to a widespread belief that “nothing works” in the field of offender rehabilitation (Martinson 1974). Moreover, approaches embracing rehabilitation (e.g., substance abuse treatment) were perceived as being “soft on crime” and doing little to prevent recidivism. As a consequence this new, punitive approach was broadly adopted for all offenders, including drunk drivers.

Of some concern, this paradigm shift led governments to implement legislation and programs which placed a greater emphasis on protecting the public through the use of increased penalties and harsher and longer sentences, often involving surveillance, control and incarceration. Not surprisingly, these policies resulted in a population explosion within correctional institutions and the rapid expansion of community corrections. Yet, while more staff and resources were required to house and manage the influx of offenders and accommodate increased security and surveillance, often these policy and program changes were not accompanied by increased funding – so-called unfunded mandates. As a result, many agencies were required to “do more with less”, so rehabilitative goals often became secondary and compliance with sentencing conditions waned.

Today, the effects of this punitive approach are still evident as justice agencies routinely cope with unmanageable caseloads and workloads, significant delays in case processing, overcrowded programs, and extended wait times for treatment and other programming. At the same time, the increased demand for incapacitation, surveillance and enforcement over the past two decades has substantially eroded the ability of practitioners to encourage and reinforce behavior change using various rehabilitative techniques, including substance abuse treatment.

This situation has considerable implications for drunk driving offenders and the public that cannot be overlooked. First, almost all drunk-driving offenders who are incarcerated are eventually released from prison or jail and returned to the community. Many of them have alcohol addiction or dependence issues that are not appropriately identified and/or addressed in a prison or jail setting. This means that many will likely continue drinking and driving after they have been released, placing the public at risk.

Secondly, there are significant cost and resource implications associated with a reliance on incarceration and surveillance. The average daily cost of incarceration in a state or federal prison is estimated at \$62 (Stephen 2004). There are also costs associated with housing offenders in local jail facilities and/or hiring probation officers to supervise offenders within the community. Even a home arrest system with alcohol monitoring costs US\$10-\$15 per day (Barrasse 2005). It must be noted that these costs are associated with the monitoring of the equipment and do not include the costs of follow-up by probation officers to take action on alerts.

This over-reliance on a punitive approach has also resulted in extensive overcrowding such that most prison and jail facilities house two to three times the number of offenders for which they were designed – it is estimated (Robertson 2007) that there are currently more than 2 million people in U.S. prisons and jails, giving the U.S. the highest per capita incarceration rate in the world (Taxman 2007; Pew Charitable Trusts 2007). As a result, many DWI offenders are frequently released from custody without serving any time at all because there is “no room” for them. In the same vein, the caseloads of probation and parole officers have expanded – there are some 750,000 people on parole (Robertson 2007) and an estimated 18 percent of the probation population (or 702,000 offenders) are DWI offenders (Robertson and Simpson 2003a). As a result, the ability of probation and parole officers to supervise offenders is nominal and “probation has deteriorated such that it is no longer taken seriously as a sentence by either offenders or the public” (Robertson and Simpson 2003a, p.70).

More recently, the limitations of a solely punitive approach have been clearly recognized by both researchers and practitioners, although there is still not widespread acceptance or understanding of these limitations at a political or public level – the “get tough” philosophy still dominates much of the application of justice.

There is, however, at the same time, a growing recognition of the importance and benefits of treatment as an alternative or complement to these measures. Research has demonstrated that properly-designed and administered treatment has beneficial effects (Taxman 2007), including reductions in recidivism, that translate into long-term risk reduction and public safety.

To this end, many justice practitioners now recognize that a combined approach incorporating punishment, surveillance, and treatment are essential to protecting the public while simultaneously changing the behavior of drunk-driving offenders. As an example of this, drug/DWI courts that embrace this philosophy of treatment, incapacitation and supervision have become widely popular due to the apparent reductions in recidivism that have been achieved with this approach.

Treatment is a key to the needed behavior change since it addresses the root causes of impaired driving for many offenders. But not all DWI offenders need treatment or the same kind of treatment, so an efficient and effective system requires a means of early identification of those most at risk of alcohol and drug problems and those who are already harmfully involved. This is the goal of screening and assessment, which are an integral part of the treatment process. The next section examines the process of screening, assessment and treatment.

4.0 Screening, Assessment and Treatment

Traditionally, each of these three components has been highly interdependent and sequential. Screening has been the initial process to determine quickly which offenders require further more detailed evaluation to assess the nature and extent of their alcohol abuse/dependency issues – this more detailed evaluation is referred to as assessment. The nature and extent of the subsequently prescribed treatment is based on this assessment. Screening and assessment are viewed, therefore, as the linchpins to treatment (Gallant 2007).

4.1 Screening

Screening is normally a precursor to assessment and treatment. “Screening refers to the application of a test to members of a population...to estimate the probability of their having a specific disorder” (Steward and Connors 2004/2005, p.1). It is a process designed to identify who can be excluded from a more detailed examination for the presence of substance abuse issues, and who needs to be included for further examination or assessment. It is “the process of identifying whether or not an individual is an at-risk drinker who may be likely to develop or have an alcohol problem” (NASADAD 2006, p.3). Screening can ascertain “...who needs further assessment to determine the extent of his/her alcohol problems” (NASADAD 2006, p.3).

Given that assessment itself can be relatively labor intensive, costly, and impractical for all offenders, screening is designed to be a reliable and efficient filter for determining who needs assessment and who does not. Screening is usually based on the results of specific testing instruments given to offenders to establish whether they have an alcohol-use disorder (AUD) and/or a drug-use disorder that requires some form of substance abuse treatment intervention. The presence or absence of such a disorder also provides important insight into an offender’s potential risk of future DWI recidivism (Chang et al. 2002). Screening is not designed to explain the nature and severity of alcohol use problems, but rather to “raise suspicion” of them (Connors and Volk 2003) and determine whether or not further assessment is warranted. As such, screening is an important first step in the broader process of substance abuse treatment.

Depending on the nature of screening that occurs (i.e., informal vs. formal) and the type of instruments that are used, screening may be administered by criminal justice practitioners or by a variety of addictions professionals who may fall along a continuum with regard to ability, interest, and accuracy. The advantage of relying upon addictions professionals is that not only do they have the ability or developing ability to use that screening time to administer a brief intervention (for more information about brief interventions see page 33 of this report), but they also have ready access to colleagues with alcohol and other drug use experience for consultation purposes.

In the more traditional approach, screening is a single event (or test) administered as a precursor to assessment. For example, Lacey et al. (1999, p.1) note that “Throughout the U.S there is a growing trend for courts to conduct a preliminary screening of DWI offenders for alcohol problems either prior to sentencing or as a component of the sentence. This screening typically takes the form of the administration of a relatively brief

screening instrument. The results of that test are used to help decide whether the DWI offender is sent on to further assessment and treatment as part of the sentence for DWI”.

However, the characteristics of screening have changed somewhat over the past few years, so the distinction between it and assessment has become blurred. For example, historically screening often entailed the administration of a single evaluative instrument, the results of which guided the decision regarding the need for more detailed clinical assessment. However, today in some cases the results from the screening instruments are actually used to make the final determination of whether an offender receives treatment – i.e., screening per se is used as an assessment (Chang et al. 2001). Indeed, in some cases, formal assessment might be by-passed altogether – i.e., in this situation screening *becomes* the assessment. This blurring between screening and assessment may pose a greater problem with regard to the hard core offender who requires a more thorough approach to interrupt their addiction patterns.

Also, traditionally, the screening process has involved the formal administration and scoring of a test/instrument. Increasingly, however, screening is also based on less formal methods and data collected from case files to more easily gain vital information about an offender’s substance use, abuse, or lack thereof. Screening using less formal methods (e.g., BAC readings, criminal record checks, offender’s history of treatment, etc.) requires little or no training and can be done by practitioners themselves simply by looking through existing case files or contacting relevant agencies (see the section below on Screening and Assessment Instruments for a description of some of the less formal methods and data sources). However, it should be noted that according to the research literature, the use of actuarial-based tests almost always greatly out-performs intuitive judgment when it comes to screening and assessment.

Moreover screening has evolved in the past decade from an initial guiding function to a process that occurs at several points during the subsequent treatment phase as a means of monitoring offender progress (i.e., repetitive screening or re-screening). This involves tracking an offender’s progress in the system and assessing their compliance with and progress in court-initiated treatment (Chang et al. 2001; Gallant 2007). However, excessive caseloads in both the justice and the treatment systems can make this difficult. As such, some offenders may be moving through the stages of change while the information in clinical records may not reflect that due to heavy paperwork requirements.

Today, the screening process may even be regarded as a form of treatment – a brief intervention. That is, exposure to the screening process is seen to have therapeutic benefits (D’Onofrio and Degutis 2002; Wilk et al. 1997; Wells-Parker and Williams 2002).

Formal screening can involve testing and interviewing (Chang et al. 2001). Both these may take place in a variety of settings (e.g., probation office, health care setting) and may or may not require additional training. Testing refers to the administration of self-report assessment instrument(s) that are applied to evaluate an offender’s history of alcohol and drug use. These tests may involve self-administered questionnaires using either paper-and-pencil formats or computer-assessments. Some of these tests may also be applied via brief interviews with trained professionals (Connors and Volk 2003).

These multiple-choice tests range from less than 10 items (e.g., CAGE) to up to 350 items (e.g., Computerized Lifestyle Assessment – CLA) (Connors and Volk 2003). Generally, the scoring of these tests can be rather simple. Further details are provided below in the section on Screening and Assessment Instruments. While both self-administered and interview-based assessments are common in a criminal justice setting, it should be noted that interview-based assessments are the more favored approach from a research perspective.

Interviewing involves employing specially trained personnel to meet with offenders and further clarify circumstances of the arrest and to learn about any family, medical, personal, or legal problems that may indicate a need for an assessment/treatment referral (Chang et al. 2001).

Summary. *The key point is that screening, once regarded as a quick and relatively simple method of ascertaining who needs additional assessment to determine the nature and extent of their alcohol/drug problems, has been broadened to the point where it is often synonymous with assessment, has been expanded to occur at several points in the treatment process itself as a means of monitoring progress, and in some cases is considered an inherent part of the treatment process itself because of its therapeutic potential.*

4.1.1 Who is involved in the screening process?

Given the diversity of approaches taken to screening today, a wide variety of individuals may be involved in the screening of DWI offenders (Chang et al. 2002; CSAT 1994; NASADAD 2006).

Screening professionals may include:

- police officers;
- prosecutors;
- magistrates or judges;
- court assessors;
- counselors;
- clinicians;
- offenders themselves;
- city and county jail employees;
- hearing officers or probation officers; and,
- pre-trial staff.

Who delivers the screening is often a function of which setting or point in the justice system that the screening takes place and whether informal or formal methods are used. The majority of available screening instruments can be administered by clinical, administrative or clerical staff with a minimal degree of training, and many instruments can be self-administered (Connors and Volk 2003). Although some screenings can be administered and scored without significant training, referral decisions for assessment and/or treatment are greatly improved when they are made by professionally trained

staff (SAMHSA 2005). This includes staff that has the appropriate certifications in substance abuse treatment, those with advanced professional degrees, and those with specialized training in the use of particular screening and assessment instruments (SAMHSA 2005).

Screening that requires an interview with the offender often requires specialized training in addition to basic counseling techniques, such as rapport building and reflective listening (see Chang et al. 2001). The use of trained professional staff in the triage and placement process helps to minimize the number of inappropriate referrals for treatment.

4.1.2 Who needs the information gathered during the screening process?

Practitioners at various stages of the justice system may require information gathered during the screening process to inform decision-making. These include:

- prosecutors;
- judges;
- assessors and treatment providers;
- probation and pre-trial officers;
- prison and jail staff; and,
- defendants/offenders.

Prosecutors. Prosecutors can benefit from data gathered by police using informal screening methods as well as information gathered using formal screening instruments. This information can assist them in determining how to proceed with a particular case and what sanctions may be most appropriate to recommend. For example, a prosecutor will need to know such things as the driver's BAC level, drinking history and prior criminal history if any. This information may impact pre-trial and pre-sentencing reports, release or sentencing recommendations advanced by the prosecutor, and influence the outcome of cases.

Judges. Similarly, judges require screening results at various stages of the offender's justice processing including pre-trial hearings, sentencing, and post-sentencing hearings. This information can guide their decision-making as they devise appropriate release conditions, sanctions or reinforcements for defendants/offenders.

Assessors and treatment providers. These professionals require screening results in order to identify the need for further assessment as well as to develop treatment plans based on offender needs.

Probation and pre-trial officers. In their efforts to effectively monitor defendants/offenders in their caseload, screening may assist officers in identifying the level of risk posed by defendants/offenders. The re-screening of offenders can be beneficial for tracking their progress while receiving, or following the completion of, treatment.

Defendants/Offenders. Many defendants/offenders do not have the opportunity to understand on what basis their level of risk is determined or to see the results from standardized screening tests. It is important to share with defendants/ offenders the information that is gathered during the screening process and explain how it contributes to risk-assessment, release conditions and sentencing. This information can allow defendants/offenders to better understand responses to their behavior and the ways in which they are processed through they system. Involving defendants/offenders in the process can raise their awareness regarding what decisions are being made about their own behavior (e.g., further assessment, treatment designs). This can assist defendants/offenders in understanding and complying with what decisions are made regarding interventions and accepting the interventions as meaningful and appropriate as opposed to punitive (Taxman et al. 2004).

4.2 Assessment

The Substance Abuse and Mental Health Services Administration (SAMHSA) is a federal agency charged with improving the nation's system of services for the prevention and treatment of substance abuse and mental health, including Department of Justice programming. SAMHSA defines assessment as “a process for defining the nature of a problem and developing specific treatment recommendations for addressing the problem” (2005, p. 7-8). Its purpose is to confirm the presence and severity of the “problems” and identify the appropriate level of care needed to address them. Traditionally, the need for more detailed assessment of alcohol use disorders (and other related problems) is determined by the results of the preliminary screening. However, as noted above, screening is often by-passed and the process moves directly to assessment.

As Beirness et al. (1997) noted, the rationale for assessing and subsequently treating DWI offenders is based on the hypothesis that problems associated with impaired driving can best be resolved by addressing the underlying problems that give rise to the behavior, most notably, problem drinking.

To address underlying problems, assessments are designed to:

- determine the extent and severity of the offender's substance abuse problems;
- determine the offender's level of maturation and readiness for treatment;
- ascertain related (co-morbid) problems, such as mental illness;
- determine the type of intervention necessary to address the problems;
- evaluate the resources offenders can assemble to help solve the problem(s), (i.e., family support, social support, educational and vocational attainment, and personal qualities such as motivation); and,
- engage the offender in the proposed treatment process (SAMHSA 2005).

In addition, assessments may identify factors leading to potential gaps in services that can affect an offender's relapse and criminal recidivism (SAMHSA 2005). These factors include: lack of social support networks, unstable employment history, poor health, criminality, unresolved legal problems, inadequate housing, lack of motivation to change, a history of physical and sexual abuse, mental illness, learning disabilities, and other

socio-psychological and criminogenic factors. These variables are all of major significance in suggesting the intensity and nature of the intervention needed (Allen 2003).

Briefly, assessing an offender's suitability for treatment can determine not only the nature and extent of problems that need to be addressed but also whether or not they are capable of benefiting from treatment or responding to a particular intervention (SAMHSA 2005).

The assessment process typically involves a combination of paper and pencil testing, clinical interviews with the offender, personal history taking, and biological testing (CSAT 1994). Key information is gathered about the offender to help the counselor identify problem areas, disabilities, strengths and weaknesses; determine the offender's readiness for change; and, in some cases, reach one or more diagnoses (CSAT 1994; SAMHSA 2005).

In contrast to screening, assessments are more formal, comprehensive, require specially trained practitioners, generally take place in mental health or health care settings, and may take longer, especially when additional in-depth assessments are needed. Assessments serve to establish a definitive diagnosis of a disorder; as discussed previously, initial screening serves to identify people who are likely to have the disorder (Steward and Connors 2004/2005). It should be noted that some insurance policies may require either screening or an assessment as a criteria for the reimbursement of treatment costs.

The depth and scope of assessments vary across settings according to a variety of factors (SAMHSA 2005), such as the:

- amount of time available to conduct the assessment;
- physical setting of assessment (e.g., holding pen, booking room, medical unit, reception center, lockup, community/corrections office);
- factors influencing the confidentiality or privacy of the assessment process and the uses of assessment findings;
- availability of qualified staff, caseload volume, and interagency cooperation;
- availability of financial resources (e.g., staffing, type of assessment chosen);
- availability of treatment options in the community; and, the number of sources of information.

Following assessment, a specially trained clinician may determine that the offender could benefit from a brief intervention, or from referral to a treatment program if they meet the criteria of alcohol use or dependence (NASADAD 2006). For example, a history of drug/alcohol use may suggest a need to conduct a comprehensive assessment to: determine the nature of an individual's drug problems; establish whether problems exist in other areas that may affect recovery; and enable the formulation of an appropriate treatment plan (NIDA 2006).

Offenders may also be continuously re-screened and re-assessed during and following treatment to monitor for positive progress towards treatment goals (Gallant 2007). If offenders are "off track", such measures can help identify problem areas that may be

affecting treatment success and treatment plans may be adjusted accordingly to ensure that goals are met and to prevent opportunities for relapse. Of interest, research has shown that the stages of change (i.e., pre-contemplation, contemplation, preparation, action, and maintenance) are decidedly different and each stage requires different types of mastery of skills in order to move to the next stage. Stage appropriate interventions make a difference but have not yet been applied to DWI offenders.

4.2.1 Who is involved in the assessment process?

Different titles may be used when referring to those who administer assessments (e.g., health care/service professionals, counselors, clinicians, service providers, etc.) but these professionals usually possess specific qualifications (Chang et al. 2002; CSAT 1994; Kerwin et al. 2006; SAMHSA 2005).

Qualifications of assessment professionals may include:

- competence in alcohol and other drug programs (i.e., addiction counseling, licensed social worker);
- credentials and/or certification as alcoholism, substance abuse, or chemical dependency counselors; and/or,
- special training in basic counseling techniques (i.e., rapport building, reflective listening) in preparation for interviewing offenders.

Ongoing training and supervision are critical to ensure the skill level and accountability of the service providers (CSAT 1994), and to help minimize the number of inappropriate referrals for treatment (SAMHSA 2005).

Assessments can be done by independent assessment groups (such as a system-wide central intake unit or an independent program) or by the same professionals who will be providing treatment depending on the jurisdiction, if it is determined that the type of intervention they provide is appropriate for the particular client (CSAT 1994). (It should be noted that if the agency conducting the assessment is providing any recommended treatment this may be a conflict of interest, although to date the treatment field has not reached agreement on this issue). Providers often exist along a continuum from those who always do the right thing to those who never do. As such, the separation of duties may not improve outcomes. However, the Treatment Alternatives for Safer Communities in Illinois is a good example of an independent screening and assessment program that works closely with the justice system for referral to treatment and case management. For more information, please visit <http://www.tasc.org/preview/abouttasc.html>.

In this context, in a sample of 10,334 “facilities” derived from those listed in the 2000 edition of the National Survey of Substance Abuse Treatment Services (N-SSATS) published in October 2001, McLellan et al. (2003) found that approximately 60 percent of the service provider agencies were private nonprofit, 26 percent were private for-profit, and 11 percent were government-owned (e.g., Department of Veterans Affairs; state-owned agencies, etc.). Also, some 78 percent of the programs in the sample provided outpatient, abstinence-oriented treatment (intensive outpatient and

traditional outpatient); inpatient or residential care was provided by 12 percent of the programs, and methadone maintenance by 10 percent of all programs. Other types of programs that were not included in their sample were in-prison programs, private office practices, and adolescent-only programs (McLellan 2003).

4.2.2 Who needs the information gathered during the assessment process?

Various professionals at different points in the justice system need the information derived from assessing DWI offenders. This includes judges, probation officers, treatment providers, jail and prison staff, and the offenders themselves. The ability of these practitioners to access this information may be constrained due to the Health Insurance Portability and Accountability Act (HIPAA) and confidentiality issues. In some instances, these issues can be addressed through the use of consent forms, privacy releases, and agreement of specific data elements that can be shared as opposed to complete assessment results.

Judges. The results of assessments (i.e., clinical diagnosis, whether or not the client agrees, their readiness for treatment, etc.) have important legal ramifications since judges can use this information at a variety of decision-making/disposition points, such as pre- and post-sentencing (CSAT 1994; SAMHSA 2005). Obviously, if the assessment information is to guide and inform the sentencing process, it must be evidence-based and relevant.

Probation officers. Offenders can be re-assessed to determine their readiness for treatment, and following treatment services, to monitor their progress towards treatment goals. Assessment results may be used to redesign treatment and supervision plans accordingly.

Treatment providers. Treatment providers require screening and assessment results in order to understand the needs of the offender. Without this information (i.e., knowledge and context of referrals), the offender's needs and problem areas may not benefit from the treatment.

Offenders. There is a need to relay assessment information back to offenders because most have not seen their actuarial risk charts or results from standardized tests. When presented with this information, offenders may be overwhelmed by the findings and it is important that feedback be provided in a clear, concrete, organized fashion and reviewed slowly to assure that the offender fully understands the assessment results (Allen 2003; Gallant 2007) and their implications. More importantly, the type and amount of information given to an offender based on the stage of change they are in can either advance or impede their continued progression through the stages of change.

4.2.3 Providing feedback.

In this context, Allen (2003) offers suggestions for effectively providing feedback to offenders. First, various techniques can be used, such as visual displays (i.e., plots or graphs) and asking clients to summarize test findings in their own words and to reflect on the meaning they ascribe to them. Second, asking clients to give concrete examples

to illustrate the findings may further their understanding of the information. And third, showing offenders how the findings influence the development of treatment plans is important because recognizing the coherence of the process with their own personal needs should further motivate them to actively participate in treatment.

The Center for Substance Abuse Treatment (1994) has also offered suggestions regarding how to present assessment findings. The results should be presented in a valid, reliable, simple document, one that can be replicated, and contains data that will be relevant in treatment. A good assessment avoids excessively simplistic formulations that reduce an offender to a number, a score, a check list, or a label. The data backing up the assessment should be presented in language that is jargon-free and can be understood by all relevant personnel, including the offender and their attorney.

Essentially, a condensed report containing assessment results should be presented with at least three definable and well-organized sections:

- an introduction, explaining how this assessment came to be, who ordered it, and why;
- a section on methodology, explaining how the data were collected, what tests were used, and how the results were interpreted; and,
- a straightforward presentation of the data gathered, followed by a clinical impression and recommendations for additional assessment or treatment referrals (i.e., a strategic management plan).

The narrative document should also include a defensible paragraph or two that explains how and why the assessor reached their conclusions.

While assessment results can be useful to a number of different individuals and agencies, in many cases they cannot be presented to anyone – including the judge or referring justice representative – without the signed consent of the offender, in accordance with Federal confidentiality regulations (CSAT 1994). Once a client is asked to sign a release, he or she should know the precise reason for the release and understand what is covered in it (CSAT 1994). Please refer to the Federal Confidentiality Regulations, 42CFR (http://www.access.gpo.gov/nara/cfr/waisidx_02/42cfr2_02.html) for more information regarding this issue.

4.3 Screening and Assessment Instruments

From a clinical diagnosis perspective, screening and assessment instruments are important in order to identify those individuals who actually have a problem such as alcohol dependence and who require further intervention. At the same time, it is important to be able to identify those who do not require such intervention. To be effective, it is important that screening and assessment instruments are validated on a DWI population to ensure the instruments can accurately predict outcomes in a majority of cases. Hence a good test instrument should have both sensitivity and specificity – i.e., meaning it can identify correctly those who have a problem and those who do not. Sensitivity of the testing instrument refers to its ability to correctly identify people who

have the problem (true positives). It is measured by the proportion of people with the problem (e.g., alcohol dependence) who have a positive test result. Specificity refers to the ability of the testing instrument to correctly identify those people who do not have the problem (true negatives). It is measured by the proportion of people who do not have the problem who have a negative test result.

A test instrument that has good sensitivity and specificity is important because it enables practitioners to minimize the identification of false positives and false negatives. A false positive is someone who tests positive but who is actually negative (e.g., the test shows the person is alcohol dependent but in fact they are not). A false negative is someone who tests negative but is in fact positive (e.g., the test shows the person is not alcohol dependent when in fact they are). So false positives mean that limited resources are wasted on offenders who don't need treatment and false negatives mean that offenders who need treatment do not receive it.

The number and variety of formal instruments/tests used in screening and assessment is quite extensive and a review of them is beyond the scope of this report. The reader is referred to several recent reviews for detailed evaluations of the more popular ones (see Chang et al. 2001; Lacey et al. 1999). To access the full report, please visit <http://www.aaafoundation.org/pdf/dwiscscreeningreport.pdf>.

It is generally accepted that no screening or assessment tool currently available has been tested or validated specifically on a DWI population (Lacey et al. 1999). However, many of the available instruments have adequate sensitivity and specificity for reasonably identifying alcohol use disorders (Stewart and Connors 2004/2005) and can be used with confidence for this purpose (Lacey et al. 1999). It must be noted, however, that instruments are generally more effective once they have been adapted and are more suited to a particular population (e.g., DWI offenders, female offenders, juvenile offenders, and minority populations).

In this context, Lacey et al. (1999) studied the predictive validity of several screening/assessment instruments – Substance Abuse Life Circumstances Evaluation (SALCE), Michigan Alcoholism Screening Test (MAST), Mortimer Filkins (MF), Driver Risk Inventory (DRI), and CAGE. They found that most instruments have not been “normed” on a DWI population and concluded that further validation work is also needed to ascertain the predictive validity of these tests. However, they also concluded that, “in the meantime, program administrators using any of the instruments listed above can be confident that they are identifying a large proportion of the problem drinkers in their client pool for further assessment and treatment” (Lacey et al. 1999).

As noted above, screening and assessment can include both less formal and formal measures/indicators that will assist in identifying the nature and extent of alcohol, drug and other problems.

The use of less formal indicators is illustrated in a study by TIRF (2001) that explored the development of an early identification program for repeat DWI offenders in Suffolk County, New York. It found that numerous factors were predictive of a subsequent arrest for DWI and these were included in a Risk Assessment Check List to be used by prosecutors in preparing for sentencing.

Less formal factors to consider during assessment include:

- alcohol-related problems (including frequent and heavy consumption);
- driving-related problems (prior moving convictions, collisions, license suspensions, reckless driving convictions);
- criminal history;
- high BAC at time of arrest;
- refusal to provide a breath or blood sample;
- prior DWI convictions (beyond a five-year window);
- arrest during daytime hours;
- marital status;
- frequent job changes; and,
- socially deviant personality traits (high levels of aggression, hostility, recklessness, thrill seeking).

The Working Group on DWI System Improvements concluded that a very promising tool (Gallant 2007) for determining the severity of abuse of alcohol and other drug problems is the Addiction Severity Index (ASI). The ASI is a 161-item multidimensional clinical and research instrument for determining severity of abuse of alcohol and other drugs and how they may be contributing to the offender's problem.

The premise of the ASI is that addiction must be evaluated within the context of problems that may have contributed to or resulted from alcohol or other drug use (CSAT 1994). It is highly correlated with objective indicators of addiction severity, is one of the few instruments that measure several different functional aspects of psychosocial functioning related to substance abuse, and it provides a concise estimate of the history of substance abuse as well as recent use (SAMHSA 2005). Specially trained clinicians interview offenders in roughly 45-75 minutes (SAMHSA 2005), collecting data to estimate the client's level of discomfort in seven areas: alcohol use, medical condition, drug use, employment, financial support, illegal activity, family and social relations, and psychiatric problems (CSAT 1994).

In this context, the ASI is the first standardized effort to assess problems other than just alcohol and drug addiction. The ASI incorporates both the client's and the assessor's evaluation of his or her needs and priorities (CSAT 1994). However, it should be noted that more recent research revealed that the interviewer severity ratings of the ASI have been shown to be unreliable and, as such, will be removed from the 6th version of the ASI. In addition, it is important to note that there are certain limitations with this tool that can make it more difficult to apply to offender populations. For example, the Composite Scores are severely affected by days-at-risk in the community, and for individuals who were recently arrested and detained. As such, the Composite Scores may be invalid or misleading. In addition, the ASI does not yield a diagnosis and is not normed on the general population or even a substance-abusing population, which is important for treatment-matching purposes.

A self-report version of the ASI has been shown to be a reliable and accurate alternative to the counselor-administered instrument (SAMHSA 2005), however, as stated previously, the latter is the more preferred approach given the recognized limitations associated with self-report instruments.

In addition to the ASI, other tools such as Gathering information, Assessing what works, Interpreting/integrating the facts, Networking, Stimulating change (GAINS) and Texas Christian University (TCU) instruments are also multi-dimensional and equally well-validated and well-studied (http://www.chestnut.org/LI/gain/GAIN_SS/index.html).

For a comprehensive list of alcohol and substance abuse measurement instruments, and links to many available instruments please visit the University of Texas at Austin, Center for Social Work Research at <http://www.utexas.edu/research/cswr/nida/instrumentListing.html>.

More recently, the Treatment Research Institute (TRI) that developed the ASI has released a Risk and Needs Triage (RANT), a decision support tool for judges and other justice decision makers to assist in matching drug-involved offenders to the community corrections program best suited to their needs for supervision and treatment (for more information, visit www.trirant.org). Efforts are underway to develop a similar tool that is designed for a DWI offender population (Marlowe 2008).

As is evident, there are numerous other instruments and sources of information are used to screen and assess this population. Which screening and assessment instruments are used is primarily a function of available resources, but also determined by the purpose of the screening and assessment – jurisdictions may elect the quickest and most efficient approach for determining who goes into treatment, while in other cases, the courts may want the greatest amount of information available about an offender (SAMHSA 2005). In the latter cases, in addition to police, corrections, and medical records, an assessment will often include family and other collateral sources of data (e.g., driver records, criminal records, prior treatment records, biological testing, etc.) for historical information about the offender (SAMHSA 2005).

An integrated approach to screening and assessing DWI offenders is needed in order to overcome under-reporting and deception of substance abuse issues and other limitations of assessment procedures. For example, self-report results can be used alongside face-to-face interviews as well as collateral data to help determine under-reporting as a means of gaining a more holistic understanding of the offender's drinking habits and its consequences (Chang et al. 2001). Moreover, since there is no single litmus test applicable to all situations and all clients, it is recommended that practitioners review available instruments and then use, combine, and/or adapt⁹ them to suit their own assessment and planning needs (CSAT 1994). Further, the assessment process should include a broad variety of components that will yield an evaluation as a means of recommending the most appropriate course of treatment.

⁹ It warrants mentioning that adapting instruments can jeopardize their validity and may require further research. More importantly, relevant laws pertaining to copyright should be reviewed.

Areas that should be investigated in the assessment include:

- archival data on the client, including – but not limited to – prior arrests and contacts with the justice system, as well as previous assessments and treatment records;
- patterns of alcohol and other drug (AOD) use;
- impact of AOD abuse on major life areas such as marriage, family, employment record, and self-concept;
- risk factors for continued AOD abuse, such as family history of AOD abuse and social problems;
- available health and medical findings, including emergency medical needs;
- psychological test findings;
- educational and vocational background;
- alcohol testing if deemed appropriate;
- suicide, health, or other crisis risk appraisal;
- client motivation and readiness for treatment; and,
- client attitudes and behavior during assessment (CSAT 1994).

As this listing of professionally accepted information and criteria suggests, the assessment process must be data driven (CSAT 1994).

In considering the patterns of AOD use, the assessor should determine the presence or absence of such signs and symptoms as:

- tolerance to alcohol (high tolerance suggests that a client has a history of heavy drinking or drug use);
- history of physical withdrawal symptoms;
- episodes of uncontrolled drug or alcohol use, binges, or overdoses;
- use of AODs for “self-medication” of painful and unpleasant emotions;
- attempts to hide use;
- physical signs of drug use, such as needle track marks, emaciation, and alcohol odor;
- positive drug test results;
- history of attempts to quit AOD use;
- family dysfunction relative to AOD use;
- history and onset of drug use;
- drug use and behavior (e.g., does client use drugs alone? for sex? to go to work?); and,
- the method of administration, including injection, snorting, smoking, or drinking (CSAT 1994).

4.4 Referral

The outcome of assessment may be a referral to a treatment program. And, as noted earlier, justice professionals provide more referrals for treatment than any other source. Owing to a number of factors many more offenders are referred to treatment than those who actually receive it – e.g., no treatment program is currently available, or offenders choose not to seek out the recommended treatment. It is important that either the Court, probation agency or service provider monitor the flow of referrals to ensure that adequate programs and staff are in place to manage the volume of referrals received. In some jurisdictions, treatment agencies experience an overwhelming demand for services and have difficulty accommodating the number of referred offenders. For this reason, there is a need for close communication between the courts and treatment agencies to overcome such problems.

A model referral process would include:

- informing the offender of the referral and the nature of the recommended treatment;
- ensuring the referred options are available, accessible and appropriate;
- ensuring the service provider receives notification of the referral so they can contact the offender for scheduling; and,
- informing the courts of the referral and service provider so that follow-up is possible.

It is also critical that justice agencies track referrals so they can share and analyze important information to better understand the effectiveness and impact of the referral process in providing needed services to offenders.

Referral data that should be routinely collected includes:

- how many offenders were referred;
- how many offenders showed up at the agency they were referred to;
- of those, how many were assessed;
- of those how many were admitted;
- of those, how many completed;
- how many remained sober and free of other substance and/or free of criminal activity;
- how many cases were successfully closed to the justice system; and,
- how many cases were re-opened.

The analysis of this data by skilled justice professionals is vital to understanding the quality of available programs and identifying and delivering needed technical assistance to improve the quality of the referral process. For example, some programs may have lots of referrals but few patients are admitted; other programs may have many patients admitted but few who complete the program. As such, information derived from data analysis can identify the need for on-site program reviews to better understand sources of problems and appropriate solutions, and support the delivery of technical assistance to programs.

4.5 Treatment

As noted earlier in this report, the treatment of DWI offenders for at least alcohol use disorders is a critical element in reducing recidivism. Accordingly, there is a growing recognition that treatment must be an essential component of the rehabilitative mix. In this context, the Working Group on DWI System Improvements views treatment as one means of achieving the goal of rehabilitation – bringing the offender back to a certain acceptable standard of behavior. Although many offenders may come from impoverished backgrounds and lack “acceptable standards of behavior”, these individuals can and do change. For example, in recovery homes, offenders can learn what many others learn in their original home environment.

The realistic goal of treatment should be risk reduction (Taxman et al. 2007; Taxman 2007). However, one of the practical limitations at this point is the burden on the system – it has been suggested (Taxman 2007) that the current treatment capacity would have to be increased four-fold to accommodate all the offenders referred for treatment. More recently, the Urban Institute Justice Policy Center released a research report in April 2008 that suggests only a small proportion of all persons that are arrested actually receive adequate treatment through the criminal justice system to reduce their offending (Full report is available at <http://www.urban.org/publications/411645.html>). Of concern, strict rules regarding eligibility and a lack of available resources limit access to treatment, even in jurisdictions that embrace the principles of therapeutic jurisprudence. As a consequence, existing relationships between the criminal justice system and substance abuse treatment are so constrained that only nominal reductions in crime can be achieved.

4.5.1 What is the purpose of treatment?

The purpose of treating DWI offenders is to help alleviate identified problems with substance abuse that they may have, or be at risk of developing. Treatment is designed to lessen and prevent negative consequences of substance abuse (e.g., DWI) and also to support the offender during times of relapse, and to get them “back on track.” Although such sustainability through relapse prevention is not usually considered part of the treatment process, it is critical (Robertson 2007).

In relation to impaired driving, treatment for alcohol and other drug abuse occurs along a continuum during the offender’s justice processing. As described throughout this report, in addition to treatment per se, this continuum encompasses initial screening and assessment, treatment referrals, as well as re-screening and re-assessments to monitor progress during and following treatment completion.

4.5.2 Who needs to be treated?

Not all offenders require placement in treatment services, and resource limitations do not allow all offenders to be treated. As illustrated throughout this report, screening and assessment measure the presence, extent, and severity of substance abuse issues. According to the Working Group, offenders found to possess moderate to serious alcohol issues and pose a high-risk of DWI recidivism are most in need of controlling their drinking behavior. These offenders should be prioritized for referrals to treatment

services that are tailored to their individual needs (SAMHSA 2005; Williams et al. 2000). Proactively speaking, the Working Group further notes that offenders who are found to be at risk of developing a severe alcohol problem should be prioritized as well.

4.5.3 When are offenders treated?

The Working Group contends that offenders who require treatment services need to be given what they need, when they need it, and in the duration they need it to ensure that their problems are addressed. Unfortunately, the reality is that when treatment plans are actually devised, it may be weeks or even months before the offender actually starts treatment, if they do at all. As such, there is no set schedule for when offenders receive treatment; consequently, they may enter treatment at various points throughout their justice processing. For instance, they may voluntarily attend treatment pre-trial as a means of impressing the judge in pre-sentence reports; offenders may attend treatment from prison-based services while incarcerated; judges may impose treatment in the post-sentencing stage (e.g., following incarceration) while on probation. Overall, when and where offenders receive treatment depends on screening and assessment results, an offender's readiness for change, available programs and services, waiting times, cost of treatment and available finances.

4.5.4 Treatment options.

Depending on the offender's screening and assessment results, and the subsequent treatment referrals, substance abuse treatment may involve different techniques (e.g., brief interventions, motivational interviewing, treatment-matching, counseling, detoxification, medication, etc.), delivered under different models (i.e., harm reduction, behavioral model, etc.), and take place within three main types of care: outpatient, non-hospital residential, and hospital inpatient (DSAIS 2005; SAMHSA 2005).

Outpatient care includes: outpatient detoxification, outpatient day treatment or partial hospitalization – professional assessment and treatment of 20+ hours per week in a structured program (DASIS 2005; SAMHSA 2005). This is the most intensive of the outpatient treatment options and can be used for treating clients who demonstrate the greatest degree of dysfunction but do not require inpatient or residential treatment (SAMHSA 2005). Also included in outpatient care is intensive outpatient treatment (professional assessment and treatment from 9 to 20 hours per week in a structured program, can be held on evenings or weekends), and regular outpatient treatment (fewer hours per week than intensive) (DASIS 2005; SAMHSA 2005).

Non-hospital residential care includes residential detoxification, residential short-term treatment (30 days or less), and residential long-term treatment (30+ days) (DASIS 2005). Hospital inpatient care includes inpatient detoxification and inpatient treatment (DASIS 2005). Furthermore, as indicated, treatment varies in length (i.e., a few weeks, months, or even years).

There are a variety of forms of treatment with DWI offenders, including:

- motivational interviewing or motivational enhancement therapy;
- cognitive behavioral therapy;
- brief interventions;
- counseling/therapy (patient-centered or group);
- pharmacological intervention;
- detoxification; and,
- multi-program agencies.

Assessment results and available resources ultimately have an impact on which treatment techniques or approaches are provided for offenders, where the services are administered, and by whom. This section briefly describes these approaches to treatment.

Motivational interviewing or motivational enhancement therapy. Motivational interviews or motivational enhancement therapy are one form of brief interventions. These one-on-one patient-centered, non-confrontational counseling sessions are brief, and may be used in at least three different stages of an offender's processing. First, if an offender screens positively for alcohol use problems, a health care professional can share the screening results and their significance with the offender in a short, 10-15 minute interview. These are patient-centered and encourage the offender to create a plan of action which ranges from reducing their drinking to seeking substance abuse treatment (NHTSA 2005). Second, as illustrated earlier, offenders who have been assessed as being unready for receiving treatment may also be engaged in motivational interviewing, where the focus is on facilitating an offender's readiness for self-change or motivation to treatment (Marques and Voas 2005). The idea is to encourage through engagement the offender into accepting their problem(s), understanding the benefits of being treated for the problem, and then accessing the necessary services that are designed to help them overcome the problem. The premise of this technique is for professional staff to build a rapport with the offenders and empower them to change on their own (Taxman et al. 2004). Third, motivational interviewing is also useful throughout the supervision process for providing critical feedback to reinforce progress by helping offenders learn to "analyze" their own attitudes and behavior and determine how they can advance their behavioral change (Taxman et al. 2004). Such aftercare programs may involve weekly counselor-led sessions, offered at treatment sites (Harrison and Asche 2001).

Similarly, motivational enhancement therapy aims to engage patients who are resistant to changing their behavior in treatment, and can help build a partnership between the patient and the practitioner. This working alliance can create a foundation on which other appropriate therapies or medications can be included. Motivational enhancement therapy may be the most acceptable approach when patients are new to treatment for alcohol and other drug use disorders (Arias et al. 2008).

Cognitive behavioral therapy (CBT). CBT encompasses a wide range of cost-effective psychotherapeutic approaches that deal with cognitions and beliefs as a means to reducing problematic behaviors (Beck 1993). Some of the better known approaches include cognitive therapy, rational emotive behavior therapy, reality therapy and multimodal therapy. All have in common the objective of identifying thoughts, assumptions, beliefs and behaviors that are related to negative emotions and underlying dysfunctional problems (e.g., drinking problems) and replacing these with more realistic and functional ones. It has been used successfully in the treatment of many disorders and behavioral problems, including substance abuse disorder.

CBT approaches are used with individual patients or with groups. Some of these approaches rely on more traditional client-therapist interactions; others rely on computer-based software.

Brief interventions. Brief interventions, as the name implies, are much smaller in number and shorter in duration than traditional treatment approaches (Babor and Higgins-Biddle 2001). They are increasingly being applied in a variety of settings and recommended for offenders who misuse alcohol and are at risk for dependence but who are not yet alcohol dependent (Lapham 2004/2005).

Numerous types of brief interventions have been developed, ranging from providing advice to individuals to cut down on or quit drinking, to agreement on goals and objectives, to brief screening and feedback, motivational interventions, and contingency contracting. One of the more simple forms of brief intervention is screening itself. Given that screening often involves contact with the client in the context of questions and issues related to drinking behaviors, it can have some impact on the offenders' behavior. This makes screening not only a valuable tool for determining the nature and extent of alcohol problems but also a part of the therapeutic process itself.

The effectiveness of brief interventions has been demonstrated in various settings (e.g., Moyer et al. 2002; Poikolainen 1999), but few studies have examined the benefits with criminal justice populations. The exception seems to be a brief motivational intervention (usually in the form of feedback regarding test results and diagnosis), which has been shown to produce significant benefits in a criminal justice population.

Group counseling. Peer-support groups are community-based, with the most common being Alcoholics Anonymous (AA) (Harrison and Asche 2001). In McLellan et al.'s (2003) sample of 10,334 programs, the predominant form of treatment was found to be abstinence-oriented group counseling (intensive outpatient and traditional outpatient), which accounted for approximately 78 percent of all programs in their sample.

The Working Group stresses the importance of not regarding 12-step programs (e.g., such as AA) as a form of treatment or counseling but rather as a mutual-aid "fellowship" or support group. The effectiveness of such programs is unknown and they are difficult to evaluate. However, there is some evidence to suggest that when AA is combined with other approaches or interventions it can have positive benefits (Dill and Wells-Parker 2006).

Pharmacological intervention. It is generally agreed that greater use of pharmacological interventions could enhance treatment progress since it stabilizes the patient and creates a facilitating environment. According to NIDA's Principles of Drug Abuse Treatment for Criminal Justice Populations, "medications are an important part of treatment for many drug abuse offenders" (NIDA 2006). Indeed it has been argued that there is a need for greater receptiveness of the fact that medications may be an integral part of treatment (Robertson 2007), and despite immense progress in pharmacotherapy research, medications that have been approved to treat alcohol dependence are still underutilized (Arias et al. 2008).

Programs and services that include a medicinal component may be referred to as pharmacotherapy, medication, drug therapy, etc. Three oral medications (naltrexone, acamprosate, and disulfiram) and one injectable medication (extended-release injectable naltrexone known as vivitrol) are currently approved for treating alcohol dependence (NIAAA 2005). They have been shown to help patients reduce drinking, avoid relapse to heavy drinking, achieve and maintain abstinence, or gain a combination of these effects (NIAAA 2005). For a comprehensive review of available pharmacotherapies for treating alcohol use, please refer to Arias et al. 2008 in *Alcohol Research and Health*, the Journal of the NIAAA.

Detoxification. Alcohol detoxification can be defined as a period of medical treatment, usually including counseling, during which a person is helped to overcome physical and psychological dependence on alcohol (Chang and Kosten 1997 cited in Hayashida 1998). The immediate objectives of alcohol detoxification are to help the patient achieve a substance-free state, relieve the immediate symptoms of alcohol withdrawal (AW), treat any co-morbid medical or psychiatric conditions (Hayashida 1998), and help prepare the patient for entry into long-term treatment or rehabilitation (Swift 1997 cited in Hayashida 1998). The signs and symptoms of AW typically appear between 6 and 48 hours after heavy alcohol consumption decreases, and may include: headaches, tremors, sweating, agitation, anxiety and irritability, nausea and vomiting, heightened sensitivity to light and sound, disorientation, difficulty concentrating, and in more serious cases, transient hallucinations (Myrick and Anton 1998). Of particular importance, offenders with a polydrug use issue often require extended periods of detoxification and experience more severe withdrawal symptoms. As such, detoxification outcomes may also be impacted by polydrug use.

Detoxification may be completed in either inpatient or outpatient treatment settings (Hayashida 1998). While there are no specific criteria for determining who could benefit from outpatient detoxification, Myrick and Anton (1998) suggest that inpatient detoxification may provide better continuity of care for patients who begin alcoholism treatment while in the hospital. And for some offenders, inpatient may be the preferred approach in order to manage detoxification and related medical concerns. For instance, inpatient detoxification separates the patient from alcohol-related social and environmental stimuli that might increase the risk of relapse (Myrick and Anton 1998). Generally, the research shows that the length of stay rather than the intensity of treatment is a greater predictor of success. Studies show that the best outcomes for those in quality treatment are associated with 90 days or longer. This period allows the return of executive cognitive functioning (Zinn et al. 2004) and enables people to move through the stages of change.

Multi-program agencies vs. DWI-only agencies. As illustrated throughout this report, DWI offenders are not a homogeneous group and can present a range of potential problems with varying degrees of severity. This section briefly compares services available in multi-program agencies with services in DWI-only programs as reported in The DASIS report (DASIS 2005). In 2004, a total of 13,454 facilities responded to The National Survey of Substance Abuse Treatment Services (N-SSATS). Of those responding, 31 percent offered a special program for drunk driving offenders.

Assessment and therapy services: Some treatment agencies may offer services that are specific to DUI/DWI offenders, while others may offer multiple programs for a diversity of offenders. Multi-program agencies were more likely than DUI/DWI-only agencies to offer comprehensive substance abuse assessment (99% vs. 89%), comprehensive mental health assessment (49% vs. 21%), individual therapy (98% vs. 85%), and family counseling (84% vs. 50%).

Testing and pharmacotherapies: Multi-program agencies were more likely than DWI-only agencies to offer drug or alcohol urine screening (82% vs. 57%) and breathalyzer or other blood alcohol testing (65% vs. 52%). With regards to pharmacotherapies, they were equally likely to offer treatment with Antabuse (19% of multi-program agencies and 20% of DWI-only agencies).

Post-treatment services: Multi-program agencies were also more likely than DWI-only agencies to offer various service coordination and post-treatment services such as: case management (67% vs. 46%); aftercare counseling (89% vs. 68%); relapse prevention groups (84% vs. 68%); discharge planning (83% vs. 64%); and assistance obtaining social services (46% vs. 15%).

4.5.5 Voluntary versus mandatory treatment.

Offenders may enter treatment programs voluntarily or as mandated by law. It should be noted that while some offenders may freely choose to enter treatment, (Young et al. 2004) argue that “voluntary” clients are rarely self-referred, but instead, enter treatment under some external pressures (e.g., from family, peers, and employers). In this regard, Wild et al. (1998) found that 37 percent of so-called self-referred clients felt coerced into attending treatment.

Research suggests five factors that might influence the extent to which treatment is perceived by the offender as coercive:

- the more likely the offender sees that there is a need for treatment, the less likely they will view it as coercive
- the more unpleasant or distressing that treatment is thought to be, the more likely it is that pressure to attend will be perceived as coercive;
- providing offenders with clear and concise information about the treatment and convincing them that the rules would be enforced, can be an effective form of coercion (see Young 2004);

- relationship with source of the pressure – views about the legitimacy of the courts to make decisions, and confidence in the legal process may affect the extent to which legal pressure is perceived as coercive. Informal pressure from family and friends may be coercive as well; and,
- personality factors – for example, psychological reactance (Brehm 1966) can be understood as a motivational state or as a personality trait, and has been defined as the degree to which an individual feels compelled to regain lost or threatened freedoms (Dowd et al. 1994). As coercion implies a loss or threat to an individual's freedom of choice to attend treatment, it is clear that those offenders who score highly on reactance would be more likely to perceive coercion (Day et al. 2004).

Treatment may also be compulsory and mandated by law and offenders may have no choice but to attend. In 2002, justice referrals accounted for 655,000 substance abuse treatment admissions – an estimated 34 percent of the 1.9 million admissions in the Treatment Episode Data Set (DASIS 2004). Such referrals may derive from State and Federal courts, other courts, probation programs, other recognized legal entities (e.g., local law enforcement, corrections, or youth agencies), diversionary programs (e.g., Treatment Accountability for Safer Communities (TASC), prisons, and DUI/DWI programs; DASIS 2004).

Furthermore, mandated interventions for DWI offenders can include generic alcoholism treatment programs offered in local communities, referral to groups such as Alcoholics Anonymous (AA), and strategies that specifically aim to reduce drinking and driving, such as education programs, supervised probation, and presentations by injured survivors or families of victims killed in alcohol-related crashes (i.e., victim impact panels; Dill and Wells-Parker 2006).

Findings from a longer-term study co-funded by NIDA and Veterans Affairs (VA) affirm the results of shorter term studies that have shown similar therapeutic outcomes for voluntary and legally mandated patients (Whitten 2006). Of interest, while references to constructs such as “therapeutic reactance” (Brehm 1966) are quite common in the criminal justice literature on treatment, they are less popular in the treatment community and such theories have never been empirically demonstrated, meaning that the debate regarding voluntary versus mandated treatment protocols may be a moot point (http://www.nida.nih.gov/NIDA_notes/NNvol20N6/Court.html).

4.5.6 Co-morbidity.

Co-morbidity refers to the co-occurrence of two or more psychiatric disorders. Screening and assessment can also identify additional co-occurring problems associated with alcohol use that may also require treatment in order to alleviate an offender's problem behavior and prevent negative consequences. For example, in cases where alcohol abuse may be a consequence of an offender's self-medication due to a mental health issue, the alcohol abuse may be a symptom of a greater problem which will determine the method of treatment(s). Moreover, many offenders who abuse substances also have histories of trauma, physical and sexual abuse, and co-occurring mental disorders (e.g., anxiety,

post-traumatic stress disorder, schizophrenia, bipolar disorder, depression, etc.) or drug-use disorders that can make treatment more complex (SAMHSA 2005). As such, NIDA recommends an integrated approach for dealing with these offenders (NIDA 2006).

A handful of larger epidemiological studies have found that between 13-17 percent of individuals in the general population who have had an alcohol use disorder during the past year have also had a co-morbid drug use disorder in the past year. This rate increases to 20-23 percent when considering lifetime use disorders (Falk et al. 2008). Of greater concern, lifetime co-morbid drug use disorder rates are relatively higher among individuals with alcohol dependence than among those who abuse alcohol and among women than men. Thus, these studies have demonstrated that alcohol use and drug use disorders are quite likely to co-occur. Not surprisingly, “DUI offenders are more likely than the general population to suffer from co-morbid psychiatric disorders in addition to a substance abuse disorders (The Dram 2007, p. 1). As a consequence “understanding the psychiatric profiles of repeat DUI offenders is important for developing and delivering effective treatment” (The Dram 2007, p. 1; <http://www.basisonline.org/2007/11/the-dram-vol-31.html>).

To illustrate, in a sample of 729 patients in a 2-week inpatient treatment facility for court-sentenced repeat DWI offenders (i.e., offenders electing treatment in place of prison time), Shaffer et al. (2007) found that the offenders had higher lifetime and past-year co-morbidity rates than the general population with regards to alcohol use and drug use disorders, conduct disorder, posttraumatic stress disorder, generalized anxiety disorder, and bipolar disorder. Almost half qualified for lifetime diagnoses of both addiction (i.e., alcohol, drug, nicotine, and/or gambling) and a psychiatric disorder.

Of interest, according to findings from the National Epidemiologic Survey of Alcohol and Related Conditions (NESARC):

- Alcohol use prevalence peaked between the ages of 25 and 44 and declined thereafter.
- The prevalence of other drug use, co-use, alcohol use disorders, drug use disorders, and co-morbid disorders were highest between the ages of 18-24 and declined steadily thereafter.
- Women and men showed similar trends for alcohol use, drug use and co-use.
- The prevalence of drug use, weekly drug use, and drug use disorders increased with increasing levels of alcohol consumption and presence of alcohol use disorders (Falk et al. 2008).

SAMHSA has released a newer Treatment Improvement Protocol (TIP 42) on co-occurring disorders that is a good resource on co-morbidity. It can be accessed at <http://ncadistore.samhsa.gov/catalog/productDetails.aspx?ProductID=17910>. As well, the SAMHSA GAINS¹⁰ Center has excellent resource materials on this issue within the justice system.

4.5.7 Who needs the information gathered during the treatment process?

Various entities at different points in an offender's justice processing need the information derived from treating DWI offenders, and for different reasons. These include: judges, offenders, justice professionals, staff, and agencies, and policy makers. As mentioned previously, the ability of these practitioners to access this information may be constrained due to HIPAA and confidentiality issues. In some instances, these issues can be addressed through the use of consent forms, privacy releases, and agreement of specific data elements that can be shared as opposed to complete assessment results.

Judges: The Working Group concluded that clinical information should be available and provided to judges to assure that offenders get the interventions they have been prescribed. Clinical information should be reported in a manner that is useful to judges, instead of merely copying pages of clinical jargon. It is more beneficial for judges to receive a succinct report that says if offenders are complying or not, what level of care they are receiving, how frequently, and general information that is not subject to misinterpretation. In this context, judges also need to understand and appreciate the dynamics of driving impaired so they can better appreciate the importance of the individual's needs and the role of treatment in the rehabilitative process.

Offenders: Crucial recipients of information in screening, assessment, and treatment are the offenders being processed. The more involved offenders are in the drafting of their treatment plans, the more they will comprehend what they are being asked to do and the more likely they will comply (Taxman et al. 2004).

Justice professionals: The Working Group emphasizes that justice professionals lack pertinent information about treatment (i.e., what is available, what works and does not work, and for whom does it work, etc.). Determining how to disseminate this information to relevant professionals is a challenge that needs to be overcome.

However, even despite research the existence of laws stating that agencies should allow access to each other's data for evaluations, in reality that does not necessarily happen. As indicated earlier, this presents a major barrier to matching offenders to program, and to effective treatment placements for offenders (SAMHSA 2005). As a final note, the need for information is predicated on the assumption that data-sharing is common place and considered a priority.

¹⁰ According to SAMHSA, the Gains Center is designed to ensure that adults diagnosed with co-occurring mental illness and substance use disorder have access to community based services at all points of contact with the justice system. The center stresses the need for consultation and technical assistance to help jurisdictions develop integrated systems of mental health and substance abuse services for persons in contact with the justice system. <http://gainscenter.samhsa.gov/html/>

Policy makers: Policy makers looking for alternatives to incarceration need better information about the effectiveness of different treatment programs and models (Young et al. 2004). It is also important that they understand the scope and dynamics of the problem behavior to ensure proper resources are available or created.

4.5.8 Other issues.

As mentioned earlier, treatment programs need to be sensitive to the unique needs (problems) of the offender. Accordingly, programs need to be sensitive to other differences among offenders, particularly socio-economic status, culture, and gender. With respect to the latter, there is a growing recognition that many treatment programs have been developed around a male model since historically some 80 to 85 percent of DWI offenders are male. However, not only does this ignore the 15 to 20 percent who are female, it also ignores the growing population of female offenders. Accordingly, there has been an increasing recognition of the need for gender sensitive and competent treatment programs (e.g., Hennessey 2005).

5.0 Barriers to Screening, Assessment and Treatment

Justice practitioners may encounter a variety of barriers to applying screening, assessment and treatment opportunities to effect change among drunk driving offenders in need of substance abuse intervention. The source of these barriers can vary widely; some are more amenable to change than others. For example, in some instances, there may be insufficient resources or inappropriate resources to apply these interventions and offenders are placed on waiting lists for several months before they may participate. In other instances, available research may not provide clear direction for practitioners to effectively identify and treat drunk driving offenders with substance abuse issues.

There are also a number of myths and misperceptions among professionals regarding these types of interventions that can discourage them from relying on such approaches. Some practitioners have a variety of legitimate concerns relating to ethical issues, offenders manipulating the system to avoid punishment, and public perceptions of the Courts as being “soft on crime”. Finally, legislation may fail to encourage, or even impede the application of such interventions as sentencing strategies may place a greater emphasis on punishment and incapacitation and a lower priority on rehabilitation. Indeed, this punitive approach to sentencing has in fact, until recently, dominated political and public opinion for more than two decades. It remains a challenge to convince people that alcohol dependency and DWI are not necessarily an issue of a weak will, but that they may have physical and psychological under-pinnings. In this respect, a media campaign to further raise awareness and promote the benefits of treatment could be beneficial.

And, in many cases, available laws or lack thereof, and inconsistent information regarding the most suitable ways to engage and support offenders in treatment can impede decision-making at all levels of the system.

Some of these barriers are explored in more detail below in order to provide insight into the challenges facing practitioners in effectively applying appropriate strategies to drunk-driving offenders in need of substance abuse intervention, and to identify where improvements can be made.

5.1. Resources

The amount of resources allocated towards screening, assessment and treatment in a given jurisdiction determines the number of DWI offenders who can be properly diagnosed and treated.

5.1.1 Cost of screening.

The cost of screening may vary depending on the types of instruments employed and the strategies by which they are applied. As discussed in section 4.1, screening instruments can range from informal paper and pencil tests that are self-administered to highly structured interviews and multiple instruments that must be administered by trained clinicians. As such the cost of screening can range from relatively inexpensive (e.g., less than US\$50.00) to very costly (US\$300.00 and upwards). Of some importance, these figures do not take into account the human resources necessary to conduct screenings and write up the reports.

Of equal concern, the number of DWI offenders that may require screening can be quite substantial, and therefore costly. For the vast majority of all criminal adult offenders alcohol was a factor in their offense. And in the United States, some 18 percent of the estimated 3.9 million persons on probation are impaired driving offenders (DOJ 2001). In any given state, this can translate into thousands of offenders who must be screened annually at substantial expense to the State or local government.

Although there is general agreement that, ideally, all DWI offenders should be screened to identify relevant substance abuse and any mental health issues (Gallant 2007), and a majority of states do require some form of screening of offenders (APPA 2007), in practice many offenders are not screened as a result of resource limitations. Depending on state requirements, the circumstances under which screening occurs vary according to factors such as the nature of the offense and the BAC at the time of arrest (if available), and available resources. It is also not uncommon for some offenders to negotiate plea agreements shortly after arrest in order to avoid screening. So while ideally all offenders should be screened, resource limitations can result in the inconsistent screening of offenders.

As evidence of this, a 2002 study (Robertson and Simpson 2002a) involving 900 judges in 44 states revealed that more than 90 percent of judges indicated that offenders were often ordered to be screened using some form of alcohol evaluation prior to sentencing, although in some jurisdictions the number of offenders who were screened was much lower. As a consequence, not all offenders who can benefit from screening, and possibly treatment are consistently identified and correctly diagnosed as a result of the costs associated with screening or due to the manner in which a case is processed. However, it should be noted that there are reasonably effective, affordable screening instruments that can be easily applied to DWI offenders at highest risk (e.g., high-BAC offenders or repeat offenders) and that is preferable to not screening.

5.1.2 Quality of screening.

Of greater concern, the quality of screening instruments that are applied to offenders can vary across jurisdictions, and this may be, in part, also a function of available resources. As discussed in the earlier section on screening (see section 4.1), a wide range of both informal and formal screening methods may be applied and the effectiveness of the screening instruments that are used can vary considerably.

Even among convicted DWI offenders, the “best” instruments are only able to correctly classify less than 70 percent of recidivists (sensitivity) and 40 percent of non-recidivists (specificity) (Anderson et al. 2000; Chang et al. 2002; C’de Baca et al. 2001). And, while research shows that many screening instruments are effective at predicting alcohol use, very few of them have shown predictive validity with regard to DWI recidivism (Chang et al. 2002). Of concern, many alcohol screening instruments have not been normed or validated on a DWI population. As a result, the use of poor quality instruments that may not ultimately provide the needed information can deplete limited resources and provide a questionable return on investment. In fact, research shows that only 25-50 percent of offenders are screened using standardized tools (Taxman 2007), although a much greater percentage of offenders are screened. For example, according

to Lacey and colleagues, “the least discerning screening instrument only identified 57 percent of non-problem drinkers correctly” (Lacey et al. 1999, p.39).

The implicit cost of using this instrument to identify problem drinkers for further examination or treatment is that the program would be dealing with a greater number of persons presumably not in need of this further action.” Again, while many screening instruments do not guarantee that all offenders in need of intervention will be correctly identified, practitioners can still be confident that a reasonable proportion will be identified, and this is a better alternative than no offenders receiving needed interventions.

5.1.3 Staffing.

Justice practitioners also express concern regarding the availability of qualified and independent staff to screen offenders and draw sound judgments regarding the need for further intervention. While some instruments can be self-administered, or administered by those with limited training, these instruments tend to be less reliable or easily circumvented, particularly by repeat offenders. Preferred instruments that tend to be more rigorous in nature often require the use of trained and qualified clinicians. As a result, those agencies without or with limited access to such personnel may encounter difficulty in screening offenders, or may ultimately incur substantial costs in order to ensure that offenders are subject to a rigorous screening protocol. However, staffing costs can be minimized with the use of self-reporting instruments and staff training to develop needed skills and improve outcomes.

5.1.4 Availability of treatment.

While screening does appear to be more widely available, opportunities for participation in treatment programs are substantially smaller. In a 2002 survey of 900 judges in 44 states, some 80 percent of respondents indicated that more alcohol treatment programs are needed for repeat offenders (Robertson and Simpson 2002b), and long waiting times for entrance into a treatment program are not uncommon. Some practitioners have noted that, for many offenders, their term of probation may expire before they gain entrance to a program. So while screening and assessment may occur much more rapidly, it may then take months before an offender is admitted to an appropriate program. Indeed, many offenders wait 90 days or longer to enter treatment even following a guilty plea (Hon 2004). This poses a substantial problem in that research shows that treatment is most effective when it is immediately available (Wells-Parker et al. 1995). Indeed, to date, the allocation of resources towards treatment have been insufficient and research shows that less than 10 percent of DWI offenders who need alcohol programs get access to them (Taxman 2007).

Of greater importance, when treatment programs are available, judges may encounter a limited selection of treatment options and are forced to rely on a “one size fits all” approach that is of little value to some offenders. And, particularly in rural areas, treatment agencies may be an unreasonable distance from an offender’s residence, making attendance difficult, particularly in instances where the driver’s license has been suspended or revoked. As a result, while offenders may be frequently referred to treatment, the quality and quantity of intervention received can be insufficient as a

function of available resources. It should be noted that almost all rural areas do have AA groups, and given the rural nature, these groups are likely more cohesive and able to provide needed support to DWI offenders.

5.1.5 Lack of aftercare for treatment.

A final resource concern in this area relates to the general lack of aftercare following treatment, which has been shown to greatly increase positive outcomes and reduce relapses (Wells-Parker et al. 1995). Indeed, continuity of care is deemed a key principle of drug abuse treatment for criminal justice populations (NIDA 2006). In most jurisdictions, there are a small number of treatment interventions that have aftercare opportunities. Practitioners in the substance abuse field readily acknowledge that relapse is common and in many instances should be expected. Aftercare can provide an early warning system to identify offenders who are likely to relapse and create opportunities for early intervention to prevent such outcomes. Indeed, aftercare opportunities can certainly increase the likelihood of long-term risk reduction. However, there are costs associated with aftercare opportunities and the availability of such programs is often a function of resource allocation. In an effort to mitigate these costs, there is now a body of research developing on how to implement low-cost continuing care interventions, such as telephonic “recovery check-ups”. For more information about this please visit the ATTC website to see their materials on recovery at <http://www.nattc.org/learn/topics/rosc/rss.asp>.

5.2 Research

The quality and quantity of research relating to the screening, assessment and treatment of DWI offenders is insufficient and/or inaccessible to allow practitioners to:

- a) identify and select reliable and accurate instruments that can identify and diagnose offenders with substance abuse issues;*
- b) ascertain which interventions or strategies are most appropriate to apply to this group; and,*
- c) select appropriate measures of effectiveness by which to evaluate success.*

5.2.1 Methodological weaknesses.

Research on screening, assessment or treatment interventions has suffered from a variety of methodological weaknesses. These may include poor research design, unclear or varying definitions of research concepts (e.g., “risk”), inconsistent measure of variables, small sample sizes, and insufficient statistical calculations (Wells-Parker et al. 1995). More importantly, few studies have been conducted specifically on DWI populations and have often included a much broader category of substance abusing offenders.

The way in which the success or effectiveness of treatment is measured also varies across studies. Mostly studies have examined effectiveness in terms of recidivism, however the impact of treatment on other areas is unknown (e.g., employment, family relationships, stable living environment, health).

Also of concern, there have been no longitudinal or cohort studies to identify under what conditions long-term risk reduction may be achieved, or a meta-analysis of screening, assessment or treatment interventions that demonstrates a clear convergence of the research evidence to guide decision-making among practitioners. In addition, the considerable variations regarding how interventions have been defined and measured have made comparisons across studies difficult.

Finally, there is considerable confusion in the research literature with regard to screening, assessment and treatment. Historically, these strategies have been separate components, however, in recent years there is a considerable blurring in the research literature, particularly with screening and assessment and these terms can be used interchangeably, resulting in confusion for lay persons. For example, many screening instruments are actually assessment tools. This blurring also occurs in practice. In many jurisdictions, screening is assessment, and the assessment process is bypassed entirely.

5.2.2 Validation of instruments.

Many screening and assessment instruments have not been validated on a DWI population. At best, most instruments are predictive of alcohol use among a general offender population, but few, if any, are predictive of DWI recidivism. This important gap in the literature makes it difficult for practitioners to identify those offenders in need of intervention and those offenders at high-risk for re-offending. As mentioned previously, even among convicted offenders, the “best” assessments are currently able to detect less than 70 percent of recidivists (i.e., sensitivity) and less than 40 percent of non-recidivists (i.e., specificity; Anderson et al. 2000; Chang et al. 2002). Of greater concern, few instruments have been validated in a natural or real world setting.

5.2.3 Treatment matching.

Treatment matching involves matching offender characteristics to suitable treatment programs and services that will best address their needs, and offenders may be matched to more than one treatment intervention. Research has demonstrated that this is a key principle of treatment intervention and, as such, NIDA recommends that it is important to tailor treatment services to fit the needs of offenders (NIDA 2006).

While there is a belief among practitioners that matching offenders to relevant programs can be an effective process and there is a desire to rely on this strategy, the research literature in this area lacks clarity, making it difficult for practitioners to determine what programs to apply to which offenders. Indeed, “matching individuals to effective interventions – based on personal characteristics, problems and risk factors – has been a major though elusive goal...” (Wells-Parker and Williams 2002, p.665). Of greater importance, most treatment-matching studies have not focused specifically on impaired driving offenders and instead focused more broadly on offenders with drinking problems.

¹¹ This report is currently being revised and updated. For more information please see <http://www.asam.org/PatientPlacementCriteria.html>

¹² APA online can be found at <http://www.psychiatryonline.com/content.aspx?aspx?alD=142085>

Matching also hinges heavily on the quality of the screening and assessment process and there are significant information gaps relating to what treatment programs are effective and with whom. Generally, the research provides limited guidance to allow practitioners to successfully match offenders to appropriate programs and more research is needed in this area. And when effective and appropriate programs are available, it may be difficult for agencies to maintain fidelity which can compromise effectiveness. In the interim, there is research to suggest, and some practitioners believe, that requiring offenders to participate in inappropriate programs can be more damaging (Gendreau and Goggin 1997; McGuire 2001; 2002; Brusman Lovins et al. 2007).

More recently, in the field of matching offenders to interventions, experimental research has been done to examine the risk principle in drug courts. This research has determined that those offenders who pose a higher risk have better outcomes when court appearances are scheduled more frequently, whereas the frequency of appearance had no impact on the outcomes with lower risk offenders (Marlowe et al. 2006; 2008).

Those persons seeking more information about treatment matching should consult the American Society of Addiction Medicine (ASAM) for their published guidelines regarding placement and treatment matching (ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders 2001¹¹). In addition, the American Psychiatric Association (APA¹²) has also published guidelines for the treatment of substance use disorders which also address the issue of placement in various treatment settings (Kleber et al. 2007).

5.3 Myths and Misconceptions

There are a range of common myths and misconceptions relating to screening, assessment and treatment that can discourage justice practitioners from routinely applying these techniques as part of effective sentencing practices. This has occurred in part because much of the research in this area is not widely known to practitioners in the field, and also because much of this literature can be time-consuming to review and challenging to access and understand. These myths and misconceptions can be overcome with proper information.

5.3.1 Screening is a time-consuming and resource-heavy process.

Many practitioners have the perception that screening requires a considerable amount of time, expensive instruments, and the services of a trained clinician. For this reason, practitioners may be hesitant to screen offenders, particularly given the court backlogs and delays that are ever-present within the system. This is compounded by growing offender populations, resource limitations and funding cutbacks that have become common in all jurisdictions. In addition, the workload of staff employed within the system has also grown substantially, making it challenging for staff to take on screening tasks for large numbers of offenders.

While it is recognized that a number of routinely applied instruments have not been normed on DWI populations, at this time these instruments are the best that are available, and to use them is better than not screening at all. Many practitioners are surprised to learn that, as discussed previously, (see section 4.1), screening can be

a relatively simple and streamlined process that does not require significant time or expense. Many instruments can be self-administered or administered by court/probation staff in a relatively brief time, although interviewer-based approaches are preferred. Similarly, for some instruments, the scoring of the test results is automated and requires little input from the interviewer. As such, it is possible that a quality screening process can be efficiently applied to offenders by court, probation or other personnel who possess a good understanding of the purpose and protocols associated with this process.

5.3.2 Screening and/or treatment is expensive.

Many practitioners have the impression that screening and/or treatment is expensive and not affordable for most offenders or for all offenders who can benefit from it, particularly with an increasing trend towards an offender-pay system. Indeed, the vast majority of impaired driving offenders are young males with relatively low levels of education and who have low-paying jobs (Jones and Lacy 2000). It is likely that this group also lacks sufficient health care coverage to absorb screening and treatment costs. However, many screening instruments can be purchased and administered for nominal costs, ranging from a few dollars to less than US\$50.00.

While treatment can be expensive, it does not have to be. Many treatment programs operate as out-patient alternatives and this is a general trend in the treatment community as part of an effort to ensure treatment is affordable to a broader population of offenders (Robertson 2007). Some agencies may also be subsidized by government grants and/or health insurance policies, or indigent funding arrangements may be available.

What many practitioners do not know is that the cost of treatment provides a better return on investment than many other sanctioning alternatives (e.g. fines, surcharges). The cost-effectiveness of treatment may vary according to the treatment outcome that is measured (e.g., legal costs, reduced health care costs, or work-related costs). Studies that have examined this issue have concluded that many treatment modalities are cost-effective in relation to reduced health care costs, although more expensive modalities do not demonstrate better outcomes (NIAAA 2000). Out-patient treatment is considered the most cost-effective measure when applied to appropriate candidates, however those with more severe alcohol problems may not achieve the same degree of benefit relative to the cost (Dill and Wells-Parker 2006).

It is important to keep in mind that the cost of treatment should be considered in relation to the costs of not treating offenders. In 1998, the NIAAA reported that the U.S. economic costs related to alcohol use problems (excluding prevention and treatment) were about \$177 billion, in relation to the 7.5 billion spent on treatment (NIAAA 2000).

5.3.3 Coercive treatment is ineffective.

There has been much debate regarding the effectiveness of voluntary treatment versus treatment that is coercive in nature, and some practitioners have concerns regarding the effectiveness of mandated treatment, in particular among those who do not demonstrate a readiness for or will to change. However, “in general, research has consistently shown that treatment has a modest effect on reducing drinking-driving

and alcohol-impaired crashes among offenders who are mandated to attend and who actually receive the intervention” (Dill and Wells-Parker 2006, p.43). In particular, one random assignment, longitudinal study of mandated treatment suggested that the benefits of mandated treatment may extend beyond the traffic safety arena (e.g., lower mortality rates; Mann et al. 1994).

Of importance, research has been more challenging to conduct in this area given the variations across programs and jurisdictions, the difficulty associated with using random assignment, and problems with outcome measures (Dill and Wells-Parker 2006).

5.3.4 Self-help programs qualify as treatment.

Within the justice community, there is an unclear understanding of what interventions qualify as a “treatment” program. Some practitioners may consider groups like Alcoholics Anonymous (AA) as a form of treatment, particularly in instances where this type of intervention is the only one that is available in a given jurisdiction. In fact, AA is a mutual self-help group designed to help individuals manage their abstinence and research shows that it can serve as an effective intervention strategy when combined with other services (Dill and Wells-Parker 2006). However, it does lack many of the important features of a traditional treatment program, and as such, may not be appropriate for all offenders, particularly those offenders who have not acknowledged their drinking issue and entered the “readiness for change” stage.

For some offenders, AA is a viable solution because it is more self-directed, and for other offenders treatment is more effective. It really depends of the attributes of the individual, the treatment and the AA group. For example, if a DWI offender participates in a smaller, more cohesive group, the offender is more likely to be welcomed and included. While many people go to AA because the Courts require it, they frequently start out in denial. However, as they listen to drinking histories of others, they may begin to relate to others and become aware of their own problem. So, as they make friends and develop support in AA, participation can begin to interrupt their addictive patterns. Conversely, if the AA group is more transient, they may be less likely to reach out to new participants and the DWI offender may not receive the needed support or recognize their drinking problem.

Of note, the justice community must also be sensitive to the potentially disruptive impact that offenders may have on such groups, particularly if offenders are resistant to change and fail to recognize that they have a substance abuse issue.

5.4 Concerns

There are a number of concerns about treatment that can discourage justice practitioners from incorporating treatment as a standard consideration of sentencing for DWI offenders.

5.4.1 Treatment is “soft on crime”.

For the past two decades, there has been considerable emphasis on the punishment, control and surveillance of offenders using traditional sanctions such as incarceration, intensive supervision, random drug or alcohol testing, and technologies to monitor offender behavior and activities around the clock. Conversely, there has been relatively

little attention given or resources allocated to treatment as an effective sentencing strategy. While this attitude is beginning to change, there is still a strong concern among practitioners that the use of treatment alternatives suggests to policymakers and to a lesser extent the public that they are “soft on crime” or “going easy on offenders”. Unfortunately, from a policy perspective, the reliance on punitive alternatives such as incarceration and intensive supervision is still vastly favored over treatment.

In particular, there is also concern among practitioners that if judges stray from standard sentencing practices (i.e., probation, incarceration) in a given jurisdiction and do incorporate treatment as a sentencing alternative, they may suffer from a backlash of public opinion and be ostracized by other practitioners for electing to employ different strategies. This can also lead to offenders going to efforts to access or avoid a particular judge or courtroom in an effort to access or avoid participation in treatment strategies.

It may be surprising to many individuals that, among DWI offenders, treatment is in fact viewed as one of the harshest sanctions that can be applied. This is clearly illustrated by the fact that offenders will routinely opt for a jail sentence in lieu of treatment. This is because treatment forces many offenders to acknowledge their drinking problem, and participation in treatment places considerable demands on offenders in terms of changing their behavior as well as the time it takes to complete this process, relative to incarceration. At the same time, the cost of treatment is substantially less than incarceration.

5.4.2 Offenders participate in treatment to avoid tougher sanctions.

There is concern among practitioners that offenders may be strongly encouraged to participate in treatment by defense attorneys in order to benefit from a reduced sanction. It is not uncommon for offenders to immediately enroll in some form of substance abuse treatment prior to conviction or sentencing in order to demonstrate their remorse/ willingness to change so that they appear in a more positive light before the Court. There is a perception among offenders that judges will be less inclined to impose sanctions that will interfere with the treatment process (e.g., such as incarceration). So in this respect, some practitioners are concerned that offenders may participate in treatment in order to influence sentencing and avoid sanctioning. Of greater concern, it is likely that these individuals are resistant to change and fail to acknowledge their problem with alcohol, and for this reason treatment may be an ineffective sentencing option (Hon 2004).

5.4.3 The use of medications to treat substance abuse.

Despite the success that has been achieved with the use of certain medications to manage substance abuse issues among offenders, practitioners can encounter a variety of due process/ constitutional and ethical dilemmas regarding the use of medications with involuntary participants to treat substance abuse.

For example, there may be unwanted or unpleasant side effects associated with some of these medications, and the frequency of consumption/injection may be problematic. For these reasons, practitioners may be hesitant to order offenders to use such medications, particularly if they are resistant to taking them.

Additionally, some such protocols require cooperation from licensed medical professionals which may be challenging to obtain. Oftentimes, medical professionals may be unwilling to encourage offenders to take medications. Of greater importance, the costs of these medications are not insignificant and Courts may be unable to provide funding and/or offenders may lack resources or health coverage that allow them to participate in such programs. Again, very positive outcomes have been achieved with the use of these medications in terms of reducing substance abuse. To overcome these concerns, Courts are encouraged to develop good working relationships with medical practitioners to support the use of such medications, as well as a model process to gain informed consent and participation from offenders by sharing the benefits of these protocols.

5.4.4 The “one-size-fits-all” approach to treatment.

Some practitioners are concerned about the lack of availability of treatment options, particularly in rural communities. Often, in these instances practitioners have limited options for treatment services and if practitioners want to incorporate a treatment protocol they are obliged to send all offenders (regardless of their issues, characteristics, severity of the problem) to the same program. Among practitioners, there is also concern that, by sending offenders to inappropriate programs, they may be doing more harm than good with offenders. To overcome these challenges, jurisdictions should promote the benefits and cost-benefits of treatment in order to encourage political and public support of these alternatives.

5.4.5 Support for treatment in rural communities.

Particularly in small and rural communities, justice practitioners can encounter resistance to applying screening, assessment and treatment alternatives to some segments of the population. There may be a strong overall lack of public support for these alternatives, and some communities may resist such options due to the stigma, and personal impact on reputation, employment and family that can be associated with participation in rural communities.

5.5 Legislation

References to or support for screening, assessment and treatment are not consistently included as part of the sanctions for DWI offenses. In some instances, legislation pertaining to health and privacy may actually impede the effective delivery of treatment.

5.5.1 Screening and/or treatment is not a sentencing priority.

Screening and treatment of DWI offenders is not consistently encouraged and/or required by law as a priority in sentencing DWI offenders. Although many jurisdictions have legislation mandating screening, an emphasis on assessment or treatment is not as pronounced relative to other sanctions such as incarceration or ignition interlocks. Of note, there is some concern regarding the way such issues are addressed in legislation because not all offenders are in need of treatment.

More importantly, legislators and policymakers may face the same challenges as justice practitioners in that they can benefit from increased knowledge of treatment modalities and effectiveness, and understanding of key treatment issues and these efforts should become a priority.

5.5.2 Information-sharing is a challenge.

Many agencies are increasingly reluctant to share personal information about clients given the abundance of concerns related to privacy and the legal implications associated with failing to protect client privacy. While legislation may suggest that agencies should and can share important information, policy and practice makes it increasingly difficult to do so. In general, the lack of communication and cooperation across agencies has been well-documented (Robertson and Simpson 2003a, 2003b) as a barrier to the effectiveness and efficiency of the justice system for dealing with drunk driving offenders. There is also considerable liability associated with inappropriately disclosing offender information and issues such as HIPAA legislation and confidentiality concerns can constrain the ability of practitioners to access relevant information. For this reason, probation, courts and service providers who deliver technologies and treatment professionals do not routinely share information unless specific policies and protocols are put in place to allow and encourage information-sharing. Options that can be considered include the use of consent forms, privacy releases, and agreement of specific data elements that can be shared as opposed to complete assessment results. Agencies should also be encouraged to consult with their partners to develop and implement appropriate policies to support information-sharing initiatives.

Note: For more information about this legal and ethical issues pertaining to treatment, please refer to Guidelines for Community Supervision of DWI Offenders available at http://www.appa-net.org/grant%20and%20special%20projects/a_docs/DWI_Guidelines.pdf and Treatment Drug Courts: Integrating Substance Abuse Treatment with Legal Case Processing. Treatment Improvement Protocol (TIP) Series 23 (Chapter 8) available at <http://ncadi.samhsa.gov/govpubs/BKD205/23j.aspx>.

5.6 Implementation

The implementation and delivery of screening, assessment, and treatment protocols is inconsistent within and across jurisdictions. The identification of those offenders in need of screening, assessment and treatment is challenging, and it is difficult to hold offenders accountable for their participation in and completion of mandated sanctions.

5.6.1 Inconsistent implementation.

The National Highway Traffic Safety Administration and the National Institute on Alcohol Abuse and Alcoholism (1996) have created general guidelines on the assessment and referral of impaired driving offenders, however the application of such guidelines varies widely across jurisdictions. The requirements for participation in such interventions, their duration and frequency, and the practices for dealing with those who fail to participate reveal broad variation. As a consequence, the delivery of services is applied using a piecemeal approach across jurisdictions, making it challenging for practitioners to consistently apply meaningful and effective interventions to those offenders in need of services.

More importantly, implementation of such interventions often fails to account for the necessary education that is a critical need among all practitioners whom are relied upon to apply such approaches in a consistent manner in order to achieve the potential

benefits. More information relating to delivery of services such as the availability of testing instruments, the point of application, the role and involvement of related agencies and the availability of funding is also needed, yet rarely received. Greater efforts to provide information to practitioners are much needed. To this end, the authors have endeavored to provide references to several key documents and materials of relevance throughout this report to aid practitioners.

5.6.2 Lack of accountability.

Practitioners face two important challenges relating to accountability. The first involves the accountability of offenders whereas the other involves accountability of service providers.

Holding offenders accountable for participation, and more importantly meaningful participation, in screening, assessment and treatment services can be challenging, particularly among offenders who are resistant to recognizing their alcohol problem. An examination of the monitoring of offenders to ensure their participation in and completion of court-mandated treatment as well as other interventions reveals challenges. Monitoring for compliance was identified as a priority problem in a survey of almost 900 probation and parole officers in 41 states (Robertson and Simpson 2003a). Indeed, this survey reported that an estimated 44 percent of offenders failed to comply, to some extent, with the terms and conditions of their sentence, and that participation in treatment is one of the sanctions that offenders are least likely to comply with.

Similarly, those that do participate in screening and assessment may under-report or minimize their drinking problems in order to avoid more intensive interventions (Lapham et al. 2002), making it difficult to determine the extent of their problem and/or identify appropriate treatment protocols. While there are screening techniques that involve a more extensive gathering of information and interviews with relevant others that can uncover such deception, these techniques may be cost-prohibitive for some jurisdictions. It should be noted, that expectations with regard to offender accountability should also be based on stages of change in order to improve outcomes. For example, an offender who is in denial of their drinking problem is not likely to be fully accepting of or actively participating in treatment programs.

Second, and perhaps more importantly, efforts are needed to hold screening, assessment and treatment agencies accountable for outcomes, and compliance site visits from state reviewers range from high quality to very low. Of equal concern, many states have absolutely no technical assistance to assist agencies in improving the quality of programs and services.

With regard to treatment agencies, in most jurisdictions Courts require only that treatment providers be licensed by the appropriate state agency (Hon 2004) and this can potentially increase accountability by ensuring minimum standards of care. A few jurisdictions (e.g., California) further require that treatment providers must complete a certification process which can also enhance the quality of services.

More recently, there is a growing trend towards the development of performance measures for treatment services based on a belief that “addiction treatment providers should be rewarded for the quality of care they deliver instead of treating patients as usual” (Hon 2004, p.9). A growing implementation of evidence-based practices that are scientifically developed and objectively applied hold promise to increase and improve treatment outcomes and move beyond the mere completion of programs that may not ultimately be effective. There is also a move toward outcome-based contracting, meaning that when agencies meet their outcomes they receive full reimbursement of costs, however those that fail to meet expected outcomes do not. This can be an incentive for agencies to perform particularly if those who exceed expectations receive additional funding. However, many treatment agencies do not employ outcome measures – particularly county and city mental health centers. Efforts are needed to encourage the broad application of outcome measures for such services and agencies are encouraged to consider this application when contracting for services.

5.6.3 Institutional approaches.

Historically, the delivery of treatment programs had been strong in an institutional setting. However, given the institutional crowding that has become commonplace in the past couple of decades and the move away from rehabilitative services due to the “tough on crime” rhetoric, there is a greater demand on services inside facilities and long-waiting times for entrance to programs. Moreover, fewer DWI offenders are being incarcerated in an institutional setting (compared to other offense types) although this is changing with the passage of more felony DWI laws. However, there has been an increased reliance on jails, probation and community-based supervision tactics. There is a need for more community-based approaches to treatment interventions, as well as a need for wraparound (e.g., childcare, transportation, housing) services to support offender participation.

5.6.4 Obstacles to early identification.

Problems in the justice system can impede the early identification of candidates for screening for alcohol or other substance abuse issues. These problems include offenders refusing to submit to a preliminary breath test or an evidential breath test. Indeed, refusal rates in some jurisdictions can be up to 80 percent (Zwicker et al. 2005) and the ability of offenders to refuse can hide the fact that offenders have a highly elevated BAC (e.g., .15 or higher) and may suffer from a substance abuse issue. Similarly, questions that are posed by police during a roadside investigation (e.g., how much have you had to drink tonight?) are also inadmissible in court and not available for judges to consider during the sentencing phase. Given that the screening of offenders may often not occur until post-conviction, it can be difficult for prosecutors to recommend treatment or for judges to determine the necessity and appropriateness of such a sanction.

6.0 Recommendations

Justice practitioners have identified a number of priority recommendations that can encourage and improve the application of quality screening, assessment and treatment to DWI offenders with alcohol abuse and related issues.

6.1 Good research to guide decision-making.

There is a substantial need for more definitive research relating to the screening, assessment and treatment of DWI offenders that can be relied upon by justice practitioners as a basis for the development of sound processing and sentencing strategies, and to guide the early identification of offenders in need of these forms of interventions. Many interventions require more rigorous evaluation, and require evaluation in combination with other strategies. For example, research has shown that AA is not effective by itself, but that it can be in combination with other services (Dill and Wells-Parker 2006). Similarly, treatment interventions achieve better outcomes when coupled with monitoring by probation (Hon 2004). Practitioners need more information regarding what interventions can be combined to increase effectiveness. In addition, it is important that interventions that show promise are evaluated for both effectiveness in reducing alcohol problems and reducing impaired driving among a DWI offender population.

Greater efforts are needed to evaluate screening, assessment and treatment interventions. More methodologically rigorous evaluations are needed, and more research is needed to identify what combinations or packages of interventions have the greatest effect with which offenders. It is also important to look at those interventions that have proven to be effective in order to determine which, if any principles are key to increased effectiveness because program fidelity may not be possible.

Research is also needed to distinguish between outcomes including those that reduce drinking behavior, those that reduce impaired driving, and those that reduce alcohol-related crashes. Such information regarding the effectiveness of various interventions can guide decision-making among justice practitioners and better achieve the goals of the justice system to reduce offending and change problem behavior.

Perhaps more importantly, it is critical that this research is clearly articulated in meaningful terms and made accessible to professionals to inform practice.

6.2 Education and cross-professional training.

Education and cross-professional training opportunities are needed to assist practitioners in understanding evidence-based practices and promising practices as they relate to screening, assessment and treatment of DWI offenders. Such educational opportunities can actively challenge and overcome myths, misperceptions and concerns that exist among practitioners. It can also help them understand the psycho-physiological aspects of alcohol dependence. This knowledge can allow practitioners to make more informed decisions regarding what strategies are most likely to be effective with certain groups of offenders, and provide a better understanding of how offenders can benefit from various strategies.

6.3 Resource allocation.

There is profound diversity within and across jurisdictions regarding how resources are applied to impaired driving offenders. More importantly, the agencies involved in the justice system, the role they play, and their level of influence can vary substantially. For this reason, it is challenging to develop a standard mechanism at a national or state level for incorporating screening, assessment and treatment in an effective manner.

Ideally, it may be more appropriate for the inclusion of such interventions for DWI offenders to occur as a function of community decision-making among local justice professionals who have the empirical knowledge of effective interventions and best understanding of how their system works. These practitioners are well-suited to identify the impact that impaired driving is having on their local communities and budgets beyond the justice system. More importantly, they are well-positioned to understand local operations and apply such interventions and strategies in a way that works and fits the needs of their locality. For example, in-patient treatment may not be an option in rural jurisdictions, however group counseling organized and managed by appropriate community organizations may work well, or the use of self-help strategies coupled with housing and childcare services and monitoring by probation.

6.4 Comprehensive services.

Research has consistently shown that combinations of interventions have better outcomes than single interventions alone. “The most effective strategy, which has substantial support from rigorously conducted studies, is combined education and treatment...Combining strategies may be more effective, regardless of treatment length or intensity, because DUI offenders have diverse and complex problems, and offering varied approaches may help address this range of problems” (Dill and Wells-Parker 2006, p.43). Similarly those treatment interventions that are partnered with effective supervision strategies (e.g., ignition interlocks, continuous alcohol monitoring) can increase accountability among offenders and result in better outcomes (Hon 2004).

At the same time, there is a need for wraparound services to be partnered with interventions. Offenders often find it difficult to participate in treatment due to family and childcare concerns, employment issues, and lack of transportation. The National Institute on Drug Abuse has identified a set of research-based core addiction treatment services that should be supported by wraparound services to enhance treatment retention and outcomes. (Ducharme et al. 2007). To date, few treatment interventions provide such comprehensive interventions or wraparound services, but this is slowly changing.

6.5 Consistent identification of appropriate offenders.

Practitioners require simple strategies to consistently identify offenders in need of screening, assessment and treatment for alcohol abuse and related issues. Agencies should be encouraged, at a minimum, to use informal methods at every phase of the system and formal methods where appropriate and practicable.

It is important to strategically allocate resources to ensure the identification of high-BAC and repeat offenders, and those who refuse testing, for screening, assessment and

treatment as early as possible in the process. Efforts are needed to develop screening tools that can be applied early on in the process. For example, the development of screening tools for patrol officers who make the arrest or officers who book the suspects to encourage them to note important factors such as the level of impairment and/or multiple arrests in reports to suggest that offenders should be examined more closely by prosecutors. Prosecutors can be educated to flag certain facts as suggestive of a drinking disorder to inform the judge of a suspected problem. Jurisdictions should be encouraged to develop composite instruments and test them for effectiveness if it is not possible to use currently validated instruments.

6.6 Streamlined policies and practices.

Practitioners require streamlined and effective strategies to apply screening, assessment and treatment. Such practices should provide them with more and comprehensive information to improve decision making throughout the processing of offenders so they can use it to effectuate the goal of reducing the rate of recidivism and changing the behavior of the offender. Such practices should also require limited time and be easily applied to facilitate an increase in screening, assessment and treatment. For example, the judge should be provided with good information about key factors associated with the offender and available screening, assessment and treatment opportunities, and information about appropriate programs and their suitability to an offender's risk-needs profile. Of importance, it is critical that prosecutors and defense attorneys have the same information as judges (e.g., number of priors, any treatment history) so recommendations are improved.

In an ideal world, the system would allow sand to fall through increasingly fine sifters to guide the need for screening, assessment and treatment. This process can begin at the point of arrest (e.g., BAC level, history of priors if available through National Crime Information Center (NCIC) or other sources) to more refined levels at prosecution (treatment and medical history), and pre-sentencing (probation interviews with family, employment history, screening results, available treatment options) to post-sentencing (risk-needs assessment). When such information is gathered along the way by relevant parties within the justice system, it can provide the judge with a better understanding of the offender that is being sentenced and allow them to impose conditions that are realistic, relevant and research-based and that can be used to create accountability for offenders.

6.7 Information-sharing protocols.

There is a critical need to share information from screening/assessment and treatment with offenders. By sharing this information, offenders may be moved towards readiness for change and it can allow offenders to recognize the effects of their drinking and create a sense of legitimacy and fairness for the sanctions imposed (procedural justice). The sharing of information can make offenders aware of why actions are taken or sanctions are recommended so they understand the context and see how society views them and why (see section 4.1.1 and 4.2.2. on offenders).

There is also a need for information-sharing across agencies (e.g., courts, probation, treatment, service providers) to increase accountability among offenders and to ensure

that interventions are effectively and appropriately applied. Increased information-sharing can reduce opportunities for offenders to fail to appear or “opt-out” of programs and increase the level of monitoring, which has been shown to improve treatment outcomes (Hon 2004). This exchange of information can also facilitate the early identification of offenders who are at risk to relapse and the modification of treatment interventions to suit offenders’ changing needs. Finally, the exchange of information can provide information of positive progress that can then be reinforced by system representatives.

6.8 Accountability and aftercare.

It is important for practitioners and policymakers to recognize that relapse is normal and does occur with some frequency. This is not to suggest that treatment does not work. It merely reflects the intensity of addiction that some offenders struggle to overcome. In legitimate treatment settings the expectation is that a person will relapse rather than not. In a high-quality program, such relapses can be identified and managed earlier to prevent severe setbacks or consequences. Two important elements that can reduce the risk of relapse are accountability and aftercare. During any intervention, monitoring of offender behavior can improve outcomes by ensuring that offenders are accountable for their behavior and that successes are positively reinforced and further encouraged. Similarly, aftercare to provide offenders with ongoing support to maintain behavior changes and reduce opportunities for offenders to return to old habits can have tremendous benefits.

Of interest, within the treatment community, aftercare or “continuing care of all types is now seen as serving a disease management role, in that brief, therapeutic or even extended monitoring can help facilitate patient self-care and connections with communities of recovery” (McKay, in press, p.258). In fact, there is a growing move among treatment services into a model of continuing care oriented services delivery systems such that “those who have had trouble with repeated relapses will routinely receive extended care and monitoring as part of their service package” (McKay, in press, p.258).

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