DWI Repeat Offenders in the Criminal Justice System

National Trends and Policy Options for New Hampshire

PRS Policy Brief 0910-06
April 26, 2010

Prepared by:

Elisabeth Ericson
Brian Freeman
Alicia Modeen

This report was written by undergraduate students at Dartmouth College under the direction of professors in the Rockefeller Center. Support for the Policy Research Shop is provided by the Ford Foundation.

Contact:
Nelson A. Rockefeller Center, 6082 Rockefeller Hall, Dartmouth College, Hanover, NH 03755
http://rockefeller.dartmouth.edu/shop/ • Email: Ronald.G.Shaiko@Dartmouth.edu

TABLE OF CONTENTS

EXECUTIVE SUMMARY 1

1. INTRODUCTION 2

2. SCREENING 2

3. ASSESSMENT 3

4. SCREENING AND ASSESSMENT IN THE ADJUDICATION PROCESS 3

4.1 RECENT TRENDS IN SCREENING AND ASSESSMENT 3
4.2 NEW HAMPSHIRE'S PROCEDURES 5
4.2.1 Driver Risk Inventory-II (DRI-II) 6
4.2.2 Research Institute on Addiction's Self-Inventory (RIASI) 6
4.2.3 Substance Abuse Life Circumstances Evaluation (SALCE) 7
4.2.4 Mortimer-Filkins (MF) 7
4.2.5 Michigan Alcoholism Screening Test (MAST) 7
4.2.6 Cut-Down, Annoyed, Guilt, and Eye-Opener (CAGE) 7
4.3 RECOMMENDATIONS FOR EVALUATING DWI MULTIPLE OFFENDERS 8
4.3.1 Instrument Recommendations 8
4.3.2 Procedural Recommendations 8

5. POST-CONVICTION SENTENCING: APPROACHES AND OPTIONS 9

5.1 PUNITIVE 10
5.2 PREVENTIVE 11
5.3 REHABILITATIVE 13

6. CASE STUDIES 15

6.1 NEW YORK 15
6.2 CALIFORNIA 15
6.3 CONNECTICUT 16
6.4 VERMONT 16
6.5 MAINE 17

7. CONCLUSION 17

REFERENCES 18

EXECUTIVE SUMMARY

This report examines the DWI repeat offender adjudication process both within New Hampshire and nationwide. Following a review of recent literature, analysis of current policies throughout the United States, and detailed case studies, authors conclude with New Hampshire-specific policy recommendations based on our findings.

1. INTRODUCTION

In the fall of 2009, the seven-day inpatient education program administered by the state that is mandated by law for a second DWI offense in New Hampshire was eliminated due to budget constraints. To replace the state-run multiple offender program (MOP), at least temporarily, the state is currently contracting with several private treatment centers. Without a permanent state program, officials from all three branches are taking this opportunity to reconsider the structure and components of New Hampshire's treatment of multiple DWI offenders.

This paper examines the adjudication process for repeat DWI offenders by synthesizing three different approaches. First, it examines and summarizes recent peer-reviewed literature for each step of the sentencing process. For this aspect of the report, authors evaluated studies done in the mental health, public policy, criminal justice, and addiction medicine fields. Second, a thorough analysis of DWI laws and policies at the state level was conducted. This required close examination of all alcohol related policies for each state in the United States. The authors collected information about each state's programs and coded them for graphical analysis producing an original dataset of state policies. The results of these analyses can be seen in the charts included in this report. Finally, detailed case studies of both innovative and neighboring state policies were conducted to place New Hampshire's procedures into a nationwide context.

Two notes are necessary prior to beginning our discussion. The first relates to the use of recidivism data. It is commonly believed that one of the most relevant measures of effectiveness for DWI regulations is a recidivism rate. In the DWI context, this rate refers to the percentage of offenders receiving a certain penalty that re-offend. However, after much research, the data has proven to be unavailable. States do not maintain records that reliably report re-offense rates. Furthermore, studies reviewed that did incorporate some type of recidivism data did so hesitantly, discussing at length the methodological complications of using such information. The second note concerns assumptions about offenders used for our analyses. For the purposes of the statutory analyses offered in this report, offenders are assumed to be second offenders, post-conviction, and with no mitigating or aggravating factors.

The structure of the paper follows the repeat offender through an adjudication process typical of most states in the United States. For each step of the process—screening, assessment, and post-sentencing—a literature review is supplemented with primary research and recommendations for New Hampshire. The report concludes with five case studies—three of "good" DWI policies and two of states geographically and demographically similar to New Hampshire.

2. SCREENING

Screening is traditionally the first rehabilitative component of the adjudication process. This preliminary procedure is intended to identify which offenders require further assessment and subsequent treatment for a substance abuse disorder and which do not.

Stewart and Connors, doctors writing for the National Institute on Alcohol Abuse and Alcoholism, define screening as "the application of a test to members of a population…to estimate the probability of their having a specific disorder."[1] Screening is typically a single event, such as an interview or test, prior to a more detailed assessment. It can be conducted in a variety of health care and criminal justice settings and often does not require a mental health professional to be administered. For example, court personnel who have completed a brief training process frequently conduct screening in addition to their general responsibilities. Pre-Sentencing Investigation laws in 40 out of 50 states now mandate that repeat DWI offenders undergo a screening procedure before sentencing. Though the specific motivations for this law may vary by state, the clearest benefit to pre-sentence screening is that it allows justice professionals to integrate personalized treatment into an offender's sentencing requirements.

3. ASSESSMENT

An assessment is traditionally used to provide a more detailed look at an individual's need for treatment. It specifies the level and type of care necessary to overcome a substance abuse problem. 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."[2] Assessments are intended to follow from a preliminary screening based on need. However, screening is increasingly bypassed and assessment is often the starting point for offender rehabilitation. The effects of this will be discussed in the next section. The evaluative depth achieved through assessments is seen as a valuable way to prevent recidivism in the DWI offender population. This perspective 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."[3]

Assessments are primarily designed to determine the severity of an individual's substance abuse problem, evaluate an individual's preparedness for treatment, and explore possible co-morbid health issues. Assessments often involve several evaluation techniques. These include an interview and/or a self-report questionnaire that are synthesized to create a composite score. As such, they are more comprehensive in form and interpretation than screening procedures. This complexity generally necessitates administration by a trained mental health professional in a health care setting. Finally, several insurance policies require an assessment as a criterion for reimbursement of treatment—a significant concern for offenders required to complete treatment at their own expense as part of a DWI sentence. [4]

4. SCREENING AND ASSESSMENT IN THE ADJUDICATION PROCESS

4.1 Recent Trends in Screening and Assessment

Three major trends are transforming the role of screening in the adjudication process for DWI repeat offenders. The most significant recent change is the fusion of screening and assessment to create a one-step evaluation process. This combination of two distinct steps

may be problematic "with regard to the hard core offender who requires a more thorough approach to interrupt their addiction patterns."[5] This concern is born out by evidence showing that a large proportion of DWI repeat offenders suffer from a substance abuse disorder requiring treatment in order to decrease the probability of recidivism. The presence of other mental health issues complicates the treatment and recovery process. If the proper treatment is not identified, those individuals are likely to re-offend, thereby doubling the state expenditure necessary. So while state and local criminal justice systems may be phasing out the two-step process in favor of a single, in-depth assessment—and therefore a single expenditure—this doesn't necessarily result in decreased expenditures. This issue will be discussed further in the treatment and procedural recommendation sections.

An additional change is seen in the methodology of screening and assessment procedures. Increasingly, informal measures obtained from case files and sources beyond the offender are used in DWI offender evaluations. Such measures include blood alcohol concentration, history of treatment, and criminal record. This type of data is often incorporated into the process and displaces rather than supplements information acquired through interviews and tests. By removing portions of the assessment procedure, the recommendations that would be provided by the instrument cannot be fully incorporated into the final treatment plan. Instead, past experiences of the evaluator inform the decision based on the informal measures described above. Research shows that "the use of actuarial-based tests almost always greatly out-performs intuitive judgment when it comes to screening and assessment" of DWI offenders.[6] This also creates the opportunity for inconsistency and discrimination in the evaluation process due to personal biases and administrator variation. These types of interference in the process may lead to a decreased ability of justice professionals to accurately identify individual need for further treatment.

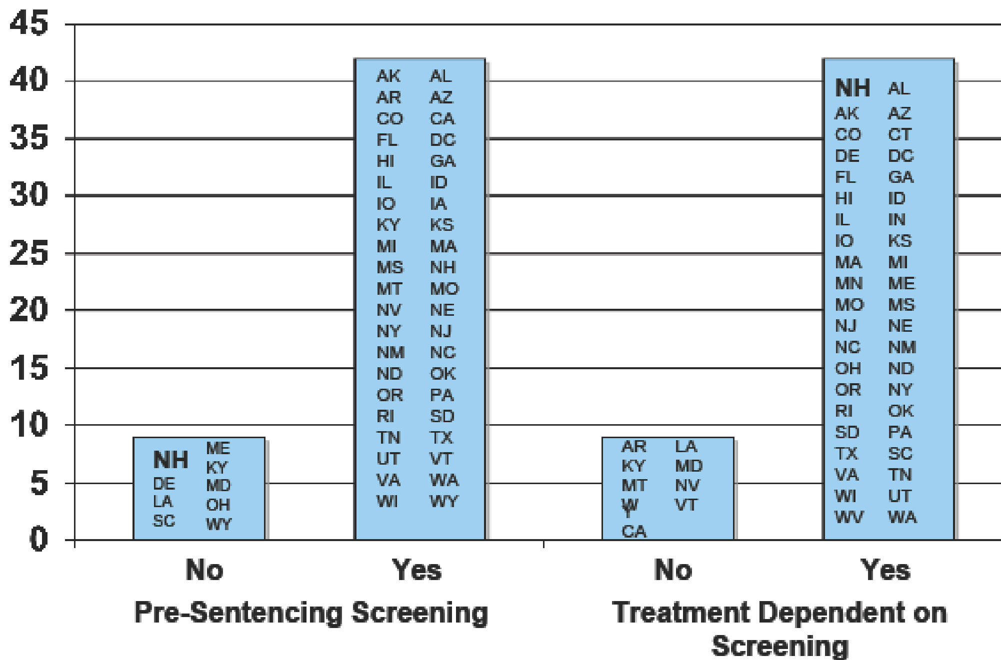
Finally, screening procedures and instruments are now frequently used as benchmarks throughout the treatment process. As opposed to their initial function to identify which DWI offenders do or do not require treatment, they are now used to monitor offender progress. This application offers a standardized methodology for measuring movement through the substance abuse rehabilitation process. This also enables the criminal justice system to hold both DWI offenders and treatment providers accountable after sentencing. However, administrative and feasibility concerns accompany this utilization of screening procedures. Associated paperwork and filing could add to an already unmanageable workload for caseworkers involved with the multiple DWI offender population. This may limit the number of screenings that are successfully completed and filed. Irregular implementation of these checkpoints could have many negative consequences for DWI offenders. It is possible, for example, that one could make substantial progress that goes unverified by the criminal justice system. If official verification is a requirement of satisfying one's sentence, this could leave offenders in a dangerous state of limbo that would impact many aspects of their lives, from transportation to employment prospects.

4.2 New Hampshire's Procedures

As an overview, second offenders in New Hampshire are automatically sentenced to three days in jail followed by a seven-day inpatient education program. At the end of the education component, each offender is assessed to determine the type and length, of treatment that will be required as part of their probation. The logistics and requirements for this program will be elaborated upon in the treatment section of this paper, but it is important to consider how this structure impacts the role of screening and assessment procedures in the adjudication process. This sentencing process does not necessitate a pre-sentencing screening because offenders are all ordered to attend the same program. This design is unique and other state laws are moving in the direction of early screening for all repeat offenders to better inform the sentencing process.

Figure 1 below illustrates all fifty states' "pre-sentencing screening" (screening before sentencing) and "screening-informed treatment" (treatment varies based on screening results) policies. The figure clearly demonstrates the trend toward pre-screening sentencing as well as individualized treatment based on in-depth evaluations. New Hampshire is one of just a few states that does not require a pre-sentencing screening but does use an assessment to shape the rehabilitation process. This anomaly is most likely attributed to the inpatient program, which adopts a one-step evaluation process for repeat DWI offenders at the end.

Figure 1: Timing and Role of Screening in the Adjudication Process



Instrument Overview: Currently in Use by New Hampshire

In November of 2002, the AAA Foundation for Traffic Safety sponsored an academic study examining the quality of screening and assessment instruments currently used with the DWI population. The primary factors considered in the evaluations were each instrument's ability to predict DWI recidivism and/or identify alcohol-use disorders (AUD). In the study, New Hampshire reported five different assessment instruments in the sentencing process for DWI offenders. Most recently, just two instruments are reportedly being used in New Hampshire—The Driver Risk Inventory-II and the Research Institute on Addiction's Self-Inventory. However, it is likely that some of the facilities providing the residential education program may still be using the older assessment tools. Instrument use appears to vary geographically, with each facility deciding which to implement. The following descriptions outline the major components of each system currently in use by service providers in the state as well as the Foundation's analysis of their credibility and applicability to the DWI offender population.

4.2.1 Driver Risk Inventory-II (DRI-II)

According to the AAA study, the DRI-II is most highly recommended instrument currently in use by New Hampshire. It was developed in 1987 specifically for DWI screening and was in use by 12 states at the time of the study. It contains six independent scales: driver risk, stress coping, alcohol, drugs, truthfulness, and substance dependence.[7] The substance dependence scale is the most recent addition to the instrument and is based on Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV) criteria. One of the most attractive aspects of this instrument is that it is computerized, which means it generally does not require that health care professionals conduct the assessment. Statewide contracts for the DRI-II result in a cost of just $7.00 per test. The AAA Foundation study placed it in the 'medium recommended' category based on its reliability, validity, and well-rounded approach.

4.2.2 Research Institute on Addiction's Self-Inventory (RIASI)

RIASI was developed in 1997 and is one of the newest instruments developed for diagnostic evaluation of DWI offenders. A study performed by the Centre for Addiction and Mental Health in Toronto, Canada, confirmed RIASA's ability to predict which individuals will have drug and/or alcohol problems in the future.[8] It is administered by pencil and paper and hand-scored to provide a continuous problem-drinking score.[9] One potential drawback of RIASI is that, unlike computerized instruments such as the DRI-II, it does not provide a printout of recommended treatment procedures. Cut-offs for the continuous score the instrument yields indicate the level of treatment needed, but some interpretation is still required. However, its efficient scoring and reliability make RIASI a good option for DWI screening and assessment.

Instruments Likely to Be in Use by Some New Hampshire Facilities

4.2.3 Substance Abuse Life Circumstances Evaluation (SALCE)

SALCE is a promising instrument for DWI offender assessments. However, until more research more definitively establishes its validity as an evaluation tool for DWI offenders, it can only be recommended with reservation. SALCE was also developed for DWI offenders in 1986 and is currently used by nine states. This instrument evaluates life stress issues, alcohol and drug use, offender driving records, general attitudes, emotional stability, relationships, employment, health, and criminality. Despite its thorough approach, "the instrument lacks sufficient rigorous research that would demonstrate its validity."[10] It is a popular instrument for reasons similar to the DRI: it is computerized, commercially available, and offers a relatively short processing time. Further adding to its convenience, it does not require a trained administrator.

4.2.4 Mortimer-Filkins (MF)

The MF was designed in 1971 specifically for DWI offenders and is used in 21 states.[11] It consists of a self-report questionnaire and an interview, but the interview is sometimes excluded. The MF includes topics such as recent stress, employment and finances, marital and family problems, drinking, feelings, depression, and coping abilities. It places individuals into one of three risk-categories: social drinker, presumptive problem drinker, or problem drinker. Authors of the AAA study found its use "problematic" in that it demonstrated minimally acceptable results for predicting DWI recidivism and the presence of AUD.[12]

4.2.5 Michigan Alcoholism Screening Test (MAST)

The MAST was developed in 1971 and is currently used in fourteen states. It was designed to "provide a consistent, quantifiable, structured interview instrument to detect alcoholism."[13] This tool is one-dimensional in that is intended only to identify the presence of an alcohol use disorder (AUD) and functions similar to a screening. This tool could be implemented for either screening or assessment of DWI offenders. This is true of many of the instruments discussed in this report. While this tool is used widely across states, it is faulted for inconsistent results and easy falsification of answers by interviewees. Despite its 26 years in use, very little research has explored the efficacy of this procedure. The AAA Foundation report does not recommend its use.

4.2.6 Cut-Down, Annoyed, Guilt, and Eye-Opener (CAGE)

CAGE was developed in 1974 and is being used in five states. Strengths of this instrument include "its brevity, non-threatening nature, and ease of scoring."[14] Similar to the MAST, this tool was not developed specifically for the DWI population which, studies show, decreases its utility as an evaluation tool in the criminal justice setting. One study found that of four assessment instruments, CAGE had the lowest estimated

reliability.[15] Additionally, it evaluates only for AUD, which limits its usefulness for the DWI application. Overall, the AAA study did not recommend CAGE for DWI assessment purposes.

4.3 Recommendations for Evaluating DWI Multiple Offenders

4.3.1 Instrument Recommendations

The AAA study discussed in the previous section used a complex combination of factors to establish confidence in two assessment instruments currently used for DWI offenders. The main concern was predictive ability, "how well the instruments categorized offenders as high or low risk."[16] This ability was characterized by predicting DWI recidivism and identifying AUD. In addition, the researchers considered four administrative criteria: ease of administration, relevancy of testing domains, reliability, and applicability of the treatment recommendations. The two highly recommended instruments from this study are the MacAndrew Alcoholism Scale and the Alcohol Use Inventory.

The MacAndrew Alcoholism Scale (MAC) of the Minnesota Multiphasic Personality Inventory (MMPI) was developed in 1943 and revised in 1989 to screen for "personality characteristics related to alcoholism without explicitly mentioning alcohol."[17] One of the strengths of the MAC scale is that it has been widely used and well studied within various clinical populations. It is also used to predict recidivism rates for DWI offenders and has been evaluated positively for its ability to do so. This instrument does require administration and interpretation by a trained professional, so while it is extremely valuable in the adjudication process for repeat DWI offenders, it is best used in conjunction with a screening tool that focuses resources on individuals at risk of problem drinking or associated disorders.

The Alcohol Use Inventory (AUI) was developed in 1977 and is currently used only by West Virginia. It includes 218 questions in four areas concerning alcohol use: benefits, styles, consequences, and concerns. Of the twelve instruments evaluated in the AAA Foundation study, it was the only other instrument to demonstrate predictive validity for DWI screening—detecting 71 percent of recidivists and 49 percent of potential problem drinkers.[18] Similar to the MAC, it is a lengthy process and is best used in conjunction with a reliable screening instrument. Additionally, the tool was normed for a hospitalized population, so when using the AUI for DWI populations, the cutoffs for determining alcohol abuse should be lower. Finally, the AUI does not evaluate for other drug use. Despite these weaknesses, its predictive validity for DWI recidivism warrants its recommendation.

4.3.2 Procedural Recommendations

Studies dating back nearly fifteen years continue to assert that at a minimum, a brief screening should occur prior to sentencing for repeat offenders.[19] There are two main reasons for this recommendation. The first is monetary—by performing low-cost, brief

screenings prior to sentencing, the criminal justice system is spared the expense in time and labor costs of administering an assessment to someone who does not require alcohol treatment. Relatedly, if the state takes the time to fully evaluate offenders that early screening identifies as needing treatment, the likelihood of recidivism decreases as do the associated social and monetary costs. The second reason is that early intervention of any kind in the adjudication process is shown to be clinically beneficial to the offender in the long run. The sooner offenders, particularly hardcore (repeat) offenders, come into contact with substance abuse treatment in any form, the sooner they can begin the recovery process and the less likely they are to recidivate.[20] The best way to engage offenders early and focus resources on those who need it the most is to maintain the two-step evaluation process with a preliminary screening and a subsequent, more detailed assessment.

Additionally, states should be wary of implementing screening procedures as progress checkpoints throughout the treatment and recovery process. In their 2003 Hardcore Drunk Driving Sourcebook, the Century Council devoted a section to the extensive paperwork that accompanies DWI adjudication. Besides causing inefficiency in the system, "excessive paperwork can also lead to frustration, and subsequently, errors or incomplete details in reports."[21] Adding to this already unmanageable workload by requiring caseworkers to complete periodic screenings with each offender would undoubtedly increase the probability of these errors.

As for which assessment tools are best for New Hampshire, both the science and criminal justice communities eagerly await further research to help answer this question. A review of literature by the AAA study and by the authors of this paper revealed that little rigorous research in this area exists. Of the instruments currently in use by the state, SALCE receives the best review. However, consideration of other evaluation tools with evidence of predictive validity and cost-effectiveness is warranted. As a final note, New Hampshire may consider streamlining the assessments that occur across facilities offering the inpatient education program. This action can contribute to a consistent and fair system for dealing with repeat DWI offenders while potentially reducing costs on an administrative level.

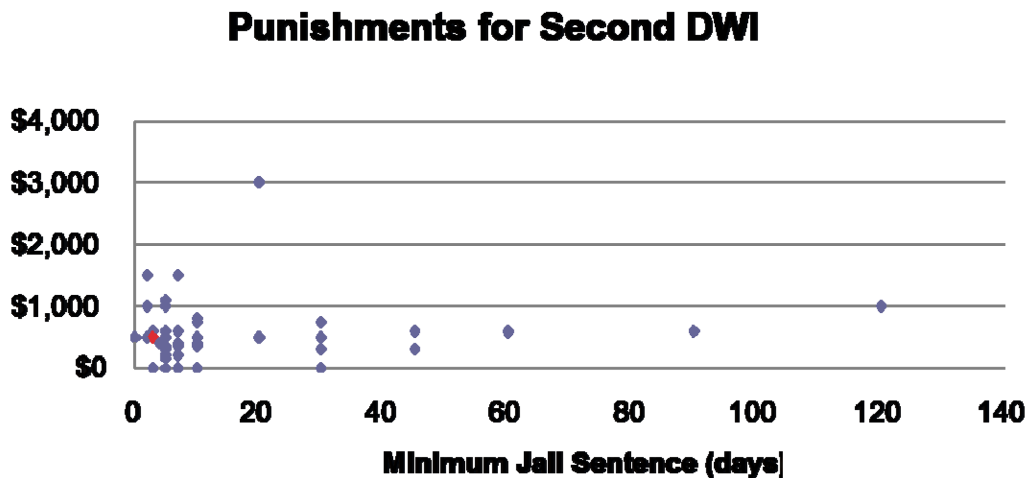
5. POST-CONVICTION SENTENCING: APPROACHES AND OPTIONS

The legal consequences of impaired-driving convictions fall along three dimensions: *punishment*, *prevention*, and *rehabilitation*. Current research recommends combining elements of all three, and most states' policies (including New Hampshire's) do. The challenge is to discern *which* elements and combinations are the most effective. Unless otherwise noted, all charts and figures concerning state laws in this section are derived from our review of impaired-driving statutes nationwide.

5.1 Punitive

Among punitive sanctions for driving while impaired, incarceration and fines are by far the most common. All states but New York mandate jail for second offenders and the national median minimum sentence is seven days. Minimum fines are imposed in 42 states and the District of Columbia, with a median of $500. New Hampshire (red dot) falls at the 10th percentile for jail time and the 32nd percentile for fines, as the chart below shows. We found no significant relationship between minimum jail sentence and minimum fine; the severity of both seems more or less arbitrarily determined.

Figure 2: Jail time and fines



The peer-reviewed literature on addiction and impaired-driving policy contains little evidence that punitive sanctions act as deterrents. Taxman (1998) found that punishment was less effective than education and treatment in preventing recidivism, and that "the movement toward more punitive sanctions against drunk drivers is not advantageous."[22] Wagenaar et al. (2007) found no statistically significant effect of mandatory jail time on alcohol-related fatal car crashes, but a possible small effect of mandatory fines.[23] In a sample of 521 multiple impaired-driving offenders, Yu (2000) found that offenders' alcohol problems were the strongest predictor of future convictions, and that when alcohol problems were controlled for, punitive sanctions did not significantly reduce the chances of recidivism.[24]

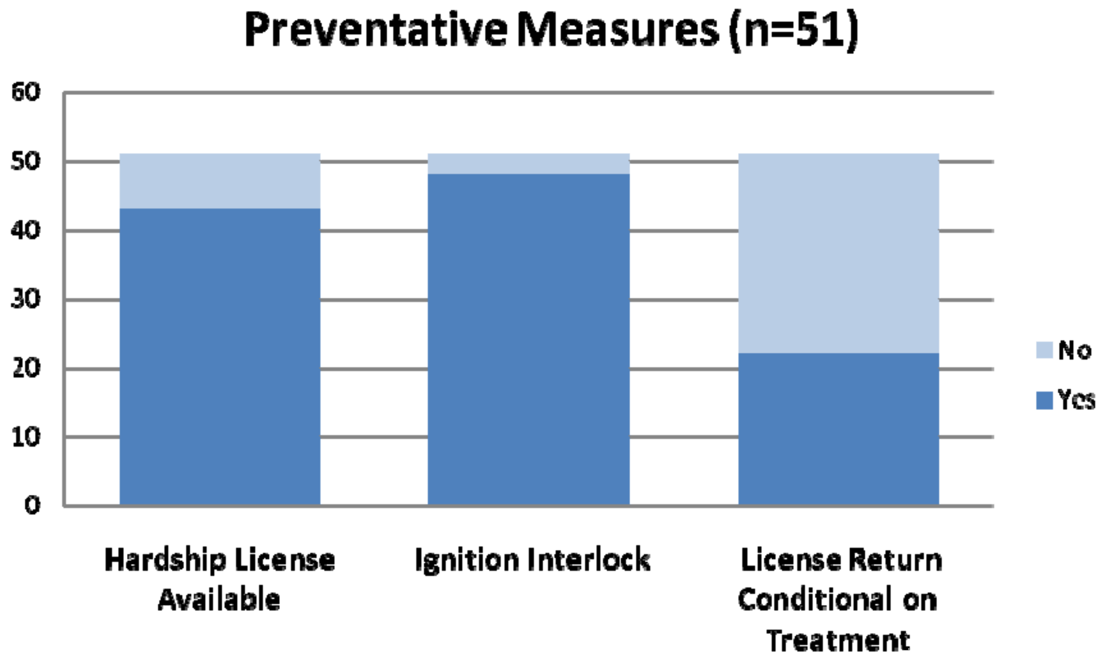
Given their minimal deterrent effect, fines in the United States serve primarily as retribution and to defray the cost of sentencing and treatment.[25] This also means that the precise nature or severity matters less for punitive than other types of sanctions.

5.2 Preventative

Preventative measures are meant to get impaired drivers off the road for the protection of the public. The most common is license suspension or revocation, present in some form in every state, with suspensions ranging from four months in Maryland to 60 months in Florida and Missouri. A modern variant is the ignition interlock device, which requires the driver to breathe into an analyzer mounted on the dashboard before operating the vehicle. Interlock devices are used in all but three states (South Dakota, Alabama, and Vermont), though the extent varies.

The chart (figure 3) below shows the proportion of states that allow variations or modifications of conventional license suspension. New Hampshire does not issue hardship licenses, which allow driving under restricted circumstances during suspension, though 42 states and the District of Columbia do. License return after suspension is conditional on treatment in only 22 states, not including New Hampshire. However, we note in the case studies later in this report that the states whose programs stood out as models all included some element of conditionality. At 36 months, New Hampshire's suspension for second offenders is the second longest in the country and three times the median of 12 months.

Figure 3: Common Preventative Measures



Evidence on the effectiveness of administrative license suspension is mixed, and for repeat offenders, largely discouraging. The Century Council's National Hardcore Drunk Driver Project (2009) states that suspension is effective because it is "swift and sure,"

contributing to a 30-percent reduction in alcohol-related fatal crashes in the United States between 1982 and 1997.[26] But the report concedes that licensing sanctions may not work on hardcore multiple offenders, who are "more likely to violate the conditions of license suspension and also are more likely to be drunk while doing so."[27]

In a meta-analysis of past research on hardcore drunk driving, Freeman et al. (2006) conclude that "the overwhelming evidence … suggests that licensing sanctions generally fail to deter habitual offenders from continuing to drink and drive."[28] The authors attribute this failure to the fact that legal sanctions alone do not produce long-term behavioral change. Beck et al. (1999) reinforce this claim, writing that "the effectiveness … may be limited with multiple alcohol offenders, many of whom continue to drive with a suspended or revoked license."[29] And offenders who continue to drive despite a suspended or revoked license are overrepresented in fatal crashes, according to the National Hardcore Drunk Driver Project.[30]

Thus, the interlock device has two distinct advantages over license suspension. First, it is *harder to circumvent* (as it requires obtaining another vehicle in violation of court order), while a suspension can be easily ignored. Second, the device prevents *only* impaired driving, but allows driving for work, errands, medical and counseling appointments, and so on, provided that the driver is sober. In a rural state where most depend on cars for transportation, the latter is especially important. Lenton et al. (2010) report that in a sample of repeat offenders with at least two convictions, 74 percent admitted to driving while unlicensed; needing to obtain and keep employment was the most frequently cited reason.[31]

So far, the evidence on the effectiveness of ignition interlock is promising. Arkansas Judge Fulkerson (2003) found in a three-year study that the breath-analyzed ignition interlock device significantly reduced recidivism for multiple offenders, even after the device itself had been removed.[32] Beck et al. found that an interlock program can "significantly reduce recidivism among drivers with multiple alcohol traffic violations," but that the effects were limited to the first year while the device was in place. [33] Nevertheless, they write,

"It may be that chronic offenders who are going to commit another alcohol traffic violation are more likely to do so during the first year of a license restriction program than in the next 12 months. An interlock restriction in the first year may serve to restrain chronic offenders during this high-risk period."[34]

The caveat, of course, is that "for certain chronic offenders, interlock restrictions may have to be maintained for longer than 12 months—perhaps indefinitely."[35] The costs for the device, normally charged to the offender, are estimated by the Florida Department of Highway Safety and Motor Vehicles as follows: "$12 interlock fee, $70 for installation $67.50 for monthly monitoring and calibration, $100 refundable deposit or a $5 monthly insurance charge."[36] For a year's sentence, in other words, the cost to the offender would be approximately $900.

In Sweden, a two-year alcohol ignition interlock program (AIIP) has been offered since 1999 as a voluntary alternative to a 12- to 24-month license revocation. Participants must be examined by a physician every three months, including blood and urine testing as proof of sobriety, and an unrestricted license is automatically reinstated upon satisfactory completion of the program.[37] Among those who had successfully completed the AIIP, Bjerre and Thorsson found significantly improved chances of regaining a full license, considerably lower recidivism rates, and a marked reduction in the number of police-reported accident rates compared to control groups.[38]

The authors attribute the unusually long-lasting effect of the program to the inclusion of regular medical check-ups and the emphasis on behavioral change, highlighting the importance of a holistic approach to sentencing.

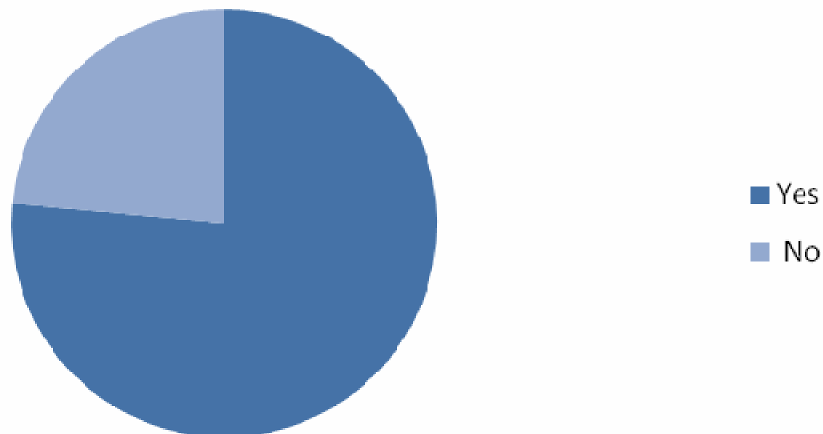
5.3 Rehabilitative

The last and most complex facet of sentencing is rehabilitation, which attempts to address not only the behavior, but the underlying issues causing it. Rehabilitation comprises both education and treatment, and both inpatient and outpatient treatment programs are widely used.

Below, two graphs show the extent to which state policies incorporate flexibility in their rehabilitative policies. More than three-quarters of states (figure 4), including New Hampshire, vary treatment options based on the results of screening and assessment. This allows for a more individualized treatment plan.

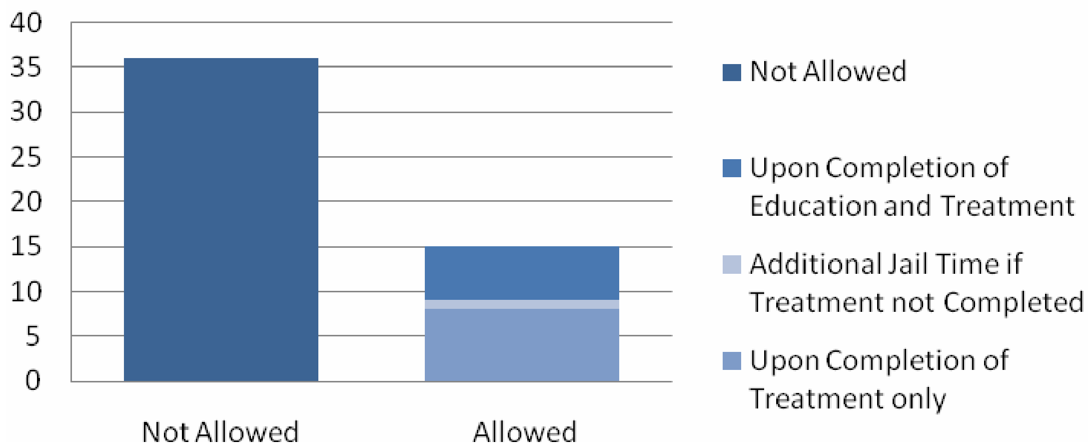
Figure 4: Customized treatment policies

Treatment Dependent on Screening (n=51)



Fewer states allow sentence reduction (figure 5), such as earlier license reinstatement, upon satisfactory completion of treatment. This may be a promising option to explore, however, as it supplies an additional incentive for compliance; the case studies discuss this in further detail.

Figure 5: Treatment as an incentive



Unfortunately, comparing the effectiveness of treatment programs is difficult. Arria et al. (2005) write that "the literature on this topic is incomplete and the studies are plagued with methodological problems, including small sample sizes, high attrition, and lack of generalizability."[39] The one consistent finding, according to this report, is that treatment in the absence of legal sanctions seems to have little impact on recidivism. Thus, though punitive sanctions by themselves have little effect, punishment combined with treatment may be more effective than treatment alone.

Complicating the matter, a comprehensive treatment plan must account for the high prevalence of comorbid psychiatric disorders in addition to substance abuse disorders (so-called dual diagnoses) in repeat impaired-driving offenders. In a sample of 459 multiple offenders, Lapham et al. (2006) found that a majority were alcohol dependent; 65 percent of men and 78 percent of women had at least one comorbid psychiatric disorder, with major depressive disorder, dysthymic disorder, and post-traumatic stress disorder most frequent.[40] McMillan et al. (2008) found that bipolar disorder, major depression, and obsessive-compulsive disorder remained undiagnosed at alarming rates during treatment,[41] suggesting that better screening mechanisms are called for. Incorporating psychiatric treatment into substance abuse treatment could improve long-term outcomes and potentially reduce recidivism.

To date, the cornerstone of New Hampshire's approach to rehabilitating multiple impaired-driving offenders has been the week-long residential education program. However, according to the National Hardcore Drunk Driver Project, this type of intensive education program is most effective for the "non-addicted multiple offender;"[42] it is far less suitable for the majority of repeat offenders who do have serious alcohol problems.

In the place of intensive inpatient programs, the NHDDP recommends outpatient treatment for at least three months, consisting of weekly individual or group sessions with a therapist or counselor.[43] Treatment should be based on a combination of strategies, "such as education plus therapy plus follow-up," and should allow time for meaningful behavioral change, which may require at least nine to 12 months.[44]

6. CASE STUDIES

In the course of our research for this report, we spoke with a number of experts in the field of alcohol abuse treatment. Almost every interviewee mentioned the same three states as examples of particularly well-designed treatment programs for multiple DWI offenders. We begin our case studies by examining these three model states of New York, California, and Connecticut. Since these states differ markedly from New Hampshire in size and population distribution, we also examine treatment regulations in Vermont and Maine, two fairly comparable neighboring states.

6.1 New York

All aspects of New York's assessment and treatment of multiple DWI offenders are enumerated in Vehicle and Traffic law 1198-a, which came into effect on November 1, 2007.[45] It requires that multiple DWI offenders undergo a mandatory screening and assessment for alcohol abuse conducted by a substance abuse professional or licensed agency upon arraignment.[46] The assessment is then forwarded to the court, which must incorporate its treatment recommendations into the offender's sentence.[47] When the offender has successfully completed the treatment regimen, he or she may petition the commissioner of OASAS for the reinstatement of their license.[48]

Several elements of New York's laws for DWI offenders are unique. First, the screening and assessment process is directly linked to sentencing. This setup tailors sentences to the treatment needs of the offender while ensuring that appropriate treatment is included in every sentence. Second, the possibility of early license reinstatement is used as an incentive for offenders to complete their treatment regimens. Overall, the procedure is straightforward and streamlined: assessment determines treatment, which allows for sentence reduction.

6.2 California

California requires multiple DUI offenders to undergo an eighteen-month outpatient education and group counseling program.[49] Twelve hours of substance abuse education

over six weeks is accompanied by 52 hours of weekly group counseling, with individual interviews every other week.[50] Group counseling sessions focus on identifying and addressing alcohol problems and making positive lifestyle changes.[51] After completing the first twelve months of treatment, an offender can receive a restricted license upon the installation of an ignition interlock device.[52] For the last six months, offenders are required to attend monthly one-hour group sessions and four hours a month of community re-entry activity.[53]

California's law differs from that of New York in that all multiple DWI offenders must attend a standard outpatient treatment program. The benefit of the standard program is that it is simpler to implement as it obviates the need for a binding assessment. It also incorporates an incentive by allowing a restricted license after completion of the main part of the program.

6.3 Connecticut

In Connecticut, a second DUI conviction requires the completion of a substance abuse treatment program of no less than nine months prior to the restoration of a driver's license.[54] The treatment program is administered by one of four nonprofit organizations spread across the state. The treatment programs are divided into four phases: evaluation, a weekend inpatient "retreat", an outpatient aftercare program, and a follow-up and monitoring period.[55] All of the programs begin with an initial evaluation by a substance abuse counselor.[56] A 48-hour weekend intensive inpatient program follows, incorporating education and group counseling. The length of aftercare varies between the providers, ranging from ten weeks to 18 months of outpatient group counseling and individual counseling. In the final phase, participants are required to attend monthly or quarterly group sessions for six months to two years as well as AA meetings.[57] License restoration also varies between the providers. Connecticut Renaissance allows participants to apply for license reinstatement after the third phase of the program, but the license will be revoked if the participant does not complete the final stage of treatment.[58] MCCA recommends license restoration after completion of the final stage of the program.[59]

Connecticut's program is unique in that it allows offenders to attend one of several programs with slightly varying approaches. Some of these programs have achieved very good results: of the nearly 4,000 DWI offenders participating in The Commonwealth Group program since 1996, fewer than 5 percent have been arrested again for DWI.[60] The possibility of early license restoration also creates an incentive for offenders to complete treatment.

6.4 Vermont

In Vermont, a second DWI offender must enroll in the state driver rehabilitation program (Project CRASH) within 30 days of license suspension or answer to a noncompliance hearing.[61] The CRASH education program offers offenders the choice of a weekend inpatient session and a 10-hour outpatient program. Inpatient sessions are offered at two facilities, while outpatient programs are offered at fourteen.[62] Though treatment is only

required for first offenders identified as having an alcohol problem by an exit interview, all second offenders are assigned treatment programs with a Licensed or Certified Alcohol and Drug Counselor which they must complete before the reinstatement of their license.[63]

6.5 Maine

In Maine, all people convicted of Operating Under the Influence (OUI) are mandated to attend a 20-hour Risk Reduction education program, which involves a preliminary screening instrument.[64] If the screening instrument suggests the presence of a substance abuse problem, offenders are referred to a 2-4 session clinical substance abuse evaluation conducted by a certified counselor.[65] If the counselor prescribes treatment, the offender must complete the treatment regimen before license restoration. An offender has the right to seek a second opinion evaluation and to appeal to an independent board of substance abuse professionals if the Office of Substance Abuse refuses to sign off on the completion of treatment.[66] Alternatively, an offender that admits to a drinking problem can opt to enter directly into treatment.[67]

7. CONCLUSION

Though it is difficult to judge relative effectiveness of DWI policies in the absence of reliable recidivism data, the academic literature and conversations with experts have pointed us toward several best practices. We recommend that New Hampshire consider implementation of an assessment instrument with proven reliability according to studies such as the AAA study. Examples include the MAC, the AUI, or expanded use of the DRI-II. Additionally, statewide standardization may improve consistency between facilities and lower administrative costs by qualifying for statewide contract discounts. New Hampshire's punitive measures are reasonable as compared to other states, although we caution that punitive measures are only effective at reducing recidivism in combination with education and treatment. Because license suspension is unlikely to prevent hardcore offenders from driving drunk, we suggest supplementing license suspensions with hardship licenses conditional on alcohol interlock and enrollment in treatment. Full license restoration can be contingent on satisfactory completion of treatment. Finally, we suggest shifting the focus of multiple offender rehabilitation from intensive inpatient education to long-term outpatient treatment.

REFERENCES

[1] Steward, S.H., and G.J. Connors (2004/2005). Screening for Alcohol Problems: What makes a Test Effective? National Institute on Alcohol Abuse and Alcoholism (NIAAA), page 1.
[2] Substance Abuse and Mental Health Services Administration (SAMHSA) (2005). Substance abuse treatment for adults in the justice system: A treatment improvement protocol TIP 44. U.S. Department of Health and Human Services. Center for Substance Abuse Treatment. www.samhsa.gov. Page 7-8.
[3] Robertson, Robyn, Simpson, Herb, and Peter Parsons (2008). Screening, Assessment, and Treatment: A Guide for Justice Professionals and Policy Makers. Traffic Injury Research Foundation (TIRF), page 11.
[4] Ibid. at 12.
[5] Ibid. at 8.
[6] Ibid.
[7] Behavior Data Systems (2007). Driver Risk Inventory II (DRI-II). <www.bdsltd.com> Accessed April 22, 2010.
[8] Shuggi R, Mann RE, Zalcman RF, Chipperfield B, Nochajski T (2006). Predictive validity of the RIASI: alcohol and drug use and problems six months following remedial program participation. American Journal of Drug and Alcohol Abuse. 2006;32(1):121-33.
[9] Chang, Iyiin, Gregory, Cindy, and Sandra C. Lapham (2002). Review of Screening Instruments and Procedures for Evaluating DWI [Driving While Intoxicated/Impaired] Offenders. AAA Foundation for Traffic Safety. www.aaafoundation.org. Page 15.
[10] Ibid. at 33.
[11] Ibid.
[12] Ibid. at 32.
[13]. Chang et al. at 32.
[14] Ibid. at 13.
[15] Ibid. at 30.
[16] Ibid. at 17.
[17] Ibid. at 14.
18 Ibid. at 29.
[19] National Highway Traffic Safety Administration and the National Institute on Alcohol Abuse and Alcoholism. 1996. A Guide to Sentencing DUI Offenders. Washington, DC: NHTSA and NIAA.
[20] Century Council, The. 2003. The Hardcore Drunk Driving Source book. National Hardcore Drunk Driver Project.
21 Ibid. at 35.
[22] Taxman. On Preventing Drunk Driving Recidivism: An Examination of Rehabilitation and Punishment Approaches. Journal of Criminal Justice (1998) vol. 26 (2) pp. 129-143
[23] Wagenaar et al. General deterrence effects of U.S. statutory DUI fine and jail penalties: Long-term follow-up in 32 states. Accident Analysis and Prevention (2007) vol. 39 pp. 982-994
[24] Yu. Punishment and alcohol problems: Recidivism among drinking-driving offenders. Journal of Criminal Justice (2000) vol. 28 pp. 261-270
[25] National Hardcore Drunk Driver Project. The National Agenda: A System to Fight Hardcore DWI. Century Council. (2009) pp. 1-146
[26] Ibid.
[27] Ibid.
[28] Freeman et al. The self-reported impact of legal and non-legal sanctions on a group of recidivist drink drivers. Transportation Research Part F (2006) vol. 9 pp. 53-64
[29] Beck et al. Effects of Ignition Interlock License Restrictions on Drivers With Multiple Alcohol Offenses: A Randomized Trial in Maryland. (1999) pp. 1-5
[30] National Hardcore Drunk Driver Project (2009)
[31] Lenton et al. Recidivist drink drivers' self-reported reasons for driving whilst unlicensed—A qualitative analysis. Accident Analysis and Prevention (2010) vol. 42 pp. 637-644
[32] Fulkerson. Blow and Go: The Breath-Analyzed Ignition Interlock Device as a Technological Response to DWI. The American Journal of Drug and Alcohol Abuse (2003) vol. 29 (1) pp. 219-235

[33] Beck et al. (1999)
[34] Ibid.
[35] Ibid.
[36] "Ignition Interlock Program." Florida Department of Highway Safety and Motor Vehicles. <http://www.flhsmv.gov/ddl/IID.html>
[37] Bjerre and Thorsson. Is an alcohol ignition interlock programme a useful tool for changing the alcohol and driving habits of drink-drivers?. Accident Analysis and Prevention (2008) vol. 40 pp. 267-273
[38] Ibid.
[39] Arria et al. Assessment and Treatment of DWI Offenders in Maryland, 1995-2003: Current Findings. Center for Substance Abuse Research (CESAR), University of Maryland. (2005) pp. 1-43 <http://www.cesar.umd.edu/cesar/pubs/20050901.pdf>
[40] Lapham et al. Psychiatric Disorders in a Sample of Repeat Impaired-Driving Offenders. Journal of Studies on Alcohol (2006) (September) pp. 707-713
[41] McMillan et al. Underdiagnosis of comorbid mental illness in repeat DUI offenders mandated to treatment. Journal of Substance Abuse Treatment (2008) vol. 34 pp. 320-325
[42] National Hardcore Drunk Driver Project (2009)
[43] Ibid.
[44] Ibid.
45 1198-a. Special *Procedures and Disposition Involving Alcohol and Substance Abuse Assessment and Treatment*. Retrieved from New York State Office of Alcoholism and Substance Abuse Services: http://www.oasas.state.ny.us/dwi/regs.cfm
[46] ibid.
[47] ibid.
[48] ibid.
[49] *Marin County DUI Program*. Available online at http://www.dui-marin.org/program5.htm
[50] ibid.
[51] ibid.
[52] *Resources for Marin County DUI Participants*. Available online at http://www.dui-marin.org/resources.htm
[53] *Marin County DUI Program*. Available online at http://www.dui-marin.org/program5.htm
[54] *Substance Abuse Treatment Program*. Retrieved from CT DMV: http://www.ct.gov/dmv/cwp/view.asp?a=813&q=447460
[55] *DMV Substance Abuse Treatment Program*. Retrieved from Midwestern Connecticut Council on Alcoholism (MCCA): http://www.mccaonline.com/inside/programs/dmvsatp.htm
[56] *DWI/Drug Education*. Retrieved from Connecticut Renaissance: http://www.ctrenaissance.com/go.php?page=drivers
[57] Connecticut Renaissance and MCCA
[58] *DWI/Drug Education*. Retrieved from Connecticut Renaissance: http://www.ctrenaissance.com/go.php?page=drivers
[59] *DMV Substance Abuse Treatment Program*. Retrieved from Midwestern Connecticut Council on Alcoholism (MCCA): http://www.mccaonline.com/inside/programs/dmvsatp.htm
[60] *About Us*. Retrieved from The Commonwealth Group: http://www.commonwealthgroupllc.com/About_Us/index.html
[61] *Drinking Driver Rehabilitation Program (Project CRASH)*. Retrieved from Vermont Department of Health: http://healthvermont.gov/adap/treatment/crash.aspx
[62] *Drinking Driver Rehabilitation Program (Project CRASH)*
[63] *Drinking Driver Rehabilitation Program (Project CRASH)*
[64] *The Risk Reduction Program (PRIME for Life).* Office of Substance Abuse, Maine Department of Health and Human Services: http://www.maine.gov/dhhs/osa/deep/faq.htm
[65] *The Risk Reduction Program (PRIME for Life)*
[66]*Appeals*. Office of Substance Abuse, Maine Department of Health and Human Services: http://www.maine.gov/dhhs/osa/deep/faq.htm
[67] *The Completion of Treatment Program*. Office of Substance Abuse, Maine Department of Health and Human Services: http://www.maine.gov/dhhs/osa/deep/faq.htm