# Treatment or Punishment:

## Sentencing Options in DWI Cases

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Alcohol-related crashes are responsible for many of the traffic fatalities in the United States, and the sad thing is that many of these are preventable. Yet the attitude of the public toward driving while impaired (DWI)[1] is conflicted, and that ambivalence is reflected in the criminal justice process. Unlike other crimes, or even smoking, the goal of the law is not to cease *all* drinking and driving, just drinking that impairs judgment and the ability to drive safely. The question then becomes how much drinking is acceptable before driving, which can vary by health, weight, and tolerance of the individual. On one hand, we as a society want to punish the offender who kills or seriously maims someone because of impaired driving, but on the other, we don't want to enroll the "social drinker" into the criminal justice system. Consequently, it was not unusual in our history to either let impaired drivers off the hook with a warning or reduce their charges to lesser misdemeanors. After all, many impaired drivers do not harm others and those that do did not intend to cause harm. Therefore, some observers argued that DWI offenders should not receive severe punishments.[2] Even if victims were severely injured or killed, prosecutions for manslaughter were rare, and even license suspensions and jail time were imposed infrequently.[3] The words of Judge Robert S. Heise echo the thoughts of many:

> The philosophy of some people is that you have to make the punishment fit the crime. But that's the wrong way to look at drunk drivers. These are social drinkers who went a little overboard. They're not alcoholics or criminals. Most of the time they've done nothing dangerous, but have merely violated a law…I just feel that some of these people [convicted of drunken-driving deaths] have already suffered more than I could impose on them.[4]

The traditional method of dealing with DWI cases has been to use the criminal justice system to arrest, prosecute, convict, and sentence impaired drivers. However, traditional remedies, such as incarcerating offenders, have not proven effective in preventing repeat offenders and may have even increased recidivism.[5] Consequently, even the criminal justice system has recognized that addiction is a health problem and treatment of offenders is the preferred solution, either alone or in conjunction with other sanctions. This, however, leaves the unanswered residual question of whether any punishment is deserved, and if so, what type?[6]

Courts have a role to play in reducing the incidence of impaired driving, especially by selecting sentences that are effective. A significant amount of work on sentencing options has already been done by the National Highway Traffic Safety Administration (NHTSA) and the National Institute on Alcohol Abuse and Alcoholism (NIAA) in their *Guide to Sentencing DWI Offenders*.[7] With advice from a multidisciplinary working group of experts, the *Guide* summarized 30 years of research on the effectiveness of various sanctions on impaired drivers.

Although the *Guide* does an excellent job in describing the various sentencing options available to judges, including a checklist of DWI sentencing options and precise estimates of their likelihood of success, it assumes that judicial sentences can *both* sanction and treat the offender. It is with this premise that sentencing can both punish and treat that I take issue with here. And the issue is not merely academic. Judges must be clear about what they want to accomplish with sentencing because the options available when rehabilitation is the goal are very different than when punishment is the goal.[8] *Conflating the contradictory goals of treatment and punishment leads to a lack of clarity in sentencing behavior and, perhaps more importantly, to unclear measures of success.*

**Footnotes**

1. The term DWI is used throughout this essay as the designation preferred by the National Highway Traffic Safety Administration, and it is used interchangeably with the terms preferred in some states: DUI, driving under the influence and OWI, operating while intoxicated.
2. James D. Stuart, *Deterrence, Desert, and Drunk Driving*, 3 Pub. Aff. Q. 105-115 (1989).
3. Barron H. Lerner, One for the Road: Drunk Driving Since 1900 6 (2011).
4. Joseph D. Whitaker, *A National Outrage: Drunken Drivers Kill 26,000 Each Year*, Wash. Post, March 22, 1981, at A1, A6.
5. David J. Wallace, *Do DWI Courts Work?*, *in* Future Trends in State Courts 92-95 (Carol R. Flango et al. eds., 2008).
6. Stuart, *supra* note 2.
7. Nat'l Highway Traffic Safety Admin. & Nat'l Inst. on Alcohol Abuse and Alcoholism, A Guide to Sentencing DWI Offenders (2d ed., 2005) [hereinafter NHTSA & NIAA].
8. The focus of this article is on the treatment versus punishment dichotomy. Other purposes of sentencing will be subsumed under these broader headings. For example, deterrence is often listed as a purpose of sentencing. If deterrence is specific to an offender, incarceration may be considered a deterrent. But the threat of punishment is a specific deterrent and thus deterrence is listed in the punishment category. (The concept of seeing punishment meted out is a deterrent to others may or may not be valid, but is not relevant to this discussion, which is limited to sentencing options for specific offenses). Incapacitation is also often listed as a separate purpose of sentencing, but to me the goal of the incapacitation is what makes it relevant—it is to punish the offenders and to prevent them from harming themselves and others. Restitution is intended to at least partly return the victim(s) to status quo ante, and that could be seen as a combination of punishment and a first step in treatment. The options become clearer when the basic question is whether sentencing is intended to punish offenders who have harmed society or to rehabilitate the offenders so they will not offend again.

## THE GOAL OF DWI SENTENCING: PUNISHMENT OR TREATMENT?

### A LEGAL OR MEDICAL APPROACH TO DWI

NHTSA's *A Guide to Sentencing DWI Offenders* says "[s]entencing for DWI should be consistent from one court to another regardless of jurisdiction, yet balanced with the need for matching offenders to the most appropriate sanctions and extent of treatment."[9] In their discussion of DWI courts, Tauber and Huddleston are even more direct in identifying the mixed purpose of sentencing:

> …to make offenders accountable for their actions, bringing about a behavioral change that ends recidivism, stops the abuse of alcohol, and protects the public; to treat the victims of DWI offenders in a fair and just way; and to educate the public as to the benefits of DWI Courts for the communities they serve.[10]

Note that this mission seems to expect courts to treat the disease *and* to sanction the offender. The argument here is that it is logically impossible for sentences to be consistent across similar DWI offenses and at the same time tailored to meet the needs of individual offenders, whose needs and degree of addiction to alcohol vary widely. Consistency represents the legal approach to sentencing, whereas individual treatment represents a very different, medical approach to sentencing. These conflicting approaches need to be kept clear and distinct for judges to sentence DWI offenders appropriately.[11]

The traditional legal approach emphasizes the crime by determining responsibility and then meting out punishment when the offender is deemed to be guilty. The basic premise of the legal approach is that humans are all equal before the law. In practice, that means treating "like cases alike"—that is, fairness requires that everyone who commits a similar offense receive a similar consequence. Conditions for finding an accused at fault should be the same for all individuals in similar circumstances. To do otherwise undermines citizen respect not only for courts but for law and government as well.

On the other hand, the medical approach to crime aims to correct the underlying problems that led to the crime. It focuses on protecting public safety by directly attacking the root cause of DWI—alcohol and substance abuse. In its simplest (perhaps oversimplified) terms, the medical approach, as originally applied in the corrections context, assumes:

> … the offender to be "sick" (physically, mentally, and/or socially); his offense to be a manifestation or symptom of his illness, a cry for help. Obviously, then, early and accurate diagnosis, followed by prompt and effective therapeutic intervention, assured an affirmative prognosis — rehabilitation.[12]

**"Different evaluation criteria are required to measure success depending upon whether the goal of the sentence is punishment or treatment."**

The remedial approach attempts to alter the personal risk factors that lead to impaired driving.[13] It treats the individual, which involves diagnosis of the problem and the development of an individualized treatment plan—which by its very nature is antithetical to treating like cases alike. Compliance with treatment is verified by frequent testing for alcohol and drug abuse, close community supervision, and frequent court hearings.

This approach is an extension of the trend toward what was once called *alternative sanctions*. Alternative sanctions were created, at least partially, by the perceived failure of punishment to stop the revolving door of recidivism. As summarized by one judge: "where the level of punishment required is diminished by the need to solve the underlying problem…so you'd rather solve the problem than punish the behavior"[14]

Restrictions on driving may be imposed as a punishment in and of itself or as a safeguard to the public until a program of treatment is completed. It is therefore necessary to classify sentencing options by their intended purpose—punishment or treatment. As an extreme example, persons involved may not perceive a distinction between solitary confinement as a punishment and confinement in a padded cell to prevent a patient from injuring themselves, but the intentions are different.

### EVALUATION CRITERIA

Evaluating sentencing success is difficult. The argument proposed here is that different evaluation criteria are required to measure success depending upon whether the goal of the sentence is punishment or treatment. If punishment is the goal, consistency in sentencing is absolutely essential to assure fairness among offenders convicted of similar DWI offenses. How-

9. NHTSA, Initiatives to Address Impaired Driving 3 (2003).
10. Jeffery S. Tauber & C. West Huddleston, Nat'l Drug Ct. Inst., DUI/Drug Courts: Defining a National Strategy 5 (1999).
11. The distinction between the legal approach to crime and the medical approach is discussed in Victor E. Flango & Thomas M. Clarke, Reimagining Courts, Ch. 8 (2015) and reflects a much earlier debate on sentencing: should the punishment fit the crime or fit the criminal? The need for separating problem-solving processes and traditional adversarial court processes is discussed in Victor E. Flango, *Never the Twain Shall Meet: Why Problem-Solving Principles Should Not Be Grafted onto Mainstream Courts,* 100 Judicature 30-36 (2016). Another way of portraying the different models is that the sciences (including medicine) are inherently probabilistic and subject to revision as new information becomes available, whereas the law demands the appearance of certainty and irrevocability. *See, e.g.* Gary B. Melton et al., Psychological Evaluations for the Courts 11-22 (3rd ed. 2007).
12. Donal E.J. MacNamara, *The Medical Model in Corrections: Requiescat in Pace*, 14 Criminology 439, 439-40 (1977).
13. Alan Cavaiola & Charles Wuth, Assessment and Treatment of the DWI Offender (2002).
14. Donald J. Farole, *Applying Problem-Solving Principles in Mainstream Courts: Lessons for State Courts*, 26 Just. Sys. J. 65 (2005).

**"The downside of using recidivism rates is that DWI arrests and crashes are infrequent occurrences even for intoxicated drivers."**

ever, consistency cannot be used to measure effectiveness of treatment programs, which by their nature must be tailored to the individual to be successful, regardless of how others similarly situated were sentenced. Reduction in recidivism is the primary way to evaluate the effectiveness of sentencing to treatment.

Before discussing in more detail the relationship between sentencing for punishment and treatment, one other complication must be mentioned. Some offenders apprehended for the very first time may be unlikely to offend again even *without* treatment or punishment. Indeed, one study reports that about a quarter of DWI offenders become repeat offenders, but a *majority* of persons arrested for DWI do not repeat the offense.[15] Which of the sentencing options is necessary for that majority of offenders?

***Consistency of Penalties***

The traditional legal approach, with its emphasis on determining guilt and meting out punishment, in one sense, provides a good control group. Except to establish a baseline, it is unfair to use recidivism to measure the success of sentencing options whose purpose is to punish the offender. If the goal is punishment, the only criteria for success is: did the offender complete the punishment, i.e., serve the required sentence, pay the fine, etc? Consistency of sentences becomes a major concern for the sake of fairness. Indeed, the consistency argument was used to make a case for specialized DWI enforcement agencies at the state level, separate incarceration facilities, and of course, specialized DWI courts.[16] That recommendation for specialized DWI courts was made before the advent of the specialized problem-solving courts in existence today, but instead favored specialized courts similar to small-claims court to handle misdemeanor DWI offenses. The growth of problem-solving courts, including drug courts and their offshoot DWI courts, represents the increasing emphasis on the medical approach of treatment and rehabilitation of offenders, which in turn reduces the number of future arrests, prosecutions, and court cases. The advantages of specialized DWI courts are more consistency in sentencing, the prevention of "judge shopping," reduction in number of plea agreements, and fewer pleas to reduced charges, such as reckless driving, as substitutes for DWI guilty pleas.[17]

More than half (54 percent) of the law enforcement officers in the Traffic Injury Research Foundation survey reported they do not believe the penalties imposed by judges reflect the severity of the offense,[18] which illustrates the problems caused by repeat offenders who continue to drive even when their driver's licenses are revoked.

Without consistency, sentencing disparity results in some offenders not receiving appropriate sanctions. The causes of sentencing disparity may be understandable. The range of sentences that can be imposed on a DWI offender, despite a similarity in offender backgrounds and circumstances, is extremely broad.

Offenders may be less willing to comply with penalties perceived to be unfair. A California study concluded that individuals who do not believe they are affected by alcohol intoxication do not respond to the standard penalties for DWI and persist in driving after drinking.[19] Thus, disparity detracts from the deterrent effect of sentences and reduces the potential for behavioral change. It encourages offenders to manipulate the system to obtain lesser sentences through practices such as "judge-shopping," which is reported to occur either occasionally or often.[20] More importantly, the inconsistent application of penalties creates a public perception of unequal justice.

***Reduction in Recidivism***

*Recidivism rates* are the primary way we use to indicate the effectiveness of treatment programs and sentences. Recidivism rates have credibility. A survey of Michigan judges and probation officers found that half reported recidivism to be an important determinant of a program's effectiveness.[21]

The downside of using recidivism rates is that DWI arrests and crashes are infrequent occurrences even for intoxicated drivers.[22] One survey estimated that the number of times a person drives drunk before being arrested is 300.[23] A more recent estimate is one arrest per 772 episodes of driving two hours after drinking.[24] Obviously, recidivism rates depend upon not only the frequency of occurrence of impaired driving, but also on the level of enforcement in any given community.

Nevertheless, courts do require feedback on the success

15. Nathan Warren-Kigenyi & Heidi Coleman, Nat'l Highway Traffic Safety Admin., DWI Recidivism in the United States: An Examination of State-Level Driver Data and the Effect of Look-Back Periods on Recidivism Prevalence 1 (2014), *available at* https://www.nhtsa.gov/staticfiles/nti/pdf/811991-DWI_Recidivism_in_USA-tsf-rn.pdf.
16. Bob Mitchell, Drunk Driving and Why the Carnage Continues 368 (2009).
17. *Id.*at 369.
18. Robyn D. Robertson & Herbert M. Simpson, Traffic Injury Res. Found. of Canada, DWI System Improvements: Stopping the Revolving Door 18 (2003).
19. Terry L. Schell, Kitty S. Chan & Andrew R. Morral, Predicting DUI Recidivism: Personality, Attitudinal, and Behavioral Risk Factors, 82 Drug & Alcohol Dependence 33 (2006).
20. Robertson & Simpson, *supra* note 18, at 18.
21. M. Lynn Breer et al., *How Judges Respond to Drunk Drivers*, 87 Judicature 72, 75 (2003).
22. Robert B. Voas & Deborah A. Fisher, *Court Procedures for Handling Intoxicated Drivers*, 25 Alcohol Res. and Health 32, 33 (2001).
23. Robert B. Voas & Janet M. Hause, *Deterring the Drinking Driver: The Stockton Experience*, 19 Accident Analysis & Prevent. 81 (1987).
24. Paul Zador, Sheila Krawchuk & Brent Moore, Nat'l Highway Traffic Safety Admin., Drinking and Driving Trips, Stops by the Police, and Arrests: Analyses of the 1995 Survey of Drinking and Driving Attitudes and Behaviors 5 (2001).

rates of various treatment programs if they are to improve sentencing effectiveness. Regardless of how recidivism is measured, recidivism rates should not only be calculated for the total number of DWI offenders receiving treatment, but also by types of individual treatment so that courts can determine which treatments or combination of treatments are most effective in reducing recidivism.

## QUESTIONS TO PONDER BEFORE SENTENCING

Before deciding upon a sentence, judges should consider the following questions:

### HAS GUILT BEEN ESTABLISHED?

Persons charged with DWI need to go through the full criminal justice process to determine guilt or innocence. Due process rights of defendants should be protected by a full adversary process until guilt is determined. Prominent drug court advocates agree that "[p]roblem solving courts emphasize traditional due process protections during the adjudication phase of a case and the achievement of a tangible, constructive outcome post-adjudication."[25] This is the practice in DWI courts. Sentencing options should be considered *only* post-adjudication.

Diversion programs allow for completion of treatment after which the DWI charge can be dismissed. This results in no conviction on the driver's record and allows repeat offenders to subsequently be treated as first-time offenders. For commercial drivers, federal law prohibits judges and prosecutors from allowing convictions to be deferred, dismissed, or left unreported. The Federal Motor Carrier Safety Administration (FMCSA) forbids a state to "mask, defer imposition of judgment, or allow an individual to enter a diversion program that would prevent a conviction" from appearing on a commercial driver's record (no matter where he or she is licensed) for *any* state or local traffic violation in any type of motor vehicle.[26] Perhaps for these reasons, NHTSA has recommended that diversion programs be eliminated.[27]

Post-adjudication treatment is the more appropriate model and preferable to deferred prosecution. Diversion programs in use pretrial are not included because they are not sentencing options for punishment, and many treatment programs require an admission of guilt as a precondition of treatment. The ethical question is: should technically innocent people be forced into treatment programs before guilt has been adjudicated? As one scholar noted, "it is not a court if you have to plead guilty to get there."[28]

### WHICH SENTENCE GOAL IS MORE APPROPRIATE—PUNISHMENT OR TREATMENT?

After a guilty judgment or verdict, the next step is to decide whether the purpose of sentencing is to punish or treat the offender.

**"Increased law enforcement and sobriety checkpoints [are] a more effective strategy for reducing alcohol-impaired driving than enhanced penalties."**

#### *Punishment*

The goal of punishment here is to prevent the offender from driving while impaired again. Punishment may incapacitate the offender while he or she is in custody, make them pay the costs, and ideally instill fear of future punishment to lower the chances of recidivism. These penalties are based on the assumption that drinking and driving occurs because the driver is not motivated to change his or her behavior and perhaps to accept inconveniences (e.g., relying on a designated driver or taxi) to avoid drunk driving. In these cases, punishment (or the threat of punishment) might favorably influence future decision making about drinking and driving.[29] However, some recent research based upon perceptions of risks of legal consequences found that increased law enforcement and sobriety checkpoints were a more effective strategy for reducing alcohol-impaired driving than enhanced penalties.[30]

Traditional criminal sanctions for DWI include jail, fines, and actions against the driver's license.[31] If *punishment* is the goal, then sentences need to have consistency from offender to offender for the sentencing process to be deemed fair. That is not to say that recidivism rates should be calculated, but if they are, they should only be used as a control group—a baseline standard of comparison from which to compare the effectiveness of various treatment options.

Even using traditional sanctions, judges must consider the degree of danger to the motoring public. Is there some percentage of offenders who are so chemically dependent that incarceration is the only option? Clearly, incarceration is a deterrent to repeat DWI violations while the offender is in custody. But does incarceration have a longer-term impact, and does it depend upon the type of offender? What are the comparative advantages of jail versus fines, licensing options, and restrictions on vehicle use?

#### *Treatment*

If treatment is the chosen option, the assumption is that treatment for addiction will prevent future dangerous driving.

25. John Feinblatt, Greg Berman & Derek Denckla, *Judicial Innovation at the Crossroads: The Future of Problem-Solving Courts*. 15 CT. MANAGER 28 (2000).
26. 49 C.F.R. § 34.226.
27. NHTSA, *supra* note 9.
28. Candace McCoy, Book Review, 16 LAW AND POLITICS BOOK REV. 964, 964 (2006) (BERMAN, GREG & JOHN FEINBLATT, GOOD COURTS: THE CASE FOR PROBLEM-SOLVING JUSTICE (2005)).
29. Voas & Fisher, *supra* note 22, at 3.
30. Frank A. Sloan, Sabrina A. McCutchan & Lindsey M. Eldred, *Alcohol-Impaired Driving and Perceived Risks of Legal Consequences,* 41 ALCOHOLISM: CLINICAL & EXPERIMENTAL RES. 432 (2017).
31. RALPH K. JONES & JOHN H. LACEY, NAT'L HIGHWAY TRAFFIC SAFETY ADMIN., ALCOHOL AND HIGHWAY SAFETY 2001: A REVIEW OF THE STATE OF KNOWLEDGE (2001).

**"The judge is not a therapist, but she . . . needs to know what treatment options are most effective . . . [and] available."**

Effectiveness here is measured by recidivism rates. What types of offenders are the best candidates for treatment? What risk assessment instruments are available to help decide when treatment is most likely to lead to the preferred result, that is, reducing the likelihood that the offender will drink and drive in the future?

Most treatment programs begin with an admission that a problem exists, and it is often difficult for the alleged perpetrator to take this first step. Incentives to the offender to encourage a successful treatment program would be couched in terms of being able to avoid incarceration, retaining a job so that the family would be supported, and keeping the family unit together.

How successful are treatment programs? A comprehensive meta-analysis of 215 interventions found a 7-9% reduction in DWI recidivism and alcohol-related crashes as a result of completing a program of intervention.[32] That meta-analysis, however, was done over two decades ago, before newer interventions, such as ignition interlock technology, were available. A more recent meta-analysis of 42 studies done between 1995 and 2015 also supported programs that used intensive supervision and education.[33] Unfortunately, there is a dearth of high-quality evaluations of DWI intervention programs, and the methodologies used among the studies that do exist are weak, limiting confidence in the findings.[34]

**WHAT SCREENING INSTRUMENTS ARE AVAILABLE TO ASSIST CHOICE OF SENTENCING OPTION?**

Marlowe contends that the critical question is: how to match offenders with the programs that best meet their needs, while still protecting public safety and keeping costs to a minimum?[35] He recommends a fourfold classification scheme to guide intervention based on the two dimensions of "need," the offenders' clinical diagnosis and need for treatment, and "risk," or amenability to treatment.

Before judges can decide between punishment and treatment, and even decide from among various treatment alternatives, offenders need to be screened *first* for treatment eligibility. Which offenders have a chance to benefit from treatment? By the same token, then, screening can identify candidates who would not benefit from treatment and for whom sanctions are necessary.

Screening is the use of easily and inexpensively administered tests and procedures in an attempt to establish the presence or absence of alcohol-use disorder, drug-use disorder, and recidivism risk.[36] Proper screening will help identify individuals who require more professional and higher cost diagnostic assessments. Determining the severity of alcohol dependence is critical to determining an appropriate treatment plan. Many jurisdictions use self-report instruments to evaluate alcohol usage, while some jurisdictions use personal interviews as well. Thirty-one states screen both pre- and post-trial, and 16 screen post-trial only. Most programs require clients to pay screening fees, although four states pay the fees themselves.[37]

The issue is further complicated by the growing recognition that many people with alcohol or drug problems also experience other psychological problems that may affect the effectiveness of treatment services. For example, people who misuse alcohol may suffer from schizophrenia, eating disorders, or post-traumatic stress disorder.[38] Also, offenders with attention deficit disorder are more likely to commit motor-vehicle-related offenses during the follow up. [39]

The diagnostic assessment of all convicted DWI offenders for alcohol problems, in contrast to screening, is an expensive proposition. Ensuring that assessments are conducted can be a major task, depending upon the number of treatment providers available in the jurisdiction.

When screening indicates the need for assessment, trained professionals should conduct the assessment. To avoid conflict of interest, assessment and treatment referral should be conducted by an agency not associated with any treatment program. Judges, prosecutors, probation officers, and other justice system staff should have general knowledge about screening, assessment, and other issues surrounding alcohol- and drug-abuse treatment.

The judge is not a therapist, but she not only needs to know what treatment options are most effective, but also which are available, or even statutorily permitted, in the local community.

32. Elizabeth Wells-Parker, Robert Banger-Drowns, Robert McMillen & Marsha M. Williams, *Final Results from a Meta-analysis of Remedial Interventions with Drink/Drive Offenders,* 90 Addictions 907 (1995).
33. Peter G. Miller et al., *Effectiveness of Interventions for Convicted DUI Offenders in Reducing Recidivism: A Systematic Review of the Peer-Reviewed Scientific Literature*, 41 Am. J. Drug and Alcohol Abuse 16 (2015), *available at* http://www.tandfonline.com/doi/pdf/10.3109/00952990.2014.966199.
34. *Id.* at 13.
35. Dr. Doug Marlowe, *Dr. Doug Marlowe on a Vision for the Future of U.S. Drug Policy*, *in* All Rise: Mag. Nat'l Drug Ct. Prof'ls, Fall 2012, at 4.
36. Lyiin Chang, Cindy Gregory & Sandra C. Lapham, AAA Found. for Traffic Safety, Review of Screening Instruments and Procedures for Evaluating DWI [Driving While Intoxicated/Impaired] Offenders (2002).
37. *Id.* at 22.
38. *See e.g.*, Michael Soyka et al., *Prevalence of Alcohol and Drug Abuse in Schizophrenic Inpatients*, 242 Eur. Archives of Psychiatry and Clinical Neurosci. 362 (1993); Claire C. Holderness, Jeanne Brooks-Gunn & Michelle P. Warren, *Co-Morbidity of Eating Disorders and Substance Abuse Review of the Literature*, 16 Int'l J. Eating Disorders 1 (1994); Richard W. Seidel, Fred D. Gusman & Francis R. Abueg, *Theoretical and Practical Foundations of an Inpatient Post-Traumatic Stress Disorder and Alcoholism Treatment Program*, 31 Psychotherapy: Theory, Res., Prac., Training, 67 (1994).
39. Sarah E. Nelson et al., *A Prospective Study of Psychiatric Comorbidity and Recidivism Among Repeat DUI Offenders*, 3 Archives of Sci. Psychol. 8 (2015).

The results of assessment and recommendations for treatment should be made available to the judge and prosecutor before sentencing. Judges and prosecutors should be familiar with the treatment providers in their jurisdictions and seek information about the quality of services they provide. Indeed, they could use their prestige to advocate for the development of supplemental services and programs as needed.

To ensure fairness in the provision of services to DWI offenders, courts and treatment providers should consider the following questions:

- How are priorities for treatment services determined?
- Are existing services available equally to individuals in court who need them?
- Are standardized protocols and risk-assessment inventories used to identify service needs and placement?
- Are the qualifications of the individuals involved in identifying service needs appropriate for the populations and problems they are expected to evaluate?
- Do recommended service plans address the specific needs of individual clients?
- What efforts are made to ensure services are culturally sensitive?
- Who monitors delivery of services and tracks client progress?[40]

The preferred instruments for DWI screening are the MacAndrew Scale of the Minnesota Multiphasic Personality Inventory and the Alcohol Use Inventory.[41] The screening instruments most widely used by the courts, however, are the Mortimer-Filkins and the Michigan Alcoholism Screening Tests, "despite the lack of published evidence that they are useful with the DWI population."[42] These tests are rated "medium" overall because they correctly classify offenders as having alcohol problems, but that is only an indirect measure of DWI recidivism. The tests are not as good at predicting DWI recidivism directly. [43]

Courts in 21 states use the Mortimer-Filkins screening test. It was explicitly designed for assessing DWI offenders, and is based upon a self-report questionnaire and structured interviews, although the interviews are sometimes omitted.[44] The questionnaire does not have a component to assess truthfulness of responses. It was developed using a sample of known problem drinkers and a sample of known non-problem drinkers and field tested on DWI offenders. Offenders are placed into one of three risk-categories—social drinker, presumptive problem drinker, or problem drinker.

**"RIA Self Inventory can identify individuals who will experience alcohol and drug problems in the future."**

Courts in 14 states use the Michigan Alcoholism Screening Test, or MAST. This 24-item questionnaire was also developed in 1971 by Melvin Selzer.[45] A Brief MAST of 10-items, a Malmo Modification of 9 items, and a Short MAST of 13 items also exist. It was created using five groups: a control group, hospitalized alcoholics, convicted DWI offenders, drunk and disorderly offenders, and drivers whose licenses were under review. The design of the MAST questionnaire has been criticized for the ease with which clients can falsify responses.[46]

The Research Institute on Addiction (RIA) and the New York State Department of Motor Vehicles implemented a new alcohol-and-drug-screening instrument called the RIA Self Inventory (RIASI) for use in the New York Drinking Driver Programs.[47] This Inventory seems to be an improvement over the MAST. Follow up research shows that RIASI can identify individuals who will experience alcohol and drug problems in the future.[48]

The Traffic Injury Research Foundation has published a more detailed review of risk-assessment instruments and treatment interventions for those practitioners interested in more discussion of the available instruments.[49]

Questions remain about the accuracy of the screening instruments, especially the ones most popular with courts, and indeed *none* of the screening instruments in use meet the stringent criteria that are the accepted standard in medical practice.[50] Most screening instruments were first developed in the 1970s, 1980s, and 1990s and are in need of updating and validation. The screening instrument featured by NHTSA at its briefing on Impaired Driver Assessment Tools on October 14, 2015 was the American Probation and Parole Association's Impaired Driving Assessment.[51] Although advertised as a

40. Pamela Casey & William E. Hewitt, Nat'l Ctr. for State Cts., Court Responses to Individuals in Need of Services: Promising Components of a Service Coordination Strategy for Courts 17-18 (2001).
41. Chang et al., *supra* note 36, at 6.
42. *Id.*
43. Aubrey Wendling & Bohdan Kolody, *An Evaluation of the Mortimer-Filkins Test as a Predictor of Alcohol-Impaired Driving Recidivism*, 43 J. Stud. on Alcohol 751 (1982).
44. Jerold S. Lower, Rudolf G. Mortimer & Lyle D. Filkins, Highway Safety Res. Inst., Court Procedures for Identifying Problem Drinkers (1971).
45. Melvin L. Selzer, *The Michigan Alcoholism Screening Test: The Quest for a New Diagnostic Instrument*, 127 Am. J. Psychiatry 1653 (1971).
46. Linda E. Myerholtz & Harold Rosenberg, *Screening DUI Offenders for Alcohol Problems: Psychometric Assessment of the Substance Abuse Subtle Screening Inventory*, 11 Psychol. Addictive Behav. 155 (1997).
47. Thomas H. Nochajski et al., Res. Inst. on Addictions, Use of Non-Obvious Indicators for Screening of DWI Offenders (1995) *available at* http://casr.adelaide.edu.au/T95/paper/ s17p3.html.
48. Rania Shuggi et al., *Predictive Validity of the RIASI: Alcohol and Drug Use and Problems Six Months Following Remedial Program Participation*, 32 Am. J. Drug and Alcohol Abuse 121 (2006).
49. Robyn D. Robertson, Katherine M. Wood & Erin A. Holmes, Impaired Driving Risk Assessment: A Primer for Practitioners (2014).
50. Chang et al., *supra* note 36, at 6.
51. See https://one.nhtsa.gov/nhtsa/symposiums/october2015/index.html. See also: Nathan Lowe, Screening for Risk and Needs Using the Impaired Driving Assessment (2008).

**"A quarter of all drivers arrested or convicted of DWI are repeat offenders."**

screener to be used around the time of sentencing, this risk screener was originally designed to predict recidivism by offenders *already convicted* of a DWI offense to help probation officers discern the most appropriate level of education and treatment services.

At the same briefing in 2015, NHTSA highlighted The Computerized Assessment and Referral System (CARS), which does not predict DWI recidivism very well, but does predict criminal re-offenses generally.[52] Like screening instruments, existing assessment instruments must also be improved and enhanced to better predict recidivism and to tailor sentencing options to individual DWI offenders.

**SHOULD REPEAT OFFENDERS BE TREATED DIFFERENTLY?**

Repeat offenders create a special situation with respect to the question of punishment or treatment. A quarter of all drivers arrested or convicted of DWI are repeat offenders.[53] The initial reaction is that repeat offenders are hardcore and should be given the most severe punishments to protect the public. After all, they have already demonstrated that some forms of punishment and treatment do not work, and that more intensive sanctions or treatment are required. At this point, milder sanctions, such as fines, would probably be used less frequently and more serious punishments, such as incarceration, house arrest with electronic monitoring, license revocation, and vehicle impoundment may come into play.

On the other hand, many alcohol-impaired offenders need to "hit bottom" before they take treatment seriously. The paradox is that some of these hardcore offenders, who have "hit bottom," may be the most likely to benefit from treatment. In this situation, treatment providers do not "cherry pick" offenders to boost their success rates, but select the "hardcore" offenders. Only repeat offenders, for example, are eligible for treatment in DWI courts according to the National Center for DWI Courts, which believes that punishment unaccompanied by treatment is an ineffective deterrent for hardcore offenders.[54] Recidivism among DWI offenders is high. NHTSA has estimated that one third of all drivers arrested, convicted or adjudicated for impaired driving are repeat offenders.[55]

How are repeat offenders treated now? A survey of Michigan judges found that the most frequently used sanctions for repeat offenders were driver's license suspension (91.9%), probation (88.8%), fines (85.2%), outpatient counseling (83.3%), support groups (78.3%), mandatory jail (78.1%), and monitoring by testing for alcohol (77.1%).[56] In a survey of the American Judges Association, monitoring by testing for alcohol, intensive supervision probation, and support groups, such as Alcoholics Anonymous, were perceived to be most effective, along with mandatory jail time.[57] Judges perceived suspended sentences and community service as least effective.

Much of the research on repeat offenders is dated, but the findings of most of the scientific literature is fairly consistent. A comprehensive review of the literature on repeat DWI offenders concluded that it cannot be determined with any degree of confidence the magnitude of the alcohol-crash problem caused by repeat DWI offenders.[58] The review cited research from California suggesting that repeat DWI offenders comprise a small, but not negligible, percentage of drivers (8% range) involved in traffic crashes. This is important to note because even if all repeat DWI offenders were taken off the streets, "at least 90% of all fatal crashes would still remain."[59]

This is the "prevention paradox" in which a larger number of lower-risk individuals may cause more harm than the smaller number of high-risk individuals. [60] Furthermore, Jones and Lacey contend that the involvement of repeat offenders in *all* crashes may be less than that of first offenders, because sober repeat offenders may drive more carefully than sober first offenders.

It is difficult to identify the hardcore, potential repeat offender. Most existing studies did not have as their primary purpose distinguishing repeat offenders from others, but were focused upon evaluating DWI countermeasures and treatment programs. Consequently, repeat DWI offenses were one of the variables in the evaluation of programs, but the repeat offenders in treatment programs are not representative of repeat offenders in general. Moreover, many repeat offenders have characteristics similar to those of first offenders, assuming this this is indeed a first offense rather than the first time caught. Some older studies were unable to distinguish first offenders from repeat offenders.[61] Nonetheless, it was found that repeat offenders tend to be involved in more crashes, take more health risks, and report being able to drive safely after more drinks than first offenders.[62]

In their review of the literature, Jones and Lacey found that repeat offenders differed from first offenders in that they did have a high BAC of 0.18 or more, two or three prior DWI offenses as well as several "other" traffic citations, and more prior criminal offenses. They were likely to be single, white

52. Nelson et al., *supra* note 39.
53. Warren-Kigenyi & Coleman, *supra* note 15. Much of the impaired-driving literature uses the estimate of one-third recidivism, which was based on a NHTSA study from 1995.
54. *FAQs*, NADCP, http://www.nadcp.org/learn/faqs
55. *Repeat DWI Offenders in the United States*, Nat'l Highway Traffic Safety Admin., https://one.nhtsa.gov/people/outreach/traftech/1995/TT085.htm.
56. Breer et al., *supra* note 21.
57. Victor E. Flango & Fred Cheesman, *When Should Judges Use Alcohol Monitoring as a Sentencing Option in DWI Cases?*, 44 Ct. Rev. 102 (2009).
58. Ralph K. Jones & John H. Lacey, State of Knowledge of Alcohol-Impaired Driving: Research on Repeat DWI Offenders (2000).
59. *Id.* at 1.
60. Lerner, *supra* note 3, at 114.
61. Jones & Lacey, *supra* note 58.
62. T. H. Nochajski & W. F. Wieczorek, Cent. for Health and Social Res., Driver Characteristics as a Function of DWI History (2000).

males under age 40, with high school or less education and blue collar employment. They have also been found to have more severe mental health problems.[63]

The National Center for DWI Courts website defines "hardcore" DWI offenders as "individuals who drive with a BAC of 0.15 percent or greater, or who are arrested for or convicted of driving while intoxicated after a prior driving while impaired (DWI) conviction."[64] Indeed, the first alcohol-impaired driving incident (violation, not just conviction) is a predictor of future recidivism, as is the number of failed breath test results on an alcohol ignition interlock device.[65] The recidivism rate among first offenders more closely resembles that of second offenders than that of nonoffenders.[66]

Repeat offenders do not seem to respond to punishment. There is some evidence that incarceration not only fails to reduce recidivism, but that recidivism increases with even longer periods of incarceration. Alternative sanctions were more effective. Jones and Lacey noted that license suspension or revocation combined with treatment was especially effective in reducing recidivism.[67]

## WHERE DO WE GO FROM HERE?

Historically, the greatest effort to reducing the impaired-driving problem has involved the legal system, with the enactment of laws, imposition of penalties, and strengthening of law enforcement. There is a growing consensus as to the limits of the law-and-order approach, which brought about the emphasis on treatment to begin with.

The public health perspective, broadly conceived, includes treatment for DWI offenders, as well as remedies like improved public transportation, reducing alcohol availability through taxation, and opposing alcohol industry sponsorship of events.[68] These remedies seem less directly related to impaired driving, so now the focus has turned more to technology. An Insurance Institute for Highway Safety survey found that two-thirds of Americans favor routine installation of alcohol detection devices in all cars.[69] These devices include ankle bracelets for more "hardcore" offenders, but more often involve ignition interlocks for even first-time impaired-driving offenders.[70] The ultimate technological solution, of course, would be the self-driving car.

For the present, what is the role of the legal system in the reduction of DWI offenses? The *de facto* compromise that seems to have been reached is to distinguish "responsible" drinking and driving, which many people do, from irresponsible impaired driving. This perspective is supported by the alcohol industry, which tries to separate the majority of people who can drink responsibly from the "hardcore," alcohol-addicted offenders. But is it the role of the court to encourage "responsible" drinking or to treat alcoholism unrelated to criminal offenses? Or should courts be solely focused on the crime of DWI?

**"The ultimate technological solution, of course, would be the self-driving car."**

**If** crashes occur with fatalities or serious injuries, equivalent to manslaughter, punishment is necessary, which means involvement of the criminal justice system. Although the treatment vs. punishment dichotomy probably is not useful from a treatment perspective, a key purpose of the legal system is to assign blame and responsibility, and then to punish the guilty. So, in law, the role of punishment cannot be ignored and punishment imposed should be consistent with sentences given to similar offenders.

If crashes occur with no fatalities or serious injuries, treatment may be the order of the day to reduce possibility of future recidivism. Then:

1. Screening instruments and assessment tools need to be updated and improved to help judges determine the most effective treatment for each offender. Screening is a quick and inexpensive way to identify individuals who require more in-depth and expensive diagnostic evaluation to determine the most effective treatment. Yet, ironically, the two best screening tools for predicting recidivism are the ones least used.[71]

2. When screening indicates the need for more in-depth assessment, trained officials should conduct the diagnosis. To avoid conflicts of interest, assessment and treatment referral should be conducted by an agency not associated with any treatment program.

63. David L. McMillen et al., *Personality Traits and Behaviors of Alcohol-Impaired Drivers: A Comparison of First and Multiple Offenders*, 17 ADDICTIVE BEHAV. 407 (1992).
64. National Center for DWI Courts, www.dwicourts.org.
65. W. J. Rauch et al., *Any First Alcohol-Impaired Driving Event is a Significant and Substantial Predictor of Future Recidivism*, *in* PROCEEDINGS OF THE 16TH INTERNATIONAL CONFERENCE ON ALCOHOL, DRUGS AND TRAFFIC SAFETY (Council on Alcohol, Drugs and Traffic Safety, vol. 1 2002); Paul R. Marque, Robert B. Voas & A. Scott Tippetts, *Behavioral Measures of Drinking, Patterns in the Interlock Record*, 98 ADDICTION 13-19 (2003).
66. William J. Rauch et al., *Risk of Alcohol-Impaired Driving Recidivism Among First Offenders and Multiple Offenders*, 100 AM. J. PUB. HEALTH 919 (2010).
67. JONES & LACEY, *supra* note 58.
68. LERNER, *supra* note 3, at 172.
69. *New Survey Results: Stop Anyone Impaired by Alcohol from Driving Any Vehicle*, INS. INST. FOR HIGHWAY SAFETY, HIGHWAY LOSS DATA INST. (Sept. 17, 2009), http://www.iihs.org/iihs/news/desktopnews/new-survey-results-stop-anyone-impaired-by-alcohol-from-driving-any-vehicle-public-says.
70. Flango & Cheesman, *supra* note 57.
71. The Alcohol Use Inventory was developed in 1977 as an assessment tool for treatment planning, rather than a screening tool, and is currently used only in West Virginia. It is the most expensive of all of the testing instruments evaluated by CHANG ET AL., *supra* note 36 at 29. The McAndrew Scale detected about two thirds of recidivists, but that research is based upon only a single offender population and has not been confirmed in other DWI populations. It is currently used in Arizona, North Carolina and North Dakota. CHANG ET AL., *supra* note 36 at 31.

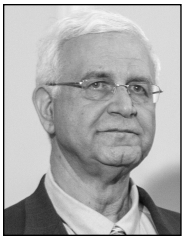
3. Treatment options must be selected tailored to each offender, and consistency of sentences across offenders is irrelevant. What Marlowe said about drug courts applies as well to DWI courts:"… no one intervention should be expected to work for every drug-involved offender."[72]

4. Treatment options vary by jurisdiction and the most appropriate treatment may not be available to meet the needs of each individual offender. The availability of health coverage may help influence the treatments used.

5. Compliance with treatment plans must be closely monitored. For example, if ignition interlocks are part of the sentence, follow up is necessary to see that they are installed and used.

6. Swift action is necessary to correct non-compliance with treatment, with the most severe sanction being elimination from the treatment program.

7. Recidivism rates should be calculated separately for each type of treatment program to provide judges and others with evidence on which treatments are most effective in reducing recidivism for each type of offender.



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72. Douglas B. Marlowe, *The Verdict on Drug Courts and Other Problem-Solving Courts*, 2 CHAP. J. CRIM. JUST. 53 (2011).



**Answers to Crossword**
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