

FRONTLINES

linking alcohol services research & practice

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Alcohol and Highway Safety Research: A Brief History

By Dennis McCarty, Ph.D., Oregon Health and Science University

In 1968, the landmark U.S. Department of Transportation report, *Alcohol and Highway Safety*, stimulated the first efforts to mount systemic initiatives to modify legislation, facilitate interventions, and reduce the costly toll of deaths related to drinking and driving.¹ Required by the Highway Safety Act of 1966, the report estimated that 25,000 highway fatalities each year were related to alcohol use. The report observed that alcoholics and other problem drinkers accounted for a majority of the deaths. The report encouraged broad-based countermeasures including intervention and diagnostic services, but noted the lack of data on their effectiveness. In one of its most striking findings, the report determined that fewer than 100 clinics in the nation were devoted to the treatment of alcoholism and asserted that most treatment personnel were unaware of the compelling relationship between problem drinking and highway safety.

Mobilized by the report's findings, the National Highway Traffic Safety Administration (NHTSA) supported the development of Alcohol Safety Action Programs in 35 communities from 1970 to 1977. These community initiatives increased traffic safety enforcement, improved court processes, screened offenders for problem drinking, and provided education and rehabilitation services. Evaluations suggested that offenders with less severe alcohol problems were more responsive to the interventions and that arrest rates declined for drivers with lower levels of alcohol problems but not for those with more problematic patterns

of alcohol use. The initiatives offered less evidence of change among problem drinkers. Despite modest levels of change overall among offenders, the programs were widely adopted and continue to serve as the foundation for post-arrest interventions and treatment.

The multi-dimensional Alcohol Safety Action Programs helped catalyze public concern and nurtured a climate that promoted persistent public education efforts. During the 1980s, the private group, Mothers Against Drunk Driving, and the Presidential Commission on Drunk Driving pressed for more severe sanctions for multiple offenders and led to current policies that include mandatory incarceration and prolonged periods of treatment. At the time, research suggested that increased enforcement was the most effective deterrent to driving after drinking and that increases in the severity of sanctions without stronger enforcement had little impact.² These findings continue to shape enforcement policy.

Drinking and driving remains a persistent public safety hazard to this day. Since the mid-1990s, NHTSA's Fatality Analysis Reporting System has estimated consistently that more than 12,000 traffic deaths on U.S. roadways (almost one-third of the nation's more than 40,000 annual highway fatalities) are related to alcohol use each year.³ The nation must, therefore, renew its efforts to eliminate the public harm stemming from alcohol use and



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driving. Electronic monitoring technologies offer increased potential to prevent multiple offenders from repeated drinking and driving. Systemic interventions such as courts for high-risk driving under the influence (DUI) offenders provide alternatives to incarceration and offer the potential for more effective treatment and rehabilitation.

Much work, however, remains for investigators, treatment providers, and policymakers. Screening and assessment procedures for drunk driving offenders have changed little since the 1970s and the invention of Alcohol Safety Action Programs. More sophisticated tools need to be developed that identify both the risk to highway safety and the risk of alcohol use problems. State policies need to be shaped to permit a range of responses that can be matched to the level of risk once it has been identified. Similarly, treatment interventions need to better address co-occurring disorders (e.g., drug use), mental health status, and behavioral risks. Policies,

moreover, must be developed and tested to promote better compliance with requests for breath and blood alcohol testing. Too many arrested offenders escape legal consequences because they refuse a breath test; in the absence of a breath test, courts are often reluctant to convict.

While practitioners and investigators craft more effective intervention strategies for offenders who have been arrested, public health initiatives must cast a broader net. Most individuals who drive after drinking are never stopped and arrested. Enforcement is simply very expensive and thus very limited. Many of these individuals, however, receive medical care for injuries suffered in crashes and other events. Better screening protocols and intervention initiatives in medical settings—especially emergency departments—could extend the capacity to identify high-risk drinkers and to provide interventions that may reduce their alcohol use and their risk of drinking and driving.

Health services research continues to play an important role in addressing the relationship between alcohol and highway safety. This issue of *Frontlines* reviews the latest research, outlines recommendations for renewed policy and research initiatives, and calls for renewed interest in the multi-dimensional problems associated with drinking and driving. ■

References

- 1 U.S. Department of Transportation. *Alcohol and Highway Safety: A Review of the State of Knowledge*. Washington, D.C.: U.S. Government Printing Office. 1968.
- 2 Ross, H.L. *Detering the Drinking Driver: Legal Policy and Social Control*. Lexington, MA: Lexington Books. 1982.
- 3 National Institute on Alcohol Abuse and Alcoholism, "Traffic crashes, traffic crash fatalities, and alcohol-related crash fatalities, United States, 1977–2001." Data are from the Fatality Analysis Reporting System maintained by the NHTSA.

Editor's Note

Safe driving depends upon combining a complex array of tasks. Drinking alcohol impairs many of the skills necessary for adequately performing these tasks and increases the risk of traffic crashes.¹ Almost one in three of the nation's more than 42,000 traffic crash fatalities in 2001 were alcohol related.² This figure has remained consistent over almost a decade, suggesting that progress in reducing alcohol-related traffic fatalities has slowed. Societal responses to driving under the influence (DUI) offenses can directly maintain highway safety as well as steer problem drinkers toward treatment. License suspension, vehicle impoundment, education, counseling, and electronic monitoring can help reduce repeat DUI offenses.

This issue of *Frontlines* examines the latest research on drunk driving and interventions designed both to improve treatment for offenders and to reduce the threat that they pose to highway safety. To set the stage, Dennis McCarty of the Oregon Health and Science University discusses the landmark 1968 report from the Department of Transportation, *Alcohol and Highway Safety*. Stephen Wing of the Substance Abuse and Mental Health Services Administration reports on the discussions of a federal workgroup that examined current research on alcohol-impaired driving and assessed the threats to public safety and public health. As a defense attorney specializing in drunk driving cases, Bruce T. Macdonald tells a powerful story of his efforts to improve access to driver alcohol education programs. Elizabeth Wells-Parker of Mississippi State Univer-

sity reports on a comprehensive meta-analysis examining the effectiveness of remedial interventions for DUI offenders.

Frontlines is pleased that nearly four decades after he authored *Alcohol and Highway Safety*, Robert B. Voas of the Pacific Institute for Research and Evaluation remains on the cutting edge of research in this area and provides an update on the potential for technology to deter drunk driving. Finally, the Honorable Eric J. Bloch of the Multnomah County Circuit Court and Sandra Lapham of the Behavioral Health Research Center of the Southwest describe a unique and impressively successful rehabilitation program in Multnomah County, Ore., for repeat drunk driving offenders.

We hope you find this issue of *Frontlines* to be a valuable source of information on the latest research and thinking about treatment for DUI offenders.
—Margaret Trinity, Editor

References

- 1 National Institute on Alcohol Abuse and Alcoholism, *Alcohol Alert*, No. 31 PH 362, January 1996.
- 2 National Institute on Alcohol Abuse and Alcoholism, "Traffic crashes, traffic crash fatalities, and alcohol-related crash fatalities, United States, 1977–2001." Data are from the Fatality Analysis Reporting System maintained by the National Highway Traffic Safety Administration.

A Review of Practice and Research on Alcohol-Impaired Driving

By Stephen Wing, M.S.W., Substance Abuse and Mental Health Services Administration

“While many impaired drivers are never arrested, individuals with alcohol use problems are over-represented as patients in emergency departments and trauma centers.”

Multi-Agency Workgroup Findings

The Substance Abuse and Mental Health Services Administration (SAMHSA), the National Highway Traffic Safety Administration (NHTSA), and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) convened a workgroup that examined the current research on alcohol-impaired driving, assessing the threats to public safety and public health. The workgroup examined five aspects of impaired driving:

- arrest and adjudication
- screening and assessment
- remedial interventions
- financing treatment
- research and evaluation needs.

This article summarizes the workgroup's discussions, which do not necessarily reflect the opinions of individual workgroup members or the policies of the sponsoring federal agencies.

The public health and safety risks associated with driving while impaired remain unacceptably high. Criminal sanctions and rehabilitation services must be aligned to reduce impaired driving, improve treatment for alcohol abuse and dependence, and ensure restitution for the legal and social costs associated with driving while impaired.

Arrest and Adjudication

Detecting impaired driving is difficult. Police use probable cause such as observable behavior, an assessment of the offender's physical appearance, and results of standardized field sobriety tests. Many offenders, however, go undetected. For those arrested, court conviction and sanctions may depend on the results of breath alcohol testing. Refusal to submit to an alcohol breath test occurs in 25 to 50 percent of arrests. In addition, many drivers are not tested for blood alcohol levels, especially when they have been injured and transferred to a medical facility, resulting in the loss of critical data and difficulty imposing appropriate sanctions.

Impaired driving offenders often are offered plea agreements or referral to diversion programs instead of going to trial. Plea agreements and diversion programs may lead to reduced charges, and a reduction in the severity of the offense and the sanctions imposed. If the first offense is not properly recorded, recidivists may be treated repeatedly as first-time offenders.

Some sanctions have proved to be more effective than others. License suspension and revocation are among the most effective strategies for reducing the risk to public safety from continued driving; however, some offenders continue to drive without a valid license. Courts frequently impose fines and community service; however, research evidence has not shown that

these sanctions reduce the risk of impaired driving. Increasingly, courts are resorting to the use of vehicle interlocks and house arrest to prevent the highest risk individuals from driving while impaired.

Screening and Assessment

Impaired driving offenders should be screened or assessed for driving and alcohol dependence risks. Most arrestees should complete a comprehensive diagnostic assessment that addresses both poor driving behavior and the potential for abuse and dependence on alcohol and other drugs. Effective assessments include criminal history and driving record, alcohol and drug use, breath alcohol level at arrest, and mental health status. Most substance abuse assessment tools, however, have not been standardized or validated with impaired driving offenders. Offenders, moreover, have incentives to respond to assessment questions in a manner that minimizes their relationship with alcohol and drugs, so less obvious assessment tools may be useful.

Arrest offers an opportunity for intervention. In fact, many individuals reduce or eliminate alcohol use following an arrest. While many impaired drivers are never arrested, individuals with alcohol use problems are over-represented as patients in emergency departments and trauma centers. Doctors and other health care professionals in emergency rooms, trauma centers, and other medical care facilities have a valuable opportunity to conduct alcohol screening and brief intervention with these patients.

Remedial Interventions

A variety of strategies that have proved useful for treating alcohol problems in the general

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Driver Alcohol Education—Only for the Contrite?

By Bruce T. Macdonald, J.D.

Driver Alcohol Education (DAE) programs, common throughout the country as alternative, less punitive dispositions for defendants convicted of their first drunk driving offense, have intuitive appeal from both public health and public safety perspectives. But entry into such programs, usually within the control of the sentencing judge, can turn on the realities of case management in busy trial courts—or at least that was the scene in the spring of 1991 in one Massachusetts District Court.

A client of mine, whom I will call David, had been convicted of first offense drunk driving. When the prosecutor and I had met in the judge's lobby prior to trial, the judge sent a subtle but unmistakable message: the window for entry into the Massachusetts DAE program would close if my client took his case to trial and was convicted. So if he wanted the considerable benefits of the DAE disposition, referred to as the "24D" program, he would have to plead guilty. The judge was applying the judicial thumb, as did all judges in that particular court, to clear the cases scheduled for trial that day.

Following a hard fought case, and immediately after hearing that dreaded word from the jury foreman—"Guilty!"—the judge was ready to impose sentence. After hearing about my client's life, employment, and lack of criminal record, and despite my request that David be given a "24D" disposition, the judge imposed one year's probation with the resulting one year loss of license. This sentence was in marked contrast to the 45-day loss of license David would have received had he been granted a "24D" disposition. I felt a tap on my shoulder and turned to see a well-known attorney who had a busy drunk driving defense practice. He whispered in my ear: "Ask the judge to put the reasons for denying him the '24D'

program on the record." I made the request, which was summarily denied. Of course, the only reason the judge could have placed on the record was that my client exercised his *constitutional* right to a jury trial.

I was determined to challenge this *de facto* policy of the judges in this court to deny a "24D" disposition to any defendant who contested his/her guilt by taking a case to trial. My research revealed that 90 percent of defendants who pled guilty received a "24D" disposition, while 90 percent of defendants who took their cases to trial and lost did not.

Although it was communicated to me that my persistence might have negative consequences for my law practice in this court, I was determined to follow through. Eventually I learned that the judge would reconsider the disposition if I made a formal request. Within a month, David was re-sentenced to the "24D" program and a 45-day loss of license.

The following year, I learned that David, having recently graduated from the DAE program, had come to the realization that he was an alcoholic. He was now several months sober. He talked about how the education he received at his weekly classes and the interaction with his instructor and classmates led him to take a hard look at his life and his drinking. I then shared with him that I, too, was an alcoholic in recovery for six years. David became a resident of a sober house northwest of Boston and eventually became its president—a success story that may never have occurred if the judge had not relented.

Some months earlier, I had arranged to enroll in a DAE program myself to see firsthand what David and others like him were going through. I knew that many other eli-

gible defendants were still being denied the DAE program by overworked judges pressed to move crowded court dockets. For 16 weeks I sat in classes with 13 first offenders learning about alcohol and alcohol abuse. During that time, my classmates progressed from a resentful, angry, suspicious group to 13 individuals who had evaluated their lives and their drinking and who, at graduation, were somewhat sad to be parting.

Convinced more than ever that the DAE program should be the rule, not the exception, both for defendants who pled guilty and for those who were found guilty after trial, I drafted legislation in late 1993 to make the DAE program presumptive for *every* defendant who was found or pled guilty. On March 7, 1994, David and I were invited to testify at a hearing of the Massachusetts Legislature's Joint Criminal Justice Committee. Representatives and senators listened attentively to David's powerful story of his journey from arrest to awareness to recovery, and how this may never have happened if his original sentence denying him entry into the DAE program had stood.

In a major overhaul of the state's drunk driving laws, signed by Governor William Weld on May 25, 1994, the following sentence was enacted into law: "A defendant not otherwise prohibited by this section, upon conviction after a trial on the merits, shall be presumed to be an appropriate candidate for the above mentioned programs; provided, however, that a judge who deems that the defendant is not a suitable candidate for said programs shall make such findings in writing."

Sometimes persistence pays off. ■

Attorney Bruce T. Macdonald is a sole practitioner in Cambridge, Mass., where he has a general practice with specialization in the trial of drunk driving cases. He has been involved in substance abuse treatment and prevention issues, and particularly sober housing, for the past 15 years.

Effectiveness of Court-Mandated Remedial Interventions for DUI Offenders

By Elizabeth Wells-Parker, Ph.D., Mississippi State University

Driving under the influence (DUI) offenses reflect a driving problem as well as an individual's alcohol or other drug use problem. Since these offenses concern both the traffic safety and alcohol treatment communities, the effectiveness of remedial interventions must be viewed from both perspectives.

Remedial interventions include various treatment modalities, educational modalities, probation, victim impact panels, self-help groups, and combination strategies. The effectiveness of individual interventions should be considered within the social, political, and economic environment of the individual and the community when formulating best practices and policy standards.

A recent review of the literature provides evidence for the effectiveness of remedial interventions for DUI offenders and also identifies areas where additional research could enhance the application of these interventions.¹ The review was based on an earlier comprehensive meta-analysis of the effectiveness of remedial interventions for DUI offenders and a review of subsequent relevant studies.

Do remedial interventions for DUI offenders work?

Reductions in DUI recidivism and crashes are the most commonly reported indicators of intervention success; measures of consumption and other indicators of alcohol problem severity are less commonly used and have proved problematic with DUI offenders. In general, remedial interventions reduce DUI recidivism compared to standard sanctions such as fines and jail time. The meta-analysis shows that, on average, remedial interventions result in a 7 to 9 percent reduction in DUI recidivism

rates and a similar reduction in alcohol-related crash rates.

How do the effects of remedial intervention compare to licensing actions?

Licensing actions such as revocation and suspension have proved more effective than remedial interventions in addressing traffic safety, however, they are less effective than remedial interventions in reducing alcohol-related driving events such as DUIs and alcohol-involved crashes. DUI remedial intervention targets alcohol-related driving rather than driving exposure in general. Therefore, combining licensing action and remedial intervention produces both a reduction in alcohol-related driving outcomes and a general traffic safety benefit. This combination is appropriate because research has suggested that many DUI offenders are high-risk drivers even when sober.

Which remedial strategies work best?

The most frequently evaluated remedial interventions include education, supervised contact, probation, and programs that combine one or more strategies (e.g., education, psychotherapy, and supportive follow-up). Research has found combined strategies to be the most effective approach. Longer or more intense combined strategy programs did not differ significantly from shorter, less intense combined strategy programs for reducing recidivism, in spite of a relatively broad range of length and intensity of the multiple-strategy programs. The issue of length and intensity in terms of effectiveness needs further study.

The field urgently needs studies of the efficacy and effectiveness of specific treatment modalities for court-mandated DUI offenders.

Several modalities, such as court-mandated Alcoholics Anonymous and victims' impact panels, failed to show a positive effect on DUI recidivism, with some evidence that those mandated to these treatments had higher recidivism rates. Although additional research is needed to evaluate these strategies, caution should be exercised with respect to mandatory assignment.

Is there good empirical evidence to match individual offenders to specific interventions and treatment regimens?

Few definitive matching studies have been conducted for DUI offenders. Studies have suggested that sociodemographic characteristics such as age, and co-occurring conditions such as depression, should be taken into account when determining intervention needs. However, these studies have addressed only a limited range of treatment options. Since most intervention assignment schema used for DUI offenders have not been adequately evaluated, the field needs additional matching studies that address DUI offenders as a distinct group.

What additional evidence is needed?

The expansion of well-evaluated treatment options for DUI offenders is critical. Promising alcohol treatment strategies should be evaluated specifically for DUI offenders in terms of their effectiveness for reducing alcohol problems and for reducing impaired driving and crash risk. The field needs to develop cost-effective, easily implementable programs that combine strategies and have components targeted at diverse sub-groups of drinking drivers. Future research also needs to focus on effective programs that can be delivered in areas with restricted resources such as personnel, time, and facilities. ■

Reference

1 Wells-Parker, E. et al. "Final results from a meta-analysis of remedial interventions with drink/drive offenders," *Addiction*, Vol. 90, Issue 7, July 1995, pp. 907-26.

Technological Developments Open New Opportunities to Reduce the Recidivism of Convicted Drinking Drivers

By Robert B. Voas, Ph.D., Pacific Institute for Research and Evaluation

America's progress toward reducing alcohol-related highway deaths has stalled during the last decade. Although several reasons explain this setback, the continuing failure to prevent future drunk driving by individuals apprehended driving under the influence (DUI) is an important factor. Approximately a third of DUI offenders will repeat the offense, and a driver with a DUI offense is 4.5 times more likely than the average driver to be involved in an alcohol-related fatal crash. The criminal justice system needs to do a better job of controlling offenders' driving while their alcohol problem is being treated through court-mandated programs.

Jail terms for first offenders are too short to keep dangerous drivers off the road for a significant period. License suspension is more effective because it is generally imposed for a longer time—from three to 12 months for first offenders and up to two years for multiple offenders. On our crowded roads, however, the laws against unlicensed driving are difficult for the police to enforce, and approximately three of four DUI offenders drive while suspended. Three types of electronic monitoring systems are providing potentially more effective means for controlling the driving and/or the drinking of DUI offenders.

Alcohol Safety Interlocks

Alcohol Safety Interlocks are designed to limit impaired driving by requiring the driver to take a breath test to start the car. These devices are very difficult to circumvent and have been shown to reduce recidivism by up to 80 to 90 percent.

Electronically Monitored Home Detention

This control system limits the nighttime and recreational driving of DUI offenders and has been shown to reduce recidivism. Recently, this type of location monitoring has been extended by devices that can be attached to the body and produce a record of the offender's location on a 24/7 basis. Such systems use two units: 1) a bracelet "locked" onto the ankle of the offender, which must be in constant radio contact with 2) a portable unit attached to the belt that contains a Global Positioning System (GPS) receiver, a computer, and a recording system.

Electronic BAC Monitoring

Electronic systems have been developed to monitor breath alcohol concentration (BAC). The earliest versions involved random breath tests that could be monitored over a phone line, but a recently developed transdermal sensor attached to the ankle can detect alcohol in sweat and transmit data to a recorder attached to the belt. Several courts have begun to use these transdermal sensors with DUI offenders as a method of monitoring abstinence.

The transdermal sensor, along with the electronic monitoring systems attached to home confinement and interlock systems, acquire a large amount of BAC data over an extended period. Data from interlock users (typically averaging about seven BAC tests per day) has been used effectively in specially designed treatment programs to help offenders address their alcohol problems.

The interlock breath-test data has also been shown to track the offenders' progress in steering clear of impaired driving and is useful in predicting future recidivism once the interlock is removed.

Court-mandated alcohol treatment programs have been shown to produce a small (7 to 9 percent) but important reduction in DUI recidivism. In the past, treatment programs have operated independently of court-ordered sanctions programs. The court probation department has overseen both types of programs, yet treatment providers have had little access to information from providers that run impoundment, home confinement, interlock, or position monitoring systems. One important limitation on court-mandated treatment programs is their typically short length. Although they may make some progress in reducing the offender's dependence on alcohol, relapse is common, and much of the benefit may be lost without after-treatment follow up.

The recent growth in the number of DUI courts is extending the length and increasing the intensity of offender monitoring, thereby allowing for expanded treatment programs. DUI courts follow the model developed for courts handling drug offenders. DUI courts require tight monitoring of offender alcohol consumption through surprise visits from court probation officers to conduct random alcohol breath tests. In addition, offenders must return to court regularly for an assessment of their treatment progress. DUI courts are very expensive to operate, in part because of the enforcement costs of alcohol monitoring programs. Electronic monitoring systems offer the possibility of more comprehensive and ultimately less expensive control of offender drinking by DUI courts.

More research is required to better understand the long-term effects of electronic controls so that the courts and treatment professionals can use appropriate tools to help offenders and to keep the road safe. ■

A Five-Step Approach to Adjudicating the Repeat Drunk Driver

By Honorable Eric J. Bloch, Multnomah County Circuit Court, and Sandra Lapham, M.D., M.P.H., Behavioral Health Research Center of the Southwest

Case Study

Ralph Pennington (not his real name) is a 54-year-old felon with six DUI (driving under the influence) offenses. When he was charged with a seventh offense, he was sure he would be spending a long time in jail. "My life was a mess," he said. "I'd been drinking for years—gambling, fighting, lying. I had a string of broken relationships. I'd even lost my girlfriend of many years." He was referred to a unique offender rehabilitation program, called the DUI Intensive Supervision Program (DISP).

When Ralph started the DISP, he had a job but no other life. He disliked the idea of outside social activity because he was tired after work, but he participated because it was a probation condition. He went to treatment and Alcoholics Anonymous meetings. He joined a gym, took dance and yoga classes, joined a golf team, and felt better than ever. He discovered he wasn't too old to have fun, and began to enjoy getting out of bed in the morning. He made the decision to remain sober, bought a house, and reunited with his girlfriend. Eventually he was allowed to drive again. Ralph cried tears of joy at his graduation from the DISP.

Repeat drunk-driving offenders pose a significant public health threat, often continuing to drink and drive even after their drivers' licenses have been revoked. They don't readily stop drinking and driving, even when faced with long jail terms. Interviews reveal that most are alcohol dependent, many are addicted to other drugs, and a high proportion suffers from other mental health problems.

The DUI Intensive Supervision Program (DISP) was developed and implemented in 1998 by Judge Dorothy Baker in Multnomah County, Ore., and is currently directed by the Honorable Eric J. Bloch of the Multnomah County Circuit Court. The goals of the DISP are to affect thinking and life changes that will reduce recidivism, reduce risk to the community, and increase quality of life for the offender. The program includes sanctions, treatment, and close monitoring of offenders' compliance with the program.

Originally limited to offenders with three or more DUIs, the program has expanded to include all repeat offenders. The DISP has an impressive record: At the end of May 2004, 357 offenders had successfully completed the three-year program and stayed off probation an average of 406 days. Only 10 graduates (0.7 percent) have re-offended. Court statistics indicate that the overall recidivism rate, including those who did not complete the program, is 12.5 percent—much lower than comparable groups.

The DISP has five key components:

1) Honesty. Sentences are "cast in stone" so offenders can give a complete report of their alcohol use and driving without fear of increased sanctions. False statements in court regarding alcohol, drugs, driving, or working will result in the offender being taken into cus-

tody. Short jail terms are imposed as negative consequences to discourage future probation violations.

2) Zero tolerance for alcohol and drugs. Offender-funded electronic monitoring (EM) with a bracelet and breath testing over telephone lines is required. A patch and/or urine drug tests are required for offenders who use illegal or controlled substances. Adults living with an offender must sign a notice agreeing that there will be no alcohol or drugs in residence. All offenders are required to undergo intensive monitoring with monthly in-person visits.

3) Zero tolerance for driving. Offenders are required to sell their vehicles on the open market and are encouraged to ride a bicycle or take public transportation. Adults living with offenders are required to sign a notice of possible criminal sanctions if their vehicles are made available to the offender.

4) Treatment. Within one month of release from custody, the court refers the client to outpatient treatment consisting of individual and group therapy for 90 days to one year or more. Offenders pay for treatment unless indigent. A state-sponsored program supplements fees for indigent clients, with additional provision for sliding scale fees. The therapists are licensed and the programs approved by the state mental health department.

5) Payment of monetary obligations. Offenders must obtain full-time employment. The court coordinator calculates the total payments (for EM, treatment, fines) for the offender and provides all information required to complete probation. The court system's accounting department notifies the judge if the offender does not pay fees, fines, and restitution as scheduled. As an incentive, the court waives the DUI fine upon successful completion of DISP. ■

population are applicable to impaired driving offenders. Because a significant segment of this population meets DSM-IV diagnostic criteria for alcohol abuse or dependence, strategies shown to be effective in other alcohol treatment settings may be successful with significant portions of the impaired driving offender population as well. Research suggests that interventions should reflect the severity of alcohol problems and traffic safety risk. Well-developed evidence-based treatments are most likely to be effective when they also address co-existing risk factors such as depression, sensation-seeking, and peer influence.

Most important, intervention and treatment should be combined with proven consequences, including sanctions such as driver license suspension or the use of interlock devices, which have been shown to reduce recidivism and risk exposure. When combined with other sanctions, remedial interventions have been shown to reduce re-arrest for impaired driving by 7 to 9 percent.

Financing Treatment

The costs associated with sanctions for impaired driving convictions include costs to courts, departments of corrections,

health plans, motor vehicle departments, and local law enforcement. Offenders may face financial decisions regarding trial choices, sanction choices, treatment options, and driver licensing actions. Some offenders may choose jail time over costly treatment options. Many third-party payers, moreover, do not cover court-ordered treatment. Coverage, when available, often falls short of a clinically meaningful course of treatment. Viable financing strategies must be identified and tested.

Research and Evaluation

The complex interactions among criminal justice processes and sanctions, remediation and treatment, and offender attributes provide rich opportunities for continued research.

Studies are needed to assess breath test refusal rates and test strategies to increase compliance with breath testing requirements. The effectiveness of combining technology (e.g., interlock systems, electronic house-monitoring) with varying lengths and intensities of treatment should also be investigated. Similarly, research should explore the impact of co-occurring mental health conditions (e.g., depression, antisocial personality disorder or criminal behavior, and post-traumatic stress disorder) on treatment outcomes. ■

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