



Treatment or Punishment: Sentencing Options in DWI Cases

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June 22, 2016

Points of view expressed in this monograph are those of the author and do not necessarily represent the views of the National Center for State Courts or the National Highway Traffic Safety Administration.

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ABSTRACT

Sentencing Options in DWI Cases

In 1996 the National Highway Traffic Safety Administration (NHTSA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) produced *A Guide to Sentencing DUI Offenders* to assist judges and prosecutors in reducing recidivism among people convicted of drinking and driving offenses (known as driving under the influence, DUI, or driving while impaired, DWI). This *Guide*, which was updated in 2005, was designed to provide information on matching offenders to the most effective combination of sanctions and treatment, especially for repeat offenders. The original purpose of this essay was to update the evaluations of sentencing options in light of recent research and new sentencing options, such as DWI courts.

In reviewing the recent sentencing literature, it is clear that reduced recidivism is the most frequently used measure of success. This is the best measure of success for sentences whose objective is to treat offenders so they will not be likely to drink and drive again. However, I would argue that it is not fair to use recidivism as a measure for sentencing options designed not to rehabilitate, but to punish offenders for serious, even fatal, driving offenses. To measure more accurately the success of treatment using recidivism as the criterion of success, sentences designed to punish need to be identified and subtracted from all offenses. This requires that sentences be separated into two categories: those designed to punish and those designed to treat the offenders. Unfortunately, it was difficult to do this using current data on recidivism, so offenses here are classified into punishment and treatment categories so that these

distinctions can be made in the future. With punishment options removed, the effectiveness of treatment options will be more easily evaluated.

For the present, what is the role of the legal system in the reduction of DWI offenses?

Punishment

- 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.
- It is not possible to tailor a sentencing remedy to an individual offender and at the same time have a consistent sentencing policy in which every offender committing the same DWI offense receives the same sentence.
- If a crash occurs with fatalities or serious injuries, equivalent to manslaughter, punishment is necessary, which means legal-system involvement. Indeed, at one time, Husak (1994) proposed a separate crime, “aggravated drunk driving,” for drivers with high BACs who have driven recklessly. If the legal system needs to be involved, punishments should be consistent with sentences given to similar offenders.
- Current research seems to indicate that the need for judicial involvement is most apparent in cases where the offender is high risk/high need. Triage could be

used to identify high risk/high need offenders for court processing, with all others going into the traditional probation/corrections system.

Treatment

- If a crash occurs with no fatalities or serious injuries, treatment is the order of the day to reduce the possibility of future recidivism. Treatment options should be evidence based and tailored to the needs of each offender. The availability of health coverage may help influence the treatments used.
- Treatment options vary by jurisdiction, and the most appropriate treatment may not be available to meet the needs of each individual offender. What Marlowe (2012:7) said about drug courts applies as well to DWI courts: “no one intervention should be expected to work for every drug-involved offender.”
- Compliance with treatment plans must be closely monitored by courts or probation services, with swift responses used to correct noncompliance with treatment.
- Recidivism rates should be calculated separately for each type of treatment program to provide judges and others and evidence on which treatments are most effective for each type of offender.

I. Introduction and Definition of the Problem

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) is conflicted, and that ambivalence is reflected in the criminal justice process.¹ 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, and that varies by health, weight, and tolerance of the individual. On one hand, we want to punish the offender who kills or seriously maims someone because of impaired driving; on the other, we do not want to enroll the “social drinker” into the criminal justice system because even judges want to have some wine with dinner out. 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 (Stuart, 1989) argued that DWI offenders should not receive severe punishments. Even if victims were severely injured or killed, prosecutions for manslaughter were rare, and even license suspensions and jail time were imposed infrequently (Lerner, 2011: 6).

¹ The term DWI is used throughout this monograph 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.

The words of one judge echoes the thoughts of many: “I just feel that some of those people have suffered more than I could impose on them” (quoted in Whitaker, 1981).

Some of the activists who charged that the problem of impaired driving was being minimized or ignored belonged to churches that were morally opposed to drinking alcohol and opposed all drinking and driving. Others were not opposed to drinking, just to driving after drinking—a problem that could be solved by designating sober drivers or using mass transit. One advocate even suggested a surtax in drinks served in bars to provide subsidized taxi rides home (Lerner, 2011:100). If the efforts toward producing driverless cars is successful, this could effectively eliminate the offense altogether.

Mothers Against Drunk Driving (MADD) was founded in 1980 by mothers and other activists whose children or other family members were killed or injured by drunk drivers. Consciousness of their cause was raised during the time of the Reagan presidency in conjunction with efforts to combat drug addiction, domestic violence, rising crime rates, and abortion. All of these victims’ rights groups maintained that the justice system paid too much attention to the rights of criminals versus the rights of victims. The emphasis here was on arrests and prosecution of offenders and resulted in a series of interventions ranging from tougher laws, more consistent punishments, sobriety checkpoints, and ignition interlocks.

The success of MADD and other victims groups did result in a backlash from the alcohol industry to civil libertarians, who asserted their right to make individual choices to drink and perhaps to drive home. In a Virginia Senate speech criticizing legislation to make drunk-driving laws stricter, William E. Fears stated, “We’re going to take all the sport out

of drinking and driving” (Robertson, 2008). Foreshadowing the current debate, however, is the attempt to change the conception of the problem from a law-and-order issue to a public-health issue—from a sin to a disease. It is difficult to know the extent to which conceptualization of alcoholism as a disease hindered prosecution. Lerner (2011: 23) explained that “to the degree that treatment of the underlying illness was becoming increasingly important for alcoholics, punishing them for drunk driving seemed counterproductive.”

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 (Wallace, 2008). Consequently, even the criminal justice system has recognized that addiction is a health problem and treatment of offenders has been the preferred solution, sometimes alone and sometimes in conjunction with other sanctions. It does leave, however, the residual question of whether any punishment is deserved and, if so, what type? (Stuart, 1989.)

Courts have a role to play in reducing the incidence of impaired driving, especially in selecting sentences that are effective. A recent survey of 960 court officials gave even odds that states would give significantly more sentencing discretion to judges within the next ten years, especially over nonviolent offenders (Knox and Kiefer, 2015). Because judges sentence individual offenders one at a time, they often do not receive feedback on the efficacy of various sentencing options for different types of offenders. In a survey of 900 judges asking for their recommendations for improvement of the handling of DWI cases, over 80 percent said that their sentencing decisions would benefit from

summaries of scientific research on the effectiveness of DWI sanctions (Robertson and Simpson, 2002: 47). The sentencing literature is incomplete and spotty, and most judges do not have the time to keep up with all the latest research, especially on the effectiveness of various treatment options.

A significant amount of work on sentencing options has 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* (2005). 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 this *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 does assume that judicial sentences can *both* sanction and treat the offender. That conclusion was carried over from the earlier version of the *Guide* and was based upon research conducted in the 1990s, which was based upon a small number of research studies focused upon “alternative sanctions” to the traditional criminal justice penalties. Indeed, in one of the most recent of these studies, conducted in a single county court in Georgia, a judge routinely used jail time in conjunction with alternative sanctions, such as house arrest and electronic monitoring (Jones and Lacey, 1998: 16).

Consequently, the success of sentencing designed to punish or treat the offender is measured by recidivism. It is with this premise that sentencing can both punish and treat that I take issue with here, and the challenge is not just 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.²

Conflating the contradictory goals of treatment and punishment leads to a lack of clarity in the purpose of the sentence imposed, and consequently to a lack of clarity in measuring the success of the sentence. As will be discussed later, measuring effectiveness by recidivism implicitly assumes the goal of treatment or rehabilitation, but is not the appropriate measuring stick to use if punishment of the offender is the goal.

² In this monograph, the focus will be on the treatment vs. 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; thus, deterrence is listed in the punishment category. (The concept of seeing punishment meted out as 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—to punish the offenders and to prevent them from harming themselves and others. Restitution is intended to at least partly to return the victim/victims to *status quo ante*, and that could be seen as a combination punishment and first step in treatment. The options become clear when asking the basic question of what judges are trying to accomplish with sentencing—punishing offenders who have harmed society in some way or rehabilitating offenders so they will not offend again.

II. The Goal of DWI Sentencing: Punishment or Treatment?

A. Legal or Medical Approach to DWI

A Guide to Sentencing DWI Offenders (2005: 3) says, "Sentencing 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." In their discussion of DWI courts, Tauber and Huddleston (1999) 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" (quoting the draft mission statement of the National Association of Drug Court Professionals Advisory Panel).

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, including 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.

The distinction between the legal approach to crime and the medical approach is discussed in Flango and Clarke (2015: ch. 8) and reflects a much earlier debate on sentencing: should the punishment fit the crime or fit the criminal?

The object of the legal approach is to achieve the *status quo ante*—that is, the restoration of things to where they were before the crime was committed or the injury was inflicted. Pure legal remedies, then, are more narrowly limited to punishing someone or awarding compensation.

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.

The premise of resolving similar disputes similarly also helps explain the importance that law places on precedent. Reasoning by analogy permits the judge to decide how a case before the court is like or unlike previous cases and, therefore, which legal rule to use to resolve the issue. The rule itself is not just a solution for a particular individual, but must fit an entire category of cases—those with similar fact patterns.

The opinion keeps courts accountable by requiring a justification for the decision that is transparent to all. Requiring judges to state reasons for their decisions discourages arbitrary and capricious decisions. Adherence to precedent encourages consistency in outcomes and, therefore, predictability of expectations.

On the other hand, the medical approach to crime aims to correct the problems that led to the crime. It focuses on protecting public safety by attacking directly the root cause of DWI—alcohol and substance abuse. As stated by McNamara (1977: 439-40):

In its simplest (perhaps oversimplified) terms, the medical approach, as originally applied in the corrections context, assumed 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.

The medical approach 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.

B. Classification of Sentencing Options

There are two parallel ways of dealing with DWI offenses. The first is the traditional legal approach with its emphasis on determining responsibility and then meting out punishment when the offender is deemed to be guilty. The second is an extension of the trend toward what was called *alternative sanctions*. The growth of problem-solving courts, including drug courts and their offshoot DWI courts, represents the medical approach of treatment and rehabilitation of offenders to reduce recidivism, which reduces the number of future arrests, prosecutions, and court cases.

Alternative sanctions were created, at least partially, by the perceived failure of punishment to stop the revolving door of recidivism. One judge summarized alternative sanctions as follows: “Where the level of punishment required is diminished by the need to solve the underlying problem and so you’d rather solve the problem than punish the behavior” (Farole et al., 2005: 65).

The following two chapters intend to classify sentencing options as either punishment or treatment, but this is very difficult to do because many, if not most, sentencing options have elements of both. Even the most traditional sentence of incarceration has been modified to include a treatment component. Incarceration has been used as an opportunity to place offenders into residential treatment programs, such as special DWI facilities or weekend intervention programs (NHTSA and NIAAA, 2005).

Restrictions on driving may be imposed as a punishment 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 patients from injuring themselves, but the intentions are different.

Despite the difficulty of classifying sentencing options into punishment and treatment categories, the attempt will be made here because it is absolutely critical to identify the purpose of the sentence before evaluating its effectiveness.

III. Sentencing Options When Punishment Is the Goal

Sentencing criteria are different when the purpose is to punish those guilty of DWI offenses. These sanctions are based on the assumption that punishment will be effective if it is certain, swift, and appropriately severe. Many of the sanctions listed below provide variety in the severity of punishment; research suggests that *certainty* and *swiftness* of punishment are greater deterrents than severity of punishment (Ross, 1992).

If the punishment of offenders is made public, punishment may have the additional value of deterring others from driving while impaired (Hingston, 1996). Deterrence-based strategies have been called “the most common means used within the United States to decrease recidivism,” even though deterrence effects are often small (Tyler et al., 2007). Indeed, in one of the most publicized cases, the paralysis of Laura Lamb—child of one of the founders of Mothers Against Drunk Driving—the judge sentenced the impaired driver to only two years in prison, in part because he believed internment would have little deterrent effect on his future behavior (Lerner, 2011: 83).

Ross (1987) contended that harsh punishments that appear to “exceed established levels of fairness” might discourage the prosecution of drunk drivers. Even anti-drunk-driving organizations, such as RID (Remove Intoxicated Drivers), went on record as opposing severe penalties, such as mandatory jail sentences, for first-time offenders who did not cause significant harm.

The goal of punishment is the hope of preventing the offender from driving while impaired again. Punishment may incapacitate offenders while they are in custody, make them pay the costs, and ideally instill fear of future punishment. 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 (Voas and Fisher, 2001: 3).

As noted above, sentencing options for DWI offenders are well identified and described in the NHTSA and NIAAA *Guide*, and those descriptions do not need to be repeated here. These options do need to be placed in a different context, however, according to whether their primary purpose is punishment or treatment.

Because so many sentences have mixed purposes, this chapter will classify sentencing options as to their predominant intentions. Traditional criminal sanctions for DWI include jail, fines, and actions against the driver's license (Jones and Lacey, 2000).

A. Incarceration

The traditional punishment in a criminal justice setting is *incarceration*—some form of correctional supervision. Many states have adopted some form of mandatory jail sentences for misdemeanor DWI and prison sentences for felony DWI.

B. Home Detention and Electronic Monitoring

A modern form of incarceration, home detention with electronic monitoring permits offenders to drive to work or court-ordered treatment, but does not permit driving at other times, especially the critical evening and night times when most DWI violations occur (Schmidt, 1989: 2-5).

Another form of electronic monitoring is not a form of home incarceration, but rather a bracelet that monitors alcohol consumption. The Secure, Continuous, Remote, Alcohol Monitor (SCRAM), which became commercially available in 2003, is an automated alcohol-testing ankle bracelet that provides 24-hour monitoring of consumption and of attempts to tamper with the bracelet. It captures transdermal alcohol readings from continuous samples of vaporous or insensible perspiration collected from the air above the skin (Robertson, Vanlaar, and Simpson, 2006:2). This type of personal monitoring permits offenders to remain employed, to fulfill family obligations, and to remain in treatment (Flango and Cheesman, 2009).

In a recent survey on the Future of the Courts, respondents said it was likely that electronic probation would be the norm within the next ten years as the combination of ankle bracelets, global positioning systems, and video monitoring becomes less costly and less intrusive (Knox and Keifer, 2015).

C. Incapacitating Sanctions

Punishment can also include some *incapacitating sanctions*, such as license suspension and vehicle actions (e.g., vehicle impoundment), which are designed to protect the public (at least for the duration of the sanction) by making it impossible for the offender to drink and drive. Impoundments incapacitate the vehicle, but do not

prevent the offender from borrowing, renting, or stealing a different vehicle. Most states allow police to take away the license of people who either fail alcohol tests or refuse to be tested. Because this occurs before conviction, administrative license suspension is not a sentencing option.

D. Fines

Fines, in addition to paying ever-increasing court costs, are another form of punishment. To be an effective punishment, fines should be paid in full in a timely manner. However, many fines are not collected, or can be paid in small increments over a long period of time, and, thus, do not place a substantial financial burden on the offender (Voas and Fisher, 2001: 4). The fairest form of fines are based on a portion of the offender's daily income.

IV. Sentencing Options When Treatment Is the Goal

The pure medical approach to treatment of DWI offenders would be a sanction based on the premise that many DWI offenders are dependent on alcohol and must recover from their uncontrolled pattern of alcohol consumption to avoid impaired driving (Voas and Fisher, 2001: 3).

A very large caveat, which must be discussed at the outset, is that some treatment options may not be available, or even statutorily permitted, in some jurisdictions. Many of these are listed under the heading of alternative sanctions listed below.

A. Education and Counseling

Sentencing options can vary widely from outpatient-counseling sessions all the way up to long-term inpatient programs conducted in hospitals and clinics. Alcoholics Anonymous, and its 12-step program, has been a primary aid to recovery. For DWI offenders, this approach may be most effective in hospital or correctional settings where attendance can be monitored (McCrary and Miller, 1993).

B. Medication

Medications can be used to help offenders maintain sobriety while attempting to change the behavioral patterns leading to alcohol abuse. Some courts use Antabuse (disulfiram) or Naltraxone as treatment, although it is usually recommended that drug therapy be combined with psychosocial therapies for the most benefit (O'Malley, 1998: xv). Naltrexone (ReVia) is a nonaddictive medication that suppresses the craving for alcohol. Antabuse produces unpleasant side effects when a person drinks alcohol while taking the drug (Benson and Lynch, 2004: 51).

C. Ignition Interlocks

Alcohol-ignition-interlock devices prevent an impaired driver from operating a vehicle. Many judges are unsure of how to categorize ignition interlocks in their sentencing philosophies. As a punitive sanction, it appears too lenient for repeat offenders and too harsh for first offenders (Robertson, Vanlaar, and Simpson, 2005: 5). It is classified here as a treatment, because it has been used as an alternative sanction to incarceration, often in conjunction with other treatment programs. The interlock device is not intended to change the behavior of offenders in the long term, but does prevent them from driving particular vehicles while impaired. This allows offenders to maintain their employment

and family obligations while maintaining public safety as well. There has been at least one suggestion to make ignition interlocks mandatory equipment for all vehicles (Neugebauer, 2002). But in addition to being unnecessary in cars driven by people who do not drink alcohol, they are inconvenient, are expensive, and do require calibration.

Interlock devices have been found to reduce recidivism for repeat offenders, young drivers, and persons with high-blood-alcohol concentration (BAC) levels (Fulkerson, 2003). Some judges find ignition interlocks costly compared to other treatment alternatives, and more importantly, their use does not mitigate the need for counseling and treatment of impaired drivers. Many judges are surprised to learn that offenders frequently fail to install the ignition interlock, a situation that is easily remedied by making a certificate of installation a condition of sentencing.

D. Probation

Probation has been used in conjunction with traditional sentencing, but is listed here because it puts conditions on the freedoms of offenders and is critical to ensuring compliance with treatment, education, and other sanction programs. Variations include basic supervision probation (monthly visits), unsupervised probation, and individualized restrictions.

Intensive supervision probation provides offenders with more contact with probation officers and participation in education and therapeutic programs in the community.

Intensive supervised probation is an intermediate sanction between prison and regular

probation and may include a variety of control mechanisms, including house arrest and electronic monitoring. Under intensive supervision, offenders retain their freedom but are subject to requirements such as curfews, drug testing, daily contacts, and mandatory community service (Byrne, Lurigio, and Baird, 1989:8).

E. DWI Courts

DWI courts are listed here, because in many respects they are similar to intensive supervision probation programs. The high incidence of crimes committed while under the influence of alcohol, including driving while impaired (DWI), has prompted several jurisdictions to develop sobriety or DWI courts, most based on the drug-court model.

DWI courts were established to protect public safety and to reduce recidivism by attacking the root cause of impaired driving—impairment caused by alcohol and substance abuse (Flango, 2005).

Most DWI courts are post-adjudication programs, which means participants can be required to serve some portion of a jail sentence with the remainder being suspended pending completion of treatment. Failure to graduate from DWI court can result in a return to custody or a return to traditional adjudication.

Common characteristics of sobriety and DWI courts include intense alcohol-addiction treatment and heavy court supervision, with jail sentences as a last resort. Compliance with treatment and other court-mandated requirements is verified by frequent alcohol and drug testing, close community supervision, and interaction with the judge in nonadversarial hearings (Huddleston and Wosje, 2004: 11). Monitoring DWI offenders is more difficult than monitoring drug-court participants because alcohol goes through

the body quickly and is more difficult to detect than most drugs. Alcohol is also legally available and easier to obtain.

Many judges believe that the use of DWI courts should be expanded, allowing experienced judges to use treatment resources and sentence, sanction, or reward offenders with greater consistency (Robertson and Simpson, 2002: 47). Since that call was made a dozen years ago, the number of DWI courts has increased to 242 and the number of hybrid DWI/drug courts to 448 as of June 30, 2014 (Harron and Kavanaugh, 2015: 2).

F. Other Alternative Sanctions

Other alternative sanctions that have been used in DWI cases include community services in lieu of or in addition to jail, victim restitution, visits to hospital emergency rooms that treat traffic-crash victims, and license plates that identify the vehicle owner as a DWI offender.

The first set of alternative sanctions appear to be treatment oriented. For example, programs that provide information and education on the medical and legal consequences of drinking, including the effect on driving performance, DWI laws, and videos of alcohol-related crashes and injuries, would appear to support treatment. Victim impact panels, one-time programs in which victims of DWI crashes or their relatives describe the effects on them, are another form of education. Victim impact panels use an emotional appeal designed to change the attitudes of offenders toward drinking and driving by illustrating the real impact of crashes (Donat, 2004: 41). Victim impact panels are recommended for first-time offenders, but only in conjunction with

other treatments (Haddon, Franchina, and Gordon, 2003: ch. 3). Community groups, such as Mothers Against Drunk Driving, are often responsible for organizing the programs, and the court staff is responsible for assigning and monitoring the offender's attendance.

In some senses, *restorative justice conferences*, in which offenders meet with the victim in the company of their friends, family, and other interested parties in the presence of a trained facilitator, can also be considered educational. These conferences not only focus on appropriate punishment for past behavior, but also encourage offenders to take personal responsibility for their actions in the future.

Vehicle-plate actions seem to be more punitive, but have promoted public safety by alerting law-enforcement to cars owned by DWI offenders. Special plates, stickers, or numbers are issued for a vehicle owned by a convicted impaired driver and may constitute probable cause for stopping the vehicle. The special plates or stickers permit family members to continue to operate the vehicle that otherwise might have been impounded or had its registration suspended or revoked. Police in Washington and Oregon can place a "zebra" sticker over the annual portion of the license plate of the offender's vehicle at the time of the stop (Witte, 2004: 30). Subsequently, any officer could stop these stickered vehicles and request that drivers produce valid licenses.

V. Evaluation Criteria: Measuring Effectiveness of Punishment and Treatment

Evaluation of the success of punishment or treatment is difficult. The argument proposed here is that different evaluation criteria are required to measure success of punishment or treatment. Consistency in sentencing is absolutely essential to ensure fairness among offenders convicted of similar DWI offenses, but 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.

Further complicating the issue is that some offenders apprehended for the very first time may be unlikely to offend again even without treatment or punishment. Indeed, one study (Warren-Kigenyi and Coleman, 2014) reports that about a quarter of DWI offenders become repeat offenders, but a *majority* of persons arrested for DWI do not repeat the offense. Which of the sentencing options listed above is necessary for that majority of offenders?

A. Punishment: 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 criterion for

success is did the offender serve the required sentence, pay the fine, etc., and 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 (Mitchell, 2009: 368). The recommendation for specialized DWI courts was made before the advent of the specialized problem-solving courts in existence today, but favored specialized courts similar to small-claims court to handle misdemeanor DWI offenses. The advantages of specialized DWI courts would be more consistency in sentencing, the prevention of “judge shopping,” reduction in plea bargains, and fewer pleas of related offenses, such as reckless driving, in place of DWI (Mitchell, 2009: 369).

Sentencing disparity results in some offenders not receiving appropriate sanctions. More than half (54 percent) of the law-enforcement officers in a Traffic Injury Research Foundation survey reported they do not believe the penalties imposed by judges reflect the severity of the offense (Robertson and Simpson, 2003: 18). And some offenders do not comply with sanctions that are imposed. For example, many offenders continue to drive even when their driver’s licenses are revoked.

Sentencing disparity reduces the potential for behavioral change and increases the likelihood of recidivism. Further, the inconsistent application of penalties creates a public perception of unequal justice. Most important, disparity permits and 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 (Robertson and Simpson, 2003:18).

The causes of sentencing disparity may be understandable, but it makes monitoring more complicated. The range of sentences that can be imposed on a DWI offender, despite a similarity in offender backgrounds and circumstances, is extremely broad. Offenders who are aware of the disparity may be less willing to comply with penalties perceived to be unfair. Disparity can also detract from the deterrent effect of sentences and reduce the potential for behavioral change.

B. Treatment: Reduction in Recidivism

Sentencing alternatives for courts often depend on the availability of treatment alternatives in the community. Nevertheless, courts do require feedback on the success rates of various treatment programs if judges are to improve the effectiveness of their sentences and reduce recidivism.

Recidivism rates are the primary way used to indicate the effectiveness of treatment programs and the effectiveness of sentences and treatment alternatives. 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 (Breer et al., 2003: 75).

The downside of using recidivism rates is that DWI arrests and crashes are infrequent occurrences even for intoxicated drivers (Voas, 2001). One survey estimated that the number of times a person drives drunk before being arrested is 300 (Voas and Hause,

1987: 81-90). A more recent estimate is one arrest per 772 episodes of driving two hours after drinking (Zador, Krawchuk, and Moore, 2000). Obviously, recidivism rates also depend upon level of enforcement in the community.

Moreover, much inconsistency is prevalent in the use of the term “recidivism.” It seems to be an easy concept to grasp, but the recidivism rates can vary tremendously by how the term is defined. Indeed, different definitions of recidivism make it very difficult to compare the effectiveness of different treatment programs and to conduct meta-analyses of various studies to reach some general consensus on the effectiveness of treatment programs.

Recidivism rates vary because of three factors:

- **Measurement definition:** Some studies classify people as recidivists only if they are rearrested, some only if the offenders are convicted a second time, or some only if offenders are reincarcerated.
- **Offense:** Several studies count recidivism as a rearrest for any reason, traffic and non-traffic violations, and others only for rearrests for DWI.

- Time period: How long before rearrest or reconvictions? Six months? One year? Three years? Recidivism rates will be lower if shorter time periods are used.

Maltz (2001:65-66) lists several alternative definitions of recidivism. The argument against using raw arrests is based on the standard for arrest being much less rigorous than that for conviction. Probable cause is sufficient to arrest an individual; proof beyond reasonable doubt is needed for conviction. Furthermore, the arrest of a person released from prison (i.e., known to have been an offender) is much more likely to occur than the arrest of a person with no prior record. The literature suggests that the number of prior DWI convictions will influence the probability of recidivism since repeat offenders are at greater risk for additional DWIs (Gould and Gould, 1992).

Lack of information is a problem overall and will affect recidivism rates. Every crime committed by individuals is simply not known. The word crime covers a lot of ground. For example, if a DWI offender is arrested, convicted, and sentenced to a correctional program specifically designed to treat such offenders, then upon release no longer drinks and drives but turns to armed robbery, should that be counted as recidivism? (Maltz, 2001:55.)

Recidivism rates also depend upon the quality of court records, and records may be inaccurate or incomplete and may even be purged periodically. Moreover, records do not routinely capture out-of-state offenses (Chang, Gregory, and Lapham, 2002: 16).

Regardless of measures used, recidivism rates should be calculated not only for the total number of DWI offenders receiving treatment, but also for types of individual treatment so that courts can determine which treatments or combination of treatments reduce recidivism the most.

VI. Conclusions and Recommendations

A. Sentencing Options Should Be Post-Adjudication

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 (Feinblatt, Berman, and Denckla, 2000: 28-34) 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.”

This is the practice in DWI courts. Sentencing options considered should be *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 record and allows repeat offenders to be treated subsequently 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), in federal law 49 CFR 34.226, 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. Perhaps

for these reasons, NHTSA (2003) has recommended that diversion programs be eliminated.

Post-adjudication treatment is the more appropriate model and preferable to deferred prosecution. Diversion programs used pretrial are not included because they are not sentencing options for punishment, and even many treatment programs require an admission of guilt as a precondition of treatment. Should technically innocent people be forced into treatment programs before guilt has been adjudicated? As one scholar (McCoy, 2006: 964) noted, “[I]t is not a court if you have to plead guilty to get there.”

B. Sentencing Track—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.

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 so chemically dependent that incarceration is the only option? Clearly, it is a deterrent to repeat DWI violations while in jail or prison, 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?

If *treatment* is the chosen option, the assumption is that treatment for addiction will prevent future dangerous driving. In that case, measures of recidivism are important. What types of offenders are best candidates for treatment? What types of risk-assessment instruments are available to help decide when treatment is the goal most likely to lead to the best result—unlikeliness to 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. If the offender fails to meet the requirements of treatment programs, it is possible to return them to the mainstream sentencing track.

The point to be emphasized here is that recidivism rates should be calculated separately by treatment program, so that the effectiveness of each can be evaluated.

C. Screening to Assist Choice of Sentencing Option

1. Screening Is Key

Marlowe (2012) contends that the critical question is how to match offenders to the best programs that meet their needs, protect public safety, and do so at least cost. 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” (amenability to treatment).

Before judges can decide between punishment and treatment, and even from among various treatment alternatives, offenders need to be screened *first* for treatment eligibility. Do 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/absence of alcohol-use disorder (AUD), drug-use disorder, and recidivism risk (Chang, Gregory, and Lapham, 2002). Determining the severity of alcohol dependence is critical to determining an appropriate treatment plan. Many jurisdictions use self-report instruments to evaluate alcohol use, and some conduct personal interviews as well. Thirty-one states screen both pretrial and posttrial, and 16 screen posttrial only. Most programs require clients to pay screening fees, but in four states the costs are covered by public funds (Chang, Gregory, and Lapham, 2002:22).

The issue is further complicated by the growing recognition that many people with alcohol or drug problems also are experiencing other psychological problems that may affect the effectiveness of treatment services. For example, people who misuse alcohol may suffer from schizophrenia, eating disorders, and post-traumatic-stress disorder

(Soyka et al., 1993; Holderness, Brooks-Gunn, and Warren, 1994; Seidel, Gusman, and Aubueg, 1994).

The assessment of all convicted DWI offenders for alcohol problems 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 officials 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 does need to know the range of treatment options available and the practices that support each of the treatment approaches. 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 (adapted from Casey and Hewitt, 2001: 17-18):

- 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?

2. Screening Instruments

The best instruments for DWI screening are the MacAndrew Scale of the Minnesota Multiphasic Personality Inventory and the Alcohol Use Inventory (Chang, Gregory, and Lapham, 2002: 6). 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” (Chang, Gregory, and Lapham, 2002: 6). 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 (Wendling and Kolody, 1982).

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 (Mortimer, Filkins, and Lowery, 1971). 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.

Courts in 14 states use the Michigan Alcoholism Screening Test, or MAST. This 24-item questionnaire was developed in 1971 by Selzer. 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 (Myerholtz and Rosenberg, 1997).

Questions remain about the accuracy of these particular screening instruments, the ones most popular with courts; however, *none* of the screening instruments in use meet

the stringent criteria that are the accepted standard in medical practice (Chang, Gregory, and Lapham, 2002: 6).

Available screening instruments are only partially successful in predicting recidivism. “Sensitivity” measures how well the screening instrument predicts who will recidivate, and “specificity” measures how well the instrument predicts who will not recidivate. The practical impact of low prediction rates in the real world can be illustrated by an example provided by Chang, Gregory, and Lapham (2002: 24). If the estimated recidivism rate is 30 percent, in a population of 1,000 offenders about 300 will reoffend. A test with a sensitivity of 70 percent will accurately predict 210 of these 300 and miss 90. In the same population, a test with 50 percent specificity will accurately predict 350 of the 700 non-recidivists and miss the other 350.

Note the high number of inaccurate predictions with the very best testing instruments. Mortimer-Filkins in three separate samples had sensitivity rates of 22 percent, 29 percent, and 30 percent—much less than the 70 percent used in the example above. MAST had a sensitivity rate in one New Mexico sample of 47 percent (Chang, Gregory, and Lapham, 2002: table 5). With this performance, in the same fictional population of 1,000, the MAST would predict correctly less than half of the recidivists (accurate on 141, but miss 159 of the offenders). Similarly, the specificity rate for the Mortimer-Filkins ranged from 74 percent to 86 percent, and on the MAST from 58 percent to 73 percent. This is much better than the 50 percent specificity used in the example above and means that a test with 73 percent sensitivity would accurately predict 511 non-recidivists

and miss 189. This is interesting because it shows that the tests preferred by courts are below par in identifying possible recidivists, but better at predicting non-recidivists. Existing assessment instruments will undoubtedly need to be improved and enhanced to better predict recidivism and, thus, the sentencing options that would be best for each type of DWI offender.

D. Sentencing Options for High-Risk Offenders

Recidivism among DWI offenders is high. NHTSA (1995) has estimated that one third of all drivers arrested, convicted, or adjudicated for impaired driving are repeat offenders.

The introduction to this monograph noted the ambivalence to DWI that does not occur with other crimes. Unlike some drugs, including drugs available only with prescriptions, which can be prohibited completely, the question is how much drinking can occur before impairment ensues? Interestingly enough, Blood Alcohol Concentration (BAC) standards set by the American Medical Association back in 1939 are still in use to define hardcore drunk drivers (Lerner, 2011: 28). These are:

- BAC of less than 0.05 percent no impairment, thus no prosecution for DWI
- BAC greater than 0.15 percent definite impairment, should be prosecuted and the standard for admission to DWI courts as “hardcore” offenders
- BAC between 0.05 percent and 0.15 percent, prosecution if circumstances warrant, which gives discretion to local law enforcement and prosecutors

Since that time, the “in-between” standard has moved down. On October 25, 1982, President Reagan signed the first federal drunk-driving legislation—a bill that provided highway funding for the states, which set the BAC impairment level at 0.10 percent. By 1984, all states had lowered their legal BACs to that level (Lerner, 2011: 89). By 2004, all states had set the legal BAC level at 0.08 percent, which is close to, but slightly above, the 0.05 percent level at which impairment generally begins.

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.

Moderation then became the marketing and public-relations strategy of the industry (Morgan, 1988). Rather than a more focused attempt to reduce binge drinking and drunk driving, the imprecise term “responsible drinking” was used as the focal point of the traffic safety campaign (Barry and Goodson, 2009). The alcohol industry did support for traffic-safety groups, including such leaders as MADD, the National Center for DWI Courts, and the Traffic Injury Research Foundation, and gained some credibility by partnering with MADD and others to advocate for the 0.08 percent BAC, administrative license revocation, and other anti-drunk-driving measures. In 2008 the U.S. Department of Agriculture added the Distilled Spirits Council’s “Educational Tool Kit on Beverage Alcohol Consumption” to its Dietary Guidelines in an effort to define responsible drinking (DISCUS, 2008). Of course, if alcoholism is a genetically acquired illness, then the alcoholic cannot be taught to drink “responsibly” (Deaver and Hickle, 1985).

Much of the research on repeat offenders is dated, but the findings of most of the scientific literature is fairly consistent. Jones and Lacey's (2000) review of the literature on repeat DWI offenders concluded that they could not determine with any degree of confidence the magnitude of the alcohol-crash problem caused by repeat DWI offenders. They cited research from California that repeat DWI offenders comprise a small, but not negligible, percentage of drivers (8 percent range) involved in traffic crashes. The Insurance Institute for Highway Safety reports that 95.5 percent of drivers in fatal crashes did not have DWI convictions three years before the crash (McCartt, 2014). 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" (Jones and Lacey, 2000: 1).

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 (Lerner, 2011:114).

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.

Incarceration not only fails to reduce recidivism, but there is even some evidence that longer periods of incarceration increase recidivism. Alternative sanctions were more effective than traditional sanctions in reducing recidivism. Jones and Lacey (2000) noted that license suspension or revocation combined with treatment was especially effective in reducing recidivism.

- *Punishment or Treatment*

Repeat offenders create a special situation with respect to the question of punishment or treatment. 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 did 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 (FAQ Section), who believes that punishment unaccompanied by treatment is an ineffective deterrent for hardcore offenders.

- *Screening*

It is difficult to identify the hardcore, potential repeat offender. Many of these people have characteristics similar to those of first offenders, assuming that this is indeed a first offense rather than the first time caught. Some older studies were unable to distinguish

first offenders from repeat offenders (Jones and Lacey, 2000), but they do tend to be involved in more crashes, take more health risks, and report being able to drive safely after more drinks than first offenders (Nochajski and Wieczorek, 2000).

Moreover, 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.

The National Center for DWI Courts website (FAQ) 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. Indeed, the first alcohol-impaired driving incident is a predictor of future recidivism, as is the number of failed breath test results on an alcohol-ignition-interlock device (Rauch et al., 2002; Marque, Voas, and Tippets, 2003).

In their review of the literature, Jones and Lacey (2001) did find 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 males under age 40 with a high-school education or less and blue-collar employment. They have also been found to have more severe mental health problems (McMillen et al., 1992).

- *Interrelated Offenses*

Sentencing becomes more complex when impaired driving occurs conjointly with other related offenses and actually provides some support for those who want to distinguish “hardcore” impaired drivers from “responsible” social drinkers.

Many high-risk driving behaviors are interrelated, which may make it more difficult to change a single driving behavior. People who drink and drive are less likely to wear seat belts and more likely to be distracted. Problem-behavior theory was formulated to account for behavior of adolescents, which includes not only impaired driving, but speeding, aggressive driving, nonuse of seatbelts, heavy drinking, illicit drug use, and sexual precocity (Jessor, 1987). Students who reported frequently taking risks while driving also reported driving after having “a good bit to drink.” Today, these risks would also include behaviors such as texting while driving and other forms of distracted driving.

With respect to use of other drugs, convicted impaired drivers were intermediate between alcoholics and general licensed drivers in their use of prescription drugs, including sedatives and tranquilizers, but more likely than the other groups to use stimulants and drugs such as marijuana or LSD (Selzer and Barton, 1977). There is also a correlation between number of drugs used and frequency of impaired driving (Wilson and Jonah, 1988; Elliott, 1987), which makes it difficult to determine which impairment was most responsible for a crash.

E. Where Do We Go from Here?

Historically, the greatest effort to reducing impaired-driving problems has involved the legal system, with the enactment of laws, imposition of penalties, and strengthening of law enforcement. A California study (Schell, Chan, and Morrel, 2006) showed that driving after drinking was correlated with frequency of drinking. The authors concluded that individuals who believe they are affected by alcohol intoxication do not respond to the standard penalties for DWI and persist in driving after drinking. 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, which broadly conceived would include improving public transportation, reducing alcohol availability through taxation, and opposing alcohol-industry sponsorship of events, does not appear to be directly related to impaired driving (Lerner, 2011: 172).

So now the focus has turned to technology. An Insurance Institute for Highway Safety survey (IIHS, 2009) found that two-thirds of Americans favor routine installation of alcohol-detection devices in all cars. This includes the ankle bracelets worn by Lindsay Lohan, but is primarily focused on ignition interlocks for anyone one convicted of impaired driving, even first-time offenders. In Belgium, a group called Responsible Young Drivers required thousands of drivers exiting a parking lot after a celebration to blow into a breathalyzer before they could exit. Many automobile manufacturers are working on technological driver-assistance features. One is a sensor, located either in the steering wheel or the driver-side door, that can “smell” the driver’s breath and

prevent the car from starting. Another is a touch sensor on the ignition button or gear shift that can scan blood-alcohol content. The ultimate technological solution, of course, would be the self-driving car (see figures below, from McCartt, 2014).

Google autonomous car

Autonomous Driving

Google's modified Toyota Prius uses an array of sensors to navigate public roads without a human driver. Other components, not shown, include a GPS receiver and an inertial motion sensor.

LIDAR

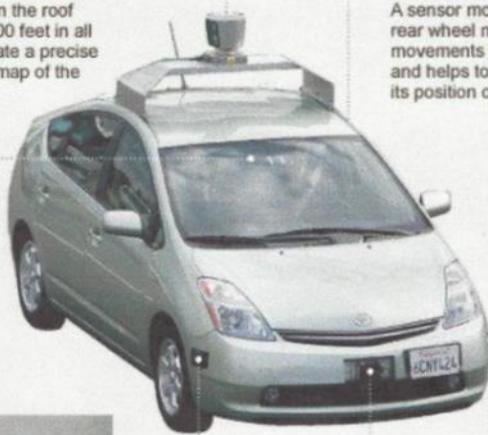
A rotating sensor on the roof scans more than 200 feet in all directions to generate a precise three-dimensional map of the car's surroundings.

POSITION ESTIMATOR

A sensor mounted on the left rear wheel measures small movements made by the car and helps to accurately locate its position on the map.

VIDEO CAMERA

A camera mounted near the rear-view mirror detects traffic lights and helps the car's onboard computers recognize moving obstacles like pedestrians and bicyclists.



RADAR

Four standard automotive radar sensors, three in front and one in the rear, help determine the positions of distant objects.

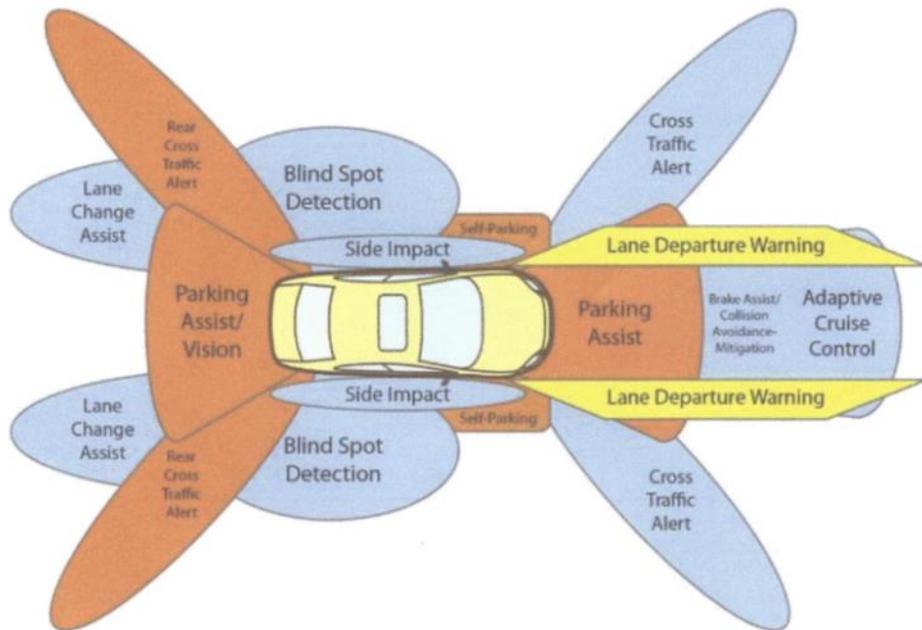
Source: Google

THE NEW YORK TIMES, PHOTOGRAPH BY SAMI SAHMIN FOR THE NEW YORK TIMES

www.ihs.org

Driver assistance features

Radar, LIDAR, ultrasonic, infrared, cameras, GPS



www.iihs.org

For the present, what is the role of the legal system in the reduction of DWI offenses?

Punishment

- 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.
- It is not possible to tailor a sentencing remedy to an individual offender and at the same time have a consistent sentencing policy such that every offender committing the same DWI offense receives the same sentence.
- If a crash occurs with fatalities or serious injuries, equivalent to manslaughter, punishment is necessary, which means legal-system involvement. Indeed, at one time, Husak (1994) proposed a separate crime, “aggravated drunk driving,” for drivers with high BACs who have driven recklessly. If the legal system needs to be involved, punishment imposed should be consistent with sentences given to similar offenders.

- Current research seems to indicate that the need for judicial involvement is most apparent in cases where the offender is high risk/high need. Triage could be used to identify high risk/high need offenders for court processing, with all others going into the traditional probation/corrections system.

Treatment

- If a crash occurs with no fatalities or serious injuries, treatment is the order of the day to reduce possibility of future recidivism. Treatment options should be evidence based and tailored to the needs of each offender. The availability of health coverage may help influence the treatments used.
- Treatment options vary by jurisdiction, and the most appropriate treatment may not be available to meet the needs of each individual offender. What Marlowe (2012:7) said about drug courts applies as well to DWI courts: “no one intervention should be expected to work for every drug-involved offender.”
- Compliance with treatment plans must be closely monitored by courts or probation services, with swift responses used to correct noncompliance with treatment.

- 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 for each type of offender

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