

EFFECTIVE COURT RESPONSES TO PERSONS CHARGED WITH DRIVING UNDER THE INFLUENCE (DUI)

UNDERSTANDING THE PROBLEM: IMPAIRED DRIVING

In 2016, over one million people were arrested for driving under the influence (DUI).¹ According to recent reports by the Bureau of Justice Statistics, 13 to 14% of all probationers are sentenced for DUI annually.² Of all traffic fatalities, 31% involve alcohol-impaired drivers, occurring at a rate of one death every 50 minutes.³ In addition, 39% of fatally injured drivers, and 50% of severely injured drivers, had illicit drugs in their systems.⁴ In the most recent National Highway Traffic Safety Administration (NHTSA) National Roadside Survey of nighttime weekend drivers, about 1.5% of drivers had blood alcohol content (BAC) levels exceeding .08, while about 5% tested positive for medications or other legal drugs and 15% tested positive for illegal drugs (primarily marijuana or cocaine).⁵ Depending on the survey, 80 to 200 times more people self-report that they have driven under the influence than are arrested for DUI.⁶

Although the problem seems pervasive, two-thirds of all persons convicted of DUI self-correct.⁷ The large majority of all DUI incidents (80%) are committed by fewer than 5% of drivers.⁸ The challenge for the court lies in identifying who is at risk for future DUI recidivism and who is likely to benefit from – or be harmed by – further justice system intervention.

Persons convicted of multiple (repeat) DUI offenses and those found driving with BAC levels of .15 (almost twice the legal limit) or more have been referred to as “hard-core drunk drivers” (HCDDs) or “high-risk” drunk drivers.⁹ In the U.S., about two million people have three or more DUI convictions and 400,000 have five or more.¹⁰ Of drivers involved in fatal accidents, 25 to 30% have committed multiple DUI offenses.¹¹ As a group, HCDDs account for nearly 60% of all alcohol-impaired traffic fatalities.¹² Although persons convicted of multiple DUI offenses are generally not high risk to also commit other crimes, they are more than 7 times more likely to commit another DUI.¹³

Approximately one-third to one-half of all persons convicted of DUI have a chronic, diagnosable substance abuse problem.¹⁴ Among those with a history of multiple DUI convictions, this rate is higher: 41% have a substance use disorder, and many have other criminogenic risk factors as well.¹⁵ In addition, 45% have a major



co-occurring mental health disorder (50% of women and 33% of men).¹⁶ One study of persons with multiple prior DUI convictions electing to participate in a 2-week inpatient treatment program in lieu of prison time found that almost half qualified for lifetime diagnoses of both addiction and a psychiatric disorder.¹⁷

The court faces other challenges in addressing HCDD. People often do not identify HCDD behavior as “criminal” and it may not be caught every time to establish DUI as a pattern of behavior.¹⁸ People can be highly resistant to behavior change, often preferring to serve a prescribed jail sentence instead of participating in a treatment program. Conviction also imposes high monetary costs on defendants, including an array of court fines, probation services and attorney fees, increased auto insurance rates, and additional out-of-pocket expenses (e.g., to cover ignition interlock or other monitoring technologies, treatment or other court program costs, additional transportation costs after license suspension). These cumulative costs can create additional challenges for those seeking to comply with the court.¹⁹

KEY FINDINGS: ELEMENTS OF EFFECTIVE COURT RESPONSES

As part of the development of a curriculum for judges, the National Center for State Courts reviewed the literature and interviewed researchers and practitioners regarding effective court responses to address HCDD behavior at three intercept points: pretrial, sentencing, and probation supervision. This brief summarizes nine key conclusions that emerged from the review.

- 1. Avoid pretrial detention: use pretrial risk assessment tools, pretrial supervision, alcohol/drug monitoring, and driving restrictions to reduce risk of non-appearance and/or recidivism.**

Many jurisdictions have successful pretrial release programs for HCDDs that reduce use of pretrial incarceration while at the same time enhancing public safety through use of pretrial risk assessments, intensive supervision, release conditions such as alcohol monitoring (e.g., blood alcohol testing, continuous electronic monitoring), driving restrictions (e.g., ignition interlock devices), and location monitoring (e.g., GPS systems). These programs have been demonstrated to increase compliance with

pretrial conditions and reduce traffic accidents and recidivism.²⁰

2. Use ignition interlock devices (IIDs) or 24/7 sobriety programs in lieu of license suspension or revocation and, where indicated, in concert with assessment and treatment.

Ignition interlock devices. Recognizing the difficulties in enforcing driving restrictions through mandated license suspensions or revocations, most courts have turned to the use of ignition interlock devices. IIDs have largely replaced other types of vehicle restrictions (e.g., impoundments, boots) and mandated driving suspensions and revocations as a means of preventing an impaired driver's access to a vehicle.²¹ These devices have proven extremely effective in reducing DUI incidents for as long as they remain on the vehicle(s) used by the driver.²² IIDs alone are not effective in reducing recidivism long term (i.e., after the device is removed from the car), but combining them with treatment can produce lasting recidivism reduction benefits.²³ For example, one recent study found that an IID group of individuals receiving mandatory substance abuse treatment following three IID-related violations experienced 32% lower recidivism after the IID device was removed compared to the IID group that did not receive treatment.²⁴

24/7 sobriety programs. In 2015, Congress amended 23 U.S.C. section 164 to add the provision allowing a person with multiple (repeat) DUI convictions to avoid suspension of driving privileges if (s)he participates in a "24/7 sobriety program."²⁵ To retain driving privileges, a participant must comply with 24/7 sobriety program requirements that include: twice daily breath testing; use of SCRAM electronic monitoring devices (see #4, below) and drug patches; random urine testing; and swift, certain, and moderate jail sanctions to enforce sobriety compliance. The program does not include any significant treatment component.

Similar to IID use, 24/7 sobriety programs can be effective in securing behavioral compliance and have positive deterrent effects on participants while they are actively enrolled in the program, but recidivism reduction benefits deteriorate after the program period is over.²⁶ One recent study found that although the program reduced DUI and other traffic-related recidivism among active participants, over 70% of those who recidivated did so after program completion. These individuals were also 9 times more likely to have participated in the program multiple times.²⁷ Some 24/7 sobriety programs are now reportedly building in a treatment component, including brief screening and intervention modules and formal links to additional substance use disorder treatment options.²⁸

3. Monitor substance usage through use of drug testing and/or electronic monitoring devices while offenders are on community supervision.

Older techniques to monitor substance use, such as random breath or blood testing at a fixed location or reporting center, have been largely replaced by newer electronic technologies. Mobile-phone based alcohol monitoring (e.g., BacTrack, Siberlink) and more expensive, non-transferable transdermal ankle bracelet monitoring devices (e.g., SCRAM) keep a record of any alcohol use by the individual and report information electronically to a monitoring station.²⁹ Sometimes electronic location monitoring capabilities (e.g., GPS) are also built into these devices.³⁰

Monitoring devices have been shown to reduce the use of alcohol and DUI incidents while they are in place, but there is little evidence that they reduce DUI incidents after their termination or removal.³¹ The devices are more effective if monitoring data are reviewed frequently to ensure that responses to any violations are swift and certain. The data can also be very useful, for example, to supervision agencies in assessing an individual's risk and needs factors and the risk of future recidivism.³²

4. Enforce compliance with conditions of release and supervision through use of incentives and swift, certain, and fair sanctions.

As indicated above, better outcomes are observed when monitoring activities are combined with swift and certain responses to any violations, but also with the use of incentives.³³ For example, in Staggered Sentencing interventions for persons convicted of repeat DUI offenses, some portions of a jail sentence are stayed on the condition of successful participation in a prescribed intervention program, typically lasting a period of at least 3 and up to 6 years. The program typically includes intensive probation supervision, allows driving privileges with permission of the supervising probation officer, requires participation in Alcoholics Anonymous, mandates alcohol testing, and also encourages voluntary participation in substance use disorder treatment. Upon proof of sobriety and with a positive probation recommendation, the defendant may then file motions with the court to vacate the stayed jail sentences. Staggered Sentencing interventions provide incentives for compliance and voluntary participation in treatment with less use of court time than a traditional DUI problem-solving court. In a NHTSA-funded study, Staggered Sentencing was found to reduce recidivism by 30% over a 4-year follow-up period.³⁴ It is not clear whether the study follow-up period included any period of post-program review, leaving questions about the longer-term recidivism reduction benefits of this approach yet unanswered.³⁵

5. Use validated DUI screening and assessment tools; criminogenic risk/needs assessment instruments; and alcohol, substance abuse, and mental health clinical assessment tools as appropriate to guide supervision and treatment decisions.

DUI offenses constitute the largest segment of misdemeanor offenses on probation supervision in the U.S.³⁶ In at least some states, persons convicted of DUI offenses are also the least likely (of all those placed on probation for a misdemeanor offense) to reoffend.³⁷ Research suggests that individuals should be screened for risk and needs as early as possible in the criminal justice process, using validated actuarial risk/needs and clinical assessments of the individual person and not the offense committed, to inform decisions about the appropriate supervision level, treatment interventions and referrals.

Among the most significant justice system challenges in responding effectively to impaired driving behavior are (a) the failure to use actuarial risk/needs and clinical assessment tools and (b) the lack of or failure to use evidence-based treatment programs.³⁸ With HCDDs, the elements of effective community supervision are generally the same as with the broader probation population.³⁹ But recidivism risk for persons convicted of DUI is often less attributable to a clinical substance use disorder than to underlying anti-social attitudes.⁴⁰ Thus in addition to a specific DUI assessment tool, actuarial risk/needs assessment tools designed to assess general recidivism risk (e.g., COMPAS, LS/CMI or LSI-R, ORAS) and specific alcohol and substance abuse tools should be utilized.⁴¹

Three common types of evidence-based treatment programs that may be used with HCDDs include substance abuse treatment, medication assisted treatment (MAT), and cognitive behavioral therapy (CBT). On average, for individuals diagnosed with substance use disorders, substance abuse treatment alone has been found to reduce DUI recidivism and alcohol-related crashes by 7 to 9%. A more effective court response, however, combines substance abuse treatment interventions with intensive supervision and appropriate use of incentives and sanctions to promote compliance and facilitate behavior change.⁴² When substance abuse treatment is tailored to the assessed criminogenic needs, combining therapies can result in even better outcomes for these individuals, who often face a range of diverse and complex problems.⁴³ Also helpful to substance-dependent HCDDs as they complete substance abuse treatment is MAT. Medications such as naltrexone, known as Vivitrol in its injectable form, are intended to reduce or block addiction cravings. They have been found effective in promoting abstinence from alcohol and, when used in combination with substance abuse treatment, in delaying and reducing recidivism.⁴⁴

Finally, CBT addresses the anti-social attitudes and thinking patterns (as determined by an actuarial risk/needs assessment tool) that underlie criminal behaviors and is an important component of effective treatment programs for most HCDDs.⁴⁵

6. Consider specific responsivity challenges facing female offenders, e.g., mental health, trauma, child care, financial, housing, and transportation.

Among those arrested for DUI, women tend to have higher BAC levels than men.⁴⁶ Because women have lower levels of a stomach enzyme that metabolizes alcohol than men do, they are more vulnerable to the impairing effects of alcohol. Females convicted of DUI are also more likely than their male counterparts to have co-occurring disorders which, because of their inherent complexity, are more difficult to successfully treat. Half of females convicted of DUI have a major mental disorder.

Generally, females tend to be more responsive to individual counselling and gender-specific treatment than mixed-gender group treatment interventions.⁴⁷ It is important that assessment tools used with females (e.g., COMPAS-women, WRNA) be responsive to gender-specific issues including trauma, depression, anxiety, abuse and victimization, and that treatment programs for women incorporate relapse planning, child care, social-support networks, and trauma-informed care providing safety, reconnection, and remembrance or mourning. Women are disproportionately affected by social-economic marginalization, housing problems, child care needs, and financial and transportation problems.⁴⁸ Protective factors for females include self-efficacy, social networks, and relatively higher education levels compared to men.⁴⁹

7. Be aware that incarceration and other sanctions have no long-term positive impact on reducing recidivism, and may increase the risk of recidivism.

Although use of swift and certain sanctions is effective as a specific deterrent in securing short-term compliance as an element of a monitoring or supervision program, sanctions alone do not change an individual's future behavior or reduce recidivism once the monitoring or supervision program has terminated.⁵⁰ Research in California, for example, found that persons sentenced to jail for DUI had almost double the number of subsequent DUIs as offenders assigned to treatment with license restrictions.⁵¹ A review of numerous studies found that mandatory jail "might be a counterproductive policy ... that increases alcohol-related crashes."⁵² Research also shows no correlation between fines and reduced recidivism or traffic fatalities.⁵³ Used as an alternative to incarceration, community service also appears to have little beneficial effect on repeat DUI

incidents.⁵⁴ Likewise, a study of 46 states found that post-conviction license suspension had no discernible effects on alcohol-related fatal crashes.⁵⁵ Most studies also suggest that Victim Impact Panels do not reduce recidivism.⁵⁶

8. Consider DUI court interventions only for high-risk/high-need individuals (i.e., people with repeat DUI offenses who are also substance dependent). These interventions may increase recidivism among those who are not high risk or substance dependent.

Modeled after drug courts, DUI courts have proven very effective in retaining high-risk/high-need impaired drivers in treatment, avoiding violations, and reducing recidivism.⁵⁷ But they have proven less effective with large caseloads (i.e., exceeding 125 cases) and even harmful for lower-risk individuals (i.e., those with few or no prior DUI offenses).⁵⁸ One study also found that DUI courts were ineffective with low-need individuals (see #10 below). As such, it is imperative that potential participants be screened and assessed to determine their risk and needs levels prior to admission to a DUI court.

9. Closely monitor alcohol use and driving activity for high-risk/low-need individuals (i.e., people with a history of repeat DUI offenses but who are not substance dependent).

Proper use of actuarial and clinical screening and assessment tools can reduce recidivism and enable more effective use of limited treatment resources. High-risk/non-dependent individuals convicted of DUI are most effectively served through close monitoring of alcohol use and driving activity.

San Joaquin County, for example, developed a two-track system for persons with repeat DUI convictions. Using the DUI-RANT, the court found that only about 31% of over 1,000 high-risk individuals were also high-need (i.e., addicted or substance-dependent and in need of intensive treatment resources). To better serve this high-risk/high-need subpopulation, the court created a specialized DUI treatment court track. High-risk/low-need individuals, on the other hand, were placed into a one-year DUI monitoring track presided over by a case manager. This track requires abstinence monitored with SCRAM and transdermal drug patches, mobile-phone based technologies, IIDs, and court appearances at 1-month, 6-month, and 1-year intervals (with additional appearances required following non-compliance). Although the low-need individuals constituted 69% of the high-risk caseload, the cost of the court monitoring track comprised only 20% of the total operating costs of the two-track system. The cost of the DUI court constituted 80% of overall costs. Research to date on the two-track system compared with the previous business-as-usual documents significant reductions in recidivism, traffic accidents, traffic injuries, traffic fatalities, and court caseloads.⁵⁹

ABOUT THIS BRIEF

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ENDNOTES

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4. Ibid., National Highway Traffic Safety Administration and National Institute on Alcohol Abuse and Alcoholism; National Association of State Judicial Educators.
5. National Highway Traffic Safety Administration. (2015). Results of the 2013–2014 national roadside survey of alcohol and drug use by drivers. Washington, DC: Authors. Retrieved from https://www.nhtsa.gov/sites/nhtsa.dot.gov/files/812118-roadside_survey_2014.pdf.
6. See National Highway Traffic Safety Administration and National Institute on Alcohol Abuse and Alcoholism (2005) and Warren-Kigenyi & Coleman (2014) at endnote 3. Also see National Highway Traffic Safety Administration. (2016). Proven sentencing strategies for the multiple DWI offender [Webcast]. Washington, DC: Authors. Retrieved from <http://www.judges.org/nhtsa-webcast-proven-sentencing-strategies-for-the-multiple-dwi-offender/>.
7. See Stodola (2017) at endnote 1.
8. DeMichele, M., & Payne, B. (2012). Predicting repeat DWI: Chronic offending, risk assessment, and community supervision. Lexington, KY: American Probation & Parole Association. Retrieved from <https://www.ncjrs.gov/App/Publications/Abstract.aspx?id=260552>.
9. See National Association of State Judicial Educators (2015) at endnote 3.
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12. See Stodola (2017) at endnote 1 and National Association of State Judicial Educators (2015) at endnote 3.
13. See Vlavianos, R. (2017). A multi-track DUI court system for repeat offenders [PowerPoint presentation]. Presentation at the 2017 Lifesavers Conference. Retrieved from <https://lifesaversconference.org/wp-content/uploads/2017/03/VlavianosR.pdf>. Also see Voas et al. (2011) at endnote 10.
14. Ibid., Voas.
15. See National Association of State Judicial Educators (2015) at endnote 3.
16. Ibid. Also see Holmes, E. (2017). Computerized Assessment Referral System (CARS): Screening and assessment of co-occurring disorders [webinar]. Alexandria, VA: National Center for DWI Courts. Retrieved from <https://www.dwicourts.org/wp-content/uploads/2017/08/Holmes-2017-CARS-NCDC-Webinar-8.1.pdf>.
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18. See Stodola (2017) at endnote 1
19. Ibid.
20. See National Association of State Judicial Educators (2015) at endnote 3. Also see 1: McKnight, A., Fell, J., & Auld-Owens, A. (2012). Transdermal alcohol monitoring: Case studies (Report No. DOT HS 811 603). Washington, DC: National Highway Traffic Safety Administration. Retrieved from <http://www.ajc.state.ak.us/ajc/dui/nhst12monitor.pdf>. 2: Foundation for Advancing Alcohol Responsibility (2015). Pre-trial actions for repeat DUI offenders. Arlington, VA: Authors. Retrieved from <https://www.responsibility.org/wp-content/uploads/2015/03/Pre-Trial-actions-for-Repeat-DUI-Offenders-20151.pdf> (24/7 sobriety program as condition of pretrial release). In addition, it is recommended to avoid plea-downs of DUI charges to reckless driving or other lower-level offenses. Despite opposition from traffic safety experts and often due to the high volume of DUI cases, courts in some states continue to plea-down (e.g., to reckless driving) or divert some first-time defendants into diversion programs which, if successfully completed, result in dismissal or reduction of the DUI charge. Public safety concerns strongly discourage such practices as an option, especially with HCDDs, for whom lenient sentences weaken the deterrent effect of a conviction and exponentially increase the likelihood of recidivism. See pp. 12-13 in National Association of State Judicial Educators (2015).
21. IID's typically cost about \$150 or more to install and about \$75 per month to maintain – costs that are typically borne by the offender. In the case of offenders who cannot afford the full costs, it is subsidized either out of fees paid by other users or by the public.
22. See DeMichele & Payne (2012) at endnote 8 and National Association of State Judicial Educators (2015) at endnote 3. Also see Washington State Institute for Public Policy. (2017). Review of adult criminal justice programs [Webpage]. Olympia, WA: Authors. Retrieved from <http://www.wsipp.wa.gov/BenefitCost?topicId=2>. One challenge with this approach is assuring that the offender does not have access to other vehicles (see National Highway Traffic Safety Administration, 2016, at endnote 6.).
23. See National Highway Traffic Safety Administration (2016) at endnote 6 and National Association of State Judicial Educators (2015) at endnote 3. Also see Voas, R., Tippetts, A., Bergen, G., Grosz, M., & Marques, P. (2016). Mandating treatment based on interlock performance: Evidence for effectiveness. *Alcoholism*, 40, 1953-1960. (A violation was defined as 2 "lockouts" within 4 hours.)
24. Ibid., Voas
25. The 24/7 sobriety program began in 2005 as a short-term pilot project in South Dakota that was subsequently made permanent as an expanded 1 to 2 year program. Similar pilot or permanent 24/7 sobriety programs are now implemented in North Dakota and 15 other jurisdictions.
26. Several studies have found the original South Dakota 24/7 sobriety program to be very effective in securing compliance by participating offenders, reducing DUIs in participating jurisdictions compared with non-participating jurisdictions. Subsequent reductions in statewide impaired driving fatalities have been attributed in part to the effectiveness of this program. See National Highway Traffic Safety Administration (2016) at endnote 6, National Association of State Judicial Educators (2015) at endnote 3, and Voas et al. (2011) at endnote 10.
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28. See Voas et al. (2011) at endnote 10.
29. Electronic monitoring devices are typically rented to the user at fees ranging from perhaps \$125/month for the mobile-phone based monitoring devices and up to \$400/month for transdermal devices and must be returned to the provider (in lieu of a replacement fee) at the termination of the program.
30. See DeMichele & Payne (2012) at endnote 8, National Highway Traffic Safety Administration (2016) at endnote 6, and National Association of State Judicial Educators (2015) at endnote 3. Also see Dunlap, K., Mullins, T., & Stein, M. (2007). Guidelines for community supervision of DWI offenders. Lexington, KY: American Probation and Parole Association. Retrieved from <http://www.appa-net.org/eweb/docs/appa/pubs/DWI.pdf>
31. See Goodwin et al. (2015) at endnote 17, National Highway Traffic Safety Administration (2016) at endnote 6, and National Association of State Judicial Educators (2015) at endnote 3.
32. See Voas et al. (2011) at endnote 10.
33. See Dunlap, Mullins, & Stein (2007) at endnote 30 and Goodwin et al. (2015) at endnote 17.

34. See National Association of State Judicial Educators (2015) at endnote 3 and National Highway Traffic Safety Administration (2016) at endnote 6. Also see Wiliszowski, C., Fell, J., McKnight, S., & Tippetts, S. (2011). An evaluation of intensive supervision programs for serious DWI offenders. Washington, D.C.: U.S. Department of Transportation.
35. Ibid
36. See Kaeble & Bonczar (2016) at endnote 2.
37. See, e.g., University of Alaska Anchorage Justice Center. (2013). Offender recidivism figures. Alaska Justice Forum, 28-29, 6-8. Retrieved from https://www.uaa.alaska.edu/academics/college-of-health/departments/justice-center/alaska-justice-forum/28/4-1winterspring2012/d_recidivism_figures.cshtml.
38. Other key challenges include DUI cases being traditionally placed on administrative supervision or banked caseloads and insufficient staff training on DUI. Stodola, M. (2016). Addressing unique challenges in the supervision of impaired drivers [blog post]. Retrieved from <https://connect.reliaslearning.com/groups/community-corrections-connect/blog/2016/04/19/addressing-unique-challenges-in-the-supervision-of-impaired-drivers>.
39. See Dunlap et al. (2007) at endnote 30.
40. See DeMichele & Payne (2012) at endnote 8.
41. See National Association of State Judicial Educators (2015) at endnote 3. Some tools are proprietary and require annual and/or per-user fees, whereas others are freely available. Some tools are self-administered whereas others are informed by a semi-structured interview conducted by a trained assessment administrator. Some examples of validated DUI screening and assessment tools, in alphabetical order, include: the DUI-RANT, the Driver Risk Inventory (DRI), the Impaired Driver Assessment (IDA), and the Mortimer Filkins DWI. See DeMichele & Payne (2012) at endnote 8, Dunlap et al. (2007) at endnote 30, and Vlavianos (2017) at endnote 13. Also see Lowe, N. (2014). The impaired driving assessment: A screening tool for community corrections. Lexington, KY: American Probation and Parole Association. Retrieved from https://one.nhtsa.gov/nhtsa/symposiums/october2015/assets/Perspectives_V38_N3_P114.pdf (describing the tool). Examples of alcohol and substance abuse assessment tools include: the Alcohol Dependence Scale (ADS), the Alcohol Substance Use and Driving Survey – Revised (ASUDS-R), the Alcohol Severity Index (ASI), the Alcohol Use Disorders Identification Test (AUDIT), the Computerized Assessment and Referral System (CARS), the Drug Abuse Screening Test (DAST), the Inventory Drug-Taking Situations (IDTS), the Michigan Alcoholism Screening Test (MAST), the Research Institute on Addiction Self Inventory (RIASI), and the Substance Abuse Subtle Screening Inventory (SASSI). See Holmes (2017) at endnote 16, National Association of State Judicial Educators (2015) at endnote 3, and Stodola (2017) at endnote 1.
42. See Goodwin et al. (2015) at endnote 17.
43. Ibid
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45. Ibid., pp. 45-48.
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47. See National Association of State Judicial Educators (2015) at endnote 3.
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50. See Center for Problem Orienting Policing (n.d.). Responses to the problem of drunk driving [Webpage]. Retrieved from http://www.popcenter.org/problems/drunk_driving/3.
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52. Ibid., Goodwin.

53. See Center for Problem Orienting Policing (n.d.) at endnote 50, Goodwin et al. (2015) at endnote 17, and National Association of State Judicial Educators (2015) at endnote 3.

54. Ibid., Goodwin and National Association of State Judicial Educators.

55. See Center for Problem Orienting Policing (n.d.) at endnote 50 and Goodwin et al. (2015) at endnote 17.

56. Ibid.

57. These problem-solving courts typically involve regular (weekly) court appearances before a judge-led team of criminal justice stakeholders for 1 to 2 years; frequent random alcohol/drug testing; use of incentives and swift, certain, and modest sanctions; intensive probation supervision; and appropriate treatment for substance use and mental health disorders). See Goodwin et al. (2015) at endnote 17, National Highway Traffic Safety Administration (2004) at endnote 44; National Highway Traffic Safety Administration (2016) at endnote 6, National Association of State Judicial Educators (2015) at endnote 3, Voas et al. (2011) at endnote 10, and Washington State Institute for Public Policy (2017) at endnote 22. Also see 1: National Center for DWI Courts (n.d.). Research: DWI courts are showing success [Webpage]. Washington, DC: Authors. Retrieved from <http://www.dwicourts.org/learn/about-dwi-court/research>. 2: National Highway Traffic Safety Administration (2011). An evaluation of the three Georgia DUI courts. Washington, DC: Authors. Retrieved from <https://www.dwicourts.org/wp-content/uploads/2009/04/Georgia-Final-Study-1.pdf>.

58. See Vlavianos (2017) at endnote 13. See also NPC Research. (2014). Minnesota DWI courts: A summary of evaluation findings in nine DWI court programs. Portland, OR: Authors. Retrieved from <https://dps.mn.gov/divisions/ots/reports-statistics/Documents/mn-dwi-summary.PDF>.

59. See Vlavianos (2017) at endnote 13.