THE CURRENT LANDSCAPE OF IMPAIRED DRIVING

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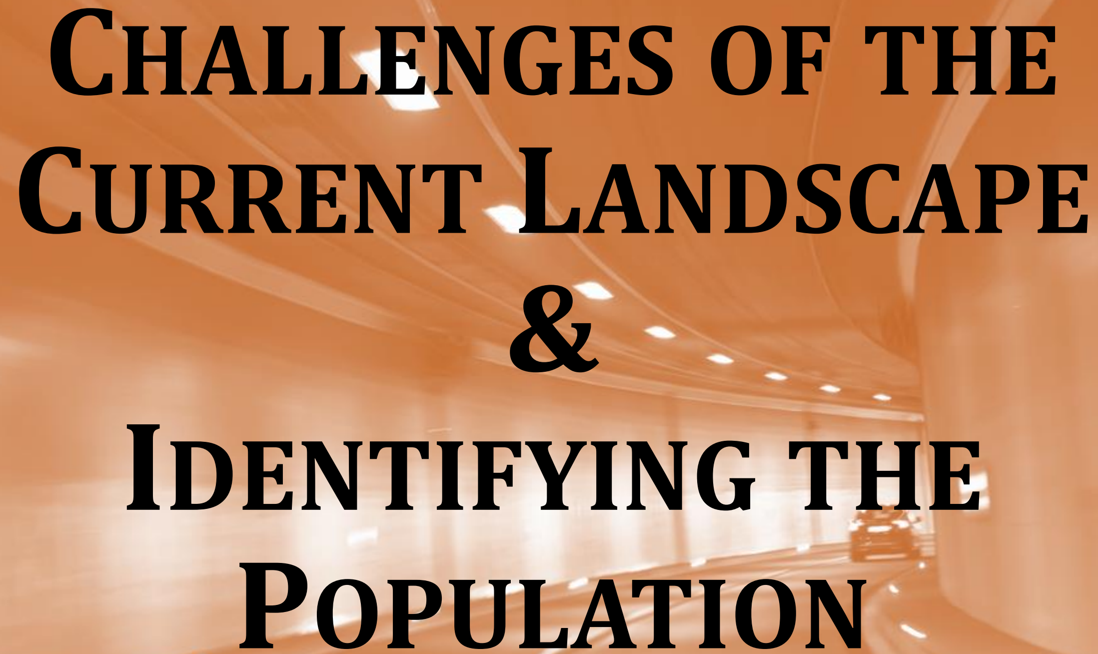
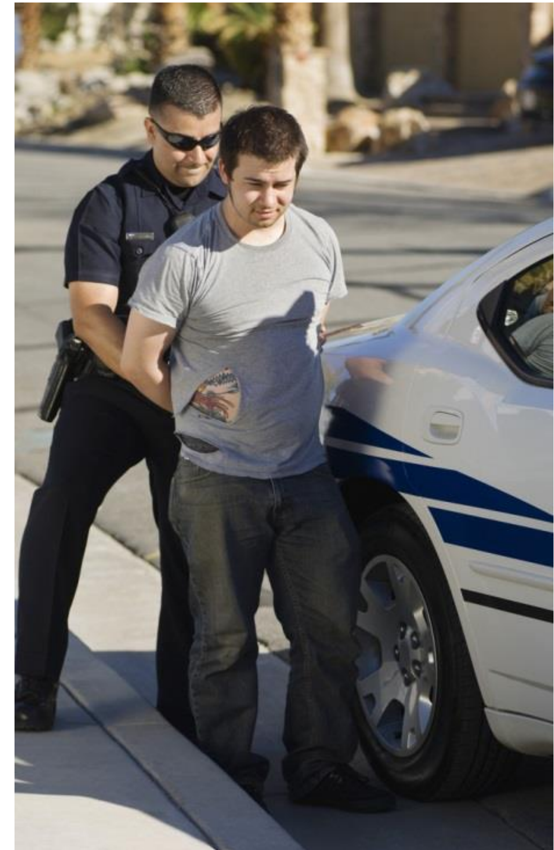
Challenges of the Current Landscape & Identifying the Population

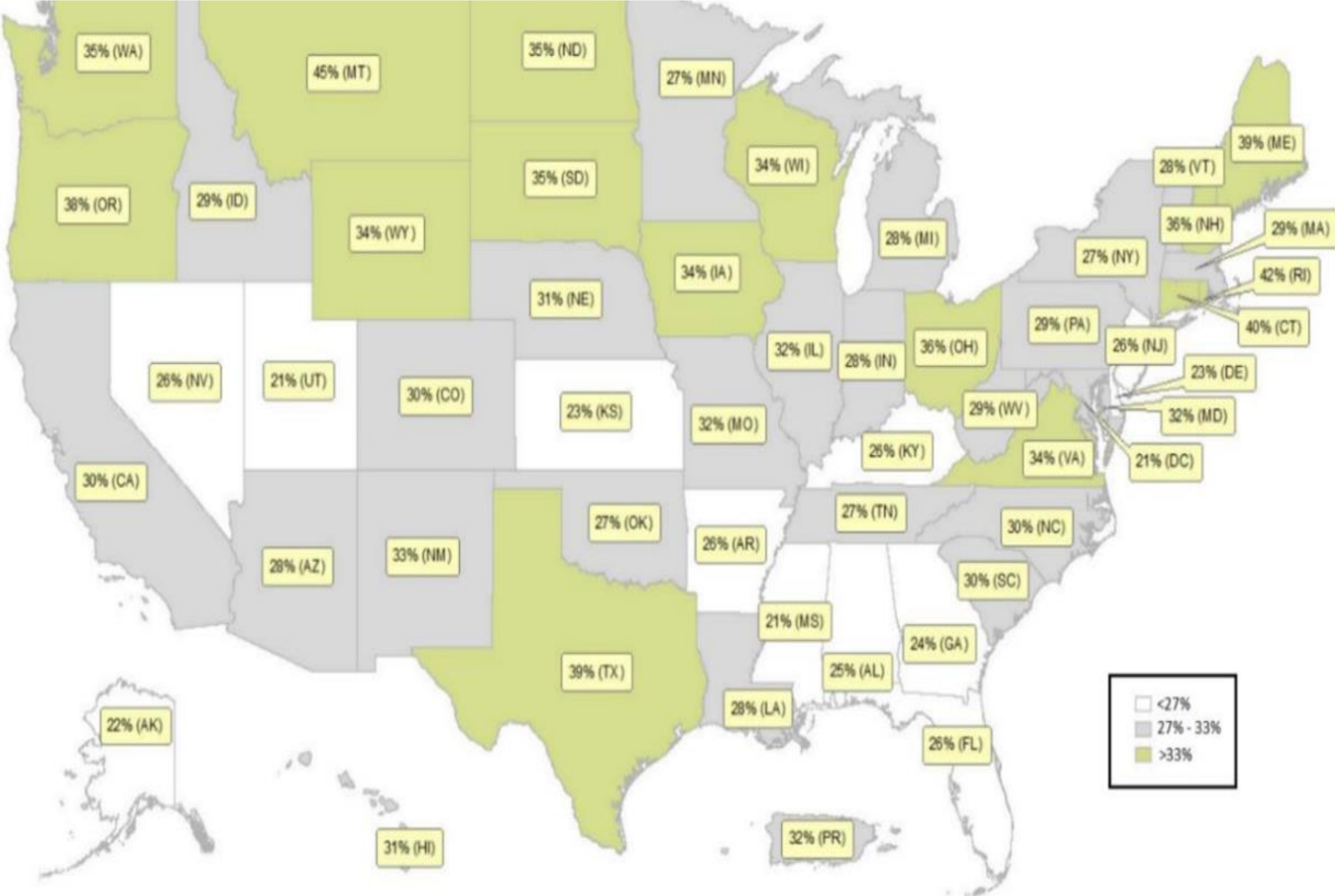


Drunk Driving by the Numbers

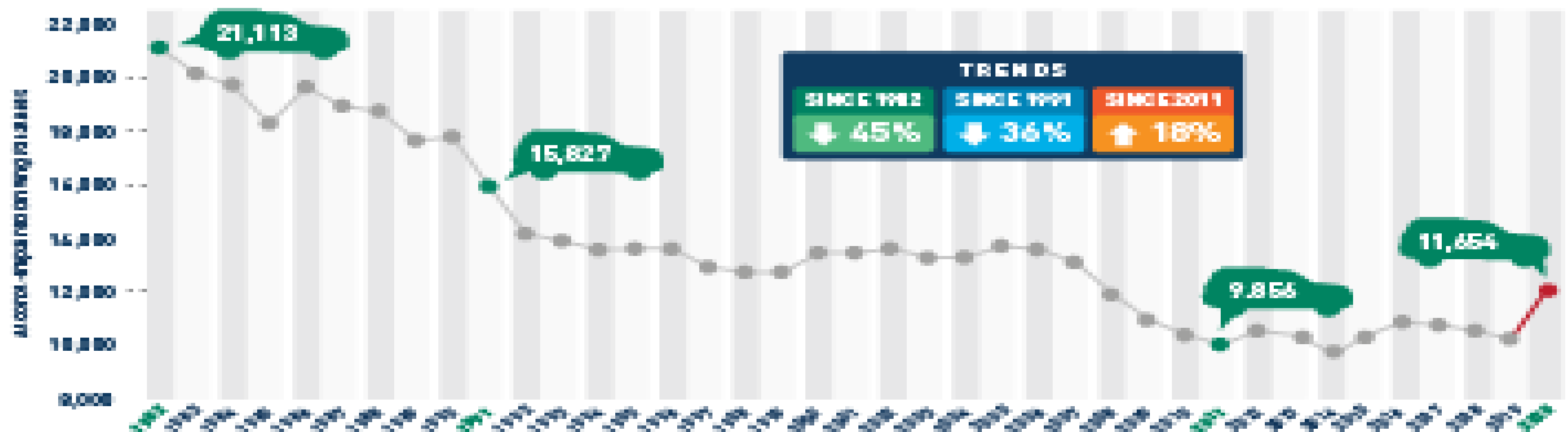
- **In 2019, there were 1,024,508 drivers arrested for DUI.**
- **In 2020, there was a 14% increase in DWI fatalities**
- **An alcohol-impaired driving fatality occurs every 48 minutes.**
- **In 2020, there were 11,654 alcohol-related traffic fatalities.**
  - **68% were in crashes where one driver had a BAC of .15>**
- **In 2018, the most frequently recorded BAC among drinking drivers in fatal crashes was .16.**
- **121 million drunk driving episodes occurred in 2019.**



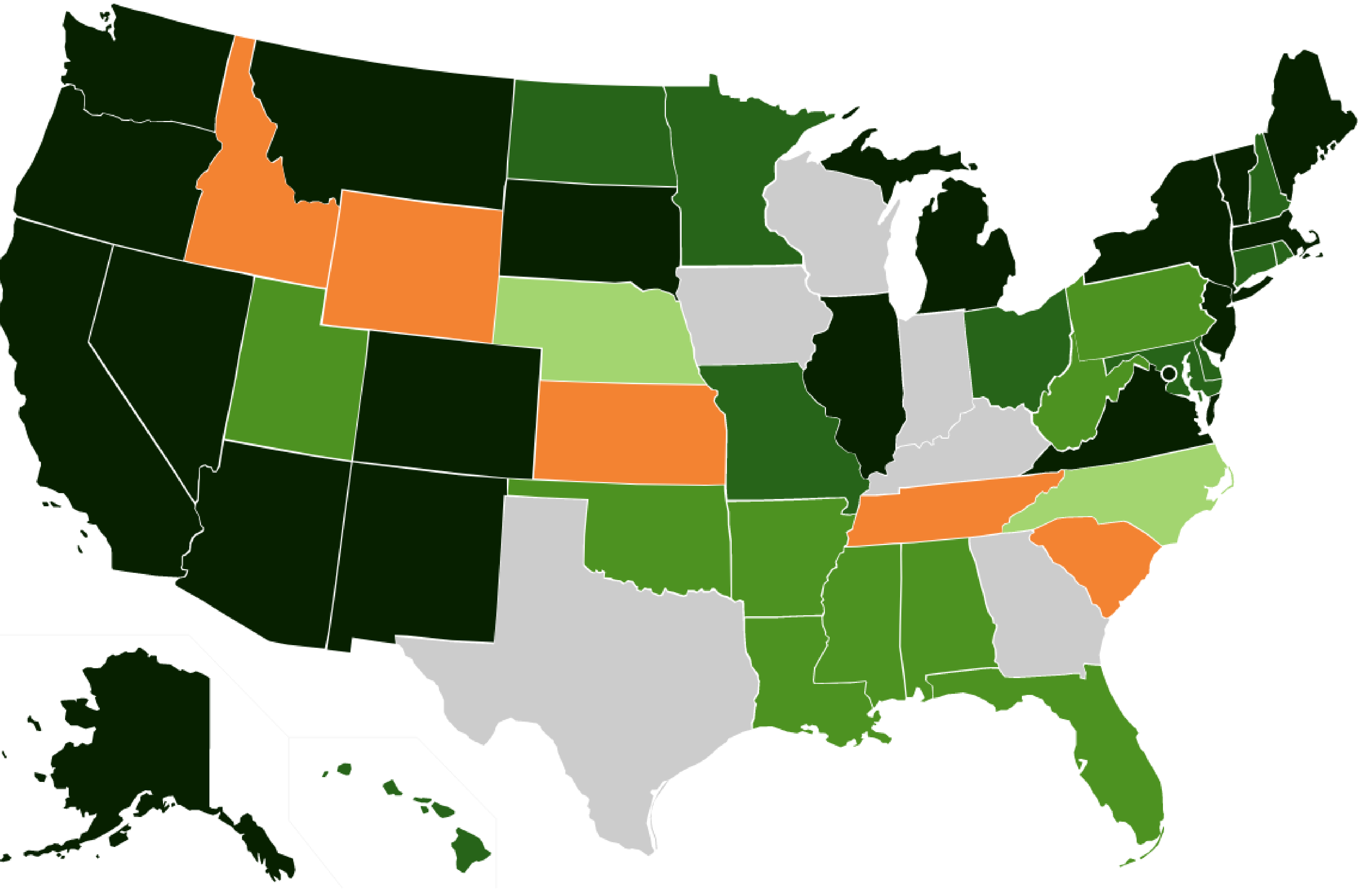
Alcohol-Impaired-Driving Fatalities as a Percentage of Total Fatalities, by State, 2020

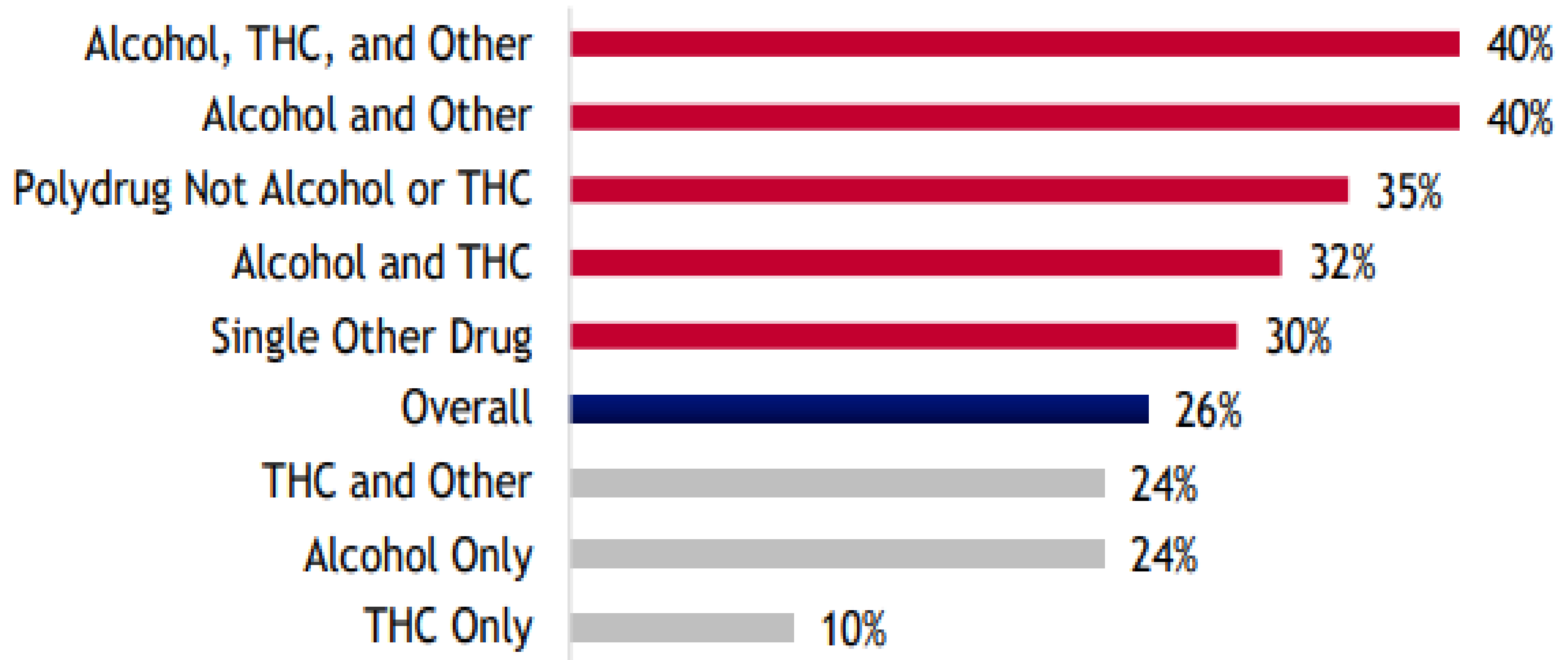


Drunk Driving Deaths Increased 14% in 2020



Together, we can end impaired driving, and it will take everyone and effective and proven solutions.


Legalized
Medical and Decriminalized
Medical
Decriminalized
CBD Only
Fully Illegal



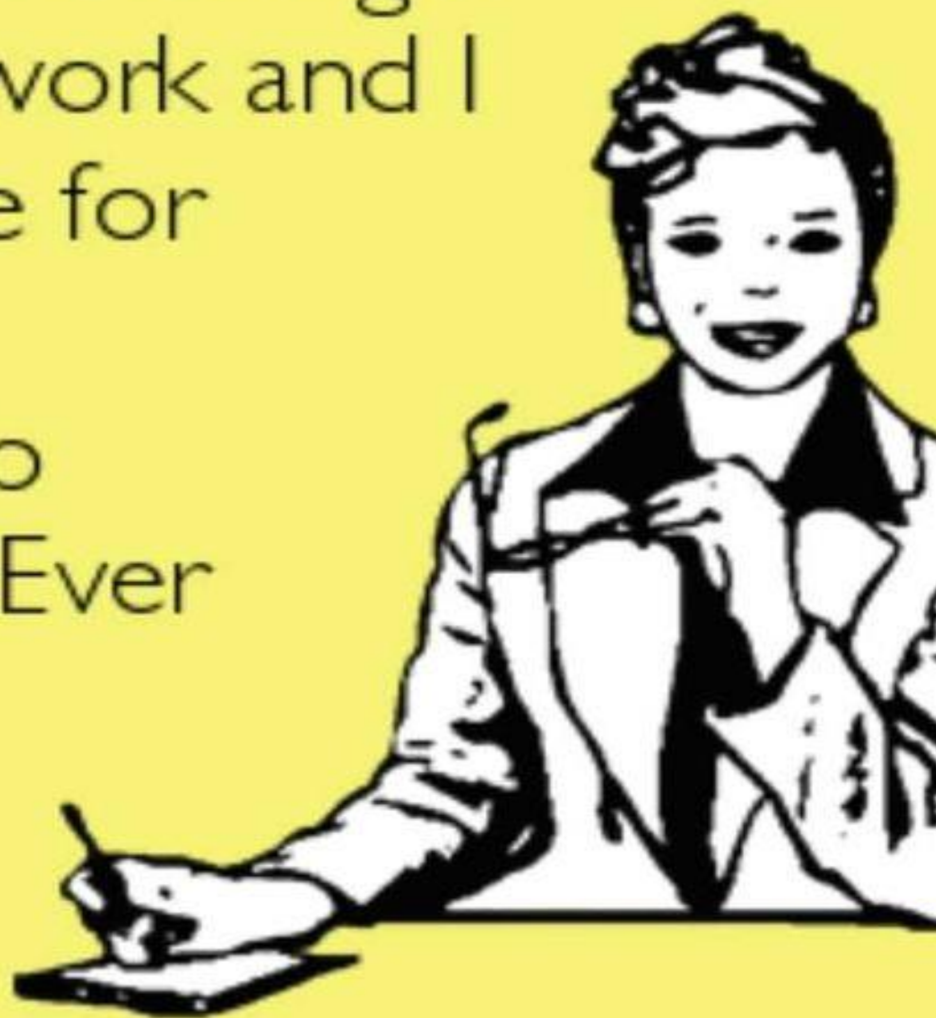
Data Sources: Office of Behavioral Health. Analyzed by the Office of Research and Statistics, Division of Criminal Justice, Colorado Department of Public Safety.

What do DUIs look like in your jurisdiction in 2022?

With impaired drivers, don't assume!

The drunk driver before you could actually be a polysubstance user.

"I can say that I am all caught up with all of my work and I think there is hope for everyone on my caseload." -Said No Probation Officer Ever



someecards
user card

Community supervision challenges in working with the DWI population…

Treatment Limitations

Community indifference

CJ “attitude” toward DWI

High Caseloads

Competing interests of community supervision

SCREENING & ASSESSMENT

Do you assess for risk and needs with impaired drivers?

Do your assessment tools tell you what you need to know?

Limitations of instruments

- Majority of instruments are not designed for or validated among DUI offender population.
- Using traditional assessments, DUI offenders are **commonly identified as low risk due to a lack of criminogenic factors.**
- DUI offenders often have unique needs and are resistant to change on account of limited insight.
- Recognition that specialized instruments should be created to accurately assess risk and needs of impaired drivers.

Screening

- Screening is the first step in the process of determining whether a DUI offender should be referred for treatment.
- At this stage, offenders who do not have substance or mental health issues are identified and those who may have issues can be sent for a more in-depth assessment.
- Essentially, screening is a way to strategically target limited resources by separating offenders into different categories (i.e., those who do not have an alcohol/mental health problem and those who likely do).
- The screening process in and of itself can also serve as a brief intervention as it requires the individual to begin to think about their use patterns and whether they are problematic.

Assessment

- After the screening process is completed, offenders who show signs of substance or mental health issues can be referred for an assessment.
- An assessment tends to be more formal than screening and these instruments are standardized, comprehensive, and explore individual issues in-depth.
- In contrast with screening, a formal assessment process takes longer to complete (it can take several hours) and is typically administered by a trained clinician or professional.
- This second step is meant to evaluate not only the presence of a substance use disorder (alcohol and/or drugs) but its extent and severity.

Assessment

- Ideally, screening and assessment would occur at the beginning of the process (such as during the pre-trial stage).
- The results can then be used to inform:
  - Sentencing decisions
  - Case management plans
  - Supervision levels
  - Treatment referrals/plans

- It is important to note that assessments can be repeated at multiple junctures throughout an offender's involvement in the criminal justice system to identify progress and to inform changes to existing plans as needed.

Which instrument should I use?

- Validated through research
- Reliability; predictive value
- Standardized
- Appropriate for the target population
- Easy to use
- Informs decision-making
- Cost

ASSESSMENT IS ONGOING & DYNAMIC

Utilize all tools available

- Screening/assessment for substance use and mental health disorders
- Refer to appropriate treatment interventions that are tailored to individuals' risk level and specific needs
- Treat co-occurring disorders concurrently
- Use technology to monitor compliance and progress (e.g., ignition interlocks, continuous alcohol monitoring, random drug testing, etc.)
- Hold offenders accountable for non-compliance
- Apply swift, certain, and meaningful sanctions

Understanding Addiction
and Treatment

Addiction ABC's

A Inability to consistently *Abstain*

B Impairment in *Behavioral* control

C *Craving*

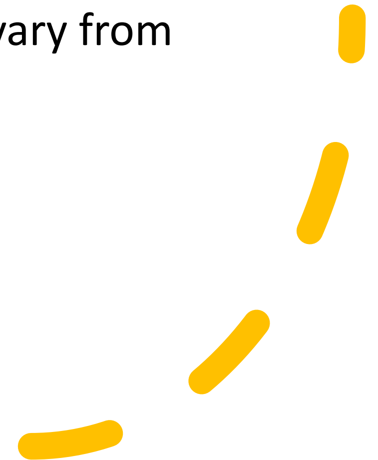
D *Diminished* recognition of significant problems

E A dysfunctional *Emotional* response

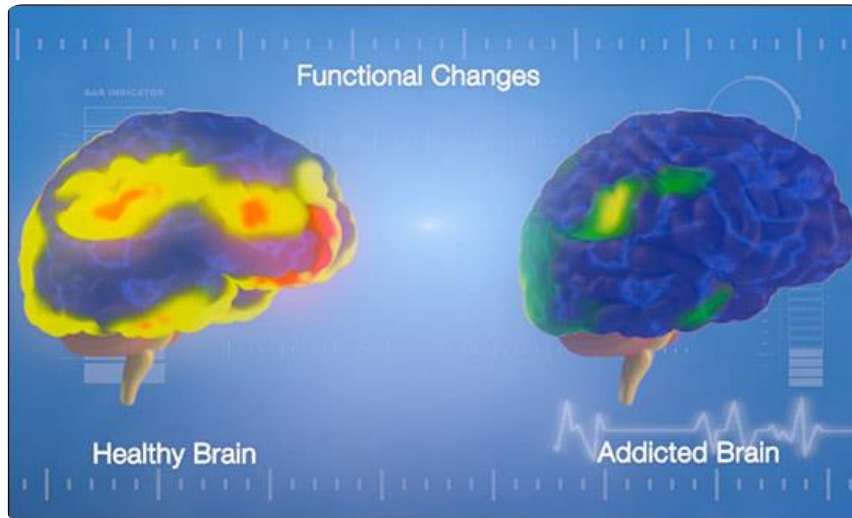
Adapted from www.asam.org

ADDICTION

- **Biopsychosocial Model (BPS)**
  - Complex interactions between biological, psychological, and socio-cultural factors
  - Origins of addictive behavior are complex, variable, and multifactorial
    - Ongoing interaction between factors
    - Interactions and weighting vary from person to person



IT'S A BRAIN DISEASE BECAUSE…



- Drugs and alcohol change the brain
- These changes can be long lasting

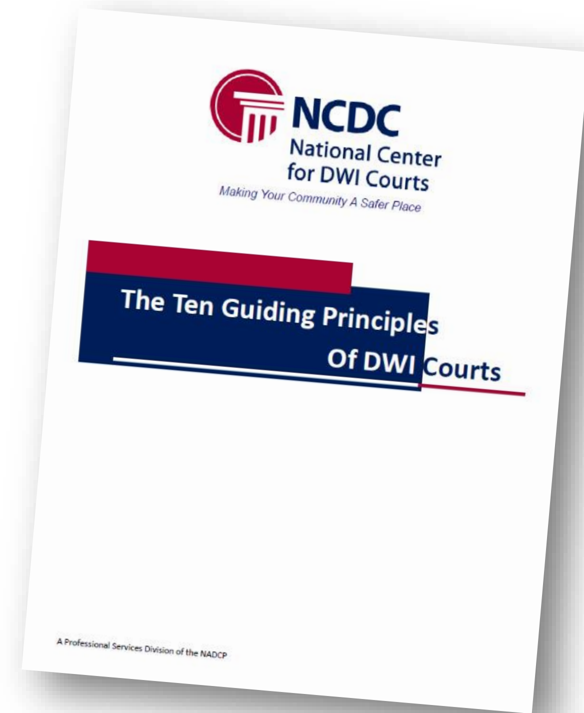
Long Term Use Rewires Brain Circuits

- Trigger adaptation in habit or non-conscious memory systems
- Conditioning: environmental cues become associated with the use experience and can trigger uncontrollable cravings
- This learned "reflex" is extremely robust and can emerge even after many years of abstinence

GUIDING PRINCIPLE #3

Develop the Treatment Plan

- Appropriately Screen
- Clinically Assess
- Place
- Treat



Principles of Effective Treatment

No single treatment is effective for everyone

Readily available

Multidimensional

Program length

Treatment/services plan continually assessed and adjusted

Treatment for Substance Use Disorder

- Complex – not a “one size fits all” approach
- Varied levels of care
  - Outpatient
  - Inpatient or residential treatment
- Behavioral therapies
- Medications
- Comprehensive approach

Acute Care Model

Brief period of professional intervention followed by cessation of services.

Screen, assess, place, treat and discharge

Works well in acute trauma settings

Less effective in SUD treatment with clients who have complex and high severity needs

Considerations of an acute care model

Services are delivered programmatically and uniform

Professional expert often directs and determines plan

Services are provided over a short period of time (time limited, usually payer driven)

Impression that discharge or “graduation” is completion. Putting the onerous of long-term recovery

Post-treatment relapse and re-admissions are viewed as failure or non-compliance of the individual- rather

Chronic Condition Model

Long-term involvement with health care system

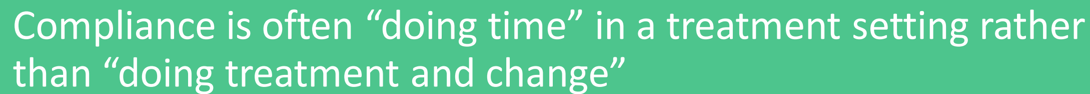
Continued care following treatment

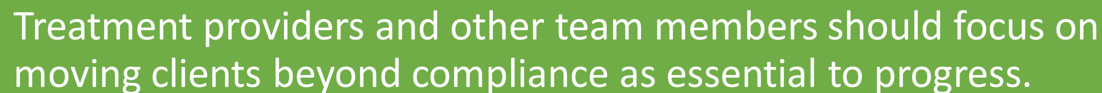
Education regarding self-care

Regular check-ups

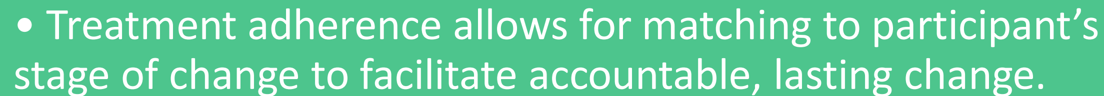
Linkage to community resources

Compliance



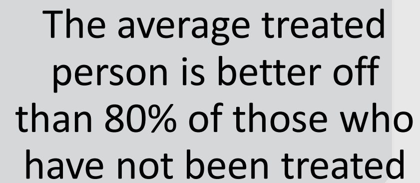


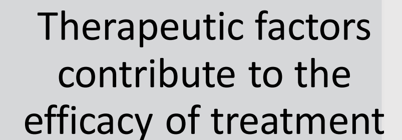
Adherence



- Meaningful adherence improves when participant has some choice, even when choices are limited

Research on Outcomes





Therapeutic Alliance

The therapeutic alliance was consistently a predictor of outcome for all the measures of treatment outcome.

Change Happens When…

Compassion

Empathy

Acceptance

Bringing it all Together

RECOVERY SERVICES AND SUPPORTS MUST BE FLEXIBLE

RECOVERY SERVICES MUST BE INDIVIDUALIZED

RECOVERY SERVICES ARE STRENGTH-BASED

Appropriate Interventions
Based on Risk and Need

Use Risk-Need-Responsivity Principles

Model as a guide to Best Practices

RISK

WHO

Match the intensity of the individual's intervention to their risk of reoffending

Deliver more intense intervention to higher-***risk*** offenders

NEED

WHAT

Target criminogenic needs: antisocial behaviors and attitudes, SUD, and criminogenic peers

Target criminogenic ***needs*** to reduce risk of recidivism

RESPONSIVITY

HOW

Tailor the intervention to the learning style, motivation, culture, demographics, and abilities of the offender

Address the issues that affect ***responsivity***

Applying the wrong intervention may have undesirable effects

Treatment alone
Intensive supervision
Frequent testing
Ignition interlock
Incarceration
DWI courts

Quadrant Model

	High Risk	Low Risk
High Needs	Standard Track Accountability, treatment, and habilitation	Treatment Track Treatment and habilitation
Low Needs	Supervision Track Accountability and habilitation	Diversion Track Secondary prevention

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Practical Implications

	High Risk	Low Risk
High Needs	✓ Status calendar ✓ Treatment ✓ Prosocial & adaptive habilit. ✓ Abstinence is distal ✓ Positive reinforcement ✓ Self-help/alumni groups ✓ ~ 18–24 treatment court ✓ 9 to 12 mos. treatment (~200 hrs.)	✓ Noncompliance calendar ✓ Treatment (separate milieu) ✓ Adaptive habilitation ✓ Abstinence is distal ✓ Positive reinforcement ✓ Self-help/alumni groups ✓ ~ 12–18 mos. program ✓ 9 to 12 mos. treatment (~200 hrs.)
Low Needs	✓ Status calendar ✓ Prosocial habilitation ✓ Abstinence is proximal ✓ Negative reinforcement ✓ ~ 12–18 mos. program ✓ Criminal thinking (~100 hrs.)	✓ Noncompliance calendar ✓ Psycho-education ✓ Abstinence is proximal ✓ Individual/stratified groups ✓ ~ 3–6 mos. program ✓ Education (~ 12–26 hrs. or less)

High Risk & High Need
Stages
Pretrial
Community Corrections
Incarceration
Reentry
High Risk & Low Need
Stages
Pretrial
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Reentry
High Risk & High Need
Low Risk & High Need
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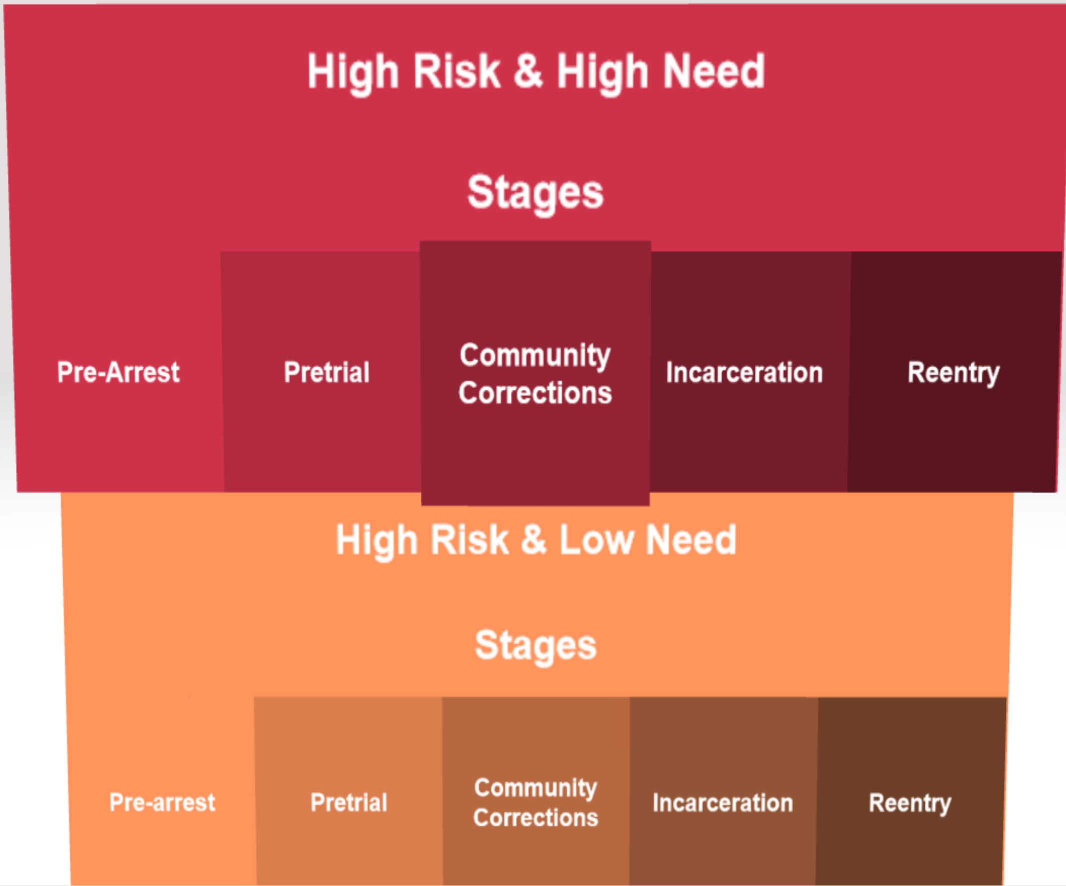
Low Risk & Low Need



Collapse Content | Search | How To Use The ARK

High Risk & High Need / Community Corrections

Evidence Based Program

DUI Court

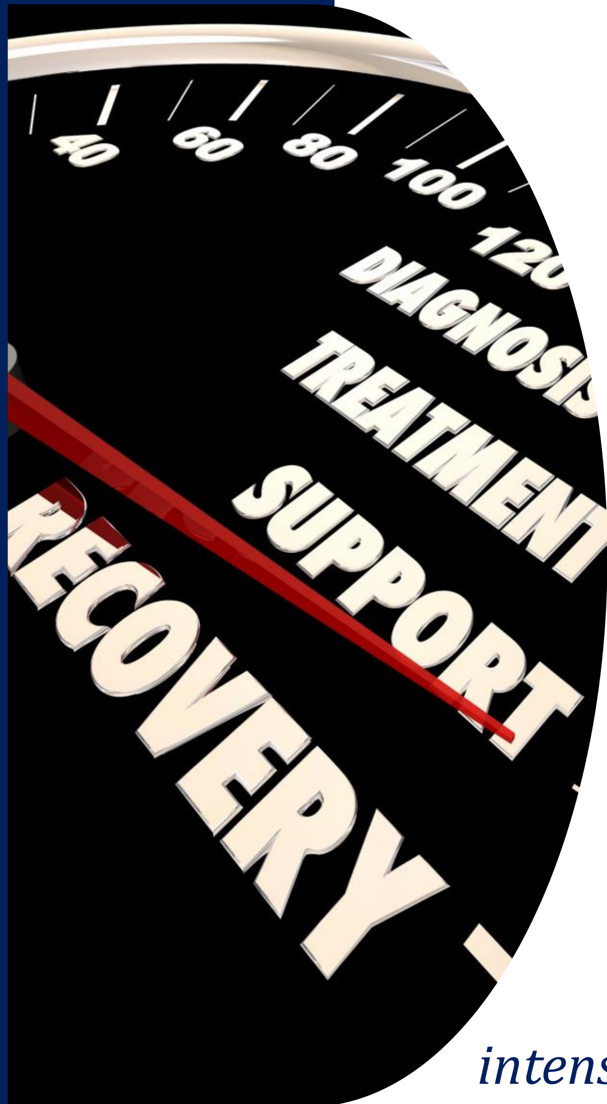
Description

DUI courts adapt the drug court model to serve persons with serious substance use disorders who are charged with repeated instances of driving under the influence (DUI) of drugs or alcohol or driving while intoxicated (DWI), or have a high blood alcohol content (BAC) at the time of their arrest. Participants are required to complete an intensive regimen of substance use disorder treatment and other indicated services, attend frequent status hearings in court, undergo random or continuous biological testing for alcohol and other drugs, and receive gradually escalating incentives for achievements and sanctions for infractions. Most DUI courts are post-adjudication or post-sentencing programs by statute, and participants may be required to serve a portion of a jail sentence with the remainder of detention being suspended pending completion of treatment. Failure to complete the program may result in a return to custody or traditional adjudication.

Effectiveness Studies

A meta-analysis published by the Campbell Collaboration concluded that DUI courts reduce DUI recidivism and general criminal recidivism by an average of approximately 12% with the best DUI courts reducing recidivism by 50% to 60% (Mitchell et al., 2012). At least three studies with long follow-up windows determined that reductions in recidivism lasted for at least four years, well after participants had been discharged from the programs (Fell et al., 2011; Kierkus & Johnson, 2015; Ronan et al., 2009). Two studies also found that DUI court participants had significantly fewer alcohol or drug-related car accidents than matched DUI probationers over follow periods of 18 months (Carey et al., 2012; Carey et al., 2015).

A multisite evaluation of nine DUI courts in Minnesota determined that the DUI courts produced an average of $2.06 in cost benefits for every $1 invested in the programs (NPC Research, 2014). Other evaluations have reported that DUI courts produced net cost-benefits of approximately $1,500 to $8,000 per participant compared to traditional adjudication (Mackin et al., 2009a; Mackin et al., 2009b; Zil et al., 2014).



What is a DWI court?

change behavior

collaborative team approach

court monitoring

holistic and comprehensive

accountability

high-risk / high-need

frequent alcohol and drug testing

long-term treatment

recovery

non-adversarial

intensive supervision

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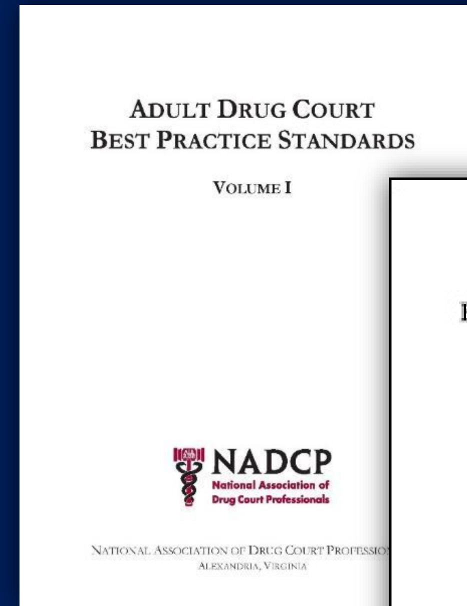
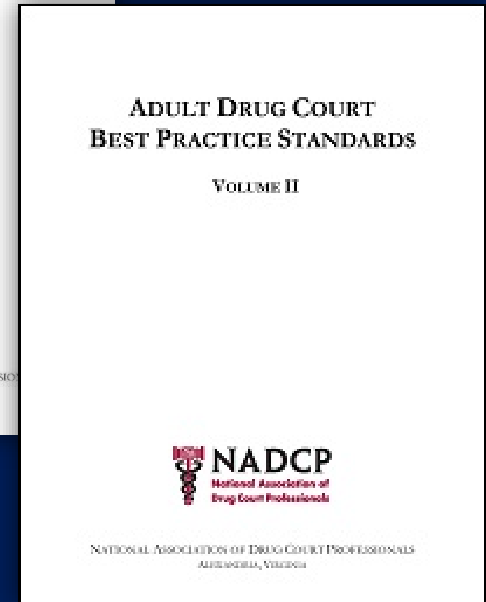
Why are DWI courts effective?

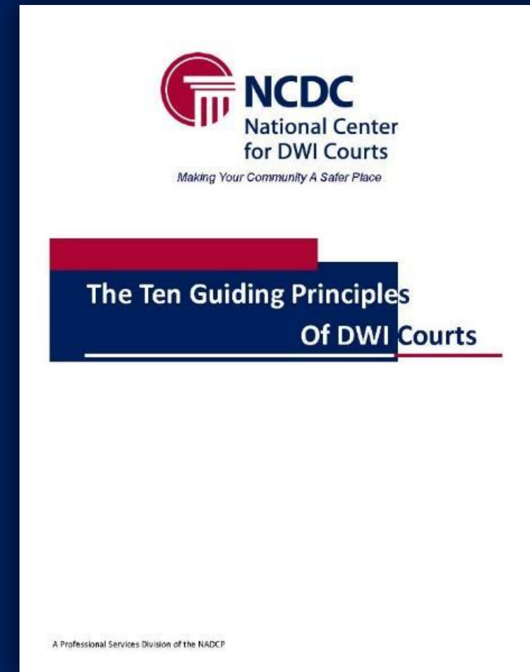
I. Target Population
II. Equity and Inclusion
III. Roles and Responsibilities of the Judge
IV. Incentives, Sanctions, and Therapeutic Adjustments
V. Substance Use Disorder Treatment
VI. Complementary Treatment and Social Services
VII. Drug and Alcohol Testing
VIII. Multidisciplinary Team
IX. Census and Caseloads
X. Monitoring and Evaluation





Why are DWI courts effective?

1. Target the Population
2. Provide a Clinical Assessment
3. Develop the Treatment Model
4. Supervise and Detect Behavior
5. Develop Community Partnerships
6. Take an Active Judicial Role
7. Provide Case Management
8. Solve Transportation Barriers
9. Evaluate the Program
10. Ensure Sustainability



How Does Technology Play a Role?

ADCBPS

IV. Incentives, Sanctions, and Therapeutic Adjustments

VII. Drug and Alcohol Testing

10GPs

IV. Supervise and Detect Behavior

V. Develop Community Partnerships

VIII. Solve Transportation Barriers

ADULT DRUG COURT
BEST PRACTICE STANDARDS
VOLUME I

ADULT DRUG COURT
BEST PRACTICE STANDARDS
VOLUME II

NATIONAL ASSOCIATION OF DRUG COURT PROFESSIONALS
ALEXANDRIA, VIRGINIA

The Ten Guiding Principles
Of DWI Courts

A Professional Services Division of the NADCP

Fidelity to the Model

Research shows an increase in criminogenic factors in clients for programs that do not follow the Guiding Principles or Best Practices

QUESTIONS?

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