The 24/7 Sobriety Program Expansion Project

I. Introduction

South Dakota's 24/7 Sobriety Project is one of the most progressive programs in the country. Conceived of and administered by Attorney General Larry Long, this award-winning program offers several benefits. It has:

- reduced recidivism;
- improved public safety;
- provided an alternative to incarceration and reduced the number of people in local jails;
- allowed offenders to remain in the community with their family and friends;
- permitted offenders to maintain employment;
- cut jail and prison populations; and
- saved tax dollars by combining enhanced monitoring with real accountability.

Offenders pay for their services. Accordingly, although the program was seeded through multiple legislative appropriations, it will be fully self-sustaining by the end of 2009.

The Attorney General, several state agencies and local sheriffs, are partnering with the National Partnership on Alcohol Misuse and Crime (NPAMC) to create a national model that integrates evidence and consensus based solutions involving brief screening and interventions, formal assessments, and treatment and employing contingency management with the expectation of achieving even more profound results.

A. Background

South Dakotans misuse drugs at a lower rate, but misuse alcohol at a higher rate, than most other states. In the 2005-2006 National Surveys of Drug Use and Health (NSDUH):

- South Dakota ranked among the lowest states on several measures of drugs usage for ages 18 and up, including:
  - Fourth lowest rate of past year illicit drug dependence or abuse;
  - Second lowest rate of past year non-medical use of pain relievers;
  - 11th lowest rate for past year serious psychological distress;
  - 8th lowest rate of persons having at least one major depressive episode in the past year.
- South Dakota ranked among the highest states on several measures of alcohol misuse for ages 18 and up, including:
  - Second highest rate of past year alcohol dependence or abuse;
  - Fourth fewest percentage of people who perceive the "great risk" associated with drinking five or more drinks of an alcoholic beverage once or twice a week.

The estimated number of people with alcohol, drug and/or mental health issues in South Dakota is significant. See Figure 1.

Figure 1. NSDUH Averages for 2005-2006, provided by age group (number in thousands and percentages of population)

Condition (past year)	12 and over	12-17	18-25	26 and over
Illicit drug dependence	9 1.45	2 2.62	4 3.92	4 0.82
Illicit drug dependence or abuse	15 2.32	3 4.58	6 6.45	6 1.21
Alcohol dependence	23 3.55	2 2.34	7 8.01	14 2.85
Alcohol dependence or abuse	64 10.05	5 6.86	22 23.72	38 7.86
Serious psychological distress	61 10.73	--	15 16.55	46 9.61
Having at least one major depressive episode	38 6.64	5 7.57	8 8.65	30 6.26

Alcohol misuse and drug-related offenses fuel much of the crime problem in South Dakota. For example:

- Felony DUI (three or more offenses in ten years), vehicular homicide, and battery cases accounted for approximately 35% of all felony convictions in South Dakota.
- Felony DUI offenses and felony drug offenses combined accounted for approximately 60% of the total felony convictions in South Dakota between 1996 and 2007.
- DUI offenders comprised 15% percent of the state prison population.
- A significant majority of prison inmates had alcohol or drug misuse issues - 87% of men and 91% of women sentenced to the South Dakota Penitentiary suffered from alcohol and/or illegal drug dependency.[1]

B. Development of the 24/7 Sobriety Program

The impetus for the 24/7 Project began more than twenty years ago in Bennett County, a very rural area in South Dakota with a current population of 3,441. In the early 1980s, Bennett County's then-prosecutor Larry Long convinced his local judge to address alcohol-related offenses, primarily drunk driving and domestic abuse, more aggressively and efficiently.

Long convinced the judge to order offenders to refrain from consuming alcohol and require them to present themselves twice daily to the sheriff's office for breath alcohol testing. Offenders who failed to appear for a scheduled test or who tested positive were incarcerated immediately for a short period of

[1] South Dakota Office of the Attorney General 2008.

time to "get their attention." The program produced tangible results as offenders quickly changed their behavior − hardcore alcoholics maintained sobriety, recidivism dropped and the jail population decreased.

In 2004, the South Dakota Governor appointed then Long to a task force charged with examining incarceration rates in South Dakota.

Although judges frequently required repeat offenders to abstain from the use of alcohol as a condition of probation, there was no effective program to ensure compliance. Long suggested that the state pilot his Bennett County program in three counties. The task force agreed to pilot his solution.

Long convinced the Circuit Court judges in the test counties to require that offenders abstain from the consumption of alcohol as a condition of bond. Every defendant arrested for a second or subsequent DUI offense was required to submit to a breath test between 7:00 a.m. and 9:00 a.m. and 7:00 p.m. and 9:00 p.m. at the local sheriff's office. The judges immediately revoked the bond of anyone who failed to appear for a scheduled test or who tested positive. Over time, the judges witnessed the success of the program and began utilizing it for domestic violence and drug cases. Long obtained funding for the project from the National Highway Traffic Safety Administration (NHTSA), the South Dakota Office of Highway Safety, Department of Public Safety and private companies.

In 2007, Long proposed expanding the program and the state legislature unanimously approved the formal creation of the 24/7 Sobriety Project. Long was authorized to coordinate the efforts of the various state and local government entities participating in the project.

The new law permitted courts to:

- Condition any bond or pre-trial release on the person's participation in the 24/7 Sobriety Project and payment of associated costs and expenses.
- Condition the granting of a suspended imposition of sentence, suspended execution of sentence, or probation upon participation in the 24/7 Sobriety Project and payment of associated costs and expenses.
- Require parents of abused or neglected children to participate in the program as a condition for their children to be placed back at home.

The law also authorized the Board of Pardons and Paroles, the Department of Corrections, or any parole agent to condition release upon participation in the 24/7 Sobriety Project and payment of associated costs and expenses.

Long appointed Bill Mickelson to direct the program. Under their leadership, the program quickly expanded statewide and now operates in almost every county. With the assistance of local sheriffs, they established protocols that ensure accuracy, efficiency and success. The two largest jurisdictions supervise and process hundreds of offenders twice each day.

Offenders pay for their supervision and testing. The Attorney General and local sheriffs invest whatever profits they may obtain in the program to allow for additional enhancements like random visits or random breath testing.

Long, in partnership with several state agencies and NPAMC seeks to incorporate screening, assessment, and treatment protocols into the program to achieve optimum benefits.

II. The 24/7 Sobriety Program: Monitoring and Accountability

A. Administration

The Office of the Attorney General administers the program in collaboration with all state and county agencies with an interest in the sanctioning and rehabilitation of offenders, including the:

- Department of Corrections
- Department of Human Services
- Department of Public Safety
- Department of Social Services
- Local sheriff's departments
- Unified Judicial System

Participants are required to pay for their participation. This has contributed to the cost savings and is consistent with the premise that accountability produces results. The program utilizes a secure web-based management system to document and track participant performance and facilitate research.

A complete listing of the administrative rules, copies of forms, and program statistics can be found on the South Dakota Attorney General's website at: www.state.sd.us/attorney/DUI247/index.htm.

B. Protocol

Currently, the 24/7 Sobriety Project operates in almost every county in South Dakota. The program utilizes a number of mechanisms to ensure sobriety and abstinence from alcohol and other drugs, including twice-daily breath testing for alcohol, SCRAM® (Secure Continuous Remote Alcohol Monitor) ankle bracelets that continuously monitor wearers for alcohol consumption, PharmChem drug patches that collect sweat samples for laboratory testing, and random urine testing for drugs. Offenders are tested at their local sheriff's office. If they test positive, they are taken into custody *immediately and brought to court within 24 hours*. Judges typically give them escalating jail terms. A first violation typically results in "flash incarceration" or one night of jail. Sanctioning is swift and certain.

The 24/7 Sobriety Program as originally constituted *does not* incorporate any screening, assessments or treatment. However, state law requires DUI offenders to participate in treatment programs upon conviction. There is no requirement that these offenders undergo treatment *pretrial*. Regardless, the treatment and justice systems operate parallel to one another.

C. Program Results

The 24/7 Sobriety Project is producing impressive results. The program appears to be saving lives and tax dollars. This comes as no surprise to justice and treatment professionals who are aware that the "most effective aversive stimuli [for changing behavior through punishment] are certain, severe, and immediately related to the unwanted behavior."[2] As noted earlier, testing takes place at the local sheriff's office. Offenders who test positive are taken into custody immediately and appear in court within 24 hours.

1. Offender Performance

[2] R. Gable and R. Gable, "Electronic Monitoring: Positive Intervention Strategies," 69 Federal Probation (2005), http://www.uscourts.gov/fedprob/jun2005/index.html.

Offenders participate in the program for an average of over 100 days.[3] Despite initial skepticism regarding the offenders' ability to maintain sobriety, most offenders have performed quite well, as the below delineated data reflect. These results are particularly impressive given that almost half of the participants are third or subsequent DUI offenders.[4]

a. Alcohol Testing

i. Twice Daily Testing

As of March 15, 2009, Almost 11,000 offenders participated in twice daily breath testing. They have taken over 1.8 million tests, passing 99.6% of them. Over 66% of them were totally compliant during the entire term of their participation.[5]

ii. SCRAM Testing

As of March 25, 2009, 1,244 offenders have worn the SCRAM ankle bracelet. Over 900 offenders have completed the SCRAM program, 331 remain on the device. Offenders wore the device for an average of 105 days; compliant offenders averaged 96 days, non-compliant offenders averaged 130 days. Approximately 75% of offenders were totally compliant, over 95% were totally compliant or violated one or two times. The daily compliance rate is 95.5%.[6]

b. Drug Testing

i. Drug Patch Testing

Forty offenders wore drug patches, passing 92.8% of the tests.[7]

ii. Random Urine Testing

Over 1,000 offenders took urine tests, passing 97.6% of the time.[8]

[3] R. Loudenberg, "Analysis of South Dakota 24-7 Sobriety Program Data" at 8 (Mountain Plains Evaluation, LLC January 2007).
[4] R. Loudenberg, "Analysis of South Dakota 24-7 Sobriety Program Data" at 3 (Mountain Plains Evaluation, LLC January 2007).
[5] South Dakota Office of the Attorney General 2009.
[6] Alcohol Monitoring Systems, Inc., 2009.
[7] South Dakota Office of the Attorney General 2009.
[8] South Dakota Office of the Attorney General 2009.

c. Survey Data

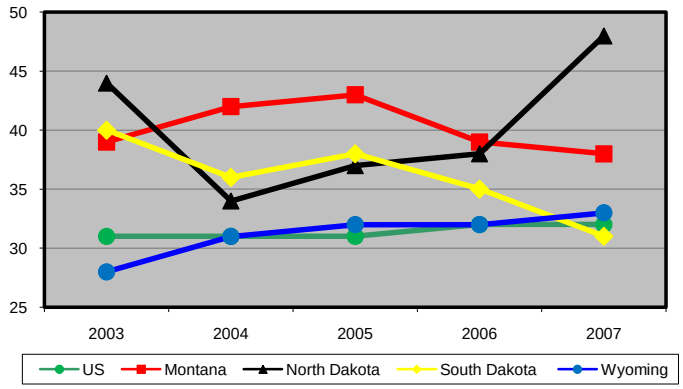
Some participants who were surveyed about the program indicated that the program helped them gain control over their alcohol consumption, improved their family function and helped them maintain or improvement their employment.[9]

2. Public Impact

At the time the program was introduced, South Dakota had one of the highest DUI rates in the nation (21.6%) and nearly three-fourths of those involved in fatal crashes had a blood alcohol level (BAC) of 0.15 or higher. Since the program's inception, the number of people killed in alcohol-impaired crashes[10] has declined steadily. From 2006 to 2007, alcohol-impaired traffic deaths in South Dakota declined by 33%. (NHTSA 2008). In a year where the U.S. had a 4% decline in DUI fatalities, South Dakota outperformed every other state in its percentage reduction of DUI fatalities. Preliminary data indicates that the number fell another 45% from 2007 to 2008.[11] It is difficult to attribute the improvements to any one cause or causes. However, many of the typical factors can be eliminated easily.

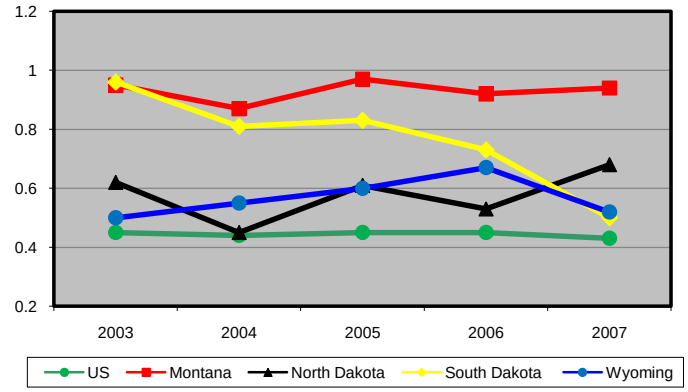
South Dakota's gains do not appear to be the result of a national or regional effect. See Figures 1 and 2.

Figure 1. Percentage of Motor Vehicle Fatalities Where at Least One Driver had a BAC at or Above the 0.08 Illegal Limit (Alcohol-Impaired Fatalities as a Percentage of Total Fatalities)[12]



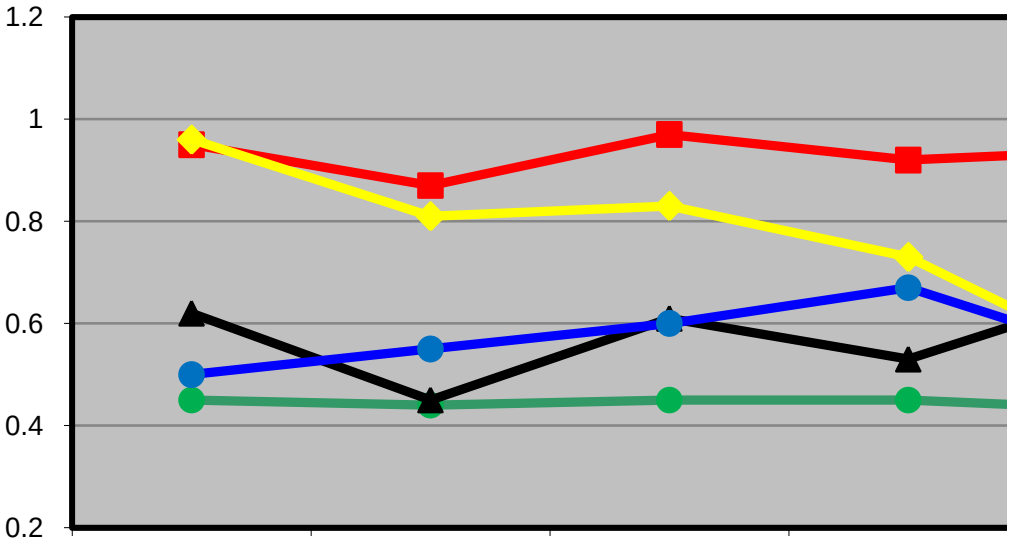
[9] South Dakota Office of the Attorney General 2009.
[10] NHTSA defines an alcohol-impaired crash as one where at least one driver had a blood or breath alcohol level at or above the 0.08 illegal limit.
[11] South Dakota Department of Public Safety 2009.
[12] All data was gleaned from the NHTSA website containing each state's Traffic Safety Facts, 2003-2007.

Figure 2. Raw Number of Alcohol-Impaired Motor Vehicle Fatalities[13]



Additionally, the drop in fatalities is not attributable to a decrease in vehicle miles traveled, as reflected in Figure 3.

Figure 3. Alcohol-Impaired Motor Vehicle Fatalities by 100 Million Vehicle Miles Traveled (Rate)[14]



Nor can it be fully and adequately explained by an increase in high visibility law enforcement or arrest, as demonstrated by Figures 4, 5, and 6. It is unlikely that the less than dramatic increase shown in those figures would impact the fatality rate significantly as demonstrated by a recent NHTSA funded study in Tennessee.[15]

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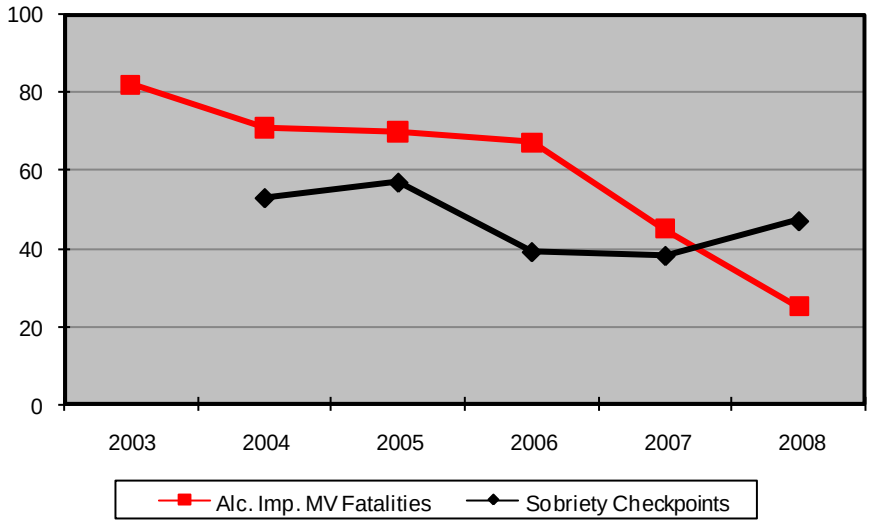
[13] Id.
[14] Id.
[15] See C. Dula, W. Dwyer and G. LeVerne, "Policing the drunk driver: Measuring law enforcement involvement in reducing alcohol-impaired driving," 398 Journal of Safety Research 267, 270 (2007). Dula, et al, reviewed

Figure 4. Raw Numbers of Alcohol-Impaired Motor Vehicle Fatalities and Sobriety Checkpoints[16]



Tennessee data for 2001 and 2003. They concluded that continued enforcement efforts were critical to maintaining the gains the states made in the 1980's and 1990's, but that doubling it "is likely to be a futile effort" unless more is done. They argue that the only way to drive down the fatality rates significantly is through a comprehensive program encompassing significantly more enforcement, prosecution and media.

[16] The alcohol-impaired motor vehicle fatalities data was obtained from NHTSA's website containing South Dakota's Traffic Safety Facts, 2003-2007. The sobriety checkpoint data was obtained from the Department of Public Safety in 2009.

Figure 5. Raw Numbers of Alcohol-Impaired Motor Vehicle Fatalities and DUI Filings[17]

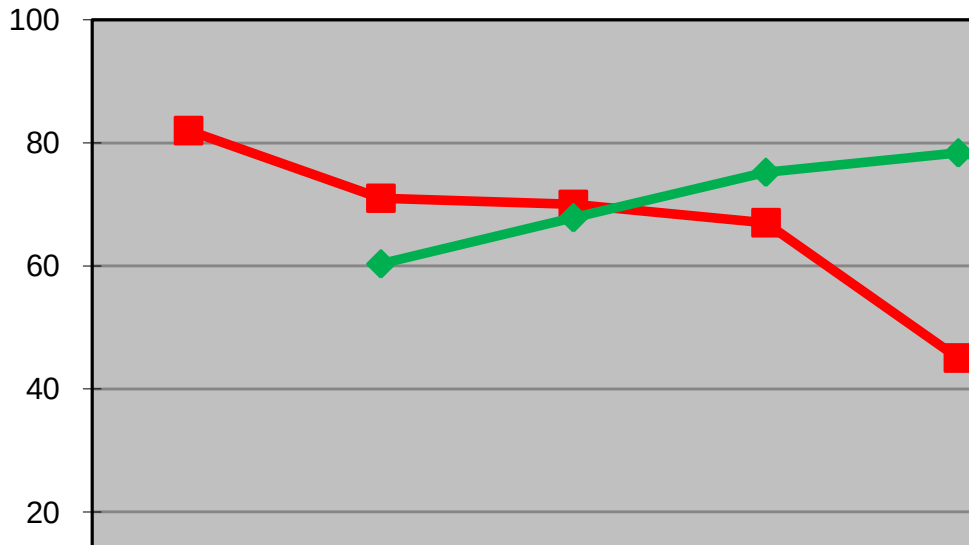
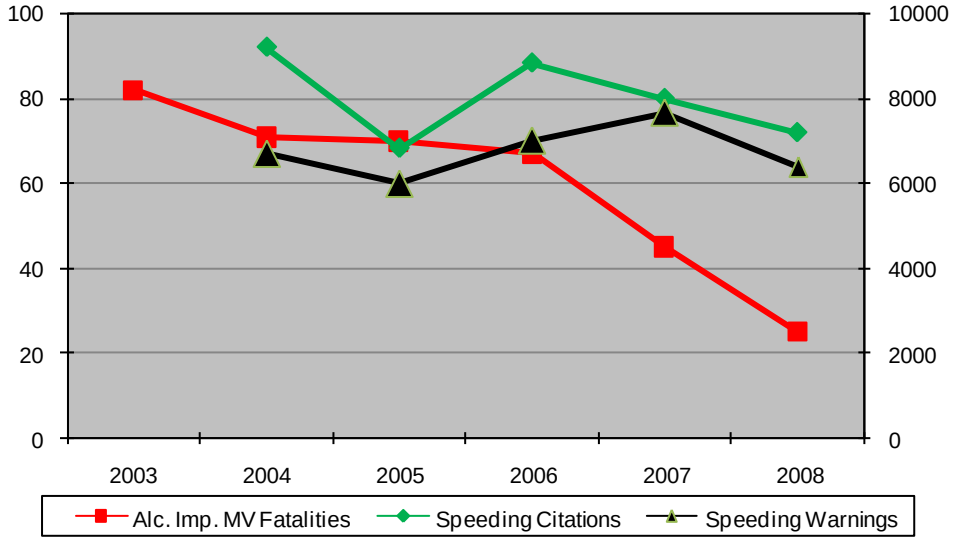


Figure 6. Raw Numbers of Alcohol-Impaired Motor Vehicle Fatalities and Speeding Citations and Warnings[18]

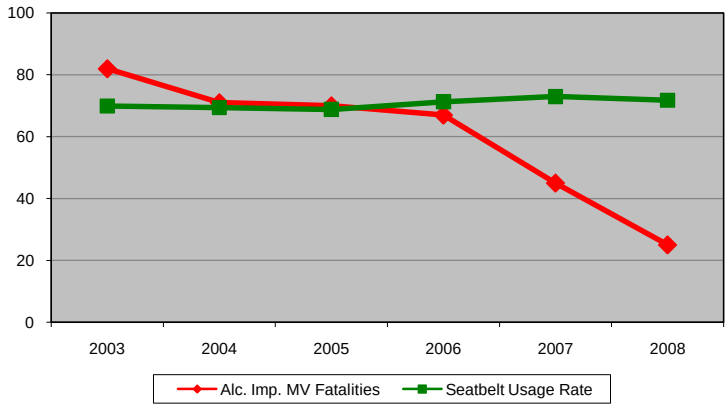


[17] The alcohol-impaired motor vehicle fatalities data was obtained from NHTSA's website containing South Dakota's Traffic Safety Facts, 2003-2007. The data on the number of DUI filings was obtained from the Unified Judicial System in 2009.

[18] The alcohol-impaired motor vehicle fatalities data was obtained from NHTSA's website containing South Dakota's Traffic Safety Facts, 2003-2007. The data on speeding citations and warnings was obtained from the South Dakota Department of Public Safety 2009.

Fluctuations in seatbelt usage rates also did not contribute significantly to the gains. See Figure 7.

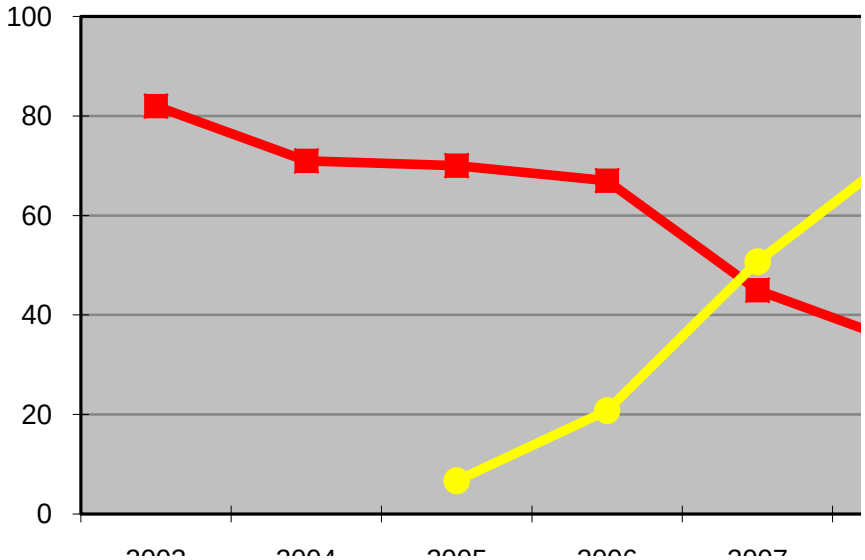
Figure 7. Alcohol-Impaired Motor Vehicle Fatalities and the Seatbelt Usage Rate[19]



However, the dramatic drop in the number of alcohol-impaired motor vehicle fatalities correlates perfectly with the implementation and growth of the 24/7 Sobriety Program. See Figure 8.

[19] The alcohol-impaired motor vehicle fatalities data was obtained from NHTSA's website containing South Dakota's Traffic Safety Facts, 2003-2007. The seatbelt data was obtained from the 2008 South Dakota Statewide Seatbelt Survey, South Dakota Office of Highway Safety (Struckman-Johnson, BalDUIn, and Struckman-Johnson, August 2008). The researchers weighted the data for road type and vehicle miles traveled. N/P indicates "not provided."

Figure 8. Alcohol-Impaired Motor Vehicle Fatalities and 24/7 Sobriety Program Participation[20]



Accordingly, while a combination of factors likely contributed to the dramatic improvement, the 24/7 Program appears to be a contributing factor.[21]

The 24/7 Sobriety Program is not just saving lives, it's reducing jail populations and saving tax dollars. As noted earlier, the program is used as an alternative to jail and has reduced recidivism. Consequently, jail populations have decreased in most counties. In the two largest counties, populations have dropped by almost 100 people per day. With jail costs estimated at $75 per day per person, the state is saving millions of dollars.[22] At least part of these gains are due to the 24/7 Sobriety Program. Offenders like the program because they may stay with their families and maintain employment. This results in additional benefit to the state.

D. National Recognition

The 24/7 Project won a Council of State Governments' 2008 Innovations Award. This award is given out each year, and highlights outstanding state programs that address a trend affecting the states and their future policies. In 2009, the Institute for Behavior and Health recognized Long and Mickelson with the prestigious McGovern Award.

Other states have expressed interest in implementing a similar program, and the North Dakota Attorney General's Office began a pilot of its own 24/7 Project in January 2008.

[20] The alcohol-impaired motor vehicle fatalities data was obtained from NHTSA's website containing South Dakota's Traffic Safety Facts, 2003-2007. The data on 24/7 Sobriety Program participation was obtained from the South Dakota Office of the Attorney General in 2009.
[21] South Dakota implemented an enforcement initiative, an educational curriculum for first time DUI offenders, a Parents Matter campaign and school/youth programming that may have impacted the numbers as well.
[22] South Dakota Office of the Attorney General 2009.

III. The Next Phase: Integrating Screening, Brief Intervention, Formal Assessment, Treatment and Contingency Management for DUI Offenders

Despite the program's successes, Long continually strives for improvement. In late 2008, Long partnered with NPAMC to explore the possibility of integrating screening, assessment, brief intervention, and treatment protocols for offenders with alcohol misuse, drug, and mental health issues into the program.

Together with Mickelson and Gilbert "Gib" Sudbeck, the Director of the Department of Human Service's Division on Alcohol and Drug Abuse (DADA), they decided to expand the program. The new program ultimately will be the first to:

- Fully integrate the efforts of state and local criminal justice and treatment professionals;[23]
- Require all offenders who are booked into jail to be briefly screened for alcohol, drug and mental health issues *at the time of booking*;
- Provide brief interventions for offenders who screen positive for alcohol, drug or mental health issues *at the time of booking*;
- View pre-trial release and sentencing as a continuum;
- Utilize a formal contingency management plan.

A. Plan Development

With Long's approval, NPAMC convened a national advisory council comprised of leading national experts in alcohol or drug misuse for the purpose of developing an initial proposal. Committee members include:

- Thomas Beauclair, Deputy Director of the National Institute of Corrections
- Dr. Richard Denisco, Medical Officer in the Division of Epidemiology, Services and Prevention Research at the National Institute on Drug Abuse (NIDA)
- Dr. Robert DuPont, President of the Institute for Behavior and Health, former Director of the Office of National Drug Control Policy (ONDCP; Drug Czar) and first Director of the National Institute on Drug Abuse (NIDA)
- Dr. David Gastfriend, Vice President, Scientific Communications at Alkermes Pharmaceuticals
- Dr. Ralph Hingson, Director of the Division of Epidemiology and Prevention Research at the National Institute on Alcohol Abuse and Alcoholism (NIAAA)
- Dr. Jack Stein, Director of the Center for Substance Abuse Treatment (CSAT) Division of Services Improvement at Abuse and Mental Health Services Administration (SAMHSA)
- Dr. Mark Willenbring, Director of the Division of Treatment and Recovery at NIAAA
- Stephen Wing, Associate Administrator of Alcohol Prevention and Treatment Policy at the SAMHSA

The committee developed a contingency management plan which was presented to and discussed with state and local officials in February and March 2009 at various meetings and/or teleconferences, including:

[23] Many states require DWI and other offenders to participate in treatment programs. In fact, the criminal justice system provides more referrals to treatment than any other single source. Unfortunately, the justice and treatment systems traditionally are segregated, resulting in poor communication, inefficiencies and uninformed sentencing.

- Paul Bachand, Traffic Safety Resource Prosecutor
- Keith Bonenberger, Mountain Plains Evaluation, LLC
- Jeff Hallem, Assistant Attorney General
- Amy Iverson-Pollreisz, Director of the Department of Human Services' Division on Mental Health (DMH)
- Dr. Beau Kilmer, RAND Corporation
- Honorable Larry Long, Attorney General
- Roland Loudenberg, Mountain Plains Evaluation, LLC
- Bill Mickelson, Mickelson Consulting Group
- Sheriff Mike Milstead, Sheriff of Minnehaha County
- Sheriff Byron Nogelmeier, Sheriff of Turner County
- Gib Sudbeck, Director of the Department of Human Services' Division on Alcohol And Drug Abuse
- Jim Vlahakis, 24/7 Administrator for the Office of the Attorney General
- Deputy Sheriff Cory D. Winter, 24/7 Sobriety Program Coordinator for Minnehaha County

Each of the officials provided much needed state and local context. Together, they dissected, modified and supplemented the plan, which now is ready for implementation and described in subsection C.

Sudbeck agreed to fund assessments and treatment for indigent offenders in a pilot.

B. The Science Behind the Expansion

Researchers and justice professionals have long recognized the correlation between crime and substance misuse. We believe that, by treating offenders' underlying addictions and co-occurring mental health problems, we can improve public safety and restore offenders' lives simultaneously.

1. The Impact of Chronic Substance Misuse

People who misuse alcohol or drugs for long periods of time often experience cognitive deficits in impulse control, reasoning, memory, and learning skills.[24] This may impact their ability to make good decisions, conform their behavior and respond to treatment. Indeed, "cognitive deficit is an important predictor of outcome following treatment;"[25] "individuals with higher levels of cognitive impairment are less likely to comply with treatment."[26]

[24] E. Goplerud and L. Jacobus-Kantor, "Improving Criminal Justice Interventions for People with Alcohol Problems" (NPAMC 2009).
[25] See H. Moselhy, G. Georgiou and A. Kahn, "Frontal Lobe Changes in Alcoholism: A Review of the Literature," 36 Alcohol & Alcoholism 357 (2001).
[26] E. Goplerud and L. Jacobus-Kantor, "Improving Criminal Justice Interventions for People with Alcohol Problems" (NPAMC 2009).

2. Substance Misuse and Crime

Substance abuse is strongly associated with crime. According to the Bureau of Justice Statistics, an estimated seventy-five percent of "convicted jail inmates were alcohol or drugs-involved *at the time of their current offense*" in 2002.[27] In addition, over two-thirds of jail inmates "were dependent on or abused alcohol or drugs, based on symptoms for diagnosing substance dependence or abuse in the DM-IV."[28] Researchers estimate that alcohol and drug related crimes cost society over $200 billion dollars ($200,000,000,000.00) each year.[29]

DWI remains the most frequently committed violent crime in America; almost 13,000 people are killed in crashes where at least one driver had a blood or breath alcohol above the 0.08 illegal limit.[30]

3. Deterrence

People are deterred from engaging in certain acts or behaving in a particular way when they believe that negative consequences or punishment will be swift, certain and meaningful.[31] This assumes, of course, that actors are capable of rationally assessing the consequences of their action.[32] Unfortunately, many people with alcohol, drug and mental health issues exercise poor judgment and have difficulties thinking "long-term." Not surprisingly, many researchers believe that they are unlikely to respond to increased enforcement and prosecution without more.[33]

4. Incarceration Alone Does Not Work

Incarceration is a uniquely effective way to incapacitate people, vis a vis the general public, for a definite period of time. However, its long term impact is dubious. As noted earlier, people are deterred only when they are capable of making rational choices. Therefore, it is not surprising that research demonstrates that "[p]unishment alone is a futile and ineffective response to drug abuse."[34]

In fact, "the average effect of incarceration on crime following release from prison is approximately zero. Equally discouraging, 70% to 85% of drug-abusing inmates return to drug use within 1 year of release from prison and 95% return to drug use within 3 years."[35] The failure to adequately address offenders'

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[27] Criminal Offenders Statistics, http://www.ojp.usdoj.gov/bjs/crimoff.htm at 3 (emphasis added).
[28] J. Karberg and D. James, "Substance Dependence, Abuse, and Treatment of Jail Inmates, 2002," Bureau of Justice Statistics Special Report (July 2005).
[29] T. Miller, D. Levy, M. Cohen and K. Cox, "Costs of Alcohol and Drug-Involved Crime," 7 Preventive Science 333 (2006).
[30] See e.g. "2007 Traffic Safety Annual Assessment – Alcohol-Impaired Driving Fatalities," Traffic Safety Facts Research Note (NHTSA August 2008).
[31] C. Dula, W. Dwyer and G. LeVerne, "Policing the drunk driver: Measuring law enforcement involvement in reducing alcohol-impaired driving," 398 Journal of Safety Research 267, 268 (2007).
See also T. O'Schea, "Getting the Deterrence Message Out: The Project Safe Nieghborhoods Public Private Partnership," 10 Police Quarterly 288 (2007). See also J. Yu, "Punishment and alcohol problems – Recidivism among drinking-driving offenders," 28 Journal of Criminal Justice 261, 267-268 (2000).
[32] See e.g. T. O'Schea, "Getting the Deterrence Message Out: The Project Safe Neighborhoods Public Private Partnership," 10 Police Quarterly 288 (2007).
[33] See e.g. C. Dula, W. Dwyer and G. LeVerne, "Policing the drunk driver: Measuring law enforcement involvement in reducing alcohol-impaired driving," 398 Journal of Safety Research 267, 268 (2007).
[34] See e.g. R. Chandler, B. Fletcher and N. Volkow, "Treating Drug Abuse and Addiction in the Criminal Justice System: Improving Public Health and Safety," 301 JAMA 183 (January 14, 2009).
[35] D. Marlowe, "Evidence-Based Sentencing for Drug Offenders: An Analysis of Prognostic Risks and Criminogenic Needs," Chapman Journal of Criminal Justice (In Press 2009).

needs in prison, prepare them to re-enter our communities, provide them with ongoing treatment opportunities and monitor their successes and failures can have significant consequences;[36] "[o]f the 272,111 released from prisons in 15 States in 1994, an estimated 67.5% were rearrested for a felony or serious misdemeanor within 3 years, 46.9% were reconvicted, and 25.4% resentenced to prison for a new crime."[37] Simply stated, short term jail or prison sentences are unlikely to change the behavior of people with real substance misuse issues and offer little in the way of public safety, particularly in the context of DWI. [38]

5. Abstinence and Recovery

Research suggests that "many of the cognitive deficits associated with excessive alcohol use can be recovered over time."[39] Fortunately, "[c]linically significant recovery of function [occurs] in most cognitive domains over the first months to 1 year of abstinence," however, years of treatment may be necessary to achieve optimal results in some cases.[40] The single most significant predictor of cognitive dysfunction appears to be length of abstinence.[41]

Abstinence impacts more than cognitive recovery; it leads to better decision making and reduces criminal behavior. In one study, researchers from the Yale School of Public Health reviewed a multi-site dataset of 3,500 drug users who entered treatment. They determined that "for each 1% reduction in heroin, other drugs and alcohol use days . . . there is a reduction in crime-days of 0.27%, 0.53% and 0.14% respectively."[42]

6. Brief Screening and Intervention

"Screening tests" allow us to determine the "probability" that a person has an alcohol, drug or mental health issue. They "are not the same as diagnostic testing, which serves to establish a *definite* diagnosis of a disorder."[43] Many of these tests are simple to administer and interpret. The screening process not

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[36] See e.g. D. Marlowe, "Evidence-Based Sentencing for Drug Offenders: An Analysis of Prognostic Risks and Criminogenic Needs," Chapman Journal of Criminal Justice (In Press 2009).
[37] Criminal Offenders Statistics, http://www.ojp.usdoj.gov/bjs/crimoff.htm at 4 (emphasis added).
[38] See e.g. H. Delaney, S. Kunitz, H. Zhao, W. Woodall, V. Westerberg, E. Rogers and D. Wheeler, "Variations in Jail Sentences and the Probability of Re-Arrest for Driving While Intoxicated," 6:2 Traffic Injury Prevention 105 (2005). See also J. Yu, "Punishment and alcohol problems – Recidivism among drinking-driving offenders," 28 Journal of Criminal Justice 261 (2000) and A. Wagenaar, M. Maldonado-Molina, D. Erickson, L. Ma, A. Tobler and K. Komro, "General deterrence effects of U.S. statutory DUI fine and jail penalties: Long-term follow-up in 32 states," 39 Accident Analysis and Prevention 982 (2007). Incarceration also is unlikely to deter the general public from drinking and driving. See e.g. A. Wagenaar, M. Maldonado-Molina, D. Erickson, L. Ma, A. Tobler and K. Komro, "General deterrence effects of U.S. statutory DUI fine and jail penalties: Long-term follow-up in 32 states," 39 Accident Analysis and Prevention 982 (2007).
[39] E. Goplerud and L. Jacobus-Kantor, "Improving Criminal Justice Interventions for People with Alcohol Problems" (NPAMC 2009). See also H. Moselhy, G. Georgiou and A. Kahn, "Frontal Lobe Changes in Alcoholism: A Review of the Literature," 36 Alcohol & Alcoholism 357 (2001).
[40] G. Fein, J. Torres, L. Price and V. Di Scalafani, "Cognitive Performance in Long-Term Abstinent Individuals," 30 Alcoholism: Clinical and Experimental Research 1538 (September 2006).
[41] See G. Fein, L. Bachman, S. Fisher and L. Davenport, "Cognitive Impairments in Abstinent Alcoholics," 152 Addiction Medicine 531 (Special Issue May 1990).
[42] See e.g. M. Jofre-Bonet and J. Sindelar, "Drug Treatment as a Crime Fighting Tool," Working Paper 9083 (National Bureau of Economic Research 2002), http://www.nber.org/papers/w9038.
[43] S. Steward and G. Connors, "Screening for Alcohol Problems: What Makes a Test Effective?" (NIAAA), http://pubs.niaaa.nih.gov/publications/arh28-1/5-16.htm.

only informs administrators, but "can have therapeutic benefits" in and of itself for substance misusers,[44] ostensibly because it forces the participant to consider his or her alcohol or drug use.

Brief interventions are short intercessions where a person of some apparent authority advises a person with suspected alcohol or drug misuse issues to reduce or eliminate consumption and/or seek help. Brief screenings and intervention have proven to moderate drinking in a variety of environments, include college campuses, emergency rooms and primary care settings.[45]

7. Treatment and Recovery

Offenders with serious alcohol or drug issues require interventions that address the contributing causes of their behavior: their substance misuse. Abstinence is important, but "[f]orced abstinence without treatment does not cure addiction. Abstinent individuals must still learn how to avoid relapse . . ."[46] In the DWI context, "[e]ffectively screening DD offenders' drinking problems and providing alcoholism treatment to offenders (who are in need of such services) are the essential tasks in reducing DD recidivism."[47]

Of course, results are dependent on quality and effort. Researchers believe that "90 days may be the minimum threshold to have treatment take effect. For addictions in general, six to twelve months of treatment may be necessary to achieve sobriety."[48]

8. Coercion

Many substance abusers, including offenders, lack the insight or motivation to obtain treatment or complete it. In fact, "[l]eft to their own devices without supervision, approximately 25% of offenders referred to substance abuse treatment fail to enroll and of those who do arrive for treatment approximately half drop out before receiving a minimally sufficient dosage of 3 months of services."[49]

Unlike medical professionals, courts can coerce offenders into treatment, monitor their progress, sanction their failure to perform, and force them to conform their behavior. While research on the effectiveness of mandated treatment is varied,[50] "there is a widespread, research-based consensus that programs that use

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[44] R. Robertson, H. Simpson and P. Parsons, "Screening, Assessment and Treatment of DWI Offenders: A Guide for Justice Professionals and Policy Makers (Traffic Injury Research Foundation 2008).

[45] See e.g. M. Larimer, J. Cronce, C. Lee and J. Kilmer, "Brief Intervention in College Settings" (NIAAA), http://pubs.niaaa.nih.gov/publications/arh28-2/94-104.htm; G. Chang, "Screening and Brief Intervention in Prenatal Care Settings" (NIAAA), http://pubs.niaaa.nih.gov/publications/arh28-2/80-84.htm; M. Fleming, "Screening and Brief Intervention in Primary Care Settings (NIAAA), http://pubs.niaaa.nih.gov/publications/arh28-2/57-62.htm, G. D'Onofrio and L. Degutis, "Screening and Brief Intervention in the Emergency Department (NIAAA), http://pubs.niaaa.nih.gov/publications/arh28-2/63-72.htm.

[46] Principles of Drug Abuse Treatment for Criminal Justice Populations at 15 (NIDA 2006).

[47] J. Yu, "Punishment and alcohol problems – Recidivism among drinking-driving offenders," 28 Journal of Criminal Justice 261, 267 (2000).

[48] V. Flango and F. Cheeseman, "When Should Judges Use Alcohol Monitoring as a Sentencing Option in DWI Cases?," 44 Court Review 102 (American Judges Association 2009). See also E. Goplerud and L. Jacobus-Kantor, "Improving Criminal Justice Interventions for People with Alcohol Problems" (National Partnership on Alcohol Misuse and Crime 2009), http://www.alcoholandcrime.org/npamc/resources/npamc-publications/; Principles of Drug Abuse Treatment for Criminal Justice Populations at 20 (NIDA 2006)("Generally, better outcomes are associated with treatment that lasts longer than 90 days").

[49] D. Marlowe, "Evidence-Based Sentencing for Drug Offenders: An Analysis of Prognostic Risks and Criminogenic Needs," Chapman Journal of Criminal Justice (In Press 2009).

[50] The variation in outcomes is, of course, no great surprise. There is no question that a poorly conceived or implemented program will have little, if any, positive impact.

the coercive powers of the justice system retain clients for the same or longer periods than clients who are not legally mandated, leading in turn to improved employment and criminal recidivism outcomes."[51]

9. Monitoring and Accountability

Recovery depends on abstinence; "[a]n undetected relapse can progress to serious drug abuse, but detected use can present opportunities for therapeutic intervention."[52] The best and only objective way to ensure and enforce abstinence is through a system of frequent testing and accountability.[53]

"Monitoring drug use through urinalysis or other objective methods, as part of treatment or criminal justice supervision, provides a basis for assessing and providing feedback on the participant's treatment progress. It also provides an opportunity to change unconstructive behavior—determining rewards and sanctions to facilitate change, and modifying instrument plans according to progress."[54]

Research demonstrates that these systems can be very effective if implemented properly. For example, the National Center of State Courts (NCSC) reviewed data from 114 probationers who wore a CAM ankle bracelet and compared them to a matched comparison group. They found that that probationers who wore the bracelets for more than 90 days recidivated at half the rate of offenders who did not wear bracelets or wore them for shorter periods of time.[55] Significantly, they also determined that the program was most effective for repeat offenders, the offenders who are most likely to have substantial alcohol misuse issues and least likely to respond to traditional sanctioning. They reported that offenders with at least two prior convictions recidivated at 45% of their matched group counterparts (15.7% v. 28.6%).[56]

The importance of monitoring cannot be overstated. Monitoring may serve as a "behavioral intervention" by reminding people of "the potential consequences of substance use."[57] Indeed, some suggest that it "may be the most effective component of treatment."[58]

10. Contact with Justice Officials

Research indicates that frequent contact with judicial officials may deter inappropriate behavior and improve treatment outcomes, particularly for high risk offenders.[59] The contacts reinforce the perception that "big brother is watching" and contribute to a perception that violations will be identified.

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[51] D. Young, R. Fluellen, and S. Belenko, "Criminal recidivism in three models of mandatory drug treatment," 27 Journal of Substance Abuse Treatment 313, 314 (2004). Accord Principles of Drug Abuse Treatment for Criminal Justice Populations at 18 (NIDA 2006). Mandated abstinence-based treatment has proven effective in other contexts as well. For example, researchers found that Physicians' Health Programs (PHP) can be extremely effective. See e.g. R. DuPont, A. McLellan, W. White, L. Merlo and M. Gold, "Setting the standard for recovery: Physicians' Health Programs," 36 Journal of Substance Abuse Treatment 159 (2009).

[52] Principles of Drug Abuse Treatment for Criminal Justice Populations at 2-3 (NIDA 2006).

[53] See e.g. S. Lapham, "Screening and Brief Intervention in the Criminal Justice System," 28 Alcohol Research & Health 85, 92 (2004/2005).

[54] Principles of Drug Abuse Treatment for Criminal Justice Populations at 3 (NIDA 2006).

[55] V. Flango and F. Cheeseman, "When Should Judges Use Alcohol Monitoring as a Sentencing Option in DWI Cases?," 44 Court Review 102 (American Judges Association 2009).

[56] Id.

[57] R. DuPont, A. McLellan, W. White, L. Merlo and M. Gold, "Setting the standard for recovery: Physicians' Health Programs," 36 Journal of Substance Abuse Treatment 159, 167 (2009)(citations omitted).

[58] R. DuPont, A. McLellan, W. White, L. Merlo and M. Gold, "Setting the standard for recovery: Physicians' Health Programs," 36 Journal of Substance Abuse Treatment 159, 167 (2009)(citations omitted).

[59] See e.g. D. Marlowe, D. Festinger, K. Dugosh, P. Lee and K. Benasutti, "Adapting Judicial Supervision ot the Risk Level of Drug Offenders: Discharge and 6-month Outcomes from a Prospective Matching Study," 88 Drug

11. Contingency Management

For non-violent and low level felony offenders, "incapacitation and punishment are short-term solutions to a long-term problem."[60] Monitoring helps justice professionals verify and reward abstinence, identify the need for increased treatment and determine when sanctions are appropriate.

i. Incentives

Contingency management plans incorporate positive and negative reinforcers to encourage offenders to change their behavior. They typically incentivize offenders to participate in treatment programs, abide by program rules, and behave appropriately by allowing them to earn small "gifts," lower levels of supervision, reduced monitoring, etc. These incentives are critical: "Rewarding positive behavior is more effective in producing long-term positive change than punishing negative behavior."[61]

ii. Sanctions

"Behavioral scientists have carefully studied the effects of punishment for more than 35 years and the basic principles are firmly established."[62] Effective contingency management plans include swift, certain and substantial sanctions for non-compliance.

Needless to say, it is vital that sanctions be appropriate and fair.[63] Many people believe that relapse is "inevitable." However, if vigorous monitoring is coupled with "meaningful consequences," "we might find that relapse was far from inevitable."[64] Treatment professionals recommend that sanctions for non-compliant behavior be applied incrementally.[65] Examples include: a special court appearance and judicial admonishment, curfew restrictions, more frequent drug testing.

Offenders who test positive should be sanctioned as quickly as possible because "people are more strongly influenced by immediate and certain consequences . . . than by consequences that may or may not occur in the future."[66] Additionally, swift response to "bad" behavior is likely to deter future misconduct by reinforcing the perception of enforcement.[67]

C. The 24/7 Sobriety Program Expansion Project

1. Brief Screening and Intervention at Booking

In order to better address offenders with alcohol, drug or mental health issues, and tailor treatment to their individual needs, justice professionals need more information. *All* offenders who are booked into jail will

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and Alcohol Dependence S4 (May 2007). See also D. Young, R. Fluellen, and S. Belenko, "Criminal recidivism in three models of mandatory drug treatment," 27 Journal of Substance Abuse Treatment 313, 322 (2004).

[60] Gable and Gable, http://www.uscourts.gov/fedprob/jun2005/index.html.

[61] Principles of Drug Abuse Treatment for Criminal Justice Populations at 21 (NIDA 2006).

[62] Gable and Galbe, http://www.uscourts.gov/fedprob/jun2005/index.html (citation omitted).

[63] Principles of Drug Abuse Treatment for Criminal Justice Populations at 22 (NIDA 2006).

[64] R. DuPont, A. McLellan, W. White, L. Merlo and M. Gold, "Setting the standard for recovery: Physicians' Health Programs," 36 Journal of Substance Abuse Treatment 159, 167 (2009).

[65] Gable and Galbe, http://www.uscourts.gov/fedprob/jun2005/index.html.

[66] C. Dula, W. Dwyer and G. LeVerne, "Policing the drunk driver: Measuring law enforcement involvement in reducing alcohol-impaired driving," 398 Journal of Safety Research 267, 268 (2007).

[67] See e.g. D. Young, R. Fluellen, and S. Belenko, "Criminal recidivism in three models of mandatory drug treatment," 27 Journal of Substance Abuse Treatment 313, 314 (2004).

be assessed for alcohol, drug and mental health issues during the booking process. Offenders who test positive for alcohol will be given a brief intervention tool published by NIAAA. Offenders who test positive for drug misuse (or alcohol and drug misuse) will be given a document published by SAMHSA.[68]

2. Contingency Management During Pre-Trial Release and Probation

The 24/7 expansion is focusing on DUI offenders. After appropriate testing, it will be expanded to include other offenders as well.

High risk offenders (first offenders who provide a blood or breath sample of 0.08 or higher and all repeat offenders) arrested for DUI are required to participate in the 24/7 Sobriety Program.
Because the program operates as an alternative to incarceration, offenders will continue to be required to participate in the program during pre-trial release. The stringent monitoring and accountability not only protects the public, but has the added benefit of reaching offenders before the "learning opportunity" expires.[69]

In the traditional 24/7 Program, many judges removed offenders after they are convicted and placed on probation. Under the expanded program, offenders will be required to ***continue participating throughout their probation***, as indicated below. In this sense, pre-trial release and probation will be viewed and addressed as a continuum. This is expected to yield better results because:

- ninety days of treatment "appears to be the minimum threshold for detecting dose response effects from the interventions";[70]
- it will allow for greater continuity of care, which is "essential" for abusers in the community;[71]
- the longer a person remains abstinent, the better the outcome, as noted above; and
- the possibility of additional sanctioning may deter offenders from prematurely terminating their treatment.[72]

All participants will have the option of earning reduced supervision (twice daily testing will be replaced by computer-based random breath testing on an incremental basis) and other incentives by complying with program rules and, where appropriate, addressing their drinking in constructive ways as described in Figure 9. Offenders who choose not to participate in the incentive program during pre-trial release will be subjected to twice daily testing or CAM monitoring while on pre-trial release and required to participate in the incentive program upon conviction as a condition of probation.

All offenders will commence their participation with twice daily testing or CAM for alcohol and random urine or saliva tests for drugs. Recommended rewards and sanctions are based on the number of each

[68] NIDA is in the process of developing a brief intervention tool for people with drug misuse problems. The tool should be available in 2009. The program will distribute the tool at that time.
[69] As one research notes, DWI offenders typically are not placed into treatment programs until weeks or months post-arrest, often after the "teachable moment" has passed. S. Lapham, "Screening and Brief Intervention in the Criminal Justice System," 28 Alcohol Research & Health 85, 89 (2004/2005).
[70] D. Marlowe, "Evidence-Based Sentencing for Drug Offenders: An Analysis of Prognostic Risks and Criminogenic Needs," Chapman Journal of Criminal Justice fn. 12 (In Press 2009).
[71] See e.g. R. Chandler, B. Fletcher and N. Volkow, "Treating Drug Abuse and Addiction in the Criminal Justice System: Improving Public Health and Safety," 301 JAMA 183 (January 14, 2009). See also R. DuPont, A. McLellan, W. White, L. Merlo and M. Gold, "Setting the standard for recovery: Physicians' Health Programs," 36 Journal of Substance Abuse Treatment 159, 167 (2009).
[72] See e.g. H. Sung and L. Richter, "Rational Choice and Environmental Deterrence in the Retention of Mandated Drug Abuse Treatment Clients," 51 International Journal of Offender Therapy and Comparative Criminology 686, 698 (December 2007).

offender's prior convictions. Offenders will have to move through each phase sequentially (they cannot skip a step). All offenders will be subject to additional penalties as required by statute or imposed by the court at the time of sentencing.

Offenders who test positive or otherwise violate program rules will face swift and certain sanctions. Offenders who test positive for alcohol or drugs will be incarcerated immediately.

In an effort to assist justice professionals, create reasonable expectations, increase predictability and ensure measured and proportional incentives and sanctioning, a *draft* contingency management chart providing recommended judicial responses to compliance and violations has been developed. See Figures 9 and 10. The program will use prior convictions as a proxy for risk assessment; requirements, rewards and sanctions are scaled according to each offender's priors. While imperfect, this is consistent with the research demonstrating that the "risk of future DUI arrest rises in tandem with the number of prior DUI arrests."[73]

NOTE: Every case is different. Prosecutors and judges ***will*** be able to deviate from these guidelines in appropriate cases with significant aggravating circumstances such as a crash involving serious bodily injury or death or many more prior convictions.

[73] W. White and D. Gasperin, "Management of the High-Risk Offender" (Institute for Legal and Policy Studies, Center for State Policy and Leadership, University of Illinois at Springfield, Spring 2006).

Figure 9. Draft Contingency Management Chart: Compliant and Appropriate Behavior[74]

DUI Offense	Action	Recommended Response[75]
1st [76]		
	4 weeks of compliance (28 days) and submission to a formal evaluation for alcohol and drug misuse issues [high BAC offenders also must participate in 2 meetings that are part of a 12 step program]	Progress noted by the court
	4 additional weeks of compliance (8 total weeks/56 days) and participation in whatever treatment program(s) were indicated by the formal evaluation.[77] If no treatment is indicated, then the offender must complete the SD Public Safety DUI Curriculum	Random breath testing instead of twice daily testing Tuesday through Thursday (twice daily testing on the other days) If treatment is recommended, then Gift cards totaling $50 will be given to participants during their course of treatment as milestones are met. No financial incentive if treatment is not recommended
	8 additional weeks (16 total weeks/ 112 days) and participation in recommended treatment programs	Random breath testing instead of twice daily testing until the end of pre-trial release/probation (whichever ends later) if the person completes or continues undergoing recommended treatment
2nd		
	4 weeks of compliance (28 days), participation in 2 meetings that are part of a 12 step program, and submission to a formal evaluation for alcohol and drug misuse issues	Progress noted by the court
	3 additional weeks (7 total weeks/49 days) and participation in whatever treatment program(s) were indicated by the formal evaluation. If no treatment is indicated, then the offender must complete the SD Public Safety DUI Curriculum	Progress noted by the court
	3 additional weeks (10 total weeks/70 days) and participation in recommended treatment programs	Progress noted by the court

[74] Offenders will pay $15 a week to participate in the twice daily testing program irrespective of how often they are tested, instead of $1 per test ($14 a week).
[75] As offenders progress, they retain all prior rewards unless they violate the terms of the program.
[76] First offenders ordinarily should not be subjected to the 24/7 Sobriety Program. However, a judge may, in his or her discretion, place someone in the program, particularly if there are aggravating circumstances, including a high blood or breath alcohol concentration at the time of the arrest.
[77] This may include 12-step programs.

	4 additional weeks (14 total weeks/98 days) and participation in recommended treatment program(s)	Random breath testing instead of twice daily breath testing Tuesday through Thursday (twice daily testing on the other days)
	8 additional weeks (22 total weeks/133 days) and participation in recommended treatment program(s)	Random breath testing instead of twice daily breath testing Monday through Friday (twice daily testing on the other days)
	8 additional weeks (30 total weeks/210 days) and participation in recommended treatment program(s)	Random breath testing instead of twice daily breath testing until the end of pre-trial release/probation (whichever ends later) if the person completes or continues undergoing recommended treatment
3rd		
	4 weeks of compliance (28 days), participation in 2 meetings that are part of a 12 step program, and submission to a formal evaluation for alcohol and drug misuse issues	Progress noted by the court
	3 additional weeks (7 total weeks/49 days) and participation in whatever treatment program(s) were indicated by the formal evaluation (it is anticipated that every 3rd and subsequent offender will be referred to treatment)	Progress noted by the court
	3 additional weeks (10 total weeks/70 days) and participation in recommended treatment programs	Progress noted by the court
	4 additional weeks (14 total weeks/98 days) and participation in recommended treatment program(s)	Progress noted by the court
	8 additional weeks (22 total weeks/133 days) and participation in recommended treatment program(s)	Random breath testing instead of twice daily breath testing Tuesday through Thursday (twice daily testing on the other days)
	8 additional weeks (30 total weeks/210 days) and participation in recommended treatment program(s)	Random breath testing instead of twice daily breath testing Monday through Friday (twice daily testing on the other days)
	8 additional weeks (38 total weeks/266 days) and participation in recommended treatment program(s)	Random breath testing instead of twice daily breath testing until the end of pre-trial release/probation (whichever ends later) if the person completes or continues undergoing recommended treatment
4th or more		
	4 weeks of compliance (28 days), participation in 2 meetings that are part of a 12 step program, and submission to a formal evaluation for alcohol and drug misuse issues	Progress noted by the court

	3 additional weeks (7 total weeks/49 days) and participation in whatever treatment program(s) were indicated by the formal evaluation (it is anticipated that every 4th and subsequent offender will be referred to treatment)	Progress noted by the court
	3 additional weeks (10 total weeks/70 days) and participation in recommended treatment programs	Progress noted by the court
	4 additional weeks (14 total weeks/98 days) and participation in recommended treatment program(s)	Progress noted by the court
	4 additional weeks (18 total weeks/126 days) and participation in recommended treatment program(s)	Progress noted by the court
	4 additional weeks (22 total weeks/154 days) and participation in recommended treatment program(s)	Progress noted by the court
	8 additional weeks (30 total weeks/210 days) and participation in recommended treatment program(s)	Random breath testing instead of twice daily breath testing Tuesday through Thursday (twice daily testing on the other days)
	8 additional weeks (38 total weeks/266 days) and participation in recommended treatment program(s)	Random breath testing instead of twice daily breath testing Monday through Friday (twice daily testing on the other days)
	8 additional weeks (46 total weeks/322 days) and participation in recommended treatment program(s)	Random breath testing instead of twice daily breath testing until the end of pre-trial release/probation (whichever ends later) if the person completes or continues undergoing recommended treatment

Additional notes: Gift cards totaling $50.00 per participant may be given during the course of treatment as milestones are met. The decision to provide financial incentives will be made within the sole discretion of the Division of Alcohol and Drug Abuse and is not subject to review.

Figure 10. Violations

DUI Offense	Action[78]	Description	Recommended Response[79]
1st	Failed breath test	First time	1 night in jail
		Second time	2 nights in jail
		Third time	3 nights in jail and interlock
		Fourth time	2 weekends in jail, interlock and CAM
	Failed CAM test	First time	1 night in jail
		Second time	2 nights in jail
		Third time	2 weekends in jail and interlock
		Fourth time	3 weekends jail and interlock
2nd	Failed breath test	First time	1 night in jail
		Second time	2 nights in jail
		Third time	1 weekend in jail and interlock
		Fourth time	2 weekends in jail, interlock and CAM
	Failed CAM test	First time	1 night in jail
		Second time	2 nights in jail
		Third time	1 weekends in jail and interlock
		Fourth time	2 weekends in jail and interlock
3rd and more	Failed test of any kind	First time	*For offenders on pre-trial release*: pre-trial detention. If a judge does not detain the offender, the judge should, at the least, impose short jail time, interlock and consider enhancing the monitoring to include CAM *For offenders on probation*: Two weeks in jail, interlock and CAM
	Failed test of any kind	Second or subsequent time	*For offenders on pre-trial release*: pre-trial detention *For offenders on probation*: Additional jail/prison sentences (increasing the time given for each successive violation), interlock and CAM (see below for additional notes)

3. Program Notes

a. Pre-Trial Release

The court may require any offender who violates the terms of the incentive program to forfeit previously earned incentives and begin anew.

[78] "Failed breath test" contemplates a positive reading on any breath testing instrument, including an interlock device. A failure to appear for testing is considered a "failed test" for these purposes. Also, if an interlock device prevents someone from starting a vehicle or is tampered with, it shall be treated as a "failed breath test." The offender bears the burden of proving that he or she was not the person who caused the lockout or tampered with the device.

[79] For fifth or subsequent violations of pre-trial release, the court should strongly consider jail or, for eligible probationers, prison.

If a 1st or 2nd time offender violates program conditions during pre-trial release, the court will consider increasing the level of treatment if recommended by the offender's treatment counselor in addition to the above described sanctions.

If a 3rd or subsequent offender violates program conditions during pre-trial release, the court will strongly consider detaining the individual. If the court releases the offender, the court will consider, in addition to flash jail:

- Increasing the level of treatment, if recommended by the offender's treatment counselor;
- Enhancing the monitoring by including CAM for a period of time (see below for further explanation);
- Requiring the individual to install an ignition interlock device on his or her car (assuming a device is available that can be implemented consistently with the 24/7 Program protocols, as explained below).

b. Probation

The court may require any offender who violates the terms of the incentive program to forfeit previously earned incentives and begin anew.

If a 1st or 2nd time offender violates program conditions while on probation, the court will consider enhancing the treatment regimen in addition to the above sanctions.

If a 3rd or subsequent offender violates program conditions while on probation, the court should impose jail time, but refrain from terminating the offender's probation unless absolutely necessary. Upon release, the court will strongly consider:

- Increase the level of treatment, if recommended by the offender's treatment counselor;
- Enhance the monitoring by including CAM for a period of time (see below for further explanation);
- Require the individual to install an ignition interlock device on his or her car (assuming a device is available that can be implemented consistently with the 24/7 Program protocols, as explained below).

If a third or subsequent offender violates the terms of his or her probation multiple times, the court will consider imposing an extended jail or prison sanction, but require the offender to continue in the program upon release, if possible.

c. CAM

If an offender is removed from twice daily testing and placed on CAM because of a violation or violations, the court will strongly consider returning the offender to twice daily testing after 30 days if the offender is a first offender, 60 days if the offender is a second offender, 90 days if the offender is a third offender and 150 days if the offender is a fourth or subsequent offender.

d. Ignition Interlock

If a court requires an offender to install an interlock device because of non-compliance, the court will strongly consider allowing the offender to remove the device after 90 days of program compliance for first time and second time offenders and 150 days of compliance for third and subsequent offenders.

Interlock devices will not be used unless they are:

1. On NHTSA's Conforming Products List;
2. Are fuel cell based (no lesser technology Taguchi cells);
3. Are equipped with a camera;
4. Have anti-circumvention technology that is activated at all times); and
5. Are set to shut down the vehicles if not brought in for service within one business day after any type of event (positive test, detected circumvention, etc.).

Interlock providers will be required to report any violations or potential violations within one business day of service (and within two business days of any event)

Offenders will be held accountable for all violations unless the interlock camera shows that another person was responsible (offenders are responsible for their vehicles; identity is an affirmative defense).

4. Data Tracking and Program Evaluation

Long recognizes that the program must be assessed and evaluated regularly to maximize its potential. The 24/7 Sobriety Program maintains detailed records on all participants to ensure efficient tracking and provide opportunities for review and evaluation. As noted earlier, Loudenberg is evaluating the current program. Long has given him access to all program data and each participant's criminal history. Loudenberg already has identified several areas of strength and opportunities for improvement.

Mickelson is developing additional mechanisms to electronically document offender responses on screening and assessment tools and participation in treatment as we enter the second phase.

5. The Pilot: Brookings, South Dakota

South Dakota stakeholders are coalescing around the program and developing strong agency-community relationships. The South Dakota Department of Health and Human Service's Division of Alcohol and Drug Abuse (DADA) has contracted with the East Central Mental Health and Chemical Dependency Center (the "Center"), a private, non-profit, organization to provide services to individuals with alcohol and/or drug misuse issues in Brookings, South Dakota. The Center and DADA have agreed to participate in the Brookings Pilot.

e. Available Services

The Center's multi-disciplinary staff is accredited to provide chemical dependency assessments, individual, couples and family counseling, DUI classes, early intervention services, outpatient treatment programming, intensive outpatient treatment and medication management.

All offenders referred to the Center are assessed for alcohol, drug and mental health issues. They are placed in a program or programs that best meet their needs. Co-occurring substance misuse and mental health issues are treated in an integrated manner; participants are not required to move from one "program" to another in order to receive appropriate services and support.

The Center traditionally provides mental health counseling services at its central Brookings office. However, the Center is transitioning toward a family and community orientation.

Under the new system, offenders will be required to remain in treatment until they are discharged, their case is dismissed, or they complete their probation.

Specific programs include:

- DUI First Offender Program (Early Intervention Services): Offenders who provide blood or breath samples of 0.15 and above typically are placed in the 24/7 Sobriety Program for 30 days. These offenders must participate in the DUI First Offender Program, which is designed to educate them about alcohol use and the dangers associated with drunk driving.
  - The DUI First Offender Program involves 12 hours of instruction on the risks and consequences of alcohol and other drug misuse.
  - Topics include: Laws and Consequences, Alcohol/Other Drugs and Their Effects, Use, Abuse and Addiction, Self-Evaluation, and Change Plan.
- Level I Adult Outpatient Program: Offenders who meet the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)(American Psychiatric Association 1994) criteria for a Substance-Related Disorder and/or the American Society of Addiction Medicine's (ASAM) Patient Placement Criteria for the Treatment of Substance-Related Disorders, PPC-2R, are placed in the Level I program if they do not need more intensive care.
  - The Level I program educates participants about chemical dependency and the recovery process and provides them with new coping skills. Specific topics include: Orientation, Recovery Process, Relapse Dynamic, Post Acute Withdrawal-Recognition and Management, Problem Solving Skills, Stress Management Skills, Decisions Making Skills, Coping Skills, Relapse Warning Signs, Alternatives to use/Recreational Activities, Family and Social Aspects of Recovery, HIV-AIDS and TB Education, and Support Systems.
  - The program provides a minimum of 26 hours of structured group and/or individual therapy sessions over a 26 week period. Activities may include individual counseling, group counseling, education groups and family groups.
  - Participants are re-assessed every 30 working days and remain in the program until they meet ASAM Discharge/Transfer Criteria or their criminal case ends.
- Level II Intensive Outpatient Treatment: Offenders who meet the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)(American Psychiatric Association 1994) criteria for a Substance-Related Disorder and/or the American Society of Addiction Medicine's (ASAM) Patient Placement Criteria for the Treatment of Substance-Related Disorders, PPC-2R, are placed in the Level II program if they need intensive treatment but not inpatient care.
  - The Level II program educates participants about chemical dependency and the recovery process and provides them with new coping skills. Specific topics include: Orientation, Medical Aspects of Alcohol and Mood Altering Chemicals, Symptoms of Chemical Dependency, HIV-AIDS and TB Education, Disease process, Spirituality, Feelings, Grief Process, Communication styles, Decision making skills, Money management skills, Stress management skills, Family and Social Aspects of Chemical Dependency, and the Recovery Process.
  - The program provides a minimum of 54 hours of structured group and/or individual therapy sessions over a 6 week period. Each participant receives a minimum of nine hours of services that include individual counseling, group counseling, educational groups and family groups.
  - Participants are re-assessed every 14 working days and remain in the program until they meet ASAM Discharge/Transfer Criteria or their criminal case ends.
- Inpatient Treatment: The Center does not provide inpatient treatment. Please see subsection b for a description of supplemental services.
- Mental Health Counseling: The Center provides a full range of outpatient mental health.

These programs are not, of course, mutually exclusive. Offenders may receive mental health counseling in lieu of up to three hours of substance abuse counseling. Additionally, participants discharged from the Level II program may be transitioned into a lower level program.

f. Supplemental Services

The Center has no detoxification or residential programming; accordingly, the Center's ability to address severely impaired individuals is limited. If a person is in need of detoxification initially or as a result of relapse, the person would be transferred to a detoxification program in Sioux Falls, South Dakota. There, the person would undergo an extensive evaluation and may be referred to an inpatient treatment program in Canton, South Dakota. Individuals who complete inpatient treatment will be required to participate in a six-month aftercare program.