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BETWEEN THE LINES

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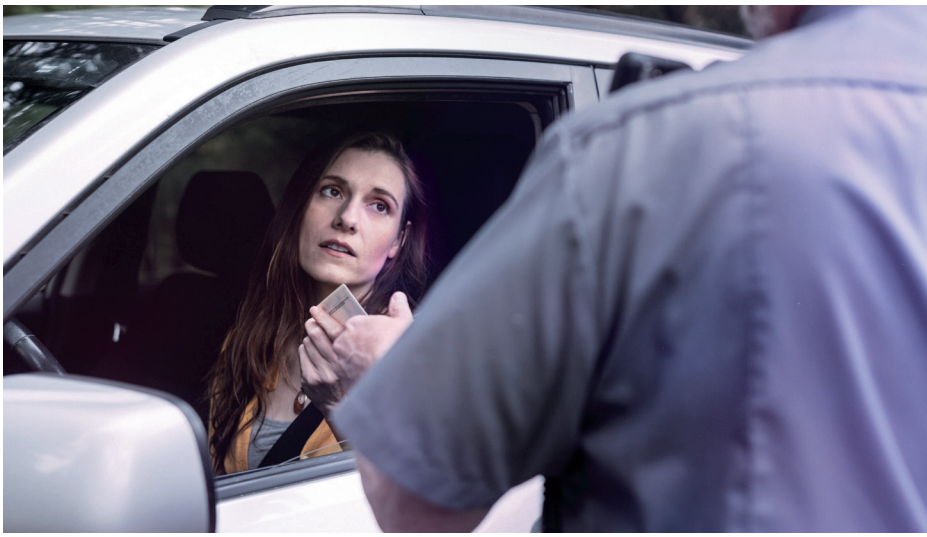

Breaking the Cycle of Impaired Driving Recidivism

Screening and Assessment for Mental Health and Substance Use

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For those of us who have spent years (or decades) attempting to clear our roadways of drunk and drugged drivers, this country's sobering fatality statistics may make us feel like Sisyphus, spending eternity rolling a huge stone up a hill only to have it fall down again. Yet, we have come a long way from the days when we viewed impaired drivers as individuals who

simply drink too much. We have come to recognize there are a myriad of factors that contribute to impaired driving, and a cookie cutter approach to eradication that focuses on the offense type rather than the unique risk and needs of the individual, show limited outcomes.

As a case in point, there is a correlation with individuals who have multiple impaired driving convictions and mental health challenges. Research tells us that 33% of men and 50% of women with multiple DUI convictions, have a diagnosable mental health issue.[1] These numbers may well be conservative when considering the mental health crisis associated with the COVID-19 pandemic and its aftermath. Increases in self-reported depressive episodes and suicide plans and reductions in full-time law enforcement personnel were both associated with rises in impaired-driver deaths, an IIHS analysis of fatal crashes from 2018–2022 showed.[2]

"Repeat" impaired driving represents a complex problem, one that often cannot solely be punished or incarcerated away. The characteristics of individuals involved in this habitual behavior show that fatal crashes involving impaired drivers often include higher blood alcohol concentration (BAC), are more likely to have prior impaired driving convictions, and involve more than one impairing substance. These behaviors often point to underlying symptoms resulting in high-risk/high-need individuals who pose a significant risk to public safety. This population also experiences a higher incidence of co-occurring mental health disorders. The complex problem of repeat impaired driving requires a diverse solution, including accountability and individualized interventions. Historically, the justice system has focused on accountability while downplaying or ignoring potential clinical and criminogenic needs. Criminogenic needs refer to dynamic risk factors that are directly linked to an individual's likelihood of engaging in criminal behavior. Clinical needs, on the other hand, relate to mental health, substance use disorders, trauma, and other behavioral health conditions that impact a person's overall functioning and well-being. While criminogenic needs are associated with public safety outcomes and recidivism risk, clinical needs are focused on health outcomes and symptom reduction. The distinction is important: addressing clinical needs alone may not reduce criminal behavior, and focusing only on criminogenic needs may neglect essential aspects of health and recovery. Effective treatment, court, and correctional interventions must assess and address both types of needs to support long-term recovery and reduce reoffending.

The complex problem of repeat impaired driving requires a diverse solution, including accountability and individualized interventions.

Substance use disorder (i.e., addiction) is a complex and multifaceted condition that uniquely affects individuals. Therefore, it remains essential to provide individualized treatment that addresses the specific needs of that individual. Screening and assessment are critical to determining the individual's criminogenic risk level and clinical needs. They represent two essential processes with key differences, while serving a similar purpose. The primary purpose of screening focuses on identifying individuals who may be at risk or potentially have a mental health and/or substance use disorder. Screening instruments are brief, and the preliminary process seeks to determine if further assessment is needed; *it does not provide a definitive diagnosis*. Various professionals can conduct screenings in many settings, including the courts.

The assessments gather comprehensive information about substance use patterns, related behaviors, and problems. Completed by professionals with specialized training and qualifications, a comprehensive clinical assessment provides a diagnosis, which informs treatment planning. The evaluation involves utilizing validated tools to examine substance use history, co-occurring mental health disorders, biomedical conditions, continued use potential, recovery environment, and motivation to change. To effect long-term change for this population, individuals who enter the system because of impaired driving should be screened and/or assessed for co-occurring disorders to ensure all behavioral health needs are identified and addressed.

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[1] Sandra C. Lapham, MD, MPH; Elizabeth Smith, PhD; Janet C'de Baca, PhD; et al, Prevalence of Psychiatric Disorders Among Persons Convicted of Driving While Impaired, *JAMA Psychiatry*. Available at jamanetwork.com/journals/jamapsychiatry/fullarticle/481831.

[2] Eichelberger, Angela H., July 2025. Factors associated with alcohol-impaired driver crash deaths in the United States, 2018–2022. Insurance Institute for Highway Safety. Available at www.iihs.org/news/detail/poor-mental-health-police-cuts-fueled-pandemic-spike-in-impaired-driving-deaths, last accessed on July 17, 2025.

Many repeat DUI offenders have an undiagnosed history of mental health issues in addition to substance use disorders. Why does that matter? We know that untreated mental health problems can contribute to substance use relapse and DUI recidivism. Research shows many DUI offenders have every intention to stop.[3] But when they relapse or re-offend, there is often a triggering event that can be identified—a relationship problem, an unexpected life event, a challenge at work—that, when coupled with underlying mental health issues, leads to unhealthy coping strategies including re-engagement with substances.

So, mental health issues certainly influence DUI. But why should we screen for them within DUI programs? It is common to hear the argument that we should not ask about mental health challenges other than substance use among DUI offenders because we cannot do anything about them. The idea is that DUI programs know that many of these offenders suffer from mental health issues, but do not have the resources or may be statutorily restricted from addressing mental health disorders. This logic is flawed. The first step to addressing mental health issues with the DUI population is to identify them. The reasons for this are threefold.

- First, diagnosis can itself be a part of treatment. Asking questions about mental health can help DUI offenders recognize or accept these issues and move toward seeking treatment.
- Second, to gain appropriate resources, programs need to first identify the problems. A program that can document the high prevalence of mental health issues in their population is better poised to gain the resources to begin to deal with those issues.
- Third, screening for problems does not always necessitate treating them in-house. A strong referral network can be built that allows programs to make referrals for the problems they identify.

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The next question is when to screen. If psychiatric comorbidity (i.e., having multiple mental health issues) does indeed contribute to DUI recidivism, as evidence suggests it does, then first-time DUI offenders should be screened for mental health issues along with repeat offenders. By screening early, we can identify individuals who might be particularly at risk for recidivism and who could most benefit from treatment.

How should we screen, and for what? Screening does not have to be complicated and does not have to be done by a clinician. Here are some key points:

- What is important is that screening be standardized—it does not work if everyone asks different questions of different clients.
- It must provide meaningful information about whether an offender is struggling with moderate to severe mental health issues. A screener does not work if it identifies everyone as having problems because the criteria it uses are too widely endorsed, but it also does not work if too many actual cases slip through unidentified.
- A good screener is highly sensitive, meaning it does not miss many true cases, but also has decent specificity, meaning it does not over-identify cases. In a process where screening leads to additional assessment, which we recommend, it is acceptable for a screener to cast a wide net, producing some false positives to ensure that there are no false negatives.
- As far as what to screen for, we have found that trauma, anxiety, and attention and impulse problems are highly prevalent among repeat DUI offenders. A screener should be able to, in addition to screening for specific substance-related problems, screen for symptoms of post-traumatic stress disorder (PTSD), anxiety

[3] Wiliszowski C, Murphy P, Jones R, Lacey J. Washington, DC: National Highway Traffic Safety Administration; 1996. Determine reasons for repeat drinking and driving. DOT HS 808 401.

disorders (including panic attacks), ADHD, depression and mania, and anger issues (e.g., intermittent explosive disorder). Lifetime histories can be informative, but if resources are scarce, screening for past-year symptoms can identify the most pressing issues.

Ideally, screening and assessment should be a two-tiered system, with screening happening as early as possible in the DUI chain of events (e.g., pre-trial if possible) with full assessment following for those who screen positive for disorders. And screening should not be a one-time occurrence. Screening should happen throughout the DUI sentencing and treatment process. A DUI offender who does not admit to symptoms of mental health issues pre-trial might be ready to discuss those issues with a program counselor after adjudication. And a DUI offender who does not accept a referral to treatment when first presented, might accept it the third time it's presented.

In addition to comprehensive screening and assessment, addressing substance use and mental health disorders requires clinical placement meeting the individual's complex needs. Moving away from "one size fits all" models of care to an individualized approach recognizes the need to match treatment settings, service, and intensity based on the individual's clinical needs. Substance use disorder occurs on a spectrum; treatment intervention necessitates a continuum of care. Effective treatment recognizes the Transtheoretical Stages of Change model (TTM).[4] The TTM framework, developed by James Prochaska and Carlo DiClemente, describes the process individuals experience when making behavior changes. The six-stage model recognizes that change is not a linear process but a series of individual stages. For treatment to be effective, it is essential to tailor the interventions to meet the individuals where they are in their change process.

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The high-risk, high-need impaired driving population has demonstrated a high degree of compliance-driven change. In other words, with the discontinuation of supervision and accountability of probation or programming, individuals return to use/problem behaviors. Adherence, on the other hand, lies in finding what intrinsically motivates the client to change, meeting them where they are in their stage of change, and creating a meaningful and lasting change plan for the client, something they will continue to employ after the programming ends. Moving from program- and time-driven treatment planning to individual outcome-driven treatment planning effectively aids in the process of change.

Time-driven treatment frequently represents an arbitrary practice, and the requirements refer to criteria or guidelines lacking in evidence-based practices. The requirements of time-driven treatment often promote subjectivity and lack validity resulting in treatment agencies and courts employing program-driven care (a certain number of hours, modules, etc.). This approach fails to consider the complexity of substance use disorder and the need for comprehensive assessments to determine clinical needs and placement.

The research supports that, while treatment works, not all interventions work for everyone.[5] One of the best predictors of positive outcomes in treatment remains a solid therapeutic alliance, the collaborative relationship between a therapist or treatment provider and the client.[6] Alliance factors promote client engagement, collaboration, empowerment, and treatment adherence. When clients feel heard, understood, and agree on goals, they are more likely to adhere to their treatment plans. To understand if a therapeutic alliance exists, using validated tools is vital, as relying on the therapist's interpretation alone often demonstrates bias. Several

[4] Prochaska, J. O., & DiClemente, C. C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research & Practice*, 19(3), 276–288. doi.org/10.1037/h0088437.

[5] NIDA. 2020, July 6. Treatment and Recovery. Retrieved from nida.nih.gov/publications/drugs-brains-behavior-science-addiction/treatment-recovery on July 12, 2025.

[6] Stubbe DE. The Therapeutic Alliance: The Fundamental Element of Psychotherapy. *Focus* (Am Psychiatr Publ). 2018 Oct;16(4):402–403.

methods can be employed when measuring therapeutic alliance, varying from client self-report to therapist-rated measures. While no single tool captures the complexity of substance use disorders and therapeutic alliance, effective treatment must integrate these practices when working with all individuals in clinical practice.

Historically, treatment for substance use disorders stemmed from the acute care model. In other words, periods of brief intervention followed by cessation of services. The traditional model may work well in an emergency room but is impractical for substance use and mental health disorders. Substance use and mental health are more like chronic illnesses like diabetes or hypertension. Effective treatment requires long-term involvement, continued care, regular check-ups, and linkage to community resources.

The success of the justice system in focusing on the accountability piece for impaired drivers fails to recognize the need to adapt the system to those who present with treatment needs, a necessity if the systemic goal adjusts to a genuine desire to make an impact on all segments of the impaired driving population. Treatment reform aims to decrease barriers to people seeking substance use disorder treatment, ensuring that people have timely access to the continuum of needed services. Good outcomes depend on individualized treatment plans and adequate treatment length. Said differently, outcomes improve when an individual participates in the right treatment for the right amount of time.

Impaired Driver Screening Tools

In the age of assessment-driven supervision, we have found that there are some populations within the criminal justice system that have risk factors that are not easily captured with generic risk/needs screening and assessment tools. This is true of the impaired driving population. Before the development of the Impaired Driving Assessment (IDA) and the Computerized Assessment and Referral System (CARS), community supervision officers overseeing impaired drivers were quick to note that this population typically scored as being low risk to reoffend on generic assessment tools. However, their behaviors under supervision often belied these scores. In fact, many of the criminogenic risk factors of impaired drivers are different than other populations under community supervision, typically skewing assessment results and showing them to be at a lower risk to recidivate.

Good outcomes depend on individualized treatment plans and adequate treatment length.

The impaired driving population generally tends to have higher levels of education and employment and more stable family situations than other populations under community supervision.[7] These are factors that play a significant role in determining future risk to recidivate within the criminal justice population.

There are a limited number of screening and assessment tools that are designed for the impaired driving population. Two of these tools are IDA and CARS. In addition to being developed for use with the impaired driver, they are also free to use.

IDA

Developed in 2012, the IDA[8] was designed to capture the unique risk factors of impaired drivers using a Convergent Validation Mode. The tool includes a client self-report consisting of questions that identify the client's perception of the DWI, and an evaluator report consisting of questions that capture static information including the client's arrest, treatment, and intervention history. By comparing the information in both reports, the evaluator can determine the best estimate of client risk and preliminary information on treatment needs, their level of defensiveness, and their acceptance and motivation to change.

[7] Maruschak, L. DWI offenders under correctional supervision. NCJ 172212. Washington, DC: Office of Justice Programs, Bureau of Justice Statistics, 1999, at pg. 1. Available at bjs.ojp.gov/content/pub/pdf/dwiocs.pdf, last accessed July 22, 2025.

[8] For additional information, please visit www.appa-net.org/idarc/resources-using-the-ida.html.

The tool focuses on domains including alcohol and other drug disorders, legal non-conformity, and defensiveness, as well as acceptance and motivation. Included in these risk domains are psychosocial disorders. These questions address the client's self-view of recent and current psychological and work status. The scores reflect the extent of distress related to stress, depression, anger management, and alcohol and other drug use to manage these conditions and difficulty around job productivity.

CARS

CARS[9] is the result of a collaboration between the Cambridge Health Alliance Division on Addiction and Responsibility.org, a nonprofit organization with a focus on preventing drunk driving. Mental health problems that extend beyond substance use disorders are common among impaired drivers and can affect treatment and intervention outcomes. However, in many impaired driving programs, clients do not undergo comprehensive screening for psychiatric disorders. CARS is an easy-to-use computer guided interview that screens for a wide range of mental health disorders that likely contribute to addiction-related problems, including impaired driving. CARS can be administered by anyone, and is easy to understand, providing immediate personalized information about the mental health disorders for which a client qualifies or is at risk, a summary of other risk factors and important issues, and a list of resources personalized by a client's issues and location.

The goal of treatment professionals and criminal justice professionals is to provide the resources to make the last DUI conviction, truly the last DUI.

There are many benefits to using CARS with impaired driving offenders. CARS provides accurate and reliable diagnostic information for up to 16 major psychiatric disorders that facilitate effective treatment planning. It improves the intake and data collection processes for programs, making it easier and more efficient for employees to collect, maintain, integrate, and share information about their clients. CARS generates user-friendly reports at the click of a button. The screening tool adapts questions from the Composite International Diagnostic Instrument (CIDI), a well-validated tool designed for lay interviewers who may not have expertise or training in mental health assessments. The CARS flow and interface make it easy for clinicians and laypeople alike to use it to administer comprehensive mental health assessments, with minimal time and effort.

The goal of treatment professionals and criminal justice professionals is to provide the resources to make the last DUI conviction, truly the last DUI. By looking at the individual, and not just the charge, we are better able to focus on the mental health factors that can lead to a stop in recidivism and a path to recovery.

About the Authors

Dr. Sarah E. Nelson

Dr. Nelson is the Director of Research at the Division on Addiction, Cambridge Health Alliance, and an Associate Professor in the Department of Psychiatry at Harvard Medical School. Dr. Nelson's work covers many facets of addiction, including the relationship between psychiatric comorbidity and DUI offense, how best to develop community recovery environments for youth with substance use problems, and the distribution and determinants of gambling and gambling problems. Dr. Nelson's DUI work began with the study of mental health disorders among repeat DUI offenders and the relationship between that comorbidity and DUI re-offense. Based on this work, Dr. Nelson has led the development, implementation, and evaluation of a mental health assessment system (the Computerized Assessment and Referral System: CARS) at DUI programs and courts across the country.

[9] For additional information, please visit www.carstrainingcenter.org.

Julie Seitz

Julie Seitz LGSW, MSW, LADC is a Project Director with Impaired Driving Solutions (IDS), All Rise (formerly NADCP) division, providing training and technical assistance to the treatment court field. Julie joined IDS in 2018, bringing over 20 years of experience in the clinical sector and community program development. Before joining IDS, Julie was the clinical director of an internationally recognized treatment center offering the entire continuum of clinical care, including a first-of-its-kind direct access opioid withdrawal unit, where she was the project lead. Identifying the barriers to accessing treatment, Julie worked collaboratively as an advocate for systems change while ensuring clients' voices and choices were honored. Recognizing the many pathways to recovery and the need for additional recovery services, she worked with a small team to develop and launch a recovery community organization serving rural communities in northern Minnesota. Julie spent ten years as the treatment provider with the Minnesota Sixth Judicial District DWI and Mental Health courts, which are recognized for their excellence at state and national levels. As a published author and clinician, she has spent the last 25 years of her career giving clients a voice. Her work with clients has focused on feedback-informed, research, and outcome-driven practice. As a fierce advocate for education and growing the field, she is also an adjunct professor at the College of St. Scholastica in the Master of Social Work program. Julie has trained at the local, national, and international levels. Julie lives in northern Minnesota with her family and is an avid knitter.

Mark Stodola

As American Probation and Parole Association's Probation Fellow, Mark Stodola brings over 30 years of experience working in the field of court management and adult probation in Arizona. Mark worked at the Maricopa County Adult Probation Department for 18 years serving in a number of capacities including division director overseeing drug and alcohol treatment programs, problem solving courts and services for the mentally ill. Mark later became the Court Administrator of the Tempe Municipal Court where he served for eight years managing the day to day activities of the court. Most recently Mark served as Program Services Manager in the Adult Probation Services Division of the Arizona Supreme Court where he had oversight of treatment programs for Arizona's Adult Probation Departments. Mark has presented training on topics surrounding high risk drunk drivers at national, regional and state conferences throughout the country. Mark also is an adjunct instructor at Arizona State University. Mark received his undergraduate degree in History from the University of Wisconsin–Madison and his Master's Degree in Education from Northern Arizona University. Mark became a Graduate Fellow through the National Council of State Courts Institute of Court Management.

Chris Konschak

Chris Konschak is an impaired driving and traffic safety professional and lawyer who began working on community-based substance abuse prevention efforts in high school. He earned a Juris Doctorate from Howard University School of Law and a Bachelor of Arts in Political Science and Speech Communications from the University of Richmond. He joined Responsibility.org in 2020 and works with both the Traffic Safety and Government Relations teams. Key responsibilities for Chris include managing the Responsibility.org Judicial Advisory Board, leading educational efforts on the link between impaired driving and mental health disorders, serving as the lead on the Computerized Assessment and Referral System (CARS), and guiding response to legislation in all 50 states and the District of Columbia. Chris also served as Virginia's Director of Mothers Against Drunk Driving for 17 years. He led a 6-year campaign to pass Virginia's mandatory ignition interlock law for all DUI convictions. He has also worked in political, criminal justice and public safety offices on the local, state and national levels.