

## Is 24/7 sobriety a good goal for repeat driving under the influence (DUI) offenders?

*The experience of the South Dakota '24/7 Sobriety' programme suggests that complete sobriety is a viable goal for most repeat DUI offenders.*

### INTRODUCTION

Driving under the influence (DUI) of alcohol and/or illegal drugs is an important problem by any measure. On average, associated crashes kill someone in the United States every 40 minutes [1].

Various control strategies have been tried, including punitive sanctions; in the United States, DUI accounts for 1.4 million arrests annually [2], 40 000 inmates in jail [3] and another 32 000 in prison [Eric Sevigny, personal communication]. Another approach tries to prevent offenders from driving by suspending or revoking licenses, impounding cars or requiring breath alcohol ignition interlock devices [4]. A recent emphasis lowers permissible blood alcohol content. While these strategies work, to some degree, DUI continues to generate enormous harms, implying that existing interventions are not entirely satisfactory.

South Dakota, a state in the northern plains of the United States, has adopted a different approach. Its '24/7 Sobriety' program attempts to prevent repeat DUI offenders from drinking through frequent testing. The program has teeth; the punishment for a failed test is immediate and automatic incarceration. However, incarceration is so brief (24 hours), and compliance rates so high, that total sanctioning may actually have declined [5].

South Dakota's fundamental innovation is to require offenders to stop drinking, rather than stop driving. Simple trend data suggest stunning success. Traffic fatalities involving alcohol impairment dropped from 71 in 2004 to 34 in 2008 [6], and some have suggested that there are favorable effects on other alcohol-associated crimes (e.g. domestic violence). The initiative has not been evaluated scientifically, but if a formal study produced outcomes approaching those suggested by the descriptive statistics, it might spark some rethinking about approaches to dealing with harms related to substance abuse.

### SOUTH DAKOTA'S 24/7 SOBRIETY PROGRAM

South Dakota's 24/7 Sobriety program began in the 1980s in one rural county with extensive alcohol abuse

problems. The program required repeat DUI arrestees to submit to twice-daily (7–9 a.m. and 7–9 p.m.) breath testing as a condition of bail. Failed tests constituted a violation of bond terms and were punishable by immediate 24-hour incarceration; missed tests led to issuance of an arrest warrant.

The program expanded to three counties by 2005 and 12 by 2006. The legislature authorized state-wide implementation effective from 1 July 2007. It now operates in 57 counties covering 90% of the state's population, and is being replicated in North Dakota [7]. Legislation extended 24/7 Sobriety both to include illegal drugs and, beyond impaired driving, to be a possible condition of pre-trial release, probation or parole, suspended sentence and returning abused or neglected children to their parents. Defendants are responsible for covering costs in all but child abuse cases.

Four testing modalities are used: (i) twice-daily breath testing for alcohol; (ii) ankle bracelets that monitor alcohol consumption continuously with daily remote electronic reporting; (iii) twice-weekly urine testing for drugs; and (iv) sweat patches for drug monitoring (worn for 7–10 days and mailed in) [8]. Random drug testing was added to alcohol testing to discourage substitution.

Reported compliance rates are impressive [9]. Roughly two-thirds of those subject to twice-daily alcohol testing never had a single positive or missed test. That proportion increases to 94% when one includes those with just one or two positive or missed tests. Similarly, 78% of those wearing ankle bracelets were fully compliant. Clean tests increased with frequency of testing; 99.6% of twice-daily alcohol tests, 98% of twice-weekly urinalysis tests and 92% of drug patches were clean.

### IMPLICATIONS

The 24/7 Sobriety program has not been evaluated scientifically, so the only firm conclusion to be drawn now is that such an evaluation is needed. However, one may speculate about some possible implications.

Low expectations with respect to abstinence have become common, with the treatment objective sometimes seen as managing the consequences of ongoing use rather than seeking to eliminate use; yet some interventions do achieve high rates of abstinence. In another

example with intensive monitoring, one that has been evaluated rigorously, 78% of physicians admitted to 16 state Physicians' Health Programs achieved complete abstinence over a 5-year period [9].

The 24/7 Sobriety project's success is striking, inasmuch as the program is all sticks and no carrots. Participants were free to seek treatment, and presumably some did. However, the program did not include treatment, treatment referral or any treatment requirement. Conventionally administered criminal justice sanctions have what might charitably be called a mixed track record at changing behavior [10]. However, their failure may be due to poor implementation. Most criminal justice sanctions are severe but delayed and uncertain. The 24/7 Sobriety program sanctions are modest but immediate and certain. Hawaii's Opportunity Probation with Enforcement (HOPE) also increases compliance with court conditions dramatically among a recalcitrant population by taking this approach of frequent testing and brief, almost immediate incarceration [11]. Both achieve what Mark Kleiman calls coerced or mandated abstinence [10,12]. As one referee encouraged us to note, these results may be viewed as being at odds with the dominant understanding of addiction as a chronic relapsing brain disorder.

Administrative structures often determine success or failure in practice. The 24/7 approach makes less intensive use than do drug courts of scarce judges' time. Its challenge is the need for substantial cooperation across organizational boundaries. Past programs with similar ambitions have run into severe administrative challenges [13]. It remains to be seen how well 24/7 Sobriety would replicate in larger and/or more bureaucratic jurisdictions.

If, 5 years from now, 24/7 Sobriety is recognized widely as an important innovation, we in academe might ask ourselves why this innovation came from practitioners, not researchers. The answer may simply be that its genius lies not in the concept, but in its leaders' tenacity in overcoming administrative and bureaucratic obstacles. If so, then perhaps academe needs to be a little less 'academic' if the key to dramatic success at controlling drug-related harms can lie in gritty aspects of implementation, not new 'silver bullet' technologies.

Or, perhaps, academics focus upon an extreme tail of the substance abuse continuum, whereas practitioners see a spectrum. Hawken [A. Hawken, unpublished data] suggests that aggressive monitoring can achieve 'behavioral triage' in the criminal justice system. Most become abstinent when their environment becomes intolerant to continued use. The minority who fail self-select for more intensive interventions. Perhaps the objective should be

intensive treatment for a few, rather than (inevitably somewhat mediocre) treatment for all.

Again, these are simply speculations. However, the 24/7 Sobriety program's apparent success is so dramatic as to be provocative. Our purpose here is simply to point *Addiction's* readers to this interesting case and to raise for discussion some possible implications, should a rigorous evaluation confirm what the initial data suggest.

#### Declaration of interests

None.

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