Interpreting Research for Practice: A Challenge for Evidence-Based Assessment and Intervention with DWI Offenders

Assessment and Treatment of the DWI Offender

By Alan Cavaiola and Charles Wuth

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Review by Elisabeth Wells-Parker and Marsha Williams

Cavaiola and Wurth summarize their objective for this book as providing "information based on the accumulation of knowledge, in the key areas vital to assessment, treatment planning, and treatment" (pp. 32-33) of DWI offenders. Their goal is particularly challenging for several reasons. First, the process of assessment and treatment of the DWI offender represents an intersection of interests from the traffic safety, criminal justice, alcohol treatment, and public health communities as well as grassroots organizations such as Mothers Against Drunk Driving (MADD). Each of these communities envisions particular outcome goals that are distinct though arguably interrelated. For example, the alcohol treatment community focuses on drinking reduction or abstinence for the offender in treatment; the traffic safety community focuses on prevention of crashes; and the public health community embraces a broader perspective focusing on how DWI policies and countermeasures affect drinking drivers who may not be detected by the criminal justice system. Grass roots organizations such as MADD focus on preventing harm to "innocent victims" of the drinking driver. To the authors' credit, the diversity of objectives from the various communities is recognized as an important context for understanding assessment and treatment issues. In an especially comprehensive forward, Robert Voas traces the historical development of an understanding of alcoholism and of drinking driving problems as interrelated problems that "proceeded on separate tracks" (p. *xi*). An excellent history of the development of these varied perspectives with a flavor of how these perspectives can sometimes be in conflict follows. The first chapter expands upon the theme by further tracing the development of assessment and treatment countermeasures for DWI offenders, and the issues of differing perspectives are integrated into other chapters (e.g. chapter 9 that deals with divergent goals of DWI treatment).

A second challenge faced by the authors is that there is a vast body of relevant research that varies substantially in quality of methodology. Unfortunately, in spite of this large body of research, there are still important gaps in adequate evidence to determine best practices for screening, assessing and intervening with DWI offenders. Furthermore, even when solid evidence exists, there can be difficulties with translating evidence into practice, especially when such "best evidence" practices vary substantially from standard and widely accepted practices in the field. The authors recognize and accept these draconian challenges and are to be congratulated that this book represents progress toward translating research into practice. The book can provide a useful reference for practitioners and policy makers. However, as with any ambitious first attempt there are some caveats that should be considered by readers. The remainder of this review will identify these caveats as well as emphasize the strengths of the authors' discussion of the three major topics: (a) DWI offender characteristics, (b) screening/assessment, and (c) intervention/treatment.

Who are DWI offenders?

In chapters 2 and 3 the authors focus on characteristics of DWI offenders that may contribute to crash risk, suggest intervention issues, or tend to distinguish convicted DWI offender populations from "alcoholics." Here the authors identify and recount findings of major studies, and these chapters are successful in summarizing much of the literature on characteristics of convicted DWI offenders. For example, the authors review research suggesting that significant numbers of convicted drinking drivers are high risk drivers even under conditions of sobriety; therefore, severity of the drinking problem alone may not be the only indicator of crash risk. They review DWI offender typologies that have been used to characterize problematic psychological characteristics prevalent among DWI populations.

However, there are some underlying problems with the literature taken as a whole. For example, the authors accept "typologies" without questioning their meaning. Because discrete decisions—what to do with a particular offender—must be made in the real world, typologies, whether they are based on either alcohol specific or more general psychological characteristics, are very attractive because they seem to provide an empirical basis for deciding that an offender is a certain "type." In this regard, the authors pose the question whether all DWI offenders are "alcoholic" or whether there are different subtypes of DWI offenders (p. 49). However, their question, while apparently rhetorical, reflects an underlying confusion about classification that seems to permeate much of the typological or classification research with DWI offenders. When examined closely, the reality is that "empirical" typologies are arbitrary constructions that may simplify decision making but belie the fact that these "problematic" characteristics exist along multiple continua (Wells-Parker, Bangert-Drowns, Allegrezza, McMillen and Williams, 1995). When is an offender "depressed" enough to be characterized into the frequently cited "depressive" subtype or "angry" or antisocial enough to be classified into a "hostile" subtype? Parallel issues exist when attempting to characterize offenders as "nonproblem" versus "problem" drinkers or "alcoholics" versus "nonalcoholics." A seminal report from The Institute of Medicine (Broadening the Base of Treatment for Alcohol Problems, 1990) stated the issue well: " . . . both alcohol consumption and alcohol problems lie along a continuum and . . . categories, such as moderate or severe, are conveniences for communication rather than fixed entities" (p. 31).

Assessment of DWI Offenders

The use of arbitrary classification schemes that are taken literally poses a problem for interpreting the research on assessment of DWI offenders—the topic of chapters 4 and 5. The

authors are faced with research studies that frequently use classifications, such as problem and nonproblem drinkers, literally, adding confusion both to attempts to describe population similarities or differences as well as attempts to validate assessment devices. For example, all too often "validation" of screening and assessment instruments, as well as comparison of particular instruments to determine relative merits, is done by using a particular cut score with each instrument. This cut score usually divides offenders into nonproblem and problem groups. Although the authors discuss the issue of cut score selection in chapter 4, much of the validation research they cite when comparing or recommending specific instruments relies primarily on the evaluation of sensitivity and selectivity of instruments using particular cut scores without considering the arbitrary nature of the cut-score classification—an example of a failure to recognize underlying continua. It is possible to evaluate instruments independently of cut scores (Anderson, Snow and Wells-Parker, 2000), but most of the existing studies fail to do this. Failure to recognize the arbitrary nature of classifications determined by cut-scores is one of several problems that lead to oversimplification of screening and assessment issues for many policy makers in the field. (See Anderson et al., 2000 for further discussion.)

A related problem in many assessment validation studies is the use of unevaluated clinical judgements (e.g., in classification of "non-problem" and "problem") as criteria—"gold standards"--against which screening and assessment tools are validated. To their credit, Caviola and Wurth discuss problems with reliance on clinical judgement alone in classification decisions. They state: "What is essential to remember is that using a variety of assessment measures along with clinical judgment is superior to clinical judgement alone in making a screening and referral decision" (p. 73). Unfortunately, they stop short of critically questioning the all too frequent use of clinical judgements as the final criterion in the assessment process for DWI offenders. A case

in point is the study by Lacey, Jones, and Wilisnowski (1999), on which Caviola and Wurth rely heavily for comparisons of various structured screening tools (e.g., p. 97). In this study the criterion measure for determining validity of several widely used standardized assessment tools was a single classification by "assessors" of DWI offenders as "problem" or "non-problem" drinkers. Although a structured interview, developed specifically for the study using input from a panel of expert judges, was used to obtain the information, there is no verifiable process by which the various "assessors," who were employed in several DWI programs, made their category assignments, nor is there even mention of reliability or validity of these essentially clinical judgements—a shortcoming of the Lacey et al., study that even the study authors themselves acknowledge (Lacey et al., 1999). However Caviola and Wurth seem to accept the results and conclusions of this study uncritically. It is time for both researchers and practitioners in the DWI field to come to terms with a substantial literature suggesting that clinical judgements are usually inferior to and almost never superior to more mechanical means of making classifications (Grove and Meehl, 1996). Hastie and Davies (2001) capture the essence of this large body of research succinctly: when the same information is available to both methods, global clinical judgement is either worse or no better than mechanical methods. In summary, Caviola and Wurth do a good job of identifying the relevant literature on screening and assessment and do point out some of the pitfalls—for instance possible conflicts of interest when the clinical evaluators work for treatment agencies that would receive the assessment-based referrals. However, a more critical examination of DWI screening/assessment research is important because of a wide spread adoption in the United States of mandated screening and assessment, which is often accompanied by specifications that the final assessment be made by

"qualified evaluators," but no research is conducted on the validity or reliability of these "qualified evaluators'" judgements.

Intervening with the DWI Offender

Chapter 6 provides a useful summary of various DWI countermeasures that are in general use in the United States. Chapter 7 focuses on the issue of resistance in DWI treatment and recasts the concept of "resistance" in the context of the transtheoretical model's "stages of change." Chapter 7 also discusses "assessment" as an ongoing process related to moving the offender toward higher stages of change. The authors advocate a variety of techniques, including various structured group exercises and individual counseling techniques, to move DWI clients through the change process. In doing so they allude to an insidious problem--that all too often policy makers, especially when formulating guidelines for sending offenders to intervention, tend to think of available DWI interventions as either didactic education or traditional alcohol treatment. In reality many enlightened programs, whether called "education" or "treatment" incorporate multiple strategies and techniques, making it inappropriate to label them simplistically in either category (see Well-Parker et al., 1995).

Chapters 8 and 9 continue the focus on specific strategies, beginning with an insightful discussion of the controversy surrounding the degree of importance of rehabilitative treatment programs as effective DWI control countermeasures. Here the authors present a comprehensive and balanced review of what is known about effectiveness of DWI interventions as well as research issues surrounding treatment matching in DWI populations, especially the need for more rigorous treatment matching research. The next objective of the authors is to describe components of successful DWI programs. Here again their frustrating dilemma is that the body of methodologically sound research on intervention effectiveness supports general rather than

specific effectiveness of broadly defined offender-specific rehabilitative interventions when compared to no remediation or criminal sanctions (e.g., fines, jail; Wells-Parker et al., 1995). There are only a few studies that provide well-developed evidence on either the effectiveness of specific treatment techniques for DWI populations or techniques that work for specific offenders (i.e., lack of treatment matching evidence). Although these few studies are summarized by the authors in chapter 8 (p. 154-156), most of the comprehensive schemes that are described by the authors in chapter 9 have not been rigorously evaluated or, more problematic, have been evaluated in studies with inadequate methodology (Wells-Parker et al., 1995). In general these schemes are carefully presented, but the reader should exercise equal care in reading about these comprehensive but unevaluated programs so as not to misunderstand the need for rigorous evaluation of such plans.

In Chapters 8 and 9, the authors do a good job of interpreting complex research issues, although in several passages they appear to be confused about interpretation of research findings. For example, on page 163, they cite a commonly reported finding that treatment completers tend to have lower recidivism rates than do non completers and conclude from these findings that treatment completion improves success. They do not appear to recognize the equivocal nature of this finding—for example, treatment "failure" (e.g., recidivating prior to completion) may affect treatment completion through receipt of additional sanctions such as jail or the removal of incentives (e.g., license reinstatement) for treatment completion. Chapter 10 is a curious departure from earlier chapters. Much of chapter 10 seems to strongly advocate the inclusion of treatment for the offender's family as part of the intervention program, even though the authors acknowledge that there is no research that adequately addresses family therapy in DWI programs. The only empirical data that they cite is that less than half of DWI offender families

complete therapy even when strong financial incentives are offered. They acknowledge "a definite need . . . to empirically validate" their judgements regarding family therapy for DWI offenders (p. 216).

Conclusions.

The authors conclude with a series of recommendations for promising strategies to "help prevent recidivism" (p. 217). They carefully word their recommendations so that no claims are made that conclusive evidence supports the effectiveness of some of the programs they discuss. It is important that the reader does not infer proven efficacy of programs that are presented as promising. A case in point is their inclusion of Victims Impact Panels as an intervention innovation. Recent well-designed research that examined the effects of these panels calls into question their efficacy for reducing recidivism (Fors and Rujek, 1999). In summary, it is essential that the reader carefully reads this book with an understanding of the large gaps in available evidence for many of the assessment and rehabilitative interventions that are presented and, in some cases, advocated. If the reader understands these caveats, the book can be a useful resource for practitioners and policy makers and provide a guide for developing innovative programs that could be evaluated with appropriate methodology.

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