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EFFECT OF PRISON-BASED ALCOHOL TREATMENT: A MULTI-SITE PROCESS AND OUTCOME EVALUATION FINAL REPORT

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ABSTRACT

Alcohol abuse and drunk driving present challenges for the criminal justice system in terms of maintaining public safety, delivering effective rehabilitative services, and managing offender populations. While treatment for illicit drug abuse in correctional settings has been broadly implemented throughout the United States, alcohol-specific recovery programming is far less common. In that alcohol related crime commands a greater amount of resources than illicit substances, in-prison alcohol treatment for felony driving while intoxicated (DWI) and driving while under the influence of alcohol (DUI) offenders is a promising opportunity to rehabilitate serial inebriates through cognitive restructuring oriented toward behavioral change.

Given the scarcity of alcohol-specific treatment delivered in correctional settings, it is not surprising that alcohol treatment programming within the criminal justice system has not been thoroughly evaluated. There is a need for empirical knowledge regarding whether prison-based alcohol treatment is effective and, if so, which treatment practices are most strategic for disrupting the alcohol and crime nexus. This mixed methods study entailed process and outcome evaluations of three separate state-sponsored alcohol-specific treatment programs delivered in prisons located in Montana, Ohio, and Texas. The study examined three interrelated research questions regarding the evaluated programs: 1) Do justice system delivered alcohol treatment programs adhere to evidence based practices?; 2) Is treatment delivered in a manner consistent with program protocols demonstrating program fidelity?; and 3) Are program graduates more or less likely to re-offend?

Research Design and Protocols

Qualitative and quantitative data collection and analysis were executed to answer the focal concerns of evidenced-based program design, program fidelity, and recidivism reduction. On-site qualitative data collection throughout the duration of the evaluation period concentrated on assessing degree of evidence based practice and level of program fidelity. In-depth interviews were conducted with facility administrators, correctional staff, and treatment professionals according to an interview guide to ensure systematic data collection across individual respondents and sites and three series of focus group interviews were conducted at each site with a sample of treatment group participants according to a semi-structured questionnaire. Follow-

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up site visits enabled observation of the continuity and consistency of modality delivery, as well as responsiveness to identified treatment barriers.

To determine program impact, a quasi-experimental design was employed that entailed comparison groups to maximize the likelihood that observed outcomes are attributable to treatment, criterion measures indicative of offender rehabilitation and public safety, and a follow-up period tracking offender success for a year post-release. The samples for quantitative analysis were comprised of male state prisoners in programs located in one of the three study settings, each of which serve demographically distinct offender populations. Outcome data was provided by the Montana Department of Corrections, Ohio Department of Rehabilitation and Correction, and the Texas Department of Criminal Justice. The primary criterion measure indicative of program impact and effectiveness was recidivism, defined as a return to a correctional facility.

Findings

The intervention strategies and treatment modalities in Montana were found to be sound and reflect an evidence-based practices design. The Ohio program, while featuring evidence based treatment protocols in services delivery, is challenged by an ineffective referral process, questionable program placement contradicting the risk principle, and gross under-enrollment. Also troubling is the fact that the Ohio program, though described as a therapeutic community, houses its treatment participants with the general population of a medium security prison in violation of the principle of isolating treatment participants to ensure the integrity of the treatment climate. The Montana program was found to be near ideal as indicated by high scores from all research team members for all program fidelity indicators (adherence, exposure, quality of services delivery, participant engagement, and program differentiation) across site visits.

Statistical analysis specified the level of effectiveness of the treatment programs, both individually and collectively. While findings from Ohio should be interpreted very cautiously due to low sample size, the sample sizes for Montana and Texas are more robust and suggest that in-prison alcohol treatment can meaningfully impact future offender behavior consistent with treatment goals per observed recidivism outcomes reflecting reduction.

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Implications

The findings suggest policy, practice, and future research direction implications. Alcohol treatment strategies generally reflected evidence based practices design but services delivery varies considerably in terms of program fidelity. Evidence based practices common across the treatment program evaluated include: 1) utilization of assessment instrumentation to identify and link offender needs with appropriate treatment services, 2) sufficient treatment duration, 3) the development and execution of individualized treatment plans, 4) delivery of cognitive-behavioral intervention therapy, and 5) drug use monitoring. While the issue of voluntary treatment participation remains controversial, short-term treatment facility placement for the purpose of coercing exposure to programming followed by voluntary continuation proved effective in Montana and Ohio and may be a viable method for increasing participatory engagement and treatment cohort size. The study also noted barriers to effective treatment, including that treatment participants should be isolated from the general correctional population as mixing participants and non-participants undermines the treatment environment and limits impact as inmate ideation is redirected from recovery to security. Facilities mixing treatment and general population inmates due to inadequate space or too few eligible participants are poorly suited for therapeutic community-based modalities due to support limitations.

Political support and endorsement of alcohol treatment is variable and relevant to program viability. Justice systems realignment and reinvestment movements (such as increased community corrections rather than state management of lower level felony offenders in Ohio per House Bill 86) and a lack of coordinated planning across system components and functionaries suggest that some programs are at risk of underperformance as empty treatment beds reflect inefficiency and limited impact. Better and more synthesized referral processes are needed to replace present hybrid orientations comprised of legislative parameters, judicial discretion, and warden autonomy. Theoretically, the successful treatment of repeat alcohol offenders enhances public safety through reducing the degree of drunk driving in society and, in turn, system costs associated with arrests and incarcerations attributable to DWI convictions. Through rigorous programs, such as the Montana initiative, correctional policymakers can better realize offender rehabilitation and public safety while reducing prison populations. The study design featured

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offender follow-up for a period of one year so longer range outcomes regarding offender success are unknown and likely responsive to aftercare realities. Additional research on the longitudinal impact of correctional-based drug and alcohol treatment, particularly during the aftercare period, is recommended.

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EXECUTIVE SUMMARY

Alcohol abuse and drunk driving present specific challenges for the criminal justice system in terms of maintaining public safety, delivering rehabilitative services, and offender population management. While treatment for illicit drug abuse in correctional settings has been broadly implemented throughout the United States, alcohol-specific recovery programs are far less common. In-prison alcohol treatment for felony driving while intoxicated (DWI) and driving while under the influence (of alcohol) (DUI) offenders has been identified as a promising opportunity to rehabilitate serial inebriates through cognitive restructuring oriented toward behavioral change.

Given the scarcity of alcohol-specific treatment initiatives in correctional settings, it is not surprising that very few alcohol treatment programs delivered within the criminal justice system have been evaluated. Related, there is a need for empirical knowledge regarding: 1) which therapeutic and treatment practices are most strategic for disrupting the alcohol and crime nexus, 2) which programmatic elements most significantly influence the recovery process, and, most fundamentally, 3) whether prison-based alcohol treatment is effective. Toward addressing these knowledge gaps, this two year project executed process and outcome evaluations of three separate state-sponsored alcohol-specific treatment programs delivered in prisons located in Montana, Ohio, and Texas. Program design, quality of treatment delivery, and program effectiveness were thematic project goals steering evaluation activity.

Research Questions

The study examined three interrelated research questions regarding the evaluated programs:

1. Do the alcohol treatment programs adhere to evidence based practices that have documented success in addressing substance abuse?
2. Do the alcohol treatment programs deliver treatment in a manner consistent with program protocols thereby demonstrating program fidelity?
3. Are alcohol treatment program graduates more or less likely to re-offend compared to a comparison group of non-program participants?

Research Design and Protocols

A mixed-methods (qualitative and quantitative data collection and analysis) research design was executed to answer the focal concerns of evidenced-based program design, program

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fidelity, and recidivism reduction raised by the research questions. Qualitative research activity throughout the duration of the evaluation concentrated on assessing the degree of evidence based practice represented in the program designs and level of program fidelity (i.e., the extent to which treatment services were delivered relative to the original program design). On-site qualitative data collection entailed three site visits to the study treatment programs in Montana and Ohio (two site visits during the first year of the evaluation and a follow-up visit during the second year).

The research team reviewed both treatment modality materials describing program content and the services delivery plan to affirm evidence based practices inclusion in treatment strategies. In-depth interviews were conducted with facility administrators, correctional staff, and treatment professionals according to an interview guide to ensure systematic data collection across individual respondents and sites (Appendix B). Also, three series of focus group interviews were conducted at each site with a sample of treatment group participants according to a semi-structured questionnaire to ensure systematic data collection across respondents (see Appendix B). In-depth and focus group interviews enabled data collection informing level of program fidelity and identification of barriers to operational success. Second year follow-up visits enabled observation of the continuity and consistency of modality delivery (i.e., whether program adaptation has occurred) and determination of responsiveness to recommendations resulting from first year feedback.

In addition to continuation of site based process evaluation, second year activity centered on comparison group construction, official data collection, and data management in preparation for impact analysis specifying program outcome effectiveness (i.e., the degree to which intended program objectives were realized). A quasi-experimental design was utilized to determine program impact, consisting of comparison groups to maximize the likelihood that observed outcomes are attributable to treatment, criterion measures indicative of offender rehabilitation and public safety, and a follow-up period tracking offender success for a year post-release.

Research Settings & Sample

Treatment participants comprised of male state prisoners in separate programs, located in different regions of the country (Montana, Ohio, and Texas) and serving demographically distinct offender populations, comprised the samples for quantitative analysis. These programs

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all deliver cognitive change modalities reflective of common recovery strategies delivered in correctional contexts across the nation.

Montana: The Montana treatment initiative, the WATCh program, is located in Warm Springs, Montana and serves felony drunk driving offenders with a history of multiple DUI convictions. The program is a partnership between Community, Counseling, and Correctional Services, Inc. (CCCS) and the Montana Department of Corrections (MDOC) and is located on the campus of Montana State Hospital Warm Springs near Butte in the southwestern part of the state. The program has been in operation since 2002 and has the capacity to serve 106 individuals at a time. The program is six months (180 days) in duration and utilizes a cognitive-behavioral based modified therapeutic community. The Montana program is multifaceted and draws from a number of established treatment modalities and protocols supportive of its core curriculum modality, *Criminal Conduct and Substance Abuse Treatment: Strategies for Self-Improvement and Change*, for addressing chemical dependency and criminal conduct. The Montana Department of Corrections provided outcome data for analysis on 908 treated offenders, 760 of which completed WATCh treatment programming.

Ohio: The Ohio Department of Rehabilitation and Correction (ODRC) has operated a DUI/DWI program for nearly fifteen years through subcontract with a private company that was recently taken over by the state and relocated from northern Ohio to the Madison Correctional Institution near Columbus, Ohio in the Fall of 2009. The primary goal of the Ohio DUI program is to assist offenders in learning the skills necessary to live a sober, drug-free, and crime-free life. Programmatic objectives include behavioral change focused on the address of behavioral errors, the improvement of decision-making skills, and job force readiness. From the perspective of the ODRC, the DUI program, along with the other system operated treatment programs, are intended to increase public safety through the reduction of recidivism and to decrease the overall prison population in the State of Ohio.

The Ohio DUI program is a 90-day program that focuses primarily on alcohol and drug abuse treatment. The Madison Correctional Institution is a medium security facility near the state's capital, Columbus and also the primary facility for housing Ohio's convicted sex offenders. The program is designed to accommodate 24 offenders at one time, resulting in low client-to-counselor ratios (i.e., 12:1) with two full-time treatment staff assigned. ODRC designed the program to require a minimum of 32 hours of program activity each week

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comprised of 13.5 hours of substance abuse programming per week with an additional 19 hours devoted to other therapeutic activities. Enrollment in the Ohio DUI program was low, with only 45 of 151 eligible offenders admitted to treatment and another 1,137 offenders deemed ineligible by participation criteria or either judicial or warden discretion.

Texas: The In-Prison DWI Recovery Program is housed at the East Texas Treatment Facility in Henderson, TX in the northeast part of the state. The facility and treatment program is operated by the Management & Training Corporation (MTC), who contracted with the State of Texas to provide treatment services based on requirements passed in a recent legislative session. The program received its initial cohort of participants in March 2008. Program capacity is limited to 500 beds and assignment to the treatment program is based on several criteria created by the Texas Department of Criminal Justice (TDCJ). All potential treatment participants must have been convicted of multiple DWI related offenses (i.e., at least four felony DUIs) have no history of violent offenses or major disciplinary infractions, and have an expected parole hearing scheduled within six to nine months of transfer to the treatment facility.

Licensed counselors assess all inmates and develop individualized relapse treatment plans (ITP) specific to each individual's needs. Once processed, all residents are assigned to one of nine dormitories that house approximately fifty-six individuals. Treatment staff delivers the core treatment curriculum in four-hour blocks five days a week which consists of three components: 1) an hour per session is allocated to working on the DWI Flex Module, a cognitive-behavioral modification program comprised of six interrelated phases or "tracks" that can be completed within a six-month timeframe (one phase per month); 2) curriculum based on the Residential Drug Abuse Treatment (RDAT) provided to state and local correctional institutions by the Federal Bureau of Prisons that focuses on breaking down criminal thinking, building rational thought, improving relationships and interpersonal skills, and helping inmates develop a strategy to maintain recovery and a crime-free lifestyle. The final hour is centered on developing life skills within a group setting for use once released from the facility.

Data was provided by the Texas Department of Criminal Justice (TDCJ) on three different types of individuals for the evaluation period: 1) inmates meeting criteria for inclusion, but not selected for treatment based on TDCJ assessment; 2) participants that successfully completed the program; and 3) individuals who began, but did not complete treatment

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programming. The TDCJ originally provided information on 4,080 offenders across all three of these groups during the study period, of which 2,840 graduated from the treatment program.

Outcome Measures

Outcome data was provided by the Montana Department of Corrections, Ohio Department of Rehabilitation and Correction, and the Texas Department of Criminal Justice. The primary criterion measure indicative of program impact and effectiveness was recidivism. For the purposes of this study, recidivism was defined as a return to a DOC facility. From the perspectives of the states' departments of corrections, an offender has recidivated when he/she has returned to a correctional facility.

Findings

The mixed method evaluation data collection and analyses generated findings regarding evidence based practices, program fidelity, and program effectiveness.

Evidence Based Orientation: The intervention strategies and treatment modalities in Montana were found to be sound and reflect an evidence based practices orientated design. The Ohio program, while featuring evidence based treatment protocols in services delivery, is challenged by an ineffective referral process and questionable program placement. The Ohio program is grossly under-enrolled due to strict screening criteria, which precludes treatment for some offenders. In addition to ignoring the risk principle of treatment, additional potential participants are denied program admission through judicial and warden discretion. More troubling is the fact that the program, though described as a therapeutic community, houses its treatment participants with the general population of a medium security prison in violation of the principle of isolating treatment inmates from the general population to assure the integrity of the treatment climate.

Program Fidelity: In that lack of program fidelity raises concerns over the value of observed treatment findings through the blurring of program design and program operation effects, demonstration of operational intensity and program integrity are essential to outcome effectiveness determination. The Montana program was found to be near ideal as indicated by high scores from all research team members for all program fidelity indicators (adherence, exposure, quality of services delivery, participant engagement, and program differentiation). The WATCh program is true to its design, meeting or exceeding dosage and exposure expectations.

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The Ohio program, not surprisingly given the noted design flaws, was scored low on several program fidelity indicators across research team members. The low number of program participants ostensibly undermines a critical mass of fellow treatment participants to provide moral support and encouragement during the treatment experience. Though claimed to be, the logistical outlay of the program is far from an evidence-based therapeutic community approach and violates known best practices for treatment in correctional settings. Moreover, absolute and total failure of a halfway house receiving treatment participants during their transition back to the community undermines treatment program objectives. Rather than effecting a seamless continuum of treatment services begun in prison and intended for completion during the halfway house residency period, halfway house staff were found to deliver very little treatment and the minimal therapeutic activity that does occur has little connectivity to the program and its mission.

Recidivism Reduction: Statistical analysis and output specified the level of effectiveness of the treatment programs, both individually and collectively. Findings regarding the viability of delivering behavioral change oriented modalities and related best-practices implications for similar rehabilitative efforts in other correctional settings are generally positive for all of the study states. Observed findings from Ohio should be interpreted very cautiously given the very low sample size. The sample sizes for Montana and Texas are more robust and suggest that in-prison alcohol treatment can meaningfully impact future offender behavior consistent with treatment goals.

Summary

Based on study findings, several general lessons were learned that have policy, practice, and research direction implications. In addition to these potential replication observations, identified barriers to treatment delivery and impact are noted.

Lessons Learned and Implications

- The alcohol treatment initiatives studied adhered to evidence based practices design, but services delivery varied considerably in terms of program fidelity.
- Evidence based practices common across the treatment program evaluated include: 1) utilization of assessment instrumentation to identify and link offender needs with appropriate treatment services, 2) sufficient treatment duration, 3) the

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development and execution of individualized treatment plans, 4) delivery of cognitive-behavioral intervention therapy, and 5) drug use monitoring.

- While the issue of voluntary treatment participation remains controversial, short-term treatment facility placement for the purpose of coercing exposure to programming followed by voluntary continuation proved effective in Montana and Ohio and may be a viable method for increasing participatory engagement and treatment cohort size.

Barriers to Effective Treatment

- Treatment participants should be isolated from the general correctional population as mixing participants and non-participants undermines the treatment environment and limits impact as inmate ideation is redirected from recovery to security.
- Facilities mixing treatment and general population inmates due to inadequate space or too few eligible participants are poorly suited for therapeutic community-based modalities due to support limitations (e.g., the Ohio program). Programs should be housed in settings not hindered by these issues (e.g., the Montana program).
- Political support and endorsement of alcohol treatment is variable and relevant to program viability. National justice systems realignment movements (such as increased community corrections rather than state management of lower level felony offenders in Ohio per House Bill 86) and a lack of coordinated planning across system components and functionaries suggest that some programs are at risk of underperformance as empty treatment beds reflect inefficiency and limited impact. Better and more synthesized referral processes, for example, are needed to replace present hybrid orientations comprised of legislative parameters, judicial discretion, and warden autonomy.

Theoretically, the successful treatment of repeat alcohol offenders enhances public safety through reducing the degree of drunk driving in society and, in turn, system costs associated with arrests and incarcerations attributable to DWI convictions. Through rigorous programs, such as the Montana WATCh initiative, correctional policymakers can better realize offender rehabilitation and public safety while reducing prison populations. The study design featured

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offender follow-up for a period of one year so longer range outcomes regarding offender success are unknown and likely responsive to aftercare realities. Additional research on the longitudinal impact of correctional-based drug and alcohol treatment, particularly during the aftercare period, is recommended.

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CHAPTER I: INTRODUCTION

Compared to alcohol, illicit drug use and abuse generally has been considered a much larger social problem. While illicit substance abuse is certainly an ongoing problem, alcohol misuse and abuse is a far more pressing public health crisis within the United States that produces effects far more widespread and deleterious than all illicit substances combined. In 2007, the proportion of Americans classified as either alcohol abusers or alcohol dependent was 16.8% of adults ages 18-25 and 6.2% of adults aged 26 and older. In comparison, less than 8% in the 18-25 age cohort and only 1.7% in the 26 and older age group are considered to be illicit substance dependent (SAMHSA, 2008).

Alcohol abuse necessarily compels criminal justice system attention and involvement. Those in contact with the criminal justice system (i.e., arrestees, inmates, probationers, and parolees) are far more likely to suffer from addiction or other substance abuse disorders than the general population. One of the most salient findings in the extant drug-related crime literature is that most inmates are seriously involved with drugs and alcohol, many at the time of arrest. The U.S. Bureau of Justice Statistics (2008) reports that nearly 38% of all inmates held in local, state and federal facilities were drinking at the time of the offenses for which they were convicted. Alcohol-related arrests are more prevalent than those for either violent or property crime and represent nearly one-fifth of all crimes committed in the United States (FBI, 2009).

Alcohol-related fatalities also continue to present a public health crisis in the United States. Approximately one-third of all annual traffic deaths are alcohol-related, a number roughly equal to the total number of homicides in an average year, according to recent estimates (FBI, 2009). Overall, alcohol is believed to play a role in at least 100,000 deaths each year ranging from accidental falls to suicide and homicide (CDC, 2009). Arrests for "Driving While

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Intoxicated" (DWI) and "Driving Under the Influence" (DUI) neared 1.5 million in 2008 and the total costs associated with drinking and driving are estimated at a staggering $9 billion per year (FBI, 2009; Levitt & Porter, 2001).

Empirical evidence suggests that those convicted of drunk driving offenses, particularly those with more than one conviction, are not infrequent drinkers who simply “made a mistake”. Rather, research indicates that the vast majority of these individuals are suffering from serious alcohol problems that meet the diagnostic criteria for an alcohol use disorder, as specified by the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) (Stasiewicz, Nochakski, & Homish, 2007). These serial inebriates are, then, repeat offenders in desperate need of treatment in order to prevent post-release relapse and additional justice system involvement. The need for treatment in addition to punishment for DWI/DUI offenses is further buttressed by recent research which indicates that individuals with severe alcohol addiction are more likely to commit additional offenses regardless of the nature of sanctions experienced (Ahlin, Rauch, Howard, & Duncan, 2011; Yu, Evans, & Clark, 2006). In effect, alcohol addiction prevents individuals from making rational choices and thus increases offender likelihood of driving drunk, as well as other crimes resulting from poor decision-making.

Ostensibly, providing alcohol treatment in correctional settings prior to release is strategic. The delivery of treatment services in prisons offers certain advantages relative to outpatient and voluntary treatment, including: 1) certainty of program enrollment and participation by individuals who would not likely seek treatment on their own (i.e. coerced participation/guaranteed delivery of treatment) or fail to comply with compulsory conditions to be in treatment, 2) program modalities specific to residential settings as treatment options (i.e., the ability to deliver more intensive treatment), and 3) the parole process ensures participation in

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post-release aftercare services. The prison-based treatment of inmates that are likely recidivists thus seems a logical and efficient approach by which to impact both the general crime rate and the likelihood of future alcohol-related offenses. Consistent with the objectives of the reentry movement in American corrections, alcohol treatment serves the interrelated goals of rehabilitating offenders, increasing public safety, lowering recidivism rates, and thus prison populations.

Whereas residential substance abuse treatment for illicit drugs in correctional settings is now embedded throughout the United States prison systems at both the state and federal level as normative rehabilitative programming, alcohol-specific treatment is far less available in correctional contexts. In response to the social problem of alcohol, primarily due to driving while intoxicated offenses, various correctional systems have developed and implemented alcohol-specific treatment programs for chronic DWI/DUI offenders. Though in-prison alcohol-specific treatment is an emerging trend, few of these programs have been scientifically evaluated. In turn, the empirical knowledge base on residential alcohol treatment delivered in correctional settings is very limited.

The balance of this report is comprised of: 1) a review of the extant scientific literature on alcohol treatment in the criminal justice system, 2) a mixed-methods research design executed to evaluate the design, operation, and impact of prison-based alcohol treatment programs in three states, 3) qualitative and quantitative findings for each assessed program, and 4) consideration of the implications of the study's findings for correctional practice, criminal justice policy, and future related research. Before examining the central study concerns of theoretically based and empirically supported best practices utilization, the congruence between the stated goals, objectives, and delivery plan of the treatment in each program and actual degree in delivery, and

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the extent of effectiveness, the following section provides a brief overview of the alcohol and crime relationship, leading programmatic orientations for alcohol treatment, and evidence based practices in addiction treatment.

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CHAPTER II: LITERATURE REVIEW

This chapter provides a background on alcohol abuse in the United States and the response of the criminal justice system, with a specific focus on the nature and availability of alcohol-specific treatment within the context of corrections. While alcohol-specific treatment is a rarity in institutional corrections, there is a robust literature base related to alcohol rehabilitation, generally, and substance abuse treatment in correctional settings, specifically. The first section of this chapter offers an overview of alcohol use and abuse in the United States, including data related to the number of DUI offenses annually. The second section of this chapter details the alcohol-crime nexus and the criminal justice system's response to substance abusing offenders. The third section of the chapter examines the extant literature on alcohol treatment modalities, with a focus on the approaches utilized by the programs that were evaluated for this project. The fourth and final section of this chapter addresses evidence-based practices in substance abuse treatment, generally, and for alcoholism, specifically.

Alcohol Use and Abuse in the United States

The effects of alcohol use constitute a pervasive and pronounced national societal problem for the United States. From 2000 to 2006, over six million clients received drug and alcohol treatment in the U.S. (BJS, 2007). In 2006 alone, over 90,000 of these drug and alcohol dependent clients were under 18 years of age and already seeking treatment in residential facilities. National Highway Traffic Safety Administration (NHTSA) data from 2010 revealed approximately 33,000 fatalities in motor vehicle crashes with alcohol playing a role in more than one-third of all fatalities (NHTSA, 2012).

Each year, millions of Americans operate a motor vehicle while under the influence of alcohol or other drugs (Shults, Beck, Dellinger, 2010). While there are 147 million self-reported

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episodes of alcohol-impaired driving among U.S. adults annually, only 1.4 million arrests are actually made for driving under the influence (FBI, 2009, 2010). This number represents but a fraction (approximately 1%) of the total number of instances of DUI in a given year. Overall, driving under the influence is a common, though under-detected, domestic threat to public safety across the nation.

Criminal Justice and the Alcohol-Crime Nexus

The use and abuse of both licit and illicit substances has long been a focus of research across a diverse range of disciplines (e.g., medicine, public health, psychology, criminology, social work, sociology). The criminogenic effect of drugs and alcohol has been a dominant research theme in criminal justice and criminology for over three decades (Inciardi, 1981; MacKenzie & Uchida, 1994; Menard, Mihalic, & Huizinga, 2001; Tonry & Wilson, 1990; Walters, 1994). While offender substance abuse varies across studies, findings consistently reveal a staggering and embedded problem. In fact, most inmates are seriously involved with drugs and alcohol, many at the time of their arrest (BJA, 2008). In response, correctional systems throughout much of the United States have made treatment for substance abuse commonplace.

Most of the available resources for rehabilitation within the criminal justice system, however, have been directed toward illicit drug use and abuse. This is problematic, though, as alcohol misuse and abuse presents a more significant problem within the United States and particularly among the incarcerated. Recent estimates suggest that alcohol dependence is, by far, the most common substance abuse problem among imprisoned populations (Hoffman, 2002; Jones & Hoffmann, 2006). Unfortunately, only recently have criminologists begun to call attention to alcohol-related policy (see, for example, Frattaroli, 2010; Hadfield & Measham,

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2010; Humphreys & Eisner, 2010; Treno, 2010). Though the need for alcohol-specific treatment is demonstrable, the knowledge base lags behind that of the illicit drug treatment literature.

Problems with alcohol use are prevalent within criminal justice contexts both as a driving and collateral factor. Those in contact with the criminal justice system (i.e., arrestees, inmates, probationers, and parolees) are far more likely to suffer from addiction or other substance abuse disorders than the general population. Epidemiological studies have indicated that alcohol is the most prevalent substance abused by this group (Hoffman, 2002; Jones & Hoffmann, 2006). BJS (2008) reports that nearly 38% of all inmates held in local, state and federal facilities were drinking at the time of the offense(s) for which they were convicted.

In terms of DWI offenders, previous research has indicated that convicted impaired drivers represent the largest category of probationers in most jurisdictions and that approximately two-thirds have already participated in alcohol treatment programs (BJS, 1998). According to the Bureau of Justice Statistics (2007), more than 500,000 of the United States corrections residential population are serving sentences for alcohol-related offenses under the jurisdiction of state and federal correctional authorities. Annually, there are approximately 2,500,000 arrests for alcohol-related offenses (BJS, 2007) and 1,400,000 arrests for driving under the influence (FBI, 2010) which together represents nearly a quarter (23.5%) of all arrests and very much accentuates the scope and general import of alcohol related crime.

In particular, driving under the influence presents significant public health and safety issues for the nation. Each year, adults in the U.S. drive under the influence of alcohol more than 100 million times resulting in more than 10,000 deaths annually (CDC, 2012; NHTSA, 2012). These deaths are concentrated mainly among young people with about one out of every three drivers (34%) involved in fatal crashes being between the ages of 21 and 24 (NHTSA, 2012).

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Data indicate that legally impaired drivers involved in fatal crashes are eight times more likely to have a prior DWI conviction than drivers who had not been drinking. More than 10,000 people were killed in 2010 in alcohol-impaired motor vehicle crashes, accounting for nearly one-third of all traffic-related deaths throughout the nation. On average, an alcohol-impaired driving fatality occurs once every 51 minutes in the U.S. (NHTSA, 2012).

Approaches to Alcohol Treatment

Numerous treatment modalities are employed to address the problem of alcoholism. We limit our discussion to those modalities identified in the extant literature as holding the most promise and utilized by programs evaluated in the current. Though a number of treatment options are available for alcohol-involved offenders, ranging from alcohol education (Fors & Rojek, 1997; Foon, 1988) to legal intervention (e.g., license suspension) (BJS, 1998; Chaloupka et al., 1993; Legge & Park, 1994; Ruhm, 1996; Sloan & Reilly, 1994; Villaveces et al., 2003; Wagenaar et al., 2007; Whetten-Goldstein et al., 2000), few have demonstrated effectiveness from an evidence-based perspective (SAMHSA, 2010). The following section focuses on three distinct modalities, each employed to varying degrees by the three programs under study: cognitive-behavioral therapy (CBT), therapeutic community (TC), and the Twelve Step Fellowship program.

Cognitive-Behavioral Therapy (CBT)

Approximately one-third of all alcohol intervention designs are based on the concept of cognitive reconstructing or cognitive-behavioral modification (Wells-Parker, Bangert-Drowns, McMillen, & Williams, 1995). This approach has been developed into various cognitive-behavioral therapy programs across the U.S., both as a primary and supplemental modality for alcohol and illicit substance abuse (Moore, Harrison, Young, & Ochshorn, 2008). Cognitive-

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behavioral treatment (CBT) is fairly common within prison-based substance abuse treatment programs as a primary or secondary program component (Pearson & Lipton, 1999).

CBT for substance abuse was first developed as a method to prevent relapse when treating problem drinking and later was adapted for individuals addicted to illicit substances such as cocaine (NIDA, 2006, 2007, 2009a, 2009b, 2012a, 2012b). Cognitive-behavioral strategies are largely based on theories of learning and reinforcement and are rooted in the idea that learning processes play a critical role in the development of maladaptive behavioral patterns like substance abuse. Individuals receiving CBT learn to identify and correct problematic behaviors by applying a range of different skills that can be used not only to stop drug abuse, but also to address a range of other problems that often co-occur with it (e.g., mood and anxiety disorders, anger management).

A central element of CBT is anticipating potential problems and enhancing clients' self-control through the development of effective coping strategies (NIDA, 2012a, 2012b). Specific techniques include exploring the positive and negative consequences of continued drug use, self-monitoring to recognize cravings early, identifying situations that might put one at risk for use (i.e., "triggering mechanisms" or "triggers'), developing strategies for coping with cravings, and avoiding those high-risk situations or individuals. CBT aims to reduce DWI recidivism by identifying and modifying the cognitive distortions possessed by repeat drinking and driving offenders. This modality is designed to help patients recognize, avoid, and cope with the situations in which they are most likely to abuse drugs. Considered highly compatible with a variety of other treatments, this approach is often used in conjunction with two or more modalities (NIDA, 2009). CBT has been shown effective for a number of populations, including

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alcohol and drug-involved offenders (NIDA, 2006; Pearson & Lipton, 1999) and often serves as the core of many criminal justice treatment programs.

Therapeutic Communities

Therapeutic communities (TCs) are group-based treatment approaches often employed by correctional programs for the long-term residential treatment of chemical dependency. TCs differ from other methods of drug treatment in that the primary therapist and teacher is the community itself. The TC approach views drug abuse as a disorder of the whole person and thus focus is less on drug-use patterns, specifically, and more on psychological dysfunction and social deficits, generally. TCs emphasize a view of "right living" and often require adherence to the precepts and values of Twelve Steps programs. Much like cognitive-behavioral therapies, the primary psychological goal of treatment is to alter problematic patterns of thinking, feeling, and behaving; in other words, to address criminal thinking errors. TCs employ a holistic approach to substance abuse where addiction is viewed as an illness of the mind, body, and spirit. The primary social goal of the TC is to develop a responsible drug-free lifestyle with a specific focus on the impact of the addict's behavior on self, family, friends, and colleagues (DeLeon, 1994).

Early examinations of therapeutic communities largely showed the modality to effect positive change among members. During the 1980s and 1990s, several large scale evaluations of prison-based TCs linked these programs to lower rates of recidivism (Field, 1985, 1992; Wexler, Falkin, & Lipton, 1990; Wexler, Falkin, Lipton, & Rosenblum, 1992; Wexler & Williams, 1986) and a number of more recent longitudinal outcome studies also support the TC model for drug abuse treatment in correctional settings (Butzin, Martin, & Inciardi, 2002; Inciardi et al., 2004; Predergast et al., 2004; Wexler, Melnick, Lowe, & Peters, 1999). Pearson and Lipton (1999) conducted a meta-analysis of published and unpublished evaluation research occurring between

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1968 and 1996 and found support for the TC model relative to other approaches such as boot camps and drug-focused group counseling. The TC approach is also considered advantageous because it provides a context in which other program components can be delivered (e.g., CBT, Twelve Step).

Twelve Step Fellowship

One of the most common treatments for alcoholism is the Alcoholics Anonymous program, which is based upon the idea of total sobriety. This approach utilizes the well-known Twelve Step Program and numerous studies have offered positive feedback on the treatment's attendance and abstinence rates (Miller & Hester, 1980, 1986). Some have criticized this program, however, for lack of experimental support (Bebbington, 1976). While anecdotal information regarding the program has been positive for decades, recent empirical examinations also appear to lend credibility to this approach (Glasner-Edwards, Tate, McQuaid, Cummins, Granholm, & Brown, 2007; Tonigan, 2001). Much like the modalities discussed above, the Twelve Step Fellowship is often utilized in conjunction with other treatment approaches.

Twelve Step programs are ubiquitous in corrections-based addiction treatment and many programs include this element as either a mandatory or supplementary component. These "Anonymous" programs are advantageous in many respects for correctional-based treatment, including the ease with which they can be implemented as a supplement to existing programming. Furthermore, from a resource standpoint, AA is a relatively inexpensive program component which does not require any staff training or special qualifications. Finally, because of the mere prevalence of the Anonymous groups in most areas of the U.S., participation in these programs can be utilized as a component of aftercare services. Past research indicates that treatment outcomes, including criminal justice outcomes, are most favorable when a seamless

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continuum of care is in place linking program activity while incarcerated to recovery following release (Miller & Miller, 2010; NIDA, 2012a, 2012b; Springer, McNeece, & Arnold, 2003). Twelve Step programs are often included as a cost-effective aftercare service and are sometimes a condition of release on probation or parole (Miller & Miller, 2010).

Best Practices in Addiction Treatment

Identifying best practices in substance abuse treatment requires reliance on evidence-based programming (NIDA, 2012a, 2012b; SAMHSA, 2003, 2007, 2008, 2010). Effective treatment begins with appropriate assessment and classification and is tailored, to a certain degree, according to the individual's needs. Treatment must also be flexible and capable of continual assessment and modification per client needs. Duration of program enrollment is also critical to successful treatment; typically, treatment lengths less than 90 days are considered insufficient. The monitoring of drug use during treatment is also essential from a best-practices standpoint. Individuals recovering from drug addiction may experience relapse during or after the treatment period and monitoring helps to identify relapse episodes.

When treating addiction in criminal justice populations, the targeting of criminal thinking errors is also considered essential for successful treatment. Criminal thinking consists of attitudes and beliefs which contribute to offending behavior, such as feelings of entitlement, use of neutralizations, externalizing behavior, and short-sightedness. Additionally, successful treatment approaches include a continuity of care for the addict following program participation. Within the criminal justice system, offenders who complete prison-based treatment are more successful when they receive aftercare services in the community following release.

In reality, many alcohol treatment programs, like those designed for illicit drug abuse, attempt to address addiction holistically by employing two or more modalities in concert. These

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treatments address the plurality of interrelated problems in an individual's life rather than focusing on the alcohol problem exclusively. These programs typically incorporate several components, each designed to address a particular aspect of the illness and its consequences (NIDA, 2009). In general, drug treatment should address a wide range of issues, including motivation, problem-solving, identification of criminal thinking errors, substance use triggers, and interpersonal relationships (NIDA, 2012a, 2012b).

Overall, evaluations conducted on alcohol treatment programs have produced inconsistent results that prevent proclamation of one specific modality as the optimal alcohol intervention and recovery strategy. Rather, there are a number of strategies for treating addiction that have been shown effective (NIDA, 2012a, 2012b). Several modalities are considered particularly conducive to effective treatment including cognitive-behavioral therapy and therapeutic communities, both of which have been established through empirical research as capable of producing demonstrable improvement among participants (NIDA, 2006, 2007, 2012a, 2012b). Cognitive-behavioral therapy is widely considered to be a necessary element of any successful treatment program (Moore et al., 2008) and, in meta-analyses, therapeutic communities are shown to be most effective relative to other modalities (Pearson & Lipton, 1999). Twelve Step programs are also commonly utilized in conjunction with CBT or TCs and provide offenders with an opportunity to continue treatment following release through community-based AA or NA meetings.

The three programs evaluated by the current project feature design components drawn draw from the modalities discussed above. All three programs, to varying degrees, utilize behavioral modification approaches augmented with more general life-skills training to assist in offender transition back into the community. Two of the programs, Ohio and Montana, operate

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as modified therapeutic communities while the Texas program is oriented toward group-based counseling rooted in a cognitive-behavioral framework. All three programs utilize the Twelve Step Fellowship program as well as cognitive-behavioral modification curricula. Although the need for alcohol treatment in correctional settings is demonstrable, few programs explicitly targeting alcohol offenders exist and even fewer empirical examinations have been conducted. The current study was designed to fill this gap and augment the extant literature regarding in-prison alcohol treatment.

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CHAPTER III: METHODOLOGY

Determining the effectiveness of rehabilitation in correctional settings is one of the most challenging tasks in evaluation research (Cullen & Gendreau, 1989). The process entails not only determining if the treatment "works" in terms of reducing recidivism and relapse, but also identifying the specific element(s) of the approach responsible for observed outcomes. Considering the possible barriers that an exclusively quantitative approach may present for ascertaining a program's efficacy, a mixed-methodological approach enables affirmation of program fidelity and the ability to contextualize quantitative findings through stakeholder input, direct observation of programmatic activities, and participant interviewing. Interviewing inmates within an evaluation context enables consideration of their everyday world in treatment, environmental features perceived as barriers to recovery, and whether the program is living up to stakeholders' expectations (Miller, Tillyer, & Miller, 2012).

The research plan below describes an evaluation of the quality of DUI/DWI treatment delivery and program effectiveness in reducing recidivism in Montana, Ohio, and Texas. A mixed-methodological research design was employed to assess the operation, delivery, and utility of these programs. The overall aim of the project was to generate findings that provide needed evidence-based knowledge on in-prison DUI/DWI program implementation and effectiveness toward the specification of best practices elements generalizable for future alcohol recovery program development.

Research Questions

The research design consisted of qualitative data collection and analysis and a quasi-experimental quantitative design to answer three key research questions:

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1. Do the alcohol treatment programs adhere to evidence based practices that have documented success in addressing substance abuse?
2. Do the alcohol treatment programs deliver treatment in a manner consistent with program protocols thereby demonstrating program fidelity?
3. Are alcohol treatment program graduates more or less likely to re-offend compared to a comparison group of non-program participants?

The qualitative data collection component of the study focused on program content and its delivery to identify possible problems, barriers, or other issues relevant to program operation and success. Qualitative research techniques were utilized to address the first two research questions. This qualitative phase consisted of on-site in-depth interviews with facility administration and program staff, focus group interviews with a sample of treatment group participants, and observation of treatment services at the sites. Collection and analysis of germane program documents were also conducted toward the goal of informing understanding of operations and practices. The resulting qualitative data provided the foundation for drawing conclusions regarding fidelity, barriers to program quality, and the development of policy recommendations regarding evidence-based practices.

The quantitative data collection component addressed outcome performance based on comparing the recidivism rates of treated offenders to those of a non-treated comparison group (Berk & Rossi, 1990). Data on recidivism and individual level characteristics were provided by each state's correctional agency. Analyses of recidivism outcomes addressed the study's third research question (i.e., treatment effectiveness).

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Research Sites

Montana, Ohio, and Texas were selected for inclusion in this study for several reasons. First, each of these states is currently operating a DUI/DWI program targeted directly at drinking and driving violations within at least one of their correctional institutions. Second, each of these states delivers alcohol recovery services vested in the efficacy of cognitive-behavioral change – identified in the correctional literature as the primary substance abuse treatment modality utilized across the nation. In that the generalizability of findings is an important consideration, states delivering normative and representative programming were considered preferable study sites. Last, these states agreed to participate in this research thereby: 1) ensuring inmates, staff, and administrator availability for recorded interviews, 2) admittance to the treatment environment for observation of the program, and 3) full and complete access to electronic data records allowing outcome analysis.

Montana

The Warm Springs Addictions Treatment & Change (WATCh) Program serves felony drunk driving offenders with a history of multiple DUI convictions. The program, a partnership between Community, Counseling, and Correctional Services, Inc. (CCCS) and the Montana Department of Corrections (MDOC), is located on the campus of Montana State Hospital in the southwestern part of the state. In operation since 2002, the WATCh program has the capacity to serve 106 individuals at a time. The program is a six-month, intensive, cognitive-behavioral based Modified Therapeutic Community designed to assist members (offenders) in developing the skills necessary for engaging pro-social change and reducing antisocial thinking and criminal behavior. Program components include cognitive-behavioral therapy via individual and group counseling, use of the *Criminal Conduct and Substance Abuse Treatment* curriculum, and

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participation in a variety of group-based activities such as AA, anger management, and life skills development.

Ohio

The Ohio Department of Rehabilitation and Correction (ODRC) has operated a DUI/DWI program for nearly fifteen years through subcontract with a private company, but recently this program was relocated and taken over by the state. In the past, the program operated at a site in northern Ohio, but in the Fall of 2009, the program was moved to Madison Correctional Center near Columbus, Ohio. Preliminary conversations with the Chief of Recovery for ODRC revealed that the curriculum had been modified slightly since the relocation and that they were anxious for an independent assessment of its implementation and effectiveness. This program is also cognitive change based and is delivered on targeted six-month cycles.

Texas

In Texas, the DUI/DWI program is housed at the East Texas Treatment Facility in Henderson, Texas and operates under the supervision of the Texas Department of Criminal Justice (TDCJ). It is a privately-run facility owned and operated by the Management & Training Company (MTC) and the State of Texas contracts with MTC to house offenders and conduct the In-Prison DWI Recovery Program. The program has been in operation since 2008, has bed space for roughly five hundred inmates, and program admission is determined by several criteria including, but not limited to: multiple DWI related offenses, no history of violent offenses or major disciplinary infractions, and an expected parole hearing within six to nine months of transfer to the treatment facility. This group program operates on a six-month cycle and involves a cognitive-behavioral approach to rehabilitation consisting of six interrelated phases and the Residential Drug Abuse Treatment (RDAT) curriculum. Soon after the project was initiated, the

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research team contacted TDCJ to gain access to the treatment program as per the agreement reached prior to submission of the research proposal (see the research team's response to the NIJ RFP for the letter of support from TDCJ). After a lengthy review process, access to the treatment program was denied by TDCJ. No definitive reason was provided to the research team for the denial of access. The research team was provided with quantitative data on all program participants and other TDCJ inmates who matched the criteria for selection but were not treatment participants. Thus, no qualitative information was gathered from the Texas treatment program and all subsequent discussion of qualitative work refers exclusively to the Montana and Ohio sites.

Qualitative Methods

The qualitative phase of the project was designed to address the first two research questions. In-depth and focus group interviews, direct observation, and document analysis were utilized to assess each program's adherence to evidence based practices (RQ #1) and to examine the extent to which these sites demonstrate programmatic fidelity (RQ #2). The qualitative phase of the project was executed through three multi-day site visits conducted over the course of the project. More specifically, two site visits were made during the first year of the project while the third occurred during the first half of the second year. Prior to describing the qualitative data collection and analysis process in detail, we first provide an overview of the substantive meanings of evidence-based compliance and program fidelity as they relate to the current project.

Evidence-Based Compliance

Document analysis of official program materials was conducted to determine the degree to which evidence-based practices were incorporated into treatment program design and

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implementation. Document analysis is a systematic procedure for reviewing or evaluating documents toward the goal of data triangulation (Yin, 1994). Document analysis is a useful method, which can provide researchers with background and context, identify additional areas of inquiry, offer supplementary data, and enable the verification of findings (Bowen, 2009). Specifically, referral and admissions forms, in-take assessments, treatment modality plans, program curricula, and instructional materials were assessed relative to evidence-based treatment strategies. This component of the research design assisted in answering the question of whether the programs were designed to effectively address their intended target populations and supplement interview data (i.e., whether the treatment plan reflects best-practices and a research-based design). Adherence to evidence-based principles was also assessed through direct observations of program sessions and activities which included a half day to full day of observation per site visit.

Each program's compliance with evidence-based treatment practices is gauged primarily by its consistency with guidelines set forth by the National Institute on Drug Abuse (NIDA) in *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide* (Revised Ed.) (2012a) and *Principles of Drug Addiction Treatment: A Research-Based Guide* (3rd Ed.) (2012b). More specifically, each program was assessed on the following areas:

1) Assessment: A comprehensive assessment to determine the nature and extent of an individual's drug problems and establish how these issues relate to other life spheres is requisite for successful treatment.
2) Treatment length: According NIDA, treatment should be a minimum of three months for criminal justice-involved populations.

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3) Individualized treatment: Treatment services should be tailored to fit the needs of the individual. Individualized treatment is possible only after proper assessment.
4) Drug use monitoring: Individuals recovering from drug addiction may experience relapse during or after the treatment period. Drug use monitoring is necessary to identify relapse episodes.
5) Target "criminal thinking": Criminal thinking consists of attitudes and beliefs which contribute to offending behavior. These attitudes and beliefs include feelings of entitlement, use of neutralizations, externalizing behavior, and short-sightedness. In order to alter criminal thinking errors, a cognitive-behavioral change therapy is required.
6) Continuity of care: Offenders who complete prison-based treatment are more successful when they receive aftercare services in the community following release.

Program Fidelity

Fidelity is the extent to which delivery of an intervention adheres to the selected program model or protocol. As programs are implemented and delivered in real-world settings, practical matters, political pressures, and unanticipated problems (e.g., shortage of credentialed counselors at rural facilities) can prompt program innovation and adaptation (Rohrbach, Gunning, & Sussman, 2010; Carroll, Patterson, Wood, Both, & Balain, 2007). It is vital to consider if changes occurred and, if so, to what extent so that outcome results can be attributed to treatment as defined, not some adapted version of the modality. In short, it is not possible to test the effectiveness of an intervention if the intervention failed to be implemented properly (Scott & Sechrest, 1989). Establishing program fidelity serves multiple functions, including more accurately attributing outcomes to treatment, increasing the generalizability of program findings

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through model validation, feedback for program improvement, and accountability in terms of documenting whether service providing grantees are doing what they were funded to do.

Fidelity determination has become increasingly significant in evaluation research, particularly assessments of drug prevention and treatment programs (Stead, Stradling, Macneil, Macintosh & Minty, 2007). While researchers have used measurement instruments to assign fidelity scores (Mowbray, Holter, Teague & Bybee, 2003), qualitative approaches (Melde, Esbensen & Tusinski, 2010) have specified the following primary elements comprising fidelity in criminal justice and treatment contexts:

1. *Adherence* (whether the program is delivered as designed)

    Are all core components being delivered to the appropriate population?

    Are staff adequately credentialed and trained?

    Are protocols delivered consistently?

    What is the delivery context?

2. *Exposure* (time-based realities)

    Number of sessions implemented?

    Length of each session?

    Frequency of sessions?

3. *Delivery Quality* (the manner in which treatment is delivered by program staff)

    Skill in using techniques or methods?

    Enthusiasm?

    Preparedness?

    Attitude?

4. *Participant Responsiveness*

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Engagement?

Involvement in treatment components/content?

Program fidelity was assessed according to this conceptual framework based on data derived from interviews, observations, and document analysis. A fidelity instrument (Appendix A) was used to document and compare observations that, in conjunction with field notes, enable objective and systematic consideration of fidelity level across programs. Each component of fidelity were evaluated independently by the research team members (N=3) using the fidelity scale; following this initial round of scores, the research team met to compare ratings and achieve inter-coder consensus. Programs were then given a final score which reflected the assessment of all three researchers.

The fidelity instrument was developed by the research team prior to the start of the current project and was based on the extant program evaluation literature (Stead et al., 2007; Melde et al., 2010) and the research team's prior experiences with addiction treatment program evaluation (Miller, Koons-Witt, & Ventura, 2004; Miller & Miller, 2010; Miller & Miller, 2011; Miller et al., 2012; Miller, Miller, Tillyer, & Lopez, 2010). As noted above, the instrument was developed in accordance with the primary elements comprising fidelity in criminal justice and treatment contexts: adherence, exposure, delivery quality, and participant engagement. Prior to the start of the project, the research team added one additional category by which to assess program fidelity, termed "program differentiation".

Adherence refers to whether the program service or intervention is delivered as it was designed (Dane & Schneider, 1998) and was operationalized by assessing each program's formal staff qualifications, treatment components, prescribed caseload, intake timeliness, individualized treatment plans, and prescribed dosage compliance. *Exposure* refers to the amount of time and

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in what combination treatment content is delivered and was measured through contact frequency hours (per day) and program duration (i.e., length of time). *Delivery quality* refers to the manner in which staff delivered the program and was measured by treatment plan compliance as well as counselor/staff qualifications, attitude, and continued training/education. *Participant responsiveness* refers to the extent to which clients are engaged by and involved in the activities and content of the program and was measured by participants' attitude and involvement in the treatment activities as well as identified barriers to participation. Finally, *program differentiation* refers to the unique features of different components that are reliably differentiated from one another. This final area was measured by program size fluctuation, budget fluctuation, caseload fluctuation, and the continuity of staffing.

Qualitative Data Collection

Qualitative data collection included a series of individual in-depth interviews with facility administrators and program staff, focus groups with a random sample of program participants, on-site observation of treatment activities, and document analysis of all program curricula, treatment plans, and other germane materials. The research team conducted two rounds of site visits during the first year (1st and 3rd quarters) and a third follow-up site visit in the second year (6th quarter). During these visits, interviews, focus groups, direct observation, and collection of program materials took place toward the goal of informing the first two research questions (evidence-based program design and program fidelity).

Interviews and direct observation are well-documented strategic research methods to collect in-depth information and enrich knowledge regarding program performance, problems, and improvement opportunities (Krueger, 1988; Maxfield & Babbie, 2008; Morgan, 1988, 1996; Shover, 1979). Specifically, in-depth interviews offered the ability to gauge the level of

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administration and staff endorsement of the program and identification of institutional and infrastructure barriers (Miller et al., 2004). Drawing data from multiple stakeholders (program staff, participants, and administrators) allows for the triangulation of information on program design, content, and operation as well as client responses to treatment.

In-depth interviews followed a semi-structured format (see Appendix B for participants, administration, and staff interview schedules) in which facilitators introduced topics by asking pre-determined questions to ensure systematic data collection across individual respondents and sites. Open-ended follow-up questions were raised when appropriate to ensure all necessary areas of importance were addressed. Thus, the research design intentionally invited respondent input to enable the collection of richer, more detailed information. These interviews were conducted with program administrators (facility treatment programming managers, DWI-program managers, Head licensed counselors), including the wardens and assistant wardens of the facilities. All responses were kept confidential and no individual-level identifiers are reported in the deliverables or any other material produced from this research.

The interview schedule utilized in the administration and staff interviews included a wide range of topics, including their endorsement of the program and its intended objectives, logistical implementation of the program, and recommendations for change in content or operation. Administrators were queried as to their ideological agreement with the program and its objectives, the commitment of the agency to achieve these goals, and the prioritization of the program within the facility. Facility administrators were also interviewed about staff training and credentials as well as any institutional or agency barriers that disrupted the delivery of services.

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Staff interviews also included a broad range of somewhat variant topics from the administrator interviews. Members of the treatment staff were interviewed as to their training and credentials, including educational attainment, previous experiences with treatment delivery, and substance-abuse specific credentialing. The interviews also focused on issues related to best practices utilization and program fidelity, including intake and assessment of inmates, program content and operation, weekly treatment dosage, and curriculum utility. Staff were also asked to identify any barriers to effective implementation of the program and provide recommendations for program improvement.

Focus group interviews also followed a semi-structured format and were posed to randomly selected program participants. Participants were selected randomly to ensure that no bias existed in terms of interviewee selection (e.g., attempts at "cherry-picking" by the staff). At the Montana site, six one hour focus group interviews (two focus groups per each researcher) were conducted with five participants per session totaling 30 interviewees per visit (60 per site during year one and 30 during year two). As a result, a total of 90 inmates were interviewed at the Montana site over the course of the project.

Due to low enrollment numbers and state-level legislative action in Ohio (discussed further in the final chapter of the report), fewer offenders were interviewed at the Ohio site. Two visits were made to the Madison Correctional Center and the entire population of program participants was interviewed each time (N=7 and N=5). Another 10 participants were interviewed following release to a halfway house in Cincinnati. On two separate occasions, members of the research team traveled to the Talbert House (i.e., the halfway house) to conduct interviews with a sample of offenders who had been recently released from the Madison Correctional Center. By interviewing offenders post-treatment, a longitudinal, qualitative

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element to the research design was realized, enabling us to explore both treatment delivery and the context of aftercare services and recovery following release from custody. These additional in-depth interviews presented an unanticipated opportunity for a more holistic assessment of mid- to long-term treatment effects following program participation across the sites. Furthermore, these interviews allowed the research team to assess retrospective evaluations of the program by participants following release. Similarly, these interviews shed light on the fidelity of aftercare services and allowed for the collection of data from the offenders' perspectives regarding their experiences following release.

Topics and questions were presented to the participants and all responses digitally-recorded for accuracy and transcription for qualitative analysis. Interview questions were systematic across focus groups to ensure similar topic coverage and data availability. These interviews were conducted without the presence of administrators or staff to ensure that the residents were able to provide unencumbered opinions regarding the program. All participants were informed that their participation was voluntary and would not affect their parole or position in the program in any way, and that all information offered would be kept confidential. The research team was not made aware, nor did we solicit the names or other personal identifiers of respondents selected by program administration. Care was taken during this process to avoid the influence of groupthink, external validity, participant subjectivity, and coder subjectivity (Babbie, 2004; Maxfield & Babbie, 2008; Shadish, Cook & Campbell, 2002).

The program participant interview schedule was oriented around six central areas of interest: 1) transfer/placement, 2) needs assessment, 3) program components, 4) counselors, 5) environment, and 6) overall assessment. Topics related to the participants' transfer and placement included facility and program orientation, the process for selection into the program,

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and the appropriateness of placement in the program in terms of themselves and others. Participants were also queried about the needs assessment that did (or did not) occur early in program enrollment. More specifically, questions were posed to the participants regarding the development of individualized treatment plans (ITPs) and the priority that staff afforded this element of the treatment.

After discussion of their transfer, placement, and initial assessment, focus group interviews turned to program components, including counseling, curriculum, and treatment delivery logistics. Subjects were asked to report their daily schedule, including all phases of the treatment program (i.e., individual versus group counseling, TC-related activities, etc.). Respondents were also asked to comment on specific topics and skills introduced through the program's curriculum, which included the consequences of drinking, identification and elimination of triggering mechanisms, exploration of feelings and emotions, and identification of thinking errors. Finally, participants were asked to offer their opinion on the duration of the program's (i.e., program length of time).

Focus group interviews also examined the participants' opinions regarding the efficacy of the counselors who staffed the program. In particular, questions were posed to subjects related to the counselors' effectiveness, knowledge, and attitude. Respondents were asked to offer their opinions as to how effective staff were at engaging program participants and developing rapport with them throughout the course of treatment. Participants were queried as to how knowledgeable staff were, both in terms of their understanding and delivery of program curriculum and their understanding of addiction and recovery. Finally, the research team inquired as to the attitude and demeanor exhibited by the program staff in order to gauge its impact of treatment delivery and participant engagement.

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The environment of the programs contrasted between a large, medium-security level correctional institution in Ohio to a minimum-security treatment facility operated by a private company in Montana. As such, the environment represents an important variable in understanding participants' experiences in the program, their attitude and receptivity toward treatment, and, ultimately, their success or failure after release. Given the importance environment may have in affecting experiences both during and after program participation, focus group interviews also covered topics related to the facility (i.e., treatment environment) where the program is delivered. More specifically, respondents were queried regarding facility safety and services, including medical services and the availability of food and supplies. Additionally, subjects reported on security measures at the facility, especially their relationship and interaction with the guards (as opposed to treatment staff). The research team also posed questions related to the privileges afforded participants, including access to books, television, and educational materials, recreation time, commissary visits and supplies, and phone access and visitation with family members.

The focus group interviews concluded with the research team offering the subjects a final opportunity to provide information not covered by the previous topics. During this last part of the interviews, subjects were also asked about their attitude toward rehabilitation and their level of confidence in their ability to avoid relapse. Finally, the subjects were asked to provide input into what they viewed as the central strengths and weaknesses of the program.

Qualitative Data Analysis

All qualitative data gathered during the on-site interviews and focus groups were transcribed and then analyzed using NVIVO qualitative data analysis software program. Two research-team members coded the qualitative data to ensure reliability of the information. These

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transcriptions were then content analyzed to identify major themes discussed during the interviews and focus groups. Content analysis is a recognized research tool to determine the presence of specific words or phrases that represent a larger topical theme (Weber, 1990). This process often results in the identification of several sub-topics that offer more manageable and meaningful information regarding primary topics of interest. The main topics and sub-topics identified provide important information regarding program operation and offer contextual knowledge for data interpretation.

The focus groups and staff interviews were guided largely by the project's goals related to evidence-based practice utilization and program fidelity determination. Accordingly, analysis began with identification of data relevant to the major areas outlined in the data collection instruments. Following interview transcription, each interview was reviewed by two members of the research team who then identified areas of the narrative which elucidated particular information germane to the first two research questions. The field notes taken during the site visits were also transcribed and analyzed in a similar manner.

The analysis was executed using NVIVO 9, a new generation qualitative data analysis software program. NVIVO is used to analyze interviews, field notes, text sources, and other types of qualitative or text-based data. More specifically, narratives were coded using NVIVO's "node" function which allows the user to represent a code, theme, or idea about the data. NVIVO allows users to create various types of nodes, the most common of which are *free nodes* and *tree nodes*. Free nodes, as indicated by their name, are free-standing and are not necessarily associated with a structured framework of themes or concepts. Tree nodes, conversely, are codes that are organized in a hierarchical structure. Both approaches were utilized in the current analysis.

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The qualitative data were also assessed using document analysis which evaluated program materials and documents for consistency with evidence-based practice. In particular, referral and admissions forms, in-take assessments, treatment modality plans, program curricula, and instructional materials were assessed relative to evidence-based treatment strategies. This component of the research design assisted in answering the question of whether the programs were designed to effectively address their intended target populations using the criteria set forth by the National Institute on Drug Abuse (NIDA, 2012a, 2012b).

Consistent with prior research, document analysis was used here in combination with other qualitative research methods (i.e., interviews, focus groups, direct observation) as a means of data triangulation. In projects such as these, researchers are expected to draw upon multiple sources of evidence in an effort to seek convergence and corroboration through the use of different data sources and methods (Bowen, 2009). The totality of the evidence produced from multiple sources can enhance the credibility of the data and result in greater validity of the findings with respect to determinations such as evidence-based practice utilization and program fidelity.

Quantitative Methods

All three research sites were contacted early in the research project and asked to provide access to electronic data regarding all DUI/DWI offenders. In all cases, the research team was referred to the state correctional agency, and specifically, the research and planning or data control section of the agency. Access was granted by all agencies to these data, with varying degrees of variable availability. In all cases, data was received in electronic form, but required some cleaning and manipulation prior to analysis. The specific variables and transformations for each set of data are described in detail in the following chapters.

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For each research site, descriptive and inferential analyses were employed to describe the sample and test for the potential impact of the treatment program on future behavior. Descriptive statistics include percentages, means, standard deviations, minimums, and maximums for all relevant variables. Originally, propensity score matching (PSM) was to be used as the primary inferential tool to assess whether the treatment experience was related to a reduced likelihood of future violations (i.e., failure). This approach was planned due to concerns of selection bias that present a challenge to quasi-experimental designs (i.e., lack of random assignment) such as the one used in this project. Selection bias stems from potential measured and unmeasured differences on variables other than the primary dependent (i.e., recidivism) and independent variables (i.e., treatment participation) including, but not limited to, demographics, criminal history, and other individual characteristics. PSM allows for the creation of statistically equivalent groups to be formed, thereby minimizing the selection bias concern. In effect, the PSM approach creates propensities for those who received treatment and those who did not and involves a balancing between the two groups to allow an assessment of the counterfactual (i.e., estimates of the outcomes given no treatment) (see Gibson, Miller, Jennings, Swatt & Gover, 2009; King, Massoglia, & MacMillian, 2007; Ridgeway, 2006; Sampson, Laub, & Wimer, 2006; Tita & Ridgeway, 2007).

Unfortunately, the PSM technique was unable to be applied to the data accessed for this project for a variety of reasons. Sample size was the primary problem. The project was developed with the expectations (confirmed by communication with the research sites) that there would be a reasonable number of individuals available in both the treatment and non-treatment groups to allow for the creation of the propensities. Unfortunately, the size of the available populations was severely limited and well below expectations. For example in Ohio, only 45

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individuals received treatment during the study period. This shortfall largely was due to the passing of Ohio House Bill 86 in 2011 which transferred the housing of lower level felony offenders from state prisons to community corrections. A majority of Ohio DUI offenders and thus potential treatment program participants fell under this legal change and explain low program enrollment. Conversely, in Montana, all the eligible treatment individuals received at least some treatment due to judicial and legislative mechanisms that prioritize their program. Thus, there was no comparison group from which to match with the treatment group.

As a result of these limitations, multivariate modeling was used to assess the potential relationship between treatment experience and behavior after release from the correctional facility. Multivariate models localize the independent effect of each variable while simultaneously considering the effect of all other variables (Hanushek & Jackson, 1977; Weisburd & Britt, 2007). Given the dichotomous nature of the dependent variable, logistic regression models were used to estimate the simultaneous effects of the independent variables on the likelihood of recidivism. Logistic regression applies maximum likelihood estimation after transforming the outcome into the natural log of the odds (logit) of the event occurring or not and calculates changes in the log odds of the dependent variable.

Variables analyzed from each of the three research locales differed slightly and are described in detail within each of the following sub-sections. Broadly, the main dependent variable indicates if the individual violated their parole conditions, committed a new offense, or was found to have committed a technical violation. More specific measures of "failure" were created when possible to further explore the potential relationship between this behavior and treatment participation. Other independent variables considered include, but are not limited to:

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criminal history, previous facility infractions, gender, age, education, marital status, and pre-incarceration employment status.

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CHAPTER IV: MONTANA FINDINGS

This chapter reports the findings for the Montana treatment program, the Warm Springs Addictions Treatment & Change (WATCh) Program. Initially, the treatment program is described in detail followed by a summary of the qualitative findings generated from the site visits to the treatment facility. Additionally, the quantitative data are analyzed using descriptive statistics and inferential models.

Program Description

The Warm Springs Addictions Treatment & Change (WATCh) Program serves felony drunk driving offenders with a history of multiple DUI convictions. The program is a partnership between Community, Counseling, and Correctional Services, Inc. (CCCS) and the Montana Department of Corrections (MDOC) and is located on the campus of Montana State Hospital Warm Springs near Butte in the southwestern part of the state. The program has been in operation since 2002 and has the capacity to serve 106 individuals at a time. The program is six months (180 days) in duration and utilizes a cognitive-behavioral based modified therapeutic community (TC) designed to assist "family members" (i.e., offenders) in developing the skills necessary for engaging prosocial change and reducing antisocial thinking and criminal behavior. Program components include cognitive-behavioral therapy via individual and group counseling, use of the *Criminal Conduct and Substance Abuse Treatment* curriculum, and participation in a variety of group-based activities such as Alcoholics Anonymous (AA), anger management, and life skills development.

The WATCh program is designed for adult offenders in Montana who have been convicted of a fourth or subsequent DUI. Participation in the program is voluntary and typically all offenders convicted of a fourth or subsequent DUI are accepted. The program does exclude

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individuals with certain offense histories including sex offenders and those convicted of violent crimes. The program also excludes those offenders with multiple convictions requiring a higher supervision level or those with medical conditions or cognitive impairments that impact their ability to successfully participate in programmatic activities.

The overarching goal of the WATCh program is to assist offenders in developing the skills necessary for prosocial change and the reduction of antisocial thinking and behavior in order to successfully transition back into society upon release. The specific program goals include: 1) increasing offenders' knowledge of chemical dependency and the consequences of drinking and driving, 2) providing offenders with treatment and associated services necessary to create prosocial change and reduce antisocial thinking and behavior, 3) promoting responsibility and accountability of offenders by providing an experiential prosocial community environment, and 4) decreasing the incidence of DUI and other drug-related convictions.

The WATCh program is designed according to three distinct phases (Phases I, II, and III), each with specific requirements as well as individual responsibilities and privileges. Participants progress though the phases only after receiving the endorsement of their respective treatment team. For each of these phases, participants are assessed by program staff and are expected to assist in the development of their individualized treatment plan. These plans are updated as needed throughout the phases and are viewed as a collaborative effort between program participants and staff designed to individualize treatment efforts.

The Montana program is multifaceted and draws from a number of established treatment modalities and protocols. As noted above, WATCh utilizes *Criminal Conduct and Substance Abuse Treatment: Strategies for Self-Improvement and Change* as its core curriculum for addressing both chemical dependency and criminal conduct among program participants.

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Chemical dependency group serves as the program's core and is conducted six days per week for approximately 1.5 hours per day. The treatment curriculum is delineated into three phases which correspond to the three phases of the program itself (Phases I, II, and III). The first phase is termed "Challenge to Change" and is a reflective period which involves building rapport and a working relationship with the participant and assisting them in developing the motivation to change. The major foci of this phase include developing self-awareness through self-disclosure and receiving feedback from family members and program staff. The second phase is referred to as an "Action Phase" which requires the family member to undergo an in-depth assessment of their life situations and problems toward the goal of behavioral change and improvement. The third and final phase is referred to as "Ownership of Change" and involves the stabilization and maintenance of family members' ownership of behavioral change over time. Programming during this phase utilizes treatment experiences designed to reinforce and strengthen commitment to behavioral change.

While the *Criminal Conduct and Substance Abuse Treatment* curriculum provides the core of the WATCh program, a number of other elements also comprise the treatment content and activities. Fundamentally, the Montana program is a cognitive-behavioral (CB) change treatment approach delivered within the context of a modified therapeutic community and, as such, places a premium upon CB programming. The WATCh program utilizes the *Cognitive Principles and Restructuring* (CP&R) approach developed by the Montana State Prison. CP&R is conducted five days per week for approximately 1.5 hours per session and is delivered in both individual and group settings by the program staff. CP&R entails the following "steps to change": 1) see the behavior to change, 2) identify the thinking behind the behavior, 3) identify the patterns and cycles of that behavior, 4) detail the underlying attitudes and beliefs that drive

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the thinking, 5) develop interventions, controls, and alternative ways of thinking, 6) prepare a plan to make and sustain change, and 7) apply and monitor the plan. It is through these seven steps that program participants are expected to alter the criminal thinking errors that impact their antisocial and addictive behavior.

In addition to the content discussed above, the WATCh program includes a variety of other mandatory and voluntary elements, ranging from anger management to parenting classes to participation in AA, NA, or GA. Other aspects of the program include "Truthought", devoted to addressing criminal thinking errors; grief group, used to address grief and loss issues; life skills development, mandatory for all participants; victims' issues, also mandatory for all participants; and spiritual services, voluntary for any members wishing to participate. Collectively, these elements offer a robust, multifaceted, and holistic approach to addiction recovery designed to rehabilitate and reintegrate participants both during and after program involvement.

The WATCh program operates according to a modified therapeutic community (TC), which is modified to meet the special needs of an incarcerated correctional population. The goal of the TC is to teach individuals how to function with the larger society and within their own families in a sober, prosocial manner. As a result, program participants are not labeled as offenders, residents, or clients, but rather are referred to as "Family Members". As participants enter the program, they are assigned to one of four units, referred to as "Families". These groups become the primary method for promoting social and psychological change within individuals. The TC unites and empowers participants to learn about themselves and use that knowledge toward effecting behavioral change. Each participant thus symbiotically shares responsibility for all TC members and, ideally, strives to be a role model for behavioral change.

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Participants receive extensive and varied programming seven days a week and are expected to complete individualized treatment-related assignments as well as participate in recreational and religious opportunities. The program is fairly regimented and all participants are expected to adhere closely to the schedule which varies slightly according to day of the week. A typical day begins at 6:00 a.m. when participants are expected to wake up and shower, engage in a period of personal reflection, and be ready for breakfast by 7:00 a.m. The first count of the day takes place at 8:30 a.m., after which participants participate in the TC and then proceed to chemical dependency class. These groups last until approximately noon when lunch is offered for one hour. 1:00 p.m. brings on the second head count of the day, followed by individualized activities such as Bible study, study hall, Knights' group[1], and Centurion group[2]. The afternoons are devoted to additional group programming such as life skills classes, anger management, CP&R, and phase-specific activities. The day typically concludes around 4:00 p.m. at which point another head count and family meetings take place prior to dinner at 4:30 p.m. Evenings are a time for recreation, homework, television viewing (typically news only), and supplementary addiction treatment such as AA or NA. A typical weekly program schedule is included in Appendix C.

Program participants have been convicted of driving under the influence of drugs or alcohol and are sent to the WATCh program under the authority of Montana Code Annotated (MCA) 61-8-401, 61-8-406, 45-5-104, or 45-5-205. Montana law stipulates that on the fourth or subsequent conviction for a DUI offense, the person is sentenced to the department of corrections (MDOC) for placement in an appropriate correctional facility or treatment program for a term of 13 months. The law also mandates that if the person successfully completes a

[1] The Knights' group refers to participants who have been convicted of negligent vehicular homicide. Montana law allows for individuals with such convictions to receive treatment while serving their sentences.
[2] The Centurion group refers to participants who are over the age of 65.

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residential alcohol treatment program operated or approved by the department of corrections, the remainder of the 13 month sentence must be served on probation. This 13 month sentence may not be deferred or suspended and the individual is ineligible for parole. Montana law further provides the specific conditions under which these offenders may receive probation including prohibitions against the consumption of alcohol and the frequenting of establishments that serve alcoholic beverages. Offenders on probation may not operate a motor vehicle unless authorized by their probation officer to do so and those that do operate vehicles must have automobiles that are equipped with an ignition interlock system to prevent driving under the influence. Several of these mandatory probation conditions are related to treatment and recovery and include the use of random or routine drug and alcohol testing. Montana law also mandates that offenders enter in and remain in an aftercare treatment program for the entirety of the probationary period. Toward this end, the WATCh program liaisons with more than 90 probation officers, 24 chemical dependency aftercare providers, and 10 transitional living facilities within Montana to ensure clients' compliance with this condition of probation.

Qualitative Results: Evidence-Based Practices Design

As described in the methodology chapter (Chapter III), each program's compliance with evidence-based practice was assessed primarily by its consistency with guidelines set forth by the National Institute on Drug Abuse (NIDA) in *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide* (Revised Ed.) (2012a) and *Principles of Drug Addiction Treatment: A Research-Based Guide* (3rd Ed.) (2012b). More specifically, each program was assessed on the following areas: 1) assessment, 2) treatment length, 3) individualized treatment, 4) drug use monitoring, 5) focus on "criminal thinking, and 6) continuity of care (i.e., aftercare). The findings presented below are organized around these six

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key areas and evaluate how well the program complied with guidelines set forth by NIDA (2012a, 2012b).

Assessment

The Montana program is designed so that participants are assessed upon intake using several diagnostic tools. The use of multiple diagnostic instruments can be advantageous in that it increases the validity of these important initial assessments. WATCh program participants are assessed using the following: 1) DSM-IV, 2) SASSI, 3) Short Michigan Alcoholism Screening Test (Short MAST), and 4) CAGE, a verbal screening method used to establish an index of suspicion. Each of these assessment tools are well established in the addiction treatment literature and have been previously validated.

The Diagnostic and Statistical Manual of Mental Disorders, or DSM-IV, offers criteria for determining both substance abuse and substance dependence and is frequently used in clinical settings. Substance dependence is defined by the DSM-IV as a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by three (or more) of seven distinct criteria, occurring any time in the same 12-month period. The DSM-IV criteria have been positively assessed previously for both reliability and validity, and in relation to alcohol diagnoses (Hason, Schuckit, Martin, Grant, Bucholz, & Helzer, 2003). The Substance Abuse Subtle Screening Inventory, or SASSI, is one of the most well known and frequently used diagnostic instruments in addictions treatment. This tool has demonstrated high reliability using multiple methodologies and corresponds closely with clinical diagnoses (Lazowski, Miller, Boye, & Miller, 1998). The Short MAST is a brief diagnostic tool designed to identify alcohol abuse and has also been validated previously using criminal justice system-involved populations (Hays, Merz, & Nicholas, 1995). Finally, the CAGE is considered the shortest of the alcohol

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dependency diagnostic instruments and entails only four items measured dichotomously. Evaluations of the validity of the CAGE indicate that while it is capable of providing a substantial amount of information quickly, more reliable and valid information can be obtained using other measures such as the short MAST (Hays et al., 1995).

Conclusion - Consistent with NIDA Guidelines?: YES

Treatment Length

The Montana WATCh program is designed to operate on a six month (180 day) cycle and is structured in three consecutive phases (Phases I, II, and III). Each phase has specific requirements as well as individual responsibilities and privileges. Progression to the next phase is not an automatic function of time, but rather occurs only after the endorsement of the treatment team. These three phases, described in detail in the previous section "Program Description", are based in large part on the chemical dependency programming utilized by WATCh, *Criminal Conduct and Substance Abuse Treatment*. As such, the program length does meet the minimum 90 day guideline set forth by NIDA and in fact exceeds it by an additional 90 days.

Conclusion - Consistent with NIDA Guidelines?: YES

Individualized Treatment

The Montana WATCh program is designed such that clients are assessed immediately upon entry to the treatment facility toward the goal of developing an individualized treatment plan (ITP). These ITPs are created with input from both the assessment and treatments teams and the clients themselves, and are designed to address the totality of the participant's recovery needs. More specifically, these ITPs include some details common to all participants (e.g.,

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chemical dependency needs) and others that are more particular to the individual client (e.g., dual diagnosis needs).

The Montana program requires that ITPs are developed at the start of Phase I. Following the successful completion of Phase I programming, clients are expected to use their time in Phase II to develop an individualized recovery plan which takes into account their treatment needs following release from prison. These Phase II plans are intended as a more forward-looking approach to the recovery process which will last for much longer than the treatment program itself. Following the successful completion of Phase II, all clients are again expected to participate in developing a Phase III ITP (the final phase of the program). Finally, all program participants are expected to meet with their counselors upon admission to Phase I and subsequent advancements to Phases II and III in order to ensure the successful development and implementation of these individualized plans.

Conclusion - Consistent with NIDA Guidelines?: YES

Drug Use Monitoring

The WATCh program is predicated on the principle of abstinence from substance use; as a result, drug use is not tolerated among program participants. During the course of treatment, regular and random breathalyzer and urinalysis are employed to immediately detect any relapse episodes. The WATCh program acknowledges that relapse is an expected part of the recovery process and mandates that these episodes are identified and addressed as soon as possible.

While the WATCh program is a treatment program and the Xanopolos Building where it is located is a treatment facility, it remains a correctional program aimed at felony offenders. As such, security remains paramount for this minimum security facility. Facility staff provide 24 hour per day, seven days per week security along with regular and random security searches of

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offenders and their living areas. The facility also utilizes perimeter fencing and video monitoring of the interior and exterior areas. Collectively, the security procedures and program monitoring enable effective drug use monitoring of WATCh participants. Furthermore, Montana state law requires these felony offenders to be monitored for drug and alcohol use throughout the probationary period following successful completion of the program and release from the department of corrections.

Conclusion - Consistent with NIDA Guidelines?: YES

Targeting Criminal Thinking

As reported previously, the Montana program utilizes the *Criminal Conduct and Substance Abuse Treatment* as its core curriculum. This modality is a cognitive-behavioral based approach which is suited for long term programs such as WATCh and focuses on the address of criminal thinking errors. The program also incorporates the Cognitive Principles and Restructuring (CP&R) approach which was developed by the Montana State Prison. CP&R is conducted five days per week and is delivered in both individual and groups settings by treatment staff trained in the curriculum. Substantively, the CP&R employs a multi-step approach which includes: 1) see the behavior to change, 2) identify the thinking behind the behavior, 3) identify the patterns and cycles of that behavior, 4) detail the underlying attitudes and beliefs that drive the thinking, 5) develop interventions, controls, and alternative ways of thinking, 6) prepare a plan to make and sustain change, and 7) apply and monitor the plan.

In addition to the above mentioned programs, WATCh also utilizes the "Truthought" approach which focuses exclusively on criminal thinking errors. This element of the program consists of lectures and homework assignments focusing on the identification of criminal thinking errors such as feelings of entitlement, use of neutralizations, externalizing behavior, and

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short-sightedness. Overall, this multi-prong approach to cognitive behavioral change places a premium on the identification and remedy of criminal thinking errors.

Conclusion - Consistent with NIDA Guidelines?: YES

Continuity of Care

A key element of corrections-based substance abuse treatment is the provision of aftercare service following release (Springer et al., 2003). The Montana WATCh program is mindful of this reality and employs an "aftercare coordinator" whose job is to create viable aftercare plans for each client prior to release. The program also mandates that all participants meet with the aftercare coordinator at least 60 days prior to program completion. Participants are also expected to develop a community based aftercare plan by the end of Phase III. This plan is developed in collaboration with the aftercare coordinator and addresses a range of issues such as living arrangement, employment plans, family reunification, and out-patient treatment option, among others. As noted previously, Montana state law requires that program participants receive aftercare services while on probation following release from DOC custody. The WATCh program staff works actively with more than 90 probation officers, 24 chemical dependency aftercare providers, and 10 transitional living facilities within Montana to ensure clients' compliance with this condition of probation.

Conclusion - Consistent with NIDA Guidelines?: YES

Qualitative Results: Program Fidelity

As described in Chapter 3, program fidelity was assessed using data derived from interviews, observations, and document analysis. A fidelity instrument (Appendix A) was used to document and compare observations that, in conjunction with field notes, enable objective and systematic consideration of fidelity level across programs. Each component of fidelity were

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evaluated independently by the research team members (N=3) using the fidelity scale; following this initial round of scores, the research team met to compare ratings and achieve inter-coder consensus. Programs were then given a score which reflected the assessment of all three researchers.

The fidelity instrument was developed by the research team prior to the start of the current project and was based on the extant program evaluation literature (Stead et al., 2007; Melde et al., 2010) and the research team's prior experiences with addiction treatment program evaluation (Miller et al., 2004; Miller & Miller, 2010; Miller & Miller, 2011; Miller et al., 2012; Miller et al., 2010). The instrument was developed in accordance with the primary elements comprising fidelity in criminal justice and treatment contexts: adherence, exposure, delivery quality, participant engagement, and program differentiation.

Adherence

Adherence was assessed through six (6) separate items which were scored dichotomously as yes or no, where yes = 1 and no = 0. These items denoted whether or not the program had met the minimum requirement per the intended design. Specifically, staff qualifications, program components, caseload, intake and assessment, individualized service plans, and dosage were examined for adherence to evidence-based practice.

In terms of formal staff qualifications, the WATCh program requires all treatment staff to be licensed substance abuse/chemical dependency counselors thereby meeting this particular requirement. Moreover, the state of Montana has codified in law the licensing requirements for all those who deliver substance abuse treatment, so there is little discretion afforded program administrators in this respect. Many program staff exceeded the minimum requirements for their respective positions, holding baccalaureate or post-baccalaureate degrees, as well as a number of

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licensed master's-level counselors. Program component standards were similarly met by the WATCh in terms of daily activities and were delivered to the appropriate target population. More specifically, the program contained multiple elements including chemical dependency classes, cognitive-behavioral therapy delivered in both individual and group settings, the targeting of criminal thinking errors, life skills development, anger management, and several variants of the "Anonymous" support groups (i.e., AA, NA, GA).

The prescribed caseload element of the adherence measure was slightly more difficult to determine due to the nature of the program's design and operation. Typically, substance abuse treatment best practice mandates a client to counselor ratio that ideally ranges between 15:1 and 25:1, with better outcomes and increased treatment services more likely with a lower ratio (CSAT, 2005; SAMHSA, 2003). The Montana program, however, had a varied client to counselor ratio, depending on the element of the program that was occurring. The WATCh program is a modified therapeutic community and individual participants are first grouped into one of three "families" which contain three groups concordant with the three phases of the program. Observations of various program components suggested that, overall, the WATCh program generally maintained acceptable client to counselor ratios. For example, the research team observed multiple sessions where the ratios ranged from 12:1 to 20:1, depending on the element. Overall, the WATCh program employs approximately twenty treatment staff (not including security or administration staff) to service 106 participants. Based on the totality of the observations, interviews with participants, administrators, and staff, and review of official documents, the research team concluded that the program did adhere to this element of program design.

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Both intake timeliness and individualized service plans were also examined in the assessment of design adherence. In terms of intake timeliness, subjects universally confirmed that assessment occurred almost immediately upon intake to the facility. The first week of the program is considered the orientation week and is designed to introduce the participants to the program and facility, while affording the treatment staff an opportunity for the adequate assessment of individual's rehabilitative needs. The purpose of these assessments is to develop the client's individualized treatment plan (ITP) which guides the recovery process.

As their name suggests, these ITPs are intended to reflect the individualized needs of the particular client. Individualized treatment is considered an evidence-based best practice for chemically dependent offenders (NIDA, 2012a) and a cornerstone of effective rehabilitation (NIDA, 2012b; SAMHSA, 2003). Review of program documents indicated that the WATCh program is designed such that each participant meets with their treatment team shortly after admission and assessment to develop an ITP. The interviews with program administrators and staff similarly suggested that each client's treatment was designed and implemented with attention to individual needs. Both direct observation of program activities and review of the daily and weekly schedules also revealed a relatively high level of treatment component differentiation available for program participants. For example, the WATCh program offers numerous group-based treatment options for clients, including the Knights group (for those who have been convicted of vehicular manslaughter/homicide), the Centurion group (for older participants), and the Second Watch (for those who are in their second visit to the WATCh program after being convicted of an additional DUI following a previous treatment stay). The program also offers access to AA, NA, and GA as well as Bible Study and specialized classes such as anger management, parenting, and life skills development. While these specialized

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elements of treatment are open to all program participants, members are not forced to engage all of these activities, but rather attend groups and classes that are relevant to their ITPs.

While the administration and staff interviews, document analysis, and direct observation of program activities indicated that the program utilized ITPs, several of the inmates reported similarities between their ITPs and those of their fellow participants. Essentially, these clients suggested that the individualized treatment plans were not actually designed for each participant, but rather followed a standardized treatment plan. Other focus group respondents reported that most of the ITP content was the same across participants, but that certain specialized elements were included as well. The majority of interviewees, however, indicated that their plans were in fact individualized for their specific needs and offered examples of these elements. Overall, the data suggests that the WATCh program does utilize ITPs for participants.

Finally, the adherence measure included compliance with the substance abuse literature's best practices for prescribed treatment dosage. Prescribed dosage compliance refers to the relative exposure of participants to the combined elements of the program. Essentially, this measure was designed to reflect whether or not the program was structured and executed in a way such that the individual program components are being delivered at a rate and ratio prescribed by the modality. Based on the interviews, focus groups, document analysis, and direct observation of the daily schedule over multiple days, the research team concluded that the prescribed dosage criterion was met. Overall, the Montana program earned high scores on the adherence measure of the program fidelity scale.

Exposure

The second element of the fidelity scale is exposure which refers to the amount of time and in what combination treatment content is delivered. More specifically, exposure was

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measured by contact frequency hours (per day) and program duration, which denotes the length of time clients participate in treatment activities (i.e., program length). Both of these items were ranked on a five-point ordinal Likert scale with higher scores denoting greater consistency with treatment protocols. The two scores were then averaged for an overall exposure score (possible range 1-5).

In terms of contact frequency, the WATCh met the recommended hours per day of treatment according to the program's design. Participants engaged in two hours per day, six days per week of chemical dependency class which serves as the programmatic backbone of the treatment (i.e., *Criminal Conduct and Substance Abuse Treatment: Strategies for Self-Improvement and Change*). They also participate in five sessions per week (1.5 hours per session) of the CP&R program developed for the purpose of cognitive-behavioral restructuring. While these two elements represent the core of the schedule, additional hours are devoted each week to specialized treatment services, per the ITPs. As noted previously in the "Program Description" section of this chapter, numerous other program elements are offered by WATCh, including, but not limited to: anger management, grief group, like skills development, and victims' issues classes. Collectively, treatment programming occupies anywhere from six to eight hours per day, every day for the participants of the Montana WATCh.

The assessment of exposure also included a measure of program duration, or the amount of time that participants spend in the program. The WATCh program is executed across three interrelated phases spanning six months (180 days). This length of time is consistent with, and in fact exceeds by 100 percent, the recommended program duration length of three months (NIDA, 2012a). The data derived from each of the qualitative methodologies (i.e., interviews, focus groups, document analysis, and direct observation) confirmed that the program duration in

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practice was consistent with evidence-based design. Based on the scores obtained on this measure across the three research team members, the WATCh program received high scores on the exposure measure of the program fidelity scale.

Delivery Quality

Delivery quality was assessed by four separate items which were scored using a five-point ordinal Likert scale with higher scores denoting higher delivery quality. These four items included treatment plan compliance, counselor/staff qualifications, counselor/staff attitude, and counselor/staff continued training. These items were designed to capture the overall quality of treatment content delivery with a specific focus on those responsible for its delivery – treatment staff. Scores were then averaged across the four items for a mean delivery quality score.

The first element of delivery quality examined the extent to which the treatment was compliant with the individualized plans devised for each participant. To inform this question, interviews with both program staff and participant focus groups included questions related to the consistency with which actual treatment activities and protocols reflected the elements included in the ITPs. Program participants were pointedly queried about this issue as they were in a particularly unique position to confirm or deny compliance with these plans. Findings generated from the focus groups revealed overwhelming agreement with the idea that the treatment the clients received was in fact consistent with that delineated in the individualized plans. Accordingly, the WATCh program received high scores from each member of the research team on the issue of ITP compliance.

The remaining three items used to assess delivery quality centered on the qualifications, attitude, and continued training of the treatment staff. A treatment program's staff, and especially staff members' ability to develop rapport with clients, is considered a salient factor in

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successful recovery and rehabilitation approaches. Programs whose participants do not have confidence in the ability of the treatment staff are less likely to produce successful outcomes than those that employ staff who are experienced, committed, sincere, and enthusiastic about treatment delivery. In terms of qualifications and continued training, all staff interviewed indicated that they had met the minimum education and training requirements for substance abuse counseling and many possessed credentials that exceeded these minimum expectations. Interviews with program administration and staff as well as review of official program materials and documents also suggested that treatment staff are not only expected to possess the requisite qualifications for the position, they are also encouraged to engage continued education while employed.

The attitude and level of engagement of the treatment staff was assessed through staff interviews, focus groups with program participants, and direct observation of program activities during the site visits. Based on data drawn from all three of these sources, it was clear that the attitudes conveyed by the program staff were among the most committed and positive that the research team has observed across a number of treatment sites and research projects. The research team was able to observe a number of counselors engaged in a wide range of treatment activities, all of which indicated significant effort on the part of the program staff. Staff members were enthusiastic, knowledgeable, and committed to the activities which comprised the program components. Staff members engaged the participants in program activities and were not afraid of becoming confrontational with their clients if they perceived a lack of commitment or honesty on the part of the individual offender.

The focus group interview schedule also examined the participants' perceptions of the counselors and staff with a particular emphasis on their effectiveness, knowledge, and attitude.

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Overall, the data gleaned from these focus group interviews were consistent with the observations made by the research team. Few respondents had anything negative to offer related to the treatment staff and the vast majority offered laudatory comments about them. Below are some representative participant responses related to the program treatment staff:

> *"They're willing to go as far as you're willing to go. You know, they can only take us as far as we're willing to take ourselves. I think that's a good thing, a good direct approach to the way they treat us."*
>
> *"I think the counselors are great all around. I don't think there are any here that are here for any other reason than to see you succeed in life. You know they want, that's what their passion is, and you can see that in all of the counselors here."*
>
> *"He'd say that, he's got a heart the size of Texas when it comes to this treatment program and his job. He cares about each and every one of us individually. He knows everybody's name."*
>
> *"He's really good at what he does and the in your face, you know the loud and proud… They get you out of your comfort zone, and I think that's, for me, that's what works for me is getting me out of my comfort zone."*
>
> *"I'm an easy read, as are most people are that come in here, and she is very good at what she does. And it may seem cruel, some of the things that she does, but they're absolutely mandatory. I wouldn't have it any other way. I'm grateful she's my counselor, my primary and my phase counselor. I'm grateful for all the critiquing and the criticism I've received from her. It's changed me, including my first days in here."*
>
> *"For me, my counselor, he is, he's very personable but direct with what he's trying to I guess, by giving me information or helping me out and with listening. You know, he's able to relate to me on a personal level, which is nice, as he's able to be direct with explaining the program to me."*
>
> *"Every one of the counselors has a sincere care for us, which is awesome, and they help guide and direct us…"*

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Based on the totality of the data collected through interviews, focus groups, and observation, the WATCh program received high scores from each member of the research team on the issue of staff attitude. Similarly, the research team afforded a high score to the Montana program on delivery quality overall.

Participant Engagement

Participant engagement was assessed by three separate items which were scored using a five-point ordinal Likert scale with higher scores denoting higher participant engagement. These three items included participant attitude, participant involvement, and participant barriers. The participant barriers item was reverse coded, so that higher scores indicated fewer barriers to client participation. These items were designed to capture the overall engagement level of the program participants across the treatment activities. Scores were then averaged across the three items for a mean participant engagement score.

Participant engagement was investigated primarily through the use of direct observation of program activities and the focus group interviews. Data produced from these aspects of the study revealed that the vast majority of program participants were highly engaged in treatment activities and committed to their recovery. Observation of treatment activities revealed high levels of involvement and participation in group activities across multiple phases and families. For example, multiple hands were raised in response to questions posed by treatment staff and at very few times did the counselor have to repeat his or her inquiry before someone volunteered a response. Program participants were interactive with the counselor and each other throughout the sessions and those who failed to participate or afford the activities the requisite attention were signaled out for their lack of effort. In many cases, more clients wanted to participate and offer suggestions than could be reasonably accommodated.

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Participant attitudes were similarly assessed through the use of direct observation and, in particular, focus group interviews. These focus group interviews afforded participants the opportunity to speak freely and honestly about their attitudes toward the program and their own recovery without the fear of repercussions from facility staff. While there were a small number of clients who appeared slightly less than enthused about their participation in the program, the vast majority of respondents reported a positive attitude about the program overall. Subjects spoke about the program both in terms of its specific components and how it fared compared to other treatment programs they had experienced previously. Below are some representative subject responses illustrating participant attitudes towards the program:

> *"And you start participating because you realize that when you do speak up, you do help people all the time in here, without even knowing it you help somebody, and that helps you in the long run."*
>
> *"And you can watch those changes in people. Like I've seen changes in Jason*[3]*specifically, what he's talking about, he came in resisting, he didn't want to be here and now he's wanting to get involved and be an active part in the community."*
>
> *"This is like 100% participation from the time you wake up at six o'clock in the morning till the time you go to bed at ten o'clock at night. You need to be actively involved or like I said, we self police ourselves here too. So if somebody isn't doing anything for a couple of days we might let it slide, but by the third or fourth day of doing it there's going to be people on his case…"*
>
> *"I've been to four treatments before and this is the most intense treatment I've been to. But from the start, I kind of didn't really want to be here until you get into it. And now I can't wait for the next day, like now because my group is in the mornings, before lunch, are the best groups that we got. When we sit around in a big circle and we all combine our thoughts and out problems and we work them out…"*

[3] All names have been changed to protect subject confidentiality.

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The therapeutic community model employed by the WATCh program appeared to influence the extent to which participants were engaged in programmatic activities. Recall that the primary change agent is theorized as the group dynamic itself in the TC and when clients embrace this aspect of the therapy, they become active participants in each other's rehabilitation. Both the direct observation of program activities and the focus group interviews supported this key finding. The focus group respondents frequently identified the nature of the TC and the relationships produced from it as reasons why this particular program was different from other treatment they had received previously. Subjects reported that their commitment to the program was based on both their own desires for addiction recovery and their wishes for their TC family members' shared success. The TC, then, appears to be a significant factor in creating interest and commitment among program participants as well as engendering accountability between group members for shared sobriety.

Often times, prison-based treatment can introduce a number of barriers to program participation and recovery for drug-addicted offenders (Miller et al., 2010). There is even considerable doubt as to whether the prison environment is appropriate or even feasible for rehabilitation (Prendergast, Farabee, Cartier, & Henkin, 2002). Recovery from addiction is a difficult period for any individual, and from a best-practices orientation, a therapeutic environment is favorable. The basic deprivation of liberty along with the specific discomforts and humiliations characteristic of prison life are not necessarily conducive to recovery. The Montana WATCh, however, is unique relative to many treatment programs set in correctional contexts in that it is located in a standalone minimum security treatment facility. This facility does not contain any offenders other than those who are receiving officially sanctioned

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treatment. As a result, fewer barriers to program participation and client recovery were identified during the site visits.

One common barrier to program participation relates to tensions between treatment and security staff and in particular how the conflicting objectives of punishment and rehabilitation are concurrently realized. Interviews with program administration and staff as well as focus group interviews with participants indicated that there were few, if any, problems between the security and treatment aspects of life in the WATCh. Program administrators were able to execute a fairly seamless integration of treatment and security into daily operation and focus group respondents failed to identify any barriers or obstacles related to this issue. The one barrier that several interviewees identified related to the availability of physical exercise options. A number of subjects indicated that while there was a minimal amount of time each week reserved for recreation, including physical activities, that this was not sufficient for their needs. Several participants linked physical exercise to their overall holistic recovery from addiction, arguing that to fully recover, the mind, body and spirit must be healed. Therefore, they argued, additional opportunities for physical exercise were consistent with the program's approach to addiction which views the disorder as one of the mind, body, and spirit. In particular, respondents offered statements such as:

> *"As far as what I think could be improve around here, what I would say. Probably is, they don't let us really be active around here. As far as exercising, you don't lift and play basketball, any kind of contact sport whatsoever, and walking around a circle is all you get and I think there should be more of that just for the reason of the health issues. I can gain 20 pounds right now, then you lose, and I don't think that's healthy, so I would say, exercising."*
>
> *"We have a little yard that we can go outside but there's really nothing there, especially walking around the yard and that's about it. You know something with*

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a little more involvement like a little gym class where you can play basketball or anything. So that would be my only complaint about something to add or change."

"Yeah, the health thing, it makes me angry, I don't even think its right for them to tell me that I can't do push-ups. You can actually, literally see people get fat here, and I can see myself get fat. We get three-thousand calories a day, and we get an hour to go run around in a circle."

"The exercise. They used to have weights here and stuff but I guess too many alcoholics criminalized it and got hurt, and said they couldn't get out of bed, and didn't have to go to group so they took that away. So I understand where they're coming from but I'm sure they could figure out a happy medium somewhere."

"Negatives, yeah the lack of exercise, I mean most of us come from active jobs on the outside. There's not a lot of business men in here you know, so there's a lot of missed exercise."

Though a number of respondents expressed disappointment or dissatisfaction with the lack of physical exercise opportunities, there were few other topics which were repeatedly revisited over the course of the interviews. Comparatively, these subjects identified far fewer barriers to success than the average in-prison treatment program participant. Prior research has identified these common barriers including misplacement of other participants (i.e., lack of effective screening leading to inappropriate treatment placements), tensions between security and treatment staff, lack of interest on the part of counselors, lack of basic privileges (including visitation and phone calls from family), and facility safety. For the current project, however, none of these issues were considered salient barriers by WATCh program participants.

Based on the totality of the data collected through interviews, focus groups, and direct observation, the WATCh program received high scores from each member of the research team on the issues of participant involvement, attitude, and barriers. Similarly, the research team afforded a high score to the Montana program on participant engagement overall.

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Program Differentiation

Program differentiation served as the last of the five elements comprising program fidelity and was assessed using four (4) items: program size fluctuation, program budget fluctuation, caseload fluctuation, and continuity of staffing. Differentiation refers to the unique features of different program components that are reliably differentiated from one another. These four items were scored using a five-point ordinal Likert scale (1-5) with higher scores denoting greater program differentiation. The first three items (program size fluctuation, program budget fluctuation, caseload fluctuation) were reverse coded so that higher scores indicated a more favorable assessment (i.e., programs were assessed more positively when program size, budget, and caseload did not fluctuate considerably over time). The continuity of staffing item was coded 1-5 with higher scores indicating a greater continuity of staffing.

Research team member scores were the most consistent across this measure of program fidelity since the information needed to inform this aspect of the fidelity scale was less subject to interpretation. The Montana program is codified in state law and, as a result, does not suffer from many of the common problems associated with treatment program operation. For example, the WATCh can treat up to 106 offenders at one time which is a relatively large number of offenders given the size of Montana's overall correctional population. Related, more than nearly all of those referred to the WATCh are accepted into the program which affords the state excellent treatment coverage in terms of those who are in need. The program's budget is appropriated by the Montana State Legislature and is thus not subject to fiscal insecurity like many treatment programs which are funded through "soft money", temporary legislative action, or grants acquisition.

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The treatment staff's caseloads are similarly secure in that the program consistently fills all bed space. Consequently, there is very little caseload fluctuation in the Montana WATCh program, enhancing the day to day operating procedures from a treatment staff perspective. Treatment staff need not worry about how many clients will be placed on their caseload as they are already aware of this reality per the program size. The consistency of the caseload, then, is advantageous for program operation in that treatment components and protocols can be reliably implemented.

Finally, the research team also assessed the WATCh program for continuity of staffing, with a particular focus on treatment staff. Correctional staff turnover has been well documented in the criminological literature (see Lambert, 2001 for a review) and poses a considerable challenge to treatment programs. In that staff quality, engagement, enthusiasm, and rapport-building skills are paramount to successful rehabilitative programs, the continuity of these treatment staff members are also of considerable importance, particularly from the participants' perspective. The Montana WATCh received fairly high scores in this respect, as the vast majority of the treatment staff employed during the first site visit in 2011 was also with the program during the subsequent visits in 2011 and 2012. Overall, the Montana WATCh received high scores from each member of the research team on the issues of program size fluctuation, budget fluctuation, caseload fluctuation, and continuity of staffing. Similarly, the research team afforded a high score to the Montana program on program differentiation overall.

Quantitative Results

To address the quantitative element of the project, the research team contacted the Montana Department of Corrections (MDC) and requested electronic data on the WATCh treatment program. The WATCh program actually operates at two locations; the East facility is

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located near Billings, MT, and the West facility is just outside Butte, MT. MDC provided all quantative data on all program participants at both facilities from July 1, 2006 until May 16, 2012. During this time period, 1,275 individuals entered the program, of which 908 were assigned to the West facility. All East facility participants were removed from further consideration to match the qualitative element of this project, which was conducted exclusively at the West facility.

The 908 West participants were categorized into two separate groups for analysis purposes. Group 1 includes individuals who received some treatment, but did not complete the treatment program (N=114); Group 2 represents all individuals who graduated from the program (N=794). After removing cases that were missing information on variables of interest[4], Group 1 contained 106 cases and 760 individuals were categorized into Group 2.

MDC provided demographic, criminal history, and incarceration infraction information on all individuals within these groups. Program participant demographics included age measured as a continuous variable, gender and race/ethnicity (White, Black, Hispanic, Native American, Other) recorded as dichotomous variables, and marital status[5] as a single dummy variable. Individual criminal history was measured using a series of dummy variables indicating the number of trips an offender had made to an MDC facility (e.g., 1st, 2nd, 3rd or more). Also, a dichotomous measure of violence was developed indicating if the individual had been convicted for a violent offense. A series of dichotomous variables were also created from institutional records to indicate if the individual possessed any previous incarceration-based infractions, if

[4] There were an additional 16 individuals who were assigned to one of the two treatment facilities more than one time; however, due to the inconsistency in treatment location and receiving more than one "dosage" of treatment, these individuals were excluded from further analyses.
[5] Marital status of single reflects individuals who are not married, divorced, or widowed.

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there were between one and five infractions, or if the individual committed six or more infractions.

A series of temporal variables were also created based on the date variables provided by MDC. Time to Program measures the number of days an individual waited to enter the program since their entrance to MDC. Similarly, Time in Program indicates the number of days that an individual spent in the program. Additional temporal measures also summarized the number of days from program graduation to MDC release (i.e., Time from Program), the number of overall days in MDC (i.e., Time in MDC), and the number of days from MDC release to the end of the study period (i.e., Time at Risk).

Table 4.1 summarizes the minimum, maximum, mean, and standard deviation for all variables in Groups 1 & 2. Individual age was, on average, similar with Group 1 slightly older (i.e., 46.42 years of age) than those who completed the program (43.27 years of age). All members of both groups were male.[6] With regard to race/ethnicity, Group 2 was largely White (76.8%) with Native Americans comprising the largest minority group (19.5%). Group 1 also was predominately White (67.0%), and Native Americans similarly represented the largest minority group (30.2%). Both groups were largely comprised of single individuals (Group 1, 77.4%; Group 2, 74.7%).

[6] The lack of variation in gender was also a product of only examining the West facility, as all female MDC inmates were assigned to the East facility. The East facility houses both males and females.

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Table 4.1: Montana - Group Characteristics

	Group 1: Some Treatment (N=106)				Group 2: Completed (N=760)			
	Min	**Max**	**Mean**	**S.D.**	**Min**	**Max**	**Mean**	**S.D.**
Age at Prog. Entrance	23	67	46.417	10.186	19	76	43.268	10.007
Male	1	1	1.000	.000	1	1	1.000	.000
Race								
White	0	1	.670	.473	0	1	.768	.422
Black	0	1	.009	.097	0	1	.005	.072
Hispanic	0	1	.019	.137	0	1	.028	.164
Native American	0	1	.302	.461	0	1	.195	.396
Other	0	1	.000	.000	0	1	.004	.063
Marital Status								
Single	0	1	.774	.421	0	1	.747	.435
Criminal History								
1st Trip	0	1	.359	.482	0	1	.474	.500
2nd Trip	0	1	.274	.448	0	1	.182	.386
3 or more	0	1	.368	.485	0	1	.345	.476
Violence	0	1	.132	.340	0	1	.092	.289
Infractions								
Zero Previous	0	1	1.000	.000	0	1	.863	.344
1-5 Previous	0	1	.000	.000	0	1	.133	.340
6 or More Previous	0	1	.000	.000	0	1	.004	.063
Time to Program	1	8,757	265.585	918.928	0	2,179	121.295	219.147
Time in Program	0	211	59.859	60.857	10	337	180.621	27.922
Time from Program	5	1,330	357.783	304.815	0	852	44.191	94.681
Time in MDC	197	9,232	683.226	1,023.839	136	2,833	346.107	271.980
Time at Risk	33	2,043	917.585	466.774	215	1,983	1,196.992	427.006

One noticeable difference between the groups was in their criminal history experiences. Nearly half of Group 2 (47.4%) were on their first trip to MDC, whereas only 35.9% of Group 2 were first time offenders; however, differences between these groups is less pronounced when considering that the rate of 2nd time offenders was 18.2% for Group 1 and 27.4% for Group 2. Also, those that did not complete treatment had higher collective rates of previous violence (13.2%) compared to the group that completed the program (9.2%). Incarceration based infractions were only reported for Group 2 with slightly more than 13% involved in such incidents.

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The temporal variables indicated different experiences across the groups. Group 2, on average, spent much fewer days waiting to enter the program (121.3 days) compared to those who did not complete the program (265.6 days). Unsurprisingly, the average number of days in the program were noticeable different with Group 1 only spending 59.9 days and Group 2 approximately 180 days, which corresponds with the intended amount of time in the program (i.e., six months). Related, the average number of days between release from the program and release from MDC was substantially higher in Group 1 (357.8 days) compared to Group 2 (44.2 days). Overall, amount of days under MDC supervision was roughly twice as long for Group 1 members (683.2 days) compared to Group 2 individuals (346.1 days). Finally, the average number of days between MDC release and the end of the study period varied slightly with Group 1 possessing a slightly lower average (917.6 days) compared to Group 2 (1,197.0 days).

The dependent variable of interest was based on the MDC definition of recidivism and represents individual failure (see Table 4.2). Of the 106 individuals who did not complete the treatment program, 27 (25.5%) were identified as committing an action that deemed their release as a failure. In comparison, 228 of the 760 program graduates (30.0%) were deemed to have failed based on their post-release behavior. At a simple descriptive level, these failure rates indicate that Group 2 treatment participants actually were more likely to be unsuccessful once released from MDC. No definitive conclusions should be drawn from these preliminary descriptive statistics, however, as multivariate analyses are required to properly assess the relationship between treatment and failure. Another method to assess treatment success or failure is to consider the number of days until failure. Group 2 members, on average, allowed 496.4 days to elapse prior to failure, whereas Group 1 individuals, on average, failed in 409.2 days. Moreover, the maximum number of days to elapse prior to failure for Group 2 was 1,778

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compared to 1,051 for Group 2. Table 4.2 also indicates that all members of Group 1 who failed were returned to prison, whereas approximately half of program graduates (46.49%) were assessed, or not returned to prison, and another 19.74% were given some other form of treatment rather than prison.

Table 4.2: Montana - Failure & Revocation

	Group 1: Some Treatment (N = 27)				Group 2: Completed (N =228)			
	Min	**Max**	**Mean**	**S.D.**	**Min**	**Max**	**Mean**	**S.D.**
Time to Failure	61	1,051	409.259	248.368	15	1,778	496.408	372.568
			%				**%**	
Failure Rate[7]			**25.47**				**30.00**	
Assessment Rate			--				46.49	
Treatment Rate			--				19.74	
Prison Rate			100.00[8]				33.77	

Although descriptive statistics are useful to summarize the characteristics of the sample, additional analysis are appropriate to properly answer the research questions. As such, a bivariate analysis was undertaken to assess if the failure rate differed substantially between Groups 1 & 2. As evidenced in Table 4.3, a slight statistical difference in the failure rate was discovered between those who completed some treatment and those who completed the entire treatment. While not definitive regarding the relationship between the two groups, a t-test is well suited to provide an initial assessment of any potential relationship between the independent variable of interest and the dependent variable. Full exploration of this relationship, however, is best undertaken through multivariate analyses.

Table 4.3: Montana – Bivariate Analysis: T-Test

	t	**df**	**Sig (2-tailed)** [9]	**Mean Difference**
Failure	2.565	865	.010*	.040

Note: *p≤0.05

[7] Defined as a return to the Department of Corrections.
[8] No information was provided on this group regarding whether some were sent to assessment or treatment; they were all returned to prison.
[9] One-sample T Test was estimated using a point estimate of 0.2547.

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To properly assess the relationship between Groups 1 & 2 (and the potential effect of the treatment experience), multivariate models were estimated to localize any relationship between treatment experience and failure after release. Using a cumulative sample of 866 (i.e., Groups 1 & 2 combined), several independent variables were statistically significant when regressed on the likelihood of failure. For all variables, the coefficient, standard error, and odds ratio (when statistically significant) are reported in Table 4.4. Most importantly, those who successfully completed the treatment program (i.e., Program Completion) *were not less likely* to fail; they were statistically indistinguishable from those in Group 1 who received partial treatment. Time at Risk was positively related to failure indicating that the longer an individual was outside of a MDC facility their chances of failure increased. This variable was not substantively impactful, but necessary to include as a measure that acknowledges individuals may vary in the amount of days released from a MDC facility. Other relevant predictors of failure include younger individuals (0.97 odds ratio) and Native Americans who were 2.3 times more likely to fail compared to Whites. Also, those with a three or more previous trips to MDC were 3.2 times more likely to fail, which conforms to the criminological axiom that past behavior is the best predictor of future behavior. Finally, individuals with previous institutional infractions were substantially more likely to fail. Interestingly, individuals with a previous violent conviction were no more likely to re-offend.

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Table 4.4: Montana - Logistic Regression of Treatment Effect: Dichotomous (N=866)

	Coef.	S.E.	O.R.
Constant	-1.818**	0.313	--
Programmatic Factors			
Program Completion	-0.629	0.339	--
Time in MDC	0.000	0.000	--
Time from Treatment	-0.001	0.001	--
Time at Risk	0.001***	0.000	1.001
Demographic Factors			
Age at Prog. Entrance	-0.027**	0.010	0.973
Black	-0.990	1.420	--
Hispanic	0.079	0.591	--
Native American	0.811***	0.213	2.251
Marital Status - Single	0.211	0.209	--
Criminal History			
2nd Trip to MDC	0.293	0.258	--
3 or Greater Trip to MDC	1.154***	0.215	3.171
Violence	-0.063	0.296	--
Institutional Factors			
1-5 Infractions	3.040***	0.335	20.915
Chi-Square		259.63***	
R^2		0.369	

Note: *p≤0.05; **p≤0.01; ***p≤0.001; Dropped due to lack of variation and/or inflated standard errors: Male, Other, 6 or More Infractions.

Reference groups: White, No Previous Criminal History, No Infractions.

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To further investigate the potential effectiveness of program treatment, an additional logistic regression model was estimated (see Table 4.5). The dependent variable was failure, but the key independent variable was the number of days in the program (i.e., Time in Program). While all other variables exhibited substantively similar relationships with the dependent variable as reported previously, individuals with fewer days in treatment *were more likely to fail*. This result suggests that some effect of treatment may be working to influence the likelihood of success post-release. This issue is discussed in greater detail in Chapter 7.

Table 4.5: Montana - Logistic Regression of Treatment Effect: Dosage (N=866)

	Coef.	**S.E.**	**O.R.**
Constant	-1.370*	0.644	--
Programmatic Factors			
Time in Program	-0.006**	0.002	0.994
Time in MDC	0.000	0.000	--
Time from Treatment	-0.001	0.001	--
Time at Risk	0.001***	0.000	1.001
Demographic Factors			
Age at Prog. Entrance	-0.027**	0.010	0.973
Black	-1.089	1.396	--
Hispanic	0.076	0.588	--
Native American	0.815***	0.213	2.259
Marital Status - Single	0.214	0.210	--
Criminal History			
2nd Trip to MDC	0.285	0.260	--
3 or Greater Trip to MDC	1.191***	0.216	3.290
Violence	-0.128	0.297	--
Institutional Factors			
1-5 Infractions	3.033***	0.333	20.763
Chi-Square		265.42***	
R^2		0.376	

Note: *p≤0.05; **p≤0.01; ***p≤0.001; Dropped due to lack of variation and/or inflated standard errors: Male, Other, 6 or More Infractions.

Reference groups: White, No Previous Criminal History, No Infractions.

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A final model was estimated to examine indicators of success for only those who completed the program. The results of this analysis were substantively similar to the previous models, with one exception. Time in MDC was positively related to failure indicating that the longer an offender is held by MDC, the more likely they are to be unsuccessful once treatment is complete. Importantly, the substantive impact of this variable, however, is minimal. Time at Risk, younger offenders, Native Americans, and those with criminal histories and previous institutional infractions were also more likely to fail post-release. Please see Table 4.6 for specifics. Interpretation and implications of the results from the WATCh program are presented in Chapter 7.

Table 4.6: Montana - Logistic Regression of Program Completers (N=760)

	Coef.	S.E.	O.R.
Constant	-2.509***	0.580	--
Programmatic Factors			
Time in MDC	0.001*	0.000	1.001
Time from Treatment	-0.002	0.001	--
Time at Risk	0.001***	0.000	1.001
Demographic Factors			
Age at Prog. Entrance	-0.034**	0.011	0.966
Black	-0.737	1.453	--
Hispanic	0.130	0.609	--
Native American	0.885***	0.236	2.422
Marital Status - Single	0.288	0.227	--
Criminal History			
2nd Trip to MDC	0.370	0.280	--
3 or Greater Trip to MDC	1.131***	0.239	3.098
Violence	-0.222	0.330	--
Institutional Factors			
1-5 Infractions	3.016***	0.343	20.411
Chi-Square		250.33***	
R^2		0.398	

Note: *p≤0.05; **p≤0.01; ***p≤0.001; Dropped due to lack of variation and/or inflated standard errors: Male, Other, 6 or More Infractions.
Reference groups: White, No Previous Criminal History, No Infractions.

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CHAPTER V: OHIO FINDINGS

This chapter reports the findings generated by the project's qualitative data collection and analyses for the Ohio program. This includes those results used to inform the first two research questions: 1) Do these programs adhere to evidence based practices that have documented success in addressing substance abuse?, and 2) Do these programs deliver treatment in a manner consistent with program protocols thereby demonstrating program fidelity?

The findings presented in this chapter are organized around these questions and draw from data gleaned from in-depth interviews, focus groups, and document analysis. Prior to discussion of each program's evidence-based design and implementation fidelity, a descriptive overview of the program is offered including its content and structure. The Montana and Ohio programs are presented as separate chapters and follow the same organization: program description, compliance with evidence based practices, and program fidelity.

Program Description

The Ohio Department of Rehabilitation and Correction (ODRC) has operated a DUI/DWI program for nearly fifteen years through subcontract with a private company, but recently this program was relocated and taken over by the state. In the past, the program operated at a site in northern Ohio, but in the Fall of 2009, the program was moved to Madison Correctional Institution near Columbus, Ohio. Preliminary conversations with the Chief of Recovery for ODRC revealed that the curriculum had been modified slightly since the relocation and that they were anxious for an independent assessment of its implementation and effectiveness. This program is also cognitive change based and is delivered on targeted three month cycles.

Admission to the DUI program is reserved for offenders who are serving a felony level 3 or 4 OMVI (i.e., operating a motor vehicle under the influence) and are classified as Level 1.

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These offenders must also have a security level of 1A or 1B in order to qualify for program eligibility. Offenders are considered ineligible for the DUI program if they have a history of violence, are sex offenders, or have been convicted of a crime which violates the public trust. Beyond these stated criteria, there is a considerable amount of discretion for judges and the facility's (i.e., Madison Correctional Institution) warden in terms of who is actually admitted to the program. Findings suggest that there are a number of other Ohio offenders who meet the statutory requirements for program admission but who are denied entry by either the sentencing judge or by the warden during screening.

Statutory authority for the Ohio DUI program was first granted by Senate Bill 166 which became effective in late 1996 and established intensive program prisons (IPPs) for certain offenders who had been convicted of DUI crimes. Operation of and admission to the ODRC program is governed by Ohio Revised Code §5120.033. Under the revised code, ODRC may place a prisoner who is sentenced to a mandatory prison term for a third or fourth degree felony OVI offense unless the sentencing judge disapproves the placement. This is a unique political feature of the selection process for this program relative to other rehabilitative correctional programs in that it places ultimate authority for treatment not in the hands of correctional staff or treatment professionals, but elected agents of the judiciary. Once selected for program admission, offenders are required to remain in the program for a period of three weeks, after which they may choose to remove themselves from treatment and return to the general population for the remainder of their original sentence.

The primary goal of the Ohio DUI program is to assist offenders in learning the skills necessary to live a sober, drug-free, and crime-free life. The programmatic objectives designed to achieve this overall goal of behavioral change include the address of thinking and behavioral

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errors, the improvement of decision-making skills, and job force readiness, which includes employment skills development and resume writing. From the perspective of the ODRC, the DUI program, along with the other system operated IPPs, are intended to increase public safety through the reduction of recidivism and to decrease the overall prison population in the State of Ohio.

The Ohio DUI program is a 90-day program that focuses primarily on alcohol and drug abuse treatment. As noted above, the program is housed at the Madison Correctional Institution which is a medium security facility near the state's capital, Columbus. Madison is also the primary facility for housing Ohio's convicted sex offenders. The program is designed to accommodate 24 offenders at one time, resulting in low client-to-counselor ratios (i.e., 12:1) with two full-time treatment staff assigned. ODRC designed the program such that there is a minimum of 32 hours of program activity each week comprised of 13.5 hours of AOD programming per week with an additional 19 hours devoted to other program activities.

Program participation begins with an intake assessment designed to provide offenders with an individualized treatment plan (ITP). These ITPs are revisited every 30 days and altered according to offender's progress in the program. The Ohio DUI program is essentially a cognitive-behavioral change program which utilizes the "Residential Drug Abuse Program", or RDAP, curriculum. The RDAP curriculum is provided to state and local correctional institutions by the Federal Bureau of Prisons (FBOP) and is designed so that RDAP participants live together in a housing unit separate from the general population (Federal Bureau of Prisons, 2009). This cognitive-behavioral program includes components to break down criminal thinking, build rational thinking, improve relationships and interpersonal skills, and help inmates develop a

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strategy to maintain recovery and a crime-free lifestyle. The Ohio program also utilizes AOD classes to supplement the RDAP curriculum.

Treatment is delivered in both individual and group settings, with two group sessions taking place each day (once in the morning and again in the afternoon). Participants are also required to attend five days a week of AOD classes and Twelve Step Fellowship meetings each evening. Offenders are expected to participate in community service while in treatment which involves working with a company Prince Computers on a range of projects, such as creating materials used in elementary education (e.g., math flashcards). This activity is designed to serve as a segue way for employment following release, with the company providing opportunities for participants once they have successfully completed the program.

While the Ohio program is 90 days in duration, all offenders are expected to continue their treatment following release. Participants are transferred to a community corrections location (i.e., halfway house) upon release from Madison. This halfway house, Talbert House, is located in Cincinnati, in the southwestern part of the state, approximately 120 miles from Columbus. This element of the program, referred to as "Phase II", is designed to build upon the work begun at Madison and is anywhere between 30 and 90 days in duration. Activities are intended to be linked with the treatment received while incarcerated and materials utilized while inside Madison are transferred along with the offender for continued use at Talbert House. The overall goal of the halfway house program is to reinforce the offender's decision to eliminate the use of alcohol.

Like the in-prison phase of the program, the halfway house phase is rooted in cognitive-behavioral programming designed to reinforce prosocial ways of thinking, feeling, and behaving and to avoid the traps of criminal thinking errors while on the outside. Each client attends

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Corrective Thinking and AOD treatment groups while at the halfway house and are expected to engage meaningful employment or volunteer opportunities during this phase. Work or community service cannot interfere with the program's treatment schedule. Treatment is primarily group-based at the halfway house and includes the RDAP curriculum as well as "Thinking for a Change".

Offenders are assessed upon arrival to Talbert House using several diagnostic tools including the Ohio Risk Assessment and the SASSI. Information gleaned from the assessment process is then utilized to develop the individualized service plans guiding aftercare. Plans for aftercare services are to be implemented while at the Talbert House so as to create an easier transition back to the community. This halfway house phase of the program also aims to connect offenders with family and community resources in the location to which they will be eventually released. This aspect of the program is a particular challenge since most offenders are not from the Cincinnati area and in some cases can be as much as five hours from their communities.

While at the Talbert House, offenders are eligible for additional service components including job readiness training, anger management classes, and money management. These additional service needs are identified during the assessment and incorporated as appropriate into the individualized service plans. The halfway house phase of the program lasts anywhere between 30 and 90 days with most offenders released from custody within two months (60 days).

Qualitative Results: Evidence-Based Practices Design

As described in the methodology chapter (Chapter III), each program's compliance with evidence-based practice was assessed primarily by its consistency with guidelines set forth by the National Institute on Drug Abuse (NIDA) in *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide* (Revised Ed.) (2012) and *Principles of*

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Drug Addiction Treatment: A Research-Based Guide (3rd Ed.) (2012). More specifically, each program was assessed on the following areas: 1) assessment, 2) treatment length, 3) individualized treatment, 4) drug use monitoring, 5) focus on "criminal thinking, and 6) continuity of care (i.e., aftercare). The findings presented below are organized around these six key areas and evaluate how well the program complied with guidelines set forth by NIDA (2012a, 2012b).

Assessment

The Ohio program is designed so that participants are assessed upon intake using several diagnostic tools. The use of multiple diagnostic instruments can be advantageous in that it increases the validity of these important initial assessments. DUI-IPP program participants are assessed using the following: 1) ORAS, 2) SASSI, and 3) TCUDS. Each of these assessment tools are well established in the addiction treatment literature and have been previously validated.

The Ohio Risk Assessment System, or ORAS, was developed specifically for use in the Ohio Department of Rehabilitation and Correction (ODRC) and is utilized at various points in the criminal justice system for assessing Ohio's offenders. The main purpose of this diagnostic tool is to predict the likelihood of recidivism at various points of system involvement.). The Substance Abuse Subtle Screening Inventory, or SASSI, is one of the most well known and frequently used diagnostic instruments in addictions treatment. This tool has demonstrated high reliability using multiple methodologies and corresponds closely with clinical diagnoses (Lazowski et al., 1998). Finally, the Texas Christian University Drug Screen, or TCUDS, is a brief self-administered tool for DSM-IV classification of drug use and dependence, and it is widely used in correctional settings (Knight, Simpson, & Hiller, 2002).

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Conclusion - Consistent with NIDA Guidelines?: YES

Treatment Length

The Ohio DUI-IPP program is designed to operate on two three-month (90 day) cycles and is structured in two consecutive phases (Phases I and II; 180 days total in treatment). Phase I entails 90 days of in-prison treatment consisting of group-based cognitive-behavioral therapy. Phase II consists of an additional 30-90 days of post-release treatment in a community corrections facility (i.e., halfway house). These two phases, described in detail in the previous section "Program Description", are based on the cognitive-behavioral "Residential Drug Abuse Program", or RDAP, curriculum (FBOP, 2009). As such, the program length does meet the minimum 90 day guideline set forth by NIDA and in fact exceeds it by an additional 30-90 days, depending on offender progress.

Conclusion - Consistent with NIDA Guidelines?: YES

Individualized Treatment

The Ohio DUI-IPP program is designed such that clients are assessed immediately upon entry to the program toward the goal of developing an individualized treatment plan (ITP). These ITPs are created with input from both the assessment and treatments teams and the clients themselves, and are designed to address the totality of the participant's recovery needs. More specifically, these ITPs include some details common to all participants (e.g., chemical dependency needs/alcohol abuse) and others that are more particular to the individual client (e.g., dual diagnosis needs).

The Ohio DUI-IPP program requires that ITPs are developed at the start of Phase I. These ITPs are then updated every 30 days while in the program to reflect participant progress and changing needs. Following the successful completion of Phase I programming (i.e., that

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which occurs in prison), clients again develop an ITP for the halfway house component of the program. These Phase II plans are intended as an approach to recovery which takes into account their eventual release back to their community following their stay at the halfway house. The case manager from the Talbert House meets with each participant approximately two weeks before their release from Madison Correctional Institution to ensure consistency between the ITPs developed in prison and those for use at the halfway house.

Conclusion - Consistent with NIDA Guidelines?: YES

Drug Use Monitoring

The Ohio DUI-IPP program is predicated on the principle of abstinence from substance use; as a result, drug use is not tolerated among program participants. Drug use monitoring is an important feature of the Ohio DUI-IPP during both the in-prison and halfway house components of the program. During the course of treatment, regular and random breathalyzer and urinalysis are employed to immediately detect any relapse episodes. Furthermore, unlike the other programs examined by this project, the DUI-IPP is located in a medium-security correctional facility, not a treatment facility *per se*. As such, security remains paramount for this medium security facility. Correctional staff provide 24 hour per day, seven days per week security along with regular and random security searches of offenders and their living areas. The facility also utilizes multiple levels of razor-wire perimeter fencing and video monitoring of the interior and exterior areas. Collectively, the security procedures and program monitoring enable effective drug use monitoring of DUI-IPP participants.

Conclusion - Consistent with NIDA Guidelines?: YES

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Targeting Criminal Thinking

As reported previously, the Ohio program utilizes the *Residential Drug Abuse Program* (RDAP) as its core curriculum. This modality is a cognitive-behavioral based approach which is suited for long term programs such as the DUI-IPP and focuses on the address of criminal thinking errors. This cognitive-behavioral program includes components to break down criminal thinking, build rational thinking, improve relationships and interpersonal skills, and help inmates develop a strategy to maintain recovery and a crime-free lifestyle.

The DUI-IPP is designed to explicitly target criminogenic needs, including antisocial personalities, attitudes, and values, as well as poor self-control and problem-solving skills. This focus on criminal thinking is continued during the halfway house phase of the program which includes continuation of the RDAP curriculum and the well-known cognitive-behavioral approach "Thinking for a Change". Collectively, the focus placed on criminogenic needs by the program enables the targeting of criminal thinking errors.

Conclusion - Consistent with NIDA Guidelines?: YES

Continuity of Care

A key element of corrections-based substance abuse treatment is the provision of aftercare services following release (Springer et al., 2003). While the Ohio DUI-IPP begins in prison, it ends at a halfway house where structured treatment continues for an additional 30-90 days. In fact, the state law which created the DUI-IPP program (Ohio Revised Code §5120.033) also mandates that participants are transferred to the halfway house to begin the reentry process. While at the halfway house, offenders participate in aftercare services which are linked with resources in the community.

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Overall, the program is designed with attention to aftercare services and individualized recovery plans. Approximately two weeks prior to their release from the Madison Correctional Institution, the participants meet with the halfway house case manager for the purposes of planning the individualized service plans that are used during this second phases (i.e., the reentry accountability plans). After transfer to the halfway house, activities are intended to be linked with the treatment received while incarcerated and materials utilized while inside Madison are transferred along with the offender for continued use at Talbert House.

Conclusion - Consistent with NIDA Guidelines?: YES

Qualitative Results: Program Fidelity

As described in Chapter 3, program fidelity was assessed using data derived from interviews, observations, and document analysis. A fidelity instrument (Appendix A) was used to document and compare observations that, in conjunction with field notes, enable objective and systematic consideration of fidelity level across programs. Each component of fidelity were evaluated independently by the research team members (N=3) using the fidelity scale; following this initial round of scores, the research team met to compare ratings and achieve inter-coder consensus. Programs were then given a score which reflected the assessment of all three researchers.

The fidelity instrument was developed by the research team prior to the start of the current project and was based on the extant program evaluation literature (Stead et al., 2007; Melde et al., 2010) and the research team's prior experiences with addiction treatment program evaluation (Miller et al., 2004; Miller & Miller, 2010; Miller & Miller, 2011; Miller et al., 2012; Miller et al., 2010). The instrument was developed in accordance with the primary elements

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comprising fidelity in criminal justice and treatment contexts: adherence, exposure, delivery quality, participant engagement, and program differentiation.

Adherence

Adherence was assessed through six (6) separate items which were scored dichotomously as yes or no, where yes = 1 and no = 0. These items denoted whether or not the program had met the minimum requirement per the intended design. Specifically, staff qualifications, program components, caseload, intake and assessment, individualized service plans, and dosage were examined for adherence to evidence-based practice.

In terms of formal staff qualifications, the DUI-IPP program requires the treatment staff to be licensed substance abuse/chemical dependency counselors thus meeting this particular criterion. The DUI-IPP is operated by two primary treatment staff members who are responsible for delivery of the program content, development of the ITPs, and counseling of the participants. Both of these staff members exceeded the minimum requirements for their positions with each holding both baccalaureate degrees and advanced certification in chemical dependency counseling. Both had considerable experience at ODRC with a combined 43 years of service in the department. Formal staff qualifications were also assessed at the halfway house and found to similarly be met by those operating this component of the program. Two primary treatment staff are responsible for program delivery at the halfway house and both met the minimum requirements for their positions. Similar to the in-prison staff, both held baccalaureate degrees and advanced certification in chemical dependency counseling.

Program component standards varied by phase of the program, that is, the in-prison component or the halfway house component. The program was initially intended and described by ODRC as a cognitive-behavioral approach situated within a therapeutic community. In

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reality, the program is a cognitive-behavioral approach executed primarily through group-based counseling and alcohol and drug (AOD) classes. The participants are not separated from the general prison population and are not housed together in the same dormitories within the medium security facility. The program does, however, deliver cognitive-behavioral treatment in both individual and group settings. The program utilizes the RDAP curriculum, a well known cognitive-behavioral approach, along with AOD courses, victim awareness classes, and Twelve Step Fellowship (i.e., AA, NA). The halfway house is similarly designed to provide CBT which is linked with the treatment received during the in-prison phase of the program. Data gleaned from the halfway house site visit, however, suggested a pattern of inconsistent treatment with dubious connections to in-prison activities.

The prescribed caseload element of the adherence measure was easily met by the Ohio program. Both phases of the program (in-prison and halfway house) included small cohorts of participants thus lessening the burden for case managers and counselors. Substance abuse treatment best practices mandates a client to counselor ratio that ideally ranges between 15:1 and 25:1, with better outcomes and increase treatment services more likely with a lower ratio (CSAT, 2005; SAMHSA, 2003). As noted in Chapter 3, the DUI-IPP did not exceed more than seven participants during either year of the current study (N=7 in Year 1, N=5 in Year 2). And with two full-time treatment staff members, the client to counselor ratio remained well below best practices recommendations. Interviews with halfway house program participants, however, indicated that despite the low numbers of DUI-IPP participants residing at Talbert House, the case manager was also responsible for other residents and as a result was burdened with too many cases. Consequently, the program's in-prison component was consistent with the prescribed caseload recommendations while the halfway house component was not consistent.

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Both intake timeliness and individualized service plans were also examined in the assessment of design adherence. In terms of intake timeliness, subjects universally confirmed that assessment occurred at two junctures; first, upon admission to ORDC and again after referral to the program housed at Madison Correctional Institution. All participants had been located at other correctional facilities prior to their transfer to the program and initial assessments were completed at those original locations. The purpose of these assessments at the start of the program is to develop the client's individualized treatment plan (ITP) which guides the recovery process. ITPs are developed and updated at several points during the in-prison phase of the program. The first ITP is done at the start of the program with additional revisions taking place every four weeks. Another ITP is created to serve as the blueprint for reentry shortly before transfer to the halfway house. This ITP is done in conjunction with program staff and the halfway house case manager who travels to Madison approximately two weeks prior to the participants' release. Interviews with program participants at Madison suggested that some ITP content was similar across participants but that certain specialized elements were included as well.

Interviews with halfway house residents suggested greater inconsistency in the assessments completed during Phase II. For example, several participants reported that while assessment was mandated within 48 hours of arrival, they had waited 10 days for their initial meeting and assessment with treatment staff. Additionally, interviewees reported that the workbooks that guided treatment activities while they were incarcerated, and were intended for continued use during the halfway house phase of the program, were instead not available to the participants during Phase II. As a result, the transition to the halfway house phase of the program served as an interruption to a continuum of treatment activities intended by the ITPs.

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The content of the treatment sessions was also called into question by the participants who characterized them as lacking in substance compared to Phase I. This, in turn, prevented goals outlined in the ITPs from being realized by program participants. Overall, evidence suggested that while the in-prison component of the program utilized ITPs, attention to these plans fell by the wayside somewhat at the halfway house.

Finally, the adherence measure included compliance with the substance abuse literature's best practices for prescribed treatment dosage. Prescribed dosage compliance refers to the relative exposure of participants to the combined elements of the program. Essentially, this measure was designed to reflect whether or not the program was structured and executed in a way such that the individual program components are being delivered at a rate and ratio prescribed by the modality. Based on the interviews, focus groups, and document analysis, the research team concluded that the prescribed dosage criterion was met in the prison but not at the halfway house. Overall, the Ohio program earned mixed scores on the adherence measure of the fidelity scale largely due to deficiencies in the halfway house phase.

Exposure

The second element of the fidelity scale is exposure which refers to the amount of time and in what combination treatment content is delivered. More specifically, exposure was measured by contact frequency hours (per day) and program duration, which denotes the length of time clients participate in treatment activities (i.e., program length). Both of these items were ranked on a five-point ordinal Likert scale with higher scores denoting greater consistency with treatment protocols. The two scores were then averaged for an overall exposure score (possible range 1-5).

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In terms of contact frequency, the DUI-IPP met the recommended hours per day of treatment according to original program design. Participants engaged in four hours per day, five days per week of the RDAP curriculum, which was supplemented with additional hours of AOD classes (five hours per week), victim awareness classes (variable between weeks), and Twelve Step Fellowship meetings (AA/NA, five nights per week). Collectively, treatment programming occupies between six and seven hours per day, five days per week for the participants of the DUI-IPP.

The assessment of exposure also included a measure of program duration, or the amount of time participants spent in the program. The DUI-IPP program is executed across two interrelated phases (i.e., in-prison phase and halfway house phase) spanning approximately six months (180 days)[10]. This length of time is consistent with, and in fact exceeds, the recommended program duration length of three months (NIDA, 2012a). The data derived from each of the qualitative methodologies (i.e., interviews, focus groups, document analysis) confirmed that the program duration in practice was consistent with evidence-based design. Based on the scores obtained on this measure across the three research team members, the DUI-IPP program received high scores on the exposure measure of the program fidelity scale. It should be noted, however, that while the program is designed to continue at the halfway house, there was considerably less implementation intensity during this second phase. So, despite the best practices design with respect for frequency and exposure, execution was lacking during Phase II.

[10] Note that the second phase of the program, located at the halfway house, ranges between 30 and 90 days, with most participants completing Phase II within 60-90 days.

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Delivery Quality

Delivery quality was assessed by four separate items which were scored using a five-point ordinal Likert scale with higher scores denoting higher delivery quality. These four items included treatment plan compliance, counselor/staff qualifications, counselor/staff attitude, and counselor/staff continued training. These items were designed to capture the overall quality of treatment content delivery with a specific focus on those responsible for its delivery – treatment staff. Scores were then averaged across the four items for a mean delivery quality score.

The first element of delivery quality examined the extent to which the treatment was compliant with the individualized plans devised for each participant. To inform this question, interviews with both program staff and participant focus groups included questions related to the consistency with which actual treatment activities and protocols reflected the elements included in the ITPs. Program participants at both the prison and the halfway house were pointedly queried about this issue as they were in a particularly unique position to confirm or deny compliance with these plans. For the in-prison participants, focus group interviews revealed overwhelming agreement with the idea that the treatment the clients received was in fact consistent with that delineated in the individualized plans. Again, however, this was inconsistent across phases, with the halfway house cohort indicating that very little treatment at all was taking place, to say nothing for individualized treatment. Accordingly, the DUI-IPP program received inconsistent scores from each member of the research team on the issue of ITP compliance across the two phases of the program.

The remaining three items used to assess delivery quality centered on the qualifications, attitude, and continued training of the treatment staff. A treatment program's staff, and especially staff members' ability to develop rapport with clients, is considered a salient factor in

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successful recovery and rehabilitation approaches. Programs whose participants do not have confidence in the ability of the treatment staff are less likely to produce successful outcomes than those that employ staff who are experienced, committed, sincere, and enthusiastic about treatment delivery. In terms of qualifications and continued training, all staff interviewed indicated that they had met the minimum education and training requirements for substance abuse counseling and all possessed credentials that exceeded these minimum expectations (n=4; 2 Phase I staff, 2 Phase II staff). Interviews with program administration and staff as well as review of official program materials and documents also suggested that treatment staff are not only expected to possess the requisite qualifications for the position, they are also encouraged to engage continued education while employed. More specifically, staff interviews at the prison indicated that they were expected to complete an additional 40 hours of training every two years in order to remain licensed substance abuse counselors.

The attitude and level of engagement of the treatment staff was assessed through staff interviews and focus groups with program participants during the site visits. The focus group interview schedule also examined the participants' perceptions of the counselors and staff with a particular emphasis on their effectiveness, knowledge, and attitude. Based on data drawn from these sources, it was clear that Phase I program staff displayed a committed and positive attitude toward their careers and the participants. Staff members were enthusiastic, knowledgeable, and committed to the activities which comprised the program components. Few respondents had anything negative to offer related to the treatment staff and the vast majority offered laudatory comments about them. Interviews were also conducted with staff and participants at the halfway house wherein residents offered less than positive comments about the Phase II staff.

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Below are some representative participant responses related to the program treatment staff, delineated by phases:

Phase I Staff:

"He's awesome. Mr. Lowe, he's awesome."

"No we've dealt with a couple of them, but Mr. Lowe, he like actually takes the time and explains everything to you. He puts it in a way which you can understand it… You know, it all comes together one way or another, and then he even makes it like a little bit fun. He makes you want to come here for class, and that's my opinion of Mr. Lowe."

"Yeah, Mr. Lowe is a real good counselor. Lowe is good. I mean he actually stood there and he'd talk to you."

"…if there was any way in my power to keep that man and not let him retire I would because he's good."

Phase II Staff:

"That's what I was going to say about working, you can't schedule because the classes are so inconsistent. They started out to be 10:00 till 12:00, then sometimes they're 2:00 to 4:00, and now they've got us in this other class corrective thinking class that they're going to make us take that's sometimes in the morning and sometimes in the evening. There's no way you can schedule any work. And then they go on vacation, and then they didn't come in today or whatever."

"She said, "Why don't you just take a taxi when you're out drinking?" So in other words you're saying go ahead and drink."

[In reference to a question about staff quality at the halfway house]

"The warden said he was going to send a copy of all the files. We heard that one before. The thing of it is when they said they were going through our files I assumed they would know what our prior treatment plans were going to be and everything else but it seemed like they didn't know anything."

"So far we only know one because it is pretty chaotic. This person doesn't know what this person is doing."

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Based on the totality of the data collected through interviews and focus groups, the DUI-IPP program received mixed scores from each member of the research team on the issues of treatment plan compliance and staff quality/attitude. As with the prior assessments detailed above, Phase I staff and activities receive high fidelity scores while Phase II staff and activities receive low fidelity scores. Overall, the research team afforded a moderate score to the Ohio program on delivery quality overall.

Participant Engagement

Participant engagement was assessed by three separate items which were scored using a five-point ordinal Likert scale with higher scores denoting higher participant engagement. These three items included participant attitude, participant involvement, and participant barriers. The participant barriers item was reverse coded, so that higher scores indicated fewer barriers to client participation. These items were designed to capture the overall engagement level of the program participants across the treatment activities. Scores were then averaged across the three items for a mean participant engagement score.

Participant involvement was investigated primarily through the focus group and staff interviews. Data produced from these aspects of the study revealed that the majority of program participants were engaged in treatment activities and committed to their recovery. However, halfway house participants reported disparities in the treatment quality across the phases and indicated that they were not as engaged in Phase II treatment as they had been with the in-prison programming. This was due in large part to the haphazard manner in which treatment protocols were administered at the halfway house and the lack of confidence participants had in the Phase II staff relative to their in-prison counterparts.

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Participant attitudes were similarly assessed through the use of focus group interviews. These focus group interviews afforded participants the opportunity to speak freely and honestly about their attitudes toward the program and their own recovery without the fear of repercussions from facility staff. While there were a small number of clients who appeared slightly less than enthused about their participation in the program, the majority of respondents reported a positive attitude about the program overall. Subjects spoke about the program both in terms of its specific components and how it fared compared to other treatment programs they had experienced previously. Below are some representative subject responses illustrating participant attitudes towards the program:

> *"At Madison I think I got a lot out of that program. Down here am I going to say this place made me negative? Guarantee it has made me not want to be in this situation again but the whole thing of it is I don't think what I learned in Madison and then come here is going to affect me in a negative way because I did learn a lot from those 90 days in there. What I learned here is patience. It is what it is. It is out of my control and I got to do this and complete this so I can go home."*
>
> *"Yeah I would say it was good. I mean, if you got to go to prison for such a thing anyhow, we might as well do something productive. When I first was told I was going to prison I told myself, "Something good is going to come of this." And that class, it helped make the time go during the day; you know it gave you something to do. We had homework to do, you know, something to work on, and it kept your mind occupied on that one topic."*
>
> *"The deeper we go into these journals; it's making me think a lot. A lot more than I've ever thought about; about problems I never knew I had."*
>
> *"I think it's going to give us more tools. I mean just the threat of coming back here is the biggest stick in the bag that got a hold of me. I mean, I've suffered enough, but this will help. I've just got to change some habits is all, and this will help look and take a deeper look and find out the easier way to have fun without the darn bottle."*

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"It's part of life. If I didn't put myself in this situation, I wouldn't have to sit here and complain about it."

The final item examined to assess participant engagement was the extent to which environmental/contextual barriers made participation in the treatment program challenging or problematic. Often times, prison-based treatment can introduce a number of barriers to program participation and recovery for drug addicted offenders (Miller et al., 2010). There is even considerable doubt as to whether the prison environment is appropriate or even feasible for rehabilitation (Prendergast et al., 2002). Recovery from addiction is a difficult period for any individual, and from a best-practices orientation, a therapeutic environment is favorable. The basic deprivation of liberty along with the specific discomforts and humiliations characteristic of prison life are not necessarily conducive to recovery.

One common barrier to program participation relates to tensions between treatment and security staff and in particular how the conflicting objectives of punishment and rehabilitation are concurrently realized. Interviews with program administration and staff as well as focus group interviews with participants indicated that there were significant problems associated with the setting in which the treatment was delivered. While the DUI-IPP was originally conceived as a therapeutic community, once the program was transferred from the North Coast Correctional Facility to the Madison Correctional Institution, this type of delivery format was abandoned. Instead, participants are housed along with the general population at Madison, inconsistent with best practices design. Participants are not even housed together in the same dormitory, leading to even greater isolation among this group. Participants were queried about the barriers to recovery that they perceived as most challenging to them. Below are some representative examples of comments made regarding the treatment environment:

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"…do I feel this is an environment conducive to my mental stability and my recovery? No, I do not. I absolutely don't, but it is what it is."

"Well, then come closer to the time when the new class started we got that all taken care of, but I figured when I got here we were all going to be housed because it says therapeutic community and I figured, you know, we were all going to be housed together. Well, boy was I wrong. We're scattered throughout the camp and when I first got here I was in one of the worst dorm ever. They're kicking boxes, fighting, you know you get everything and here you are sitting here trying to change yourself and get in the ruckus..."

"Like other people get in trouble, and I'm on bunk restriction. So I've got nothing to do for 24 hours a day, just think of things to do, be loud and obnoxious like he was saying. I was just sitting there doing my homework, and its chaos going on right there, and it's like "Why don't they just put us all in one quiet dorm?"

"And that's what started out at North Coast. I mean at North Coast it started out, that's what it's supposed to be, and then you come down here. You go from an institution that has people that are doing a mandatory, a maximum of like four years, to come down here to where this place is known as a sex offender camp. That's all it's known for. And they say that they're over there, well that's what they told me when I came down, "Oh you don't see them, you don't see them." Yeah ok. Yeah, they started out over in that other building. Well then after six months or however long those freak shows are over there, they come over here. So you're all mixed together."

"Well when you're getting out of the program and someone else starts a fight with us, we can get kicked out of this program if someone else causes trouble you know, because we're involved. They don't stop us, and then they have to do an investigation and all this other stuff. Then it's something bogus to see if we can come back in."

"They can extort you for it, because somebody who's not allowed, or doesn't want to get in a fight, somebody who is going to do what they can not to get in a fight, to protect going home, can be extorted."

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"There's a lot of people that want this program, but how can you really concentrate on this program when you got to worry about what's going to happen when you go back to your dorm? You know the issues you have to deal with back there. I mean it's suppose to be inside the walls, but I mean if you really want the program then you want to try and concentrate on it. You know like they give us homework, we go back and we sit down and try to concentrate on doing homework and stuff like that, and you got freaking idiots around you that are doing different things, saying different things, playing like kids. I mean, how are you supposed to concentrate?"

Based on the totality of the data collected through interviews and focus groups, the DUI-IPP program received mixed scores from each member of the research team on the issues of participant involvement, attitude, and barriers. As with the prior assessments detailed above, the first phase of the program received high scores for participant involvement and attitude and low scores on barriers, while Phase II received low scores on all three indicators: involvement, attitude, and barriers. As a result, the research team afforded a moderate score to the Ohio program on participant engagement overall.

Program Differentiation

Program differentiation served as the last of the five elements comprising program fidelity and was assessed using four (4) items: program size fluctuation, program budget fluctuation, caseload fluctuation, and continuity of staffing. Differentiation refers to the unique features of different program components that are reliably differentiated from one another. These four items were scored using a five-point ordinal Likert scale (1-5) with higher scores denoting greater program differentiation. The first three items (program size fluctuation, program budget fluctuation, caseload fluctuation) were reverse coded so that higher scores indicated a more favorable assessment (i.e., programs were assessed more positively when

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program size, budget, and caseload did not fluctuate considerably over time). The continuity of staffing item was coded 1-5 with higher scores indicating a greater continuity of staffing.

The Ohio program is codified in state law and, as a result, has not suffered from many of the common problems associated with treatment program operation. The program operates with a maximum of 24 beds and two full-time staffers; as such there was little fluctuation in either program size or caseload. Staff positions have been funded by ODRC's budget and there have been few offenders referred to the program who were not able to enroll in treatment activities shortly after their arrival at Madison. The treatment staff's caseloads are similarly secure in that the program can serve only 24 offenders at one time. Consequently, there is very little caseload fluctuation in the DUI-IPP program, enhancing the day to day operating procedures from a treatment staff perspective. Treatment staff need not worry about how many clients will be placed on their caseload as they are already aware of this reality per the program size. The consistency of the caseload, then, is advantageous for program operation in that treatment components and protocols can be reliably implemented. Finally, the research team also assessed the Ohio program for continuity of staffing, with a particular focus on treatment staff. Correctional staff turnover has been well documented in the criminological literature (see Lambert, 2001 for a review) and poses a considerable challenge to treatment programs. In that staff quality, engagement, enthusiasm, and rapport-building skills are paramount to successful rehabilitative programs, the continuity of these treatment staff members are also of considerable importance, particularly from the participants' perspective. The DUI-IPP received fairly high scores in this respect, as both members of the treatment staff employed during the first site visit in 2011 were also with the program during the subsequent visits in 2012.

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At the current time, however, recent legislative changes have all but eliminated program operation. Though discussed in greater detail in the final chapter of this report (see Chapter VII), briefly, the Ohio legislature recently mandated that nearly all low-level offenders, such as those served by the DUI-IPP program, must be incarcerated and treated in local jails, not ODRC facilities. Not only does this present a tremendous burden for Ohio's counties, it renders assessment of this program's differentiation moot. Offenders were no longer being admitted to the program as of September 2012 and the future of not only the DUI-specific program, but all IPPs offered by ODRC, remain in jeopardy.

Overall, however, based on the program's assessment while in operation, the DUI-IPP received high scores from each member of the research team on the issues of program size fluctuation, budget fluctuation, caseload fluctuation, and continuity of staffing. Similarly, the research team afforded a high score to the Ohio program on program differentiation overall.

Quantitative Results

The Ohio Department of Rehabilitation & Corrections (ODRC) provided data to the research team on program participants and other ODRC members under supervision between the Fall of 2009 and September 17, 2012. This time period overlaps with the study period and allows for an assessment of treatment effects once individuals were released from ODRC facilities. These data were subsequently categorized into three groups. Group 1 were DUI offenders under the supervision of the ODRC, but based on program eligibility criteria were deemed ineligible for program participation. Group 2 members met the admission criteria, entered the program, and successfully completed the 90-day treatment plan. Group 3 includes ODRC inmates that met the criteria for treatment, but were not enrolled in the program and

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ultimately did not receive any treatment. This group is closest in characteristics to Group 2 (i.e., those who received treatment) and was used as the comparison group for analysis purposes.

The ODRC data indicated that Group 1 (i.e., DUI offenders deemed not eligible, received no treatment) consisted of 1,192 individuals for which information on relevant variables was available in 1,137 cases (4.6% missing data). Groups 2 & 3 had 46 and 112 members, respectively, with information on 45 and 106 individuals on all relevant variables (2.2% and 5.4% missing data, respectively). For all groups, variables provided information on offender characteristics and behavior including demographic information, criminal history, and institutional infractions. A series of temporal variables were also created based on ODRC data. The primary dependent variable of interest was whether or not an individual committed a community supervision violation, a technical violation, a parole violation, or a new offense. These were grouped into a general measure of days to failure.

Variables were dichotomized when appropriate; in some cases, variables were operationalized as continuous measures. For example, offender age was a continuous measure, whereas gender and race/ethnicity were dichotomized (i.e., White, Black, Hispanic, and Other[11]). Education was measured with one variable indicating whether or not the individual possesses a GED or high school diploma. Similarly, marital status was measured as a series of dichotomous variables indicating if the participant is single (or divorced, separated, or widowed), married/common law, or unknown. Offender criminal history (i.e., 1st trip to ODRC, 2nd trip to ODRC, 3 or more ODRC trips) and institutional infractions (i.e., no previous, between 1 and 5 previous infractions, between 6 and 10 previous infractions, and more than 10 previous infractions) were also dichotomized.

[11] The Other category consists of any other race/ethnicity including American Indian, Asian, or Middle Eastern.

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Temporal variables were all continuous measures of the number of days between entrance into the ODRC and the start of the treatment program (i.e., Time to Program), the number of days in the program (i.e., Time in Program), the number of days between completion of the program and release from the ODRC (i.e., Time to Release), the number of total days within an ODRC facility (i.e., Time in ODRC), and the number of days between release from the ODRC and the end of the study period (i.e., Time at Risk). To measure the dependent variable of failure, a continuous measure of the number of days between release and failure was created and a series of dichotomous variables indicating whether or not the individual failed as a result of a community supervision violation, a technical violation, a parole violation, or a new offense were created.

Table 5.1 summarizes the minimum and maximum values, mean, and standard deviation for all variables in all groups. This presentation allows for both within and across group comparisons. Although Group 1 statistics are provided, discussion of Table 5.1 will be restricted to Groups 2 & 3, as they are the most comparable and represent the primary focus of interest in this study. Overall, there are considerable similarities between the Groups 2 & 3 including with respect to their demographic characteristics. Those who received treatment were, on average, slightly younger than Group 3 (i.e., 40.6 years of age compared to 41.1 years of age). In both groups, White members were the majority with 93.3% of Group 2 members comprising this category and 92.5% of Group 3 members categorized as White. One slight difference was in the Hispanic representation, as Group 3 had slightly more Hispanics (4.7%) compared to Group 2 (2.2%).

Differences were also revealed when considering other factors. For example, education levels differed as only 48.9% of Group 2 possessed a GED or high school degree compared to

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63.2% of Group 3. Group 2 also contained more single individuals (91.1%) compared to Group 3 (70.8%). Unsurprisingly, the treatment group had lower aggregate criminal histories with 84.4% of the group indicating this was their first trip to ODRC; roughly half of Group 3 had previously been incarcerated in ODRC (48.1%). Interestingly, previous history of institutional infractions was similar with 88.9% of Group 2 and 91.5% of Group 3 indicating no previous institutional violations.

Temporal measures related to the treatment program were only available for Group 2 and indicate that participants waited between 42 and 1,318 days from ODRC entrance until they began the treatment program. All completers finished in 90 days (the intended length of the program) and all were released from ODRC immediately following program completion. Overall time in ODRC was calculated for both Groups 2 & 3 with Group 3 averaging 524 days in prison and Group 2 spending 340 days under ODRC supervision. Similarly, Group 3 had longer Time at Risk (on average, 744 days) compared to Group 2 (on average, 597 days).

The central interest, and primary dependent variable, is behavior post-release from the ODRC. As summarized in Table 5.1, the failure rate for those who completed the treatment program was 2.2% - one of the 45 individuals was recorded committing a new crime. For those who were eligible, but did not receive treatment, the failure rate was 11.3%. That is, 12 of the 106 individuals were identified committing a parole violation (8.3%) or a new crime (91.7%)[12]. Days to Failure indicate that Group 3 members "failed" after an average of 444 days, whereas the one individual in Group 2 failed after 961 days. Obviously with such a low number of cases, not a lot of substantive conclusions can be drawn from these statistics.

[12] No Group 3 members committed a community supervision or technical violation.

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Table 5.1: Ohio - Basic Demographics

	Group 1: No Treatment, Not Eligible (N=1,137)				Group 2: Treatment (N=45)				Group 3: Eligible, but No Treatment (N=106)			
	Min	**Max**	**Mean**	**S.D.**	**Min**	**Max**	**Mean**	**S.D.**	**Min**	**Max**	**Mean**	**S.D.**
Age	18	73	41.60	9.219	23	65	40.62	9.372	23	64	41.10	8.510
Male	0	1	.945	.229	--	--	--	--	0	1	.868	.340
Race												
White	0	1	.894	.309	0	1	.933	.252	0	1	.925	.265
Black	0	1	.086	.279	0	1	.022	.149	0	1	.028	.167
Hispanic	0	1	.019	.138	0	1	.022	.149	0	1	.047	.213
Other	0	1	.002	.042	0	1	.022	.149	--	--	--	--
Education												
GED or High School	0	1	.651	.477	0	1	.489	.506	0	1	.632	.485
Marital Status												
Single (Div., Sep., Wid.)	0	1	.798	.402	0	1	.911	.288	0	1	.708	.457
Married/Common Law	0	1	.201	.401	0	1	.089	.288	0	1	.293	.457
Unknown	0	1	.001	.030	--	--	--	--	--	--	--	--
Criminal History												
1st Trip	0	1	.506	.500	0	1	.844	.367	0	1	.519	.502
2nd Trip	0	1	.255	.436	0	1	.156	.367	0	1	.311	.465
3 or more	0	1	.239	.427	--	--	--	--	0	1	.170	.377
Institutional Infractions												
No Previous	0	1	.805	.397	0	1	.889	.318	0	1	.915	.280
1-5 Previous	0	1	.174	.379	0	1	.089	.288	0	1	.076	.265
6-10 Previous	0	1	.013	.114	0	1	.022	.149	--	--	--	--
More than 10	0	1	.008	.089	--	--	--	--	0	1	.009	.097
Time to Program	--	--	--	--	42	1,318	234.289	263.695	--	--	--	--
Time in Program	--	--	--	--	90	90	90.000	--	--	--	--	--
Time from Program	--	--	--	--	0	0	--	--	--	--	--	--
Time in ODRC	0	4,639	612.836	511.867	132	1,408	340.378	266.647	45	1,790	524.142	391.000
Time at Risk	18	1,174	627.434	333.848	131	1,076	597.444	283.786	38	1,174	744.509	357.183
	N = 114				**N = 1**				**N = 12**			
Days to Failure	13	1,027	392.158	234.268	961	961	961.00	--	153	939	444.500	259.359
Comm. Super. Violation	0	1	.044	.206	0	1	--	--	0	1	--	--
Technical Violation	0	1	.009	.094	0	1	--	--	0	1	--	--
Parole Violation	0	1	.254	.437	0	1	--	--	0	1	.083	.289
New Offense	0	1	.693	.463	0	1	1.000	--	0	1	.917	.289
Failure Rate	**10.03**				**2.22**				**11.32**			

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A bivariate analysis was undertaken to assess if the failure rate differed substantially between Groups 2 & 3. While not definitive regarding the relationship between the two groups, a t-test is well suited to provide an initial assessment of any potential relationship between the independent variable of interest and the dependent variable. As evidenced in Table 5.2, a statistical difference in failure rate was discovered between those who completed treatment and those who did not participate in treatment. Full exploration of this relationship is best undertaken through multivariate analyses.

Table 5.2: Ohio – Bivariate Analysis: T-Test

	t	**df**	**Sig (2-tailed)** [13]	**Mean Difference**
Failure	2.791	151	.006**	.064

Note: *p≤0.05; **p≤0.01; ***p≤0.001

To assess the potential impact of the treatment program, a multivariate, logistic regression model was estimated. Several caveats are required prior to discussing the results of this analysis. First, combining Groups 2 & 3 to assess for any treatment effect resulted in an extremely small sample. Collectively, 151 individuals were included in the model, the majority of which did not receive treatment. Second, due to the small sample size, the number of independent variables available for the model was significantly reduced. Marital status, a lack of criminal history, and Time at Risk were selected as independent variables. The first two variable were chosen based on their different representations within Groups 2 & 3,[14] while Time at Risk was included as a temporal control. Third, only one individual from the treatment group failed thereby significantly limiting the variability on the dependent variable. Collectively, these factors require extreme caution when interpreting the results of the logistic regression model.

[13] One-sample T Test was estimated with a point estimate of 0.022.

[14] Education level was also noticeably different in the descriptive tables, but was not included in this model due to the limited sample size; marital status and criminal history were selected as conceptually more likely to be related to failure. Additional models included education level, but no statistically significant effects were uncovered.

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Results of the model are provided in Table 5.3 and indicate the only statistically significant variable related to failure is Time at Risk. This is not surprising, as the greater the time away from the program, the greater the chance of failure. Most importantly, program participation was not related to the likelihood of failure. Again, caution must be exercised in drawing strong conclusions from this result due to the aforementioned limitations, but based on this limited sample, it appears that the treatment program did not reduce the likelihood of failure. Neither marital status nor criminal history was related to the likelihood of failure.

Table 5.3: Ohio - Logistic Regression assessing Treatment Effect (N=151)

	Coef.	**S.E.**	**O.R.**
Constant	-3.599**	1.260	--
Program Participant	-0.834	1.114	--
Time at Risk	0.003*	0.001	1.003
Marital Status – Single	-0.433	0.648	--
1st Criminal History	-1.195	0.664	--
Chi-Square		14.919**	
R^2		0.212	

Note: *p≤0.05; **p≤0.01; ***p≤0.001

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CHAPTER VI: TEXAS FINDINGS

Program Description

The In-Prison DWI Recovery Program is housed at the East Texas Treatment Facility in Henderson, TX in the northeast part of the state. The facility and treatment program is operated by the Management & Training Corporation (MTC), who contracted with the State of Texas to provide treatment services based on requirements passed in a recent legislative session. The program received its initial cohort of participants in March 2008. Program capacity is limited to 500 beds and assignment to the treatment program is based on several criteria created by the Texas Department of Criminal Justice (TDCJ). All potential treatment participants must have been convicted of multiple DWI related offenses (i.e., at least four felony DUIs) have no history of violent offenses or major disciplinary infractions, and have an expected parole hearing scheduled within six to nine months of transfer to the treatment facility.

Upon arrival at the facility, licensed counselors assess all inmates and develop an individualized relapse treatment plan (ITP) specific to each individual's needs. Once processed, all residents are assigned to one of nine dormitories that house approximately fifty-six individuals. Licensed counselors deliver the core treatment curriculum in four-hour blocks five days a week. These sessions consist of three components. One hour per session is allocated to working on the DWI Flex Module, a cognitive-behavioral modification program comprised of six interrelated phases or "tracks" that can be completed within a six-month timeframe (one phase per month). The second component introduces curriculum based on the Residential Drug Abuse Treatment (RDAT) provided to state and local correctional institutions by the Federal Bureau of Prisons. The RDAT material focuses on breaking down criminal thinking, building rational thinking, improving relationships and interpersonal skills, and helping inmates develop a

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strategy to maintain recovery and a crime-free lifestyle. The final hour is centered on developing life skills within a group setting for use once released from the facility. Other activities include time spent in educational classes, working within the facility, and engaging the curriculum provided during the treatment sessions. Graduation from the program is achieved when all components of the curriculum are satisfied as determined by the licensed counselors.

Quantitative Results

Quantitative data were requested from the TDCJ from March 2008 (i.e., the start of the program) through December 31, 2011. This time period was selected to coincide with the length of the project while also allowing enough post-release time to generate a scientifically valid measure of program effectiveness. Data was provided by the TDCJ on three different types of individuals during this time period. Group 1 members met the criteria for inclusion, but were not selected for treatment based on an assessment of the TDCJ (i.e., no treatment), Group 2 participants successfully completed the program (i.e., treatment), and Group 3 individuals began, but did not complete the program (i.e., some treatment).

The TDCJ originally provided information on 4,080 offenders across all three groups during the study period (March 2008-December 2011). As of December 31, 2011, 416 of the 4,080 offenders were actively enrolled in the program as participants. Group 1 contained 589 individuals, Group 2 had 2,840 members, and Group 3 included 235 participants. The noticeable distinction between these groups reflects the relatively large number of beds available in the treatment program and the small number of program participants that did not complete the program once admitted. Group 3 was removed from further analysis because of the small number of cases and their mixed experience with the treatment protocol. Basic descriptives are provided for this group in Appendix D.

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For Groups 1 & 2, data were provided by the TDCJ on a variety of measures including demographic information, educational and familial characteristics, previous criminal history, and prior in-prison infractions. Based on the dates of entrance, completion, and release provided by the TDCJ, additional temporal variables were also created. The primary dependent variable of interest was whether or not an individual committed a new crime or technical violation post-release, while the primary independent variable of interest was program participation.

Demographic information included offender age at release from TDCJ for Group 1 and offender age at the beginning of the program for Group 2; both were measured as continuous variables. Offender race/ethnicity was also provided and dichotomized into White, Black, Hispanic, and Other.[15] Gender information was available, but all members of Group 1 & 2 were male, thus, this variable was not analyzed further. Offender education was a series of mutually exclusive variables representing: less than high school, high school graduate, some college, and college graduate or higher. Familial characteristics included marital status dichotomized into single (including divorced, separated, or widowed) and married/common law, and the number of children categorized as no children, 1 or 2 children, and 3 or more children. A series of variables were also created to measure previous criminal history by mutually exclusive variables indicating if this was the individual's first trip to TDCJ, their second trip, or if this was their third or more trip to TDCJ. Previous in-prison infractions were also measured as major and minor (as defined by the TDCJ) and dichotomized into no previous infractions, between one and five previous infractions, between six and ten infractions, or more than ten previous infractions. Finally, a dichotomized variable was created to indicate whether or not the offender was previous an outside trusty which afforded him greater freedom and responsibilities while serving his sentence within a TDCJ facility.

[15] The Other category consists of any other race/ethnicity including American Indian, Asian, or Middle Eastern.

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A variety of temporal measures were also developed to represent the number of days from TDCJ entrance to program entrance (i.e., Time to Program), the number of days in the program (i.e., Time in Program), and the number of days from program completion to release from the TDCJ (i.e., Time from Program). These three variables were only created for Group 2, as Group 1 members did not enter the program. For Groups 1 & 2, the number of days in the TDCJ (i.e., Time in TDCJ), the reason for release as represented by a series of mutually exclusive dichotomous variables indicating parole, mandatory supervision, discharge, or some other reason, and the number of days between release from the TDCJ and the end of the study period (i.e., Time at Risk) were created. The descriptives for each of these variables for Groups 1 & 2 are summarized below and in Table 6.1.[16]

A separate series of variables were also created to be used as the primary dependent variable of interest and reflect the success or failure of the individual. Failure is defined as the commission of a new offense or a technical violation subsequent to release, regardless of whether or not the individual was categorized in Group 1 or 2. Days to Violation is the number of days from TDCJ release until failure, while the failure rate is number of cases that committed a new criminal offense or technical violation divided by the overall number of cases in that group (multiplied by 100). The Failure Rate is decomposed into the New Crime Rate and a Technical Violation Rate using the same process. For each of these statistics, a revocation rate was calculated that reflects the number of individuals that were returned to TDCJ as a result of the failure.

During the process of data cleaning and variable creation, several cases (i.e., Group 1 or 2 members) were missing information on key information. Subsequent multivariate analyses require each case to have complete information on all cases; as a result, 43 cases (7.3%) from

[16] The majority of these variables were slightly modified for analysis purposes based on TDCJ information.

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Group 1 were removed from further consideration which left 546 cases in Group 1. In Group 2, 437 cases (15.4%) were missing information on a variable of interest resulting in 2,403 cases remaining for analyses.

As mentioned, Table 6.1 summarizes the minimum and maximum values, mean, and standard deviation for all variables in Groups 1 & 2. This presentation allows for both within and across group comparisons. Overall, there are considerable similarities between the groups including with respect to their demographic characteristics. Those who received treatment were, on average, slightly older than Group 1 (i.e., 46.33 compared to 46.11), but Group 1 had at least one individual who was older than anyone in Group 2. In both groups, White members were the majority with 52.8% of Group 1 members comprising this category and 50.7% of Group 2 members categorized as White. Hispanics comprised a noticeable portion of each group with Group 2 possessing a slightly higher percentage (41.5% compared to 39.2%); Black individuals comprised less than 10% of either group (8.0% in Group 1 and 7.4% in Group 2). With respect to education, the majority of Group 1 (54.8%) and Group 2 (54.0%) possessed less than a high school degree while another 40.7% of Group 1 and 43.7% of Group 2 graduated with a high school degree. Overall, less than 5% (4.6%) of Group 1 and less than 3% (2.3%) of Group 2 possessed any higher education. The considerable majority of Group 1 (70.3%) and Group 2 (72.6%) indicated they were single; however, the majority of individuals in Group 1 (63.5%) and Group 2 (65.7%) had children. Specifically, 36.3% of Group 1 and 38.2% of Group 2 had one or two children, while 27.3% of Group 1 and 27.5% of Group 2 had at least three children.

One area where Groups 1 and 2 differed was in their previous criminal history and in-prison infractions (major and minor). Surprisingly, Group 1 had a higher percentage of individuals on their first trip to TDCJ (44.5%) compared to Group 2 (41.4%); although, Group 2

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had a higher percentage of second time individuals (35.6%) compared to Group 1 (28.9%). More significant differences are evident when examining major and minor infractions. Consistent with expectations, 92.9% of Group 2 members had no previous major infractions compared to only 44.7% of Group 1; conversely, 81.9% of Group 1 members possessed no previous minor infractions compared to 56.5% of Group 2 with no previous minor infractions. Broadly, this suggests that Group 1 members had greater histories of in-prison major infractions and fewer minor infractions, whereas Group 2 members displayed the opposite pattern with a small number of major infractions and more frequent minor infractions. This may be a partial explanation for why specific individuals were assigned to the program, although this is speculative without specific information on the decision-making processes undertaken by the TDCJ. Finally, slightly more than 15% of Group 1 (16.9%) and Group 2 (17.6%) were transferred from being outside trusties.

Temporal characteristics of Groups 1 & 2 are also reported in Table 6.1. With respect to program based variables (i.e., Group 2 only), the amount of time from TDCJ entrance to program entrance ranged from 20 days to slightly more than 12 years with the average wait time at slightly less than one year (342.3 days). Once in the program, participants completed in an average 182.1 days which is consistent with the scheduled six month program; there is a considerable range on this variable, but a very small standard deviation indicating that only a few cases deviated from the mean and could be considered outliers. Once the program was completed, some individuals were released the same day, but others remained in TDCJ facilities for up to 1,132 days. On average, program graduates remained in a facility for 96.9 days, although it is not clear where they were housed while awaiting release from the TDCJ. More broadly, the average number of days spent in TDCJ varied between groups with Group 1

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members confined on average for 763.7 days and Group 2 participants retained for an average of 621.0 days. Group 2 had both higher minimum number of days (224 compared to 18) and higher maximum number of days (4,607 compared to 3,616). Another area of difference between Groups 1 & 2 is the reason for release, as mandatory supervision was the most frequent reason for release of Group 1 individuals (51.7%), whereas parole was the most common reason for release of Group 2 members (64.3%). Finally, Group 1 had a higher average number of days at risk (i.e., number of days between release from TDCJ to end of study period) compared to Group 2; however, these values hold little value beyond acting as a control for time at risk in the subsequent multivariate models.

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Table 6.1: Texas - Group Characteristics

	Group 1: No Treatment (N=546)				Group 2: Completed (N=2,403)			
	Min	**Max**	**Mean**	**S.D.**	**Min**	**Max**	**Mean**	**S.D.**
Age	--	--	--	--	22	78	46.33	9.020
Age at Release	23	81	46.11	10.486	--	--	--	--
Race								
White	0	1	.528	.500	0	1	.507	.500
Black	0	1	.080	.272	0	1	.074	.261
Hispanic	0	1	.392	.489	0	1	.415	.493
Other	0	1	.000	.000	0	1	.004	.064
Education								
Less than H.S. Degree	0	1	.548	.498	0	1	.540	.498
High School Graduate	0	1	.407	.492	0	1	.437	.496
Some College	0	1	.040	.197	0	1	.022	.147
College Graduate	0	1	.006	.074	0	1	.001	.035
Marital Status								
Single	0	1	.703	.457	0	1	.726	.446
Married/Common Law	0	1	.297	.457	0	1	.274	.446
Number of Children								
Zero	0	1	.365	.482	0	1	.343	.475
1or 2	0	1	.363	.481	0	1	.382	.486
3 or more	0	1	.273	.446	0	1	.275	.446
Criminal History								
1st Trip	0	1	.445	.497	0	1	.414	.493
2nd Trip	0	1	.289	.454	0	1	.356	.479
3 or more	0	1	.266	.442	0	1	.230	.421
Major Infractions								
Zero Previous	0	1	.447	.498	0	1	.929	.256
1-5 Previous	0	1	.502	.500	0	1	.070	.255
6-10 Previous	0	1	.048	.213	0	1	.000	.020
More than 10	0	1	.004	.060	0	1	.000	.020
Minor Infractions								
Zero Previous	0	1	.819	.386	0	1	.565	.496
1-5 Previous	0	1	.172	.378	0	1	.416	.493
6-10 Previous	0	1	.009	.095	0	1	.018	.134
More than 10	0	1	.000	.000	0	1	.001	.035
Outside Trusty	0	1	.169	.375	0	1	.176	.381
Time to Program	--	--	--	--	20	4,396	342.332	318.406
Time in Program	--	--	--	--	133	280	182.124	6.442
Time from Program	--	--	--	--	0	1,132	96.899	134.993
Time in TDCJ	18	3,616	763.66	474.220	224	4,607	620.985	346.264
Reason for Release								
Parole	0	1	.310	.463	0	1	.643	.479
Mandatory Supervision	0	1	.517	.500	0	1	.309	.462
Discharge	0	1	.055	.228	0	1	.006	.076
Other	0	1	.119	.324	0	1	.042	.202
Time at Risk	214	1,415	669.865	296.88	1	1,199	566.039	356.055

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The dependent variable of interest was participant failure defined as the commission of a new crime or a technical violation (see Table 6.2 below for specifics). Of the 546 Group 1 participants, TDCJ reported that 74 individuals (13.6%) either committed a new offense or a technical violation. For Group 2, 354 (14.7%) of the 2,403 members were identified as involved in one of these two behaviors. At a simple descriptive level, these failure rates indicate that Group 2 treatment participants actually were more likely to be unsuccessful once released from TDCJ. No definitive conclusions should be drawn from these preliminary descriptive statistics, as multivariate analyses are required to properly assess the relationship between treatment and failure. Group 2 members, on average, waited longer to fail (i.e., 394.9 days) compared to Group 1 individuals (i.e., 389.8 days), although this difference is relatively small given the size of the scale. Moreover, Group 2 had at least one member fail after only 32 days after release, whereas the earliest a Group 1 member failed was 74 days. When considering the 13.6% of Group 1 and 14.7% of Group 2 that failed, Group 2 had a much higher rate of revocation or return to TDCJ (i.e., 66.4% compared to 50.0%). Also, Group 2 had a higher rate of new crime offenses (i.e., 9.0% compared to 6.4%) and an associated higher rate of revocation for these incidents (i.e., 73.3% compared to 45.7%). Finally, despite a slightly higher failure rate for Group 1 technical violators (i.e., 7.1% compared to 5.7%), the revocation rate was comparable between Group 1 (i.e., 53.9%) and Group 2 (i.e., 55.5%).

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Table 6.2: Texas - Failure & Revocation

	Group 1: No Treatment (N = 74)				Group 2: Completed (N = 354)			
	Min	**Max**	**Mean**	**S.D.**	**Min**	**Max**	**Mean**	**S.D.**
Days to Violation	74	1,111	389.757	237.596	32	1,053	394.867	231.935
			%				**%**	
Failure Rate			**13.55**				**14.73**	
Revocation Rate			50.00				66.38	
New Crime Rate			**6.41**				**9.03**	
Revocation Rate			45.71				73.27	
Technical Violation Rate			**7.14**				**5.70**	
Revocation Rate			53.85				55.47	

A bivariate analysis was undertaken to assess if the failure rate differed substantially between Groups 1 & 2. While not definitive regarding the relationship between the two groups, a t-test is well suited to provide an initial assessment of any potential relationship between the independent variable of interest and the dependent variable. As evidenced in Table 6.3, no statistical difference in failure rate was discovered between those who completed treatment and those who did not participate in treatment. Full exploration of this relationship is best undertaken through multivariate analyses.

Table 6.3: Texas – Bivariate Analysis: T-Test

	t	**df**	**Sig (2-tailed)** [17]	**Mean Difference**
Failure	1.485	2,948	.138	.009

Note: *p≤0.05; **p≤0.01; ***p≤0.001

To properly assess the relationship between Groups 1 & 2 (and the potential effect of the treatment experience), multivariate models were estimated to localize any relationship between treatment experience and failure after release. Using a cumulative sample of 2,949 (i.e., Groups 1 & 2 combined), several independent variables were statistically significant when regressed on the likelihood of failure. For all variables, the coefficient, standard error, and odds ratio (when

[17] One-sample T Test was estimated with a test value of 0.1355.

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statistically significant) are reported in Table 6.4. Most importantly, those who successfully completed the treatment program (i.e., Program Participant) *were not less likely* to fail; they were statistically indistinguishable from those in Group 1 who received no treatment. Time in TDCJ was negatively related to failure, but the effect was substantively not meaningful (O.R. – 0.99); conversely, Time at Risk was positively related to failure indicating that the longer an individual was outside of a TDCJ facility their chances of failure increased. Similar to Time in TDCJ, this variable was not substantively impactful, but necessary to include as a measure that acknowledges individuals may vary in the amount of days released from a TDCJ facility. Other relevant predictors of failure include being a parent as both 1 or 2 children and 3 or more children increased the odds of failure (1.4 times more likely and 1.5 times more likely, respectively). Individuals who had a longer previous criminal history (i.e., 3 or more previous trips to TDCJ) were also much more likely to fail (2.3 times more likely). Finally, individuals with a history of previous minor and major infractions were the most likely to fail; individuals with between 6 & 10 major infractions were 2.6 times more likely to fail and individuals with between 6 & 10 minor infractions were 4.7 times more likely to fail (this latter effect was the strongest effect on the model). No demographic characteristics or level of education was related to failure.

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Table 6.4: Texas - Logistic Regression of Treatment Effect (N=2,949)

	Coef.	S.E.	O.R.
Constant	-3.955***	0.313	--
Programmatic Factors			
Program Participant	0.119	0.179	--
Time in TDCJ	-0.001***	0.000	0.999
Time at Risk	0.003***	0.000	1.003
Demographic Factors			
Race			
Black	-0.143	0.229	--
Hispanic	0.010	0.120	--
Education			
High School Graduate	-0.086	0.118	--
Some College	-0.038	0.354	--
Familial Factors			
Marital Status - Single	0.109	0.129	--
Children			
1 or 2 Children	0.297*	0.132	1.346
3 or More Children	0.373*	0.157	1.452
Criminal History			
2nd Trip to TDCJ	0.224	0.135	--
3 or Greater Trip to TDCJ	0.826***	0.148	2.284
Institutional Factors			
Infractions			
1-5 Major	0.110	0.186	--
6-10 Major	0.972*	0.487	2.643
1-5 Minor	0.630***	0.120	1.878
6-10 Minor	1.545***	0.378	4.687
Outside Trusty	-0.119	0.161	--
Chi-Square		308.26***	
R^2		0.176	

Note: *p≤0.05; **p≤0.01; ***p≤0.001; Dropped due to lack of variation and inflated standard errors: Other, College Graduate, 10+ Major Infractions, 10+ Minor Infractions.

Reference groups: White, Less than High School Graduate, No Children, No Previous Criminal History, No Major Infractions, No Minor Infractions.

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A second model was estimated to investigate variation within the treatment pool (i.e., Group 2), see Table 6.5 below. The dependent variable is the same as the previous model – failure. Given the specific focus, the sample size was reduced to 2,396 cases, but included all variables reported in the previous model. In addition, temporal variables related to program participation were included – Time to Program, Time in Program, Time to Release. Time in TDCJ was not included due to concerns of multicollinearity, but Time at Risk was maintained in the model to control for differential length of time between TDCJ release and the end of the study period. Age of the individual was also included as this sample was restricted to only treatment participants (offender age was not available for Group 1, only age at release; thus, no measure of offender age was included in the previous model).

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Table 6.5: Texas - Logistic Regression of Failure among Program Participants (N=2,396[18])

	Coef.	S.E.	O.R.
Constant	-5.076**	1.718	--
Programmatic Factors			
Time to Program	-0.001***	0.000	0.999
Time in Program	0.013	0.009	--
Time to Release	0.000	0.001	--
Time at Risk	0.003***	0.000	1.003
Demographic Factors			
Age	-0.042***	0.008	0.959
Race			
Black	-0.169	0.259	--
Hispanic	-0.159	0.139	--
Education			
High School Graduate	-0.215	0.134	--
Some College	-0.180	0.423	--
Familial Factors			
Marital Status - Single	0.082	0.145	--
Children			
1 or 2 Children	0.502**	0.153	1.652
3 or More Children	0.684***	0.182	1.981
Criminal History			
2nd Trip to TDCJ	0.414**	0.153	1.513
3 or Greater Trip to TDCJ	1.081***	0.171	2.949
Institutional Factors			
Infractions			
1-5 Major	0.207	0.248	--
1-5 Minor	0.645***	0.132	1.905
6-10 Minor	1.400**	0.416	4.053
Outside Trusty	-0.070	0.186	--
Chi-Square		343.51***	
R^2		0.236	

Note: *p≤0.05; **p≤0.01; ***p≤0.001; Dropped due to lack of variation and inflated standard errors: Other, College Graduate, 6-10 Major Infractions, 10+ Major Infractions, 10+ Minor Infractions.
Reference groups: White, Less than High School Graduate, No Children, No Previous Criminal History, No Major Infractions, No Minor Infractions.

[18] 7 cases were removed from this model due to incongruent dates of release from the program and release from TDCJ.

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Additional analyses were conducted using sub-samples of the data to assess for treatment effects depending on length of time. In Tables 6.6 – 6.13 below, two criteria were applied to create the sub-sample. First, all cases were released at least 365 days (i.e., one year) prior to the end of the study period of December 31, 2011. This ensures that all individuals had the potential to be released for at least one year independent of whether or not they failed. Second, in creating the dependent variable of failure, only those that occurred within one year of release were considered in the analyses. As expected, these criteria reduced the sample size of the analytic models to 1,984 cases from 2,949; however, the descriptive statistics shown in Table 6.6 demonstrate that the general characteristics of this sub-sample are largely unchanged compared to the full sample. In short, offenders in Group 1 averaged 46 years of age, were predominately White, possessed less than a high school degree, were mostly single, and a slight majority were parents. Roughly half of Group 1 had no criminal history or a record of major or minor institutional infractions, less than 20% were outside trusties, and members were either released on mandatory supervision or parole. Group 2 (i.e., the treatment group) had similar characteristics with the exception of their institutional violation history: a large majority had no major institutional infractions, but a higher number possessed a history of minor infractions. Group 2 members were much more likely to be released on parole than any other category.

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Table 6.6: Texas - Group Characteristics, Released Minimum 1 Year

	Group 1: No Treatment (N=414)				Group 2: Completed (N=1,570)			
	Min	**Max**	**Mean**	**S.D.**	**Min**	**Max**	**Mean**	**S.D.**
Age	--	--	--	--	24	75	46.89	8.772
Age at Release	23	81	46.07	10.772	--	--	--	--
Race								
White	0	1	.527	.500	0	1	.503	.500
Black	0	1	.077	.267	0	1	.073	.260
Hispanic	0	1	.396	.490	0	1	.420	.494
Other	0	1	.000	.000	0	1	.005	.071
Education								
Less than H.S. Degree	0	1	.548	.498	0	1	.527	.499
High School Graduate	0	1	.406	.492	0	1	.450	.498
Some College	0	1	.038	.193	0	1	.021	.143
College Graduate	0	1	.007	.085	0	1	.002	.044
Marital Status								
Single	0	1	.713	.453	0	1	.721	.449
Married/Common Law	0	1	.287	.453	0	1	.279	.449
Number of Children								
Zero	0	1	.418	.494	0	1	.394	.489
1or 2	0	1	.343	.475	0	1	.368	.482
3 or more	0	1	.239	.427	0	1	.238	.426
Criminal History								
1st Trip	0	1	.444	.498	0	1	.413	.492
2nd Trip	0	1	.285	.452	0	1	.375	.484
3 or more	0	1	.271	.445	0	1	.212	.409
Major Infractions								
Zero Previous	0	1	.447	.498	0	1	.932	.252
1-5 Previous	0	1	.500	.501	0	1	.068	.251
6-10 Previous	0	1	.051	.220	0	1	.000	.000
More than 10	0	1	.002	.049	0	1	.001	.025
Minor Infractions								
Zero Previous	0	1	.807	.395	0	1	.556	.497
1-5 Previous	0	1	.186	.390	0	1	.425	.494
6-10 Previous	0	1	.007	.085	0	1	.019	.135
More than 10	0	1	.000	.000	0	1	.001	.036
Outside Trusty	0	1	.181	.386	0	1	.162	.369
Time to Program	--	--	--	--	20	3,132	352.950	306.885
Time in Program	--	--	--	--	133	280	181.855	6.963
Time from Program	--	--	--	--	0	743	82.449	87.094
Time in TDCJ	18	3,616	778.196	496.56	231	3,403	617.027	313.707
Reason for Release								
Parole	0	1	.314	.465	0	1	.607	.489
Mandatory Supervision	0	1	.493	.501	0	1	.340	.474
Discharge	0	1	.056	.229	0	1	.008	.087
Other	0	1	.138	.345	0	1	.045	.208
Time at Risk	366	1,415	792.442	231.272	366	1,199	770.157	262.200

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As mentioned, this sub-sample was limited to failures occurring within one year of release (considering at least one year of time availability from the end of the study). Table 6.7 reports the resulting similarity in average number of days to failure between Groups 1 & 2 (227.41 and 221.73, respectively). Similar to the full sample, Group 2 had a slightly higher failure rate compared to non-treatment individuals, but possessed higher rates of revocation regardless of the reason for the failure.

Table 6.7: Texas - Failure & Revocation, Released Minimum 1 Year

	Group 1: No Treatment (N = 34)				**Group 2: Completed (N = 160)**			
	Min	**Max**	**Mean**	**S.D.**	**Min**	**Max**	**Mean**	**S.D.**
Days to Violation	64	359	227.412	82.439	32	363	221.725	91.233
			%				**%**	
Failure Rate			**8.21**				**10.19**	
Revocation Rate			52.94				66.88	
New Crime Rate			**3.38**				**5.29**	
Revocation Rate			57.14				77.11	
Technical Violation Rate			**4.83**				**4.90**	
Revocation Rate			50.00				55.84	

A multivariate, logistic regression model was estimated using these cases to assess the potential impact of the treatment. All independent variables used in the full model analyses were used except for Time at Risk, as this is considered in the criteria for selection into the sub-sample. As summarized in Table 6.8, program participation was not related to failure within one year of release from TDCJ; in other words, individuals who received treatment were no more or less likely to fail compared to those who did not receive treatment. Factors that increased the likelihood of failure included those who had made at two previous trips to TDCJ facilities (1.9 times more likely) and those with a higher number of minor institutional infractions (1.8 and 6.0 times more likely for between 1 and 5 infractions and 6 and 10 infractions, respectively). Time in TDCJ was also statistically significant with those spending more time in a facility less likely

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to fail; however, this effect is not substantively meaningful and largely reflective of a control for amount of time under TDCJ supervision. Overall, this model explained roughly 5.4% of the variance in failure.

Table 6.8: Texas - Logistic Regression of Treatment Effect, Released Minimum 1 Year (N=1,984)

	Coef.	S.E.	O.R.
Constant	-2.060***	0.350	--
Programmatic Factors			
Program Participant	0.081	0.253	--
Time in TDCJ	-0.001**	0.000	0.999
Demographic Factors			
Race			
Black	0.025	0.297	--
Hispanic	-0.216	0.168	--
Education			
High School Graduate	-0.236	0.163	--
Some College	-0.754	0.613	--
Familial Factors			
Marital Status - Single	0.052	0.181	--
Children			
1 or 2 Children	0.012	0.174	--
3 or More Children	-0.303	0.217	--
Criminal History			
2nd Trip to TDCJ	0.137	0.188	--
3 or Greater Trip to TDCJ	0.642**	0.196	1.901
Institutional Factors			
Infractions			
1-5 Major	0.099	0.256	--
6-10 Major	0.944	0.635	--
1-5 Minor	0.603***	0.166	1.827
6-10 Minor	1.796***	0.453	6.027
Outside Trusty	-0.138	0.218	--
Chi-Square		51.500***	
R^2		0.054	

Note: *p≤0.05; **p≤0.01; ***p≤0.001; Dropped due to lack of variation and inflated standard errors: Other, College Graduate, 10+ Major Infractions, 10+ Minor Infractions.
Reference groups: White, Less than High School Graduate, No Children, No Previous Criminal History, No Major Infractions, No Minor Infractions.

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Finally, program participants were examined to identify important elements of this group. Similar to those in Group 1, those with greater criminal histories, and more institutional infractions were more likely to fail within one year of release. Also, graduates that were released sooner and younger individuals were more likely to fail. Please see Table 6.9 for a list of all variables.

Table 6.9: Texas - Logistic Regression of Failure among Program Participants, Released Minimum 1 Year (N=1,567[19])

	Coef.	S.E.	O.R.
Constant	-0.815	2.355	--
Programmatic Factors			
Time to Program	-0.001	0.000	--
Time in Program	-0.003	0.013	--
Time to Release	-0.003*	0.001	0.997
Demographic Factors			
Age	-0.022*	0.010	0.977
Race			
Black	0.146	0.324	--
Hispanic	-0.160	0.189	--
Education			
High School Graduate	-0.256	0.183	--
Some College	-0.926	0.748	--
Familial Factors			
Marital Status - Single	0.058	0.200	--
Children			
1 or 2 Children	0.157	0.198	--
3 or More Children	-0.082	0.239	--
Criminal History			
2nd Trip to TDCJ	0.327	0.211	--
3 or Greater Trip to TDCJ	0.911***	0.220	2.488
Institutional Factors			
Infractions			
1-5 Major	0.235	0.321	--
1-5 Minor	0.607**	0.180	1.835
6-10 Minor	1.527**	0.489	4.604
Outside Trusty	-0.164	0.245	--
Chi-Square		52.816***	
R^2		0.069	

Note: *p≤0.05; **p≤0.01; ***p≤0.001; Dropped due to lack of variation and inflated standard errors: Other, College Graduate, 6-10 Major Infractions, 10+ Major Infractions, 10+ Minor Infractions.
Reference groups: White, Less than High School Graduate, No Children, No Previous Criminal History, No Major Infractions, No Minor Infractions.

[19] 3 cases were removed from this model due to incongruent dates of release from the program and release from TDCJ.

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Similar to the criteria applied to create the sub-sample described in Tables 6.6 – 6.9, two criteria were also applied to create a second sub-sample. The first criterion required that individuals be released for at least 730 days (i.e., two years) prior to the end of the study period on December 31, 2011. The second criterion was applied to the operationalization of the dependent variable by identifying cases in which a failure occurred within two years of release. Based on these criteria, descriptive statistics are summarized in Tables 6.10 & 6.11 and multivariate models in Table 6.12 & 6.13. The results of these analyses indicate a similar set of conclusions reached in the previous two sets of analyses: no relationship exists between treatment participation and the likelihood of failure. Several other variables reached statistical significance in both the treatment/no treatment and the treatment only models including criminal history and institutional infractions. Please see Tables 6.10 – 6.13 for specifics.

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Table 6.10: Texas - Group Characteristics, Released Minimum 2 Year

	Group 1: No Treatment (N=233)				Group 2: Completed (N=812)			
	Min	**Max**	**Mean**	**S.D.**	**Min**	**Max**	**Mean**	**S.D.**
Age	--	--	--	--	24	75	47.48	8.683
Age at Release	23	80	45.82	10.750	--	--	--	--
Race								
White	0	1	.489	.501	0	1	.489	.500
Black	0	1	.073	.261	0	1	.067	.249
Hispanic	0	1	.438	.497	0	1	.441	.497
Other	0	1	.000	.000	0	1	.005	.070
Education								
Less than H.S. Degree	0	1	.618	.487	0	1	.533	.499
High School Graduate	0	1	.343	.476	0	1	.451	.498
Some College	0	1	.030	.171	0	1	.016	.126
College Graduate	0	1	.009	.092	0	1	.000	.000
Marital Status								
Single	0	1	.730	.445	0	1	.693	.461
Married/Common Law	0	1	.270	.445	0	1	.307	.461
Number of Children								
Zero	0	1	.545	.499	0	1	.533	.499
1or 2	0	1	.283	.452	0	1	.325	.469
3 or more	0	1	.172	.378	0	1	.142	.349
Criminal History								
1st Trip	0	1	.485	.501	0	1	.457	.498
2nd Trip	0	1	.300	.459	0	1	.384	.487
3 or more	0	1	.215	.411	0	1	.159	.366
Major Infractions								
Zero Previous	0	1	.485	.501	0	1	.927	.260
1-5 Previous	0	1	.451	.499	0	1	.071	.258
6-10 Previous	0	1	.064	.246	0	1	.000	.000
More than 10	0	1	.000	.000	0	1	.001	.035
Minor Infractions								
Zero Previous	0	1	.828	.378	0	1	.525	.500
1-5 Previous	0	1	.172	.378	0	1	.450	.498
6-10 Previous	0	1	.000	.000	0	1	.023	.151
More than 10	0	1	.000	.000	0	1	.003	.050
Outside Trusty	0	1	.223	.417	0	1	.102	.303
Time to Program	--	--	--	--	20	3,132	400.937	354.011
Time in Program	--	--	--	--	133	250	181.038	7.526
Time from Program	--	--	--	--	0	448	60.905	53.325
Time in TDCJ	59	3,616	799.592	533.019	231	3,403	642.804	352.234
Reason for Release								
Parole	0	1	.283	.452	0	1	.590	.492
Mandatory Supervision	0	1	.511	.501	0	1	.361	.481
Discharge	0	1	.064	.246	0	1	.006	.078
Other	0	1	.142	.349	0	1	.043	.203
Time at Risk	730	1,415	961.528	143.111	730	1,199	996.828	128.541

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Table 6.11: Texas - Failure & Revocation, Released Minimum 2 Year

	Group 1: No Treatment (N = 35)				Group 2: Completed (N = 178)			
	Min	**Max**	**Mean**	**S.D.**	**Min**	**Max**	**Mean**	**S.D.**
Days to Violation	64	629	304.114	159.960	49	730	385.258	173.300
			%				**%**	
Failure Rate			**15.70**				**21.92**	
Revocation Rate			45.71				66.29	
New Crime Rate			**7.62**				**12.81**	
Revocation Rate			41.18				77.88	
Technical Violation Rate			**8.07**				**9.11**	
Revocation Rate			50.00				50.00	

Table 6.12: Texas - Logistic Regression assessing Treatment Effect, Released Minimum 2 Year (N=1,045)

	Coef.	**S.E.**	**O.R.**
Constant	-1.782***	0.349	--
Programmatic Factors			
Program Participant	0.325	0.265	--
Time in TDCJ	-0.001***	0.000	0.999
Demographic Factors			
Race			
Black	-0.072	0.335	--
Hispanic	-0.085	0.171	--
Education			
High School Graduate	-0.115	0.169	--
Some College	-0.800	0.768	--
Familial Factors			
Marital Status - Single	0.285	0.184	--
Children			
1 or 2 Children	0.488**	0.178	1.629
3 or More Children	0.362	0.239	--
Criminal History			
2nd Trip to TDCJ	0.162	0.184	--
3 or Greater Trip to TDCJ	0.546*	0.221	1.727
Institutional Factors			
Infractions			
1-5 Major	0.176	0.268	--
6-10 Major	1.449*	0.617	4.258
1-5 Minor	0.632***	0.172	1.881
6-10 Minor	1.336*	0.532	3.802
Outside Trusty	-0.326	0.263	--
Chi-Square		56.458***	
R^2		0.083	

Note: *p≤0.05; **p≤0.01; ***p≤0.001; Dropped due to lack of variation and inflated standard errors: Other, College Graduate, 10+ Major Infractions, 10+ Minor Infractions.
Reference groups: White, Less than High School Graduate, No Children, No Previous Criminal History, No Major Infractions, No Minor Infractions.

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Table 6.13: Texas - Logistic Regression of Failure among Program Participants, Released Minimum 2 Year (N=811[20])

	Coef.	S.E.	O.R.
Constant	-1.196	2.284	--
Programmatic Factors			
Time to Program	-0.001*	0.000	0.999
Time in Program	0.012	0.012	--
Time to Release	-0.002	0.002	--
Demographic Factors			
Age	-0.061***	0.012	0.941
Race			
Black	0.022	0.373	--
Hispanic	-0.249	0.199	--
Education			
High School Graduate	-0.185	0.191	--
Some College	-1.506	1.071	--
Familial Factors			
Marital Status - Single	0.207	0.203	--
Children			
1 or 2 Children	0.839***	0.209	2.313
3 or More Children	0.880**	0.277	2.410
Criminal History			
2nd Trip to TDCJ	0.315	0.206	--
3 or Greater Trip to TDCJ	0.710**	0.252	2.034
Institutional Factors			
Infractions			
1-5 Major	0.392	0.341	--
1-5 Minor	0.553**	0.188	1.739
6-10 Minor	0.965	0.578	--
Outside Trusty	-0.229	0.305	--
Chi-Square		73.626***	
R^2		0.133	

Note: *p≤0.05; **p≤0.01; ***p≤0.001; Dropped due to lack of variation and inflated standard errors: Other, College Graduate, 6-10 Major Infractions, 10+ Major Infractions, 10+ Minor Infractions.
Reference groups: White, Less than High School Graduate, No Children, No Previous Criminal History, No Major Infractions, No Minor Infractions.

[20] 1 case was removed from this model due to incongruent dates of release from the program and release from TDCJ.

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CHAPTER VII: DISCUSSION

This evaluation examined the design, operational process, and impact of three separate alcohol treatment programs delivered in prisons located in Montana, Ohio, and Texas using a mixed methodological research strategy addressing evidence based design, program fidelity, and impact. Site visits enabled analysis of program content and qualitative data collection through in-depth interviews with correctional institution administrators and treatment professionals, focus group interviews with inmate treatment participants in prison and half-way house settings, and direct, real-time observation of treatment services delivery. After both affirming that the programs were evidence based practices compliant in design (as indicated by NIDA guidelines) and assessing their degree of program fidelity, an outcome analysis was conducted to assess the program's effectiveness in realizing recidivism reduction among the treatment cohorts. This mixed-methods strategy allowed examination of three primary research questions:

1. Do the alcohol treatment programs adhere to evidence based practices that have documented success in addressing substance abuse?
2. Do the alcohol treatment programs deliver treatment in a manner consistent with program protocols thereby demonstrating program fidelity?
3. Are alcohol treatment program graduates more or less likely to re-offend compared to a comparison group of non-program participants?

Collectively, data collection and analysis generated numerous detailed findings as reported in the previous chapters. The broader implications of these findings for correctional practice, criminal justice policy, and future related research efforts are also considered below.

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Discussion of Findings

The qualitative components of the mixed methods design utilized in this study proved useful for answering the first two research questions regarding whether the studied programs were designed according to evidence based practices and the level of program fidelity in services delivery and overall operation. Data collection, analysis, and findings for the first two research questions are based on the Montana and Ohio programs. A quasi-experimental design was also conducted so as to address the third research question concerning program impact and effectiveness. Data collection, analysis, and findings regarding program impact are also based on the Montana and Ohio programs, as well as a Texas program.

Program Design

Multiple site visits to the treatment setting in each state indicated that both the Montana and Ohio programs are designed, overall, consistent with evidence based best practices in terms of: 1) the use of assessment instruments to identify offender needs and suitability for treatment, 2) appropriate treatment lengths, 3) the development and execution of individualized treatment plans, 4) drug use monitoring, 5) cognitive behavioral therapy addressing criminal thinking, and 6) planned continuity of care. The general evidence based orientation of these programs, however, is different between the two sites with noted design problems in the Ohio DUI-IPP. This program, in violation of the widely acknowledged principle of isolated housing for treatment inmates, mixes program participants within the general prison population.

Qualitative findings, especially data from treatment participant interviews, confirmed a negative and undermining effect of blending treatment and non-treatment inmates, suggesting that rehabilitation experiences are less than optimal. Interpretation of this treatment threat should be made in consideration of resource availability and organizational climate. An important and

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generalizable observation is that treatment programs with too few participants to justify agency space allocation large enough to accommodate a therapeutic community or similar configuration favorable to treatment engagement should not be implemented. Low enrollment programs also face the challenge of inadequate reinforcement and moral support from the treatment community when its members are few and necessarily preoccupied with concerns of being compromised or physically assaulted by other inmates.

While the legislative redirection of lower level felony offenders through Ohio House Bill 86 (2011) suggests that there will be far fewer future inmates eligible for treatment, program cohorts were already very low with a constancy of unfilled slots prior to legislation. This reality concentrates services on remaining participants but it is unlikely that this unintended form of service delivery intensification (e.g., lower staff to client ratio resulting in greater individualized attention) offsets the inefficiency associated with not engaging eligible offenders in need. Presumably, failing to deliver the program to the maximum number of inmates eligible to the point of full enrollment lessens potential program impact and is incongruous with the broader goal of rehabilitation as a means to enhanced public safety.

Both the Montana and Ohio programs coerce initial program involvement for a brief introductory period of one and two weeks, respectively; but then leave continued program participation for inmates to decide. These quasi-voluntary program participation processes weed out offenders who often poison the treatment environment. Regarding design intent for program participation criteria, neither state limits services to first-time offenders. Accordingly, the programs in Montana and Ohio theoretically incorporate the risk principle of correctional programming. However, political endorsement and agency prioritization of program objectives, known potential barriers to successful program delivery and evaluation of treatment in

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incarcerated settings (Miller et al. 2004), were identified as significant factors impacting program design, operation, and performance. In Montana, referral of all potential participants into separate facilities specified as treatment centers staffed by highly credentialed and enthusiastic service providers contrasts sharply with Ohio where an insufficient number of participants enter programming due to initial judicial discretion and further cohort attrition attributable to warden autonomy which supersedes assessment tool referral for services. Further lack of adequate political endorsement in Ohio manifests in negative program realities such as daily threats and challenges to treatment participants from the general population (as opposed to a treatment friendly therapeutic community) and lack of supervision during the halfway house transition to community phase.

Program Fidelity

Empirical confirmation of a treatment design comprised of known evidence based modalities through document review is a necessary first step to affirming program fidelity. By confirming that the programs delivered services found to be successful in similar correctional settings, theory failure can be ruled out as a basis of observed program failure. Presumably, establishing program fidelity is requisite for inferring that program outcomes are a function of treatment and not faulty treatment strategy or some modification of an evidence based strategy so that it is that strategy in name only. Whereas evidence based practices documentation informed whether the treatment plans were viable as indicated through evidence based practices inclusion and in what respects they are lacking (such as the mixed housing of treatment and general prison population inmates in Ohio), program fidelity specification entails empirical assurance that actual services delivery is approximately consistent with the treatment plan. Program fidelity was assessed systematically across the programs according to predetermined elements

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(adherence, delivery quality, participant engagement, exposure/dosage, and program differentiation) for prison based treatment activities (the majority of treatment services) for the Montana and Ohio programs, as well as post-release in a halfway-house setting in Ohio only.

Generally, the evaluated programs operated with a high degree of fidelity, especially the Montana program which received high scores from all three research team members across the fidelity measures. The multifaceted Montana program offers a wide variety of programming options depending on client needs (e.g., AA, NA, GA, anger management, parenting classes, employment readiness, and GED classes). The program received particularly high scores for delivery quality and features exceptional treatment staff from program administrators to head counselors, treatment, and aftercare staff. While there is variability in credentials, the WATCh program staff members were committed, knowledgeable, and enthusiastic about treatment strategy and related activities. Participants reported near categorical satisfaction with staff members and believed them to be personally committed to the program and their (i.e., the offenders') recovery. Participants were thus enthusiastic and appeared to have internalized program goals including endorsement of the therapeutic community as the primary mechanism of recovery, moving research team members to score the participant engagement element of program fidelity high.

The study found the issue of program fidelity in Ohio to be more complicated. There is a much smaller range of services available and though the program is much less multi-faceted, in-prison treatment staff were scored favorably by the research team. This positive impression was echoed through focus group interview data wherein Ohio program prison treatment staff were praised by participants for sincerity and helpfulness. The voluntary nature of the program was found to be helpful in removing participants who poison the treatment atmosphere – an important

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issue for this setting in that the aforementioned issue of housing treatment inmates with the general population. Though problematic, at least the actual direct treatment context was void of undermining influences. The Ohio program also featured a very low client to staff ratio. Though designed according to best practices literature at a 12:1 inmate to counselor ratio, the program actually had an exceptionally low ratio of three inmates per counselor.

Despite these positive findings, there was considerable disparity between how the Ohio program was designed and its actual implementation and delivery. Beyond the related issues of low enrollment and low client to staff ratio, variable scores were observed across the fidelity measures. Advertised as a therapeutic community, (offenders are explicitly told they are going to a therapeutic community prior to participation and some even received a brochure advertising the program as a TC), the program reflects neither the structure nor operation of a therapeutic community. Participants do not even reside together in the same dorm and there is little interaction among the broader treatment cohort outside of treatment activity. Accordingly, the mutual support and encouragement normative to a therapeutic community is simply missing in the Ohio program.

The qualitative research conducted post-release in the halfway house revealed the weakest feature of the Ohio program. The halfway house was widely criticized by independent groups of treatment residents and virtually every aspect of the halfway house phase of the program was found lacking. Treatment was not continued as designed in the halfway house phase and the minimal treatment activity that was delivered was general in nature, did not provide a seamless continuum of modality delivery from prison to the community transition phase, and bordered on the fraudulent. Both the halfway house director, who served in a counselor capacity for program participants, and contracted professional treatment service

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providers assured the research team during in-depth interviewing that multi-step monthly modules were being pursued when, in fact, they were ignored altogether. Specifically, the research team was told by staff that Residential Drug Abuse Program workbooks were guiding counseling sessions through assigned reading and homework assignments. While such activity is vital to offender introspection necessary for personal change and essential to identifying critical thinking errors identified through sharing homework during treatment sessions with other treatment participants, nearly all treatment group respondents related that these workbooks were taken from them, locked away, and that they had not seen them for several weeks. Moreover, they shared that treatment sessions entailed discussions of a social nature chosen by the counselors and that the anticipated subsequent latter modules in no way were being addressed through halfway house delivered services. These observations were made across focus groups and site visits. Clearly, false claims of program maintenance and continuation of treatment through delivery and completion of multi-month stepwise modules treatment graduation reflect a greater dosage than actually delivered.

Treatment Impact

Quantitative analyses were conducted on post-release data for all three study states and summarized in Tables 7.1 & 7.2. For Montana, data were made available on 866 individuals that received at least some treatment. A group consisting of 106 individuals who did not complete the program, but did receive some treatment and a second group containing 760 participants who completed the six-month program comprised the sample. The treatment participants were mostly White, single, and exclusively male. Native Americans also comprised a noticeable portion of both groups. Between one-third and one-half of the sample had previously been incarcerated, but only 10% committed violent offenses. Roughly 10% of the sample had previous institutional

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infractions and slightly more than 25% of those not completing treatment failed (i.e., based on the Montana Department of Corrections definition of individual failure), whereas 30% of the treatment group were unsuccessful post-release from treatment. This difference is statistically significant at the bivariate level.

Multivariate models, however, reveal no statistically significant difference between the two groups. Risk factors for failure in the Montana program include: younger participants, Native Americans, those with a previous criminal history, and individuals with previous institutional infractions. Subsequent models also indicate that participants that spent less time in the treatment program were more likely to fail. Within the program completers (i.e., Group 2), longer time within a MDC facility, younger participants, Native Americans, those with a criminal history, and individuals with previous institutional infractions were also more likely to fail.

The Ohio Department of Rehabilitation & Corrections (ODRC) made data available for 1,288 individuals. The sample consisted of 1,137 individuals who were deemed ineligible for the program (no further analyses were performed on this group), a group of 45 participants who completed the treatment program, and a group of 106 individuals who were eligible, but did not receive treatment. Treatment and non-treatment groups differed on education levels, marital status, and criminal histories.

Due to the small samples for the Ohio program, extreme caution should be applied to conclusions drawn from bivariate and multivariate models. A bivariate test indicated a higher risk of failure for those who did not receive treatment, suggesting that, despite noted design and fidelity concerns, the Ohio program generated desirable results. However, multivariate analysis did not confirm this impact as treatment participation did not reduce the likelihood of failure

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compared to those who were not exposed to treatment.

The Texas Department of Criminal Justice (TDCJ) supplied data on 2,403 individuals who graduated from the treatment program and 546 individuals who were did not receive any treatment. These populations were largely White, but also contained a high percentage of Hispanics. Education level, marital status, and number of children were largely similar across groups, but some differences were noted in criminal history and previous institutional infractions. Bivariate analysis revealed no statistically significant differences between the groups in rates of failure, which both hovered around 14%. Multivariate analyses using various time periods also indicated no substantive effect of treatment services. Time at risk, number of children, and previous behavior (i.e., criminal history and institutional infractions) were all related to failure. In that TDCJ did not grant access into the treatment facility for observation and direct interaction with staff and treatment inmates to obtain data necessary to determine program fidelity, it cannot be determined if this failure is attributable to poor program design (i.e., theory failure) or the quality of services delivery (i.e., implementation failure).

The inability of the research team to access the East Texas Treatment Facility for adequate assessment of best practices design and program fidelity is an unfortunate shortcoming of the current research project. Qualitative findings can prove key in understanding fundamental program operational issues and how these act to impact quantitative outcomes. The qualitative phase of the current project enhanced the analyses of the Montana and Ohio programs and revealed data unobtainable through alternative methods. The assessment of the Texas program, however, departed from the original research design by not including a process evaluation component. Future research should place a premium on securing partnerships with agencies and programs that are willing to grant access to all phases and data related to correctional programs

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in order to conduct complete and thorough assessments of operation and outcomes.

Summaries of the quantitative analyses for all sites are provided in Tables 7.1 & 7.2. The first table provides information on the bivariate analyses of recidivism rates, while the second table summarizes the statistically significant variables for each site based on multivariate models.

Table 7.1: Summary Recidivism Rates

	Montana	Ohio	Texas
No Treatment	--	11.32** (N=106)	13.55 (N=546)
Some Treatment	25.47 (N=106)	--	--
Completed Treatment	30.00* (N=760)	2.22 (N=45)	14.73 (N=2,403)

Note: *p≤0.05; **p≤0.01; ***p≤0.001

Note: This information summarizes Table 4.2 & 4.3, 5.1 & 5.2, and 6.2 & 6.3.

Table 7.2: Summary of Recidivism-Relevant Variables

	Montana (N=866)	Ohio (N=151)	Texas (N=2,949)
Program Factors			
Program Completion	N/S	N/S	N/S
Time in Program	Negative	N/A	N/A
Temporal Factors			
Time under Supervision	N/S	N/A	Negative
Time from Treatment	N/S	N/A	N/A
Time at Risk	Positive	Positive	Positive
Demographics			
Age	Negative	N/A	N/A
Race/Ethnicity[21]	Positive	N/A	N/S
Marital Status	N/S	N/S	N/S
Children	N/A	N/A	Positive
Background Factors			
Criminal History	Positive	N/S	Positive
Previous History of Institutional Violations	Positive	N/A	Positive

Note: N/A = Not Available; N/S = Non-Significant

Note: All results based on multivariate models summarized from Tables 4.4, 5.3, and 6.4.

[21] Native Americans were more likely to recidivate compared to Whites.

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Implications for Practice & Policy

Multiple applied implications for practice and policy are gleaned from the findings. The use of a stand-alone treatment facility, as opposed to a normal correctional facility, is advantageous to program operation and client recovery and should be considered as the first option for program placement when feasible. Allocation of entire facilities may not be possible due to cost and staffing restraints in some locales. However, one of the greatest advantages of a stand-alone treatment facility, along with a fulltime treatment staff presence, is assurance of a viable treatment facility. While all jurisdictions may not be able to dedicate resources for an independent treatment institution, a commitment to evidence based practices and recognition of the importance of program fidelity by practitioners should result in space allocations within correctional facilities so as to effectively isolate treatment participants (i.e., effect therapeutic communities within prisons). Also related to preferred treatment setting, future programs should avoid implementing programming in medium security facilities, especially in cases where treatment activity is mixed with general prison population inmates and activities, as too many threats to treatment are intertwined with daily routine.

Programs should also make program participation voluntary so as to minimize offenders not serious about recovery who are counterproductive to the treatment environment. Impact expectations should be contextualized in view of criminal severity and lowered somewhat to account for chronic offenders. While selecting out potential treatment participants with multiple offenses may be tempting and promise low recidivism rates, policy-makers should remember the risk principle of rehabilitating those most in need and the associated societal benefits of successfully treating serial inebriates.

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Regardless of the extent to which treatment services are based on and exemplify evidence based practice, the lack of quality service delivery will no doubt undermine treatment effectiveness. Through observation and interaction with professional and engaged staff, such as those who deliver Montana's WATCh Program, it is clear that there is no replacement for the human factor in treatment. Treatment participants are quick to appreciate the degree of counselor sincerity and any apathy on the part of treatment providers is sure to spread to those receiving services. Despite the importance and central role of treatment providers, little or no attention is given to their concerns and daily challenges as their counseling function necessitates service to others. The provision of treatment services is demanding and focused work with limited tangible rewards and it is not surprising that programs realize a high degree of turnover, especially in the context of the merged pressures of correctional and counseling work. Accordingly, agency administrators and program managers should better factor staff well-being into maintenance and growth plans toward minimizing turnover which is known to be disruptive to treatment.

Though this study examined three programs, only Montana's WATCh program was found to be near ideal in design and performance. The WATCh program is adequately resourced as it enjoys political support both for prison based treatment programming and aftercare, known as the AfterWatch program. The program's length, content, and logistical delivery all reflect evidence based practices and a high degree of program fidelity. WATCh program staff are enthusiastic, adequately credentialed, and personally involved in offenders' recovery efforts. Not surprisingly, treatment participants are highly engaged and demonstrably knowledgeable about the process and goals of the program. Because the entire facility is oriented around treatment, multiple and overlapping service activities are systematically delivered with few

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observed or reported problems. The WATCh program is a model program in regards to operation and broad stakeholder buy-in and should be considered a replication reference for services delivery logistics.

Implications for Future Research

Future evaluation research on alcohol treatment, as well as substance abuse treatment and rehabilitation, generally, can benefit from utilization of mixed methods research designs. The vast majority of treatment programs that are evaluated either conduct outcome analysis only or address implementation and process issues to better contextualize quantitative findings. Multifaceted rigorous attention to evidence based practices and program fidelity is necessary, however, to empirically ascertain with optimal confidence that observed quantitative outcomes are a function of the treatment program rather than mitigating factors or coincidence. Through the qualitative components of a mixed methods design, specific elements comprising program differentiation threats can be identified so that the performance of programs with modality variation is not confused with modalities as designed.

Had the current study not assessed program fidelity, the problematic issues identified in the halfway house receiving treatment participants phasing back into the community in Ohio would have gone unnoticed. At a minimum, the potential for greater offender success and enhanced program performance would have been bolstered had treatment services been delivered during the halfway house phase. In that they were not, the definitional accuracy of "program graduation", designated upon transfer from ODRC to the halfway house with the assumption of treatment continuation, is questionable. The qualitative research generating this finding has great potential for the evaluation of similar correctional programs through confirming program

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integrity and providing valuable accountability to state and federal agencies toward better alignment and coordination of services.

Issues with the halfway house also call attention to the need to reconsider treatment as a continuous process rather than a simple dichotomy of pre- and post-release stages. Intermediate stages, such as halfway house placements, are usually overlooked altogether in the evaluation literature and the effects of experiences there likely are merged into observations of aftercare activity – an erroneous qualitative distinction in that halfway house residents are under supervision with restricted autonomy compared to those on probation. Greater attention to the role and effect of aftercare, generally, is needed and qualitative research into the nature, intensity, and relevance of aftercare services should inform longer period follow-up outcome observations.

While research team rapport with agency representatives and correctional institution administrators was facilitative of evaluation activity, future studies should consider developing researcher-practitioner partnerships prior to or at the juncture of program implementation. It is unlikely that funding opportunities for evaluation and many new programs aligned with research partners will organically align in time and place. Through embedded requirements for evaluation with specified resource expectation stated in funding opportunities by agencies funding new programs, these partnerships would be formed during the program design stage, early enough to factor the random assignment of eligible participants into treatment and control groups for a more rigorous true experimental design strategy.

Future evaluation research also can benefit from utilization of multiple measures of recidivism. This project operationalized recidivism as a return to a correctional facility, the most conservative measure of failure available. This decision was driven in large part because of

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limitations of DOC data in terms of how the states defined recidivism. Multiple measures of recidivism should include arrest and relapse so as to better define success and failure for participants during the recovery period.

It is assumed that initial program participation coercion is desirable in that exposing potential participants to the treatment climate results in internalization of treatment objectives and reduction of fear of the unknown for some that otherwise would not participate through a pure voluntary process. That initially placed inmates may opt out of treatment programming after a week or two seems to be a prudent compromise of delivering services to the greatest number of offenders in need while removing those who might disrupt the treatment environment as disgruntled and forced participants. Future research might isolate offenders into one of three comparison groups (voluntary, coerced/court-ordered, and a hybrid approach such as in Montana and Ohio.

Overall, this study produced several noteworthy research findings and implications for policy and practice. Chief among these is the use of TCs and stand-alone treatment facilities for treating drug-addicted offenders. The value of cognitive-behavioral programming was also substantiated by the current evaluation as was the role of aftercare in producing favorable program outcomes. Though this project produced a wealth of knowledge related to the treatment of alcohol addicted offenders, much about the recovery process remains unknown to researchers, policy makers, and practitioners. We encourage further research into all aspects of the rehabilitative process toward the goals of improving criminal justice policy and practice and addressing this serious threat to public health and safety in the United States.

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APPENDICES
APPENDIX A: Fidelity Instrument

Table 9.1: Program Fidelity Chart

Site: _____ Rater 1 initials: _____ Rater 2 initials: _____ Rater 3 initials: _____
Date of Visit: _____

	Rater 1	Rater 2	Rater 3	Consensus	Actual Value
Adherence (coded 0/1)					
Formal staff qualifications					
Program components					
Prescribed caseload					
Intake timeliness					
Individualized service plans					
Prescribed dosage compliance					
Adherence Mean:					
Exposure (coded 1-5)					
Contact frequency (hours per day)					
Duration; Program Length					
Exposure Mean:					
Delivery Quality (coded 1-5)					
Treatment plan compliance					
Counselor/staff qualifications					
Counselor/staff attitude					
Counselor/staff continued training					
Delivery Quality Mean:					
Participant Engagement					
Participant attitude					
Participant involvement					
Participation barriers (reverse code)					
Participant Engagement Mean:					
Program Differentiation					
Program size fluctuation (reverse code)					
Program budget fluctuation (reverse code)					
Caseload fluctuation (reverse code)					
Continuity of staffing					
Program Differentiation Mean:					
TOTAL MEAN SCORE					

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APPENDIX B: Interview Schedules

Table 9.2: Qualitative Interview Schedule: Administrators and Staff

Administrators:

- Ideological agreement with the program and its objectives
- Purpose of treatment program
- Specific goals for the program
- Commitment of the Texas Department of Criminal Justice (TDCJ) to achieve these goals
- Commitment of Management & Training Corporation (MTC) to achieve these goals
- Prioritization of the program within the facility
- Implementation of program – continuity across staff, effectiveness for residents
- Training of staff
- Barriers to delivery of services
- Modifications needed
- Recommendations

Staff:

- Training history
- Credentials and past experience with treatment delivery
- Intake of inmates
- Initial assessments of inmates
- Availability of resources to effectively deliver the program
- Development of rapport with inmates
- Perceptions of effectiveness
- Utility of the curriculum
- Rule violations and repercussions
- Barriers to effective implementation of the program
- Recommendations for change in program

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Table 9.3: Qualitative Interview Schedule: Program Participants

Topic Area	Specific Items
Transfer/Placement	• Facility orientation – information • Program orientation – information • Transfer status – information; selection process • Appropriateness of placement (self and others)
Needs Assessment	• Treatment Plans • Timeline for conducting this assessment and developing a plan • Meeting with a counselor

Program Components	• Counseling
	  o Individual
	  o Group
	• Curriculum assessment
	• Specific topics/skills
	  o Consequences of drinking
	  o Identification and elimination of triggering mechanisms
	  o Explore feelings or emotions
	  o Identification of thinking errors
	• Program length of time

Counselors	• Effectiveness • Knowledge • Attitude

Environment	• Safety
	• Services
	  o Medical services
	  o Availability and quality of food
	  o Availability of supplies
	• Guards
	• Privileges
	  o Access to books, TV, educational videos, etc.
	  o Recreation time
	  o Commissary visits and supplies
	  o Phone access/visitation

Overall	• Attitude toward rehabilitation • Confidence in ability to not re-offend • Strengths of program • Weaknesses of program

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APPENDIX C: Montana Daily Schedule

Table 9.4: Montana WATCh Program Schedule

WATCh Program Daily Schedule

Revised 9/1/2009

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
6:00am	Wake up	Wake up	Wake up	Wake up	Wake up	Wake up	Sleep In!
6:30am	Reflections	Reflections	Reflection	Reflection	Reflection	Reflection	
7:00am	Breakfast/Task	Breakfast/Task	Breakfast/Task	Breakfast/Task	Breakfast/Task	Breakfast/Task	Wake up!
7:30am	Recreation	Recreation Centurion Exercise	Recreation or Celebrate Recovery -Staff Lounge	Recreation Centurion Exercise	Recreation	Recreation Centurion Exercise	Breakfast
8:00am							
8:30am	Count	Count	Count	Count	Count	Count	Count
9:00am	9:00 TC	9:00 TC	9:00 TC	9:00 TC	9:00 TC	9:00 TC (No Music)	Super Clean
9:30am	CD GROUP Orientation	CD GROUP Orientation	CD GROUP Orientation	CD GROUP Orientation	CD GROUP Orientation	CD GROUP Orientation	Recreation
10:00am							
10:30am							Homework Fine Arts-10:30-11:30
11:00am							
11:30am	RA's and SFM Meet with Unit Staff (All Units)	RA's and SFM Meet with Unit Staff (All Units)	RA's and SFM Meet with Unit Staff (All Units)	RA's and SFM Meet with Unit Staff (All Units)	RA's and SFM Meet with Unit Staff (All Units)		Lunch
12:00	Lunch Staff Rx Mtg 12:05	Lunch Staff Rx Mtg 12:05	Lunch Staff Rx Mtg 12:05	Lunch Staff Rx Mtg 12:05	Lunch Staff Rx Mtg 12:05	Lunch Staff Rx Mtg 12:05	
12:30pm							
1:00pm	Count	Count	Count	Count	Count	Count	Count (12:45)
1:30pm	1:00-2:00 Bible Study 1:00-2:00 Study Hall 1:00-2:00 KNIGHTS Group & Centurion Study Group- Dk Blue	Relapse Prevention Rick K's Office CP&R 1:00p to 2:30p Phase I-LS Phase II-Upper Units Phase III-PIII Room	*Graduation Day!* Phase I- Lectures LS Phase II-Mentor Training Phase III-Study Hall Relapse Prevention Rick K's Office	CP&R 1:00pm to 2:30pm Phase I-LS Phase II-Upper Units Phase III-PIII Room	Parenting 1:00p-2:30p CP&R 1:00p to 2:30p Phase I-LS; Phase II- Upper Phase III-PIII Room	CP&R 1:00p to 2:30p	Church Services After 12:45 count
2:00pm	2:00-2:55pm 2nd WATCh -LS Phase I- Victims- LS Phase II Anger Management Upper Units Phase III Study Hall					Visit 2:00 – 4:00	Home Work 2:00p to 3:00p Centurion Peer Study in Green & Light Blue
2:30pm		CT&E 2:30 to 3:40 Ph I-LS Ph II-Dark Blue Ph III-Light Blue	Specialty Groups 2:30p to 3:30p	TC All Family Members	CP&R 2:30p-3:40p	Study Hall 2:30p to 3:40p Welcom Wagon 2:30 in Green Unit	
3:00pm	Life Skills Phase I-LS Phase II-Gym Phase III-Light Blue						Recovery Based Groups Family Units 3:00pm to 4:00pm
3:30pm							
3:50pm	Count	Count	Count	Count	Count	Family Mtg 3:50	Count @ 4:00
4:20pm	Family Mtg	Family Mtg	Family Mtg	Family Mtg	Family Mtg	Count @ 4:00	
4:30pm	Dinner	Dinner	Dinner	Dinner	Dinner	Dinner	Dinner
5:00pm							
5:30pm	Homework or TV (news ONLY!!)	Homework or TV (news ONLY!!)	Homework or TV (news ONLY!!)	Homework or TV (news ONLY!!)	Recreation 5:30 – 6:30		
6:00pm	Recovery-Based Mtg 6:00 -7:00	Outside AA mtg Recovery-Based Group 6:00 7:00	Recovery-Based Mtg 6:00 7:00	Recovery-Based Mtg 6:00 -7:00		Recreation 6:00 – 7:00	Recreation 6:00 – 7:00
6:30pm					Free Time 6:30 – 7:00		
7:00pm	CP&R Study Group (Everyone Attends)	Homework	Study Hall-All Units	Rules School (Everyone Attends)	AA Meeting – Outside Participants-All Units	7:00 – 8:00 Free Time	7:00 – Movie Mandatory (1 Hour of Movie is Mandatory)
7:30pm							
8:00pm	Recreation	Recreation	Recreation	Recreation		8:00 – 9:00 AA Speaker Meeting	Free Time
8:30pm					Free Time		
9:00pm	Count Reflections(until 9:30)	Count Reflections (until 9:30)	Count Reflections (until 9:30)	Count Reflections (until 9:30)	Count Reflections (until 9:30)	Count Reflections (until 10:00)	Count Reflections (until 9:30)
9:30pm	Prepare for Bed	Prepare for Bed	Prepare for Bed	Prepare for Bed	Prepare for Bed	Prepare for Bed	Prepare for Bed
10:00pm	Lights Out – Phase 1	Lights Out – Phase 1	Lights Out – Phase 1	Lights Out – Phase 1	Lights Out – Phase 1	Lights Out – Phase 1	Lights Out – Phase 1
10:30pm	Lights Out – Phase 2	Lights Out – Phase 2	Lights Out – Phase 2	Lights Out – Phase 2	Lights Out – Phase 2	Lights Out – Phase 2	Lights Out – Phase 2
11:00pm	Lights Out – Phase 3	Lights Out – Phase 3	Lights Out – Phase 3	Lights Out – Phase 3	Lights Out – Phase 3	Lights Out – Phase 3	Lights Out – Phase 3

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APPENDIX D: Additional Quantitative Results

Table 9.5: Texas - Group Characteristics for Group 3 (Some Treatment)

	N	Min	Max	Mean	S.D.
Age	235	25	82	46.17	10.36
Race	235				
White		0	1	.434	.497
Black		0	1	.094	.292
Hispanic		0	1	.468	.500
Other		0	1	.004	.065
Education	235				
Less than H.S. Degree		0	1	.655	.476
High School Graduate		0	1	.323	.469
Some College		0	1	.021	.145
College Graduate		0	1	--	--
Marital Status	213				
Single (Div., Sep., Wid.)		0	1	.695	.462
Married/Common Law		0	1	.305	.462
Number of Children	235				
Zero		0	1	.434	.497
1or 2		0	1	.264	.442
3 or more		0	1	.302	.460
Criminal History	235				
1st Trip		0	1	.468	.500
2nd Trip		0	1	.349	.478
3 or more		0	1	.183	.387
Major Infractions	235				
Zero Previous		0	1	.783	.413
1-5 Previous		0	1	.192	.394
6-10 Previous		0	1	.013	.113
More than 10		0	1	.013	.113
Minor Infractions	235				
Zero Previous		0	1	.438	.497
1-5 Previous		0	1	.494	.501
6-10 Previous		0	1	.051	.221
More than 10		0	1	.017	.130
Outside Trusty	235	0	1	.094	.292
Time to Program	235	34	2,525	359.65	396.21
Time in Program	11	179	184	181.91	1.81
Time from Program	13	8	1,182	276.00	370.10
Time in TDCJ	193	48	2,798	641.20	441.40
Reason for Release	193				
Parole		0	1	.275	.447
Mandatory Supervision		0	1	.415	.494
Discharge		0	1	.072	.260
Other		0	1	.238	.427
Time at Risk	193	3	1,383	581.94	403.31

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Table 9.6: Texas - Failure & Revocation, Group 3

	Group 3: Some Completed				
	N	**Min**	**Max**	**Mean**	**S.D.**
Days to Violation	16	26	968	430.688	313.016
				%	
Failure Rate				**6.81**	
Revocation Rate				62.50	
New Crime Rate				**3.83**	
Revocation Rate				66.67	
Technical Violation Rate				**2.98**	
Revocation Rate				57.14	

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