WATCh:

Montana's In-Prison DUI Treatment Program

By Marilyn C. Moses

Alcohol is the most prevalent substance abused by those in the criminal justice system — exceeding illicit drugs. In fact, alcohol poses a greater threat to our nation's public health than illicit drugs. Alcohol is more widespread and the consequences of its misuse and abuse are more deleterious than illicit substances.

It is thought that if for no other reason than corrections populations are a "captive audience," that the development of in-prison alcohol treatment programs for the felony charges of driving while intoxicated (DWI) and driving under the influence (DUI) would be strategic. Because policymakers, despite contrary evidence, have invested much more heavily in building the evidence base on illicit substance treatment, there is a knowledge gap regarding what works with alcohol misuse, abuse and treatment. In an effort to fill this void, the National Institute of Justice (NIJ) granted an award to the University of Texas at San Antonio to conduct a two-year process and outcome evaluation of three (Montana, Ohio and Texas) corrections-based DUI/DWI programs. Findings from Montana's Warm Springs Alcohol Treatment and Change (WATCh) program are reported here.[1]

Montana's WATCh Program

Operational since 2002, Montana's WATCh program is a six-month (180 days) residential treatment program for those with a history of multiple DUI convictions. Located in Warm Springs, the program is housed at the Montana State Hospital and is the result of a partnership between the Montana Department of Corrections (MDOC) and Community, Counseling and Correctional Services Inc.[2]

Individuals who have four or more DUI convictions are mandated to serve 13 months in MDOC or a residential treatment program operated or approved by the department. The 13-month sentence cannot be suspended, nor can the offender be paroled. Virtually all individuals who meet these criteria are admitted to the program. Offenders with a sexual crime history, violent crime history or a high-security classification are excluded from the program. Offenders with medical or cognitive impairments that would prevent full participation in treatment are also excluded. Participation is voluntary.[3] At the conclusion of the six-month program, graduates spend the remainder of their sentences (seven months) on probation.

Goals. The overarching goals of the treatment program are to assist offenders in developing the skills necessary to make lasting positive life changes, reduce criminal thinking and behavior, and succeed when released. Specifically, the program goals are:

- Increase offenders' knowledge of chemical dependency and the consequences of drinking and driving;
- Provide offenders with treatment and the services necessary to create pro-social change and reduce anti-social thinking and behavior;
- Promote responsibility and accountability of offenders by providing an experiential pro-social community environment; and
- Decrease the incidence of DUI and other drug-related convictions.

"Family members," as they are called — not offenders, residents or clients — proceed through the program in three phases. Upon completion, family members are released to an aftercare program and remain under probationary supervision until the conclusion of their sentence. The three phases are:

Table 1. National Institute on Drug Abuse (NIDA) Guidelines on Evidence-Based Treatment Practices for Criminal Justice Populations and WATCh

NIDA Guidelines	WATCh
Assessment: A comprehensive assessment must be used to determine the nature and extent of an individual's drug problems and establish how these issues relate to other spheres of life.	• *Diagnostic and Statistical Manual of Mental Disorders* • Substance Abuse Subtle Screening Inventory • Short Michigan Alcoholism Screening Test • CAGE — a verbal screening method
Treatment Length: Treatment should be a minimum of three months for justice-involved populations.	• The program is designed to operate on a six-month (180-day) cycle and is structured in three phases.
Individualized Treatment: Treatment should be tailored to fit the needs of the individual.	• An individualized treatment plans is developed in Phase 1. In Phase 2, the client is expected to develop an individualized recovery plan that takes into account treatment needs post-release.
Drug Use Monitoring: Drug use monitoring must be regular and random.	• Supervision is provided 24/7, along with random security searches of offenders in their living areas. Regular and random breathalyzer and urinalysis screenings are employed.
Target "Criminal Thinking:" Cognitive-behavioral change therapy to address attitudes and beliefs such as entitlement, use of neutralizations, externalizing behavior and short-sightedness is required.	• "Criminal Conduct and Substance Abuse Treatment" curriculum • The program employs the Cognitive Principles and Restructuring approach developed by Montana State Prison.
Continuity of Care: Offenders who complete prison-based treatment are more successful when they receive aftercare services in the community post-release.	• The program employs an aftercare coordinator, and clients must meet with the coordinator at least 60 days prior to program coordination. • A community-based aftercare plan is developed prior to end of Phase 3. • Montana state law requires that program participants receive aftercare services while on probation following release from DOC custody. • WATCh coordinates with 90 probation officers, 24 chemical dependency aftercare providers and 10 transitional living facilities.

Sources: National Institute on Drug Abuse. 2012. Principles of drug abuse treatment for criminal justice populations: A research-based guide. *Rockville, Md.: National Institutes of Health; National Institute on Drug Abuse. 2012.* Principles of drug addiction treatment: A research-based guide, third edition. *Rockville, Md.: National Institutes of Health*.

Table 2. Group Characteristics

	Group 1: Noncompleters	Group 2: Program Completers
Age at Program Entrance	46.4 years	43.3 years
Race		
White	67%	77%
Black	9%	5%
Hispanic	19%	28%
Native American	30%	19.5%
Marital Status		
Single	77%	75%
Criminal History		
1st Incarceration	36%	47%
2nd Incarceration	27%	18%
3 or more Incarcerations	37%	34.5%
Violent Offenses	13%	9%
Infractions		
0	100	86
1-5	0	13
6 or more	0	4
Time to Program*	266 days	121 days
Time in Program	60 days	181 days
Time from Program	358 days	44 days
Time in MDOC	683 days	346 days
Time at Risk	918 days	1,197 days

** Note: "Time to program" measures the number of days an individual waited to enter the program since incarceration. "Time in program" is the number of days spent in the WATCh program. "Time from program" measures the number of days from WATCh graduation to MDOC release. "Time in MDOC" is the overall number of days spent incarcerated. "Time at risk" is the number of days from MDOC release to the end of the study period.*

- Phase 1, "Challenge to Change:" The initial phase of the program is devoted to introspection. Goals during this phase are self-disclosure, self-awareness and developing an ability to receive feedback from family members and program staff;
- Phase 2, "Action Phase:" This portion of the program is devoted to identifying the life situations that contributed to the current circumstance and developing behavioral change and improvement goals; and
- Phase 3, "Ownership of Change:" Here, the goal is stabilization and maintenance with an eye toward strengthening the commitment to behavioral change.

Evaluation. University of Texas researchers J. Mitchell Miller, Holly Ventura Miller and Rob Tillyer used qualitative and quantitative approaches to assess this program. The evaluation questions included:

- Does this alcohol treatment program adhere to evidence-based practices that have documented success in addressing substance abuse?;
- Does this alcohol treatment program deliver treatment in a manner consistent with protocols, thereby demonstrating program fidelity?; and
- Are those who graduate from this program more or less likely to reoffend compared to a comparison group of nonprogram participants?

Evidence-Based Practices

Therapeutic and legal responses to alcohol and illicit substance use disorders have developed along separate tracks, principally due to the differing perceived dangers posed by alcohol. Substance availability, historical events, legality and the ever-evolving societal understanding and attitudes about alcohol gave rise to widely different sanctions and unequal research funding availability. During the past few decades, the treatment and legal communities have tried a variety of strategies such as alcohol education and license suspension, with little success. However, until research demonstrates otherwise, treatment guidelines should center on the evidence base for general addictions treatment and for criminal justice populations with substance use disorders.

One goal of this study was to determine how successful the WATCh program designers and implementers were in adhering to industry-recognized, evidence-based guidelines. The standards set forth in the *National Institute on Drug Abuse's (NIDA) Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide* (revised edition, 2012), and *Principles of Drug Addiction Treatment: A Research-Based Guide* (third edition, 2012) were used to establish benchmarks. Assessment, treatment length, individualized treatment, drug use monitoring, targeting "criminal thinking" and continuity of care are necessary components of an evidence-based treatment approach.

In order to make their assessment, the research team made three multiple-day site visits during the course of the study. During these visits, the team conducted in-depth interviews of participants and staff, convened focus groups, engaged in direct program observation and analyzed documents (referral and admission forms, intake assessments, treatment modality plans, program curricula and instructional materials). The WATCh program designers and implementers received high marks from the research team for consistency with NIDA's established guidelines (see Table 1).

Program Fidelity

What happens when practitioners replicate or implement a program design? Do they implement it faithfully, or do they modify it to meet their needs?

This is what researchers are asking when they evaluate program fidelity. They want to know how successful the WATCh program implementers were in deploying the evidence-based treatment protocol provided to them by the program designers. Budget cuts, legislative changes, lack of qualified program staff, prohibitive provisions of union contracts and shifts in political views are a few things that can affect program fidelity. However, it is necessary for program evaluators to understand how "true" the implemented program is to the one that was originally intended. Otherwise, researchers are unable to assess whether the study outcomes (positive or negative) are due to the program as designed, or to adaptations or variations made to the program. Additionally, other jurisdictions or evaluation consumers who are interested in replicating the program need this information as well, for the same reason. In Montana, the scientists had nothing but glowing things to say about WATCh's program fidelity. "The Montana program was found to be near ideal … ," the University of Texas researchers said. "The WATCh program is true to its design, meeting or exceeding dosage and exposure expectations."[4]

Outcomes

Montana's WATCh alcohol addiction treatment program is holistic; is well-resourced; enjoys legislative support; and has received high marks from program participants. The program developers and implementers deserve to be commended. However, despite their efforts, little difference was found in the recidivism outcomes for graduates of the program versus noncompleters.

Recidivism — as measured by a return to a correctional facility within nearly six years — was the principal outcome measure examined in this study. Data was gathered on 908 men who had entered the program from July 1, 2006 to May 16, 2012. After some were eliminated due to missing data (and for other reasons), 866 individuals remained in the study. This group was then separated into program graduates (n=760) and noncompleters (n=106) for comparison purposes. The two groups were largely the same with a few variations (see Table 2). On first examination, the difference in failure rates between the two groups appears significant (see Table 3). However, when multivariate analysis is employed, that difference becomes statistically indistinguishable. This means that program completers recidivate at the same rate as noncompleters.

Predictors of recidivism did emerge from the analysis. Younger offenders and those with more time at risk (post-release time) were at increased risk of recidivism. Native Americans were 2.3 times more likely to recidivate than their White peers. Individuals who were more entrenched in the criminal justice system (defined as three or more incarcerations at MDOC) were more than three times more likely to recidivate. Along the same line, those with a history of institutional misbehavior were also more likely to recidivate.

While the findings regarding recidivism may be disappointing, a lot was learned from this effort. If nothing else, the value of investing in assessing and documenting

Table 3. Failure and Revocation

	Group 1: Noncompleters	Group 2: Completers
Recidivism Rate	25.47%	34%
Assessment	*	46.49 %
Treatment	*	19.74%
Prison Rate	100%	33.77%
Time to Failure	409 days	496 days

**Note: Assessment and treatment information was not available for noncompleters.*

program fidelity was demonstrated, as we know exactly what did not work. Given meager evaluation budgets, often researchers "cut corners" and do not invest in documenting program fidelity. Thus, evaluation results, positive or negative, may be deceiving as the research consumer does not know whether the program that was implemented by practitioners was the same as the one designed. This can make it impossible to discern positive or negative outcome results.

Further Research

This study illuminates other issues that require additional research. For example, in an optimal program measured by adherence to evidence-based guidelines, why did program graduates do no better than those who did not complete the program? One obvious, but perhaps overlooked factor is that treatment participants in the WATCh program were significantly older than the average correctional population. Additionally, by definition, those in this program are "persisters" in that they must have four or more DUI convictions to be admitted to WATCh. Further experimentation appears necessary to determine what is necessary to change this population's behavior.

Other interesting questions include an examination of coerced, voluntary and hybrid (initially coerced/then voluntary) treatment. WATCh is a hybrid program. Funding and the length of this study did not permit an exhaustive review of the role of the aftercare provided to program participants. Additionally, it would be beneficial to use multiple, rather than one (return to a correctional facility), measure of criminal justice and public health recidivism. With the large number of Native Americans failing post-release, perhaps culturally-sensitive treatment is an issue. Given that so few in-prison alcohol treatment programs have been thoroughly documented and evaluated, this evaluation of WATCh is of great value and will undoubtedly move the field forward. It forces us to reconsider the importance of establishing program fidelity toward achieving treatment success and behavioral change with this understudied population.

ENDNOTES

[1] While three sites were studied, findings from Ohio and Texas are not reported here. The Ohio program had a low capacity (24 treatment slots) and rarely, if ever, reached capacity. Post-award, there was a legislative change in Ohio that further restricted admission to the program and redirected the care, custody and treatment of qualifying offenders to local jails. Texas provided the researchers with the requested program participant data for analysis, but did not permit access to the program or its participants for qualitative analysis. Findings from the Ohio and Texas programs can be found in the grantee's final report: Miller, J.M., H. Ventura Miller and R. Tillyer. 2013. Effect of prison-based alcohol treatment: A multi-state process and outcomes evaluation final report (unpublished).

[2] This program is operated in two sites in Montana. This location is only open to males. The second location (not evaluated in this study) serves both male and female offenders.

[3] Admission is coercive for the first two weeks. After that point, the offender may decide whether to continue in the program or to fulfill his or her 13-month sentence in a MDOC correctional facility.

[4] Ventura and Tillyer. 2013.

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