Process and Outcome Evaluation of the La Crosse County OWI Court

REPORT SUBMITTED TO:

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INTRODUCTION

Treatment Courts have become a popular criminal justice response across the country, with thousands of courts currently operating in the United States (Huddleston, Marlow, and Casebold, 2008). Research on drug courts, the most popular treatment court, have continuously demonstrated that reductions in recidivism can be consistently achieved (Mitchel, Wilson, Eggers, and MacKenzie, 2012; Schaffer, 2011). Research on Operating While Intoxicated (OWI) Courts (also referred to as DWI Courts and DUI Courts) have produced mixed results (Marlowe, XXXX; Mitchell et al. 2012).

The purpose of the current report is to examine La Crosse County's OWI Court. To achieve this, La Crosse County received a grant from the Wisconsin Office of Justice Assistance and contracted with Research Driven Solutions, LLC to provide a process and outcome evaluation. The process evaluation is designed to examine how the La Crosse County OWI Court operates compared to the research on what works at reducing recidivism. To achieve this, the process evaluation uses the Correctional Program Checklist-Drug Court, a tool designed by the University of Cincinnati to assess drug court programs, to ascertain how closely drug courts (and other therapeutic courts) meet known principles of effective intervention. The CPC-Drug Court tool was used because OWI courts follow closely to the procedures used by drug courts. The second goal of this paper was to conduct an outcome evaluation to determine the effectiveness of the La Crosse County OWI Court. Data were gathered on all OWI court particpants and matched comparison group was developed to provide a rigorous evaluation of the OWI Court.

The first section of the report presents the process evaluation. It provides a description of the procedcures used in the process evaluation. This is followed by the process evaluation of the OWI Court and two outside referral agencies that provide the primary treatment for OWI Court participants. Strengths and areas of improvement are noted for each of the evaluated programs. The second half of the report provides the outcome evaluation. This section provides information and evaluation on the success of program participants. Moreover, this section also provides the analyses of OWI Court participants recidivism and a comparison to a matched group of probationers that did not receive OWI Court.

PROCESS EVALUTION

CONTEXT AND SCOPE OF THE EVALUATION

Programs that adhere to the principles of effective intervention are more likely to impact criminal reoffending (see Andrews & Bonta, 2003 for a review). Specifically, correctional research suggests that cognitive behavioral and social learning models of treatment for offenders are associated with considerable reductions in recidivism (Gendreau, 1996; Smith, Goggin & Gendreau, 2002). As such, the Evidence-Based Correctional Program Checklist – Drug Court (CPC-DC) was used to evaluate the La Crosse County OWI Court in La Crosse, Wisconsin. The objective of this assessment was to conduct a detailed review of services and program materials of the OWI court and the agencies where OWI courts clients are serviced in the community, as well as compare all agencies' current practices with the literature on "best practices" in corrections. To this end, the La Crosse County OWI Court contracted with Research Driven Solutions, LLC to provide a CPC-DC. Dr. Andrew Myer and Dr. Matthew Makarios, the evaluators of the current report, have received extensive training on the CPC by the University of Cincinnati (the developer of the tool) and have conducted multiple CPCs throughout the country. The University of Cincinnati gave permission for Research Driven Solutions, LLC to use the CPC-DC on the La Crosse County OWI Court. This report provides a synopsis of findings from the CPC evaluation as well as recommendations to enhance the effectiveness of the services delivered by the La Crosse County OWI Court.

PROCEDURES

Description of the Evidence-Based Correctional Program Checklist – Drug Court (CPC-DC)

The Evidence Based Correctional Program Checklist - Drug Court (CPC-DC) is a tool that the University of Cincinnati developed for assessing drug court programs,[1] and is used to ascertain how closely drug courts (and other therapeutic courts) meet known principles of effective intervention. Several recent studies conducted by the University of Cincinnati on both adult and juvenile drug court programs were used to develop and validate the indicators on the CPC-DC. These studies found strong correlations with outcome between both domain areas and individual items (Holsinger, 1999; Lowenkamp, 2003; Lowenkamp & Latessa, 2003, Lowenkamp & Latessa, 2005a; Lowenkamp & Latessa, 2005b; Shaffer, 2006).

The CPC-DC consists of two instruments: one for the formal drug court (CPC-DC) and the other for the major referral agencies (CPC-DC: RA) involved in providing treatment and services to drug court clients. Each of these tools is divided into two basic areas: content and capacity. The capacity area is designed to measure whether the drug court and its referral agencies have the capability to deliver evidence-based interventions and services for offenders. There are two domains in the capacity area: 1) Development, Coordination, Staff and Support, and 2) Quality Assurance. The content area focuses on the substantive aspect of the drug court and its referral agencies, and also includes two areas: 1) Assessment Practices, and 2) Treatment. The content area focuses on the extent to which the drug court and its referral agencies meet the principles of risk, need, responsivity, and treatment.

The Drug Court tool includes 41 indicators, worth 43 total points that are scored during the assessment. The Referral Agency tool has 49 indicators worth a total of 51 points. Each area and all domains are scored and rated as either "highly effective" (65% to 100%); "effective" (55% to 64%); "needs improvement" (46% to 54%); or "ineffective" (less than 45%). The scores in all domains are totaled and the same scale is used for the overall assessment score. It should be noted that not all of the

[1] The CPC is modeled after the Correctional Program Assessment Inventory developed by Gendreau and Andrews. However, only those indicators that were found to be positively correlated with outcome were retained. In addition, the CPC includes a number of items not contained in the CPAI.

domains are given equal weight, and some items may be considered "not applicable," in which case they are not included in the scoring. Data are collected through structured interviews with selected program staff and program participants as well as through observation of groups and services. In some instances, surveys may also be used to gather additional information. Other sources of information include policy and procedure manuals, schedules, treatment materials, manuals, curricula, a review of case files, and other selected program materials. Once the information is gathered and reviewed, the program is scored. The following report highlights strengths, areas that need improvement, and recommendations for each of the areas for both the OWI court and the referral agencies.

There are several limitations to the CPC-DC that should be noted. First, as with any research process, objectivity and reliability are an issue. Although steps are taken to ensure that the information gathered is accurate and reliable, given the nature of the process, decisions about the information and data gathered are invariably made by the assessor(s). Second, the process is time specific. That is, the assessment is based on the program at the time of the assessment. Though changes or modifications may be planned for the future or are under consideration, only those activities and processes that are present at the time of the review are considered for scoring. Third, the process does not take into account all system issues that can affect program integrity (i.e., political climate of the court). Finally, the process does not address the reasons that a problem exists within a program or why certain practices do or do not take place. Rather, the process is designed to determine the overall integrity of the program.

Despite these limitations, there are a number of advantages to this process. First, the criteria are based on empirically derived principles of effective programs. All of the indicators included in the CPC-DC have been found to be correlated with reductions in recidivism. Second, it allows researchers to get inside the “black box” of an OWI court and its referral agencies, something that an outcome study alone does not provide. This knowledge will extend beyond descriptive indicators, which will assist

researchers with measuring the degree to which the programs are meeting evidence-based standards. Third, the CPC-DC enables researchers to "quantify" the quality of a program through a scoring process. This allows comparisons across programs, as well as benchmarking (reassessment allows a program to reassess its progress). Fourth, it identifies both the strengths and weaknesses of a program; it provides the program with an idea of what it is doing that is consistent with the research on effective interventions, as well as those areas that need improvement. Finally, it provides specific recommendations for program improvement.

Assessment Process

The assessment process consisted of a series of structured interviews with staff members and program participants during an on-site visit on December 18th through December 21st. Additionally, data were gathered via the examination of participant files (both open and closed) as well as other relevant OWI court and treatment provider materials (e.g., client handbooks, treatment manuals, assessments, ethical guidelines, and staff evaluations). The observation of the OWI court staffing and OWI court sessions occurred on December 10th and December 18th. In addition, an observation and interviews with two primary substance abuse treatment providers, Mayo Behavioral Health of La Crosse and Hiawatha Valley Mental Health of La Crosse. Two evaluators conducted the various interviews, observations, and file reviews. Data from the various sources were then combined to generate a consensus CPC-DC score and CPC-DC: RA scores and the specific recommendations in what follows.

SUMMARY OF THE OWI COURT

The La Crosse County OWI Court has been in operation since 2006. The OWI court is funded by La Crosse County. The court primarily targets individuals convicted of their third and fourth OWI. At the time of assessment, Becky Spanjers was the OWI court program coordinator.

The OWI court requires clients to progress through three phases of treatment designed to last a minimum of twelve months. Each phase has a variety of requirements and, in general, the intensity of services and supervision are reduced as the clients progress through phases. Phase advancement is tied to sobriety time and each phase requires a minimum number of days sober. Phase 1 lasts a minimum of 90 days and clients are required to attend OWI court a minimum of twice per month. Phase 2 lasts a minimum of 120 days and participants are required to attend court at least once per month. Phase 3 lasts a minimum of 150 days and the OWI court team determines the number of appearances required in court. The court relies on the following supervision techniques to monitor clients in the program: random drug and alcohol testing by the court, electronic monitoring, day reporting, participation in substance abuse treatment, and attendance at court. The majority of treatment for participants in the OWI court is provided by three outside referral agencies, Mayo Behavioral Health, Hiawatha Valley Mental Health, and Gundersen Lutheran Behavioral Health. Supplementary programming is also provided by Justice Sanctions. It should be noted that La Crosse County OWI Court can refer their clients to other programs. These programs include: Coulee Youth Centers (for outreach services), Coulee Council on Addictions (for non-dual diagnosis, outpatient counseling), and Ophelia's House (for women's services and inpatient residence). However, referral to these programs is not used as consistently or frequently as the three referral agencies, which is why these programs are not included in the CPC-DC. Additionally, attempts to schedule a site visit with Gundersen Lutheran were unrequited.

As such, this referral agency could not be evaluated using the CPC-DC:RA. The following are the findings from the CPC-DC.

FINDINGS – OWI COURT

CPC-DC SECTIONS	SCORE	RATING
Development, Coordination, Staff, and Support	77.8%	Highly Effective
Offender Assessment	33.3%	Ineffective
Treatment	44.4%	Ineffective
Quality Assurance	33.3%	Ineffective
Overall Capacity	**60.0%**	**Effective**
Overall Content	**40.7%**	**Ineffective**
Overall Score	**47.6%**	**Needs Improvement**

Development, Coordination, and Staff Support

Strengths:

- There is a Program Coordinator who has overall responsibility for oversight and management of the OWI court program.
- Weekly staff meetings are held to discuss client progress in the OWI court. Monthly policy team meetings also occur to discuss OWI court policy changes and ways to improve the program.
- OWI court staff provide case management and supervision services to the court participants. Weekly court meetings, the use of drug testing, and day reporting are examples of how the court provides supervision to clients in the community. Although the court meets the minimum requirements for this item, there is likely room for improvement in this area. Ideally, more supervision, such as home or work visits should be utilized. The arrangement that has been made by DOC to assign a probation officer specifically for court participants is promising.
- Ethical guidelines are in place (as dictated by team members' various professional standards) and include staff boundaries and interactions with court clients.
- Funding for the OWI court was consistently rated as adequate. Responses from team members indicated that the current funding allows the court to operate as designed. Some team members

were concerned about the increase in the cost of drug testing has the potential to jeopardize the functioning of the court in the future.

- The OWI court operates on a post-conviction model. Treatment courts have more impact on recidivism rates when they only accept clients when their charges are held in abeyance, dropped, or if their sentences are reduced if the client successfully completes the program. All OWI court participants have been convicted and are able to avoid a sentence to jail if they successfully complete the program. By doing this the La Crosse County OWI court provides leverage over their clients, giving them incentive to participant in court.

Recommendations for Improvement:

- The Program Coordinator does not have a direct role in selecting and approving the individuals hired to provide supervision and treatment services. Although it is not necessary that be given final say in these decisions, efforts should be made to develop policies that ensure the Program Coordinator is provided input into hiring decisions for treatment providers and decisions about who serves on the OWI court team when changes are made.
- OWI court staff should be trained on the OWI court program and receive at least 40 hours of on-going training a year. Staff training should relate to the theory and practice of interventions used by the program including effective correctional practices and the cognitive-behavioral model. It is encouraging that the OWI court team members receive some training every year. Most team members are required to get training because of licensure requirements. Also the OWI court attempts to send team member to the state treatment court conference and, occasionally, the national drug court conference. Still, not all team members consistently attend all conferences or trainings and the content of different trainings (especially those required to maintain licensure) are not always directed at the theory of interventions used by the court.

Offender Assessment

Strengths:

- There are established criteria for the inclusion of OWI court participants. The policy is written and followed and clients were deemed appropriate for OWI court by the majority of staff.
- The risk of recidivism and a range of criminogenic needs are assessed with a validated assessment instrument. The OWI court uses the COMPAS to assess for risk and needs. COMPAS is an actuarial risk and needs assessment instrument that categorizes participants by the likelihood of recidivism and includes dynamic risk factors to identify criminogenic needs. It is encouraging that the court makes use of this instrument, but more efforts should be made to utilize the information it provides in case management and referral decisions. For example, participants that are found to have issues within different criminogenic areas, such as substance abuse or criminogenic thinking should be considered for placement in Driving with Care or Thinking for a Change respectively.

Recommendations for Improvement:

- The court should make efforts to ensure that evidenced-based, objective exclusionary criteria are in place and followed that so that inappropriate clients are not being admitted to the program. Although most offenders participating in OWI court were appropriate for the services provided, the court does not exclude violent offenders. Also, there was concern expressed by several members of the OWI court team regarding small number of participants in court with relatively severe mental health problems. Efforts should be made to either train OWI court team members on issues surrounding dual diagnoses and or look to refer these clients to other programming that is equipped to deal with these types of offenders.
- Domain specific needs, especially substance abuse, should be assessed using a validated, standardized, and objective instrument. The OWI court uses the Wisconsin Assessment of the Impaired Driver (WAID) to determine the level of need for alcohol and substance abuse. There is no evidence available that suggests that the WAID has been validated on a sample of OWI or other substance abuse populations involved in the criminal justice system. The court should make efforts to adopt a validated needs assessment instrument that measures the severity of alcohol and substance abuse problems. Examples of alcohol and substance abuse needs assessments that have been validated on OWI offending populations are the ASUDS (Adult Substance Abuse and Driving Survey), the ASI (Addiction Severity Index), CSI (Central State Institute), or the RIASI (Research Institute on Addictions Self Inventory).
- The OWI court should assess factors that directly affect engagement in the OWI court and/or treatment programming. Additionally, there should be evidence that clinical or staffing decisions are made based upon these responsivity factors. It is promising that the treatment liaison conducts a psycho-social assessment for all participants, but more efforts should be made to utilize standardized assessments. At least two major factors such as personality, motivational level, readiness for change, or mental illness should be assessed using validated instruments. Examples of appropriate responsivity instrumentation include the TCU Client Self-Rating scale, Beck's Depression Inventory, the URICA, and IQ tests. Access to the COMPAS provides the court with the ability to assess for motivation using the URICA, but the court currently does not consistently use this assessment. Efforts should be made to utilize this measure of offender motivation to engage in treatment.
- OWI courts should target moderate and high-risk offenders and low-risk offenders should be screened out or placed into a separate, low intensity program. The OWI court does provide a low intensity "modified track" that could be used for low risk participants, but it currently utilizes this option infrequently. Discussions with team members indicated that this was likely because of strict inclusionary criteria. It is important to limit the intensity of treatment for low risk cases (especially if they are also low need), because intensive treatment for low risk cases often serves to disrupt pro-social ties such as work and family obligations. It is also important to limit times where low risk participants are mixed with high risk participants, because this can expose low risk participants to antisocial peers, attitudes, and thinking errors. If low risk cases are included in the OWI court program, efforts should be made to increase the use of the modified track for low risk cases and to avoid mixing low and high risk participants (e.g., holding court for low risk cases on a separate day).
- The OWI court should target relevant higher-need clients (i.e., high-need for alcohol and substance abuse treatment). It is encouraging the court uses the WAID to assess for substance abuse dependence, but a validated needs assessment should be used to assess the need for substance abuse treatment.

- Assessments are not shared with everyone on the OWI court team including the external treatment providers. There should be established procedures that ensure all assessment information is shared between treatment providers and the OWI court in order to assist during the development of treatment plans and in case management decisions.

Treatment Characteristics

Strengths:

- The La Crosse County OWI Court targets a wide range of criminogenic needs and meets the criteria that the majority of OWI court interventions focus on criminogenic needs. The OWI court team consistently stated the following criminogenic needs were targeted: substance abuse, promotion of more positive attitudes, reducing criminal thinking errors, increasing performance regarding school or work/finances, and relapse prevention.
- The OWI court appears to operate under a cognitive behavioral model. There is a clear behavioral component that focuses on punishment and reward as well as services offered that focus on cognitive skill deficits and criminal thinking errors. It is worth noting that that a cognitive behavioral approach was not found across all service providers. Further, the delivery of some of the cognitive behavioral programming could be improved. For example, the use of the Carey Guides is promising since these have a clear cognitive behavioral focus, but participants should work through the workbooks with a trained service provider who can help them identify key points, role model appropriate behaviors, and role play with the participants. Also, the referral process for Thinking for a Change should involve the use of the antisocial cognitions domain from COMPAS instead of focusing solely on risk level.
- The OWI court makes efforts to match the program participants to treatment service providers. Interviews with multiple team members indicated that referral decisions are based in part on the personal characteristics of the participants and how good of a fit they will make with a particular service provider.
- The OWI court has a good reward structure in place. This reward structure includes a wide range of rewards such as: verbal praise, gift cards, tokens/key chains, certificates, and the early group.
- The OWI court places an emphasis on rewarding good behavior. Court sessions observed indicated that verbal praise and other rewards are used frequently and the ratio of punisher to rewards is likely 4:1.
- The OWI court does have a range of punishers in order to appropriately respond to noncompliance. Punishments include a verbal reprimand, community service, assigning a written report, day reporting, and jail. Observation of the team staffing and court sessions indicates that efforts are made to administer punishment in a graduated fashion.
- The OWI court does not require Alcoholics Anonymous as a support group. Although support groups are required, efforts have been made to provide participants with a variety of different options for support groups, such as: Smart Recovery (an online support group), church support groups, and RAVE.
- The OWI court randomly drug tests clients on a regular basis. Clients are required to contact Justice Sanctions to set up random drug testing that is conducted using a color coded system. Although the OWI court team can change the requirements of testing as needed, in general, the following drug testing is required by phase: Phase 1 clients a required to have a minimum of two

daily drug tests; Phase 2 clients have a minimum of five weekly random drug tests; Phase 3 clients have a minimum of three weekly random alcohol test. The Justice Sanctions staff members administer the random drug screens to the clients.

Recommendations for Improvement:

- Although there is a clear cognitive behavioral focus within the services provided by the court, this treatment modality is not consistently utilized across all services provided by the court. Furthermore, it is not clear to all members of the OWI court team that a cognitive behavioral approach is overarching treatment modality of the court. The OWI court should formulate policies that encourage the use of cognitive behavioral treatment across all service providers and to train all OWI court team members on its theory and practice.
- The time it takes to complete OWI court is too long. Research suggests that effective treatment courts have an average length of 12 months, and the phase system in the La Crosse County OWI court takes a minimum of 12 months. Most clients do not complete in the minimum amount of time and it is common for participants to have to re-start a phase or to have time added onto a phase as a sanction for non-compliance. As a result, the length of the OWI court extends beyond the recommended average of 12 months. Of the case files reviewed, the average time spent in court was 15.8 months. OWI court team members' estimates of time to completion were consistent with this figure. Efforts should be made to reduce the minimum amount of time required to complete OWI court so that the average length is reduced. Increased use of the modified track for low risk cases could be used to help reduce the time spent in OWI court.
- OWI court participants do not spend an adequate amount of time in structured activities. Clients are not required to work or engage in other structured activities outside of court. Although many of the participants do maintain jobs and have a good deal of structure, there is no mechanism in place to ensure that all clients are involved in structured activities and do not have long periods of idle time. It is encouraging that the court requires participants to develop a plan for structured time management, but discussions with court team members indicated this plan focused primarily on time management instead of encouraging participants to develop routines and activities that involve structured, prosocial activities.
- Intensity of the OWI court programming should vary by risk level. High-risk participants should receive higher intensity and/or duration of service than moderate-risk participants. Low-risk participants are not typically appropriate for intensive programs and services and should be screened out of the OWI court. It is encouraging that the OWI court makes efforts to this end, but there are areas for improvement. For example, the OWI court coordinators noted efforts to increase the case management and supervision of high risk cases, but this practice was not consistently implemented. The use of Thinking for a Change for high risk clients is also promising, but as noted previously, referral decisions for thinking for a Change should consider participants status on the antisocial attitudes and values domain of COMPAS. If clients are deemed appropriate for Thinking for a Change, they should be required to attend. Also, if low risk cases are not screened out, efforts should be made to increase the use of the modified track and to keep low risk and high risk clients separate. The determination of risk should be made using an objective, validated, and standardized risk assessment tool (i.e., COMPAS).
- The OWI court should have measurable completion criteria which determine how well a client has progressed in acquiring pro-social behaviors and pro-social thoughts, attitudes, and beliefs. While phase advancement is used, other methods should be incorporated such as pre/post testing

and reassessment on risk and need instrumentation. In short, completion criteria should be based on the objective acquisition of measurable skills.

- The OWI court completion rate is 59% which falls outside of the acceptable range of 65% to 85%.
- OWI court participant's family should be trained to provide support. This training should include teaching family members the ability to identify high-risk situations for their loved one and strategies for managing their environment using pro-social skills. Family sessions should target family communication and family problem solving. Family members should be taught new skills to assist their loved one to monitor and anticipate risky situations in the community.
- The OWI court should include a formal aftercare component of high quality (i.e., using evidence-based approaches) that requires supervision and attendance to programming. This should include formal services designed to assist the client in transitioning out of intensive services and help meet their needs during this transition process. This should also include planning that starts during treatment phases, reassessment of risk and needs, required attendance of facilitated groups or individual sessions of high quality, and duration and intensity based on risk level of the client.

Quality Assurance

Strengths:

- The La Crosse County OWI Court measures participant satisfaction with the program and treatment programming with an exit survey.
- Client re-arrest, reconviction, or re-incarceration data is examined regularly by the OWI court staff.

Recommendations for Improvement:

- The OWI court should have a management audit system in place to evaluate internal and external service providers. This includes site visits, monitoring of groups, regular process reports, and file review for all external service providers. It is promising that the OWI court has increased its efforts to obtain regular progress reports on clients, but more efforts should be made to provide oversight of the integrity of services being provided by referral agencies.
- Client reassessment should be completed to determine progress on meeting target behaviors. This can be achieved through a pre/post test or through reassessment on validated risk and need instruments. An example of a proper pre/post test is the TCU Criminal Thinking Scales (TCU-CTS) the Drinker Inventory of Consequences – Short Index of Problems, the Criminal Sentiments Scale, and the How I Think Questionnaire.
- The OWI court has not undergone a formal evaluation in the past five years comparing treatment outcomes *with* a risk-control comparison group. It is promising that the OWI court has contracted with an evaluator in the past, but efforts should be made to evaluate the effectiveness of the court in a more methodologically rigorous manner and on a more consistent basis.

OVERALL PROGRAM RATING

La Crosse County OWI Court received an overall score of **47.6** percent on the CPC-DC. This falls into the **Needs Improvement** category. The overall CAPACITY score designed to measure whether the program has the *capability* to deliver evidence based interventions and services for offenders is **60.0** percent, which falls into the **Effective** category. The overall CONTENT score, which focuses on the *substantive* domains of assessment and treatment, is **40.7** percent, which falls into the **Ineffective** category.

FINDINGS – La Crosse Mayo Behavioral Health

Mayo Behavioral Health of La Crosse (MBH) provides substance abuse programming to OWI Court participants. Moreover, MBH also provides some assessment services to determine eligibility and appropriateness of OWI clients for substance abuse treatment groups and other services. These other services can include individual counseling and mental health counseling. OWI court clients that attend treatment groups provided by MBH will participate in an Intensive Outpatient group and/or a Continuing Care Group. It should be noted that MBH anticipates adding new groups post evaluation. These groups include a readiness group, a relapse prevention group, and a women's IOP group. Since these groups were not in place at the time of evaluation, they are not considered into the scoring of the CPC-DC. Thus, the strengths and recommendations provided below are based on the components of the MBH delivery of its substance abuse program.

CPC-DC: RA SECTIONS	**SCORE**	**RATING**
Leadership, Staff, and Support	71.4%	Highly Effective
Offender Assessment	33.3%	Ineffective
Treatment	46.4%	Needs Improvement
Quality Assurance	25.0%	Ineffective
Overall Capacity	61.1%	**Effective**
Overall Content	45.2%	**Ineffective**
Overall Score	51.0%	**Needs Improvement**

Leadership, Staff, and Support

Strengths:

- The program director has extensive experience with Mayo Behavioral Health, and possesses a degree in a helping profession (M.S. in Marriage and Family Therapy).
- The program director is directly involved in the process to select treatment staff that work in the programs. The program director is also directly involved in providing formal training to new staff as well as providing direct supervision to treatment staff.
- At least 75% of treatment staff have an associate's degree or higher in a helping profession, as well as have at least two years of experience working with offenders. Many of the MBH staff possess graduate degrees in psychology.

- Staff are selected for skills and values that are supportive of client treatment and change. Some skills and values that staff stated were taken into consideration when hiring include: knowledge of addiction and recovery, knowledge of theories of change, personality that will work well with substance addicted clients, and having good problem solving skills.
- The program director meets with treatment staff on a regular basis to discuss client progress in treatment. There are weekly meetings with staff and the medical director, and bi-monthly meetings with the behavioral health department.
- Ethical guidelines are in place that dictates staff boundaries and interactions with clients.
- The program director and program staff report being supported by the OWI court, judges, Mayo Health System, and the community-at-large.
- Program funding is adequate to deliver treatment as designed.

Recommendations for Improvement:

- The program director should be involved in conducting some aspects of the program that involves direct service to clients. This can include facilitation of groups, individual sessions, supervising a small caseload, or conducting assessments. This is considered important in order to stay in touch with the current needs of the clients and to help understand the challenges the staff face in working with this population.
- Staff should be assessed on service delivery on a regular basis. This includes the program director or clinical supervisor observing groups and providing constructive feedback at least once per group cycle. Interviews with staff members revealed that assessment of staff service delivery is informal and infrequent.
- Staff should receive formal training on the curriculum being delivered. Currently, facilitators of the curriculum are trained through in-house observation of groups and their own reading of the training manual.
- Staff should receive at least 40 hours of ongoing training each year directly related to working with offenders and providing group-based treatment services. Staff are currently receiving ongoing training per their license requirements; however, this requirement is below the threshold of 40 hours each year. Interviews with staff revealed inconsistent responses on the requirement of on-going training. Examples of ongoing training topics include: effective correctional interventions, training on assessment instruments, booster sessions on the curriculum, training on cognitive-behavioral therapy, training on group processes and facilitation skills, and training on core correctional practices.
- Funding has not been stable over the past two years due to system wide budget cuts.

Client Assessment

Strengths:

- MBH targets clients that have a relative higher level of criminogenic need; in this case, clients with high needs in substance abuse. Only clients who are assessed as having a moderate or high need in the domain of substance abuse should be targeted for substance abuse interventions.

Recommendations for Improvement:

- Domain specific needs, especially substance abuse, should be assessed using a validated, standardized, and objective instrument. Examples of proper instrumentation for substance abuse include the Addiction Severity Index, the Substance Abuse Subtle Screening Inventory, TCU Drug Screen II, and the Global Appraisal of Individual Needs. The OWI court should be providing MBH with a list of assessed needs (as assessed by COMPAS).
- A range of responsivity factors are not assessed at any of the programs. Factors that affect client engagement in treatment should be measured with validated tools. MBH does not currently use a range of validated tools to measure responsivity factors. MBH clients do receive the Wisconsin UPC (to determine treatment placement) and a bio-psych-social interview. Depending on the treatment provider, some clients may receive an Alcohol Use Disorder Identification (AUDIT) or a PHQ9 (to assess for depressive disorders). However, these latter assessments are not consistently administered to all clients. Responsivity factors include mental health, learning styles, personality traits, and IQ. Examples of specific instrumentation include the TCU Client Self-Rating Scale, Beck's Depression, and URICA.
- Only clients who are high-risk and moderate-risk to engage in criminal behavior should be receiving intensive treatment services. Also, low-risk clients should not be mixed with high-risk clients in treatment groups. The use of the COMPAS (as administered by the OWI Court) is an appropriate way to measure the risk of clients; however, COMPAS scores are not being consistently shared with MBH for every client referred for services. Once all OWI clients receive a COMPAS score, those who are low-risk should not be receiving intensive treatment. Moreover, the MBH treatment programs should separate treatment groups by risk, especially since many MBH clients are not criminal justice referred clients.

Treatment

Strengths:

- Mayo Behavioral Health programs have the majority of their focus on appropriate criminogenic targets. Specifically, MBH targets substance abuse, relapse prevention, and underlying attitudes/values that lead to substance abuse.
- Treatment modalities that have been determined effective in changing offender behavior should be utilized by the referral agencies providing services. The programs at MBH are intended to be delivered under a cognitive-behavioral framework.
- Treatment groups appear to consistently start and end on-time.
- Group facilitators are knowledgeable about the materials discussed in group.
- In order to ensure that all clients are engaging in treatment, facilitators should make sure that all group members participate in discussion and activities. Group participation should be a mandatory requirement for a participant in treatment. Group facilitators encourage group participation, which was confirmed through observations of groups and interviews with facilitators and treatment group members.
- Group norms/rules are established, documented, and reviewed with the groups when appropriate. This occurs as part of MBH programming.
- The length of treatment is sufficient to produce behavioral change. Specifically, clients of IOP attend group for three hours, two days a week for 12 weeks. This results in a total of 72 dosage

hours. (It should be noted that after the CPC site visit, MBH changed their schedule to 2 hour groups, three days a week for 12 weeks, maintaining a 72 hour dosage.)

- Treatment groups are always conducted and monitored by a facilitator.
- The program applies appropriate punishers. Punishers are appropriate to assist in extinguishing antisocial expressions and to promote behavioral change by showing that behavior has consequences. Punishers include verbal disapproval and removal for one-on-one talks.
- Facilitators model prosocial skills and explain the benefits of prosocial behavior. These demonstrations occur while the clients are taught to observe and anticipate problematic situations. This modeling should continue and be incorporated into the program so that it occurs in almost every group session
- MBH does identify and target underlying thoughts and values that lead to substance abuse and antisocial behavior.
- Facilitators appear to have a good rapport with group participants. This was noted through observation of groups and interviews with participants.
- Facilitators did not get into arguments with participants and used appropriate techniques to roll with resistance, such as redirection or extinction.

Recommendations for Improvement:

- While the treatment programs are designed to be delivered using a cognitive-behavioral model, there was inconsistent evidence that a true CBT approach was used by all facilitators. Many groups were delivered using a talk therapy/process oriented approach. Significantly, more evidence-based treatment modalities (i.e., social learning and cognitive-behavioral interventions) should be incorporated into all treatment sessions. While observation of groups and interviews with clients and treatment providers did suggest that there is some emphasis on the thought-behavior link and restructuring of antisocial thoughts, it was clear that these interventions did not occur regularly. Furthermore, structured skill building (i.e., teaching offenders prosocial skills to replace antisocial skills), including the use of modeling and role play, needs to be implemented in the treatment groups on a consistent basis. Observation of groups, review of the curriculum, and interviews with clients and treatment providers revealed few sessions that emphasized the thought-behavior link, and little to no structured skill building. Likewise, graduated rehearsal should be used to teach participants skills in increasingly difficult situations. Observation of groups and interviews with clients in program revealed that little to no role play or practicing of skills took place during group treatment.
- All groups should be single sex groups. Evidence shows that greater reductions in recidivism result when males and females are kept in different groups.
- Homework should be a regular part of the treatment process and the counselor should consistently review homework with the client. Homework should be used to reinforce what is learned in a session and it should be reviewed to ensure that the client has developed some proficiency in the concepts. While some facilitators give homework weekly, others give homework only occasionally and some do not give any homework. Homework is an essential part of the active component of cognitive-behavioral programming, and should be consistently used across all groups and facilitators.
- Groups do not have a set curriculum or manual that is consistently followed. A review of the materials and interviews with group facilitators that the manual has been supplemented many times by information from a wide variety of sources. While supplemental material to benefit the teaching style of different facilitators is not prohibited, the current manual has become an

amalgamation of information where a participant in one group can receive information that a participant in another group does not. Furthermore, interviews with facilitators indicated that some facilitators do not follow the outline of the curriculum. There should be consistent information taught across all groups and facilitators.

- Interviews with facilitators and group observations demonstrated that group sizes start around with around 12-15 people. These group sizes are too large for one facilitator; groups should be no larger than 8-10 clients per facilitator.
- The programs should address and respond to the different learning styles and barriers of the participants in the groups. While interviews indicated that facilitators have administered individual sessions in the past if a client is struggling, there is no formal assessment in place to alert facilitators to different learning styles, reading levels, and other barriers to the delivery of treatment to their clients. Responsivity assessments should guide this process.
- Rewards appear to be consistently administered across the groups. However, verbal praise is the sole reward used throughout the groups. This was consistently stated in interviews with facilitators and clients. There should be a range of reinforcers used, which can include tangible and social rewards such as: earning privileges, certificates of completions, indirect praise, points/tokens, gift certificates, etc.
- Rewards should outweigh punishers by a ratio of at least 4:1. MBH did not consistently apply the appropriate application of rewards. Reinforcers should: 1) occur immediately following the pro-social behavior; 2) vary in terms of type; 3) be applied consistently until the behavior is well developed and then intermittently; 4) be desired by the recipient; 5) be individualized; 6) be administered consistently by staff; and 7) outweigh the frequency of punishers.
- While MBH demonstrated appropriate punishers, there were inconsistencies noted in the process for punishing. This process should include the following components: punishers should be individualized, considered undesirable by the participants, varied, match the intensity of the infraction, and immediately applied following the infraction. After a punisher is applied, prosocial alternatives should be modeled by the facilitator. MBH facilitators should not rely solely on the OWI court to apply all forms of punishment.
- Participants should consistently (almost every group and individual session) practice and rehearse the new skills with the client, and facilitators should provide structured feedback. There is no consistent use of skill training, skill rehearsal with corrective feedback, or graduated practice. These are all essential components of an evidenced-based, cognitive-behavioral program. They should occur in virtually every treatment session.
- While underlying thoughts and values are targeted by group facilitators, participants should be taught how to replace antisocial thinking with appropriate prosocial thoughts. Tools such as a thinking report, functional analysis, or cost benefit analysis should be used to assist the participants in recognizing anti-social/distorted thinking and replacing those thoughts with prosocial thoughts.
- Risk or relapse prevention plans should be incorporated into the treatment sessions. MBH does develop relapse prevention plans during the course of treatment; however, clients only present the plan to the group, and are not required to practice the skills outlined in the treatment plan. Clients should have to regularly practice the coping skills listed on the plan and the counselor should provide feedback.

Quality Assurance

Strengths:

- A formal discharge summary is created for all clients and it is shared with the OWI court.

Recommendations for Improvement:

- The program does not incorporate a thorough management audit system. While file reviews occur randomly every 90 days, MBH does not consistently monitor groups, have regular observation of treatment delivery with feedback, or have a formal process for client feedback on service delivery.
- Monitoring of groups by a program director or clinical supervisor should occur on at least a quarterly basis. Formal feedback of the group observation should be provided to the facilitator.
- A pre-posttest should be used to measure client progress on target behaviors.

OVERALL PROGRAM RATING

Mayo Behavioral Health of La Crosse (MBH) received an overall score of **51.0%** percent on the CPC-DC. This falls into the **Needs Improvement** category. The overall CAPACITY score designed to measure whether the program has the *capability* to deliver evidence based interventions and services for offenders is **61.1** percent, which falls into the **Effective** category. The overall CONTENT score, which focuses on the *substantive* domains of assessment and treatment, is **45.2** percent, which falls into the **Ineffective** category.

FINDINGS – Hiawatha Valley Mental Health, La crosse

Hiawatha Valley Mental Health of La Crosse (HVMH) provides substance abuse programming and counseling to OWI Court participants. Moreover, HVMH also provides some assessment services to determine eligibility and appropriateness of OWI clients for substance abuse treatment groups and other services. These other services can include individual counseling and mental health counseling. OWI court clients that attend treatment groups provided by HVMH will participate in a Structured Outpatient group (SOP), CORE group, and/or a Women's or Men's Group. The strengths and recommendations provided below are based on the components of the HVMH delivery of its substance abuse program.

CPC-DC: RA SECTIONS	**SCORE**	**RATING**
Leadership, Staff, and Support	64.3%	Effective
Offender Assessment	0.0%	Ineffective
Treatment	41.4%	Ineffective
Quality Assurance	50.0%	Effective
Overall Capacity	61.1%	**Effective**
Overall Content	37.5%	**Ineffective**
Overall Score	46.0%	**Needs Improvement**

Leadership, Staff, and Support

Strengths:

- The program director has at least three years of experience working at an offender treatment program, and possesses a degree in a helping profession (M.S. in Community Counseling).
- The program director is directly involved in the process to select treatment staff that work in the programs. The program director is also directly involved in providing formal training to new staff as well as providing direct supervision to treatment staff.
- At least 75% of treatment staff have an associate's degree or higher in a helping profession.
- Staff are selected for skills and values that are supportive of client treatment and change. Skills and values that staff stated were taken into consideration when hiring include: ethics, integrity,

flexibility in working with dual diagnosis clients, knowledge of addiction, and client focused treatment.

- The program director meets with treatment staff on a regular basis to discuss client progress in treatment. There are weekly meetings with staff and the clinical supervisor, and bi-monthly meetings with the program director and treatment staff.
- Ethical guidelines are in place that dictates staff boundaries and interactions with clients. HVMH places a great deal of emphasis on staff ethics.
- The program director and program staff report being supported by the OWI court, judges, Hiawatha Valley Mental Health (at-large), and the surrounding community.
- Program funding is adequate to deliver treatment as designed. Program funding has been stable over the past two years.

Recommendations for Improvement:

- The program director should be involved in conducting some aspects of the program that involves direct service to OWI clients. This can include facilitation of groups, individual sessions, supervising a small caseload, or conducting assessments. This is considered important in order to stay in touch with the current needs of the clients and to help understand the challenges the staff face in working with this population. Currently, the program director is involved with assessments and carries a caseload of juvenile clients—not clients directly involved with the OWI court.
- Less than 75 percent of the staff have at least two years of experience working with offenders.
- Staff should be assessed on service delivery on a regular basis. This includes the program director or clinical supervisor observing groups and providing constructive feedback at least once per group cycle. Interviews with staff members revealed that assessment of staff service delivery is informal and infrequent.
- Staff should receive formal training on the curriculum being delivered. Currently, facilitators of curriculum are trained through in-house observation of groups and their own reading of the training manual. In the past, there has been formal training on the CORE curriculum; however, not all staff had received this training.
- Staff should receive at least 40 hours of ongoing training each year directly related to working with offenders and providing group-based treatment services. Staff are currently receiving ongoing training per their license requirements; however, this requirement is below the threshold of 40 hours each year. In house training is offered on ethics and cultural competency, but not on issues directly related to offender group-based treatment services. Examples of ongoing training topics include: effective correctional interventions, training on assessment instruments, booster sessions on curriculum, training on cognitive-behavioral therapy, training on group processes and facilitation skills, and training on core correctional practices.
- Research demonstrates that programs that have been in place for a minimum of three years are more effective. The current program (i.e., CORE) has been in place less than three years.

Client Assessment

Recommendations for Improvement:

- HVMH does not assess a range of responsivity factors. Responsivity factors are elements that affect client engagement in treatment, but are not direct causes of criminal behavior. Responsivity factors should be measured by validated tools. It should be noted that HVMH does assess for depressive disorders via the PHQ9; however, this is the only full assessment tool used. Some clients do receive the GAIN-SS, but this is a short screener and not a full assessment. Thus, clients that may be flagged for an internalizing or externalizing disorder may not receive a full assessment after the screen. In addition to mental health, responsivity factors include: learning styles, personality traits, and IQ. Examples of specific instrumentation include the TCU Client Self-Rating Scale, Beck's Depression, and URICA.
- Only clients who are high-risk and moderate-risk should be receiving intensive treatment services. Also, low-risk clients should not be mixed with high-risk clients in treatment groups. The use of the COMPAS (as administered by the OWI Court) is an appropriate way to measure the risk of clients; however, COMPAS scores are not being consistently shared with HVMH for every client referred for services. Once all OWI clients receive a COMPAS score, those who are low-risk should not be receiving intensive treatment. Moreover, the HVMH treatment programs should separate treatment groups by risk, especially since some HVMH clients are not criminal justice involved clients.
- HVMH does not assess clients using an empirical, validated criminogenic need assessment. As such, HVMH does not know if it targets clients that have relatively higher criminogenic needs; in this case, clients with high needs in substance abuse. Only clients who are assessed as having a moderate or high substance abuse domain need should be targeted for substance abuse interventions. Domain specific needs, especially substance abuse, should be assessed using a validated, standardized, and objective instrument. Examples of proper instrumentation for substance abuse include the Addiction Severity Index, the Substance Abuse Subtle Screening Inventory, TCU Drug Screen II, and the Global Appraisal of Individual Needs (not just the GAIN-SS). The OWI court should be providing HVMH with a list of assessed needs (as assessed by COMPAS).

Treatment

Strengths:

- Hiawatha Valley Mental Health, La Crosse programs have the majority of their focus on appropriate criminogenic targets. Specifically, HVMH targets substance abuse and antisocial thinking.
- Treatment modalities that have been determined effective in changing offender behavior should be utilized by the referral agencies providing services. The some of the programs at HVMH are intended to be delivered under a cognitive-behavioral framework.
- Treatment groups appear to consistently start and end on-time.
- Group facilitators are knowledgeable about the materials discussed in group.
- In order to ensure that all clients are engaging in treatment, facilitators should make sure that all group members participate in discussion and activities. Group participation should be a mandatory requirement for a participant in treatment. Group facilitators appear to encourage

group participation, via check-ins, calling on group members, and making participation mandatory.

- Group norms/rules are established, documented, and reviewed with the groups when appropriate. This occurs as part of HVMH programming.
- Treatment groups are always conducted and monitored by a facilitator.
- Most groups are between 6-16 people. HVMH requires that all groups larger than 8 have a co-facilitator. As such, no groups at HVMH are larger than 8-10 clients per facilitator.
- HVMH does identify and target underlying thoughts and values.
- Facilitators appear to have a good rapport with group participants.
- Facilitators did not get into arguments with participants and used appropriate techniques to roll with resistance, such as redirection or extinction.

Recommendations for Improvement:

- While the treatment programs are designed to be delivered using a cognitive-behavioral model, there was inconsistent evidence that a true CBT approach was used by all facilitators and across all groups. While the CORE curriculum is delivered using a CBT approach, the Men's and Women's groups are delivered using a talk therapy/process oriented approach. Moreover, the SOP group is education based. Significantly more evidence-based treatment modalities (i.e., social learning and cognitive-behavioral interventions) should be incorporated into all programming. Interviews with treatment providers did suggest that there is some emphasis on the thought-behavior link and restructuring of antisocial thoughts, but it was clear that these interventions did not occur regularly. Structured skill building (i.e., teaching offenders prosocial skills to replace antisocial skills), including the use of modeling and role play, needs to be implemented in the treatment groups on a regular and consistent basis. Currently, treatment providers indicated that they do role-plays in one-on-one sessions or not at all. Role-play should be a incorporated into group sessions so that (1) more practice is achieved and (2) those who learn through observation can witness others performing pro-social skills. Graduated rehearsal should be used to teach participants skills in increasingly difficult situations.
- All groups should be single sex groups. Evidence shows that greater reductions in recidivism result when males and females are kept in different groups. While there is a Men's and Women's only process groups. The CORE and SOP groups should also be single sex.
- Homework should be a regular part of the treatment process and the counselor should consistently review homework with the client. Homework should be used to reinforce what is learned in a session and it should be reviewed to ensure that the client has developed some proficiency in the concepts. No facilitators give homework weekly. It appears that homework is only given in one-on-one counseling sessions by some therapists. Homework is an essential part of the active component of cognitive-behavioral programming, and should be consistently used across all groups and facilitators.
- The length of treatment is insufficient to produce behavioral change. Specifically, clients of SOP attend group for two hours, twice a week for 10 weeks. This results in a total of 40 dosage hours. Those who attend CORE programming attend class once a week, for two hours, for 16-20 weeks. This results in 32-40 dosage hours. The decision of what programs (i.e., SOP, CORE, and/or Men's or Women's group) an OWI client receives at HVMH is determined by the counselor, and is not based on objective, empirical, and validated assessment results. Interviews with treatment facilitators revealed inconsistent responses as to when a person would receive

different programming and for how long. There should be a consistent, empirically driven assessment process that drives program referral to ensure that proper lengths of treatment are achieved.

- Not all groups have a set curriculum or manual that is consistently followed. The CORE group follows a Hazelton manual; the SOP has a manual that was developed in house, but is not strictly followed by all facilitators; finally, the Men's and Women's groups do not have a manual. There should be set material for each group that is consistently followed by all group facilitators.
- The programs should address and respond to the different learning styles and barriers of the participants in the groups. While interviews indicated that facilitators have administered individual sessions in the past if a client is struggling, there is no formal assessment in place to alert facilitators to different learning styles, reading levels, and other barriers to the delivery of treatment to their clients. Responsivity assessments should guide this process.
- Rewards appear to be consistently administered across the groups. However, verbal praise is the sole reward used throughout the groups. This was consistently stated in interviews with facilitators. There should be a range of reinforcers used, which can include tangible and social rewards such as: earning privileges, certificates of completions, indirect praise, points/tokens, gift certificates, etc.
- Rewards should outweigh punishers by a ratio of at least 4:1. HVMH did not consistently apply the appropriate application of rewards. Reinforcers should: 1) occur immediately following the pro-social behavior; 2) vary in terms of type; 3) be applied consistently until the behavior is well developed and then intermittently; 4) be desired by the recipient; 5) be individualized; 6) be administered consistently by staff; and 7) outweigh the frequency of punishers.
- Across interviews with HVMH staff, in was consistently stated that no punishers were used to extinguish inappropriate behavior. If a therapist felt something was necessary, they stated that they may bring it up with the OWI court (and sometimes with the primary counselor), but tended to not address it in group. While rewards should outnumber punishers, clients' antisocial statements/attitudes/behaviors should be challenged when exhibited to ensure behavioral change. HVMH staff should not rely solely on the OWI court to delivery punishers. Moreover, HVMH staff should administer effective disapproval. This process should include the following components: punishers should be individualized, considered undesirable by the participants, varied, match the intensity of the infraction, and immediately applied following the infraction. After a punisher is applied, prosocial alternatives should be modeled by the facilitator. HVMH facilitators should not rely solely on the OWI court to apply all forms of punishment.
- Facilitators do not model new prosocial skills and explain the benefits of prosocial behavior. These demonstrations should occur during group time and while the clients are taught to observe and anticipate problematic situations. This modeling should continue and be incorporated into the program so that it occurs in almost every group session
- Participants should consistently (almost every group and individual session) practice and rehearse the new skills with the client, and facilitators should provide structured feedback. There is no consistent use of skill training, skill rehearsal with corrective feedback, or graduated practice. These are all essential components of an evidenced-based, cognitive-behavioral program. They should occur in virtually every treatment session.
- While underlying thoughts and values are targeted by group facilitators, participants should be taught how to replace antisocial thinking with appropriate prosocial thoughts. Tools such as a thinking report, functional analysis, or cost benefit analysis should be used to assist the

participants in recognizing anti-social/distorted thinking and replacing those thoughts with prosocial thoughts.

- Risk or relapse prevention plans should be incorporated into the treatment sessions. HVMH does not develop relapse prevention plans during the course of treatment groups, but some counselors develop them in one-on-one sessions; however, clients are not required to practice the skills outlined in the treatment plan. Clients should have to regularly practice the coping skills listed on the plan and the counselor should provide feedback.

Quality Assurance

Strengths:

- The program does incorporate a management audit system. File reviews occur randomly every 30 days, and there is a formal process for client feedback on service delivery that occurs quarterly.
- A formal discharge summary is created for all clients and it is shared with the OWI court.

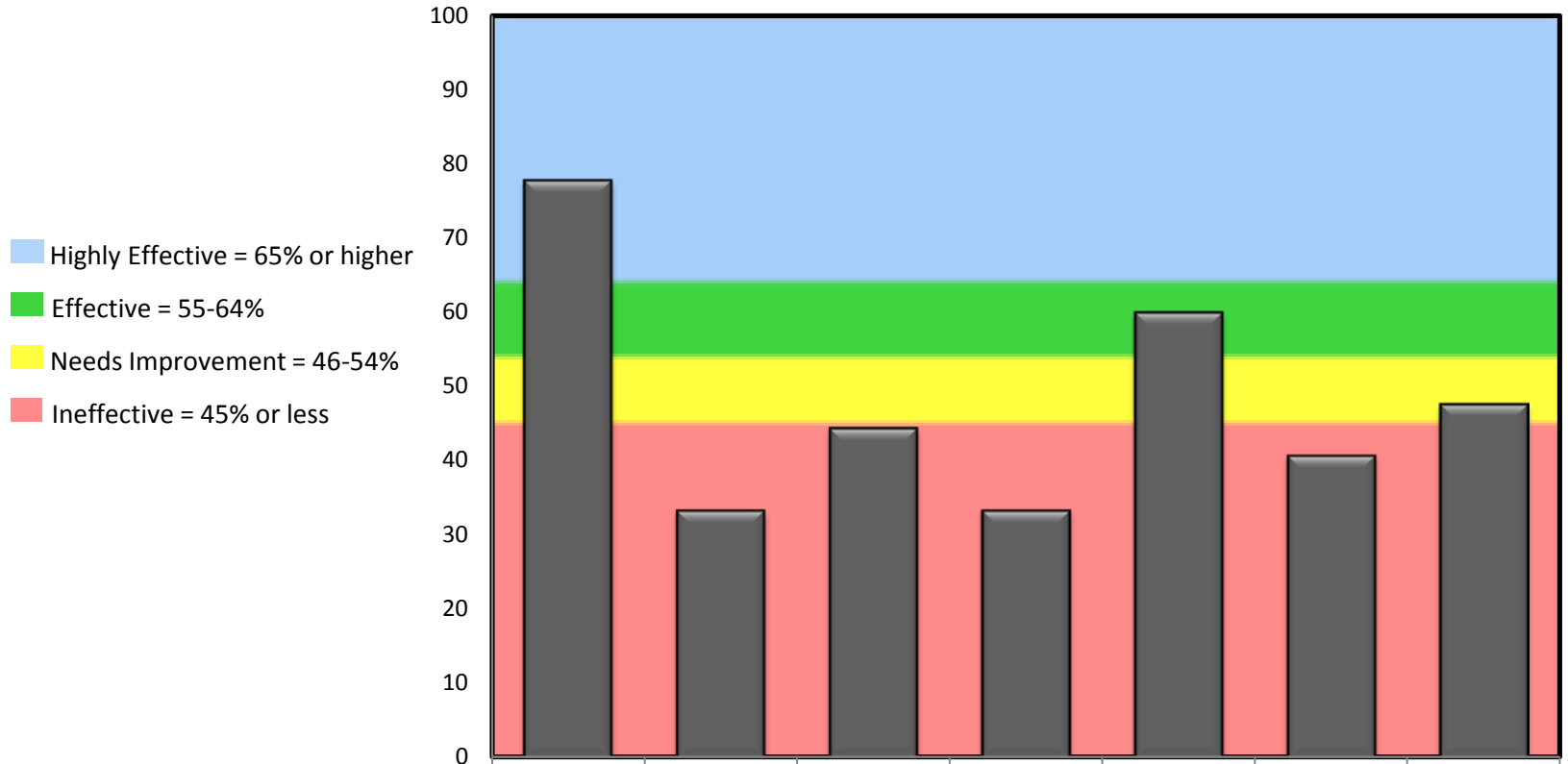
Recommendations for Improvement:

- Monitoring of groups by a program director or clinical supervisor should occur on at least a quarterly basis. Formal feedback of the group observation should be provided to the facilitator.
- A pre-posttest should be used to measure client progress on target behaviors.

OVERALL PROGRAM RATING

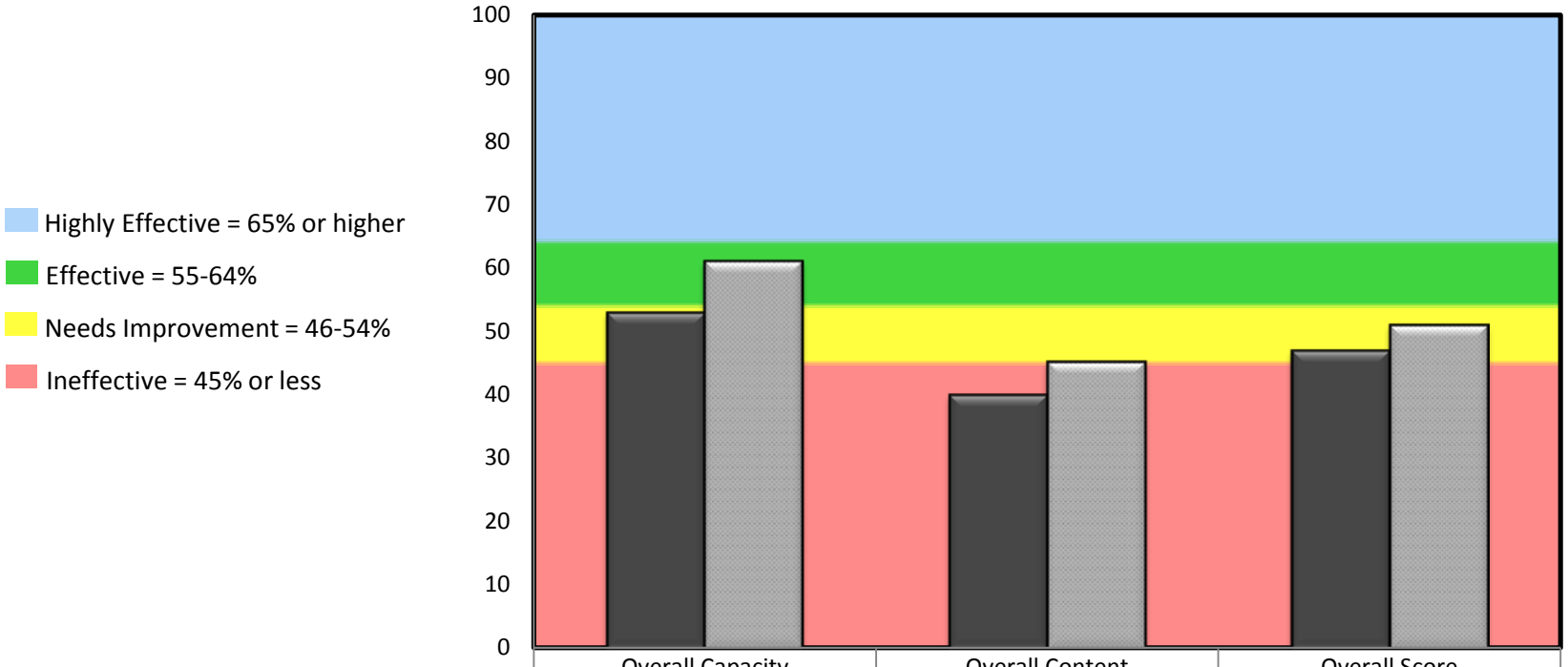
Hiawatha Valley Mental Health of La Crosse (HVMH) received an overall score of **46.0%** percent on the CPC-DC. This falls into the **Needs Improvement** category. The overall CAPACITY score designed to measure whether the program has the *capability* to deliver evidence based interventions and services for offenders is **61.1** percent, which falls into the **Effective** category. The overall CONTENT score, which focuses on the *substantive* domains of assessment and treatment, is **37.5** percent, which falls into the **Ineffective** category.

Figure 1: La Crosse County OWI Court CPC-DC Scores



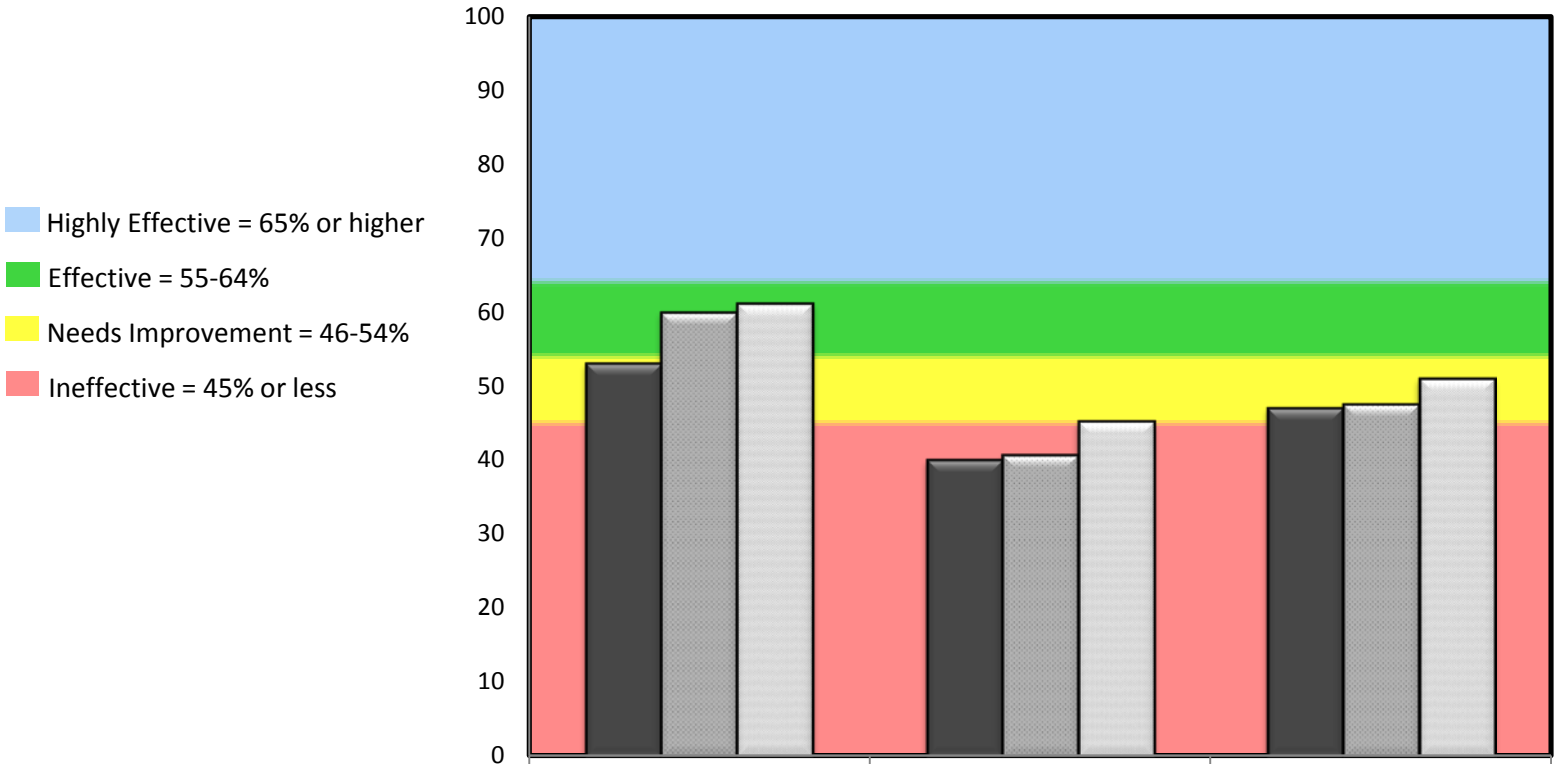
	Dev. Coordination, Staff, & Support	Offender Assessment	Treatment	Quality Assurance	Overall Capacity	Overal Content	Overall Score
La Crosse County OWI Court CPC-DC Scores	77.8	33.3	44.4	33.3	60	40.7	47.6

Figure 2: Mayo Behavioral Health of La Crosse CPC-DC: RA Scores



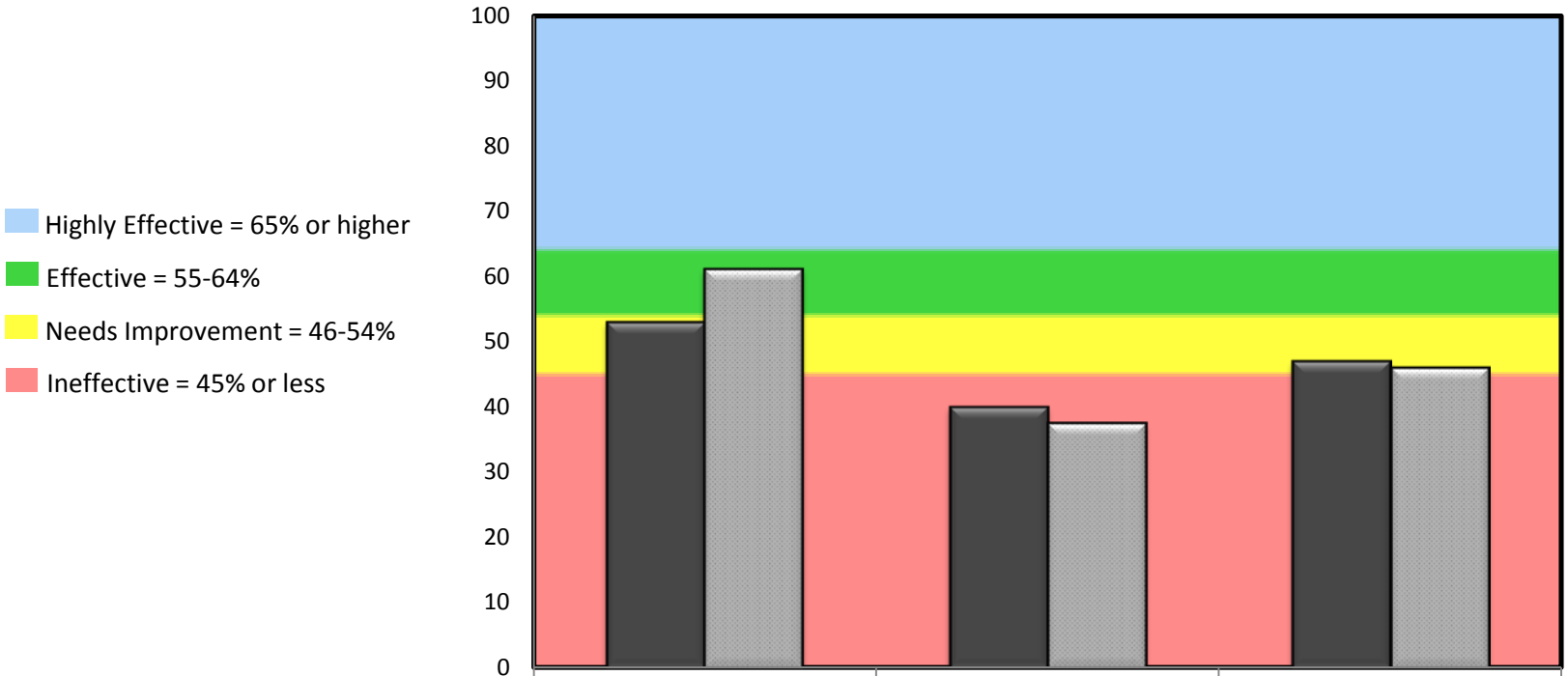
	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
Mayo Behavioral Health of La Crosse	61.1	45.2	51

Figure 3: La Crosse County OWI Court and Mayo Behavioral Health Overall



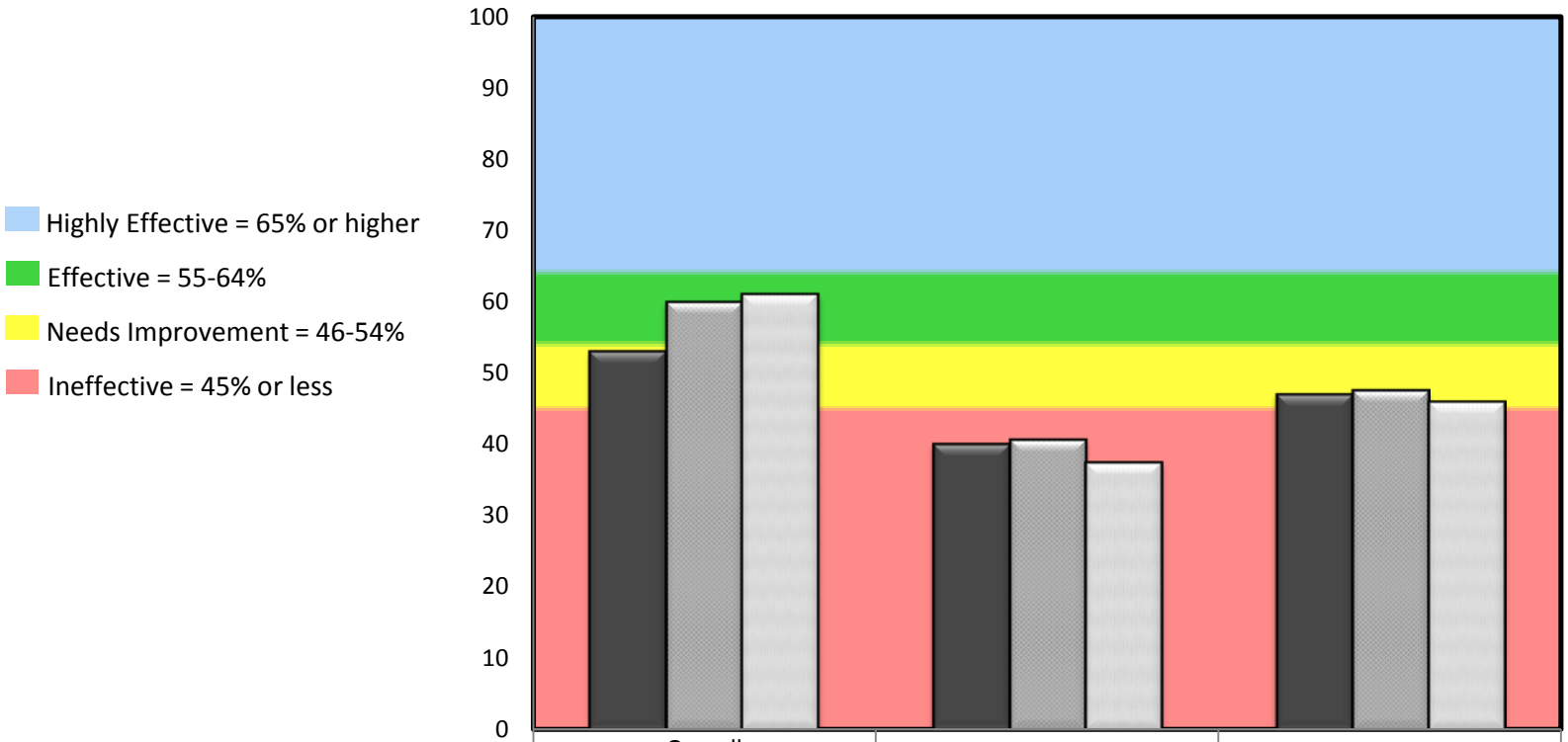
	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
La Crosse County OWI Court Overall	60	40.7	47.6
Mayo Behavioral Health of La Crosse	61.1	45.2	51

Figure 4: Hiawatha Valley Mental Health, La Crosse CPC-DC: RA Scores



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
Hiawatha Valley Mental Health, La Crosse	61.1	37.5	46

Figure 5: La Crosse County OWI Court and Hiawatha Behavioral Health Overall



	Overall Capacity	Overall Content	Overall Score
Average	53	40	47
La Crosse County OWI Court Overall	60	40.7	47.6
Hiawatha Valley Mental Health, La Crosse	61.1	37.5	46

OUTCOME EVALUATION

Introduction

Outcome evaluations are designed to measure effects post program (Royse, Thyer, Padgett, and Logan, 2010; Weiss, 1997). While the above section of the report was focused on the process involved in the program, this aspect of the report will focus on outcomes of the OWI Court. Thus, this section of the report is concerned with investigating the effectiveness of the of OWI Court Participants after their time in the program is complete.

Methods

Data were collected by the OWI Treatment Court Team as part of their normal court processes. These data were then extracted from the county's database by the La Crosse County IT Department and provided to the research team in a series of Excel files for evaluation. Data were on all OWI court participants from 2006 to 2012. The final dataset included 936 entries into treatment court. Table 1 provides descriptive statistics for all treatment court entries.

The current outcome evaluation uses a quasi-experimental matched-comparison group design. This design was chosen because experimental design was not an option. The gold standard of comparison groups come in the form of experimental design. In this situation, all eligible OWI Court participants would be randomly assigned to either the OWI Court or regular probation. However, random assignment was not possible for the current study. Therefore, a matched comparison group was utilized to have the maximum similarity to the OWI Court participants so that as many threats to internal validity are eliminated (Shadish, Cook, and Campbell, 2002).

To build a matched comparison group for the current outcome evaluation, data were needed on a group similar to OWI Court participants. The Wisconsin Department of Corrections provided the research team data on 179,283 supervision cases occurring between 2006 and 2012. The data set contained information on probationers' age, race, sex, risk level, and offense. A matched comparison group was selected from these data using information from all probationers under Wisconsin DOC supervision from 2006 to 2012. That is, individuals in the OWI Court were matched to probationers who did not receive OWI Court characteristics that might be related to differences in recidivism (e.g., age, race, gender, and risk). Because the two different groups are matched on these characteristics, there are no differences between the groups. By matching on characteristics that may be related to recidivism, you are able to methodologically control for these factors so that any impact they may have on recidivism is the same for each group. Thus, the only difference between your treatment and control group is that one received the treatment and one did not. Further information on the matching procedure is discussed below.

Finally, recidivism data were collected by the research team using the Wisconsin Circuit Court Access Program (CCAP). All OWI Court Entrants names and dates of birth were used to look up charges post entrance into OWI Court. As such, recidivism was defined in two ways. First, whether or not an individual received any criminal charge up to 36 months post intake. Civil charges and minor track charges were not counted as recidivating. However, operating after revocation (OAR) was included as recidivism. This definition of recidivism was chosen as it has been recommend for use for all treatment courts in Wisconsin (National Center for State Courts, 2013); moreover, a review of research on OWI Courts recommends that outcome studies follow participants 2 years from entry to allow for sufficient follow-up time (Marlowe, 2012. Thus we employ this definition in the current outcome evaluation. The second definition looked

at whether or not the person was convicted on a new charge. Thus, individuals that were found not guilty or chargers were dropped, they were not counted as recidivating in this measure. Also, if there disposition was still open or pending, the individual was not considered to have recidivated.

All data analyses were conducted by the research team using SPSS version 21.

Findings

Table 1 provides descriptive statistics for all 936 treatment court entries.

Table 1: Demographic Characteristics of all OWI Court Entries

Variable	n	%
Gender (n=936)		
Male	740	79.3
Female	193	20.7
Race (n=911)		
White	822	90.2
Black	44	4.8
Asian	20	2.2
Native American	13	1.4
Latino	8	0.9
Mixed Race	4	0.4
Age (n=936)		
Less than 20	6	0.6
20-29	294	31.4
30-39	258	27.6
40-49	226	24.1
50-59	127	13.6
60 or Higher	25	2.7
	Mean = 37.5	
	Std. Dev. = 16.8	
Marital Status (n=767)		
Married	109	14.2
Single	410	53.5
Single, w/ Children	81	10.6
Divorced	144	18.8
Separated	23	3.0

Table 1 demonstrates that the over three quarters of all OWI entries are male (79.3%). Ninety percent of all OWI court entries are White, the next largest racial group is Black with nearly five percent (4.8%) of entries. Finally, the average age of an OWI court entrant is 37.5, with the most common age group being individuals aged 20 to 29 (31.4%). Finally, over half of the OWI court entrants are single (53.5%), with the next most typical marital status being divorced (18.8%).

The main goal of an outcome study is to determine how individuals do after exiting the program. Table 2 describes the OWI program status of all entrants. As depicted in Table 2, nearly half of all court entrants successfully completed the OWI court program (42.2%), with the next most common outcome being unsuccessful completion (29.5%). Those who were labeled as Active are currently participating in the OWI Court program; those who are labeled as nonparticipants are individuals who were referred to OWI court but elected not to participate; and those who are labeled pending have not yet elected to or not to participate in the court. Ignoring the participants who are labeled as active, nonparticipant, or pending reveals that the OWI court has a successful completion percentage of 58.9 percent (395/671). As noted in the process outcome of the current report, an ideal successful completion percentage is between 65 and 85 percent.

Table 2: Court Characteristics of All OWI Court Entries

Variable	n	%
Program Status (n=936)		
Successful	395	42.2
Unsuccessful	276	29.5
Active	128	13.7
Nonparticipant	133	14.2
Pending	4	0.4

Table 3 depicts the levels of risk as assessed by two instruments. The OWI Court began assessing a program participant's likelihood of committing a future crime (risk) using the Level of Service Inventory—Revised (LSI-R). However, as of 2012, the program has switched over to using the COMPAS instrument as a way to assess risk for recidivism. The change in instruments is a result of the State of Wisconsin's purchasing of the COMPAS for statewide use. Table 2 demonstrates that 87 percent (592 of 680) program entrants had been assessed using the LSI-R, while the remaining entrants were assessed with the COMPAS. For those assessed with the LSI-R, the most common risk level was Low/Moderate (42.9%), followed by Low (26.4). COMPAS results for the OWI Court Participants also demonstrate that the most common risk level is Low (72.7%), followed by moderate and high.

Two findings are of interest: first, 69 percent of program entrants are assessed as low to low/moderate risk on the LSI-R and over 70% of participants who were assessed with COMPAS scored as low. This is an important findings, as research shows that low risk individuals should receive limited interventions. Research on interventions with low risk populations have demonstrated little positive effect, with some interventions increasing the likelihood of recidivism. As such, most research recommends that high risk individuals should be receiving the more structured, intense interventions (Lowenkamp and Latessa, 2004). This is related to the second finding of interest: very few participants are scored as high risk. Only one entrant was scored as high on the LSI-R, while 10 percent were scored as High on the COMPAS. This finding is relevant because this is the group of participants that research says treatment courts should target (NADCP, 2013; Shaffer, 2011), but is the group with the lowest percentage for the OWI Court.

Table 3: Risk Levels of all OWI Court Entrants by Risk Assessment Instrument		
Variable	n	%
LSI-R Risk Level (n=592)		
Low	156	26.4
Low/Moderate	254	42.9
Moderate	155	26.2
Medium/High	26	4.4
High	1	0.2
COMPAS Risk Level (n=88)		
Low	64	72.7
Moderate	15	17.0
High	9	10.2

Table 4 presents a statistical analysis of successful and unsuccessful OWI Court Participants by LSI-R risk level. For the purposes of statistical analysis, LSI-R risk was collapsed from five categories to three categories.[2] The low risk category include all participants in the Low and Low/Moderate category; the Moderate risk level remains unchanged; the High risk category now includes Medium/High and High risk participants. As Table 4 demonstrates, nearly 65 percent (64.8) of low risk individuals completed successfully, whereas only 39 percent of moderate individuals completed successfully and only 19 percent of high risk participants finished successfully. These results were significantly different meaning that low risk participants were significantly more likely to complete successfully than moderate or high risk participants. There was no significant difference between moderate and high risk participants and their completion status (χ^2=3.18; df=1; p=.08).

[2] Chi-square analysis using all five categories was not statistically interpretable, as there were too few cell values to provide meaningful comparison. Specifically, there were too few high risk individuals to run a stable chi-square test.

Table 4: LSI-R Risk Levels by Completion Status

Variable	LSI-R Risk Level							
	Low		Moderate		High		Total	
Completion Status*	n	%	n	%	n	%	n	%
Unsuccessful	117	35.2	66	60.6	17	81.0	200	43.3
Successful	215	64.8	43	39.4	4	19.0	262	56.7
Total	332	100.0	109	100.0	21	100.0	462	100.0

* χ^2=34.12; df=2; p<.000

Table 5 presents the analysis of successful and unsuccessful OWI Court Participants by COMPAS risk level. Immediately the reader should note the low sample size (n=18). This is because the COMPAS has only been administered to 88 people, and the majority of those people are still active in the court. Because of the small sample size, no statistical comparison was calculated in Table 5. While no statistical results can be drawn from Table 5, the reader should note the pattern of results. Specifically, the pattern appears to be mimicking those of Table 4—Low risk individuals are successfully completing more often than medium or high risk individuals.

Table 5: COMPAS Risk Level by Completion Status.

Variable	COMPAS Risk Level							
	Low		Moderate		High		Total	
Completion Status	n	%	n	%	n	%	n	%
Unsuccessful	7	50.0	3	100.0	1	100.0	11	61.1
Successful	7	50.0	0	0.0	0	0.0	7	38.9
Total	14	100.0	3	100.0	1	100.0	18	100.0

Recidivism is a major outcome measure all criminal justice programs are concerned with. As such, the major intent of this outcome study was to understand the recidivism of OWI Court Participants. Figure 6 depicts the recidivism percentage for all OWI Court Participants by

program status. The reader can see that roughly 23 percent of successful graduates of the OWI Court recidivate. This is the lowest group and demonstrates the success of the OWI court. Furthermore, nonparticipants—the group that opted not to take part in the OWI Court—recidivate at a higher percentage than successful graduates of the OWI Court. Specifically, nonparticipants of the OWI Court recidivate at just over 35 percent—twelve percent more than the successful graduate. Unsuccessful participants are the most likely to recidivate, with 46 percent of unsuccessful graduates recidivating. This demonstrates the importance of the programming the OWI Court provides. Finally, only 24 percent of active participants in the OWI Court recidivate. This low percentage demonstrates the effectiveness of the OWI Court program.

Figure 6: Percent Recidivate on New Charge by Program Status

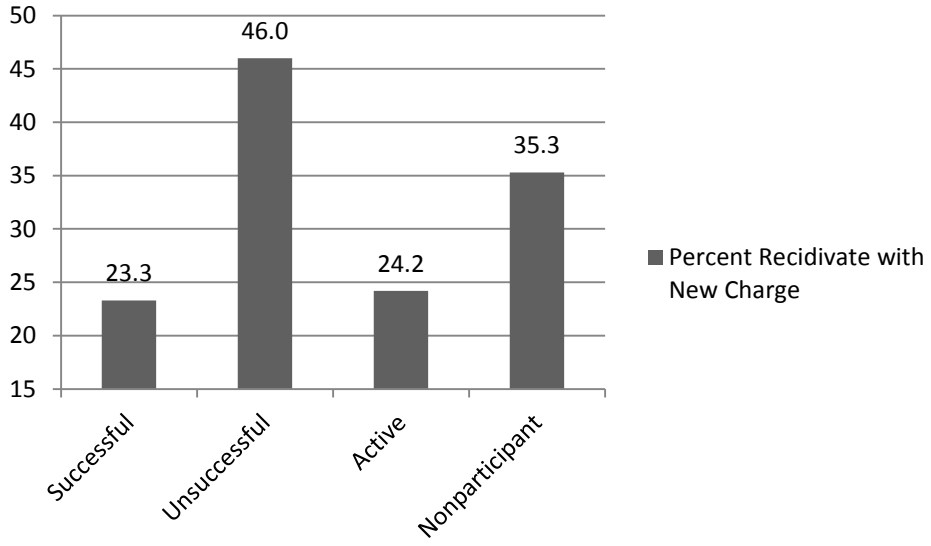


Figure 7 provides information on the percent convicted of a new charge by program status. The findings in Figure 7 are similar to those presented above. Successful program participants were convicted on a new charge just under 21 percent of the time. Similarly, just

under 16 percent of individuals active in the OWI Court are convicted on a new charge. These two findings demonstrate the effectiveness of the OWI Court in reducing the number of individuals receiving new charges. Just over 27 percent of individuals who elected not to participate in OWI Court were convicted on a new charge. This percent was higher than the both the successful and active program status participants. Finally, nearly 43 percent of unsuccessful participants were convicted on a new charge, demonstrating the importance of completing the program successfully.

Figure 7: Percent Convicted on a New Charge by Program Status

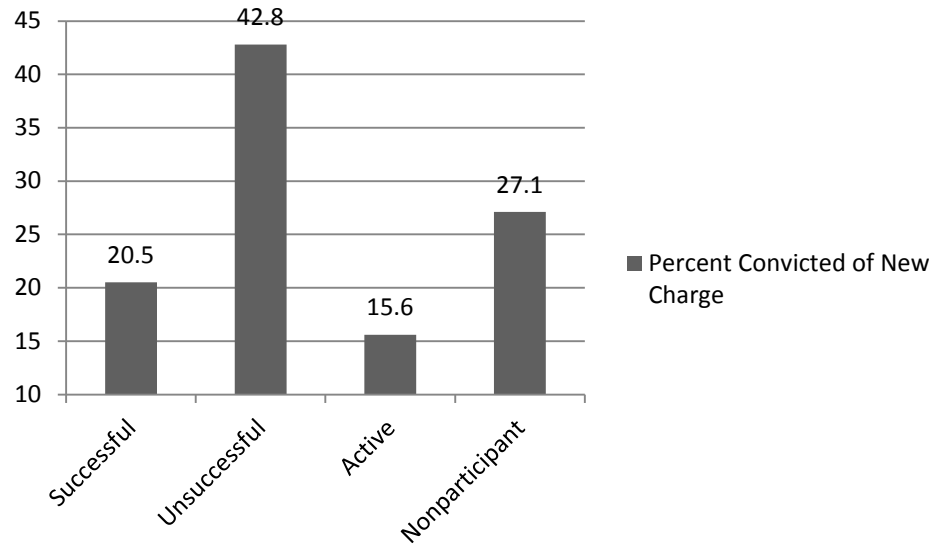


Table 6 provides information on both measures of recidivism by LSI-R risk level. For both measures of recidivism, the reader will note a similar patter—low risk offenders have the lowest recidivism percentage, followed by an increase for moderate and high risk offenders. For example, OWI Court entrants that were assessed as low risk had the lowest recidivism percentage, with 28 percent of low risk entrants receiving a new charge. This is followed by 36 percent of moderate risk entrants receiving a new charge, and 59 percent of high risk entrants receiving a new charge. The same pattern holds for those entrants receiving a new conviction.

The reader should note that chi square analyses demonstrated statistically significant results for both of the measures of recidivism. This means that low risk entrants were significantly less likely to recidivate (new charge and new conviction) compared to moderate and high risk entrants. This demonstrates that the OWI courts assessment process is accurately identifying risk levels—an important component of evidence based correctional programming (Lowenkamp, 2003; Smith, Gendreau, and Goggin, 2002).

Table 6: Comparison of Two Recidivism Measures Across Risk Levels

Variable	Risk Level							
	Low		Moderate		High		Total	
New Charge*	n	%	n	%	n	%	n	%
No	295	72.0	99	63.9	11	40.7	405	68.4
Yes	115	28.0	56	36.1	16	59.3	187	31.6
Total	410	100.0	3	100.0	1	100.0	18	100.0
New Conviction**	n	%	n	%	n	%	n	%
No	309	75.4	105	67.7	16	59.3	430	72.6
Yes	101	24.6	50	32.3	11	40.7	162	27.4
Total	410	100.0	155	100.0	27	100.0	592	100.0

*χ^2=13.42; df=2; p<.001
** χ^2=5.84; df=2; p=.05

Table 7 provides information on percent receiving a new charge by risk level for successful and unsuccessful OWI Court graduates only. The findings of Table 7 demonstrate the success of the OWI Court graduate compared to unsuccessful OWI Court participants. For example, nearly 78 percent of low risk, successful graduate do not have a new charge within 36 months of program start, compared to 58 percent of unsuccessful graduates. That means that there is a 20 percent difference in success across the same risk level for successful versus unsuccessful completers. Nearly 80 percent of moderate risk offenders who successfully complete do not receive a new charge. However, 49 percent of moderate risk offenders do not receive a new charge who graduate unsuccessfully. That means that there is a 31 percent

decrease in the percentage of recidivism for moderate risk, successful OWI Court participants. Looking at successful high risk OWI Court completers, 75 percent do not receive a new charge, whereas only 29 percent of unsuccessful, high risk offenders do not receive a new charge within 36 months of program start. That means that there is a 45.6 percent reduction in recidivism for high risk participants who graduate successfully compared to those who graduate unsuccessfully.

Taken all together, the findings in Table 7 demonstrate that the OWI Court receives larger reductions in the percentage of participants who recidivate from higher risk individuals. Thus, this demonstrates support for the risk principle. This is important point for the La Crosse County OWI Court, given that higher risk individuals are more likely to unsuccessfully complete (see Table 4). Given that higher risk successful completers are less likely to recidivate compared to higher risk, the OWI Court should address issues causing higher risk individuals to be unsuccessful in OWI Court.

Table 7: Evaluation of New Charge Recidivism for Successful and Unsuccessful Completer Across Risk Levels

Variable	Risk Level							
	Low		Moderate		High		Total	
Successful Participants	n	%	n	%	n	%	n	%
No, New Charge	167	77.7	34	79.1	3	75.0	204	77.9
Yes, New Charge	48	22.3	9	20.9	1	25.0	58	22.1
Total	215	100.0	43	100.0	4	100.0	262	100.0
Unsuccessful Participants	n	%	n	%	n	%	n	%
No, New Charge	68	58.1	32	48.5	5	29.4	105	52.5
Yes, New Charge	49	41.9	34	51.5	12	70.6	95	47.5
Total	117	100.0	66	100.0	17	100.0	200	100.0

Matched Comparison Analyses

The report has thus far summarized the characteristics of OWI Court participants, evaluated differences across program status, and investigated recidivism by program status and risk level. The totality of the reports demonstrates that the OWI Court has recidivism rates that are similar to other successful treatment courts (Mitchell et al. 2012; Shaffer, 2011) and that these rates improve when participants successfully complete the OWI Court. The next section of the outcome report will compare OWI Court participants to a comparison group.

Comparison groups are essential to a good outcome study because the provide a contrast to what would be likely to occur had the participant not received treatment, in this case the OWI Court. This study provides a quasi-experimental design by building a matched-comparison group. Matched comparison groups are preferable because they match individual who receive a treatment (i.e., OWI Court) to those who did not receive the treatment (i.e., those on probation) on characteristics that might be related to differences in recidivism (e.g., age, race, gender, and risk). Because the two different groups are matched on these characteristics, there are no differences between the groups. For example, when matching on gender, there will be equal amounts of men and women across both the treatment and control groups. By matching on characteristics that may be related to recidivism, you are able to methodologically control these factors so that any impact they may have on recidivism is the same for each group. Thus, the only difference between your treatment and control group is that one received the treatment and one did not.

The first step in building the matched comparison group was to control for offense. Because the OWI Court is concerned with only individual who have received an arrest for an OWI, the research team used data on probationers with had a referral offense with an OWI

statute. Thus, the research team only selected from probationers who were placed on probation as a result of an OWI. The next step was to match the OWI Court participants with probationers on gender, race, age, and risk level. As such, OWI Court men were matched to only male probationers, and female OWI Court participants were matched to only female probationers. Race was matched across data files as White, Black, and Other. To facilitate matching by age, it was necessary to match individuals using a range of ages rather than an exact age. Thus, age was matched at plus or minus 5 years. For example, an OWI court participant who was 35 years old could be matched to a probationer between the ages of 30 and 40. This allowed for the greatest amount of matching.

The last variable that was matched on was risk level. This proved to be the most challenging variable to match on because of difference in risk instruments used. The OWI Treatment Court used the LSI-R and then transitioned to the COMPAS. The Wisconsin DOC used the WI-502 and then transitioned to the COMPAS. Because there were three different risk assessment instruments used across three different time points, matching on risk needed to be standardized across the different instruments. While the instruments have different scoring criteria their overall goal is the same—to provide a level or risk. Thus, the first step to matching on risk was to create standardized risk levels. Matching on risk level was chosen by the researchers because it is guided by the risk principle—treatment decisions should be made on the risk level, and not the score itself (Lowenkamp and Latessa, 2004). Both the COMPAS and the WI502 scored on three risk levels, low, moderate, and high. The LSI-R has five risk levels, low, low/moderate, moderate, medium/high, high. Thus, the LSI-R risk levels were collapsed to create three risk levels that were standardized across all instruments. Accordingly, the LSI-R

was now recoded to reflect low (low), moderate (low/moderate and moderate) and high (medium/high and high).

Now that each instrument had the same three levels, the next step was to match individuals across risk levels. First, individuals from the treatment court who had a completed COMPAS score were matched to control group individuals who had a COMPAS. This was done to make sure that matching was prioritized to people who had the same instrument across treatment groups. This resulted in 88 individuals from the treatment group being matched to 88 individuals from the comparison group. The remaining OWI court participants had an LSI-R completed (give numbers). This group was then matched to the control database that had COMPAS completed. This resulted in 451 people in OWI court matched to 451 people in the control group. However, 158 people from the OWI court were not matched. These remaining 158 OWI court participants were then matched on risk using their LSI-R risk to the control groups WI502 scores. Of the remaining 158 OWI Court participants, 149 were matched to a comparison group participant. This left 9 OWI Court participants who could not be matched with a control group member.[3] Finally, active and nonparticipant were excluded from the matched comparison analysis. This resulted in a sample size of 923 cases, with 466 cases coming from the OWI Court.

Table 8 compares differences in the percentage of new charges by treatment and comparison groups. The results demonstrate that participants of the OWI court have a lower percentage of individuals with a new charge. Specifically, 3.3 percent fewer (36.3-33.0) OWI Court participants received a new charge. This finding does show that fewer people received a new charge; however, the difference was not statistically significant. Table 9 compares

[3] Chi-square analyses revealed no statistical differences between the OWI Court and comparison group on Gender, Race, Age, and risk. This demonstrates that the matched comparison process was successful.

differences in new convictions for each group. Table 9 produces a slightly different finding. OWI Court participants had a slightly higher percentage of people receiving a new conviction compared to the comparison group. While 28.7 percent of the comparison group received a new conviction, 29.2 percent of the treatment group received a new conviction. However, this difference was not statistically significant, meaning that there was no difference between the comparison and treatment group in their likelihood to receive a new conviction.

Table 8: New Charge Recidivism by Group

Variable	Comparison Group		Treatment Group	
New Charge	n	%	n	%
No	291	63.7	312	67.0
Yes	166	36.3	154	33.0
Total	457	100.0	466	100.0

*χ^2=1.094; df=1; p=.296

Table 9: New Conviction Recidivism by Group

Variable	Comparison Group		Treatment Group	
New Conviction	n	%	n	%
No	326	71.3	330	70.8
Yes	131	28.7	136	29.2
Total	457	100.0	466	100.0

*χ^2=0.030; df=1; p=.862

To further investigate the findings of Tables 8 and 9, outcomes were examined by program status—successful completers versus unsuccessful completers. Therefore, successful completers of the OWI Court and their matched comparison group were compared to unsuccessful OWI court participants and their respective matched comparison group. Table 10 presents differences in new charges for successful and unsuccessful comparison and treatment

group completers. The findings show that 22.2 percent of successful completers of the OWI Court received a new charge compared to 32.8 percent of the matched comparison group. This finding was statistically significant. This means that successful OWI court participants are significantly less likely to receive a new charge. Table 10 also provides information on unsuccessful OWI Court providers. In this case, 47.5 percent of unsuccessful OWI Court completers received a new charge compared to 41 percent of the matched group. While 6.5 percent more unsuccessful OWI Court completers receive a new charge, this finding was not significant at $p < .05$—meaning that the group were no more or less likely to receive a new charge. Regardless, the pattern is clear—successful OWI Court completers are significantly less likely to receive a new charge, while unsuccessful completers are no more or less likely to recidivate.

Table 10: Comparison of New Charges for Successful and Unsuccessful OWI Court Completers Across Groups

Variable	Comparison Group		Treatment Group	
Successful Participants*	n	%	n	%
No, New Charge	176	67.2	207	77.8
Yes, New Charge	86	32.8	59	22.2
Total	262	100.0	266	100.0
	Comparison Group		Treatment Group	
Unsuccessful Participants^	n	%	n	%
No, New Charge	115	59.0	105	52.5
Yes, New Charge	80	41.0	95	47.5
Total	195	100.0	200	100.0

*χ^2=7.507; df=1; p=.006
^χ^2=1.677; df=1; p=.195

Table 11 presents the analysis on success participants by group on whether or not a new conviction is received. Again, the reader will see a similar pattern found in Table 10. Successful

participants received fewer new convictions (18.4%) compared to their matched comparison group (25.2). However, this value failed to reach significance, meaning that the treatment group was no more or less likely to receive a new conviction. However, the relationship is approaching the critical $p < .05$ indicating significance. When looking at unsuccessful participants, treatment group participants were significantly more likely to receive a new conviction compared to comparison group participants (43.5 vs. 33.3). This finding may suggest that unsuccessful completers of treatment court are held more accountable for future offense than individuals not in treatment court.

Table 11: Comparison of New Convictions for Successful and Unsuccessful OWI Court Completers Across Groups

Variable	Comparison Group		Treatment Group	
Successful Participants^	n	%	n	%
No, New Conviction	196	74.8	217	81.6
Yes, New Conviction	66	25.2	49	18.4
Total	262	100.0	266	100.0
	Comparison Group		Treatment Group	
Unsuccessful Participants*	n	%	n	%
No, New Conviction	130	66.7	113	56.5
Yes, New Conviction	65	33.3	87	43.5
Total	195	100.0	200	100.0

^χ^2=3.551; df=1; p=.060
* χ^2=4.311; df=1; p=.038

Finally, three separate analyses were performed to investigate differences across risk levels. Table 12 looks at all OWI Program participants (successful and unsuccessful) and evaluated differences in new convictions across all three risk levels for comparison and treatment group participants. For both the low risk and moderate risk levels, OWI Court participants had

Table 12: Comparison of New Charges All OWI Court Completers Across Groups by Risk Level

Variable	Comparison Group		Treatment Group	
Low Risk Participants^	n	%	n	%
No, New Charge	91	67.9	97	71.9
Yes, New Charge	43	32.1	38	28.1
Total	134	100.0	135	100.0
	Comparison Group		Treatment Group	
Moderate Risk Participants^^	n	%	n	%
No, New Charge	188	62.3	207	67.0
Yes, New Charge	114	37.7	102	33.0
Total	302	100.0	309	100.0
	Comparison Group		Treatment Group	
High Risk Participants^^^	n	%	n	%
No, New Charge	12	57.1	8	36.4
Yes, New Charge	9	42.9	14	63.6
Total	21	100.0	22	100.0

^χ^2=0.496; df=1; p=.481;
^^χ^2=1.501; df=1; p=.221;
^^^Cell values too low for statistical interpretation

lower percentages of recidivism. For low risk, only 28.1 percent of OWI Court participants received a new charge whereas 32.1 percent of the comparison group received a new charge. For moderate risk participants, 33 percent of OWI Court participants received a new charge whereas 38 percent of comparison group members received a new charge. While the lower levels demonstrate smaller percentages of new charges, these differences were not significantly different. Finally, looking at the high risk participants. 63.6 percent of high risk OWI Court participants received a new charge compared to 42.9 percent of comparison group members. However, this difference should be viewed caution, as there were too few people across groups to allow for meaningful comparison.

Table 13 provides the same information as Table 12, but only includes successful completers and their matched comparison group members. Again, we see that low risk successful completers were receiving new charges at lower percentages than those in the comparison group. Specifically, 21.6 percent of successful OWI Court graduate received a new charge, whereas 8.6 percent more comparison group participants (30.2%) received a new charge. While this difference is not statistically significant, it does demonstrate that a larger difference between successful low risk OWI completers and matched comparison participants. Again, successful high risk OWI court completers had a larger percentage of new charges compared to the comparison group; however, the cell values are too low to allow any meaningful interpretation of this finding. Finally, it is notable that moderate risk individuals are significantly less likely to receive a new charge if they successfully complete the OWI Court compared to a matched comparison group. Specifically, only 22 percent of moderate risk, successful completers received a new charge. For the comparison group, 35 percent of comparison group participants received a new charge. Again, this 13 percentage point decrease was statistically significant.

Table 13: Comparison of New Charges for Only Successful OWI Court Completers Across Groups by Risk Level

Variable	Comparison Group		Treatment Group	
Low Risk Participants^	n	%	n	%
No, New Charge	67	69.8	76	78.4
Yes, New Charge	29	30.2	21	21.6
Total	96	100.0	97	100.0
	Comparison Group		Treatment Group	
Moderate Risk Participants*	n	%	n	%
No, New Charge	105	64.8	128	77.6
Yes, New Charge	57	35.2	37	22.4
Total	162	100.0	165	100.0
	Comparison Group		Treatment Group	
High Risk Participants^^	n	%	n	%
No, New Charge	4	100.0	3	75.0
Yes, New Charge	0	0.0	1	25.0
Total	4	100.0	4	100.0

^χ^2=1.841; df=1; p=.175
*χ^2=6.499; df=1; p=.011
^^Cell values too low for statistical interpretation

Table 14 includes looks at differences in new charges for each risk level for unsuccessful completers and their matched comparison group members. The reader will note that unsuccessful OWI court participants had higher percentages of new charges across all three risk levels. However, these differences were not statistically significant. This can be interpreted as low, moderate, and high risk unsuccessful participants are no more or less likely to receive a new charge compared to their matched comparison group.

Table 14: Comparison of New Charges for Only Unsuccessful OWI Court Completers Across Groups by Risk Level				
Variable	Comparison Group		Treatment Group	
Low Risk Participants^	n	%	n	%
No, New Charge	24	63.2	21	55.3
Yes, New Charge	14	36.8	17	44.7
Total	38	100.0	38	100.0
	Comparison Group		Treatment Group	
Moderate Risk Participants^^	n	%	n	%
No, New Charge	83	59.3	79	54.9
Yes, New Charge	57	40.7	65	45.1
Total	140	100.0	144	100.0
	Comparison Group		Treatment Group	
High Risk Participants^^^	n	%	n	%
No, New Charge	8	47.1	5	27.8
Yes, New Charge	9	52.9	13	72.2
Total	17	100.0	18	100.0

^χ^2=0.490; df=1; p=.484
^^χ^2=0.567; df=1; p=.451
^^^ χ^2=1.392; df=1; p=.238

Conclusion

The present outcome study was conducted to investigate the effectiveness of the La Crosse County OWI Court. The findings suggest that the OWI Court is producing recidivism percentages that are similar to other successful treatment court programs (Mitchell et al. 2012; Shaffer, 2011). Results of outcome analysis demonstrated that the screening process used to assess risk is identifying risk levels of individuals. This is an extremely important aspect of conducting evidence based programming (Lowenkamp and Latessa, 2004; Smith, Gendreau, and Goggin, 2002), and the OWI Court should be commended and continue their assessment process.

Findings also demonstrated that low risk individuals were significantly more likely to graduate successfully from the OWI Court than moderate or high risk individuals. While may

not be surprising that a group that is generally more pro-social is more successful in structured situations, the court must make efforts to investigate how to increase the likelihood of successful moderate and high risk participants. This is important because moderate and high risk individuals are the group that should be the focus of structured interventions like OWI Court, as they are the group that has the most anti-social characteristics in need of change (Andrews and Bonta, 2003; Lowenkamp and Latessa, 2004). The importance of this finding is buttressed by the fact that successful moderate risk OWI Court graduates are significantly less likely than their matched comparison group to recidivate. The OWI Court again deserves praise for producing these promising results. Finally, the OWI Court should be praised for significantly reducing the recidivism of successful graduate compared to the matched comparison group. Successful graduate demonstrated a greater than 10 percent difference in new charges.

REFERENCES

Andrews, D. & Bonta, J. (2003). *The Psychology of Criminal Conduct* (Third Edition). Cincinnati, OH: Anderson.

Gendreau, P. (1996) The principles of effective intervention with offenders. In A. T. Harland (Ed.), *Choosing Correctional Options that Work: Defining the Demand and Evaluating the Supply* (p. 117-130). Thousand Oaks: Sage.

Holsinger, A. M. (1999). *Opening the 'black box': Assessing the relationship between program integrity and recidivism.* Doctoral Dissertation. University of Cincinnati.

Huddleston, C. W., III, Marlowe, D. B., & Casebolt, R. (2008). Painting the current picture: A national report card on drug courts and other problem-solving court programs in the United States. Washington, D.C.: National Drug Court Institute.

Lowenkamp, C. T. (2003). *A Program Level Analysis of the Relationship between Correctional Program Integrity and Treatment Effectiveness*. Doctoral Dissertation. University of Cincinnati.

Lowenkamp, C. T., & E. J. Latessa (2003). Evaluation of Ohio's Halfway Houses and Community Based Correctional Facilities. Center for Criminal Justice Research, University of Cincinnati, Cincinnati, OH.

Lowenkamp, C.T., & Latessa, E.J. (2004). Understanding the risk principle: How and why correctional interventions can harm low-risk offenders. *Topics in Community Corrections*, 3-8.

Lowenkamp, C. T., & E. J. Latessa (2005a). *Evaluation of Ohio's CCA Programs.* Center for Criminal Justice Research, University of Cincinnati, Cincinnati, OH.

Lowenkamp, C. T., & E. J. Latessa (2005b). *Evaluation of Ohio's Reclaim Funded Programs, Community Correctional Facilities, and DYS Facilities.* Center for Criminal Justice Research, University of Cincinnati, Cincinnati, OH.

Marlowe, D.B. (2012). The facts on dwi courts. Retrieved from: http://www.nccourts.org/_dtc/dtcconf/documents/factsdwi.doc.

Mitchell, O., Wilson, D.B., Eggers, A., & MacKenzie, D.L. (2012). Assessing the effectiveness of drug courts on recidivism: A meta-analytic review of traditional and non-traditional drug courts. *Journal of Criminal Justice*, 40, 60-71.

National Association of Drug Court Professionals. (2013). Adult drug court best practice standards: Volume I. Alexandria, VA: NADCP.

National Center for State Courts. (2013) Development of Statewide Drug Court Performance Measures for Wisconsin Adult and Hybrid Drug Courts. Draft Report.

Royse, D., Thyer, B.A., & Padgett, D.K. (2010). Program evaluation: An introduction. 5th Ed. Belmont, CA:Wadsworth.

Shadish, W.R., Cook, T.D., and Campbell, T. (2002). Experimental and quasi-experimental designs for generalized causal inference. Boston, MA: Houghton Mifflin Company.

Shaffer, D.K. (2011). Looking inside the black box of drug courts: A meta-analytic review. *Justice Quarterly*, 28(3), 493-521.

Smith, P., Gendreau, P., & Goggin, C. (2002). *Correctional treatment: Accomplishments and Realities.* In P. Van Voorhis, M. Braswell & D. Lester (Eds.), *Correctional Counseling and Rehabilitation* (Fifth edition). Cincinnati, OH: Anderson Publishing.

Weiss, C. (1997). Evaluation. 2nd Ed. Upper Saddle River, NJ: Prentice Hall.