

NO. 70463-0-1

COURT OF APPEALS OF THE STATE OF WASHINGTON

DIVISION I

STATE OF WASHINGTON,

Respondent,

v.

CHAZ I. SCHMITZ,

Appellant.

FILED  
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STATE OF WASHINGTON  
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APPEAL FROM THE SUPERIOR COURT FOR KING COUNTY,  
THE HONORABLE BETH M. ANDRUS, JUDGE

BRIEF OF RESPONDENT

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**A. ISSUES PRESENTED**

1. Did the trial court exceed its statutory authority by ordering an offender to participate and complete Moral Reconciliation Therapy (MRT) or a Cognitive Behavior Therapy (CBT) alternative which works to change faulty thinking that leads to offending when evidence presented at trial showed the defendant violently assaulted his girlfriend on several different occasions on the same night without provocation and at times in the presence of young children?

**B. STATEMENT OF THE CASE<sup>1</sup>**

On the night of February 2, 2013, Andrea McCarthy, her children and the defendant, Chaz Schmitz and his son were staying at the home of Andrea's father in Duvall house-sitting while he was out of town. Report of Proceedings (RP) 70. At some time between 8 and 8:30 p.m. the couple put the children to bed. RP 71. Once the children were asleep, McCarthy and Schmitz opened a bottle of wine and went to the detached the garage to

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<sup>1</sup> For the purpose of this brief the State has designated the Report of Proceedings (RP) as follows: RP referenced in this brief refers to the transcript of the trial from April 16, 2013, and 2RP referenced in this brief refers to the transcript of the sentencing hearing from May 17, 2013.

play pool. RP 72. The couple completed one game and decided to play a second game. RP 74.

During the second game there was a heated disagreement over what ball McCarthy should have hit. RP 74-75. McCarthy testified that Schmitz was very agitated because she was disagreeing with him. RP 75. Schmitz began bumping McCarthy with his chest in an aggressive manner. Id. McCarthy responded by pushing him away with her hands and told him that he needed to stop. Id. Schmitz then struck her on the right side of her face causing McCarthy to fall to the side. RP 76. Shocked she exclaimed, "Oh my God, I cannot believe you just hit me..." RP 77.

Schmitz suddenly grabbed McCarthy by the back of her head and smashed her face into a glass bistro table that was inside the garage causing her nose to begin bleeding immediately. RP 77, 79. McCarthy fell to her knees, hunched over the table as blood flowed from her face. RP 80. She then exclaimed, "Oh my God, I can't believe you did this to me..." RP 80. When McCarthy asked Schmitz why he was doing this to her, Schmitz revealed that he relapsed and began using heroin again. RP 82.

Schmitz and McCarthy began to argue about his relapse. RP 85. Schmitz left the garage, re-entered the house, with McCarthy

following him demanding he leave. RP 85. Schmitz initially refused to leave the house because he did not have a car there, but then decided he would take McCarthy's car. Id. Schmitz grabbed the keys to McCarthy's car from her coat pocket and headed to her car. RP 88. McCarthy followed Schmitz outside to her car. RP 88. She did not want him to take her car because they had been drinking and he had relapsed on heroin. Id.

When McCarthy reached her car she stood in between the driver's door and Schmitz refusing to let him leave. RP 89. Schmitz threatened to strangle her and then suddenly grabbed her around her neck with both of his hands and strangled her until she lost consciousness. RP 91. As McCarthy regained consciousness she saw Schmitz go back into the house. RP 92. She got to her feet and went inside the house where she found Schmitz sitting on a barstool. RP 93.

McCarthy testified that Schmitz was "eerily calm" and "he was very quiet and wouldn't talk to her." Id. McCarthy reached for her phone to call police but Schmitz took it from her and tossed into the backyard. RP 94-95. Schmitz also tossed his phone outside out of frustration. RP 95. Schmitz eventually went outside to retrieve both phones. Id.

When he came back inside the house McCarthy tried to calm him down and told him that she believed her nose was broken. RP 96. In an effort to appease Schmitz, McCarthy told him that she was willing to come up with a story about how she was injured when they went to the hospital. RP 96. However, Schmitz would not speak to her and remained silent. RP 97. Schmitz picked up one of the cordless phones and called 911 to report that McCarthy had assaulted him and that he needed the police to respond. RP 98. During this call McCarthy could be heard in the background yelling that her nose was broken. RP 98.

McCarthy called her sister, Erin Hagen, because she wanted help and because she fearful that Schmitz was going to kill her. RP 97. McCarthy called her sister at least twice and also called her father but the calls were cut short because Schmitz would pull the phone cords out of the wall. RP 99-100. McCarthy ran around the house trying to get to a phone to call for help but every time she reached a phone Schmitz pulled the cord out of the wall. RP 100.

At one point McCarthy fled to the room where the children were to call for help. RP 101. While she was talking to a 911 dispatcher Schmitz forced his way into the room, ripped the phone out of the wall and hit her on the side of the face. RP 101-02.

McCarthy testified at trial that she made at least three calls to 911 that evening trying to get help. RP 102.

McCarthy's sister, Erin Hagen, testified that she received a call from her sister at about 3 a.m. on February 3, 2013 and her sister sounded distressed and was crying hard. RP 54. Hagen testified that McCarthy told her that she needed her and the "phone line "instantly cut out." RP 56.

Hagen and her fiancée immediately got dressed and rushed to the house. RP 58. On the way Hagen attempted to reach her sister without success. Id. Hagen received another call from McCarthy but that call was also ended abruptly. RP 58-59. When Hagen finally arrived at the house police and medical personnel were already on scene. RP 59-60. Hagen observed that the house was in disarray and there "was blood everywhere." RP 60. Hagen was reunited with her sister and she saw that McCarthy had bruises on her neck, dried blood all over her nose. RP 61.

McCarthy was examined by EMT Rebecca Harrott at the scene. RP 40. Harrott observed that McCarthy had a laceration on her nose, and a contusion on her eye RP 41-42. McCarthy reported that her face felt swollen, she complained of pain to the back of her head, and she had been strangled. RP 42-43. During

the examination of McCarthy, Harrott observed petechia in both of her eyes. RP 44. Harrott testified that the presence of petechia can be the result of strangulation. Id.

McCarthy was subsequently taken to the hospital for treatment. RP 123. McCarthy testified that as a result of Schmitz's slamming her face on the table she has permanent scarring to her nose. RP 79, 128. On April 17, 2013, the jury ultimately convicted Schmitz of two counts of Assault in the Second Degree Domestic-Violence. Clerk's papers (CP) 23-25.

Schmitz was sentenced on May 17, 2013. At the sentencing hearing the State requested that the trial court order Schmitz to complete substance abuse treatment and Moral Reconciliation Therapy or Cognitive Behavior Therapy alternative. 2RP 17. The State argued that the evidence presented at trial supported the MRT recommendation because of the character of the offense, the gravity the injury to the victim, the fact that Schmitz continued his assaultive behavior despite the presence of his four year old son and McCarthy's two young children. 2RP 17.

After the conclusion of the State's sentencing recommendation, the victim, Andrea McCarthy addressed the trial court. McCarthy discussed the how hurt she was over the entire

incident and that her family was attending counseling to cope with what had happened. 2RP 19. During her remarks McCarthy stated, "I hope that he is able to recognize that his decisions and his choices ultimately led to this outcome; that there were opportunities for it to go a different path and he chose for things to end up this way." 2RP 19.

During his statement to the court Schmitz told the court that he was not the person that he was that night and asked the court for leniency given his limited criminal history. Schmitz did not object to any portion of the State's sentencing recommendation. 2RP 20-23.

After hearing from all parties the trial court imposed a sentence of 13 months on both counts to be served concurrently, no-contact with McCarthy, substance treatment and MRT or a CBT alternative. 2RP 23-24, CP 43-50. Schmitz did not object to the MRT/CBT condition. 2RP 23-28.

**C. ARGUMENT**

Schmitz challenges the Court's authority to impose Moral Reconciliation Therapy (MRT), a form of Cognitive Behavior Therapy (CBT), as a condition of his community custody following his release from the Washington State Department of Corrections

(DOC).

Schmitz argues that the MRT condition is not reasonably related to the circumstances of the crime he was convicted of following a trial, his risk of re-offense, or community safety.

Schmitz's argues that MRT is designed to teach offenders how to make better decisions in certain situations and because it is not tailored specifically for domestic violence, the trial court did not have authority to impose it. Br. of App. at 4.

However this argument fails to appreciate the discretion that legislature has given courts regarding discretionary conditions of community custody. Schmitz's violent, unprovoked actions toward the victim on multiple separate occasions, some of which occurred in the presence of very young children, demonstrated why MRT or a CBT alternative would be appropriate. Schmitz's behavior demonstrates an inability to control his anger, make rational decisions, and handle stressful social situations.

**1. THE TRIAL COURT DID NOT EXCEED ITS  
AUTHORITY BY IMPOSING MRT AS A  
CONDITION OF COMMUNITY CUSTODY.**

The trial court lacks the authority to impose a condition of community custody unless authorized by the legislature. State v. Kolesnik, 146 Wn. App. 790, 806, 192 P.3d 937 (2008). Whether

a trial court has exceeded its authority under the Sentencing Reform Act (SRA) is an issue of law reviewed de novo. State v. Hale, 94 Wn. App. 46, 54, 971 P.2d 88 (1999). An unlawful sentence may be challenged for the first time on appeal. State v. Ford, 137 Wn.2d 472, 477, 973 P.2d 452 (1999).

The legislature has given sentencing courts the authority to impose affirmative discretionary conditions on an offender. RCW 9.94A.505(8) states: "As a part of any sentence, the court may impose and enforce crime-related prohibitions and affirmative conditions as provided in this chapter." Under RCW 9.94A.703(3)(c)-(d), as a condition of community custody the trial court is authorized to order an offender to "Participate in crime-related treatment or counseling services and also "rehabilitative programs or otherwise perform affirmative conduct reasonably related to the circumstance of the offense, the offender's risk to re-offend, or the safety of the community."

There is no requirement of a causal link between the condition imposed and the crime committed so long as the condition relates to the circumstances of the crime. See, State v. Parramore, 53 Wn. App. 527, 768 P.2d 530 (1989) (community custody condition requiring defendant convicted of selling

marijuana to submit to urinalysis was directly related to his drug conviction despite absence of evidence on whether defendant smoked marijuana).

Schmitz argues that the trial court exceeded its authority by imposing MRT as a condition of community custody. In support of this argument Schmitz relies solely on State v. Vasquez, 95 Wn. App. 12, 972 P.2d 109 (1998).

In Vasquez, the defendant entered an Alford plea to the crime of Assault in the Second Degree. Vasquez's community corrections officer (CCO) recommended that the defendant be order to complete a MRT program. Vasquez objected to the condition of MRT, however, the sentencing court adopted the CCO's recommendation and imposed MRT. On appeal the MRT condition was stricken because the appellate found that the record below was insufficient to determine if MRT was a crime-related condition.

The facts in Vasquez, are distinguishable from the present case because at the time that Vasquez was decided, former RCW 9.94A.120 (c) (iii) only allowed a trial court to impose crime-related

treatment.<sup>2</sup> However, under RCW 9.94A.703(3) (d), the trial court has more discretion in imposing rehabilitative or affirmative conditions. The trial court in the present case had the authority to impose MRT or a CBT alternative as an affirmative condition of community custody.

Since the trial court has the authority to impose a rehabilitative program such as MRT, the question becomes whether such a condition is reasonably related to the circumstances of the offense, the offender's risk of re-offending, or community safety. Cognitive Behavioral Therapy is a particular method of counseling. CBT offers a direct, pragmatic approach to individuals with a variety of diagnoses.

Cognitive-behavioral therapy (CBT) emphasizes individual accountability and teaches offenders that cognitive deficits, distortions, and flawed thinking processes cause criminal behavior. Lee, S., Aos, S., Drake, E., Pennucci, A., Miller, M., & Anderson, L. Return on investment: Evidence-based options to improve

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<sup>2</sup> RCW 9.94A.030 (10) states: "Crime-related prohibition" means an order of a court prohibiting conduct that directly relates to the circumstances of the crime for which the offender has been convicted, and shall not be construed to mean order directing an offender affirmatively to participate in rehabilitative programs or to otherwise perform affirmative conduct. However, affirmative acts necessary to monitor compliance with the order of a court may be required by the department.

statewide outcomes, Olympia: Washington State Institute for Public Policy, 4 (April 2012) (Attached as Appendix A). MRT is a brand name form of CBT that is evidence based. Id. CBT programs like MRT offer a direct, pragmatic approach to individuals with a variety of diagnoses.

CBT is often the foundation of effective, evidence-based interventions for the general offender population. This type of group therapy addresses the irrational thoughts and beliefs that lead to anti-social behavior. Steve Aos, Marna Miller, and Elizabeth Drake. Evidence-Based Adult Corrections Programs: What Works and What Does Not, Olympia: Washington State Institute for Public Policy, 5 (2006) (Attached as Appendix B).

The programs are designed to help offenders correct their thinking and provide opportunities to model and practice problem-solving and pro-social skills. Id. CBT helps people change the faulty thinking that can lead to offending. CBT also teaches skills to manage destructive emotions such as anger, to more effectively handle social situations, and to better meet emotional needs. CBT programs, such as MRT, are found to be evidence based<sup>3</sup> and

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<sup>3</sup> “Evidence based” is a research term that demands strict methodology and support to demonstrate efficacy. Washington is one of the few states that has defined the use of the term “evidence based” in statute See RCW 71.24.025(14).

effective at reducing offender recidivism. Id.

A sentence condition of CBT is reasonable in the context of the facts of this case and a need to reduce the offender's risk of recidivism. Here, Schmitz acted in an irrational manner when he attacked McCarthy. It is concerning how quickly the level of violence escalated. Also concerning was the fact that despite McCarthy's efforts to deescalate the situation, Schmitz continued to carry out his violent behavior even in the presence of children. Here the sentencing court viewed the evidence admitted and heard the testimony of the witnesses. At the sentencing the court referenced reviewing the case file, the aggravating circumstances and comments by the parties prior to imposing sentence. RP 23-24. When the court imposed MRT or a CBT alternative, it stated this type of treatment was recommended for people that have had incidents of domestic violence even if isolated. 2RP 24.

The court's analysis is supported by research in the state of Washington. The Washington State Institute for Public Policy (WSIPP) published research that found Domestic Violence treatment programs were ineffective in preventing recidivism. WSIPP was then tasked by the legislature in HB2363 (2012), See,

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RCW 26.50.800, to assess domestic violence perpetrator treatment.

WSIPP renewed its finding that domestic violence perpetrator treatment was ineffective. Marna Miller, Elizabeth Drake, Mia Nafziger, What works to reduce recidivism by domestic violence offenders? Olympia: Washington State Institute for Public Policy, (January 2013) (Attached as Appendix C). CBT alternatives were found to be effective in reducing recidivism for domestic violence offenders. Id. at 6-7. MRT or CBT alternatives were found to be effective in reducing recidivism for domestic violence offenders. Id.

The trial court was not precluded from imposing MRT or a CBT alternative as a rehabilitative program or as other affirmative conduct in light of the facts of the case and the available evidence-based research. Therefore, the imposition of MRT or a CBT alternative as appropriate and should not be stricken.

**D. CONCLUSION**

RCW 9.94A.703 gives a sentencing court the authority to impose discretionary conditions as a part of any term of community custody. Specifically, RCW 9.94A.703 (d) allows a sentencing court to impose a rehabilitative program or affirmative conduct.

Here the trial court did not exceed its statutory authority when it imposed the MRT condition of community custody.

Although MRT is not the typically prescribed form of treatment in domestic violence cases, there is nothing that precludes the trial court from imposing this form of treatment as a rehabilitative program. The MRT condition imposed in this case was a lawfully ordered condition of community custody. Therefore, this condition of community custody should be not be stricken from Schmitz's sentence.

DATED this 4th day of April, 2014.

Respectfully submitted,

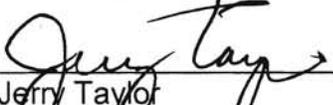
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Certificate of Service by Electronic Mail

Today I directed electronic mail addressed to the attorneys for the appellant, CHAZ SCHMITZ, containing a copy of the Brief of Respondent, in STATE V. CHAZ SCHMITZ, Cause No. 70463-0-1, in the Court of Appeals, Division I, for the State of Washington.

I certify under penalty of perjury of the laws of the State of Washington that the foregoing is true and correct.

  
\_\_\_\_\_  
Jerry Taylor

Done in Seattle, Washington on April 4, 2014.

# APPENDIX A

April 2012

## **Return on Investment: Evidence-Based Options to Improve Statewide Outcomes** —April 2012 Update—

In the mid-1990s, the Washington State Legislature first began to direct the Washington State Institute for Public Policy (Institute) to identify "evidence-based" policies that have been shown to improve particular outcomes.

The motivation for these assignments is straightforward: to provide Washington policymakers and budget writers with a list of well-researched policies that can, with a high degree of probability, lead to better statewide results and a more efficient use of taxpayer dollars.

This short report provides a snapshot, as of April 2012, of our current list of evidence-based policy options on many public policy topics. Where possible, we provide an independent assessment of the benefits and costs of each option from the perspective of Washington citizens and taxpayers.

In essence, this report is similar to an investment advisor's "buy-sell" list—it contains current recommendations on policy options that can give taxpayers a good return on their investment ("buys"), as well as those that apparently cannot ("sells"). **This report replaces previously published Institute reports on these topics.**

We will occasionally add or update results for individual policy options on our website as new information becomes available. Exhibit 1 of this report includes hyperlinks to detailed results for each program.

Suggested citation: Lee, S., Aos, S., Drake, E., Pennucci, A., Miller, M., & Anderson, L. (2012). *Return on investment: Evidence-based options to improve statewide outcomes, April 2012* (Document No. 12-04-1201). Olympia: Washington State Institute for Public Policy.

### **Background**

The Institute was created by the 1983 Washington Legislature to carry out non-partisan research at legislative direction.

The 1997 Legislature directed the Institute to review "evidence-based" policy strategies in juvenile justice and adult corrections. We identified several programs that had been tried and evaluated elsewhere but were not then operating in Washington. We found that some, but not all, programs had the potential to reduce crime and save Washington taxpayers money.<sup>1</sup> In subsequent sessions, the legislature used the information to begin a series of policy reforms.<sup>2</sup> Many practical lessons have been learned about how to implement these programs with fidelity statewide.<sup>3</sup>

Based on this initial success, in the early 2000s the legislature began to direct the Institute to apply the same evidence-based and benefit-cost approach to other public policy areas, including K-12 education, early childhood education, prevention, child welfare, mental health, substance abuse, and public health.<sup>4</sup>

In this report, we discuss our research approach and summarize our current results on these topics.

### **General Research Approach**

As we have carried out these legislative assignments, we have been implementing a three-step research approach.

- 1) We systematically assess evidence on "what works" (and what does not) to improve outcomes.
- 2) We calculate costs and benefits for Washington State and produce a ranking of public policy options.
- 3) We measure the riskiness of our conclusions by testing how bottom lines vary when estimates and assumptions change.

A brief description of each step follows.

### **Step 1: What Works? What Doesn't?**

In the first research step, we estimate the probability that various policies and programs can improve outcomes. Once the legislature has indicated an outcome of interest, we then carefully analyze all high-quality studies from the United States and elsewhere to identify well-researched policy options that have achieved the outcome (as well as those that have not). We look for research studies with strong evaluation designs; we ignore studies with weak research methods. Our empirical approach then follows a meta-analytic framework to assess systematically all credible evaluations we can locate on a given topic. We produce an estimated effect of a policy on a particular outcome of interest, as well as an estimate of the margin of error in that effect.

### **Step 2: What Makes Economic Sense?**

Next, we insert benefits and costs into the analysis by answering two questions.

- ✓ How much does it cost to produce the results found in Step 1?
- ✓ How much is it worth to people in Washington State to achieve the outcome? That is, in dollar and cents terms, what are the program's benefits?

To answer these questions, we have developed—and we continue to refine—an economic model that assesses benefits and costs. The goal is to provide an internally consistent monetary valuation so that one option can be compared fairly to another. Our bottom line benefit-cost measures include standard financial statistics: net present values, benefit-cost ratios, and rates of return on investment.

We present these monetary estimates from three distinct perspectives: the benefits and costs that accrue solely to program participants, those received by taxpayers, and those received by other people in society (for example, crime victims).

The sum of these three perspectives provides a “total Washington” view on whether a policy or program produces benefits that exceed costs. Our model can also restrict the focus solely to the taxpayer perspective which can be useful for fiscal analysis and state budget preparation.

### **Step 3: Assessing the Riskiness of the Estimates.**

The third analytical step involves testing the robustness of our results. Any tabulation of benefits and costs involves some degree of speculation about future performance. This is expected in any investment analysis, whether it is in the private or public sector. To assess the riskiness of our

conclusions, we perform a “Monte Carlo simulation” in which we vary the key factors in our calculations. The purpose of the risk analysis is to determine the odds that a particular policy option will at least break even. This type of analysis is used by many businesses in investment decision making.

Thus, for each option, we produce two “big picture” findings: expected benefit-cost results (net present values and rates of return) and, given our understanding of the risks involved, the odds that the policy will at least have benefits greater than costs.

### **Changes Since the July 2011 Update**

Since the Institute's benefit-cost findings were last published in July 2011, several findings have changed substantially, due to improvements in our benefit-cost methodology. The changes affect our previous results in two major ways, one that affects a particular topic area, and another that cuts across all topic areas.

First, we changed the method by which we monetize children's mental health disorders to more closely match the methods we use to monetize adult mental health disorders. The benefit-cost model is now able to distinguish between the effects of preventing disruptive behavior disorders compared to the effects of treating youth who already have these disorders. The effect of this modeling change, relative to our July 2011 findings, lowers the expected benefits of programs that affect child externalizing behaviors.

Second, we have updated our methods to avoid “double counting” benefits from a single monetary source. For instance, a program evaluation that measures high school graduation rates, test scores, and disordered alcohol use would be monetized, in part, via changes to lifetime earnings in the labor market from each of these outcomes. In the former version of our model, to avoid double counting, we allowed the highest of these three values to “trump” the other values. We discovered that, in a Monte Carlo simulation, consistently selecting the highest of the three values biased the results in a positive direction, and may not have accurately represented the expected monetary benefits of a policy. Thus our prior trumping method favored policies that measured multiple outcomes in their evaluations; for example, the more ways a study measured impacts on labor market earnings, the more likely our previous model would have estimated a positive overall benefit.

In the current update, we have improved our trumping method by taking a weighted average of all outcomes that derive benefits from a single monetary source. Using the new method, we more accurately represent the expected benefits from programs that measure multiple outcomes. This modeling change lowered the estimated benefits of a number of programs that measured certain monetary benefits through multiple outcomes.

For more detail on these modeling changes, see the [technical appendix](#).<sup>5</sup>

## April 2012 Results

In this report, we summarize our results in a *Consumer Reports*-like list of what works and what does not, ranked by benefit-cost statistics and a measure of investment risk. We identify a number of evidence-based options that can help policy makers achieve desired outcomes as well as offer taxpayers a good return on their investment, with low risk of failure. Washington is already investing in several of these options. We also find other evidence-based options that do not produce favorable results.

In Exhibit 1, we have arranged the information by major topic. Some programs listed, of course, achieve outcomes that cut across these topics. The documents hyperlinked to the program titles in this exhibit provide comprehensive outcome information.

For some programs, insufficient information was available to allow a calculation of benefits and costs. We list these programs in each topic area, along with the reason for their exclusion.

### Example: How to Read Exhibit 1.

To illustrate our findings, we summarize results for a program called Functional Family Therapy (FFT), designed for juveniles on probation. This program is listed under the topic of juvenile justice in Exhibit 1. FFT was originally tested in Utah; Washington began to implement the program in the mid-1990s. The legislature continues to fund FFT, and it is now used by many Washington juvenile courts.

We reviewed all research we could find on FFT and found eight credible evaluations that investigated whether it reduces crime. The appendix linked in Exhibit 1 provides specific information on the eight studies in our meta-analysis of FFT.

- In Exhibit 1, we show our estimate of the total benefits of FFT per participant (2011 dollars). These benefits spring primarily from reduced crime, but also include labor market and health care benefits due to increased probability of high school graduation.

- Of the total benefits, Exhibit 1 shows that we expect some to be received by taxpayers and the majority to accrue to others, including the participants and people who were not victimized.
- Exhibit 1 also shows our estimates of the program costs per participant in Washington.
- The columns in the right-hand side of Exhibit 1 display our benefit-cost summary statistics for FFT. We show the net present value (benefits minus costs), and the benefit-to-cost ratio. Finally, we show the results of a risk analysis of our estimated bottom line for FFT.
- Based on these findings, one would conclude that FFT is an attractive evidence-based program that reduces crime and achieves a favorable return on investment, with a small chance of an undesirable outcome. These are the central reasons why FFT continues to be part of Washington's crime-reduction portfolio.

In addition to the summary information displayed in Exhibit 1, we have prepared supplementary documents. The individually linked documents provide detailed results for each option summarized in Exhibit 1, while the technical appendix provides a comprehensive description of the research methods used to compute the results.

<sup>1</sup> Aos, S., Barnoski, R., & Lieb, R. (1998). *Watching the bottom line: cost-effective interventions for reducing crime in Washington* (Document No. 98-01-1201), Olympia: Washington State Institute for Public Policy.

<sup>2</sup> Barnoski, R. (2004). *Outcome evaluation of Washington State's research-based programs for juvenile offenders* (Document No. 04-01-1201), Olympia: Washington State Institute for Public Policy.

<sup>3</sup> Drake, E.K. (2010). *Washington State juvenile court funding: Applying research in a public policy setting*. (Document No. 10-12-1201), Olympia: Washington State Institute for Public Policy. See also: Barnoski, R. (2009). *Providing evidence-based programs with fidelity in Washington State juvenile courts: Cost analysis* (Document No. 09-12-1201), Olympia: Washington State Institute for Public Policy.

<sup>4</sup> Previous benefit-cost studies prepared by the Washington State Institute for Public Policy for the legislature include:

- Aos, S., Lee, S., Drake, E., Pennucci, A., Klima, T., Miller, M., Anderson, L., Mayfield, J., & Burley, M. (2011). *Return on investment: evidence-based options to improve statewide outcomes - July 2011 update* - (Document No. 11-07-1201).
- Lee, S., Aos, S., & Miller, M. (2008). *Evidence-based programs to prevent children from entering and remaining in the child welfare system: Benefits and costs for Washington* (Document No. 08-07-3901).
- Aos, S., & Pennucci, A. (2007). *Report to the Joint Task Force on Basic Education Finance: School employee compensation and student outcomes* (Document No. 07-12-2201).
- Aos, S., Miller, M., & Mayfield, J. (2007). *Benefits and costs of k-12 educational policies: Evidence-based effects of class size reductions and full-day kindergarten* (Document No. 07-03-2201).
- Aos, S., Miller, M., & Drake, E. (2006). *Evidence-based public policy options to reduce future prison construction, criminal justice costs, and crime rates* (Document No. 06-10-1201).
- Aos, S., Mayfield, J., Miller, M., & Yen, W. (2006). *Evidence-based treatment of alcohol, drug, and mental health disorders: Potential benefits, costs, and fiscal impacts for Washington State* (Document No. 06-06-3901).
- Aos, S., Lieb, R., Mayfield, J., Miller, M., & Pennucci A. (2004). *Benefits and costs of prevention and early intervention programs for youth* (Document No. 04-07-3901).

<sup>5</sup> [www.wsipp.wa.gov/rptfiles/12-04-1201B.pdf](http://www.wsipp.wa.gov/rptfiles/12-04-1201B.pdf).

**Exhibit 1**

**Monetary Benefits and Costs of Evidence-Based Public Policies**

*Summary of policy topics assigned to the Washington State Institute for Public Policy by the Washington State Legislature  
Estimates for Washington State, as of April 2012*

<b>Topic Area/Program</b> <small>Benefits and costs are life-cycle present-values per participant, in 2011 dollars. The programs are listed by major topic area, although some programs achieve benefits in multiple areas. Also, some programs achieve benefits that we cannot monetize; see linked documents for program-specific details.</small>	<b>Last Updated</b>	<b>Monetary Benefits</b>			<b>Costs</b>	<b>Summary Statistics</b>		
		<b>Total Benefits</b>	<b>Taxpayer</b>	<b>Non-Taxpayer</b>		<b>Benefits Minus Costs (net present value)</b>	<b>Benefit to Cost Ratio<sup>1</sup></b>	<b>Measured Risk (odds of a positive net present value)</b>
<b>Juvenile Justice</b>								
<a href="#">Functional Family Therapy (Institutions<sup>2</sup>)</a>	April 2012	\$70,370	\$14,476	\$55,895	(\$3,262)	\$67,108	\$21.57	100%
<a href="#">Aggression Replacement Training (Institutions)</a>	April 2012	\$62,947	\$12,972	\$49,976	(\$1,508)	\$61,440	\$41.75	94%
<a href="#">Multidimensional Treatment Foster Care</a>	April 2012	\$39,197	\$8,165	\$31,032	(\$7,922)	\$31,276	\$4.95	85%
<a href="#">Functional Family Therapy (Probation)</a>	April 2012	\$33,967	\$8,052	\$25,916	(\$3,261)	\$30,706	\$10.42	100%
<a href="#">Aggression Replacement Training (Probation)</a>	April 2012	\$31,249	\$7,423	\$23,826	(\$1,510)	\$29,740	\$20.70	96%
<a href="#">Multisystemic Therapy (MST)</a>	April 2012	\$32,121	\$7,138	\$24,983	(\$7,370)	\$24,751	\$4.36	98%
<a href="#">Family Integrated Transitions (Institutions)</a>	April 2012	\$28,137	\$5,751	\$22,386	(\$11,219)	\$16,918	\$2.51	91%
<a href="#">Drug Court</a>	April 2012	\$13,667	\$3,084	\$10,583	(\$3,091)	\$10,576	\$4.42	94%
<a href="#">Coordination of Services</a>	April 2012	\$5,501	\$1,412	\$4,089	(\$395)	\$5,106	\$13.94	82%
<a href="#">Victim Offender Mediation</a>	April 2012	\$4,205	\$1,080	\$3,125	(\$579)	\$3,626	\$7.27	95%
<a href="#">Scared Straight</a>	April 2012	(\$4,949)	(\$1,271)	(\$3,678)	(\$65)	(\$5,014)	(\$76.35)	0%
Juvenile justice programs for which we have not calculated benefits and costs (at this time):								
<a href="#">Cognitive Behavioral Therapy (general)</a>	October 2006							See previous WSIPP <a href="#">publication</a> for past findings.
<a href="#">Diversion Programs</a>	October 2006							See previous WSIPP <a href="#">publication</a> for past findings.
<a href="#">Juvenile Boot Camps</a>	October 2006							See previous WSIPP <a href="#">publication</a> for past findings.
<a href="#">Supervision for Juvenile Offenders</a>	October 2006							See previous WSIPP <a href="#">publication</a> for past findings.
<a href="#">Sex Offender Treatment for Juvenile Offenders</a>	October 2006							See previous WSIPP <a href="#">publication</a> for past findings.
<a href="#">Team Child</a>	October 2006							See previous WSIPP <a href="#">publication</a> for past findings.
<a href="#">Team Courts</a>	October 2006							See previous WSIPP <a href="#">publication</a> for past findings.
<a href="#">Vocational Challenge Programs</a>	October 2006							See previous WSIPP <a href="#">publication</a> for past findings.
<b>Adult Criminal Justice</b>								
<a href="#">Offender Re-entry Community Safety Program (dangerously mentally ill offenders)</a>	April 2012	\$70,535	\$18,120	\$52,415	(\$32,247)	\$38,288	\$2.19	100%
<a href="#">Drug Offender Sentencing Alternative (drug offenders)</a>	April 2012	\$22,365	\$5,318	\$17,047	(\$1,542)	\$20,823	\$14.51	100%
<a href="#">Supervision with Risk Need and Responsivity Principles (high and moderate risk)</a>	April 2012	\$24,203	\$5,817	\$18,386	(\$3,543)	\$20,660	\$6.83	100%
<a href="#">Correctional Education in Prison</a>	April 2012	\$21,426	\$5,238	\$16,188	(\$1,128)	\$20,298	\$19.00	100%
<a href="#">Electronic Monitoring (radio frequency or global positioning systems)</a>	April 2012	\$18,745	\$4,438	\$14,307	\$1,067	\$19,812	n/e	100%
<a href="#">Vocational Education in Prison</a>	April 2012	\$20,446	\$5,017	\$15,429	(\$1,571)	\$18,875	\$13.01	100%
<a href="#">Mental Health Courts</a>	April 2012	\$20,424	\$4,998	\$15,425	(\$2,935)	\$17,488	\$6.96	100%
<a href="#">Drug Treatment in the Community</a>	April 2012	\$17,711	\$4,206	\$13,504	(\$1,602)	\$16,108	\$11.05	100%
<a href="#">Drug Courts</a>	April 2012	\$15,433	\$3,376	\$12,057	(\$4,178)	\$11,255	\$3.69	100%
<a href="#">Drug Treatment in Prison</a>	April 2012	\$15,577	\$3,834	\$11,743	(\$4,603)	\$10,974	\$3.38	100%
<a href="#">Drug Offender Sentencing Alternative (property offenders)</a>	April 2012	\$11,273	\$2,666	\$8,607	(\$1,540)	\$9,733	\$7.32	78%
<a href="#">Cognitive Behavioral Therapy (moderate and high risk)</a>	April 2012	\$9,695	\$2,308	\$7,387	(\$412)	\$9,283	\$23.55	100%
<a href="#">Intensive Supervision: With Treatment</a>	April 2012	\$15,169	\$3,610	\$11,559	(\$7,874)	\$7,295	\$1.93	96%
<a href="#">Work Release</a>	April 2012	\$7,117	\$1,749	\$5,368	(\$661)	\$6,456	\$10.77	99%
<a href="#">Correctional Industries in Prison</a>	April 2012	\$7,042	\$1,713	\$5,329	(\$1,417)	\$5,625	\$4.97	100%
<a href="#">Employment Training/Job Assistance in the Community</a>	April 2012	\$5,501	\$1,311	\$4,190	(\$135)	\$5,366	\$40.76	100%
<a href="#">Intensive Supervision: Surveillance Only</a>	April 2012	(\$578)	(\$133)	(\$445)	(\$4,140)	(\$4,718)	(\$0.14)	11%
<a href="#">Domestic Violence Perpetrator Treatment Programs</a>	April 2012	(\$4,908)	(\$1,165)	(\$3,742)	(\$1,359)	(\$5,266)	(\$3.61)	14%
Adult criminal justice programs for which we have not calculated benefits and costs (at this time):								
<a href="#">Adult Boot Camps</a>	October 2006							See previous WSIPP <a href="#">publication</a> for past findings.
<a href="#">Drug Treatment in Jail</a>	October 2006							See previous WSIPP <a href="#">publication</a> for past findings.
<a href="#">Jail Diversion for Mentally Ill Offenders</a>	October 2006							See previous WSIPP <a href="#">publication</a> for past findings.
<a href="#">Life Skills Education Programs for Adults</a>	October 2006							See previous WSIPP <a href="#">publication</a> for past findings.
<a href="#">Restorative Justice for Lower-Risk Adult Offenders</a>	October 2006							See previous WSIPP <a href="#">publication</a> for past findings.
<a href="#">Sex Offender Community Notification and Registration</a>	June 2009							See previous WSIPP <a href="#">publication</a> for past findings.
<a href="#">Sex Offender Treatment</a>	October 2006							See previous WSIPP <a href="#">publication</a> for past findings.

**Exhibit 1**

**Monetary Benefits and Costs of Evidence-Based Public Policies**

*Summary of policy topics assigned to the Washington State Institute for Public Policy by the Washington State Legislature  
Estimates for Washington State, as of April 2012*

<b>Topic Area/Program</b> Benefits and costs are life-cycle present-values per participant, in 2011 dollars. The programs are listed by major topic area, although some programs achieve benefits in multiple areas. Also, some programs achieve benefits that we cannot monetize, see linked documents for program-specific details.	<b>Last Updated</b>	<b>Monetary Benefits</b>			<b>Costs</b>	<b>Summary Statistics</b>		
		<b>Total Benefits</b>	<b>Taxpayer</b>	<b>Non-Taxpayer</b>		<b>Benefits Minus Costs (net present value)</b>	<b>Benefit to Cost Ratio<sup>1</sup></b>	<b>Measured Risk (odds of a positive net present value)</b>
<b>Child Welfare</b>								
<a href="#">Nurse Family Partnership for Low-Income Families</a>	April 2012	\$22,781	\$6,219	\$16,562	(\$9,600)	\$13,181	\$2.37	80%
<a href="#">Parent Child Interaction Therapy (PCIT) for Families in the Child Welfare System</a>	April 2012	\$7,168	\$1,277	\$5,892	(\$1,551)	\$5,617	\$4.62	100%
<a href="#">Intensive Family Preservation Services (Homebuilders)</a>	April 2012	\$6,942	\$3,759	\$3,183	(\$3,288)	\$3,655	\$2.11	99%
<a href="#">SafeCare</a>	April 2012	\$1,501	\$278	\$1,223	(\$102)	\$1,399	\$14.65	100%
<a href="#">Parents as Teachers</a>	April 2012	\$4,992	\$1,116	\$3,876	(\$4,227)	\$765	\$1.18	57%
<a href="#">Alternative Response</a>	April 2012	\$852	\$257	\$595	(\$96)	\$756	\$8.88	100%
<a href="#">Triple P Positive Parenting Program (System)</a>	April 2012	\$865	\$334	\$531	(\$143)	\$722	\$6.06	100%
<a href="#">Other home visiting programs for at-risk mothers and children</a>	April 2012	\$5,138	\$1,233	\$3,904	(\$5,603)	(\$465)	\$0.92	44%
<a href="#">Parent Child Home Program</a>	April 2012	\$3,920	\$1,082	\$2,838	(\$5,496)	(\$1,576)	\$0.71	38%
<a href="#">Healthy Families America</a>	April 2012	\$2,589	\$1,165	\$1,424	(\$4,601)	(\$2,011)	\$0.56	26%
<a href="#">Other Family Preservation Services (non-Homebuilders)</a>	April 2012	(\$902)	(\$208)	(\$693)	(\$3,046)	(\$3,948)	(\$0.30)	0%
Child welfare programs for which we have not calculated benefits and costs (at this time):								
<a href="#">Family Team Decision Making</a>	April 2012							See linked document for meta-analytic results.
<a href="#">Structured Decision Making Risk Assessment</a>	April 2012							See linked document for meta-analytic results.
<a href="#">Dependency for Family Treatment Drug Courts</a>	July 2008							See previous WSIPP <a href="#">publication</a> for past findings; update in process.
<a href="#">Flexible Funding via Title IV-E Waivers</a>	July 2008							See previous WSIPP <a href="#">publication</a> for past findings.
<a href="#">Subsidized Guardianship</a>	July 2008							See previous WSIPP <a href="#">publication</a> for past findings.
<a href="#">Circle of Security</a>								Too few rigorous evaluations.
<a href="#">Project KEEP</a>								Too few rigorous evaluations.
<a href="#">Promoting First Relationships</a>								Too few rigorous evaluations.
<b>Pre-K to 12 Education</b>								
<a href="#">Reading Recovery (K-12 Tutoring)</a>	April 2012	\$18,603	\$4,410	\$14,194	(\$1,895)	\$16,708	\$9.82	100%
<a href="#">Early Childhood Education for Low Income 3- and 4-Year Olds</a>	April 2012	\$22,457	\$6,802	\$15,655	(\$7,523)	\$14,934	\$2.99	100%
<a href="#">K-12 Tutoring by Peers</a>	April 2012	\$12,273	\$2,904	\$9,369	(\$1,016)	\$11,257	\$12.08	100%
<a href="#">Tutoring (vs. No Tutoring) for English Language Learner Students</a>	April 2012	\$10,938	\$2,598	\$8,341	(\$1,362)	\$9,576	\$8.03	85%
<a href="#">Special Literacy Instruction for English Language Learner Students</a>	April 2012	\$6,969	\$1,652	\$5,317	(\$282)	\$6,688	\$24.75	90%
<a href="#">K-12 Tutoring by Adults</a>	April 2012	\$6,683	\$1,586	\$5,097	(\$1,992)	\$4,691	\$3.36	93%
<a href="#">Teacher Induction Programs</a>	April 2012	\$3,648	\$866	\$2,783	(\$63)	\$3,585	\$57.79	88%
<a href="#">K-12 Parent Involvement Programs</a>	April 2012	\$3,575	\$850	\$2,725	(\$836)	\$2,739	\$4.28	68%
<a href="#">National Board for Professional Teaching Standards (NBPTS) Certification Bonuses</a>	April 2012	\$1,802	\$428	\$1,374	(\$69)	\$1,734	\$26.28	100%
<a href="#">Teacher Performance Pay Programs</a>	April 2012	\$295	\$69	\$225	(\$34)	\$261	\$8.62	63%
<a href="#">Additional Day of K-12 Instructional Time</a>	April 2012	\$86	\$20	\$65	(\$27)	\$59	\$3.18	59%
<a href="#">K-12 Educator Content-Specific Professional Development</a>	April 2012	\$19	\$4	\$14	(\$6)	\$12	\$3.01	52%
<a href="#">K-12 Educator Professional Development (Non-Content Specific)</a>	April 2012	(\$1)	(\$0)	(\$0)	(\$6)	(\$7)	(\$0.11)	48%
<a href="#">Even Start</a>	April 2012	(\$1,257)	(\$296)	(\$961)	(\$4,125)	(\$5,383)	(\$0.30)	14%
<a href="#">Early Head Start</a>	April 2012	\$2,264	\$1,516	\$748	(\$10,420)	(\$8,156)	\$0.22	17%
Pre-K to 12 education programs for which we have not calculated benefits and costs (at this time):								
<a href="#">Pre-K and Elementary Bilingual Instructional Programs (vs. English-based) for English Language Learners</a>	April 2012							See linked document for meta-analytic results.
<a href="#">K-12 Teachers—Impact of Having a Graduate Degree</a>	April 2012							See linked document for meta-analytic results.
<a href="#">K-12 Teachers—Impact of Having an In-subject Graduate Degree</a>	April 2012							See linked document for meta-analytic results.
<a href="#">K-12 Teachers—Effectiveness by Years of Experience</a>	April 2012							See linked document for meta-analytic results.
<a href="#">First Step</a>	March 2007							See previous WSIPP <a href="#">publication</a> for past findings.
<a href="#">Full Day vs. Half-day</a>	March 2007							See previous WSIPP <a href="#">publication</a> for past findings.
<a href="#">Reduced Pre-Student Expenditures</a>	December 2007							See previous WSIPP <a href="#">publication</a> for past findings.

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		Total Benefits	Taxpayer	Non-Taxpayer		Benefits Minus Costs (net present value)	Benefit to Cost Ratio <sup>1</sup>	Measured Risk (odds of a positive net present value)
<b>Children's Mental Health</b>								
<a href="#"><u>Cognitive Behavioral Therapy (CBT)-Based Models for Child Trauma</u></a>	April 2012	\$8,929	\$2,779	\$6,151	\$317	\$9,246	n/e	100%
<a href="#"><u>Remote Cognitive Behavioral Therapy (CBT) for Anxious Children</u></a>	April 2012	\$7,653	\$2,265	\$5,388	\$741	\$8,393	n/e	96%
<a href="#"><u>Group Cognitive Behavioral Therapy (CBT) for Anxious Children</u></a>	April 2012	\$7,247	\$2,143	\$5,104	\$393	\$7,640	n/e	98%
<a href="#"><u>Individual Cognitive Behavioral Therapy (CBT) for Anxious Children</u></a>	April 2012	\$7,337	\$2,170	\$5,166	(\$734)	\$6,603	\$10.00	95%
<a href="#"><u>Eye Movement Desensitization and Reprocessing (EMDR) for Child Trauma</u></a>	April 2012	\$5,804	\$1,815	\$3,989	\$155	\$5,959	n/e	79%
<a href="#"><u>Parent Cognitive Behavioral Therapy (CBT) for Anxious Young Children</u></a>	April 2012	\$3,291	\$998	\$2,293	\$608	\$3,899	n/e	81%
<a href="#"><u>Cognitive Behavioral Therapy (CBT) for Depressed Adolescents</u></a>	April 2012	\$3,441	\$1,022	\$2,419	(\$484)	\$2,957	\$7.11	99%
<a href="#"><u>Brief Strategic Family Therapy (BSFT)</u></a>	April 2012	\$3,112	\$965	\$2,147	(\$512)	\$2,601	\$6.08	69%
<a href="#"><u>Parent Child Interaction Therapy (PCIT) for Children with Disruptive Behavior Problems</u></a>	April 2012	\$3,385	\$1,120	\$2,265	(\$1,335)	\$2,049	\$2.53	100%
<a href="#"><u>Triple P Positive Parenting Program: Level 4, Individual</u></a>	April 2012	\$3,621	\$1,195	\$2,426	(\$1,833)	\$1,788	\$1.98	92%
<a href="#"><u>Triple P Positive Parenting Program: Level 4, Group</u></a>	April 2012	\$2,112	\$696	\$1,416	(\$375)	\$1,737	\$5.63	100%
<a href="#"><u>Multisystemic Therapy (MST) for Youth with Serious Emotional Disturbance (SED)</u></a>	April 2012	\$7,443	\$2,885	\$4,558	(\$6,501)	\$942	\$1.14	68%
<a href="#"><u>Behavioral Parent Training (BPT) for Children with Disruptive Behavior Disorders</u></a>	April 2012	\$768	\$252	\$516	\$105	\$873	n/e	68%
<a href="#"><u>Families and Schools Together (FAST)</u></a>	April 2012	\$2,610	\$775	\$1,834	(\$1,759)	\$851	\$1.48	52%
<a href="#"><u>Behavioral Parent Training (BPT) for Children with ADHD</u></a>	April 2012	\$430	\$126	\$304	\$106	\$536	n/e	98%
<a href="#"><u>Incredible Years: Parent Training</u></a>	April 2012	\$2,482	\$797	\$1,685	(\$2,074)	\$408	\$1.20	61%
<a href="#"><u>Incredible Years: Parent Training + Child Training</u></a>	April 2012	\$2,429	\$774	\$1,655	(\$2,135)	\$295	\$1.14	59%
<a href="#"><u>Multimodal Therapy (MMT) for Children with Disruptive Behavior</u></a>	April 2012	\$656	\$222	\$435	(\$1,274)	(\$617)	\$0.52	42%
<a href="#"><u>Cognitive Behavioral Therapy (CBT) for Children with ADHD</u></a>	April 2012	(\$37)	(\$8)	(\$28)	(\$985)	(\$1,021)	(\$0.04)	3%
<a href="#"><u>Multimodal Therapy (MMT) for Children with ADHD</u></a>	April 2012	\$1,749	\$440	\$1,309	(\$8,343)	(\$6,593)	\$0.21	11%
Children's mental health programs for which we have not calculated benefits and costs (at this time):								
Intensive Case Management (Wraparound) for youth with Emotional Disturbance	July 2008	See previous WSIPP <a href="#">publication</a> for past findings.						
<b>General Prevention Programs for Children and Adolescents</b>								
<a href="#"><u>Youth Mentoring Programs (taxpayer costs only)</u></a>	April 2012	\$7,207	\$1,958	\$5,249	(\$1,479)	\$5,728	\$4.87	61%
<a href="#"><u>Good Behavior Game</u></a>	April 2012	\$4,790	\$1,337	\$3,454	(\$154)	\$4,637	\$31.19	100%
<a href="#"><u>Quantum Opportunities Program</u></a>	April 2012	\$30,311	\$8,737	\$21,574	(\$25,743)	\$4,568	\$1.18	60%
<a href="#"><u>Youth Mentoring Programs</u></a>	April 2012	\$8,333	\$2,348	\$5,985	(\$4,799)	\$3,534	\$1.74	58%
<a href="#"><u>Seattle Social Development Project</u></a>	April 2012	\$5,804	\$1,686	\$4,118	(\$3,026)	\$2,779	\$1.92	59%
<a href="#"><u>Guiding Good Choices</u></a>	April 2012	\$2,540	\$598	\$1,942	(\$870)	\$1,670	\$2.92	85%
<a href="#"><u>Behavioral Monitoring and Reinforcement Program</u></a>	April 2012	\$1,995	\$531	\$1,463	(\$1,276)	\$719	\$1.56	58%
<a href="#"><u>Promoting Alternative Thinking Strategies (PATHS)</u></a>	April 2012	(\$19)	(\$6)	(\$13)	(\$115)	(\$134)	(\$0.17)	23%
<a href="#"><u>Strengthening Families for Parents and Youth 10-14</u></a>	April 2012	\$696	\$213	\$483	(\$1,077)	(\$381)	\$0.65	7%
<a href="#"><u>Children's Aid Society--Carrera</u></a>	April 2012	\$7,184	\$2,381	\$4,802	(\$14,220)	(\$7,036)	\$0.51	37%
<a href="#"><u>CASASTART</u></a>	April 2012	(\$1,574)	(\$385)	(\$1,188)	(\$6,806)	(\$8,380)	(\$0.23)	0%
<a href="#"><u>Fast Track prevention program</u></a>	April 2012	\$1,953	\$450	\$1,503	(\$58,747)	(\$56,794)	\$0.03	0%

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		<b>Total Benefits</b>	<b>Taxpayer</b>	<b>Non-Taxpayer</b>		<b>Benefits Minus Costs (net present value)</b>	<b>Benefit to Cost Ratio<sup>1</sup></b>	<b>Measured Risk (odds of a positive net present value)</b>
<b>Substance Abuse</b>								
<a href="#">Motivational Interviewing / Motivational Enhancement Therapy for Alcohol Abuse</a>	April 2012	\$9,164	\$1,926	\$7,238	(\$206)	\$8,957	\$44.38	100%
<a href="#">Motivational Interviewing / Motivational Enhancement Therapy for Smoking</a>	April 2012	\$7,949	\$295	\$7,654	(\$206)	\$7,743	\$38.49	99%
<a href="#">Brief Alcohol Screening and Intervention for College Students (BASICS)</a>	April 2012	\$3,110	\$771	\$2,339	(\$226)	\$2,883	\$13.75	97%
<a href="#">Motivational Interviewing / Motivational Enhancement Therapy for Cannabis Abuse</a>	April 2012	\$2,388	\$691	\$1,697	(\$206)	\$2,182	\$11.58	100%
<a href="#">Motivational Interviewing / Motivational Enhancement Therapy for Illicit Drug Abuse</a>	April 2012	\$2,023	\$593	\$1,430	(\$207)	\$1,816	\$9.78	97%
<a href="#">Life Skills Training</a>	April 2012	\$1,290	\$289	\$1,001	(\$34)	\$1,256	\$37.52	100%
<a href="#">Project Towards No Drug Abuse (TND)</a>	April 2012	\$123	\$31	\$92	(\$14)	\$109	\$8.61	76%
<a href="#">Project STAR</a>	April 2012	\$582	\$151	\$431	(\$489)	\$93	\$1.19	71%
<a href="#">Project ALERT</a>	April 2012	\$7	\$2	\$5	(\$145)	(\$138)	\$0.05	1%
Substance abuse prevention and treatment programs for which we have not calculated benefits and costs (at this time):								
All Stars	July 2004	See previous WSIPP <a href="#">publication</a> for past findings.						
DARE	July 2004	See previous WSIPP <a href="#">publication</a> for past findings.						
Minnesota Smoking Prevention Program	July 2004	See previous WSIPP <a href="#">publication</a> for past findings.						
Project Northland	July 2004	See previous WSIPP <a href="#">publication</a> for past findings.						
Project Towards No Tobacco Use	July 2004	See previous WSIPP <a href="#">publication</a> for past findings.						
<b>Adult Mental Health</b>								
<a href="#">Cognitive Behavioral Therapy (CBT) for Adult Anxiety</a>	April 2012	\$17,731	\$4,938	\$12,793	(\$341)	\$17,390	\$52.01	97%
<a href="#">Cognitive Behavioral Therapy (CBT) for Adult Depression</a>	April 2012	\$15,632	\$4,619	\$11,013	(\$227)	\$15,405	\$68.90	100%
Adult mental health treatment programs for which we have not calculated benefits and costs (at this time):								
Day PE program for Seriously Ill Adults		Review in process.						
Enhance Behavioral Therapy		Review in process.						
Enhance the Post-Traumatic Stress Disorder		Review in process.						
Eye Movement Desensitization and Reprocessing		Review in process.						
Primary Care Interventions for Depression		Review in process.						
<b>Public Health</b>								
See Technical Appendix I for meta-analytic results for prevention programs targeting teen pregnancy and obesity. We have not have not completed our computation of benefits and costs for these programs.								
<b>Teen Pregnancy Prevention:</b>								
<a href="#">Postponing Sexual Involvement</a>	April 2012	See linked document for meta-analytic results.						
<a href="#">School-Based Service Learning</a>	April 2012	See linked document for meta-analytic results.						
<a href="#">School-based Sexual Education</a>	April 2012	See linked document for meta-analytic results.						
<a href="#">Teen Outreach Program</a>	April 2012	See linked document for meta-analytic results.						
<a href="#">Adolescent Sibling Pregnancy Prevention</a>	April 2012	See linked document for meta-analytic results.						
<b>Obesity Prevention:</b>								
<a href="#">School programs for healthy eating to prevent obesity</a>	April 2012	See linked document for meta-analytic results.						
<a href="#">School programs for physical activity to prevent obesity</a>	April 2012	See linked document for meta-analytic results.						
<a href="#">School programs for healthy eating &amp; physical activity to prevent obesity</a>	April 2012	See linked document for meta-analytic results.						
Obesity prevention programs for which we have not calculated meta-analytic results (at this time):								
Early child care centers & home's nutrition & physical activity programs		Too few rigorous evaluations.						
Taxes on sweetened beverages and snack food		Too few rigorous evaluations.						
Nutrition labeling on menus & posting nutritional information		Too few rigorous evaluations.						

**Exhibit 1**

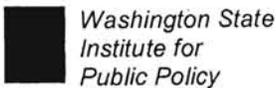
**Monetary Benefits and Costs of Evidence-Based Public Policies**

*Summary of policy topics assigned to the Washington State Institute for Public Policy by the Washington State Legislature  
Estimates for Washington State, as of April 2012*

<b>Topic Area/Program</b> Benefits and costs are life-cycle present-values per participant, in 2011 dollars. The programs are listed by major topic area, although some programs achieve benefits in multiple areas. Also, some programs achieve benefits that we cannot monetize; see linked documents for program-specific details.	<b>Last Updated</b>	<b>Monetary Benefits</b>			<b>Costs</b>	<b>Summary Statistics</b>		
		<b>Total Benefits</b>	<b>Taxpayer</b>	<b>Non-Taxpayer</b>		<b>Benefits Minus Costs</b> (net present value)	<b>Benefit to Cost Ratio<sup>1</sup></b>	<b>Measured Risk</b> (odds of a positive net present value)
<b>Housing</b>								
See Technical Appendix I for meta-analytic results for housing programs for offenders returning to the community and adults with mental illness. We have not completed our computation of benefits and costs for these programs.								
<a href="#">Housing Supports for Offenders Returning to the Community</a>	April 2012							See linked document for meta-analytic results.
<a href="#">Housing Support for Adults With Mental Illness</a>	April 2012							See linked document for meta-analytic results.
<a href="#">Housing Supports for Serious Violent Offenders</a>	April 2012							See linked document for meta-analytic results.
<b>Notes to Exhibit 1</b>								
<sup>1</sup> Benefit to cost ratios cannot be computed in every case; we list "n/e" for those that cannot be reliably estimated.								
<sup>2</sup> Institutions = state institutionalized juvenile justice populations								

For further information, contact Stephanie Lee at [slee@wsipp.wa.gov](mailto:slee@wsipp.wa.gov)

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The Washington State Legislature created the Washington State Institute for Public Policy in 1983. A Board of Directors—representing the legislature, the governor, and public universities—governs the Institute and guides the development of all activities. The Institute's mission is to carry out practical research, at legislative direction, on issues of importance to Washington State.

## **APPENDIX B**

January 2006

## EVIDENCE-BASED ADULT CORRECTIONS PROGRAMS: WHAT WORKS AND WHAT DOES NOT<sup>‡</sup>

In recent years, public policy decision-makers throughout the United States have expressed interest in adopting "evidence-based" criminal justice programs. Similar to the pursuit of evidence-based medicine, the goal is to improve the criminal justice system by implementing programs and policies that have been shown to work. Just as important, research findings can be used to eliminate programs that have failed to produce desired outcomes. Whether for medicine, criminal justice, or other areas, the watchwords of the evidence-based approach to public policy include: outcome-based performance, rigorous evaluation, and a positive return on taxpayer investment.

This report to the Washington State Legislature summarizes our latest review of evidence-based adult corrections programs. We previously published a review on this topic in 2001.<sup>1</sup> In this study, we update and significantly extend our earlier effort.

The overall goal of this research is to provide Washington State policymakers with a comprehensive assessment of adult corrections programs and policies that have a proven ability to affect crime rates.

We are publishing our findings in two installments. In this preliminary report, we provide a systematic review of the evidence on what works (and what does not) to reduce crime. In a subsequent final report, to be published in October 2006, we will extend this analysis to include a benefit-cost estimate for each option.

<sup>‡</sup> Suggested citation: Steve Aos, Marna Miller, and Elizabeth Drake. (2006). *Evidence-Based Adult Corrections Programs: What Works and What Does Not*. Olympia: Washington State Institute for Public Policy.

<sup>1</sup> S. Aos, P. Phipps, R. Barnoski, and R. Lieb (2001). *The Comparative Costs and Benefits of Programs to Reduce Crime*. Olympia: Washington State Institute for Public Policy.

### Summary

**This study provides a comprehensive review of evidence-based programs for adult offenders. We asked a simple question: What works, if anything, to lower the criminal recidivism rates of adult offenders? To provide an answer, we systematically reviewed the evidence from 291 rigorous evaluations conducted throughout the United States and other English-speaking countries during the last 35 years.**

**We find that some types of adult corrections programs have a demonstrated ability to reduce crime, but other types do not. The implication is clear: Washington's adult corrections system will be more successful in reducing recidivism rates if policy focuses on proven evidence-based approaches.**

### **Washington's Offender Accountability Act**

This research was undertaken as part of our evaluation of Washington's Offender Accountability Act (OAA). Passed in 1999, the OAA affects how the state provides community supervision to adult felony offenders. In broad terms, the OAA directs the Washington State Department of Corrections to do two things:

- 1) Classify felony offenders according to their risk for future offending as well as the amount of harm they have caused society in the past; and
- 2) Deploy more staff and rehabilitative resources to higher-classified offenders and—because budgets are limited—spend correspondingly fewer dollars on lower-classified offenders.

When the Legislature enacted the OAA, it defined a straight-forward goal for the Act: to "reduce the risk of reoffending by offenders in the community."<sup>2</sup> To determine whether the OAA results in lower recidivism rates, the Legislature also directed the Washington State Institute for Public Policy (Institute) to evaluate the impact of the Act.<sup>3</sup>

Whether the OAA is able to affect crime rates will depend, in part, on the policy and programming choices made to implement the Act. As we show in this report, there are some adult corrections programs that have a demonstrated ability to reduce crime, but there are other types of programs that fail to affect crime rates. Given these mixed results, it is reasonable to conclude that the OAA (or any other adult corrections policy initiative) will be successful in reducing crime only if it encourages the implementation of effective approaches and discourages the use of ineffective programs. The purpose of this report is to assist policymakers in sorting through the many evidence-based choices.

### **The Evidence-Based Review: The Basic Question**

The goal of the present study is to answer a simple question: Are there any adult corrections programs that work? Additionally, in order to estimate costs and benefits, we seek to estimate the magnitude of the crime reduction effect of each option.

To answer these fundamental questions, we conducted a comprehensive statistical review of all program evaluations conducted over the last 40 years in the United States and other English-speaking countries. As we describe, we found 291 evaluations of individual adult corrections programs with sufficiently rigorous research to be included in our analysis. These evaluations were of many types of programs—drug courts, boot camps, sex offender treatment programs, and correctional industries employment programs, to name a few.

It is important to note that only a few of these 291 evaluations were of Washington State adult

corrections programs; rather, almost all of the evaluations in our review were of programs conducted in other locations. A primary purpose of our study is to take advantage of all these rigorous evaluations and, thereby, learn whether there are conclusions that can allow policymakers in Washington to improve this state's adult criminal justice system.

### **Research Methods**

The research approach we employ in this report is called a "systematic" review of the evidence. In a systematic review, the results of *all* rigorous evaluation studies are analyzed to determine if, on average, it can be stated scientifically that a program achieves an outcome. A systematic review can be contrasted with a so-called "narrative" review of the literature where a writer selectively cites studies to tell a story about a topic, such as crime prevention. Both types of reviews have their place, but systematic reviews are generally regarded as more rigorous and, because they assess all available studies and employ statistical hypotheses tests, they have less potential for drawing biased or inaccurate conclusions. Systematic reviews are being used with increased frequency in medicine, education, criminal justice, and many other policy areas.<sup>4</sup>

For this report, the outcome of legislative interest is crime reduction. In particular, since the programs we consider in this review are intended for adult offenders already in the criminal justice system, the specific outcome of interest is reduction in recidivism rates. Therefore, the research question is straightforward: *What works, if anything, to lower the recidivism rates of adult offenders?*

As we describe in the Appendix, we only include rigorous evaluation studies in our review. To be included, an evaluation must have a non-treatment comparison group that is well matched to the treatment group.

<sup>2</sup> RCW 9.94A.010.

<sup>3</sup> The Institute's first five publications on the Offender Accountability Act are available for downloading at the Institute's website: [www.wsipp.wa.gov](http://www.wsipp.wa.gov). The final OAA report is due in 2010.

<sup>4</sup> An international effort aimed at organizing systematic reviews is the Campbell Collaborative—a non-profit organization that supports systematic reviews in the social, behavioral, and educational arenas. See: <http://www.campbellcollaboration.org>.

Researchers have developed a set of statistical tools to facilitate systematic reviews of the evidence. The set of procedures is called "meta-analysis," and we employ that methodology in this study.<sup>5</sup> In the Technical Appendix to this report (beginning on page 9) we list the specific coding rules and statistical formulas we use to conduct the analysis—technical readers can find a full description of our methods and detailed results.

## Findings

The findings from our systematic review of the adult corrections evaluation literature are summarized on Exhibit 1.<sup>6</sup> We show the expected percentage change in recidivism rates for many types of evaluated adult corrections programs. A zero percent change means that, based on our review, a program does not achieve a statistically significant change in recidivism rates compared with treatment as usual.

We found a number of adult corrections programs that have a demonstrated ability to achieve reductions in recidivism rates. We also found other approaches that do not reduce recidivism. Thus, the first basic lesson from our evidence-based review is that some adult corrections programs work and some do not. A direct implication from these mixed findings is that a corrections policy that reduces recidivism will be one that focuses resources on effective evidence-based programming and avoids ineffective approaches.

As an example of the information on Exhibit 1, we analyzed the findings from 25 well-researched cognitive-

<sup>5</sup> We follow the meta-analytic methods described in: M. W. Lipsey and D. Wilson (2001). *Practical meta-analysis*. Thousand Oaks: Sage Publications.  
<sup>6</sup> Technical meta-analytical results are presented in Exhibit 2.

<b>Exhibit 1</b>		
<b>Adult Corrections: What Works?</b>		
<b>Estimated Percentage Change in Recidivism Rates (and the number of studies on which the estimate is based)</b>		
<p><b>Example of how to read the table:</b> an analysis of 56 adult drug court evaluations indicates that drug courts achieve, on average, a statistically significant 10.7 percent reduction in the recidivism rates of program participants compared with a treatment-as-usual group.</p>		
<b>Programs for Drug-Involved Offenders</b>		
Adult drug courts	-10.7%	(56)
In-prison "therapeutic communities" with community aftercare	-6.9%	(6)
In-prison "therapeutic communities" without community aftercare	-5.3%	(7)
Cognitive-behavioral drug treatment in prison	-6.8%	(8)
Drug treatment in the community	-12.4%	(5)
Drug treatment in jail	-6.0%	(9)
<b>Programs for Offenders With Co-Occurring Disorders</b>		
Jail diversion (pre- and post-booking programs)	0.0%	(11)
<b>Programs for the General Offender Population</b>		
General and specific cognitive-behavioral treatment programs	-8.2%	(25)
<b>Programs for Domestic Violence Offenders</b>		
Education/cognitive-behavioral treatment	0.0%	(9)
<b>Programs for Sex Offenders</b>		
Psychotherapy for sex offenders	0.0%	(3)
Cognitive-behavioral treatment in prison	-14.9%	(5)
Cognitive-behavioral treatment for low-risk offenders on probation	-31.2%	(6)
Behavioral therapy for sex offenders	0.0%	(2)
<b>Intermediate Sanctions</b>		
Intensive supervision: surveillance-oriented programs	0.0%	(24)
Intensive supervision: treatment-oriented programs	-21.9%	(10)
Adult boot camps	0.0%	(22)
Electronic monitoring	0.0%	(12)
Restorative justice programs for lower-risk adult offenders	0.0%	(6)
<b>Work and Education Programs for the General Offender Population</b>		
Correctional industries programs in prison	-7.8%	(4)
Basic adult education programs in prison	-5.1%	(7)
Employment training and job assistance in the community	-4.8%	(16)
Vocational education in prison	-12.6%	(3)
<b>Program Areas in Need of Additional Research &amp; Development</b>		
<i>(The following types of programs require additional research before it can be concluded that they do or do not reduce adult recidivism rates)</i>		
Case management in the community for drug offenders	0.0%	(12)
"Therapeutic community" programs for mentally ill offenders	-27.4%	(2)
Faith-based programs	0.0%	(5)
Domestic violence courts	0.0%	(2)
Intensive supervision of sex offenders in the community	0.0%	(4)
Mixed treatment of sex offenders in the community	0.0%	(2)
Medical treatment of sex offenders	0.0%	(1)
COSA (Faith-based supervision of sex offenders)	-31.6%	(1)
Regular parole supervision vs. no parole supervision	0.0%	(1)
Day fines (compared to standard probation)	0.0%	(1)
Work release programs	-5.6%	(4)

behavioral treatment programs for general adult offenders. We found that, on average, these programs can be expected to reduce recidivism rates by 8.2 percent. That is, without a cognitive-behavioral program we expect that about 49 percent of these offenders will recidivate with a new felony conviction after an eight-year follow-up. With a cognitive-behavioral treatment program, we expect the recidivism probability to drop four points to 45 percent—an 8.2 percent reduction in recidivism rates.

It is important to note that even relatively small reductions in recidivism rates can be quite cost-beneficial. For example, a 5 percent reduction in the reconviction rates of high risk offenders can generate significant benefits for taxpayers and crime victims. Moreover, a program that has no statistically significant effect on recidivism rates can be cost-beneficial if the cost of the program is less than the cost of the alternative. Jail diversion programs are examples of this; even if research demonstrates that diversion programs have no effect on recidivism, the programs may still be economically attractive if they cost less than avoided jail costs. In the final version of this report, to be delivered to the Legislature in October 2006, we will present full benefit-cost estimates for each of the programs shown in Exhibit 1.<sup>7</sup>

### Findings by Type of Program

We organized our review of the adult corrections evidence base into eight categories of correctional programming (as shown in Exhibit 1). A brief discussion of our findings for each of these categories follows.

**Programs for Drug-Involved Offenders.** We analyzed 92 rigorous evaluations of drug treatment programs. These programs are for drug-involved adult offenders in a variety of prison and community settings. We found that, on average, drug treatment leads to a statistically significant reduction in criminal recidivism rates. We examined adult drug courts, in-prison therapeutic communities, and other types of drug

treatment including cognitive-behavioral approaches.

*Adult Drug Courts.* Specialized courts for drug-involved offenders have proliferated throughout the United States, and there are several adult drug courts in Washington. We found 56 evaluations with sufficient rigor to be included in our statistical review. We conclude that drug courts achieve, on average, a statistically significant 10.7 percent reduction in the recidivism rates of program participants relative to treatment-as-usual comparison groups.

*In-Prison Therapeutic Communities.* Programs for drug offenders in a prison or jail setting are typically called “therapeutic communities” when they contain separate residential units for the offenders and when they follow group-run principles of organizing and operating the drug-free unit. Some evaluations of the effectiveness of in-prison therapeutic community programs have also included community-based aftercare for offenders once they leave incarceration. Based on our review of the evaluation literature, we found that the average therapeutic community reduces recidivism by 5.3 percent. The community aftercare component, however, produces only a modest additional boost to program effectiveness—to a 6.9 percent reduction. Thus, most of the recidivism reduction effect appears to stem from the prison-based therapeutic community experience for these offenders.

*Other Types of Drug Treatment.* As shown in Exhibit 1, we also studied the effects of three other types of drug treatment modalities: prison-based drug treatment that employs a cognitive-behavioral approach, general drug treatment approaches in the community, and general drug treatment programs in local jails. We found that each of these approaches achieve, on average, a statistically significant reduction in recidivism.

**Jail Diversion Programs for Offenders With Mental Illness and Co-Occurring Disorders.** There is young but growing research literature testing the effectiveness of jail diversion programs for mentally ill adults and for offenders with co-occurring mental health and substance abuse disorders. Some of these are pre-booking programs implemented by the police, and some are post-booking programs implemented by court personnel, such as mental health courts. We found 11 evaluations with sufficient research rigor

<sup>7</sup> An overview of what will be included in the October 2006 report can be found at [www.wsipp.wa.gov/](http://www.wsipp.wa.gov/) Steve Aos (2006). *Options to Stabilize Prison Populations in Washington State. Interim Report*, Olympia, Washington State Institute for Public Policy.

to be included in our review. Eight of these programs were part of a recent federally-funded effort (Broner et al., 2004). On average, these approaches have not demonstrated a statistically significant reduction in the recidivism rates of program participants. This null finding does not mean the programs are not valuable; since they are typically designed to divert offenders from costly sentences in local jails, they may save more money than the programs cost. As mentioned earlier, we will review the economics of all programs in the present study in our October 2006 final report.

### **Treatment Programs for the General Offender Population.**

Cognitive-Behavioral Treatment. We found 25 rigorous evaluations of programs for the general offender population that employ cognitive-behavioral treatment. This type of group therapy addresses the irrational thoughts and beliefs that lead to anti-social behavior. The programs are designed to help offenders correct their thinking and provide opportunities to model and practice problem-solving and pro-social skills. On average, we found these programs significantly reduce recidivism by 8.2 percent. We identified three well-defined programs that provide manuals and staff training regimens: *Reasoning and Rehabilitation (R&R)*, *Moral Reconation Therapy (MRT)*, and *Thinking for a Change (T4C)*. Effects of R&R and MRT are significant and similar to each other and to the other cognitive-behavioral treatment programs in our review. Only a single evaluation of T4C is currently available. Since, on average, all of these programs produce similar results, we recommend the state choose any of the three well-defined programs for implementation in Washington.

### **Programs for Domestic-Violence Offenders**

Education/Cognitive-Behavioral Treatment. Treatment programs for domestic violence offenders most frequently involve an educational component focusing on the historical oppression of women and cognitive-behavioral treatment emphasizing alternatives to violence. Treatment is commonly mandated by the court. Based on our review of nine rigorous evaluations, domestic violence treatment programs have yet, on average, to demonstrate reductions in recidivism.

**Programs for Sex Offenders.**<sup>8</sup> We found 18 well-designed evaluations of treatment programs for sex offenders. Some of these programs are located in a prison setting and some are in the community. Sex offenders sentenced to prison are typically convicted of more serious crimes than those sentenced to probation. We found that cognitive-behavioral treatments are, on average, effective at reducing recidivism, but other types of sex offender treatment fail to demonstrate significant effects on further criminal behavior.

Psychotherapy/Counseling for Sex Offenders.<sup>9</sup> These programs involve insight-oriented individual or group therapy or counseling. We found only three rigorous studies of this approach to treatment. The results indicate that this approach does not reduce recidivism in sex offenders.

Cognitive-Behavioral Treatment of Sex Offenders in Prison. Sex offenders sentenced to prison are typically convicted of more serious crimes than those sentenced to probation. We examined five rigorous studies of these specialized cognitive-behavioral programs that may also include behavioral reconditioning to discourage deviant arousal, and modules addressing relapse prevention. Among the five programs in this category was a randomized trial<sup>10</sup> with an eight-year follow-up showing small but non-significant effects on recidivism. On average across all five studies, however, we found that cognitive-behavioral therapy for sex offenders in prison significantly reduces recidivism by 14.9 percent.

Cognitive-Behavioral Treatment of Low-Risk Sex Offenders on Probation. Offenders sentenced to probation have usually been convicted of less serious crimes than sex offenders sentenced to prison. Cognitive-behavioral programs for sex offenders on probation are similar to the programs in prisons, and may also incorporate behavioral reconditioning and relapse prevention. We found six rigorous studies and conclude that cognitive-

<sup>8</sup> The categories of sex offender treatment listed here are based on those outlined in two recent reviews of sex offender treatment literature: R. K. Hanson, A. Gordon, A. J. Harris, J. K. Marques, W. Murphy, V. L. Quinsey, and M. C. Seto (2002). First report of the collaborative outcome data project on the effectiveness of psychological treatment for sex offenders, *Sexual Abuse: A Journal of Research and Treatment*, 14(2): 169-194; F. Losel, and M. Schmucker (2005). The effectiveness of treatment for sexual offenders: A comprehensive meta-analysis, *Journal of Experimental Criminology*, 1: 117-146

<sup>9</sup> Psychotherapy and counseling are not currently used as stand-alone treatment for sex offenders (Hanson, et al., 2002).

<sup>10</sup> J. K. Marques, M. Wiederanders, D. M. Day, C. Nelson, and A. van Ommeren (2005). Effects of a relapse prevention program on sexual recidivism: Final results from California's Sex Offender Treatment and Evaluation Project (SOTEP), *Sexual Abuse: A Journal of Research and Treatment*, 17(1): 79-107.

behavioral therapy for sex offenders on probation significantly reduces recidivism. As a group, these programs demonstrated the largest effects observed in our analysis.

*Behavioral Treatment of Sex Offenders.* Behavioral treatments focus on reducing deviant arousal (using biofeedback or other conditioning) and increasing skills necessary for social interaction with age appropriate individuals. The two rigorous studies of programs using only behavioral treatment failed to show reductions in recidivism.

**Intermediate Sanctions.** In the 1980s and 1990s a number of sanctioning and sentencing alternatives were proposed and evaluated. Interest in developing additional alternatives continues. We found studies that center on five types of these "intermediate" sanctions.

*Intensive Supervision With and Without a Focus on Treatment.* We found 24 evaluations of intensive community supervision programs where the focus was on offender monitoring and surveillance. These programs are usually implemented by lowering the caseload size of the community supervision officer. This approach to offender management has not, on average, produced statistically significant reductions in recidivism rates. On the other hand, intensive supervision programs where the focus is on providing treatment services for the offenders have produced significant reductions; we found 10 well-researched evaluations of treatment-oriented intensive supervision programs that on average produced considerable recidivism reductions. The lesson from this research is that it is the treatment—not the intensive monitoring—that results in recidivism reduction.

*Adult Boot Camps.* Boot camps are intensive regimens of training, drilling, and some treatment. We found 24 rigorous evaluations of adult boot camps and, on average, they do not produce a statistically significant reduction in re-offense rates. As with our comment on jail diversion programs, however, it is possible that boot camps are economically attractive if they cost less to run than the alternative. Our October 2006 report will analyze the economics of adult boot camps.

*Electronic Monitoring.* Supervision of offenders in the community that is aided with electronic monitoring devices has been the focus of some rigorous evaluation efforts. We found 12 control-group studies; on average they indicate that electronic monitoring does not reduce recidivism.

*Restorative Justice for Lower-Risk Adult Offenders.* Restorative justice approaches have been tried for both juvenile and adult offenders. Offenders placed in restorative justice programs are often, but not always, lower risk compared with offenders processed through the usual court procedures. Restorative justice typically involves a form of victim-offender mediation, family group conferences, or restitution. We found six rigorous evaluations of these programs for adult offenders. On average, they did not result in lower recidivism rates. Our October 2006 report will also report on restorative justice programs for juvenile offenders. Unlike our findings for the restorative justice programs for adult offenders, our preliminary findings indicate that restorative justice programs do achieve significant reductions in recidivism rates of lower-risk juvenile offenders.

**Work and Education Programs for General Offenders.** We found 30 rigorous evaluations of programs that attempt to augment the educational, vocational, and job skills of adult offenders. Some of these programs are for offenders in prison and some are in community settings. On average, we found that employment- and education-related programs lead to modest but statistically significant reductions in criminal recidivism rates. We examined the following five categories of these programs.

*In-prison Correctional Industries Program.* Most states run in-prison correctional industries programs, yet only a few have been evaluated rigorously. We located only four outcome evaluations of correctional industries programs. On average, these programs produce a statistically significant reduction in recidivism rates. Our updated economic analysis of this finding will be presented in October 2006.

*Basic Adult Education Programs in Prison.* We found seven rigorous evaluations of programs that teach remedial educational skills to adult offenders when they are in prison. On average, these programs reduce the recidivism rates of program participants.

*Employment Training and Job Assistance Programs in the Community.* We analyzed the results of 16 rigorous evaluations of community-based employment training, job search, and job assistance programs for adult offenders. These programs produce a modest but statistically significant reduction in recidivism.

Vocational Education Programs in Prison. We found only three quality studies of vocational training programs for offenders while they are in prison. On average, the programs appear to reduce recidivism, but additional tests of this tentative finding is necessary.

**Programs Requiring Further Study.** In our review of the adult corrections literature, we were unable to draw conclusions about recidivism reduction for a number of programs. In Exhibit 1, we list these inconclusive findings at the bottom of the table. For each of these approaches, further research is required before even tentative conclusions can be drawn.<sup>11</sup>

Case Management in the Community for Drug Offenders. These types of programs typically involve an outside third-party agency that provides case coordination services and drug testing. The goal is to provide the coordination of other existing monitoring and treatment services for offenders in the community. We found 12 rigorous tests of this approach. Our statistical tests reveal that while, on average, these programs have no significant effect on recidivism, some case management programs do have an effect and some do not. This inconclusive result means that additional research is required on this class of programming in order to identify the aspects of case management that are effective or ineffective. In other words, additional research may indicate that some forms of case management reduce recidivism.<sup>12</sup>

"Therapeutic Community" Programs for Mentally Ill Offenders. A relatively new approach to providing treatment to mentally-ill offenders follows a modified version of the therapeutic community approach to drug offenders described earlier. This approach appears to show promise in reducing recidivism rates.

<sup>11</sup> Technical Note. As we explain in the technical appendix, we employ "fixed effects" and "random effects" modeling to derive meta-analytic estimates of program effectiveness. Sometimes, a collection of evaluations of similar programs has significant recidivism when judged with fixed effects modeling, but the same set of programs has insignificant findings when a random effects model is used. This situation provides an indication that additional meta-analytic research is needed to identify the factors that produced the heterogeneity in the outcomes. Several of the programs listed here fall into this category. For more information, see the technical appendices.

<sup>12</sup> As a technical note, Exhibit 2 shows that case management services produce a marginally significant ( $p=.114$ ) effect on recidivism in a fixed effects model but the model indicates significant ( $p=.000$ ) heterogeneity. The random effects model indicates non-significance ( $p=.48$ ). Thus, a multivariate meta-analysis of this literature may isolate the factors that were associated with successful approaches among the 12 studies.

However, this is based on only two rigorous studies, and they involved small samples of offenders. Thus, this is an approach that requires additional research.

Faith-Based Programs. These Christian-based programs provide religious ministry, including bible study, to offenders in prison and/or when offenders re-enter the community. The faith-based offender programs that have been evaluated to date do not significantly reduce recidivism.<sup>13</sup> Rigorous evaluations of faith-based programs are still relatively rare—we found only five thorough evaluations—and future studies may provide evidence of better outcomes.

Domestic Violence Courts. These specialized courts are designed to provide effective coordinated response to domestic violence. Domestic violence courts commonly bring together criminal justice and social service agencies and may mandate treatment for offenders. The two courts included here differed—one was exclusively for felony cases and the other for misdemeanors. In the misdemeanor court, recidivism was lowered, while the felony court observed increased recidivism. Thus, this is an area that requires additional research.

Intensive Supervision of Sex Offenders in the Community. The programs included in the analysis were all developed in Illinois and varied by county. All involve a specialized probation caseload, frequent face-to-face meetings with offenders, and home visits and inspections. Supervision programs may also include treatment. The recidivism results in the four counties vary widely, suggesting that some of the programs may be effective while others are not. Additional research is needed to identify these characteristics.

Mixed Treatment of Sex Offenders. Two rigorous studies evaluated community sex offender treatments employed across geographic areas (Washington State and British Columbia). In each case, the individual treatment programs varied widely. On average, these mixtures of treatments significantly reduced recidivism; however, while the treatments in Washington were significant and large, those in British Columbia were very small and non-significant. Controlling for the variation, the overall effect was zero.

<sup>13</sup> Similar findings were recently published in a review of faith-based prison programs: J. Burnside, N. Loucks, J. R. Addler, and G. Rose (2005). *My brother's keeper: Faith-based units in prison*, Cullompton, Devon, U.K.: Willan Publishing, p. 314.

Medical Treatment of Sex Offenders. Several medical approaches to treating sex offenders have been tried. These include castration and two types of hormonal therapy. Ethical considerations have made it difficult to conduct rigorous evaluations of these types of treatment. The single study we used in our analysis compared men who volunteered for castration to another group who volunteered but did not receive the surgery. Recidivism was significantly less among castrated offenders.

Circles of Support and Accountability (COSA/ Faith-Based Supervision of Sex Offenders). This program originated among members of the Mennonite church in Canada. Volunteers provide support to sex offenders being released from prison. Five lay volunteers visit or contact the offender every week. The volunteers are supported by community-based professionals, typically psychologists, law enforcement, correctional officers, or social service workers; the full circle meets weekly. The single evaluation of this program showed a significant reduction in recidivism of 31.6 percent.

Regular Parole Supervision vs. No Parole Supervision. The Urban Institute recently reported the results of a study that compared the recidivism rates of adult prisoners released from prison with parole to those released from prison without parole. The study used a large national database covering 15 states. It found no statistically significant effect of parole on recidivism. This null result is consistent with our results for surveillance-oriented intensive supervision programs versus regular levels of supervision (reported above). We would like to see additional treatment and comparison group tests of the parole vs. no-parole question before drawing firm conclusions.

Day Fines (compared with standard probation). We found one rigorous study of "day fines." These fines, which are more common in Europe than the United States, allow judges to impose fines that are commensurate with an offender's ability to pay and the seriousness of the offence. This approach has been evaluated for low-risk felony offenders and was used to divert these offenders from regular parole supervision. The approach had no effect on recidivism rates but additional research is needed to estimate whether this sentencing alternative is cost-beneficial.

Work Release Programs. We found only four quality studies of work release programs. While, on average, these programs appear to reduce recidivism, more rigorous outcome research is needed on this type of adult corrections program.

## Technical Appendices

**Appendix 1: Meta-Analysis Coding Criteria**

**Appendix 2: Procedures for Calculating Effect Sizes**

**Appendix 3: Institute Adjustments to Effect Sizes for Methodological Quality, Outcome Measure Relevance, and Researcher Involvement**

**Appendix 4: Meta-Analytic Results—Estimated Effect Sizes and Citations to Studies Used in the Analyses**

### Appendix 1: Meta-Analysis Coding Criteria

A meta-analysis is only as good as the selection and coding criteria used to conduct the study. The following are the key choices we made and implemented for this meta-analysis of adult corrections programs.

- 1. Study Search and Identification Procedures.** We searched for all adult corrections evaluation studies conducted since 1970. The studies had to be written in English. We used three primary means to identify and locate these studies: a) we consulted the study lists of other systematic and narrative reviews of the adult corrections research literature—there have been a number of recent reviews on particular topics; b) we examined the citations in the individual studies; and c) we conducted independent literature searches of research databases using search engines such as Google, Proquest, Ebsco, ERIC, and SAGE. As we describe, the most important inclusion criteria in our study was that an evaluation have a control or comparison group. Therefore, after first identifying all possible studies using these search methods, we attempted to determine whether the study was an outcome evaluation that had a comparison group. If a study met these criteria, we then secured a paper copy of the study for our review.
- 2. Peer-Reviewed and Other Studies.** We examined all program evaluation studies we could locate with these search procedures. Many of these studies were published in peer-reviewed academic journals, while many others were from government reports obtained from the agencies themselves. It is important to include non-peer reviewed studies, because it has been suggested that peer-reviewed publications may be biased to show positive program effects. Therefore, our meta-analysis included all available studies regardless of published source.
- 3. Control and Comparison Group Studies.** We only included studies in our analysis if they had a control or comparison group. That is, we did not include studies with a single-group, pre-post research design. This choice was made because we believe that it is only through rigorous comparison group studies that average treatment effects can be reliably estimated.
- 4. Exclusion of Studies of Program Completers Only.** We did not include a comparison study in our meta-analytic review if the treatment group was made up solely of program completers. We adopted this rule, because we believe there are too many significant unobserved self-selection factors that distinguish a program completer from a program dropout, and that these unobserved factors are likely to significantly bias estimated treatment effects. Some comparison group studies of program completers, however, contain information on program dropouts in addition to a comparison group. In these situations, we included the study if sufficient information was provided to allow us to reconstruct an intent-to-treat group that included both completers and non-completers, or if the demonstrated rate of program non-completion was very small (e.g. under 10 percent). In these cases, the study still needed to meet the other inclusion requirements listed here.
- 5. Random Assignment and Quasi- Experiments.** Random assignment studies were preferred for inclusion in our review, but we also included non-randomly assigned control groups. We only included quasi-experimental studies if, and only if, sufficient information was provided to demonstrate comparability between the treatment and comparison groups on important pre-existing conditions such as age, gender, and prior criminal history. Of the 291 individual studies in our review, about 20 percent were effects estimated from well implemented random assignment studies.
- 6. Enough information to Calculate an Effect Size.** Following the statistical procedures in Lipsey and Wilson (2001), a study had to provide the necessary information to calculate an effect size. If the necessary information was not provided, the study was not included in our review.
- 7. Mean-Difference Effect Sizes.** For this study we coded mean-difference effect sizes following the procedures in Lipsey and Wilson (2001). For dichotomous crime measures, we used the arcsine transformation to approximate the mean difference effect size, again following Lipsey and Wilson. We chose to use the mean-difference effect size rather than the odds ratio effect size because we frequently coded both dichotomous and continuous outcomes (odds ratio effect sizes could also have been used with appropriate transformations).
- 8. Unit of Analysis.** Our unit of analysis for this study was an independent test of a treatment in a particular site. Some studies reported outcome evaluation information for multiple sites; we included each site as an independent observation if a unique and independent comparison group was also used at each site.

9. **Multivariate Results Preferred.** Some studies presented two types of analyses: raw outcomes that were not adjusted for covariates such as age, gender, criminal history; and those that had been adjusted with multivariate statistical methods. In these situations, we coded the multivariate outcomes.
10. **Broadest Measure of Criminal Activity.** Some studies presented several types of crime-related outcomes. For example, studies frequently measured one or more of the following outcomes: total arrests, total convictions, felony arrests, misdemeanor arrests, violent arrests, and so on. In these situations, we coded the broadest crime outcome measure. Thus, most of the crime outcome measures that we coded in this analysis were total arrests and total convictions.
11. **Averaging Effect Sizes for Arrests and Convictions.** When a study reported both total arrests and total convictions, we calculated an effect size for each measure then took a simple average of the two effect sizes.
12. **Dichotomous Measures Preferred Over Continuous Measures.** Some studies included two types of measures for the same outcome: a dichotomous (yes/no) outcome and a continuous (mean number) measure. In these situations, we coded an effect size for the dichotomous measure. Our rationale for this choice is that in small or relatively small sample studies, continuous measures of crime outcomes can be unduly influenced by a small number of outliers, while dichotomous measures can avoid this problem. Of course, if a study only presented a continuous measure, then we coded the continuous measure.
13. **Longest Follow-Up Times.** When a study presented outcomes with varying follow-up periods, we generally coded the effect size for the longest follow-up period. The reason for this is that our intention for this analysis is to compute the long-run benefits and costs of different programs. The longest follow-up period allows us to gain the most insight into the long-run effect of these programs on criminality. Occasionally, we did not use the longest follow-up period if it was clear that a longer reported follow-up period adversely affected the attrition rate of the treatment and comparison group samples.
14. **Measures of New Criminal Activity.** Whenever possible, we excluded outcome measures that did not report on new criminal activity. For example, we avoided coding measure of technical violations of probation or parole. We do not think that technical violations are unimportant, but our purpose in this meta-analysis is to ascertain whether these programs affect new criminal activity.
15. **Some Special Coding Rules for Effect Sizes.** Most studies in our review had sufficient information to code exact mean-difference effect sizes. Some studies, however, reported some, but not all of the information required. The rules we followed for these situations are these:
  - a. **Two-Tail P-Values.** Some studies only reported p-values for significance testing of program outcomes. When we had to rely on these results, if the study reported a one-tail p-value, we converted it to a two-tail test.
  - b. **Declaration of Significance by Category.** Some studies reported results of statistical significance tests in terms of categories of p-values. Examples include:  $p \leq .01$ ,  $p \leq .05$ , or "non-significant at the  $p = .05$  level." We calculated effect sizes for these categories by using the highest p-value in the category. Thus if a study reported significance at " $p \leq .05$ ," we calculated the effect size at  $p = .05$ . This is the most conservative strategy. If the study simply stated a result was "non-significant," we computed the effect size assuming a p-value of .50 (i.e.  $p = .50$ ).

## Appendix 2: Procedures for Calculating Effect Sizes

Effect sizes measure the degree to which a program has been shown to change an outcome for program participants relative to a comparison group. There are several methods used by meta-analysts to calculate effect sizes, as described in Lipsey and Wilson (2001). In this, we use statistical procedures to calculate the *mean difference effect sizes* of programs. We did not use the odds-ratio effect size because many of the outcomes measured in this study are continuously measured. Thus, the mean difference effect size was a natural choice.

Many of the outcomes we record, however, are measured as dichotomies. For these yes/no outcomes, Lipsey and Wilson (2001) show that the mean difference effect size calculation can be approximated using the arcsine transformation of the difference between proportions.<sup>14</sup>

$$(A1) \quad ES_{m(p)} = 2 \times \arcsin \sqrt{P_e} - 2 \times \arcsin \sqrt{P_c}$$

In this formula,  $ES_{m(p)}$  is the estimated effect size for the difference between proportions from the research information;  $P_e$  is the percentage of the population that had an outcome such as re-arrest rates for the experimental or treatment group; and  $P_c$  is the percentage of the population that was re-arrested for the control or comparison group.

A second effect size calculation involves continuous data where the differences are in the means of an outcome. When an evaluation reports this type of information, we use the standard mean difference effect size statistic.<sup>15</sup>

<sup>14</sup> Lipsey and Wilson, *Practical meta-analysis*, Table B10, formula (22).

<sup>15</sup> *Ibid.*, Table B10, formula (1).

$$(A2) \quad ES_m = \frac{M_e - M_c}{\sqrt{\frac{SD_e^2 + SD_c^2}{2}}}$$

In this formula,  $ES_m$  is the estimated effect size for the difference between means from the research information;  $M_e$  is the mean number of an outcome for the experimental group;  $M_c$  is the mean number of an outcome for the control group;  $SD_e$  is the standard deviation of the mean number for the experimental group; and  $SD_c$  is the standard deviation of the mean number for the control group.

Often, research studies report the mean values needed to compute  $ES_m$  in (A2), but they fail to report the standard deviations. Sometimes, however, the research will report information about statistical tests or confidence intervals that can then allow the pooled standard deviation to be estimated. These procedures are also described in Lipsey and Wilson (2001).

#### Adjusting Effect Sizes for Small Sample Sizes

Since some studies have very small sample sizes, we follow the recommendation of many meta-analysts and adjust for this. Small sample sizes have been shown to upwardly bias effect sizes, especially when samples are less than 20. Following Hedges (1981),<sup>16</sup> Lipsey and Wilson (2001)<sup>17</sup> report the "Hedges correction factor," which we use to adjust all mean difference effect sizes (N is the total sample size of the combined treatment and comparison groups):

$$(A3) \quad ES'_m = \left[1 - \frac{3}{4N - 9}\right] \times [ES_m, \text{or}, ES_{m(p)}]$$

#### Computing Weighted Average Effect Sizes, Confidence Intervals, and Homogeneity Tests

Once effect sizes are calculated for each program effect, the individual measures are summed to produce a weighted average effect size for a program area. We calculate the inverse variance weight for each program effect, and these weights are used to compute the average. These calculations involve three steps. First, the standard error,  $SE_m$  of each mean effect size is computed with:<sup>18</sup>

$$(A4) \quad SE_m = \sqrt{\frac{n_e + n_c}{n_e n_c} + \frac{(ES'_m)^2}{2(n_e + n_c)}}$$

In equation (A4),  $n_e$  and  $n_c$  are the number of participants in the experimental and control groups and  $ES'_m$  is from equation (A3).

Next, the inverse variance weight  $w_m$  is computed for each mean effect size with:<sup>19</sup>

$$(A5) \quad w_m = \frac{1}{SE_m^2}$$

The weighted mean effect size for a group of studies in program area  $i$  is then computed with:<sup>20</sup>

$$(A6) \quad \overline{ES} = \frac{\sum (w_{m_i} ES'_m)}{\sum w_{m_i}}$$

Confidence intervals around this mean are then computed by first calculating the standard error of the mean with:<sup>21</sup>

$$(A7) \quad SE_{\overline{ES}} = \sqrt{\frac{1}{\sum w_{m_i}}}$$

Next, the lower,  $ES_L$ , and upper limits,  $ES_U$ , of the confidence interval are computed with:<sup>22</sup>

$$(A8) \quad \overline{ES}_L = \overline{ES} - z_{(1-\alpha)}(SE_{\overline{ES}})$$

$$(A9) \quad \overline{ES}_U = \overline{ES} + z_{(1-\alpha)}(SE_{\overline{ES}})$$

In equations (A8) and (A9),  $z_{(1-\alpha)}$  is the critical value for the z-distribution (1.96 for  $\alpha = .05$ ).

The test for homogeneity, which provides a measure of the dispersion of the effect sizes around their mean, is given by:<sup>23</sup>

$$(A10) \quad Q_i = \left(\sum w_i ES_i^2\right) - \frac{\left(\sum w_i ES_i\right)^2}{\sum w_i}$$

The Q-test is distributed as a chi-square with  $k-1$  degrees of freedom (where  $k$  is the number of effect sizes).

#### Computing Random Effects Weighted Average Effect Sizes and Confidence Intervals

When the p-value on the Q-test indicates significance at values of p less than or equal to .05, a random effects model is performed to calculate the weighted average effect size. This is accomplished by first calculating the random effects variance component,  $v$ .<sup>24</sup>

$$(A11) \quad v = \frac{Q_i - (k-1)}{\sum w_i - \left(\sum w_i^2 / \sum w_i\right)}$$

This random variance factor is then added to the variance of each effect size and then all inverse variance weights are recomputed, as are the other meta-analytic test statistics.

<sup>16</sup> L. V. Hedges (1981). Distribution theory for Glass's estimator of effect size and related estimators. *Journal of Educational Statistics*, 6: 107-128.

<sup>17</sup> Lipsey and Wilson, *Practical meta-analysis*, 49, formula 3.22.

<sup>18</sup> Ibid., 49, equation 3.23.

<sup>19</sup> Ibid., 49, equation 3.24.

<sup>20</sup> Ibid., 114.

<sup>21</sup> Ibid., 114.

<sup>22</sup> Ibid., 114.

<sup>23</sup> Ibid., 116.

<sup>24</sup> Ibid., 134.

### Appendix 3: Institute Adjustments to Effect Sizes for Methodological Quality, Outcome Measure Relevance, and Researcher Involvement

In Exhibit 2 we show the results of our meta-analyses calculated with the standard meta-analytic formulas described in Appendix 2. In the last column in Exhibit 2, however, we list "Adjusted Effect Sizes" that we actually use in our benefit-cost analysis of each of the programs we review. These adjusted effect sizes, which are derived from the unadjusted results, are always smaller than or equal to the unadjusted effect sizes we report in the other columns in Exhibit 2.

In Appendix 3, we describe our rationale for making these downward adjustments. In particular, we make three types of adjustments that we believe are necessary to better estimate the results that we think each program is likely to actually achieve in real-world settings. We make adjustments for: a) the methodological quality of each of the studies we include in the meta-analyses; b) the relevance or quality of the outcome measure that individual studies use; and c) the degree to which the researcher(s) who conducted a study were invested in the program's design and implementation.

**3a. Methodological Quality.** Not all research is of equal quality, and this, we believe, greatly influences the confidence that can be placed in the results from a study. Some studies are well designed and implemented, and the results can be viewed as accurate representations of whether the program itself worked. Other studies are not designed as well and less confidence can be placed in any reported differences. In particular, studies of inferior research design cannot completely control for sample selection bias or other unobserved threats to the validity of reported research results. This does not mean that results from these studies are of no value, but it does mean that less confidence can be placed in any cause-and-effect conclusions drawn from the results.

To account for the differences in the quality of research designs, we use a 5-point scale as a way to adjust the reported results. The scale is based closely on the 5-point scale developed by researchers at the University of Maryland.<sup>25</sup> On this 5-point scale, a rating of "5" reflects an evaluation in which the most confidence can be placed. As the evaluation ranking gets lower, less confidence can be placed in any reported differences (or lack of differences) between the program and comparison or control groups.

On the 5-point scale, as interpreted by the Institute, each study is rated with the following numerical ratings.

- A "5" is assigned to an evaluation with well-implemented random assignment of subjects to a treatment group and a control group that does not receive the treatment/program. A good random assignment study should also indicate how well the random assignment actually occurred by reporting

values for pre-existing characteristics for the program and control groups.

- A "4" is assigned to a study that employs a rigorous quasi-experimental research design with a program and matched comparison group, controlling with statistical methods for self-selection bias that might otherwise influence outcomes. These quasi-experimental methods may include estimates made with a convincing instrumental variables modeling approach, or a Heckman approach to modeling self-selection.<sup>26</sup> A level 4 study may also be used to "downgrade" an experimental random assignment design that had problems in implementation, perhaps with significant attrition rates.
- A "3" indicates a non-experimental evaluation where the program and comparison groups were reasonably well matched on pre-existing differences in key variables. There must be evidence presented in the evaluation that indicates few, if any, significant differences were observed in these salient pre-existing variables. Alternatively, if an evaluation employs sound multivariate statistical techniques (e.g. logistic regression) to control for pre-existing differences, and if the analysis is successfully completed, then a study with some differences in pre-existing variables can qualify as a level 3.
- A "2" involves a study with a program and matched comparison group where the two groups lack comparability on pre-existing variables and no attempt was made to control for these differences in the study.
- A "1" involves a study where no comparison group is utilized. Instead, the relationship between a program and an outcome, i.e., recidivism, is analyzed before and after the program.

We do not use the results from program evaluations rated as a "1" on this scale, because they do not include a comparison group and we believe that there is no context to judge program effectiveness. We also regard evaluations with a rating of "2" as highly problematic and, as a result, we do not consider their findings in the calculations of effect. In this study, we only consider evaluations that rate at least a 3 on this 5-point scale.

An explicit adjustment factor is assigned to the results of individual effect sizes based on the Institute's judgment concerning research design quality. We believe this adjustment is critical and is the only practical way to combine the results of a high quality study (i.e., a level 5 study) with those of lesser design quality. The specific adjustments made for these studies depend on the topic area being considered. In some areas, such as criminal justice program evaluations, there is strong evidence that less-than-random assignment studies (i.e., less than level 5 studies) have, on average, smaller effect

<sup>25</sup> L. W. Sherman, D. Gottfredson, D. MacKenzie, J. Eck, P. Reuter, and S. Bushway (1998). *Preventing crime: What works, what doesn't, what's promising*. Prepared for the National Institute of Justice. Department of Criminology and Criminal Justice, University of Maryland. Chapter 2.

<sup>26</sup> For a discussion of these methods, see W. Rhodes, B. Pelissier, G. Gaes, W. Saylor, S. Camp, and S. Wallace (2001). *Alternative solutions to the problem of selection bias in an analysis of federal residential drug treatment programs*. *Evaluation Review*, 25(3): 331-369.

sizes than weaker-designed studies.<sup>27</sup> Thus, for the typical criminal justice evaluation, we use the following “default” adjustments to account for studies of different research design quality:

- A level 5 study carries a factor of 1.0 (that is, there is no discounting of the study’s evaluation outcomes).
- A level 4 study carries a factor of .75 (effect sizes discounted by 25 percent).
- A level 3 study carries a factor of .50 (effect sizes discounted by 50 percent).
- We do not include level 2 and level 1 studies in our analyses.

These factors are subjective to a degree; they are based on the Institute’s general impressions of the confidence that can be placed in the predictive power of criminal justice studies of different quality.

The effect of the adjustment is to multiply the effect size for any study,  $ES'_m$ , in equation (A3) by the appropriate research design factor. For example, if a study has an effect size of -.20 and it is deemed a level 4 study, then the -.20 effect size would be multiplied by .75 to produce a -.15 adjusted effect size for use in the benefit-cost analysis.

**3b. Adjusting Effect Sizes for Relevance or Quality of the Outcome Measure.** As noted in Appendix 1, our focus in this analysis is whether adult corrections programs reduce new criminal activity. We prefer measures such as arrests or convictions and avoid measures such as technical violations of parole or probation, since these may or may not be related to the commission of new crimes. In addition, we require that all studies have at least a six-month follow up period. For those studies that had a follow-up period of under 12 months, but greater than six months, and for those studies that only reported weak measures of new criminal activity, we reduced effects sizes by 25 percent. This adjustment multiplies the effect size for any study with a short follow-up or weak measure by .75.

**3c. Adjusting Effect Sizes for Research Involvement in the Program’s Design and Implementation.** The purpose of the Institute’s work is to identify and evaluate programs that can make cost-beneficial improvements to Washington’s actual service delivery system. There is some evidence that programs that are closely controlled by researchers or program developers have better results than those that operate in “real world” administrative structures.<sup>28</sup> In our own evaluation of a real-world implementation of a research-based juvenile justice program in Washington, we found that the actual results were considerably lower than the results obtained when the intervention was conducted by the originators of the program.<sup>29</sup> Therefore, we make an adjustment to effect sizes  $ES'_m$  to reflect this distinction. As a parameter for all studies deemed not to be “real world” trials, the Institute discounts  $ES'_m$  by .5, although this can be modified on a study-by-study basis.

#### **Appendix 4: Meta-Analytic Results—Estimated Effect Sizes and Citations to Studies Used in the Analyses**

Exhibit 2 provides technical meta-analytic results for the effect sizes computed for these groupings of programs, including the results of the adjustments described above. Exhibit 3 lists the citations for all the studies used in the meta-analyses, arranged by program area.

<sup>27</sup> M. W. Lipsey (2003). Those confounded moderators in meta-analysis: Good, bad, and ugly. *The Annals of the American Academy of Political and Social Science*, 587(1): 69-81. Lipsey found that, for juvenile delinquency evaluations, random assignment studies produced effect sizes only 56 percent as large as nonrandom assignment studies.

<sup>28</sup> Ibid. Lipsey found that, for juvenile delinquency evaluations, programs in routine practice (i.e., “real world” programs) produced effect sizes only 61 percent as large as research/demonstration projects. See also: A. Petrosino, & H. Soydan (2005). The impact of program developers as evaluators on criminal recidivism: Results from meta-analyses of experimental and quasi-experimental research. *Journal of Experimental Criminology*, 1(4): 435-450.

<sup>29</sup> R. Barnoski (2004). *Outcome evaluation of Washington State’s research-based programs for juvenile offenders*. Olympia: Washington State Institute for Public Policy, available at <<http://www.wsipp.wa.gov/rptfiles/04-01-1201.pdf>>.

**Exhibit 2**  
**Estimated Effect Sizes on Crime Outcomes**  
(A Negative Effect Size Indicates the Program Achieves Less Crime)

Program listed in italics require, in our judgment, additional research for it can be concluded that they do or do not reduce recidivism.	Number of Studies Included in the Review (total number of subjects in the treatment groups in the studies in parentheses)	Meta-Analytic Results Before Applying Institute Adjustments						Adjusted Effect Size Used in the Benefit-Cost Analysis (estimated effect after downward adjustments for the methodological quality of the evidence, outcome measurement relevance, and researcher involvement)
		Fixed Effects Model			Random Effects Model			
		Weighted Mean Effect Size	Homogeneity Test		Weighted Mean Effect Size			
			ES	p-value		ES	p-value	
<b>Adult Offenders</b>								
<b>Programs for Drug-Involved Offenders</b>								
Adult drug courts	56 (18957)	-.160	.000	.000	-.183	.000	-.094	
In-prison therapeutic communities with community aftercare	6 (1989)	-.152	.000	.735	na	na	-.077	
In-prison therapeutic communities without community aftercare	7 (1582)	-.119	.001	.079	na	na	-.059	
Cognitive-behavioral therapy in prison	8 (3788)	-.130	.000	.905	na	na	-.077	
<i>Case management in the community</i>	12 (2572)	-.046	.114	.000	-.039	.480	.000	
Drug treatment in the community	5 (54334)	-.137	.000	.000	-.221	.007	-.109	
Drug treatment in jail	9 (1436)	-.110	.008	.025	-.106	.094	-.052	
<b>Programs for Mentally Ill and Co-Occurring Offenders</b>								
Jail diversion (pre & post booking programs)	11 (1243)	.060	.141	.682	na	na	.000	
<i>Therapeutic community programs</i>	2 (145)	-.361	.004	.542	na	na	-.230	
<b>Treatment Programs for General Offenders</b>								
Cognitive-behavioral for the general population	25 (6546)	-.147	.000	.000	-.164	.000	-.081	
<i>Faith-based programs</i>	5 (630)	-.015	.767	.043	-.028	.728	.000	
<b>Programs for Domestic Violence Offenders</b>								
Education/cognitive-behavioral treatment	9 (1254)	-.025	.523	.120	na	na	.000	
<i>Domestic violence courts</i>	2 (327)	-.086	.309	.009	-.013	.956	.000	
<b>Programs for Sex Offenders</b>								
Psychotherapy, sex offenders	3 (313)	.134	.179	.038	.027	.892	.000	
Cognitive-behavioral treatment in prison	5 (894)	-.144	.005	.173	na	na	-.087	
Cognitive-behavioral treatment in the community	6 (359)	-.391	.000	.438	na	na	-.195	
Cognitive-behavioral treatment in prison (sex offense outcomes)	4 (705)	-.119	.027	.080	na	na	-.069	
Cognitive-behavioral treatment in the community (sex off. outcomes)	5 (262)	-.357	.001	.846	na	na	-.177	
<i>Intensive supervision of sex offenders in the community</i>	4 (392)	.207	.003	.000	.202	.359	.000	
Behavioral Therapy - Sex Offenders.	2 (130)	-.190	.126	.635	na	na	.000	
<i>Mixed Treatment-Sex Offenders in the Community</i>	2 (724)	-.176	.001	.015	-.184	.169	.000	
<i>Circles of Support &amp; Accountability (Faith-based supervision of sex offenders)</i>	1 (60)	-.388	.035	na	na	na	-.193	
<i>Medical Treatment of Sex Offenders</i>	1 (99)	-.372	.060	na	na	na	-.185	
<b>Intermediate Sanctions</b>								
Intensive supervision: surveillance-oriented approaches	24 (2699)	-.033	.244	.146	na	na	.000	
Intensive supervision: treatment-oriented approaches	10 (2156)	-.287	.000	.000	-.291	.041	-.190	
<i>Regular supervision compared to no supervision</i>	1 (22016)	-.010	.591	na	na	na	.000	
<i>Day fines (compared to standard probation)</i>	1 (191)	-.084	.411	na	na	na	.000	
Adult boot camps	22 (5910)	-.030	.103	.000	-.017	.632	.000	
Electronic monitoring	12 (2175)	.025	.411	.025	.015	.765	.000	
Restorative justice programs for lower risk adult offenders	6 (783)	-.077	.130	.013	-.125	.165	.000	
<b>Work and Education Programs for General Offenders</b>								
Correctional industries programs in prison	4 (7178)	-.119	.000	.174	na	na	-.077	
Basic adult education programs in prison	7 (2399)	-.094	.001	.006	-.114	.034	-.050	
Employment training & job assistance programs in the community	16 (9217)	-.047	.003	.017	-.061	.021	-.047	
<i>Work release programs from prison</i>	4 (621)	-.122	.045	.285	na	na	-.055	
Vocational education in prison	3 (1950)	-.189	.000	.868	na	na	-.124	

Notes to the Table:  
Appendices 1, 2, and 3 describe the meta-analytic methods and decision criteria used to produce these estimates. Briefly, to be included in this review: 1) a study had to be published in English between 1970 and 2005; 2) the study could be published in any format—peer-reviewed journals, government reports, or other unpublished results; 3) the study had to have a randomly-assigned or demonstrably well-matched comparison group; 4) the study had to have intent-to-treat groups that included both completers and program dropouts, or sufficient information that the combined effects could be tallied; 5) the study had to provide sufficient information to code effect sizes; and 6) the study had to have at least a six-month follow-up period and include a measure of criminal recidivism as an outcome.

### Exhibit 3

## Citations to the Studies Used in the Meta-Analyses

(Some studies contributed independent effect sizes from more than one location)

Program Grouping	Study
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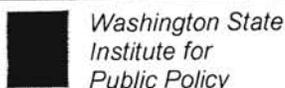
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The Washington State Legislature created the Washington State Institute for Public Policy in 1983. A Board of Directors—representing the legislature, the governor, and public universities—governs the Institute and guides the development of all activities. The Institute's mission is to carry out practical research, at legislative direction, on issues of importance to Washington State.

# APPENDIX C

January 2013

## WHAT WORKS TO REDUCE RECIDIVISM BY DOMESTIC VIOLENCE OFFENDERS?

In Washington and across the United States, courts often order offenders charged with domestic violence (DV) crimes to attend DV treatment. Attending DV treatment may be a condition of a sentence handed down by a judge or a requirement of a deferred disposition.

The 2012 Washington State Legislature directed the Washington State Institute for Public Policy (Institute) to update its systematic review of the national and international literature on the effectiveness of DV treatment programs.<sup>1</sup> The Institute had previously found that DV treatment has little or no significant impact on repeat domestic violence (recidivism).<sup>2</sup> Other researchers have reached similar conclusions.<sup>3</sup>

In this report, we update and extend our earlier review to include other types of DV interventions. The Institute was directed to conduct the review of the DV literature in collaboration with the Washington State Supreme Court Gender and Justice Commission and experts on domestic violence.

The 2012 Legislature also asked the Institute to survey other states regarding legal requirements for DV cases, and to report recidivism rates of Washington's DV offenders (see box, page 2).

This report first presents findings from our review of the literature to determine "what works" to reduce recidivism by DV offenders. Second, we report the results from our survey of other states regarding the legal requirements for DV treatment. Recidivism rates will be presented in an upcoming Institute report to be published later in January 2013.

<sup>1</sup> RCW 26.50.800

<sup>2</sup> Lee, S., Aos, S., Drake, E., Pennucci, A., Miller, M., Anderson, L. (2012). *Return on investment: Evidence-based options to improve statewide outcomes, April 2012 update* (Document No. 12-04-1201). Olympia: Washington State Institute for Public Policy.

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### Summary

The 2012 Washington State Legislature directed the Washington State Institute for Public Policy to: a) update its analysis of the national and international literature on domestic violence (DV) treatment; b) report on other interventions effective at reducing recidivism by DV offenders and criminal offenders in general; and c) survey other states' laws regarding DV treatment for offenders.

Similar to 25 other states, Washington's legal standards for DV treatment require treatment to be group-based and incorporate elements of a treatment model developed in the 1980s in Duluth, MN.

In updating our review of the literature, we identified 11 rigorous evaluations—none from Washington—testing whether DV treatment has a cause-and-effect relationship with DV recidivism. Six of those evaluations tested the effectiveness of Duluth-like treatments. We found no effect on DV recidivism with the Duluth model. There may be other reasons for courts to order offenders to participate in these Duluth-like programs, but the evidence to date suggests that DV recidivism will not decrease as a result.

Our review indicates that there may be other group-based treatments for male DV offenders that effectively reduce DV recidivism. We found five rigorous evaluations covering a variety of non-Duluth group-based treatments. On average, this diverse collection of programs reduced DV recidivism by 33%. Unfortunately, these interventions are so varied in their approaches that we cannot identify a particular group-based treatment to replace the Duluth-like model required by Washington State law. Additional outcome evaluations, perhaps of the particular DV programs in Washington State, would help identify effective alternatives to the Duluth model.

This report includes separate statements from the Washington State Supreme Court Gender and Justice Commission and the Northwest Association of Domestic Violence Treatment Professionals.

Suggested citation: Miller, M., Drake, E., & Nafziger, M. (2013). *What works to reduce recidivism by domestic violence offenders?* (Document No. 13-01-1201). Olympia: Washington State Institute for Public Policy.

## I. WHAT WORKS TO REDUCE RECIDIVISM BY DV OFFENDERS?

### BACKGROUND

Washington State law defines domestic violence broadly as acts or threats of physical harm, sexual assault, or stalking by one household or family member against another household or family member.<sup>4</sup> For this study, however, we use a narrower definition of DV, limited to violence between intimate partners, where the perpetrator is an adult male. While some women physically abuse their intimate partners, the vast majority of those prosecuted for DV are male.<sup>5</sup>

DV offenders may be ordered to attend a DV treatment program as a condition of a sentence handed down by a judge or as a requirement of a deferred disposition.<sup>6</sup> Typically, the offenders are responsible for paying the costs of treatment. Based on a brief survey in Washington, we estimate the average cost of treatment to be \$1,365 per person.<sup>7</sup>

Judges report two main reasons to order DV offenders to treatment: first, to hold offenders accountable for the crime for which they were convicted; and second, to reduce the likelihood of future crime through the anticipated rehabilitative effects of DV treatment. In a national survey of the courts, 75% of judicial officers who order DV treatment consider it to be a form of accountability; 90% also do so with the goal of rehabilitation.<sup>8</sup>

It is important to note that this report focuses solely on the question of "what works" to reduce recidivism—that is, the degree to which DV treatment rehabilitates offenders to reduce future crimes. We do not address the use of DV treatment as a form of accountability.

<sup>4</sup> RCW 26.50.010

<sup>5</sup> In Washington, from 2004–2006, 77% of DV offenders were male. See: George, T. (2012). *Domestic violence sentencing conditions and recidivism*. Olympia: Washington Center for Court Research, Administrative Office of the Courts.

<sup>6</sup> Ibid

<sup>7</sup> This is the middle of the range of costs based on a survey of seven treatment providers in Olympia, Seattle, Bellingham, Yakima, Spokane, and Moses Lake on June 2011. All offenders were on probation; program costs do not include the cost of probation.

<sup>8</sup> Labriola, M., Rempel, M., O'Sullivan, C., & Frank, P. B. (2007). *Court responses to batterer program noncompliance: A national perspective*. New York: Center for Court Innovation.

### Legislative Study Direction

The 2012 Legislature directed the Institute to do three things:

- 1) In collaboration with the Washington State Gender and Justice Commission and experts on domestic violence, "...review and update of the literature on domestic violence perpetrator treatment, and provide a description of studies used in meta-analysis of domestic violence perpetrator treatment. The institute shall report on other treatments and programs, including related findings on evidence-based community supervision, that are effective at reducing recidivism among the general offender population."
- 2) "The institute shall survey other states to study how misdemeanor and felony domestic violence cases are handled and assess whether domestic violence perpetrator treatment is required by law and whether a treatment modality is codified in law."
- 3) "...report recidivism rates of domestic violence offenders in Washington, and if data is available, the report must also include an estimate of the number of domestic violence offenders sentenced to certified domestic violence perpetrator treatment in Washington state and completion rates for those entering treatment."

*Engrossed Substitute House Bill 2363, Laws of 2012.*

**Current Washington State Laws and Rules on DV Treatment.** Current Washington State criminal law and administrative rules specify aspects of what is called the "Duluth model" of DV treatment for state-certified DV perpetrator treatment programs. The laws and rules prohibit substitution of other non-Duluth approaches to DV perpetrator treatment. Specifically, certain approaches cannot be used in place of the Duluth model, including individual, couples, or family therapy; substance abuse treatment; or anger management.<sup>9</sup>

The Duluth model is a commonly used intervention throughout the United States, Canada, and Great Britain for males charged with misdemeanor domestic violence. The intervention is based on a model developed in Duluth, Minnesota, in the early 1980's. The treatment approach assumes that domestic violence "...is a gender-specific behavior which is socially and historically constructed. Men are socialized to take control and to use physical force when necessary to maintain dominance."<sup>10</sup>

<sup>9</sup> WAC 388-60 and RCW 26.50.150

<sup>10</sup> Ganley, A. (1996). Understanding domestic violence. In: W. Warshaw & A. Ganley (eds.), *Improving Health Care Response*

Further, the model assumes that DV does not result from mental illness, substance abuse, anger, stress or dysfunctional relationships.<sup>11</sup>

In this report, we review the evaluation literature on the degree to which the Duluth model, as well as other forms of DV treatment, impact recidivism.

## METHODS

The Institute has previously published extensive analyses of "what works" in criminal justice and other policy areas.<sup>12</sup> To accomplish the current legislative assignment, we systematically reviewed the research literature on DV treatments. We located 34 studies from throughout the United States and Canada that evaluated the effect of DV group-based treatment for male offenders on recidivism.<sup>13</sup>

It is important to note that this study is a systematic review of the literature, and is not an evaluation of whether specific group-based DV programs for male offenders in Washington State affect recidivism. Our approach is to review the national and international research literature to provide insight on the likely effectiveness of DV programs in Washington. To date, unfortunately, programs in Washington State have not been rigorously evaluated.

Most of the studies (30 of 34) evaluated male-only group treatment. The remaining four studies concerned couples group treatment for couples where men were the abusers. We found no outcome evaluations of interventions for female batterers.

After locating these 34 evaluations, we then applied our standard research design criteria for inclusion in our analysis. We assessed whether each study met minimum standards of research rigor. These criteria gave us confidence that any changes in outcomes are caused by the interventions and were not due to unknown characteristics or motivational factors of the program participants.

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to *Domestic Violence* (pp. 15-44). San Francisco: Futures Without Violence. Retrieved from [http://www.futureswithoutviolence.org/userfiles/file/HealthCare/improving\\_healthcare\\_manual\\_1.pdf](http://www.futureswithoutviolence.org/userfiles/file/HealthCare/improving_healthcare_manual_1.pdf)

<sup>11</sup> Ibid

<sup>12</sup> Lee et al., 2012

<sup>13</sup> The following rigorous evaluation was excluded from these analyses because it did not include a measure of DV recidivism: Chen, H., Bersani, C., Myers, S. C., & Denton, R. (1989). Evaluating the effectiveness of a court sponsored abuser treatment program. *Journal of Family Violence*, 4(4), 309-322.

**Research design.** To be included in our meta-analysis, studies must have used a comparison group similar to the treatment group. We preferred studies where offenders were randomly assigned to treatment or comparison conditions, but we also included "quasi-experimental" studies that used appropriate statistical controls.

Some studies excluded from the analysis compared those successfully completing treatment with those who dropped out. While such designs have their advocates,<sup>14</sup> these study designs cannot control for the motivational factors and other risk factors associated with treatment completion. Compared to completers, dropouts are less likely to be employed<sup>15</sup> or married,<sup>16</sup> and are more likely to have an extensive criminal history<sup>17</sup> or severe psychopathology.<sup>18</sup> All of these characteristics are risk factors for recidivism.<sup>19</sup>

We also required that studies provided enough information to create effect sizes based on "intention-to-treat." That is, we only included studies where outcome information was provided for all those assigned to the treatment, not just those who completed the program. We adopted this rule to avoid unobserved self-selection factors that distinguish a program completer from a program dropout, since these unobserved factors are likely to significantly bias estimated treatment effects. We included a study reporting on completers only if the demonstrated rate of program non-completion was very small (e.g. under 10%).

**Population.** Our legislative assignment directs us to focus on criminal DV offenders. Therefore, we excluded studies where subjects volunteered or were ordered to treatment by civil court, as is sometimes the case in child custody cases.

**Outcomes.** To be included in our analysis, studies must have reported measures of criminal

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<sup>14</sup> Gondolf, E. W. (2012). *The future of batterer programs: Reassessing evidence-based practice*. Boston: Northeastern University Press.

<sup>15</sup> Bennett, L., Call, C., Flett, H., Stoops, C. (2005). *Program completion, behavioral change, and re-arrest for the batterer intervention system of Cook County Illinois: Final report to the Illinois Criminal Justice Information Authority*. Chicago: Illinois Criminal Justice Information Authority.

<sup>16</sup> Ibid

<sup>17</sup> Ibid and Hanson, R.K. & Wallace-Capretta, S. (2000). *A multi-site study of treatment for abusive men*. User Report 2000-05. Ottawa: Department of the Solicitor General of Canada.

<sup>18</sup> Gondolf, E. W. (1999). MCMI-III results for batterer program participants in four cities: less "pathological" than expected. *Journal of Family Violence*, 14(1), 1-17.

<sup>19</sup> Ibid and Hanson & Wallace-Capretta op. cit.

recidivism. We preferred information from official police or court records. Frequently, studies on DV treatment measured recidivism from victim reports. If no official records were available, we included such studies if researchers were able to reach most of the victims. One study met this criterion.<sup>20</sup>

**Reliability of the Review.** To assure an accurate assessment of each study, two Institute researchers reviewed every evaluation. We also engaged the assistance of an external reviewer with extensive experience conducting systematic reviews.<sup>21</sup> Each reviewer independently read and coded each study. Final decisions regarding inclusion of studies were determined by consensus.

**Calculating Effect Sizes (ES).** After screening the 34 studies of group DV treatment for the inclusion criteria, we identified nine rigorous evaluations to include in our analysis. We then calculated an effect size (ES) for each study. The ES is a measure of how large the effect of the treatment is relative to the comparison group. We then combined the results from multiple studies to estimate the overall average effect size of the studies. This "meta-analysis" gives increased statistical power and allows greater confidence in the average overall effect of the intervention on recidivism.<sup>22</sup>

**Defining Promising Practice.** The 2012 Legislature directed the Institute and the University of Washington's Evidence Based Practice Institute to develop definitions for "evidence-based," "research-based," and "promising" programs in the areas of children's welfare, mental health, and juvenile justice.<sup>23</sup> These definitions rank programs

<sup>20</sup> Easton, C. J., Mandel, D. L., Hunkele, K. A., Nich, C., Rounsaville, B. J., & Carroll, K. M. (2007). A cognitive behavioral therapy for alcohol-dependent domestic violence offenders: An integrated substance abuse-domestic violence treatment approach (SADV). *American Journal on Addictions, 16*(1), 24-31.

<sup>21</sup> We contracted with Emily Tanner-Smith, Research Assistant Professor at the Peabody Research Institute and Department of Human and Organizational Development at Vanderbilt University. Dr. Tanner-Smith is currently the Associate Editor for the Methods Coordinating Group of The Campbell Collaboration, an international organization that prepares and disseminates systematic reviews in education, crime and justice, and social welfare.

<sup>22</sup> Following standard meta-analytic procedures, random effects inverse variance weights are used to calculate the weighted average effect size for each topic.

<sup>23</sup> The definition of "promising" is: a program or practice that, based on statistical analyses or a well-established theory of change, shows potential for meeting the "evidence-based" or "research-based" criteria, which could include the use of a program that is evidence-based for outcomes other than the

based on the strength of the evidence, with evidence-based programs considered to have the best evidence that the programs achieve desired results. Research-based programs have at least one rigorous evaluation but do not meet all criteria for evidence-based. "Promising" approaches are based on statistical analyses or a well-established theory of change. For all the studies reviewed in this analysis, we classified programs according to these definitions.

## COLLABORATION

The Institute was directed to collaborate with the Washington State Gender and Justice Commission and experts on domestic violence. We met on four occasions with representatives of the Gender and Justice Commission. This report includes a statement by the Commission in Section III.

In early September 2012, we participated in the Seattle Domestic Violence Symposium. We also attended the annual conference of the Northwest Association of Domestic Violence Treatment Professionals (NWADVTP) in late August 2012, and met with representatives of NWADVTP on December 7, 2012. A statement from NWADVTP is included in Section IV.

## FINDINGS

Our primary charge was to examine the effectiveness of DV treatment. The legislative study direction included a requirement to examine supervision and other options for the general offender population; the Gender and Justice Commission also expressed interest in other approaches. Therefore, we expanded our review of the DV treatment literature and present our findings based on the type of treatment approach, as follows:

- A. Group-based DV Treatment
- B. Other Approaches to Reducing Recidivism by DV Offenders
- C. Interventions for the General Offender Population that may Apply to DV Populations

alternative use. See:  
<http://www.wsipp.wa.gov/rptfiles/E2SHB2536.pdf>

## A. Group DV Treatment

As mentioned, of the 34 studies of group treatment for DV offenders that we located, only nine studies met our inclusion criteria for analysis. Those nine studies include 11 effect sizes, shown in Exhibit 1.

In the table, negative effect sizes indicate that the program group had lower rates of recidivism than the comparison group. Thus, negative effect sizes indicate desirable outcomes for these programs.

The more negative the effect sizes, the greater the reduction in recidivism. For example, an effect size of -0.4 would indicate a greater reduction than an effect size of -0.2. Full citations for this group of studies are provided in Exhibit B1 in the appendix.<sup>24</sup>

**Exhibit 1**  
**Studies of DV Offender Group Treatment Included in the Meta-Analysis**

Study	Location	Treatment Type	Treatment N	Duration	Comparison	Effect Size (p-value)*	
						DV recidivism	Any recidivism
Davis et al., 2000a	Brooklyn	Duluth model	129	40 hrs over 26 wks	40 hr community service	-0.447 (p=0.01)**	N/A
Davis et al., 2000b	Brooklyn	Duluth model	61	40 hrs over 8 wks	40 hr community service	-0.091 (p=0.67)	N/A
Dunford, 2000a	San Diego Naval Base	Cognitive-behavior, focus on relationships, communication, empathy.	168	26 weekly sessions followed by 6 monthly sessions	No treatment	-0.066 (p=0.85)	N/A
Dunford, 2000b	San Diego Naval Base	Couples group therapy	153	26 weekly sessions followed by 6 monthly sessions	No treatment	-0.269 (p=0.50)	N/A
Easton et al., 2007	New Haven	Substance abuse treatment	29	12 weekly sessions	12-step program	-0.317	N/A
Feder, 2000	Broward County	Duluth model	227	26 weekly sessions	Probation only	-0.113 (p=0.68)	+0.320 (p=0.02)
Gordon, 2003	Virginia	Duluth model	132	20 or 24 wks	Probation only	+0.219 (p=0.20)	N/A
Harrell, 1991	Baltimore	Mixed, 82% were Duluth model	81	Varied 8 to 18 wks	Probation only	+0.490 (p=0.054)	N/A
Labriola et al., 2008	Bronx	Duluth model	173	26 weekly sessions	Probation only	+0.237 (p=0.12)	+0.089 (p=0.51)
Palmer et al., 1992	Ontario Canada	Cognitive-behavioral, client-centered, focus on understanding violence, coping with conflict, self-esteem, relationships with women	30	10 weekly sessions	Probation only	-0.835 (p=0.06)	N/A
Waldo, 1988	East Coast US	Relationship enhancement therapy	60	12 weekly sessions	No treatment	-0.487 (p=0.20)	N/A

\* p-values indicate the level of statistical significance. For example, a p-value of 0.05 indicates that five percent of the time we might expect to see the effect by chance

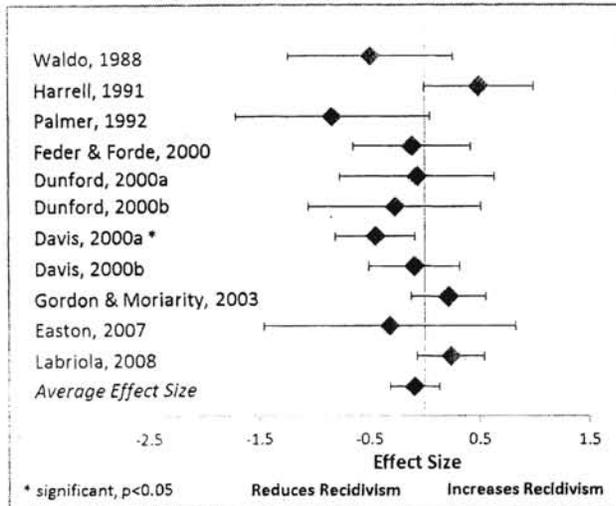
\*\*Davis et al., 2000a showed a statistically significant impact on reduction.

<sup>24</sup> The 25 studies excluded from the analysis are described in Exhibits B2 and B3 in the Appendix.

Exhibit 2 displays the effect sizes (ES's) for each study and the combined ES for this group of studies.<sup>25</sup> In this "forest plot," the effect size is displayed along the horizontal axis. The diamonds show the effect size calculated for each study and the horizontal bars show the 95% confidence intervals—the statistical range of values that would contain the actual "true" value. If a study demonstrates a statistically significant effect, the confidence intervals would not include zero. In the collection of 11 effects included here, one (Davis, 2000a) is statistically significant.

We calculated a meta-analytic average for this combined group of studies—shown as the "average effect size" in Exhibit 2. The average effect size is not statistically different from zero. Thus, from this review of the most rigorous evaluations of group-based DV treatment, we would conclude that this form of treatment has no effect on DV recidivism.

**Exhibit 2**  
Effect Sizes for Group DV Treatment  
Domestic Violence Recidivism

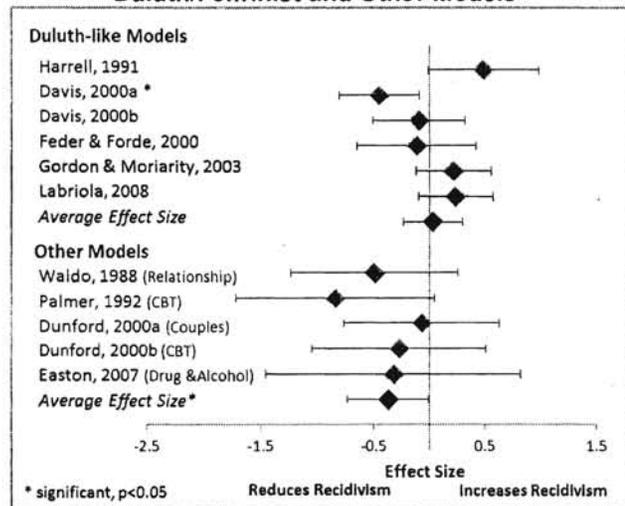


We then analyzed this group of studies to determine whether certain group-based approaches are more effective in reducing DV recidivism than others. We divided the 11 effect sizes into two categories: treatments based on the Duluth model, and those that used other methods.

**The Duluth Group-based DV Treatment.** We attempted to identify whether the treatments assessed in the 11 effect sizes were similar to the Duluth model. In some studies, the Duluth model

was specifically identified. We also considered programs to be similar to Duluth if the study authors said the curriculum included "power and control" dynamics, "sex role stereotyping," or gender-based values. Six of the 11 effect sizes assessed Duluth-like programs. We analyzed separately the results of these six effect sizes and found that, on average, programs using Duluth-like models had no effect on recidivism (see the upper panel in Exhibit 3); therefore, this approach cannot be considered "evidence-based" (or research-based or promising).

**Exhibit 3**  
Effects Sizes for Group DV Treatment  
Duluth/Feminist and Other Models



**Other Group-based DV Treatments.** Of the 11 effect sizes, five were for rigorous evaluations of non-Duluth group-based DV treatment. These other treatments are a collection of various approaches, described on the next page. As displayed on the lower panel of Exhibit 3, individually, all of the programs reduced DV recidivism, but none of the alternative approaches had sample sizes large enough to achieve statistical significance.

When the studies are combined in a meta-analysis, however, the resulting larger sample size increases the ability to draw statistical conclusions. Thus, when these other non-Duluth models are analyzed as a whole, the combined effects indicate a statistically significant reduction in DV recidivism (the lower "average effect size" in Exhibit 3). The average effect was a 33% reduction in domestic violence recidivism.<sup>26</sup>

<sup>25</sup> Eleven effect sizes are displayed because two of the nine studies included more than one treatment modality.

<sup>26</sup> George, T. (2012). The Washington Center for Court Research indicates that 45% of all DV offenders commit another DV crime within five years. When the average effect size for the other (non-

It is important to note that some of these treatments are not appropriate for every offender. For example, substance abuse treatment would not be the treatment of choice for a DV offender who does not have substance abuse problems. Also, as noted earlier, under Washington State law, these treatments cannot be substitutes for Duluth-like DV treatment.

The "other models" shown in Exhibit 3 are described below.

- *Cognitive behavioral therapy.* Two studies (Palmer, 1992, and Dunford, 2000b) reported on similar cognitive-behavioral group treatments for DV offenders with emphasis on improving empathy, communication, and relationships with women.
- *Relationship enhancement.* One study (Waldo, 1988) examined men's groups for DV offenders where the focus is on improving their intimate relationships.
- *Substance Abuse Treatment.* The use of alcohol and/or other drugs frequently occur on the same day as domestic violence abuse.<sup>27</sup> We found one rigorous evaluation of a substance abuse treatment designed specifically for DV offenders (Easton, 2007).
- *Group couples counseling for DV offenders.* One approach to treatment is couples group counseling for couples wishing to stay together. One study included in the meta-analysis (Dunford, 2000a) showed a non-significant reduction in recidivism.

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Duluth) DV treatments is applied to this recidivism rate, the DV recidivism rate reduces to 30%. This 15 percentage point reduction translates into a 33% (15/45) reduction in DV recidivism.<sup>27</sup> Fals-Stewart, W., Golden, J., & Schumacher, J. A. (2003). Intimate partner violence and substance use: A longitudinal day-to-day examination. *Addictive Behaviors*, 28(9), 1555-1574; and Friend, J., Langhinrichsen-Rohling, J., & Eichold, I. I. B. H. (2011). Same-day substance use in men and women charged with felony domestic violence offenses. *Criminal Justice and Behavior*, 38(6), 619-633.

## B. Other "Promising" Approaches to Reducing Recidivism by DV Offenders

The primary focus of our legislative direction was to search for evidence of effectiveness of DV treatment programs. The treatments just described are those with rigorous evaluations. We also searched the literature for other treatments not yet evaluated, as well as justice system approaches for DV cases.

The approaches, listed in Exhibit 4 (next page) and described in this section, can only be regarded as "promising," not evidence- or research-based.

**Other Promising Approaches for DV Treatment.** The following promising treatment approaches have not yet been evaluated.

- *Addressing Psychopathology.* In a multi-site study of DV offenders, 25% exhibited severe psychopathology.<sup>28</sup> Two mental disorders (described below) have been associated with severity of domestic violence.
  - (1) *Borderline Personality Disorder (BPD).* A subset of DV offenders have characteristics associated with BPD.<sup>29</sup> Persons with BPD "attach themselves to others, then become intensely angry or hostile when they believe they are being ignored or mistreated."<sup>30</sup> Dialectical Behavior Therapy (DBT) is an evidence-based treatment<sup>31</sup> for BPD that is sometimes used with DV offenders exhibiting BPD symptoms.<sup>32</sup> To date, however, the effects on DV recidivism have not been evaluated.
  - (2) *Posttraumatic Stress Disorder (PTSD).* Symptoms of PTSD are more common in abusive men than in non-abusive men.<sup>33</sup> In a sample of active military and veterans in a DV treatment program, greater severity

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<sup>28</sup> E.W. Gondolf, E. W. (1999). MCMI-III results for batterer program participants in four cities: less "pathological" than expected. *Journal of Family Violence*, 14(1), 1-17

<sup>29</sup> For example, see: Dutton, D.G. & Starzomski, A. (1993) Borderline personality in perpetrators of psychological and physical abuse. *Victims and Violence*, 8(4), 327-337.

<sup>30</sup> Morrison, J. (1995). *DSM-IV made easy* (p. 478). New York: The Guilford Press.

<sup>31</sup> National Registry of Evidence-Based Programs and Practices. <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=36>

<sup>32</sup> Fruzzetti, A.E. & Levensky, E.R. (2000). Dialectical behavior therapy for domestic violence. *Cognitive and Behavioral Practice*, 7, 435-447; and Waltz, J. (2003) Dialectical behavior therapy in the treatment of abusive behavior. *Journal of Aggression, Maltreatment & Trauma*, 7(1)(2), 75-703.

<sup>33</sup> Dutton, D. (1995). Trauma symptoms and PTSD-like profiles in perpetrators of intimate violence. *Journal of Traumatic Stress*, 8(2), 299-316.

of symptoms of PTSD was associated with increased severity of DV.<sup>34</sup> While there are treatments that can reduce PTSD symptoms,<sup>35</sup> we were unable to locate any studies of PTSD treatment specifically for DV offenders.

- *Mind-Body Bridging*. This approach focuses on the mind-body state of the offender before his aggressiveness, which may be caused by lack of awareness and inability to modulate psychological and physical arousal.<sup>36</sup>
- *Moral Recondition Therapy (MRT) for DV*. MRT is one of several cognitive behavioral programs that have been shown to reduce recidivism; it is currently used by the Washington State Department of Corrections (DOC) for the general offender population. There is now a version of MRT specifically for DV offenders, but it has not yet been evaluated.<sup>37</sup>
- *Interactive journaling: Stopping Abuse for Everyone (SAFE)*.<sup>38</sup> Washington State DOC currently uses several cognitive-behavioral programs for general offenders, including an interactive journaling program, "Getting It Right!" The company that produces "Getting It Right!" has developed a version specifically for DV offenders. An evaluation of SAFE's effect on recidivism is currently underway.
- *Faith-based treatment for DV offenders*.<sup>39</sup> Religious individuals may turn to their churches for help in resolving family violence. Although faith-based programs for DV offenders exist, to date there have been no evaluations on the effects of such programs on DV recidivism.

**Judicial System Approaches to DV.** There are also criminal justice system approaches to reducing DV recidivism and increasing victim safety. The first four system options shown in Exhibit 4 (DV courts, judicial monitoring, specialized supervision, and GPS monitoring) have had a least one rigorous evaluation examining whether recidivism is reduced. The last two (Coordinated Community Response and DV risk assessment) have not been rigorously evaluated regarding their effect on recidivism. Each of these approaches is described below.

- *DV courts*. DV courts are specialized courts with separate calendars for DV cases and specially trained judicial officers. DV courts also frequently coordinate with victim advocacy services. To date, there have been only two rigorous evaluations of domestic violence courts, one for felons and another for misdemeanants. The evaluation of the felony court reported any new arrests (not specific to DV) and found an increase in re-arrests for those served by the DV court.<sup>40</sup> The study on the misdemeanor court reported a significant decrease in DV recidivism.<sup>41</sup>
- *Judicial monitoring* involves more frequent judicial contact, often within the context of DV court. A single rigorous evaluation of enhanced monitoring in a misdemeanor DV court found no effect on either re-arrests for any crime or re-arrest for DV.<sup>42</sup>
- *Specialized DV community supervision*. A single study on a specialized DV probation unit found that this approach reduced recidivism for lowest risk offenders, but had no effect on high risk offenders.<sup>43</sup>

<sup>34</sup> Gerlock, A. (2004). Domestic violence and post-traumatic stress disorder severity for participants of a domestic violence rehabilitation program. *Military Medicine*, 169(6), 470-474.

<sup>35</sup> Lee et al., 2012

<sup>36</sup> Tollefson, D. R., Webb, K., Shumway, D., Block, S. H., & Nakamura, Y. (2009). A mind-body approach to domestic violence perpetrator treatment: Program overview and preliminary outcomes. *Journal of Aggression, Maltreatment & Trauma*, 18(1), 17-45.

<sup>37</sup> See <https://www.ccimrt.com/materials/domestic-violence> for more information.

<sup>38</sup> Dwayne Young, personal communication, September 14, 2012. The Change Companies is currently evaluating a modification of its offender program for domestic violence offenders. See: <http://www.changecompanies.net/>

<sup>39</sup> Nason-Clark, N., Murphy, N., Fisher-Townsend, B., & Ruff, L. (2003). An overview of the characteristics of the clients at a faith-based batterers intervention program. *Journal of Religion and Abuse*, 5(4), 51-72.

<sup>40</sup> Newmark, L., Rempel, M., Diffily, K., Kane, K.M. (2001). *Specialized felony domestic violence courts: Lessons on implementations and impacts from the Kings County experience*. Washington DC: Urban Institute.

<sup>41</sup> Gover, A.R., MacDonald, J.M., Alpert, G.P., & Geary, I.A., Jr. (2003). *The Lexington County domestic violence courts: A partnership and evaluation*. National Institute of Justice Grant 2000-WT-VX-0015.

<sup>42</sup> Labriola, M., Rempel, M., & Davis, R. C. (2008). Do batterer programs reduce recidivism? Results from a randomized trial in the Bronx. *Justice Quarterly*, 25(2), 252-282.

<sup>43</sup> Klein, A. R., Wilson, D., Crowe, A. H., & DeMichele, M. (2005). *Evaluation of the Rhode Island Probation Specialized Domestic Violence Supervision Unit*. National Institute of Justice Grant 2002-WG-BX-0011.

**Exhibit 4**

**Other Promising Approaches to Reducing Domestic Violence Recidivism**

*None of these approaches can be regarded as evidence-based at this time because there is insufficient rigorous research, but each approach meets the definition of a promising practice.*

Type of intervention	Specific to a sub-population?	Number of rigorous evaluations?	Findings from available credible evaluations
<b>Treatments</b>			
Addressing psychopathology: Dialectical Behavior Therapy for Borderline Personality Disorder (BPD)	Yes (those with BPD)	None	N/A
Addressing psychopathology: Posttraumatic Stress Disorder (PTSD)	Yes (those with PTSD)	None	N/A
Mind-Body Bridging	No	None	N/A
MRT for DV	No	None	N/A
Interactive Journaling	No	None	N/A
<b>System level</b>			
DV Courts	No	Two	Mixed
Judicial monitoring	No	One	Small impact (reduced recidivism)
Specialized supervision	No	One	Mixed
GPS monitoring	Yes (those with protection orders)	One	Small impact (reduced recidivism)
Coordinated Community Response	No	None	N/A
Risk assessment	No	None	N/A

- *Global Positioning System (GPS) monitoring.* The use of GPS during the pre-sentence period allows better enforcement of court orders of protection. GPS monitoring also has the capability to quickly inform victims via text message if the offender ventures into locations prohibited by the order. In a multi-site study, in one site, DV recidivism was measured. At this same site, DV recidivism decreased. The study also found that arrests during the pre-trial period increased, which may indicate improved victim safety.<sup>44</sup>
- *Coordinated Community Response (CCR).* The Duluth treatment model was developed as part of a larger community response to DV. CCR involves coordinated response to DV with collaboration among criminal justice agencies

(police, courts, and prosecutors), human service agencies, and community corrections.<sup>45</sup> It is thought that such coordination provides support for victims and makes clear that the community will hold DV offenders accountable for their actions. To date there have been no rigorous evaluations of CCR (see list of excluded studies in Exhibit C3 in the Appendix).

- *Risk assessment.* In recent years, several tools have been developed to assess the risk of DV re-offense by DV offenders. Typically, police officers at the scene use the assessment to collect information about the DV offender. This information is used by police agencies, prosecutors, the defense bar, and judicial officers to help decide how to proceed with each

<sup>44</sup> Erez, E., Ibarra, P.R., Bales, W.D., Gur, O.M. (2012) *GPS Monitoring technologies and domestic violence: An evaluation study.* Report to the National Institute of Justice, Document 238910.

<sup>45</sup> Hart, B. J. (2005). *Coordinated community approaches to domestic violence.* Minnesota Center Against Violence and Abuse. Retrieved from <http://www.mincava.umn.edu/documents/hart/cca/cca.pdf>

case. Two such tools are in various stages of implementation and validation in Washington State (in Thurston County and the City of Seattle).

### C. Interventions for the General Offender Population that May Apply to DV Populations

Evidence from Washington State suggests that many DV offenders commit crimes other than DV. A study of DV offenders in Seattle found that 60% of recidivism was for crimes other than DV.<sup>46</sup> Two recent studies from the Washington State Center for Court Research found that among DV offenders who re-offended, a large proportion did not have a new DV offense. For example, in one study, 70% of DV offenders re-offended; but only 45% had a new DV court case.<sup>47</sup>

The Institute was directed to report on "other treatments and programs, including related

findings on evidence-based community supervision, that are effective at reducing recidivism among the general offender population." The Institute has previously published extensive analyses of "what works" to reduce the recidivism rate in the general offender population.<sup>48</sup> The purpose of this section is to describe elements of the Institute's previous work that may be relevant for policy focused on DV offenders.

Exhibit 5 summarizes those previous analyses,<sup>49</sup> and provides information on the number of studies included, the number of participants in the treatment group, the average effect size for each type of intervention, and the p-value. All but two of these interventions (case management without swift and certain sanctions, and other drug treatment – non-therapeutic communities) were associated with statistically significant reductions in recidivism.

**Exhibit 5**  
**Summary of WSIPP Reviews of Interventions for Offenders in the Community**

Interventions for Adult Criminal Offenders	Last Updated	Number studies	Number in Treatment Groups	Effect Size	P-value
Offender Re-entry Community Safety Program (Dangerously mentally ill offenders)	Apr-12	1	172	-0.756	<0.001
Drug Offender Sentencing Alternative (drug offenders)	Apr-12	1	323	-0.272	0.013
Supervision with Risk Need and Responsivity Principles (moderate and high risk)	Apr-12	6	3,024	-0.307	<0.001
Electronic Monitoring (radio frequency or global positioning systems)	Apr-12	16	18,263	-0.165	<0.001
Mental Health Courts	Apr-12	6	1,424	-0.238	<0.001
Drug Courts	Apr-12	67	27,872	-0.249	<0.001
Drug treatment delivered in the community					
Therapeutic communities	Dec-12	8	5,043	-0.147	0.001
Other drug treatment (non-therapeutic communities)	Dec-12	9	109,461	-0.048	0.221
Case management for substance-abusing offenders					
Swift and certain sanctions	Dec-12	7	4,004	-0.232	0.003
Not swift and certain	Dec-12	13	2,786	-0.074	0.457
Drug Offender Sentencing Alternative (Property offenders)	Apr-12	1	264	-0.272	0.015
Cognitive Behavioral Therapy (moderate and high risk)	Apr-12	38	31,775	-0.144	0.001
Work Release	Apr-12	7	16,406	-0.084	0.029
Employment Training/Job Assistance	Apr-12	16	9,217	-0.074	0.020

<sup>46</sup> Babcock, J. C., & Steiner, R. (1999). The relationship between treatment, incarceration, and recidivism of battering: A program evaluation of Seattle's coordinated community response to domestic violence. *Journal of Family Psychology*, 13(1), 46-59.

<sup>47</sup> George, T. (2012). *Domestic violence sentencing conditions and recidivism*. Olympia: Washington Center for Court Research, Administrative Office of the Courts.

<sup>48</sup> Lee et al., 2012

<sup>49</sup> Lee et al., 2012; and Drake, E. (2012). *Chemical Dependency Treatment for Offenders: A Review of the Evidence and Benefit-Cost Findings* (Document No. 12-12-1201). Olympia: Washington State Institute for Public Policy.

We also provide more detail on community supervision below, as requested by the legislature.

**Community Supervision of General Adult Offender Populations**

To date, we have systematically reviewed<sup>50</sup> three areas within the adult supervision literature to determine “what works”:

- Intensive supervision—surveillance only;
- Intensive supervision—with treatment; and
- Supervision using the “Risk Need Responsivity” model.

Our review found that intensive supervision without treatment has no detectable effects on recidivism rates. When evidence-based treatment is added to intensive supervision, however, we find a recidivism reduction.

In addition to our reviews of intensive supervision with and without treatment, we analyzed an emerging literature on a model of supervision that utilizes the principles of “Risk Need Responsivity” (RNR). This model was first developed by Canadian researchers in 1990 and is defined as follows.<sup>51</sup>

- *Risk principle*—utilize interventions commensurate with an offender’s risk for re-offense.
- *Need principle*—target offender’s criminogenic needs such as anti-social attitudes or substance abuse; and
- *Responsivity principle*—utilize interventions geared toward the offender’s abilities and motivation (generally cognitive behavioral or social learning interventions).

Exhibit 6 displays the main findings from our literature review of community supervision of general adult offenders. The exhibit shows the percentage change in crime outcomes for each of the three types of supervision. We find that intensive supervision with surveillance only has a 0.16% increase in recidivism, while intensive supervision with evidence-based treatment reduces recidivism, on average, by 10%. When community supervision is delivered with the RNR model, we find a larger (16%) reduction in crime outcomes.

**Exhibit 6**  
**Supervision for Adult Offenders: Effect on Crime**

Supervision Strategy	Number of Studies	N	Effect Size	p-value	Percentage Change in Crime*
Intensive Supervision Probation/Parole (surveillance only)	14	1,699	+0.004	0.951	+0.16%
Intensive Supervision Probation/Parole (with treatment)	17	3,078	-.205	0.004	-10%
Supervision with Risk Responsivity Need model	6	3,024	-.303	0.000	-16%

\* We calculate the percentage change in crime as an average reduction over a long-term follow-up of 15 years. Citations of studies used in these analyses are provided in Exhibits D1, D1, and D3 in the appendix.

<sup>50</sup> Drake, E. & Aos, S. (2012). *Confinement for Technical Violations of Community Supervision: Is There an Effect on Felony Recidivism?* (Document No. 12-07-1201). Olympia: Washington State Institute for Public Policy.

<sup>51</sup> Andrews, D., Bonta, J., & Hoge, R. (1990). Classification for effective rehabilitation: Rediscovering psychology. *Criminal Justice and Behavior*, 17, 19-52.

## SUMMARY OF FINDINGS

Based on six rigorous outcome evaluations of group-based DV treatment for male offenders, we conclude that the Duluth model, the most common treatment approach, appears to have no effect on recidivism. This updated finding is consistent with our (and others') previous work on this topic.<sup>52</sup> There may be other reasons for courts to order offenders to participate in these Duluth-like programs, but the evidence suggests that DV recidivism will not decrease as a result.

There may be other group-based treatments for male DV offenders that effectively reduce DV recidivism. We found five rigorous evaluations covering a variety of non-Duluth group-based treatments. On average, this diverse collection of programs reduced DV recidivism by a statistically significant 33%. Unfortunately, these interventions are so varied in their approaches that we cannot identify a particular group-based treatment approach to replace the Duluth-like model required by Washington State law.

We also searched for evaluations of other approaches to reducing DV recidivism. Unfortunately, we did not find enough credible studies to categorize any specific approach as evidence-based. We did, however, identify a number of approaches to reducing DV recidivism that could be considered promising.

Some strategies that are effective for criminal offenders in general may work for DV offenders as well. The Institute previously published extensive analyses of "what works" to reduce the recidivism rate in the general offender population.<sup>53</sup> Many of these other approaches reduce recidivism and save more money than they cost. The same approaches, if implemented for DV offenders, may also reduce recidivism. Until these approaches are tested and evaluated with DV offenders, however, this can only be regarded as a tentative assumption.

It should also be emphasized that none of the rigorous studies in our review was conducted in Washington State. If the legislature wishes to learn whether Washington's programs are more effective than the non-Washington programs reviewed here, we recommend that rigorous outcome evaluations be conducted.

Treatment providers in Washington State report that, in addition to the legally required Duluth-like group-based model, they also provide other types of treatment, as described in Section IV of this report. Those other treatments could be assessed in a rigorous outcome evaluation. Through a series of outcome evaluations of Washington programs, it may be possible for Washington State to identify an evidence-based DV strategy.

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<sup>52</sup> Lee et al., 2012; Klein, 2009; Feder & Wilson, 2005; and Babcock et al., 2004

<sup>53</sup> Lee et al., 2012

## **II. DV TREATMENT IN OTHER STATES**

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We surveyed other states to determine whether they mandate a specific type of treatment and other aspects of treatment. We found that 44 of 50 states currently have legal guidelines for DV treatment. In 28 states, standards for DV treatment specify the Duluth model by name, or require that power and control dynamics—central to the Duluth model—must be included in the treatment curriculum. In 12 states, the guidelines are less specific in mandating a curriculum or approach. The remaining four states have standards regarding intake and assessment but do not specify treatment type.

Appendix D provides the details of our survey methods and a state-by-state comparison of requirements for DV treatment.

### III. STATEMENT OF THE WASHINGTON STATE SUPREME COURT GENDER AND JUSTICE COMMISSION

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The Washington State Legislature passed HB 2363 which directs the Washington State Institute for Public Policy to:

- assess recidivism by domestic violence offenders
- examine effective community supervision practices as it relates to the WSIPP's findings on evidence-based community supervision; and
- assess domestic violence perpetrator treatment.

HB 2363 also directs WSIPP to collaborate with the Washington State Supreme Court Gender and Justice Commission. The intent of this collaboration is an acknowledgement of the challenges and complexity of reducing recidivism of domestic violence perpetrators so victims are safer and the pattern of abuse is severed. It is a community problem requiring a coordinated systemic problem solving approach. As Dr. Thomas George states in his report, *Domestic Violence Sentencing Conditions and Recidivism*, "Over the last few decades, a wide variety of statutory, procedural, and organizational reforms have been enacted throughout the legal system to combat the widespread and destructive effects of domestic violence."

While efforts attempting to identify effective domestic violence treatment programs should be applauded, a quandary still remains for the court system. Research hasn't identified which perpetrators need lengthy treatment and which ones don't, as well as who is amenable to treatment and who isn't. There is wide variance in the conditions set by the court so it has been difficult to determine the combination of conditions that will be the most effective in reducing recidivism. Thus, judicial officers are left unclear about what sentencing conditions to impose.

Dr. George researched the effect of a variety of sentencing conditions in a multitude of combinations. He found that "[f]rom imposing only fines and/or proscriptions to crafting sentences that involve fines, proscriptions, jail, assessment, treatment, and probation, little consistency exists both within and across jurisdictions." He concludes that this suggests a "lack of clarity and consistency in goals underlying domestic violence sentencing and reflects the ambiguous relationships between goals and sentence conditions. It highlights the lack of research evidence on successful approaches to reducing recidivism upon which judicial officers could base their decisions."

Dr. George's work reflects the legislative mandate that WSIPP "must collaborate" with the Commission. Because of the complexity of domestic violence, the solution is also complex and multifaceted. The HB 2363 report to the legislature must include this reality. More work is needed in this area to determine what role the courts can play in changing abusive behavior so that those victimized by it can feel safe.

Additional work needs to be done in exploring the potential combinations of sentencing conditions that seem to have a positive effect on recidivism and what resources are required by courts to implement these sentencing conditions. Currently, researchers are exploring the impact of judicial monitoring on reducing recidivism. Limited work has been done on identifying the different condition options and which combinations of conditions will be most effective. With the support of the legislature, the Commission is prepared to begin this work for Washington State.

All of the above addresses the "must collaborate" language in HB 2363. The Commission builds its work from the end of the research conducted by WSIPP. Our work will focus on identifying the policies and practices instituted within the court setting that have promise in reducing recidivism in domestic violence cases and as a result enhance safety for the victims.

#### IV. NORTHWEST ASSOCIATION OF DOMESTIC VIOLENCE TREATMENT PROFESSIONALS (NWADVTP) POSITION PAPER REGARDING DOMESTIC VIOLENCE TREATMENT IN WASHINGTON

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This is in response to the research and meta-analysis required by RCW 26.50.800, which WSIPP, the Washington State Institute for Public Policy, has been conducting to evaluate the effectiveness of domestic violence perpetrator treatment in our state. There has been talk in some circles of turning over clinical work with perpetrators to the Department of Corrections Probation Officers, and local probation departments, or sending domestic violence perpetrators to short term anger management type programs. Another option being talked about is jail time for DV offenses with no other intervention. If these changes were to occur, it would effectively remove current Washington State Certified Domestic Violence Perpetrator Programs from providing treatment services to court ordered offenders. State Certified programs meet or exceed 25 pages of regulations in WAC 388-60 designed to maximize victim safety and perpetrator accountability. Our concern is that the manner in which the research is being conducted leads to erroneous conclusions. Those conclusions can be the basis for very dangerous policy decisions that undermine the safety of domestic violence victims and the accountability of perpetrators.

**1. Professional, independent review of the Meta-Analysis and other research required by RCW 26.50.800.** The NWADVTP has contacted professional domestic violence researchers to conduct an independent review of the research, and meta-analysis that is being conducted by Marna Miller, PhD and her team at WSIPP. We have grave concerns about a meta-analysis that only considers a dozen random controlled studies while excluding scores of well conducted, peer-reviewed research projects that show the effectiveness of Domestic Violence Treatment. Further, research that only focuses on legal recidivism misses a more complete picture of how peoples' lives are positively affected by a well-coordinated community response to domestic violence that includes a strong clinical perpetrator treatment component. Though WSIPP believes its standards for evidence lead to more reliable results, we do not believe that the methodology employed by WSIPP can take stock of the complexities of Domestic Violence. The idea of turning over Domestic Violence Treatment to the Department of Corrections and local probation departments is an idea that has not been adequately researched or discussed by all concerned parties. And without such dialogue and research, such a shift in policy can have dangerous and unexpected results.

We believe that victims truly can be safer with quality perpetrator treatment, and we believe that the best research bears this out. Community Corrections Officers and Probation Officers do a great job, but they do not have the clinical background and training to provide effective treatment to domestic violence offenders.

The professionals that we have contacted for review are: Eric Mankowski, PhD, Portland State University; Donald Dutton, PhD, University of British Columbia, Canada; and Edward Gondolf, PhD, University of Indiana.

**2. Domestic Violence is not a simple issue.** Most cases are very complex with many offenders that we see in treatment presenting with multiple issues. The current standards outlined in WAC 388-60 give us minimum guidelines for treatment, and are up for review. Around 80 % or so of our offender clients have Chemical Abuse/Dependency issues at some level. Approximately 1/3<sup>rd</sup> of offender clients have some Mental Health issues including personality disorders. Most offender clients have Power & Control issues, and underlying those issues are:

- a. Attachment Disorders.
- b. Toxic Shame/Guilt from childhood.
- c. Trauma issues from physical, emotional, and sexual abuse as a child.
- d. Trauma issues and PTSD from War, and Family of Origin.
- e. 85% of male offenders, and close to 100% of female offenders have experienced or witnessed Domestic Violence in their Families of Origin.
- f. Dependency/Co-Dependency issues.
- g. Fear/Insecurity/Low Self-Esteem issues.
- h. Many offender clients lack life skills, and coping skills.
- i. Lack of emotional development, emotionally stunted.
- j. Externally focused orientation to life with little, if any, internal focus.

It has been found with most offenders that there is a large amount of denial, minimization and blaming that takes a considerable amount of time to work through. It often takes around three months or so of weekly treatment sessions to allow for a reduction in denial, minimization, and blaming. The above listed issues become a part of the offender's treatment plan. Those offenders with multiple issues as indicated above may need more than one year to address them effectively. If the above issues are not adequately addressed in treatment, the violence is likely to continue and new generations will be exposed to more violence. Short term interventions do not provide enough time or therapy to work through basic issues of denial, minimization or blaming, much less the other pieces necessary for significant and lasting changes in behavior. Arresting, and prosecuting without follow up intervention only aggravates the situation by putting the victims in more danger.

**3. An effective Coordinated Community Response to Domestic Violence** requires that all parties involved in Domestic Violence intervention communicate, and cooperate with each other on a regular on-going basis. The major components of a Coordinated Community Response have historically been the Criminal Justice System, Victim Advocacy Services, and Domestic Violence Treatment Providers. There have been others in the community that have also been a part of this response such as Faith Based Communities, Employers, Violent Crime Victims Advocates, and others providing adjunct services like Chemical Dependency Treatment, Mental Health Services, Non-Violent Parenting Programs, etc.

Most cities, and counties around the State of Washington have meetings in which the members of the Coordinated Community Response come together, at least once per month, to discuss issues with services that are needed in those communities. Those Domestic Violence Intervention Committees (DVIC's), Taskforces, or Commissions have helped to keep the Coordinated Community Response moving in a positive, healthy direction. Many of these groups have been meeting for many years. One of the oldest groups is the Tacoma/Pierce County DVIC which has been meeting regularly since 1989

Over the past few years, we have seen a deterioration of some of those groups, and the overall effectiveness of a Coordinated Community Response in many communities around the State of Washington due in part to the economy and shrinking resources. This deterioration has put more victims of domestic violence at risk, and our overall numbers of domestic violence crimes in the State of Washington have been steadily increasing since 2008 according to WASPC statistics.

We do realize that financial concerns and other priorities have contributed to the deterioration of the Coordinated Community Response. In some communities key players in the Coordinated Community Response are volunteering their time to continue the meetings that are so necessary in maintaining an active Coordinated Community Response to Domestic Violence.

We believe that the right of all human beings to live safely, and peacefully should be the number one priority in all our communities. We need to not lose sight of our priorities if we are to help keep victims safe.

**4. RCW 26.50.150 and WAC 388-60 set the minimum standards for Domestic Violence Treatment.** Certified Domestic Violence Perpetrator Treatment Programs are mandated to adhere to WAC 388-60, but they also have some leeway as to how these standards are implemented by programs. This is as it should be so that offenders can choose a program that fits their needs as is regulated by Federal Statute.

Washington State Department of Health and other regulatory agencies have never been allowed to show preference of one mode of therapy over another. Such decisions are left up to the professionals providing the services, as long as the requirements of the statutes are fulfilled.

At times, some people have promoted specific models of treatment and modes of therapy implying that somehow one is better than another. There is little evidence to prove their case. It is more likely that the therapist-client therapeutic bond would be a better indicator of the client's success in making behavioral change than what mode of therapy is being employed. It has been effectively shown that punitive forms of treatment do not work as they interfere with the establishment of a therapeutic bond, and they model the same inappropriate behaviors that we are attempting to have our client's correct in their own lives.

Many certified programs in the State of Washington use a mode or model of therapy that is Cognitive Behavioral Based with some other aspects of other models included as well. Most programs use a process oriented group therapy that allows for clients to process their issues in a group setting. There are also some culturally relevant treatment programs that include culturally specific elements and language into the treatment process. There are culturally relevant programs for Spanish Speaking Cultures, Native American Cultures, Russian-Ukrainian Cultures, and Afro-American Cultures.

Some of the modes of therapy used in treatment programs around the State of Washington include, but are not limited to:

- a. Cognitive Behavioral Therapy (CBT).
- b. Reality Therapy, and other versions of Reality type Therapy.
- c. Developmental Therapy.
- d. Adlerian Therapy.
- e. Transpersonal Therapy.
- f. Moral Reconciliation Therapy (MRT).
- g. Culturally Relevant Therapies.
- h. Trauma-informed Therapies.

There are also some adjunct types of therapy in addition to Domestic Violence Treatment that are beneficial to the success of our clients, such as:

- a. Trauma Reduction Therapies (EMDR, Hypnotherapy, NLP, etc.).
- b. Chemical Dependency Treatment and 12 Step Program Participation.
- c. Alanon, Co-Dependency Anonymous, Adult Children of Alcoholics, Sex and Love Addicts Anonymous, as an adjunct or aftercare program, etc.
- d. Mental Health Counseling/Medication.
- e. Individual Therapy for PTSD, Personality Disorders, etc.

Most Domestic Violence Treatment Programs in the State of Washington require clients to complete homework assignments. Some of the assignments may include:

- a. Writing and presenting of Life Story to the group.
- b. Empathy Letter to the victim/victims.
- c. Reports on certain topics/books pertinent to the client's recovery.
- d. Recovery Plans/Safety Plans.
- e. Cultural Stories to present to group.
- f. Ceremonies/rituals to make change and reduce violence.
- g. Anger and Control logs.
- h. and many other types of assignments pertinent to the clients recovery.

Domestic Violence Treatment Programs have to address the serious problem of relapse of Chemical use as well as Behavioral Relapse. Though relapse is not a requirement for clients going through treatment, it seems to be problematic for some of our clients. This needs to be taken into consideration when doing research about recidivism. Some clients seem to need to prove to themselves that they have a problem. Relapse tends to happen for some clients before they make real lasting change. So, some clients will have their programs extended or re-start treatment more than once in some cases, and make several trips to see the judge or probation officer for violations of their agreement or for new offenses. Domestic Violence Treatment and lasting recovery from the perpetration of violence is a process that is on-going for the rest of the client's life. We need to realize that it is a process, and not a one time or short term event.

**5. Domestic Violence Treatment does work.** When there is a solid Coordinated Community Response treatment works very well for many people. Most treatment providers know this. It's why we continue to do this difficult and often thankless work. Providers are encouraged to have some way of measuring outcomes with their programs. Some programs have well thought out methods of tracking client outcomes. There has not been much real research done on treatment programs in the State of Washington. There needs to be quality research on all available programs to clearly see the validity and effectiveness of Domestic Violence Treatment. Most research has been done on other programs outside the State of

Washington with attempts to compare them to what we do in Washington. Not all programs are the same in length, content, or structure.

**6. Short term CCAP/MRT type programs have not been adequately researched to show their effectiveness in addressing Domestic Violence issues.** Some short term programs that have cropped up in the State of Washington have not been shown to be effective for long-term recovery from violence and abuse. Some programs see an offender anywhere from one or two sessions to maybe 20 sessions with no consistency in length or content. Many of these types of programs do not have time to address issues of denial, minimization, and blaming effectively, and they certainly don't have time to address the myriad of other issues. There seems to be a movement among some judges and attorneys to find different ways to address Domestic Violence issues. Looking for ways to improve the quality of Domestic Violence Intervention is what we all want, but without a solid understanding of the complexities of Domestic Violence we can end up with simplistic, ineffective solutions to very complex issues.

**7. What we see as valid outcomes of DV Treatment, and possible outcome based evaluations.** In addition to completing all of the requirements of WAC 388-60 and the treatment program contract, some programs around the state have developed tools to assist in measuring outcomes of perpetrator treatment. One such tool is the Perpetrator Index that was developed many years ago by the Tacoma/Pierce County DVIC, a work group of the Pierce County Commission Against Domestic Violence. The Perpetrator Index was developed with input from victim advocacy services, criminal justice system, and treatment providers. It is currently used by some programs around the State of Washington. There are probably other types of outcome evaluations being used in different parts of the state. We would like to see a collaborative effort to create a way to conduct outcome type research with treatment programs around the state. Documentation needs to go beyond recidivism looking at the reduction of negative behaviors and activities, replaced by positive behaviors and activities. Having verification of these behavioral changes from the victim and others in the client's life without placing the victim in a dangerous position would be an important part of this process.

**8. Possible solutions to current situation in DV Program supervision with DSHS, peer review, possible DOH Credentialing, and possible RCW and WAC revisions.** It is obvious to most people that the State of Washington has never put forth resources to adequately supervise and monitor Domestic Violence Treatment Programs. Additionally, people in those positions over the years have not possessed the experience or training needed to effectively supervise DV treatment programs (no offense to any of them). One of the requirements is to have experience working with Perpetrators of Domestic Violence in a State Certified Treatment Program. The people who are charged with Program Management at DSHS typically have worked alone, with no administrative or clerical help. They provide certification of programs, re-certification of programs, and investigation of complaints against programs. The DSHS Advisory Committee that is outlined in WAC 388-60 has not met in close to 15 years. The explanation that has been given has been that DSHS does not have the money to pay travel expenses to members of that committee. Most people would volunteer their time, and travel expenses to provide quality input to DSHS regarding Domestic Violence Treatment. There is no excuse for not having the Advisory Committee meet on a regular basis as is required by WAC 388-60.

The NWADVTP (formerly known as WADVIP) has over the years attempted to provide programs with Peer Review/Consultation (free of charge). We have also provided on-going continuing education in the form of Annual Domestic Violence Conferences (since 1994), and short term workshops where we bring in Domestic Violence Experts from the local community, and around the world to present on relevant issues, and new ideas on the Treatment of Domestic Violence. Presentations have been made by; Ellen Pence, PhD, Lenore Walker, EdD, Donald Dutton, PhD, Daniel Sonkin, PhD, Caroline West, PhD, Barbara Hart, PhD, and Oliver Williams, PhD just to name a few. With some local expert presenters such as: Anne Ganley, PhD, Roland Maiuro, PhD, April Gerlock, PhD, ARNP, and others from the Northwest. These trainings continue to be widely accepted and attended by treatment providers. The NWADVTP currently represents approximately 75 % of Domestic Violence Treatment Providers from around the State of Washington with some members from Oregon, Idaho, and British Columbia.

We believe that the current WAC 388-60 should be revised and updated as a means of continuing to improve the quality of clinical work done in Domestic Violence Treatment Programs in our state. Topics for discussion about WAC updates among all stakeholders could include:

- a. Domestic Violence specific education/training requirements for potential providers (review or upgrade as needed).
- b. Change the name of our organization from WADVIP to NWADVTP.
- c. Re-activate the DSHS Advisory Committee as a volunteer committee.
- d. Establishing standards for Family Court Evaluations, and Criminal Court Assessments.
- e. Possible Peer Review/Consultation for Domestic Violence Programs.
- f. Improved trainee and staff supervision.
- g. Other possible changes as suggestions are submitted.

Washington State has been at the forefront of addressing the issues of Domestic Violence in all of its complexities, in order to create a safer community for all of our citizens, especially those who are most vulnerable. The State of Washington has been deemed as progressive by many in the Domestic Violence movement around the country. This is not a time to retreat from the gains that have been made over the last several decades in establishing an effective Coordinated Community Response to Domestic Violence: it is a time to build on those gains and move forward in a progressive manner. To do that will require hearing from all who are affected by and concerned about Domestic Violence. Nothing less than the best, fullest, and most accurate information is what will allow us to shape policies and practices that can truly help to end the on-going cycle of Domestic Violence in our community.

Respectfully,

NWADVTP Board of Directors

"Electronically Signed"

Steven C. Pepping, MA, CDP, DVP

Northwest Association of Domestic Violence Treatment Professionals, President

## ACKNOWLEDGEMENTS

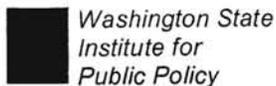
We are grateful to the Washington Supreme Court Gender and Justice Commission for meeting with us as we updated our systematic review of the literature.

The Northwest Association of Domestic Violence Treatment Professionals (NWADVTP) generously allowed time on their conference agenda to discuss our review of the treatment literature and the board of NWADVTP met with us in Olympia to discuss our methods for selecting studies to use in meta-analysis.

We thank Dr. Emily Tanner-Smith at the Vanderbilt University who served as a third coder to review studies to determine which met inclusion criteria.

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