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Evaluation of Washington State Domestic Violence - Moral Reconation Therapy (DV-MRT) Programs Process and Outcomes

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Evaluation of Washington State Domestic Violence – Moral Reconation Therapy (DV-MRT) Programs Process and Outcomes

June 30, 2021

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This report was developed under Project Grant number SJI-18-N-029 from the State Justice Institute. The points of view expressed are those of the authors and do not necessarily represent the official position or policies of the State Justice Institute.

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Acknowledgements

The researcher at Washington State University would like to thank the following individuals for their involvement and support in this project:

- The Washington State Administrative Office of the Courts for their assistance in providing access to data and answers to my questions. Specifically I would like to thank the following individuals: Dr. Amanda Gilman and Kevin Cottingham.

- The Gender and Justice Commission for their technical assistance in conducting the evaluation to term, by providing both knowledge of the content area, introductions to the various evaluation sites, connections to knowledgeable individuals, and feedback on earlier drafts. I am particularly appreciative of the following individuals: Sierra Rotakhina, Kelley Amburgey-Richardson, Laura Jones, Dr. Dana Raigrodski and Justice Sheryl Gordon McCloud.

- Two program facilitators who I will not name to preserve the confidentiality of their identities but who answered many of my questions about the inner workings of the program in a timely manner.

- Washington State University graduate students Samantha Tjaden for assistance with the outcome evaluation and Erica Magana for assistance with the process evaluation.

- Washington State University colleague Dale Willits for his insight on various methodological ideas, Wade Lafferty for his technical expertise in data security and Amanda Yager for her work on contract management.

Table of Contents

Acknowledgements....2

Table of Contents....3

List of Tables....6

List of Figures....7

Executive Summary....8

Section 1: Introduction....10

Section 2: Program Background....12

- MRT Theoretical Background....12
- MRT Empirical Support....13

Section 3: Overview DV-MRT program in Washington State....16

- Counties And Courts With DV-MRT Access....16
- Court-Sponsored DV-MRT Programs Included In the Current Evaluation....21

Section 4: Program Documents Review....22

- DV-MRT Program And Workbook....22
- Progress Through The Program....26
- DV-MRT Contract....27
- Cost....29

Section 5: Process Evaluation: Survey and Focus Group Results 30
Program Implementation 31
Eligibility Criteria 31
Male and Female DV-MRT Programs 33
Enforcement of Rules about Timeliness and Absences 34
Treatment Modalities During COVID-19 34
Interview Results 35
Results of Individual Interviews with Program Participants 35
Theme 1: Program Content 36
Theme 2: Program Facilitators 37
Theme 3: Peers 37
Theme 4: Cost Of Program 38
Theme 5: Workbook 39
Theme 6: Program Process 40
Theme 7: DV-MRT During COVID-19 41
Results of Interviews and Survey with DV-MRT Facilitators 43
Theme 8: Program Content and Perceived Effectiveness 43
Theme 9: Workload 45
Theme 10: Program Scheduling 45
Theme 11: Workbook 46
Theme 12: DV-MRT During COVID-19 47
Summary 49
Section 6: Outcome Evaluation 50
Research Question 50
Study Design 51
Study Groups 51
Measures 52
Matching Procedure: Propensity Score Modeling (PSM) 54

Analysis Plan 58

Outcome Evaluation Results 59

Any DV Reconviction 59

Felony DV Reconviction 61

Subgroup Analyses 62

Sex 63

Race 64

Program Completion 66

Summary 67

Section 7: Conclusion and Recommendations 68

References 71

List of Tables

Table 1. Counties And Courts With DV-MRT Access 18

Table 2. Counties And Courts Without DV-MRT Access 19

Table 3. Type Of DV-MRT Referrals In Courts With DV-MRT 20

Table 4. Court-Sponsored DV-MRT Programs Accepting Participants From Outside Jurisdictions 20

Table 5. List Of Court-Sponsored DV-MRT Programs Included In The Evaluation 21

Table 6. Facilitator DV-MRT Certification Training Schedule 23

Table 7. Themes From Individual Interviews 35

Table 8. Propensity Score Modeling And Sample Descriptives 57

Table 9. Chi-Square Analyses: Any DV Reconviction By Treatment And Comparison Groups 59

Table 10. Cox Regression Coefficient By Treatment Group For Any DV Reconviction Model 60

Table 11. Chi-Square Analyses: Felony DV Reconviction By Treatment And Comparison Group 62

Table 12. Chi-Square Analyses: Any DV Reconviction For Females And Males By Treatment And Comparison Groups 64

Table 13. Chi-Square Analyses: Any DV Reconviction By Race By Treatment And Comparison Groups 65

Table 14. Chi-Square Analyses: Any DV Reconviction By Program Completion Status 66

List of Figures

Figure 1. Counties (And Number Of Courts) With DV-MRT Access..17

Figure 2. MRT Treatment Components..24

Figure 3. Percent Of Any Reconviction By Treatment And Comparison Groups At 2 Time Points 59

Figure 4. Hazard Function – Any DV Reconviction By DV-MRT Treatment And Comparison Groups...61

Figure 5. Percent Of Felony DV Reconviction By Treatment And Comparison Groups At 2 time points 62

Figure 6. Percent Of Any DV Reconviction For Females And Males By Treatment And Comparison Groups At 2 Time Points 64

Figure 7. Percent Of Any DV Reconviction By Race By Treatment and Comparison Groups At 2 Time Points..65

Figure 8. Percent Of Any DV Reconviction By Program Completion Status At 2 Time Points........66

Executive Summary

Domestic Violence (DV) is a problematic issue that is often cyclical in nature. As such, significant efforts and resources have been invested to reduce the recurrence of DV offending. These efforts include implementing intervention programs to foster behavioral change in known perpetrators. While there has been a vast amount of research conducted to identify various programs' effectiveness at reducing such recidivism, costs of traditional DV treatment are high and often prohibitive for many justice-involved individuals. In an attempt to counteract the cyclical nature of DV and to address the high costs of DV treatment, the Washington State Supreme Court Gender and Justice Commission called for an evaluation of court-sponsored Domestic Violence – Moral Reconation Therapy (DV-MRT) programs. An important goal of DV-MRT is to provide treatment to DV justice-involved individuals and enhance their moral reasoning, decision-making, and ultimately their behavior in the context of domestic conflict.

DV-MRT is founded on sound treatment principles. It specifically addresses the lack of affordable DV treatment in some jurisdictions by offering DV treatment at a fraction of its usual cost. As such, DV-MRT has the potential to better serve a population of DV justice-involved individuals and to increase public safety by reducing the occurrence of DV recidivism. However, DV-MRT's effectiveness remains to be established through a rigorous research design. To this end, researchers at Washington State University (WSU) completed a multi-phase evaluation project to examine the implementation, process, and outcomes of court-sponsored DV-MRT treatment.

***Process Evaluation**:* The purpose of this research is to provide a deeper understanding of the DV-MRT programs implemented at five courts in Washington State located in King and Snohomish Counties, and review their implementation and operations with court-involved individuals (men and women). To conduct the current process evaluation, WSU researchers undertook the following tasks: 1) review of documents relative to the program; 2) individual interviews of current and graduate DV-MRT program participants; 3) individual interviews with DV-MRT program facilitators; and 4) analysis of short survey data administered to program facilitators.

When examining the implementation and operations, we uncovered four areas of divergent implementation, specifically 1) inconsistent exclusion of individuals charged with a DV offense but not adjudicated; 2) same-sex or mixed-sex treatment group; 3) rules relative to absences and tardiness

and; 4) treatment modalities during COVID-19. As a whole, these areas of divergence do not pose an important implementation fidelity risk, but court-sponsored DV-MRT programs should strive to be as consistent as possible.

Findings from the qualitative data analysis of individual interview transcripts and short surveys revealed several major themes for both program participants and program facilitators. They are summarized as follows:

Program Participants	Program Facilitators
Program Content Facilitators and Peers Program Cost Workbook Program Process DV-MRT During COVID-19	Program Content and Perceived Effectiveness Workload Program Scheduling Workbook DV-MRT During COVID-19

DV-MRT program participants (both current and graduate) highlighted strengths to the existing program, notably its content, the dedication of its facilitators, and the program's low cost, but were critical of the workbook. The facilitators restated these themes, also discussing some additional challenges to their workload due to managing the DV-MRT program. We also found that COVID-19 changed the treatment modalities of court-sponsored DV-MRT programs and presented new challenges (more interruptions and distractions, lower accountability), but also provided opportunities, notably for increased flexibility, that many hoped would remain even post-COVID-19.

Outcome Evaluation: The focus of the outcome evaluation was to examine if DV-MRT was meeting its intended goal of DV reconviction reduction. We utilized a rigorous quasi-experimental design and made use of a historical matched comparison group comprised of individuals who were released in King and Snohomish counties prior to the implementation of court-sponsored DV-MRT. Overall, the findings of the outcome evaluation are positive and indicate that participation in the DV-MRT program appears to reduce the likelihood of Any DV Reconviction (1-year: 8.4% versus 12.5%; 2-year: 14.9% versus 19.0%). This differential pattern of recidivism between study groups demonstrates that the DV-MRT program appears to increase public safety in preventing the reoccurrence of DV crimes in the short-term by court-involved individuals. This makes court-sponsored DV-MRT a promising program considering its much lower costs compared to traditional DV treatment.

Section 1: Introduction

This report is written and submitted by a researcher with Washington State University (WSU) Department of Criminal Justice and Criminology in response to the request for a process and outcome evaluation of the court-sponsored Domestic Violence Moral Reconation Therapy programs (DV-MRT) implemented at various sites in Washington State. This report covers the combined findings from the *process and outcome evaluation* of six DV-MRT programs in Washington State.

As part of the process evaluation, this report examines the practice (i.e., implementation and operations) of court-sponsored DV-MRT programs at five[1] courts of limited jurisdiction in Washington State. Data for the process evaluation were gathered via document review, individual interviews, and short surveys. We specifically recorded experiences with DV-MRT from program participants (both current participants and graduates of the program) and DV-MRT facilitators. Findings from these various sources are combined to produce a general understanding of how DV-MRT is implemented and operates at these sites, both before and during COVID-19. The process evaluation also identifies areas of strengths and of potential improvements in the program's operations, allowing for recommendations of useful modifications going forward. The process evaluation also serves to inform the subsequent outcome study.

For the outcome evaluation, this report seeks to determine whether six court-sponsored DV-MRT programs in Washington State are effective in achieving their goals of DV recidivism reduction among program participants when compared to a similar group of individuals not participating in the program. Quantitative data for the outcome evaluation were compiled by the Administrative Office of the Courts; they received information about DV-MRT program participants from each of the court sites and linked it with criminal history and recidivism data, along with providing similar information

[1] Six courts were reviewed for both the process and outcome evaluation, however, one court failed to respond to requests during the process evaluation. This resulted in the inclusion of only five of the six courts in the process evaluation. All six courts were examined for the outcome evaluation.

about a large pool of comparison subjects. Statistical analyses of these data are conducted to determine if DV-MRT participants had lower reconviction rates for any type of DV-related offenses and for felony DV specifically. This section answers the question "*Does DV-MRT work in reducing DV reconviction?"* by providing evidence about its effectiveness.

Section 2: Program Background

Domestic Violence is a problematic issue. It is estimated that approximately one in four women and one in nine men will experience a type of violence perpetrated by a current or former intimate partner (National Coalition Against Domestic Violence (NCADV)). One response to this issue by the Criminal Justice System was the creation of domestic violence courts and the use of treatment as a legal remedy (Labriola et al., 2008). The most common treatment of domestic violence perpetrators are batterer intervention programs (BIPs). BIPs are education-oriented treatment programs that focus on reducing re-offending through education about accountability, empathy for victims, and non-violent resolution behaviors (GoodTherapy, 2019). A popular BIP utilized in the Criminal Justice System is Moral Reconation Therapy (MRT). MRT is a structured, cognitive behavioral-based program aimed at helping individuals increase their moral judgement and reasoning skills (Little & Robinson, 1988) that can be administered as a stand-alone treatment or along with other existing treatment programs [2] (Moral Reconation Therapy (MRT), n.d.).

MRT Theoretical Background

While MRT draws heavily from various psychological and personality development theories (G. Little & Robinson, 1988), two of the main theories framing MRT are reconation therapy as devised by Wood & Sweet (1972) (Moral Reconation Therapy (MRT), n.d.) and the theory of moral development (Kohlberg, 1976). *Reconation therapy* aims to help individuals learn how to reflect on past behaviors and decisions, as well as to learn how to make better decisions moving forward, with an emphasis on reducing the influence of hedonistic tendencies on individuals' decision-making and behaviors (G. Little & Robinson, 1988), comprising the "cognitive" component. The "moral" component of MRT is based on Lawrence Kohlberg's (1976) *theory of moral development* in which he put forth three levels of morality: preconventional morality, conventional morality, and post-conventional morality. He posits that as individuals grow, morality progresses from self-interested needs to moral judgement based on

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[2] MRT advertises the ability of the program to be utilized in combination with other treatment programs but there is a lack of clarification of which programs MRT is effective with.

broader factors, and then finally to a moral judgement based on universal principles of mutual benefits and respect. Relying on these moral development concepts, MRT programs aim to help individuals make a shift from preconventional to conventional morality by helping individuals not only reflect on their decisions, but also increase their moral judgement and reasoning skills. One of the ways in which MRT works to increase moral reasoning is by addressing the underlying roadblocks, like an underdeveloped concept of self and identity, that prevent individuals from reaching a higher level of morality. This in turn is expected to help individuals reduce and/or eliminate criminal involvement and related destructive behaviors.

MRT Empirical Support

MRT programs and their target populations have expanded since the establishment of the first MRT pilot program in 1987 at Shelby County Jail with a group of justice-involved women from the general population (Moral Reconation Therapy (MRT), n.d.). The initial success of the pilot program led to the creation of Correctional Counseling Inc. (CCI), a private company responsible for the creation of MRT training/curriculum materials and facilitation of MRT programs at other sites (Ferguson & Wormith, 2013). While the program's target population were originally those with substance abuse problems only, MRT has been extended to treat other offending populations like court-involved youth and individuals who committed domestic violence offenses (Ferguson & Wormith, 2013; Moral Reconation Therapy (MRT), n.d.).

MRT is an adaptable approach to treating a myriad of behavioral problems among various types of justice-involved individuals and has been posited to reduce recidivism rates (Moral Reconation Therapy (MRT), n.d.). Existing research lends support to the idea that MRT can decrease criminal thinking (Burnette et al., 2004; Little, 2000). Specifically, MRT has been found to reduce criminogenic thinking by reducing hedonistic tendencies among MRT-treated individuals (Burnette et al., 2004, 2005; Little, 2000). In other words, individuals learn how to reduce or overcome impulsive behaviors that may lead them to engage in criminal behavior. Researchers have also found other MRT benefits. Using an array of psychological instruments, findings suggest that MRT can help increase individuals' locus of internal control, showing an increased perception of the control they believe they have over their lives and events (Burnette et al., 2004). MRT has also been associated with increased levels of self-esteem (Burnette et al., 2004, 2005; Little, 2000), increased perceptions of one's life purpose (Burnette et al., 2004; Little, 2000), and increased perceptions of social support (Burnette et al., 2004).

Considering these general positive outcomes, MRT seems well positioned to address risk factors for intimate partner violence and domestic violence, such as anger, hostility, and internalization of negative emotions (Birkley & Eckhardt, 2015; Eckhardt et al., 2008; Stith et al., 2004).

While MRT has been utilized since 1995 as a treatment for domestic violence offending, referred to as DV-MRT, few outcome evaluations studying the effectiveness of MRT in reducing DV recidivism specifically have been published (Little, 2000). In a study with domestic violence perpetrators treated with MRT, Fann & Watson, (1999) found a 64% completion rate for participants. They also found differences in terms of re-arrest rates for domestic violence offenses between program completers and non-completers. Individuals who completed the program had a 7.3% re-arrest rate compared to the 35% re-arrest rate for non-completers (as cited in Little, 2000). In another study of MRT effectiveness, Leonardson, (2000) evaluated general and domestic violence recidivism outcomes among 175-court ordered DV justice-involved individuals over a two-year period. Program participants were divided into three groups: no-show, started/dropped, and completed. At the one-year mark, those who completed the program had lower rates of any new arrest, 29.4% versus 50.6% for no-shows and 60% for those who started but dropped (starters/droppers). For new domestic violence arrests, program completers also had lower rates, 7.8% versus 19% for no-shows and 13.3% starters/droppers. At the two-year mark, those who completed the program had lower rates for new arrests, with completers having a rate of 48.6% versus 58.7% for no-shows and 74.2% for starters/droppers. Similarly, program completers had a new domestic violence arrest rate of 10.8% versus 39.1% for no-shows and 22.6% for starters/droppers. Overall, these two studies suggest that MRT may be an effective strategy in reducing specific-offense recidivism among DV justice-involved individuals.

Whilst MRT appears promising in reducing recidivism rates, more research needs to be done about the outcomes of DV-MRT for justice-involved individuals having committed DV offenses. Of notable concern is that existing research has focused on outcomes only, with little to no research on the program implementation and process. Additionally, existing research lacks the inclusion of control variables or has failed to specify control variables (Little, 2000; Little et al., 1990, 1993) and lacks equivalent and comparable control groups (Burnette et al., 2004; Deschamps, 1998; Little et al., 1990, 1999; Little & Robinson, 1989; Wallace, 2001).

Having studied domestic violence perpetrator treatment extensively in Domestic Violence Work Groups established by 2017 and 2019 legislation, the Gender and Justice Commission selected the

court-sponsored DV-MRT programs implemented and operating at various sites in Washington State for further evaluation. The programs aimed to reduce DV recidivism among justice-involved individuals who had committed such an offense by providing accessible treatment. Under DV-MRT, these individuals are now provided with low-cost treatment services for at least 24 weeks. This report evaluates DV-MRT's implementation, process, and program outcomes at six selected sites[3] in Washington State. It also addresses existing issues in the current literature, specifically by considering program process and building a strong equivalent comparison group.

[3] Six courts in Washington with DV-MRT were included in the outcome evaluation, however, only five courts responded to researcher requests for participation in the process evaluation.

Section 3: Overview DV-MRT program in Washington State

In this section, we present a current portrayal of court-sponsored DV-MRT programs in Washington State. DV-MRT in Washington State does not have an organizing body overseeing all programs offered in courts and is limited to being offered by courts of limited jurisdiction (CLJ); thus, our first step in recruiting programs to participate in the evaluation was compiling an inventory of past and current DV-MRT programs. We used two strategies. The first was to send out a survey to the court administrators and presiding judges of all courts of limited jurisdiction (CLJs) in the state. In this survey we asked participants about DV-MRT programs offered within their courts as well as programs they were aware of in other courts. Of the 246 courts, at least one representative from 134 (54%) responded to the survey. Second, we contacted representatives from the court-sponsored DV-MRT programs that were already known to the Gender and Justice Commission and asked those representatives about other programs of which they were aware.

Counties And Courts With DV-MRT Access

Based on the survey results, we present a list of counties and courts with and without DV-MRT access (see Tables 1 and 2). A map of Washington State highlighting the counties offering DV-MRT referrals is included in Figure 1. Of the 39 counties within Washington[4], 12 counties have courts offering DV-MRT referrals. Table 3 presents the list of all 51 Washington courts with DV-MRT access. Among those courts, the 22 courts listed in the far-left column of Table 3 refer individuals to their own in-court program. In comparison, courts listed in the middle column of Table 3 refer individuals from their jurisdiction to outside programs but do not themselves offer a court-sponsored DV-MRT program. Finally, the courts listed in the far-right column refer individuals to programs provided within their court and to programs outside of the court. A list of court-sponsored DV-MRT programs accepting participants from outside jurisdictions is presented in Table 4.

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4 Court response was low with over half not responding to requests for information, which has resulted in programs/counties not being identified and/or included in the following tables.

Figure 1. Counties (And Number Of Courts) With DV-MRT Access

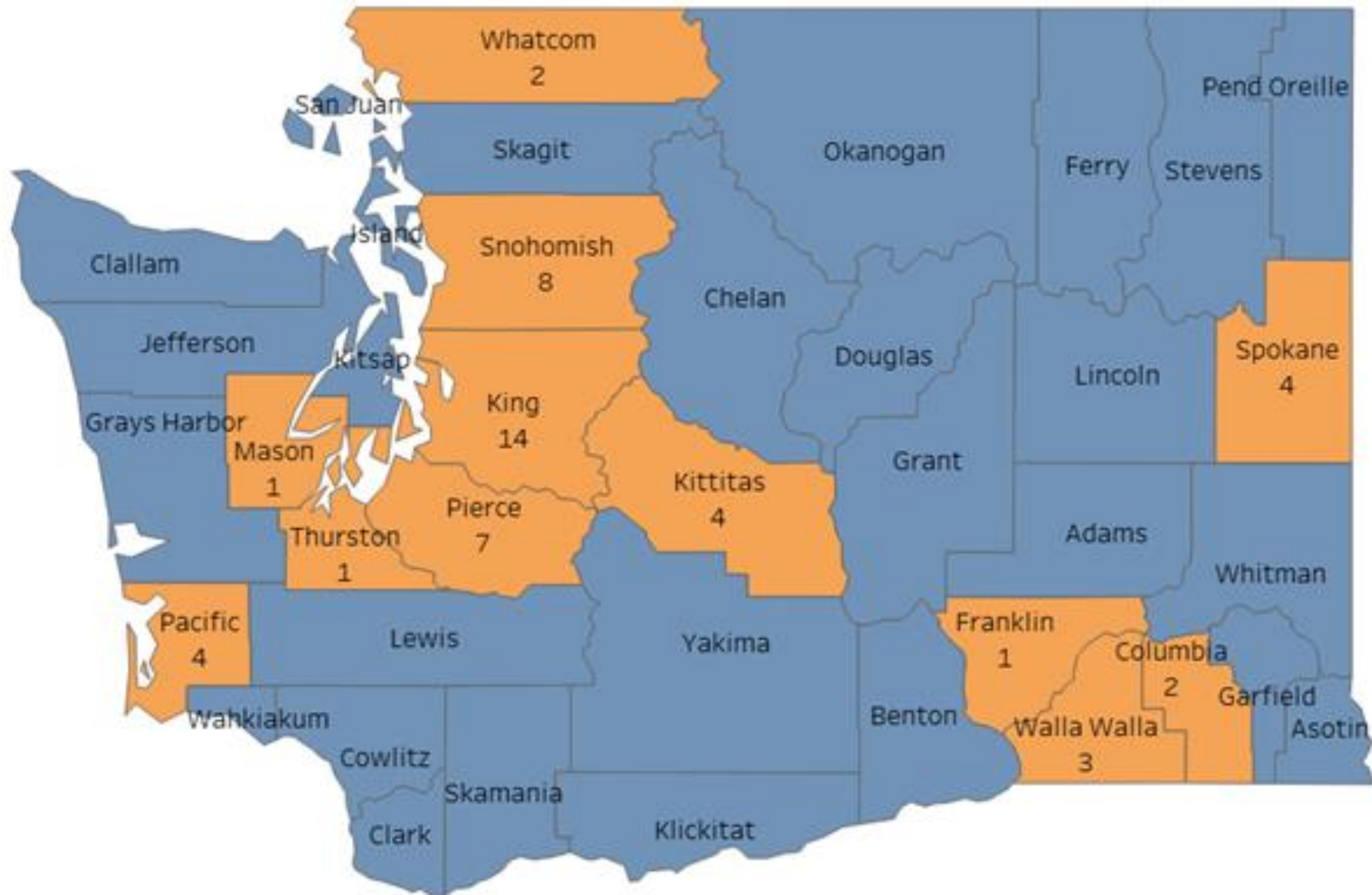


Table 1. Counties And Courts With DV-MRT Access

County	**Court(s)**
Columbia	Columbia District Court; Dayton Municipal Court
Franklin	Pasco Municipal Court
King	Bellevue Municipal Court; Bothell Municipal Court; Des Moines Municipal Court; Enumclaw Municipal Court; Federal Way Municipal Court; Issaquah Municipal Court; Kent Municipal Court; Kirkland Municipal Court; Maple Valley Municipal Court; Normandy Park Municipal Court; Pacific Municipal Court; Renton Municipal Court; SeaTac Municipal Court; Tukwila Municipal Court
Kittitas	Cle Elum Municipal Court; Lower Kittitas District Court; Roslyn Municipal Court; Upper Kittitas District Court
Mason	Mason District Court
Pacific	Ilwaco Municipal Court; Long Beach Municipal Court; N. Pacific District Court; S. Pacific District Court
Pierce	Bonney Lake Municipal Court; Eatonville Municipal Court; Milton Municipal Court; Pierce District Court**; Puyallup Municipal Court; S. Prairie Municipal Court; Sumner Municipal Court
Snohomish	Cascade District Court; Edmonds Municipal Court; Everett District Court; Everett Municipal Court; Evergreen District Court; Lake Stevens Municipal Court; Marysville Municipal Court; S. Snohomish District Court
Spokane	Airway Heights Municipal Court**; Cheney Municipal Court; Spokane District Court; Spokane Municipal Court
Thurston	Olympia Municipal Court
Walla Walla	College Place Municipal Court; Walla Walla District Court; Walla Walla Municipal Court
Whatcom	Bellingham Municipal Court; Whatcom District Court

** Conflicting survey information due to more than one response per court

Table 2. Counties And Courts Without DV-MRT Access

County	Court(s)
Adams	Ritzville District Court
Chelan	Chelan District Court; Wenatchee Municipal Court
Clallam	Clallam 1 District Court; Clallam 2 District Court; Port Angeles Municipal Court; Sequim Municipal Court
Clark	Battle Ground Municipal Court; Clark District Court
Douglas	Bridgeport Municipal Court; Douglas District Court; E. Wenatchee Municipal Court
Franklin	Connell Municipal Court; Franklin District Court
Grays Harbor	Aberdeen Municipal Court; Elma Municipal Court; Grays Harbor District Court - Dept. 1; Grays Harbor District Court - Dept. 2; Hoquiam Municipal Court; McCleary Municipal Court; Oakville Municipal Court; Ocean Shores Municipal Court; Westport Municipal Court
Island	Coupville Municipal Court; Island District Court; Langley Municipal Court; Oak Harbor Municipal Court
Jefferson	Jefferson District Court; Port Townsend Municipal Court
King	Lake Forest Park Municipal Court; Mercer Island Municipal Court; Newcastle Municipal Court; Seattle Municipal Court
Kitsap	Bremerton Municipal Court; Kitsap District Court; Port Orchard Municipal Court; Poulsbo Municipal Court
Klickitat	Bingen Municipal Court; E. Klickitat District Court; Goldendale Municipal Court; W. Klickitat District Court; White Salmon Municipal Court
Lewis	Centralia Municipal Court; Chehalis Municipal Court; Lewis District Court; Morton Municipal Court; Mossyrock Municipal Court; Napavine Municipal Court; Pe Ell Municipal Court; Toledo Municipal Court; Winlock Municipal Court
Lincoln	Lincoln District Court; Odessa Municipal Court; Reardan Municipal Court; Sprague Municipal Court; Wilbur Municipal Court
Okanogan	Okanogan District Court; Twisp Municipal Court
Pacific	Raymond Municipal Court; South Bend Municipal Court
Pend Oreille	Pend Oreille District Court
Pierce	Buckley Municipal Court; DuPont Municipal Court; Gig Harbor Municipal Court; Lakewood Municipal Court; Roy Municipal Court; Steilacoom Municipal Court; University Place Municipal Court
San Juan	San Juan District Court
Skamania	N. Bonneville Municipal Court; Skamania District Court; Stevenson Municipal Court
Thurston	Tenino Municipal Court
Wahkiakum	Wahkiakum District Court
Whatcom	Everson Nooksack Municipal Court; Ferndale Municipal Court; Lynden Municipal Court
Whitman	Colfax Municipal Court; Union Town Municipal Court; Whitman District Court
Yakima	Sunnyside Municipal Court; Toppenish Municipal Court; Yakima Municipal Court

Table 3. Type Of DV-MRT Referrals In Courts With DV-MRT

In-Court Referrals	Out-of-Court Referrals	Both Types of Referrals
Bonney Lake Municipal Court	Airway Heights Municipal Court***	Cascade District Court
Bothell Municipal Court	Bellingham Municipal Court	Des Moines Municipal Court
Cle Elum Municipal Court	Columbia District Court	Edmonds Municipal Court
College Place Municipal Court	Dayton Municipal Court	Everett Municipal Court
Eatonville Municipal Court	Enumclaw Municipal Court	Evergreen District Court
Kirkland Municipal Court	Federal Way Municipal Court	Normandy Park Municipal Court
Lake Stevens Municipal Court	Issaquah Municipal Court	Puyallup Municipal Court
Lower Kittitas District Court	Kent Municipal Court	S. Snohomish District Court
Marysville Municipal Court	Maple Valley Municipal Court	Tukwila Municipal Court
Mason District Court	Pacific Municipal Court	
Milton Municipal Court	Pierce District Court **	
Olympia Municipal Court	Renton Municipal Court	
Pasco Municipal Court	Spokane District Court	
Roslyn Municipal Court		
S. Prairie Municipal Court		
SeaTac Municipal Court		
Spokane Municipal Court		
Sumner Municipal Court		
Upper Kittitas District Court		
Walla Walla Municipal Court		
Walla Walla District Court		
Whatcom District Court		

** Conflicting survey information due to more than one response per court
*** Court reported past access to DV-MRT program

Table 4. Court-Sponsored DV-MRT Programs Accepting Participants From Outside Jurisdictions

Bonney Lake Municipal	Mason District
Bothell Municipal Court	Normandy Park Municipal Court
Cascade District Court	Roslyn Municipal Court
Cle Elum Municipal Court	S. Prairie Municipal Court
Des Moines Municipal Court	S. Snohomish District Court
Eatonville Municipal Court	SeaTac Municipal Court
Edmonds Municipal Court	Spokane Municipal Court
Everett Municipal Court	Sumner Municipal Court
Evergreen District Court	Tukwila Municipal Court
Kirkland Municipal Court	Upper Kittitas District Court
Lower Kittitas District Court	

Court-Sponsored DV-MRT Programs Included In the Current Evaluation

Through these two efforts described in the introduction of the current section, we identified various DV-MRT programs offered through Courts of Limited Jurisdiction (CLJ) in the state (either currently or historically). Many of the DV-MRT programs were small and/or had not been operating long, and as a result, had enrolled very few participants. We decided against recruiting from nine such programs. Of the fifteen programs we contacted, seven agreed to participate in the evaluation in some capacity. All but one of these programs were located in King or Snohomish County. One program from the east side of the state agreed to participate in the evaluation, but we ultimately decided to exclude it as it was the only program we encountered that was targeted to a specific population (veterans) rather than the general population of individuals charged with a DV offense. In addition, we wanted to avoid introducing potential bias based on geography. Thus, our treatment group consisted of individuals who participated in a court-sponsored DV-MRT program in one of six CLJs in King and Snohomish counties. They are listed in Table 5.

Table 5. List Of Court-Sponsored DV-MRT Programs Included In The Evaluation

Process Evaluation	Outcome Evaluation
Des Moines Municipal Court Edmonds Municipal Court Everett Municipal Court Snohomish District Court Tukwila Municipal Court	Bellevue Municipal Court Des Moines Municipal Court Edmonds Municipal Court Everett Municipal Court Snohomish District Court Tukwila Municipal Court

Section 4: Program Documents Review

When conducting a qualitative evaluation, a review of program documentation is necessary to gain insight into the program background and operations. This is an important first step as it helps the evaluators understand the full model of the program and the rules that govern it. For the current evaluation, researchers reviewed a series of documents relative to the program including the workbook *Bringing Peace to Relationships*, recruitment flyers detailing program information and the contracts used by the programs. Following is a detailed description of these materials.

DV-MRT Program And Workbook

The program DV-MRT was created by Correctional Counseling Inc.. It is an outpatient and evidence-based program based on cognitive behavioral principles. In the workbook *Bringing Peace to Relationships*[5], DV-MRT has been formatted to address the needs of justice-involved individuals with a history of Domestic Violence perpetration. While the program is not certified as a Washington state-certified Domestic Violence treatment program, courts and probation officers have the ability to refer clients to this program for treatment. One of the main goals of this program is to increase participant accountability while also gaining insight into the motivation behind their DV crimes. As a result of DV-MRT participation, it is expected that participants will gain the ability to identify and confront those tendencies to react violently within relationships in current and future situations.

Program adoption and implementation is facilitated by the Correctional Counseling Inc (CCI). They provide training and a workbook for facilitators as well as the program curriculum and workbook. According to the CCI MRT website, there are no specific educational requirements for facilitators beyond completion of a 32-hour training program in MRT. For Domestic Violence MRT (DV-MRT) facilitators, the training program is comprised of four days consisting of 32 hours of specialized training. The training begins at 8:30 am and ends at 5:00 pm each day, with the exception of the last

[5] The workbook *Bringing Peace to Relationships* currently used is 25 years old. Critiques raised are addressed in Section 5, Themes 5 and 11 under Interview Results.

day that ends at 3:00 pm, facilitators in training are required to complete multiple modules each day in addition to two hours of homework assigned each night. A schedule of modules can be found in Table 6.

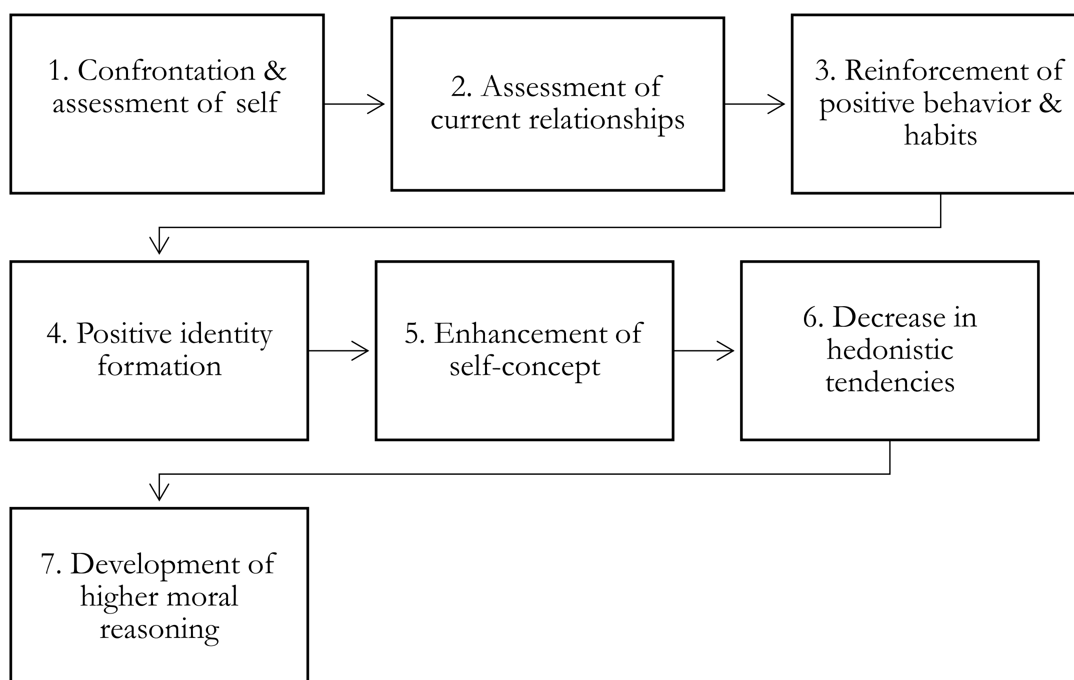
Table 6. Facilitator DV-MRT Certification Training Schedule

Training Day	Module	Length of Time
Day 1	Who Batters? Abuse Cycle Research Finding & Treating Those Who Batter & Treatment Resistant Clients Characteristics of Cluster B Personality Disorders	1.5 hours 1.75 hours 2 hours 1.75 hours
Day 2	Systemic & Consistent Treatment Approaches Chapter 1- Domestic Violence is Not Normal; Chapter 2- Who Batters & Group Process Chapter 3- Honesty & Group Process; Chapter 4- Trust & Group Process Chapter 5- Client Acceptance; Chapter 6- Client Awareness	1.5 hours 1.75 hours 2 hours 1.75 hours
Day 3	Chapter 7- Damaged Relationships; Chapter 8- Anger & Abuse Cycle Chapter 9- Anger & Development of Appropriate Responses Chapter 10- Relationships & Responses to Anger Chapter 11- Formation of Positive Habits & Behaviors; Chapter 12- Choosing an Identity	1.5 hours 1.75 hours 2 hours 1.75 hours
Day 4	Chapter 13- Forming Relationship Goals; Chapter 14- Identifying Values in Relationship to Goals Chapter 15- Making Firm Commitments, Chapter 16- Peaceful Partnership & Equality How to Implement the Cognitive Behavioral Domestic Violence Program: Questions & Answers: Awarding of Certificate of Completion	1.5 hours 1.75 hours 2.5 hours

During the four days of training, prospective facilitators receive: 1) a copy of the *Bringing Peace to Relationships* workbook, 2) MRT for DV Counselors' Handbook which provides the instructions and guidelines, 3) DV-MRT client exercises, 4) DV articles, 5) copies of Effective Counseling Approaches for Chemical Abusers and Offenders; Understanding & Treating Antisocial Personality Disorder: Criminals, Chemical Abusers, & Batterers; Self-Preservation: Resources & Hints for Crime Victims, Spiritual Reflections, and Crisis Intervention, along with 6) 5 Minute Stress Manager and Imaginary Time Out CD. Completion of training will result in a certificate of attendance/completion along with 3.2 continuing education units from Louisiana State University at Shreveport at an additional cost. The cost of participating in a training online is $610, however, trainings can also be scheduled to be given at the requesting location by contacting CCI at a higher cost.

MRT programs are typically implemented in institutional settings such as prison; this is not the case at the six sites under review, which are all court-ordered and take place at locations outside of the courthouse setting, often being held at probation offices. Program participants typically attend a weekly group session lasting one to two hours. Enrollment is rolling, which allows for the continuous admittance of new participants. As a result, at any given time, a treatment group will comprise members at different stages of the treatment process, including new, advanced, and graduating clients. For example, a new participant will complete the work for the first module, while another participant at a later stage will present the work completed for module 22 in the same group session. Each participant goes through the modules in order (modules 1 through 24) but is exposed to materials covered in latter modules by listening to their peers. Those treated under MRT are required to complete weekly homework assignments from the designated workbook, *Bringing Peace to Relationships*. The provided materials and homework assignments are designed to foster identity formation and moral development using seven components:

Figure 2. MRT Treatment Components



According to the MRT treatment model presented in Figure 2, MRT participants are:

- First required to learn how to confront themselves via a variety of self-assessment exercises.

- Second, participants learn how to assess their existing relationships which are then discussed in individual or group sessions. The goal is to help individuals assess which relationships warrant fostering or termination.

- Third, MRT participants are afforded opportunities that aid in developing and reinforcing positive behaviors and habits, with an emphasis on learning personal responsibility.

- Fourth, individuals learn how to develop a sense of self, specifically their inner selves, and in turn, individuals are encouraged to set goals and devise a plan to achieve those goals.

- Fifth, individuals partake in activities that help develop a healthy self-concept, which simply refers to what they think of themselves.

- Sixth, MRT activities are designed in such a way that delays instant gratification (e.g., engaging in public service work) to reduce hedonistic tendencies.

- Lastly, individuals are tasked with activities that stimulate moral reasoning with the goal being that individuals reach a higher level of morality. This is done in one of two ways. Individuals may be presented with moral dilemmas during group discussion in which they are required to share their opination but also see the situation from the perspective of others in the group. Alternatively, individuals must demonstrate they are being genuine and honest and show effort via continuous participation. Importantly, staff need to see that individuals are holding themselves accountable, to an extent, for their actions, behaviors, and progress. Individuals' progress through the program is contingent on whether MRT-certified staff believe that individuals' work in the group sessions and homework assignments meet the objective criteria outlined in the book.

The DV-MRT workbook *Bringing Peace to Relationships* consists of 24 modules that include weekly activities to be completed by participants. It consists of 16 chapters; some chapters contain multiple modules. The book is framed as a participatory, educational tool to be used along with group discussions, designed to confront participants' beliefs and behaviors especially in regard to power and

control within relationships. The authors posit within the introduction that the program will successfully reduce participant recidivism. Each chapter is comprised of a basic overview of facts and assumptions that are presented to the participant along with group and individual exercises to be completed along with the readings. Exercises marked with a facilitator are meant to be private while those marked with group are meant to be shared within the group setting. Individual focused readings and exercises do not begin until Chapter 7, and with the exception of Chapter 7, each chapter beginning with Chapter 8 consists of a mix of private and group shareable readings and exercises. Chapter 7 is solely for the participant and is meant to remain private.

Progress Through The Program

Each participant can only complete one module per week. Each participant goes through the modules in order they were designed (modules 1 through 24). Therefore, participants are required to attend weekly group meetings for a minimum of 24 weeks (6 months). According to the DV-MRT creators, while completion of the program could occur at 24 weeks minimum, the program may take longer.

Participants are required to maintain the original workbook assigned to them at the beginning of the program, as their participation completion checklist requiring facilitator signature is kept at the front of the workbook. Loss of the workbook will result in a required replacement at the participant's expense. Failure to bring workbook to the group meeting will result in the participant being unable to complete that weeks' module.

All participants are expected to complete and submit the assigned module work to the group coordinator prior to the beginning of the weekly meeting. Attendance and workbook completion is tracked with a sign-on sheet, which requires the facilitator confirmation through signature confirming participant attendance and submission. Upon review, the facilitator will determine if the module completion is satisfactory or unsatisfactory. Participants are then given the opportunity to resubmit their module work for consideration or move onto the next module.

The number of attempts allowed is dependent on the specific group location. For Tukwila, Snohomish County, and Edmonds, participants are allowed a maximum 3 attempts to complete each module. Failure to successfully complete the module in 3 attempts may result in a court referral for non-compliance. Des Moines and Everett do not specify their attempts policy in documentation provided

to evaluators. Successful completion as determined by the coordinator is required to move onto the next module.

DV-MRT Contract

As one of the goals of DV-MRT is to increase accountability, all participants are required to sign a contract at the onset. Generally, the DV-MRT program contracts dictate the number of absences a participant can have and provide a set list of rules and behaviors that program participants must follow. The following rules apply:

- Substance-free: Participants cannot be under the influence of alcohol, drugs, or non-prescribed medication while participating in group treatment.

- Attendance: Weekly attendance is mandatory with participants expected to arrive on time prior to the beginning of the session with all course materials in their possession and completed, ready to share. It is the program recommendation that group meetings last 1 hour 45 minutes in duration. In the unforeseen event in which an absence from the session is necessary, the contract requires all program participants to notify the facilitator in writing or by call of their expected absence. Failure to notify the facilitator will result in an unexcused absence. Excessive absences, both excused and unexcused, will result in participant sanctions. Criteria for unexcused determination is dependent on the individual program. Des Moines only allows 1 unexcused absence only and that after 2 absences, requires participants to restart the modules from Chapter 1. Edmonds, Snohomish County, and Tukwila allow for a maximum of 3 absences both unexcused and excused. After 3 absences, participants will automatically be referred back to court for non-compliance.

- Tardiness: Late arrival to group could also affect participant attendance. Edmonds has a zero-tolerance policy for late arrival. Participants who are late will automatically be sent home and have that counted as an absence. Des Moines also has a strict attendance policy. Group session doors are be locked 5 minutes after the group starts. Failure to be in the room and present work to facilitator before that time will result in non-participation and an absence. Tukwila breaks down arrival penalties into three

categories. If participants arrive within 15 minutes of the group session beginning, they will be allowed to participate and get full credit for that session. If they are 15-30 minutes late, they will get credit for attendance only but will not be allowed to participate. Participants who are 30 minutes or more late will get no credit for class and will have it result in an absence. No information is provided for Snohomish County regarding their late arrival policy.

- Confidentiality: All group work is confidential. While it is acceptable that participants share their individual progress with their immediate support system, all participants are expected to keep other participants' progress and group discussions private.

Participation in DV-MRT is voluntary in the sense that participants may opt not to participate. However, the program is court-ordered via conditions imposed at sentencing. If the potential participant opts against completing DV-MRT, they are referred back to the court for an alternative sentence. To be referred to the DV-MRT program for treatment, a referral request must be completed by the court. The referral request occurs during the sentencing phase for a domestic violence conviction. A referral request can also be made after sentencing for domestic violence or a related domestic violence act, specifically when failure to comply with sentencing requirements has occurred. The referral is then assigned to a DV-MRT probation officer who contacts potential participants to schedule a screening interview.

Screening interviews are scheduled shortly after the court date or release from custody. Upon approval, a notification letter is sent to both the participant and the court advising of the start date[6]. Non-approval results in the individual being sent back to court and a new court hearing being scheduled. Periodic progress reports are provided to the court and failure to complete the DV-MRT will result in a referral back to the court for a show cause hearing. Successful completion of the DV-

[6] Participants have raised concerns about delays before program start date and waitlists. Refer to Section 5 - Theme 6 for more insight.

MRT program will result in a certificate of completion, which is provided to the court and participant for their records.

Cost

Costs associated with DV-MRT participation range from $100-$200 depending on the location[7]. DV-MRT participation at Tukwila costs $100, it costs $200 at Snohomish County, and it costs $100 for in-court referrals (i.e., the court ordering DV-MRT is also sponsoring the DV-MRT program attended) or $125 for out of court referrals (i.e., the court ordering DV-MRT is different from the court-sponsored DV-MRT program attended) at Edmonds and Des Moines. If a participant loses or damages the workbook requiring replacement, there is a $25-$35 fee per each replacement. Transportation is also not provided to participants.

[7] In interviews, DV-MRT participants have commented that the full cost of DV-MRT is comparable to the cost of one session with a private provider.

Section 5: Process Evaluation: Survey and Focus Group Results

As part of the process evaluation, WSU researchers completed two main tasks. First, we reviewed the implementation of the DV-MRT programs at the sites that agreed to participate. For this purpose, we examined the characteristics of the population served at various sites and the process of each program. This was done to determine concordance between the design of the program model and its actual implementation, with respect to the target population eligibility criteria. We also wanted to learn basic information about the status of program participants and their progress in the program.

Second, we conducted individual interviews with DV-MRT program participants (both men and women[8]), at both the pre- and post-completion phases, during fall and winter 2021. We conducted additional interviews with program facilitators from 3 sites and administered a short survey to facilitators at additional sites when they could not be interviewed. Conducting a process evaluation during a pandemic proved to be a difficult task. It required multiple emails and follow-ups that went unanswered. The data collection strategy -originally planned as multiple focus group interviews and an in-depth survey- had to be adapted to offer more flexibility to participants, specifically to be able to do it at a convenient time. Whilst most participants were at home, they reported added responsibilities in these settings, which made it impractical to organize focus group interviews requiring synchronizing the schedules of 8-10 individuals. Instead, researchers organized individual interviews lasting between 20 and 30 minutes and the length of the survey administered to facilitators was reduced to less than 10 minutes.

This methodology allowed us to gather information regarding aspects of the program that were positive and challenging both for program participants at various stages of the program and at various sites, and for program facilitators from various sites. All interviews were conducted by a WSU researcher trained in research methodology and evaluation approaches. Each participant was informed

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[8] The source of information about participants' sex were administrative records. Participants could not self-identify according to their preferred gender identity. This constitutes an important limitation because it imposes a dichotomous scope to the analysis (i.e., male and female only) and excludes various gender identities.

that the interview process was voluntary and confidential, and consented to their voice being recorded. Two research participants (one program participant and one facilitator) asked not to be recorded. In those cases, copious notes were taken to capture their experience. The interviews for both program participants and facilitators had similar open-ended questions: they focused on key topics such as personal experience with the DV-MRT program, positive aspects of the program, and areas recommended for improvement or change. Interviews averaged approximately a half hour. Audio recordings of interviews were transcribed for qualitative data analysis.

Program Implementation

The first component of the process evaluation was to determine concordance between the design and the implementation of the program model, specifically considering the set of criteria regarding target population size and conditions for eligibility. The program textbook specifies that the program is appropriate for perpetrators of domestic violence and that the designated treatment settings is open-ended groups with ongoing enrollment, so that new program participants can join a group at any stage. A treatment group therefore comprises participants at various stages of completion of the program, in which more senior members can provide peer support to more junior members. These criteria were all consistently applied in the programs reviewed and there are no fidelity concerns. Some sites added a geographical location requirement, as was previously illustrated in the section on DV-MRT in Washington State. We could not establish why these rules differ but hypothesize that this is probably explained by the need for effective use of limited therapeutic resources at some sites.

Next, we present four areas that were identified as areas in which various sites had implemented the DV-MRT program differently: eligibility criteria, mixed-sex or same-sex treatment groups, program rules about timeliness and absences, and modalities of treatment during COVID-19.

Eligibility Criteria

One area of uncertain implementation relates to verification of eligibility for potential program participants at each site. When we examined the quantitative data descriptively, it became apparent that a small number of DV-MRT participants had not been adjudicated for a DV-related offense prior to starting, and in some cases, completing treatment. The reasons why that might be the case became apparent that not all sites were precluding non-adjudicated individuals with a DV charge from participating. It is unclear whether these different eligibility criteria impact the patterns noted and

discussed in the rest of this evaluation, both qualitative and quantitative, considering their small numbers, but they should be noted.

"Our rule is that the court must have authorized the person to enroll in DV-MRT (vs. ordering a batterer's program). When clients call to enroll, we look up their court docket (using JIS [9]or JABS[10]) and check it to make sure that DV-MRT was ordered/authorized. If we cannot find something in the docket, we contact the probation officer or the attorney to make sure that DV-MRT is allowed. ... We have had a couple people who have participated on their own, not because they were ordered to. We have also had people who sign up before they are ordered to do so, typically when they are in the pre-trial stage of their case. We allow them to do so, especially since our waiting list is so long. However, before we let them enroll, we follow the same process and verify that the court actually authorized our program."

"There is no formal verification or screening process. I think the attorneys working on the case determine if someone is eligible or not with the help of the DV Coordinator who knows a lot about the case as well. In regards to referrals coming from other courts, they call me to ask about the program and I do a quick screen myself over the phone. I make sure they:

1) can read and write in either English or Spanish - enough to get through the program;

2) have the ability to at least pay for the book;

3) have access to either a smart phone or computer with a camera and;

4) are able to attend to one of the … groups we currently run.

If they lack any one of these, I either work with them or refer them back to their attorney or another program."

[9] JIS is the acronym for Judicial Information System.

[10] JABS is the acronym for Judicial Access Brower System.

Male and Female DV-MRT Programs[11]

First, some sites implemented treatment group comprising only program participants of the same sex (all males or all females) whilst others allowed groups with participants of both sexes. Concretely, mixed groups were the results of practical considerations, with a facilitator noting it was how their program operated because there were not enough females to maintain a full group going considering the rolling enrollment format of DV-MRT.

> "We've never had enough females to make an all female group. ... So right now we're just incorporating them with the males."

This can be an area of concern, as some research demonstrates that treatment is not gender neutral. One facilitator noted that mixed groups might be particularly problematic for female participants as many of them might have experienced past trauma at the hands of men, which could potentially hinder the benefits of DV-MRT in such group. Another facilitator conveyed having made the decision not to offer treatment to women considering their low numbers and a desire to exercise caution towards possible deleterious effects. Another facilitator noted that their site had moved from mixed groups to distinct same-sex groups for males and females; this experience had opened their eyes about the changing nature of female participants' contributions to group, which the same-sex settings allowing more space for processing of prior trauma as victims of violence.

> "At first we had women … we just had them in our regular group. We haven't really had any problems with that but what I have found now is that the women are telling so much more of their backgrounds and their stories that they had originally. We didn't realize that because they were doing their assignments, they seemed to be open at our meetings but what they weren't telling was how much they suffered at the hands of men in their lives and they weren't telling that with the men in the group. So it was something that I thought was successful with the men group when

[11] Participants could not self-identify their preferred gender identity. This limitation of the data imposes a dichotomous scope to our analysis. Empirical research generally indicates that IPV is differentially experienced by individuals based on their gender identity (Ansara & Hindin, 2010; Cho et al., 2020; Langenderfer-Magruder et al., 2016), especially when considering gender in interaction with sexual orientation (Goldberg & Meyer, 2013; Graham et al., 2017; Walters et al., 2013).

> we were doing it, but now I realize that we were really, we were really shortchanging those women."

Enforcement of Rules about Timeliness and Absences

A third area of implementation difference is noted specifically relative to the enforcement of the rules discussed in the prior section reviewing program documents, specifically those relative to attending group on time and absenteeism.

> "I know some facilitators are very strict on the 'you have to be on time otherwise I won't let you in. You're five minutes late, I'm not gonna let you or you missed two groups, you're discharged', something like that, which I understand everybody is a little bit different and they can make their own rules, but with me I've been a little bit more tolerant. I came from a social work background. I understand the struggle, especially when it was back in person, the whole bus thing. I understood all that. Now with the capability of being anywhere … listening in, I'm a little more strict on that but with absences as long as they communicate with me … so I give them a little bit more leeway but I think you need to have both a passion and just like an understanding that this is a six-month program. If I were to do a six-month program and you wanted me to be there every week, I'm gonna miss a few weeks. So I have to be understanding about that, you know, that they're human."
>
> "One of the things we were not being real consistent with was if somebody missed a module or missed a week because they had a really good excuse, I was letting them make up the module the next week and somebody else was "Nope! They're absent, they're absent. They're not making it up."

Treatment Modalities During COVID-19

The fourth area of implementation difference is noted specifically in the context of COVID-19 in which modality of treatment differed. Specifically, the nature of what "remote" DV-MRT treatment meant varied by sites. Some sites opted for teleconferencing treatment in which participants had to check in by phone. They did so for accessibility reasons to ensure program participants were able to continue progressing through the program steps. Noted drawbacks to this approach were a belief about decreased program effectiveness, explained by a facilitator as their lack of ability to evaluate any nonverbal communications by participants, rendering difficult the evaluation of whether the "work" was completed.

> "One of the things we haven't been consistent with in COVID-19, and part of the reason is our judge is pretty insistent about it, we really wanted to be accepting of clients regardless of whether they had a computer or not, so we allowed call in and

> not be on cameras, but we talked to other agencies who were "absolutely not, we will not allow anyone to be without being on camera" and our judge was pretty adamant that people could call in without being on camera… We're not going to go against somebody because they just don't have the technology. … I recognize all the voices, I know who they are. We get good participation, but of course, there's certain [participants], I'd like to see their module … so I am not really sure if we are doing people a disservice by being more inclusive. That's something we've been struggling with for a few months."

Other sites opted instead for video call options, in which participants were required to participate on a system in which they were seen and heard (video and audio). This option was selected because it was thought to more closely preserve the integrity of the program and ensure alignment with the group accountability model that is core to the DV-MRT program. A facilitator noted how this option had also increased flexibility and eased program participation, giving the example of a woman participant who had been able to complete a module a few days after giving birth while still in the hospital. Drawbacks from this approach are interruptions from the participants' environment are more likely to interrupt the flow of the entire group since they can be seen by everyone. While those changes in treatment modalities were dictated by the reality of COVID-19, their possible impact on therapeutic outcomes should be kept in mind and remain to be investigated in the future.

Interview Results

Findings from the qualitative data analysis of individual interview transcripts reveal important themes for both program participants and facilitators. They are summarized in Table 7 and presented in more details in the following subsections of the report.

Table 7. Themes From Individual Interviews

Program Participants	Program Facilitators
Program Content Facilitators and Peers Program Cost Workbook Program Process DV-MRT During COVID-19	Program Content and Perceived Effectiveness Workload Program Scheduling Workbook DV-MRT During COVID-19

Results of Individual Interviews with Program Participants: Overall, participants talked positively about the program and its low cost. They rated its content, the facilitators and peers as important components. However, they did note some difficulties relative to the workbook, the wait

time to access the program, and some challenges in completing the program while maintaining stable employment due to scheduling of programmatic activities. Finally, they also discussed opportunities and challenges that arose during COVID-19. What follows is a description of each of the themes and subthemes, with quotes from participants to support our interpretations. We have transcribed participants' quotes verbatim to fully represent their patterns of speech.

***Theme 1: Program Content*.**

As part of the qualitative program participant interviews, we asked them to discuss the nature of their personal experience with the DV-MRT program, and their answers emphasized important aspects of the program content and its perceived effectiveness.

> " It is useful with people that have anger issues"
>
> "I view that illustration phenomenal because you get a chance to talk about ... y'know give a testimony on what happened in the... in those portions of those years and also get to see where if you didn't make those same choices and decisions where you could have been at "
>
> "I love it so far."
>
> "It definitely created a healthier environment at home"
>
> "It's very good practical information and I guess it gets you to look at things a lot of different perspectives"
>
> "I feel I have gotten more out of this program then I have in the several years that I have been seeing my one on one counselor"
>
> "I find that the things, the coping mechanisms, the way to communicate and talk has spilled over into my … life"
>
> "Uh you know… Quite honestly, I love it. I wasn't skeptical of it um coming into it. I knew that I needed help um so I was very open to anything that came through the program um but it has been… it has far exceeded anything that I expected."

Next, we highlight two important aspects of the program content, specifically its facilitators and the peer format as important components of the DV-MRT program.

***Theme 2: Program Facilitators*.**

The individual interviews conducted highlighted the importance of the facilitators' role in the DV-MRT program. Significantly, no specific question was asked about the facilitators in the qualitative interviews, yet they emerged as a consistent and positive theme among participants at both the pre- and post-release phases.

> "Having a good person to organize it is definitely an important factor."
>
> "[Facilitator's name] is phenomenal."
>
> "[Facilitator's name], I think is [their] name, [facilitator's name]... [They] was really solid. [They] um really dove into the program with both feet and was really um a strong advocate and uh non-judgmental and [he/she]'s a probation officer. I don't know what you know about the administrators of the program but um if there aren't other guys like [them], there needs to be."
>
> "Some of this has to do with the person who gives instruction. Obviously, my instructor was [facilitator's name] and [they] made it very practical… you gotta have to have somebody like [facilitator's name] who's comfortable in front leading a group of very diverse... the the.. your clientele is a very diverse group of people and [facilitator's name] was somebody who was comfortable in that environment and that made a big difference."
>
> "[Facilitator's name]is a very easy going … and [they] kinda just allows us to just say and express things without umm you know [he/she]will ask questions in places and kinda challenge people to a degree…"
>
> "The main the organizer of the course was [facilitator's name]?, [they] was really, really good, made us feel comfortable."

***Theme 3: Peers*.**

The individual interviews conducted also discussed the importance of their peers in the DV-MRT program. This is another area in which no specific question was directly asked about peers, yet consistently emerged as an important component of the program content.

> "Being able to discuss this… you know… with other people who are going through similar challenges um… makes you not feel alone or isolated. Umm It gives you the opportunity of being able to hear umm you know different levels of people may not have had worser situations than you so um… you could be able to be a leader and let them know like you don't want get this far into it or some people have been

> a little further than you so your like you know you can kinda… see things on both sides of the fence. That's not where I want to end up so this the steps I need to do in order not to end up that far."
>
> "The one thing that really stood out to me when I started was knowing that I wasn't alone."
>
> "Good group of people."
>
> "I like how personal it is and that you get personal attention through other peers in the program and the counsellor."

***Theme 4: Cost Of Program*.**

While the program textbook specifies that all costs for the program should be borne by program participants, one of the stated goals of the implementation of DV-MRT in Washington State is affordability. Specifically, because of the low costs associated with enrollment and completion in DV-MRT in contrast to the cost of a private treatment provider, it was hoped that low-income clients would be better served, leading to their pro-social reintegration. This is a final area of satisfaction that generally emerged from the individual interviews.

> "The cost of the program of the program was very affordable."
>
> "I was actually blown away because I think when I looked into other programs, it was almost like $50 per class um and at that rate, I am financially burdened right now so I probably only did like 4 or 5 classes you know for like $200 or I would only did… uh let me see.. two classes for that price that I paid to join with you guys, that would only took me two classes with somebody else.. another program and then I would have to stop but I get the benefit of doing 24 classes for that same basically $100 range instead of paying over $200 or $50 per class and then having to drop out because I couldn't pay or afford."
>
> " It was extremely cost effective I mean um compared to any other um recovery or treatment related services. It was the most valuable dollar for donuts."
>
> "It's low cost… It's not really financially difficult to get in and complete the program."
>
> "I would say that's one of the positives is it is very accessible. They don't say this is going to cost you $600 and you got to do it. The only thing I had to spend money on I think was the book and I don't remember but I don't remember it being very expensive. The money thing that I saw was for 25-40% of the group depending on what point in time you look at the group, financially, they are having a tough time getting bus money to get to the class."

> "Umm to me it's a bargain, an absolute throw away bargain."

Most participants interviewed were satisfied with the costs of the program, but a few minority opinions should be noted. Specifically, two participants noted that the DV-MRT program was only affordable if a participant was employed, and that unemployment status would render the cost prohibitive. Another participant also noted that the program should be free altogether.

Theme 5: Workbook.

Another theme for interview participants was their concerns about some aspects of the workbook *Bringing peace to relationships*. As presented earlier, many participants expressed satisfaction with the content of the program, which they identified as meaningful due to the facilitator's role. However, an area of consistent dissatisfaction was the workbook in which this content was presented. They noted that the book that was developed more than 25 years ago and that it focused exclusively on men victimizing women, to the exclusion of violence perpetrated by women or to the same-sex nature of the intimate relationships of some program participants[12]. Generally, participants noted how some examples were narrow and a little silly, feeling that this was not representative of the challenges in their own relationships or in the relationships of other group members.

> "There are silly little stories within the book that are kind of cheesy and not really relatable."
>
> "If you follow the book, they have got all kinda funny little rules that the people who wrote the book came up with and I understand that it was originally designed for an inmate population so they wanted to put some parameters that were sort of harsh in it. To me, any implementation of these harsh sorta non... there were rules that didn't have anything to do with the outcome, they were more administrative, some of this kind of stuff seems kinda silly."
>
> "I think 70% of it is really on target and 30% of it is going in the wrong direction… it's a little outdated."

[12] It was reported by facilitators that some program participants had victimized their same-sex partner and were receiving DV-MRT treatment. It is unknown how frequently that was the case.

> "Nearly all the phrasing and all the terminology in the book is male-on-female centric umm which I actually find fairly offensive umm just because I mean there's women in the group as well. Umm you know so to be overly prescriptive like that granted it was written at a time when things were less aware so I kinda get it but as the world shifts you know we should be dealing with a little bit more."

Theme 6: Program Process.

Participants also expressed concerns with their ability to meaningfully participate and ultimately graduate from the program given the difficulty of program participation while employed, in a way that they perceived was exacerbated by the process of the DV-MRT program. Next, we explore various areas of dissatisfaction, including program wait list and full groups, program length, and difficulties in reconciling work and participating in DV-MRT.

a) *Wait List***.** A few participants noted their frustration at having to wait for an available spot at a DV-MRT program before they could satisfy this probation requirement.

> "It was the lead time waiting to get into the class. I think it was a 6 month wait or something. … and you have all these other things going on, the ball is kinda rolling in the wrong direction umm you know one is pretty desperate for a solution and if that solution is going to be MRT for that person, I think it would be beneficial for them not to have to wait 6 months before they receive that help."

b) *Group Size and Rate of Progress***.** Other participants remarked on the difficulty of progress in therapeutic groups comprising a high number of participants.

> "A lot of times there would be 20 plus students in a class which I don't think it was intended for one instructor trying to work through the book in a class with over twenty kids... Every extra person is makes it just that more difficult for that lessons of the day to be understood thoroughly and uh a good enough discussion around it so that you really feel like you've thoroughly covered today's subject matter."

c) *Program Length***.** A minority number of participants also reported that the program was too long to complete.

> "For me, it was long and drawn out. Umm… the fact that it was umm dispensed over the course of such a long calendar, that umm I noticed for me, it was kind of you know umm it wasn't uh potent as maybe it could have been if it was more of an intensive program maybe a couple times a week or longer sessions towards a 9

> or 10-month ordeal. I noticed also a lot of my classmates um they kinda lost interest and dropped out at some point and came back."

However, it should be noted that most participants did not believe this was the case, insisting in fact that hard therapeutic work required a significant time investment and that they understood why the program was designed the way it is.

> "An hour and half once a week you know plus whatever time it takes outside of that to go through the lesson… that's table scraps. If I can't make time for that then I'm doing something wrong."
>
> "I feel it [length of program] was about right."

d) *Program Schedule***.** A much more common theme captures a concern of program participants over the scheduling of the DV-MRT sessions, which fall during working hours, with no weekend or evening options. Many participants noted how this added complexity to their re-entry, specifically in maintaining employment and managing the lost income.

> "My class was started at, I believe, 4:30... It was either 4 or 4:30 on Wednesday afternoons… Well that's a terrible time to be. … And now you got people coming from a pretty good, um pretty large geographical area that are trying to get there in rush hour traffic so that's very disruptive to the group."
>
> "Let's say you know for example.. someone working at jiffy lube or some factory or something like that where they have to be on the clock at this time, … for them to be able take that amount of time on a given day, that's got to be insanely expensive for them."

Theme 7: DV-MRT During COVID-19.

During the qualitative interviews, participants were asked about the programmatic changes that happened during COVID-19 and the stay-at-home orders, which resulted in changes of modalities in DV-MRT; for some sites, that meant a switch to voice DV-MRT over the phone, while for others it meant a switch to Zoom. Participants identified a number of drawbacks and advantages to those changes. Positive changes included increased flexibility. Negative changes comprised interruptions and disruptions to treatment, lower accountability, and technological challenges. These subthemes are presented in more detail next.

a) *Increased Flexibility*. Considering the challenges identified by program participants with the process of the DV-MRT program, most saw the increased flexibility in treatment modality as a positive change during COVID-19. Many expressed that they hope such flexibility will remain in the future, as it facilitates program participation and graduation.

> " I would say because my lack of transportation right now, umm I think that this is a phenomenal way of making it more tangible for you to make people appear umm every week umm and things of that nature so on the transportation piece because of COVID-19 and my lack of transportation, even if it wasn't COVID-19, I think I would struggle because of my lack of transportation to be able to get there and you know stuff like that on time or maybe just get there period."
>
> "I love the fact that it is on Zoom for that purpose because it makes it easier to get too."
>
> "Just the travel of it alone… umm I know that I would have spent probably three plus hours in just driving time to and from the meeting let alone the hour and half of the meeting itself so that would have been pretty much like I would have had to wipe that day off of my calendar so that by itself is a huge savings."
>
> "I thought Zoom was great. Actually we should really be using it. It's a lot easier for a lot of people."

b) *Increased Interruptions and Distractions*. A first drawback that the participants discussed is a higher number of interruption and distractions following the change in treatment modality. Specifically, because participants are no longer outside their home environment, this context is much more likely to infringe upon treatment time. Many participants told stories of such interruptions, sometimes with laughter and sometimes with irritation.

> "There is a lot of other distractions of you being at home umm in the comfort of your home."

c) *Decreased Accountability*. Most participants recognized that a drawback of the treatment modality change that occurred due to COVID-19 resulted in lower levels of engagement with the program materials and overall level of accountability.

> "When you're able to step outside the box out of your comfort zone, you're able to really grow a lot more and be more engaged … For some people who are new to doing zoom... umm it [in-person treatment] would take them out of their comfort zone and stretch their umm ability to learn and grow and challenge them a lot more."

"If they don't have the direct accountability of being in front of someone, then they're not putting their whole heart into it."

"I mean with Zoom you have the face-to-face but it's not the same."

"Just the lack of interpersonal… not interpersonal, but just being able to be there live and present."

d) *Technological Challenges***.** A final drawback identified through the qualitative interviews relates to some technological challenges faced by program participants. A few participants expressed concern over the quality of their internet connection, which they believed made it harder for them to progress through the program at times because they had trouble following along. This was a minority concern that was raised infrequently.

Results of Interviews and Survey with DV-MRT Facilitators: The interviews conducted with program facilitators offered a complementary perspective to that of program participants in terms of experience with the DV-MRT program. The results we present next highlight a number of shared themes about the topics covered in the prior section, but also illuminate new nuances that are better explained in the words of those responsible for implementing and running the day-to-day activities of these programs. In the sections that follow, these themes and their subthemes are detailed and supported with quotes. As for program participants, we present facilitators' quotes verbatim to accurately represent their meaning.

Theme 8: Program Content and Perceived Effectiveness.

As part of the qualitative interviews with program facilitators, we asked about the positive aspects of the DV-MRT program, specifically to discuss their experience with the program as facilitators. Their answers emphasized important aspects of the program content, and specifically that it put the workload on program participants and that it seems to foster a level of cognitive transformation for many program participants. This led facilitators to state they believed the program was effective in transforming behaviors.

"I've been in probation for [number of years removed] and I've had lots of DV cases and clients. … I've never experiences clients coming in and telling me how much they learned in their DV class or what they got out of it. It was always just sort of 'I went to my class' sort of thing. … What I found with DV-MRT is that although almost everyone talks about how much they hate coming at the beginning

> there is like a point where all the sudden it changes and then they start telling everybody else that's new to stick with it, that all of a sudden they're going to start getting it, it will start making sense, when I first started I was angry too… you're going to recognize what you need to change and all of us as facilitators just sit there and are like "did that just happened?". It surprises us but it's really consistent. … So that's what I really love about it is for me the last 5 years I've seen so many DV offenders change behavior and change what they recognize. … they screw up again and will come back and say I've got a new offense, this is what I should have done, and they are recognizing they messed up instead of arguing about it saying "it wasn't my fault, it was this", they say '[facilitator name], I should have done a time out, I should have walked away and this is what happened' but they are at least recognizing the behavior."
>
> "What I like about it is that, so we're not counselors … The only thing we are doing there is 'hey it's your turn', 'does anybody has any questions', and just kind of to keep order and stuff like that. What I like about it is that they are doing all the work themselves so it's very interesting to see humm especially the ones that are against the program, that are you know week 1, 2 3 they're, they're just doing the bare minimum to get by and it's interesting to see… and everybody is a little different, they're at different stages throughout the program but you hear a lot 'ah ah' moments and that's what I like about the program, that's what keeps me wanting to continue to do it because you can see the progression, almost week by week. It's motivating how it happens."
>
> "But so towards the middle of the book I see most of them, reaching that point where they are getting it."
>
> "You get to almost live with them throughout those six months and you get to see, you know, what's really going on in their day-to-day lives, and some are really going through a hard time and then they go through this lesson and they say 'this lesson really helped me out, especially this week when I was going through this … I maybe could have violated the no contact order and this could have been very ugly but I didn't because of this'. A lot of those instances you get to hear and you're saying 'wow … it's working, they're not recidivating'."

Additional written comments submitted by program facilitators in answer to the survey question about the biggest strength of the DV-MRT program reiterated some of the same points. Keep in mind that the question only asked for a short answer, which might explain the brevity of some answers.

> "Participants identifying abusive behaviors themselves."
>
> "The insights it incrementally offers to students as they complete the assignments and the life-changing tools that they obtain by making a few attainable behavioral adjustments discussed in the course materials."

> "Giving clients the tools to discover a need for behavior change on their own, without lectures or guilt."

The positive aspects of the program emphasized in these quotes are further illuminated by the result, in the supplemental short survey administered, that all facilitator respondents believed the program to be effective and that the program contributed to the overall success.

***Theme 9: Workload*.**

During interviews with program facilitators, we asked about balancing the task of facilitating and managing the DV-MRT program with their other professional duties. Their answers indicated an additional burden in workload, coming not from facilitating group itself, but instead in managing the administrative tasks related to the program.

> "It is definitely an added workload. And doing things like status reports, I have so many. Now all the phone calls come to me. So like those 100 and some people that are on the wait list, I've answered all of those calls, I talked to all of those people and I am writing letters and sending them off to their attorneys and to their courts. And then I am following up when they call where they are. … I could really use a clerk. … I've got so many other things that I need to do. … It's just time consuming. It's not that I mind talking to people, it's just, it's busy work."
>
> "Not necessarily the classes … but I think the phone calls and the progress reports and the payments, and then they make the payments to the wrong place and just a lot of the troubleshooting that goes wrong with it takes a lot of time. People call in to ask questions about it, attorneys call so I think if I had a little bit more help, cause I do all of that myself, so maybe if I had another person from the court help me with that, that would be easier on me."

The added workload is also apparent in the supplemental short survey administered, in which 80% of all facilitators who responded indicated that their workload increased as a result of the DV-MRT program. However, all respondents still reported that the amount of work they had to accomplish for the DV-MRT program was reasonable.

***Theme 10: Program Scheduling*.**

The program facilitators also highlighted the scheduling of DV-MRT group sessions when it was in person as another possible area of improvement, especially considering the reality of public

transportation in their geographical areas, and the resulting difficulties in be on time for program participants.

> "Back then we weren't allowed to work past our closing time … I don't know what happened with the union or something like that, we got stuck back to working 7:30 to 4:30 Monday through Friday and that… now being online it's a little easier to get people because they can do it on their lunch break, you know, some people are in their car while they are doing it, but I think just having access to, not everybody had that capability of doing it. Maybe if we were to offer one of our classes late in the evening for those folks that, you know, that can't be there."
>
> "When it was in person we had a lot of straggling people because of the bus and the rides."

***Theme 11: Workbook*.**

One of the most recurrent area of improvements identified by the program facilitators relates to the content of the program. They critiqued the workbook's organization and its targets (and exclusions). They specifically echo the comments of program participants about the workbook being outdated[13].

> "For the program itself, the workbook is really outdated and it's not organized in a way that makes sense for clients. There's 16 chapters but 24 modules. So they do one module per week. But almost everybody, and it doesn't matter how many times you tell them, they all try to do the entire chapter every week. That's just how their brain works. … There are some clip arts … and a lot of our clients get really put off by some of the clip arts. In particular in Module 16, there's a picture of a policeman pointing at them and we have found that it offends a lot of them. They just do not like that at all. … It's very threatening. We have a seen a lot of, especially our guys who have been in prison, who have been in gangs, it's just a very authoritative angry type of outlook and they don't like it. … It really needs to be updated. … It's not accepting of same-sex relationships, or it does not acknowledge them, and it's very male-versus-female instead of being more generic. So like in my women's class we are constantly changing the language, and when we know we have same-sex partners, we're trying to say, we're trying to verbally change it without making it awkward, so I feel like the book just need to be updated."

[13] Critiques of the workbook being outdated can also be found under Section 5 - Theme 5.

> "The negative feedback that I've gotten is from people that feel it's a little outdated I think for the times. It's geared to the average White male , I think. And with Seattle here, we have people from a lot of different background and races, and same-sex people, females, so it's really not ?? towards those other populations so sometimes you know, in reading some of this stuff, they might get triggered a little bit or they may …. So I have to, you know, assist them through that phase of where I tell them to just get what you get out of it and to just not look too much into it. So it's a little outdated and it's not for every body and we're trying to do the best we can with it."

Additional written comments submitted by program facilitators in answer to the survey question about the most important way in which the DV-MRT program could be improved, also concerned the program workbook and its apparent lack of tailoring to some populations that are currently being served by the program.

> "Update the book, make it suitable for women and LGBT members."
>
> "The book needs to be updated so that it is not directed to just inmates and to only the male gender."
>
> "If the book was gender neutral. Right now the book is geared towards men who abuse. We use the same book to facilitate the women's group."
>
> "The workbook needs to be updated for clarity and to better reflect current times."

Theme 12: DV-MRT During COVID-19.

The nature of the programmatic changes needed to be implemented rapidly in response to the COVID-19 pandemic and subsequent stay-at-home order have been previously discussed in the current report's chapter on DV-MRT in Washington State and earlier on the chapter in the section on implementation. In the current section, we focus not on the nature on the changes themselves but on the resulting programmatic conditions identified by the facilitators, some of which were seen positively and others as challenges for program facilitators. Positive changes included increased flexibility. Areas of increased challenge comprised interruptions and disruptions, slower pace of group resulting in a need for smaller groups, and difficulties in fostering traditional treatment conditions due to lessened participation and peer relationship and accountability. These subthemes are presented in more detail next.

a) *Increased Flexibility***.** All the facilitators interviewed considered the increased flexibility resulting from the change in treatment modality as a positive change resulting from Covid-19 and expressed their hope that it would continue going forward.

> "There's a lot of positives because like I said we have people from all over Washington now. We're one of the ones that take people and females and three times a week and stuff so that opens up the door to a lot more people, it's convenient, everybody is on time, for the most part, when it was in person we had a lot of straggling people because of the bus and the rides, something, so most people are on time. … If it was up to me, once it's all over, I would think we might have like one class in person and maybe two online."
>
> "[Going forward] I would kind of like the option, honestly, to have virtual group. We've had some people that have been out of state or people that, we've had one gal appear for group, in the hospital, she had a baby the day before. She was in her hospital bed on zoom, doing her class. They came in, they are releasing her from the hospital. She participated in the entire session while they were wheeling her out of the hospital. … and then she is in the car on Zoom, still participating. And I was like "Oh my God' She would have missed weeks of group" if she had to be in person but she literally participated from her hospital bed. … I kind of hope they are gonna allow for circumstances to continue to participate virtually."

b) *Increased Interruptions and Distractions***.** The facilitators also noted that DV-MRT treatment in a time of COVID-19 meant a number of interruption and distractions in the home environments of program participants.

> "And we do notice that people end up multitasking. So like in my women's group, they're taking care of their kids because they're at home. … We got one woman, she works for [company name], puts together [company product] and she literally sits there with her camera putting the [company product] together while she is going through the class."
>
> "I do have one that, he has ADHD. So it's very hard for him to sit for an hour and a half. So I see him doing sit ups and push ups. I just turn his camera off. This is distracting to the group."

c) *Difficulties in Fostering Traditional Treatment Conditions***.** Three of the program facilitators expressed concerns over some ways in which the new treatment modalities may lack fidelity from the way they were designed and intended by the program creators. For example, concerns over lesser levels of participation during treatment, fewer interactions and accountability with peers and facilitators, were mentioned.

> "And they're not as expressive so when it was live in person I think we had a lot more feedback, there was a a lot of dialogue. Now everybody is almost shy to speak up. … A majority of them are a little shy to speak up on camera I think. I think they just want to class rolling to finish on time or maybe they feel weird about speaking. I don't know what it is."
>
> "The negative side that I have seen it that it's harder for people to get to know one another, cause they're not physically, they're not talking before group, after group, getting rides with each other, things like that."

Summary

A process evaluation is useful to document the implementation and operations of a program. In this section of the evaluation, we uncovered four areas of divergent implementation, specifically 1) inconsistent exclusion of individuals charged with a DV offense but not adjudicated; 2) combined male-female treatment groups or treatment groups separated by sex; 3) rules relative to absences and tardiness and; 4) treatment modalities during COVID-19. As a whole, these areas of divergence do not pose an important implementation fidelity risk, but court-sponsored DV-MRT programs should strive to be as consistent as possible in light of prior research demonstrating that treatment outcomes emerge more strongly in programs implemented with fidelity (Durlak & DuPre, 2008). Additionally, interviews with program participants (both current and graduate) highlighted strengths to the existing program, notably its content, the dedication of facilitators, and its low cost, but were critical of the outdated workbook. The facilitators echoed these themes, also discussing some additional challenges to their workload due to managing the DV-MRT program. COVID-19 changed the treatment modalities of court-sponsored DV-MRT programs and presented new challenges (more interruptions and distractions, lower accountability), but also provided opportunities, notably for increased flexibility, that many hoped would remain even post-COVID-19.

Section 6: Outcome Evaluation

Outcome evaluations allow evaluators to determine if an intervention or program improves outcomes of interest for the participants in a program compared to comparable subjects who do not go through the program. In the prior section, we presented results from individual interviews that indicated that both participants and program facilitators perceived the DV-MRT program as effective. However, answering the question about program effectiveness requires a specific methodological approach. In the current section of the report, we first identify the key questions we sought to answer regarding the program effectiveness and describe the methodological design and statistical analyses we implemented to answer these questions. Finally, the results section provides evidence to determine whether the DV-MRT program was effective in achieving its goal of reducing DV-recidivism. For this purpose, we compared program participants to equivalent individuals who did not participate in the program. We also investigate the association of outcomes in specific strata of participants.

Research Question

There are multiple goals to the DV-MRT program, as documented in the second and fourth sections of the current report, including enhancement of moral reasoning, decision making, and more precisely, behaviors in the context of domestic conflict. The adoption of the court-sponsored DV-MRT programs ultimately aims to reduce the often cyclical and recidivistic nature of DV offending, by seeking DV-recidivism reduction in program participants. The definition of DV-recidivism adopted for the purpose of the current evaluation is: any DV-related conviction received after a case was filed for a prior DV offense and the individual started DV-MRT treatment (if in the treatment group) or the case was adjudicated (if in the comparison group). Based on this goal, the core focus of the outcome evaluation was determining if DV-MRT participants are less likely to be reconvicted for a DV-offense than a matched comparison group. The general research question examined was:

> *Do DV-MRT participants display a reduced likelihood for DV reconviction than comparison subjects at 1-year and 2-year follow-up?*

We specifically examined two types of reconvictions:

1) *Any DV Reconviction* includes both misdemeanor and felony reconviction for a case that was flagged[14] as DV;
2) *Felony DV Reconviction* includes only reconviction for a felony case that was flagged as DV.

Specifically, it was hypothesized as part of the program model that DV-MRT program participants who completed the program would have lower DV-recidivism rates than comparable subjects who did not receive the program. This hypothesis was tested using robust methods to isolate the program impact and analyze the distinctions between program participants and a comparison group. Next a description of the study design is provided, including: the sampling procedure and study groups, measures, and matching technique used to ensure the comparability of the groups.

Study Design

We used a retrospective quasi-experimental design to study the impact of DV-MRT program across DV-recidivism outcomes contrasted between a first group comprising program participants and a second comparison group created from historical justice-involved individuals. A randomized and/or prospective study was not feasible because the DV-MRT program was implemented in many courts in Washington State before the start of the current evaluative work, and with the goal of fulfilling the treatment needs of as many justice-involved individuals meeting the eligibility criteria.

Study Groups

Two study groups were created, which comprised first a group of DV-MRT program participants and second a group of comparison subjects that were also charged with a DV offense. The first group was comprised of DV-MRT participants, both who completed and did not complete the program (due to dropping out or not being done at the end of the evaluation follow-up), and amounted to a total of 631 subjects. The subjects within the first group were participants of DV-MRT intervention programs

[14] The prosecutor or city attorney of the case makes the determination whether each charge meets the DV criteria. After further inquiries, it was determined that this measure has validity and is updated to reflect court findings about the case.

located in King and Snohomish counties. The subjects were primarily male (89 percent) and were on average 38 years of ages at the time of the study. A majority of the subjects were reported to be White (45.5 percent), followed by Black (27.5 percent), LatinX (15.4%)and Asian/Pacific Islander (9.8 percent). Subjects who identified as American Indian/Alaskan Native comprised the smallest portion of the DV-MRT group (1.8 percent). The second group of analysis comprised comparison subjects. We created a historical comparison group comprising comparable individuals with a DV charge. Considering the discovery that many other court sites ordered and/or offered DV-MRT, all with different programmatic start dates, it was decided that a historical comparison group from the two larger counties offering DV-MRT was the safest option to ensure that possible members of the comparison group had not received the treatment. This extended sample frame allowed for a larger population of potential study subjects to which DV-MRT participants could be matched and compared (n = 15,736). All potential comparisons subjects were included in the pool if they met the following criteria: sex, age, and race were reported as well as having a DV offense. Once the pool of potential comparable subjects was constituted, we proceeded with propensity score modeling (a procedure we described more later on this section) to select from this pool only those participants that were similar to DV-MRT program participants on key demographics, qualifying offense severity, criminal history, and child maltreatment indicator variables. The size of this reduced comparison group amounted to a total of 407 subjects.

Measures

To conduct the propensity score matching procedure, we used items measuring four domains: 1- key demographics, 2- qualifying offense severity, 3- criminal history, and 4- child maltreatment indicator variables. These domains were selected because they would include members in the comparison groups that closely resemble program participants on the risk factors addressed by the program, in addition to matching them on key demographic characteristics.

Under the first domain, the specific demographic characteristics used were sex, race, and age, all collected through administrative records[15]. With regard to second domain about qualifying offense, we considered its severity (classified by a number ranging from 1 to 142, as determined by the Washington State Institute for Public Policy). For ease of interpretation, readers should note that higher numbers reflect offenses that are more serious in nature. In the third domain considered (criminal history), offenses committed prior to the qualifying case were identified and classified based on six categories: Public Order violations, Drug Law Violations, Misdemeanor offenses involving property, Misdemeanor offenses involving a person, Felony offenses involving property, and Felony offenses involving a person. The numbers of each category of offenses the subject had prior to the qualifying case was then imputed under the correct category. Subjects who did not have a prior criminal offense had a 0 imputed in each category. Finally, two variables were utilized to capture indications of the participants' maltreatment as a child. First was a binary indicator of a dependency filing history (coded 0= no record; 1= record of dependency filing), to represent subjects who were abandoned, abused or neglected as children, or without parent, guardian, or custodian capable of adequately caring for them which resulted in a court filing. Second was a binary indicator of a Becca petition filing history (coded 0= no record; 1= record of Becca petition filing). In Washington State, Becca petitions include At-Risk Youth petitions (filed by parents seeking assistance when they believe their children are out of control or in danger), Child In Need of Services petitions (filed by either parent or child seeking temporary placement to give time for reconciliation) and truancy petitions.

Several measures were collected to serve as dependent variables to examine the study questions identified previously. As per the program model, DV recidivism was operationalized as DV reconviction. Two types of reconvictions were collected, including *Any DV Reconviction and Felony DV Reconviction*. Reconviction was assessed for each subject as a dichotomous measure (No/Yes) to

[15] There are limitations to these data. For sex, analyses are limited to the dichotomous options of male or female and remove the possibility for a participant to self-identify their preferred gender identity. For race, it also classifies each participant in a unique category, which can be reductive as it might ignore part of their racial and ethnic identity, or group diverse populations together, such as is the case with existing categories of Asian/Pacific Islander and American Indian/Alaskan Native.

capture the occurrence of each type of recidivism after participation in the DV-MRT program started, or after adjudication for a DV offense for the comparison group. Because subjects were adjudicated at different dates, we did not have a standardized follow-up length. For program participants, we utilized program start date and end of analysis period (December 31st, 2020) or recidivism event date to compute a continuous measure of *Time at Risk* for DV-MRT. For comparison subjects, we measured the number of days spent after adjudication for the qualifying offense until either the end of the analysis period or until a recidivism event occurred.

Matching Procedure: Propensity Score Modeling (PSM)

Although a randomized design would have been best to eliminate biases stemming from group selection, ethical considerations along with feasibility restrictions prevented the utilization of this gold standard of research to analyze the DV-MRT program outcomes. Instead, a quasi-experimental[16] study design was utilized to collect a sizable pool of eligible historical comparison group subjects. However, retrospective designs commonly have unanticipated selection bias issues, which could prevent our ability to isolate the impact of DV-MRT. Propensity Score Modeling (PSM) is a technique that can be used to correct for selection bias in observational studies. Briefly, PSM entails the creation of a propensity score, which is used to match participants from the treatment condition to participants from the control condition. This matching process creates balance between treated and untreated participants, and it reduces selection bias. As such, it simulates a randomized design, and typically returns a comparison group that is similar to the treatment group on many key characteristics (Guo & Fraser, 2010; Rosenbaum & Rubin, 1983, 1985).

[16] The goal of a quasi-experimental design is to establish causation (i.e., that a program causes the behavioral changes observed in program participants) in the absence of random assignment to the treatment condition. In the case under study, assignment to DV-MRT is decided by a judge, instead of following a random statistical pattern. In this context, a quasi-experimental approach identifies a comparison group that is as close as possible to the treatment group, without having received the treatment, in order to determine what the behavioral outcomes would have been if the program were not implemented.

We created one PSM match, matching treatment program participants (T group) to eligible subjects from our historical comparison (HC) group pool members. Subjects were matched on all 13 available items[17], creating a match.

The procedure begins by assessing the differences between the two groups on the 13 items. Bivariate comparisons are completed and significant differences between groups are assessed. Standardized Differences (STD) tests were also completed, where a standardized absolute bias equal to or greater than 20 percent was used as an indication of imbalance (Rosenbaum & Rubin, 1985). Finally, a backwards, stepwise binary logistic regression was used to eliminate items that were not found to be significant at the multivariate level. Using a somewhat liberal alpha, those item comparisons indicating at least a marginal significance ($p<0.1$) pre-match were included in the PSM. It should be noted that only cases with complete data on the selected predictor items were included in the matching procedure. This process reduced the T group size from 631 to 407.

The propensity score modeling routine was completed with a one-to-one, greedy matching procedure, utilizing a selection caliper (less than 0.05 of a standard deviation unit). A total of 407 HC subjects were selected and matched to the T group for a total sample size of 814. Summary statistics of post-match results are also provided in Table 8.

The matched groups were then used to examine the study questions. Specifically, nine of the 13 items used differed significantly ($p<.05$) and three items differed substantially ($|STD|>20$) when comparing the HC to the T group. Furthermore, the global estimate of group differences used, the Area Under the Curve (AUC) statistic, indicated that the items used in the match were substantial predictors of group assignment (AUC=0.675), which is a moderate effect size (Rice & Harris, 2005). Following the match, zero items were found to be significantly, or substantially, different between the groups and the global measure indicated negligible-to-small differences between the groups (AUC = 0.534). In lay

[17] Items used to match: Sex, Race, Age, Prior Public Order, Prior Drug Law Violations, Prior Misdemeanors Property, Prior Misdemeanors Person, Prior Felonies Property, Prior Felonies Person, Qualifying Offense Severity Score, Prior DV Treatment, Any Maltreatment Dependency Filing, and Any Maltreatment Becca Filing.

terms, what these results indicate is that we were able to find comparison subjects that are very close in their characteristics to the DV-MRT participants, in that there were no more significant differences between the two groups after the matching procedure.

Overall, the findings of both matching procedures indicated high quality matches between the subject in the T group and the HC group match. Based on these analyses, we proceeded to examine recidivism outcomes using the matched groups. This means that all unmatched subjects from the HC group are no longer considered in the remaining analyses.

Table 8. Propensity Score Modeling And Sample Descriptives

Predictors	Pre-Matching					Post-Matching				
	N	T Group	N	HC Group		N	T Group	N	HC Group	
		Mean		Mean	STD		Mean		Mean	STD
Male	631	0.8821***	15736	0.7329	0.4619***	407	0.8821	407	0.9017	-0.0609
White	606	0.4570***	15372	0.6179	-0.3231***	407	0.4570	407	0.4521	0.0099
Age	423	34.3543*	15736	35.5892	-0.1138*	407	34.3543	407	34.8374	-0.0445
Prior Criminal History										
Public Order	631	0.6486***	15736	0.9014	-0.1775**	407	0.6486	407	0.6413	0.0052
Drug Law Violations	631	0.3342**	15736	0.4436	-0.1331*	407	0.3342	407	0.3784	-0.0538
Misdemeanor: Property	631	0.6486***	15736	0.8617	-0.1294**	407	0.6486	407	0.6732	-0.0149
Misdemeanor: Person	631	0.7494	15736	0.8892	-0.0965	407	0.7494	407	0.8649	-0.0797
Felony: Property	631	0.2703***	15736	0.3701	-0.1303**	407	0.2703	407	0.2948	-0.0321
Felony: Person	631	0.1966	15736	0.1998	-0.0058	407	0.1966	407	0.2138	-0.0304
Qualifying Offense Severity Score	423	62.7150***	15736	56.8862	0.7269***	407	62.7150	407	61.8673	0.1057
Received Prior DV Treatment	631	0.7248***	15736	0.6670	0.1295***	407	0.7248	407	0.7150	0.0220
Child Maltreatment										
Dependency Filing	631	0.0565	15736	0.0474	0.0394	407	0.0565	407	0.0713	-0.0638
Becca Filing	631	0.1327	15736	0.1558	-0.0682	407	0.1327	407	0.1327	0.0000
AUC	.675					.534				

*** $p \leq 001$; ** $p \leq .01$; * $p \leq .05$

Analysis Plan

Following the PSM procedure, statistical analyses were calculated to answer the study research question: *was the DV-MRT group less likely to be reconvicted for a DV offense than the comparison group?* We examined differences between these two groups on the two types of conviction outcomes identified previously (*Any DV Reconviction* and *Felony DV Reconviction*) at two points in times (1 year and 2 years), using cross-tabulations and chi-square tests[18]. When significant differences between the treatment and comparison groups are detected, we also present odds ratio in text to give further meaning to the results. We also conducted semi-parametric Cox proportional hazards regression models[19] in order to study the association of groups (i.e., DV-MRT treatment or comparison) with time to recidivism to examine group trends across the supervision follow-up period. By incorporating time-to-event information, our approach is more powerful than simply examining the occurrence of recidivism. We focus not only on whether reconviction occurs, but also examines when it occurs during the follow-up period, to deepen our understanding of the pattern of recidivism in time. As a final step, we examined recidivistic outcomes by sex and race, along with program completion, using cross-tabulations and chi-square tests, to examine the program effectiveness in different strata of program participants.

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[18] Cross-tabulations and chi-square analyses are used to determine whether there is a significant association between two categorical variables. First, a cross tabulation displays the frequency of data based on two categorical variables. In the evaluation study, it displayed the frequency of recidivism by participation or not to a DV-MRT program. The joint frequency data is further analyzed with the chi-square statistic to evaluate whether participation in a DV-MRT program was associated with recidivism or absence of recidivism.

[19] Cox proportional hazards regression is used to investigate the effect of variables on the time a specified event takes to happen. In the evaluation conducted, it specifically considered the role of participation in a DV-MRT program on time-to-recidivism. Specifically, the analysis identifies the risk or probability of recidivism, given that the participant has not recidivated for a specific length of time.

Outcome Evaluation Results

Any DV Reconviction

Results generally indicate that DV-MRT is effective in reducing DV-related recidivism for Any Reconviction (including both misdemeanor and felony). Figure 3 visually represents those differences. To correctly interpret this chart, it is important for readers to first note the scale of the y-axis, and second to also refer to Table 9 to identify whether the noted differences are statistically significant. Specifically, we find that in contrast to the comparison group, DV-MRT participants have reduced levels of Any DV Reconviction at 1 year follow-up; the results were right at statistical significance (*p* = .051). Odds ratio calculations indicate that DV-MRT program participants are 57% more likely to be successful for Any DV Reconviction (i.e., not have experienced a recidivistic event) at the one-year mark compared to individuals in the comparison group. After 2 years, the difference between the two groups is not statistically significant anymore (*p* = .130), indicating that the program impact might be most notable during and in the immediate aftermath of participation.

Figure 3. Percent Of Any Reconviction By Treatment And Comparison Groups At 2 Time Points

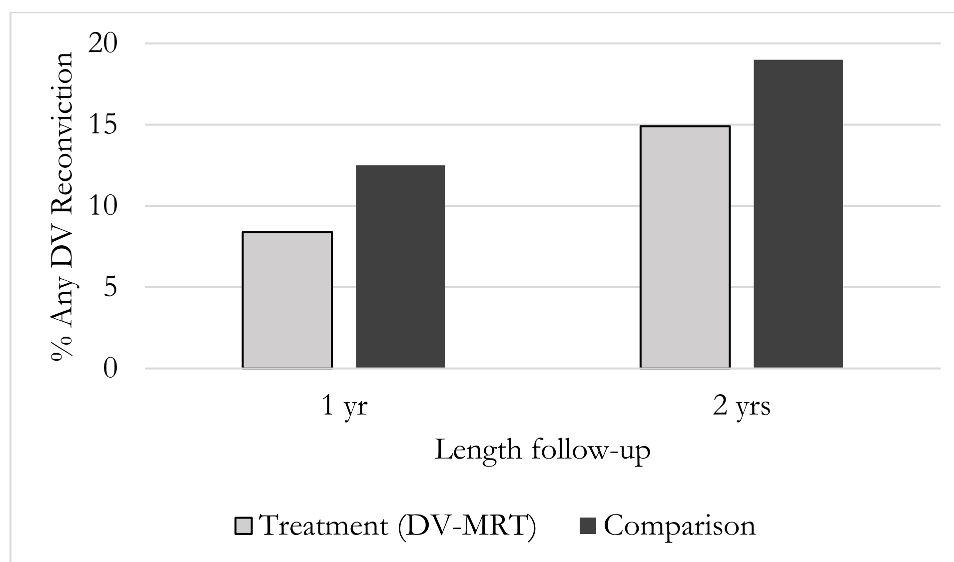

Table 9. Chi-Square Analyses: Any DV Reconviction By Treatment And Comparison Groups

	Sample size	Treatment group (DV-MRT)	Comparison group	χ^2	*p*-value
1 yr	814	8.4%	12.5%	3.795	.051
2 yrs	782	14.9%	19.0%	2.293	.130

To also account for the impact of time on reconviction risk, we present the results of Cox regression analysis to examine possible differences in the hazard rates (i.e., risk of Any DV Reconviction) of the treatment DV-MRT and comparison groups. The results indicated hazard differences between the two groups did not reach statistical significance for Any DV Reconviction ($\chi 2 = 2.447$; $p = .118$). The regression results are presented in Table 10. Regression coefficient (β value) should be interpreted as follow: 1) it identifies the risk of Any DV Reconviction occurring for the DV-MRT treatment group; and 2) a positive coefficient indicates higher risk of reconviction and negative coefficient indicates a lower risk of reconviction. In the case under review, results indicate that the DV-MRT treatment group had lower hazard rates than the comparison group. Specifically, their risk of reconviction for any type of DV was 22.3% lower, controlling for the effects of time. Hazard risks by group are graphed in Figure 4 to ease interpretation and visually represent the lower recidivism risk for DV-MRT, keeping in mind that the results did not reach statistical significance.

Table 10. Cox Regression Coefficient By Treatment Group For Any DV Reconviction Model

	β	exp β	SE	*p*-value
Treatment DV-MRT group	-.253	0.777	.162	.119

Figure 4. Hazard Function – Any DV Reconviction By DV-MRT Treatment And Comparison Groups

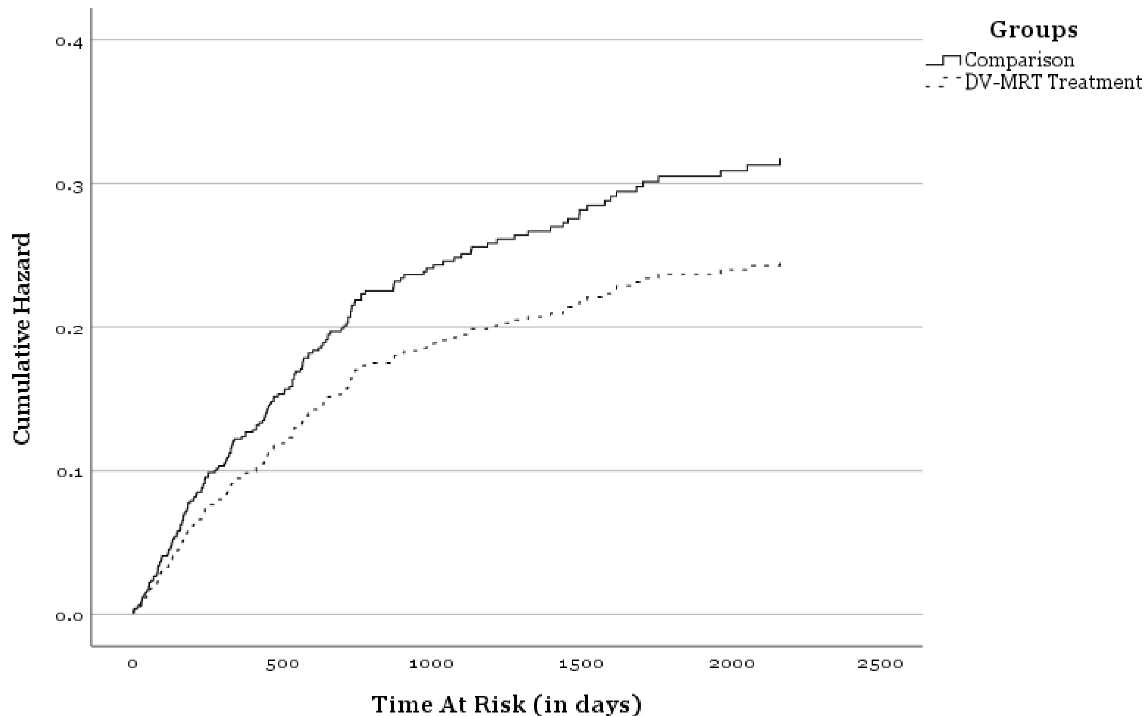

Figure Note: Time at risk in days extrapolated over the follow-up period based on the value of β coefficient

Felony DV Reconviction

Results do not support the effectiveness of DV-MRT to reduce Felony DV Reconviction. The differences are visually represented in Figure 5, which should be examined in conjunction to Table 11. Specifically, we find no significant difference between the comparison group and DV-MRT participants after 1 year and 2 years follow-up. In the absence of a significant association between treatment status and felony recidivistic outcomes, we did not proceed with the Cox regression analysis.

Figure 5. Percent Of Felony DV Reconviction By Treatment And Comparison Groups At 2 time points

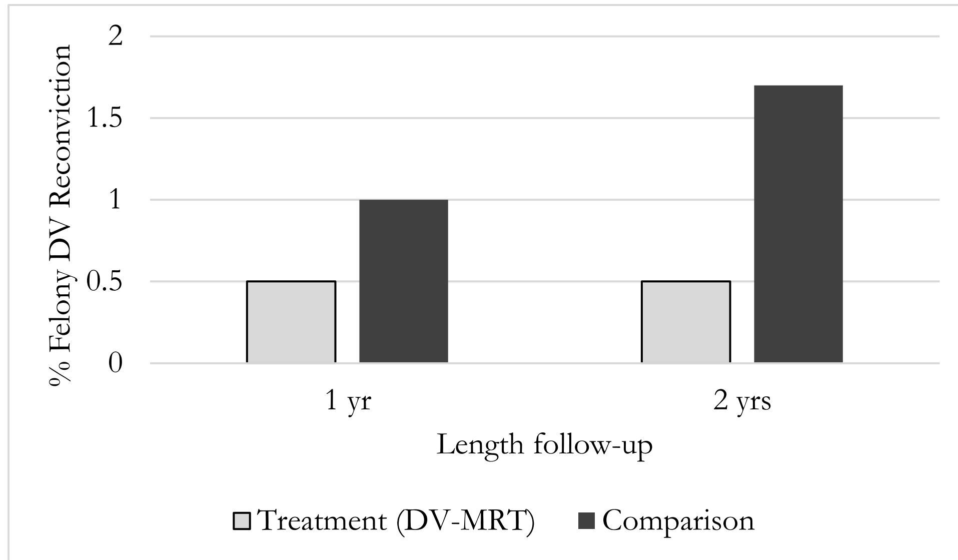

Table 11. Chi-Square Analyses: Felony DV Reconviction By Treatment And Comparison Group

	Sample size	Treatment group (DV-MRT)	Comparison group	χ^2	p-value
1 yr	814	0.5%	1.0%	0.672	.412
2 yrs	782	0.5%	1.7%	2.439	.118

Subgroup Analyses

In a second step of the outcome evaluation, we wanted to investigate whether DV-MRT treatment was as effective in different subpopulations of program participants. Prior limitations about the measures of sex and race should be kept in mind; they are discussed more at length in Footnote 15. In addition, we note the lack of consideration of sexuality and type of romantic relationships. Overall, the goal of subgroup analyses is to identify patterns of DV-MRT effectiveness for different subpopulations. Due to limited sample size (e.g., females), inability to consider more meaningful subgroups (e.g., race and ethnicity) or absence of relevant factors from measures administratively collected (e.g., sexuality), issues of generalizability plague these analyses. These results should therefore not be taken as the final answers on this topic but the beginning; their usefulness reside in the identification of areas of future research to further determine how DV programs can best serve diverse segments of the population.

Sex

The first stratum investigated is sex. This was informed by prior findings of the process evaluation discussing the lack of workbook inclusivity for female-perpetrated DV. Inconsistent practices between the DV-MRT programs studied related to the treatment provided to females also explain our interest. Specifically, one site denies DV-MRT treatment to females, another includes them in treatment group comprising both males and female participants, and a different site offers a female-only DV-MRT treatment group.

Visual results are presented in Figure 6 and statistical results in Table 12. We observe that male participants experienced the outcome of interest from program participant and had lower recidivistic outcomes for Any DV Reconviction (1 yr: 8.6% versus 13.1%; 2 yrs: 14.8% versus 20.2%). This finding is not replicated for female DV-MRT participants. Specifically, we find that DV-MRT females and comparison females are not different in their rate of Any DV Reconviction (1 yr: 6.3% versus 7.5%; 2 yrs: 6.3% versus 7.5%). The DV reconviction rate of females appeared to be much lower than for males in general, with or without participation in DV-MRT treatment. Based on the limited sample[20] of females studied, they do not appear to receive the same recidivism reduction benefits from DV-MRT as male participants. However, the small size of the female sample cautions against making a definitive conclusion about the effectiveness of DV-MRT for females based on these results alone. Additional research involving bigger samples is needed before we can make reliable conclusions about treatment effects for females.

[20] A total of 88 females were studied. Half were in the DV-MRT treatment group (*n* = 44) and half in the comparison group (*n* = 44).

Figure 6. Percent Of Any DV Reconviction For Females And Males By Treatment And Comparison Groups At 2 Time Points

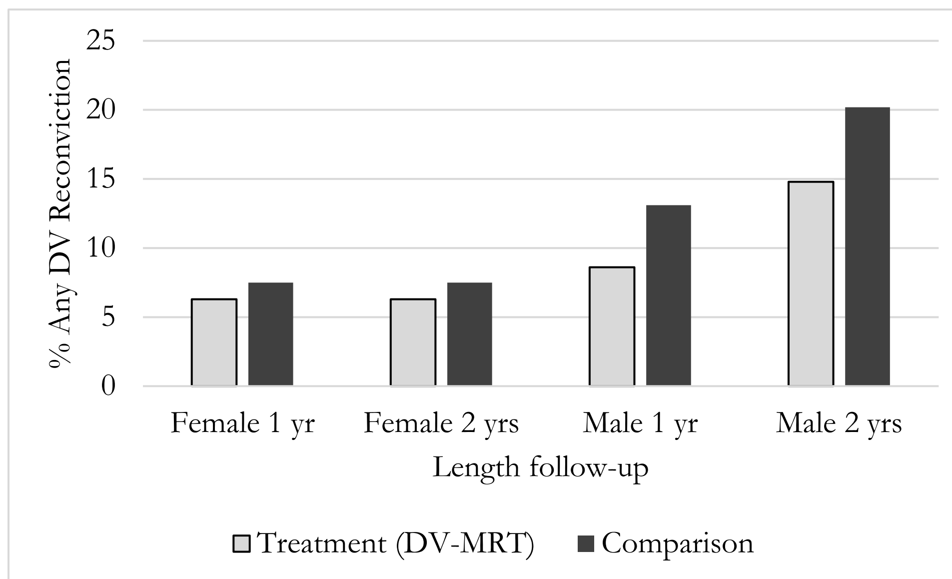

Table 12. Chi-Square Analyses: Any DV Reconviction For Females And Males By Treatment And Comparison Groups

		Treatment group (DV-MRT)	Comparison group	χ^2	p-value
Female	1 yr	6.3%	7.5%	.054	.817
	2 yrs	6.3%	7.5%	.054	.817
Male	1 yr	8.6%	13.1%	3.696	.055
	2 yrs	14.8%	20.2%	3.667	.056

Race

Patterns about race and effectiveness of DV-MRT treatment are presented in Figure 7 and Table 13. We observe that DV-MRT Black, Indigenous, and People of Color participants[21] experienced the

[21] For analytical purposes, all Black, Indigenous, and People of Color were combined in the same category. There are important limitations to this approach, including the lack of recognition about the differential experiences with DV-MRT programs for individual with varied racial and ethnic groups. The possible nuanced impact of the programs are lost in the current analysis.

outcome of interest and had lower recidivistic outcomes for Any DV Reconviction compared to matched Black, Indigenous, and People of Color comparison subjects who did not receive DV-MRT treatment (1 yr: 8.1% versus 14.3%; 2 yrs: 14.5% versus 22.4%). This finding is not replicated for White DV-MRT participants. While there are differences for White participants compared to White comparisons (1 yr: 8.6% versus 10.3%; 2 yrs: 12.9% versus 14.7%), their magnitude is smaller and does not reach statistical significance. This appears to indicate that DV-MRT treatment appears particularly effective for POC participants. At this point, we are reticent to speculate about possible implications and would note the absence of an important control variable (i.e., socioeconomic status). Its inclusion would further illuminate the noted association, especially given that one of the stated goal of DV-MRT is to expand financial accessibility of DV treatment. Importantly, we caution against the use of these results to impose further criminal justice sanctioning (including additional treatment) to groups that are already overrepresented in the criminal justice system. This needs to be researched more in the future.

Figure 7. Percent Of Any DV Reconviction By Race By Treatment and Comparison Groups At 2 Time Points

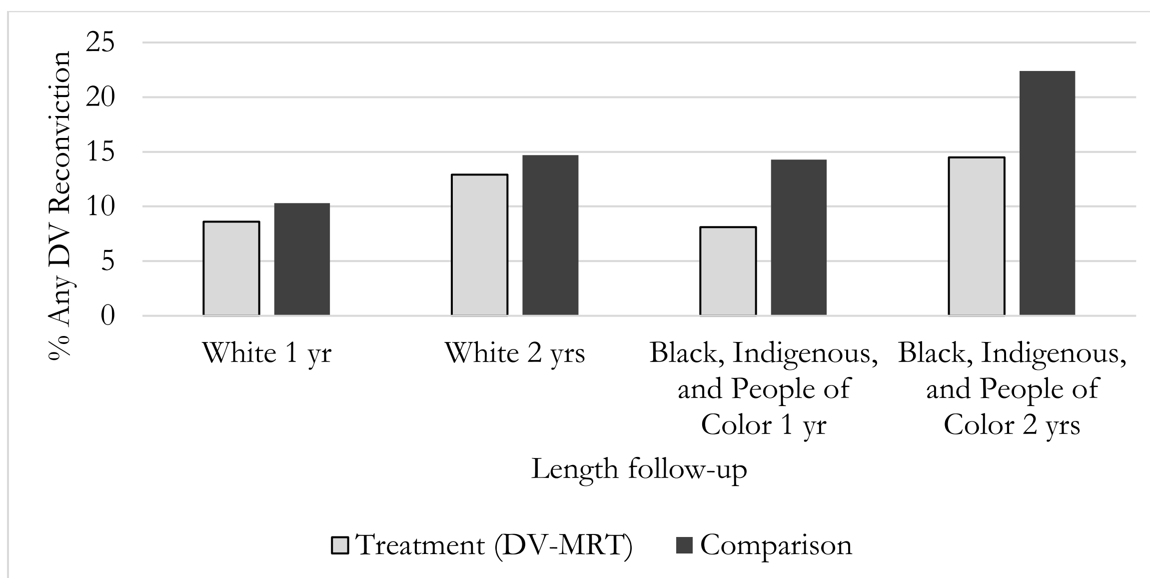

Table 13. Chi-Square Analyses: Any DV Reconviction By Race By Treatment And Comparison Groups

		Treatment group (DV-MRT)	Comparison group	χ^2	p-value
White	1 yr	8.6%	10.3%	0.321	.571
	2 yrs	12.9%	14.7%	0.244	.621
POC	1 yr	8.1%	14.3%	4.277	.039
	2 yrs	14.5%	22.4%	4.649	.031

Program Completion

Lastly, we considered the impact of program completion on recidivistic outcomes for DV-MRT participants. As presented in Figure 8 and Table 14, DV-MRT program participants who completed the program experienced much better outcomes compared to those who did not. At the one-year mark, only 5.2% of the completers had recidivated with Any DV Reconviction, compared to 18.2% of the participants who did not complete. At the two-year marks, the difference is still markedly different: 10.1% versus 25.3%. While interesting, we note a possible time ordering issue in that it is unclear whether a recidivistic event might result in the termination from the program. Still, investigating factors that promote success in the program appears to be a worthy line of inquiry for the future.

Figure 8. Percent Of Any DV Reconviction By Program Completion Status At 2 Time Points

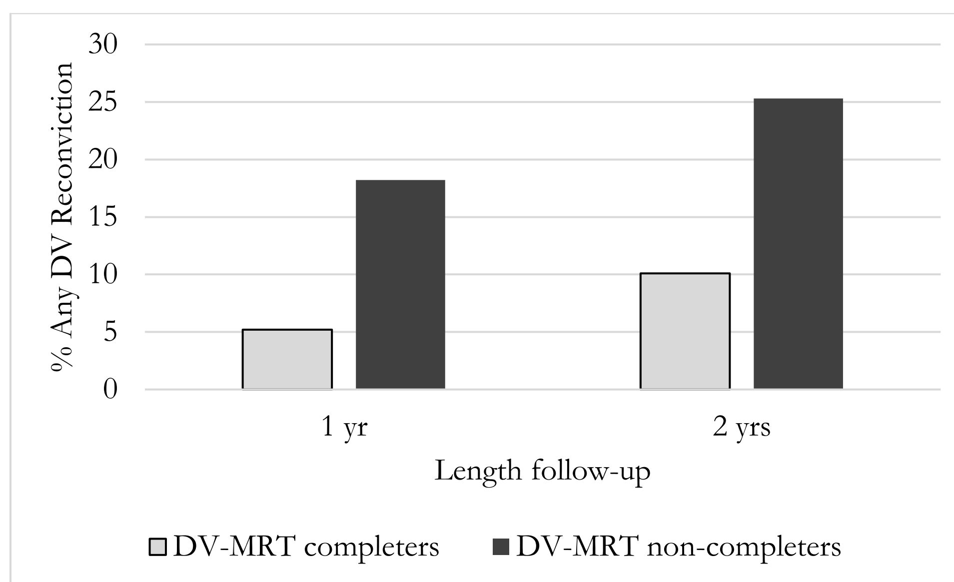

Table 14. Chi-Square Analyses: Any DV Reconviction By Program Completion Status

	Completers	Non-completers	χ^2	p-value
1 yr	5.2%	18.2%	16.505	.001
2 yrs	10.1%	25.3%	14.563	.001

Summary

Overall, the findings of the outcome evaluation, conducted after obtaining a robust comparison sample, indicate that participation in the DV-MRT program appears to reduce the likelihood of Any DV Reconviction at 1-year follow-up. Specifically, the program impact is more marked in the first year for Any DV Reconviction but appears to weaken over time for any DV Reconviction. No program impact was noted for Felony DV Reconviction.

This differential pattern of reconviction between study groups demonstrates that the DV-MRT program appears effective in preventing the reoccurrence of DV crimes in the short-term by court-involved individuals. This makes court-sponsored DV-MRT a promising program considering its much lower costs compared to traditional DV treatment. However, follow-up length was limited, and it will be important to include longer follow-up of DV-MRT in the future to see if such positive impact is maintained over time. Further consideration of program effectiveness patterns relative to sex and race should also be investigated to provide a better understanding of its nuanced impact in various subpopulations, along with factors that are associated with DV-MRT program completion.

Section 7: Conclusion and Recommendations

As a program, DV-MRT holds a lot of promise. Firstly, it provides treatment based on therapeutic principles aimed at increasing moral reasoning and quality of decision making and ultimately change behavior in the context of domestic conflict. Secondly, it addresses a critical practical matter that often impedes criminal desistance for DV justice-involved individuals: the lack of affordable DV treatment. Prior to the current evaluation work, DV-MRT's effectiveness remained to be established through a rigorous research design. This was the task undertaken with the present evaluation.

Specifically, the current study examined the effectiveness of six court-sponsored DV-MRT programs in Washington State, including their process (i.e., implementation and operations), and evaluated their achievement of their stated goal of decreasing DV reconvictions. The current evaluation work was conducted in the specific and challenging context of COVID-19. The evaluators, facilitators and most of the program participants spent an inordinate amount of time at home in the last year. Every aspect of the evaluation was conducted remotely, without any site visits or in-person contact. There are limitations that arose from this context: a more intellectual understanding of the program and its operations without observational backing; difficulties in recruiting and engaging with various key individuals at some sites due to impersonal remote contact; and scheduling difficulties due to convergence of familial and work life at home for all individuals involved in the evaluation. There were also deep and novel insight generated about the DV-MRT program and its delivery in this context; these ideas inform the recommendations we identify.

Results generally indicated a number of strengths to the DV-MRT program, including its content and cost, and the quality of the facilitators' work. Importantly, the quantitative analysis indicates a short-term reduction in DV reconviction for DV-MRT program participants compared to a rigorously matched comparison group. The court-sponsored DV-MRT programs studied appear to increase public safety in preventing the reoccurrence of Any DV crimes committed by court-involved individuals. This is notable considering that the follow-up period includes the year 2020 marked by Washington State's Covid-19 stay-at-home order; such measures were associated with DV cases (Boserup et al., 2020; Moreira & da Costa, 2020). As such, this makes court-sponsored DV-MRT a promising program, especially in light of its much lower costs compared to traditional DV treatment. It may be worth continuing and expanding court-sponsored DV-MRT programs in Washington State.

The following are some recommendations arising from the current evaluative results that might be useful as the program continues its activities and/or expands in the future.

1) Urge Correctional Counseling, Inc. (CCI) to update the program workbook.

One of the most unequivocal themes emerging from the interviews conducted related to the outdated nature of the workbook. All program participants and facilitators indicated a desire for these materials to be revised in order to be more inclusive of the various contexts in which DV occurs, including same-sex relationships and female-perpetrated DV. The DV-MRT program content is proprietary to CCI and it is outside of the scope of our purview as evaluators or to the program facilitators to identify the nature of such changes and implement them. We recommend that the Gender and Justice Commission shares the current results and recommendations with CCI in the hope that it propels them in improving what was undividedly identified as the most significant area to target for improvement. Alternatively, it is also possible to instead specify the types of materials (i.e., gender responsive and inclusive of same-sex relationships) needed for a court to refer an individual to a specific program.

2) Offer extended times and modes of program delivery, including remote options, and evaluate their effectiveness

Both program participants and facilitators discussed difficulties in program access when its delivery required face-to-face contact, which is problematic considering the limited availability of DV-MRT in most Washington State jurisdictions (see Figure 1). The geographical context of the courts studied entailed challenges for many participants in getting to the treatment sites via existing public transportation options and arriving on time, especially if working a full-time job. COVID-19 “forced” remote delivery, which many saw in a positive light due to the increased flexibility it provided and recommended that such extended modes of delivery, including remote access, remain even post-COVID-19. In addition, remote options could allow program participants to attend DV-MRT at a different court location at a more advantageous time for them considering their work schedule. That being said, drawbacks to remote delivery were also identified, including increased interruptions and distractions, and difficulties in generating the same level of participant engagement and foster therapeutic treatment conditions. As such, we strongly recommend evaluating the treatment effectiveness of these different delivery modes.

3) Offer additional administrative support to existing court-sponsored DV-MRT programs.

The DV-MRT program facilitators surveyed and/or interviewed all indicated an increase in their workload after undertaking this role. They specifically discussed an increased in administrative tasks and client management that takes up time. Additional resources to lighten this load would help.

4) Continue researching DV-MRT's effectiveness, specifically with better measures of key concepts, larger samples and longer follow-up periods for participants' recidivistic outcomes, to examine treatment effectiveness for subgroups using intersectional lenses.

Measures of sex, race and ethnicity that are administratively compiled have important limitations due to their imposed dichotomous nature. This erases the true diversity of program participants' self-identified gender identity and racial and ethnic identity. Other factors are simply absent from administrative records (sexuality and type of relationships). If anything, results to the current evaluation are a call for "better" and "more" research about DV-MRT. By "better" research, we recommend using more nuanced measures of these important factors. Such analysis will yield insight about the DV-MRT program's effectiveness in various subpopulations such as female and Black, Indigenous, and People of Color participants. We also recommend "more" research on the topic, specifically through larger samples to bolster generalizability and longer follow-up periods. Considering the short time period in which the DV-MRT programs studied were implemented and evaluated, there are a number of limitations to the current study findings. A follow-up period of 2 years is in line with the DV literature, but a longer period would allow to better measure permanent behavioral change in program participants and comparison subjects. This would serve to increase confidence in our conclusions as many program effects diminish over time, which seems to be what the results indicate. Ultimately, better insight can be generated about the nuanced impact of the DV-MRT programs through an intersectional approach, in which subgroups are examined by considering their combined experience with the program considering the combination of their gender identity, racial and ethnic identities, sexuality, and other relevant factors. This will allow to understand *for whom* the program works and in *what context*, illuminating the mechanism/s explaining the program effects.

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