

Evaluation of Specialized Substance Abuse Treatment Services for Women

August

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In 2010, a pilot of Beyond Violence was conducted within the Residential Substance Abuse Unit at the Women’s Huron Valley Correctional Facility in Ypsilanti, Michigan. Beyond Violence, developed by Dr. Stephanie Covington, in collaboration with MDOC and Dr. Sheryl Kubiak of Michigan State University, is the first intervention in the United States focused on reducing and preventing violence for women in the criminal justice system. The pilot and ensuing group comparison study demonstrated the intervention’s feasibility and effectiveness in treating women with assaultive histories in a prison setting. Short-term outcomes showed reductions in mental health symptoms and anger. As a result, Beyond Violence was added to the Residential Substance Abuse Treatment Unit curriculum and was implemented in the Mental Health Unit to replace the Assaultive Offender Program traditionally delivered there. In 2012-2013, long-term outcomes, including effects on recidivism, relapse, and treatment adherence, were monitored and two outpatient groups for women with life sentences were conducted. This report presents the long-term outcomes of Beyond Violence, as well as results for women with life sentences.

Report of Long-term Outcomes

Evaluation of Specialized Substance Abuse Treatment Services
for Women Convicted of Violent Offenses:
Report of Long-term Outcomes

Michigan Department of Corrections
Women's Huron Valley Correctional Facility
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EXECUTIVE SUMMARY

As part of MDOC's effort to enhance treatment, Dr. Sheryl Pimlott Kubiak of Michigan State University (MSU) was contracted to engage in a three-year study involving the development, implementation, and evaluation of enhanced substance abuse services for women convicted of violent offenses at Women's Huron Valley Correctional Facility (WHVCF). The enhanced services focused primarily on a new curriculum developed specifically for women with violent offenses. Beyond Violence (BV), is a 20-week program designed to explore the interrelationship between substance abuse, trauma, mental health, and violence in women's lives. BV, developed by Dr. Stephanie Covington, is the first curriculum in the United States focused on reducing and preventing violence for women involved with the criminal justice system.

The MSU study began in 2009 and was comprised of four phases. The first three phases, conducted from 2009 – 2012, included: 1) the initial assessment of risk factors among women who have and have not committed violent offenses and determination of instruments to differentiate women with greater risk for engagement/re-engagement in violence; 2) a pilot implementation and feasibility study conducted within the Residential Substance Abuse Treatment Unit to determine if the program could be delivered as intended to the target population in a corrections setting; and 3) a two-phase group comparison study (GCS) comprised of three conditions conducted in an outpatient setting – BV, Assaultive Offender Program (AOP), and treatment as usual (TAU) – to determine if BV was a suitable replacement for AOP. The results of these phases were shared in the Evaluation of Specialized Substance Abuse Treatment Services for Women Assessment, Process, and Short-term Outcomes provided to MDOC in 2010, 2011, and 2012 respectively.

During the fourth year (2012 – 2013), the long-term effects of the BV pilot and GCS phases were monitored through the review of administrative data for one year following discharge from WHVCF. In addition, two BV groups were administered in an outpatient setting to women serving life sentences. Because the majority of participants in the GCS were either not yet released or paroled for less than 12 months, analysis of long-term outcomes was limited to participants of the pilot phase. Outcomes including recidivism, relapse, and treatment adherence were considered. Analyses revealed that women participating in the BV group experienced better outcomes than similar women in the TAU group. During the first 12 months of parole, women in BV group were less likely to recidivate (33% of BV v. 40% of TAU); were less likely to test positive for drugs (58% of BV v. 80% of TAU); and produced fewer positive drug screens (1.9 for BV v. 3.6 for TAU). Significant differences were found between the BV and TAU group regarding treatment adherence: women in the BV group were more likely to participate in treatment (58% of BV v. 20% of TAU); more likely to complete treatment (77% of BV v. 50% of TAU); and remain in treatment longer (70 days for BV v. 22 days for TAU).

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I. Overview

The Michigan Department of Corrections (MDOC) – through the Office Substance Abuse Services (OSAS) – aims to preserve public safety and prevent longer periods of incarceration for women convicted of violent offenses by enhancing substance abuse treatment services offered to women at Women’s Huron Valley Correctional Facility (WHVCF). Most interventions for violent offenders are developed for men and based on the knowledge of what is known about male offending, risk factors, and rehabilitation. MDOC consulted with Dr. Stephanie Covington of the Center for Gender and Justice to develop the first curriculum in the United States focused on reducing and preventing violence for women involved with the criminal justice system. The result was Beyond Violence (BV), a 20-week program designed to systematically explore the interrelationship between substance abuse, trauma, mental health, and violence in women’s lives.

As part of its effort to enhance treatment at WHVCF, MDOC contracted with Dr. Sheryl Pimlott Kubiak of Michigan State University (MSU) to engage in a three-year study involving the development, implementation, and evaluation of enhanced substance abuse services for women convicted of violent offenses at WHVCF. Following is an overview of the study concluding with the most recent phase completed in 2012-2013. Reports detailing the methods employed and outcomes achieved during earlier phases were previously provided to MDOC in separate reports in 2010, 2011, and 2012. A more detailed overview is also included in Appendix A at the back of this report.

During the first year of the study (2009-2010), Dr. Kubiak’s Evaluation Team engaged in activities to assess similarities and differences in risk factors between women who have and have not committed violent offenses; explore similarities and differences in risk among women with violent offenses; determine instruments and measures to differentiate between levels of risk for engagement or re-engagement in violent offenses; and inform the development and implementation of the BV intervention. A report detailing the assessment findings, *Assessing Factors Associated with Assaultive Offenses Among Women with Substance Use Disorders within Michigan*, was presented to MDOC in September 2010.

In the second year of the study (2010-2011), the Evaluation Team assessed the implementation of the new BV curriculum at WHVCF. A pilot of the intervention was conducted within the Residential Substance Abuse Treatment (RSAT) Unit. The primary goals of the pilot were to determine if the intervention could be delivered as intended to the target population in an appropriate setting and if the target population would be receptive to and benefit from the intervention. A report detailing the implementation of the intervention in RSAT, *Evaluation of Specialized Substance Abuse Treatment Services for Women – Process Report*, was presented to MDOC in November 2011.

During the third year of this study (2011 – 2012), the Evaluation Team began to monitor long-term effects of BV for the women involved in the pilot study in 2010 – 2011. Preliminary outcomes demonstrated short-term improvement in mental health symptoms (see below), but

more time was needed to determine the long-term effects of the intervention on behavior and aggression. The Evaluation Team also conducted a group comparison study (GCS) to evaluate the feasibility of BV in an outpatient setting, as well as to compare the benefits of BV with the Assaultive Offender Program (AOP), the intervention traditionally provided to women at WHVCF who are completing sentences for assaultive offenses. A report detailing the short-term outcomes associated with BV, *Evaluation of Specialized Substance Abuse Treatment Services for Women – Short-term Outcomes*, were previously presented to MDOC in November 2012.

This phase of the study was conducted in 2012 – 2013 and is presented within this report. Activities during this period focused on monitoring the long-term effects of BV on the pilot group; follow-up interviews with participants serving life sentences; and the facilitation of two outpatient BV groups provided to women with life sentences. The Evaluation Team collected and reviewed MDOC administrative data, including parole notes and OSAS substance abuse treatment billing data, and OTIS data, to examine recidivism, treatment adherence, and relapse for a period of one year following discharge from the facility for women involved in the pilot phase (2010-2011). In addition, two outpatient BV groups specifically targeted to women with life sentences were conducted by the Evaluation Team from July 2012 – November 2012. The long-term outcomes associated with those involved in the pilot of BV, as well as the results of the groups for women with life sentences, are presented in Sections III and IV of this report. The final phase of this evaluation will be to assess the long-term outcomes of those women randomized to either BV or Assaultive Offender Programming (AOP) as part of the group comparison study in 2012.

II. Summary of Short-term Outcomes Previously Reported to MDOC

Below previously reported results are reviewed as a precursor to the new findings reported here. A brief review of short-term outcomes associated with two phases, the pilot and group comparison, are presented.

A. Pilot Implementation Study

The primary goals of the pilot phase of the study were to determine if the curriculum could be delivered as intended to the target population in a corrections setting and if the target population would be receptive to and benefit from the intervention. Changes in mental health and anger were measured through the collection of pre- and post-tests administered to study participants at the start and completion of the intervention. The short-term outcomes, or benefits of the intervention, achieved during the pilot phase are summarized below. In addition to the report to MDOC presented in November 2011, these findings have also been published in two academic manuscripts (Kubiak et al, 2012; Kubiak et al, 2013).

Changes in Mental Health. Mental health symptoms indicating depression, anxiety, PTSD, and/or serious mental illness (SMI) were measured over the course of treatment from pre- to

post-test for women in the pilot groups. Women in these groups experienced statistically significant reductions in all measures of mental health symptoms.

Changes in Anger. Anger indicators, including verbal aggression, hostility, and indirect aggression, were also measured over the course of treatment from pre- to post-test. Though differences in anger between pre- and post-tests were not statistically significant, it is believed that the lack of statistically significant reductions in anger was an issue of instrumentation and not of intervention effectiveness. Instruments used to measure anger at the pre- and post-test points during the pilot phase did not differentiate the measurement of “state” anger (i.e. anger that fluctuates and changes) from “trait” anger (i.e. anger that exists as part of the personality). This issue was addressed in the next phase of research, the group comparison phase (see next section).

Changes in Mental Health and Anger – Women with Life Sentences v. Shorter Sentences.

Data from the pilot phase also revealed significant differences between women with life sentences and those with shorter sentences within the BV pilot groups. Though both groups were similar in terms of current age and offense type, the groups varied in terms of changes in mental health and anger. Pre-test measures of mental health (i.e., depression, anxiety, PTSD, and SMI) and anger (i.e., verbal aggression, hostility, and indirect aggression), were significantly higher among women with life sentences than those with shorter sentences indicating different experiences and perspectives between the two groups. Despite these pre-test differences, post-test scores between the two groups were similar, and in some cases, were even lower for those with life sentences. Changes in both mental health and anger between the two groups were statistically significant.

Summary. Short-term outcomes from the pilot phase demonstrated statistically significant improvements in mental health symptoms, though it is difficult to parse out the effect of BV from the overall effect of the RSAT programming that all of the women received. However, the decrease in mental health symptoms is important due to the link between depression and PTSD with anger and/or rage. The pilot phase provided preliminary indication that BV could be administered successfully within a prison, that changes over time were in a positive direction, and that BV may have a stronger effect on women with life sentences than those without. All of these results indicate the need for testing BV using an experimental design with a randomized group comparison.

B. Group Comparison Study

The primary question of the group comparison study was to determine if BV, a 20-session gender-specific curriculum, could be substituted for AOP, the 44-session curriculum traditionally mandated for women serving sentences for assaultive offenses at WHVCF. In order to determine if BV is a suitable substitution for AOP, the effectiveness of both programs was assessed. Women were randomly selected from a list generated by MDOC, all meeting the same criteria, for inclusion in the experimental condition (BV) or the treatment as usual condition (AOP). The short-term outcomes of the group comparison study are summarized below.

Changes in Mental Health. Mental health indicators, including SMI and PTSD, were measured over the course of treatment from pre-test to post-test for women in the AOP and BV groups. Women in both groups experienced declines in symptoms indicative of SMI and symptoms associated with PTSD. However, there were no statistically significant between group differences in the mental health symptoms.

Changes in Anger. Building on the results of the pilot phase, three anger indicators were measured in the group comparison: anger expression (i.e. general reaction in certain situations), state anger (i.e. the intensity of angry feelings at a particular time, including the feeling of anger and the expression of anger verbally and physically), and trait anger (i.e. temperament and emotions expressed over time). Women in the BV and AOP groups experienced substantial overall declines in all three types of anger; there were no statistically significant group differences in the changes to anger over time.

Summary. Given the short-term outcomes of the group comparison, it is fair to say that both the AOP and BV programs are effective and equivalent in producing short-term improvements in mental health and anger. However, BV produces these improvements more efficiently, in just 20 sessions administered over 10 weeks compared to AOP, comprised of 44 sessions administered over the course of 22 weeks. ***Note: In subsequent analysis of this data, using only the women who met the initial criteria for randomization, a treatment effect attributable to BV was found: women in the BV condition were more likely to have significant reduction in anxiety symptoms, as well as reductions in state anger. These results will be forthcoming in an academic manuscript.***

III. Long-term Outcomes

During the remainder of the study (2012 – 2013), the Evaluation Team assessed the long-term outcomes associated with BV. Long term outcomes are defined as: 1) recidivism, 2) relapse, and 3) treatment adherence in the community. While the short-term outcomes summarized above demonstrated the effectiveness of BV in yielding improvements in mental health and anger, it is important to ascertain if the positive effects of the intervention were sustained beyond the end of the program and extended to when women were paroled and released to the community.

A. *Methods*

To determine the long-term effects of BV, post-release recidivism, behavior, and substance abuse treatment were examined using MDOC parole notes, OTIS, and Office of Substance Abuse Services (OSAS) treatment data (See Table 1). Data from all sources was collected for participants of the pilot and group comparison phases for a period of one year following release from prison.

Table 1: Long-term Outcome Methods

Outcome	Measure	Data Source
Recidivism	Return to state institution (prison or technical rule violation center)	MDOC Parole Notes and MDOC OTIS
	Arrest for any offense and/or Jail incarceration	MDOC Parole Notes
Relapse	Indicators of the use of drugs or alcohol through drug testing; orders for drug tests; and number of positive drug tests by parole officer	MDOC Parole Notes
Treatment Adherence in Community	Substance abuse treatment including presence/absence of treatment; referrals to treatment, time to treatment; and discharge status	MDOC OSAS Data and MDOC Parole Notes

For purposes of assessing the long-term effects of BV, recidivism was defined as: 1) return to state institution, either prison or the technical rule violation center (TRV), and 2) incarceration in jail or any new arrest. Jail and arrest were combined because the overlap between both was so high that it could not be considered a ‘unique’ event. Relapse was defined as the presence of any positive drug screen while on parole. However, since some women were never tested, a ratio was created to determine the rate of positive screens by the number of drug tests. Post-release substance abuse treatment adherence was assessed by examining data obtained from the MDOC OSAS, as well as parole notes, including referrals to community based treatment, admission, length of stay and discharge status.

B. Study Participants: Pilot Implementation Phase (N=73)

In assessing outcomes associated with BV, it should be noted that all women involved in the pilot phase were participants of the RSAT program. Since all women in RSAT are involved in a minimum of 40 hours of programming per week, it is difficult to tease apart the effects of BV from the effects of RSAT. It should be remembered that the primary reason for this pilot study was to assess the feasibility of being able to implement the BV curriculum in a prison setting. For purposes of this report, some comparisons between women who received BV, and those who did not, will be conducted to determine if any group differences can be noted. Furthermore, a smaller group, those with a violent offense in RSAT that did not receive BV (RSAT – TAU with violent offense), will be utilized to increase the equivalency or similarities between the comparison groups. **Overall, it is noted that outcomes reported here are outcomes attributable to the RSAT program and staff.**

As described above, long-term outcomes were assessed by examining MDOC data for a period of 12 months post-release from WHVCF. Because the majority of the women who participated in the group comparison study from July 2011 – May 2012 had not been paroled as of 05/20/13, the data cut-off for this analysis, long-term outcomes for those in the group comparison are not currently available. As a result, the following post-release participant characteristics and long-term outcomes analyses will focus on the 70 women from the pilot phase who were paroled for at least 12 months, or a minimum of 350 days, including 24 (34%)

women who received the BV intervention during their stay in RSAT Unit (RSAT – BV); ten women with a violent offense who received ‘treatment as usual’ (TAU) in the RSAT Unit during the same time frame (RSAT – TAU with violent offense); and 36 women without a violent offense who also received TAU in the RSAT Unit during the same time frame (RSAT – TAU w/out violent offense). The ten women convicted of an assaultive/violent offense (RSAT – TAU with violent offense) are considered to be a close comparison to the women in the RSAT – BV condition.

Table 2: Number of Participants

Phase	Group	#	Paroled To Date		Paroled 12+ Mos.	
Pilot						
Cohort 1	RSAT – BV	8	7	87.5%	7	87.5%
	RSAT – TAU with violent offense*	9	9	100.0%	8	88.8%
	RSAT – TAU w/out violent offense	22	22	100.0%	22	100.0%
		39	38	97.4%	37	94.8%
Cohort 2	RSAT – BV**	19	18	94.7%	17	89.4%
	RSAT – TAU with violent offense	2	2	100.0%	2	100.0%
	RSAT – TAU w/out violent offense***	15	15	100.0%	14	86.6%
		36	35	97.2%	33	88.8%
Total		75	73	97.3%	70	93.3%

* Incomplete data for one RSAT – TAU with violent offense participant who paroled 03/11 under supervision of another state.

**Incomplete data for one RSAT – BV participant who had less than the minimum of 350 days on parole to be considered for analysis.

***Incomplete data for one RSAT – TAU w/out violent offense participant who paroled 08/11 and died 11/11.

C. Participant Post-Release Characteristics

As noted in Table 2, above, of the 73 women paroled to date, three are not included in this data analysis – one from each of the three groups: one woman from the RSAT – BV group had less than the minimum 350 days of parole to be considered for the analysis; one woman from the RSAT – TAU with violent offense moved to a different state for parole supervision; and one woman from the RSAT – TAU without violent offense died shortly after being paroled. All three of these women were removed from the analysis. The data is grouped by outcome (recidivism, relapse, and treatment adherence) and presented for the entire group and then split by specific group for means of comparing different groups within RSAT. Data is presented on three groups: 1) RSAT – BV, n=24; 2) RSAT – TAU with violent offenses, n=10; and 3) RSAT – TAU w/out violent offenses, n=36. The distinction between women in the RSAT – TAU conditions (with and w/out violent offenses) is an attempt to create a more direct comparison between women in the RSAT – BV condition – all of whom have a violent offense.

D. Recidivism

Recidivism outcomes reported by MDOC are generally defined as those who return to prison. For this analysis, return to prison is combined with return to the MDOC Technical Rule Violation Center (TRV). In addition, another indicator of recidivism not generally used in MDOC assessments, evidence of any arrest or jail confinement, is used. Both are used to compare these outcomes with other MDOC reports, as well as assessing other indicators of problematic

behaviors. Reporting this level of data could assist in developing preventative interventions in community settings.

Table 3: Recidivism Outcomes

Variable	Total RSAT N=70	Differences by RSAT Groups		
		RSAT – BV n=24 %(n)	RSAT – TAU with vio offense n=10 %(n)	RSAT – TAU w/out vio offense n=36 %(n)
Any Arrest/Jail 1 st Year Parole	35.7% (25)	33.3% (8)	40.0% (4)	36.1% (13)
Any TRV/Prison 1 st Year Parole	1.4% (1)	0	0	2.8% (1)
Avg Month of 1 st Jail/Arrest	8	7	6	9
Avg Month of 1 st Prison/TRV	1	0	0	1

Table 3, above, illustrates recidivism outcomes for the entire RSAT population, as well as the different groups within RSAT, for the first 12 months of parole. Of the entire group, only one woman was sent back to TRV or prison during the period. That the vast majority (98.6%) of all women completing RSAT in both conditions did not return to prison during the first year of parole, is a very impressive outcome – surpassing the previous outcome study of RSAT completed by University of Michigan’s Substance Abuse Research Center in 2004 in which 94% of women completing RSAT were still in the community after 12 months (Boyd, Young, Roach & Slayden, 2004). However, there were quite a few women either arrested or confined to jail at some point during the period (n=25; 36%). Although not significant, there is variation in the proportion of those in each group with an arrest or jail experience. Those in the RSAT – BV group had the lowest interface (33%) and women in the RSAT – TAU with violent offenses had the highest interface (40%). The average time to the first jail/arrest recidivism was 7.7 months; the longest time was for those in RSAT – TAU w/out a violent offense (8.8 months); and the shortest time to jail was for those in RSAT – TAU with a violent offense (6.0 months).

E. Relapse

Conditions of parole, particularly for individuals assessed as having a substance use problem, generally require drug testing twice per month¹. Data indicated that five women (7%) were never drug tested during the 12 month period. Interestingly, three women with a violent offense (two RSAT – TAU with violent offense and one RSAT – BV), were among those who were not drug tested during the period. Of those who were tested, the number of drug tests

¹ Public Act 487 of 2006 mandates that parolees with a history of substance abuse, who are assigned to intensive, maximum, or medium supervision, as determined by offenses considered to be violent per the Statutory Violent Felonies List (State of Michigan 93rd Legislature, 2006), shall be drug tested at least twice per month.

averaged 13 across the 12 month period (1.1/month). Those with a violent offense (RSAT – BV and RSAT – TAU with violent offense) were tested more frequently, averaging 15 tests over the 12 month period (1.3/month) while those without a violent offense (RSAT – TAU w/out violent offense) averaged 11 tests over the year (0.9/month).

Table 4: Relapse Outcomes

Variable	Total RSAT N=70	Differences by RSAT Groups		
		RSAT – BV n=24 %(n)	RSAT – TAU with vio offenses n=10 %(n)	RSAT - TAU w/out vio offense n=36 %(n)
% Drug Tested During Parole	92.9% (65)	95.8% (23)	80% (8)	94.4% (34)
% Positive Drug Screen 1 st Year Parole	52.9% (37)	58.3% (14)	80.0% (8)	41.7% (15)
Avg Month 1 st Positive Drug Test	5.8	6.1	6.8	5.1
Avg Proportion Positive Drug Screens to Total # Screens Performed	16.3%	18.0%	25.0%	13.3%
Avg # Positive Tests Per Person	1.97	1.88	3.60	1.58

As shown in Table 4, above, of the total group, 53% (n=37) tested positive for drugs or alcohol at some point during the 12 month period. The group with the largest proportion of women testing positive was RSAT – TAU with violent offenses (80%), followed by 58% of the RSAT – BV group, and 42% of the RSAT – TAU w/out violent offense group. Although women in the RSAT – TAU w/out violent offense group were least likely to have a positive drug screen, they were more likely to relapse sooner (average of five months into parole) compared to the RSAT – BV (6 months) and RSAT – TAU with violent offense groups (7 months).

Because of differences in the frequency of drug testing, the proportion of positive drug screens based upon the total number of drug screens performed were considered. In this way those who were more frequently drug tested were not penalized. Across the group, 16% of drug tests were positive. Women in the RSAT – TAU with violent offenses group had the highest proportion (25%) of positive screens, while those in the RSAT – TAU w/out violent offense group had the lowest proportion (13%). Finally, there was an average of two positive screens per person during the 12 month period with women in the RSAT – TAU with violent offense group averaged the highest (3.6) and those in the RSAT – TAU w/out violent offense averaged 1.58. In both of these assessments, women in the RSAT – BV group scored closer to those in the RSAT – TAU w/out violent offense group.

F. Treatment Adherence

Generally those involved in RSAT during incarceration are referred to some type of community treatment programming during parole. Overall, 66% of the women were referred to substance abuse treatment by their parole agent during the 12 month period following release (See Table

5). Parole notes indicate that 71% were admitted into substance abuse treatment at some point during the period. The average number of months to treatment referral, according to parole notes, was 3.2 months, with little variation by group.

In an attempt to cross-validate treatment involvement while on parole, billing records for substance abuse treatment were obtained through MDOC OSAS and examined. There was evidence that 31 women (44%) were admitted into treatment by a MDOC-contracted substance abuse treatment agency within the community. This data verifies that 24 women – or 34% of the entire sample of the women – were admitted in the first two months of parole. For women admitted into one of these MDOC-contracted agencies, more comprehensive data on length of stay (LOS) and completion status can be provided. Of those admitted into treatment, the average LOS was 63 days. Those in the RSAT – BV group averaged 70 days compared to 61 days for those in the RSAT – TAU w/out violent offense group and 22 days for those in the RSAT – TAU with violent offense group. Moreover, 61% of the 31 women admitted to treatment successfully completed treatment; 77% of those women in the BV condition and 50% of the RSAT only groups – irrespective of offense type. It is noted that data regarding the treatment interface for women on parole is likely incomplete and cannot be fully expounded on since women may have received treatment at other community-based programs not funded by MDOC.

Table 5: Substance Abuse Treatment Adherence Outcomes

Variable	Total RSAT N=70 % (n)	Differences by RSAT Groups		
		RSAT – BV n=24 %(n)	RSAT – TAU with vio offense n=10 %(n)	RSAT – TAU w/out vio offense n=36 %(n)
<i>% Referred to SA Treatment During Parole (per parole notes)</i>	65.7% (46)	75.0% (18)	70.0% (7)	58.3% (21)
<i>% Admitted to SA Treatment During Parole (per parole notes)</i>	71.4% (50)	75.0% (18)	70.0% (7)	69.4% (25)
<i>Avg Month of 1st Referral to SA Treatment</i>	3.2	3.7	3.0	2.7
<i>% Verified as Admitted to SA Treatment within first two months of parole (per MDOC OSAS data)</i>	34.3% (24)	33.3% (8)	50.0% (5)	30.6% (11)
<i>% of Verified Admissions (n=31) Who Successfully Completed SA Treatment in Community (per MDOC OSAS data)</i>	61.3% (19)	76.9% (10)	50.0% (1)	50.0% (8)

+Data from MDOC OSAS billing records.

It should be noted that when comparing women with violent offenses (RSAT – BV versus RSAT – TAU with violent offense), those attending BV were significantly more likely to participate in

treatment (58% versus 20%)², complete treatment (77% versus 50%)³ and remain in treatment for a longer period of time (70 days versus 22 days)⁴ compared to women in the RSAT – TAU condition. This level of significance is noteworthy given the small group sizes, but should be replicated in other studies. Also, these results are computed for women enrolled in MDOC-funded treatment only and, therefore, do not account for women who may have received treatment through other channels.

IV. Beyond Violence and Women with Life Sentences: Feasibility and Outcomes

Though women with life sentences do not usually qualify for RSAT or other rehabilitative programming due to prioritization of programs and services for parole- and discharge-eligible prisoners, the inclusion of these women in this study produced positive results and warrants additional consideration.

A. Feasibility of Treating Women with Life Sentences

Below is a summary of the involvement of women with life sentences throughout this study.

Participation of Women with Life Sentences in Pilot Phase

The pilot phase of this study involved eight women serving life sentences for violent offenses. As previously reported in November 2011, the women with life sentences involved in the pilot phase were hand-selected by RSAT Unit staff as part of an initiative supported by administrators at WHVCF for women with extended sentences to become eligible to serve as peer facilitators on an ongoing basis in the RSAT Unit. All eight women successfully completed treatment and remained within the RSAT Unit upon completion of the program to serve as mentors. Feedback from RSAT staff indicated that the engagement of the women with life sentences positively influenced the culture within the RSAT Unit. The staff credited the women with providing RSAT residents with hope, encouragement, and support throughout treatment by modeling appropriate behavior and identifying and appropriately addressing negative behaviors. Staff members also credited the women with generating renewed interest for the RSAT program because of the positive changes women in general population noticed in the mentors.

The short-term outcomes associated with BV were positive. As noted earlier in this report, preliminary outcomes indicated that BV may have had a stronger effect on women with life sentences than those without. Positive short- and long-term outcomes for women with life sentences can potentially influence current prison culture.

² Statistical significance on treatment participation during parole: $\chi_2 = 4.16$, $p=.04$

³ Statistical significance on treatment completion during parole: $\chi_2 = 10.03$, $p=.05$

⁴ Statistical significance on length of stay in treatment during parole: $t=2.13$; $p=.05$

Additional Opportunity to Treat Women with Life Sentences

In order to provide further opportunity for therapeutic intervention for women with life sentences, two outpatient BV groups, exclusively for those serving life sentences, were conducted during the final phase of this study. This initiative, supported by the administration of WHVCF, was intended to incrementally improve overall institutional behavior by directly improving the mental health and anger symptoms of women with life sentences, the most highly influential peer group within the institution. It was anticipated that participation in the outpatient BV groups for women residing in housing units throughout the institution would serve to further improve the institutional environment.

B. Outpatient Beyond Violence Groups for Women with Life Sentences

The opportunity for involvement in the pilot implementation of BV was positively received by women with life sentences and, as found in pre- and post-test measures and substantiated in follow-up interviews and focus groups, the women benefited greatly from the experience. Based upon their experience, and their suggestion that positive institutional leaders could emerge from the experience, additional groups were proposed.

As detailed in the Evaluation of Specialized Substance Abuse Treatment Services for Women – Short-term Outcomes Report provided to MDOC in November 2012, the initiative to conduct two outpatient BV groups exclusively for women with life sentences began in June 2012 with the selection of 27 women serving life sentences who had qualifying SASSI scores of 3 or 4. Of the 27 women invited to attend an informational session facilitated by two members of the Evaluation Team, 26 consented to participate in treatment and one declined participation. Kathy Tayeh, a retired RSAT therapist, was contracted by the Evaluation Team to conduct the groups.

Group Participants

The first outpatient group (Group 1) consisted of 12 women and was held from July 2012 – September 2012. The second group (Group 2) consisted of 14 women and was held from September 2012 – November 2012. As shown in Table 6, below, of the 26 participants, 25 successfully completed the group and one was sent to segregation and, as a result, was terminated from the group.

Table 6: Number of Participants in Groups for Women with Life Sentences

	Time Frame of Group	Number of Participants	Number of Participants Terminated
Group 1	07/12 – 09/12	12	1
Group 2	08/12 – 11/12	14	0

Participant Characteristics

As shown in Table 7, below, the average age of participants in the two groups for women with life sentences was 42 years old with the youngest participant 23 years old and the oldest 60

years old. Participants had served an average of 14 years in prison (range of 1 – 38 years) beginning at the age of 38 (range of 17 – 46 years old).

Table 7: Participant Characteristics for Groups for Women with Life Sentences

Characteristics	Average	Range
Age	42 years	23-60 years
Length of Incarceration	14 years	1-38 years
Age when Incarcerated	38 years	17-46 years

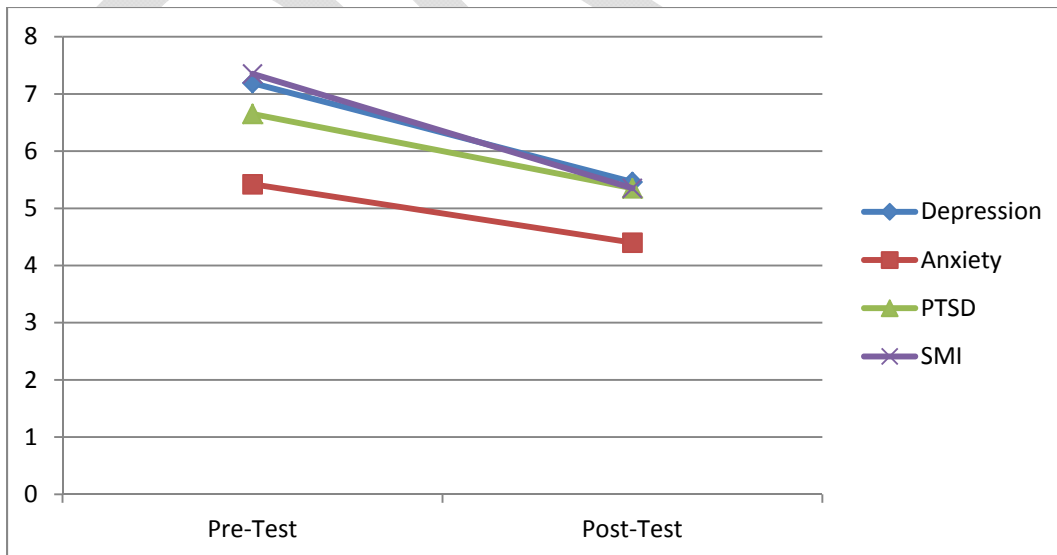
C. Short-term Outcomes for Women with Life Sentences

The preliminary results of the outpatient BV groups for women with life sentences are presented below. These results were previously presented by the Evaluation Team to WHVCF and MDOC Office of Offender Reentry staff in March 2013. The primary purpose of the outpatient groups for women with life sentences was to incrementally improve overall institutional behavior by directly improving their mental health and anger symptoms, as they are the most highly influential peer group within the institution. As in the previous study phases, mental health and anger indicators were measured over the course of treatment from pre-test to post-test for women in both groups. The short-term outcomes of these groups are summarized below.

Changes in Mental Health

As illustrated in Figure 1, below, post-test scores showed a decrease in symptoms of Major Depressive Disorder, anxiety, PTSD, and SMI. The change in symptoms of SMI was a statistically significant decrease.

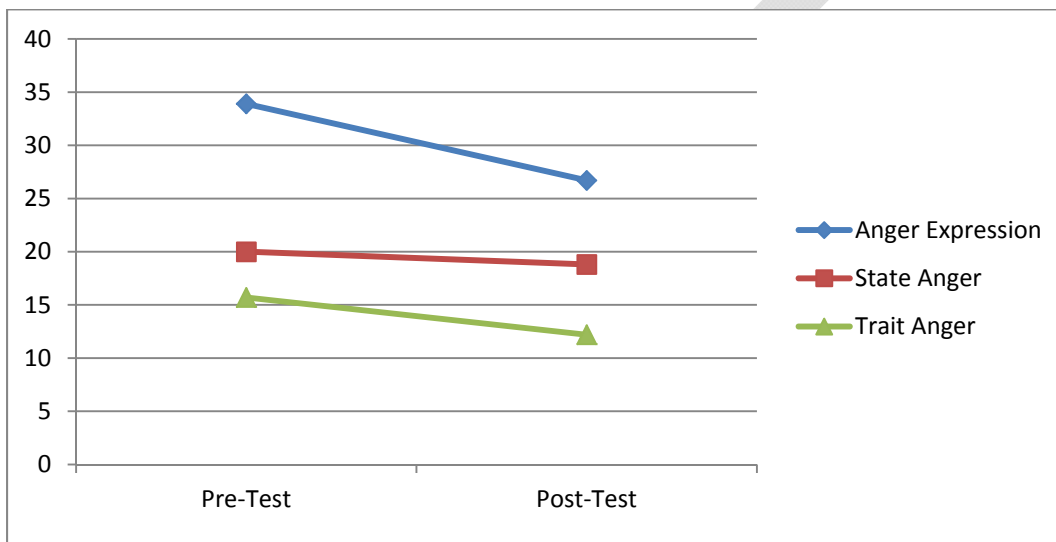
Figure 1: Changes in Mental Health Indicators (N=25)



Changes in Anger

Anger indicators, including verbal aggression, hostility, and indirect aggression, were measured over the course of treatment from pre- to post-test. Three indicators of anger were measured: anger expression (i.e. general reaction in certain situations), state anger (i.e. the intensity of angry feelings at a particular time, including the feeling of anger and the expression of anger verbally and physically), and trait anger (i.e. temperament and emotions expressed over time). Women experienced declines in all three types of anger, with statistically significant changes in anger expression and trait anger (See Figure 2).

Figure 2: Changes in Anger Indicators (N=25)



Participant Feedback and Focus Groups

Participants in the groups for women with life sentences were offered three ways in which to provide feedback about their experiences in the BV groups including: 1) written feedback on the group progress form at the end of each session; 2) focus groups conducted by members of the Evaluation Team at the conclusion of the groups; and 3) individual interviews conducted by a member of the Evaluation team three months following the conclusion of the groups. Comments provided by participants can be described using three main themes: (1) Beyond Violence creates positive changes in self and others; (2) it assists in understanding self and previous behaviors; and (3) it provides motivation and tools for positive change. Participants also offered suggestions for future BV groups for women with life sentences.

Creates Positive Changes in Self & Others

I received what I expected – to see changes in myself and others and in how I think and handle situations. I have been tested! And I've seen changes in others. I see differences in the before and after in others.

This was a choice to be here, in this group. Being here was a choice. And I think that is most commendable. We were all committed. We came regularly. Even though we were

allowed 2 absences, no one missed except for other call-outs. There were times when we were younger when we'd want to hang out on the yard instead of doing something like this. It's a big change for all of us to commit and want to commit to group.

The officers see a change in my attitude, the look in my face, and the control I have of my temper. I used to fly off the handle, but I've now been taught how to control it

Assists in Understanding Self & Previous Behaviors

I liked the lessons we learned. They helped connect the dots so I could see my behaviors throughout my life and the decisions I made so I don't make the same decisions again. I enjoyed the information about previous experiences. I could better understand the details that ultimately played a part in my ending up here. I didn't understand why I did what I did or why I participated but it (BV) draws together childhood and adulthood and how the effects were still there – it starts to make sense. It is vital.

This group allowed opportunities to figure out your triggers. When dealing with a situation, you could see how it might be caused by a trigger either from the past or the present. You could see how different you respond when you're responding based on something that just occurred versus something being triggered from the past. It was very powerful and it helped me understand how I've suppressed trauma. Some people think I'm crazy but they don't understand how I am responding. I am actually dealing with something from when I was younger that I tried to suppress. I understand the dynamics of trauma and deal with an issue as it occurs – not just react with a trigger. I'm able to stop and respond better.

Provides Motivation & Tools for Positive Change

I prayed for a group like this. I can't rehabilitate myself. I don't know how to. It's been life changing for me. I'm not an angel or a saint. I've learned that I put myself in predicaments that I shouldn't have. I put myself in more trauma because of trauma. I don't have to be the person who causes it anymore. [BV] teaches you a lot about yourself and I've learned where I want to go. I want to better myself.

I realized that my issues weren't isolated and that I'm not by myself. Before BV, I talked about pushing people down. With the help of my peers, I realized that this is not the way to go. I am glad I had this experience. I don't feel so isolated.

It showed me different ways of dealing with things. A lot of times I have only 1 outlet – you get on my nerves so I push you down. But now I have different ways of looking at situations. Now I think about why my temper has got me freaking out. I think more and stay out of trouble. I ask "what's wrong with me?" instead of just thinking "What is wrong with you?" Instead of thinking about "you", I think about "I" – I put "I" in the situation. I also think about what is the underlying issue that made me mad at her.

Suggestions for Improvement

For the lifers who have been locked up for years, there is a lot of pain and hurt and we have our guard up. The group needs to be longer—after 3 months, we were just getting comfortable. I know they are offering BV to women on their way out – that’s different. We are lifers – we are not in a hurry... It should have been a longer group of maybe 6 months to a year.

It would be helpful to have the group at the beginning of your sentence and then again at 10 years – in order to get that message of “Don’t give up” to keep hope alive.

There wasn’t enough time. It was so enlightening and exciting. I looked forward to group and then time goes by too fast both in terms of session length and number of sessions. I wanted a safe place to come talk – it was positive which is rare here. Now it’s done and there’s not a safe place.

We need other groups for lifers. They offer groups to women leaving to go back to society, but they need to offer groups to those here – we still need change. It doesn’t need to always be for society – this (the prison) is my society now. I need to love my neighbor instead of pushing her down while here. They need to give us groups to help us learn how to deal in here. Especially with things like losing loved ones while in here... We need groups for women in here – how to become a better person while in here and to show parole board that we’re changing.

We need more groups for lifers, but they have to be structured like BV – they have to have meaning.

D. Summary

At the end of both groups for women with life sentences, there were reductions in the average number of mental health symptoms of depression, anxiety, PTSD, and SMI for women. Likewise, based on the women’s scores on the anger measures, BV appears to be influencing aspects of women’s anger in a positive manner, especially for anger expression, state, and trait anger. Women with life sentences who participated in the groups also report that BV encouraged positive changes for all members of the group, helped with self-understanding of past behaviors, as well as how to prevent future negative behaviors, and builds motivation for continued positive change while supplying the tools necessary to make that change.

V. Summary

The pilot, implementation, and resulting short- and long-term outcomes of the BV intervention should be considered a success by MDOC. Below is a summary of outcomes of BV, including short-term changes in mental health and anger among study participants, as well as the long-term impact of the intervention on recidivism, relapse, and treatment adherence in the year following discharge from WHVCF. This section concludes with a summary of additional findings, as well as recommendations based on the results of this study.

A. Long-term Outcomes

Listed below are the key long-term outcomes achieved by women in the pilot phase of the study.

Women in BV group recidivate less than TAU group. Raw data demonstrates that participants in the BV group achieved better recidivism outcomes than similar women in the TAU group. Only 33% of women from the BV group interfaced with the criminal justice system in the first 12 months of parole (i.e. arrest, jail, prison, or TRV) compared to 40% of women in the TAU group with a violent offense. While not statistically significant, the trend is favorable and future outcomes on the group comparison study (BV v. AOP) will further explore.

Women in BV group less likely to relapse than TAU group. Participants in the BV group achieved better relapse outcomes than similar women in the TAU group. Only 58% of women from the BV group tested positive for drugs in the first 12 months of parole compared to 80% of women in the TAU group with a violent offense. Similarly, women in the BV group produced an average of 1.88 positive drug screens during the 12 month period compared to 3.60 positive drug screens produced by women in the TAU group. Owing to small sample size, these results are not statistically significant, but the large differences demonstrate some effect of BV.

Women in BV group more likely to participate in treatment, complete treatment, and remain in treatment longer than TAU group. Participants in the BV group achieved significantly better treatment adherence outcomes than similar women in the TAU group. Women in the BV group were more likely to participate in treatment (58% of BV v. 20% of TAU); complete treatment (77% of BV v. 50% of TAU); and remain in treatment longer (70 days for BV v. 22 days for TAU). These results are statistically significant and are likely to be important in maintaining positive outcomes beyond the 12 month post-release period.

B. Additional Findings and Recommendations from Current Phase

Listed below are some additional key findings, as well as recommendations to further enhance treatment services offered at WHVCF.

Feasibility of providing treatment to women with life sentences. Though women with life sentences do not usually qualify for RSAT or other rehabilitative programming, the inclusion of these women in this study yielded improvements in mental health and anger and, as observed by RSAT clinicians, positively influenced women throughout the institution. The inclusion of women with life sentences in RSAT and/or outpatient treatment groups, on a regular, ongoing basis, will yield positive mental health and anger outcomes for a greater number of women at the individual-level and, hence, can positively influence prison culture by improving the quality of life and mental health of those women known to be the most influential within the prison.

Majority of women completing RSAT did not return to prison during the first year of parole. 98.6% of women who completed the RSAT program during the BV pilot phase did not return to

prison during the first year of parole. This finding surpasses the rate of 94% who remained within the community in a previous study conducted in 2004.

Statistically significant treatment adherence outcomes for women in BV group. Though group sizes in the pilot phase were relatively small, the level of significance in treatment adherence outcomes between the BV and TAU groups is compelling and should be replicated in future studies.

VII. Next Steps

The Evaluation Team continues to monitor the long-term outcomes of those women from the BV and AOP conditions of the group comparison study phase through the collection of parole note, OSAS, and OTIS data. As of the data cut-off on 05/20/13, only 23 of the 42 women across both conditions had received parole and, of those receiving parole, only three had been on parole for a full 12 months. Continued data collection for these groups will not only provide additional data to conduct more robust analyses of long-term outcomes for BV, but will also provide the opportunity to explore outcomes for women who received the BV intervention in an outpatient setting. As noted in Section III, the purpose of the pilot implementation phase was to assess the feasibility of implementing the BV curriculum in a prison setting. All women involved in the pilot phase were participants of the RSAT program where they received a minimum of 40 hours of programming per week. The co-occurrence of this added therapeutic programming makes it difficult to separate the effects of BV from those of regular RSAT programming. The ability to collect and assess data for 24 women who received BV in an outpatient setting, absent of other therapeutic programming, will provide stronger evidence of the long-term effects directly attributable to BV. The inclusion of 18 women from the AOP condition who did not receive BV, but who are similar to the women in the BV condition in terms of SASSI score, mental health status, and offense type, will further enhance the ability to assess the effects of the BV intervention.

The next data collection is planned for November 2013, six months following the last pull in May 2013. Based on the number of women anticipated to be paroled for 12 months as of November, at least two additional data pulls are planned for May 2014 and November 2014 to allow for the collection of 12 months of post-release data for the greatest number of women from both conditions.

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Appendix A: Overview & Methodology

There are nearly 115,000 women in the custody of federal or state prisons in the United States comprising 7% of all incarcerated offenders (Sabol, 2009). In 2008, of the women incarcerated nationwide, 29% were sentenced for property crimes (i.e. burglary, larceny, fraud, etc.), 28% percent for drug related offenses, and 32% percent were sentenced for violent or assaultive crimes, accounting for approximately 4% of the total violent offender population overall (Sabol, 2009). In Michigan, women comprise approximately 5% of the total prison population and accounted for 6.5% of the total prison commitments in 2009. Although approximately 20% of all women newly admitted to prison have an assaultive offense, among the current population of women incarcerated in Michigan's state prisons at the end of 2009, an estimated 47% of women were serving time for assaultive offenses (MDOC, 2009). A more accurate picture of violent offenses among women was obtained during a 2010 assessment within Michigan prisons, using a random sample of nearly 600 women. The assessment demonstrated that 61% of women had an assaultive offense (i.e., robbery, physical assault, homicide, or sex offense). Although only 20% of admissions involve an assaultive offense, the longer sentences result in a greater proportion of women with assaultive offenses within the institution at any time.

Substance use and misuse has been associated with assaultive behavior and is considered a risk factor for both men and women. Since the majority of women (75%) within Michigan prisons have a substance use disorder (SUD) (Kubiak, Boyd, Young, & Slayden, 2005), understanding and intervening in this particular area is imperative. Additional risk factors associated with violent offending for women include a history of child abuse (Pollock, Mullings, & Crouch, 2006), mental health issue (Silver, Felson & Vaneseltin, 2008), and a family member suffering from mental health issues (Pollock et al, 2006). Frequently, these women are initiated into criminal networks and resultant criminal activity (such as robbery) by their male partners (Torres, 2007; Koons-Witt & Schram, 2006; Pollock et al, 2006). When women do commit violent crimes, their victims tend to be family members or intimate partners, especially within the context of intimate partner violence. However, because alcohol and drug abuse are prevalent among female offenders, and they are more likely to be from an impoverished community with widespread drug use, researchers are suggesting that female violent crime is extending beyond family members and intimate partners to include strangers (Kruttschnitt, 2002; Baskin & Sommers, 1993).

Posttraumatic stress disorder (PTSD) is a mental health disorder that is strongly associated with substance use disorders, as well as experiences of physical and sexual assault (Greenfield & Marks, 2010; Mechanic, Weaver, & Resick, 2008; Pico-Alfonso et al., 2006; Schneider, Baumrind, & Kimerling, 2007; Temple, Weston, Rodriguez, & Marshall, 2007) and commonly found in samples of women involved in the criminal justice system (Jordan, Schlenger, Fairbank, & Caddell, 1996; Kubiak, Beeble, & Bybee, 2010; Teplin Abram, & McClelland, 1996; Zlotnick et al., 1998). This is pivotal, as mental health disorders in general have been linked to women's use of violence (Logan & Blackburn, 2009; Silver, Felson, & Vaneseltine, 2008) and incarcerated women have higher rates of mental health disorders when compared to women in surrounding communities (Jordan et al., 1996; Teplin et al., 1996) or men involved in the criminal justice

system (James & Glaze, 2006). Furthermore, symptoms of specific disorders such as PTSD and depression have been linked to women who use violence (Abel, 2001; Anderson, 2002; Goldenson, Geffner, Foster, & Clipson, 2007; Hamberger, 1997; Leisring, Dowd, & Rosenbaum, 2003; Swan, Gambone, Fields, Sullivan, & Snow, 2005).

The Michigan Department of Corrections (MDOC) – through the Office Substance Abuse Services (OSAS) – aims to preserve public safety and prevent longer periods of incarceration for women convicted of violent offenses by enhancing substance abuse treatment services offered to women at Women’s Huron Valley Correctional Facility (WHVCF). Most interventions for violent offenders are developed for men and based on the knowledge of what is known about male offending, risk factors, and rehabilitation. MDOC engaged Dr. Stephanie Covington of the Center for Gender and Justice to develop the first curriculum in the United States focused on reducing and preventing violence for women involved with the criminal justice system. The result is Beyond Violence (BV), a 20-week program designed to systematically explore the interrelationship between substance abuse, trauma, mental health, and violence in women’s lives.

As part of this effort at enhancing treatment, MDOC contracted with Dr. Sheryl Pimlott Kubiak of Michigan State University (MSU) to engage in a three-year study involving the development, implementation, and evaluation of enhanced substance abuse services for women convicted of violent offenses at WHVCF. During the first year of the study (2009-2010), the MSU Evaluation Team engaged in activities including: 1) assessing the similarities and differences in risk factors between women who have and have not committed violent offenses; 2) exploring the similarities and differences in risk among women with violent offenses; 3) determining what instruments and measures might differentiate women with greater risks for engagement or re-engagement in violent offenses; and 4) informing the development and implementation of clinical intervention to prevent women’s reengagement in violent behavior. A report detailing the above activities was provided to OSAS in December 2010.

During the second year of the study (2010-2011), the Evaluation Team assessed the implementation of the new BV curriculum at WHVCF. A pilot of the curriculum was conducted from September 2010 – June 2011 within the Residential Substance Abuse Treatment (RSAT) Unit. The pilot included a feasibility assessment of the implementation of the BV model among the intended target population of females convicted of assaultive offenses with a substance use disorder (SUD) who volunteered for RSAT. The pilot was conducted in the RSAT Unit because it offers a structured therapeutic environment with trained clinical staff skilled in substance abuse treatment and trained in BV. The primary goals of the implementation pilot were to determine if the curriculum could be delivered as intended to the target population in an appropriate setting and if the target population would be receptive to and benefit from the intervention. A report detailing the curriculum, the selection of study participants, and the results of fidelity monitoring and focus group activities, as well as a preliminary analysis of pilot group outcome data was provided to OSAS in November 2011.

During the third year of this study (2011 – 2012), the Evaluation Team continues to monitor long-term effects of BV for the women involved in the pilot study in 2010 – 2011. While preliminary outcomes demonstrated improvement in mental health symptoms, more time is needed to determine the long-term effects of the intervention on behavior and aggression. Will women engage in less institutional aggression? Will they be charged with fewer violent crimes? Will they recidivate less? Will they successfully complete parole?

To determine the long-term effects of BV, the Evaluation Team is currently reviewing administrative data, including MDOC parole notes for women in the pilot who have paroled, to examine recidivism and behavior within group (BV only) and between group (BV versus TAU) for one year following the conclusion treatment. Recidivism will be defined in three ways: 1) return to the facility for technical rule violations, 2) any new arrest, and 3) new arrest on violent offense. Additionally, one year post-treatment follow-up interviews were conducted with eight women serving life sentences who participated in the first two cohorts of the BV curriculum from September 2010 – June 2011. A report detailing the long-term outcomes of the pilot study will be provided to OSAS in May 2013.

In 2011 – 2012, the Evaluation Team began planning a randomized control trial (RCT) to evaluate the feasibility of BV in an outpatient setting and the benefits of the program when compared to existing outpatient treatment programs (i.e., outpatient substance abuse and AOP). Although there was great administrative and institutional support and much care taken in selecting the women for each condition, some errors and delays in updates to women's files created problems with group assignment. When confronted with this problem, staff assigned to one of the conditions followed regular department protocol and replaced those erroneously assigned to the group with women on the department's wait list who did not meet the criteria set forth for the RCT. Although this approach is a feasible solution from a pragmatic point of view, it created imbalance, and thus 'non-equivalent groups' (Note: See more on this on Page 10-11). Due to the resulting non-equivalency of the groups, the format of the study was changed from a RCT to a group comparison study (GCS).

The GCS was conducted from July 2011 – May 2012 with staff from the RSAT, Programs, and Mental Health Units. The two-phase study was comprised of three conditions:

- 1) Two outpatient BV groups (BV);
- 2) Two treatment as usual (TAU) outpatient substance abuse groups; and
- 3) Two outpatient assaultive offender program groups (AOP).

Although the study included a feasibility assessment of the implementation of BV in an outpatient setting, the primary goal was to compare the benefits of BV with AOP, the intervention traditionally provided to women at HVWCF who are completing sentences for assaultive offenses. Methods employed during the study included completion of pre- and post-test surveys to assess short-term outcomes; tracking process indicators and feedback through the use of Group Progress Notes (See Attachment A) within all three conditions (BV, TAU, and AOP); facilitation of focus groups with the six groups participating in the three conditions at or

near the completion of the programs; and monitoring long-term outcomes through the use of MSP and MDOC administrative data. This report details the selection of the study participants, a review of the curriculums utilized in each condition, and the results of fidelity monitoring, focus group activities, and preliminary analysis of outcome data for the BV and AOP groups.

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