



Evaluating DOC's Validated Treatment Provider List for Reentry Navigators: *Final Report*

In Washington, reentry navigators work with individuals as they transition from full custody to community custody. Reentry navigators connect people to supportive services, rehabilitation programs, and potential employers. With funding from the Department of Justice, the Washington State Department of Corrections (DOC) explored the impact of equipping reentry navigators with a more comprehensive list of verified service providers. The intent of the verified provider list (VPL) was to improve upon historical practices by creating a provider directory that was more complete, accurate, and up to date.

The Department of Corrections contracted with the Washington State Institute for Public Policy (WSIPP) to (1) assess the effectiveness of the VPL in improving engagement with services; (2) assess the effectiveness of the VPL in reducing recidivism; (3) examine differences in effectiveness across demographic characteristics; and (4) provide recommendations for additional research and analysis that may be needed.

A preliminary report completed by WSIPP described program activity and participant characteristics in 2024.¹ This second and final report updates program activity and assesses potential impacts on recidivism.

Summary

The Washington State Department of Corrections explored the impact of equipping community reentry navigators with lists of verified service providers. The verified provider list (VPL) improved upon historical practices by creating a provider directory that was more comprehensive, accurate, and up to date. The VPL was implemented in four reentry centers in two counties. Three reentry centers serving three additional counties serve as comparison locations.

As of December 2025, the VPL contained 250 service providers offering 290 services. Reentry navigators in areas with access to the VPL provided more referrals and provided those referrals more quickly. On average, the first referral was over two weeks faster in treatment reentry centers versus comparison reentry centers. Once a referral had occurred, people in the treatment facilities also engaged with providers more quickly (23 versus 34 days).

Despite additional referral activity, there were no differences between treatment and comparison group participants on recidivism (measured through arrest, conviction, and reincarceration).

These results should be interpreted with caution, however, as the study had low statistical power to detect an effect and was conducted on a shorter than typical recidivism observation period. Future analyses of longer-term recidivism trends may be informative.

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¹ Taniguchi, T. (2024). *Evaluating DOC's Validated treatment provider list for reentry navigators: Preliminary report* (Doc.

I. Background

In Washington, about 5,000 people are released from DOC custody each year.² People reentering communities after a period of confinement often have trouble finding stable employment that provides a living wage,³ are 13 times more likely to experience homelessness than the general population,⁴ and have limited access to mental health services⁵ or treatment for substance use disorders.⁶ These challenges contribute to persistent recidivism rates of about 30% within three years of release.⁷

Supportive services play a critical role in addressing the challenges faced by people reentering communities. Service providers may facilitate obtaining employment, achieving housing stability, and provide or connect people with treatment for mental health services and substance use disorders.⁸ However, providers often have limited capacity and are dispersed among numerous organizations, making it more difficult to locate and enroll in their services.

To address the fragmented nature of supportive services, jurisdictions have created programs to help formerly incarcerated people identify and enroll in supportive services. Reentry navigators have been one strategy to address the fragmented nature of service providers.

Reentry Navigator Programs

Reentry navigator programs are designed to help people identify and connect with supportive services as they are transitioning to community custody. Reentry navigator programs vary considerably in structure, format, and implementation based on local needs and resources. Programs may rely on navigators with lived experiences similar to those they assist.⁹ Programs may focus on specific issues, such as connecting people to mental health treatment¹⁰ or employment,¹¹ or provide referrals to multiple services based on needs.¹²

² Washington State Department of Corrections. (2023). *Prison admissions and Releases by county of admission*.

³ Couloute, L., & Kopf, D. (2018, July). *Out of prison & out of work*. Prison Policy Initiative.

⁴ Couloute, L. (2018, August). *Nowhere to go: Homelessness among formerly incarcerated people*. Prison Policy Initiative.

⁵ Mongelli, F., Georgakopoulos, P., & Pato, M.T. (2020). Challenges and opportunities to meet the mental health needs of underserved and disenfranchised populations in the United States. *FOCUS*, 18(1), 16–24.

⁶ Wang, P.S., Demler, O., & Kessler, R.C. (2002). Adequacy of treatment for serious mental illness in the United States. *American Journal of Public Health*, 92(1), 92–98.

⁷ Knoth, L., Wanner, P., & He, L. (2019). *Washington State adult and juvenile recidivism trends: FY 1995 - FY 2014 (Doc. No. 19-03-1901)*. Washington State Institute for Public Policy.

⁸ Lattimore, P.K., & Visher, C.A. (2013). The impact of prison reentry services on short-term outcomes: Evidence from a multisite evaluation. *Evaluation Review*, 37(3–4), 274–313.

⁹ Matthews, E. (2021). Peer-focused prison reentry programs: Which peer characteristics matter most? *Incarceration*, 2(2).

¹⁰ Hailemariam, M., Weinstock, L.M., & Johnson, J.E. (2020). Peer navigation for individuals with serious mental illness leaving jail: a pilot randomized trial study protocol. *Pilot and Feasibility Studies*, 6(1), 114.

¹¹ Jaegers, L.A., Skinner, E., Conners, B., Hayes, C., West-Bruce, S., Vaughn, M.G., Smith, D.L., & Barney, K.F. (2020). Evaluation of the jail-based occupational therapy transition and integration services program for community reentry. *The American Journal of Occupational Therapy*, 74(3).

¹² Tillson, M., Fallin-Bennett, A., & Staton, M. (2022). Providing peer navigation services to women with a history of opioid misuse pre- and post-release from jail: A program description. *Journal of Clinical and Translational Science*, 6(1), e106.

In a recent review of the research, the Substance Abuse and Mental Health Services Administration identified seven relevant, high-quality studies and concluded that case management, which primarily focused on making referrals to community-based service providers, was associated with lower recidivism, increased engagement in mental health and substance use treatment, and greater use of employment and education services.¹³ Other research has found that combining reentry services with peer mentoring was associated with lower recidivism.¹⁴

However, not all studies have found such positive results, with some finding no impacts¹⁵ or finding benefits for secondary outcomes (e.g., earnings) but not recidivism.¹⁶ A large-scale multi-site study found no impact on recidivism or labor market outcomes.¹⁷ These studies have relied on higher-quality randomized designs.

Some researchers have argued that reentry navigator programs have failed to reduce recidivism because individual program components (e.g., skills training, substance use treatment) are insufficient or ineffective, or comprehensive case management was

not well implemented.¹⁸ Studies on reentry services have been further hampered by difficult research conditions and weak implementation.¹⁹

Reentry Centers in Washington

As of 2026, DOC operated nine reentry centers with a goal of creating “a smoother transition from prison confinement.”²⁰ Reentry centers are partial confinement facilities where people can leave for approved reasons, such as going to work. During stays at reentry centers, people are expected to be employed or seeking employment, attend education or vocational training, reestablish relationships with family, and develop life skills.

People sentenced to a period of incarceration are eligible to transfer to reentry centers consistent with DOC Policy 300.500.²¹ Eligibility requires that a person be eligible for the lowest level restrictive custody within 18 months of their earned release date. Transfer may be denied if an individual refuses to complete programming, does not intend to participate in programming at the reentry center, has been previously terminated from a reentry center, or if there are victim safety concerns.²²

¹³ Substance Abuse and Mental Health Services Administration. (2023). *Best practices for successful reentry from criminal justice settings for people living with mental health conditions and/or substance use disorders* (Publication No. PEP23-06-06-001). Substance Abuse and Mental Health Services Administration.

¹⁴ Sells, D., Curtis, A., Abdur-Raheem, J., Klimczak, M., Barber, C., Meaden, C., Hasson, J., Fallon, P., & Emigh-Guy, M. (2020). Peer-mentored community reentry reduces recidivism. *Criminal Justice and Behavior*, 47(4), 437–456.

¹⁵ Grommon, E., Davidson II, W.S., & Bynum, T.S. (2013). A randomized trial of a multimodal community-based prisoner reentry program emphasizing substance abuse treatment. *Journal of Offender Rehabilitation*, 52(4), 287–309.

¹⁶ Cook, P.J., Kang, S., Braga, A.A., Ludwig, J., & O'Brien, M.E. (2015). An experimental evaluation of a comprehensive

employment-oriented prisoner re-entry program. *Journal of Quantitative Criminology*, 31(3), 355–382.

¹⁷ Wiegand, A., & Sussell, J. (2016). *Evaluation of the Re-Integration of Ex-Offenders (RExO) Program: Final impact report*. Social Policy Research Associates.

¹⁸ Doleac, J.L. (2019). Wrap-around services don't improve prisoner reentry outcomes. *Journal of Policy Analysis and Management*, 38(2), 508–514.

¹⁹ Eberth, S.D., Diaconu, M., & Koob, C. (2022). A cautionary tale of a prisoner re-entry initiative: Lessons learned. *The International Journal of Interdisciplinary Social and Community Studies*, 17(2), 167–177.

²⁰ DOC. [About reentry centers](#).

²¹ DOC. [Policy Number 300.500](#).

²² Conviction of some offense types also imposes additional transfer eligibility restrictions.

Current Study

Reentry navigators work to ease a person's transition from DOC custody to the community by providing referrals to supportive services. However, supportive services have limited capacity and are dispersed between numerous organizations. The current study explored the use of a verified provider list (VPL) as a strategy to improve the quality and speed of referral to services for people in reentry centers.

Reentry Navigators

In Washington, reentry navigators work full-time on connecting people with external services.²³ Upon transfer to a reentry center, risk and needs assessment information is sent to the reentry navigator. During the initial meeting with the client, the reentry navigator defines participant needs and develops referrals to services. Reentry navigators typically try to meet with clients monthly to review progress with their referred services and identify any need for additional resources.

Reentry navigators are also responsible for collecting and entering data in the Offender Management Network Information (OMNI) database. They work with service providers to collect information about program participation and completion.

Reentry navigators were not staffed in the treatment facility during the entire evaluation ([Appendix I](#)).

Staff turnover resulted in coverage gaps, which may have delayed the intake and referral activity. This may have also negatively impacted continuity of care and tracking engagement with services.

Verified Provider List (VPL)

The VPL was developed to address several challenges. Information on service providers has historically been decentralized, out of date, or incomplete. By creating a verified list, DOC aimed to improve knowledge of available services to facilitate the most appropriate connections.

To create the VPL, program staff developed an application form and conducted outreach to local service providers. Information submitted by providers was reviewed by program staff to determine if the provider was licensed, incorporated best practices, and offered no or low-cost services.

Providers that passed screening were entered into the VPL, which was accessible to reentry navigators in the treatment reentry centers. The VPL was updated during the evaluation as new providers, or updates to existing providers, were identified.²⁴

At the time of retrieval, the VPL contained 250 unique service providers offering 290 services ([Exhibit 1](#)).²⁵ The most prevalent type of service offered by providers was associated with securing employment (N = 64; 22%).

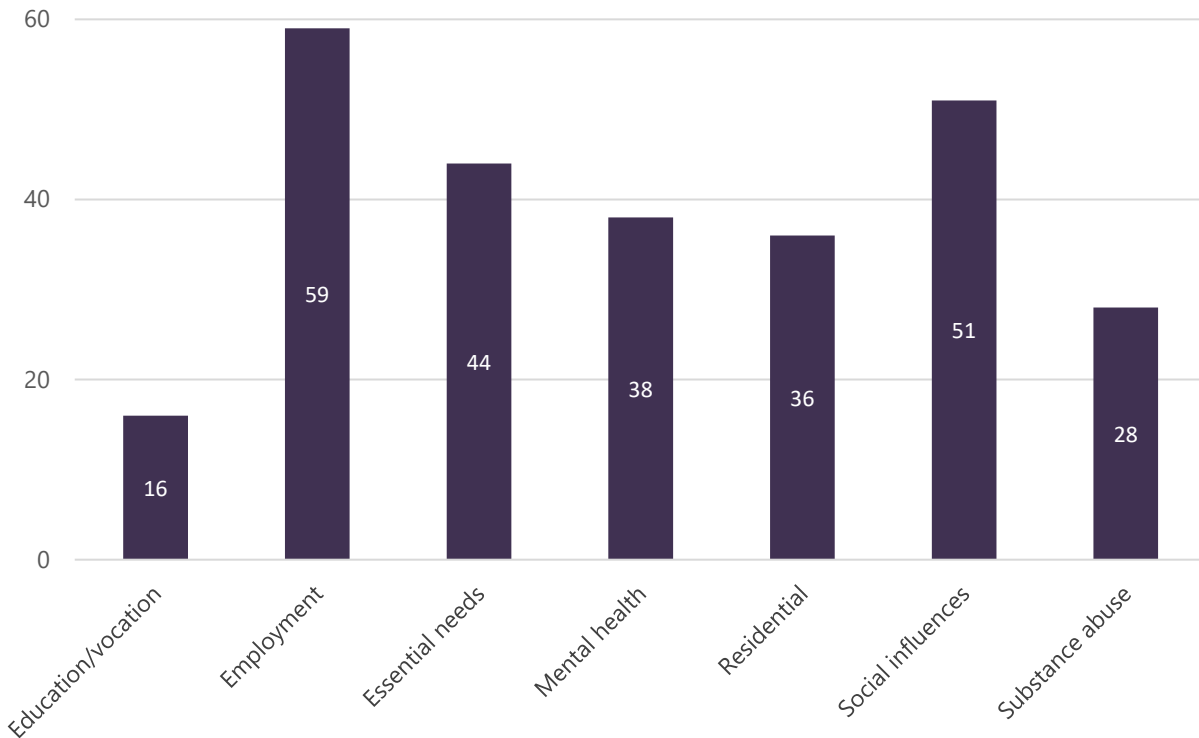
²³ DOC. [Reentry navigation services](#).

²⁴ Verification did not expire, but could be ended if reentry navigators obtained new information about the provider. This was not frequent and only occurred with 13 providers (all in King County).

²⁵ There were some ambiguities in how providers were recorded. For example, some providers operate multiple locations. WSIPP reviewed provider details and consolidated records where possible. Organizations in different counties were always counted independently. Despite these efforts, duplicate provider records may still exist.

Exhibit 1

Number of Services on VPL, by Type



Note:

Provider counts for aggression (N = 3), attitudes/behaviors (N = 1), and peer support (N = 1) were omitted from the exhibit because they were uncommon.

VPL Implementation

The Department of Corrections contracted with WSIPP to test the impact of the VPL. The VPL was evaluated in seven reentry facilities serving five counties. Reentry centers in King (Reynolds, Bishop Lewis, and Helen B. Ratcliffe) and Yakima counties (Ahtanum View) were assigned to the treatment condition. Reentry centers in Benton/Franklin County (Tri-Cities Reentry Center) and Spokane County (Eleanor Chase and Brownstone Reentry Centers) were assigned to the comparison condition.

In comparison facilities, reentry navigators relied upon their knowledge of local treatment resources without access to any formalized list of providers (i.e., treatment as usual).

Research Questions

This report addresses the following research questions:

- 1) What was the composition of providers on the VPL?
- 2) What were the characteristics of people assigned to treatment and comparison reentry facilities?
- 3) Was the VPL associated with improved engagement with services, measured through the number of provider referrals, the length of time between referral and engagement, and the reason for ending the referral?
- 4) Was the use of VPL associated with recidivism, measured through arrests, convictions, and incarcerations?

A preliminary report addressed the first three questions, finding that people in reentry centers that used the VPL received more referrals and received those referrals more quickly.

This final report updates these findings and provides additional findings related to changes in recidivism.

II. Data and Methods

Data

Information for the analysis was derived from several sources, including the VPL, the program referral database, DOC's OMNI system, and WSIPP's Criminal History Database (CHD).²⁶

Verified Provider List

Development of the VPL began in the fall of 2023 and was continually updated to ensure information on providers was current. The VPL contained information on provider name, services provided, and the dates verification was started, completed, and ended.

Program Referrals

Reentry navigators captured information on each referral, including service provider name, referral reason, dates (i.e., referral, engagement, and end dates), and the reason they ended engagement with the service. A person may have had multiple concurrent referrals and multiple referrals for the same type of service.

Recidivism

Recidivism was operationalized through three measures: arrests, convictions, and reincarcerations.²⁷

Data from the Washington State Patrol (WSP) were used to measure arrests for an offense after release from incarceration. The Washington State Patrol collects arrest data from law enforcement agencies throughout the state.²⁸ Two measures of arrest were calculated: the time until the first arrest and whether an arrest occurred in the 12 months after transfer to the reentry center.²⁹

Conviction measures indicated if a person was convicted of a new offense that occurred within 12 months of prison release.³⁰

Reincarceration measures indicated if a person was returned to prison within 12 months of release from prison.³¹ Information needed to calculate these measures was derived from records provided by the Administrative Office of the Courts and DOC.

A 12-month observation period is considerably shorter than what is typically used in research, limiting the ability to make comparisons to other published recidivism statistics.³²

²⁶ WSIPP retrieved a copy of the VPL and program engagement dataset on December 1, 2025. Additional person-level data were appended in January 2026.

²⁷ Washington State Statistical Analysis Center. (2022). [Washington's criminal justice funnel](#).

²⁸ WSP only collects arrest data when a person is taken into custody and fingerprinted for identity confirmation purposes. Cite and release, also known as a non-custodial arrest, would not appear in WSP arrest records. As such, the arrest indicator used here should be considered a subset of all arrests made by law enforcement.

²⁹ The recidivism observation period began at the time someone was transferred to the reentry center. This was the point at which someone was in the community and could have reoffended.

³⁰ For arrest or conviction outcomes, the alleged date of offense or charge action resulting in a conviction must have occurred within the 12-month observation period. If the alleged offense date or charge filing date were not available, we used the date of arrest or the date of filing, respectively.

³¹ Reincarceration includes prison stays for new offenses and violations of current terms of release. The reincarceration date is based on the date someone was actually reconfined. Due to a lack of data, we could not identify people detained in jails.

³² Barnoski, R. (1997). [Standards for improving research effectiveness in adult and juvenile justice](#) (Doc. No. 97-12-1201). Olympia: Washington State Institute for Public Policy.

Data Cleaning and Processing

Data cleaning was performed to standardize text-based variables and deduplicate person records. In a few cases, people had multiple stays at the reentry center during the analysis period. When this occurred, the most recent record was retained.

To ensure that program participants had sufficient time in a reentry facility for referrals, we restricted the analysis to participants who entered reentry facilities between January 1, 2023, and December 31, 2024, and referrals occurring between January 1, 2023, and December 1, 2025.³³

We excluded one person from analysis of arrests and reincarceration because they did not have at least a 12-month post-transfer observation period (i.e., the time between their transfer to the reentry center and the end of the available recidivism data). For convictions, people were omitted if they did not have at least an 18-month recidivism observation period (N = 218). These additional six months were provided to ensure convictions could be processed by the criminal legal system and reported in our data.

Analytic Approach

We assessed mean differences between treatment and comparison group participants on the number of provider referrals, length of time until first provider engagement, and reason(s) for ending provider engagement.

³³ WSIPP retained referral records that were missing dates. About 2% of referrals were missing a referral date; about 22% were missing an engagement date. They were omitted from analyses based on dates but contributed to referral counts.

In an initial analysis, we identified demographic differences in people assigned to treatment or comparison facilities. This suggests that assignment to treatment or comparison conditions was not effective in producing groups that were equivalent on observable characteristics. To minimize the impact of these differences, we used entropy balancing to improve comparability between treatment and comparison groups. Variables used in entropy balancing included demographics, criminal history at the start of their current period of incarceration, length of incarceration, age at first conviction, and recidivism risk scores.

To assess differences in recidivism, we first predict each person's likelihood of recidivism based on their individual characteristics and criminal history. Then, we compare whether individuals in program facilities were arrested more or less often than would be expected given those characteristics. This approach adjusts for person-level characteristics, facility-level effects, and intraclass correlation (ICC).³⁴

WSIPP also explored differences in time to first arrest between people in treatment and comparison facilities. If the VPL was effective, it might be expected that the treatment group would have a longer delay until the first recidivism event relative to the comparison group.

Alternative strategies for analyzing the relationship between treatment and recidivism were also tested.

Additional information on the analytic approach is available in [Appendix I](#).

³⁴ ICC is a measure of clustering and is used to assess the importance of group membership in explaining outcome variability. A higher ICC value suggests that people within groups tend to be more similar than people in different groups. Accounting for ICC helps to obtain more valid inference.

III. Results

Participant Characteristics

There were 864 people transferred to reentry centers during the analysis period. The number of individuals in the treatment and comparison conditions was not equivalent; 530 (61%) people were transferred to reentry centers in the treatment area, 334 (39%) were transferred to reentry centers in the comparison area ([Exhibit 2](#)).

Most participants were White (70%) or Black (15%; [Exhibit 3](#)). In the comparison reentry facilities, there were fewer Hispanic participants (12% vs 21%) and more White participants (75% vs 67%).

In both treatment and comparison conditions, women were less common in reentry centers and represented about 16% of participants.³⁵ The average age of participants was about 39.

The Washington Offender Needs Evaluation (Washington ONE) is used by DOC to assess the risk of reoffending and to determine needs to guide treatment and program planning.³⁶

WSIPP compared values on the four component scores (i.e., violence, drug, property, and overall felony risk) across treatment and comparison participants. People assigned to comparison facilities tended to have higher values across all categories. These differences were significant for property, drug, and felony crime risk.

Exhibit 2
Participation by Facility

Assignment	County	Facility	# of participants
Treatment	King	Reynolds	248
		Bishop Lewis	36
		Helen B. Ratcliffe	80
	Yakima	Ahtanum View	166
	Total		530
Comparison	Benton/Franklin Spokane	Tri-Cities	76
		Eleanor Chase	52
		Brownstone	206
	Total		334
Total			864

Notes:

Helen B. Ratcliffe and Eleanor Chase Reentry Centers are women-only facilities.

Bishop Lewis Reentry Center was closed in August 2023; people were transferred to other King County facilities.

³⁵ Both treatment and comparison groups had one women-only reentry facility.

³⁶ Bagdon-Cox, C., & Adams, G. (2023). *Overview of the Washington ONE Risk Assessment tool*. Washington State Department of Corrections, Research & Data Analytics.

Exhibit 3 Participant Characteristics

Characteristic	Category	Treatment N (%)	Comparison N (%)	Percentage- point difference
Gender	Male	438 (83.0)	286 (85.6)	-2.6
Race	American Indian or Native American	32 (6.1)	31 (9.3)	-3.2
	Asian or Pacific Islander	37 (7.0)	7 (2.1)	4.9**
	Black	91 (17.2)	41 (12.3)	4.9*
	Other	13 (2.5)	3 (0.9)	1.6
	Unknown	2 (0.4)	2 (0.6)	-0.2
	White	353 (66.9)	250 (74.9)	-8.0*
Ethnicity	Hispanic or Latino	110 (20.8)	41 (12.3)	8.5**
		Mean (SD)	Mean (SD)	Mean Difference (SE)
Age (years)		39.3 (10.1)	38.1 (9.7)	-1.2 (0.7)
WA ONE risk score	Violent crime risk	242.4 (107.9)	250.6 (104.0)	8.2 (7.4)
	Property crime risk	302.8 (129.5)	323.5 (140.6)	20.7 (9.4)*
	Drug crime risk	251.1 (110.1)	268.5 (114.5)	17.4 (7.8)*
	Felony crime risk	268.5 (104.5)	284.1 (107.1)	15.6 (7.4)*

Notes:

Program participants entering reentry centers between January 2023 and December 2024.

May not sum to the total number of participants due to missing data.

Unweighted unadjusted values reported.

Difference between treatment and comparison significant at * $p < 0.05$ or ** $p < 0.01$.

Program Referrals and Engagement

Number of Referrals

People in treatment facilities tended to have more referrals (1.6 vs 0.6 referrals on average) and were less likely to have no referrals (17% vs 49%), compared to people in comparison facilities (Exhibit 4). These differences were statistically significant ($p < 0.001$)

The maximum number of referrals was higher for people in treatment facilities.

No person assigned to a comparison facility received more than three referrals, while the maximum for participants in treatment facilities was six.

Time to First Referral and Engagement

Overall, the mean time to first referral was 22 days after transfer to a reentry center.³⁷ However, on average, the first referral was about two weeks faster for people in treatment reentry centers (17 days) compared to comparison facilities (34 days, Exhibit 5).³⁸ This difference was statistically significant ($p < 0.001$)

³⁷ The referral with the first engagement may be different than the first referral that was made.

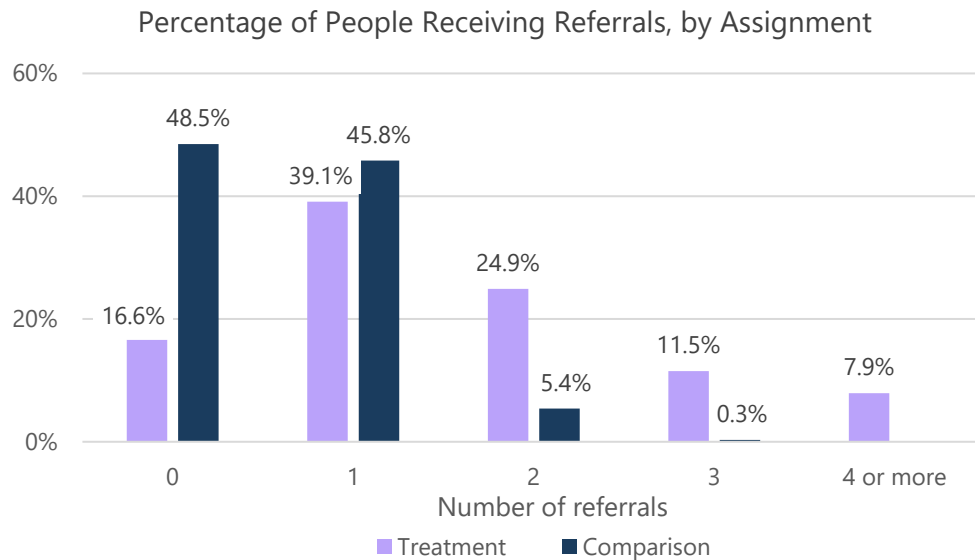
³⁸ A small number of people were recorded as having their first referral or engagement before transferring to the

reentry center. These were excluded from duration calculations.

On average, for people who received at least one referral, the first engagement occurred within 26 days of transfer to a reentry center.³⁹

The first engagement for people in treatment facilities was faster compared to the people assigned to comparison facilities (23 days versus 34 days; $p < 0.01$).

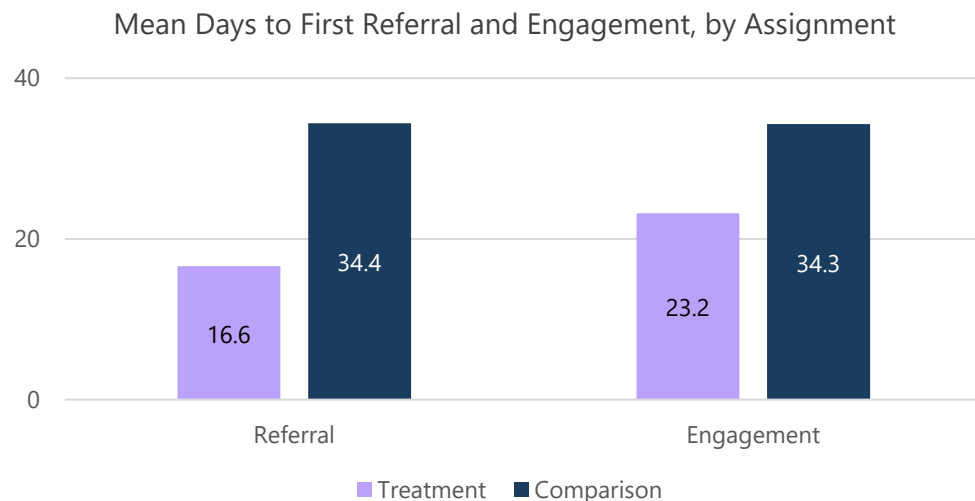
Exhibit 4



Note:

Participants could receive multiple types of referrals and multiple referrals to the same type of program.

Exhibit 5



Notes:

Participants could receive multiple types of referrals and multiple referrals to the same type of program.
 The engagement date is the date that the participant contacted, enrolled, or began treatment with the provider.
 The referral with the first engagement may not be the same as the first referral.

³⁹ Reentry navigators collected information on when a person engaged with the referred service provider.

Engagement was recorded when the person reached out to the provider to use or enroll in services.

Referral Types

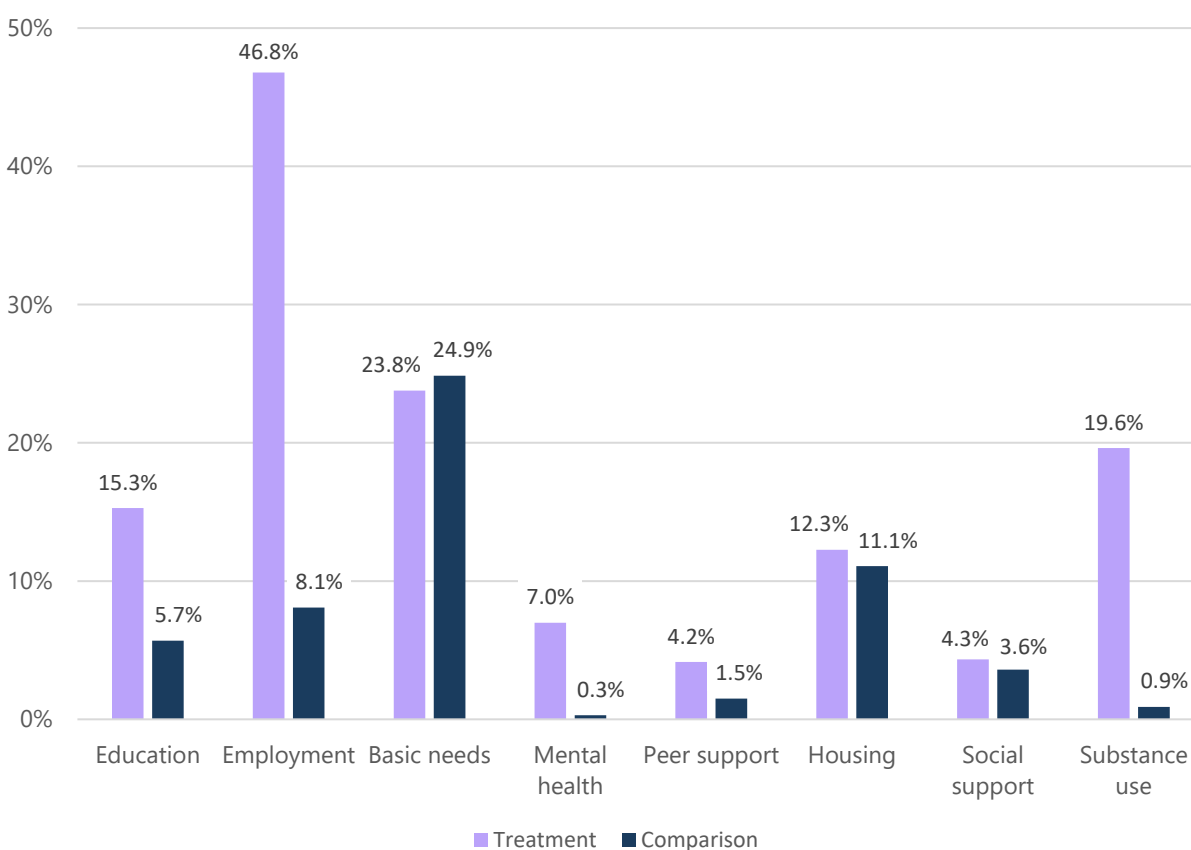
There were 1,039 referrals across all participants ([Exhibit 6](#)). The most prevalent type of referral for people in the treatment facilities was associated with services for employment. In contrast, the most common referral for people in comparison facilities was to a basic needs provider.

Reason Program Participation Ended

The most prevalent reason for ending program participation was successfully completing program requirements ([Exhibit 7](#)). Referrals from treatment facilities were less likely to end in success (70%) compared to those from comparison facilities (77%). There was a considerable amount of missing data (approximately 15%), suggesting that interpretation should be made with caution.

Exhibit 6

Percentage of People who Received a Referral Type, by Assignment



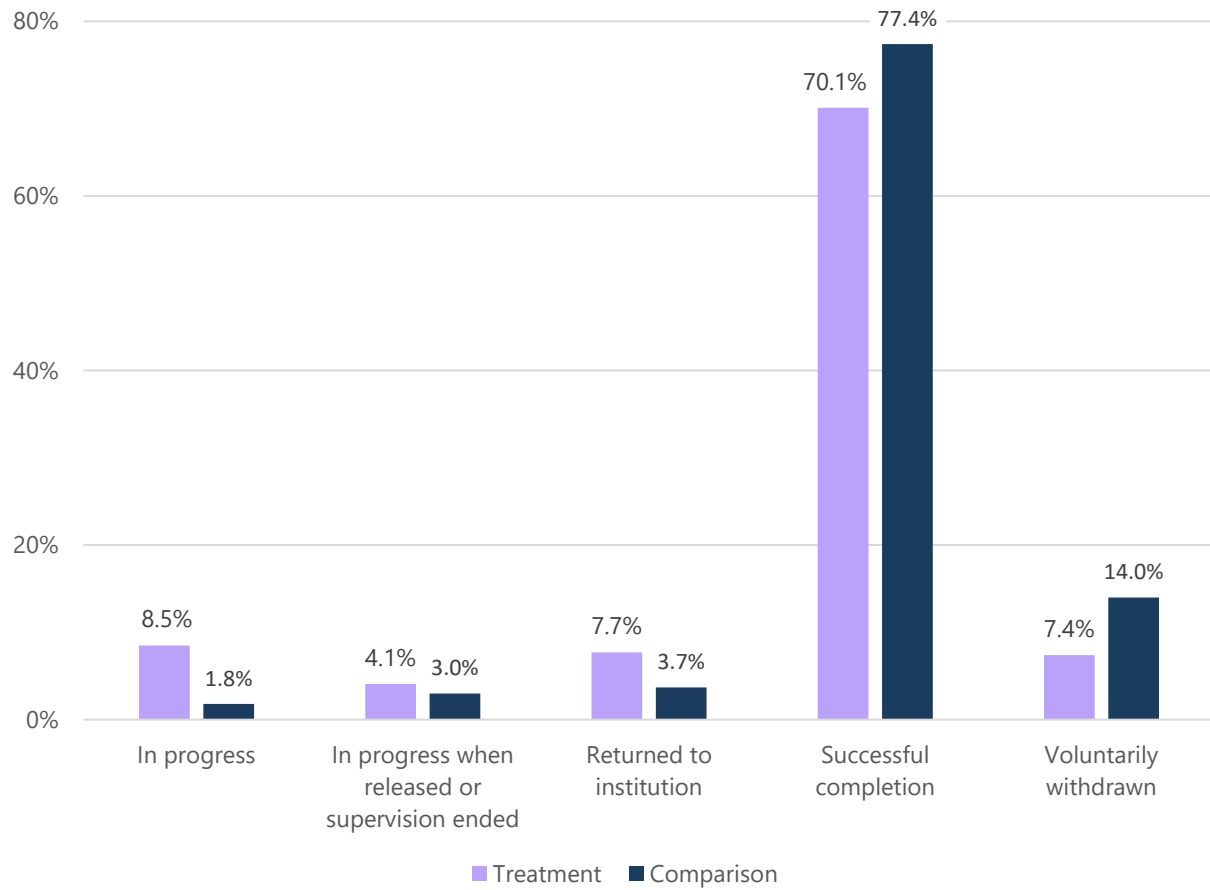
Notes:

Participants could receive multiple types of referrals; referrals to the same type of program were counted once.

Referrals for aggression (N = 3), attitudes/behaviors (N = 2), bus/public transportation (N = 1), clothing (N = 1), and medical services (N = 1) were omitted because they were infrequent.

Exhibit 7

Reasons Program Participation Ended, by Assignment



Notes:

The end reasons of failure to comply (N = 7), other (N = 7), provider did not follow through (N = 1), and transfer to graduated reentry (GRE) (N = 1) were omitted because they were infrequent.

About 15% of referrals were missing data on the reason participation ended.

Recidivism

Various analytic methods and model specifications failed to find a difference in recidivism between treatment and comparison groups. This was true for both the rate of recidivism and the time to first recidivism event.

Arrests

Treatment assignment was associated with a 3.3 percentage point *higher* probability of arrest among people in treatment facilities relative to people in comparison facilities, after adjusting for baseline differences (Exhibit 8). This relationship was not statistically significant ($p = 0.62$).

Time to first arrest was about the same for people in the treatment and comparison groups; the difference was not statistically significant.

Convictions

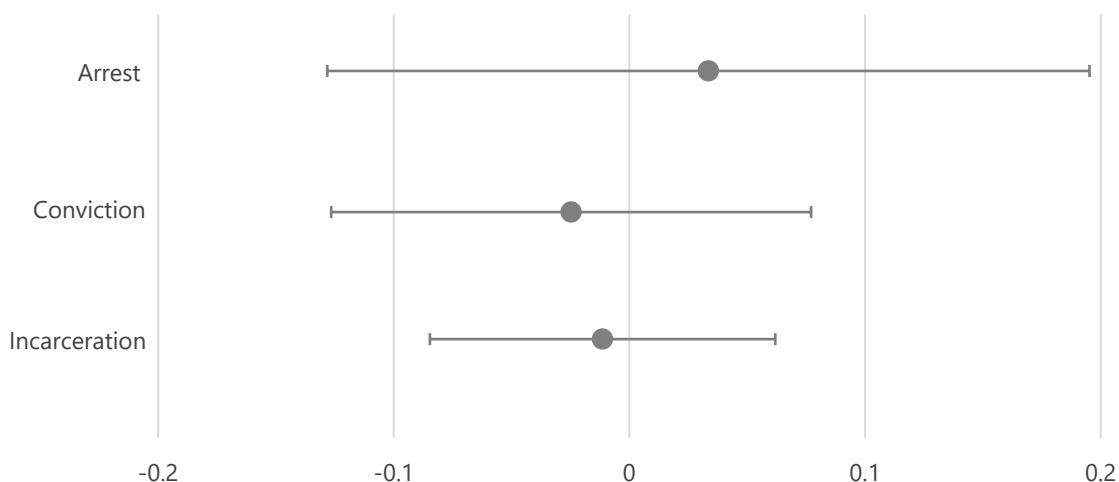
Treatment assignment was associated with a 2.5 percentage point lower probability of conviction among people in treatment facilities relative to people in comparison facilities after adjusting for baseline characteristics, but this difference was not statistically significant ($p = 0.56$). There was no statistically significant relationship with the time to first conviction.

Incarceration

Treatment assignment was associated with a 1.1 percentage point lower probability of incarceration among people in treatment facilities relative to people in comparison facilities after adjusting for baseline characteristics, but this difference was not statistically significant ($p = 0.71$). There was no statistically significant relationship with the time to first incarceration.

Exhibit 8

Estimated Difference in Recidivism Probability



Note:

Coefficient for treatment indicator predicting arrest, conviction, or incarceration probability; values less than 1 indicate a lower probability of recidivism in treatment facilities compared to comparison facilities.

IV. Discussion and Limitations

The results of this evaluation should be interpreted cautiously. Allocation to treatment and comparison groups was imbalanced, and facility-level randomization failed to produce groups that were equivalent on observable characteristics. More people were assigned to treatment, and significant differences in participant characteristics (e.g., race and ethnicity) were identified. We attempted to adjust for these differences in the analyses, but unobservable differences may remain. Relationships should be interpreted as descriptive rather than causal.

Two additional issues reduced our ability to test the impact of the VPL. First, the small number of reentry facilities reduced statistical power and limited the ability to find an effect, if one was present. Due to the limited number of facilities and the number of reentry navigators, DOC could not increase the number of participating facilities. Achieved (post-hoc) power calculations suggested that the design had less than 25% chance of finding significant results, if present, even under ideal circumstances. This is lower than typical best practices in evaluative research.⁴⁰

Second, the recidivism observation period was shorter than typical, further hindering the ability to detect an effect. Evaluation of recidivism usually requires following a person for three or more years.⁴¹

Unfortunately, there was insufficient time from when the program started to when the evaluation was conducted to allow this length of time.

Issues related to data reliability and missingness may be more prevalent in the comparison areas because reentry navigators there did not need to interact with the VPL. If true, this could overemphasize differences in referral activity between treatment and comparison facilities. There may also be differences in the quality of data between larger and smaller reentry centers, as a higher case load may reduce capacity for follow-up. Strengthening data systems and longer-term outcome tracking would support more robust research in the future.

Finally, this evaluation did not test the effectiveness of reentry navigators in reducing recidivism. Instead, the analysis explored differences between reentry navigators with access to the VPL and reentry navigators working without a verified list. It is not a test of whether reentry navigators are generally effective in reducing recidivism.

⁴⁰ Using post-hoc power analysis with actual values for the number of facilities, people assigned to treatment and comparison, mean arrest recidivism rates, and calculated intraclass correlation, WSIPP estimated power based on reductions in recidivism ranging from 10% to 90%. Achievable

power, even if the treatment was associated with reducing recidivism by 90%, was 0.21. Best practices suggest that research should be designed so that power exceeds 0.80.

⁴¹ [Knoth et al. \(2019\)](#).

V. Conclusion

Reentry navigators work with individuals after they leave prison and enter the transitional period while reentering the community. The main role of reentry navigators is to connect individuals to supportive services, rehabilitation programs, and employment opportunities to ease the transition back into the community with the longer-term goal of facilitating desistance from crime. The purpose of the VPL was to improve this referral process by ensuring that reentry navigators had the most complete and up-to-date information on available services.

People assigned to treatment reentry centers had, on average, more referrals, received those referrals more quickly, and engaged with service providers faster.

Despite the additional referral activity among treatment group participants, there was no evidence that the VPL was associated with reduced recidivism. Across various modeling approaches, model specifications, and ways of operationalizing recidivism, recidivism for people placed in a facility that used the VPL was no different than recidivism for people in comparison facilities.

Future Research

Several areas for future research exist. Following recidivism over a longer period of time may be insightful. Due to timeline constraints, the recidivism observation period was shorter than typical. Additional research could address this limitation.

Recidivism is only one of several measures of reentry performance. Other measures, such as housing stability and securing employment, are also important indicators of successful reentry and can be useful for understanding how reentry programs may work to reduce recidivism. Future research could provide a more holistic view of reentry by incorporating these additional performance measures.

The administrative data used in this evaluation may not fully describe important aspects of how reentry navigators provide services. Future research could collect qualitative data about the experiences of people receiving referrals, reentry navigators, or the relationships between participants and reentry navigators. This information may be useful in understanding the quality of referrals and how the VPL was used. The effectiveness of reentry navigators may depend on the ability to build rapport between the navigator and the participant, which may help explain why there was no overall impact on recidivism.



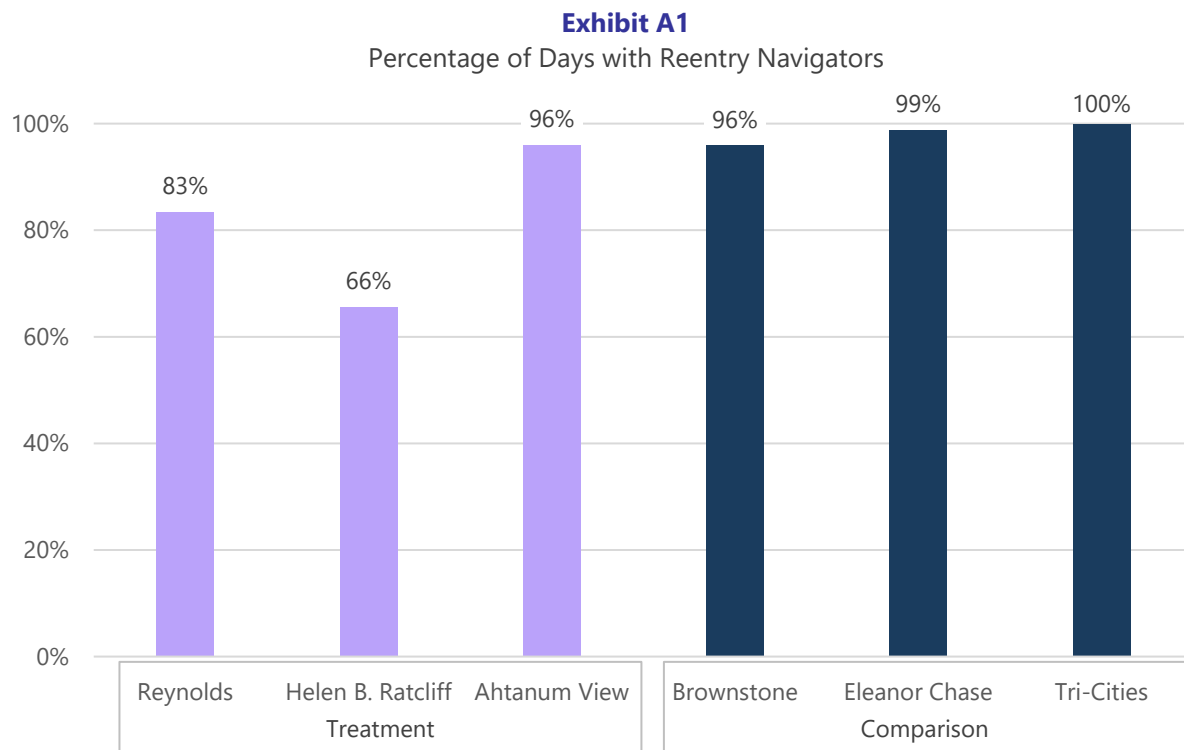
Appendices

Evaluating DOC's Validated Treatment Provider List for Community Navigators: *Final Report*

Appendix I. Analytical Details

Implementation Fidelity

Staffing changes and budgetary challenges resulted in periods where no reentry navigators were present in some facilities. Facilities with access to the verified provider list (VPL) generally had lower levels of reentry navigator coverage compared to comparison facilities. Helen B. Ratcliff had the lowest coverage, with nearly a third of days having no reentry navigator present ([Exhibit A1](#)).



Note:

Bishop Lewis was assigned as a treatment facility but was omitted from this exhibit because it was closed during the evaluation period.

Equivalency of Treatment and Comparison Group Participants

WSIPP used several analytic techniques to explore the relationship between placement in a treatment reentry center facility and recidivism. Models were estimated accounting for characteristics that have, in other studies, been associated with recidivism ([Exhibit A2](#)).

Exhibit A2

Description of Model Covariates

Characteristic	Description
Age	Age at date of release
Race	Race indicator recorded by DOC Included in the model as a set of binary indicators
Ethnicity	Ethnicity indicator recorded by DOC Indicated if someone was Hispanic or not
Sex	Sex as recorded by DOC
Incarceration duration	Length of incarceration during current period of incarceration (in days)
Number of felony convictions	Number of adult felony convictions prior to the current period of incarceration
Number of misdemeanor convictions	Number of adult misdemeanor convictions prior to the current period of incarceration
Number of traffic infractions	Number of traffic convictions prior to the current period of incarceration
Age at first conviction	Age at the date of first criminal conviction
WA ONE risk assessment	Calculated felony, violent, property, and drug risk score

Note:

WA ONE variables are based on the assessment conducted closest to the time of release.

A review of participant characteristics suggested differences between people assigned to treatment and comparison conditions. To minimize the impact of these differences, we used entropy balancing to create analytical weights used in subsequent analyses ([Table A3](#)). Variables were balanced on mean and variance.

Exhibit A3

Results of Entropy Balancing Procedure – 12 Months from Transfer to Reentry Center

Characteristic	Treatment		Comparison: Unweighted		Comparison: Weighted	
	Mean	Variance	Mean	Variance	Mean	Variance
Age	39.31	100.90	37.95	92.27	39.31	101.00
Gender (male)	0.83	0.14	0.86	0.12	0.83	0.14
Race and Ethnicity						
American Indian or Alaska Native	0.06	0.06	0.09	0.09	0.06	0.06
Asian or Pacific Islander	0.07	0.07	0.02	0.02	0.07	0.07
Black	0.17	0.14	0.12	0.11	0.17	0.14
Hispanic	0.21	0.16	0.12	0.11	0.21	0.16
Unknown	0.00	0.00	0.01	0.01	0.00	0.00
White	0.67	0.22	0.75	0.19	0.67	0.22
Another race	0.02	0.02	0.01	0.01	0.02	0.02
Criminal legal system experience						
Incarceration duration (days)	1,098	3,468,639	1,016	3,469,428	1,098	3,468,776
Age of first prior conviction	20.83	97.74	18.97	64.68	20.83	97.72
Total felonies	8.59	41.38	8.07	38.04	8.59	41.38
Total misdemeanors	12.51	144.50	10.90	91.88	12.51	144.50
Total traffic	0.58	2.18	0.41	0.72	0.58	2.18
WA ONE risk score						
Violent	242.40	11,642	250.40	10,816	242.40	11,641
Property	302.80	16,768	323.10	19,770	302.80	16,773
Drug	251.10	12,130	268.50	13,157	251.10	12,131
Felony	268.50	10,920	283.80	11,468	268.50	10,921

Notes:

VPL recipients (N = 530); Non-VPL recipients (N = 333).

Results of entropy balancing for observations based on 18 months post-incarceration duration are available upon request.

Two-Stage Covariate Adjusted Residuals Estimator

This evaluation was designed as a cluster randomized trial (CRT)⁴² where the treatment (VPL) was implemented at some reentry centers (the clusters) but not others. Cluster randomized trials are a popular evaluation strategy when there is a high risk of contamination between treatment and comparison groups.⁴³ In this instance, if people had been randomized to treatment and comparison conditions, it would have been impractical for a reentry navigator to use the VPL for some people but not others. However, for CRTs to be effective in producing equivalency, it is typically necessary to have a large number of clusters.⁴⁴ Unfortunately, due to the limited number of reentry centers and reentry navigators, it was not possible to increase the number of clusters in the analysis.

Analysis of data generated from a CRT must account for the effects of clustering. The primary analytic approach used to address this concern was a two-stage covariate-adjusted residuals estimator (CARE).⁴⁵ The stages were:

- Stage 1. Residualize outcome
 - a) At the person level, predict recidivism (as a binary indicator) using characteristics that are commonly associated with recidivism (see [Exhibit A2](#)). Entropy balancing weights are applied during this step.
 - b) Save the residual values from the model (i.e., the difference between the actual and predicted value) for use in stage 2.
- Stage 2. Estimate treatment effect
 - a) Aggregate the average person-level residual calculated in Stage 1 to each facility.
 - b) Estimate the average difference in residual values for treatment and comparison facilities.

Results for the second stage treatment indicator are presented in [Exhibit A4](#). There were no significant relationships between the treatment and any measures of recidivism.

Exhibit A4

Results from Two-Stage Covariate-Adjusted Residuals Estimator

Recidivism measure	Treatment (B)	Robust SE	p-value
Arrest	0.03	0.06	0.62
Conviction	-0.02	0.04	0.56
Incarceration	-0.01	0.03	0.71

Note:

Two-stage covariate-adjusted residuals estimator predicting if the person had a recidivism event following transfer to the reentry center. Stage 1 model adjusted for demographics and other person-level characteristics. Stage 2 analysis was weighted by the number of people in each facility and adjusted for intraclass correlation. Complete model results are available upon request.

⁴² Giraudeau, B., Weijer, C., Eldridge, S. M., Hemming, K., & Taljaard, M. (2024). Why and when should we cluster randomize? *Journal of Epidemiology and Population Health*, 72(1), 202197.

⁴³ Taljaard, M., Goldstein, C.E., Giraudeau, B., Nicholls, S.G., Carroll, K., Hey, S.P., Brehaut, J.C., Jairath, V., London, A.J., Eldridge, S.M., Grimshaw, J.M., Fergusson, D.A., & Weijer, C. (2020). Cluster over individual randomization: are study design choices appropriately justified? Review of a random sample of trials. *Clinical Trials*, 17(3), 253–263.

⁴⁴ Hemming, K., & Taljaard, M. (2023). Key considerations for designing, conducting and analysing a cluster randomized trial. *International Journal of Epidemiology*, 52(5), 1648–1658.

⁴⁵ Lauer, S.A., Reich, N.G., & Balzer, L.B. (2019). *The covariate-adjusted residual estimator and its use in both randomized trials and observational settings*. arXiv.

Survival Analysis

Survival analysis was used to estimate the impact of the treatment on time until arrest, conviction, and incarceration. WSIPP used multilevel mixed-effects parametric survival models⁴⁶ specified with a Weibull distribution and robust standard errors. Model results for the treatment indicator are presented in [Exhibit A5](#) (additional covariates from each model were omitted for brevity).

Being in a treatment facility was not related to the time to arrest, conviction, or incarceration. These results were consistent across various model specifications and included covariates.

Exhibit A5

Results from Multilevel Mixed-Effects Parametric Survival Analysis

Recidivism measure	Treatment (Hazard rate)	Robust SE	p-value
Arrest	1.12	0.31	0.70
Conviction	0.74	0.29	0.45
Incarceration	0.94	0.24	0.82

Notes:

Mixed-effects parametric survival model predicting time to failure after transfer to the reentry center.

The full model adjusted for demographic and other person-level characteristics.

Complete model results are available upon request.

Alternative Analytic Strategies

WSIPP explored two alternative methods to test the relationship between treatment and recidivism.

Mixed Effects Logistic Regression

We used mixed effects logistic regression,⁴⁷ which adjusted for facility-level clustering but tends to inflate the risk of type I error when there are fewer than ten clusters.⁴⁸ Model results for the treatment indicator are presented in [Exhibit A6](#). Consistent with our primary analysis, there was no significant relationship between being in a treatment facility and any operationalization of recidivism.

Exhibit A6

Results from Mixed Effects Logistic Regression

Recidivism measure	Treatment (Odds ratio)	Robust SE	p-value
Arrest	0.44	0.44	0.32
Conviction	-0.20	0.33	0.55
Incarceration	-0.04	0.38	0.92

Notes:

Mixed effects logistic model predicting if the person had a recidivism event following transfer to the reentry center.

Model adjusted for demographics and other person-level characteristics.

Complete model results are available upon request.

⁴⁶ Crowther, M.J. (2019). Multilevel mixed-effects parametric survival analysis: Estimation, simulation, and application. *The Stata Journal*, 19(4), 931–949.

⁴⁷ Heo, M., & Leon, A.C. (2005). Performance of a mixed effects logistic regression model for binary outcomes with unequal cluster size. *Journal of Biopharmaceutical Statistics*, 15(3), 513–526.

⁴⁸ Kahan, B.C., Forbes, G., Ali, Y., Jairath, V., Bremner, S., Harhay, M.O., Hooper, R., Wright, N., Eldridge, S.M., & Leyrat, C. (2016). Increased risk of type I errors in cluster randomised trials with small or medium numbers of clusters: a review, reanalysis, and simulation study. *Trials*, 17(1), 438.

Poisson Regression

Models were tested using the actual count of recidivism events rather than a binary indicator of recidivism. Due to the short observation period, having more than one recidivism event was uncommon. Using mixed effects Poisson regression models produced results similar to those from the logistic model described above. We found no significant relationship between placement in a treatment facility and counts of recidivism events.

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