COGNITIVE BEHAVIORAL TREATMENT REVIEW

& Moral Reconation Therapy (MRT®) News
Correctional Counseling, Inc.

CORRECTIONAL COUNSELING INC. • MEMPHIS, TENNESSEE • VOLUME 12, #1 • FIRST QUARTER 2003

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Cognitive Behavioral Treatment Review
& Moral Reconation Therapy (MRT®) News

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CBTR is a quarterly publication focusing on enhancing and improving treatment outcomes for offenders, substance abusers, at-risk youth, domestic violence perpetrators, and others with resistant personalities. Article submissions are encouraged.

Effects of Moral Reconation Therapy® Upon Female Offenders in a Prison-Based Therapeutic Community

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Summary—Pre- and posttest scores from five test measures were collected and analyzed in 174 female offenders participating in a specialized 32-bed prison-based therapeutic community utilizing the cognitive behavioral approach of MRT. Results showed that program participants had significantly lower locus of control scores, higher life purpose scores, and significantly enhanced support from family, friends, and a significant other as a result of treatment. In addition, clients showed desirable changes in moral reasoning scores over the course of treatment. All of these beneficial changes were most observed in program completers but some were also present in dropouts. A number of analyses showed that the variable most likely producing these beneficial changes was completion of the program's treatment steps rather than simply remaining in the program.

Introduction

In the past decade, prison-based therapeutic communities (TC) have become increasingly popular and have demonstrated effectiveness as a treatment approach with criminal justice clients—especially in those clients who complete treatment as compared to program dropouts (Wexler, DeLeon, Thomas, Kressel, & Peters, 1999). However, in 1999 the Washington State Institute for Public Policy released the findings of a comprehensive cost-benefit analysis of 18 treatment approaches utilized on adult offenders (Aos, Phipps, Barnoski, & Lieb, 1999). The report indicated that for each dollar spent on prison therapeutic community treatment, a total of only $1.07 in savings were recovered in the eight years following treatment. Of all the 18 program approaches evaluated by that report, the one showing the greatest cost-benefits was Moral Reconation Therapy (MRT®). For each dollar spent on MRT treatment, a total of $11.48 in savings was recovered over the next eight years. Thus, the TC model, in and of itself, does not appear to produce as great a cost-benefit as does the MRT approach. In addition, almost no research has been performed on females participating in TCs.

In November 1999, Correctional Counseling, Inc. (CCI) of Memphis, Tennessee implemented a drug treatment program for female offenders housed at the Mark Luttrell Correctional Center (MLCC), a state of Tennessee prison located in Memphis. The program was organized and developed as a drug therapeutic community and is operated under contract from the Tennessee Department of Corrections and funded through RSAT. It was designed to house 32 offenders with each participant in the program for at least six months. The program maintains the classical TC structure and also employs cognitive-behavioral programming (MRT) to optimize effectiveness.

MRT was initially developed in 1985 as a cognitive-behavioral method designed to be employed in prison TCs (Little & Robinson, 1988). Because of its profound beneficial

effect on virtually every area of the TC and its ease of implementation, the method has spread to every area of treatment as well as every venue of treatment (e.g., inpatient/outpatient). Since its inception in the late 1980s, CCI has employed MRT in a host of treatment facilities and CCI is the single source provider of MRT training and materials.

In a comprehensive review of MRT outcome research, Little (2002) summarized outcomes from 81 published reports. Of those, five studies focused on female offenders. Those studies showed that MRT treatment consistently resulted in significantly lower recidivism and a host beneficial personality variable changes. However, none of those reports were on female offenders participating in a prison-based TC. This study is the first to report on female offenders participating in MRT within a prison TC.

Program Description

The MLCC TC program utilizes all of the traditional components of a TC including behavioral management techniques, rewards and punishers, various groups, and a peer hierarchy designed to instill responsible behavior. The program utilizes MRT in several weekly groups and also assigns clients to other programmatic treatments based on individualized treatment plans. Other treatment elements employed in the program include anger management, relapse prevention, parenting, codependency, and drug education. Except for the drug education component, all of these program elements are cognitive-behavioral and were developed especially for use in MRT-based programs. In addition, 12-Step groups, basic educational classes, and religious programs are offered to all clients.

Clients enter the program following a prescreening interview. Clients must meet six criteria for entry: a documented history of substance use/abuse; must be within 6 years of release eligibility; must not have a mental health diagnosis which would prohibit participation as determined by a psychiatric consultation; must not have a history of assault on staff; must agree to comply with rules and agree to take drug screens; and must be eligible to receive one-year of substance abuse treatment within a federally funded program.

Within five days of program entry, clients complete a battery of five research tests (pretreatment testing). Depending on individual client need, assistance is provided to some clients in reading as well as understanding test items. Upon program completion or termination, the same five tests are administered to clients (posttests). Testing is typically completed within the final month of a client's participation; however, clients who are terminated for disciplinary reasons or who dropout voluntarily are required to take the tests prior to exiting the program. In some situations, clients refuse to take posttests or provide invalid tests.

Method

Participants

From November 1999 until August 28, 2002, a total of 174 female offenders had entered the program. Average age of participants was 32.3 years with a range of 18-53. Whites comprised 71 percent of participants while 28 percent were African-American. Excluding current program participants, 43 percent of all participants completed the program or remained in the program until institutional discharge. Further evaluation of the completion rate indicated that the initial year of the program's existence showed only a 31 percent completion rate as compared to a recent completion rate of over 50 percent. This is explained by a change in the prescreening procedure implemented after problems were encountered during the first year. During that time period, the Tennessee Department of Corrections was referring a high number of seriously mentally ill clients to the program who were "entered" into the program automatically. After the initial year the prescreening procedures made referrals of such clients to the institution's psychiatrist who determined the appropriateness of the client's participation.

For the purposes of statistical analysis, clients were categorized as stayers or dropouts. Program stayers were of two types: *Completers* were defined as those who successfully completed all 12 of the program's primary treatment *steps* from the cognitive-behavioral approach of Moral Reconation Therapy (MRT®), remained in the program for at least six months, and fulfilled all other objectives outlined in individual treatment plans. The other type of program stayer was defined as a client who was discharged from the institution on parole, probation, or sentence expiration prior to program completion. These clients are not dropouts, but for uncontrollable reasons did not have sufficient time to complete the entire program—yet substantial progress was made. *Dropouts* were defined as those who left the program—for any reason other than institutional discharge—prior to completing the program. However, since completion of MRT steps is a sequential measure of program progress—rather than an all-or-nothing variable—correlational analyses are made possible on MRT step completion with other variables. Finally, since time in treatment is often a variable cited as important in outcome research, this report also evaluated the effects of days in treatment on outcomes.

Tests Utilized

As discussed previously, the duration of time between the pre- and posttests varied, but was generally between six months to a year. Valid pre- and posttest results were available for 117 clients with current program participants excluded along with a small number of clients who did not, for a variety of reasons, complete posttests. However, all usable data that was gathered from clients (*i.e.*, some pretests) were utilized when possible. The five research tests employed in the CCI therapeutic community are all considered to be reliable, valid, and meaningful. All have been shown to have varying levels of predictive ability.

1. The *Prison Locus of Control* (PLOC) is intended to measure the degree to which an individual believes she has control over her life (Pugh, 1994). Ideally, a program should instill feelings of increasing control in clients—what is commonly referred to as *internal locus of control*. Internal locus of control is believed to be

one of the keystones of a healthy personality. Test scores on the PLOC can range from 24 (internal locus of control) to 240 (external locus of control).

2. The *Life Purpose Questionnaire* (LPQ) is designed to assess the degree to which an individual perceives purpose or meaning in her life (Hablas & Hutzell, 1982). People with high life purpose tend to be more committed to goals, engage in responsible behaviors, and are committed to important relationships. Participation in effective programming should increase clients' levels of life purpose. Scores on the LPQ range from 0 (no purpose perceived) to 20 (high life purpose).

3. *The Short Sensation-Seeking Scale* (SSS) is a 10-item questionnaire designed to assess risk-taking behaviors (Zuckerman, 1984). It is highly correlated to antisocial personality. Individuals with high scores tend to engage in substance abuse behaviors, abusive relationships, and a host of risky activities designed to provide excitement. Ideally, an effective program should result in lower sensation-seeking behaviors. Scores on the SSS range from 0 (no risk-taking) to 10 (extreme risk-taking).

4. The *Multidimensional Scale of Perceived Social Support* (PSS) is designed to assess the degree to which an individual believes she has support from three different areas: *friends, family, and significant others* (Zimet, et. al., 1988). Rationally, it appears appropriate that the social support variables should increase with effective programming. Scores on all three subtests range from a low of 4 (no support) to 24 (high support).

5. The *Defining Issues Test* (DIT) is an objective measure of an individual's moral reasoning as defined by Kohlberg's stages of moral reasoning (Rest, 1986). The test measures the percentage of reasoning an individual incorporates into decision-making on five of Kohlberg's stages. Stage 2 reasoning is often described as pleasure and pain decisions; Stage 3 reasoning is essentially manipulative and is based on doing what would please other people; Stage 4 reasoning is based on following the rules or law; Stage 5 reasoning is based on what is best for society or others; Stage 6 reasoning is based on ethical principles about right and wrong that transcend the individual's situation or possible gain from a given decision. The test apportions a percentage of decision-making to these five scales (from 100% of all reasoning). In addition, stages 5 and 6 are combined into a percentage of Principled reasoning—called P%. Finally, a lie-scale (M) is employed in the test which purports to assess the degree to which an individual is attempting to "look good" in the test. The M scale is also a test of validity.

Results

The initial statistical analyses divided program stayers (n = 50) and dropouts (n = 67) into two groups. A total of 26 different t-tests were performed comparing the pretest scores of the two groups on all of the tests and their subscales. Significant pre-treatment differences were found on only two scores. Program stayers had a significantly higher pretest mean on the DIT Scale 6 as compared to dropouts (stayers = 5.66; dropouts = 3.99; $t_{111} = 2.27$; $p = .025$). In addition, stayers showed a significantly higher pretest mean on the family support scale of the PSS as compared to the dropouts (stayers = 23.29; dropouts = 19.01; $t_{111} = 2.39$; $p = .02$). In sum, those who remained in the program can be characterized by two variables present at the time of program entry: higher moral reasoning at the highest stage and more perceived family support.

Another series of 26 t-tests compared program completers (n = 37) to noncompleters (n = 80) on all pretests and subscales. None of the tests were significant and only one (family support) approached significance. As in the prior question results (#4 above), those who completed all 12 steps had slightly higher perceived family support prior to treatment. It should be noted that low cell frequencies in groupings by completer, stayer, and dropout status precluded *ANOVA* analyses.

Pre- to Posttest Changes

Prison Locus of Control. At treatment initiation, the mean LOC score for all program participants was 57.19. This is considered to be on the "internal" side of the scale, which can go as high as 240. The posttest score mean was even more "internal": 53.05. A subsequent t-test for repeated measures showed that this difference approached significance ($t_{101} = 1.4$; $p = .08$; one-tailed). At treatment initiation, LOC means were 53.24 for completers and 59.71 for noncompleters. This difference was nonsignificant as indicated by a t-test. LOC posttest scores for program completers was 38.58 and 60.93 for noncompleters. Two t-tests showed that the completers LOC test scores became significantly more internal over the course of treatment and was significantly lower than noncompleters ($t_{37} = 4.13$; $p = .000$). Thus, those who completed the program showed a significant and substantial shift to a more internal locus of control. Those who did not complete the program showed no change in LOC scores.

Life Purpose Questionnaire. The mean LPQ scores of all program participants on program entry were 11.73 and 14.46 at the posttest. A t-test for repeated measures showed this change to be significantly different ($t_{100} = 5.67$; $p = .000$). Thus, program participants have a significantly enhanced perceived purpose in life as a result of treatment participation. At treatment initiation, LPQ scores for completers (12.24) and noncompleters (11.29) were essentially identical. At the time of the posttest, both the completers (16.22) and noncompleters (13.48) showed significant increases in LPQ scores. However, the completers showed significantly higher posttest scores than the noncompleters ($t_{101} = 3.72$; $p = .000$). Thus, all participants in the program tend to show significant increases in LPQ scores, but completers show significantly higher scores.

Short Sensation Seeking Scale. Pre- and posttest SSS scores for all participants were essentially identical (3.61 vs. 3.71). In addition, when t-tests were performed between completers and noncompleters, all group means were essentially identical. In comparison to prior reports, the mean level of SSS scores in the MLCC population is significantly lower than that found in other female institutions. For example, females in Oklahoma programs show means of 5 and higher on this variable. Scores in the 3-4 range are considered to be "normal" (Little, 2002).

Multidimensional Scale of Perceived Social Support. Pre- and posttest scores for all program participants on all three scales of the PSS test were subjected to t-tests for repeated measures. Changes in the "social support from friends" scale approached significance ($t_{101} = 1.76$; $p = .08$) showing that participants had nearly significant increases in support from friends over the course of treatment (pretreatment mean = 18.8 versus 20.3). Additional analyses were performed to investigate possible differences between program completers and noncompleters. Results showed that completers had significantly higher posttest scores than noncompleters on the significant other support scale ($t_{102} = 2.82$; $p = .006$), and the family support scale ($t_{102} = 3.07$; $p = .003$). Since a prior analysis indicated that completers tend to have a slightly

higher family support at program entry, the results show that treatment significantly enhances perceived support from a significant other and only slightly enhances support from family.

Defining Issues Test. A total of seven *t*-tests for repeated measures evaluated differences in the mean pre- and posttest scores of all program participants. The tests evaluated scores on DIT scale 2, 3, 4, 5, 6, P%, and the M scale (a measure of honesty). None of these were statistically significant nor did any approach significance.

A series of *t*-tests on posttest mean scores of all DIT scales between completers and noncompleters showed that the completers had significantly higher Scale 4 scores (47.83 vs. 40.24; $t_{93} = 2.76$; $p = .007$) and significantly lower scale M scores (6.83 vs. 9.26; $t_{93} = 2.43$; $p = .035$). Thus, treatment completers tend to show higher scores showing conformity to laws and rules as well as increased honesty. Program dropouts experienced no significant changes in DIT scores.

Relationships Among MRT Step Completion, Time in Program, and Test Scores. Of all program participants, 70 percent completed three or more MRT steps. A host of studies have shown that completion of MRT steps 3 and above leads to improved outcomes—even in those who are deemed as dropouts (Little, 2002). Program stayers completed an average of 10.27 steps compared to 2.89 steps for dropouts. In addition, length of time in treatment is often cited as an important variable in TC effectiveness. These variables were explored in a series of Pearson correlations.

The first correlation evaluated the relationship between days in program and the number of MRT steps completed. The resulting significant correlation ($r_{115} = .897$; $p = .000$) was not surprising as the two variables are obviously related. It takes time to complete MRT steps.

The second correlation evaluated the relationship between each client's last MRT step (0-12) completed with each client's LOC posttest scores. The resulting correlation was statistically significant ($r_{102} = -.382$; $p = .000$). Thus, as more MRT steps are completed, LOC scores are significantly more internal. Another correlation evaluated the relationship between days in program to LOC scores for each client. Results showed a significant relationship ($r_{102} = -.368$; $p = .000$).

Additional correlations related last MRT step completed to the LPQ posttest for each client. Results were significant ($r_{102} = .388$; $p = .000$) indicating that, as MRT step completion increases, life purpose scores tend to increase. The correlation between days in program and LPQ scores was also significant ($r_{101} = .383$; $p = .000$).

Six Pearson correlations investigated the relationships between last MRT step completed (and days in program) with posttest scores on each of the three scales of the PSS. All were statistically significant: MRT Step to PSS scores (significant other $r_{102} = .296$; $p = .003$; family support $r_{102} = .328$; $p = .001$; support from friends $r_{102} = .297$; $p = .002$); Days in program to PSS scores: (significant other $r_{102} = .314$; $p = .001$; family support $r_{102} = .317$; $p = .001$; support from friends $r_{102} = .263$; $p = .008$). Thus, as participants complete steps and remain in the program, their level of perceived support from friends, family, and significant others tend to increase. Completion of steps appears to be the most important factor in the increased support from a significant other and increased support from friends.

Four Pearson correlations investigated the relationships between MRT Step completion and days in program with DIT scores on Scales 4 and M. The first related the last step completed for all participants to posttest Scale 4 scores. The result showed a significant relationship ($r_{94} = .251$; $p = .014$) indicating that as step completion increases, Scale 4 scores significantly increase. The second correlation related last step completed to M scale scores. This correlation approached significance ($r_{95} = -.184$; $p = .07$) showing that as step completion increases, M scale scores tend to decrease. The correlation between M scale scores and participants' days in program did not approach significance. However, the correlation between days in program and scores on Scale 4 was significant ($r_{95} = .222$; $p = .03$).

Summary and Discussion

Results from this study reveal a program that has adapted and changed in that program completion rates have dramatically increased and dropouts have dramatically decreased. This can be viewed as the maturation of a relatively new therapeutic community that has adapted to both the characteristics of the clientele as well as better preparing clients as they enter the program. Since 70 percent of all clients complete three MRT steps or more, it would be appropriate to surmise that the program is producing beneficial changes in the vast majority of participants—whether they "complete" the program or not. The results of pre- and posttests tend to support this assertion. Program participants tend to show significantly more internal locus of control scores with a moderately strong correlation to the number of MRT steps completed. In addition, participants experience significantly enhanced life purpose from participation in the program, again, with the completion of MRT steps the most important factor. Finally, participants tend to perceive more support from friends as a result of program participation and MRT step completion appears to be the most influential variable. In summary, clients who participate in the therapeutic community—whether they "complete" the program or not—show significant improvements in test scores that measure a host of critical variables. These results would tend to predict lower recidivism rates in participants, however, future analyses will address this issue when recidivism data become available.

Another important area of investigation addressed in this report is the differences between program stayers and dropouts. Those who eventually drop out of the program tend to have two significant pretreatment differences that predict their eventual dropout—albeit, only slightly so. First, dropouts tend to have lower moral reasoning at the highest reasoning level at the time of program entry. That is, eventual dropouts tend to enter the program with little—or no—reasoning described as "universal ethical" principles. For example, people who are characterized like this will often state that individuals like Martin Luther King or Mother Theresa did what they did for some sort of ill-defined personal gain. The second pre-treatment difference between stayers and dropouts was that stayers perceived more support from their family at the time of program entry. This may be a measure of a motivation factor.

Finally, the present report revealed a host of beneficial changes in those who completed the program—as compared to noncompleters. Program completers showed large and significant shifts to internal locus of control, greatly enhanced life purpose, increased support from family and significant others, increases in moral reasoning characterized as adherence to rules and laws, and increased honesty. These significant, important, and beneficial

changes appear to be facilitated by the completion of the programmatic MRT steps employed in the TC program.

In sum, the MLCC therapeutic community is clearly impacting its clients for the better as revealed by the results of pre- and posttest measures. The program appears to have become increasingly effective as it has matured in both retaining clients as well as producing beneficial changes. Future evaluations including recidivism data should further clarify the most important variables as well as providing predictive measures that could be employed in determining needed interventions for specific clients.

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Recent MRT Reports & Evaluations Received

Personality Changes in Youthful Offenders Treated in an MRT-Based Therapeutic Community Program at the Woodland Hills Youth Development Center by K. D. Burnette, K. D. Robinson, & G. L. Little. (To be published in next issue of CBTR.)

Pre- and posttest scores from six test measures were evaluated in 33 male juvenile offenders participating in a specialized 12-bed therapeutic community. Results showed that program participants had significantly lower locus of control scores, significantly higher life purpose scores, significantly enhanced support from family, friends, and a significant other, and significantly less problem areas as a result of treatment. In addition, clients showed desirable changes in sensation seeking and moral reasoning scores over the course of treatment. All of these beneficial changes were most observed in program completers but were also present in dropouts.

Outcome Evaluation of the MRT-Based Therapeutic Community Program at the Northwest Correctional Center Complex by K. D. Burnette, D. Lester, K. D. Robinson, & G. L. Little. (To be published in a 2003 issue of CBTR.)

Pre- and posttest scores from five test measures were evaluated in 88 male offenders participating in a specialized 48-bed prison-based therapeutic community. Results showed that program participants had significantly higher life purpose scores and significantly enhanced support from family, friends, and a significant other as a result of treatment. In addition, clients showed desirable changes in moral reasoning scores over the course of treatment. Comparisons between program completers and dropouts showed that completers became significantly more internally controlled, experienced significant increases in life purpose, demonstrated significant declines in sensation seeking, and showed higher levels of social support as compared to dropouts. A number of analyses showed that participants who were most likely to complete the program were older and had more children.

Outcome Evaluation of the MRT-Based Therapeutic Community Program at the Tennessee Prison for Women by K. D. Burnette, A. Leonard, K. D. Robinson, & G. L. Little. (To be published in a 2003 issue of CBTR.)

Pre- and posttest scores from five test measures were evaluated in 291 female offenders participating in a specialized 64-bed prison-based therapeutic community. Results showed that program participants had significantly lower locus of control scores, significantly higher life purpose scores, and significantly enhanced support from family, friends, and a significant other as a result of treatment. In addition, clients showed desirable changes in moral reasoning and sensation seeking scores over the course of treatment. All of these beneficial changes were most observed in program completers but some were also present in dropouts. A number of analyses showed that the variable most likely producing these beneficial changes was completion of the program's treatment steps rather than simply remaining in the program.

The effectiveness of cognitive behavioral treatment for adult offenders: a methodological, quality based review by L. C. Allen, D. L. MacKenzie, & L. J. Hickman. (2001) *International Journal of Offender Therapy and Comparative Criminology*, 45, 498-514.

Previous research on cognitive skills treatment for adult offenders has not included a comprehensive review of the effectiveness of these programs on reducing recidivism. This article reviews—at least partially—recent recidivism for two cognitive behavioral programs including Moral Reconation Therapy. Using the Maryland Scale for Scientific rigor, these studies were evaluated for their methodological strength and for the program's success in reducing the recidivism of offenders. In considering the findings and strength of the methods for each program, this review concludes that Moral Reconation Therapy is a successful approaches to reducing recidivism.

SRT™ SCHOOL CURRICULUM TRAINING

CCI now offers a school curriculum for at-risk youth entitled: ***Social Responsibility Training***™ (SRT™). This two semester, five day per week class has been approved for one half-credit per semester. SRT™ has been field-tested and has demonstrated significant positive behavior impact for regular education students in Montana. The class is appropriate for delivery by classroom teachers to middle school and high school youth. ***Social Responsibility Training***™ is open-ended so that students can enter the program during the first three months of the semester. During the school year, students complete all 12 MRT® Steps, set specific behavior change goals, learn to change problem habits, complete public service projects, learn communication skills, and receive support for resolving both school and family behavior problems.

- ✔ Direct personal behavior in alignment with goals.
- ✔ Take full responsibility for behavior and adjustment in the school setting.
- ✔ Understand how problem habits develop and how to change these patterns.
- ✔ Practice the principles of honesty, trust and following the rules in school and in the community.
- ✔ Use communication skills to develop positive relationships with others.
- ✔ Practice skills in leadership, teaching others, and providing assistance to peers in the class setting.
- ✔ Understand your unique abilities and goals and develop realistic, specific and measurable action plans. to achieve these goals.

Social Responsibility Training™ for Certified MRT® Facilitators

Certified MRT® facilitators can utilize the *Social Responsibility Training*™ Curriculum upon completion of a two-day training that covers all aspects of the curriculum and implementation. Trainees will receive the SRT™ Facilitator's Guide with class outlines for the full-year curriculum, discussion guides, and class evaluation tools. Cost of the two-day training for certified MRT® facilitators is $ 250. Please call 901-360-1564 for information about upcoming trainings.

Juvenile DWI/Drug Court Albuquerque, NM

By: LeeAnn McCracken, Christine Hearn, and Sarah Stuckey

Introduction

The Albuquerque Juvenile DWI/Drug Court was established August 26, 1998, after recognizing that traditional methods of substance abuse treatment were not working. The Juvenile DWI/Drug Court is an intensive supervision program, accepting juveniles between the ages of 13 –18. They are offenders that have demonstrated their drug dependency by involvement in the juvenile justice system. Sometimes their offenses are non-drug related but symptomatic of their substance use.

Judge Geraldine Rivera presides over the Drug Court. This is in addition to her delinquency and abuse/neglect dockets. In 1998 it was Judge Rivera who decided to take on the drug court project. As a result of her hard work and dedication to the drug court and other children's court issues, she has been chosen to receive the Outstanding Judicial Service Award by the State Bar of New Mexico.

Treatment Activities

The program consists of four phases. The first phase lasts a minimum of 10 weeks. The second and third phases last 7 weeks and aftercare lasts 1-3 months. A minimum number of points must be earned during each phase before a participant is allowed to move into the next phase. Even though a participant has accumulated the minimum number of points for a phase, he/she is not automatically guaranteed movement. The drug court judge with recommendations from the team may choose to hold a participant in a phase for a period of time if it is beneficial for the participant to remain in that phase.

Using Moral Reconation Therapy (MRT®) has provided a useful approach in working with juveniles who enter a counseling setting for the first time. Because participants often possess a wide range of learning difficulties and educational levels, MRT's concrete format has been particularly useful. For example, clients range in academic skill level from special education to advanced placement.

The Program's primary purpose in utilizing MRT is to assist group participants in establishing an internalized locus of control, developing a sense of accountability, and setting long-term goals in the interest of mitigating substance abuse problems. The MRT workbook steps address a wide range of topics and require participants to reflect on past behaviors, some of which have resulted in referrals to the juvenile justice system. Additionally, current and future behaviors are considered with the ultimate goal of developing a broader range of adaptive coping mechanisms and problem solving capabilities.

The use of MRT in groups has enhanced all the treatment strategies.

A challenge that has been encountered using MRT with high functioning resistant adolescents is that they often attempt to complete assignments without fully examining problematic behaviors. The MRT's method is particularly useful in addressing this resistance. Also, MRT is particularly helpful in facilitating change in lower functioning participants who experience success and a sense of competence by presenting their illustrative assignments.

The use of MRT in groups has enhanced all of the treatment strategies. We have experienced successes with adolescents that have entered our program under a "last chance" situation and would have been described as otherwise "untreatable." The MRT work assists our DWI/Drug Court participants in climbing a ladder towards sobriety, better family functioning, connection with their community, and an improved sense of self.

One of the highlights for drug court participants is the completion of a wilderness and learning-based adventure program. Many of the activities are done outdoors over a period of several months. These activities are created in a way to make the participants aware of how they get along with themselves, their family, and other people. The exercises

MRT is particularly helpful in facilitating change in lower functioning participants who experience success and a sense of competence by presenting their illustrative assignments.

provide tools that will help the participants solve problems facing them in real life.

Outcomes and Results

Data from a process evaluation indicates that the program has the lowest urine analysis "positive" test rate for New Mexico juvenile drug courts. United States Federal Pretrial Services does the analysis for all samples taken. Since this collaboration began in January 1999, the program is **at a 3%** positive test rate, meaning that 3% urine tests indicated drug usage.

In a study done by the Institute for Social Research at the University of New Mexico, 34 Juvenile DWI/Drug Court program participants were matched with 33 non-participants by gender, ethnicity, and referring offense. The percentage of control group participants who had new court referrals following exit was 60.6% compared to only 35.3% of the Drug Court participants. Also, the average time to a new referral was 224.3 days for the drug court group and 120.2 days for the comparison group. There were 6 drug court participants (17.6%) with a petition filed compared to 14 participants in the comparison group (42.4%). "The comparison group had a larger number and percentage of new petitions filed following exit from probation than the drug court group. This difference is statistically significant. The average time in days to acquiring a new petition was greater for the drug court group (236.2) when compared to the comparison group (165.1)." (Guerin, 2001)

Only three percent of urine drug tests indicated drug usage.

The percentage of control group participants who had new court referrals following exit was 60.6% compared to only 35.3% of the Drug Court participants.

The Juvenile DWI/Drug court has provided services to 92 individuals and their families. Currently, 17 individuals are actively involved in the program. At present, a total of 37 clients have graduated from the program. When these individuals completed the drug court program, all reported improved family relationships. In addition, all of these clients were either in school, gainfully employed, or had received a GED. Noteworthy is that the individuals who did not successfully complete the program are re-offending at lower rates compared to a similar group of probationers who were unable to participate in the drug court. Juveniles that are able to participate seem to do better overall, even if they don't complete the program.

Reference

Guerin, P. (2001) *Evaluation of the Second Judicial District Court County Juvenile Drug Court: Quasi-Experimental Outcome Study Using Historical Information.* The Institute for Social Research, University of New Mexico.

Moral Reconation Therapy — MRT® Trademark Renewed

Some Institutions Use Deceptive Practices In Attempt To Meet Legal Obligations

On May 2, 2002 the United States Patent and Trademark Office approved and extended the registered trademark on Moral Reconation Therapy — MRT®. The trademark period will be in effect until 2012. (The registration number is 1969933; serial number: 74/674027.)

Those who employ the terms MRT® or Moral Reconation Therapy® are required by law to utilize the registered trademark symbol (®) in all documents, reports, or publications. In addition, all MRT® materials are copyrighted.

Some institutions and agencies have placed the term "Moral Reconation Therapy" on program completion certificates given to offenders who have attended other classes or forms of counseling in a deceptive attempt to meet legal or contractual requirements stipulated by states—but the offenders neither participated in nor completed MRT®. In addition, a few programs and agencies have copied a few exercises from MRT® workbooks, supplying offenders with the copies. Both practices are illegal and unethical. One large privately-operated institution argued that an educational approach was "the equivalent" to MRT®, and since their offenders were required to attend MRT® by the state that contracted with them to house and treat offenders, they believed it was appropriate to give inmates MRT® completion certificates. The individuals making these decisions cited cost savings as their primary motive.

While this is a blatant attempt to deceive the state which made the contract, it is also a violation of numerous laws and professional ethics. In addition, it raises a set of philosophical moral issues. One of these directly relates to the nature of criminality and offender treatment. It is paradoxical that a program would send the message to offenders that, if you don't want to pay for something, or you believe you can't afford something, then you have justification for stealing it.

COGNITIVE-BEHAVIORAL TRAINING IN BASIC MRT® & MRT® DOMESTIC VIOLENCE PROGRAMMING

How MRT Is Implemented:

MRT® is a trademarked and copyrighted cognitive-behavioral treatment system for offenders, juveniles, substance abusers, and others with resistant personalities. The system was developed in the mid-1980s and has had substantial outcome research published in the scientific literature showing that recidivism is significantly lowered for ten years following treatment. MRT® is performed in open-ended groups typically meeting once or twice per week. Clients complete tasks and exercises outside of group and present their work in group. The MRT-trained facilitator passes clients' work according to objective guidelines and criteria outlined in training. ***Programs using MRT® must supply clients with a copy of an MRT® workbook that are purchased from CCI for $25 per copy.*** MRT® formats are in use for general offenders, juveniles, perpetrators of domestic violence, and others. MRT® trainings are held routinely across the United States and monthly in Memphis. Accredited CEUs for MRT training are offered from Louisiana State University at Shreveport for participants who complete training. Training dates and a registration form can be found on the next page. Feel free to call or write for more details.

— MRT® Trainers —

CCI staff conduct each training session. Trainers may include Dr. Ken Robinson (a co-developer of MRT®), Kathy Burnette, M.S. (CCI's Vice President of Clinical & Field Services), E. Stephen Swan, M.Ed. (CCI's Vice President of Administrative Services), Patricia Brown, LADAC, or a regional CCI licensee.Dr. Robinson has over 25 years direct experience in criminal justice programming. Ms. Burnette has over 15 years direct criminal justice and substance abuse treatment experience and was involved in the initial implementation of MRT®. Mr. Swan has 30 years in counseling and correctional administration. Those interested in being licensed as exclusive providers of MRT® in regions should call Dr. Ken Robinson.

CCI's DOMESTIC VIOLENCE PROGRAM:

- **24 Sessions**
- **Printed Formats & Manual**
- **Objective Cognitive Behavioral Criteria**
- **Meets State's Requirements on Power & Control Model**
- **CEUs Offered**

For Information call or write CCI:
Dr. Ken Robinson, Pres.
or Steve Swan, V.P.
3155 Hickory Hill • Suite 104
Memphis, TN 38115
(901) 360-1564
e-mail ccimrt@aol.com

MRT OR DOMESTIC VIOLENCE TRAINING REGISTRATION FORM

Please register the following persons for MRT or Domestic Violence Training:

	COST
NAME 1 _____	$600
NAME 2 _____	$500
NAME 3 _____	$500
NAME 4 _____	$500

CREDIT CARD ORDERS CALL (901) 360-1564

AGENCY _____

ADDRESS _____

CITY/STATE/ZIP _____

PHONE # _____

TRAINING DATES SELECTED: _____ TOTAL: _____

Mail form with payment to: CCI • 3155 Hickory Hill • Suite 104 • Memphis, TN 38115

Payment Enclosed (please check one): __Check __Money Order __Purchase Order (attached)

Be sure to check that your training dates correspond to the training for which you are registering (e.g. MRT or Domestic Violence). A $50 processing fee will be assessed on refunds due to participant cancellation 10 days or less before training. Note that some training dates have limited availability of open slots. CCI reserves the right to cancel training dates if insufficient participants have enrolled.

Upcoming Trainings In MRT® & Domestic Violence

January 7- 10, 2003, MRT in Texarkana, Texas
January 13- 17, 2003, MRT in Memphis, Tennessee
January 27- 30, 2003, MRT in Shawnee, Oklahoma
February 17- 21, 2003, MRT in Memphis, Tennessee
March 17- 21, 2003, Domestic Violence in Memphis, TN
April 7- 11, 2003, MRT in Memphis, Tennessee
May 12- 16, 2003, MRT in Memphis, Tennessee
June 23- 27, 2003, MRT in Memphis, Tennessee
July 14- 18, 2003, Domestic Violence in Memphis, TN
August 25- 29, 2003, MRT in Memphis, Tennessee
September 22- 26, 2003, MRT in Memphis, Tennessee
October 20- 24, 2003, MRT in Memphis, Tennessee
November 17- 21, 2003, MRT in Memphis, Tennessee

Note: Additional trainings will be scheduled in various locations in the US. See our website at www.ccimrt.com or call CCI concerning specific trainings.

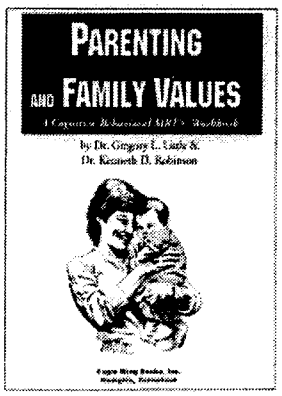
CCI can also arrange a training in your area. Call 901-360-1564 for details.

PARENTING AND FAMILY VALUES

A Cognitive-Behavioral MRT® Workbook

A 12 group session workbook aimed at assisting parents and caregivers discover and develop appropriate and effective parenting methods while focusing on the underlying family values. In this 75 page workbook, parents confront their own parenting styles, values, and methods of discipline.

- Parent Values
- Parenting Young Children
- Values In Children
- Handling Children's Problems
- Parenting Adolescents & Teens
- Problems In Adolescents & Teens
- The Healthy Family

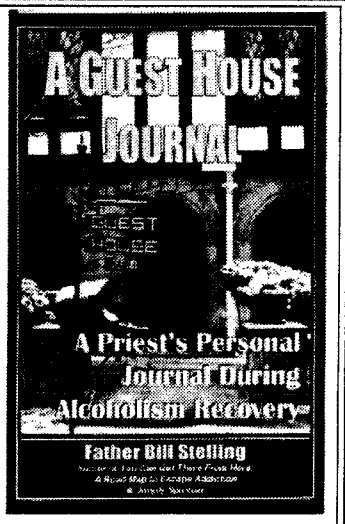


- Parents of Delinquents
- Offenders With Children
- Substance Abusers With Children
- Parents Experiencing Problems
- Parents Seeking Understanding

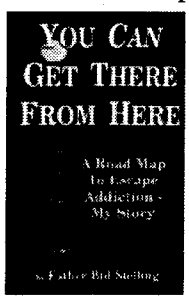
Parenting and Family Values is $15.00 per copy.

NEW

These two remarkable books tell the story of a priest's alcoholism recovery. From his intervention by the Bishop, to his entry into inpatient treatment at Guest House, to his return to his parish, Father Bill Stelling gives an astonishing, completely open and honest day-by-day account. *A Guest House Journal* is his actual daily journal during treatment. *You Can Get There From Here* tells how others can form a road map to recovery.



181 pages, softcover, $14.95



85 pages, softcover, $8.95

NEW

See page 19 for order details

CBTR Literature Reviews

Editorial: Delinquency, juvenile offending and personality disorder by C. Van Velsen (2001) *Criminal Behaviour and Mental Health*, 11, s1-s5.

This British editorial precedes reviews of recent books in the field of juvenile delinquency and begins by emphasizing "the necessity of constantly being alert to the social context of our definitions of juvenile delinquency." The author asserts that "I see a failure to apply the knowledge and expertise we have " especially because a "considerable body of work [exists] which helps us to understand the aetiology of conduct disorder and of juvenile offending (and indeed the connection between them), and their relationship to later adult personality disorder and criminality." The author agrees that a genetic marker may well be present in conduct disorder, but believes that its usefulness will be limited in practice. Multiple views of the development of the disorder are needed rather than the tired nature versus nurture debate. The editorial ends by summarizing how psychoanalytic and empirical approaches have been "integrated" leading to a conclusion that the literature has long supported: "delinquency is committed by young people with inadequate capacity to mentalise change and reflect on self and others, linking to the research, and the clinical finding, that people with anti social personality disorder lack a capacity to emphathise with a victim's distress."

What are the adolescent antecedents to antisocial personality disorder? By R. Loeber, J. D. Burke, & B. B. Lahey. (2002) *Criminal Behaviour and Mental Health*, 12, 24-36.

This study attempted to clarify the connection between conduct disorder and later development of adult antisocial personality disorder (APD). A sample of 177 males, age 7-12, was recruited from clinics in Pittsburgh, PA and Atlanta, GA in 1987. The participants were subjected to annual assessments (personality measures, substance abuse reports, and clinical interviews) as well as parent and teacher interviews until age 19. In addition, adult offending was determined at ages 18 and 19 in all participants. Of the original 177 participants, full data was collected on 158. Results showed that Conduct Disorder was diagnosed in 59% of the participants prior to age 18. By age 18 or 19, antisocial personality disorder was diagnosed in 38%. Further investigation showed that just over half (52.1%) of those who had been diagnosed with Conduct Disorder progressed to the antisocial personality disorder diagnosis. A host of other variables present in childhood were significantly related to the development of antisocial personality disorder: Oppositional-Defiant Disorder, depression, ADHD, callous/unemotional behavior, tobacco use, alcohol use, marihuana use, and other drug use. The final regression model predictive of APD (with Conduct Disorder ignored) included three variables: callous/unemotional behavior, depression, and marihuana use.

Relapse prevention with sex offenders: practice, theory and research by G. Launay. (2001) *Criminal Behaviour and Mental Health*, 11, 38-54.

Relapse prevention models (RP), designed for use with addictive behaviors, have been applied to sex offenders in the last decade. However, in the last few years, research on these addictive models has shown that the addition of some forms of relapse prevention have produced little or no beneficial effects. The author describes the program utilized at British SOTP (sex offender treatment programs) facilities. One of the areas mentioned as weak in RP approaches, is that "lapses" and risky behaviors are typically defined as actions. However, in sex offenders, fantasy appears to be a risky "behavior" that is seldom addressed. The article concludes, "the theory on which relapse prevention for sex offenders is based is sound in essence but the RP model suffers from an overlay of cumbersome vocabulary and from the recent addition of some complex constructs which are not useful clinically."

Psychopathy in female offenders: An investigation of its underlying dimensions by R. L. Jackson, R. Rogers, C. S. Neumann, & P. L. Lambert. (2002) *Criminal Justice and Behavior*, 29, 692-704.

The diagnosis of antisocial personality disorder (psychopathy) is present much more frequently in males than with females. It should not be surprising then, that the bulk of research on the disorder has been carried out on male populations. This study utilized 119 female inmates from the Dallas-Ft. Worth Jail, in an attempt to identify the underlying dimensions in females. The Psychopathy Checklist-Revised (PCL-R), Wide-Range Achievement Test, and Self-Report of Psychopathy-II (SRP-II) were administered to all participants. Results showed a moderate level of psychopathy as measured by the PCL-R (mean for the group was 18.17). Only seven female participants scored 30 or above, the score Hare recommends for diagnosing psychopathy. However, 26 females (21.9%) scored 25 and above, an important point as the authors cite recent research showing that the cutoff score for females should be lower than males. Other data analysis showed that a three-factor model of female psychopathy was supported. The most important dimension appeared to be lack of emotional range and lack of empathy.

Cutting Edge Research Notes

Psychopharmacology

New Drug Reduces the Effects of Marijuana

Marijuana achieves its effects by altering receptor functions in brain areas controlling movement, reasoning, and attention. A set of receptors in those brain areas, called "CB-1 cannabinoid," are the primary site of action for THC. A new compound (SR141716) was recently developed by the Pennsylvania pharmaceutical firm Sanofi-Synthelabo to block the effects of marijuana. Studies have shown that the compound blocks the CB-1 receptors in pigeons, rats, and monkeys. A just released report summarizes the first research of the compound on humans. Sixty-three men with a history of marijuana smoking were given 5 different dosage levels of the compound or a placebo. Two hours later each participant smoked a marijuana cigarette with or without THC present. They then rated the strength of the cigarette. Those who received the highest dose of the CB-1 blocking compound rated the effect of the marijuana 40 to 75 percent lower. The compound is now in further testing and may eventually be useful in treatment. For example, SR141716 has now been shown to reduce cocaine craving that lead to relapse. Source: *NIDA Notes* (2002), 17 (3).

Marijuana Withdrawal

It should not be a big surprise to any treatment personnel that persistent, heavy marijuana use leads to actual physical dependence. Animal studies have long shown the presence of withdrawal symptoms after marijuana was discontinued in marijuana-dependent animals. But in humans, only a host of antedotal reports have existed. A recent study on 12 adult marijuana smokers has shown that marijuana withdrawal is quite similar to nicotine withdrawal. Source: *NIDA Notes* (2002), 17 (3).

COGNITIVE BEHAVIORAL MATERIALS AVAILABLE FROM CCI

To order go online at www.ccimrt.com or use the coupon on the following page.

Understanding & Treating Antisocial Personality Disorder: Criminals, Chemical Abusers, & Batterers — 65-page updated softcover text by Drs. Greg Little and Ken Robinson. Covers the gamut of treating the most resistant of clients. With 93 refs.; $10.00.

CBT Applied To Substance Abusers — a 29-page monograph reviews primary characteristics of CBT interventions and research with substance abusers; $6.00.

Effective Counseling Approaches for Chemical Abusers & Offenders — 104-page text covering major counseling theories and outcomes; $12.00.

Crisis Intervention Strategies for Chemical Abusers & Offenders — 61-page text covering crisis intervention techniques; $10.00.

Five-Minute Stress Manager — cassette tape of three, 5-minute relaxation segments used in MRT® and Domestic Violence; $8.95.

Parenting and Family Values — 75 page, 12 session MRT® group workbook designed to be used with parents of children experiencing problems; $15.00.

Imaginary Future — 15 minute cassette tape used in Step 7 of MRT® to assist clients in visualizing appropriate goals; $8.95.

Imaginary Time Out — 15 minute cassette tape used in MRT® domestic violence to assist clients in visualizing appropriate time out strategies; $8.95.

Family Support — 26 page (8.5 X 11 softcover) CBT workbook used in groups with clients who fail to pay child and family support. Exercises for group work; $9.00.

Job Readiness — 26 page (8.5 X 11 softcover) CBT workbook designed for use in groups with clients who have faulty beliefs about the work world; $9.00.

Simply Spiritual book & Workbook set — 64-page softcover book by Father Bill Stelling describing the 7 spirituality building blocks and 6 common stumbling blocks. A powerful and useful treatment program aid. Makes the mystery of spirituality understandable to those in recovery with 38-page CBT workbook designed to accompany *Simply Spiritual* for use in groups. Workbook exercises follow text of book; $15.95 for set of books.

Spiritual Reflections book & tape set — 167-page softcover book by Father Bill Stelling with 54 chapters, each on various issues. Relevant to offenders and those in recovery; comes with 90-minute cassette tape of Father Bill addressing specific questions; $18.95 for both

You Can Get There From Here — 85-page softcover book by Father Bill Stelling telling how addictions can be changed. A priest tells how he overcame alcoholism; $8.95

A Guest House Journal — 181-page softcover book by Father Bill Stelling detailing his personal day-by-day journal during alcoholism recovery at Guest House. A stunningly honest portrayal of how a priest participated in inpatient alcoholism treatment; $14.95

An Introduction To Spirituality — 100-page softcover book by corrections' counselor/minister Steve Sanders can be used as an excellent source for those in recovery or interested in spiritual growth. Offers a health/wellness plan; $12.00

The Joy of Journaling — 110-page softcover by Drs. Pat & Paul D'Encarnacao covers the hows and whys of journaling. Shows how counselors can use journaling as a CBT method of aligning clients' beliefs and behavior; $11.95.

PSYCHOPHARMACOLOGY: Basics for Counselors — 279 page softcover text covering the basics of the field - up-to-date and comprehensive; $24.95.

Coping With Anger— 49-page anger management cognitive behavioral workbook. Designed for use in 8 group sessions; $10.00

Facilitator's Guide for Coping With Anger — 8 page how-to guide for implementing the *Coping With Anger* anger management groups; $5.00.

Making Changes for Good — 56-page workbook designed for sex offender relapse prevention group program; $18.00.

Facilitator's Guide for Making Changes for Good - 12 page how-to guide for implementing the sex offender relapse prevention program; $10.00.

Untangling Relationships: Coping With Codependent Relationships Using The MRT Model — 28-page workbook for use with those who have codependent issues; $10.00

Staying Quit: A Cognitive-Behavioral Approach to Relapse Prevention — 40-pg client workbook for relapse prevention groups. 8 program modules; $10.00.

Facilitator's Guide to Staying Quit — 8 page how-to guide for implementing *Staying Quit* relapse prevention groups; $5.00.

Audiotape set for Staying Quit — 3 boxed cassette audiotapes with the *Staying Quit* workbook on tape, basic relaxation, progressive muscle relaxation, clean & sober visualization, and desensitization; $50.00.

Staying Quit Group Starter Kit — 11 client workbooks, 1 Facilitator's Guide, review article, and audiotape set; $140.00.

Responsible Living — 26-page client workbook with 8 group sessions designed for "bad check" writers, shoplifters, and petty crime misdemeanants; $10.00.

Thinking For Good — Group workbook directly addressing criminal thinking, behaviors, and beliefs from MRT personality stages. 10 sessions — Samenow's criminal thoughts are disputed; $10.00.

Thinking For Good Facilitator's Guide — A simple, easy-to-follow facilitator's guide for implementing Thinking For Good; $5.00.

Character Development Through Will Power & Self-Discipline — CBT group exercise workbook for use with probationers, parolees, and juveniles. Designed for 16 group sessions with scenarios discussed in group; $20.00.

Character Development Facilitator's Guide — 54-page counselor's guide to Character Development; $20.00.

RAPPORT test package - 25/$25; 100/$85; 500/$375.

Objective Tests & Measures Vol. I — 35 copyright free tests; $105.

Only those trained in MRT® may order the following materials

MRT® Counselor's Handbook — Bound 8.5 X 11, 20-page book giving the objective criteria for each MRT® step. Includes sections on group processes, rules, dynamics, hints, and instructions for starting an ongoing MRT® group; $10.00.

MRT® Freedom Ladder Poster — large white paper poster of MRT® stages, steps, and personality descriptions; $10.00.

How To Escape Your Prison Cassette Tape Set — Three cassette tapes (3.5 hours in length) with the complete text of the MRT® workbook, *How To Escape Your Prison*, containing brief explanations by Dr. Little of exercises and tasks. For use with clients in groups where reading assistance is not present. Boxed in a vinyl tape book with color coded tapes for easy reference to steps; $59.95.

How To Escape Your Prison — The MRT® workbook used in criminal justice, 138 pages, 8.5 X 11 perfect bound format, with all relevant exercises — by Drs. Greg Little & Ken Robinson; $25.00.

How To Escape Your Prison in Spanish — The Spanish MRT® workbook used in criminal justice, 138 pages, 8.5 X 11 perfect bound format, identical to English version — by Drs. Greg Little & Ken Robinson; $25.00.

How To Escape Your Prison Audiotape Set in Spanish — The Spanish MRT® workbook on three cassette tapes - boxed.; $59.95.

Juvenile MRT® How To Escape Your Prison — MRT workbook for juvenile offenders, 8.5 X 11 perfect bound format, with all exercises.; $25.00.

Domestic Violence Workbook — 119 pages in 8.5 X 11 format, titled, *Bringing Peace To Relationships*, for use with perpetrators of domestic violence. The MRT® format used on violent perpetrators, contains dozens of exercises specifically designed to focus on CBT issues of faulty beliefs, attitudes, and behaviors leading to violence in relationships; $25.00. (Must be trained in Dom. Vio. to order.)

Domestic Violence Facilitator's Guide — 21 pg. how-to facilitator's guide to *Bringing Peace To Relationships* domestic violence groups; $10.00.

Filling The Inner Void — MRT® workbook, 120-page spiral bound, used with juveniles, in schools - by Drs. Little & Robinson. Discusses the "Inner Enemy" (the Shadow in Jungian psychology), projection, and how we try to fill basic needs; $25.00.

Discovering Life & Liberty in the Pursuit of Happiness — MRT® workbook for youth and others not in criminal justice; $25.00.

CBT Materials Order Form

Item	Price Each	# Ordered	Subtotal
Understanding & Treating APD	$10.00		
CBT Applied To Substance Abusers	$6.00		
Effective Counseling Approaches text	$12.00		
Crisis Intervention text	$10.00		
Five-Minute Stress Manager (audio cassette)	$8.95		
Parenting and Family Values	$15.00		
Imaginary Future (audio cassette)	$8.95		
Imaginary Time Out (audio cassette)	$8.95		
Family Support (CBT workbook)	$9.00		
Job Readiness (CBT workbook)	$9.00		
Simply Spiritual Book + Workbook	$15.95		
Spiritual Reflections Book + Tape	$18.95		
You Can Get There From Here	$8.95		
A Guest House Journal	$14.95		
An Introduction To Spirituality book	$12.00		
The Joy Of Journaling	$11.95		
Psychopharmacology: Basics for Couns.	$24.95		
Coping With Anger (workbook)	$10.00		
Coping With Anger Facilitator Guide	$5.00		
Making Changes Sex Offender Workbook	$18.00		
Making Changes Facilitator Guide	$10.00		
Untangling Relationships Workbook	$10.00		
Staying Quit (workbook)	$10.00		
Staying Quit Facilitator Guide	$5.00		
Staying Quit Audiotape Set	$50.00		
Staying Quit Group Starter Kit	$140.00		
Responsible Living workbook	$10.00		
Thinking For Good workbook	$10.00		
Thinking For Good Facilitator Guide	$5.00		
Character Development	$20.00		
Character Development Facilitator's Guide	$20.00		
RAPPORT	$25/$85/$375		
Objective Tests & Measures - I	$105		
MRT ***Materials below can only be ordered by trained MRT facilitators***			
MRT Counselor's Handbook	$10.00		
MRT Poster (Freedom Ladder)	$10.00		
How To Escape Your Prison (cassette tapes)	$59.95		
How To Escape Your Prison	$25.00		
How To Escape Your Prison (In Spanish)	$25.00		
How To Escape Spanish (cassette tapes)	$59.95		
Juvenile MRT® - How To Escape Your Prison	$25.00		
Domestic Violence (Must take Dom. Vio.)	$25.00		
Domestic Violence ***Facilitator's Guide***	$10.00		
Filling The Inner Void	$25.00		
Discovering Life & Liberty...	$25.00		

You can now order online! See our web site at www.ccimrt.com for additional information.

Ordering Instructions

To order materials, clip or copy coupon and send with check, money order, or purchase order. All orders are shipped by UPS — no post office box delivery.There is a $5.00 shipping fee for all orders of a single item. If you order more than one item, you should call CCI at (901) 360-1564 for UPS shipping, insurance, and handling charges. Orders are typically shipped within 5 working days of receipt.

Materials below the line stating **"MRT Materials..." can only be ordered by persons or agencies with trained MRT® facilitators.** Call for details if you have any questions.

CREDIT CARD ORDERS:

(901) 360-1564

ORDER COUPON

Your Name and Shipping Address:

Name: _____

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Agency: _____

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Address: _____

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City/State/Zip: _____

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Phone: _____

Send form and payment to:
Correctional Counseling, Inc.
3155 Hickory Hill • Suite 104
Memphis, TN 38115

_____ = TOTAL ORDER

_____ = (call for)Shipping

_____ = Grand Total

Memphis MRT® Training Daily Agenda

This schedule is for Memphis trainings only. Regional times and costs vary. Lunch served in Memphis only.
Lecture, discussion, group work, and individual exercises comprise MRT® training.

Monday	Tuesday	Wednesday	Thursday	Friday
8:00 a.m. to 5:00 p.m. *(Lunch-provided in Memphis)* Introduction to CBT. Treating and understanding APD and treatment-resistant clients. Background of MRT® personality theory.	8:00 a.m. to 12:30 p.m. *(Lunch - on your own)* Personality theory continued. Systematic treatment approaches. MRT® Steps 1 - 2. About 2 hours of homework is assigned.	8:00 a.m. to 5:00 p.m. *(Lunch - on your own)* MRT® Steps 3 - 5.	8:00 a.m. to 12:30 p.m. *(Lunch - on your own)* MRT® Steps 6 - 8. About 2 hours of homework is assigned.	8:00 a.m. to 2:00 p.m. *(Lunch - provided in Memphis)* MRT® Steps 8-16. How to implement MRT®. Questions & answers. Awarding completion certificates.

MRT® Or Domestic Violence For Your Program
Training and other consulting services can be arranged for your location. For information call Steve Swan : 901-360-1564.

2003 MRT® AND DOMESTIC VIOLENCE TRAININGS

January 7- 10, 2003, MRT in Texarkana, Texas
January 13- 17, 2003, MRT in Memphis, Tennessee
January 27- 30, 2003, MRT in Shawnee, Oklahoma
Febuary 17- 21, 2003, MRT in Memphis, Tennessee
March 17- 21, 2003, Domestic Violence in Memphis, TN
April 7- 11, 2003, MRT in Memphis, Tennessee
May 12- 16, 2003, MRT in Memphis, Tennessee
June 23- 27, 2003, MRT in Memphis, Tennessee
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September 22- 26, 2003, MRT in Memphis, Tennessee
October 20- 24, 2003, MRT in Memphis, Tennessee
November 17- 21, 2003, MRT in Memphis, Tennessee

Please check our website at www.ccimrt.com for additional training dates.

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