COGNITIVE BEHAVIORAL TREATMENT REVIEW

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

CORRECTIONAL COUNSELING INC. • MEMPHIS, TENNESSEE • VOLUME 12, #2 • SECOND QUARTER 2003

Table of Contents

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

3155 Hickory Hill • Suite 104
Memphis, TN 38115
(901) 360-1564 • FAX (901) 365-6146
email CCIMRT@aol.com
WEB SITES: www.ccimrt.com
www.moral-reconation-therapy.com

Kenneth D. Robinson, Ed.D.
Executive Editor

E. Stephen Swan, M.Ed.
Editor

Katherine D. Burnette, M.S.
Associate Editor

Gregory L. Little, Ed.D.
Associate Editor

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.

Washington State's Drug Courts For Adult Defendants: Outcome Evaluation and Cost-Benefit Analysis—Summary —Issued March 2003—

"In 2002, the Washington Legislature directed the Washington State Institute for Public Policy to evaluate adult drug courts in Washington. Developed during the 1990s, drug courts use frequent courtroom activity and drug treatment resources in an attempt to modify the criminal behavior of certain drug-involved defendants. The questions for this evaluation are whether drug courts—when compared with regular criminal courts—reduce recidivism and produce more benefits than costs.

We began the study by reviewing previous drug court evaluations undertaken in the United States. We identified 30 evaluations with reasonably strong research designs and found that drug courts, on average, have been shown to reduce recidivism rates by 13.3 percent, a statistically significant reduction.

We then evaluated six adult drug courts in Washington operating during 1998 and 1999 to test whether Washington's drug courts reduce recidivism rates. We found that five of these drug courts reduce recidivism by a statistically significant 13 percent, a reduction almost identical to the national average. This favorable finding, however, must be tempered: one of the courts failed to reduce recidivism significantly.

We conducted a cost-benefit analysis. We estimate that these five drug courts cost $3,891 more per participant than regular criminal court. These extra costs cover more frequent use of court resources and drug treatment.

The economic question is whether the benefits of reduced recidivism outweigh these extra costs. We found that the five adult drug courts generate $1.74 in benefits for each dollar of costs. Thus, adult drug courts appear to be cost-effective additions to Washington's criminal justice system."

Additional notes: The counties in the report represent 58 percent of Washington state's total population. The full report can be downloaded at: www.wsipp.wa.gov

April 17, 2003 Report Says California Drug Courts Cut Costs and Recidivism

On April 17 the Associated Press released an article citing major cost savings and reduced recidivism due to the implementation of 90 drug courts in California. Studies based on courts in Los Angeles, San Diego, and Butte counties estimated that the courts produced a $200,000 yearly cost savings for every 100 participants in drug courts. The 90 courts in California average about 100 participants each, so the overall yearly cost savings is cited as $18 million.

Effects of MRT® on Male Juvenile Offenders Participating in a Therapeutic Community Program

Katherine D. Burnette, E. Stephen Swan, Kenneth D. Robinson, Marilyn Woods-Robinson,
Correctional Counseling, Inc.
& Gregory L. Little
Advanced Training Associates

Summary—Pre- and posttest scores from six test measures were evaluated in 33 male juvenile offenders who participated 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.

Introduction

The utilization of therapeutic communities (TC) with criminal justice and substance-abusing populations has a long history, however, relatively few of such programs have been employed with juvenile offenders (Wexler, DeLeon, Thomas, Kressel, & Peters, 1999). In September 1999, Correctional Counseling, Inc. (CCI) of Memphis, Tennessee implemented a drug treatment program for male juveniles housed at the Woodland Hills Youth Development Center (WHYDC), a state of Tennessee Department of Children's Services facility located in Nashville. The program was organized and developed as a drug therapeutic community and is operated under contract from the Tennessee Department of Children's Services and funded through RSAT. It was designed to house 12 juveniles with each participant in the program for at least six months. The program utilizes MRT® as its primary treatment mode. Since its beginning, the program has operated at full capacity.

From the initiation of the program until the present, CCI has utilized a battery of pre- and posttests to measure client characteristics as well as document possible changes in client variables over the course of treatment. The tests employed are considered to be research tools rather than assessment instruments. Results utilizing these research tests form the basis of much of this report.

Method

From September 1999 until January 29, 2002, a total of 56 juvenile males had entered the WHYDC program. Pre-tests were administered within the first week of a client's program entry and within a week of program release (usually the day before release). Thus, the duration of time between the pre- and posttests varied, but was generally between six months to a year. Pre- and posttest results were available for 33 clients with current program participants ($n = 12$) excluded along with a number of clients ($n = 11$) who did not, for a variety of reasons, complete a valid pretest and/or posttest. However, all usable data gathered from clients (*i.e.*, a few pretests and posttests) were utilized when possible.

Tests Utilized

The six 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 he has control over his life (Pugh, 1994). Ideally, a program should instill feelings of increasing control in clients—what is commonly referred to as ***internal locus of control***. That is, as a client progresses, he should come to see that his current decisions and current behavior can have an impact on future events. In the simplest of terms, an internally controlled person believes that, "I have much control over my life." On the other extreme, clients who believe that luck or other people completely determine what happens to them are said to have an ***external locus of control***. Externally controlled people believe that, "I have little or no control over my life and what happens to me." Internal locus of control is believed to be one of the keystones of a healthy personality. For example, people spend years in college and working in jobs with the belief that their actions can help build a positive future. A related concept is personal responsibility. Individuals who come to believe that they have no influence over their lives feel no sense of personal responsibility—thus their behavior is frequently irresponsible. 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 his 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. They see goals and relationships as important and believe that life has meaning beyond the pleasure or pain that may be present in the immediate situation. 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 conduct disorder in juveniles and antisocial personality in adults. 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 he has support from three different areas: ***friends, family, and significant others*** (Zimet, *et. al.*, 1988). The test was included in CCI's evaluation plan for several reasons. First, it is recognized that, after release into the community, a juvenile's success can be influenced by support from others. In general, most researchers believe that increased support on all three variables is desirable. Scores on all three PSS 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 who are deemed as important; 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. An extreme example of Stage 6 reasoning can be when an adult sacrifices his or her life to save the life of a child not known by the adult. 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, two other subscales are measured: 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; An authoritarian scale (A) measures the degree to which an individual looks to an authority for decisions.

6. The **Problem Oriented Screening Instrument for Teenagers** (POSIT) was developed by the National Institute on Drug Abuse as a screening tool to identify potential problem areas in need of deeper assessment and possibly focused treatment. It is a 139-item questionnaire that reports on a host of functional areas as well as on a total "problem score." The present study focused on the total score. The test is specifically recommended by NIDA as a pre- posttest instrument to identify client changes as a result of treatment. Ideally, effective treatment would result in lowered scores on the POSIT.

Client Characteristics

Male juveniles were referred to the program by the Department of Children's Services as a result of persistent problems with the juvenile justice system involving substance use. The average age of all clients was 16.33 years with 67% of participants falling between the ages of 15.22 to 17.44 years. Fifty percent of clients were African American, 45 percent were White, and five percent were Hispanic or "Other." Clients spent an average of 151 days in the program.

Excluding current program participants, 70 percent of participants completed the program. Program completers were defined as spending at least 6 months in the program, completing the drug treatment program format of Moral Reconation Therapy® (MRT), and completion of other treatment plan objectives. Program dropouts (30 percent of all clients) generally left the program voluntarily.

Results

Initial analyses compared program stayers (or completers) to dropouts. One analysis divided the completers ($n = 23$) and dropouts ($n = 10$), all of whom completed pretests, into two groups. Since many cell frequencies were too low to allow an ANOVA, a total of 16 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 one score. *Program completers had a significantly lower pretest mean on the Locus of Control* than dropouts (stayers = 85.57; dropouts = 104.1) $t_{26} = 1.97$; $p = .05$. In sum, those who completed the program can be characterized as *having a more internal locus of control at the time of program entry as compared to those who eventually became dropouts.* Additional nonparametric tests showed no differences between dropouts and completers on age or race.

Pre- to Posttest Changes

Prison Locus of Control. At treatment initiation, the mean LOC score for all program participants was 91.18. This is generally considered to be on the high "external" side of the scale. The posttest score mean was a less "external" 74.63. A subsequent *t*-test for repeated measures showed that this difference was statistically significant ($t_{26} = 2.72$; $p = .011$). *Thus, program participants showed a significant shift to a more internal locus of control as a result of treatment.*

As discussed above, at treatment initiation program completers showed significantly lower LOC scores than

dropouts. However, we wanted to assess if both completers and dropouts showed significant declines in LOC scores as a result of treatment. Thus, separate *t*-tests for repeated measures were performed on pre- to posttest scores for both the completers and dropout groups. Results showed that *LOC posttest scores in both completers and dropouts declined significantly from pretests* (85.57 to 76.05 for completers; 104.1 to 68.4 for dropouts). A t-test showed that the posttest scores of the two groups did not differ significantly. *Thus, all those who participated in the program showed a significant and substantial shift to a more internal locus of control.* Those who did not complete the program showed the largest shift in scores, but it was not significantly different from the shift in completers.

Life Purpose Questionnaire. The mean LPQ score of all program participants on program entry was 11.22 and was 12.29 at the posttest. A *t*-test showed this change to approach significance ($t_{26} = 1.54$; $p = .136$). Thus, *program participants have an enhanced, but not statistically significant, perceived purpose in life as a result of treatment participation.*

To assess differences in LPQ scores between completers and dropouts, a series of analyses were performed. At treatment initiation, LPQ scores for completers (12.0) and noncompleters (9.5) were not statistically different due to high variability ($t_{30} = 1.54$; $p = .133$). However, at face value, it appears that completers tend to enter the program with slightly more perceived purpose in life. At the time of the posttest, *the completers* (mean=13.0) *showed a nonsignificant increase in LPQ scores while the dropouts showed no change* (mean=9.0). However, the *completers showed significantly higher posttest scores than the noncompleters* ($t_{26} = 2.36$; $p = .026$). Thus, *program completers showed desirable increases in LPQ scores from pre- to posttest, and completers showed significantly higher LPQ posttest scores than dropouts.*

To assess the relationship between LPQ scores and time spent in the program, two Pearson correlations were performed. The first related the total days each client participated in the program to the client's LPQ pretest score. Results were significant ($r_{31} = .622$; $p = .000$) indicating that *those with higher LPQ scores at program entry tended to remain in the program for longer periods.* The correlation between days in program and LPQ posttest scores approached significance ($r_{27} = .302$; $p = .126$). Thus, *high LPQ scores at the time of program entry significantly predict a client's subsequent time in program. In addition, time in program tends to result in enhanced life purpose scores.*

Short Sensation Seeking Scale. To assess the effects of program participation on SSS scores, several *t*-tests were performed. The first evaluated pre- to posttest SSS scores. Results showed that *pre- to posttest SSS scores for all participants showed a slight decline but were essentially identical* (5.27 vs. 5.11). In addition, when *t*-tests were performed between completers and noncompleters, *there were no significant differences between the groups.* Interestingly, program completers had slightly higher but nonsignificant sensation seeking scores at both the pretest (completers = 5.48 versus dropouts = 4.8) and posttest (completers = 5.22 versus dropouts = 4.6). None of the correlations with sensation seeking scores and days spent in the program approached significance.

Multidimensional Scale of Perceived Social Support. Pre- and posttest scores for all program participants on all three scales of the PSS test showed beneficial changes and were as follows: Support from "significant other" (pretest = 23.58; posttest = 25.46); Support from "family" (pretest = 24.52; posttest = 26.29); Support from "friends" (pretest = 21.18; posttest = 23.82). Three *t*-tests for repeated measures showed that the pre- to posttest changes in the "social support from family" scale was significant ($t_{27} = 2.54$; $p = .017$) as was the "support from friends" change ($t_{27} = 2.41$; $p = .023$). The pre- to posttest change in support from "significant other" scale approached significance ($t_{27} = 1.85$; $p = .075$). Thus, *participants had significant increases in support from family and a significant other over the course of treatment as well as a nearly significant increase in support from friends.* Additional analyses were performed to investigate possible differences between program completers and dropouts. Results showed no significant differences. Thus, program participation appears to enhance the overall support system of all program clients.

To assess the effects of time in program to changes in PSS scores, three Pearson correlations were performed. Correlations were performed between days in program and posttest scores on each of the three scales of the PSS. None of these were significant.

Defining Issues Test. A total of eight *t*-tests 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) and the A scale. None of these were statistically significant nor did any approach significance. Inspection of scale means showed that DIT scales 2, 3, and M decreased from pretest to posttest, while scales 4 and 6 showed increases. All of these are desirable changes and are consistent with changes seen in other participating in MRT.

POSIT Scores. The pretreatment mean on the POSIT for all participants was 87.09 as compared to 66.15 on the posttest. A t-test for repeated measures showed this change to be statistically significant ($t_{26} = 4.57$; $p = .000$). *Thus, participants tended to show a high level of problems upon program entry. By the time of the posttest, however, participants showed a significant decline in problem areas. In summary, participation in the program resulted in a significant relief of overall problem areas.*

To assess differences between program completers and dropouts, a series of analyses were performed. Pre- and posttreatment means on the POSIT were as follows: Completers pretreatment = 89.91; Dropouts pretreatment = 80.60; Completers posttreatment = 63.77; Dropouts posttreatment = 76.6). Thus, those who complete the program tend to have high problem levels at the time of entry and experience the largest decline in problems at the time of treatment termination. Due to high variability and low cell frequencies, however, these differences were not statistically significant. The correlations

between POSIT scores and other variables were not significant. However, as related in the prior paragraph, as a result of treatment, significant relief of all participants' problem areas occurred from pre- to posttest.

Summary and Discussion

Results from this study reveal a program that produces a host of beneficial and desirable changes in participants. Program participants have a significant shift in locus of control scores from the external side to a more internal locus. In practical terms, clients tend to enter the program with feelings of helplessness and the belief that there is little they can do to change their destiny. After program participation, these clients show significantly less helplessness and shift to beliefs that they can control—to some extent—their lives. This change would predict more responsible behavior as well as producing long-term efforts to change one's life for the better.

In addition, participants enter the program with a perception of having extensive problem areas in their lives. As a result of treatment, participants show significantly less problem areas. In fact, those who complete the program enter with more problems than do eventual dropouts. Thus, something within the program appears to reduce their overall perception of problems providing significant relief. Perhaps related to this finding are the three beneficial changes observed in clients' perceived social support as a consequence of program participation. Clients tend to show significantly higher levels of support from family, a significant other, and from friends as a result of program participation.

Other results show that the clientele who enter the program have strong antisocial tendencies at the time of entry as well as typical moral reasoning employed by teenagers. When these two variables are combined, acting out tends to occur frequently. The program does appear to be both reducing sensation seeking (antisocial tendencies) as well as enhancing moral reasoning in desirable ways. Such personality characteristics are extremely difficult to change and the average time clients spend in the program (151 days) may be insufficient. In sum, the WHYDC therapeutic community is clearly impacting its clients for the better as revealed by the results of pre- and posttest measures. The program is effective in both retaining clients as well as producing beneficial changes in participants.

References

Hablas, R., & Hutzell, R. R. (1982) The Life Purpose Questionnaire. In: S. A. Wayrytko (Ed.) *Analecta Frankliana.*

Little, G. L. (2002) Comprehensive review of MRT outcome research. Originally published in *Addictive Behaviors Treatment Review* (1999), revised: www.moral-reconation-therapy.com.

Pugh, D. N. (1994) Revision and further assessment of the prison locus of control scale. *Psychological Reports*, 74, 979-986.

Rest, J. R. (1986) *Manual for the Defining Issues Test.* Minneapolis, MN: Univ. of Minnesota Center for Ethical Studies.

Wexler, H.K., DeLeon, G., Thomas, G., Kressel, D., & Peters, J. (1999) The Amity Prison TC Evaluation: Reincarceration outcomes. *Criminal Justice and Behavior*, 26, 147-167.

Zimet, G. D., Dahlem, N. W., Zimet, S. G., & Farley, G. K. (1998) The multidimensional scale of perceived social support. *Journal of Personality Assessment*, 52, 30-41.

Zuckerman, M. (1984) Experience and desire: A new formula for sensation seeking scales. *Journal of Behavioral Assessment*, 2, 101-114.

NIDA Therapeutic Community Research Report Available Online

A 12-page PDF downloadable research report on Therapeutic Communities (TC) was issued by NIDA in August 2002. The report answers questions about TCs including: What is a TC; How beneficial are TCs; Who is treated in TCs; What is the typical length of stay; What are the fundamental components; How are TCs structured; How is treatment provided; and Can TCs be modified?

The report states, "The therapeutic community (TC) for the treatment of drug abuse and addiction has existed for about 40 years. In general, TCs are drug-free residential settings that use a hierarchical model with treatment stages that reflect increased levels of personal and social responsibility. Peer influence, mediated through a variety of group processes, is used to help individuals learn and assimilate social norms and develop more effective social skills. TCs differ from other treatment approaches principally in their use of the community, comprising treatment staff and those in recovery, as key agents of change. This approach is often referred to as "community as method." TC members interact in structured and unstructured ways to influence attitudes, perceptions, and behaviors associated with drug use." (www.drugabuse.gov)

SRT™ SCHOOL CURRICULUM TRAINING

CCI offers a school curriculum for at-risk youth entitled: ***Social Responsibility Training***™ (SRT™). 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™

Educators can utilize the *Social Responsibility Training*™ Curriculum upon completion of a three-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 three-day training is $ 450.

Upcoming training dates date are below:

June 4-6, Durango, CO
August 6-8, Stephens County, GA

Please call 901-360-1564 for information about upcoming trainings.

Comparison of Post-Treatment Recidivism Rates Between The NIC's *Thinking for a Change* Program and MRT®

Gregory L. Little
Advanced Training Associates

The *Thinking for a Change* program was developed by the National Institute of Corrections (NIC) as a cognitive behavioral program resource and designed to be employed within probation, parole, and prison settings. The program has been widely utilized since 1997, but until recently virtually no outcome data has been published on it. Its wide implementation, prior to any assessments on its effectiveness, is attributable to its low cost. The program consists of 22 group sessions with each group lasting two hours and programs can copy needed materials.

In 2002, Lori Golden, Ph.D., of the University of Texas Southwestern Medical Center at Dallas, published the first outcome evaluation of *Thinking for a Change*. The dissertation, titled "Evaluation of the Efficacy of a Cognitive Behavioral Program for Offenders on Probation: Thinking for a Change," focused on the program implementation with probationers in Dallas County.

In contrast, Moral Reconation Therapy (MRT®) was first employed in 1986 in a prison-based Therapeutic Community. After a few years of outcome research and refinements, the program was applied to repeat alcohol offenders and then to probationers and other criminal justice populations. MRT is conducted in groups; however, since each participant works at his or her own pace, the number of sessions is not fixed. In general, clients take between 12 to 30 sessions to complete it. Currently, 85 published outcome reports exist on the effects of MRT (Little, 2003). These studies include results from nearly 17,000 treated individuals and 74,000 controls.

Golden's (2002) *Thinking for a Change* Study

Golden obtained the demographics and outcomes of 142 male and female probationers who were required to participate in the *Thinking for a Change* program in Dallas County. Of the 142 participants, 100 were male. Clients averaged 27 years of age with 71% described as African-American. A matched comparison group was formed from probationers who met all the criteria for participating in the program, but who were not referred to it.

Recidivism. A sample of 120 program participants was used to assess the effects of the program on recidivism. No explanation was made as to why only 86% of participants were used in the recidivism study or how they were chosen. Rearrest data was collected at three months or one-year after program completion. Program completers showed a 13.2% rearrest rate for new crimes; dropouts showed an 18.2% rearrest rate. The matched comparison group showed a 20% rearrest rate. Statistical analyses showed no significant differences between any of the groups. The recidivism rate of all participants in the *Thinking for a Change* group was 15.1% while the comparison group recidivism rate was 20%. This difference was also nonsignificant.

Comparing MRT-Treated Probationers and Parolee's Recidivism to *Thinking for a Change*

At least 10 outcome studies have been published on the effects of MRT on probationers and parolees, however, in many of those reports participants were assigned to MRT *because* of technical violations or specialized substance abuse treatment needs. To date, three studies have been performed on MRT-treated probationers and parolees that included matched comparison groups similar to the procedure utilized in Golden's report as well as employing a similar time frame for collecting recidivism. However, the vast majority of MRT outcome research has compared all those treated by MRT (whether clients completed or dropped out) to nontreated controls.

In a university-based study, Burnett (1997) matched two groups of 30 parolees in Washington state parole field offices and assigned one group to MRT and the other to standard supervision. After 7 months he found a 10% rearrest rate in the MRT group and a 20% rearrest rate in the controls.

Boston (2001) evaluated a voluntary counseling program in Portland, Oregon designed to assist probationers to obtain and retain employment. The study looked at rearrests, reindictments, and reincarcerations in 68 clients who attended the program and 68 who had applied voluntarily but did not attend. Six months after entry, 3% of the treated group had rearrests compared to 12% of controls.

In the most recent study, Anderson (2002) compared the one-year rearrest rates of 1,503 high-risk parolees assigned to MRT to 871 parolees in a matched control group in Illinois. Results showed that the MRT-treated group showed significantly fewer rearrests (10% in the MRT group; 33% in the comparisons).

Combining the participants and data in these studies produces an MRT-treated group of 1601 and a matched comparison group of 969. All MRT-treated participants (including dropouts and program completers) showed a 9.7% rearrest rate. The comparison group showed a 31% rearrest rate.

Since rearrest rates in the MRT studies were collected over longer time periods than that employed in the Golden study and the MRT studies included parolees, the most appropriate way to compare outcomes from the two treatment methods is to calculate a relative difference between treated and nontreated groups. For example, the relative difference between a 5% recidivism rate and a 10% recidivism rate is 50%. (That is, 5 is half, or 50%, of 10.) In relative terms, the MRT group showed 69% fewer rearrests than comparisons. By contrast, all *Thinking for a Change* participants showed a 15.1% rearrest rate as compared to 20% for the comparison group. In relative terms,

the *Thinking for a Change* participants showed 24.5% fewer rearrests than comparisons. In summary, the lowered relative rearrest rate in MRT participants (69%) is dramatically better than the *Thinking for a Change* rate (24.5%).

References

Anderson, J. (2002) Overview of the Illinois DOC high-risk parolee re-entry program and 3-year recidivism outcomes of program participants. *Cognitive-Behavioral Treatment Review*, 11 (1/2), 4-5.

Boston, C. M. (2001) Changing offenders behavior: evaluating Moral Reconation Therapy in the Better People Program. *Cognitive-Behavioral Treatment Review*, 10, 1/2, 12-13.

Burnett, W. L. (1997) Treating post-incarcerated offenders with Moral Reconation Therapy: a one-year recidivism study. *Cognitive Behavioral Treatment Review*, 6 (3/4), 2.

Golden, L. (2002) Evaluation of the efficacy of a cognitive behavioral program for offenders on probation: *Thinking for a Change*. Dissertation: University of Texas Southwestern Medical Center at Dallas.

Outcome Data for the Adult Drug Court in Las Cruces, NM.

Mark L. Whitehead, Ph.D.
Counseling & Recovery, Inc. • 642 S. Alameda • Las Cruces, NM 88005

Counseling & Recovery, Inc. of Las Cruces, NM provides drug treatment and other services for clients participating in the Las Cruces' Adult Drug Court. The program has been in existence since early 1995 and includes MRT in its treatment.

In October 2002 the Third Judicial District's District Attorney's office scanned both state and national databases for new arrests of drug court participants. Arrests were chosen as the most appropriate outcome variable because arrests cost money and consume the time of court and professional staff. In addition, arrests are a category of quantifiable data directly related to the mission of drug courts. Since data for control groups is difficult to obtain in drug court settings, we chose the arrest rates of several groups of offenders for the purposes of comparison. However, there are few reliable measures of the recidivism rates of DWI and other drug-related offenders, which match our specific demographics. In addition, the statistics of the population of offenders we are reporting on may now be skewed due to the amount of treatment, which is currently mandated.

For purposes of the present report, New Mexico's statewide DWI recidivism rates (from 1992 to 1997) were utilized as a comparison statistic. The reason these were chosen is that in 1992 few DWI and drug offenders were being mandated into treatment and the data represents a "pure" group that is minimally affected by mandated treatment. This group of nontreated DWIs in New Mexico was comprised of approximately 70% first offender DWIs and 30% multiple-offenders. The drug court treatment program accepts only multiple DWIs and drug related offenders, further skewing the

— Continued on next page —

Las Cruces Drug Court—continued.

comparison data. Additionally, it took approximately 9 months from arrest to program entry and the graduates completed the program in approximately a year. The graduates were, on average, 21 months past their entry arrest when they left the program.

Results

The following rearrest data was collected on 146 drug court graduates during the month of October 2002. It covers three years of client exit dates from September 1999 through September 2002. Of the program graduates, 10 percent had been rearrested over the initial 18-month period of the study. By contrast, DWI offenders not participating in drug courts show a 15.7 percent rearrest rate at 18 months following their initial arrest. Thus, at the 18-month follow-up period, drug court treatment cut the expected rearrest rate by just over one-third (36.3%). At the 45-month rearrest data collection follow-up, only 11 percent of graduates had been rearrested. Statewide DWI rearrest data showed that between 19 months to 48 months after their release, 35.9% of nontreated offenders are rearrested.

Cutting Edge Research Notes

Psychopharmacology

Buprenorphine Approved for Physician Dispe -Door Opening for Medical of Narcotic Addiction

In October 2002 he FDA approved the use of buprenorphine as an opiate addiction replacement medication that will be available for physician prescription. Buprenorphine has been in long-term testing by NIDA and has been used in the treatment of over 2400 patients. By January 2003, over 2000 physicians had become qualified to dispense the medication that may well replace methadone in many treatment settings. Buprenorphine is reported to have a high safety margin and is not believed to have much potential for abuse. The drug blocks the effects of heroin, reduces cravings for heroin and other opiates, and prevents withdrawal symptoms. (Source: *NIDA Notes*, January 2003)

Solvent Abusers Show More Brain Abnormalities and Cognitive Impairments Than Cocaine Abusers

A study at the Univ. of Colorado Health Sciences Center in Denver was recently conducted to compare the brain abnormalities in cocaine abusers to those who abuse volatile solvents such as paint thinners and correction fluids. 55 inhalant abusers and 51 cocaine abusers were compared in various cognitive tests and MRI scans. Both groups performed on tests well below nonabusers in cognitive tests such as short-term memory, delayed recall, and executive cognitive functioning. However, the inhalant abusers performed more poorly than the cocaine abusers on many tests. In addition, both groups showed MRI abnormalities in the Basal Ganglia, Cerebellum, Pons, and Thalamus regions of the brain. However, while 25.5% of the cocaine abusers showed such abnormalities, an astonishing 44% of the solvent abusers displayed MRI abnormalities. (Source: *NIDA Notes*, November 2002)

Does Grouping High-Risk Youths for Prevention Increase Problem Behavior?

NIDA Notes (January 2003, 17[3]) published a caution on the grouping of high-risk adolescents in certain prevention programs. A NIDA-funded study at the Univ. of Oregon grouped high-risk 11- to 14-year-olds in a 12-week program designed to reduce problem behaviors. The study found that the program actually increased levels of self-reported smoking and teacher-reported delinquency over a 3-year period. The study discussed the findings as probably being caused by negative peer dynamics within the high-risk clients as well as the program format. The program, called "Adolescent Transitions Program" (ATP), was applied to a group chosen from 158 at-risk youths. The researchers termed the negative effects observed in the ATP program as the result of "deviancy training."

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

May 12-16, 2003; MRT in Memphis, Tennessee
June 9-12, 2003; MRT in Buffalo, NY
June 17-20, 2003; MRT in Olympia, Washington
June 23-27, 2003; MRT in Memphis, Tennessee
July 7-10, 2003; MRT in Idaho Falls, Idaho
August 25-29, 2003; MRT in Memphis, Tennessee
September 22-26, 2003; MRT in Memphis, Tennessee
September 23-26, 2003; MRT in Kamloops, BC, Canada
October 20-24, 2003; MRT in Memphis, Tennessee
November 17-21, 2003; MRT in Memphis, Tennessee

July 14-18, 2003 Domestic Violence 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 to 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.

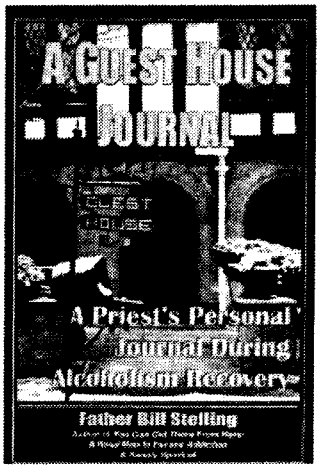
- ✱ Parent Values
- ✱ Parenting Young Children
- ✱ Values In Children
- ✱ Handling Children's Problems
- ✱ Parenting Adolescents & Teens
- ✱ Problems In Adolescents & Teens
- ✱ The Healthy Family

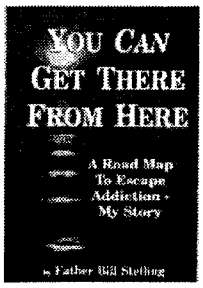
- Parents of Delinquents
- Offenders With Children
- Substance Abusers With Children
- Parents Experiencing Problems
- Parents Seeking Understanding

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.





85 pages, softcover, $8.95

NEW

181 pages, softcover, $14.95

See page 19 for order details

CBTR Literature Reviews

Personality and Executive Functioning as Risk Factors in Recidivists by P. M. Valliant, A. Freeston, D. Pottier, & R. Kosmyna. *Psychological Reports* (2003), 92, 299-306.

Twenty-four inmates in a Canadian jail were classified as recidivists (n=12) or nonrecidivists (n=12). Recidivists were defined as those who had committed two or more adjucated criminal offenses. Nonrecidivists were defined as those who had committed one adjucated criminal offense with no record of any other offenses. An additional nonoffenders' control group (n=15) was formed from undergraduate psychology students at a local university.

A battery of tests was administered to all subjects. The tests were the MMPI, the Violence Risk Scale, the Coopersmith Self-Esteem Inventory, and the Wisconsin Card Sorting Task. The Wisconsin Card Sorting Task is designed to assess "executive functioning." It is a measure of prefrontal lobe damage and prefrontal functioning. The prefrontal lobe is associated with inhibitions, planning, and impulse control.

Results showed that the nonrecidivist group scored significantly higher in the MMPI scale Hypochondriasis than did nonoffenders. Both offender groups scored significantly higher on the MMPI scale Psychopathic Deviate than the nonoffenders. In addition, the recidivist offender group scored significantly higher than the nonoffenders on the MMPI scale Hypomania. Scores on the Violence Risk Scale showed significant differences among all three groups. Recidivists were significantly higher than nonrecidivists who were, in turn, significantly higher than nonoffenders. Scores on the Wisconsin Card Sorting Task showed that the nonoffender group had a significantly lower percent of perseverative responses (errors) than recidivists. No differences were found in the Coopersmith Self-Esteem Inventory.

A stepwise multiple discriminant analysis subsequently placed 86.8% of the study's participants into the correct group. One of the most important issues discussed in the study is the implication seen in prefrontal lobe damage and functioning. Other research has indicated that offender populations have lower prefrontal lobe functioning than do nonoffenders, and the present study confirms this finding. In brief, offenders tend to "act before they think of the consequences." Individuals with lower prefrontal lobe functioning tend be impulsive and display poor judgment and little planning resulting in "bad decisions and poor choices."

Patterns and Correlates of Substance Use Among American Indians in Washington State by S. Akins, C. Mosher, T. Rotolo, & R. Griffin. *Journal of Drug Issues* (2003), 33, 45-72.

A household sample of nearly 7,000 adult residents of Washington state was collected on the use of drugs and alcohol. The individuals in the study were classified into five racial/ethnic groups with a special emphasis placed on Native Americans. Native Americans showed the following "lifetime use" of various drugs: alcohol, 94.4%; marihuana, 48.6%; stimulants, 29.2%; hallucinogens, 20.8%; cocaine, 17.4%; sedatives, 5.6%. Native Americans reported higher lifetime usage for those drugs than any other racial category. Current usage of drugs and alcohol reported by Native Americans was similar (or lower than) other racial categories' reported levels. Other analyses showed that Native Americans were the most likely to have drug usage disorders, however, it may well be that the Native American population in the study was essentially more open and honest than other racial groups.

Psychopathy and Treatment Response in Incarcerated Substance Abusers by H. J. Richards, J. O. Casey, & S. W. Lucente. *Criminal Justice and Behavior* (2003), 30, 251-276.

Female offenders participating in a substance abuse program during their incarceration in a Maryland prison were assessed for psychopathy using the PCL-R or PCL:SV (short version). A total of 404 females participated with their mean age 35.2 years; 64% were African-American. Following screening with the two psychopathy instruments, participants were randomly (with seven exceptions) assigned into three groups: a therapeutic community (TC); a dedicated housing unit utilizing Heuristic Systems (each client receives an Addiction Treatment Guide and counseling) (HD); or Heuristic Systems without dedicated housing (HND). Over the course of treatment and after release, participants were assessed in several areas. These areas included institutional infractions, urinalysis, attendance, therapist ratings, and recidivism.

Initial analyses indicated that the HND group showed significantly higher psychopathy scores, however, this was the unit where the seven client exceptions to randomization were assigned. Psychopathy scores on all participants were significantly associated with higher numbers of institutional infractions and the psychopathic characteristics of superficiality, grandiosity, and shallow affect were related to drop out status (with some group difference discussed below). In addition, those with higher psychopathic scores had a significantly higher level of "inability" to provide urine samples for testing.

Recidivism data was collected on 239 participants who had at least 90 days in treatment after an average of 14 months of release time. Psychopathy scores did not correlate with rearrests; 27.9% were charged with new crimes during this period. Contrary to predictions, higher psychopathy scores were related to higher attendance in the HD condition, but in the other direction for HND group. The authors suggested that manipulation and subtle influences create this finding. Finally, there were no significant differences in recidivism rates among the three treatment conditions.

New Program Training Set for Early 2004 —Designed to Provide "Transformational" Experience— Trained MRT Facilitators Especially Encouraged to Attend

In January or February of 2004, CCI will hold the first of what is anticipated to be ongoing training sessions for counselors and others who are interested in a group method that allows personal exploration to a level far deeper than our previous methods. As trained MRT facilitators know, MRT is designed to assist individuals in the process of exploring beliefs, attitudes, and behavior as well as helping in the formation of personal goals. One of the most frequently-observed comments that has been made by those who complete MRT training is that it provided counselors with a powerful growth experience. This experience enables counselors to be revitalized in their jobs and provide clients with powerful group tools and experiences so that their primarily offender-based clients can alter the direction in their lives. However, many counselors have asked, repeatedly, for something more and something deeper to continue their growth experience. Thus, the program would be appropriate for counselors and for advanced clients.

During the past few years, CCI staff and Dr. Greg Little have discussed the possibility of creating a group process that would provide something deeper and profoundly meaningful to follow up the MRT experience. This new program, which will be conducted in a week-long session, is designed to create a safe, group-based transformational experience. It is a systematic process of exploring personal philosophy and science-based findings. Dr. Greg Little will be involved in the first training sessions.

Juvenile MRT® Workbooks

A juvenile version of *How To Escape Your Prison* is available. Programs and institutions with trained MRT facilitators may order copies of this 117 page workbook. ***Juvenile MRT*** is written on a lower reading level but retains the basic flow of MRT concepts and exercises **and is very user-friendly.** The book is appropriate for delinquents and juveniles in chemical abuse/conduct disorder programs as well as those in offender programs. Order on page 19 or call CCI at 901-360-1564.

CBTR Literature Reviews

The Validity of Arrestees' Self-Reports: Variations Across Questions and Persons by A. Golub, B. D. Johnson, A. Taylor, & H. J. Liberty. *Justice Quarterly* (2002), 19, 477-502.

Self-report measures were collected from 892 New York arrestees and compared to urinalysis test results and official criminal records to assess the degree to which self-reports are deceptive. This is an important question since self-reports form the basis of many screening tools and treatment needs assessments. Prior research utilizing hair test results has shown that both adult and juvenile offenders seriously under report drug use.

The sample in the present study included 63% African-American, 25% Hispanic, and 11% White with the mean age 32 years. All subjects completed the ADAM-initiated interview and submitted to urinalysis via the EMIT system. There was wide variation in the accurate disclosure rates of items ranging between 5% and 85%. 85% accurately disclosed that they had been arrested (ever) in the past, 78% accurately disclosed arrests in the past 6 months, 76% accurately disclosed prior jail time, 78% accurately disclosed a prior prison sentence, and 81% admitted recent use of marihuana. The accuracy rates of disclosure for prior drug arrests was 65%, recent use of cocaine or crack was 58%, and recent heroin use was 62%. Only 28% accurately disclosed prior index offenses with the following rates of specific types of index offenses: property crime 19%, robbery 22%, violent crime 5%. Interviewers were assessed on their ability to discern those who were deceptive or nondisclosing. None of the results from this analysis were significant. Another interesting finding was that those who accurately would disclose some items would not do so on other items. In brief, and in this reviewer's words, intake assessments on offenders cannot be trusted for accuracy nor can interviewers discern the accuracy of statements by offenders.

Alcoholism Treatment Outcome Studies, 1970-1998: An Expanded Look at the Nature of the Research by C. E. Swearingen, A. Moyer, & J. W. Finney. *Addictive Behaviors* (2003), 415-436.

The authors reviewed 701 alcohol treatment outcome studies released between 1970-1998 to assess trends in research. Only 14.6% of studies were conducted by females. Early studies tended to use reduced drinking as the primary outcome measure while abstinence is the current outcome focus. Behavioral and pharmacological studies are more commonplace in recent years. In particular, the use of anticraving drugs and antidepressants in modern research is quite prevalent.

HOW MRT SAVED A LIFE

LeAnne Fletcher
Clallam Bay Corrections Center, Clallam Bay, WA

The Tele-Incident Report (TIR), with names protected, reads like this:

ON 11-21-02 AT 1: 02PM 'B' UNIT BOOTH OFFICER XXX, OBSERVED OFFENDER YYY PROCEED UP THE STAIRS IN THE RED POD. OFFICER XXX GAVE SEVERAL ORDERS FOR OFFENDER YYY TO STOP, AS THE OFFENDER WAS OUT OF BOUNDS. YYY IGNORED THE OFFICER'S ORDERS AND CONTINUED TO THE TOP TIER AND BEGAN TO CLIMB THE RAILING IN FRONT OF CELL M. OFFENDER ZZZ HEARD THE COMMOTION AND EXITED HIS CELL AND OBSERVED OFFENDER YYY ON THE HANDRAIL, APPEARING TO JUMP. OFFENDER ZZZ WRAPPED HIS ARMS AROUND OFFENDER YYY AND PULLED HIM TO THE FLOOR WITH THE ASSISTANCE OF OFFENDER XY. RESPONDING STAFF THEN APPLIED HAND AND LEG RESTRAINTS TO OFFENDER YYY. OFFENDER YYY DID NOT RESIST STAFF PLACEMENT OF RESTRAINTS AND NO USE OF FORCE BY STAFF OCCURRED. OFFENDER YYY WAS ESCORTED TO CBCC HEALTH CARE UNIT AND EXAMINED AND PLACED ON SUICIDE WATCH. OFFENDERS ZZZ AND XY WERE EXAMINED BY HEALTH CARE STAFF, NO OFFENDER OR STAFF INJURIES WERE NOTED.

Normally these reports are not all that common within the Department, but when you read carefully you see that an offender decided to get involved and help out another distressed inmate, then this report become more meaningful and interesting. After Associate Superintendent Kathy Kaatz read this TIR, she went to the unit to thank inmates ZZZ and XY for their action and assistance in saving the suicidal inmate's life. Inmate ZZZ stated that if he had not completed MRT, he would have stood there and watched the inmate jump, shrugged his shoulders and walked away. He stated it was only because of what he learned in that program that made him wrap his arms around the inmate and pull him off the rail to the floor.

I also interviewed this inmate, as this was definitely an indication that MRT really does influence an individual. As I sat down with inmate ZZZ I asked him why he had attended the MRT class in the first place. He stated that it was part of his transition plan from IMS, and that MRT was mandatory. He would not have taken this class if it weren't mandatory. Once he began the program he saw an opportunity to "Open myself to being honest and apply it to my life." I asked him what MRT meant to him, and he replied "To help my peers, the ones in need. You do something that is right. It has to come from the heart." ZZZ stated that he saw someone who needed his help and so he helped. He also stated that he might have subjected himself to some ridicule as in the facility the code is to only help yourself, "Kindness in the world (prison) is forbidden and seen as weakness." But ZZZ said he had to do what was right regardless of what other offenders think. "Physical courage is a reflection of moral courage".

ZZZ does not think of himself as a hero or even want recognition for the act of kindness he showed. He does want recognition for the facilitator of the MRT class he attended, Barbara Watt-Asin. He said that her style of teaching MRT is what made him do what he did.

COGNITIVE BEHAVIORAL MATERIALS AVAILABLE FROM CCI

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

The Punishment Myth—Understanding the criminal mind and when and why conventional wisdom fails. 8.5 x 11 softcover by Dennis A. Challeen, J. D. and Ken Robinson. $20.00.

Rules Are Made to be Followed—16 page, 4-session workbook designed to be used with underage drinkers and false ID users.$10.00.

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. 1 — 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
The Punishment Myth	$20.00		
Rules Are Made to be Followed (Workbook)	$10.00		
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	$105.00		
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: _____

Agency: _____

Address: _____

City/State/Zip: _____

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 treat-ment-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

May 12-16, 2003; MRT in Memphis, Tennessee
June 9-12, 2003; MRT in Buffalo, NY
June 17-20, 2003; MRT in Olympia, Washington
June 23-27, 2003; MRT in Memphis, Tennessee
July 7-10, 2003; MRT in Idaho Falls, Idaho
August 25-29, 2003; MRT in Memphis, Tennessee
September 22-26, 2003; MRT in Memphis, Tennessee
September 23-26, 2003; MRT in Kamloops, BC, Canada
October 20-24, 2003; MRT in Memphis, Tennessee
November 17-21, 2003; MRT in Memphis, Tennessee

July 14-18, 2003 Domestic Violence in Memphis, Tennessee

CBTR
3155 Hickory Hill
Suite 104
Memphis, TN
38115