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Cognitive-Behavioral Treatment of Offenders: A Comprehensive Ten-Year Review of MRT® Outcome Research- Part 1

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Summary — Outcome research frm 65 published reports investigating the effects of MRT on offender populations are reviewed. These reports include 13,498 MRT-treated individuals and 72,384 individuals forming control and comparison groups. Twenty-eight studies have evaluated the effect of MRT on inmate recidivism. All of these found that MRT leads to lower rearrest and reincarceration rates for time periods up to a full 10 years after treatment and release. Other outcome research consistently indicates that MRT leads to reduced disciplinary problems in participants. Perhaps the most significant research resulted from an independent cost-benefit analysis from Washington State showing that MRT produces the greatest cost-benefit savings of any offender treatment. For each $1 spent on MRT treatment, the cost savings in criminal justice related costs was $11.48. The next best program (job placement) showed a savings of $4.

Moral Reconation Therapy (MRT®) is a systematic, cognitive-behavioral treatment system initially designed to be utilized within a prison-based drug treatment therapeutic community. The first published report on MRT appeared in 1988 (Little & Robinson, 1988), however, the initial implementation of the method occurred in 1986. The system was federally trademarked in the early 1990's and all of its workbooks and materials are copyrighted. Correctional Counseling, Inc. of Memphis, TN holds an exclusive contract for the sales and distribution of MRT materials.

While the approach was first designed as a criminal justice-based drug treatment method, a host of other treatment adaptations have been made. These

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include DWI treatment, domestic violence, educational uses, and various problem-specific materials. MRT programs utilize workbooks designed for the specific type of client and particular program characteristics. Programs utilizing MRT typically use counselors or teachers as MRT group facilitators after a 32 hour training in the method. MRT is conducted in open-ended, ongoing groups where participants present a series of homework assignments outlined in the specific MRT workbook utilized. Depending on the program's focus and purpose, MRT groups meet a minimum of once per month to 5 times per week. For example, some probation programs may meet monthly while prison-based therapeutic communities may meet each weekday. MRT groups often meet twice weekly for about 1.5 hours per meeting. Group sizes vary from 5-6 clients to some groups with 20 members. Facilitators of MRT groups maintain a focus on clients completing and presenting MRT steps or modules in the group and decide on the suitability of a client's work based on objective criteria outlined in MRT training. A group begins with clients on the lowest program step or module presenting their work first and sequentially progressing through clients on higher steps. Each group is designed to allow all participants the opportunity to present his or her step materials. As a client completes the program, a new client is entered. Thus, participants work at their own pace and are exposed to both beginning and advanced participants in each group.

Background & Assumptions

MRT is based, in part, upon the assumption that offenders and drug abusers have relatively low moral reasoning as defined by Kohlberg's theory (Kohlberg, 1980). The moral component of MRT seeks to increase participants' reasoning levels from hedonistic, self-centered concerns to levels that involve concern for the welfare of others. In general, it is assumed that drug usage is mediated by pleasure/pain-based hedonism and many decisions made by offenders are based upon seeking pleasure, avoiding pain, manipulating others for personal gain, and seeking approval from others who may be able to provide rewards. Higher reasoning levels based upon societal rules and laws, social responsibility, and conscience are rarely observed in these clients.

The term *reconation* is derived from *conation*: "the aspect of personality characterized by a conscious willing..." (Wolman, 1973). Conation was a popular term in psychology until ego processes and cognitive terminology gradually replaced it. Reconation implies that the method attempts to facilitate a change in the client's process of conscious decision-making. Thus, MRT seeks to increase a client's awareness of decision-making and to enhance appropriate behavior through development of higher moral reasoning.

As a cognitive-behavioral approach, MRT assumes that clients have a host of faulty beliefs. Faulty beliefs are addressed in each MRT step and through various program exercises.

MRT Research

MRT outcome research has been published since 1988. The present author has been involved in a substantial amount of this research as well as assisting in the implementation of the method in numerous states. MRT is currently in use in over 40 states. Since the initial publication on MRT, the present author has collected virtually all of the published material on the method. A 1999 summary of MRT (Little & Robinson, 1999) prepared for a law-oriented journal stated that over 60 outcome studies on MRT had been published with data coming from approximately 20,000 treated subjects and 65,000 non-treated controls.

MRT outcome data has evaluated completion rates and treatment attrition, changes in moral reasoning, a host of personality characteristics, client compliance and disciplinary infractions, completion of work release status, employment, and recidivism. Recidivism data on MRT-treated offenders has come from prisons, jails, parole and probation, community corrections, drug courts, juvenile programs, and domestic violence treatment programs. In addition, several cost-effectiveness reports have been published. Each of these areas is addressed separately. It should be noted that some reports cited contained similar data published in different venues. In tables, these are signified with an asterisk (*) after the reference. In most of these duplicated reports, some type of additional finding was reported. Data is presented from the most extensive and detailed report.

A total of 65 published reports are included in this review. The primary criteria for inclusion herein was that objective outcome data was collected on treated subjects and that an appropriate comparison group was included if available. For some research (e.g. personality variable changes as a consequence of treatment), it was required that both pretest and posttest data was obtained and reported. Reports were only included if officially published by a governmental body, journal, or in a compendium of research typically published by an association. Approximately 40 other published papers, articles, and reports on MRT were not included because they only concerned program information on implementation or did not contain outcome data. These studies are not included in the references however, the 65 that did meet the criteria are referenced.

MRT Effects Upon Misconducts (Disciplinary Infractions) in Prison, Parole, & Probation

One of the most important outcomes in criminal justice treatment is the effect of program participation on offender conduct within the criminal justice system. Seven studies have addressed the effect of MRT on disciplinary infractions and misconducts after offenders enter (and/or complete) treatment. Table 1 summarizes these results. Hobler (1995) reported on the post-MRT rules violation rate of 138 Delaware life skills participants compared to 21 controls. MRT participants showed a violation rate (15.7%) only half that of appropriate controls (33.3%).

In two related reports (Brame, MacKenzie, Waggoner, & Robinson, 1996; MacKenzie, Brame, Waggoner, & Robinson, 1995), offender misconduct reports were analyzed in 2,721 MRT participants in Oklahoma Department of Correction prisons and compared to 9,896 inmates in other DOC programs. MRT participants showed significantly fewer misconducts than all inmates and significantly fewer misconducts in comparison to other program participants. The relative misconduct rate of MRT participants was 28% lower than other inmates. MRT graduates showed a 40% lower misconduct rate. These studies also analyzed misconduct rates in 2,865 MRT participants on probation compared to 40,904 other probationers. MRT completers showed a statistically significant misconduct rate 40% lower than other probationers. All MRT participants showed a 7% lower misconduct rate as compared to others.

Grandberry (1998) evaluated misconducts in 109 MRT participants in Washington state's parole/probation community corrections program and compared it to 101 controls. Results were difficult to interpret because many MRT participants were entered into the program because of a misconduct and need for treatment. Results showed that MRT completers had a lower misconduct rate while all MRT participants had a higher misconduct rate than controls.

Sandhu (1998) reported on the results of 800 drug usage urine screens from 266 prison inmates in MRT-based drug treatment but did not have access to comparison data. Only 10 (3.8%) of the 266 inmates had a "dirty" drug screen. Of the 266 inmates, 12.8% had at least one disciplinary infraction while participating in MRT.

Lindholm (1998) performed a preliminary analysis on the pre- and post-MRT disciplinary infraction rate in 12 offenders in a Texas restitution center. These offenders were entered into MRT because of their high rate of disciplinary problems. The subjects showed a pre-MRT disciplinary infraction rate of 5 per week compared to only 1 per week post-MRT.

Black (2000) also analyzed disciplinary infractions at a different Texas restitution center. MRT was implemented in this center because of disciplinary problems. The 60 inmates in the center received 178 disciplinary infractions during a 4-month period prior to MRT. The same 4-month period after MRT implementation showed only 83 infractions.

TABLE 1
DISCIPLINARY INFRACTIONS & MRT

Reference	Site	N MRT	N cont.	Outcome
Hobler, 1995	Del. DOC	138	21	MRT violations sig. lower
Brame, MacKenzie, Waggoner, & Robinson, 1996	OK prob.	2,865	40,904	MRT group significantly lower
MacKenzie, Brame, Waggoner, & Robinson, 1995	OK DOC	2,721	9,896	MRT group significantly lower
Grandberry, 1998	WA pro/pa	109	101	MRT completers sig. lower, all MRT participants higher.
Sandhu, 1998	OK prison	266	•	3.8% had "dirty" urine screens; 12.8% had disc. infractions
Lindholm, 1998	TX Rest.	12	•	Pre-MRT rate was 5; post-MRT rate was 1.
Black, 2000	TX Rest.	60	•	Pre-MRT infractions 178; post-MRT infractions 83.

Summary. All studies on MRT's effect on disciplinary infractions with offenders housed in prisons or community corrections facilities have shown significant declines in the number and rate of infractions after MRT implementation. These studies included 6,177 MRT participants and 50,922 controls. In general, the disciplinary rate falls by 28% to 50% after MRT is implemented. Results on probation implementations of MRT are more difficult to analyze because MRT participation is often required as a result of an infraction pattern. Probationers who complete MRT consistently show a lower infraction rate, however, those who do not complete MRT generally do not.

Offender Recidivism Following MRT Treatment

By far, the most important — and most researched -outcome in the treatment of offender populations is recidivism. A total of 28 studies have reported on rearrests, reconvictions, and reincarceration of treated offenders after MRT participation. Table 2 summarizes these results.

Fourteen studies have been published on the recidivism of MRT-treated felony drug-abusing offenders at the Shelby County Correction Center in Memphis. These studies reported on the rearrests, reincarcerations, and days of additional sentence in 1,052 male offenders at periods of 6 months to 10 years after treatment and institutional release. The initial 70 felony offenders treated with MRT while participating in the prison's TC have been studied separately over their 10 years of release. This series of reports included appropriate controls and most closely approximates an experiment with randomly assigned treatment and control groups. Figure 1 summarizes the reincarceration rates of treated and control offenders at each year from one to ten years following release. Results include reincarcerations for all offenses including misdemeanors and felonies. MRT-treated offenders showed a statistically significant lower reincarceration rate at each year of data collection. In general, MRT-treated offenders showed a reincarceration rate 25%-35% lower than nontreated controls at each data collection point from 2-10 years post-release. In the initial year of release, MRT-treated offenders showed a reincarceration rate 75% lower than controls. Other data collected on these groups have shown that treated offenders have a significantly higher rate of "clean records" (no rearrests for any offense), lower mean numbers of rearrests, and fewer days of additional sentence in those who are reconvicted of a new offense.

Four recidivism studies on MRT-treated inmates have been published from Oklahoma. Seales (1990) compared the one-year reincarceration rate of 46 MRT-treated offenders in an alternative incarceration setting (6.38%) to offenders treated in Oklahoma Department of Corrections non-MRT programs (9.6%) and all DOC inmates (14.7%). Sandhu (1998) evaluated the recidivism status of 345 offenders released from a prison-based MRT program after varying (short) amounts of time. His study showed that only 3.19% had been rearrested and reconvicted.

By far, the largest and most extensive MRT recidivism study was conducted on Oklahoma offenders (Brame, MacKenzie, Waggoner, & Robinson, 1996: MacKenzie, Brame, Waggoner, & Robinson, 1995). This unique analysis looked at the relative rate of a "recidivism incident" (rearrest, violation, etc.) during each 30 day period following offenders' release from prison. The study included 2,814 MRT participants and 5,222 participants in other DOC programs. An analysis showed that inmates participating in MRT showed the highest risk for recidivism prior to MRT participation (nearly double the risk). This result can be interpreted as meaning inmates with the most severe problems were placed into MRT. Offenders who subsequently participated in MRT then showed a significant and substantial decline in recidivism risk (declining by 75% from the expected rate). In addition, the MRT participants showed a recidivism rate significantly lower (40%) of that found in all other DOC programs. Subsequent analyses showed that offenders completing MRT steps 3, 6, and 9 showed progressive declines in recidivism risk.

Four recidivism studies have been conducted on Delaware DOC life skills participants. Hobler (1995) cited 18-week post-release rearrest rates on 138 MRT participants compared to 21 controls. The MRT group showed a 1.4% rearrest rate compared to 9.5% for controls. Miller (1996) reported on the one-year rearrest rate of the life skills participants. An 8.1% rearrest rate in 62 males and a 0% rearrest rate for 21 females — all of whom had participated in MRT — was found to be statistically lower than the respective 34.9% and 41.2% rearrest rates for appropriate controls. In a more detailed analysis, Miller (1997) reported two-year recidivism on these subjects. Results showed a 20% rearrest rate for MRT participants and a 50% rate for controls.

Five studies have evaluated recidivism in jail inmates participating in MRT. Godwin, Stone, & Hambrock (1995) collected the 12 and 24 month rearrest rates of 98 MRT participants at the Lake County (FL) Detention Center and compared it to the rearrest rates over the same time period in 5,119 nontreated jail inmates. Both 12 and 24-month MRT rearrest rates were significantly lower than that in controls. The one year MRT rearrest rate was 11.25% compared to 29.7% for controls; the two year MRT rearrest rate was 25.3% compared to 37.4% for controls.

In a series of reports, Krueger (1993, 1995, 1996, 1997) tracked rearrests of MRT-participating inmates at the Wayne County (Ohio) jail. The initial report indicated that the program had become popular with inmates and that a waiting list quickly formed. Subsequent studies compared the one, two, three, four and five year rearrest rates of participants to all jail inmates and a small group of randomly chosen controls. A total of 401 MRT participants showed a one-year rearrest rate of 7.8% of 82 MRT participants had been released for 5 years at the time of the latest study. These participants showed a 62% rearrest rate over all 5 years as compared to a 95% rate for controls.

Summary. All of the MRT-treated inmate recidivism studies making comparisons to control groups or inmate populations have found that MRT participants consistently show significantly lower recidivism. These reports have come from prisons and jails using MRT in several states and locations. Several of these large reports resulted from independent evaluations funded by specialized federal grants. A compilation of recidivism data on treated inmates shows that 4,973 individuals were included and compared to a total of 17,773

TABLE 2
DRUG OFFENDER RECIDIVISM & MRT

Reference	Site	N MRT	N cont.	Time	Outcome
Little & Robinson, 1989a	TC	103	•	6 mo.	7.8% rein. MRT; 16% expected
Little & Robinson, 1990	TC	103	•	9 mo.	8% rein. MRT; 16% expected
Freeman, Little, Robinson, & Swan 1990	*				
Little, Robinson, & Burnette, 1991b	TC	70	82	1 yr.	24.3% MRT rein.; 36.6% cont.
Little, Robinson, & Burnette, 1992	*				
Correctional Counseling, Inc., 1992	prison	828	244	1-3 yr.	MRT gps. sig. lower at all yrs.
Robinson, & Ming, 1992	*				
Correctional Counseling, Inc., 1993a	*				
Little, Robinson, & Burnette, 1993	TC	70	82	5 yr.	37.1% MRT rein.; 54.9% cont.
Little, Robinson, & Burnette, 1994	prison	1,052	329	3.5 yr.	33.1% MRT rein.; 48.9% cont.
Robinson, 1994c	*				
Little, Robinson, Burnette, & Swan, 1995	TC	70	82	6 yr.	42.9% MRT rein.; 58.8% cont.
Little, Robinson, Burnette, & Swan, 1996	TC	70	82	7 yr.	42.9% MRT rein.; 60% cont.
Little, Robinson, Burnette, & Swan, 1999a	prison	1052	329	1-10 yr.	MRT sig. lower each year
Seales, 1990	OK	42	DOC	1 yr.	6.38% 1-year MRT rein. rate, 9.6% others.
Sandhu, 1998	OK DOC	345	•	•	3.19% reconvicted
Brame, MacKenzie, Waggoner, & Robinson, 1996	OK DOC	2,814	5,222	•	MRT treated sig. lower
MacKenzie, Brame, Waggoner, & Robinson, 1995	*				
Hobler, 1995	Del. DOC	138	21	12 wk.	MRT sig. lower
Miller, 1996	Del. DOC	83	355	12 mo.	MRT sig. lower
Miller, & Hobler, 1996	*				
Miller, 1997	Del. DOC	83	355	24 mo.	MRT sig. lower
Godwin, Stone, & Hambrock, 1995	FL Jail	98	5,119	1-2 yr.	MRT groups sig lower
Krueger, 1993	Ohio Jail	62	NA	•	3% rearrested
Krueger, 1995	Ohio Jail	221	NA	•	Number of MRT sessions corr. with low rearrests.
Krueger, 1996	Ohio Jail	309	6,727	1-4 yr.	MRT groups sig. lower 1 to 4 years.
Krueger, 1997	Ohio Jail	401	6727	1-5 yr.	MRT groups sig. lower 1-5 yr.

inmates who served as comparison controls. Several of these studies were conducted as experiments and appear to be highly reliable especially in view of the consistency and similarity of findings from studies from different locations and different investigators — including independent evaluators. The largest differences between MRT-treated inmates and nontreated controls' recidivism rates come during the first two years of observation with the treated groups showing recidivism rates at least 75% lower than controls. The years 3 to 10 after inmates' MRT treatment and release result in lower recidivism rates averaging between 25%-30%.

MRT & Drug Court Recidivism

MRT has been utilized in numerous drug court programs, however, few recidivism outcome evaluations have been published that focused on MRT's effect. Three small studies have come from a drug court in Oklahoma that utilized MRT. Anderson (1995) summarized preliminary data on the Payne County (OK) drug court program's implementation. During the court's first 18 months of operation, none of the 13 graduates reoffended. Huddleston (1996; 1997) reported on an independent study by the Oklahoma State Bureau of Investigation on the Payne County's first 48 program graduates. Only 4% of those MRT participants were rearrested and reconvicted during their initial 18 month period.

MRT & DWI Recidivism

Table 3 summarizes the 15 studies on DWI offender recidivism following MRT treatment. All of the 15 published reports on the effect of MRT treatment on DWI offenders have come from the developer's initial use of MRT on the Alcohol Treatment Unit, a specialized 40-bed treatment unit at the Shelby County Correction Center in Memphis. Little & Robinson (1989a; 1989b) initially reported a 0% rearrest rate in the first 18 released offenders after an average of 6 months of release. When the initial 115 MRT participants had been released for 6 months, a 20% rearrest rate (for any offense) was found in the treated group compared to a 27.6% rearrest rate in 65 appropriate controls. Alcohol-related charges were found in 8.7% of treated clients and 10.8% of controls. Several subsequent reports presented various aspects of this recidivism data and tracked these 115 MRT-treated DWI offenders and nontreated controls for a 10 year period after release.

Little, Robinson, & Burnette (1990) reported a 13.9% reincarceration rate for treated offenders after 18 months of release as compared to 21.5% in controls. During this time period, 61% of treated subjects showed no arrests as compared to 54% in controls. The treated group showed a 4.2% rearrest rate for new DWI offenses as compared to 15.4% in controls. After 30 months of release (Little, Robinson, & Burnette, 1991a) the treated group showed a 22.6% reincarceration rate, a 45.2% rearrest rate, and a 18.3% rearrest rate for DWI. By comparison, controls showed a 36.9% reincarceration rate, 61.5% rearrest rate, and 16.9% rearrest rate for DWI.

Additional studies tracked the recidivism of these

groups at 42 months (Little, Robinson, & Burnette, 1992; Correctional Counseling, Inc., 1993c) and for 5 years (Little, Robinson, Burnette, & Swan, 1995). Reincarceration rates for the treated DWI offenders were consistently lower than controls in all categories except DWI offenses. At all subsequent data collection points, the treated and control group's DWI rearrest rates were essentially equal.

Ten-year recidivism outcome data on the initial 115 MRT-treated DWI offenders (Little, Robinson, Burnette, & Swan 1999b) showed that the treated group had a significantly lower reincarceration rate (44.35% to 61.54%), a significantly higher percentage of "clean records" — no rearrests for any offense (25.2% to 13.8%), a lower rearrest rate for non-DWI offenses (66.1% to 73.1%), but virtually identical DWI rearrest rates (37.4% to 36.9%).

Summary. The research on these 115 MRT-treated DWI offenders and 65 controls is extensive and long-term. However, no other reports have appeared in the literature on the use of MRT on alcohol offenders. The results from the present research are promising and thought-provoking. The MRT-treated DWI offenders showed a significantly lower reincarceration rate, lower rates of arrest for non-DWI offenses, but identical DWI rearrest rates (beginning at the 30-month period). MRT did appear to reduce DWI offending for the initial two years of an offender's release, however, after that point DWI arrests reach the same level as nontreated controls. Thus, it could be concluded that MRT treatment produced a significant long-term decline in criminal behavior for everything but DWI. DWI treatment data is seldom reported and recidivism appears to be extremely high. The reluctance of alcohol treatment programs to implement MRT (or other cognitive-behavioral programs) may be due to skepticism about the usefulness of outcome data and adherence to a 12-Step (AA) treatment tradition.

TABLE 3
RECIDIVISM IN MRT-TREATED DWI OFFENDERS

Reference	Site	MRT N	Con. N	Time	Outcome
Little & Robinson, 1989a	TN	18	NA	6 mo.	0% recidivism
Little & Robinson, 1989b	TN	115	65	6 mo.	MRT 20% recid., cont. 27.6%
Little & Robinson, 1989c	*				
Little & Robinson, 1990	*				
Little, 1990	*				
Freeman, Little, Robinson, & Swan 1990	*				
Little, Robinson, & Burnette, 1990	TN	115	65	18 mo.	Treated group lower in all recidivism categories
Little, Robinson, & Burnette, 1991a	TN	115	65	30 mo.	Treated group lower in reinc., and rearrests
Little, Robinson, & Burnette, 1992	TN	115	65	42 mo.	Treated group lower in all areas
Robinson, & Ming, 1992	*				
Correctional Counseling, Inc., 1993c	*				
Robinson, 1994c	*				
Little, Robinson, Burnette, & Swan, 1995	TN	115	65	5.5 yr.	Treated group lower in all categories but DWI arrests.
Robinson, 1995	*				
Little, Robinson, Burnette, & Swan, 1999b	TN	115	65	10 yr.	MRT group sig. lower reinc., sig. higher rate of no arrests, fewer non-DWI arrests, identical rates of DWI arrests.

MRT & Recidivism in Parole/Probation

Recidivism in MRT-treated parolees and probationers has been evaluated in two locations. These studies are presented in Table 4. Two studies (MacKenzie, Brame, Waggoner, & Robinson, 1995; Brame, MacKenzie, Waggoner, & Robinson, 1996) compiled the risk of a recidivism incident in each 30 day period of all 41,087 Oklahoma probationers' probation sentences. The study evaluated the effects of all Oklahoma programs offered to probationers. The study first indicated that probationers who were referred to programs represented the highest risk offenders. Offenders assigned to MRT programming showed the highest risk of recidivism at the initiation of treatment. Results showed that 560 MRT-treated probationers displayed a significantly lowered recidivism risk following MRT participation approximating that of probationers not assigned to any programming. Offenders assigned to other probation programs (non-MRT) showed a greatly escalated recidivism risk (more than doubled). A further analysis compared the recidivism risk of a group of MRT-treated probationers who had substance abuse treatment needs (N = 430) to a group (N = 481) of probationers who had non-MRT substance abuse treatment. Results showed the MRT group's recidivism risk declined by over 60% while the nonMRT treated group actually showed an escalated recidivism risk more than double the risk expected without treatment.

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.

TABLE 4
PROBATION PAROLE RECIDIVISM IN MRT TREATED OFFENDERS

Reference	Site	N MRT	N cont.	Outcome
MacKenzie, Brame, Waggoner, & Robinson, 1995	OK	560	2588	MRT recidivism sig. lower
Brame, MacKenzie, Waggoner, & Robinson, 1996	OK	430	481	MRT recid. risk sig. lower than drug treatment, all other prog. sig. higher
Burnett, 1997	WA	30	30	MRT rec. 10%, Con. rec. 20%
Grandberry, 1998	WA	109	101	MRT 44% rearrested, 1.8 offenses on average; controls 40% rearrested 2.1 offenses on average

Grandberry (1998) compared a group of 109 Washington state community corrections offenders participating in MRT to a group of 101 demographically similar offenders not participating in MRT. Pretreatment differences in the groups were identified: the MRT group had more substance abuse problems and a much higher rate of prior probation violations indicating that the offenders referred to MRT had more preexisting behavior problems. The one-year arrest rate for the MRT group was 44% compared to 40% of controls, however, the MRT group showed an average of 1.8 arrests compared to 2.1 for controls.

Summary. Studies investigating the effects of MRT on probation/parole recidivism are few and complicated by the difficulty of forming comparable control groups. MRT has been used to treat probation/parole offenders who display problem behaviors (drug abuse, disciplinary infractions) and who are at the greatest risk for recidivism, thus, comparisons to other probationers are difficult to interpret. The studies reviewed have used 699 MRT-treated probationers and made comparisons to 3,200 other probationers. In two of the three studies, MRT-treated probationers showed significantly fewer rearrests and lower reincarceration than comparison groups. Oklahoma's extensive study found that, out of all the programs available to probationers, only MRT reduced recidivism risk. (That study also evaluated the recidivism of 2,588 probationers assigned to nonMRT programs. Participation and completion of all these other programs significantly and greatly escalated recidivism risk. This is a curious, yet important, finding.)

Cost-Effectiveness

One of the most important methods of evaluating the effectiveness of a treatment is in its cost-effectiveness. MRT has had two cost-benefit analyses. The first analysis (Correctional Counseling, Inc., 1992) was performed for Shelby County Government to evaluate the MRT implementation at the county-operated CorrectionCenter. This highly-conservative and narrow analysis was done on direct and actual costs of inmate treatment over a 3-year period, known arrest costs, and actual incarceration costs per day. No estimated benefits were included. The days of incarceration saved by treatment was calculated and added to actual arrest cost savings. The analysis showed that Shelby County saved $1.71 in inmate housing and arrest costs (over 3 years) for each $1 in MRT treatment cost.

A recent independent cost-benefit analysis was performed by the Washington State Institute for Public Policy (Aos, Phipps, Barnoski, & Lieb, 1999; Planning and Research Forum, 1999) on 18 adult offender treatment programs utilized nationally. MRT was one of the 18 programs evaluated in this extensive analysis. MRT showed the highest cost-benefit of all programs. For each $1 spent on treatment, MRT returned $11.48 in eventual criminal justice and other related costs. The second best program was job counseling/search programs for inmates leaving prisons (saving $4.00 for each $1 spent). The analysis also showed that many programs are not effective from a cost-benefit perspective.

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This is part one of a two part article. Please see next issue for the conclusion of the MRT® research review.

Article Submissions

CBTR is interested in publishing brief reports on cognitive-behavioral implementations, outcome studies, and reviews of cognitive-behavioral materials. Articles should be no more than 6 double spaced pages in length and may be submitted on IBM or MAC disk formats including Microsoft Word, Claris, and Pagemaker. Articles should be submitted to:

E. Stephen Swan, Editor, CBTR
3155 Hickory Hill • Suite 104 • Memphis, TN 38115

What is MRT®?

Moral Reconation Therapy® is a systematic, step-by-step cognitive-behavioral treatment system for offender populations. MRT is designed to alter how offenders think and how they make decisions about right and wrong. MRT:

•Addresses the unique needs of offender populations including criminologic factors, values, beliefs, behaviors and attitudes.

• Enhances ego, social, and moral growth in a step-by-step fashion.

• Develops a strong sense of personal identity with behavior and relationships based upon higher levels of moral judgement.

• Re-educates clients socially, morally and behaviorally to instill appropriate goals, motivation, and values.

• Is easy to implement in ongoing, open-ended groups with staff trained in the method.

Your staff can be trained in MRT in a week-long, state-of-the-art training. Once training is complete, your staff can implement the groups by obtaining copies of the appropriate MRT workbook for clients. Many drug courts require clients to bear the costs of workbooks and groups.

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— 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 15 years direct, behind-the-bars experience in criminal justice programming. Ms. Burnette has over 14 years direct criminal justice and substance abuse treatment experience and was involved in the initial implementation of MRT®. Mr. Swan has 25 years in counseling and correctional administration. Those interested in being licensed as exclusive providers of MRT® in regions should call Dr. Ken Robinson.

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YOUTH AND PARENTS BENEFIT FROM LAS CRUCES, NEW MEXICO JUVENILE DRUG COURT PROGRAM

By Ann Wallace, Director, 3rd Judicial District Drug Court

The Third Judicial District Court in Las Cruces, New Mexico, operates an Adult and a Juvenile Drug Court Program. During their First New Mexico Association of Drug Court Professionals meeting in Albuquerque in 1997, Dr. Ken Robinson addressed counseling among an offender population. Dr. Mark Whitehead, our Clinical Director, believed that Dr. Robinson, with the MRT approach was finally addressing an area where we were experiencing a gap within our adult offender population. After researching MRT further and speaking more with Dr. Robinson, Dr. Whitehead decided to incorporate MRT into our Drug Court group curriculum.

Dr. Whitehead began sending each of his adult counselors to MRT training; each time a counselor would return from training, they were excited and ready to begin this approach. As soon as all of the counselors were trained, including a counselor for our Spanish Speaking group, we began to include MRT within our group settings in March, 1999. Since that time we have had 56 graduates from our Adult program.

Given the successes we experienced with MRT in our Adult Program, we unanimously agreed to see how MRT would work with our Juvenile Drug Court population ranging in age from 14-18. Again, we sent our Juvenile Drug Court counselors to MRT training, and in June 1999 we incorporated MRT into our Juvenile program. Since that time, we have had 21 graduates who have benefitted from their exposure to the steps in MRT (in English and in Spanish). In addition to the youth in our program, parents are required to attend a 12-week parenting program. This component also includes MRT in their curriculum and has been so successful that we now have an alumni parenting group that continues to meet, offer support, and provide advice to parents who are just beginning their journey through this program.

Our most recent preliminary outcome data indicate that 65% of those youth who have graduated from the Juvenile Drug Court program have not reoffended.

The following are just some of the accomplishments our graduates have made:

- One of our graduates, who had strong gang affiliations and was especially difficult to work with when he began is now attending school and is currently maintaining 3 A's and 1 B. Whenever he sees our surveillance officers in school,

he always makes a point of visiting with them. He has also volunteered on several occasions to work with law enforcement officers.

- Our local police department has just received a Weed & Seed grant. They are looking into hiring one of our graduates for a clerical position that may become available. Until then, this young lady continues to work with them on a volunteer ba sis.

- At our alternative high school, an awards ceremony was held in May. The awards include Board of Education members placing an Honors Rope on students. Eight students received honors this year. Two of them were our graduates.

- Two of our most recent graduates are off to college-one will study culinary arts and the other will be pursuing a degree in criminal justice.

The following are excerpts from letters sent to Judge Cornish from the parents of two of our July 27 graduates:

> *"He is staying clean, following all rules, including curfew and getting along with all of our family.....In closing, I want to thank you and the program for what is has done for _____. He is a different person now, a person I love very much."*

> *"As our son _____ graduates from the Juvenile Drug court program on July 27, 2000 we reflect on the last year and wish to offer our sincerest thanks, respect and warmest regards to you and all of the fine men and women who have made this program a total success....The positive is constantly being reinforced....It is gratifying to see the interpersonal contact between the youths and each of you. I am particularly amazed at the positive contact between the law enforcement officers and the youths. As a former law enforcement officer, I rarely got to see any activity of this nature. In looking at this program as an 'insider' at first I viewed it as rehabilitation. I have changed my mind. I now view this as a positive mentoring program....I am positive that your approach to problem solving and helping each of these young folks toward self-sufficiency and self-discipline is spot on....I am convinced that the seeds you are sowing and have sowed will be reaped many times by each of our children, the greater community and each one of us....Lastly, we would like to offer our heartfelt thanks to each of you for the service each of you provide to our community and for helping provide a solid foundation for our son."*

Because of the advances made by so many of our youth who are exposed to MRT, many community businesses are becoming partners with this program and offering opportunities to these youth that would not have been available to them without this program.

Our counselors believe that MRT has been a success because not only does it provide a mechanism for counselors to hold our drug court participants accountable, it offers an opportunity for the participants to hold each other accountable. MRT steps help individuals see what choices in the past led them to where they are today and advances them through a process where they begin to practice honesty and can now say the they choose to behave in a certain manner because it is the right choice to make.

For additional information about this program, please contact Ann Wallace. Phone:(505)523-8287, Fax: (505)523-8290, or Email: LCRDAMW@ NMCourts.Com.

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- • Substance Abusers With Children
- • Parents Experiencing Problems
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CBTR LITERATURE REVIEWS

Does Alcoholics Anonymous Work? The Results from a Meta-Analysis of Controlled Experiments
by Richard J. Kownacki, & William R. Syhadish (1999)
Substance Use & Misuse, 34, 1897-1916.

The AA subculture is rife with success statistics thrown around by generally well-meaning members. A "60% success figure" is one often cited by AA proponents although all of the Triennial Reports issued by AA's own General Services cite a remarkably consistent 95% dropout rate during the first year of membership. According to AA's own research, if an individual is one of the 5% who manages to stay in AA for the first year, the odds of abstinence at the end of the year is about 40%. Those few who manage to stay in AA for three years show a 60% rate of self-reported abstinence. If the 95% of AA dropouts are completely ignored, a 3-year success rate of 60% certainly looks good. However, if the 95% of dropouts are counted, the actual 3-year rate of abstinence for AA is a dismal 3%. Pancreas cancer, considered untreatable (from a survival standpoint), shows a 5-year survival rate of only 5% or so - a dismal "survival" rate that is actually two-thirds higher than AA's "success" rate.

While AA proponents suggest a higher success rate than other alcohol treatments, many argue that the anonymous character of AA makes it impossible to gather accurate data. AA, of course, does its own group research for their Triennial Survey and relies on a reasonable level of validity and reliability.

As related in this meta-analysis of AA research, recent publications claim "a 75% sobriety rate for alcoholics who really try the program." Such statements are considered to be unwarranted and lending nothing of value to the scientific body of treatment literature. In an effort to assess all of the accurate data on AA outcome, the authors gathered all controlled outcome studies and dissertations on AA. A total of 355 published studies and 48 dissertations were found. This study was the "first meta-analysis of AA designed primarily to draw causal inferences about AA efficacy based on controlled experiments."

Out of all 403 outcome studies, only 21 had comparisons of AA to any other treatment (or no treatment), and only 10 had random assignment to treatment groups. However, these 21 studies included 7,000 subjects, 92% of whom were male, their average age was 39 years, 79% were Caucasian, 37% were married, 56% showed less than a high-school diploma, and 34% were unemployed. A 12-month outcome measure for abstinence was utilized since the majority of studies used that time period. A meta-analytic statistic was utilized to convert all data into comparable statistics.

All of the randomized studies comparing abstinence of individuals in conventional AA as compared to no treatment showed that the results in the AA group were significantly worse than no treatment. Studies where clients self-selected AA groups showed that those in AA fared significantly better than those who self-selected no treatment. Randomized studies where clients were assigned into AA-based residential programs showed that the AA programs had nonsignificantly worse results as compared to clients assigned into non-AA based residential programs. However the number of subjects in these studies was very small. Studies where client self-selected participation in AA-based residential programs showed that those in AA fared significantly better than those who self-selected alternatives.

The authors drew several important conclusions: "First is the fact that randomized trials suggest that AA at best does no better than alternatives, and in some cases may do significantly worse." The second conclusion was that research supporting AA is poorly done and usually biased..." professionals, alcoholics and the general public need to know about the poor

CBTR LITERATURE REVIEWS

research base supporting this very popular and widespread form of treatment..."

Another conclusion is that individuals who are coerced into AA (e.g., as in many drug courts, EAP, and criminal justice programs) often show worse outcomes on the whole than if left untreated. This ethical issue is one that should be seriously considered by professionals responsible for program design and operation since counselors immersed in the AA subculture aren't likely to understand or accept it. On the other hand, data indicate that clients who seek out AA-based treatment are better off if they are given access to it as opposed to entering an alternative form of treatment. (Reprinted from Addictive Behaviors Treatment, 2(1). Used with permission.)

The Forgotten Issue in Effective Correctional Treatment: Program Implementation by P. Gendreau, C. Goggin, and P. Smith. *International Journal of Offender Therapy and Comparative Criminology* (1999), 43,2, 180-187.

The authors identify a number of implementation factors that are considered critical to the development of effective treatment programs in corrections. They point out that the issue of implementation has largely been ignored in correctional research.

The article identifies thirty-two implementation factors that fall within four main categories: general organizational factors, program factors, change agent, and staffing activities. In the area of organizational factors, they identify staff turnover as a key indicator of personnel problems. "We have not yet seen an effective program that has also experienced substantial staff turnover." Among program factors, it is important that the program is based on credible scientific evidence and that it does not overstate the gains to be realized. With regard to the change agent, they point out that involvement must be maintained until there are clear indications that the staff is capable of maintaining program delivery. Finally, staff factors include insuring that all those delivering program services must have the technical/professional skill to implement the program.

The authors conclude by cautioning neophytes that program implementation is not an easy task.

JACKSON, MISSISSIPPI MISDEMEANOR RECIDIVISM IS REDUCED BY NEW PROBATION PROGRAM

By Charles Robinson, Director, CCM

In the summer of 1999, the Municipal Court of Jackson, Mississippi was frustrated by the burgeoning caseloads and limited funds available to administer justice. As with many courts in the United States, the judges were tackling crowding in their jail and a lack of state funding for misdemeanor probation. The judges decided that a plan had to be implemented in order to overcome these problems. In a brainstorming effort, the judges identified their goals: 1) improve offender accountably to the court, 2) expand sentencing options, and, as Judge Bob Waller stated, 3) relief from the present revolving door of the court. Judge David Rozier validated the vision of the program, " We want to implement a model program for the state as well as the country."

The program was a coordinated effort by Correctional Counseling Inc. (CCI) of Memphis, TN and Court Watch Inc. (CWI) of Ridgeland, Ms. The two companies formed Correction Counseling of MS. (CCM). CCI was able to contribute their very successful MRT based programs and CWI supplied their state of the art offender tracking system. The probation team consists of a certified alcohol and drug counselor, two masters level officers, and one officer with a college degree in criminal justice.

The combined 30 years of criminal justice experience had taught the group that the majority of the offenders to be involved in the program will have some sort of substance abuse history. The program was designed to attack the misdemeanor recidivism by incorporating the following elements: use of both a community risk and needs assessment and a substance abuse assessment, assistance in securing employment, referral to GED programs, and holding offenders accountable for paying their court fines.

Once the offender has been through the intense assessment, an individual probation plan is developed. The plan includes payment of fines and costs, any treatment/MRT-based programming, full time employment, a GED if high school was not completed, and a minimum of one monthly report. The court is given update reports on offender progress in the program, as well as,notification of violations and completions.

In the first six months of the program implementation, the probation team has identified 85 percent of the offenders as repeat offenders. Through the community resources, 150 participants have gained full time employment, numerous clients are working toward their GED, over 200 have participated or finished MRT-based programming, and 83% of participants are current with their fines and costs plans. Charles Robinson, director of CCM stated, "Through this aggressive approach toward misdemeanor offenders, we are positively changing lives, recidivism is at a record low for the court, fines collections are up significantly, and we have been able to give the community a brighter tomorrow."

For additional information, please call (601)949-9960.

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CBTR is interested in publishing brief reports on cognitive-behavioral implementations, outcome studies, and reviews of cognitive-behavioral materials. Articles should be no more than 6 double spaced pages in length and may be submitted on IBM or MAC disk formats including Microsoft Word, Claris, and Pagemaker. Articles should be submitted to:

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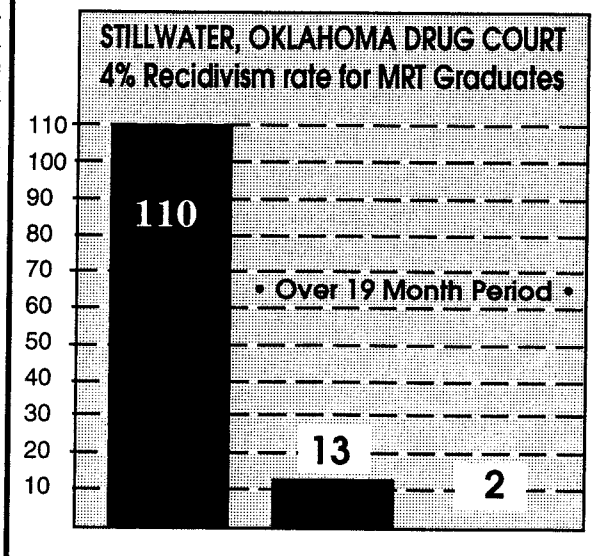

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8:00 a.m. to 5:00 p.m. *(Lunch-provided in Memphis)* Introduction to CBT. Treating and understanding APD and treatment-resistant clients. Background of MRT® personality theory.	8:00 a.m. to 12:30 p.m. *(Lunch - on your own)* Personality theory continued. 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.

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