Recidivism Outcome Research On Moral Reconation Therapy® In Prison-Based Therapeutic Communities: A Comprehensive Review

By Gregory L. Little, Ed.D. & Kenneth D. Robinson, Ed.D.

Moral Reconation Therapy (MRT®) was initially employed within an established prison-based Therapeutic Community (TC) in 1986 at the Shelby County Correction Center (SCCC) in Memphis, Tennessee. The TC began in 1972 as a self-contained drug treatment Therapeutic Community separated from the main prison complex. The program was patterned after the early Federal Prison TC at Danbury, Connecticut and employed a former Danbury resident as a consultant. The program initially housed 24 male misdemeanor and felony offenders with sentences of approximately one-year.

The first (pre-MRT) outcome report on the program (Wood & Sweet, 1974) indicated that after two years of program existence, 67 percent of released program graduates had not been reincarcerated, but rearrests were not evaluated or reported. In addition, the rate of program completion was low.

A more comprehensive report was issued two years later (Sweet, Little, Wood, & Harrison, 1977). Only 43 percent of the 254 offenders who entered the program completed treatment. Recidivism data showed that by the third year after release, 53.5 percent of program graduates had not been reincarcerated. The regimented behavior-modification approach of the TC was then termed "Reconation Therapy" (Wood & Sweet, 1974).

MRT Implementation Background

In 1985, the TC drug program at the SCCC became the focal point of the present authors, and because of program problems (high dropout rate and high recidivism), the new approach, called "Moral Reconation Therapy," was added to the treatment regimen in early 1986. The program was designed to incorporate cognitive elements into the behavioral program—especially moral reasoning components. The major intention was to impact three outcomes: increase the completion rate; increase minority participation; and lower recidivism. In fact, in the four years prior to MRT implementation, the rate of graduation was only 30 percent and only 25 percent of participants were minorities.

While earlier research had delineated some of the reasons for TC dropouts (Little, 1981; Little & Robinson, 1987; Robinson & Little, 1982), another factor was found to be low morale among staff (Welch & Little, 1983). Counselors were spending much less than half of their time in "counseling" functions. Internal research also showed that counselors substantially spent more time with specific participants within the program—generally with clients of similar ethnic backgrounds and interests. When an analysis was made of how clients actually completed the program, the greatest factor was found to be twofold: staff judgments made on each participant (done in client staffing) and time participants spent in the behavioral TC program. Another intriguing finding was that the vast majority of program graduates who were deemed by staff to have a high probability of success after release—actually became recidivists. Oddly, it appeared that the higher a program participant was rated by program staff, the greater the odds of quick recidivism. Because the institution administered MMPI and intelligence tests to all inmates, we were able to determine that the participants who garnered the most support by staff were generally high in psychopathic deviation and intelligence. We surmised that the staff was subtly manipulated and conned by these inmates. MRT was designed in ways to specifically address all of these factors.

How MRT Was Implemented

The TC's behavioral structure, program elements, and overall activities were essentially unchanged with the addition of MRT. MRT simply became a new group that was held twice a week with several other times during the week allotted for homework. But MRT was immediately integrated into the TC program's entire framework. First, MRT was made the prime method of determining program completion. Clients entering the program were given MRT program materials and told that when they completed Step 12 they would graduate the program. This gave us an objective means to assess progress and make nonjudgmental reports to parole, probation, and judicial authorities. It also gave clients a way to easily assess their own progress.

Secondly, MRT alleviated many of the subjective judgments from the counseling staff. Staff judgment was no longer the primary determinant of client completion. MRT was established with clearly delineated tasks and objectives, which clients had to complete at each of the program's steps. More specifically, a step was either completed correctly or it wasn't. Program counselors (and on some steps, clients) determined if the work was completed successfully. The program also instituted two levels of appeal on all steps for participants—to ensure that clients were treated fairly. Over 5 years, only two appeals were made. This is partly because routine evaluations of clients' step