

## **Review Of One- to Three-Year Recidivism Of Felony Offenders Treated With MRT® In Prison Settings**

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Moral Reconciliation Therapy (MRT®) was one of the first (if not the first) cognitive-behavioral programs implemented with offenders housed in prison settings. While many components of the approach were utilized in a 1979 trial in a Federal prison, the first formal implementation of MRT was performed in a prison-based therapeutic community in 1985. In this implementation, MRT groups were easily established as one of the routine groups program participants attended, however, the MRT groups soon became a focal point of all the program activities. As the method and materials were gradually refined and researched, the first MRT publication was made in 1988 (Little & Robinson, 1988).

The initial results of MRT were drastic and immediately positive with increased minority participation in the program, a lower dropout rate, and more positive attitudes obvious in both staff and program participants. The ongoing drug therapeutic community program was quickly expanded and a new therapeutic community was established within the same prison for multiple DUI offenders serving felony sentences. Both programs were deemed highly successful by the administration and the new approach of MRT showed significantly lower recidivism in participants who had been released. This success led to the utilization of MRT in an aftercare component for all program participants after their release in the community. At the same time, the efficacy of the cognitive-behavioral approach was tried on a large group of “general population” inmates who participated in MRT during weekly group sessions. A series of outcome studies were subsequently published on the recidivism of MRT-treated felons drug offenders and multiple-DUI offenders. All of the MRT implementations showed significant-ly lower recidivism as well as beneficial change scores on a battery of personality tests utilized to assess client attitudes, beliefs, and characteristics. A comprehensive review of all the MRT outcome literature was published in 2002 (Little, 2002).

Since the initial 1988 MRT publication, MRT has been implemented in a wide variety of settings including in parole and probation, with juvenile offenders, in schools, halfway houses, drug treatment programs, jails, and venues covering the entire range of corrections. A 2005 review of MRT publications reported that 116 studies had been published on MRT outcomes (Little, 2005). A meta-analysis (Little, 2005) of the recidivism of parolees

and probationers treated with MRT found that nine-studies ( $N = 10,139$ ) showed that MRT treatment led to a reduction of subsequent recidivism by .2257 (reducing expected recidivism by approximately 50 percent). A 2001 meta-analysis (Little, 2001) on seven studies ( $N = 21,255$ ) showed that after one year of release, felons treated with MRT during their incarceration showed a reduction in recidivism by .226 (less than half the recidivism of nontreated controls).

Several evaluations have compared the recidivism results of MRT to other cognitive programs. In a meta-analysis comparison to recidivism outcomes of the *Reasoning and Rehabilitation* program, a 2005 study (Wilson, Bouffard, & MacKenzie, 2005) reported that MRT's mean recidivism reduction effect was .33 as compared to only .16 for *Reasoning and Rehabilitation*. A 2003 study (Little, 2003) compared one-year MRT recidivism (rearrests) to the widely employed *Thinking for a Change* model's one-year recidivism. Results showed that MRT-treated offenders showed 69 percent fewer arrests compared to controls while *Thinking for a Change* yielded a only 24.5 percent less arrests than controls. The present report summarizes the overall one-to-three-year recidivism compiled for prison-based implementations of MRT with comparisons to control groups.

### **Studies Included**

Little (2001) identified 29 separate outcome studies of recidivism after MRT treatment in prison settings. These studies included 24,342 total subjects (treated individuals and controls). Since that 2001 report, three additional recidivism outcome studies from MRT treatment at prison settings have been published. The additional subjects increase the total of individuals in the reports (treated and controls) to 27,283. The additional reports are as follows.

Burnette, *et. al.* (2005a) reported on the recidivism of 579 felony female offenders who participated in MRT within a prison-based therapeutic community. The participants had been released into the community for an average of 33 months. The rearrest rate (for any offense) was 34.9 percent. An additional 180 participants had been released for an average of 21 months. These participants showed a 15.5 percent rearrest rate. A comparison group was formed from female offenders in Tennessee and 14 other southern states who had been released for 24 months. Their rearrest rate was 49.9 percent.

Burnette, *et. al.* (2005b) evaluated the recidivism (reincarceration) of MRT-treated male felony offenders who participated in a prison-based therapeutic community. MRT-treated participants ( $n = 135$ ) who had been

released for an average of 21.5 months of release showed a 6 percent reincarceration rate for new offences and an additional 20.6 percent reincarceration rate for technical violations. The reincarceration rate for an additional 95 program participants who had been released for an average of 28 months was 33.7 percent. These figures were compared to the official Tennessee Department of Correction (TDOC) 24-month reincarceration rate of 38 percent.

Pourett (2004) evaluated the recidivism of 638 male offenders who participated in MRT in an Oklahoma prison-based therapeutic community. The three-year participant recidivism rate was 11.6 percent compared to the Oklahoma DOC three-year recidivism rate of 26 percent.

### **One-to-Three Year Recidivism of MRT-Treated Offenders**

Data from a total of 32 outcome studies were combined to form an average of MRT-treated and nontreated control recidivism for one-, two-, and three-year post release periods. While recidivism was calculated in varying ways in these reports, the weighting of relative recidivism in each study, including controls and treated subjects, would yield appropriate comparisons. Twenty-nine of the studies were reported in Little (2002) with the additional three studies described above.

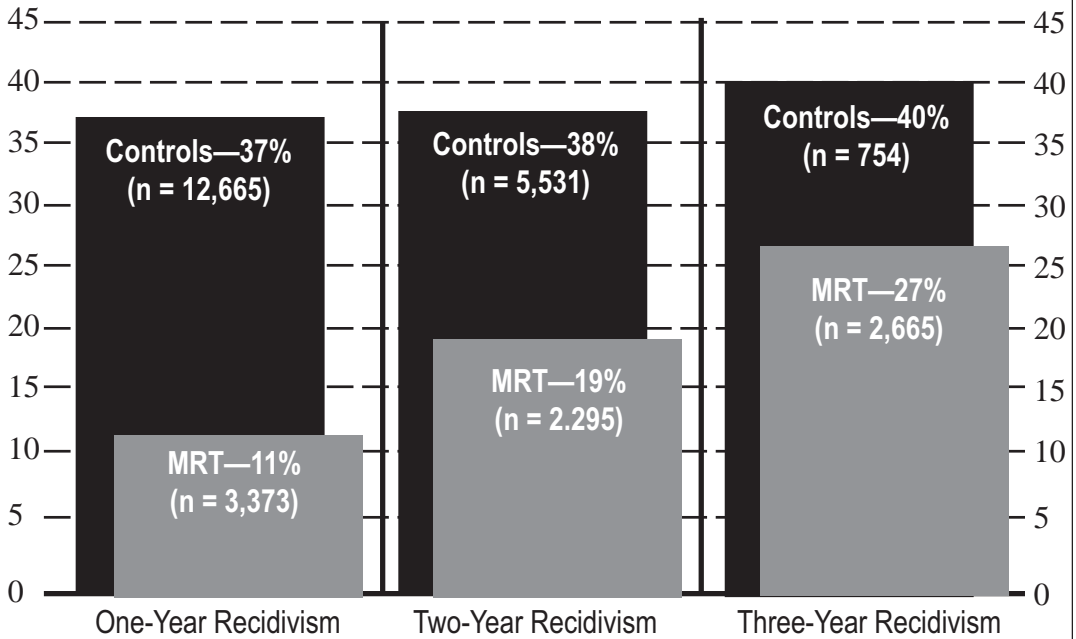
A total of 3373 MRT-treated offenders showed a one-year recidivism rate of 11 percent as compared to a 37 percent rate in 12,665 nontreated controls. The difference between the two groups (.26) is in line with the meta-analysis difference of .226 found by Little (2001) and the .33 difference found in the meta-analysis of Wilson, *et. al.* (2005).

The two-year recidivism rate of MRT-treated offenders was 19 percent ( $N = 2295$ ) as compared to 38 percent in controls ( $N = 5531$ ). The three-year recidivism rate of MRT-treated offenders ( $N = 2655$ ) was 27 percent as compared to 40 percent in controls ( $N = 754$ ).

### **Discussion**

The data included in this report are consistent with previous research and in line with meta-analyses conducted on MRT outcomes. MRT treatment leads to reduced rearrests and reincarceration after participant release. Previous research on MRT-treated offenders recidivism (Little, 2002) has shown that treated offenders show significant differences from controls for a ten-year period after release. In addition, MRT had been

### One, Two, and Three-Year Recidivism Rates of Incarcerated Felons Treated With MRT Compared to Controls



cited as the most cost-effective of all cognitive interventions (Aos, *et. al.*, 1999).

Cognitive-behavioral programming has become the preferred treatment approach for offender populations for obvious reasons. In brief, the approach is one of the few that has been consistently shown to reduce recidivism. Such programming can be easily implemented within prison settings by brief staff training and management support.

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