

# **Treating Juvenile Offenders and At-Risk Youth With MRT®: Comprehensive Review of Outcome Literature**

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*Summary*—Twenty published reports on the use of MRT with juvenile populations are reviewed. MRT has been implemented in juvenile boot camps, in educational “at-risk” student programs, in juvenile drug courts, at residential juvenile facilities, and within various other programs. Results on school-based implementations show increased retention rates in at-risk populations leading to substantial cost-savings; Juvenile drug courts consistently report high completion rates and lower recidivism in MRT participants, and; Boot camps and probation sites have reported lower recidivism or lessened crime severity in participants. All but one of the studies on outcomes with juveniles housed in residential facilities report significantly lower recidivism and beneficial changes in personality variables. The sole study that reported nonsignificant results revealed that the MRT-treated juveniles showed substantially lower recidivism than the nontreated controls at the 0.06 one-tailed probability level.

While Moral Reconciliation Therapy (MRT®) was developed in 1986, the first use of MRT with juveniles occurred in 1989 in a large implementation in Puerto Rico’s now-defunct Volunteers in Service of Puerto Rico Program (VISPU). The program was a multisite, residential job preparation program that stressed vocational training and education in adolescents and young adults who volunteered for their training program. The federally funded program had experienced a large dropout rate, which was unaffected by traditional counseling and other support methods. Over the course of several months, staff from the various facilities of VISPU were trained in a Spanish-adapted version of MRT and the approach was rapidly implemented in all program sites. While the program disbanded a few years later after federal funding ceased, a significant decline in dropout rate occurred immediately after MRT implementation and was sustained until the program ended (Little, Robinson, & Burnette, 1992). Clark (1990) also cited preliminary research showing the improved retention in the VISPU Program. Since the Puerto Rico implementation of MRT, MRT programming has been implemented for youthful offenders in boot camps, juvenile drug courts, residential juvenile facilities, and schools. This article reviews published results from these implementations.

## **MRT in Juvenile Boot Camps & Probation**

MRT was first utilized in juvenile boot camps in the early 1990s, but with the gradual demise of the boot camp movement, little outcome data has been published. For example, the Second Chance juvenile boot camp in Washington State began using MRT in 1995 (Rinaldo, 1995). The program name was subsequently changed to Camp Outlook and continues to utilize MRT in its 120-day program (Kubie, 1999).

Two related studies conducted by the Bureau of Educational Research at the University of Memphis (Petry, Bowman, Douzenis, Kenney, & Bolding, 1992; Petry, & Kenney, 1995) investigated the effectiveness of MRT on treating 218 delinquent males participating in a boot camp. Rearrest rates (37%) were quoted as being unexpectedly low following treatment, however, comparable data was not supplied to the university evaluators performing the study by the overseeing juvenile authorities. One significant finding from the study showed that in those treated juveniles who did reoffend following treatment, the severity of their crime was lessened.

### MRT in Juvenile Drug Courts

MRT has been implemented in dozens of juvenile drug courts, however, few data analyses and outcome studies have been published. A process evaluation of The Delaware County Juvenile Drug Court (which utilizes MRT) was published in late 2002 (Shaffer & Latessa, 2002). The program began in June 2000 and targets juveniles between 14 and 17 years of age. From the program's initiation until July 2002, 41 youth entered the drug court and another 73 entered a specialized risk reduction program. Results showed that 61% of drug court participants completed the program but the recidivism of participants was not studied.

Idaho also utilizes MRT in five of its seven drug court districts (including several juvenile courts). A 2004 report stated, "Our MRT has proven to be so popular that four probationers not in drug court came in and asked to be allowed to participate in MRT groups" (Idaho Supreme Court, 2004).

Wallace (2000) reported on the implementation of MRT in a juvenile drug court in Las Cruces, NM. The drug court's adult program reported that their success in treating 56 adults spurred an effort to implement MRT with juveniles. While no comparative data was cited, the report stated that 21 juveniles had completed their program. In a follow-up study, Wallace (2001) reported a 17.5% rearrest rate in the 40 graduates from the Las Cruces drug court compared to a rearrest rate of 44% in 39 graduates who participated in the same program prior to the implementation of MRT. The difference was statistically significant.

A process evaluation on the Albuquerque, NM juvenile drug court by the Institute for Social Research of the University of New Mexico (Guerin, 2001) compared 34 MRT program participants to 33 matched controls who did not participate in MRT. Results showed the MRT-treated group had a 35% new court referral rate as compared to 61% in controls, indicating that the MRT-treated group had a significantly lower referral rate. In addition, the average time to a new charge (called a referral) was significantly longer for the MRT-treated participants. McCracken, Hearn, & Stuckey (2003) reported that the Albuquerque juvenile drug court program had served nearly 100 juveniles since its inception in 1998 and that a lower rearrest rate was also present in MRT participants who failed to complete the program as compared to controls.

Lasater (2003) briefly reported on the outcome of a juvenile drug court's probation service in Durango, CO. Between July 2001 to the beginning of 2003, 63 youthful offenders had participated in the MRT-based program. During that time period, only 7.9% committed a new offense.

## MRT in Juvenile Offender Residential Programs

MRT has been implemented in numerous facilities housing juvenile offenders. A State of Tennessee Department of Children's Services facility began utilizing MRT in 1999 in a therapeutic community program. An outcome report on 56 male participants compared pre- and posttest results on a host of personality variables and objective test measures. Male participants (averaging 16 years of age) showed significant and desired shifts from pre- to posttest in locus of control, life purpose, enhanced support from family, friends, and a significant other, and less overall problem areas (Burnette, Swan, Robinson, Woods-Robinson, & Little, 2003). A later evaluation of the program (and 29 more participants) showed that the program had a 70% completion rate as well as maintained all the desired personality variable changes (Burnette, Swan, Robinson, Wood-Robinson, & Little, 2004). In addition, pre- to posttest results showed a significant decline in measures of antisocial attitudes.

Two of the most interesting outcome reports on treating juvenile offenders with MRT show vastly different ideology and conclusions by researchers. Armstrong (2003) purported to perform a fully randomized experiment on the effects of MRT with "juveniles" at the Montgomery County Detention Center (Maryland) and the brief abstract of the study has been posted on the internet since 2000 (Armstrong, 2000). The abstract cited one outcome result from the study and made recommendations without acknowledging any limitations or problems in the study. The "juveniles" mean age was 20.21 years. A 40-bed treatment program within the institution utilized MRT. A total of 256 residents were "randomly assigned" to the MRT-treated ( $n=129$ ) or a nontreated ( $n=127$ ) control group. Rearrest data was collected in mid-1999 with treatment occurring sometime between 1997-1998. Total recidivism for the supposed MRT-treated group (64.54%) was virtually identical to the control group (64.71%). The author concluded, "This work finds the MRT program lacks portability. While it is important to note that this is but one trial of the MRT program, it is also important to note that this trial casts doubt on the wisdom of this program's widespread implementation." Armstrong added that only two studies had ever been published on MRT.

While the internet abstract of the study failed to acknowledge a host of problems with the "randomization" and that substantial differences were found between the treated and control groups prior to the study, the 2003 published report is more revealing. In brief, 19 of the study's "randomly assigned" MRT-treated subjects *never entered treatment* and 25 of his control subjects *were treated with MRT!* In addition, the "randomly assigned" treated and nontreated groups significantly differed in racial composition. Thus, the assertion that randomization was accomplished is statistically improbable. The treated group was comprised of 67% African Americans and 22% Whites while the control group had 41% Whites and 48% African Americans. Despite these major flaws, the author asserted that the "randomized" treated and control groups could be fairly compared and did not differ in recidivism rate. In the published study, one additional analysis was reported. That analysis controlled for those who actually received substantial MRT treatment and those who did not, but the treated and control groups still showed pretreatment differences in racial composition. Despite this limitation, the treated group's recidivism (56.9%) was found to be lower than the control

group's recidivism (64.1%), but the report simply stated the results were not significant. A one-tailed test of the two group's recidivism difference yields a probability of 0.06.

In contrast to the previous study, Deschamps (1998) began her study on MRT with open skepticism: "It was hypothesized that MRT would have little effect on recidivism because it does not adequately address the social control bonds..." (p. iii). As a master's thesis at the University of Windsor in Canada, Deschamps compared recidivism of 134 juvenile offenders treated with MRT at the Windsor New Beginnings Program to 134 randomly selected controls who served time at a similar non-MRT facility (Wycliffe Booth House) during the same time period. The author expressed surprise when the MRT-treated group showed significantly lower rearrests than the nontreated controls (46% and 57%, respectively). A host of other analyses were done to indicate whether the differences in recidivism were due to MRT or other factors. All of these analyses indicated that the differences were, indeed, due to MRT treatment. The author concluded that MRT did produce significantly lower recidivism despite her initial skepticism.

### MRT With At-Risk Students in Educational Programs

MRT has been implemented in several educational programs including in high schools, colleges, and even in welfare-to-work programs. Data on a few of these implementations has only recently been published but many programs have publicized their adaptation of MRT. For example, an adolescent program in Tulsa, OK (Willard Home) reported on their success with runaway juveniles by utilizing MRT (Winslow, 1995).

Lasater & Robinson (2001) reported on data collected from an implementation of MRT on high school students in Montana who were facing suspension. During the first two years of the program, 83 students entered the MRT program and 60.2% of them completed the program requirements, thus avoiding suspension. School officials partly credited the program with reducing the school's dropout rate from 10% to 3%. The report cited a substantial cost-effectiveness on using MRT on at-risk students.

Lasater (2003) also reported on the use of MRT in the Durango, CO High School "at-risk" youth program. The program served 85 students during 2002 and managed a retention rate of 82.4% of these students, all of whom were expected to dropout or be expelled. The school estimated its revenue savings at \$55,000 from the student retention.

The same form of MRT implementation was made in a high school in rural Louisiana. Swann (2002) utilized MRT on 19 behaviorally disruptive students who had produced 151 disciplinary referrals before participation in the program. During participation in the specialized MRT program, disciplinary referrals fell by 46% from participants. In addition, suspensions fell by 67% during the same time period.

### Discussion

In comparison to the numerous adult implementations of MRT, juvenile program implementations are relatively few. Nearly 85 studies have been published on adult offenders treated with MRT. By contrast, this report cites less than a dozen outcome reports on juveniles. Only one of these studies however, concluded that MRT did not produce significant results. That study did find that MRT-treated juveniles showed

lower recidivism after treatment, although the one-tailed difference was at the 0.06 probability level.

In summary, MRT appears to produce beneficial changes in juveniles participating in MRT in a wide range of venues and utilizing various outcome measures. Schools interested in retaining at-risk students have consistently reported that the approach leads to both higher retention and substantial cost savings. One report cites a substantial reduction in student disciplinary infractions after employing MRT. The implementation of MRT in schools is an ongoing process and has been accomplished with combining MRT with Social Responsibility Training. More implementations of MRT in schools are currently being made.

Juvenile drug courts appear to have been the sites of the most numerous MRT implementations with juvenile offenders. All of the outcome studies on juvenile drug court implementations have reported significant differences between MRT-treated participants and controls or found that recidivism and referrals were substantially lower following MRT implementation. However, relatively few outcome studies on juvenile drug courts have appeared.

MRT has also been employed in few juvenile boot camps. In those few locations that have published outcomes, all showed positive, beneficial effects.

Finally, MRT remains in use at a host of juvenile facilities as well as in various juvenile probation sites. All of the outcome studies on these populations showed that the MRT-treated participants showed lower recidivism than controls and only one report cited that the difference was not significant. In addition, several studies measuring pre- to posttest results on personality variables have indicated a host of beneficial personality changes.

MRT is perhaps the most widely implemented cognitive behavioral treatment approach on adult offenders and is rapidly gaining acceptance into the more difficult juvenile offender treatment field. Presently, approximately 100 outcome studies have been published on MRT implementations. Virtually all of these have shown that MRT leads to significantly lower recidivism as well as various other benefits.

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