UNIVERSITY OF NEBRASKA AT OMAHA
NEBRASKA CENTER FOR JUSTICE RESEARCH

Evaluation of the Moral Reconation Therapy (MRT) Program at the Nebraska Department of Correctional Services

Results Summary

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Table of Contents

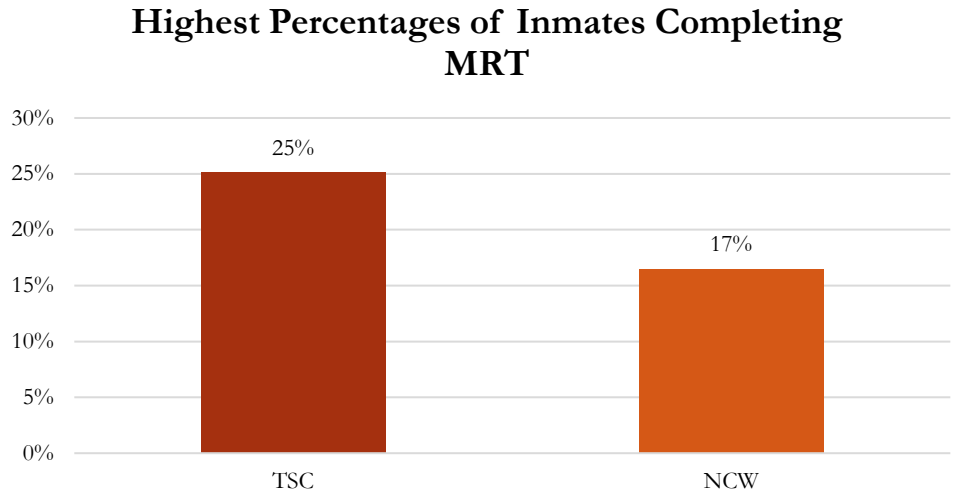
Executive Summary

This project evaluated the Moral Reconation Therapy (MRT) program that is used in the Nebraska Department of Correctional Services (NDCS). The goals of the project were to provide feedback to NDCS regarding: 1. The NDCS facilities that successfully provide MRT services to inmates; 2. Whether MRT participation reduces institutional misconducts and recidivism among inmates; 3. Whether MRT program participation is related to inmates' participation in other types of programming; and 4. The characteristics of inmates who participate in and complete MRT programming. The findings from the evaluation are presented below, and recommendations are provided as well.

Data and Methodology: This evaluation examined quantitative data provided by the Nebraska Department of Correctional Services (NDCS) and includes inmates who participated in an MRT program in any of the 10 facilities under NDCS supervision from October 2015 through February 2017. This included 9,306 inmates – 1,418 of whom were in the MRT group, and 7,888 who did not participate in the MRT program (referred hereafter as the "comparison group"). The MRT group includes inmates who participated in any of the 13 MRT steps during this timeframe, according to NDCS records.

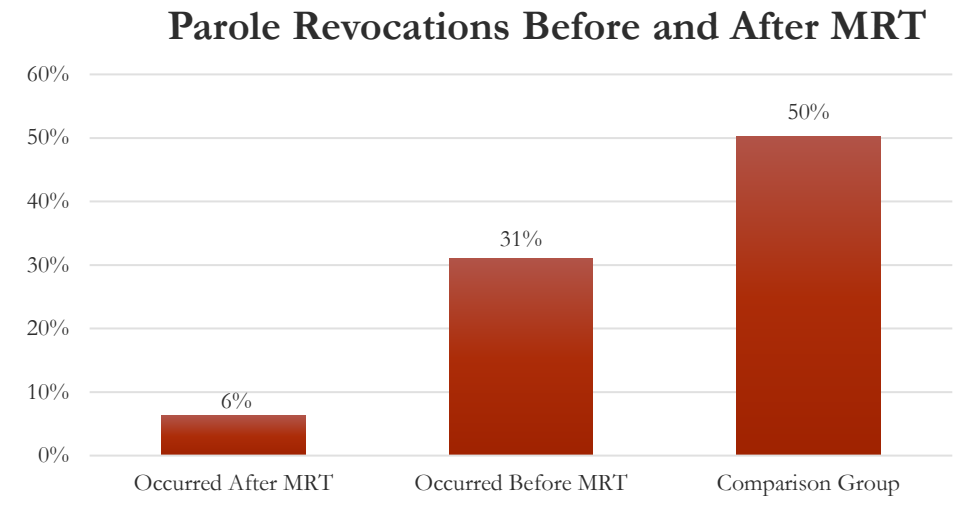
Which NDCS Facilities Provide MRT Programming to the Most Inmates?

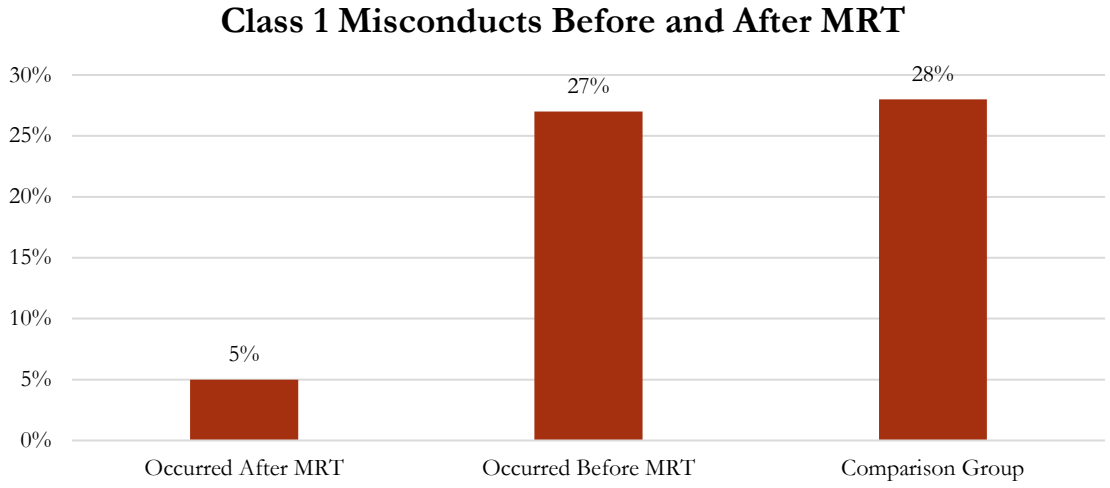
Because many inmates are transferred across NDCS facilities for various reasons, we examined MRT program completion by the facility in which inmates were initially received and by the facility in which misconduct occurred. Analyses revealed that Tecumseh State Correctional Institution and the Nebraska Correctional Center for Women have the highest proportion of inmates completing MRT programming compared to all other NDCS facilities.

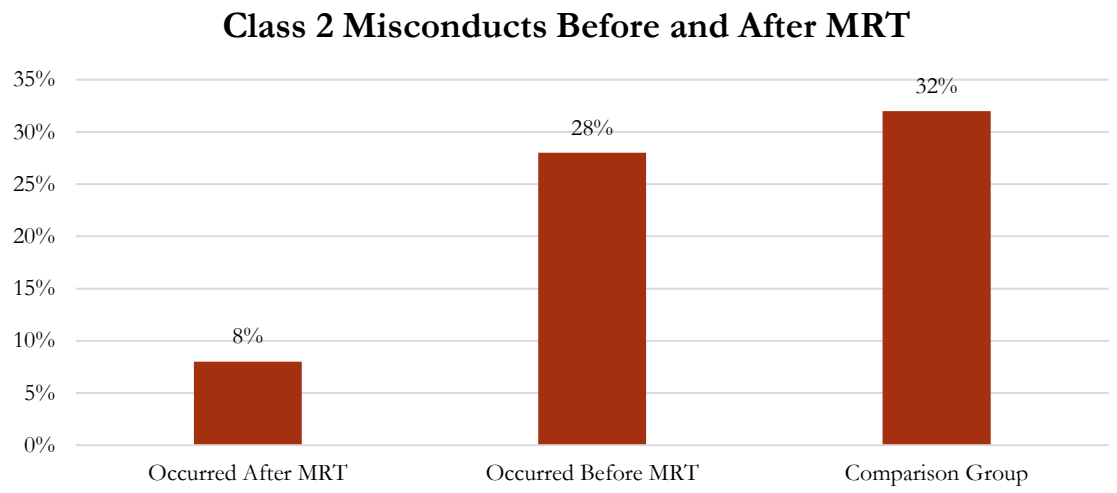


Does MRT Participation Reduce Institutional Misconducts and Recidivism?

It is very important to determine the temporal order between MRT program participation and misconducts or parole violation, primarily because many inmates begin the MRT program *after* they misbehave. The results of this evaluation show that MRT program participation is related to lower Class 1 and Class 2 misconducts, as well as parole revocations – and this is relative to both the comparison group *and* the MRT participants who engaged in misbehavior *prior to* entering the program. We found that rates of misconduct and parole violations after inmates entered into the MRT program were less than 10%, with rates 2-3 times higher among the comparison group and MRT group who engaged in misbehavior prior to entering into the program. Additionally, completing 2/3 steps of the program appears to exert the most drastic reduction in all outcomes among the MRT group.

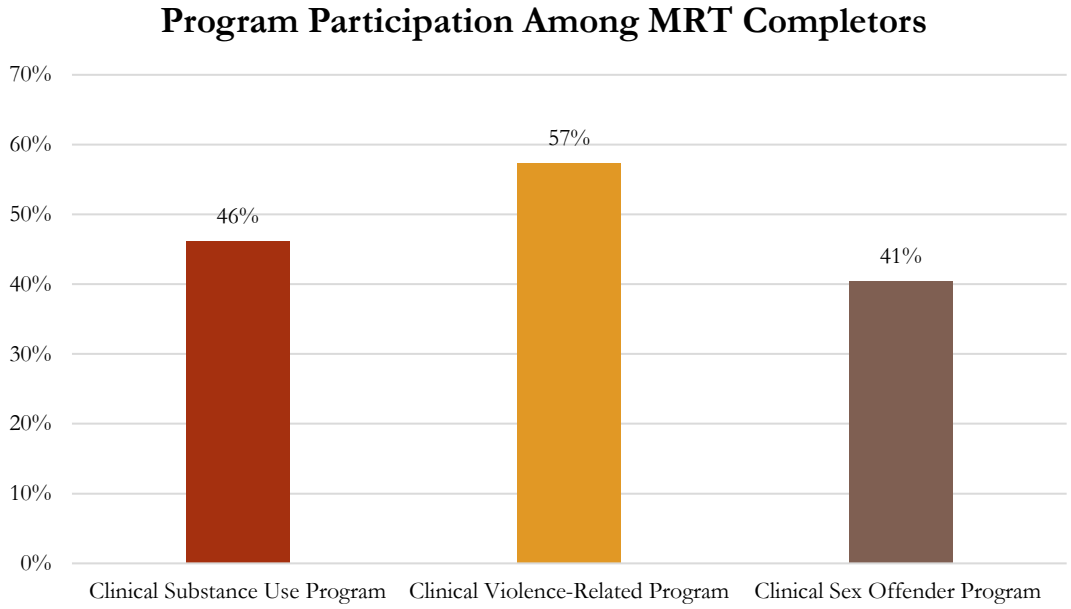






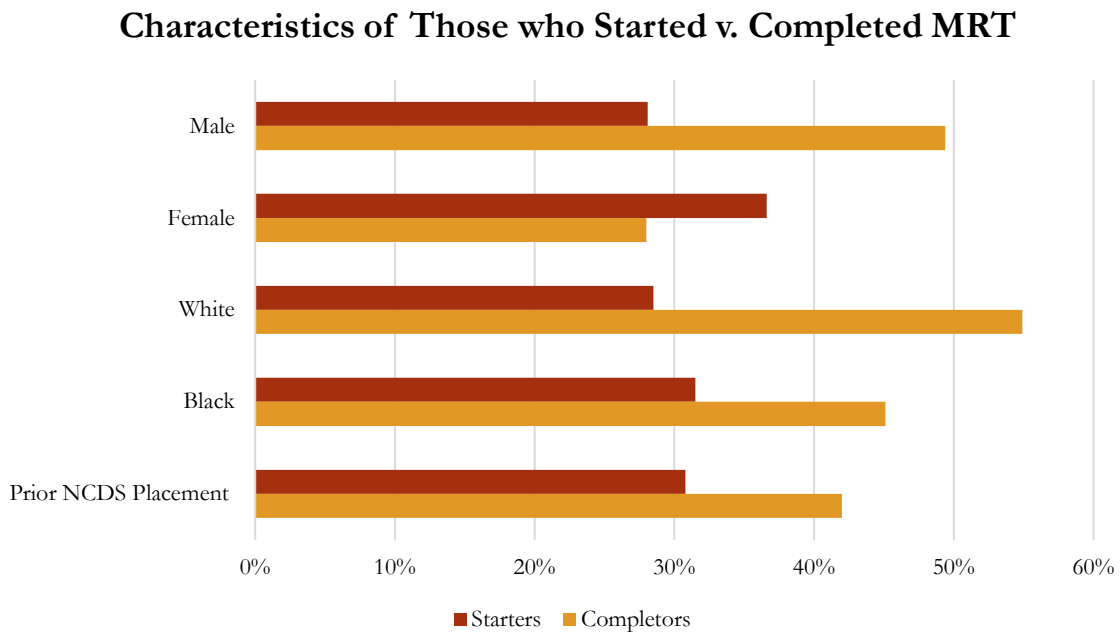
Is MRT Program Participation Related to Participation in Other Types of Programming?

We found that over 40% of those who completed the MRT program also participated in other clinical programming offered at NDCS.



What are the Characteristics of Inmates who Participate In and Complete MRT?

MRT participants who start the program are most likely to be female, black, and have a prior NDCS placement, while those who finish the program are likely to be male, white, and have a prior NDCS placement.



Recommendations

Three recommendations follow from the results of this study:

1. NDCS should continue providing the MRT program at its facilities, since the results of this study suggest that the MRT program is associated with lower levels of misbehavior among inmates.
2. The results suggest that participants who complete 2/3 of the MRT steps (7-8 steps) might see a precipitous decline in misbehavior. NDCS should focus on attempting to keep participants in the MRT program (reduce dropouts) so that they can proceed through the steps in order to realize these benefits of the program.
3. NDCS should focus on trying to keep women and minority inmates from dropping out of the program before completing it.

Background

The MRT Program

Moral Reconation Therapy (MRT) is based on a simplified personality theory that combines components from Erikson and Loevinger's ego development, Maslow's hierarchy of needs, Kohlberg and Piaget's moral development theories, and work by Carl Jung (Little & Robinson, 1988). MRT participants are introduced to these theoretical concepts through lecture, individual discussion, treatment manuals, and workbooks. According to the creators of MRT, "The personality theory proposes that people form their personalities through a progressive accumulation of beliefs, attitudes, and habits that layer themselves over the 'Inner Self,' the essential essence of the person" (Little & Robinson, 1988, p. 139). This perspective posits that personalities are resistant to change. Therefore, when the personality obscures the person's positive potential as a human (i.e., the Inner Self), defense mechanisms, such as criminal or delinquent behavior, are produced in order to maintain the personality.

The primary goal of MRT is the moral development of the client. The therapy identifies 13 stages of moral development and explains that these stages exist on a continuum. A series of treatment steps parallel these stages. It is anticipated that treatment results in moral development; as individuals progress through the treatment steps, they will begin to act in a manner consistent with more sophisticated levels of moral reasoning, ultimately, lowering recidivism and other negative outcomes (e.g., Ferguson & Wormith, 2013). The steps involve fundamental issues related to: Honesty (step 1), Trust (step 2), Acceptance (step 3), Awareness (step 4), Healing Relationships (step 5), Helping Others (step 6), Goal Setting and Identity Formation (step 7), Consistency Between Short and Long-Term Goals (step 8), Never Give(ing) Up (step 9), Maintain Positive Change (step 10), Backsliding and Firm Commitments (step 11), Setting Appropriate Goals (step 12), and Moral Refinements, Going Further (steps 13-16) (Little & Robinson, 2009).

The Evidence of MRT

Evidence regarding MRT has typically been positive. MRT clients have shown improvements across a wide range of outcomes (e.g., recidivism, prison locus of control, life purpose, short sensation seeking, perceived social support; Burnette, Leonard, Robinson, Swan, & Little, 2004; Burnette, Prachniak, Leonard, Robinson, Swan, & Little, 2005; Little, 2000; 2001; 2004; 2005; 2006). For example, Kirchner & Kirchner (2008) demonstrated that MRT reduced felony drug offenses, and improved sobriety among participants. In a related study, Boston and Meier (2001) found that former offenders who sought and received MRT had significantly fewer new arrests in the six months following their last contact with the program than did former offenders who had not received such treatment (i.e., comparison group). Significant differences were also observed regarding re-indictments and for the most stringent of recidivism measures: reconvictions (Boston & Meier, 2001).

Despite the strong evidence supporting the MRT program, mixed evidence also exists (Little et al., 2010). In attempts to better understand the implications of the MRT program on future behavior, a number of reviews and meta-analyses have been conducted. The results from these studies were bleaker than the studies published on a single site evaluation. Most notably, Ferguson and Wilson's (2013) meta-analysis of 33 studies demonstrated a positive significant association

between recidivism rates and MRT participation, however, the effect sizes were small and possibly attributed to large sample sizes. In another review, Wilson and colleagues (2005) found a mean effect size of .33, which is substantively meaningful (i.e., .20 and below are small effect sizes), however, as the authors noted, the main reason they found this effect was derived from the inclusion criteria. That is, they only included studies based on the following criteria: 1) study must have evaluated an intervention based on a cognitive-behavioral model administered in a group with highly structured treatment protocol for reducing criminal behaviors, 2) must have included a comparison group that received no treatment, a non-cognitive-behavioral intervention, or other treatment, 3) study participants must have been under the supervision of the criminal or juvenile justice system, 4) must report a post-program measure of criminal behavior, and 5) treatment was delivered after 1979. Based on this strict criteria, the authors concluded what while the theoretical underpinnings of MRT appear to work as intended, perhaps most important is the implementation of the program.

Indeed, others who have found a null relationship have come to similar conclusions of Wilson and colleagues (2005) in the recognizing the importance of implementation fidelity. For example, Little and colleagues (2010) tested the longitudinal effect of MRT on DUI recidivism and found no significant differences between treatment and comparison groups. The authors concluded that not enough time for recidivism was captured (only 2 years) and therefore no significant differences were found across groups. They argued that recidivism would be higher after 10 years, which would have allowed them to test the groups more accurately. In a study looking at the effects of MRT on a sample of juvenile delinquents, Armstrong (2003) found the risk of recidivism for the treatment group was not significantly different from the risk of recidivism for the control group. The author highlighted several implementation issues as the source leading to the null relationship, including, inconsistencies across implementation dates, how a participant comes to participate (e.g., voluntary versus assigned), and the amount of treatment exposure all.

In sum, MRT appears to be a meaningful and hopeful program intended at limiting problematic behaviors of prior offenders such as substance abuse and recidivism. In general, the extant literature is promising as most studies have demonstrated at least minimal treatment effects on behavior (Fergunson & Wormith, 2013). However, ambiguity surrounding the true relationship remains, as inconsistencies in program implementation have made clear interpretations of the treatment effect difficult. Thus, in order to come to a definitive conclusion, future MRT programs should seek to systematically implement the program as it was originally intended (Little & Robinson, 1988).

Methodology

The purpose of this study was to evaluate the MRT program as it is implemented at the Nebraska Department of Correctional Services (NDCS). Data for this project were provided by NDCS and includes inmates who participated in an MRT program in any of the 10 facilities under NDCS supervision from October 2015 through February 2017. This included 9,306 inmates – 1,418 of whom were in the MRT group, and 7,888 who did not participate in the MRT program (referred hereafter as the "comparison group") across facilities. The MRT group includes inmates who

participated in any of the 13 MRT steps during this timeframe, according to NDCS records. This project sought to provide feedback to NDCS regarding:

1. Which facilities are successfully providing MRT services to inmates;
2. Whether MRT participation reduces institutional misconducts and recidivism among inmates;
3. Whether MRT program participation is related to inmates' participation in other types of programming; and
4. The characteristics of inmates who participate in and complete MRT programming.

The results are detailed below.

Results

Characteristics of MRT Participants versus Comparison Group (no MRT)

Before answering the specific questions above, we first provide a description of the MRT and comparison groups. Table 1 shows the characteristics of all 1,418 MRT participants in the sample, pooled across facilities. As demonstrated, the majority of MRT participants are male (77%) and either white (58%) or black (27%). Almost 38% had been previously incarcerated in an NDCS facility. Many participants of MRT (37%) also participated in a clinical substance use program, followed by a clinical violence-related program (7%), and a clinical sex offender program (3%). About 16% of MRT participants were parole eligible during the October 2015 – February 2017 timeframe of this study, and 31% were in restrictive housing at some point. Approximately 95% of the MRT participants were incarcerated on charges for a felony and 5% were incarcerated for a misdemeanor offense. Overall, 31% of MRT participants engaged in a Class 1 misconduct charge within the facility, while 36% of the participants engaged in a Class 2 misconduct charge, while 32% engaged in no misconduct at all. Regarding parole revocations, 37% of MRT participants violated their parole while approximately 63% did not.

We examined the characteristics of the MRT group relative to the comparison group (who had not participated in MRT at any point) and found that the two groups differed significantly on many variables. In contrast to the comparison group, the MRT group consisted of more females, black inmates, and more inmates who had a prior NDCS incarceration. The comparison group was significantly older on average and comprised more Hispanic participants. MRT participation also appears to be highly related to other program participation – significantly more MRT participants also participated in a clinical substance use program, violence-related program, or sex offender program than the comparison group. Additionally, significantly more inmates in the MRT group had been convicted of a felony offense and had been in restrictive housing. More inmates in the comparison group had committed a misdemeanor offense upon entry into NDCS.

Regarding outcomes, significantly more inmates in the MRT group engaged in Class 1 and Class 2 misconducts than inmates in the comparison group, while significantly more of the inmates in the comparison group did not engage in any misconduct. The MRT group, however, had significantly lower rates of parole revocations. We found that many inmates begin participating in MRT *following* a misconduct or revocation, however, so we caution against taking these results to mean that MRT participation *leads to* inmates' misbehavior: it is very possible that misbehavior leads to joining the MRT program instead. We will discuss these results shortly, in Table 2.

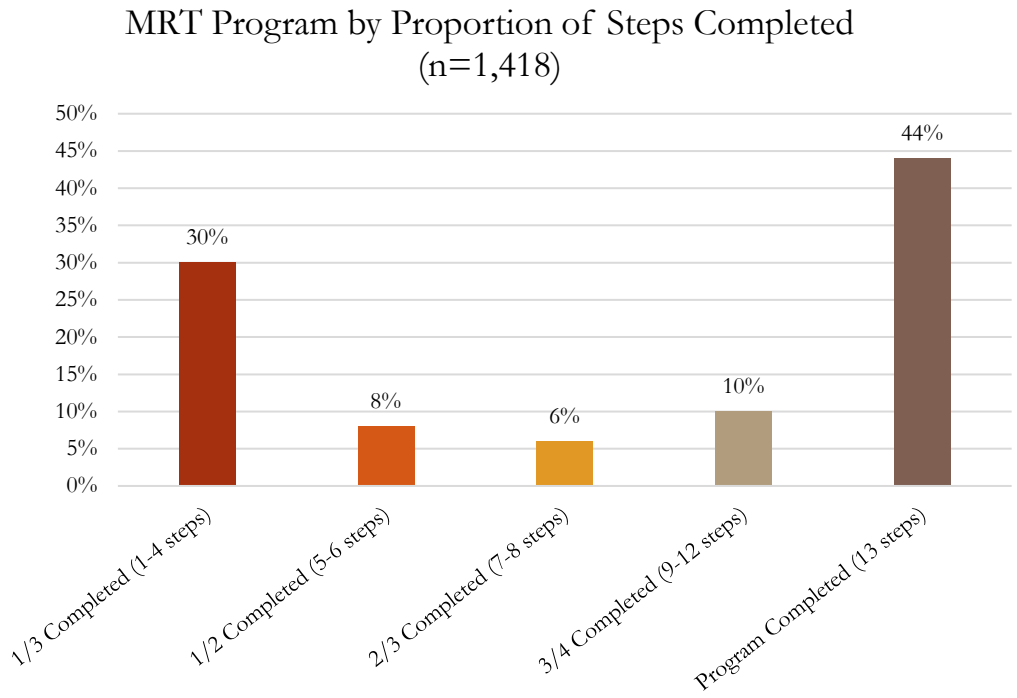
Table 1. Characteristics of MRT Participants

	MRT Participants (%)	Comparison (No MRT) (%)	Significantly Different?
Demographics			
Male	77.8	90.2	Yes
Female	22.2	9.8	Yes
Age	36.36	39.30	Yes
White	58.0	57.7	
Black	27.5	25.0	Yes
Hispanic	8.7	11.8	Yes
Native American	4.1	4.1	
Asian	0.5	0.7	
Other	1.0	0.6	
Prior NDCS Placement	37.6	34.7	Yes
Institutional Programs			
Clinical Substance Use Program	37.1	0.0	Yes
Clinical Violence-Related Program	7.8	0.0	Yes
Clinical Sex Offender Program	2.6	0.0	Yes
Institutional Factors			
Felony Offense	94.8	93.0	Yes
Misdemeanor Offense	5.2	7.0	Yes
Parole Eligible	16.1	16.8	
Restrictive Housing	31.5	27.4	Yes
Outcomes			
Class 1 Misconduct	31.4	28.2	Yes
Class 2 Misconduct	36.5	32.3	Yes
No Misconduct	32.0	39.3	Yes
Parole Revocation	37.3	50.2	Yes
No Parole Revocation	62.7	49.8	Yes
	n=1,418	*n=7,888*	

Completion Rates

Figure 1 shows that between October 2015 and February 2017, 30% (about 425 inmates) of the 1,418 MRT program participants completed at least one-third of the program (i.e., 1 – 4 steps). Approximately 44% (623 inmates) successfully completed all 13 steps of the program. It is important to note that MRT program participation can be "rolling," with inmates coming into and leaving the program very fluidly – upon transfer or parole, for example. They may be allowed to "pick up where they left off" when they move to a different facility or return to prison – to capture this fluidity, Figure 1 shows the MRT participants' last completed MRT step, as depicted in NDCS records.

Figure 1.



Completion Rate by Facility

When examining the percentage of MRT program completion across facilities where the inmate was initially received (see Figure 2), Tecumseh State Correctional Institution (TSC) has the highest proportion of inmates completing MRT (25%) compared to all other facilities, followed by the Nebraska Correctional Center for Women (NCW (17%).

Because inmates are transferred between NDCS facilities for various purposes, however, and because they can enter and exit the MRT programs on a rolling basis, we also examined MRT completion rates by the institution in which a misconduct occurred. Figure 3 shows that when the data are filtered by the site of the misconduct, the Nebraska State Penitentiary (NSP) has the highest percentage of inmates completing MRT (18%), followed by NCW (15%) and TSC (13%).

Figure 2.

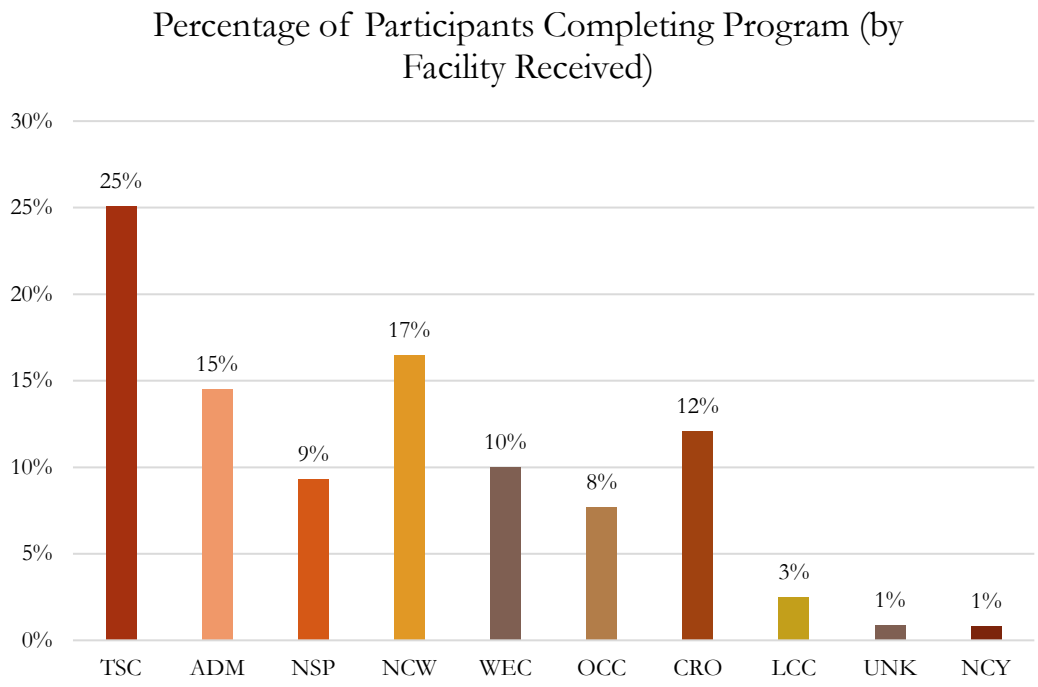
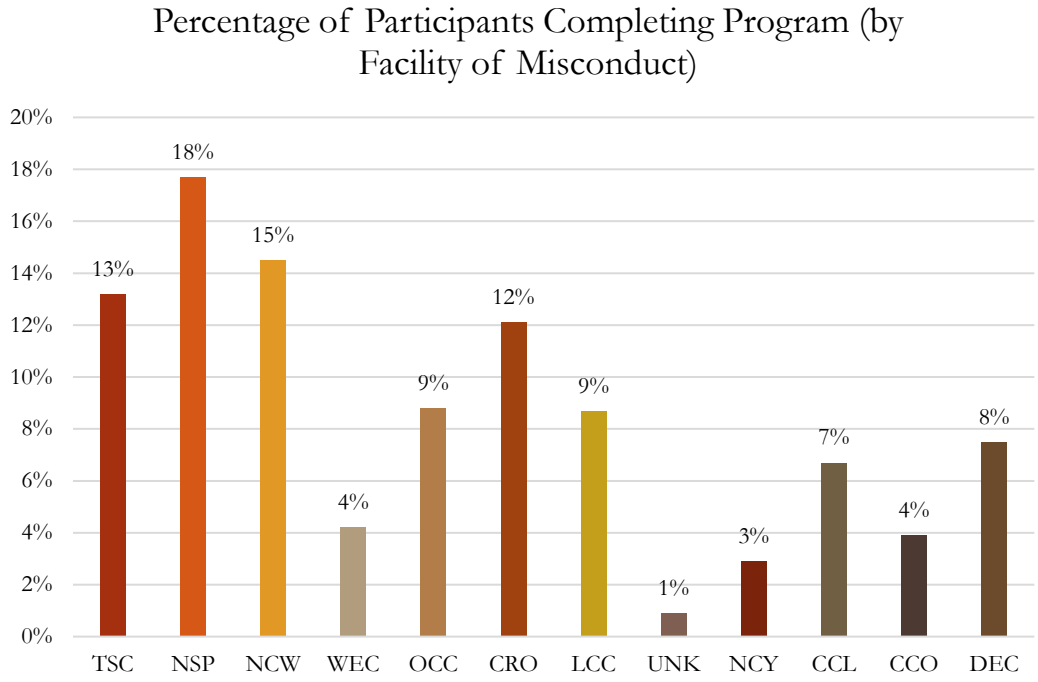


Figure 3.



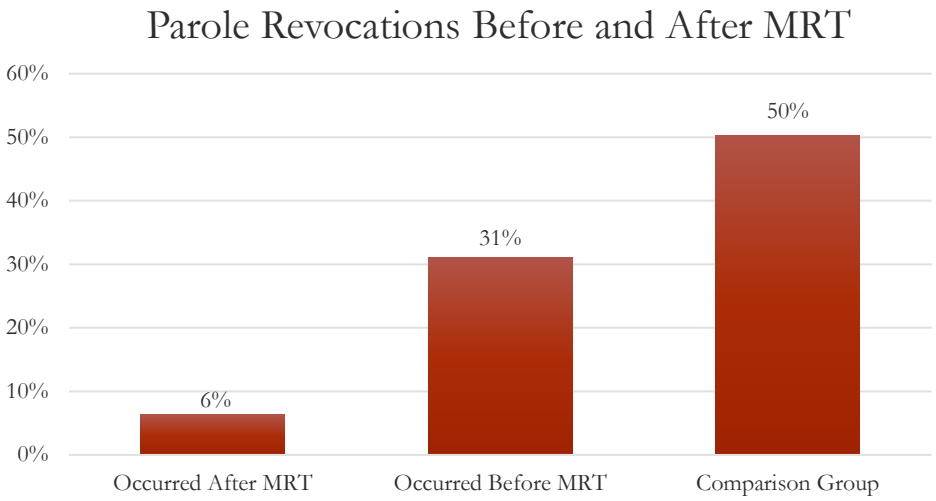
Time-Ordered Outcomes for MRT and Comparison Groups

Table 2 provides the percentage of MRT participants who engaged in misconducts and violated parole compared to the inmates in the comparison group. As mentioned, in many cases, inmates tend to start participating in the MRT program soon after they engaged in a misconduct or violated parole. Therefore, it was important to determine if their participation in the MRT program was a *result* of the misbehavior (i.e., they enrolled in MRT after they misbehaved) or an *antecedent* to it. Recall from Table 1 that the MRT group higher rates of misconducts when temporal order was not established between MRT participation and misconducts or parole revocation. We were able to determine if the misconduct and parole violation occurred before the inmate began the MRT program ("Occurred before MRT"), or whether it occurred after they began the program ("Occurred after MRT"), and the results are presented below in Table 2, and Figures 4 and 5. These results demonstrate that more inmates in the MRT group engaged in misconducts *prior to* enlisting in the MRT program (approximately 27% for Class 1 misconducts and 28% for Class 2 misconducts) than those inmates who had some form of MRT program participation first (almost 5% versus 8%, respectively). This reflects the fact that many inmates chose to participate in the program in the aftermath of misbehavior, and underscores the importance of establishing temporal ordering between MRT participation and outcomes. Similarly, 31% of MRT participants violated parole *prior to* beginning the program, compared to only 6% who did so after they had started (or completed) the MRT program.

Table 2. Time-Ordered Outcomes by Group (%)

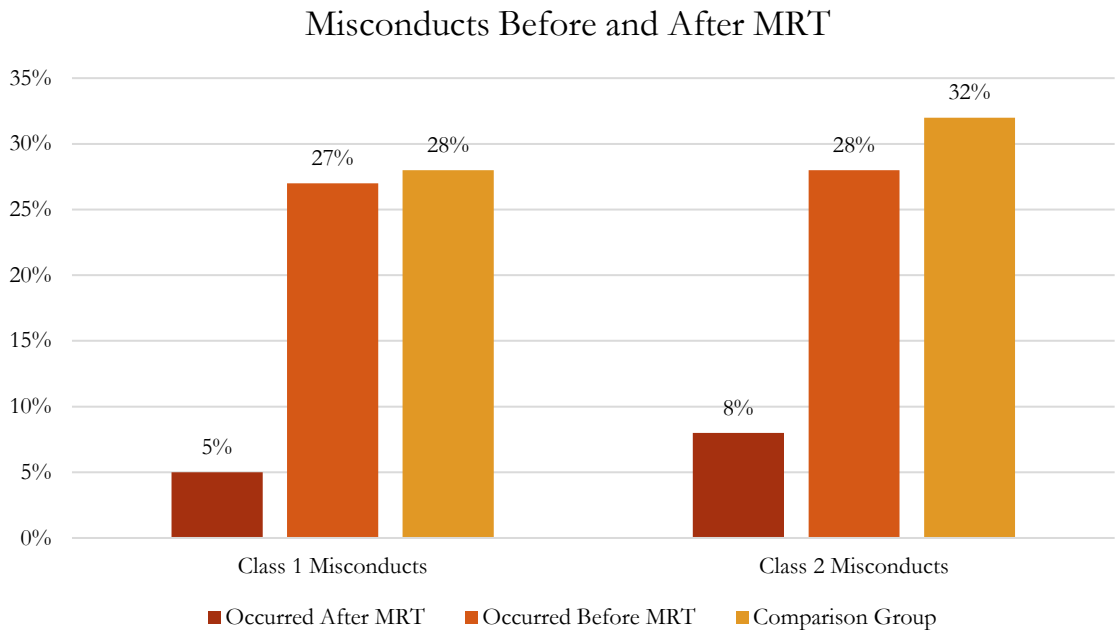
	Occurred Before MRT	Comparison Group	Significantly Different?	Occurred After MRT	Comparison Group	Significantly Different?
Misconducts						
Class 1 Misconduct	26.6	28.3		4.8	28.3	Yes
Class 2 Misconduct	28.2	32.4	Yes	8.3	32.4	Yes
No Misconduct	32.1	39.4	Yes	32.1	39.4	Yes
Parole Revocation						
Parole Revocation	31.0	50.2	Yes	6.3	50.2	Yes
No Parole Revocation	62.7	49.8	Yes	62.7	49.8	Yes

Figure 4.



Relative to the comparison group, both MRT groups (those who engaged in misbehavior before versus after MRT program participation) had significantly fewer Class 2 misconducts and parole violations, but the differences were most pronounced among the post-MRT group and the comparison group. Fewer MRT group members engaged in Class 1 misconducts (5% versus 28% of the comparison group), Class 2 misconducts (8% versus 32%), and parole revocations (6% versus 50%) *after* MRT participation than the comparison group, and these differences appear fairly robust. **Overall, these results suggest that MRT participation is significantly associated with lower rates of Class 1 and Class 2 misconducts, as well as lower rates of parole revocation.**

Figure 5.



Characteristics of MRT Participants who Violate Parole

Since returning to prison (violating parole) is a major concern for prison administrators and public safety officials, we examined the demographic and institutional factors that characterize MRT participants who violated their parole, compared to the comparison group (see Tables 3 and 4) in order to determine whether parole violations are more likely for certain MRT participants relative to the comparison group. Results in Table 3 reveal that MRT participants whose parole was revoked after MRT participation were primarily male, white, and had previously been placed under NDCS supervision (46%). MRT participants who violated their parole before beginning the MRT program were also primarily male, white and almost 40% had previously been incarcerated at an NDCS facility. Comparatively, the comparison group was overwhelmingly male, white, and fewer had been previously at an NDCS facility.

The MRT groups and comparison group were significantly different on a number of characteristics – including gender, race (white, other race), and prior NDCS placement. There were more female, white, and "other" race inmates and those with prior NDCS placements in the MRT groups and inmates who violated parole after MRT were more likely to be black. The comparison group had more Hispanic inmates than the MRT group who violated parole before entering the MRT program.

Table 3. Demographic Comparisons (%)

	Revocation Occurred Before MRT	Comparison Group	Significantly Different?	Revocation Occurred After MRT	Comparison Group	Significantly Different?
Male	69.9	90.2	Yes	74.4	90.2	Yes
Female	30.1	9.8	Yes	25.6	9.8	Yes
Age	36.7	39.30		34.5	39.30	
White	63.3	57.7	Yes	58.9	57.7	Yes
Black	21.6	25.0		27.8	25.0	Yes
Hispanic	8.2	11.8	Yes	8.9	11.8	
Other	1.6	0.6	Yes	2.2	0.6	Yes
Prior NCDS Placement	39.9	34.7	Yes	46.7	34.7	Yes
N =	*439*	*7,888*		*90*	*7,888*	

Again, MRT participation appears to be significantly related to whether inmates also participate in other forms of programming. Table 4 demonstrates that significantly more MRT participants (regardless of whether their revocation occurred before or after MRT program participation) also participated in substance use programming, while MRT participants who violated parole before MRT began were more likely to participate in clinical violence-related programming and sex offender programming, relative to the comparison group. Further, those who violated parole after MRT programming were less likely to have been incarcerated for a felony offense compared to the comparison group and were more likely to have been incarcerated for a misconduct. MRT participants were also less likely to have been in restrictive housing.

Table 4. Institutional Factors

	Revocation Occurred Before MRT	Comparison Group	Significantly Different?	Revocation Occurred After MRT	Comparison Group	Significantly Different?
Institutional Programming						
Clinical Substance Use Program	56.7	0.0	Yes	62.2	0.0	Yes
Clinical Violence-Related Program	7.5	0.0	Yes	5.6	0.0	
Clinical Sex Offender Program	1.6	0.0	Yes	0.0	0.0	
Institutional Factors						
Felony Offense	94.1	93.0		91.1	93.0	Yes
Misdemeanor Offense	5.9	7.0		8.9	7.0	Yes
Parole Eligible	31.7	16.8	Yes	100.0	16.8	Yes
Restrictive Housing	19.9	27.4	Yes	24.4	27.4	Yes
N=	*439*	*7,888*		*90*	*7,888*	

Completion Rates for those with Misconducts and Revocations

Table 5 shows the percentage of MRT participants who engaged in misconducts or violated parole (before and after MRT participation began) and how many steps of the MRT program they completed. The top half of the table shows no clear pattern where the number of MRT steps is related to a reduction in misconducts or revocations in the MRT group who misbehaved prior to beginning the program. These numbers are also portrayed in Figure 6 below, and show that about 20-40% of the inmates in this group engaged in misconduct before beginning the program, and 25-50% violated parole before entering the program.

The bottom half of the table, however, shows a pattern where there is a general decline with the number of MRT steps completed among the group that misbehaved after the program began. For instance, of those inmates who completed 1/3 of the MRT program (or 1-4 steps), about 6% engaged in a Class 1 misconduct after starting it, compared to approximately 4% who completed all 13 steps. These results are even more pronounced for the Class 2 misconducts and parole violations: 12% of participants who completed 1/3 of the program engaged in Class 2 misconduct after beginning the program, compared to only 6% of those who completed all 13 steps of the program. For revocations, 10% of those completing 1/3 of the program violated their parole after beginning the program, versus 3% of those who completed all steps of the MRT program (see also Figure 7).

Table 5. MRT Steps

	1/3 Steps	1/2 Steps	2/3 Steps	3/4 Steps	All Steps	Average Number Steps
Outcomes Before MRT Program						
Class 1 Misconduct	23.9	21.1	25.8	27.0	29.5	8.89
Class 2 Misconduct	27.2	28.1	38.7	27.6	27.6	8.39
Parole Revocation	33.7	49.1	33.3	26.3	26.6	7.81
N=	*427*	*114*	*93*	*152*	*632*	
Outcomes After MRT Program						
Class 1 Misconduct	6.1	4.4	6.5	3.3	4.1	7.31
Class 2 Misconduct	12.4	10.5	7.5	4.6	6.0	6.68
Revocation	10.1	8.8	8.6	5.3	3.3	6.20
N=	*427*	*114*	*93*	*152*	*632*	

Figure 6.

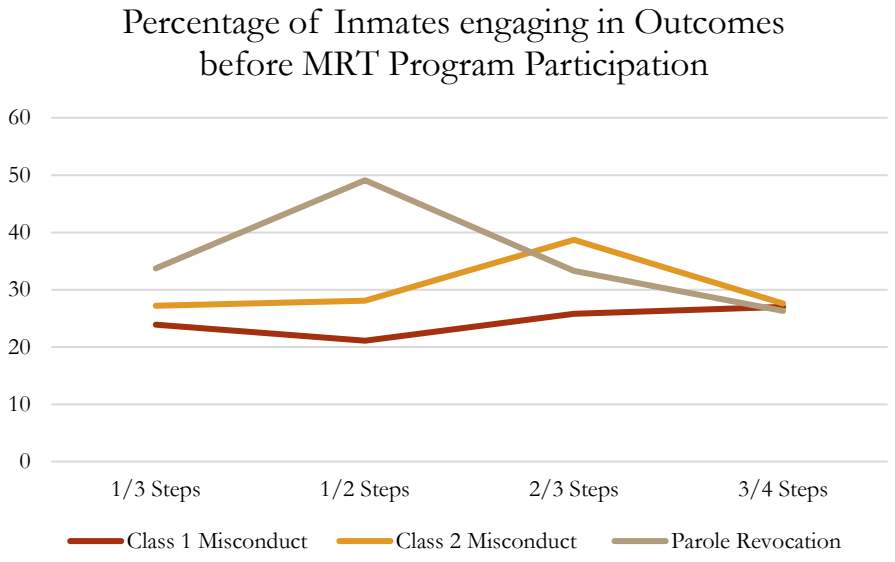
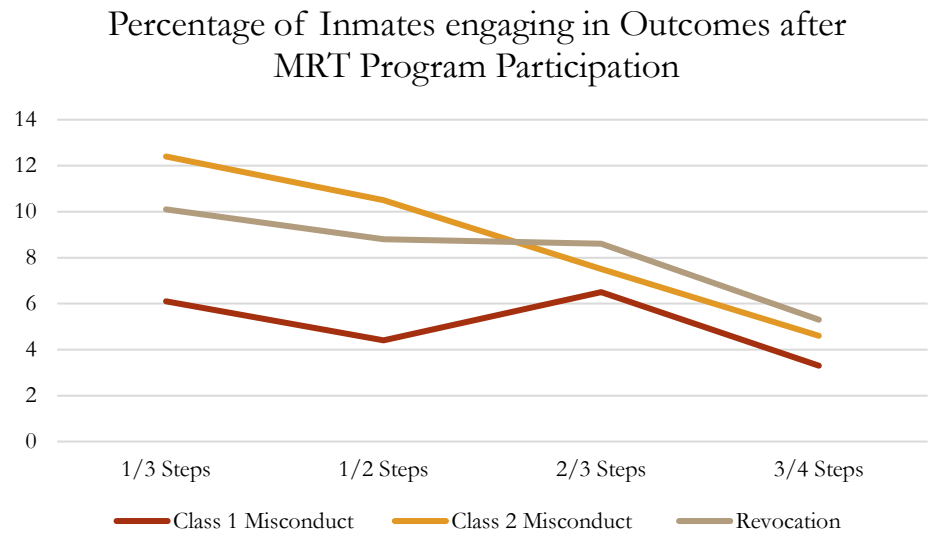


Figure 7.



Importantly, Figure 7 shows a decline in the likelihood of receiving a Class 1 misconduct or violating parole after participants complete about 2/3 of the program, or about 7-8 steps. There is also a somewhat sharp decline of Class 2 misconducts after participants complete ½ of the MRT steps, or about 5-6 steps.

Who Participates in MRT Programming?

Table 6 shows that although more female inmates begin the MRT program (36% compared to 28% of males), more males tend to complete all 13 steps of the program (49% versus 28% for females). Similarly, slightly more black inmates (31%) and Hispanic inmates (30%) begin MRT than whites (28%), but more white inmates (54%) finish all the steps of the program (compared to 45% of blacks and 43% for Hispanics). In short, MRT participants who start the program are most likely to be female, black, and have a prior NDCS placement, but those who finish the program are likely to be males, while, and have had a prior NDCS placement.

Table 6. MRT Steps

	1/3 Steps	1/2 Steps	2/3 Steps	3/4 Steps	All Steps	Average Number Steps
Demographic Characteristics						
Male	28.1	6.5	5.4	10.5	49.4	8.8
Female	36.6	13.4	10.5	11.5	28.0	7.1
Age	35.7	34.7	34.6	38.7	36.8	--
White	28.5	8.4	6.6	10.7	54.9	8.6
Black	31.5	6.7	6.7	10.0	45.1	8.4
Hispanic	30.6	7.3	7.3	11.3	43.5	8.4
Other Race	7.4	8.8	4.3	7.2	3.9	--
Prior NCDS Placement	30.8	8.8	6.2	12.2	42.0	8.3

"Other" Race includes NA, Asian, and Other

Involvement in other institutional programming (e.g., clinical substance use) is highly likely to co-occur with MRT completion – over 40% of those inmates who completed MRT also participated in other clinical programs offered at NDCS (see Table 7). Nonetheless, a large proportion of MRT completers (45%) are felony offenders, followed by 36% who are misdemeanor offenders. Almost a third are parole eligible, and 41% had been in restricted housing at some point during their incarceration.

Table7. MRT Steps

	1/3 Steps	1/2 Steps	2/3 Steps	3/4 Steps	All Steps	Average Number Steps
Institutional Programming						
Clinical Substance Use Program	28.9	9.3	5.9	9.7	46.2	8.5
Clinical Violence-Related Program	20.9	4.5	7.3	10.0	57.3	9.7
Clinical Sex Offender Program	27.0	5.4	13.5	13.5	40.5	8.3
Institutional Factors						
Felony Offense	29.9	8.0	6.6	10.4	45.0	8.4
Misdemeanor Offense	33.8	8.1	5.4	16.2	36.5	7.9
Parole Eligible	36.7	11.8	8.3	10.5	32.8	7.4
Restrictive Housing	36.1	5.8	6.7	9.6	41.7	7.9

Conclusions

This project sought to provide answers to NDCS regarding four main questions:

1. Which facilities are successfully providing MRT services to inmates?
2. Whether MRT participation reduces institutional misconducts and recidivism among inmates?
3. Whether MRT program participation is related to inmates' participation in other types of programming?
4. Which inmates participate in MRT programming?

It is difficult to provide a precise answer to the first question regarding which facilities provide MRT programming to the most inmates, primarily because inmates are transferred to different facilities. Regardless of whether MRT completion was arranged by the institution in which the inmate was received or where they engaged in misconducts, **Tecumseh State Correctional Institution and**

the Nebraska Correctional Center for Women have the highest proportion of inmates completing MRT compared to all other facilities.

The second question – whether MRT programming is associated with reductions in misconducts and parole violations – is easier to answer with the data. The simple answer to this is yes, **MRT program participation is related to lower Class 1 and Class 2 misconducts, as well as parole revocations** – and this is relative to both the comparison group *and* the MRT participants who engaged in misbehavior prior to entering the program. It is very important to determine the temporal order between MRT program participation and misconducts or parole violation, primarily because many inmates begin the MRT program after they misbehave. **Rates of misconduct and parole violations after inmates entered into the MRT program were less than 10%, with rates 2-3 times higher among the comparison group and MRT group who engaged in misbehavior prior to entering into the program. Additionally, completing 2/3 steps of the program appears to exert the most drastic reduction in all outcomes among the MRT group.**

Third, MRT participants are likely to also participate in other institutional programming that is offered at NDCS. We cannot discern if the MRT program involvement preceded inmates' participation in other programming, however. Regardless of the time order, **over 40% of those who completed the MRT program also participated in other clinical programming offered at NDCS**.

Regarding who participates in the MRT program, the answer somewhat depends on whether you look at "starters" in MRT (only completing 1-4 steps) or "completers" of MRT (who have completed all 13 steps), as some of the patterns change. In short, **MRT participants who start the program are most likely to be female, black, and have a prior NDCS placement. Those who finish the program, however, are likely to be male, white, and have a prior NDCS placement.**

Implications and Recommendations

Three recommendations follow from the results of this study.

- **First**, NDCS should continue providing the MRT program at its facilities, since the results of this study suggest that the MRT program is associated with lower levels of misbehavior among inmates. Preferably, NDCS should continue collecting data to further evaluate the program. Along these lines, the program should be evaluated from a *process* standpoint – to determine how well the program is being implemented across facilities.
- **Second**, the results suggest that participants who complete 2/3 of the MRT steps (7-8 steps) might see a precipitous decline in misbehavior. NDCS should focus on keeping participants in the MRT program (i.e., reduce dropouts) as long as possible (but preferably at least to 7 steps) in order to realize the greatest benefits of the program.
- **Third**, although more women and black inmates began the MRT program, males and white inmates were more likely to complete the program. Thus, NDCS should focus on keeping women and minority inmates from dropping out of the program prematurely.

Limitations

This study is not without limitations, which must be considered to understand these results. **First**, we have no measure of how well the MRT program is implemented across NDCS facilities. A measure of fidelity to the program is very important in order to be confident that the program itself is creating the intended results. **Second**, we have no way to tell the location at which inmates in the sample received the majority of MRT programming. This is related to program implementation fidelity, discussed above, and could mean that some MRT programs at some facilities are "better" delivered than others. Tracking this information would be helpful to NDCS administration. **Finally**, we were unable to determine why inmates did not complete the MRT program. That is, we cannot determine whether the non-completers dropped out of the program because they were uninterested or unwilling to attend the program, were released early or were transferred to a facility that did not adequately provide MRT programming, or engaged in bad behavior and were thus dismissed from the program. Understanding the reasons why MRT participants did not complete the program would be helpful for NDCS administrators. Unfortunately, we did not have enough data on this issue to provide reliable results in this report.

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