**Excerpted Review of Moral Reconation Therapy**

**From:**

A Structured Evidence Review to Identify Treatment Needs of Justice-Involved Veterans and Associated Psychological Interventions

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**Specific cognitive-behavioral therapies for criminogenic risk factors.** Specific CBT treatments are characterized by established training programs and treatment manuals aimed at standardizing the program implementation. There are three widely-used brand name CBT treatments developed for justice-involved adults: Moral Reconation Therapy (MRT), Reasoning and Rehabilitation (R&R), and Thinking 4 a Change (T4C). The next sections provide a brief review of the specific evidence for these treatments. This review focuses mainly on recidivism outcomes, as it is the outcome most consistently presented, and thus the most useful in comparing the treatments. Nonetheless, these treatments may have other important clinical benefits (e.g., in measures of social adjustment, substance use, or mental health symptoms), and some of these are highlighted for each treatment in the text below.

***Moral Reconation Therapy.***

*Treatment description.* The most extensive evidence-base is for MRT, which was developed by Little and Robinson between 1979-1983 (Little & Robinson, 1988). It was originally developed for use within a prison-based drug treatment therapeutic community, building on the behavior-based Reconation Therapy by adding elements focused on values and moral judgment as well as those aiming to reduce treatment attrition and to increase participation by justice-involved adults from minority groups (Little & Robinson, 1988). Since then, various adaptations have been developed to target specific populations, including those charged with driving while intoxicated (DWI), domestic violence, or a sex offense (Correctional Counseling Inc., 2010).

The treatment is based on the assumption that criminal behavior stems from low levels of moral reasoning, such as an inability to recognize the impact of self-centered behavior on the well-being of others and society as a whole (Correctional Counseling Inc., 2010). The group counseling sessions use cognitive-behavioral techniques to move participants through 16 Steps in the development of moral reasoning (see Table 9), leading participants to confront personal beliefs, assess relationships, develop a positive identity, enhance self-esteem, decrease hedonism, and increase ability to delay gratification (Milkman & Wanberg, 2007). The program allows each participant to move through the steps at their own pace, such that counseling groups are able to incorporate new members at any time (Little, 2003). The number of group members has varied widely depending on the adaptation and setting, from 5 group members to more than 20 (Milkman & Wanberg, 2007). The frequency of meeting has also varied widely, from once-monthly up to 5-times weekly (Milkman & Wanberg, 2007). It generally takes 12 to 30 sessions to complete the program (Little, 2003).

An important element of MRT is regular homework assignments, including drawings and short assignments designed to be appropriate even for those with low reading skills or intellectual functioning. These assignments are completed by participants and then presented to the group for feedback and assessment during regular sessions. In addition, individual counseling sessions may be provided where appropriate (e.g., to discuss confidential information; Correctional Counseling Inc., 2010).

*Overview of the evidence.* Several meta-analyses have demonstrated consistent positive effects on recidivism for MRT (Aos et al., 2006; Little, 2001, 2005; Wilson, Bouffard, & Mackenzie, 2005). Most recently, a meta-analysis of 33 published MRT studies meeting specific criteria (e.g., including a comparison group, providing enough information to calculate an effect size, specifying the treatment setting) was carried out by researchers not affiliated with the developers of MRT (Ferguson & Wormith, 2012). They estimated that MRT participants reduced their recidivism by one-third compared to participants who did not receive MRT (p<0.001). Of note, most of the studies were published in a journal owned and operated by Correctional Counseling, Inc. (CCI), which is run by one of the MRT developers. However, Ferguson and Wormith (2012) found that reduction in recidivism for the 21 studies published in CCI-owned journals was actually significantly smaller than in the 12 studies published elsewhere.

Significant positive effects on recidivism were found for studies in both institutional settings and in the community. When comparing settings, significantly larger positive effect sizes of MRT were found in the 25 studies set in institutional settings compared to the 7 studies set in the community. The 20 studies with small sample sizes (<200 participants) produced an overall effect of the same magnitude as the 8 studies with a sample size of over 500. As larger studies may have been provided under conditions more similar to routine practice, the authors concluded that this finding was encouraging. Only 2 studies in this review focused on women, but the studies had a significantly larger positive effect than the 31 studies using samples of men (Ferguson & Wormith, 2012).

*Specific studies.* Based on the meta-analyses reviewed above, we identified 28 distinct MRT trials carried out in samples of adults. To provide further details about the specific studies that form the evidence base for MRT, we present information on these studies in Table 10.

*Overview of studies.* These 28 studies were all carried out in the USA. None of the studies was a randomized controlled trial. These 28 trials included studies with a matched control group (4 studies), a sequential cohort control group (2 studies), or a non-equivalent control group (16 studies), and studies without a comparison group (6 studies). Seven of the studies were focused on justice-involved women or had a mixed sample which included separate outcome information for the women.

Overall, 12 studies in this sample found that MRT participants had significantly lower recidivism rates compared to some type of comparison group. As can be seen in Table 10, these studies had various treatment settings and offender populations. Five studies showed a non-significant difference in recidivism rates comparing MRT participants to a comparison group, while none of the studies found a significant negative effect of MRT. The remaining 11 studies presented only raw recidivism data and did not present any statistical test results for recidivism outcomes.

We classified the studies according to the Maryland Scale of Scientific Methods with Level 1 being the weakest design and Level 5 being the strongest (see Table 10; Sherman et al., 1998). Studies which are at least Level 3 are considered rigorous enough to provide interpretable evidence about the impact of an intervention (Farrington, 2003). Importantly, the 6 MRT studies that were at Level 3 or 4 (there were no Level 5 studies) all demonstrated a significant reduction in recidivism in the MRT group. None of the studies focused on justice-involved women had designs strong enough to be categorized at Level 3 or 4 and most did not report statistical tests. Thus, the evidence from studies using more rigorous methods supports the effectiveness of MRT in reducing recidivism in justice-involved men.

*Other outcomes.* Aside from recidivism, some studies highlighted other benefits of participation in MRT, a few of which are highlighted here. Several studies (e.g., Burnette, Prachniak, Swan et al., 2005; Burnette, Leonard, Robinson, Swan, & Little, 2004; Gilreath, 1995; Lindholm, 1998) found significant improvements in life purpose (Life Purpose Questionnaire; Hutzell, 1989) and moral reasoning (The Defining Issues Test; Rest, 1990). Other studies found significant reductions in substance use (e.g., Anderson, 2002; Fuller, 2003), as well as improvements in willingness to change substance use (Fuller, 2003).

*Veteran-specific research.* None of the studies in Table 10 specifically focused on justice-involved Veterans or on the subgroups of justice-involved women Veterans, justice-involved older Veterans, and justice-involved OEF/OIF/OND Veterans. However, there has been some limited implementation of MRT for reentry Veterans in VA (R. Guerra, personal communication, November 19, 2012), though this did not include a formal evaluation. The MRT developers are in the process of producing Veteran-specific adaptations of some MRT materials (K. Robinson, personal communication, October 23, 2012).

Very few studies focused on specific elements that may be of particular interest to researchers expanding MRT to Veterans. For example, none of the reports mentioned elements focused on trauma experience and/or PTSD. However, given the prevalence of IPV among justice-involved Veterans, the 2 studies that focused on IPV offenders may be of particular interest (Fann & Watson, 1999; Leonardson, 2000). In both IPV studies, treatment completers had lower recidivism rates than non-completers, but neither study reported significance levels.