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Evaluating Implementation and Adaptation of Moral Reconciliation Therapy at a Local Jail

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Evaluating Implementation and Adaptation of
Moral Reconciliation Therapy at a Local Jail

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DISSERTATION

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Doctor of Psychology in the Department of Clinical Psychology
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DISSERTATION COMMITTEE PAGE

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**EVALUATING IMPLEMENTATION AND ADAPTATION OF
MORAL RECONATION THERAPY AT A LOCAL JAIL**

presented on July 10, 2020

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Dedication

*To my husband, Kelly Dowd,
without whom I would never have been able to undertake this adventure,
and to my mother, Mary Gregory,
who seeded the dream.*

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Table of Contents

Abstract.....	1
Introduction.....	2
The Challenge of Preventing Recidivism	2
Implementation and the Unique Problems of Local Jails	3
Evaluating Implementation of Cognitive Change Program at a Local Jail	5
Key Constructs.....	6
Evidence-Based Programs in Correctional Settings	6
Implementation	7
Modification/Adaptation.....	8
Risk-Need-Responsivity	8
Moral Reconciliation Therapy	10
Theoretical Framework	11
Literature Review.....	11
Principles of Effective Intervention	11
Research Supports Efficacy of MRT	13
Quality of Implementation is Important	14
Rehabilitation in the Real World	15
The RNR Model Encourages Implementation Integrity and Shapes Adaptation	16
Research Gap and Purpose of This Study.....	18
Research Methodology and Design	19
Qualitative Design and Method	20
Participants.....	20
Measures	21
Analysis.....	25
Researcher Bias.....	26
Results.....	27
How the Program was Chosen.....	27
How Modifications were Made	28
MRT Training	30
Difference in Training.....	31
How Members were Chosen.....	32
Selection Process	33
Primacy of Antisocial Personality Traits	33
Length of Stay Related to Selection.....	34
Dosage.....	35
Length of Stay Related to Dosage	35
Pressure from Outside: Lawyers and Courts	36
Deliberate Modification: A Solution	37
Mental Health-Informed Modifications	38
Risk-Need-Responsivity	39
Risk	39
Need	42
Responsivity.....	42
Discussion.....	45

Overall Integrity.....	45
MRT Compatibility with CCHOC and How it Relates to the Literature	46
Modification: Tailored and Deliberate.....	47
Implementation Doesn't' Have to be Perfect.....	48
Significant Deviations.....	49
Risk-Needs-Responsivity.....	59
Limitations	60
Core Components.....	61
Outcomes	61
Future Research	62
Conclusions.....	62
References	64
Appendix A: Application for IRB Approval	68
Appendix B: Letter of Support	74
Appendix C: Informed Consent.....	75

Abstract

Recidivism among criminal offenders has been a persistent and intractable problem for many decades. Cognitive behavioral interventions, particularly when implemented with adherence to the Risk-Need-Responsivity (RNR) treatment model, have proven to be effective in reducing recidivism rates. However, real world circumstances in penal institutions place restrictions on how these programs are implemented and may make it difficult for these interventions to be instituted with integrity and/or adherence to the RNR model. This is a particular challenge at local jails, which house shorter-term populations and have fewer resources. Currently there is a lack of research looking at the effectiveness of treatment programs in jail settings. The majority of research has been on programs instituted within the prison system, which houses a different population, with lengthier and more predictable periods of incarceration (Lizima et al., 2014). More research is needed on treatment programs in local jails to investigate how these programs are implemented, what modifications are made, and whether or not these programs, either modified or implemented as designed, are effective (Durlak & DuPre, 2008). This study confirmed the existence of substantial challenges to maintaining integrity of implementation in a jail setting, particularly related to dosage. Interviews revealed that numerous modifications were made to the MRT protocol when implemented, both initially and over time. Many of these modifications were minor and incidental, but a number of them made substantive changes to the program. The decision-making process of the staff responsible for implementing the program was thoughtful, creative, and ultimately motivated primarily by clinical concerns related to the specific population being served. Modifications were generally consistent with the RNR model.

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Keywords: MRT, implementation, recidivism, RNR model

Evaluating Implementation and Adaptation of Moral Reconciliation Therapy at a Local Jail

The Challenge of Preventing Recidivism

High incarceration rates and recidivism have a significant impact on the United States (Kaeble et al., 2015). The most recent data from the Bureau of Justice Statistics indicates that 1 in 38 adults, or 2.6% of individuals over 18, are under some type of correctional supervision, and .85 % of adults in the U.S. were incarcerated at the year's end in 2016 (Kaeble & Cowhig, 2018). Involvement in the criminal justice system costs money in terms of incarceration and supervision, as well as lost contribution to the economy and earning power (McLaughlin et al., 2016). Costs to victims of crime are high, causing physical, psychological, and economic damage, manifested in medical care costs, lost earnings, and property loss and damage, as well as physical and psychological pain and distress (McCollister et al., 2010). Crime also results in a real and a perceived reduction in the safety of our communities, economic and emotional turmoil for the families of inmates, and the creation of a continuing generational cycle of offending (Will et al., 2014). Parental incarceration is linked to trauma for the children of incarcerated offenders (Arditti, 2012). Additionally, because black people tend to be incarcerated at higher rates than Americans of other races, high incarceration rates raise important questions of social justice (Glaze, 2011).

Recidivism rates have consistently remained high. A longitudinal study by the U.S. Department of Justice looking at recidivism rates between 2005 and 2010 showed that 67.8% of state prisoners were arrested within three years of release, and 76.6% were arrested within 5 years of release (Durose et al., 2014). A follow-up study completed in 2018 revealed that nine years following their release, 83% of state prisoners had been arrested at least once (Alper et al., 2018). For decades, those involved in the incarceration and rehabilitation of offenders have

struggled to determine what causes criminal behavior and how best to treat it to reduce the high rate of re-offending (Taxman et al., 2011). One intervention that has consistently shown promise is cognitive change programming (Landenberger & Lipsey, 2005). Research supports the efficacy of cognitive behavioral interventions, both in creating change in the cognitive “markers” linked with criminogenic thinking, and in reducing rates of recidivism (Hansen, 2008; Walters, 2016). However, to be most effective, treatment programs in correctional settings must take into account limitations on ideal implementation, as well as the unique characteristics of this population, and follow established principles for implementation based on research in correctional settings (Smith et al., 2009).

Implementation and the Unique Problems of Local Jails

Adaptation may be particularly important in jail settings, where a host of real-world limitations make implementation, according to design, very difficult. Jails are different from prisons. Prisons are state and federally operated institutions; jails are local, primarily county-run facilities that house sentenced inmates serving one year or less, as well as people being held pre-trial (Subramanian et al., 2015). While prison inmates are sentenced, the majority of the jail inmate population is pre-trial, meaning that they have not yet been convicted of the charge for which they are currently being incarcerated (Ortiz, 2015). Although some of the individuals held pre-trial are federal or state inmates who have been charged with serious felony offenses, most of the individuals being detained pre-trial are low-risk, and the length of stay for the majority of inmates averages less than a month (Subramanian et al., 2015). A numerically greater number of inmates are held in prisons in the U.S. (Kaeble & Cowhig, 2018), but the number of annual admissions to jails is far greater, almost 19 times greater, than admissions to prisons, which suggests that there is far less stability among this population, making it more difficult to predict

the length of time an inmate will remain incarcerated (Lizama et al., 2014; Subramanian et al., 2015). The rising cost of housing this population has become a growing concern for jails as it puts pressure on county budgets across the United States (Ortiz, 2015).

While the rising cost of running jails has made the reduction of recidivism a high priority for many local jurisdictions (Ortiz, 2015), jails pose specific challenges in terms of the implementation of treatment programs designed to reduce recidivism. Because jails have a much more transitory population than prisons, with a shorter duration of incarceration, it is more difficult to provide continuous treatment, or to deliver the full dosage of a given intervention (Lizama et al., 2014). In addition to the challenges posed by the short-term, transient nature of the jail population, many correctional facilities face real-world limitations in terms of budget and staffing, further complicating the implementation of programs consistent with recommended best practices for the treatment of offenders (Ortiz, 2015).

Research indicates that the way interventions are implemented in correctional settings is as important as the program itself (Landenberger & Lipsey, 2005; Wilson et al., 2005). Although select short-term treatment programs can effectively reduce recidivism when administered to a jail population, the limitations inherent in this setting may require staff to modify these programs to make them more effective (Lizama et al., 2014). Adaptation of a program is not necessarily synonymous with an ineffective intervention (Durlak & DuPre, 2008). Because treatment providers and other decision makers know the inmates and the environment, staff at local houses of correction may have the ability to modify a program so that it is sustainable within the limitations of the institution, yet it remains an effective intervention for their particular population of inmates. However, to be effective, implementation and adaption should not be done haphazardly. Decades of research has shown that certain principles should guide decisions

about the type of intervention to use, and how to administer it to achieve good outcomes (Durlak & DupPre, 2008).

Currently there is a lack of research looking at the effectiveness of treatment programs in jail settings. The majority of research has been done on programs instituted within the prison system, which houses a different population and has longer and more predictable terms of incarceration (Lizama et al., 2014). More research is needed on treatment programs in local jails to investigate (a) how these programs are implemented, (b) what modifications are made, and (c) whether or not these programs, either modified or implemented as designed, are effective (Durlak & DuPre, 2008).

Evaluating Implementation of a Cognitive Change Program at a Local County Jail

The purpose of this research was to study a newly implemented cognitive change program at a local county jail in a rural area of New England. The study explored how the intervention was implemented, looking at the degree of integrity with which the program was administered and the adaptations that were made to the program. The study also analyzed the program through the lens of the Risk-Needs-Responsivity (RNR) model, which has been empirically demonstrated to be effective with incarcerated populations. The program, Moral Reconciliation Therapy (MRT), which was the subject of this research, is a manualized, evidence-based program intended to reduce criminogenic thinking and recidivism. MRT has been shown to be effective in reducing the cognitive distortions that underlie criminal offending and re-offending (Ferguson & Wormith, 2012).

This research project explored how this program was implemented, how it was modified or adapted initially, as well as whether and what further modifications were made over time, with

particular attention to the decision-making process of staff responsible (for implementing the program and engineering changes) and the rationale for their modifications. The study focused on three salient aspect of implementation: (a) how participants were chosen, (b) what “dosage” of treatment was provided, and (c) the impact of training and support for intervention staff on the way treatment was delivered.

The primary questions this research project sought to answer are:

1. How was this particular intervention chosen and modified for use in this setting?
2. What was the degree of integrity of implementation of the MRT program at the CCHOC?
3. How were participants selected for the group, and how did this selection compare to the Risk-Needs-Responsivity model’s recommendations about which individuals are most likely to benefit from this intervention?
4. What determined the dosage of the intervention, and how did this compare to the “ideal” dosage as set forth by the creators of MRT?
5. How were modification decisions made, and what was the rationale for these changes?

Key Constructs

Evidence-Based Programs in Correctional Settings

Evidence-based programs are treatment programs that have been determined to be effective through scientific evaluation (Przybylski & Orchowsky, 2015). Programs that are shown to be effective reduce the chance of wasting resources on interventions that do not produce results and increase the overall cost-effectiveness and efficiency of treatment (Przybylski & Orchowsky, 2015). Over the past two decades there has been an increasing emphasis on using evidence-based programs in correctional settings, and a growing body of

research has emerged concerning how to target the problems faced by this population, specifically criminal behavior and recidivism (Przybylski & Orchowsky, 2015).

Implementation

How a program is implemented can have a substantial impact on its effectiveness (Durlak & Dupre, 2008). Assessment of implementation is vital to obtaining good data about whether or not a particular intervention is effective (Smith et al., 2009), as well as the ways in which programs are likely to be adapted in specific settings (Moore et al., 2013). Despite mounting evidence that the integrity of implementation increases effectiveness (Lowenkamp et al., 2006), assessment of implementation is often not done (Fixsen, 2014), and a lack of therapeutic integrity continues to be a problem in correctional settings (Smith et al., 2009). This is particularly true for jail settings (Lizama et al., 2014).

The study of program implementation looks at how an intervention is delivered in a particular setting. There are a number of different aspects of implementation, which include (a) fidelity, (b) quality of delivery, (c) participant responsiveness, and (d) program adaptation (Moore et al., 2013). *Fidelity* is the degree to which implementation adheres to program design and the model of change. *Quality of delivery* refers to how well program components have been conveyed. This includes, for example, clarity of delivery, the quality of teaching, and facilitator engagement. *Participant responsiveness* refers to the degree and quality of participant's engagement with the program (Moore et al., 2013). The terms "fidelity" and "integrity" are sometimes used interchangeably in the literature on implementation. Fidelity, however, refers specifically to how closely program implementation adheres to the details of the program design. This concept is narrower in scope than integrity, which includes other facets of implementation such as quality of delivery, participant responsiveness, and adaptation. This study did not focus

on measuring fidelity of implementation, but looked more generally at integrity of implementation, and the degree to which implementation at the jail embodied the fundamental aspects of the intervention while accommodating the local needs and circumstances of the setting (LeMahieu, 2011).

Modification/Adaptation

When programs are instituted, the environment in which they are being utilized shapes them. It is unrealistic to expect that implementation will exactly replicate the recommended protocols. Adaptation or modification refers to the ways in which interventions are changed, specifically changes to the content or method of delivery that are deliberately or accidentally made to the program in a particular setting (Bumbarger, 2014). Given that evidence-based programs are designed to be implemented in a particular manner, and that the research supporting their efficacy is based on this design, modifications—particularly modifications to “core components” of a program—have the potential to undermine the effectiveness of the treatment. In order to avoid this outcome, it is important that adaptation be done in a conscious and strategic manner and be guided by research and carefully monitored (Przybylski & Orchowsky, 2015).

Risk-Need-Responsivity

In correctional settings, it is important that any modifications that are made are consistent with the research about what works best with individuals involved in the criminal justice system (Bonta & Andrews, 2007). One model that is strongly supported in the literature on the treatment of correctional populations is the Risk-Needs-Responsivity Model (RNR). The RNR model is not an intervention, but a framework that aids in determining which interventions will be most efficient and effective with particular inmate groups. Based on decades of research, the RNR

treatment model has isolated three essential principles of effective intervention in correctional settings: (a) risk, (b) need, and (c) responsivity (Looman & Abracen, 2013).

Risk. The principle of risk refers to the concept that treatment is most likely to be effective when it is implemented with higher risk groups of offenders. It is important to be able to distinguish low-risk offenders from higher-risk offenders to ensure that the appropriate level of treatment is provided (Bonta & Andrews, 2007). In order to maximize outcomes and avoid harm, high-risk offenders should receive more intensive treatment in higher doses than low-risk offenders. Research has shown that administering low dosage of treatment to high-risk offenders may actually have a negative impact, and providing low-risk offenders with high intensity programming may actually increase, rather than decrease, the risk of recidivism among this population (VanDine & Bickle, 2010). Based on this principle, best practice requires that potential participants in any program be assessed to determine their level of risk and matched with an intervention appropriate to their risk level (Bonta & Andrews, 2007).

Need. The principle of need refers to the criminogenic characteristics of the offenders receiving treatment. Research supports the conclusion that if the goal is to reduce recidivism, the most effective treatments are interventions that target criminogenic needs such as (a) a history of antisocial behavior, (b) an antisocial personality pattern, (c) antisocial cognition, (d) an antisocial network of relationship, (e) low support in terms of family or work, (f) few positive leisure activities, and (g) substance abuse (Looman & Abracen, 2013). Interventions should be chosen that have been proven to effectively target these needs (Bonta & Andrews, 2007).

Responsivity. The principle of responsivity encompasses both general and specific aspects of the chosen intervention. Selection of an intervention should be driven by its demonstrated effectiveness with correctional populations generally but should also be tailored to

match the specific group to whom it will be administered. The Responsivity construct of the RNR theory corresponds with the participant responsiveness dimension of implementation. The most well-supported, evidence-based intervention will not be effective if it is provided to inmates who do not have the capacity to receive the treatment, generalize it, or make use of it once they have been released from incarceration. Treatment approaches should take into account the participant's learning style, motivation, and ability to ensure that participants get the maximum benefit from the intervention (Bonta & Andrews, 2007; Looman & Abracen, 2013).

Moral Reconciliation Therapy (MRT)

MRT is a manualized cognitive behavioral intervention that was designed for use with correctional populations. Based on Kohlberg's theory of moral development, the term "moral reconciliation" refers to the conscious process of decision-making and is intended to emphasize the ultimate goal of treatment (Little & Robinson, 2006). The aim of MRT is to help participants move from lower levels of moral reasoning to higher levels where their decision making is based not just on what brings them pleasure or pain, but also takes into account social rules and the needs of others (Ferguson & Wormwith, 2012). The theoretical underpinnings of MRT are supported by research that shows a negative correlation between recidivism and moral development (Van Vugt et al., 2011).

In jail and prison settings, MRT is typically done in rolling admission groups with participants who meet for 1–2 hours, one or two times per week. Each participant has an MRT workbook, which is used during group and contains homework assignments to be completed during the time between groups (Lizama et al., 2014). The MRT curriculum is based on 16 steps that are designed to promote increased moral reasoning. Twelve of the steps are to be completed during active participation in the group, with four additional steps that may be completed in the

community upon release. The program can be done in a minimum of three to six months (U.S. Department of Health and Human Services, 2013). According to the program manual, groups should contain 10–15 members, and the minimum length of the intervention is 14–16 sessions. All MRT instructors should be trained and certified (Lizama et al., 2014).

Theoretical Framework

This research studied how MRT was implemented in a local county house of corrections. The program was assessed with reference to the body of literature related to treatment integrity, using a qualitative approach to delve into questions concerning the kinds of changes or adaptations that were made to the program when it was initially implemented and over the first two years the program was being delivered. The study explored the process by which these changes were made and how various components of the intervention were affected. This study was not a program evaluation. The focus of the study was on the process of implementation and adaptation in a specific setting, not the outcome. The data gathered for this study involved the subjective experience of the program facilitators as they undertook the task of implementing an evidence-based program in a local jail setting, and how they went about it.

Literature Review

Principles of Effective Intervention

There are a number of factors that may lead to an increased risk of recidivism. Some of these factors, such as gender, inmate history, criminal record, and age, are static. No amount of intervention can alter past experience or immutable characteristics such as race and age. Cognitive distortions and deficits are considered to be dynamic factors, which are viable targets for treatment intervention (Walters, 2016). Cognitive distortions that justify criminal behavior, often referred to as “criminogenic” thinking, may weaken the prohibition against violating

societal rules and ease the pathway to criminal behavior. There are a variety of cognitive distortions that allow those who engage in criminal behavior to justify to themselves why it is acceptable to commit crimes, and these are thought to contribute to the tendency of offenders to engage in this behavior repeatedly (Taxman et al., 2011).

Research over several decades has demonstrated that rehabilitative programs are effective in reducing recidivism (Landenberger & Lipsey, 2005). However, they are not all equally efficacious. Principle of effective intervention have emerged which support the conclusion that the most successful interventions include three main characteristics: (a) participants selected for treatment are high-risk offenders, (b) treatment focuses on the criminogenic needs of the participants, and (c) interventions are based on cognitive behavioral principles which also take the offender's learning style, motivation, and abilities into consideration when selecting and delivering treatment. When all three of these characteristics are present and adherence is good, such interventions can result in a significant reduction in recidivism (Smith et al., 2009). This model has become known as the Risk-Need-Responsivity (RNR) model.

Consistent with the RNR model, cognitive change programs have been shown to be the most effective, and cost-effective, intervention for criminal offenders. Cognitive interventions can be used to modify the offender's thinking patterns and behavior so they will be more likely to conform to that of non-criminal individuals, and hence lead to a reduced risk of recidivating (Taxman et al., 2011). There are a variety of different program designs, but as dictated by the research supporting the importance of targeting criminogenic needs, the central focus of these approaches is an attempt to shift criminogenic thinking styles and attitudes (Smith et al., 2009). While this model has robust support based on extensive research, translating the model into actual treatment settings continues to pose challenges (Bonta & Andrews, 2007).

Research Supports the Efficacy of MRT

MRT has been recognized by SAMHSA and is listed in the National Registry of Evidence-Based Programs and Practices (NREPP). The use of MRT with incarcerated populations is considered a “best practice” in targeting recidivism in incarcerated populations (U.S. Department of Health and Human Services, 2013). Several controlled studies have demonstrated that MRT reduces recidivism among populations involved in the criminal justice system. The creators of the MRT program did a longitudinal study that looked at re-arrest and recidivism rates 5, 10, and 20 years after completion of the MRT program. The 20-year recidivism study yielded comparison data between MRT-treated groups and the control showing that the control group had a 81.8% re-incarceration rate and a 93.6% re-arrest rate, as compared to the MRT-treated group with a 60.8% re-incarceration rate and a 81.2% re-arrest rate over the 20-year period of release after treatment (Little et al., 2011).

A meta-analysis of MRT done by independent researchers who were not affiliated with MRT resulted in an overall effect size for the MRT program of $r=.16$. The study concluded that while this effect size might appear to be small, in the context of interventions aimed at the criminal justice population, this effect was significant in real-world terms, translating to MRT-treated offenders having a recidivism rate that was one third less than those who did not receive the intervention. This rate was comparable to that of other CBT programs offered in correctional settings (Ferguson & Wormith, 2012). Small effects such as those resulting from MRT may have a consequential impact in terms of future crimes committed, especially when these programs are offered on a large scale (Lipsey, 1992). Given the persistence of high rates of recidivism among criminal offenders, a program demonstrated to reduce recidivism by a third

has the potential over the long term to make a real difference in reducing crime, and breaking the cycle of criminal behavior for individuals involved in the criminal justice system.

Quality of Implementation is Important

While studies support the use of MRT as an effective intervention, quality of implementation is important to achieve good outcomes (Landenberger & Lipsey, 2005). There are a number of facets to implementation, and some may have more significance than others in terms of outcome (Miller & Miller, 2015). An example of the importance of quality implementation is provided by a meta-analysis conducted with adult and juvenile offenders that looked at the factors associated with effective treatment. This analysis included 58 experimental and quasi-experimental studies evaluating the recidivism effects of cognitive behavioral therapy interventions with adult and juvenile offenders and considered a variety of CBT programs with a focus on those aimed at cognitive restructuring and skill building. The study confirmed that cognitive behavioral interventions reliably reduce recidivism, though there was no indication that any particular approach worked better than any of the others aside from a larger effect size for programs that included anger control and interpersonal problem solving components (Landenberger & Lipsey, 2005).

This meta-analysis concluded that the general CBT approach was what caused the reduction in recidivism and not one particular “brand” of intervention. The most determinative factor in whether or not an intervention would be effective was the *quality of implementation*. Best results were achieved when there was a low proportion of treatment dropouts, close monitoring of the quality of implementation, and adequate training of providers. The study also noted that the effects of the interventions were larger for those offenders who were at higher risk

for recidivism, which is consistent with the principles of the RNR model (Landenberger & Lipsey, 2005).

Rehabilitation in the Real World

While cognitive programs seem to work, it is a bit less clear whether, and to what degree, this translates into a lower risk of recidivating for all the inmates who participate in these programs. Correctional institutions exist at the federal, state, and local level. They may have significant resources to devote to treatment or none at all. The prison/jail population varies significantly depending on the location and type of the facility, as does the ability and willingness of staff to provide treatment programs. Studies to date have looked at programs that have been empirically proven to improve outcomes, such as Moral Reconciliation Therapy. The programs studied are highly structured and based on manuals that provide detailed guidance on how the intervention should be implemented. Staff members who administer these programs have been trained in the use of the intervention. A common theme that emerged in the evaluative literature is the significant difference in outcomes depending on who administers the intervention and how it is implemented. It has been demonstrated that the effectiveness of these interventions decreases if the program design and implementation is compromised (Wilson et al., 2005).

In a retrospective quasi-experimental study with three separate sets of comparisons, the effect of a cognitive program targeting multiple criminogenic needs at a female prison demonstrated the importance of program integrity to treatment implementation in an actual real-life setting (Duwe & Clark, 2015). This study compared three groups of women who had participated in a cognitive behavioral program called “Moving On.” Using an historical comparison group, the study was able to compare women who had participated in the program with and without integrity in the administration of the intervention. The first and third groups of

women were provided treatment that conformed to program protocols, the second group was administered an altered program which deviated from the protocols of the intervention. For the first cohort, for whom the program was implemented with integrity, there was a 31% reduction in re-arrest and a 33% reduction in reconviction. For the second cohort, when the program had been altered and was being administered in a way that did not have program integrity, there was no discernable reduction in any of the four measures of recidivism. In the third cohort, when the program had been restored to its original intended design, the re-arrest and reconviction rate was comparable to the results from the original cohort, who received the treatment in accord with the design of the intervention (Duwe & Clark, 2015).

The “Moving On” study further demonstrates that cognitive behavioral intervention is effective in reducing recidivism, but that its effectiveness is contingent upon the quality of implementation. The modification of the program was a product of a variety of institutional factors that lead to a decision to “water down” the program, with fewer intervention hours and a shorter period of programming, among other alterations (Duwe & Clark, 2015). The question of how interventions may be modified in ways that allow them to retain efficacy has not been sufficiently studied, particularly in light of the fact that many institutions are unable to implement these programs with sufficient integrity to ensure the desired outcome (Durlak & DuPre, 2008).

The RNR Model Encourages Implementation Integrity and Shapes Adaptation

Programs that are intentionally modified due to time and budgetary considerations, in a way that takes into account local knowledge of the population being served, the length of incarceration, and the skill set of the staff available to administer the program may still be effective. It is possible that good programs could be designed under these conditions that address

the needs of the inmates and result in a reduction in recidivism. Innovations are not always bad and, given that many facilities are unable to implement programs with high levels of integrity, necessity inevitably gives rise to program modification. The question is how to use adaptation to improve implementation rather than having it lead to implementation failure. Studies have found that there are adaptations made by providers that have resulted in improved outcomes. When providers can see what needs to be adapted, believe they can get good results, have high self-efficacy, and the skills necessary to implement an intervention, they can adapt programs to better fit the needs of their local setting. It is important, when instituting these adaptations, to pay attention to which components are changed and track the results for targeted outcomes (Durlak & DuPre, 2008).

The reality is that in many local jail settings, where effective interventions could have significant impact, budgetary and staffing constraints, as well as the zeitgeist of the institution may determine what type of programming is available and how it is implemented (Durlak & DuPre, 2008). Small local jails may not be able to afford to purchase manuals and train personnel to run groups such as Moral Reconciliation Therapy. Unless ongoing training and support is provided, those running the programs may gradually fall away from adherence to best practices and the intervention will be subject to “program drift” (Bumbarger, 2014). In settings, such as the local jail that is the subject of this evaluation, other institutional priorities may shape the way the program is offered, who is allowed to participate, and how long participants may remain in the group even when this is not consistent with evidence-based protocols. Adaptation and modification are a natural part of the implementation of a program (Fixsen et al., 2005). Using the principles of RNR to guide modifications may help to ensure that while the intervention is

not being implemented exactly as designed, it still includes the essential ingredients that have been demonstrated to make treatment effective.

Research Gap and Purpose of this Study

If programs instituted in “real-world settings” are not studied, it is not possible to determine why an intervention failed (Miller & Miller, 2015). Is it because the intervention itself is not effective? Did it target the wrong individuals? Were core components of the intervention modified in such a way that the necessary elements for success were absent? If we do not evaluate programs as they are actually being instituted in correctional facilities we may run the risk of giving up on treatments that could be effective if implemented well enough, or continuing to waste resources by running programs that are ineffective or even harmful (King & Bosworth, 2014).

There is a continuing need to study programs that are adapted to suit the context where they are being used to determine whether or not they are effective interventions, as this is a reality in natural settings; many institutions are not able to implement programs with complete adherence to the principles of effective treatment. Staff limitations, shorter periods of incarceration, institutional pressure to include participants who don't meet the criteria of the model, and other considerations create conditions in which many local jails are providing treatment that is far from compliant with the protocols of the evidence-based treatments they are using. A first step in this process is developing an understanding of the specific conditions of these real-world settings, the pressures that lead to program modification, and the process by which the people implementing the interventions make decisions about how to adapt therapeutic programs to their unique environment. By looking at the ways in which personnel are modifying

the programs they implement, we can gain valuable information about what adaptations are being made in facilities that are subject to similar constraints, and how these adaptations evolve.

Research Methodology and Design

This study is a qualitative research design done from a pragmatic paradigm. From a pragmatic paradigm, research is judged not for how it corresponds with a single truth, but is instead based on effectiveness, or what “works” in solving a particular problem (Mertens, 2010). The pragmatic paradigm was chosen because the primary goal of this research is to study the integrity of implementation of the MRT program in a specific real-world setting, as well as looking at how it has been adapted to the particular setting in which it is being studied, not to discover something new about the nature of reality (Mertens, 2010). A qualitative design was chosen because the aim of this study is to obtain nuanced, “on the ground” information about how the MRT program was actually being implemented at this particular jail.

The MRT Program that is the subject of the current was implemented at a local county jail in rural New England. The jail houses pre-trial and sentenced county inmates as well as pre-trial federal inmates. Inmates have been charged with or convicted of a wide range of offenses, from relatively minor misdemeanors to serious felonies. The jail census fluctuates between 80–120 inmates. Inmates are housed on several different “pods,” with placement in the pods being based on gender, sentencing status, level of offense, past criminal history, individual behavioral concerns, and considerations having to do with the social dynamics on each pod. Although the jail houses both males and females, the MRT program was only being offered to male inmates at the time this research was conducted. Both county and federal inmates were eligible to participate in the MRT program. MRT groups were run by the mental health staff at the jail, and

were generally co-facilitated by two staff, at least one of whom was certified to lead MRT groups.

The purpose of this study was to explore the process of program implementation when a manualized program is adapted to fit real-world circumstances. Data was gathered concerning the decision-making process at the beginning of program implementation and over the first two and a half years the group was running. Interviews were conducted to explore how decisions were made about the way the program was implemented, how participants were selected, and what program modifications were made over time. Qualitative data was also gathered concerning how the implementation of the intervention deviated from the MRT program design and how closely it adhered to the principles of risk, need, and responsivity.

Qualitative Design and Method

The aim of this study was to document and analyze how local jail personnel chose, implemented, and modified an intervention designed to address the needs of inmates when the personnel implementing the program faced significant constraints that made it impossible to adhere to the evidence-based protocols for the implementation of cognitive change programming. Through semi-structured interviews, this study explored the unique day-to-day reality of program facilitators in a natural setting

Participants

At the CCHOC, facilitators were recruited from the mental health staff at the jail. Over the course of the research, six facilitators were identified. After gaining permission to conduct the study from the Superintendent of the CCHOC, the researcher recruited participants by contacting them directly and asking if they were willing to be interviewed for the study. Participation in the study was voluntary. All six facilitators who were approached agreed to be

interviewed. All of the subjects interviewed had either facilitated or co-facilitated the MRT group at the jail. Five of the facilitators were staff members of CCHOC. All of these facilitators were master's level clinicians. One facilitator was a third-year student in a Psy.D. doctoral program, who was doing a practicum at the jail. The practicum student did not run groups individually but assisted as a co-facilitator. All the staff members ran groups both as individual facilitators and as co-facilitators.

Over the course of the period researched, which encompassed the first two and a half years during which the MRT program was being delivered at the jail, there was a significant amount of fluctuation in terms of who was employed at the jail and who was running the MRT groups. EN was present for the entire period and was the person most responsible for organizing and overseeing the administration of the MRT program. SL, who was working at the jail when MRT was first implemented, contributed to the planning and early stages of the roll out. LS left a few months after the program was started. AT and MA both came in a few months after MRT had been running and were facilitating or co-facilitating groups at the jail for several months until they both left as well, AT to take a different job, and MA when her practicum ended. CH and DF were interviewed not long after they had completed the training to be certified to run MRT. These two subjects were just beginning to run the groups at the jail as EN prepared to go on leave.

Measures

Data was gathered through semi-structured in-depth interviews and review of relevant documents, including the protocol for the MRT program.

Interview Protocol. Information for this study was collected through in-depth,

semi-structured interviews. These interviews focused on how the MRT groups were formed, who was selected for group membership, and the dosage of the intervention. Interview questions also addressed how facilitators were trained, what modifications were made to the MRT protocol as well as the degree to which MRT, as implemented at the CCHOC, conformed to the RNR model. Interview questions were open-ended and invited participants in the study to explore in-depth their thoughts, feelings, and individual perspective on the MRT program as it was implemented, and their role as a facilitator. Interviews were intended to capture the ideographic experience of each participant, and understand how real time decisions about implementation were made in everyday situations, given the limitations of the environment, and also to encourage the participants to explore the clinical thought-process that informed these decisions.

Interview Questions.

The following open-ended interview questions were used with each study participant:

A. Formation of Groups

1. How did you decide on MRT as the intervention you would use?
2. What was the initial roll-out of the program like?
3. How were the MRT groups designed?
4. Are there any ways in which this differed from the MRT recommended protocols?
5. Can you tell me about the groups?
 - a. How many people were in each group?
 - b. Which inmates participated?
 - c. Who was chosen to run the groups?

B. Selection of Group Members

1. How were participants chosen to participate in the MRT group?
2. Was there any specific criteria for selection?
3. If so, who developed the criteria?
4. Did the selection process change over time?
5. If so, how did it change?
6. What factors do you think caused the changes?
7. Was group composition taken into account when individual members were selected to participate?
8. To what extent was the risk level of the inmate taken into account?
9. What about the criminogenic needs?
10. Were you able to take into account individual inmate's ability to respond to the material that was present in the MRT groups?
11. Were any modifications/adjustments made to make it easier for inmates to receive the programming/treatment in a more constructive way?

C. Dosage

1. What was the length of the program?
 - a. Number of weeks
 - b. Number of sessions
 - c. Number of sessions per week?
 - d. Length of session
2. Was there any variation from the length recommended in training and the amount of time the participants spent in the program?
3. How was this decision made?

4. What were some of the factors that went into this decision?
5. What criteria was used to determine when an inmate had “completed” the program?
6. How did the inmates respond to this?
7. How did the length of stay of inmates impact completion of the program?

D. Responsivity

1. Do you think that most of the participants were able to understand the curriculum?
2. Were there any barriers for any of them?
3. Can you tell me more about this? Any examples?

E. Adaptation/Modification

1. Can you tell me about ways you changed the program?
2. What was the reason for this change?
3. What effect do you think it had on the overall quality of the program?

F. Personnel/Training

1. Who was running the MRT programs?
2. How were they trained?
3. Were there opportunities for further training after the program began?
4. Do you feel that the people running the MRT programs were adequately trained?
5. Were they adequately supported as the program continued?

G. Influence/Contextual pressures

1. What aspects of the jail influenced decisions about how the program was run?

2. What factors influenced the decisions about which inmates participated?

Document Review. In order to evaluate the implementation of the program, the MRT manual, *Escaping Your Prison*, and protocols for implementation, including the MRT Facilitator's Handbook, were reviewed, along with original articles on MRT that were provided to trainees as part of their certification course. Other documents that were referenced included internal records relevant to the decision to implement MRT and the ongoing administration of the groups, specifically the 16-page guide for facilitators, which included specific information about any modifications that had been adopted. This guide was created by staff at the CCHOC in order to document any modifications that were made and to ensure that groups at the jail were run in a consistent manner by all facilitators.

Analysis

In the initial design phase of the study, specific domains of inquiry were established based on the literature related to implementation, specifically implementation in correctional settings. The domains included how the MRT program was chosen, experience with MRT training, how program participants were selected, what dosage of treatment was provided, how closely the implementation of MRT at the jail conformed to the RNR model, and modifications made during implementation. The interview protocol was designed to gather information about these domains from the perspective of each individual subject, based on their direct experience. After the interviews were conducted, each interview was transcribed and reviewed and key phrases and concepts that were relevant to identified domains were flagged and marked in the transcript. Passages from transcripts related to each domain were pulled from the text and organized in a separate document, so that an analysis could be made comparing views across subjects. Any themes that emerged from the different categories were documented and analyzed

to see if there were one or more themes that were of central concern to all of the participants regarding how the MRT program at the jail was chosen, implemented, and modified. Documents relevant to each domain were then further condensed, with relevant responses from each subject summarized in bulleted lists to facilitate comparison. To illustrate, in the case of the coding category related to dosage, a document was created that contained all passages across interviews in which dosage was discussed. This document was reviewed several times with reference to the context in which this category was mentioned. The passages were analyzed to identify emerging themes of importance. These themes were then reviewed to find areas of consensus as well as areas where there was a disagreement or dispute concerning the relevant area of inquiry. In this case, as one example, the theme of length of stay emerged repeatedly and consistently across interviews.

Researcher Bias

This evaluation is vulnerable to researcher bias based on knowledge of personnel at the jail, including subjects of the research. Additionally, one of the subjects of the study was a research partner who was co-facilitating MRT groups during part of the time period covered by the current study. There was ongoing contact with one of the research subjects through local board member affiliation.

Data analysis underwent peer review in order to check for bias and accuracy of coding. The peer reviewer was a doctoral candidate chosen for her attention to detail and experience with research involving qualitative interviews and analysis. The reviewer was provided with a copy of the interview protocol and transcripts of the interviews, marked with initial coding. The reviewer listened to the transcripts using text-to-speech technology, and then read them through while

reviewing the themes that had been identified and coded. At the conclusion of this process, the reviewer determined that the themes identified were comprehensive and accurate.

Results

Results are presented by going through each of the domains and providing a summary of prominent themes that emerged, highlighting areas of consensus, and exploring topics where there was disagreement or a notable difference in perspective. Passages from the transcript that best illustrate these themes have been used to emphasize certain points and to provide a richer appreciation of the actual experience and thought process of the subjects interviewed.

How the Program was Chosen

At the time the decision was made to implement MRT, only two of the facilitators (EN and LS) who were ultimately interviewed for this research were working at the jail. The mental health staff at the CCHOC had been offering individual counseling as well as a basic recovery groups, such as Seeking Safety. There was a sense among the members of the team that they wanted to be able to provide a program with a bit more substance that could address criminal thinking as well as substance abuse. A former intern who was trained in MRT suggested the MRT program. One of the mental health staff, LS, had been certified to run MRT groups and had previous experience running them in a local drug-court program. Based on her experience, LS felt MRT had the potential to be an effective intervention. EN, who was not yet certified to run MRT, located a certification training through online research. She spoke to the Superintendent, who agreed to pay for the training, despite the fact that it was fairly expensive relative to the mental health budget of the jail. After taking the training, EN was very enthusiastic about the MRT program, and determined it would be a promising addition to the mental health programming offered at the jail.

When EN returned after the training, she and LS began implementation. The initial roll out consisted of a single group, working with a lower risk population, who were generally pre-trial or sentenced county inmates. This was in part due to the fact that during the initial stages of implementation it was necessary to get special permission from the Safety and Security department at the jail to work with some of the higher risk inmates. At the beginning, inmates from separate pods were in the same group. As the program developed, two separate groups were formed, with a group for each pod. Although there was no policy to separate county and federal inmates, this bifurcation of the groups resulted in one group being heavily weighted toward federal inmates (generally a higher-risk population) and the other toward county inmates (generally less high-risk).

How Modifications Were Made

The majority of the modifications made to the MRT protocol when it was instituted at the CCHOC were deliberate. EN, who was primarily responsible for the rollout of the program, evaluated the situation on the ground at the CCHOC and realized from the beginning that certain parts of the program would need to be adapted to make it work. Although modifications were made throughout the implementation of MRT, a number of these modifications were made at the very beginning before groups were even started. EN and LS, who were the first two staff at CCHOC to facilitate the group, were responsible for the initial planning when MRT was implemented at the jail. As EN described it:

...We kind of put our heads together and compared the training, that are actually very different....there were some minor discrepancies so we got together and came up with a format that we thought would work for us. But within that we both agreed to do a lot of modifications, specific to this setting.

The types of modifications ranged from minor changes dictated by the limitations of the facility to changes that implicated the underlying theoretical approach of the MRT program. One salient constraint, which had an impact on the dosage of the program, was the length of time inmates would be at the CCHOC, and the uncertainty concerning the length of stay. This constraint also had an impact on the criteria by which inmates were chosen for inclusion in MRT groups. Some modifications were made to accommodate inmates who had cognitive barriers to completing or presenting assignments. More minor modifications were made based on the limitations of the facility and the rules of the jail governing the movement of the clients.

Some of the modifications were made in response to outside pressure from attorneys and the court. Other modifications were made over time and in response to the perceived needs of the population of offenders in the groups. One of the most significant modifications concerned the degree to which emotions were probed and processed within the groups. Other modifications of this type included a decision to have inmates make a presentation to the group on each step, as opposed to the specific steps identified in the Facilitator's Handbook, and having inmates write journals to explore underlying issues and process them in more depth.

EN was very conscious that she was making changes to the MRT protocol and was careful to keep track of any modifications that had been made. She documented these changes and constructed a guide for facilitators that detailed each step and any specific changes that had been made in how the step was implemented. Throughout the interviews, it became apparent that the facilitators were conscious that they had their own style when facilitating MRT groups, and each made some minor changes, personalizing the manner in which they presented the intervention. However, major modifications that proved useful in the smooth running of the program were formalized and adopted across facilitators and groups and were subsequently

codified by EN. Initially these changes were made in consultation with LS, and EN was in constant consultation with each facilitator as they planned and debriefed the weekly groups, but it was clear that EN had ultimate authority and decision-making power regarding how MRT was implemented at the jail.

MRT Training

By design, MRT groups are run by MRT-certified facilitators who must complete a 32-hour training in order to be certified. Trainings are conducted by trainers who are approved by Correctional Counseling, Inc. (CCI), founded in 1987 by Dr. Kenneth Robinson, who was one of the co-developers of Moral Reconciliation Therapy (CCI MRT, MRT Training & Services, n.d.). There are no specific educational qualifications to become an MRT facilitator. (MRT Training and Services, n.d.). Those trained to become facilitators may include probation officers, correctional officers, mental health staff, clinicians, and others.

MRT is a manualized treatment, and guidance in the handbook and during training is to follow the manual very closely. Clinical training is not required to be a group facilitator. According to the Facilitator's Handbook, facilitators are fungible, and the rapport between the facilitator and group members is not a core element of the program. The Facilitator's Handbook states: "Any trained MRT facilitator can enter any other MRT group and operate it. Likewise, you can enter any other MRT group and operate it...MRT is not dependent on facilitator's rapport with group members. MRT relies on facilitators following a set procedure in virtually every group session" (Little & Robinson, 2009, p. 7). It is unclear whether or not the practice of having co-facilitation is recommended. Based on the information gathered from those interviewed at the CCHOC, the guidance provided during MRT training concerning

co-facilitation was inconsistent. The prevailing view appeared to be that co-facilitators are not necessary, and the practice was discouraged as an inefficient and unnecessary use of resources.

Differences in Training

One phenomenon that became apparent throughout the interviews was that the MRT training received by the facilitators was not consistent in content or emphasis. LS had the widest range of experience with facilitating MRT, having done it both in the jail and on two separate occasions in a drug court setting. As she described it: “[T]hat to me is one of the biggest things with MRT is that every person that I worked with that has gone to a separate training, their experience is really different. And that’s why there’s often discrepancies in how to lead or co-lead groups.”

She gave several specific examples (e.g., lack of clarity on how far participants go back if they lie, what is a problem you can take care of “easily?” and how strict you should be), adding “[S]o at the jail when me and EN started doing it, her training seemed way more strict than mine and there were elements of her training that did not exist in mine whatsoever.” Other facilitators echoed this view. For example, EN stated: “[S]o I guess that LS had already had the training, I had just gotten it, so we kind of put our heads together and compared and the trainings are actually very different.” DF commented on the differences as well: “[E]veryone has this training that they go to and everyone is different and everyone interprets it in a different way.” DF viewed it from a pragmatic perspective, adding: “everyone has their own adaptations to a lot of this stuff, especially based on the setting they are in, the population they work with, their own style...:

Several of those interviewed referenced the brevity of the Facilitator’s Handbook, which is 21 pages in length. CH maintained that though it was brief, it was clear and, along with the

training itself, provided sufficient guidance to make integrity of implementation possible. Although all the facilitators were aware that the developers of MRT have a phone consultation service that can be accessed by anyone who has been certified to run MRT, most of those interviewed commented on the lack of a “refresher course” and felt that having follow-up trainings might make it easier to hold to the model and maintain integrity of implementation. None of those interviewed sought out guidance using the phone consultation service.

DF commented on the importance of what each facilitator understood as the main point of the program as communicated during training:

And I think it sort of depends on your perspective of what the main point of the program is where from our training, the one that [CH] and I attended, the main point is to retrain the way that people with antisocial personality characteristics think so they will be less antisocial, they will be more proactive in their relationships and the community, things like that. Whereas if you are looking at it from [EN]’s training, the biggest piece is you are trying to get them to not use anymore, you are trying to get them to see that their addiction is a problem they need to change, it starts with them, and all of that.

How Members Were Chosen

The CCHOC is a county facility which houses three distinct populations: (a) pre-trial inmates charged within the county, (b) sentenced inmates who have been sentenced to a county (rather than a prison) term, and (c) federal inmates who are being held pre-trial. In addition to the ever-present factor of length of stay at CCHOC, these populations vary in terms of the seriousness of their charges, length of criminal history, and for pre-trial inmates, the length of sentence they anticipate serving post-adjudication. These factors have a significant impact on

inmates' appropriateness for MRT, as well as their motivation to participate in the MRT program. Additionally, these factors are relevant to the degree to which inmates meet criteria according to the RNR model.

Selection Process

The selection process was described very similarly by all of the subjects interviewed. Flyers alerting inmates to the program were put up around the facility, and inmates who were interested were advised to contact mental health staff. Inmates also learned about the program through their individual counseling or other therapeutic groups they were enrolled in. Inmates could self-refer or could choose to apply to be in an MRT group based on the suggestion of mental health staff. All interviewees agreed that there was no formal assessment. An informal assessment was done that looked at criminal history, length of stay, why the applicant was interested in MRT, and the level of motivation. One potential barrier to maintaining integrity related to the selection of participants was the challenge of recruiting and motivating potential group members. As DF described it: "I think that at the heart of it the majority of the adaptations that she made were really sort of trying to keep this balancing act of keeping the group going while also not making it like a walk in the park either...." At least two of the facilitators interviewed referred to pressure to include inmates who did not meet these criteria. EN expressed a sense of urgency about "trying to serve as many as possible," whereas AT voiced concern about the need to have higher numbers to provide data that would justify future funding.

Primacy of Anti-Social Personality Traits

All subjects agreed that one basic criterion for group membership was the presence of antisocial personality traits. Another criterion, which was not so universally agreed on, was the presence of some type of substance use disorder. As there was no formal assessment, the

presence of antisocial personality traits or a substance use disorder was determined based on criminal history and pending charges. EN, who was the primary person responsible for initiating the MRT program at the jail, and oversaw the implementation, emerged from her MRT training with an understanding that substance use disorder was a primary target of MRT and should be used as criteria for inclusion in the MRT group. Other facilitators came out of training with the understanding that this particular module of MRT was designed specifically for individuals with anti-social traits and did not require any history of substance use disorder. Although there was a focus on substance abuse in the MRT groups, the presence of a substance use disorder was not a requirement for participation in MRT at the in jail.

As implemented, all subjects interviewed agreed that based on the informal assessment, a clinical judgment was made about whether or not the individual was diagnostically appropriate, which they understood to mean that potential participants possessed antisocial traits and thinking patterns. The criteria related to addiction was loosely defined and included not only those who has substance use disorders, but candidates that were addicted to gambling, selling drugs, or as several of those interviewed put it “addicted to the life-style.” Admission to the group generally followed these guidelines, but there were no “hard and fast” requirements for inclusion in the group, and exceptions were made for individuals who did not meet these criteria but were highly motivated or were deemed likely to benefit from MRT.

Length of Stay Related to Selection

Length of stay emerged again and again as a factor that influenced nearly all aspects of implementation. It had a substantial impact on who was chosen to participate in MRT and influenced the degree to which other factors related to program protocol could be considered when choosing who would participate in the MRT groups. The CCHOC is a shorter-term facility

than a prison. All the participants in the study agreed that the uncertainty about length of stay and the possibility that inmates would be released unexpectedly even after they had been admitted to the program posed a significant issue in terms of how to administer the treatment with consistency and integrity. The dilemma created by the uncertainty of length of stay was one of the primary drivers of the adaptations that were made to the MRT protocol as the program was rolled out and implemented.

Dosage

When administered as designed, MRT generally takes 6–9 months to complete. This is in part because the program is designed to teach participants to learn to delay gratification by having the experience of failing steps and having to wait to re-do them the following week. As DF described it, there are “loopholes that are designed to make you fail...you have to work for something and reap the benefits later.” LS described the curriculum as designed this way because “failure is a normal part of life; you can’t freak out every time you fail.” According to the manual, MRT groups should meet once or twice a week for 1–2 hours. In terms of weekly dosage, the groups at the jail were run according to design as each MRT group at the jail met weekly for two hours.

Length of Stay Related to Dosage

However, because of the uncertainty concerning length of stay, and the need to recruit enough inmates to form MRT groups, the protocols concerning the criteria for both inclusion and what constituted completion were relaxed to make it possible to run groups in this setting. These modifications themselves underwent a metamorphosis over time. According to LS, who was one of the two participants of the study who was part of the initial roll out of MRT, when MRT groups were first being formed, inmates were accepted into the program if it was determined that

they were going to be in the jail for at least 3–4 months. AT, who began facilitating several months after the MRT program first began, recalls that the uncertainty and brief length of time many inmates were in the program undermined the facilitator's ability to hold the line with inmates who might not normally have been graduated on to the next step, and contributed a feeling that getting inmates through the steps was a "rush job" and resulted in a false sense of completion: "Where I think we fell short though was that we pushed through and didn't let them simmer in the steps that were so powerful." "I am going to be responsible for holding his feet to the fire and telling him we need to work on this, because if you go out with this belief, that might be a setup for relapse, a set up for you to reoffend or to commit a crime because you've been triggered by some past experiences or some belief."

Pressure from Outside: Lawyers and Courts

Another pressure, which influenced the inmates' ability to tolerate being held to a strict standard of performance on each step, was the role of attorneys and the court system. As the MRT program became established, participation in and/or completion of the program began to be used as a mitigating fact for sentencing, or as a condition of a shorter sentence or the suspension of the portion of a stand-committed sentence. Initially, when participation was measured by the number of steps an inmate had completed, sending an inmate back to step one (this would occur as a consequence for dishonesty or major rule breaking), or failing them on any given step, often led to a degree of anger and frustration which was difficult for facilitators to manage. EN stated: "...we'd have a lot of disgruntled inmates in the moment where ok they'd come in they don't pass the step, and if in their minds they are getting set back in terms of their sentence um they're obviously very angry and the whole group become this rush to get through.

Deliberate Modification: A Solution

As the group facilitators, in particular EN (the mental health staff member primarily responsible for overseeing the program) came to experience and understand the way in which length and uncertainty of sentencing was affecting the implementation and running of MRT groups at the CCHOC, deliberate modifications were made in an effort to address this problem. Rather than measuring successful participation by completion of the steps, a cap was put on completion that was measured in weeks: inmates who were accepted into the MRT program were required to complete a minimum of 16 weeks in order to get a certificate of completion. This time frame gave them one week for the observation period (another modification that was made in order to efficiently determine early on whether or not potential group members were sufficiently interested to commit to the group without wasting time or limited resources), and three weeks to get set back without penalty. As DF described this modification:

But what would happen if the judge were to say: “as soon as you finish this you’re out”? As soon as they fail a step that is going to set them into overdrive, especially step one which almost everyone fails step one right away and it humbles them in a sense. So they sort of built in this 16-week minimum so that way that doesn’t happen and they will fail step one and it’s like “ok you still haven’t been set back, you still have to be here for 16 weeks regardless,” which I think is wildly beneficial and I would recommend that.

This system was not uniform. Federal inmates who were court ordered to do MRT as part of their sentencing were often required to complete all twelve steps, which would frequently take up to 6 months. County inmates, who generally had shorter sentences, or were housed pre-trial for shorter periods of time than the federal inmates, were more often court ordered to meet the

16-week requirement. There were other exceptions to this scheme. A small number of inmates who were only expected to be incarcerated for a couple of months were allowed to participate in the program based on high motivation and a determination that participation, even for a short period of time, could be of benefit to them. These inmates generally did not get past step three. EN justified this exception, saying “[M]y goal is to get as many people involved in the program as we can and figure out a way to make it work and use our resources the best we can.”

Mental Health-Informed Modifications

One category of modification, which was not included as a domain originally, but came up repeatedly, fell under the rubric of what most of those interviewed referred to as “processing.” This included asking “probing” rather than simply “clarifying” questions on a number of the steps, the expanded use of journals, and the addition of individual counseling. The probing questions were designed to help inmates gain more insight into their motivation and keep them more accountable for their behavior. As EN explained it:

So we do a lot more education and processing to really help them sit with the feeling they are supposed to be feeling and develop the insights that they are supposed to be gaining, and the original facilitator’s guide is you know very kind of quick and precise because if you have a group of 15 people out in the community in a two hour group you need to like really move things along to have everyone have a chance to present.

Journals were used to help them focus on underlying issues, and tie these back into what they were learning in MRT, and individual counseling provided a place where inmates could talk about what was happening in the MRT group and process their feelings one-on-one.

Risk-Need-Responsivity

The “Escaping your Prison” curriculum of MRT is designed for individuals with antisocial characteristics involved in the justice system, in particular those who are incarcerated. The goal of the MRT program is to move participants from a relatively low level of moral reasoning to a higher level, and thereby reduce criminal thinking patterns that have been linked to recidivism (Little & Robinson, 1988). MRT is designed specifically to reduce recidivism rates, and research shows that MRT does appear to lower recidivism rates for participants over both the short and long term (Granberry, 1998). However, there is an increasing body of research indicating that incorporating the RNR model into the selection process improves outcomes for incarcerated populations (Bonta & Andrews, 2007). The RNR model is not an intervention itself, but a framework that can be used to guide the fit between inmates and interventions (Looman & Abracen, 2013). Ideally, group members would be assessed and determined to be eligible based the standards for participation in MRT, in combination with a consideration of how potential group members met the RNR criteria. Subjects of the study were asked about the RNR factors to determine the degree to which this criteria was used in the MRT program at the CCHOC.

Risk

Risk is defined quite simply as the risk that any particular inmate will re-offend. Research shows that it is important to match treatment dosage with level of risk. Best practices dictate that potential program participants be assessed to determine level of risk before assigning them to any particular intervention (Bonta & Andrews, 2007). Determination of risk can be made through actuarial judgment with the use of risk assessment instruments, or professional judgment, through assessment without the use of assessment technology (Bonta & Andrews, 2007). Risk looks at static and dynamic factors such as antisocial personality patterns and traits, substance

abuse, procriminal attitudes, lack of positive social supports and the presence of social supports for crime (Bonta & Andrews, 2007).

There is no indication that the MRT program was chosen as an intervention at the CCHOC based on a “fit” to population, or that participants were chosen specifically based on levels of risk. In the selection process there was no formal assessment or utilization of risk assessment instruments; criminal history and the nature of pending charges were used as a proxy for risk. However, the subjects interviewed were cognizant during the selection process that they were trying to reach inmates who had longer criminal histories and antisocial personality traits. EN indicated that risk was explicitly factored into the selection process. When interviewed, she stated: “So the group criteria is for people with antisocial personality disorder. They have to have some sort of history of that obviously as well as some type of substance abuse disorder.” When asked how this determination was made, EN explained:

So we meet with them and nine times out of ten we know their history, so the history is really how we predict that. If we don't know them then we will sit down and do a kind of mini-biopsychosocial to get to know them a bit—have you been in and out of jail a long time? Just going over the pyramid with them is a good indicator. Do you have substance use? How long has it been around?

So kind of do like a mini-intake with them to make sure.

Most of the other subjects interviewed agreed that the vast majority of those who were chosen to participate in MRT met the criteria of high risk, and generally defined high risk as both the risk of recidivism and relapse that would lead to recidivism. CH stated:

[W]e aren't formally doing a full diagnostic screening for antisocial personality disorder, but I think it is safe to say that everyone that has been in group has some

significant antisocial traits and thinking patterns and has related pretty immediately to the material.

In response to the question of whether the group members were high risk, MA estimated that 98% of the group was at risk of recidivism and elaborated, stating: "Recidivism that goes right along with the substance, so there was a huge risk for recidivism for like I said 98%."

Although most of the group members were deemed high risk, there were exceptions. According to MA there were a "handful who it was just their first time" and added that "we were trying to set that foundation so they don't recidivate or have a chance of recidivating." Including this group of low-risk offenders violates the precepts of the RNR model. AT spoke directly to the concept that informs the risk principle of RNR and his concerns about the risk level of group members. AT identified two different groups of offenders: those who, as he put it, were "nurtured into a criminal lifestyle" and those that were using drugs and committing criminal acts to support their habits. AT felt that there was a significant distinction between these two groups, and worried that both types were included in the MRT groups at the jail.

Well you know if drug court is any indication of how you needed to vet the people that were more, had more criminal intelligence, I mean you could see we made so many errors by not making sure this person belonged in the program because of the past of the criminal history. And you feel sad because you want to help everybody and you just take anybody and that is a huge mistake because basically you are putting a person that might not be inclined to commit a crime when they were not using with people who would just commit crimes without using. So then you have someone nurturing the other person, so you create a better criminal.

Need

Need refers to criminogenic needs. These “needs” correspond to the dynamic risk factors that have been linked to criminal behavior such as a history of antisocial behavior, antisocial personality patterns, antisocial thinking, antisocial relationships networks, a lack of family support or employment, the absence of positive leisure activities, and substance abuse (Looman & Abracen, 2013). Individuals who are high risk will almost by definition meet criteria for need from an RNR perspective. According to the RNR principle, it is important to choose a treatment that addresses these needs (Bonta & Andrews, 2007). Those interviewed agreed that MRT met this standard. As DF expressed it when discussing the distinction between group members who were primarily antisocial and those whose primary problem was substance abuse: “But either way the thinking is still there, this idea that I am going to skirt, and do whatever I have to do to get what I want right away. And I think that at the end of the day that is really what this program is designed at retraining.”

Responsivity

Responsivity refers to the match between an intervention and the population on both a general and specific level. The general responsivity principle supports cognitive social learning interventions as the most effective way to promote new behaviors. To be effective cognitive social learning strategies should promote a strong working alliance with the client, and shape change in a structured manner toward increasing prosocial behavior (Bonta & Andrews, 2007). Specific responsivity requires that an intervention take into account personal factors that inform the individual’s ability to learn. This includes a number of considerations ranging from the level of anxiety or other mental disorders that may interfere with learning, to cognitive capacities such as verbal skills and concrete thinking style as well as motivation (Bonta & Andrews, 2007;

Looman & Abracen, 2013). To be most effective, an intervention treatment approach should take these various factors into account and be tailored to the individual, so that the participant can not only understand what is being taught, but generalize it beyond the confines of the group and make use of it when they are no longer incarcerated. It was apparent from the thoughtfulness with which those interviewed talked about how they chose to present the program and their concern that the material be accessible to the participants that the responsiveness principle was taken into account during the implementation of MRT at the CCHOC.

Cognitive Capacity. Not all those interviewed agreed on the degree to which the participants at the CCHOC were able to access the MRT curriculum. EN and MA expressed concern that many of the participants lacked the reasoning skills to do some of the MRT assignments without assistance. EN indicated that she had concerns about this from the very beginning of implementation:

Basically because you know I think the book was geared toward people in the community that are a little bit more high functioning, even though they do this in drug courts across the country and it was meant for the correctional system, we found that our inmates didn't have the cognitive reasoning for a lot of the quick, brief assignments that exist throughout the MRT book.

MA talked about modifications that were made to help individuals who had cognitive barriers, such as allowing participants to write on the board before presenting a step: "...we modified it even more to help those individuals who were less cognitively available and who just needed that extra push."

Not all those interviewed shared these concerns. In AT's opinion, the inmates were able to comprehend what they were being taught. AT saw MRT as designed so that the participants' understanding would increase as they moved through the program:

That's one thing that does happen frequently in MRT. That they are able to understand that these concepts can be developed or you can increase your understanding of these concepts as you move on through recovery and that happens a lot and that is why I think it is beneficial even if the person goes out and reoffends for another crime or starts to use drugs again. They can understand these things.

This was echoed by DF, who commented:

I think I understand why the training is like that in a sense that these people are just starting out in this group. They don't have insight yet, their thoughts haven't changed yet so that is their truth. If you were to ask them all of these things, they're going to be like uh it's the world against me. And then later on its when you start to see those shifts.

CH felt that despite lower levels of literacy among the inmates, the majority (over 80%) of participants were able to understand the material without support. For the participants who were challenged by the material, additional support was provided in one-on-one sessions. Other subjects interviewed also referred to the availability of individual support for participants who had barriers to understanding that were caused by low literacy rates or speaking English as a second language.

Mental Health Issues. Some participants faced barriers created by mental health issues such as depression, anxiety, or a psychotic disorder. According to all those interviewed who

spoke to this question, the inmates who were considered for group who had psychotic disorders were generally either found inappropriate or chose not to join the group and did not end up participating in MRT. Many of the inmates who did participate had varying degrees of depression and anxiety. MA addressed the presence of cognitive rigidity and depression as barriers that were taken into consideration in how the program was tailored to specific individuals. According to MA, facilitators might work with these clients outside of group or provide a margin of leeway when depression interfered with their ability to be fully engaged in the group. CH, however, spoke with greater ambivalence about the difficulty of making these kinds of exceptions:

I would say there might be a little bit of leeway, but it is tricky because you have to keep the integrity of the group. It would probably be at a level that is subtle enough that if you passed somebody, the rest of the group members wouldn't even be aware of it—it would be very subtle.

Discussion

The purpose of this study was to evaluate a newly implemented cognitive change program at a local county jail to explore how the intervention was implemented, the degree of integrity with which it was administered, and the modifications made to the program to adapt it to this specific setting. This evaluation also looked at the degree to which this program, as implemented, conformed to the RNR model.

Overall Integrity

Despite the fact that many modifications were made to the MRT program over the first two and a half years of its implementation at the CCHOC, the overall adherence to much of the program design remained robust. The size of the groups and the rolling admission procedure was

consistent with the requirements of the model. Groups were held for two hours weekly, which is also consistent with MRT protocol. All of the groups were run by at least one facilitator who was trained and certified in MRT. Groups adhered to the use of the manual, and although there were some variations in how the steps were presented and the degree of processing that happened within the group, each participant was required to complete all the assignments and follow the progression as set forth in the manual.

MRT Compatibility with CCHOC and How It Relates to the Literature

While it can be concluded that MRT was implemented at the CCHOC with a good degree of integrity within the constraints of the environment of a local county House of Corrections, it cannot be overlooked that these constraints still necessitated a number of program modifications. The short-term nature of the jail and the uncertainty of date of release for many of the inmates made it extremely difficult to remain true to the recommended dosage of MRT. Ironically, given that MRT is intended to benefit the county by reducing the rate of recidivism among county inmates, the individuals at the jail who are most appropriately served by this intervention were the federal inmates. Federal inmates tend to be at the jail for longer periods of time. Generally, they are a higher risk, higher need population with more extensive criminal histories and more ingrained antisocial personality patterns.

Many of the county inmates who wanted to participate were not primarily antisocial but did have substance use issues and significant trauma histories. They may have needed a less “cut and dried” approach than that provided by MRT. As several of those interviewed indicated, the modifications, which resulted in a more client-centered, process-oriented version of MRT may have made it more effective for these inmates. There is not sufficient data at this time to determine if this is the case. However, it can be hypothesized that if these modifications did in

fact improve participant responsiveness, it is likely that these alterations were in line with the literature which advocates for a realist position in evaluations; that is when programs are implemented in the real-world modifications are inevitable, and because those who are making these modifications have local knowledge and expertise about their specific environment and the needs of their populations, some of these adaptations are likely to be beneficial rather than deleterious (Durlak & DuPre, 2008; Moore et al., 2013).

Modification: Tailored and Deliberate

The modifications that were made were almost all both deliberate and tailored to address specific difficulties posed in adapting MRT to the unique conditions and circumstances at the jail. Discussions occurred between the staff responsible for the initial implementation concerning strategies for starting and continuing groups so that they would be sustainable in this particular setting and with the population being served at the CCHOC. As the program evolved, further modifications were made to address problems that threatened to undermine the successful administration of the program. For example, the modification establishing a number of weeks, rather than a number of steps, to determine completion helped to increase participation and decrease the dropout rate by providing a stronger incentive for inmates to enroll and remain in the program. The deliberate and strategic nature of the modifications is supported by the existence of the document written by CCHOC staff to provide guidance to facilitators about how to run MRT groups at the jail. This is a comprehensive 16-page guide, nearly as long as the Facilitator's Handbook provided by the MRT certification course, which explains in detail how to administer each step and details all of the specific modifications that have been made along with the reasoning behind each modification.

Research supports the finding that when administrators of a program are able to understand which parts of an intervention need to be adapted, have high self-efficacy and confidence that they can get good results, and possess the necessary skills, they are more likely to be able to modify programs in ways that improve the fit to the needs of their local setting (Durlak & DuPre, 2008). The mental health staff at the jail were very aware of the needs of their population and the limitations of the environment, both as it related to actual physical constraints and constraints of time. The modifications were made purposefully and were implemented consistently across groups and facilitators. Additionally, these modifications were documented, and this information was passed on to new facilitators.

Implementation Does Not Need to be Perfect

It is important to note that implementation of a program does not have to be perfect in order for it to result in positive outcomes. In fact, expecting perfect implementation in the face of the inevitable differences between local contexts is unrealistic. Positive outcomes have been documented for programs that have as little as 60% implementation levels (Durlak & DuPre, 2008). This is one of the reasons it is so important to study how programs are implemented in real world settings. Rather than viewing integrity and modification in a monolithic manner, it is important to understand which components of a program are central to its efficacy and use this information when determining whether modifications are beneficial or iatrogenic. It is not possible within the scope of this study to determine the precise level of implementation compliance, or whether or not the changes made during implementation of the MRT program at the CCHOC had a positive or negative effect on the outcomes for participants. However, this study does provide potentially useful information about which aspects of programs such as MRT are most likely to require modification to fit this type of correctional setting.

Significant Deviations

There were two primary areas where significant deviations were made from the MRT program design. Theoretically, these deviations can be broken down into those that were caused by the logistical fit between MRT and the CCHOC, and those that were caused by the philosophical fit between MRT and the staff who were running the program. Logistical fit relates to an incompatibility between program design and the context of delivery, in this case a county jail. Philosophical fit has to do with the alignment between the implementer's views about the causes for maladaptive behavior or the best way to address these behaviors (Moore et al., 2013).

Logistical Fit. The most significant institutional barrier to implementation fidelity was maintaining the recommended dosage of treatment. Aside from federal inmates and a small subset of county inmates who were serving 6 to 12 month sentences, most of those who participated in the program did not have sufficient time to complete all the steps of the MRT program. There were other, more minor, barriers created by institutional rules governing the movement of inmates and where the groups could be held, but these could generally be addressed with minimal adjustment to implementation of MRT. The shortness of length of stay, as well as the uncertainty surrounding time of release, however, necessitated a significant modification of the dosage of MRT, specifically the length of time participants were in the program and consequently the number of steps they were able to complete.

The design of MRT envisions that participants will complete all 12 steps. Only one step can be presented per session, which in the case of the CCHOC, was once a week as MRT groups met for two hours weekly. In order to further the goal of teaching the participants to delay immediate gratification, certain steps are purposely designed so that most participants will not pass them the first time, and participants are required to return to earlier steps and re-do them if

they are dishonest or engage in rule breaking behavior. MRT generally takes 24–36 sessions to complete. As the program was run at the CCHOC, anyone who was interested in doing MRT was required to attend a session to observe in order to ensure that they were willing to commit to the program, which added an additional week to the anticipated timeframe for completion.

When MRT was first implemented at the jail, there was no structured plan to address the fact that many of the inmates who were otherwise eligible for the program would not be at the jail long enough to complete all 12 steps. Length of stay was taken into account when selecting inmates for groups, but this was often only a rough estimate of how long the inmate would be incarcerated. Additionally, in order to have enough group members to keep groups up and running it was necessary to accept inmates who were almost certainly not going to be at the jail long enough to complete all 12 steps. According to several of the subjects interviewed, this caused pressure for facilitators to pass inmates through the steps and created the “rushed” feeling that AT referred to, which he felt undermined his ability to hold the line with some of the inmates in the group. As a result of this, the 16-week cap was established, which removed some of the pressure on the facilitators to pass individuals on steps, but was also well below the average time it would take for a participant to make it through all 12 steps successfully.

Research has shown that it is not necessary to complete all 12 steps to benefit from MRT, and that moral reasoning can be improved at each stage, with the largest increases happening at steps 4–7 (Granberry, 1998). However due to the short-term nature of the CCHOC, the MRT program at the jail was modified so that the majority of those participating were almost certain to get a lower dosage of treatment than that intended by the program design. This is precisely the kind of dilemma faced by short-term correctional facilities when trying to provide needed programming to inmates. Shorter treatment programs exist, but as the staff at the CCHOC

expressed, these programs tend to lack substance, and are not as likely to address the problems that lead to recidivism. Correctional staff must then choose between providing a less effective treatment that may be more easily completed and delivered with the designed dosage, or a treatment which has proven more effective with the behaviors they are hoping to target, but which must be modified to fit the constraints of their institution. Many of those interviewed spoke of a desire to have a block or pod dedicated to treatment and expressed their belief that this would enable them to provide programming with more integrity. Even having the resources to run two groups of MRT a week, rather than one, would have made it possible for many more inmates to complete the program during the time they were incarcerated. But jails have tight budgets. Staff must make a realistic assessment of resources and limitations, and make difficult decisions regarding the tradeoff between administering a mediocre program with more integrity, or a potentially more effective and engaging program, which necessitates increased modification, but that may ultimately lead to better outcomes for participants. Without more research about how these decisions are being made and the impact they are actually having on ultimate outcomes, staff in these facilities possess little information to guide them.

Philosophical Fit. Many of the modifications of the MRT program design were made in response to aspects of the jail that were intrinsic to the population or the facility itself. One category of modifications that was made independent of these intrinsic limitations or constraints was the addition of a more mental health informed approach to the curriculum. This modification was deliberate and instituted with full awareness that it was a deviation from program design, as indicated by information provided through interviews and the MRT Modification Guide. Many of the added-on mental health informed aspects of administration were explained as a means of rendering the program more accessible to participants, and also as a way to address the needs of

the many participants who were dealing with serious substance use disorders and/or had experienced significant trauma.

It may also be true, however, that the modifications which moved the curriculum in a more “process” oriented directions were an artifact of having a program which was facilitated entirely by mental health professionals as well as a lack of complete alignment between the designer’s and the implementers’ views about how best to address target thoughts and behaviors. Although mental health professionals can be trained and certified in MRT, mental health training is not a requirement to become certified to run MRT groups. The fact that all the individuals who ran MRT at the CCHOC were mental health professionals is likely to have had an influence on the types of modifications that were made to the program as implemented.

The literature and training for MRT indicate that MRT facilitators are advised to adhere closely to the manual. The theory of change for MRT is embedded in a the belief that through completing the steps and exercises in the manual, participants reach a higher level of moral reasoning and develop more prosocial goals, motivations, and values (Little & Robinson, 1988). MRT was originally designed to work with clients who were resistant to treatment, such as those with antisocial personality patterns. The developers of the program theorized that it was vital when working with this population to break down the defense mechanisms that made these individuals resistant to change (Little & Robinson, 1988). Even taking into account variations in training, all of those interviewed agreed that an important aspect of how this is accomplished is through teaching participants to delay gratification, follow rules, and learn how to cope with frustration and anger in more effective ways. As EN expressed it:

Basically, the whole premise of the group is for them to learn to delay immediate gratification. So they come in each week with a certain agenda to pass a certain

step. Each step has certain assignments they have to do to fulfill the step, they come in obviously wanting to pass, with that expectation. They present whatever the assignments may be and for every step there's little tricks that come with the teaching that are designed to get them to fail.

According to the manual as well as the training as described by those interviewed, the exercises are not designed to involve probing or inquiry into feelings and are meant to be accomplished without leaving room for much processing of emotional reactions. As DF described it:

So the whole idea behind it is to sort of retrain their thinking into understanding that isn't about the way that you feel, you are not trying to make me feel a certain way, we are literally just dealing with your thoughts, because that is where all of this is coming from.

DF explained how she understood how this was accomplished from her training:

Escaping Your Prison there's like all these little loopholes in the steps that are sort of designed to make them fail because it is teaching them to delay that gratification: you have to work for something and then you reap the benefits later.

AT summarized the theory of change as "holding their feet to the fire" to break down the resistance and get the participants to understand that they needed to change their way of approaching the world and others in order to avoid repeating the same antisocial, criminal pattern of behavior. According to those interviewed, the training was quite clear that participants should be moved through the steps quickly and efficiently, without any unnecessary processing or probing of their past history or trauma.

EN, the principle initiator of most of the modifications to MRT at the jail, was clear both about the design of MRT and the reasons for modifications made to render the program more

“process oriented.” She clearly understood that the manual was designed to be “cut and dried,” and did not intend for facilitators to engage in any probing or processing designed to elicit a deeper exploration of underlying feelings. Although she was aware that some of the modifications that were made (e.g., additional journaling, writing exercises on the board, asking clarifying questions, additional counseling) went “against MRT”, she was adamant in her belief that these additions were beneficial, and were a positive development made possible by the unique aspects of the CCHOC facility where all groups were run by master’s level clinicians.

Other facilitators also recognized this as a driver of many of the modifications made to the program at the CCHOC but were more ambivalent about these changes. As CH express it:

But I also know some of the model, there were cautionary statements about you know, for example, don’t dredge the moat in some of the steps meaning, especially for the clinicians among us in the room, that tendency to want to revert to psychotherapy or go off model and be more explorative of underlying issues particularly some of the trauma. And it is designed to not do that intentionally, purposefully.

AT felt that allowing MRT to become more process-oriented had the potential to undermine core elements of the modality, particularly the aspects aimed at addressing antisocial traits. As AT understood the training, MRT was not meant to be about feelings, and as the group was changed to help members work through feelings it made it possible for the more antisocial members of the group to avoid accepting responsibility. “For people that are antisocial they are always looking to not take responsibility and basically to find a way to get away with it.

Other facilitators echoed this sentiment. DF described MRT as designed for people with antisocial personality disorder who are “prone to manipulate other’s emotions,” and stated that

the modifications “made it a much more client-focused...more the way a therapist would do the group. She felt that an important aspect of MRT was the fact that it did not give participants an opportunity to explain themselves: “Then they have to sit with it, right, and they have to deal with the fact that I wasn’t able to say what I wanted to say, she just cut me off, and my charm didn’t work, she didn’t let me go into this sob story that I have told sixteen thousand times, you know. LS worried that once you introduced the element of emotions “it’s hard to pull back,” and stated her concern that this approach was not well suited for treating individuals with antisocial personality disorder.

Despite their ambivalence, the interviewees who expressed concerns about the mental health informed nature of some of the modifications all indicated that whether or not the mental health informed modifications made sense “depends on the population you are working with. All of those interviewed recognized that the majority of the inmates who participated in MRT had underlying trauma, and that the MRT module used was not designed to address trauma. Even those, such as AT and DF, who felt strongly that MRT was not meant to deal with feelings, agreed that given the population at the CCHOC, the modifications were beneficial for many of the inmates who enrolled in the program. As DF articulated the dilemma:

You have to meet them where they are at and you have to be able to work with them in a way that is going to be empathetic and get them to want to work with you. So I think that to me I would imagine that’s why it’s really more process oriented cause that’s I mean what works for substance use. And I think again its sort of that piece where for someone with more mild antisocial characteristics it can still be really beneficial. But I think for some of the guys that we get that are

like the very much like textbook, classic antisocial its easier for them to sort of skirt by and just do what they normally do.

From DF's perspective, there were two primary populations being served by MRT at the jail, and which approach was most effective depended on the characteristics of the population being served. As she put it: "Like if you are working with someone who genuinely meets the criteria for antisocial personality disorder, and there are a few guys who have done this program that genuinely meet that criteria...I think that the more mental health approach is not doing them any favors. She added:

I think that with certain people it would be more beneficial to really hold their feet to the fire in the way that I was trained; much more rigid and sort of strict. And I think for other people, I can name like three or four in just one of my groups right now, where it would be extremely difficult for them to stay in the group, and not just out of not having motivation or not wanting to do it, but it would just be very difficult for them to do it that way because they would just feel defeated in a way.

To her, the changes made sense based on setting:

I think yeah at the end of the day I think it's still a great program and I think that it is one of those things where you are supposed to be sort of following it by the book and text book and I also think that when it comes to certain things on it, it doesn't make sense in this particular facility and this particular setting.

Even AT, who was the most adamant proponent of the "feet to the fire" philosophy, stated:

You know allowing them to have more visuals like—the best of times was an exercise, the best of times, the worst of times. We had them write it on the board. And the impact that it had for them to see and the group to see that they were

willing to put stuff that was really intimate on the board for everyone to else to see it brings it up to a certain reality like “wow I actually did this” and people were like I appreciate that you brought that up, now I’m going to take that risk. So we did that really well, I mean that was an awesome change to the program.

Although AT remained concerned about the risks of processing trauma in the group, he reflected “[b]ut if you have the right people in the group, you will do more good than harm” and stated “I think that is where the skill of the clinician is very important. That’s where we used to do a lot. [EN] was really good at that. She would basically sit with them and help them process. She had more of the mental health kind of background.”

For EN and many of the other facilitators, it was a natural outgrowth of their training that they would pay attention to and respond to the mental health needs of the group members in a way that those without a mental health background might not. As EN expressed it: “...the majority of the people who were in my training were not clinical people so therefore they shouldn’t be doing it the way we are doing it, but being licensed mental health counselors and substance abuse counselors that’s what we do and it’s hard to kind of separate it.

Setting the implementation of MRT at the CCHOC side by side with the Facilitator’s Manual might lead to the conclusion that the modifications made to MRT by the staff at the CCHOC were inconsistent with MRT’s approach to addressing target thought patterns and behaviors, and constituted a substantial change to a core component of MRT. It is important, however, to refer not only to the Facilitator’s Handbook, which is a brief instruction manual, but to other materials provided to trainees as well, including the article from 1988, in which Kenneth Robinson and Gregory Little explicate the fundamental principles on which MRT is based. In this article, reference is made to the way in which the steps are operationalized in response to

program characteristics and client needs and anticipates that work will be done in both a group format and individual sessions (Little & Robinson, 1988). The article includes a detailed discussion of the underlying philosophy of MRT, which is to move participants, particularly those who have a history of resisting or dropping out of treatment, to a higher stage of moral reasoning. The step-by-step treatment, and the personality and behavioral elements targeted by MRT are identified and explained (Little & Robinson, 1988). Nothing in this article indicates that the kinds of mental health informed modifications made by the staff at the CCHOC are inconsistent with MRT's theory of change or recommended technique for addressing target thoughts and behaviors. In fact, an essential part of the treatment is the detailed assessment of the self as well as one's relationships with other, which was often done in individual sessions with a therapist. For example: "In the initial stages of treatment, the therapist seeks to identify the client's assets and deficits to the therapist and self. The client's beliefs, attitudes, and behaviors are extensively analyzed and discussed (Little & Robinson, 1988, p. 144). It appears apparent from this description that it was envisaged as part of the approach that intensive self-analysis would be done with MRT clients. While there is no mention of processing emotion, it is hard to imagine that an extensive analysis of one's belief, attitudes, and behaviors could be accomplished without giving rise to some feelings that might need to be processed with the therapist assisting you in this self-exploration.

As it has evolved and been marketed over the subsequent decades, MRT has been billed as an effective, affordable, evidence-based treatment that can be delivered not only by trained mental health professionals, but by correction officers, probation officers, and others without mental health training (Huddleston, 2009). As attested to by several of those interviewed for this study, the training is designed for an audience that includes individuals who have no mental

health training. Although those who are certified receive some information about the fundamental principles underlying MRT, the training is primarily a “how to”, not an exploration of the theoretical underpinnings of the intervention. While it is clear that the staff at the CCHOC diverged from the approach to implementing MRT as taught in their training, it is not so clear that this divergence put them at odds with the model’s view of best practices in treating this population. An even more important question, which must await future research to be answered, is whether or not this approach, which took into account the characteristics and needs of the individual inmates at the CCHOC, was more, or less, effective at creating the kind of change that would lead to a reduction in recidivism in this population.

Risk-Needs-Responsivity

The principles of RNR were not explicitly taken into consideration by the staff who implemented the MRT program at the CCHOC. However, it was apparent from information provided through interviews that most of those who were facilitating the MRT groups at the jail understood many of the basic principles of RNR. Many of those interviewed were very conscious of the importance of taking risk into consideration when determining which inmates would be most suitable for MRT, as well as the dangers of mixing high and low risk individuals in the same group. There was a high level of awareness of criminogenic needs and how MRT was designed to address these needs. All those interviewed were sensitive to the impediments to learning that particular individuals faced and were concerned about administering the program in a way that made it understandable and useful to participants in an individualized manner. In fact, many of the modifications made to the MRT program at the CCHOC were designed to make the material more accessible and generalizable for the specific individuals in the group. Overall,

whether intentionally or not, the principles of RNR shaped many of the modifications made to the MRT program as implemented at the CCHOC, which is consistent with best practices.

As has been mentioned, the receptivity construct from the RNR model is analogous to the dimension of implementation related to participant responsiveness. The literature on RNR makes clear the importance of ensuring that participants are able to understand and assimilate what is being taught. According to the research underlying the receptivity principle, the most effective approach is a cognitive social learning strategy, which necessitates a strong working alliance to maximize the potential to shape change (Andrews & Bonta, 2007). In this respect, the literature on program implementation, which emphasizes the importance of participant responsiveness and the RNR research concerning what makes interventions most effective with correctional populations correspond perfectly. Both theories support the importance of the relationship between the facilitator and the participant. This is in conflict with the approach of MRT, at least as set out in the current certification training, which explicitly states that facilitators are fungible. This suggests that the theoretical framework underlying MRT may be, at least in this respect, incompatible with the principles of RNR. It seems that by modifying the MRT program to include elements that fostered a strong working alliance, the facilitators at the CCHOC were more in alignment with the principles of RNR than they were with the approach promulgated by the MRT training.

Limitations

This study involved just one setting, over the period encompassing initial implementation and the first two and a half months of program delivery. The information gathered pertains to this particular setting, circumstance, and staff. Information was gathered from semi-structured interviews of individuals facilitating the program at the jail, and this information is inherently

subjective. Because it was not feasible to observe the groups or interview inmates based on the scope of the study and the difficulty inherent in gaining IRB approval to study this vulnerable population, the viewpoint from which information about the program was obtained was limited.

Core Components

Another limitation of this study concerns uncertainty regarding what constitute the “core components” of the MRT program. While it was possible to reach some conclusions about which aspects of the program were modified, and where integrity of implementation was compromised, without more information concerning which aspects of MRT are considered essential to effect change, it is difficult to determine whether or not these adaptations should, theoretically, impair the effectiveness of MRT implemented at the CCHOC.

Outcomes

Another major limitation of the study was that it looked only at how the program at the CCHOC was implemented and adapted. It was not possible to determine whether the changes made by the staff at the CCHOC had any effect, positive or negative, on outcomes. The results of a companion study indicate that the MRT program as implemented at the CCHOC resulted in a statistically significant change in specific criminogenic thinking patterns linked to recidivism. While this finding is positive, it does not reach the question of whether or not the MRT program at the jail resulted in a reduction in actual recidivism. Additionally, this study does not control for the changes made to the program at the jail, and therefore cannot answer questions regarding any impact the modifications might or might not have had on the effectiveness of MRT in this specific setting, with these specific modifications, relative to MRT administered in other settings with a greater or lesser degree of integrity. From an evaluative point of view, it is not possible to

determine how these changes, many of which were subtle and based on subjective judgment, affected the impact MRT had on those who participated in the program at the CCHOC.

Future Research

It continues to be important to do more research in jail settings to gain information about program outcomes. This research should include careful exploration of the adaptations that have been made to programs when they are implemented in local settings. The short-term, transient nature of county facilities makes this particularly challenging. This study demonstrates that practitioners who administer these programs have the motivation and capacity to track and document changes to program design. Encouraging cooperation between staff and outside evaluators could yield valuable information, which would be useful both to the individual programs being evaluated, as well as other programs seeking to find a treatment that will fit their facility and population.

Research has established that quality of implementation affects outcomes (Durlak & Dupre, 2008). It is also clear that some degree of adaptation is inevitable (Moore et al., 2013). Despite this, there continues to be a lack of research to isolate the “core components” of treatment programs (Moore et al., 2013). This research would provide important guidance about which elements of a program should be preserved, where care should be taken to maintain integrity, and which components of the program might more safely be adjusted or adapted without having an impact on the efficacy of the intervention (Moore et al., 2013).

Conclusions

This study explored the implementation of one intervention program at a single correctional facility, through the eyes of six program facilitators. The information gathered is specific to this site and these particular individuals. The results of the study are consistent with

much of the literature that has documented the challenges of translating an evidence-based program into a natural setting, specifically the struggle to maintain integrity and the inevitability of adaptation. What the study revealed, beyond the mere recapitulation of these previously identified challenges, was the thoughtfulness, resourcefulness, and creativity that was manifest throughout the process. Although there was disagreement among those interviewed about the wisdom, necessity, and effectiveness of various changes made to the MRT protocol, it was clear that those who facilitated these groups were committed to providing effective treatment to a challenging population. The facilitators demonstrated an openness to exploring what worked, and a sensitivity to the needs of individual group members that was evident across interviews. Adaptations were made with the purpose of improving treatment delivery and accessibility, and care was taken to document changes and apply them consistently. Much of the research regarding implementation comes from those who are concerned with compliance. The importance of adhering to program protocols and implementing with integrity has been well established. But there is much that can be learned from practitioners who are using their own knowledge of local reality and a spirit of innovation to make these programs work in unique settings and under imperfect conditions.

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Appendix A: Application for IRB Approval

1. Name of primary investigator: **Branwen Gregory**
2. Academic Department: Clinical Psychology
3. Departmental Status: Student
4. Name & email address of research advisor: X
5. Name & email address(es) of other researcher(s) involved in this project:
6. Name of Researcher(s)
X, X, X
7. Project Title: **Cheshire County Department of Corrections (CCDOC) Program Evaluation and Recidivism Project**
8. Is this project federally funded: No
Source of funding for this project (if applicable):
9. Expected starting date for data collection: **05/06/2019**
10. Expected completion date for data collection: **08/14/2019**
11. Project Purpose(s): (Up to 500 words)

The primary purpose of this study is to evaluate the implementation of a recently instituted cognitive change program at the Cheshire County Department of Corrections (CCDOC) in Keene, NH. This research is intended to be used to better understand how programs such as MRT are actually being implemented in real life settings such as local jails, and how modifications or adaptations during implementation affect outcomes.

The group intervention being implemented is a manualized, empirically based cognitive change program called Moral Reconciliation Therapy (MRT). This program was originally developed for a prison-based population. It is designed to increase "higher stage" moral reasoning and strengthen socially normative thinking and behavior. MRT has been shown to be effective at reducing recidivism (Little, Robinson, Burnette, & Swan, 2011). A meta-analysis conducted in 2013 confirmed that MRT has a small, but significant effect on recidivism (Ferguson & Wormith, 2013).

Cognitive behavioral interventions, particularly when implemented with adherence to the Risk-Need-Responsivity treatment model, have been demonstrated to be effective in reducing recidivism rates. However, real world circumstances in penal institutions place restrictions on how these programs are implemented and may make it difficult for these interventions to be instituted with fidelity to the design of the intervention and/or the RNR model. This poses a

particular challenge at local jails, which house shorter-term populations and have fewer resources. Through interviews with current and former CCDOC staff members involved in the administration and facilitation of the MRT program, the study will explore how the intervention was implemented and how the program was modified or adapted in this specific setting. The study will also use previously gathered data to assess whether or not the program, as implemented, was effective in reducing targeted symptoms linked to recidivism. This data was collected as part of a companion research project at the CCDOC. This research was approved by the Antioch IRB Board in the spring of 2017 and was renewed in June of 2018. Data collection for this project is now complete. The aspects of the research that will be used as part of this current project will be confined to use of de-identified data, which is not linked to the participants' identity. The application for IRB approval of this companion project included possible study of fidelity to program design and its impact on outcomes.

Research will be gathered by the primary researcher. Data analysis will undergo peer review in order to check for bias.

As a dissertation project this research will be disseminated by being uploaded to the Antioch website. Additionally, information from the project will be shared with the CCHOC. There is a possibility that the research may be submitted for publication along with the companion project looking at the outcomes of the MRT groups run at the CCHOC.

12. Describe the proposed participants- age, number, sex, race, or other special characteristics. Describe criteria for inclusion and exclusion of participants. Please provide brief justification for these criteria. (Up to 500 words)

The participants will be individuals, both current and former staff and other persons, such as practicum students who were involved in the administration, implementation, and facilitation of the MRT program at the CCDOC. All participants will be at least 18 years of age but will vary in age, race, and socioeconomic status. It is anticipated that there will be between 6-8 participants, including both men and women. Participants will be included based on their involvement in the running of MRT groups at the CCDOC. Selection will be based on subject's willingness to participate and the likelihood that they possess information relevant to the way in which the MRT program was chosen as an intervention, how it was initially implemented, any adaptations or modifications that have been made to the program based on the needs/constraints of the institution, and what kind of ongoing support/training was/is available for staff involved in administering the program and running the groups.

13. Describe how the participants are to be selected and recruited. (Up to 500 words)

Participants will be selected based on their involvement in running or administering the MRT program. Once permission is granted by the Superintendent of the CCHOC, they will be contact via phone or email to determine if they are willing to be interviewed for this project. They will be free to participate in the project or to decline to take part in the study. Each participant will be fully informed of the nature and intent of the research, including any potential risks and/or benefits.

14. Do you have a prior or current relationship, either personal, professional, and/or financial, with any person, organization, business, or entity who will be involved in your research?

Yes

14a. If yes, describe the situation that presents a potential personal, professional, and/or financial conflict of interest in the proposed research study, (e.g., if you are or have been employed at the research site, have received compensation from a participating organization, have a personal or professional relationship with any participants).

I have a prior professional relationship with several of the staff at the jail based on my previous employment as a public defender, during which time I frequently spoke to staff at the jail about issues related to my clients.

I have a current professional relationship with one of the potential subjects of the research as we currently serve together on the board of directors of a local non-profit.

I have a current professional relationship with one of the group facilitators, who is a fellow student with whom I was conducting research related to this current study about the MRT group (a previous IRB application was approved for that research. Data collection for that study has been completed.)

Additionally, prior to research on the MRT group I was a psychology practicum student at this site.

I do not believe any of these relationships pose a conflict of interest. I have never received any compensation from the site, nor have I ever been in a supervisor/supervisee relationship with any of the potential participant of the study.

14b. Describe how you will mitigate the bias caused by any conflicts of interest in your study and how you will protect the participants against real or potential bias (e.g., you will not recruit anyone who works directly for you or in your direct team, results will be reported in the aggregate so that participants will remain anonymous, any compensation received is independent of the study and its results).

Results of the research will be reported in the aggregate so that participants will remain anonymous. However, the study is based on a small group of subjects, so anonymity may be difficult to maintain even when information is reported in aggregate. In order to mitigate harm from any real or potential bias, information concerning these potential risks (and possible benefits) will be detailed in the informed consent. Additionally, the identity of any potential participants who do not wish to participate in the study will remain anonymous.

15. Describe the process you will follow to attain informed consent.

Prior to the beginning of the interview each participant will be given an informed consent form. The interviewer will go over this form in detail and respond to any questions that may arise.

Participants will be fully informed about the process, about any potential risks or benefits, as well as the fact that their participation is entirely voluntary and consent to participate in the study may be withdrawn at any time. They will be provided with contact information to ask any further follow up questions.

16. Describe the proposed procedures, (e.g., interview surveys, questionnaires, experiments, etc.) in the project. Any proposed experimental activities that are included in evaluation, research, development, demonstration, instruction, study, treatments, debriefing, questionnaires, and similar projects must be described. USE SIMPLE LANGUAGE, AVOID JARGON, AND IDENTIFY ACRONYMS. Please do not insert a copy of your methodology section from your proposal. State briefly and concisely the procedures for the project. (500 words)

The bulk of the research involves face-to-face interviews with participants, comprised largely of open-ended questions.

17. Participants in research may be exposed to the possibility of harm - physiological, psychological, and/or social - please provide the following information: (Up to 500 words)
a. Identify and describe potential risks of harm to participants (including physical, emotional, financial, or social harm).

This research is designed to elicit information that could potentially be of assistance to the jail in improving interventions designed to reduce recidivism among inmates. Questions will be focused on how the program was implemented, what changes were made either intentionally or accidentally in how the program was administered, and what kind of training and support was available to program facilitators. There is a risk that staff who agree to be interviewed may share information that reflects badly on their performance as treatment providers or in some other capacity as a colleague or employee. Because this study has a relatively small number of participants it will be difficult to guarantee complete anonymity. This poses a potential risk to subjects who are current employees of the jail. In order to mitigate any potential harm, participants will be given the opportunity to read a transcript of their interview and make any necessary corrections, as well as requesting that information they feel may have a negative effect on them be omitted.

It is felt, however, that the risk to participants is minimal, particularly in light of the fact that the CCDOC is supportive of this research as they are invested in any research that will help them determine if the MRT program is an effective intervention.

b. Identify and describe the anticipated benefits of this research (including direct benefits to participants and to society-at-large or others)

Currently there is a lack of research looking at the effectiveness of treatment programs in jail settings. The majority of research has been done on programs instituted within the prison system, which houses a different population, with lengthier and more predictable terms of incarceration (Lizama, Matthews, & Reyes, 2014). More research is needed on treatment programs in local jails to investigate how these programs are implemented, what modifications are made, and

whether or not these programs, either modified or implemented as designed, are effective (Durlak & DuPre, 2008).

This research could be of general benefit to facilities similar to the CCDOC who are making decisions about types of programs that may work in their settings, and how they should go about implementation for best outcomes. This information would also be of specific value to the CCDOC, as it could provide feedback about how well the program is working and suggest possible ways in which implementation could be improved.

c. Explain why you believe the risks are so outweighed by the benefits described above as to warrant asking participants to accept these risks. Include a discussion of why the research method you propose is superior to alternative methods that may entail less risk.

The risk of harm to participants in this study is minimal, and the benefits both to the jail that is the subject of the study as well as other institutions running programs of this type could be significant. There is a research gap in the area of how evidence-based programs are actually being implemented in the jail setting. There is a need for effective interventions with this population that will help reduce recidivism. If more is known about what kinds of modifications/adaptions are being made and what impact they have on the effectiveness of these programs, staff in these settings will be able to design their programs so that they can maximize the benefit to the inmates.

d. Explain fully how the rights and welfare of participants at risk will be protected (e.g., screening out particularly vulnerable participants, follow-up contact with participants, list of referrals, etc.) and what provisions will be made for the case of an adverse incident occurring during the study.

The participants in the study do not qualify as a vulnerable population. Participation is voluntary and they will be given full information about any potential risks of participating in the study. All information will be aggregated, and no individual names or identifying information will be used.

18. Explain how participants' privacy is addressed by your proposed research. Specify any steps taken to safeguard the anonymity of participants and/or confidentiality of their responses. Indicate what personal identifying information will be kept, and procedures for storage and ultimate disposal of personal information. Describe how you will de-identify the data or attach the signed confidentiality agreement on the attachments tab (scan, if necessary). (Up to 500 words)

The audio recordings and other identifying information will be retained in a confidential, secured electronic file under unique identifiers and will be accessible only to the primary researcher, the research supervisor and a second reviewer. The information will not be stored on a hard drive or in a cloud-based system. The Cheshire County House of Corrections will not have access to the interview data which will ameliorate the risk of recourse by the agency should any of the participants reveal any information that might reflect badly on their performance or judgment. Data will be kept until the completion of the dissertation process. Once research is complete the records will be disposed of by destroying data stored on all forms of electronic media so that it is

completely unreadable and cannot be accessed or used for unauthorized purposes. Paper documents will be shredded.

19. Will audio-visual devices be used for recording participants? Will electrical, mechanical (e.g., biofeedback, electroencephalogram, etc.) devices be used?

Yes

If YES, describe the devices and how they will be used:

Interviews will be audio recorded on an audio recorder with the permission of the participants.

20. Type of Review: Expedited

Please provide your reasons/justification for the level of review you are requesting.

The participants in this study are not a vulnerable population. The facility where the research is being conducted is in full support of the study and is interested in any information that would enable them to improve programming provided to inmates at the CCHOC. This research has been approved for submission by my advisor and by others as required by my program (e.g., my departmental IRB representative, thesis or dissertation committee or course instructor as applicable).

Yes

21. Informed consent and/or assent statements, if any are used, are to be included with this application. If information other than that provided on the informed consent form is provided (e.g. a cover letter), attach a copy of such information. If a consent form is not used, or if consent is to be presented orally, state your reason for this modification below. *Oral consent is not allowed when participants are under age 18.

*See Attached.

22. If questionnaires, tests, or related research instruments are to be used, then you must attach a copy of the instrument at the bottom of this form (unless the instrument is copyrighted material), or submit a detailed description (with examples of items) of the research instruments, questionnaires, or tests that are to be used in the project. Copies will be retained in the permanent IRB files. If you intend to use a copyrighted instrument, please consult with your research advisor and your IRB chair. Please clearly name and identify all attached documents when you add them on the attachments tab.

I have agreed to conduct this project in accordance with Antioch University's policies and requirements involving research as outlined in the IRB Manual and supplemental materials. I certify that I have attached documentation confirming completion of the CITI Modules.

Yes

Appendix B
Letter of Support from the Jail



From the desk of
, Superintendent

825 MARLBORO ROAD
KEENE, NEW HAMPSHIRE 03431
www.co.cheshire.nh.us/hoc

603-903-1600

4 April 2019

, Ph.D
Department of Clinical Psychology
Antioch University New England
40 Avon St.
Keene, NH 03431

Dear Professor ,

I am writing at the request of Branwen Gregory, a student at the PsyD program at Antioch University New England. Ms. Gregory, under the supervision of , Ph.D., has expressed interest in conducting research at the Cheshire Department of Corrections (CCDOC). Ms. Gregory met with me to discuss the nature and scope of the research she hopes to conduct here at the jail. We are highly supportive of this research opportunity and believe it could benefit group therapy programs at the CCDOC. Please feel free to contact me with any questions or concerns.

Respectfully,

Superintendent
Cheshire County Department of Corrections

Appendix C: Informed Consent

I am a doctoral student from the Department of Clinical Psychology at Antioch University New England in Keene, New Hampshire. I am doing a research project as part of my training at school. I am asking you to participate in this research project to evaluate the MRT program currently being run at the Cheshire County House of Corrections.

The goal of this study is to explore how the Moral Reconciliation Therapy program was chosen and administered at the Cheshire County House of Corrections. I will be exploring how this manualized program was adapted to the jail, both in its initial implementation and it evolved over time. I am trying to determine how programs such as MRT are modified to fit real world circumstances, and whether the program as it is administered in this setting was effective at helping to change thinking patterns related to recidivism.

If you agree to take part, I will be conducting a recorded interview with you about the MRT program. This interview will include questions about the decision making process regarding how the MRT groups were formed, how the groups were run, what kind of support facilitators were given before the MRT program was started as well as after it was implemented and similar questions of that nature.

The information you provide will be combined with information from other participants. Neither you nor anyone else taking part in the study will be named or identified. Your information will be kept entirely confidential. If you do not choose to participate in the study the choice not to participate will also be kept confidential.

It may be that reflecting on the way the MRT program has been implemented and the changes that have been made over time will be helpful to you in thinking about how best to form and run these groups in the future. Aside from this, participation in this study is not likely to be of direct benefit to you personally. However, the information you provide may be of use in making decisions about implementation that have the potential to improve the effectiveness of the MRT intervention, both in this specific setting at the Cheshire County House of Corrections as well as other local jails.

Although your identity will be kept confidential throughout the project, and any information you provide will be kept at a separate location in a secure file, this research involves a limited number of participants. Because of that, it may be difficult to guarantee absolute anonymity. If you provide information that reflects poorly on you, the institution, or other individuals involved in administering the MRT program, there may be some risk that the source of that information may be identifiable. In order to ensure that nothing is included in research that will ultimately be shared with others, you will be given the opportunity to review a transcript of your interview both to ensure its accuracy and to give you the opportunity to identify any information you wish to remain private and not have included in the final research report.

Being in this study is your choice. You can stop being in the study at any time. If you decide you no longer want to be in the study, I will not use any of the information you provide.

If you have questions about this study, please contact Branwen Gregory at X, or my research supervisor, X.

If you have any questions or concerns about your rights as a research participant, please contact X, Chair of the Human Research Committee at X, or X, Provost at X.

___ I consent to participate in this study.

SIGNATURE

DATE