RNR ATI Report: Executive Summary

Since the 1980s, Alternative to Incarceration (ATI) programs in New York City have provided defendants with community-based services that divert individuals from the criminal justice system. ATI diversion programs reduce the jail population in two ways: 1) individuals who otherwise would have received city jail sentences are instead diverted into programming in the community; and 2) individuals involved in ATI programs are provided with services to address needs that often are directly related to repeat involvement in the justice system. ATI programs are critical to minimizing interaction with the justice system and building community capacity to address the needs of justice-involved individuals. Some ATI programs in New York City have contractual agreements with the NYC Mayor's Office of Criminal Justice (MOCJ) to provide services.

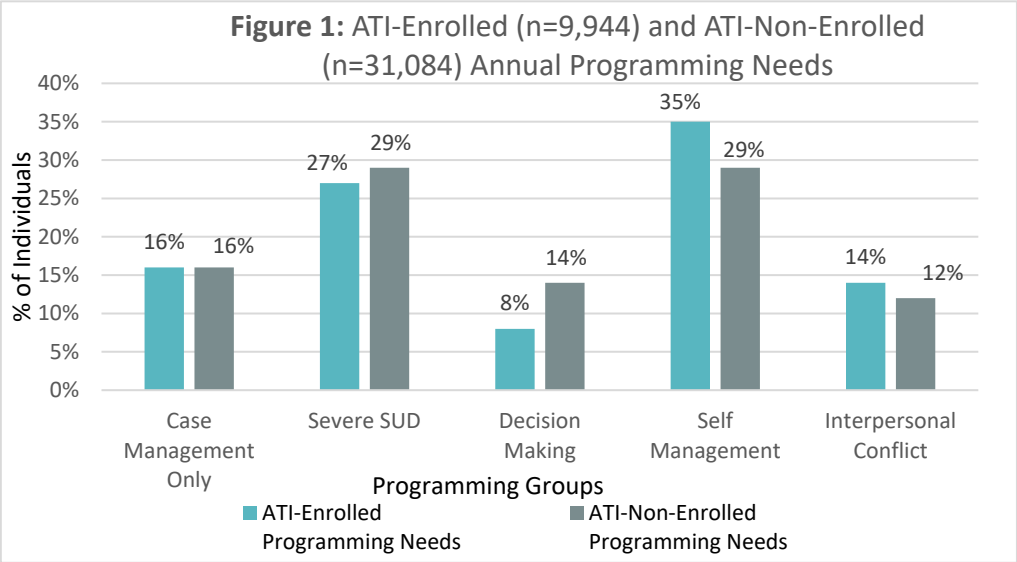
MOCJ partnered with the Center for Advancing Correctional Excellence (ACE!) at George Mason University to:

1. Understand the risk and need factors of the individuals who encounter the criminal justice system in the city annually;
2. Understand the availability of community resources for ATI services; and
3. Ensure that community resources are appropriate to address the risk and need factors of individuals that are eligible for ATI programming.

This report presents the analysis of the 19 MOCJ-funded ATI programs and the 41,000 individuals who were eligible to receive an ATI program in 2014-2016. ACE! used rigorous methodological approaches to examine: (1) the needs of individuals who come into contact with the justice system; (2) ATI program availability and quality; and (3) recidivism outcomes for individuals enrolled in ATI programs. The major finding of this study is that the existing structure (and contracts) of ATI programs are not designed in a way to maximize positive individual outcomes, and there is a service gap in terms of the type of programming needed to prevent recidivism and justice involvement.

What are the Needs of the ATI-Eligible Population?

Nearly 41,000 individuals were eligible for a MOCJ-funded ATI program from 2014-2016, 9,950 (24%) of whom were enrolled in an ATI program. ACE! examined the ATI-eligible population and identified factors that are linked to their recidivism and stabilization in the community. Based on this analysis, ACE! recommended that ATI programming should address various needs, ranging from no direct clinical programming to intensive Severe Substance Use Disorder programming. Most prevalent among ATI-eligible individuals was the need to improve daily functioning through Self-Management skills followed by the need for Severe Substance Use Disorder (SUD) programming. Few individuals need case management and referrals to services or interpersonal conflict or decision-making, in descending order of need. Figure 1 below provides the breakdown of programming needs among individuals who were enrolled in a MOCJ-funded ATI program (termed "ATI-Enrolled") and individuals who were eligible for a MOCJ-funded ATI program but were not enrolled (termed "ATI-Non-Enrolled").



What Programs and Services are Available?

Programs were defined as follows:

1. **Severe substance use disorder**—to reduce the use of illicit drug and alcohol abuse that creates compulsive behaviors that interfere with positive daily activities. Programs tend to be of longer duration (typically 12-18 months) given the severity of problem behavior.
2. **Decision-making**—to reduce thinking errors and patterns that influence involvement in criminal behaviors. Programs of a longer duration (typically 12-18 months) tend to be more effective at reducing recidivism among participants.
3. **Self-management**— to learn and practice managing daily choices and actions and to adjust daily functioning to engage in behaviors that are healthy, positive, and productive. Programs of a shorter duration (typically 3-4 months).
4. **Interpersonal skills**—to address conflict issues with family or peer relationships, or internal conflict that creates difficulties with others. Programs of a shorter duration (typically 3-4 months)
5. **Case Management, No Clinical Programming**—to address stabilization needs in the community but do not have a need that warrants clinical programming.

Program Tool Results

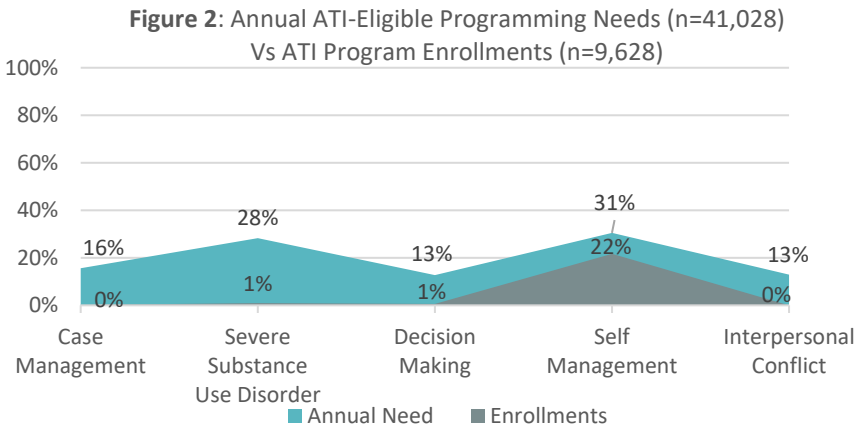
The study used the Risk-Need-Responsivity (RNR) Program Tool (developed by ACE! and available at www.gmuace.org) to: 1) classify the programs based on the primary clinical need they address and the approach they use to address this need, and 2) assess the programs' adherence to evidence-based practices surrounding the RNR framework. The RNR Program Tool is an online survey that scores programs based on their adherence to the literature on effective (evidence-based) programming. The RNR Program Tool gives a score in six categories and a total score. MOCJ used the tool to understand what community resources are available, what resources are needed, and what resources have the capacity to improve individual-level outcomes.

The ATI programs included in this survey received total scores in the moderate range on the RNR Program Tool due to the implementation of evidence-based practices. The programs

typically scored high on the best practices of using validated risk and need assessments, maintaining clear program eligibility, and developing and implementing individual client case plans. Nearly half of the ATI programs in this study also utilized an external means to assess program outcomes including using evaluators, auditors, quality assurance or acquiring software to produce reports, which is also in line with best practices. The ATI programs scored lower in the dosage category since most provided fewer clinical hours and/or less program intensity than should be required to to meet the clinical needs of their participants. In ATI programs, clinical hours were generally determined by legal mandate rather than client need. Additionally, the ATI programs scored lower in their use of incentives; while many programs indicated they used incentives to acknowledge and encourage positive behaviors, most did not have a formal, transparent incentive system, which, if implemented, could help motivate clients to engage in treatment and develop trust in the program.

Gap Analysis

To determine where gaps exist between the service needs of the ATI-eligible population and existing MOCJ-funded ATI programing, ACE! analyzed the type and amount of programming slots that would be needed in ATI programs to adequately address the needs of those eligible for such programs (depicted in Figure 2).



Several pronounced gaps in services can be seen in most clinical programming areas. ATI-eligible clients need intensive services for Severe Substance Use Disorder (SUD) programming (28%) or Self-Management programming (31%). MOCJ-funded ATI programs currently serve less than 1% of the need for Severe SUD programming; more capacity is present among existing programs for Self-Management programming, addressing the need of nearly 22% of the ATI-eligible population.

None of the MOCJ-funded ATI programs were found to address Interpersonal Conflict, though 13% of ATI-Eligible individuals would be best served with this type of clinical programming. Nearly 16% of individuals enrolled in MOCJ-funded ATI programs require case management services and do not need clinical programming. Currently there is no specific program capacity for these services, but some programs embed case management services into their program. Without specific case management services, individuals do not receive adequate referrals to help them stabilize in the community.

Recidivism Analysis

Recidivism outcomes were measured for individuals enrolled in MOCJ-funded ATI programs (termed "ATI-Enrolled") and those eligible but not enrolled in MOCJ-funded ATI programs (termed "ATI-Non-Enrolled") using data from 2014-2018. Recidivism was defined as a re-arrest

for any charge up to a two-year follow-up period. For the ATI-Enrolled group, the baseline re-arrest recidivism rate within two years is 69%, compared to 74% for ATI-Non-Enrolled group.

When individuals were matched with appropriate clinical programming, greater re-arrest recidivism reductions were achieved. For example, when ATI program participants were recommended for and received Severe SUD programming, there was a 15% reduction in re-arrest recidivism compared to individuals who were recommended this programming, but received other types of services.

This study also analyzed recidivism defined as re-admission to jail over a two-year follow-up period where reductions ranged significantly based on type of charge--from a low of nearly 8% for non-violent felony charges to a high of around 18% for high order misdemeanors.

Recommendations

Through this study of current MOCJ-funded ATI programs, ACE! found that programming should be adjusted to meet individuals' needs that affect their criminal justice system involvement. The following recommendations are designed to strengthen ATI services to decrease recidivism further and to help individuals stabilize in the community.

1. **Allow Individuals to Continue Participating in Programming after Court-Mandated ATI Program Period.** Many individuals in ATI programs have complex needs that typically cannot be fully addressed in a short-term program. They would therefore benefit from additional programming once they have completed their mandated time in the ATI program. **The mandated time should not be extended because it provides an opportunity for individuals to be violated for failure to meet ATI requirements and therefore increase the number of individuals that involved in the justice system.**
2. **Conduct Regular and Ongoing Gap Analyses.** Gap analyses, which examine the supply of programming in comparison to the demand for programming, should be used to drive strategic planning and ensure that the needs of the individuals in the system are addressed.
3. **Improve Data Sources, Data Quality, and Data Sharing.** NYC can improve data quality and sharing using standardized, universal data systems and assessment tools; encouraging collaboration among city agencies; and requiring data-sharing processes. This should facilitate routine examination and improvement of the justice system's ability to address individuals' needs.
4. **Prioritize Practices to Increase Motivation for Engaging in Treatment.** Motivation to engage in treatment is crucial, and treatment providers and corrections professionals can influence motivation through using evidence-based practices in how they interact with individuals.
5. **Prioritize Women's Mental Health Needs.** Women in jail in this study tend to be more likely to have a mental health disorder than men. Treating mental health disorders is critical to improving individual functioning, especially for those who also experience substance use disorder.
6. **Support Quality Assurance Practices Among ATI Programs.** MOCJ should put in place greater quality assurance processes for ATI programs to help improve their adherence to evidence-based practices and treatments. This includes addressing the

following implementation areas:

a. **Using Risk-Need Information to Identify Appropriate Programming.** Information from risk and need assessments, as well as other, target-specific assessments should inform both the decision to divert and the type of program an individual should be placed in.
b. **Adding Objective Standards to Contracts.** Current ATI program contracts focus on numbers of participants served. More attention should be paid to metrics regarding the content of programming to ensure standards and consistency across programs.
c. **Increasing Program Intensity.** Many ATI programs do not provide sufficient treatment hours and intensity of programming needed to achieve recidivism reductions for individuals with serious or complex needs. Voluntary post-mandate programming should be made available to address these longer-term needs.
d. **Encouraging Training, Technical Assistance, and Coaching for Service Providers.** Increasing fidelity to program models requires instituting a thorough process to develop and maintain skills of program staff.
e. **Promoting Quality Assurance Monitoring.** Quality implementation can be fostered through a learning collaborative where ATI programs work together to share improvements in their operations and the use of evidence-based practices.
f. **Using Incentives in a Systematic, Transparent Manner.** Many programs do not have incentive systems that are used systematically but incentives are more likely to improve outcomes. Incentives should be delivered early and often, as part of strategy to alter how individuals respond to their environment.

As part of this research project, ACE! developed a series of Practice Guidelines for responding to particular needs identified through this study. The guidelines, which describe evidence-based practices on the following service-related topics, can be found on the NYC Mayor's Office of Criminal Justice website here: http://criminaljustice.cityofnewyork.us/wp-content/uploads/2018/05/Practice-Guidelines-MOCJ-Final.pdf

- **Motivation and Treatment Readiness Techniques**
- **Promoting Healthy Living**
- **Developing Healthy Relationships**
- **Using Incentives**
- **Medication Management**
- **Assertive Case Management**