# NEW YORK CITY
# RISK-NEED-RESPONSIVITY (RNR)
# GAP ANALYSIS PROJECT
## Report

Developed By:
Center for Advancing Correctional Excellence! (ACE!)
George Mason University
and
Maxarth LLC

July 2019

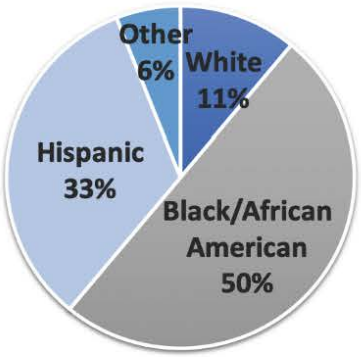
**The Mayor's Office of Cirminal Justice (MOCJ) engaged ACE! to examine**

**1)** Programming needs of NYC justice-involved individuals
**2)** Community resources available, including Alternative to Incarceration (ATI) programs, and target behaviors addressed
**3)** Ways to improve program and system outcomes

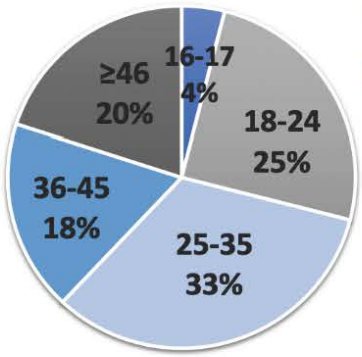
This report presents data on the needs of individuals arrested in NYC from 2014-2016 and the 197 surveyed programs to address these needs. The study further examines how the criminal justice system can better utilize existing resources to ensure that individuals receive appropriate, corrective programming and services that will decrease their likelihood of remaining in the justice system. Recommendations are provided for improving the quality and content of programming to accomplish diversion goals, including better matching of individuals with the right services to address their needs.

## Characteristics of Est. 223,000 Individuals Arrested in NYC(annual average, 2014-2016)

### Race/Ethnicity




### Age




**53%** with no prior history
**16%** with prior misdemeanor charge(s) only
**5%** with prior felony charge(s) only
**22%** with prior felony and misdemeanor charges

**85%** Male

**R**isk
**N**eed
**R**esponsivity

This study utilizes a Risk Need Responsivity (RNR) framework, which asserts that jurisdictions can reduce recidivism and increase individuals' stability in the community by using individuals' risk, needs, and responsivity factors to drive supervision, controls, and programming.

**NYC programs were surveyed using the RNR Program Tool* and categorized into one of five mutually exclusive programming groups based on the *primary* target behavior of the program and additional program components.**

**Individuals were placed into one of the programming group areas based on their *most pressing* clinical need(s) linked to recidivism behavior.**

## Case Management/ No Clinical Programming

Individuals do not have an identified need that drives behavior that is linked to offending. Case management and referral to services is recommended to improve the individual's life functioning and quality of life.

## Severe Substance Use Disorder

Individuals present with a chronic substance use disorder that includes cravings for substances that interferes with daily functioning. Requires intensive (daily) programming with high levels of structure that occur over a longer period of time due to the nature of drug use and the patterns of recovery. Individuals may present with a co-occurring mental health disorder. Some common types of treatment for severe substance use disorder (SUD) include residential treatment, therapeutic communities (TCs), problem solving courts, and intensive outpatient treatment (IOP).

## Decision-Making

Individuals present with cognitive distortions or decision-making that shows maladaptive thinking. Cognitive restructuring programming can facilitate a change in thinking and behavior patterns. Individuals in this programming group often have a number of lifestyle and cognitive errors that affect impulsive decisions and risky behaviors, and should receive programming multiple times per week with high structure.

## Self-Improvement and Management

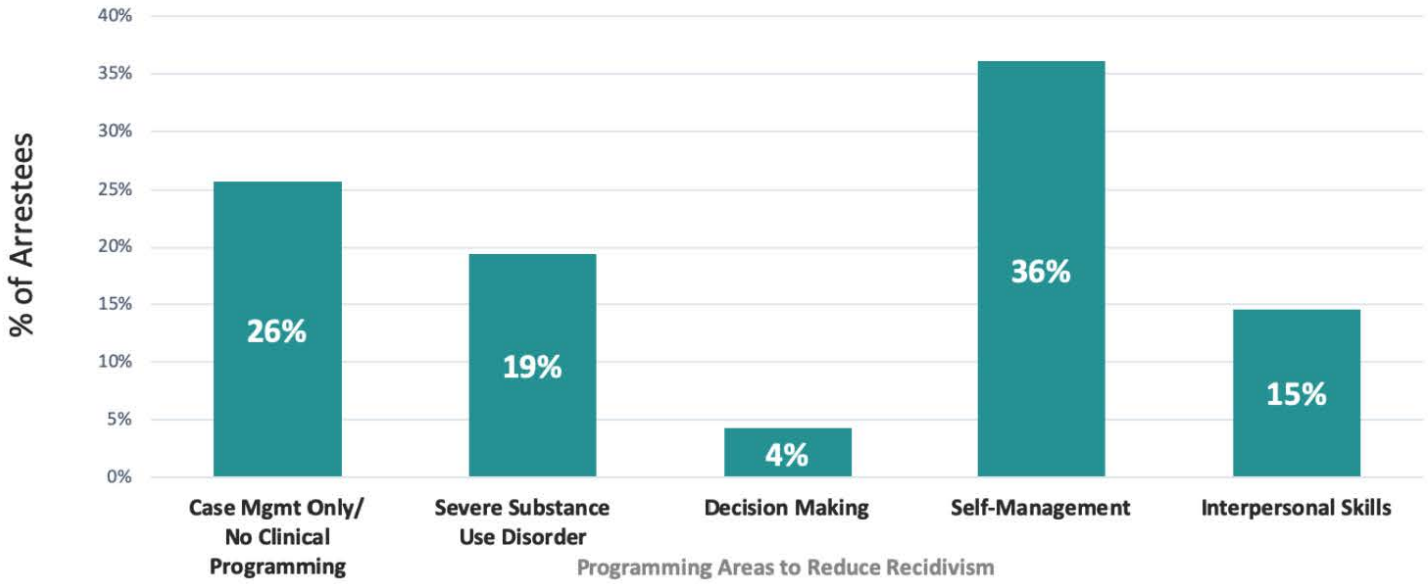
Individuals present with more moderate problem behaviors with a need for guidance in managing daily issues. Programming addresses self-management and control issues associated with mild to moderate mental health and issues or impulsive SUD behaviors by learning to self-regulate behavior, manage emotions and manage conditions. Individuals receive programming weekly or several times per month; level of dosage will vary based on whether the individual has a mental health disorder and the severity of the mental health disorder.

## Social and Interpersonal Skill Development

Individuals present with interpersonal skill issues that affect relationships and quality of life. Structured counseling and modeling of behavior to reduce interpersonal conflict and develop more positive interactions. Emphasis is on social and communication skills, especially with peers and loved ones.

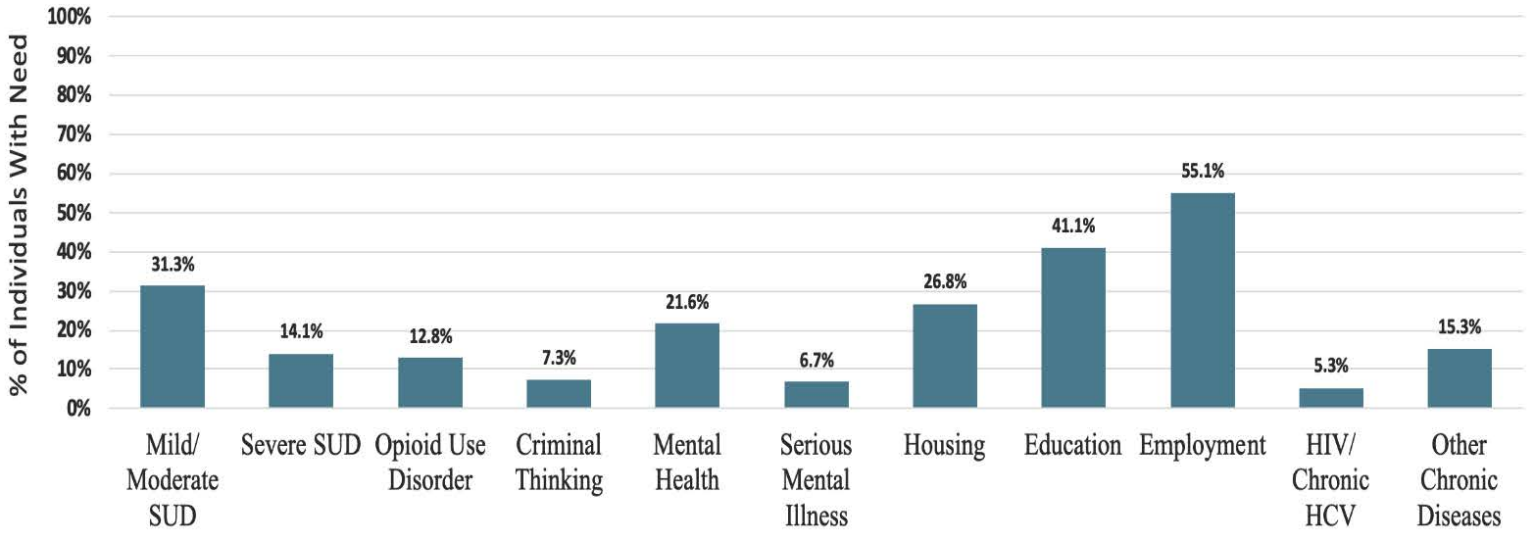
*The RNR Program Tool was developed by ACE! and partners, visit www.gmuace.org/tools
See **Appendix A** for more information on the RNR Program Tool

## Primary Programming Needs of Arrested Individuals (annaul N=223,000)



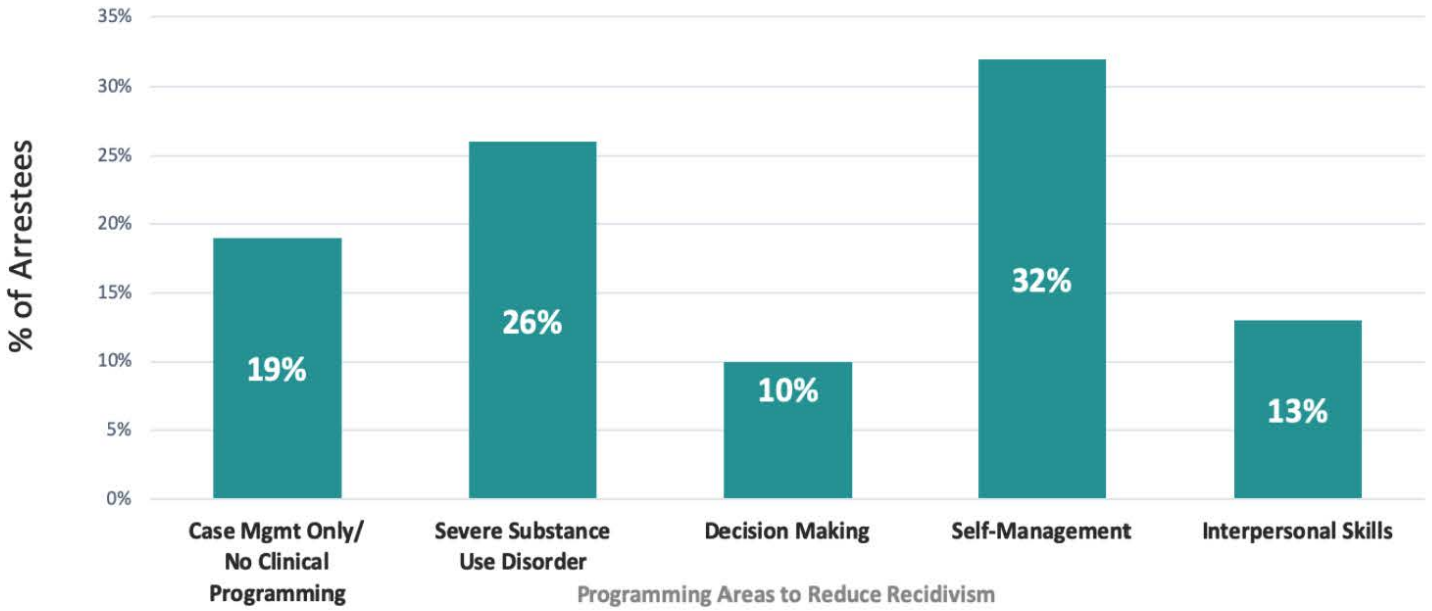

Individuals were placed into one of five mutually exclusive primary programming need areas based on their most pressing clinical need(s) linked to recidivism behavior. Given that programming to address Severe Substance Use Disorder and Decision-Making are more intensive than programming to address Self-Management and Interpersonal Skills, programming to address these intensive needs--when provided to the appropriate individuals--will have the greatest impact on reducing recidivism. Individuals can have more than one programming need, not shown here.
*(See Appendix B for data processing methodology.)*

## Additional Service Needs of Arrested Individuals



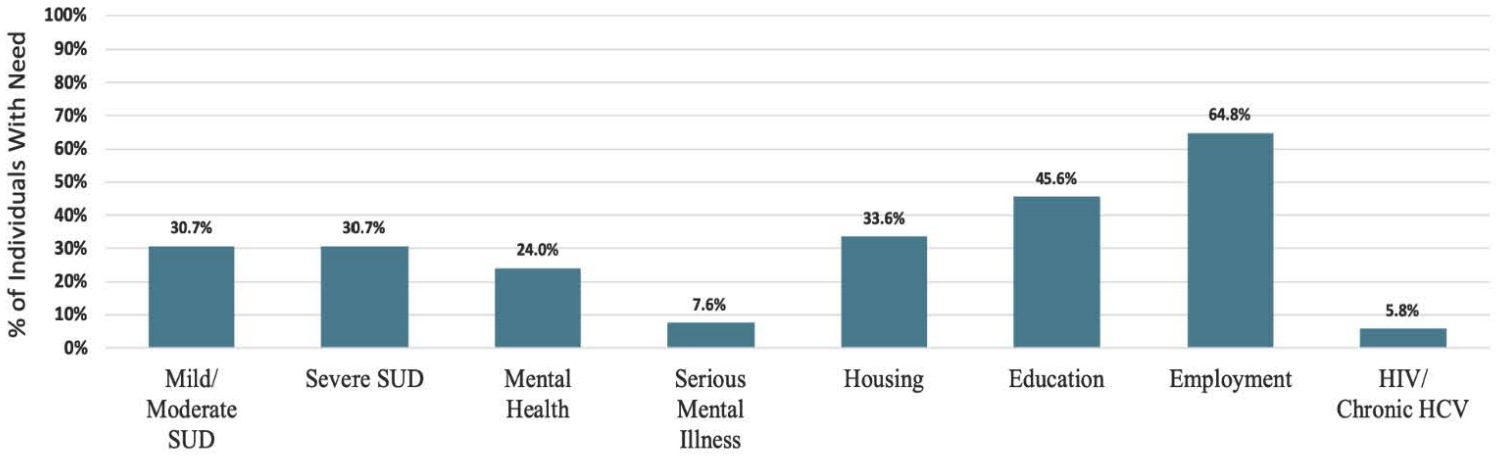

Service needs are not directly linked to reductions in recidivism but are critical for improvements in functioning and quality of life. Addressing these needs can help stabilize a person or provide protective factors to prevent criminogenic needs. These service needs are not mutually exclusive, so individuals may have none to many service need areas. Service needs include education (e.g., not having a high school diploma or GED), employment (e.g., having a spotty work history and not having full-time work), mental health (i.e., being diagnosed with a mental health disorder), and stable housing (e.g., being homeless, moving frequently, not feeling your housing is secure), etc. Service needs by programming group will be discussed in the subsequent sections.
*(See Appendix B for service need definitons.)*

## Primary Programming Needs of Individuals Admitted to DOC (As City Sentenced or Detained, N=68,982 annual average 2014-2016 )




Individuals who were admitted to DOC as city sentenced or a detainee have a higher prevalance of Severe Substance Use Disorder (26%) and Decision Making (10%) needs compared to that of the overall arrested population (19% and 4% respectively). Individuals admitted to DOC require more therapuetic programming than the overall population, as only 19% would be best served by case management services/no therapuetic programming, compared to 26% overall.

## Additional Service Needs of Individuals Admitted to DOC (City Sentenced or Detained)




Individuals who were admitted to DOC as city sentenced or a detainee have more severe substance use disorder needs (30.7%) compared to the overall population (14%). Housing (33.6%) and employment (45.6%) needs are greater among the DOC population than the arrested population (26.8% and 55.1% respectively). The prevalence of education, mental health, and chronic diseases is relatively similar among both populations.

# New York City Program Information

**198** Programs Surveyed

## Programs that are geared to reduce recidivism

- **16** Severe Substance Use Disorder (SUD) Programs
- **13** Decision-Making Programs
- **56** Self-Improvement and Management Programs
- **20** Social and Interpersonal Skill Development Programs

## Case Management/No Clinical Programming: assists individuals with stablization in the community

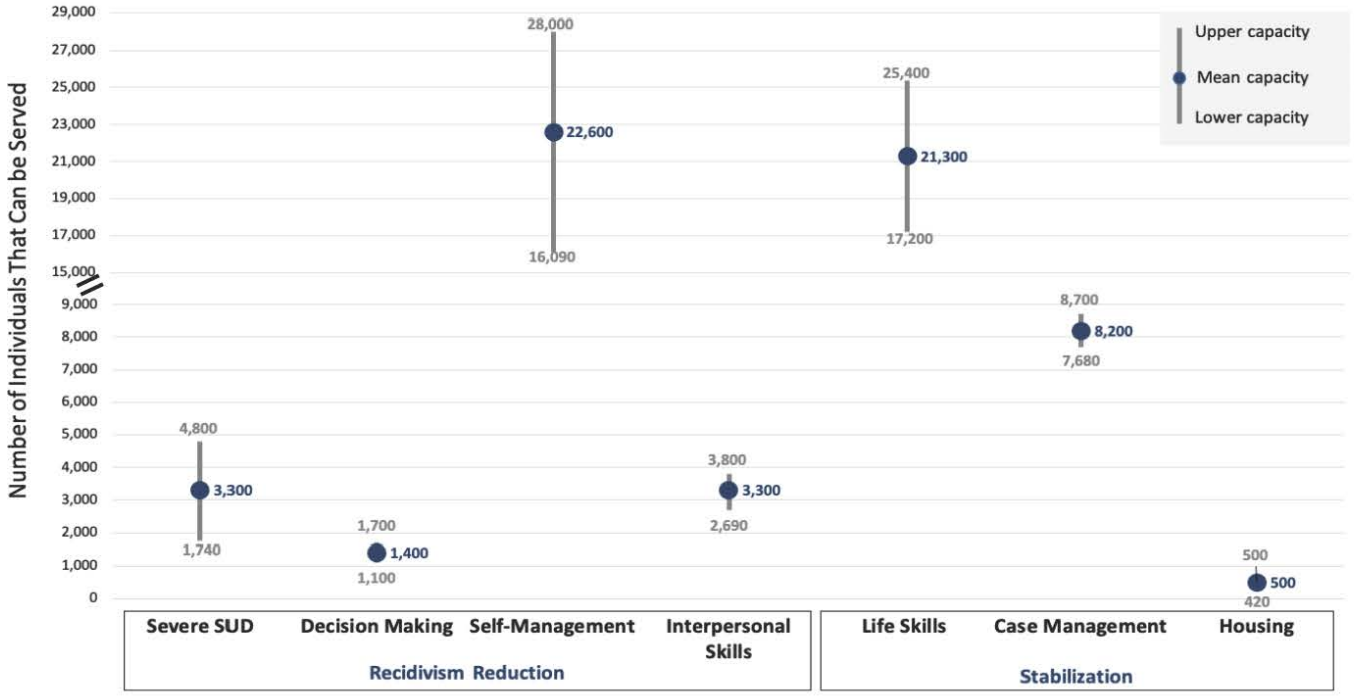
- **56** Life Skills Development Programs
- **14** Case Management Programs
- **14** Housing Programs
- **9** Services/ Supervison Only

## New York City's Capacity to Serve Criminal Justice Clients

Programs and services have a number of funding sources. The reported capacity can vary depending on which sources of funding are included. Program attrition may affect reported capacity. An estimated range of program capacity was developed using programs' self-reported capacity and program completion rates.

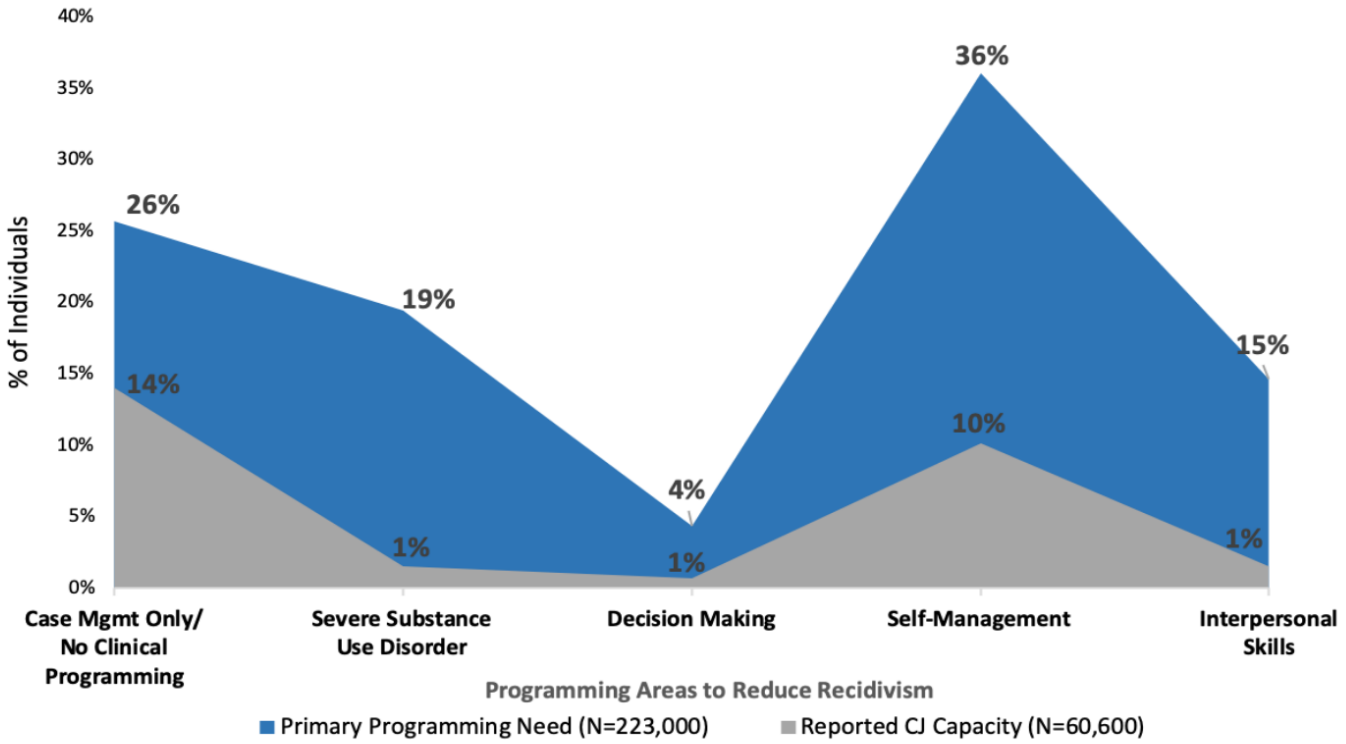
**Capacity Range**

**46,900** Low-end ← **60,600** Self-reported capacity in 12 months → **73,000** High-end




See **Appendix A** and **Appendix C** for more information on the RNR Program Tool data collection methodology and classification.

## Gap Analysis: Primary Programming Need Vs. % of Individuals Served




This gap analysis shows the difference between the percentage of arrested individuals with a primary need (dark area) and the percentage of individuals that can be served (some of which is MOCJ-funded) during a 12-month period (light area) based on programs' self-reported capacity to serve justice-involved individuals. Nearly one-fifth (19%) have a need for severe substance use disorder, however providers are only able to serve 1.5% of the population. Similar gaps exist for programs that focus on Decision-Making and Interpersonal Skills

## The RNR Program Tool: Scoring Domains to Assess Program Quality

After the RNR Program Tool categorizes programs into the appropriate program group, the underlying algorithms provide a score based on the program's adherence to evidence-based practices revolving around the RNR framework. The scoring algorithms also consider the level of programming. A description of the essential features of each domain is discussed below.
*More information on the RNR Program Tool can be found in Appendix A.*

**Risk** refers to the use of a validated risk assessment and use of risk to match service intensity and dosage.

**Need** refers to the use of target-specific assessments and the targeting of dynamic factors that affect recidivism.

**Responsivity** refers to matching the correct type of programming to individuals based on their risk and needs.

**Dosage** refers to the total amount of treatment an individual client receives in terms of the total number of clinical hours, duration of the program in terms of weeks, frequency (number of days/week) and number of hours per week.

**Clinical Standards** refers to appropriate staffing patterns, management of the program, and type of programming.

**Rewards and Sanctions** refers to a structured system of rewards and sanctions, in which rewards are targeted and based on behaviors relevant to the client's case plan/goals.

**Quality Assurance** refers to whether the program has a process in place to ensure that program components and staff are following program procedures.

**Drug Testing** refers to the use of drug testing as a measure of success.

# Severe Substance Use Disorder (SUD) Programs

- Refers to a substance use disorder that requires intensive (daily) programming with high levels of structure that occur over a longer period of time due to the severity of drug use.
- Individuals present with a chronic substance use disorder that includes cravings that interfere with daily functioning.
- Individuals may also present with a co-occurring mental health disorder or other co-morbidities.
- Common types of treatment for severe substance use disorder (SUD) include residential treatment, therapeutic communities (TCs), problem solving courts, and intensive outpatient treatment (IOP) programs.
- Medication Assisted Treatments are recommended for opioid and alcohol disorders.

**16** Programs that address Severe Substance Use Disorders.

**6,400** Annual programming slots available

Based on Overall Capacity

**43,200** Individuals present with a primary SUD that requires intensive services

# Severe SUD Programs

**To be classified as a Severe SUD program, programs must:**

- Use relevant SUD instrument(s)
- Provide minimum 100 clinical hours
- Use group therapy or individual counseling
- Use appropriate curriculum
- Have clinical staff with credentials and experience

## Capacity to address special populations:

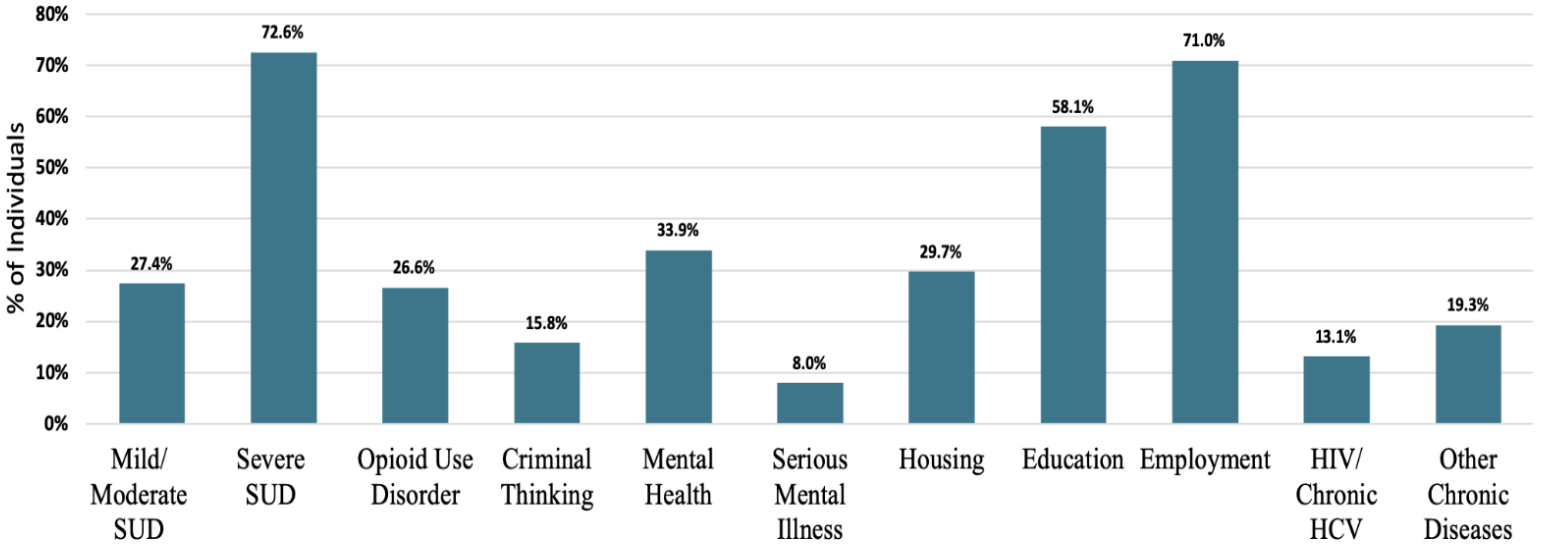
**Youth/Young Adults:**
3 programs, capacity ~230

**Women:**
1 program, capacity ~68

Severe SUD programs' completion rates ranged from 19%-89%; average 47%.

Six programs (38%) reported a completion rate of 60% or more.

## Individuals in this programming group have additional service needs

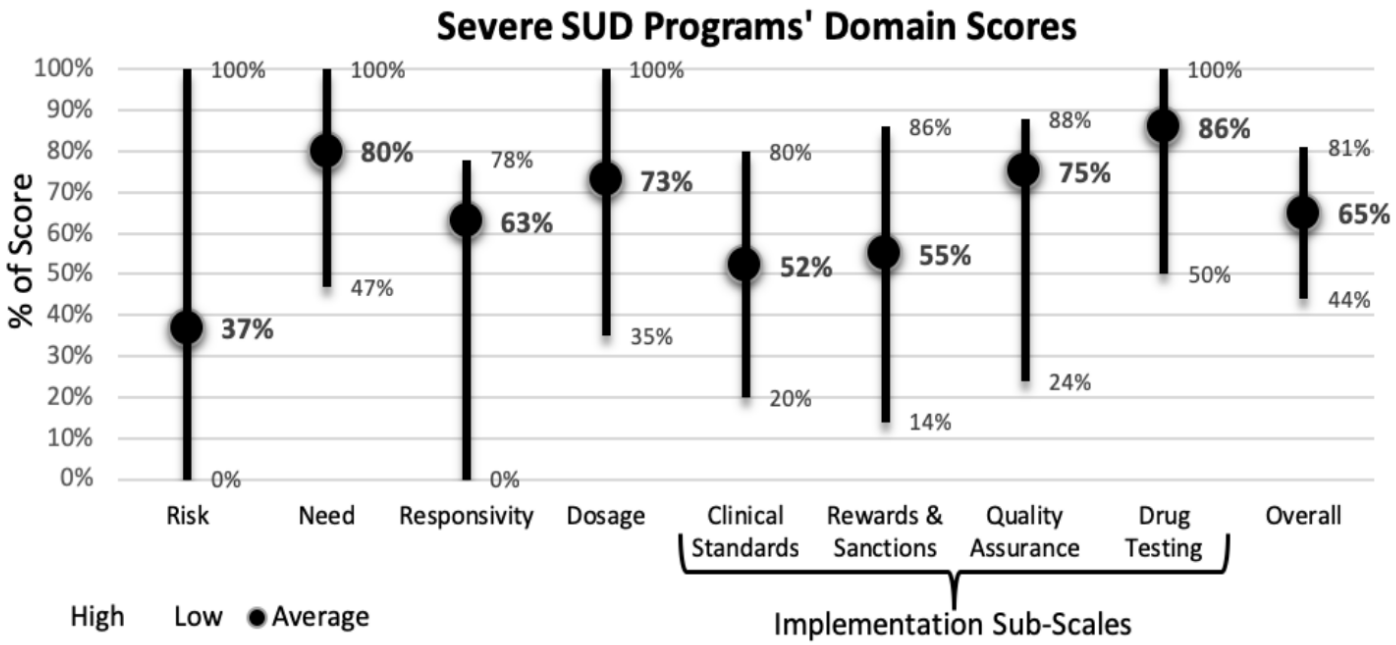



Needs are not mutually exclusive (individuals may present with many needs).

- 73% of individuals' substance use disorder is defined as "severe" vs. "mild/moderate".
- 27% of individuals live with an opioid use disorder.
- More than 40% of individuals present with a co-occurring mental health disorder, including 8% with a Serious Mental Illness.
- Nearly one-third (32%) present with co-morbid conditions that include HIV, chronic HCV, and other chronic diseases.
- Most individuals (71%) would benefit from employment/vocational services, and more than half (58%) do not have a high school degree or equivalent.

## Severe SUD Programs Tend to be High Quality

**Risk** scores ranged from 0-100%, averaging 37%
**Need** scores ranged from 47-100%, averaging 80%
**Responsivity** scores ranged from 0-78%, averaging 63%
**Dosage** scores ranged from 35-100%, averaging 73%
**Clinical Standards** scores ranged from 20-80% averaging 52%
**Rewards and Sanctions** scores ranged from 14-86%, averaging 55%
**Quality Assurance** scores ranged from 24-88%, averaging 75%
**Drug Testing** scores ranged from 50-100%, averaging 86%




See **Appendix A** for more information on the RNR Program Tool scoring

### Common Areas of Strength

- Over 80% of programs use a specific assessment instrument.
- Programs target SUD but also address 3 or fewer ancillary target behaviors.
- Use appropriate treatment modality of intensive outpatient and residential treatment. Tend to use CBT.
- Provide at least 100 hours of clinical programming which is attended daily or multiple times a week. 68% provide aftercare services.
- 86% of programs have been evaluated for outcomes, over half (53%) were conducted by an external entity.
- All programs conduct drug testing. 40% conduct random drug testing.

### Common Areas for Improvement

- Conduct or obtain Risk Need Assessment information and use it to determine eligibility and provision of services. This will assist in understanding individuals' criminogenic needs that may have an effect on their ability to participate in treatment.
- Include phases in programming as a strategy to address stages of change.
- Ensure that programs undergo an external evaluation of program outcomes.
- Implement coaching strategies and utilize technical assistance to ensure quality assurance.
- Integrate a system of structured rewards and sanctions.

# Decision-Making Programs

- Decision-making/cognitive restructuring programming facilitates a change in thinking and/or behavior patterns.
- Individuals present with cognitive distortions or decision-making patterns that results in maladaptive thinking.
- Individuals in this programming group often have a number of lifestyle and cognitive errors that affect impulsive decisions and risky behaviors; require programming multiple times per week with high structure.
  [Note: the data provided did not provide strong measures of how individuals make decisions and a proxy was used.]

**13** Programs that address decision-making

**1,600** Annual programming slots available

Based on Overall Capacity

**9,500** Individuals present with a primary need to improve decision-making skills

# Decision-Making Programs

**To be classified as a Decision-Making program, programs must:**

- Use relevant assessment instrument(s)
- Provide minimum 100 clinical hours
- Use group therapy or individual counseling
- Use appropriate curriculum
- Have clinical staff with credentials and experience

## Capacity to address special populations:

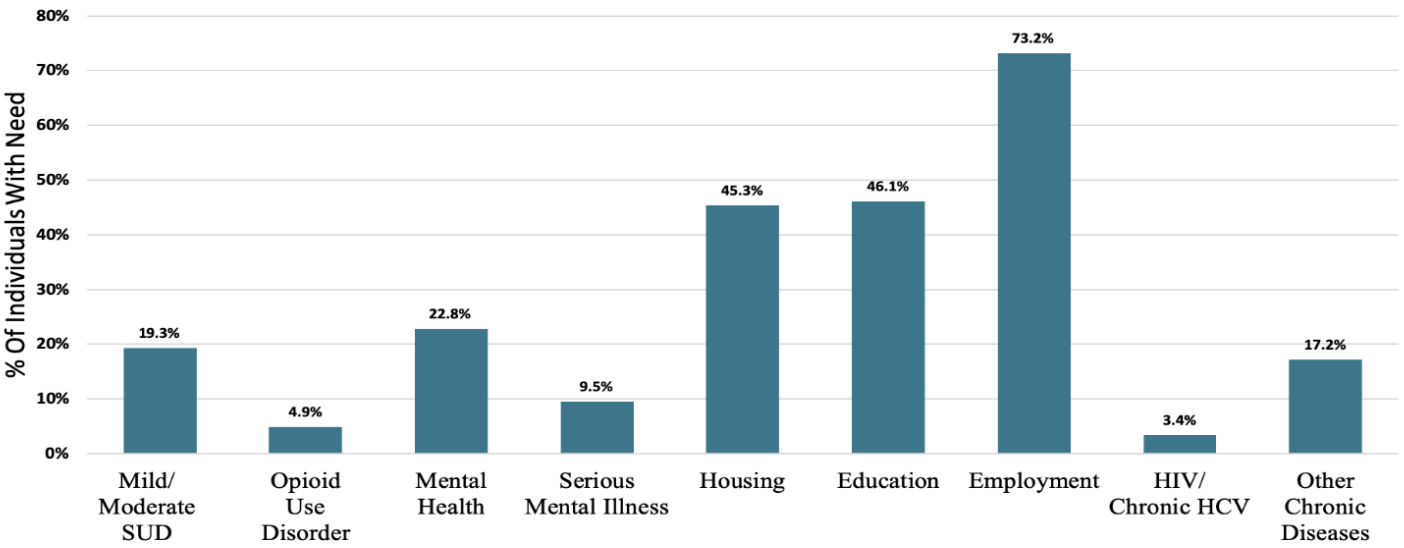
**Youth/Young Adults:**
8 programs, capacity ~400

**Violent Offenses:**
1 program, capacity ~600

Decision-Making programs' completion rates ranged from 32%-100%, with an average of 67%.

8 programs (62%) reported a completion rate above 60%.

## Individuals in this programming group have additional service needs

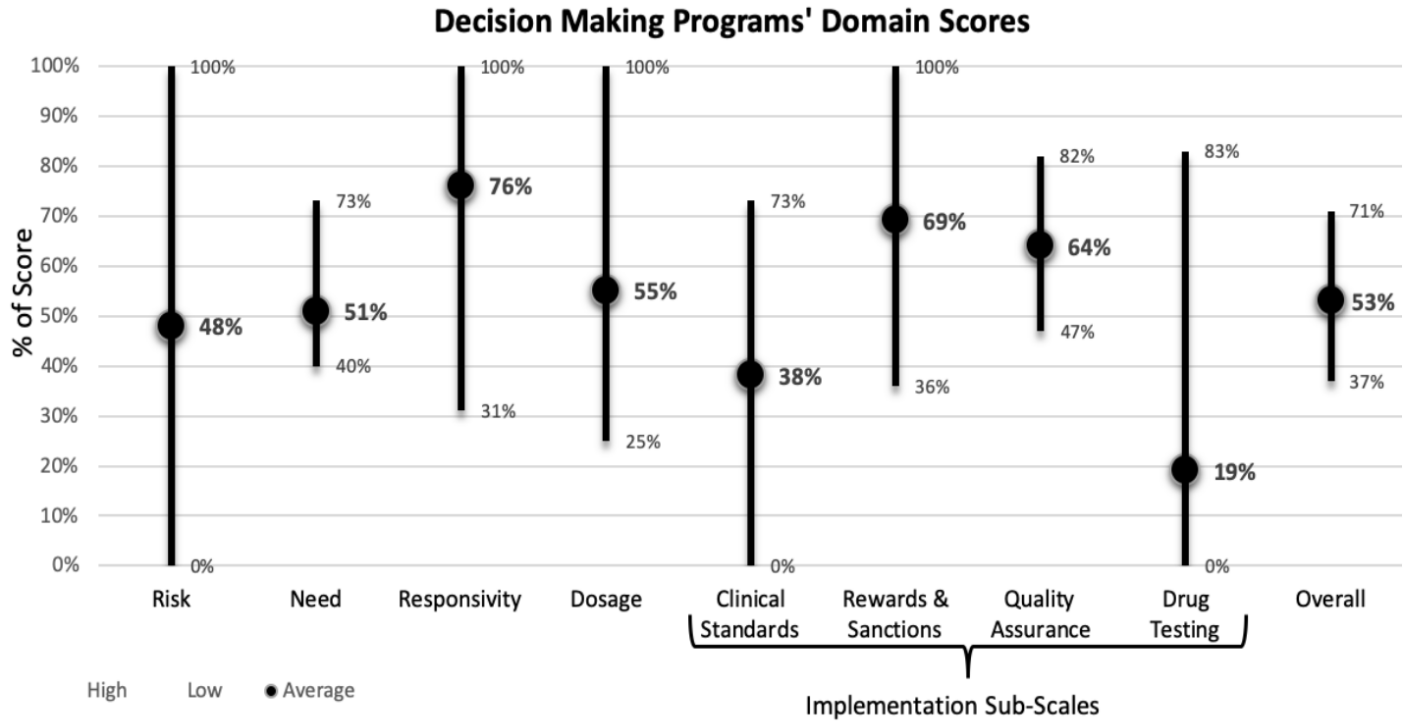



Needs are not mutually exclusive (individuals may present with many needs).

- 19.3% of individuals have a substance use disorder that is defined as "mild/moderate", meaning the substance use is not compulsive but it has some impact on the individual's life.
- 4.9% of individuals in this programming group live with an opioid use disorder.
- 30.0%+ of individuals present with a co-occurring mental health disorder, including 9.5% with a serious mental illness.
- 20.7% present with co-morbid conditions that include HIV, chronic HCV, and other chronic diseases.
- Most individuals (73.2%) would benefit from employment/vocational services, and nearly half (45.3%), do not have stable housing arrangements.

## Decision-Making Programs

**Risk** scores ranged from 0-100%, averaging 48%
**Need** scores ranged from 40-73%, averaging 51%
**Responsivity** scores ranged from 31-100%, averaging 76%
**Dosage** scores ranged from 25-100%, averaging 55%
**Clinical Standards** scores ranged from 0-73%, averaging 38%
**Rewards and Sanctions** scores ranged from 36-100%, averaging 69%
**Quality Assurance** scores ranged from 47-82%, averaging 64%
**Drug Testing** scores ranged from 0-83%, averaging 19%




## Common Areas of Strength

- Programs target fewer decision making needs but also address other ancillary target behaviors.
- Use appropriate treatment modality. E.g., 62% use CBT-based interventions.
- Provide at least 100 hours of clinical programming which is attended daily or multiple times a week. E.g., 39% provide aftercare services.
- The majority of programs (61%) have been evaluated for outcomes; almost half (46%) were conducted by an external entity such as a researcher or licensing organization.

## Common Areas for Improvement

- Utilize specific assessment instrument to identify needs, specifically a criminal thinking instrument.
- Programs should conduct or obtain Risk Need Assessment information and use it to determine eligibility and provision of services. This will assist in understanding individuals' risk and other needs that may have an effect on their ability to participate in treatment.
- Include phases in programming as a strategy to address stages of change.
- Ensure that programs undergo an external evaluation of program outcomes.
- Implement coaching strategies and utilize technical assistance to ensure quality assurance.
- Integrate a system of structured rewards and sanctions.
- Conduct drug testing for individuals with a SUD need.

# Self-Improvement and Management Programs

- Self-Improvement and Management programs address self-management associated with mild to moderate mental health and issues with substance use disorder or impulsive behaviors by helping individuals learn to self-regulate behavior, manage emotions, and manage conditions.
- Individuals present with more moderate problem behaviors with a need for guidance in managing daily issues.
- Individuals receive programming weekly or several times per month; level of dosage will vary based on whether the individual has a mental health disorder and severity of the mental health disorder.

**56** Programs that address Self-Improvement and Management

**45,200** Annual programming slots available
Based on Overall Capacity

**80,400** Individuals present with a primary need for Self-Improvment and Management

# Self-Improvement and Management Programs

**To be classified as a Self-Improvment and Management program, programs must:**

- Use relevant assessment instrument(s)
- Use group therapy or individual counseling
- Use appropriate curriculum
- Have clinical staff with credentials and experience

## Capacity to address special populations:

**Youth/Young Adults:**
6 programs, capacity ~750

**Women:**
7 programs, capacity ~530

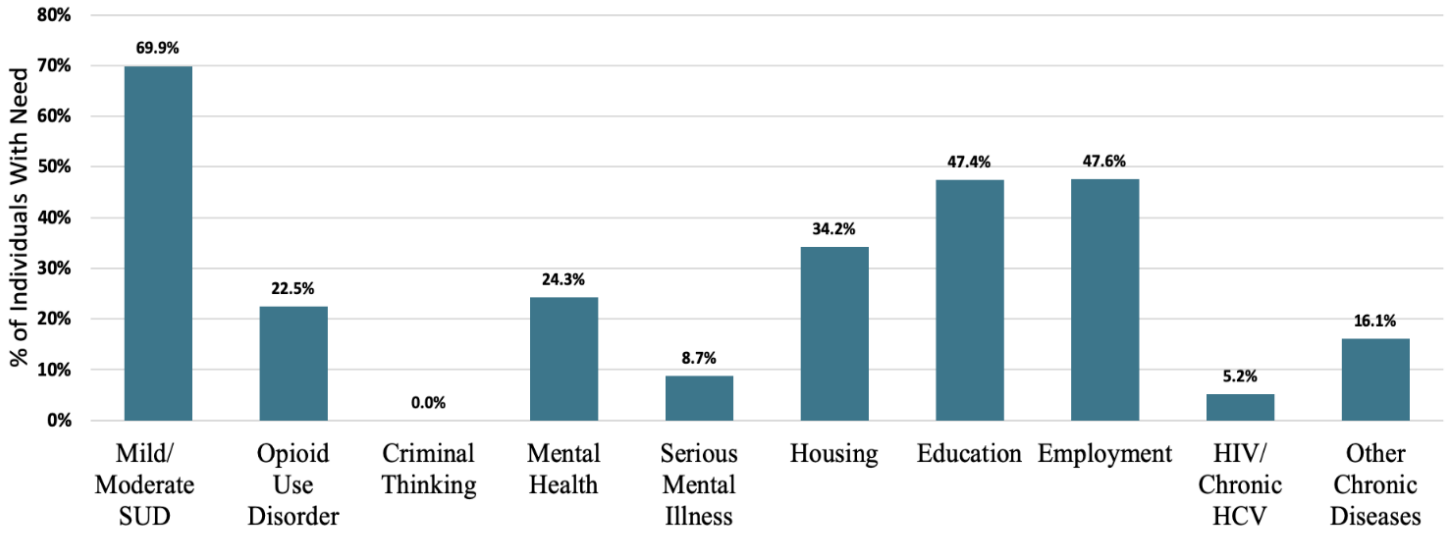
**Mental Health:**
16 programs, capacity ~5,120

**Violent Offenses:**
1 program, capacity ~96

Self-Improvement and Management programs' completion rates ranged from 2%-100%, with an average of 60%.

32 programs (57%) reported a completion rate above 60%.

## Individuals in this programming group have additional service needs

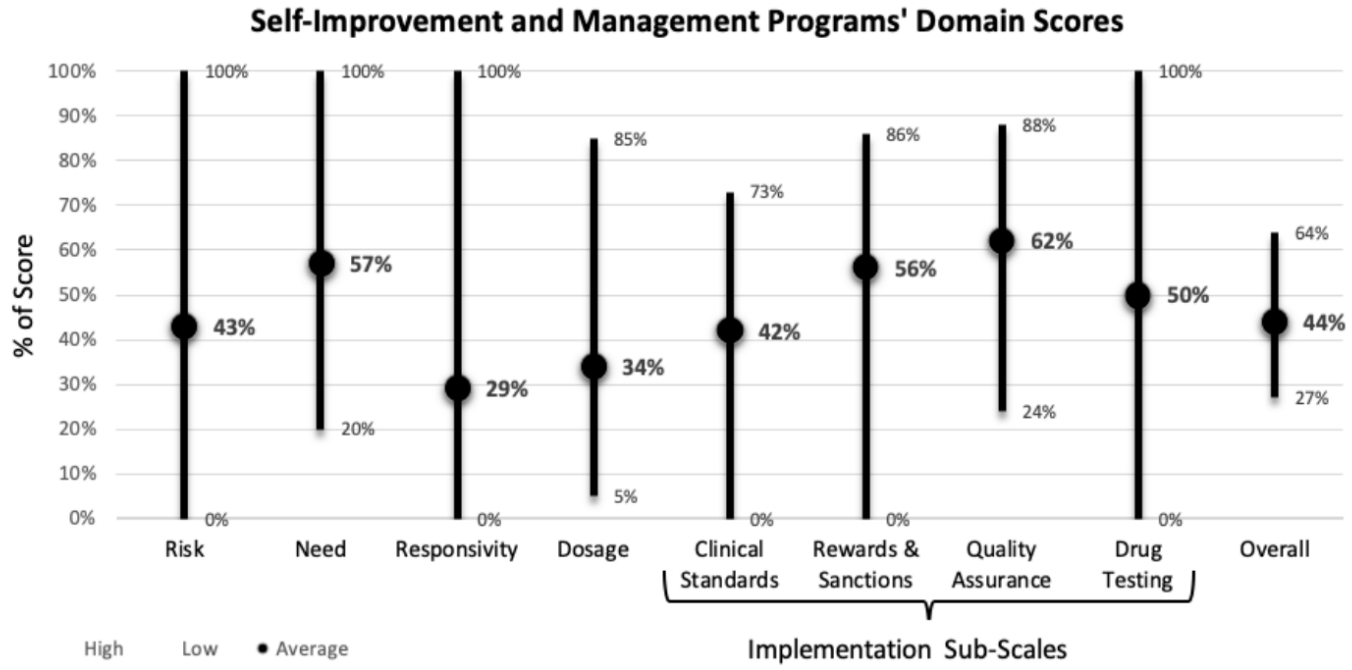



Needs are not mutually exclusive (individuals may present with many needs).

- 69.9% of individuals have a substance use disorder that is defined as "mild/moderate'".
- 22.5% of individuals in this programming group suffer from an opioid use disorder.
- More than 30% of individuals presented with a co-occurring mental health disorder, including 8.7% with a serious mental illness.
- More than 20% present with co-morbid conditions that include HIV, chronic HCV, and other chronic diseases.
- Individuals in this programming group require education (47.4%) and employment (47.6%) services.

# Self Improvement and Management Programs

**Risk** scores ranged from 0-100%, averaging 43%
**Need** scores ranged from 20-100%, averaging 57%
**Responsivity** scores ranged from 0-100%, averaging 29%
**Dosage** scores ranged from 0-85%, averaging 34%
**Clinical Standards** scores ranged from 0-73%, averaging 42%
**Rewards and Sanctions** scores ranged from 0-86%, averaging 56%
**Quality Assurance** scores ranged from 24-88%, averaging 62%
**Drug Testing** scores ranged from 0-100%, averaging 50%




## Common Areas of Strength

- 56% use a specific assessment instrument to identify needs.
- 60% use a Risk Need Assessment to determine program eligibility.
- Use appropriate treatment modality of intensive outpatient and residential treatment. Tend to use CBT.
- 77% of programs have been evaluated for outcomes, over half of which (52%) were conducted by an external entity such as a researcher or licensing organization.
- 70% of programs conduct drug testing; 10% is random drug testing.
- Programs scored low in the area of dosage. The majority of programs (77%) provide less than 100 clincial hours of programming.

## Common Areas for Improvement

- Conduct or obtain Risk Need Assessment information and use it to determine eligibility and provision of services. This will assist in understanding individuals' risk and other needs that may have an effect on the ability to participate in treatment.
- Consider criminal justice risk level for determining services.
- Include phases in programming as a strategy to address stages of change.
- Ensure that programs undergo an external evaluation of program outcomes.
- Implement coaching strategies and utilize technical assistance to ensure quality assurance.
- Integrate a system of structured rewards and sanctions.
- Conduct random drug testing for individuals with SUD.

# Social and Interpersonal Skill Development Programs

- Social and Interpersonal Skill Development programs provide structured counseling and modeling of behavior to reduce interpersonal conflict and develop more positive interactions.
- Emphasis is on social and communication skills, especially with peers and loved ones.
- Individuals present with interpersonal skill issues that affect relationships and quality of life.

**19** Programs that address Social and Interpersonal Skill Development

**3,600** Annual programming slots available
Based on Overall Capacity

**32,500** Individuals present with a primary need to improve Social and Interpersonal Skill Development

# Social and Interpersonal Skill Development Programs

**To be classified as a Social and Interpersonal Skills program, programs must:**

- Use relevant assessment instrument(s)
- Use group therapy or individual counseling

## Capacity to address special populations:

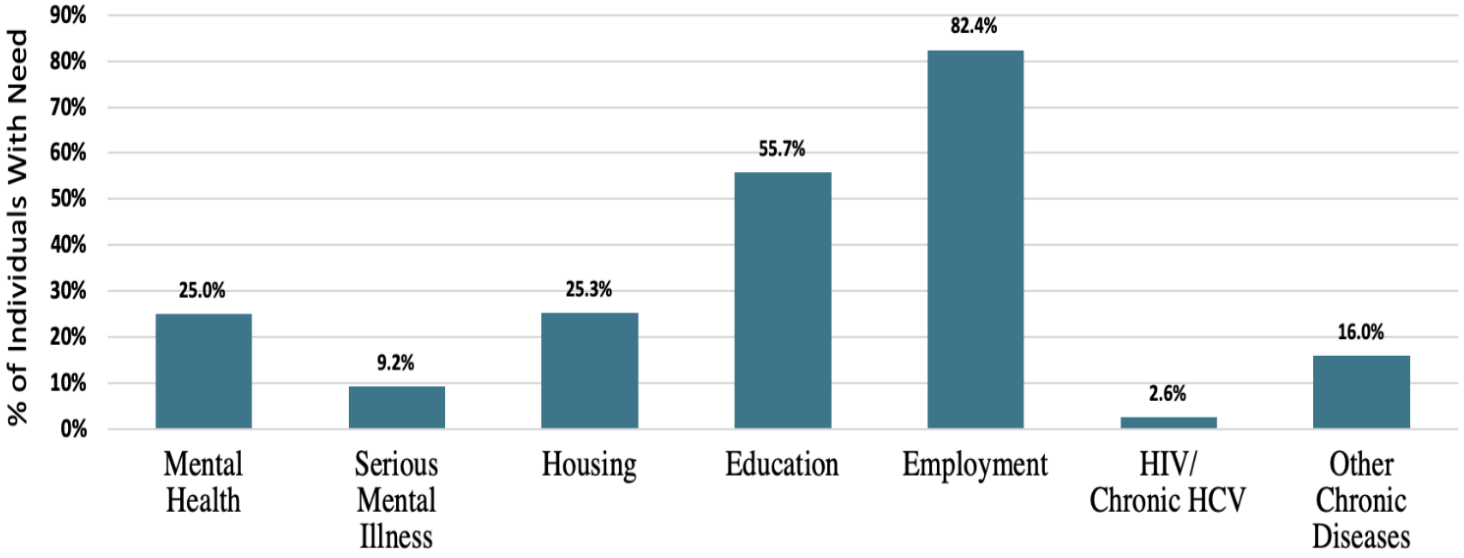
**Youth/Young Adults:**
15 programs, capacity ~2,000

**Violent Offenses:**
1 program, capacity ~600

Social and Interpersonal Skill Development programs' completion rates ranged from 40%-100%, with an average of 77%.

12 programs (63%) reported a completion rate above 60%.

## Individuals in this programming group have additional service needs

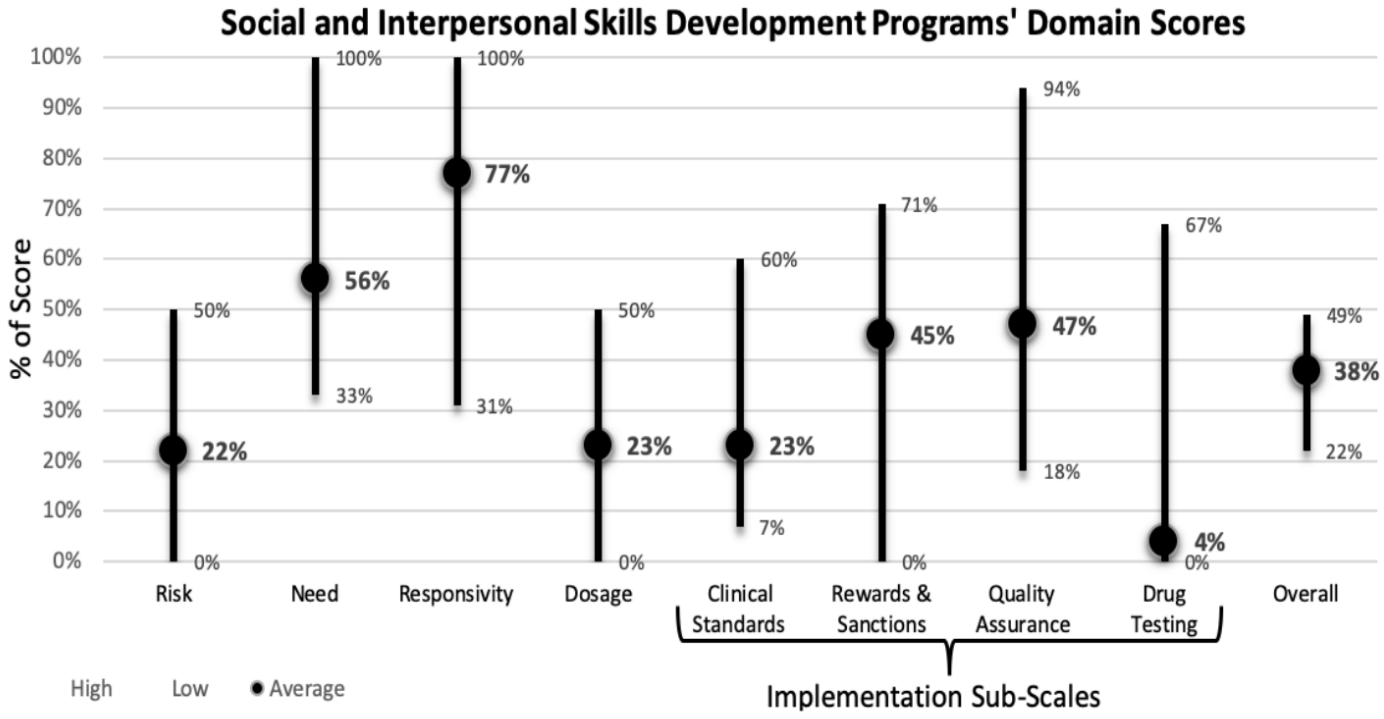



Needs are not mutually exclusive (individuals may present with many needs).

- Individuals in this group do not have any SUD needs.
- 34.4% have a need for mental health disorders, including 9.2% who present with a Serious Mental Illness.
- 18.6% present with co-morbid conditions that include HIV, chronic HCV, and other chronic diseases.
- The majority of individuals (82.4%) require employment or vocational training serices, and 55.7% have an education need.
- 25.3% do not have stable housing.

# Social and Interpersonal Skills Programs

**Risk** scores ranged from 0-50%, averaging 22%
**Need** scores ranged from 33-100%, averaging 56%
**Responsivity** scores ranged from 31-100%, averaging 77%
**Dosage** scores ranged from 0-50%, averaging 23%
**Clinical Standards** scores ranged from 7-60%, averaging 23%
**Rewards and Sanctions** scores ranged from 0-71%, averaging 45%
**Quality Assurance** scores ranged from 18-94%, averaging 47%
**Drug Testing** scores ranged from 0-67%, averaging 4%




## Common Areas of Strength

- Programs target social and interpersonal skills but also address three or fewer ancillary target behaviors.
- Over one-third of programs that target social and interpersonal skill development (35.3%) are mentoring programs. Other treatment methods include individual, group, and family counseling.
- 64% of programs have been evaluated for outcomes, over half of which (24%) were conducted by an external entity such as a researcher or licensing organization.

## Common Areas for Improvement

- Conduct or obtain Risk Need Assessment information and use it to determine eligibility and provision of services. This will assist in understanding individuals' risk levels and other needs that may have an effect on their ability to participate in treatment.
- Include phases in programming as a strategy to address stages of change.
- Ensure that programs undergo an external evaluation of program outcomes.
- Implement coaching strategies and utilize technical assistance to ensure quality assurance.
- Integrate a system of structured rewards and sanctions.

# Case Management/ No Clinical Programming

- Individuals do not have a need that can be identified to drive behavior that is linked to justice involvement.
- Case management and referral to services is recommended to improve the individual's life functioning and quality of life.

**93** Programs that address Case Management/ provide No Clinical Programming

- Life Skills Development (N=56)
- Case Management (N=14)
- Housing (N=14)
- Services (N=9)

**62,900** Annual programming slots available

Based on Overall Capacity

**57,300** Individuals present with a primary need for case management/no clincial programming

# Case Management/ No Clinical Programming

**Programs were classified under "Case Management/No Formal Programming" group if:**

- Use relevant assessment instrument(s)
- Use group therapy or individual counseling

## Capacity to address special populations:

**Youth/Young Adults:**
24 programs, capacity ~6,850

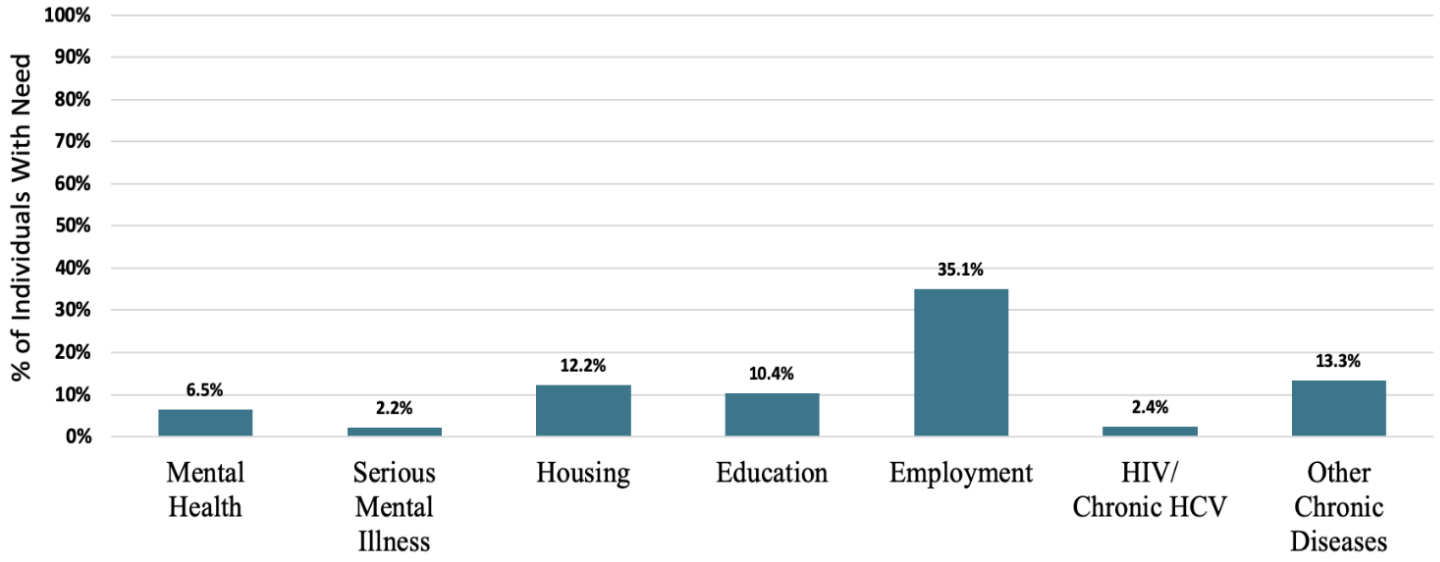
**Women:**
8 programs, capacity ~1,200

**Mental Health:**
11 programs, capacity ~3,300

Case Management and Life Skills programs' completion rates ranged from 26%-100%, with an average of 68%.

35 programs (50%) reported a completion rate above 60%.

## Individuals in this programming group have additional service needs



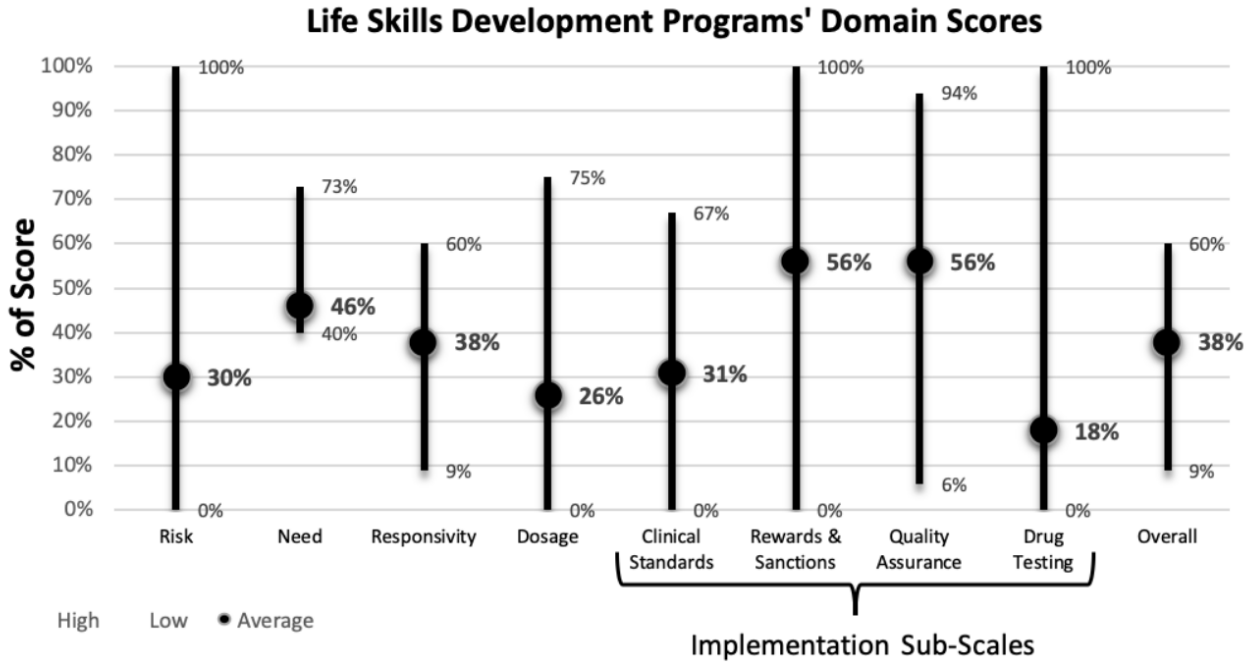

Needs are not mutually exclusive (individuals may present with many needs).

- Individuals in this group do not have any SUD needs.
- 8.7% have a need for mental health disorders, including 2.2% who present with a Serious Mental Illness.
- Nearly 16.0% present with co-morbid conditions that include HIV, chronic HCV, and other chronic diseases.
- 12.2% do not have stable housing.
- 45.5% require education and/or employment and vocational skills training.

# Case Management/No Clinical Programming

## Programs that focus on Life Skills Development (N=56)

**Risk** scores ranged from 0-100%, averaging 37%
**Need** scores ranged from 40-73%, averaging 46%
**Responsivity** scores ranged from 9-60%, averaging 38%
**Dosage** scores ranged from 0-75%, averaging 26%
**Clinical Standards** scores ranged from 0-67%, averaging 31%
**Rewards and Sanctions** scores ranged from 0-100%, averaging 56%
**Quality Assurance** scores ranged from 0-94%, averaging 56%
**Drug Testing** scores ranged from 0-100%, averaging 18%




## Common Areas of Strength

- Nearly half programs (46%) use a specific assessment instrument to identify needs.
- Programs target behaviors related to life skills development. 33% provide employment services, 18% vocational skills training, and 10% provide GED training or educational classes.
- 46% of programs provide more than 100 hours of life skills dosage.
- 74% of programs have been evaluated for outcomes, 28% were conducted by an external entity such as a researcher or licensing organization.

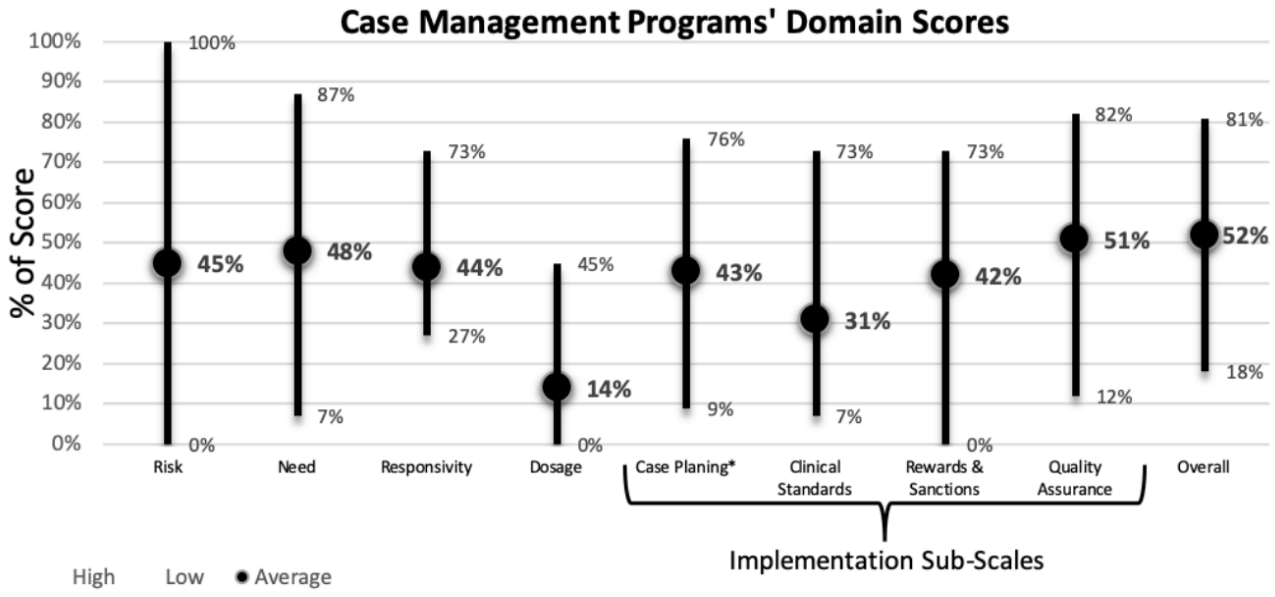
## Common Areas for Improvement

- Conduct or obtain Risk Need Assessment information and use it to determine eligibility and provision of services. This will assist in understanding individuals' risk levels and other needs that may have an effect on their ability to participate in treatment.
- Include phases in programming as a strategy to address stages of change.
- Ensure that programs undergo an external evaluation of program outcomes.
- Implement coaching strategies and utilize technical assistance to ensure quality assurance.
- Integrate a system of structured rewards and sanctions.

# Case Management/No Clinical Programming

## Case Management Programs (N=14)

**Risk** scores ranged from 0-100%, averaging 37%
**Need** scores ranged from 7-87%, averaging 48%
**Responsivity** scores ranged from 27-73%, averaging 44%
**Dosage** scores ranged from 0-45%, averaging 14%
**Case Planning** scores ranged from 9-76%, averaging 43%
(*case planning domain applicable to programs that self-identified as a reentry case management program. Based on 5 programs' responses)
**Clinical Standards** scores ranged from 7-73%, averaging 31%
**Rewards and Sanctions** scores ranged from 0-73%, averaging 42%
**Quality Assurance** scores ranged from 12-82%, averaging 51%
**Drug Testing** scores were removed, only 2 case management programs conducted drug testing




## Common Areas of Strength

- 54% conduct Risk Need Assessments for program eligibility.
- Programs conduct assessments, provide referrals for services, and case management services.
- 30% inform the client's case plan using a standardized Risk Assement or standardized Need assessment.
- 61% of programs have been evaluated for outcomes, only 23% were conducted by an external entity such as a researcher or licensing organization.

## Common Areas for Improvement

- Conduct specific assessments to identify clients' needs and to determine referrals for services.
- Use Risk Need Assessment information and use it to determine services to refer clients.
- Revise clients' case plans weekly or bi-weekly.
- Ensure that programs undergo an external evaluation of program outcomes.
- Implement coaching strategies and utilize technical assistance to ensure quality assurance.
- Integrate a system of structured rewards and sanctions.

# Recommendations

**1. Improving Data Sources, Data Quality, and Data Sharing.** The research team encountered a number of challenges and barriers to obtaining necessary data for analyses. Some of the ways NYC can improve data quality and sharing include using standardized, universal data systems and assessment tools; encouraging collaboration among city agencies; and requiring data-sharing processes.

**2. Measuring Criminal Cognitions.** Few programs used standardized, validated tools to measure criminal cognitions. Identifying criminal cognitions will assist NYC in identifying the most appropriate programming for individuals.

**3. Prioritizing Women's Mental Health Needs.** Nearly two-thirds (32%) of women present with mental health needs compared to 22% in the overall population Treating mental health disorders is critical to individual functioning, especially for those who also experience substance use disorder.

**4. Closing Gaps in Services.** Identify additional providers that can deliver services and talk to existing providers about increasing capacity. There are pronounced gaps in the need for services compared to services delivered in all categories, especially severe substance use disorder, self-management, and interpersonal skills. The gap analyses, which examine the supply of programming in comparison to the demand for programming, can drive strategic planning and ensure that jurisdictions are able to meet the needs of the individuals in the system.

**5. Ensuring Treatment Providers have Access to Naloxone**. Naloxone is a life-saving medication that reverses opioid overdoses. It is critically important that providers who treat substance use disorders have access to naloxone. See Appendix F for a practice guideline on medication management approaches to address behavioral health issues.

**6. Developing Standardized Program Referral Processes.** These should include: 1. Eligibility criteria; 2. Discussion of options with client; 3. Review of available programming; 4. Helping client obtain appointment; 5. Providing a standard information sheet about client to provider, with client's consent.

**7. Promoting Quality Assurance Monitoring.** MOCJ can work with programs to ensure they have appropriate processes in place to ensure quality implementation.

**8. Developing Standards for Quality Assurance and Fidelity Monitoring.**Fidelity has been strongly linked to program effectiveness, and there are a number of ways programs can measure fidelity and/or assure program quality. The "gold standard" is an external quality assurance audit, which only 12% of ATI programs report using. Additional methods include reviews by an internal quality assurance team or supervisor, or having an external method to evaluate program outcomes either by an outside researcher or a licensing organization. Ninety percent (90%) programs surveyed report using an internal method, such as performance measures and internal case file review. MOCJ and partners would benefit from having standardized procedures for conducting quality assurance and fidelity monitoring.

**9. Providing Programs with Specialized Technical Assistance.** Providers should identify improvements they wish to make to their programs in the next 6-12 months and how MOCJ can help them. Few programs reported receiving any technical assistance in the past year; MOCJ should consider making programs aware of technical assistance resources that are available to them, as this can improve staff skills. MOCJ should offer a series of training and technical assistance programs to assist agencies.

**10. Using Incentives in a Systematic Manner.** Many programs indicated that they use incentives/rewards, and incentives are a powerful motivational tool. Most of the current incentive systems are not done systematically; programs would benefit from having formal processes to provide incentives. For example, less than half (46%) of programs indicated they base the incentive plan on individual treatment plans. In addition, programs should ensure that they convey to participants how incentives are earned and distributed. A practice guideline, included in Appendix E of this report, identify additional standards and guidelines for using incentives.

**11. Working with Individuals on Motivation.** Motivation to engage in treatment is crucial and ever changing, and treatment providers and corrections professionals can influence motivation. A practice guideline is available on motivation readiness strategies. Several programs in this study indicated that they employ practices like Motivational Interviewing or Motivational Enhancement Therapy. Developing motivation early in the program can ensure that individuals will be successful in the program and continue in other programming post-mandate. The practice guidelines in Appendix E contain more information about building motivation for treatment.

**12. Working with Individuals on Motivation.** Individuals who are more highly motivated are, of course, more likely to engage in treatment. It is important to remember that motivation is not stagnant—individuals' levels of motivation can increase or decrease over time, and programs can influence the level of motivation. Several programs in this study indicated that they employ practices like Motivational Interviewing or Motivational Enhancement Therapy. Developing motivation early in the program can ensure that individuals will be successful in the program and continue in other programming post-mandate. The practice guidelines in Appendix E contain more information about building motivation for treatment.

# Recommendations

The study team developed a series of practice guidelines to improve programming in target areas and to facilitate attention to offering programming that is focused on strengths-based and individual growth and development. The guidelines are intended to act as a primer on the following topics and can be found in Appendix D and are available online at:
http://criminaljustice.cityofnewyork.us/wp-content/uploads/2018/05/Practice-Guidelines-MOCJ-Final.pdf

**Motivation and Treatment Readiness Techniques** are important to develop during the short ATI program mandate to help individuals see the value in continuing to engage in services after the mandated program has been completed.

**Promoting Healthy Living** as an aspect of treatment should be considered to assist the person in developing daily functioning habits.

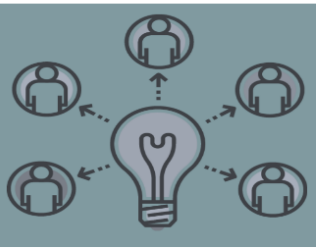
**Developing Healthy Relationships** with family and friends can provide individuals with a network of support and thus reduce the likelihood of future criminal justice involvement.

**Using Incentives** to engage people and sustain behavior change through positive reinforcement rather than a deficit-based sanctions approach.

**Medication Management** approaches to address behavioral health issues.

**Assertive Case Management,** a comprehensive approach to developing community capacity and services for individuals most at-risk for psychiatric crisis and hospitalization and involvement in the criminal justice system.

# Acknowledgments



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