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# A Road Not Taken: Substance Abuse Programming in the New York City Jail System

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## Abstract

Substance abuse represents one of the most common diagnoses in jail settings and features prominently in the path into criminal justice involvement. In addition, substance abuse plays a major role in mortality, morbidity, and recidivism after release from jail. In 2008, a substance abuse treatment program was begun within the New York City jail system, the nation's second largest. This program, A Road Not Taken (ARNT), works collaboratively with courts, security officials within the jail, and community programs to identify inmates who have substance abuse concerns and provide in-jail programming and coordination of treatment after jail. An evaluation of ARNT participants revealed that they experienced a lower rate in incarceration after their program participation than they did before participation.

## Keywords

jail, substance abuse, diversion, program evaluation, recidivism

## Introduction

Substance abuse is a common concern among the incarcerated. A 2002 national Bureau of Justice Statistics survey found that more than two thirds of local jail inmates met *Diagnostic and Statistical Manual of Mental Disorders*, Fourth edition (DSM-IV) criteria for substance dependence or abuse in the year prior to incarceration (Karberg & James, 2005). Of those substance users, 69.5% featured prior sentences—a strikingly higher statistic than the 46% of non-substance using inmates, corroborating the expansive literature documenting the association between substance use and recidivism and the resulting “revolving-door” phenomenon.

The New York City Department of Corrections (NYC DOC) is the nation's second largest jail system, with more than 80,000 new admissions annually and an average daily census of 12,000 inmates. The Department of Health and Mental Hygiene (DOHMH) is responsible for medical and

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**Figure 1.** Program pathway. A Road Not Taken offers an alternative to the traditional outcomes of continued incarceration or release to the community without adequate preparation for treatment.

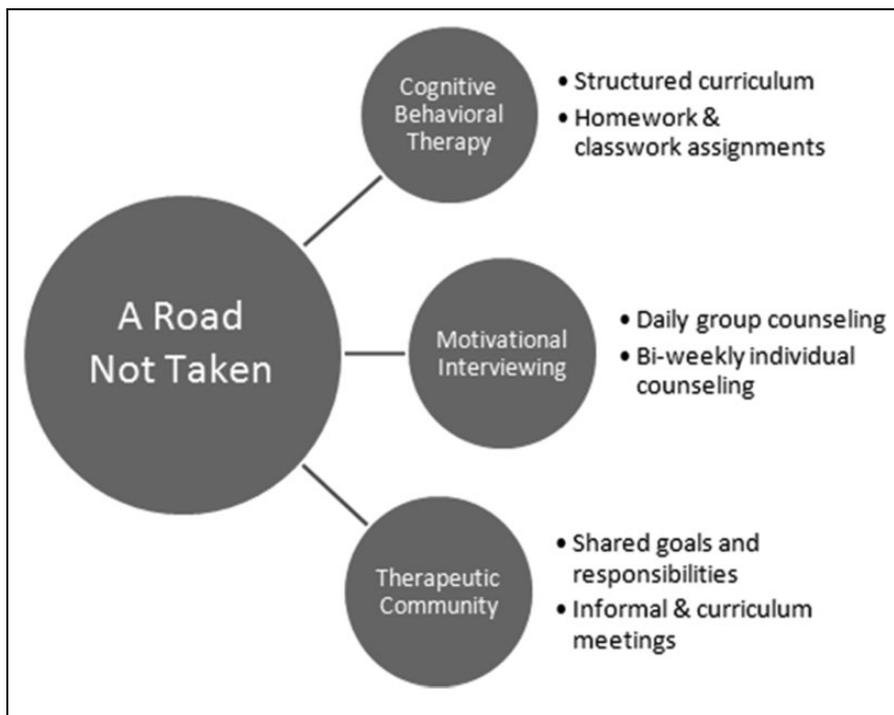
mental health care in the NYC jail system. Approximately half of inmates self-report substance use at intake, although this statistic is often considered an underestimation in light of drug-related charges ranking among the most common charges (NYC DOC, 2012). Research indicates that 80% of inmates are involved with drugs by collateral charge or self-report at admission (van Olphen, Freudenberg, Fortin, & Galea, 2006).

In response, DOHMH implemented a substance abuse treatment program in 2008 on Rikers Island, where the majority of city jail facilities are located. A Road Not Taken (ARNT) is a jail-based diversion program that focuses on inmates who are potentially eligible for a court-referred drug treatment program in lieu of continued incarceration, and assists and encourages inmates to work on the intersection of their addiction, criminal behavior, and related legal situation.

The program has enjoyed positive feedback from stakeholders including NYC treatment courts and community treatment programs. The DOC has noted lower rates of violent incidents in program units, despite housing inmates of mixed security classifications. Both DOHMH and DOC attribute this, at least partially, to the structured environment and focus on shared treatment goals.

### *Selection Into Program*

Patients are either self-referred (voluntary enrollment) while incarcerated or are referred from community sources such as treatment courts (see Figure 1). After clearing DOC security screening and clinical screening by a program counselor, candidates sign a memorandum of understanding. This documents their acknowledgment of a substance abuse problem and consent to follow program rules, such as actively participating and completing assignments. Any rule violation results in immediate removal from the program.



**Figure 2.** Theoretical framework. A Road Not Taken blends elements of three evidence-based practices into one program.

### *Treatment*

Credentialed Alcoholism and Substance Abuse Counselors supervise daily group meetings driven by a structured curriculum involving homework and classwork. Biweekly individual sessions are conducted to check progress and provide additional counseling.

The therapeutic approach is based on cognitive behavioral therapy, motivational interviewing, and therapeutic community treatment (see Figure 2). The curriculum addresses criminogenic thinking (thoughts and behaviors complicit with criminal behavior) as well as underlying drug addiction.

According to Prochaska and DiClemente's (1982) Transtheoretical Model of Change, which has been widely and successfully implemented in changing addiction behaviors, intentional behavioral change occurs in progressive stages that involve specific tasks. Counselors identify the patient's current stage and employ targeted treatment strategies (DiClemente, Schlundt, & Gemmell, 2004; Evers et al., 2012; Everson-Hock, Taylor, & Ussher, 2010; Prochaska & DiClemente, 1982). As the short average length of stay in custody (54 days) has been considered restrictive to effective treatment programming, ARNT instead elects for a "pretreatment" model, which facilitates movement through the stages of change that will enable patients to actively pursue long-term care upon discharge (NYC DOC, 2012; White, Saunders, Fisher, & Mellow, 2012).

### *Court Advocacy and Case Management*

To encourage treatment engagement after the program, patients are linked to community services. Counselors take advantage of their unique position in patients' recoveries to collaborate with community treatment programs to continue structured treatment after discharge. Likewise, community organizations conduct in-reach, visiting and presenting to program units to discuss available services

**Table 1.** Change in Incarceration Rates Pre- and Post-ARNT.

	Pre-ARNT	Post-ARNT	Difference
% Recidivism	0.544	0.416	.128*

Note.  $N = 125$ . ARNT = A Road Not Taken. Sample: All program patients who were in the two male ARNT units admitted in 2010. For those with multiple incarcerations in 2010 with ARNT involvement, the first such episode is used as the reference in determining recidivism. Exclusion criteria: Less than 1 year out of jail (discharge date after March 2011), incomplete or missing values for unique identifiers, and discharge codes that would eliminate from the potential recidivist pool (discharge to state hospital, prison, or immigration services).

\* $p = .018242$ , McNemar's test (two-tailed).

with patients. ARNT is also officially partnered with the NYC drug courts to accept referrals and work on treatment placement.

## Discussion and Evaluation

ARNT's implementation in 2008 coincided with that of DOHMH's new electronic medical records system, eClinical Works (eCW). After linking data in eCW with DOC's Inmate Information System (IIS), preliminary analysis of ARNT patients' incarceration outcomes was conducted.

Using a sample of all inmates in the two male ARNT program units admitted in 2010 ( $N = 125$ ), analysis revealed that 54.4% of patients had a prior arrest in the 365 days before the incarceration of ARNT enrollment. The percentage of patients with an arrest within the 365 days following that incarceration was 41.6%, demonstrating a statistically significant 12.8% decrease (see Table 1).

Neither eCW nor IIS contained data relevant to time outside of jail. Patients with discharge codes pertaining to state hospitalization or prison sentencing dated after ARNT enrollment were removed from analyses. Furthermore, calculations for incarceration rates in the year prior to ARNT assumed that time outside of jail was comprised solely of time at risk for arrest; that is, possible time in prison or a state hospital was ignored, thus potentially overestimating the pre-ARNT rate and underestimating ARNT's program effects.

## Next Steps

The realities of correctional institutions pose unique challenges to evaluation, particularly the selection bias, attrition, and subject crossover effect native to research in these settings (Miller, Koons-Witt, & Ventura, 2004). Furthermore, these problems are compounded by the large size of the jail population and related difficulties in operational coordination between health and correctional staff. While the former aims to foster a therapeutic culture, the latter is responsible for administrative and punitive actions that can not only disrupt treatment but also threaten internal validity of research.

While the Department of Health continues to strive for administrative cooperation, more sophisticated analytical techniques will be employed to address this difficulty in study group selection. In particular, we are exploring propensity score matching, which has been successfully implemented to evaluate in-jail substance abuse programming (Duwe, 2010; Jensen & Kane, 2012).

The improved methods will be driven by more rigorous data collection enabled by recent improvements in electronic health records and its integration into clinical operations. While outcomes related to recidivism are often the most discussed in research, we also will be interested in measures of treatment motivation and program placement.

## Declaration of Conflicting Interests

The authors disclosed no conflicts of interest with respect to the research, authorship, and/or publication of this article. For information about JCHC's disclosure policy, please see the Self-Study Exam.

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