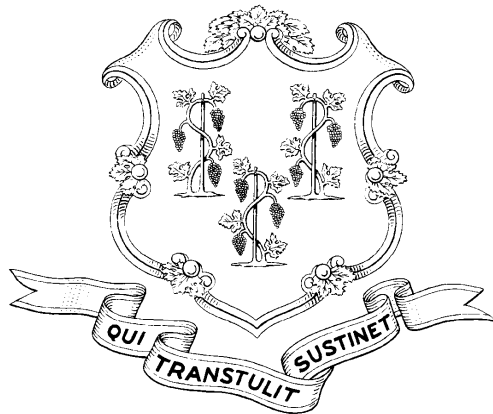


**COMMISSION ON PRISON AND JAIL
OVERCROWDING**

REPORT TO THE GOVERNOR AND THE LEGISLATURE



STATE OF CONNECTICUT

2006

COMMISSION ON PRISON AND JAIL OVERCROWDING

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**PRISON AND JAIL
OVERCROWDING COMMISSION**

To: The Honorable M. Jodi Rell, Governor

Members of the General Assembly

From: Theresa C. Lantz, Chair
Prison and Jail Overcrowding Commission

Date: January 15, 2006

On behalf of the Prison and Jail Overcrowding Commission (PJOC), I respectfully submit the 2006 Annual Report in accordance with Connecticut General Statutes, Section 18-87k.

The Commission has adopted a wide array of recommendations that address the diverse and complex issues faced by the State's criminal justice and related human service agencies. The Commission acknowledges that the challenges faced by our criminal justice system transcend agency boundaries. Truly, the problems related to prison and jail overcrowding are not just criminal justice issues. They have far broader community implications that will require our continued efforts and community collaboration to remedy. As always, the members of the Commission are dedicated to enhancing a system with public safety as its core value.

This is the final annual report of the Prison and Jail Overcrowding Commission in its current form. Public Act 05-249, An Act Concerning Criminal Justice Planning and Eligibility for Crime Victim Compensation, has altered the composition and reporting requirements of the Commission.

Speaking for the membership, we are proud of the accomplishments of this current Commission. We look forward to working with State and community leaders to implement policies and programs to support these recommendations. It continues to be our honor and privilege to serve the criminal justice system and the citizens of the State of Connecticut.

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EXECUTIVE SUMMARY

The Prison and Jail Overcrowding Commission has been the source of many recommendations that have become law during the past several years. Accomplishments have included:

- Initiating the development of a comprehensive re-entry strategy across criminal justice and human service agencies.
- Implementing of the Probation Transition Program and Risk Reduction Units to reduce technical violations of Probation.
- Expanding re-entry options available to the Department of Correction (DOC).
- Creating of a model re-entry center for women on the grounds of the York Correctional Institution.
- Increasing the attention and resources allocated to accused and convicted offenders with behavioral health issues.
- Adding Probation and Parole Officers to lower staff-to-offender ratios.
- Reducing the prison population for three consecutive calendar years coupled with a gradual increase of convicted offenders under community supervision.
- Adding 40 percent more halfway house beds available to convicted offenders under the supervision of the DOC.

The 2006 recommendations address a wide variety of issues that impact prison and jail overcrowding. They reflect the multi-disciplinary approach that has characterized recent Commission reports. With public safety as the overriding theme, the recommendations address options at each phase of the criminal justice system for accused and convicted offenders who require a period of incarceration. The recommendations are contained in this executive summary; a complete discussion of each is contained in Section III.

Recommendation 1: Alternatives to Incarceration

Expand resources available to the Judicial Branch, Court Support Services Division (CSSD) for programs that serve as alternatives to incarceration. Specifically, this recommendation includes:

- **Expand the existing Jail Re-Interview Program (JRIP) to include JRIP staff with expertise in behavioral health issues to address mental health needs, and adolescent services for youthful offenders.**
- **Expand the existing Probation Transition Program (PTP) and the Technical Violation Unit (TVU) programs to all probation offices state-wide.**

- Establish an Intensive Pretrial Supervision Track (IPST) to assist the Department of Correction (DOC) in reducing the pretrial population currently housed in correctional facilities.

***Recommendation 2 Management of Offenders with Problem Sexual Behavior
in the Community***

Implement an evidence-based systemic approach to improving the management of offenders with problem sexual behavior in the community. Specifically, this recommendation includes:

- Implement a containment model approach with the Connecticut Board of Pardons and Paroles (BPP) and the Department of Correction (DOC) to assess, treat and supervise adult offenders with problem sexual behavior who are released to parole or special parole.
- Develop and deliver a community education curriculum on offenders with problem sexual behavior. The curriculum will focus on explaining a containment model of supervision and will also address the misconceptions and realities about treatment, monitoring, registration and recidivism of offenders with problem sexual behavior.
- Expand specialized Sex Offender Supervision Units to include all offenders with problem sexual behavior currently under active supervision with the Court Support Services Division (CSSD) upon an order of the Court.

Recommendation 3 Parole Violation Reduction Program

Establish a violation reduction and expedited review program within the Board of Pardons and Paroles.

Recommendation 4 DOC's Comprehensive Re-entry Strategy

Allocate additional resources for the Department of Correction's comprehensive re-entry strategy. Specifically, this recommendation includes:

- **Fund 20 additional parole officers, two additional parole supervisors, and appropriate clerical support by July 1, 2007.**
- **Expand staff for essential re-entry preparation in correctional facilities. This includes the system-wide addition of certified schoolteachers and vocational instructors, certified institutional substance abuse and other program counselors.**
- **Expand the array of halfway house or other residential treatment options in the community, particularly for special needs populations such as young offenders and those offenders in need of significant mental health treatment.**
- **Expand the number of community non-residential treatment options such as employment services and domestic violence prevention.**
- **Fund technology utilization, such as global positioning system (GPS) tracking of offenders, in order to enhance public safety and offender accountability.**

Recommendation 5 Social Services Accessibility

Continue collaborative efforts between the Department of Correction and the Department of Social Services to increase the accessibility of social supports to releasing offenders. A process for suspending rather than terminating benefits for offenders with psychiatric disabilities upon incarceration should be explored. Access to community services where the inmates will be returning using the Community Action Agency network for case management should be developed.

Recommendation 6 Comprehensive Substance Abuse Strategy

Support and expand comprehensive strategies for accused and convicted offenders with substance abuse treatment needs. This includes continued collaboration among the Department of Correction (DOC), the Department of Mental Health and Addiction Services (DMHAS), the Department of Social Services (DSS), Judicials' Court Support Services Division (CSSD), and the Alcohol and Drug Policy Council (ADPC), and incorporation of evidence-based or preferred practices for treatment and a recovery-oriented service system. Specifically, this recommendation includes:

- Allocate state funds for the Transitional Case Management Program in Hartford and Waterbury with expansion of this type of programming in New Haven and Bridgeport. These case management services promote successful re-entry and reduce recidivism for populations with substance use disorders released from the Department of Correction (DOC). Currently, the Transitional Case Management Program is federally-funded through Justice Assistance (previously Byrne) grant dollars and is at-risk of termination within fiscal year '06.**
- Allocate state funds to establish Enhanced Cocaine/Methamphetamine Sobering Centers, specifically three (3) 8-bed Sobering Centers in Hartford, New Haven and Bridgeport communities.**
- Establish a cross-agency workgroup (DMHAS, DOC DSS, and Department of Children and Families (DCF)) to develop a plan to incorporate the use of buprenorphine in adolescent and adult community-based and correctional facility-based programs that treat opiate dependence.**
- Maintain existing levels of staffing currently supported through the federal Residential Substance Abuse Treatment (RSAT) grant. These positions provide Tier IV substance abuse treatment programming for inmates at four DOC facilities.**
- Allocate state funds to support workforce development strategies, through the DMHAS Office of Multicultural Affairs, that results in the expansion of a**

culturally diverse workforce to assure maximum access, effective treatment, and sustained outcomes for persons of color, Latino/Hispanic origin, Asian Americans, and other minorities who need services for mental health and/or substance use disorders.

Recommendation 7 Behavioral Health

Sustain and expand the array of options for accused and convicted offenders who have significant psychiatric disabilities or co-occurring mental health and substance use disorders. Specifically, this recommendation includes:

- Continue ongoing work on the establishment of Connecticut's first Mental Health Alternative to Incarceration Center (MHAIC). This center will allow individuals who require a heightened level of custodial supervision and who present with significant psychiatric disabilities or co-occurring mental health and substance use disorders the opportunity to access residential and day reporting AIC services.
- Establish Mental Health Day Reporting Centers (MHDRC) in Hartford, Waterbury, New Haven and Bridgeport.
- Allocate state funds for existing Crisis Intervention Teams (CIT) in the Hartford, Waterbury, New London/Norwich and New Haven areas. Identify funding for expansion to those communities which have requested such programs. Currently, CIT programming is federally-funded through Justice Assistance (previously Byrne) grant dollars and is at-risk of termination within fiscal year '06.
- Allocate state funds for specialized Women's Treatment and Support Diversion programs in Hartford and Bristol/New Britain with expansion of this type of programming in New Haven. Currently, federal grants support specialized Women's Treatment and Support Diversion programs in Hartford and Bristol/New Britain.

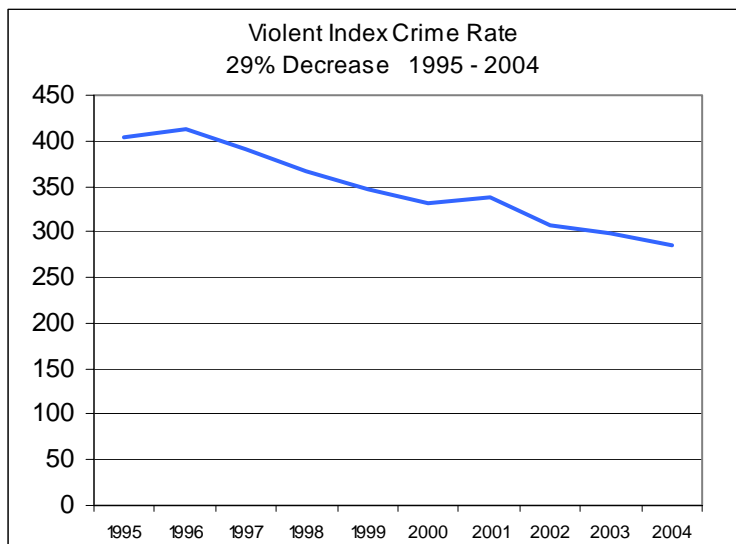
- Sustain a comprehensive array of case management options for offenders with significant psychiatric disabilities or co-occurring mental health and substance use disorders nearing release from the Department of Correction (DOC). These case management services will promote successful re-entry and reduce recidivism for this special needs population.
- Employ specially trained and/or clinically licensed professionals to provide community supervision to offenders with psychiatric disabilities, and to assist with psychiatric treatment as a condition of probation or parole.
- Review current programming and services, and identify obstacles and limitations to accessing alternatives to incarceration for persons with psychiatric disabilities or co-occurring mental health and substance use disorders.

Recommendation 8 BPP Comprehensive Discharge Services

Expand comprehensive discharge planning services for the Board of Pardons and Paroles (BPP) and the Department of Correction (DOC) for individuals with psychiatric disabilities or co-occurring mental health and substance use disorders.

Section I. CRIME TRENDS IN CONNECTICUT

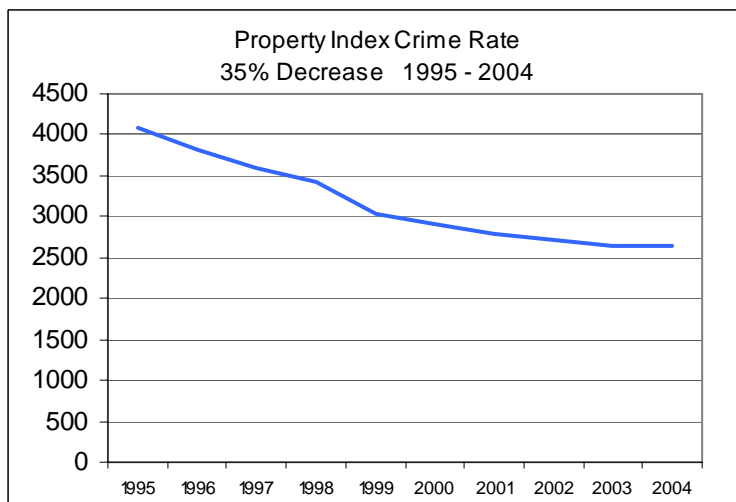
Reported Crime



Since 1995, the violent index crime rate has dropped 29 percent (from 403 per 100,000 population to 285).

However, a slight rate increase occurred during 2001, which was 2 percent higher than the previous year.

Violent index crimes include murder, rape, robbery, and aggravated assault.

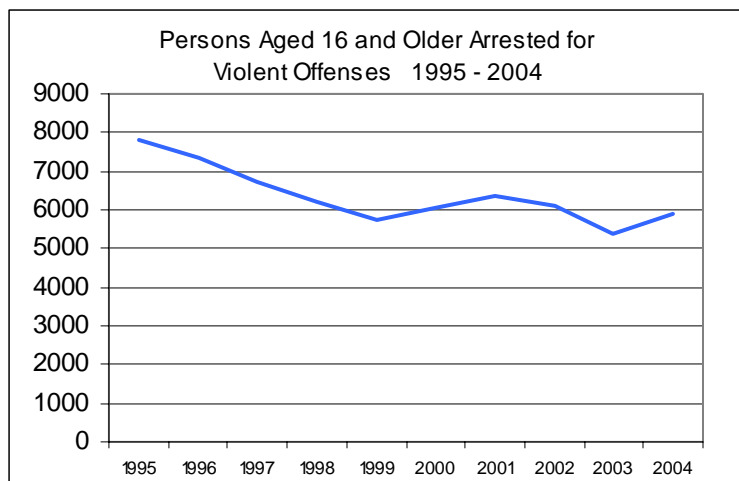


The 2004 property index crime rate was 35 percent lower than in 1995 (from 4,094 offenses per 100,000 population in 1995 to 2,649 in 2004).

Property index offenses include burglary, larceny, and motor vehicle theft.

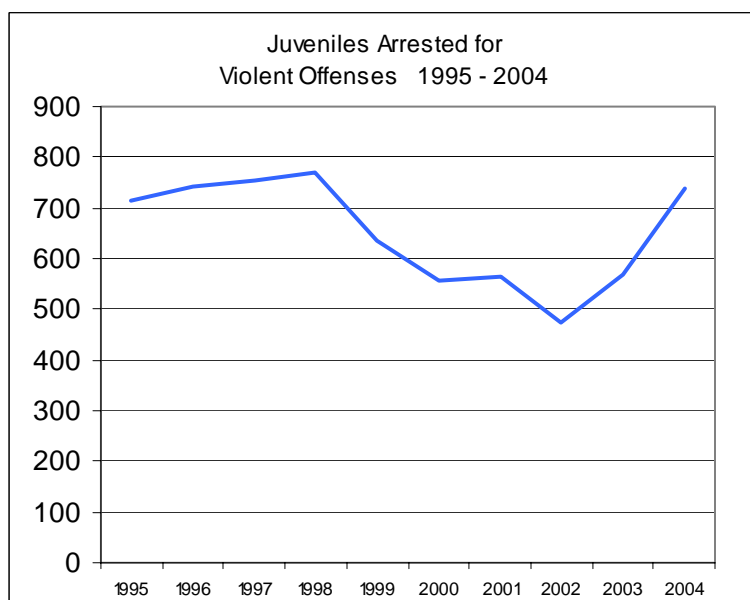
Arrests

Since not all reported crimes lead to an arrest, the number of persons arrested is a more efficient measure of persons entering or re-entering the criminal justice system.



The number of persons aged 16 years and older arrested for violent index offenses¹ decreased 25 percent (from 7,794 to 5,883) between 1995 and 2004.

However, during both 2000 and 2001, the number of adults arrested for violent crimes increased after 10 straight years of decline.



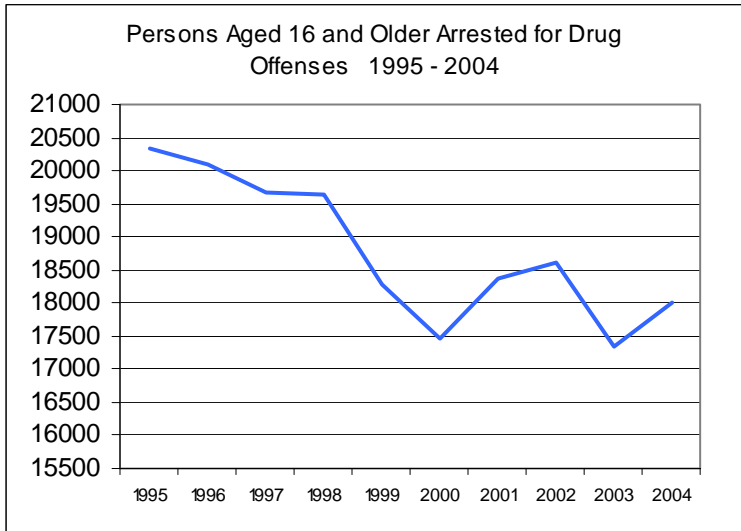
The number of juveniles (aged 15 years and younger) arrested for violent crimes rose slightly during 1995 through 1998. Considerable decreases were experienced in the following 4 years, with the lowest rate occurring in 2002 (475 juvenile arrests per 100,000 population).

However, 2003 and 2004 showed a significant increase in juvenile arrests rising to 740 arrests per 100,000 population in 2004 (which is an increase of 55.8 percent over the 2002 rate).

1995 and 2004 (from 714 up to 740).

Overall, there has been an increase of 3.6 percent between

¹ Violent index offenses include murder, forcible rape, robbery and aggravated assault.



A large number of offenders in the criminal justice system have been arrested for drug offenses. After peaking in the early 1990s with over 20,000 arrests, there has been a slow decline.

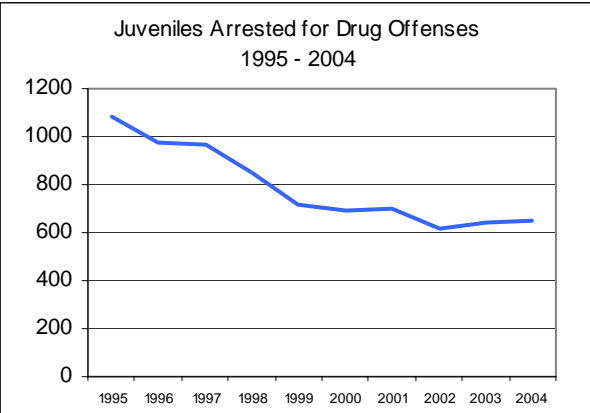
Drug arrests for persons aged 16 years and over have averaged approximately 18,000 per year for the last 4 years.

The change between 1995 and 2004 is 2,308 fewer arrests, or an 11.4 percent decrease overall.

Drug arrests for juveniles (15 years old and under) peaked in 1995, followed by 5 years of gradual decline.

The number of arrests did not change significantly in the following 5 years.

The overall change between 1995 and 2004 is 429, or a 40 percent decrease.



Connecticut Today

Crime rates¹ and the incarceration rate² remain lower in Connecticut than in the United States as a whole. The following table compares these rates for 2004.

2004	Property Crime Rate	Violent Crime Rate	Incarceration Rate*
United States	3,517	466	486
Connecticut	2,649	285	377
% Less than National Rate	25%	39%	22%

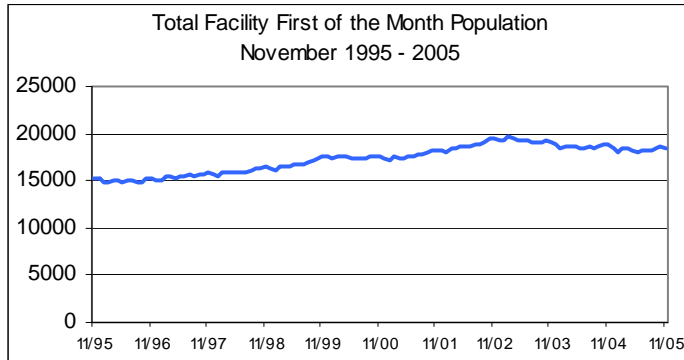
* Incarceration rate is defined as prisoners with a sentence of more than one year per 100,000 residents.

¹ Data obtained from "Crime in the United States 2004", published by the Federal Bureau of Investigation, and the Connecticut State Department of Public Safety, Crime Analysis Unit. Rate is crimes reported per 100,000 population.

² From the Bureau of Justice Statistics Bulletin "Prisoners in 2004" released November 2005, Table 4, Pg 4.

Section II. POPULATIONS

A. Department of Correction Populations

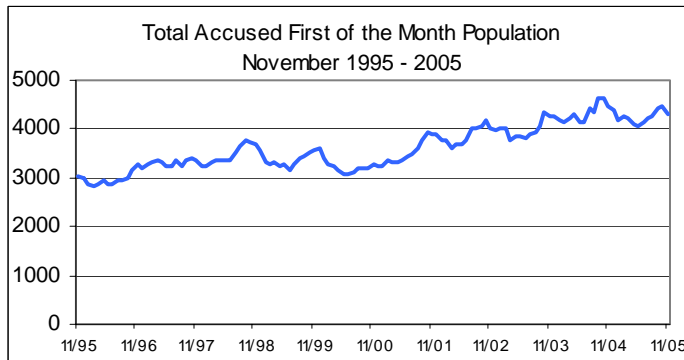
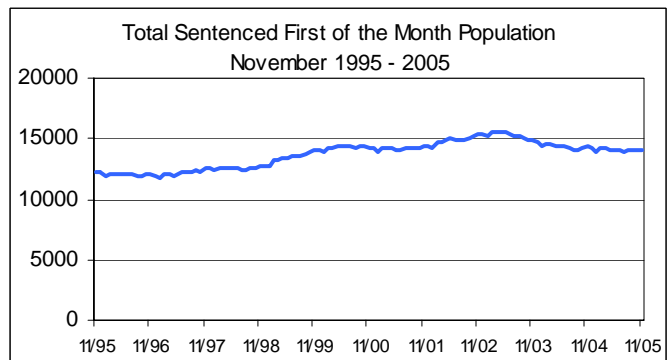


Total Facility Populations

On November 1, 2005, the total population confined in Connecticut correctional facilities was 20.5 percent higher than it was 10 years ago. However, over the past 2 years, the total confined population declined 3.6 percent, from 19,102 to 18,408, and is down 6.0 percent from the all-time high of 19,589 in January, 2003.

Sentenced Populations

In the past 10 years, the sentenced population incarcerated in correctional facilities has increased 15.2 percent from 12,251 to 14,119. However, over the past 2 years, this total has declined 4.9 percent, or by 723 inmates. Currently, the sentenced population represents 77 percent of the total incarcerated population.

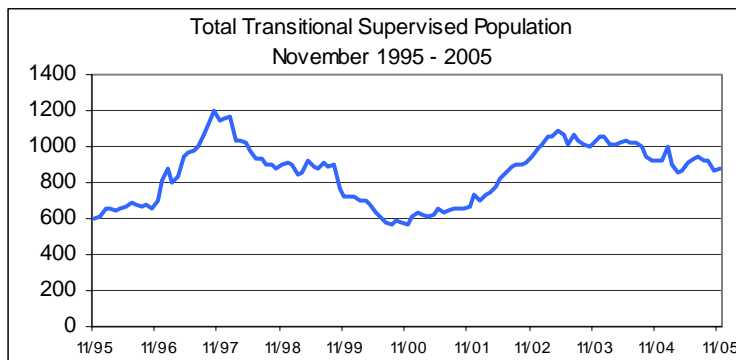


Accused Populations

Since November, 1995, the number of inmates on accused (pre-trial or unsentenced) status has increased 42.3 percent, from 3,013 to 4,289. This accused population varied considerably during the year and is down slightly since November, 2004. Those on accused status, including inmates with violations of special parole, represent 23 percent of the total incarcerated population.

Transitional Supervision

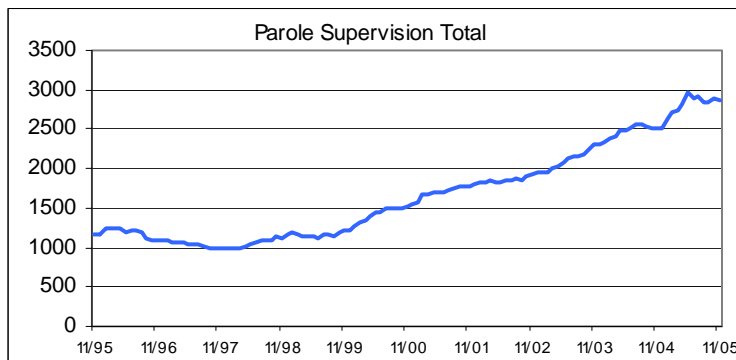
Transitional Supervision (TS) is a discretionary release program under the jurisdiction of the DOC for certain offenders with a sentence of no more than 2 years. An inmate must have served a minimum of 50 percent of his sentence and must have appropriate institutional conduct to qualify for the program. If the inmate is deemed eligible and appropriate for supervision, he may be released to an approved community residence. Inmates on TS are subject to a range of conditions and supervision regimens. The number of inmates currently on TS is 45 percent higher than it was on November 1, 1995. However, the number of inmates supervised on this status has declined slightly over the previous 12 months.



than it was on November 1, 1995. However, the number of inmates supervised on this status has declined slightly over the previous 12 months.

Halfway Houses

The DOC currently contracts for 1,094 halfway house beds throughout the state as of November 1, 2005. These programs assist sentenced offenders in the process of reintegrating into society, and may include employment assistance, substance abuse treatment, mental health and housing assistance.



Board of Pardons and Paroles

The total number of supervised parolees was 2,857 on November 1, 2005. This is an increase of 12 percent from November 1, 2004. The high number of overall supervised parolees during that 12-month time period was 2,959 in May of 2005.

B. The Judicial Branch Court Support Services Division

The Court Support Services Division (CSSD) has implemented a plan to reduce the number of technical violations of conditions of probation. This section provides an update on the progress of the implementation of this plan.

Caseload Management

Achieving manageable probation officer caseloads is a key ingredient in reducing probation violations. When officers are overloaded with cases, they simply lack the time to identify and follow-up on non-compliance before it reaches a point of a violation warrant. For example, when faced with information that a probationer has absconded, the choice is to take the necessary time to try to locate him (which involves speaking with family and friends, and perhaps looking in the neighborhood), or see 25 more probationers scheduled for appointments that day. At the same time, officers are always conscious of the potential public safety risk of this individual. For this reason, a warrant for violation will likely be issued because unmanageably high caseloads make it impossible to spend the time necessary to find the individual and bring him back into compliance.

Since the early 1990s, probation officer caseloads in Connecticut have steadily risen. For example, though the number of probation cases nearly doubled since the early 1990s, the number of officers remained relatively constant or was reduced. The result of this conflict was that probation officer caseloads in 2000 were approximately 250 per officer, putting Connecticut among the top five (5) highest caseloads per officer in the country.

To address this problem the Legislature funded 96 new Probation Officers who were hired in August 2004 and February 2005. All 96 new Probation Officers have completed a comprehensive, 200+ hour curriculum including training on Information Systems, Officer Safety, Pre-Sentence Investigations, Response to Non-compliance, Substance Use, Family Violence, Judicial Policy, Legal Issues, Motivational Interviewing, Court Orders, Ethics, Cultural Awareness, Professional Relationships and several other topics. New officer training also includes several hours of on-the-job training in a field office. All 96 officers have graduated from the CSSD Training Academy, culminating with the graduation of the second class of new hires in July 2005.

The hiring and training of these 96 new officers has resulted in a reduction in average caseload to approximately 120 cases per officer. While a reduction to an average of 120 cases per officer represents significant progress, it is not ideal. Caseloads of less than 125, especially when supervising high-risk offenders, is critical to achieving a reduction in probation violations and recidivism.

It is believed that the combination of lower average caseloads and the skills gained in classroom and on-the-job training, changes in contact standards policy, and improvements in the contracted services, will result in fewer violations of probation in general, and in the longer term, will bring fewer probationers back into the criminal justice system by achieving recidivism reduction.

Special Probation Projects

In 2004, the Judicial Branch received funding to reduce violations of probation in general, and in particular, to reduce the number of technical violations of probation. Funds were provided for 20 officers and treatment services for two populations: high-risk split sentence inmates being released from the Department of Correction's custody to probation supervision and probationers whose probation officer has determined that a technical violation of probation violation is imminent. These projects are the Probation Transition Program (PTP) and the Technical Violation Unit (TVU). Due to limited appropriations, these projects could not be operationalized statewide and were placed in five locations for the Probation Transition Program and in six locations for the Technical Violation Unit.

Probation Transition Program (PTP)

The Probation Transition Program (PTP) targets inmates who have terms of probation supervision upon their discharge from the Department of Correction. This includes those discharging at the end of sentence from a correctional facility, halfway house, parole, transitional supervision or a furlough. The goal is to increase the likelihood of a successful probation period for split sentence probationers by reducing the number and intensity of technical violations during the initial period of probation.

Two probation officers staff the PTP program at each of the five Probation office locations: Bridgeport, Hartford, New Haven, New London, and Waterbury. Each officer carries a maximum caseload of 25. Additionally, Community Partner's in Action (CPA), a non-profit agency under contract with the Judicial Branch, has hired six staff who are assigned to the five PTP offices. CPA staff initiate contact with split sentence inmates returning to any community in Connecticut. The targeted PTP program pool includes all inmates, excluding sex offenders, serving a sentence of 90 days or more, who will be discharged from DOC custody and have a period of probation to follow.

CPA staff go to the correctional facility and meet with the inmate to review the conditions of probation and obligation to report to the probation office on a specific date. An initial screening form is completed which includes information about the current offense, criminal history, behavior while incarcerated, program and education participation, and any identified needs. Additionally, staff collect the intended address of residence upon release, contact person, and any potential employment information. This information is transmitted to the probation office in the area of intended residence and is assigned to a probation officer. The probationer is informed prior to release where to report for probation.

Inmates who are to be discharged to one of the five PTP program offices undergo further assessment by a PTP probation officer. The officer arranges with the facility or other custodial staff to meet with the inmate to conduct an in-depth assessment through an LSI interview (Level of Service Inventory). The results of the LSI assist the probation officer in identifying the needs and risk level of the individual.

At this point, the probation officer identifies and arranges for service in the need areas. The main areas of focus are: housing, employment, substance abuse, and mental health treatment.

Within the first 72 hours of release from a DOC facility, the probation officer meets with the probationer in the office or in the community. Given the extent of the pre-release planning, housing, substance abuse, employment, and mental health needs should already be in place. In general, four face-to-face and two collateral contacts per month are made during the first four months of supervision with additional contacts made as need arises. The goal is to stabilize the offender during this time and then transfer him/her to a regular probation caseload. Each officer

in this unit has a caseload of not more than 25, and is equipped with a car, cell phone and laptop computer. Additionally, assistance from the probation office is available to the probationer 24 hours a day and seven days a week through the PTP officer or another probation officer at that location. The PTP supervision is designed to last 30 to 120 days. However, with a supervisor's approval, a probationer can stay in the program longer than 120 days.

Between October 12, 2004 and July 1, 2005, the Probation Transition Program has screened 2,432 inmates who were scheduled to be released from the Department of Correction. Of these, 466 were placed under the supervision of a probation officer in the PTP unit and 1,966 were screened by Community Partner's in Action (CPA) and referred for supervision in the field office nearest their town of residence. The PTP units in each of the five offices are currently operating at the caseload cap of 25.

The probationers who are under supervision of a PTP probation officer and who are screened by CPA staff are mostly males (89%), are single or divorced (85%), were unemployed prior to being incarcerated (69%), and did not complete high school (58%). One-third of those screened were less than 25 years old. For the PTP program, 25% of the probationers were drug offenders, 25% were convicted of a violent offense (robbery and assault), and 18% were property offenders. The average LSI risk score was 29 (24 and above is considered high risk).

Technical Violation Unit (TVU)

The goal of the TVU is to reduce the number of probationers sentenced to incarceration as a result of technical violations of probation. This program focuses on the probationer who is about to be violated for technical reasons – deliberate or repeated non-compliance with: court ordered conditions, reporting requirements, and service/treatment requirements. There are six units located throughout the state with two officers in each unit in Bridgeport, Hartford, New Britain, New Haven, New London, and Waterbury. Similar to PTP, caseloads are restricted to 25 cases per probation officer and probation officers have cars, cell phones, and laptop computers. Also, services are available to probationers 24 hours a day and seven days a week. Admission to the program is by a referral from the current probation officer through his/her Chief Probation Officer to the Chief Probation Officer for the TVU location. The program lasts up to 120 days from the date of referral to the unit.

During the first 30 days in the unit, the probation officer reviews the most recent LSI assessment and may reassess the probationer. A case plan is developed and referrals for services are made to address the offender's needs. Anticipated areas of need are employment, substance abuse, and mental health treatment, housing, and transportation. There is at least one face-to-face meeting per week with the offender, as well as home or field contacts as needed.

During the next 30-60 days, the probationer receives services from one or more providers. The officers are located at the Alternative Incarceration Center (AIC) where the probationers report regularly to receive services.

The last phase of the program consists of the TVU officer transferring the offender out of the unit. A discharge summary is prepared by the officer and a discharge meeting is held with the probationer. If the probationer has stabilized, he is transferred back to a regular caseload. If the probationer continues to violate the conditions of his probation and fails to make progress in the program, a warrant is prepared following a case review with the Chief Probation Officer for the TVU.

A profile of probationers referred to the Technical Violation Unit shows that they are similar to PTP participants, in that, most are males (78%), are single or divorced (91%), were unemployed prior to being incarcerated (69%), and did not complete high school (71%). Forty-two percent

(42%) are under the age of 25 years at the time of the referral to TVU. The average LSI risk score was 28 (again, 24 and above is considered to be high risk). In terms of offenses, 32% are drug offenders, 18% are property offenders, and 17 were convicted of violent offenses.

Common Aspects of the Special Projects

Both of the programs are similar, in that, the lower caseloads allow the officers to have a greater level of contact and involvement with the probationer in an effort to increase successful probationer outcomes. The probation officers who are working in both of the programs are veteran staff who have been encouraged to be creative, innovative, and to apply all necessary services that funding will allow, in a timely manner, and to use the time that a smaller caseload provides to work directly with probationers and their families in the community.

The probation officers involved in the PTP and TVU believe that the programs are worthwhile and strongly needed. They strongly agree that the level of attention they can give an individual probationer helps in preventing the probationer from committing a violation. Most officers believe that the lower caseload allows for more frequent contacts with probationers and allows for greater assistance in developing a positive relationship with the probationer. In some cases, the relationships have become so strong that it is difficult for the probationer to transition back into the general population. Success stories for these programs include but are not limited to probationers staying clean and attending all treatment programs, probationers attending school, and probationer's families becoming involved in the success of the probationer.

Research and Evaluation

Internal Efforts

In June 2005, CSSD formed the Center for Research, Program Analysis, and Quality Improvement. The responsibilities of this new Center within CSSD include: oversight of external research initiatives with academic institutions, other state agencies, and parties performing research; increasing internal capacity to conduct quality research; enhancing CSSD's capacity to evaluate the treatment programs utilized by our probationers; and leading quality improvement efforts through continual review of internal processes.

CCSU Involvement

In August of 2004, CSSD negotiated a Memorandum of Agreement with Central Connecticut State University (CCSU) to evaluate CSSD's approach to reducing technical violations. The Institute for the Study of Crime and Justice at CCSU is responsible for the research aspects of these programs. CCSU has also been providing technical assistance to CSSD in the establishment and implementation of the Probation Transition Program and Technical Violation Unit, and has designed and has been conducting both process and outcome evaluations of these projects.

By January 15 of 2006, CCSU will deliver to CSSD a Final Report on the Special Probation Projects that included:

- Findings of the process evaluation of each program, including a description of the similarities and differences of each probation office housing Special Programs;
- Preliminary findings of the outcome evaluations;
- Assessment of the effects of legislative actions, Judicial Policy and program changes, and other state agency policy and program changes that may affect the probation; and
- Policy and program recommendations regarding probation technical violations and transitioning probationers out of incarcerated settings.

Preliminary Conclusions

The preliminary findings of the outcome evaluation are promising, in that, both the Probation Transition Program and the Technical Violation Unit appear to be successful in reducing the number of probationers who have their probation violated for a new arrest or a technical violation. The outcome evaluation has found that:

- PTP and TVU appear to be targeting probationers who are most at risk of being violated (young, unmarried, unemployed, no high school diploma, were first arrested at a young age, and scored high on the LSI risk assessment).
- Once in PTP and TVU, probationers are less likely to be violated than probationers in the comparison group.
- PTP and TVU probation officers are violating probationers after they repeatedly do not comply with conditions and before they commit a new criminal offense.

Section III: RECOMMENDATIONS

Recommendation 1: Alternatives to Incarceration

Expand resources available to the Judicial Branch, Court Support Services Division (CSSD) for programs that serve as alternatives to incarceration. Specifically, this recommendation includes:

- **Expand the existing Jail Re-Interview Program (JRIP) to include JRIP staff with expertise in behavioral health issues to address mental health needs, and adolescent services for youthful offenders.**
- **Expand the existing Probation Transition Program (PTP) and the Technical Violation Unit (TVU) programs to all probation offices state-wide.**
- **Establish an Intensive Pretrial Supervision Track (IPST) to assist the Department of Correction (DOC) in reducing the pretrial population currently housed in correctional facilities.**

Jail Re-Interview

Currently, the Court Support Services Division (CSSD), the Department of Correction (DOC) and the Department of Mental Health and Addiction Services (DMHAS) are collaboratively developing a Mental Health Alternative to Incarceration Center (MHAIC) to meet the community supervision and treatment needs of those criminal justice clients with psychiatric disabilities. This project is designed to monitor, supervise and treat up to forty (40) clients at any time who would otherwise remain incarcerated. These clients have been identified as having a DOC mental health need score of 4 (moderate impairment from psychiatric condition, mental illness of sub-acute or chronic nature) and require structured environment with frequent and direct interaction of mental health staff.

This project was undertaken in direct response to the increase of a criminal justice population with mental health needs. In the past, clients with psychiatric disabilities have been unable to gain access to many community-based services and remain incarcerated as a result. Despite this MHAIC initiative, there still exists a significant population of 3,012 inmates (2,167 sentenced and 845 pre-trial) identified by DOC with a mental health score of 3 who remain incarcerated often due to a lack of appropriate community-based resources. The DOC mental health need score of 3 indicates mild or moderate impairment with latent or chronic mental illness.

Based on identified trends, it is expected that 40% (or 1,205) of all DOC mental health level 3 inmates (3,012) are from the three major cities New Haven, Hartford and Bridgeport. CSSD estimates that 1/3 or (398) of the 1,205 identified inmates could be screened and 225 supervised and treated in the community through this collaboration.

There is a similar lack of community-based services for adolescents ages 16 and 17. Currently, there are approximately 340 adolescents of this age group being held at Manson Youth Institute (MYI) and York Correctional Institute (York). While both CSSD and the DOC have attempted to provide services for this population, it has become increasingly difficult. These adolescents usually possess unique and diverse needs not traditionally met in either system and require specific, gender sensitive programming. Because of their age and criminal involvement, most other state agencies may possess services but not the supervision and

monitoring capability necessary to promote community release and supervision. This has resulted in many of these young adults remaining incarcerated.

CSSD currently contracts for community supervision through an extensive network of Alternative to Incarceration Center (AIC) programs that provide monitoring, supervision, case management and other services to the court and adult probation. However, these programs lack the ability to treat clients with psychiatric disabilities. DMHAS, through the Local Mental Health Authorities (LMHA), provides community-based psychiatric treatment services but lacks the monitoring and supervision provided by the AIC network.

By augmenting the treatment services at the LMHAs in the three large cities (New Haven, Hartford, and Bridgeport), DMHAS could provide clinical services, and CSSD, through the AICs in each of these communities, could provide the necessary space for group and individual treatment, case management, appropriate supervision and monitoring. One clinician located at the LMHA in each of these identified cities would manage a caseload of 25 clients. The average length of treatment would be four months allowing each clinician to treat 75 clients a year for a total of 225 annually. Based on an approximately 67 percent success rate for CSSD's Alternative to Incarceration Centers, CSSD estimates that 148 clients could be diverted from incarceration. This cost effective community-based alternative to incarceration would help reduce DOC's pre-trial population while providing these defendants with the necessary community treatment services to promote safe, long-lasting and productive community reintegration.

Additionally, funding would also be required for 3 full-time equivalent Intake, Assessment and Referral (IAR) Specialists to work on the Jail Re-interview Program. These Jail Re-interview staff would be assigned to Garner, Osborn, and York Correctional Institutions, to provide initial screening and assessment of the mental health populations at these three locations. These specialized Jail Re-Interviewers, with experience and knowledge in behavioral health services, would greatly enhance the coordination with local DMHAS services in developing a comprehensive community supervision and treatment plan for the defendant. These JRIP staff will also serve as a liaison with local programs and courts.

This same specialized Jail Re-interview approach could assist with the adolescent population at MYI. Presently, the JRIP staff that performs assessments at MYI is assigned to the New Haven Correctional Center (NHCC) and is unable to devote the necessary time at MYI to meet the increasing need. CSSD would propose adding one Jail Re-interviewer specifically assigned to MYI, who would coordinate release planning with DOC's counseling and educational staff, link with local high schools and develop acceptable alternatives placements to the court.

Probation Transition Program

The Probation Transition Program (PTP) targets inmates 90 days prior to release who have a term of probation following their discharge from correction custody. This includes those discharging at the end of a sentence from a correctional facility, parole, or transitional supervision. The purpose of the project is to identify a probationer's specific needs prior to release, in order to plan for transition into the community, reducing the likelihood of a violation of probation. National research has shown that the first days of release are critical in successful completion of probation.

The goal of PTP is to stabilize probationers during the first few weeks following release and transition them to traditional probation caseloads. Specialized, dedicated probation officers will have caseloads of twenty-five (25) probationers to allow them the time and resources to facilitate this transition.

Technical Violations Units

Another Judicial Branch Court Support Services Division (CSSD) initiative, Technical Violations Unit (TVU), has been developed to reduce the number of probationers sentenced to incarceration as a result of a technical violation of probation. This project concentrates on the probationer who is close to a violation for technical reasons.

Officers assigned to this project also have capped caseloads of twenty-five (25). Admission to the unit is based upon a supervisor review of the probationer's file. If accepted, the officer currently supervising the case will summarize the case and send it to the TVU.

Officers assigned to TVU are located at Alternative to Incarceration (AIC) sites where the probationer is expected to report regularly for supervision meetings and program participation designed to reduce recidivism.

Officers are selected for these assignments based on familiarity with community resources, strong group facilitation skills, strong case management skills, familiarity with clinical and assessment skills, and current best practices in the field of community corrections. Specialized training provided by the CSSD Training Academy and the Center For Best Practices supports their skill levels.

These Units also focus on enhanced collaboration with state agency stakeholders including the Departments of Labor, Mental Health and Addiction Services, and Social Services. In order to be successful in promoting non-violation behavior, facilitated access to resources that are currently available from other stakeholders must be developed. This includes enhanced priority in terms of accessing substance abuse, medical and mental health services including benefits and entitlements for housing, and employment opportunities and training.

Historically, probation violators have comprised a significant portion of the state's prison population and contributed to the overcrowded conditions in the states' prison system. In 2004, through the enactment of Public Act 04-234, An Act Concerning Prison Overcrowding, the Judicial Branch received funding to reduce violations of probation in general and, in particular, to reduce the number of technical violations of probation by 20 percent. Funds were provided for 20 officers and treatment services for two populations; split sentence inmates being released from the Department of Correction's custody to probation supervision and probationers whose probation officer has determined that a technical violation of probation warrant is imminent.

Since July of 2004, the CSSD has been developing projects targeted at these two populations. The projects that have evolved are called the Probation Transition Program and the Technical Violation Unit. With limited appropriations, the programs could not begin statewide. However, they began operation on October 12, 2004 in five (5) locations for the Probation Transition Program, and in six (6) locations for the Technical Violations Unit. Initial findings indicate that probation violations for 2005 decreased by 22 percent in the probation offices where these programs are in operation, while over the same period of time, the offices without these programs increased by 9 percent. This Budget Option would enable the programs to be expanded to every probation office.

CSSD proposes to increase these programs to all probation offices statewide by providing appropriate staff and probationer support services following the model currently in place. The need for statewide programming is explained in the chart, Projected Staff / Annual Violations per Office, following:

Supervision Office	Projected Staff		Annual Technical Violations	Annual Split Releases
	TVU	PTP		
New Britain		1		156
Milford	1	1	108	216
Danbury	1	1	108	156
Manchester	1	2	168	324
Bristol	1	1	168	144
Norwich	1	1	120	120
Bantam	1	1	120	168
Middletown	2	2	336	276
Norwalk	1	1	96	72
Danielson	1	1	180	156
Stamford	2	1	312	120
TOTALS	12	13	1,716	1,908

Intensive Pretrial Supervision

Since the Jail Re-Interview Program (JRIP) was re-established, it has had a significant impact on DOC's pretrial population. Since January of 2005, 6,757 defendants have been screened, with 3,636 released through the JRIP to the community. This has resulted in approximately 129 fewer people per month remaining incarcerated; this will result in approximately 1500 fewer individuals in DOC facilities annually.

Though the number of pretrial defendants interviewed and released to the community by the JRIP has steadily increased every quarter, DOC's pretrial population continues to fluctuate and in some cases has increased sharply throughout the year.

The JRIP staff has relied heavily on CSSD's network of contracted community providers, both residential and non-residential. However, courts have not been as willing to release defendants to non-residential programs, desiring the monitoring and supervision associated with residential programs. This has put a significant burden on CSSD's residential network. Of the 432 accused offenders/defendants currently waiting on CSSD's residential wait list, 268 or 61% are pre-trial referrals through the JRIP. Of the 411 defendants/accused offenders in CSSD's residential programs, 250 or 60% are pre-trial defendants.

CSSD proposes to establish an Intensive Pretrial Supervision Track, (IPST) for defendants currently incarcerated on a pretrial basis. This IPST would be composed of one (1) Adult Supervision Officer in each of the following regions, North Central, South Central, South West, North West, and Eastern regions for a total of five (5). The IPST officers would provide supervision and monitoring for pretrial defendants referred by the JRIP staff and coordinate outpatient services for defendants who would otherwise remain incarcerated on bond. They would remain on this case load for a period of three (3) months and then transition to a less intensive level of pretrial supervision, similar to what occurs in our IAR offices presently.

These officers would work in conjunction with the Jail Re-Interview staff. The JRIP staff would interview these defendants and utilize a newly designed questioner called the "Decision Aid", to assist in determining which defendants would be appropriate for the IPST. This Decision Aid assists IAR staff to better match release conditions with the defendant's needs in addition to ensuring their appearance in court. The CSSD, in conjunction with Central Connecticut State University, piloted this Decision Aid in Waterbury and New Britain courts on a total of 466 cases.

The results during this pilot showed a significant reduction in the Failure to Appear (FTA), rates in those two courts from 15% to 9%. The employment of this tool would provide the JRIP staff and court with a more informed recommendation on those defendants able to utilize the IPST with outpatient treatment services as opposed to being placed on a long waiting list for residential treatment services.

CSSD believes this would be an acceptable alternative to the court in addition to CSSD's residential treatment network. This intensive pre-trial supervision combined with appropriate outpatient services would dramatically decrease the courts reliance on CSSD's residential network, reducing the long waiting list while still providing community interventions without jeopardizing public safety.

Discussion of the fiscal impact of this recommendation is contained in Appendix 1.

Recommendation 2 Management of Offenders with Problem Sexual Behavior in the Community

Implement an evidence-based systemic approach to improving the management of offenders with problem sexual behavior in the community. Specifically, this recommendation includes:

- **Implement a containment model approach with the Connecticut Board of Pardons and Paroles (BPP) and the Department of Correction (DOC) to assess, treat and supervise adult offenders with problem sexual behavior who are released to parole or special parole.**
- **Develop and deliver a community education curriculum on offenders with problem sexual behavior. The curriculum will focus on explaining a containment model of supervision and will also address the misconceptions and realities about treatment, monitoring, registration and recidivism of offenders with problem sexual behavior.**
- **Expand specialized Sex Offender Supervision Units to include all offenders with problem sexual behavior currently under active supervision with the Court Support Services Division (CSSD) upon an order of the Court.**

Containment Model

Implementation of a containment model will be accomplished by adopting the nationally recognized containment model case management system for convicted adult offenders with problem sexual behavior on parole, as is presently in place with those on probation in Hartford, New London and New Haven. It is further recommended that this model be expanded to additional probation units. A victim advocate will be included as a member of each supervision/treatment team.

In spite of the strengths of the current institutional and transitional means of managing offenders with problem sexual behavior, there are a number of gaps that if effectively addressed would improve the management and treatment of offenders with problem sexual behavior in Connecticut. The gaps are:

- Pre-sentence investigations (PSIs) are not available on all sentenced offenders with problem sexual behavior, making the risk instrument scores less accurate or skewed lower.
- Only a small number of offenders with problem sexual behavior actually receive treatment in prison.
- There are few incentives or disincentives that encourage inmates to participate in problem sexual behavior treatment programs.
- Community housing placements for offenders with problem sexual behavior continues to be a major problem.
- There is minimal victim involvement in release decisions and field supervision practices.
- Untreated offenders with problem sexual behavior return to the community without comprehensive risk assessments and introduction to treatment services.

The proposed full-time victim advocate will work with victims from pre-sentence investigation to pre-release from DOC, through the time an offender with problem sexual behavior spends on parole. The proposed approach will permit the development of a seamless case management

system that will increase information to the supervision/treatment team and enhance services for victims.

Several important components will be added to the special management unit, as it currently exists in parole.

- Full time victim advocates working with victims and the parole supervision/treatment team.
- Contract with DOC/University of Connecticut Health Center to expand treatment of offenders with problem sexual behavior and services for parole eligible offenders with problem sexual behavior.
- Contract with Center for Treatment of Problem Sexual Behavior (CTBSB) to expand assessment and treatment for offenders with problem sexual behavior re-integrating into the community via parole.
- Contract with research coordinator to implement data collection and analysis for evaluation purposes.
- Part-time coordinator to implement and administer the project (BPP supervisor).

Department of Correction staffing requirements are addressed in Recommendation 4.

Adult offenders with problem sexual behavior services will be based on the following foundations:

- Victim-centered: healing and protection of victims and potential victims are the primary focus of adult offenders with problem sexual behavior treatment and management. Decisions will be focused on and considerate of the specific needs of victims and potential victims. Adult offenders with problem sexual behavior will be engaged to 1) commit to not re-traumatize the victim(s), 2) be sensitive to victim issues, 3) responsive to victim needs, 4) not to minimize the seriousness or impact, 5) be supportive of the process of victim healing, 6) provide an avenue for victim input, 7) insure a system exists for providing information to victims and 8) provide that the needs of the victims are responded to during the treatment of the adult offender with problem sexual behavior.
- Containment via Multi-disciplinary teams: containment is an overall shared philosophy that targets community and victim safety whereby multiple stakeholders with similar goals, but different roles help the adult offender with problem sexual behavior by setting healthy limits on the adult's behavior in the community. This philosophy includes: 1) the need to take into account developmental issues and current research/evidence-based practices, 2) state-of-the-art problem sexual behavior-specific management strategies, 3) assessment, treatment and supervision criteria (standards, frameworks), 4) regular support system education, 5) quality control through internal program evaluation, and 6) regularly scheduled inter-agency and inter-disciplinary collaboration meetings for all stakeholders.
- Collaboration: the collaborative process between court officials, adult parole supervision, treatment providers, victims and victim advocates is a consistent theme in CTPSB's treatment of the adult offender with problem sexual behavior. This process will result in: 1) recognizing different skills, perspectives and insights of individuals in the case planning and management process, 2) search for solutions outside one's own repertoire (e.g. victim advocates can often provide offenders with problem sexual behavior treatment providers a different perspective on the family functioning of the adult offender with problem sexual behavior since they may have contact with the victim), 3) shared risk (success and failure) for the adult offenders with problem sexual behavior, and 4) recognize that different groups/agencies retain uniqueness and autonomy (e.g. regular meetings help stakeholders to better

understand the policies that guide other stakeholders decision-making; these policies often times differ from stakeholder to stakeholder and when not addressed can create conflicts in the management of the adult offenders with problem sexual behavior).

Essential components of the release plan and transition strategy include: pre- and post-release evaluation of risk as well as needs, an understanding of registry requirements, victim notification and involvement, parole officer involvement prior to release and a comprehensive supervision model that includes parole officers and clinical staff. The strengths of the process consist of the essential components described and a strong history of inter-agency collaboration in this area.

It is important to note that this recommendation does not indicate support for civil commitment of offenders with problem sexual behavior at the end of a term of incarceration.

Community Education

The intent of the community education curriculum is to empower citizens by providing accurate and pertinent information about offenders with problem sexual behavior, including the explanation of registration and monitoring, as well as providing strategies for keeping individuals and families safe.

The curriculum will form the basis for community education forums to be presented by a collaborative team that would include representatives from law enforcement, probation, parole, the Sex Offender Registry Unit of the Department of Public Safety, Connecticut Sexual Assault Crisis Services (CONNSACS), and the Center for the Treatment of Problem Sexual Behavior.

Sex Offender Units

The Court Support Services Division (CSSD) would request funding to expand its current specialized Sex Offender Treatment Units, which are based on a nationally recognized containment model, from the current three sites, New London, Hartford, and New Haven to all adult probation offices state-wide. To accomplish this, CSSD requires additional Adult Probation Officers with specialized offender with problem sexual behavior caseloads. Currently, CSSD offenders with problem sexual behavior probation officers have an average caseload of 45 offenders with problem sexual behavior. CSSD would decrease this caseload size to 1 officer for every 25 offenders with problem sexual behavior. This would enable CSSD to achieve a caseload size similar to offenders with problem sexual behavior currently under parole supervision, reflect the recommended caseload standard outlined by the federal grant utilized by CSSD to initially establish these specialized offenders with problem sexual behavior units, and comply with the suggested caseload size referenced in the preliminary report of the Issues Committee of the American Probation and Parole Association (APPA).

Additionally, the number of victim advocates would need to be increased to maintain the ratio of one advocate for every 100 offenders with problem sexual behavior. Currently, CSSD has approximately 1400 offenders with problem sexual behavior on active supervision; 11 additional victim advocates would need to be contracted to maintain the integrity of this national model.

Based on CSSD's current offenders with problem sexual behavior supervision population, CSSD proposes the hiring 27 additional Adult Probation staff (this figure includes 24 officers and 3 chief positions) to bring current caseload sizes to 1 officer for every 25 offenders with problem sexual behavior. This would enable the officers to work closely with the offenders with problem sexual behavior treatment provider, community, victim advocate, the victim, and the offender.

Combined with the implementation of this model by the Department of Correction (DOC), a more effective and coordinated supervision process could be developed to monitor and supervise offenders with problem sexual behavior transitioning from parole or Transitional Supervision (TS) to probation. This joint effort would increase, communication, community awareness and enhance public safety.

Discussion of the fiscal impact of this recommendation is contained in Appendix 2.

Recommendation 3: Parole Violation Reduction Program

Establish a violation reduction and expedited review program within the Board of Pardons and Paroles.

A violation reduction and expedited review program would require 3 additional parole hearing officers and a parole supervisor who would be responsible for (1) performing a comprehensive review of each parole violation warrant prior to the warrant being issued, (2) ensuring a review in all cases of technical violation for potential re-parole within two to six months, and (3) diverting appropriate cases to sanctions other than revocation and re-imprisonment.

Public Act 04-234 sets the goal of reducing the number of parolees returned to prison for technical violations by 20 percent. Manageable caseloads and sufficient community support services, will reduce the number of technical violators that are returned to prison but it is also critical that the Board of Pardons and Paroles (BPP) further minimize returns to prison for technical violations by carefully scrutinizing all requests for violation warrants.

If a determination is made that some alternative to return to prison is more appropriate, the BPP may decline to issue a warrant and recommend some alternative program, up to and including residential treatment in the community.

The BPP would require an additional parole supervisor position dedicated to reviewing the increased number of warrants associated with having a substantially larger number of parolees in the community. After review, the parole supervisor would make recommendations to the Board for approval. This supervisor would also be responsible for overseeing the expedited revocation and diversion program described below.

It is also critical that the BPP further minimize returns to prison by dedicating experienced staff to scrutinize all warrant requests for possible diversion from the revocation process. Staff will identify and review those cases where probable cause to support a violation exists as well as where criminal charges are dismissed or nolle. A determination will then be made as to whether a sanction other than revocation and re-imprisonment is appropriate. The violation reduction program will utilize a graduated sanctions system that includes intermediate sanctions for parole violations including short-term re-imprisonment, placement in a residential treatment program, or some other community based sanction.

Discussion of the fiscal impact of this recommendation is contained in Appendix 3.

Recommendation 4 DOC's Comprehensive Re-entry Strategy

Allocate additional resources for the Department of Correction's comprehensive re-entry strategy. Specifically, this recommendation includes:

- **Fund 20 additional parole officers, two additional parole supervisors, and appropriate clerical support by July 1, 2007.**
- **Expand staff for essential re-entry preparation in correctional facilities. This includes the system-wide addition of certified schoolteachers and vocational instructors, certified institutional substance abuse and other program counselors.**
- **Expand the array of halfway house or other residential treatment options in the community, particularly for special needs populations such as young offenders and those offenders in need of significant mental health treatment.**
- **Expand the number of community non-residential treatment options such as employment services and domestic violence prevention.**
- **Fund technology utilization, such as global positioning system (GPS) tracking of offenders, in order to enhance public safety and offender accountability.**

Parole Supervision

Caseloads of the Department of Correction's Parole and Community Services Unit continue to rise, both discretionary and special parole. At the same time, the institutional population has remained stable. This has limited the Department's ability to re-allocate resources to the community while increasing the average caseload of parole officers. As of November 1, 2005, the average statewide regular caseload was 68 and the average special management caseload was 32.

In order to continue to accommodate expansion of parole caseloads with effective offender supervision, caseloads must be at a manageable level. With paroling rates that exceed 80 percent, and given that the Board of Pardons and Paroles projects an increase of over 1200 supervised on discretionary parole alone by January 2008, it is imperative that resources be provided for community supervision.

Institutional Re-entry Preparation

Pre-release support for accused and convicted offenders is essential to their long-term success. Education and vocational training are essential to a viable release plan and a crime free lifestyle. Both correlate to reduced recidivism. However, given the relative scarcity of education resources, only a fraction of the inmates with significant educational or vocational training are able to avail themselves of needed services, and waiting lists exist at virtually every facility. Funding additional teachers will enhance re-entry efforts and reduce the incidence of offenders being recommitted to prison.

According to the Department of Correction's objective classification system, 87 percent of the Department's clients have a significant need for treatment of substance abuse. The Department's Addiction Services Unit provides substance abuse services for accused and convicted offenders in 16 correctional facilities and 4 community offices. The substance abuse delivery system is based upon the evidence-based concepts of point of impact (offenders are

ready for treatment at specific points along the incarceration continuum), level of intervention (level of intervention should match level of need), and continuity of care (once treatment has begun, it is most effective without breaks or significant changes in modality). These three elements are essential to successful treatment outcomes for substance abusers.

The Connecticut Department of Correction has many of the components in place required to assess, assign, treat and follow through with treatment. Many inmates who are assessed with serious substance abuse issues are not afforded meaningful substance abuse treatment, and again, long waiting lists exist at virtually each correctional facility. This situation will be exacerbated in September, 2006, when the federal Violent Offender Incarceration Truth in Sentencing (VOITIS) grant is scheduled to expire; further, future federal funding under the Residential Substance Abuse Treatment (RSAT) grant is somewhat uncertain. These grants support 18 addiction services positions.

Community Supervision and Treatment Options

The Department of Correction has substantially increased its contracted halfway house capacity in the last two years. However, there exists an increased demand both for traditional halfway house, work release and residential substance abuse treatment services, and for services, both residential and non-residential for special needs populations. The Department estimates that 150 additional beds would meet this need.

For example, in June, 2005, the Department of Correction entered into a Memorandum of Agreement with the Department of Mental Health and Addiction Services (DMHAS) and the Judicial Branch's Court Support Services Division (CSSD) to support an Alternative Incarceration Center; each of the 3 State agencies is contributing \$500,000 toward this endeavor. The \$500,000 contribution by DOC is with federal VOITIS funds (Violent Offender Incarceration and Truth-in-Sentencing Grant). The VOITIS funds expire September 30, 2006. Continued funding for this innovative program, along with other programs for other under-served populations (for example, younger offenders) is important.

Also essential is employing new technology to increase public safety and offender accountability. Global Positioning Systems (GPS) systems of varying cost and utility are being utilized across the country to monitor higher risk offenders. It is important that Connecticut match its increased investment in community re-entry with systems that help maximize public safety.

Discussion of the fiscal impact of this recommendation is contained in Appendix 4.

Recommendation 5 Social Services Accessibility

Continue collaborative efforts between the Department of Correction and the Department of Social Services to increase the accessibility of social supports to releasing offenders. A process for suspending rather than terminating benefits for offenders with psychiatric disabilities upon incarceration should be explored. Access to community services where the inmates will be returning using the Community Action Agency network for case management should be developed.

DOC has funded two positions in DSS dedicated to processing the paperwork for sentenced inmates slated for release. Each staff person has the capacity to process 100 applications a month. Service has been provided to two correctional institutions. Paperwork for reinstatement of benefits has decreased. Internal referral processes will be developed within the corrections system to insure that the service is utilized throughout the state, as the model is developed. It is recommended that continued collaboration occur and that one additional DSS staff person be funded to increase capacity and expand the service to a third correctional institution. Further emphasis on developing a process to suspend rather than terminate benefits upon incarceration similar to those being developed by corrections departments in other states is recommended.

Efforts should be made to refer inmates to supportive community services where assistance can be provided to assist released men and women to access jobs and other services that prevent recidivism and support their engagement within the community. The Human Services Infrastructure (HIS) model developed by DSS, Connecticut Community Action Agencies (CAAs) and Infoline/211 uses existing resources to identify client barriers and gaps in services, provide case management for clients and track outcomes so that we know how people are doing as a result of services provided.

Recently DSS and DOC began exploring the use of this model for pre-release inmates. A pilot, being developed by a work group of DOC staff, the Connecticut Association for Community Action (CAFCA), and Community Action Agency representatives will target women inmates who are ready for release from the Charlene Perkins Re-Entry Center. The pilot will utilize one CAFCA position to do pre-assessments of inmates prior to release and a part-time CAA/HIS case manager in the communities where the inmates are returning. Part-time CAA/HIS case managers will be funded in Hartford, Bridgeport and New Haven. A strong evaluation component is included in the pilot.

It is anticipated that the evaluation will confirm that this model improves access to services, client outcomes and client stability, and results in reduced recidivism. The evaluation will include the establishment of benchmarks and provide a recommendation regarding replication of the model for use statewide with the appropriate post-release prison population.

TARGET POPULATIONS:

- 1) Incarcerated individuals with psychiatric disabilities or co-occurring mental health and substance use disorders
- 2) Women inmates who are ready for release from the Charlene Perkins Re-Entry Center.

Discussion of the fiscal impact of this recommendation is contained in Appendix 5.

Recommendation 6 Comprehensive Substance Abuse Strategy

Support and expand comprehensive strategies for accused and convicted offenders with substance abuse treatment needs. This includes continued collaboration among the Department of Correction (DOC), the Department of Mental Health and Addiction Services (DMHAS), the Department of Social Services (DSS), Judicials' Court Support Services Division (CSSD), and the Alcohol and Drug Policy Council (ADPC), and incorporation of evidence-based or preferred practices for treatment and a recovery-oriented service system. Specifically, this recommendation includes:

- **Allocate state funds for the Transitional Case Management Program in Hartford and Waterbury with expansion of this type of programming in New Haven and Bridgeport. These case management services promote successful re-entry and reduce recidivism for populations with substance use disorders released from the Department of Correction (DOC). Currently, the Transitional Case Management Program is federally-funded through Justice Assistance (previously Byrne) grant dollars and is at-risk of termination within fiscal year '06.**
- **Allocate state funds to establish Enhanced Cocaine/Methamphetamine Sobering Centers, specifically three (3) 8-bed Sobering Centers in Hartford, New Haven and Bridgeport communities.**
- **Establish a cross-agency workgroup (DMHAS, DOC DSS, and Department of Children and Families (DCF)) to develop a plan to incorporate the use of buprenorphine in adolescent and adult community-based and correctional facility-based programs that treat opiate dependence.**
- **Maintain existing levels of staffing currently supported through the federal Residential Substance Abuse Treatment (RSAT) grant. These positions provide Tier IV substance abuse treatment programming for inmates at four DOC facilities.**
- **Allocate state funds to support workforce development strategies, through the DMHAS Office of Multicultural Affairs, that results in the expansion of a culturally diverse workforce to assure maximum access, effective treatment, and sustained outcomes for persons of color, Latino/Hispanic origin, Asian Americans, and other minorities who need services for mental health and/or substance use disorders.**

Transitional Case Management Program

The Department of Mental Health and Addiction Services, in collaboration with the Department of Correction, has developed and implemented the Transitional Case Management Program. The Transitional Case Management Program is a federally-funded grant aimed at ensuring the continuity of care for sentenced male offenders with substance use disorders transitioning from the state's correctional facilities to the Hartford and Waterbury communities in a manner that encourages community reintegration, sobriety, employment, and housing stability and decreases recidivism. Through case management strategies that begin during pre-release and provide support and assistance in gaining immediate access to aftercare substance abuse treatment and support services, the Transitional Case Management Program proposes to be an effective way to overcome obstacles in community transition and re-entry process.

TARGET POPULATION: Sentenced male offenders with substance use disorders transitioning from the state's correctional facilities to the Hartford and Waterbury communities.

For additional information on this recommendation, including supporting data and fiscal notes, please refer to Appendix 6.

Enhanced Cocaine/Methamphetamine Sober Housing Program

In response to growing concerns raised by urban grassroots organizations, State Legislators, and a subsequent directive from Governor Rell, DMHAS has developed a protocol to address the unique needs of individuals who are "crack" addicted and in need of appropriate treatment services.

Due to a lack of appropriate services for those addicted to "crack", many for those in need of addiction services involved in the criminal justice system seek assistance from hospital emergency rooms and detoxification centers. These higher levels of care are inappropriate since "crack" cocaine addiction (without concurrent, potentially life threatening substance abuse or mental health problem) does not require medically-monitored detoxification. Moreover, no pharmacological treatment for cocaine withdrawal exists. Lack of appropriate addiction services for those addicted to "crack" and involved in the criminal justice system, often results in an increase in technical violations and an increase in days incarcerated.

DMHAS has established a clinically appropriate protocol to meet the treatment needs of this cohort who have historically turned to hospitals and detoxification centers for care. Sobering Centers will meet the needs of this group while appropriately interfacing with the criminal justice system to limit or eliminate periods of incarceration due to technical violations.

TARGET POPULATION: Individuals who are "crack" addicted and involved in the criminal justice system.

For additional information on this recommendation, including supporting data and fiscal notes, please refer to Appendix 7.

Cross-Agency Buprenorphine Workgroup

Establish a cross-agency workgroup (DMHAS, DOC DSS, and Department of Children and Families (DCF)) to develop a plan to incorporate the use of buprenorphine in adolescent and adult community-based and correctional facility-based programs that treat opiate dependence. Specifically, the workgroup will address the following issues for adult and youth/young adult populations:

1. Adult - Initial work needs to be done to develop a broader acceptance of buprenorphine treatment within the medical field, specifically to attract medical doctors to prescribe and offer appropriate services. The cost of this medication, which is currently on the Medicaid formulary, will need to be assessed and negotiated between agencies.
2. Youth and Young Adults - Since methadone maintenance is not available for use by opiate dependent individuals under age 18, and there is a significantly increasing incidence of opiate dependence among youth, this promising medication should be incorporated into the DCF treatment system. This, again, will necessitate development of trained and willing medical doctors to prescribe, and costs to be picked up.

TARGET POPULATION: Opiate dependent youth, young adults, and adults involved in the criminal justice system.

Workforce Development Strategy

Behavioral health treatment and intervention services can be effective in reducing recidivism and drug-related crime among the criminal justice population. Research over the last fifteen years has shown that treatment reduces drug use by criminally involved addicts and also reduces their tendency to commit crime. Paramount to the success of behavioral health treatment efforts are service approaches delivered by culturally competent behavioral health professionals who recognize the cultural needs of the populations they are serving, particularly Latino, African Origin, and Asian populations.

DMHAS, through its Office of Multicultural Affairs (OMA) seeks to implement strategies to strengthen Connecticut's behavioral health treatment delivery system by supporting the development of a culturally diverse and competent pool of behavioral health treatment professionals specifically targeting the needs of Latino, African Origin, Asian, and other under-served groups, such as Native Americans, with mental health, substance use or co-occurring mental health and substance use disorders who are involved in the criminal justice system.

TARGET POPULATION: Latino, African Origin, Asian, and other under-served groups, such as Native American populations, with mental health, substance use or co-occurring mental health and substance use disorders who are involved in the criminal justice system.

For additional information on this recommendation, including supporting data and fiscal notes, please refer to Appendix 8.

Additionally, developed in conjunction with the Alcohol and Drug Policy Council (ADPC), the Comprehensive Substance Abuse Strategy will include recommendations for enhancing and developing a full capacity, culturally competent service system for accused and convicted offenders with substance abuse treatment needs. This strategy should span the continuum of the criminal justice system and incorporate the following components:

- Expansion of the approaches developed and implemented in the DMHAS General Assistance Behavioral Health Program yielding more effective and efficient care, for persons with serious and prolonged psychiatric disabilities who frequently need high cost acute care services due to an absence of care management and alternative strategies
- Expansion of the approaches being developed through Connecticut's Robert Wood Johnson-funded project so that all levels of services needed to respond to the needs of accused and convicted offenders in the criminal justice system are in place and supported by a full-capacity, highly service effective and cost-managed collaborative system.
- Inclusion of current initiatives highlighted in this report - specifically the grant funded Women's Treatment and Support Diversion and the Transitional Case Management programs.
- Adoption of policies and implementation strategies being developed by the ADPC in areas critical to an effective healthcare system for substance use
- Maximization of treatment options and recovery-oriented supports through the multi-agency Access to Recovery Initiative.
- Screening and brief intervention strategies for early/less severe substance use, with focus on emergency departments and primary care settings.

- Recovery-oriented services found to produce better access and engagement in care, sustained abstinence and integration of persons into their community, and greater use of those in recovery as part of the healthcare workforce.
- Culturally competent approaches at all individual service, care provider and system levels to assure maximum access, effective treatment and sustained outcomes for persons of color, Latino/Hispanic origin, Asian Americans and other minorities who need services for mental health and/or substance use disorders.

TARGET POPULATION: Individuals with substance abuse treatment needs who are at risk of being, or currently are, incarcerated.

Recommendation 7 Behavioral Health

Sustain and expand the array of options for accused and convicted offenders who have significant psychiatric disabilities or co-occurring mental health and substance use disorders. Specifically, this recommendation includes:

- **Continue ongoing work on the establishment of Connecticut's first Mental Health Alternative to Incarceration Center (MHAIC). This center will allow individuals who require a heightened level of custodial supervision and who present with significant psychiatric disabilities or co-occurring mental health and substance use disorders the opportunity to access residential and day reporting AIC services.**
- **Establish Mental Health Day Reporting Centers (MHDRC) in Hartford, Waterbury, New Haven and Bridgeport.**
- **Allocate state funds for existing Crisis Intervention Teams (CIT) in the Hartford, Waterbury, New London/Norwich and New Haven areas. Identify funding for expansion to those communities which have requested such programs. Currently, CIT programming is federally-funded through Justice Assistance (previously Byrne) grant dollars and is at-risk of termination within fiscal year '06.**
- **Allocate state funds for specialized Women's Treatment and Support Diversion programs in Hartford and Bristol/New Britain with expansion of this type of programming in New Haven. Currently, federal grants support specialized Women's Treatment and Support Diversion programs in Hartford and Bristol/New Britain.**
- **Sustain a comprehensive array of case management options for offenders with significant psychiatric disabilities or co-occurring mental health and substance use disorders nearing release from the Department of Correction (DOC). These case management services will promote successful re-entry and reduce recidivism for this special needs population.**
- **Employ specially trained and/or clinically licensed professionals to provide community supervision to offenders with psychiatric disabilities, and to assist with psychiatric treatment as a condition of probation or parole.**
- **Review current programming and services, and identify obstacles and limitations to accessing alternatives to incarceration for persons with psychiatric disabilities or co-occurring mental health and substance use disorders.**

Alternatives to Incarceration Centers

Individuals with psychiatric disabilities or co-occurring mental health and substance use disorders have limited access or are denied access to Alternative to Incarceration Centers due to the lack of programming to address their clinical needs. As such, this population typically remains incarcerated through the pre-trial process and more often serves a greater proportion of their sentence with the Department of Correction.

TARGET POPULATION: Individuals who require a heightened level of custodial supervision and present with significant psychiatric disabilities and/or co-occurring disorders involved at the pre-trial phase of the criminal justice system or who are eligible for community re-entry from the Department of Correction.

For additional information on this recommendation, including supporting data and fiscal notes, please refer to Appendix 9.

Mental Health Day Reporting Centers

The success of the day reporting component of the MHAIC in Hartford has demonstrated that a distinct population of individuals with psychiatric disabilities can benefit from mandated day reporting programming. This population has specific clinical, legal and/or social issues which preclude eligibility in traditional jail diversion services.

TARGET POPULATION: Individuals who require a community level of custodial supervision and present with significant psychiatric disabilities or co-occurring disorders involved at the pre-trial phase of the criminal justice system or who are eligible for community re-entry from the Department of Correction.

For additional information on this recommendation, including supporting data and fiscal notes, please refer to Appendix 10.

Crisis Intervention Teams

Crisis Intervention Teams (CIT) are a partnership program between the local police and the community provider network, which provides for a joint response to crisis in the community involving persons with behavioral health disorders, reducing the need for arrest and resulting in safer and more effective outcomes. Additionally, CIT programs assist their communities as a whole with a broader, more effective response to people in crisis.

TARGET POPULATIONS:

1. Individuals with significant psychiatric disabilities or co-occurring disorders at-risk of arrest and incarceration.
2. People in the community needing brief crisis intervention not resulting in extensive involvement in behavioral health services.

For additional information on this recommendation, including supporting data and fiscal notes, please refer to Appendix 11.

Women's Treatment and Support Diversion Programs

These nationally recognized model programs provide gender specific, trauma-informed outreach, engagement, treatment, and intensive community support as an alternative to incarceration for women defendants who by history are considered to have a high rate of recidivism. Federal funding for current programming will expire in early 2006.

TARGET POPULATION: Women who experience psychiatric and social consequences of trauma, have abused substances, and are often at high risk of re-offending.

For additional information on this recommendation, including supporting data and fiscal notes, please refer to Appendix 12.

Clinically Trained Supervision

Such officers should be trained to act in consultation with the treatment provider network to help accused and convicted offenders successfully complete their period of supervision and to get the services they may need to do so. Caseload-to-officer ratio should be low, generally no more than 35 active cases per officer. Supervision should utilize intervention strategies and graduated sanctions that reflect the special needs of the offender.

This specialized staff will use clinically informed interventions to increase successful completion of probation and parole. By doing so, it is expected that the number of technical violations and days incarcerated for the targeted population will decrease and related interruptions of established community services, programming, and treatment will be reduced.

TARGET POPULATION: Individuals with significant psychiatric disorders or co-occurring disorders under the supervision of Probation or Parole and who are at risk of technical violations or parole revocation.

For additional information on this recommendation and fiscal notes, please refer to Appendix 13.

Case Management Services

The Commission on Prison and Jail Overcrowding recommends state funding to maintain programming for two grant funded initiatives addressing re-entry of this population: 1) The Connecticut Offender Re-Entry Program (CORP), and 2) The Transitional Case Management (TCM) program.

TARGET POPULATIONS:

- 1) CORP- Sentenced male and female offenders with psychiatric disabilities approaching release from DOC returning to Bridgeport, Hartford and New Haven.
- 2) TCM- Sentenced male offenders with substance use disorders transitioning from the state's correctional facilities to the Hartford and Waterbury communities.

For additional information on this recommendation, including supporting data and fiscal notes, please refer to Appendix 6.

Access To Treatment

Due to their psychiatric disabilities or co-occurring disorders, individuals who would otherwise qualify for alternatives to incarcerations are excluded. This cohort of individuals also serve the maximum amount of their sentence. For these reasons, DOC, CSSD and BPP will report by early February 2007 on steps to maximize access to alternatives to incarceration for those involved in the criminal justice system with psychiatric or co-occurring disorders.

TARGET POPULATION: Individuals with psychiatric disabilities or co-occurring mental health and substance use disorders involved in all stages of the criminal justice system.

Recommendation 8 BPP Comprehensive Discharge Services

Expand comprehensive discharge planning services for the Board of Pardons and Paroles (BPP) and the Department of Correction (DOC) for individuals with psychiatric disabilities or co-occurring mental health and substance use disorders.

The Board of Pardons and Paroles (BPP) should have access to discharge planning assistance for persons with psychiatric disabilities. DOC/BPP and DMHAS will continue to collaborate on re-entry planning for inmates with psychiatric disabilities on a monthly basis. Emphasis will be placed on re-entry planning for appropriate inmates being considered for parole to reduce bed days in DOC facilities.

TARGET POPULATION: Incarcerated individuals with psychiatric disabilities or co-occurring mental health and substance use disorders eligible for parole.

Discussion of the fiscal impact of this recommendation is contained in Appendix 14.

Appendix 1

Alternatives to Incarceration

Jail Re-Interview

Costs to implement would include hiring 4 Intake Assessment and Referral (IAR) Specialists at \$48,200 each; \$9,640 in other expenses; \$14,000 in equipment; and contractual services of 3 clinicians for Local Mental Health Authorities (LMHAs) at \$70,000 each. Total estimated cost is \$426,440 (11/05).

Probation Transition Program

Costs to implement would include hiring 25 Adult Probation Officers (APOs) at \$45,000 each and 3 Chief Probation Officers at \$72,000 each; other expenses at 5% (\$67,050), and 28 laptop computers at \$3,500 each. Total estimated costs are \$1,506,050 (11/05).

Intensive Pretrial Supervision

Implementation costs include hiring 5 APOs at \$45,000 each; other expenses at 5% (\$11,250), and 5 laptop computers at \$3,500 each. Total estimated costs are \$253,750 (11/05).

Appendix 2

Management of Offenders with Problem Sexual Behavior in the Community

Containment Model

Program component costs are as follows:

- Costs for a two-year contract for the parole program with victim advocacy services totals \$140,000.
- The Department of Correction through Correctional Managed Health Care will conduct 560 preliminary sex offender evaluations over two years using existing resources.
- The Center for the Treatment of Problem Sexual Behavior will conduct comprehensive sex offender evaluations to determine the individual's criminogenic dynamic risk issues and needs, and to assist in identifying appropriate treatment services prior to reentry. Costs associated with this include 1 full-time professional plus administrative costs for up to 200 evaluations at \$85,000 per year for 2 years; total estimated cost for this component is \$170,000.
- Contract services for a researcher to design and ensure data collection that will permit both process and outcome evaluation are 235 hours at \$70.00 per hour; total estimated cost for this component is \$16,450.
- Contract services for computer scans and polygraph services for offenders under parole supervision are: 100 computer scans at \$100 per scan, and 100 polygraph exams at \$120 per exam; estimated cost for this component is \$22,000.

Total estimated program costs for 2 years are \$348,450 (11/05).

Community Education

Implementation costs include the hiring of a Community Educator and associated expenses for 2 years; total estimated cost is \$140,000 (11/05).

Sex Offender Units

Cost to implement would include hiring 24 Adult Probation Officers at \$45,000 each and 3 Chief Probation Officers at \$72,000 each; other expenses at 5% (\$64,800); 27 laptop computers at \$3,500 each; and contractual services of 11 Victim Advocates at \$70,000 (includes benefits, equipment, etc). Total estimated cost is \$2,225,300 (11/05).

Appendix 3

Parole Violation Reduction Program

The cost of this additional position, including capital equipment and other expenses, would be less than \$100,000 for the first year. (11/05)

The Board of Pardons and Paroles implemented a pilot expedited revocation program in December, 2004 whereby appropriate technical parole violators are given expedited parole hearings, have their parole revoked and are re-paroled within 2 to 6 months after their re-admission to prison. As a result, the number of persons re-paroled each month increased from 48 to 63.

This program could be expanded to its maximum capacity of 100 persons re-paroled each month, by hiring three additional hearing officers. If the officers were hired at the parole trainee level, the cost for the first year would be less than \$150,000 (11/05).

Appendix 4: DOC's Comprehensive Re-entry Strategy

The cost of the various provisions of the recommendation are as follows:

Parole Officer Staffing

Funding for 20 additional parole officers, two additional supervisors and appropriate clerical support will cost \$1,523,254. (11/05)

Expansion of Essential Re-entry Functions

The following staffing is recommended, at a total cost of \$4,158,407 (11/05)

Education Services	FTEs
State School Teacher	17
Vocational Instructor	3
Pupil Service Specialist	1
Health and Addiction Services	
Correctional Counselor Supervisor	5
Correctional Counselor	17
Substance Abuse Program Director	1
Office Assistant	1
Offender Programs	
Correctional Counselor Supervisor	1
Correctional Counselor	12

Other Community Services

- The cost of an additional 150 halfway house beds is estimated to be \$3,450,000.
- Expansion of non-residential programs is estimated to be \$1,000,000.
- Funding improved technology is estimated to cost \$325,763.

(11/05)

Appendix 5: Social Services Accessibility

Expand by one social worker an established model that currently supports 2 social workers at the Department of Social Services to insure that offenders with serious psychiatric disabilities or co-occurring mental health and substance use disorders are able to get necessary medical services instated immediately upon release.

One Social Worker	\$55,000
Fringe Benefits	\$30,800
Administrative Expenses	<u>\$ 5,000</u>
	\$90,800

Utilize the Community Action Agency network to support discharge planning for women enabling their connection to customized, stabilizing community supports (e.g., child care, medical benefits, housing, food stamps, etc.). The model contemplates 1 full time coordinating case manager and 3 part time Community Action Agency case managers located in Hartford (CRT), New Haven (CAANH), and Bridgeport (ABCD):

One full-time coordinating case manager (35 hrs. @ \$24.73/hr)	\$ 45,008
CAA Fringe Benefits	\$ 18,273
Travel (\$.485 per mile)	\$ 1,050
Supplies, equipment, laptop computer, and program materials	\$ 4,000
Administrative Expenses	<u>\$ 4,883</u>
	\$ 73,214

3 part-time community action case managers (19 hrs. each @ \$24.73/hr = \$24,433 each)	\$ 73,300
CAA Fringe Benefits	\$ 29,760
Office Supplies and Administrative Expenses (3 @ \$2,443)	<u>\$ 7,329</u>
	\$110,389

Funding is recommended to accommodate the costs incurred in contracts with a local graduate program (social worker/criminal justice) to evaluate best practices, impact on recidivism, and client outcomes. It is anticipated that the pilot will contract with local social work universities using graduate student resources and support their efforts through in-kind resources from Department of Social Services and Community Action Agencies.

Program Evaluation	\$ 50,000
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T	Total	\$324,403 (11/05)
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Appendix 6: Comprehensive Substance Abuse Strategy

Connecticut Offender Re-entry Program

The Connecticut Offender Re-entry Program (CORP) is a USDOJ-funded initiative and the only such program nationwide that was granted to a mental health agency due to the outstanding collaboration between state agencies. CORP treats men and women who have significant mental health needs with or without a concomitant substance use disorder. The emphasis is on reducing recidivism by identifying and intervening in those areas most in need. The CORP grant expands culturally appropriate intensive case management, integrated mental health and substance abuse treatment services, and provides linkages for men and women to their community. Individuals eligible for the grant services must have at least one year left to serve before their release from the institution (six months for women at York) and are returning to the Hartford, Bridgeport, or New Haven communities. Services are provided through the Local Mental Health Authorities which include Capitol Region Mental Health Center (Hartford), Connecticut Mental Health Center (New Haven) and Greater Bridgeport Mental Health Center (Bridgeport).

CORP goals include:

- Expansion of case management and employment services
- Enhancement of the referral network and service coordination among State agencies
- Engagement of mentally ill offenders in behavioral health treatment services
- Strengthening of family, housing and employment linkages
- Establishment of a model that ensures the continuity of institution-based to community-based services, including faith based organizations.

PROGRESS SINCE PROGRAM IMPLEMENTATION

Program Duration

The CORP program was originally intended to be a three-year grant-funded program from the US DOJ starting in July 2004. DOJ has yet to decide whether they will allow for no cost extensions to states where funding was granted after July 2003.

Current Program Funding

FY 04/05:	US DOJ \$600,000
FY 05/06:	US DOJ \$666,666
FY 06/07:	US DOJ Funding unclear

Services Funded:

- Two full time clinicians in Hartford
- Two full time clinicians in New Haven
- Two full time clinicians in Bridgeport
- A full time program manager
- Program evaluation by UCONN
- Clinicians provide 8 groups a week at Garner and 6 groups a week at York. These groups are life-skills based.
- Clinicians provide individual case management contacts with program participants as needed

Program Status/Progress:

- 101 clients have been screened to-date
- 80 inmates have participated in group programming to-date
- 6 inmates have released to the community to-date
- All inmates who have released to the community have remained engaged in treatment services and thus avoided re-incarceration
- Early data shows a 98 percent retention pre-release retention for a voluntary program and a 100 percent retention rate post-release. These numbers are encouraging since the targeted mental health population is historically difficult to engage. The clinically astute CORP staff has consistently and persistently utilized evidenced-based engagement techniques to engage and sustain participation in the program.

Recommendations for FY 07:

If DOJ funds run out, continued funding by DMHAS or DOC would help to sustain the program. At this time, feedback has been positive as evidenced by a 98 percent retention rate once inmates are accepted into the program.

The program would require a minimum of \$740,000 to sustain current programming. This takes into account issues such as pay raises as per union mandate, cost of medical coverage, rising cost of gas prices, to name a few.

CONNECTICUT OFFENDER RE-ENTRY PROGRAM			
	Continue Current Program	Additional cost to expand	Total
Clinical Programs	\$ 664,000	\$ 664,000	\$ 1,328,000
Trainings and Conference	\$ 10,000	\$ 10,000	\$ 20,000
Housing money	\$ 36,000	\$ 36,000	\$ 72,000
Evaluation	\$ 30,000		<u>\$ 30,000</u>
Total	\$ 740,000	\$ 710,000	\$ 1,450,000

(11/05)

Transitional Case Management Program

The Department of Mental Health and Addiction Services, in collaboration with the Department of Correction, has developed and implemented the Transitional Case Management (TCM) Program. The Transitional Case Management Program is a federally-funded grant aimed at ensuring the continuity of care for sentenced male offenders with substance use disorders transitioning from the state's correctional facilities to the Hartford and Waterbury communities in a manner that encourages community reintegration, sobriety, employment, and housing stability and decreases recidivism. Through case management strategies that begin during pre-release and provide support and assistance in gaining immediate access to aftercare substance abuse treatment and support services, the Transitional Case Management Program proposes to be an effective way to overcome obstacles in community transition and re-entry process.

Successful transition to community treatment is likely to result from three elements: (1) enhancing the engagement and motivation of the inmate in the transition process, (2) fostering the collaboration of treatment and criminal justice personnel in the inmate's transition process, and (3) providing initial support to the participant in accessing treatment and other needed community services. The program meets with inmates up to three months prior to release to

complete a comprehensive strengths-based inventory that will provide the basis of the inmates' transition plan. Case management and engagement occurs during this time and services follow for approximately four months post-release. The goal of the Transitional Case Management Program is to help transition inmates back to the community in a way that promotes recovery and stability.

PROGRESS SINCE PROGRAM IMPLEMENTATION

Program Duration

The TCM program was originally intended to be a four-year grant-funded program from the US DOJ Byrne Fund starting in February 2005. However, grant funds will end as of June 2006 with continued funding being uncertain.

Current Program Funding:

FY 05/06: US DOJ Byrne Grant \$345,000
FY 06/07: Funding uncertain
FY 07/08: Funding uncertain
FY 08/09: Funding uncertain

The President's FY 06/07 budget has proposed to de-fund the Byrne Program. The House and Senate have proposed restoring some of these funds.

The program also includes significant in-kind contributions by DMHAS and the local agencies.

Services Funded:

- Two full time clinicians in Hartford at the Community Renewal Team.
- Two full time clinicians in Waterbury at Morris Foundation.
- Program evaluation by Central Connecticut State University.
- A comprehensive strengths-based inventory for all program participants that will provide the basis of the inmates' transition plan.
- A comprehensive transition plan done in collaboration with the inmate and DOC personnel.
- Substance abuse treatment groups for participants upon release to the community.
- Referrals for continued treatment, if necessary, when participants complete the TCM program.

Program Status:

- Hartford and Waterbury are actively working with 20 inmates each (20 is program capacity).
- Waterbury has 3 inmates who have been released to the community and expect to begin their substance abuse group in early November.
- Hartford has 2 inmates that have been released to the community and expect to start their substance abuse group by the end of November.
- Inmates are re-entering their communities with necessary wrap-around services and integrated social supports.
- The program has expedited access to DSS benefits prior to the inmates release.
- The program integrates with Access to Recovery to support recovery and enhance benefits to eligible inmates.

An expense summary follows.

TRANSITIONAL CASE MANAGEMENT PROGRAM

	Continue Current Program	Additional cost to expand	Total
Clinical Programs (Waterbury & Hartford)	\$ 240,000	\$ 360,000	\$ 600,000
Housing Subsidy	\$ 40,000	\$ 60,000	\$ 100,000
Trainings & Conferences	\$ 15,000	\$ 30,000	\$ 45,000
Evaluation	\$ 50,000		<u>\$ 50,000</u>
Total	\$ 345,000	\$ 450,000	<u>\$ 795,000</u> (11/05)

Appendix 7: Enhanced Cocaine/Methamphetamine Sober Housing Program

In response to growing concerns raised by urban grassroots organizations, State Legislators, and a subsequent directive from Governor Rell, DMHAS has developed a protocol to address the unique needs of individuals who are "crack" addicted and in need of appropriate treatment services.

Due to a lack of appropriate services for those addicted to "crack", many for those in need of addiction services involved in the criminal justice system seek assistance from hospital emergency rooms and detoxification centers. These higher levels of care are inappropriate since "crack" cocaine addiction (without concurrent, potentially life threatening substance abuse or mental health problem) does not require medically-monitored detoxification. Moreover, no pharmacological treatment for cocaine withdrawal exists. Lack of appropriate addiction services for those addicted to "crack" and involved in the criminal justice system, often results in an increase in technical violations and an increase in days incarcerated.

DMHAS has established a clinically appropriate protocol to meet the treatment needs of this cohort who have historically turned to hospitals and detoxification centers for care. Sobering Centers will meet the needs of this group while appropriately interfacing with the criminal justice system to limit or eliminate periods of incarceration due to technical violations.

The Cocaine/Methamphetamine Sober Housing Supports protocol would include statewide access to short-term social setting residence accommodations (non-licensed) to provide 24-hour supervision, observation, rest, and support for individuals (pre-treatment) for populations with cocaine or methamphetamine dependence.

TARGET POPULATION: Individuals with cocaine or methamphetamine addiction who are involved in the criminal justice system.

An expense summary follows.

Enhanced Cocaine/Methamphetamine Sober Housing Program	\$260,000/site X 3 sites (Bridgeport, Hartford, and New Haven)	\$ 780,000
Total		\$ 780,000 (11/05)

Appendix 8: Workforce Development Strategy

Behavioral health treatment and intervention services can be effective in reducing recidivism and drug-related crime among the criminal justice population. Research over the last fifteen years has shown that treatment reduces drug use by criminally involved addicts and also reduces their tendency to commit crime. Paramount to the success of behavioral health treatment efforts are service approaches delivered by culturally competent behavioral health professionals who recognize the cultural needs of the populations they are serving, particularly Latino, African Origin, and Asian populations.

DMHAS, through its Office of Multicultural Affairs (OMA), seeks to implement strategies to strengthen Connecticut's behavioral health treatment delivery system by supporting the development of a culturally diverse and competent pool of behavioral health treatment professionals specifically targeting the needs of Latino, African Origin, Asian, and other under-served groups, such as Native American populations, with mental health, substance use or co-occurring mental health and substance use disorders who are involved in the criminal justice system.

TARGET POPULATION: Latino, African Origin, Asian, and other under-served groups, such as Native American populations, with mental health, substance use or co-occurring mental health and substance use disorders who are involved in the criminal justice system.

An expense summary follows.

Workforce Development Strategy	Totals
Project Coordinator	\$ 65,000
Training Supplies/Materials	\$ 5,000
Training Consultant	<u>\$ 30,000</u>
Total	\$ 100,000

(11/05)

Appendix 9: Mental Health Alternative to Incarceration Center

The Department of Mental Health and Addiction Services (DMHAS), the Department of Correction (DOC), and Judicial's Court Support Services Division (CSSD) have partnered on the development of a residential and day reporting center for persons with serious and long-term psychiatric disabilities that should serve as a model for development of such programs statewide. This intensive community transition program recognizes the special needs of this population and uses the period of court probation or DOC supervision as an opportunity to engage the client in a long term recovery plan that will reduce recidivism as well as address the needs of the client.

Even if agencies fully integrate services, there will remain some persons who have such special needs as the result of more significant psychiatric disorders that current alternative and community-based programs cannot sufficiently be modified to permit their participation without compromising the integrity of the program or the safety and success of the client. Without a specialized alternative program, these persons with the greatest level of need will continue to be incarcerated longer than similarly charged persons without such disability and are much more likely to reach end of sentence without the benefit of transitional supervision or parole. This specialized program provides clinical and community support services to such persons, while providing the monitoring required by the court or DOC.

In January 2005, DMHAS, in partnership with CSSD and DOC, issued a Request for Qualification (RFQ) to open the Mental Health Alternative to Incarceration Center (MHAIC) in Hartford. Following delays in funding, the contract was awarded to The Chrysalis Center in early June 2005.

PROGRESS SINCE PROGRAM IMPLEMENTATION

Current Program Funding

The MHAIC is funded jointly by DMHAS, CSSD, and DOC. CSSD provided an initial \$500,000 in SFY05 to begin implementation. All three departments provided \$500,000 each for SFY06. This, plus money remaining from the initial \$500,000 from CSSD, created a budget of \$1,825,600 for SFY06.

Money from DOC originated with a federal VOI/TIS grant that will end on September 30, 2006. Money from CSSD and DMHAS is an annualized budget item for these agencies.

Services Funded

The MHAIC RFQ proposed a 20-bed residential and day reporting center that would accommodate another 20 day-reporting clients to be operated by a contractor. Clinical services are to be provided by Capital Region Mental Health Center (CRMHC). Funds have been reserved to assist clients with community housing following discharge from the residential component or during the day component.

Program Status

- Zoning barriers have, thus far, prevented siting of a residential facility in Hartford or close enough to Hartford to be practical.
- A day reporting center is established at the CRMHC building on Vine St. in Hartford, and began accepting clients on June 27, 2005.
- The program is staffed by four full-time and one part-time Chrysalis employees.
- CRMHC staff from other programs are providing clinical services.
- As of November 18, 2005, the MHAIC received 32 referrals. Nearly all referrals were for pretrial clients and 18 were diverted to the program.
- Of the 18 admitted clients, only 3 (17%) have been incarcerated. Ten are active in the program, 5 completed the program and the court disposed criminal charges.

Due to difficulties in locating a site for the residential component of the MHAIC, DMHAS, DOC and CSSD re-bid the project in early January, 2006.

Appendix 10: Mental Health Day Reporting Centers

These centers would reduce unnecessary incarcerations of individuals with psychiatric disabilities or co-occurring mental health and substance use disorders. Such centers will provide the courts and DOC facilities immediate access to a structured, monitored community programming which would include both clinical treatments and recovery support services. In this manner, individuals can successfully complete their legal requirements while at the same time connecting with on-going services and natural supports in their communities.

The MHDRC will provide services to a minimum of 10 persons at any one time and 40 persons annually. The target participants for the MHDRC will be adults, 18 years of age or older, who are either pre-trial or sentenced and who have either a significant psychiatric disorder or a co-occurring psychiatric and substance use disorder. DMHAS forensic services staff will work with the courts, CSSD and DOC staff to evaluate candidates for admission and either connect the person with the MHDRC or to another, more appropriate level of care.

The MHDRC will operate seven days a week and will be open both during the day and for a number of evening hours. Persons admitted to the program will reside in their own community living arrangements but will be supervised several hours per day at the MHDRC. During these times, recovery support staff will assist with community needs, clinical staff will offer individual counseling and a variety of treatment groups and peer support staff will identify natural supports in the community. Medications will be administered as necessary and connections will be made with outpatient services in the community for follow-up care. Financial supports will also be available to help participants secure permanent housing as necessary.

The proposed budget for implementation in the 4 sites of Bridgeport, Hartford, New Haven, and Waterbury is:

DMHAS/Local Mental Health Authority expenses	2.5 FTEs per LMHA x 4 sites {2 LCSWS @ \$75, 000} {.5 APRN @ \$45,000}	\$ 780,000
DMHAS Behavioral Health Clinical Manager	.5 FTE	\$ 50, 000
Contracted provider staff expenses	4.0 FTEs plus X 4	\$ 800,000
Housing	\$240,000	<u>\$ 240,000</u>
TOTAL		\$ 1,870,000 (11/05)

Appendix 11: Crisis Intervention Teams

Program Expansion:

CIT programs should be implemented in all police departments and their communities statewide. Minimal costs of a program include overtime costs to allow designated officers to attend an intensive week-long training to identify and respond to persons with behavioral health needs, cost of the training, and the cost of hiring a clinical liaison.

Program Description:

The first nationally recognized CIT program was developed by the Memphis, TN Police Department in 1988. Since then other police departments around the nation have implemented CIT training. Experience thus far from the DMHAS program is consistent with national research that shows that implementation of CIT reduces arrests, incarcerations, and injuries to consumers and officers. There is less use of lethal force, lower costs to the police departments, and improved community relations. With CIT interventions, people with psychiatric conditions avoid the limitations and stigma of a criminal history in social and family relations and when seeking housing and employment.

The Connecticut CIT program is unique because it expands on the Memphis model by funding positions for clinicians from the local DMHAS service provider who are designated to work in collaboration with the police department. These clinicians can partner with CIT officers and be present to immediately begin engaging and linking individuals to treatment and other needed services. In addition, they can also provide follow-up to engage CIT clients in treatment.

CIT models implemented around the country have consistently demonstrated:

- Significant reduction in arrests,
- Reduced workers compensation claims by police
- Reduction in the “suicide by cop” phenomenon
- Improved engagement and outcomes for persons in behavioral health crisis.
- Enhanced overall skill set for law enforcement officers in de-escalation and problem solving

PROGRESS SINCE PROGRAM IMPLEMENTATION

Program Duration

The CIT program was originally intended to be a four-year program funded by a US DOJ Byrne grant starting in July 2004. However, it appears unlikely that federal funding for Byrne grants will be continued in SFY06/07 and SFY07/08.

Current Program Funding

- SFY 04/05 - US DOJ Byrne Grant (with 25% state match) \$425,000 (includes \$30,000 program evaluation)
- SFY 05/06 - US DOJ Byrne Grant (with 25% state match) \$612,675 (includes \$30,000 program evaluation)
- SFY 06/07 - No funds identified. Byrne Grants not included in the President’s federal FY05/06 budget.
- The House and Senate have proposed restoring some of these funds.

- The program also includes significant in-kind contributions by DMHAS and the local agencies.
- Funding pays for training expenses, five full-time CIT clinicians, partial reimbursement of the Waterbury, Hartford, New Haven, West Haven, and New London police departments for the cost of overtime coverage for staff who attend the trainings, and for a program evaluation by faculty of the University of New Haven.

Program Status

- The DMHAS CIT program has funded four 5-day, 40-hour trainings since October 2004. Total attendance for these trainings was approximately 150 members of seventeen police departments, including Waterbury, Hartford, and New Haven, and 34 behavioral health professionals.
- The grant funded two one-day refresher courses, one on “Suicide by Cop” in November 2004 and one in November 2005 on “Suicide Intervention”, attended by approximately 140 police department staff and also behavioral health professionals.
- In the current SFY06 a 5-day, 40-hour CIT training is scheduled for Spring 2006, as well as continued support to police departments who have already been trained.
- The five CIT clinicians serve the Waterbury, Hartford, New Haven, West Haven, New London, Norwich, and Groton City police departments.

Preliminary Outcome Data

- The five CIT clinicians served a total of 170 clients in September 2005 and the numbers are increasing each month as implementation proceeds. This is a substantial increase from July 2005, the first month that all four programs were operational, when they served 105 clients. The number of clients served will continue to increase as the more recently trained police departments continue to implement the program.
- An indication of the level of need for CIT trained officers and clinicians is the number of calls to a police department initially coded as involving a mental health issue. The New Haven Police Department reported 457 such calls for three months ending October 31, 2005. The Hartford Police Department reported 938 such calls for six months ending October 31, 2005. In addition to these incidents, responding officers may also identify mental health issues once they reach the scene.
- In Waterbury, about 30 percent of persons seen by a CIT clinician and a CIT police officer together require some level of containment or restraint. In many cases, intervention by a trained CIT officer and a CIT clinician has prevented a likely altercation and arrest and diverted a client to treatment. This is consistent with national data that reports a reduction in shootings of consumers, a reduction in injuries to consumers and police, and a reduction in workers compensation claims by police when police departments implement CIT.
- Since CIT was implemented in November 2004, CIT officers of the Waterbury Police Department have been responding to 100-115 calls per month involving people with psychiatric disorders.
- A small number of the clients to whom the CIT clinicians respond are arrested (8-12 per month in Waterbury). This is consistent with national data that reports a decrease in arrests of persons with psychiatric disorders when police departments implement CIT.
- Approximately 50 percent of the clients served by the Waterbury CIT clinicians are persons with serious psychiatric disabilities.
- The CIT clinicians in all of the programs have been very effective at facilitating engagement with treatment for many of the clients who they serve by providing follow-up after police contact with consumers. This increases retention in treatment, leads to improved quality of life for consumers, and reduces repeated contact with police.

- CIT-trained officers report that they use the knowledge and skills obtained from CIT training with all calls, whether or not the call involved a person with a psychiatric disorder.
- The CIT program has greatly expanded collaboration among DMHAS, local police departments, and local service providers. These three systems have had very limited communication and cooperation prior to implementation of CIT in Connecticut.
- The CIT program has increased awareness of CIT in Connecticut and resulted in numerous inquiries from other Connecticut police departments that are interested in CIT training and the services of a DMHAS CIT clinician. The program has also created the organizational structure necessary for training and implementation to expand CIT in Connecticut.

Recommendations for SFY07

- State funding to sustain the current CIT programs to replace federal funding that is likely to end on June 30, 2006 (for police departments and clinicians in Waterbury, Hartford, New Haven, West Haven, New London, Norwich, and Groton).
- Continue to provide three 5-day, 40-hour CIT trainings annually for new CIT officers and clinicians and a 1-day refresher course for trained CIT officers and clinicians. Each 5-day CIT training can accommodate 50 participants.
- Hire a full-time DMHAS CIT Program Manager to coordinate budgeting, oversight, implementation, management, and evaluation of CIT in Connecticut.
- Hire a second full-time DMHAS CIT clinician to provide evening CIT services to the Hartford Police Department and police departments in neighboring towns that have CIT-trained police officers.
- Hire a second full-time DMHAS CIT clinician to provide evening CIT services to the New Haven and West Haven Police Departments and police departments in neighboring towns that have CIT-trained police officers.
- Hire a full-time DMHAS CIT clinician to provide CIT services to the Stamford Police Department. The Stamford PD received grant funds to train their officers in CIT. The training will be provided by the Connecticut Alliance to Benefit Law Enforcement, Inc., the same organization providing training in the current DMHAS CIT program.
- Hire a second full-time DMHAS CIT clinician to provide evening CIT services to the New London, Norwich, and Groton City Police Departments and police departments in neighboring towns that have CIT-trained police officers.
- Hire a full-time DMHAS CIT clinician to provide CIT services to the Windsor Police Department. The Windsor PD funded CIT training for officers in early 2005 and continue to send officers to be trained.
- Hire a full-time DMHAS CIT clinician to provide CIT services to the New Britain Police Department. The New Britain PD will have officers present for the October 2005 CIT training.
- Continue program evaluation by the University of New Haven School of Public Safety and Professional Studies.
- Provide financial support to the Waterbury, Hartford, New Haven, West Haven, New London, Windsor and New Britain police departments to make it possible for them to continue to have staff trained in CIT. The New London and West Haven departments also provide experienced CIT officers to assist with training.

Recommendations for SFY 08 and beyond

- Expansion of CIT programs to fund initial and ongoing training to all police departments in the state. This would continue initially with the urban areas to provide a strong regional center of CIT services and then expand to surrounding communities.
- Expansion of CIT programs to fund CIT clinicians in all DMHAS catchment areas that serve CIT-trained police departments.

- Continue program evaluation by the University of New Haven School of Public Safety and Professional Studies.

CIT Program Annual Cost Summary

Locations	<u>Sustain Current Program</u> <u>if Byrne Grant Ends</u>	<u>Expansion Cost</u>	<u>Total Annual</u>
	Waterbury, Hartford, New Haven, West Haven, New London, Norwich, Groton	Waterbury, Hartford, New Haven, West Haven, New London, Norwich, Groton City, Stamford, Enfield, New Britain	
Clinical Programs and Manager	\$ 513,000	\$ 712,000	\$1,225,000
CIT Trainings & Conference	\$ 45,000	\$ 0	\$ 45,000
Support for Police Depts.	\$ 65,000	\$ 15,000	\$ 80,000
Evaluation	\$ 30,000	\$ 0	<u>\$ 30,000</u>
Total Annual	\$ 653,000	\$ 727,000	\$1,380,000

The following tables reflect a breakdown of the above budget:

CIT Clinical Programs Annual Cost

State funding to sustain the current CIT programs to replace federal funding that is likely to end on June 30, 2006 (for police departments and clinicians in Waterbury, Hartford, New Haven, West Haven, New London, Norwich, and Groton). \$ 513,000

Hire a second full-time DMHAS CIT clinician to provide evening CIT services to the Hartford Police Department and police departments in neighboring towns that have CIT-trained police officers. \$ 81,000

Hire a second full-time DMHAS CIT clinician to provide evening CIT services to the New Haven and West Haven Police Departments and police departments in neighboring towns that have CIT-trained police officers. \$ 80,000

Hire a full-time DMHAS CIT clinician to provide CIT services to the Stamford Police Department. The Stamford PD received grant funds to train their officers in CIT. The training will be provided by CABLE, the same organization providing training in the current DMHAS CIT program. \$ 103,000

Hire a second full-time DMHAS CIT clinician to provide evening CIT services to the New London, Norwich, and Groton Police Departments and police departments in neighboring towns that have CIT-trained police officers. \$ 83,000

Hire a full-time DMHAS CIT Program Manager to coordinate budgeting, initiation, implementation, management, and evaluation of CIT in Connecticut.	\$ 100,000
Hire a full-time DMHAS CIT clinician to provide CIT services to the Windsor Police Department. The Windsor PD funded CIT training for their department in early 2005 and continue to send officers to be trained.	\$ 125,000
Hire a full-time DMHAS CIT clinician to provide CIT services to the New Britain Police Department. The New Britain PD will have officers present for the October 2005 CIT training.	<u>\$ 140,000</u>
Total Clinical Programs Annual	\$1,225,000
<i>CIT Evaluation Annual Cost</i>	
Continue program evaluation by the University of New Haven School of Public Safety and Professional Studies.	<u>\$ 30,000</u>
Total	\$ 30,000
<i>Support for CIT Police Departments Annual Costs</i>	
Support for Waterbury PD	\$ 20,000
Support for Hartford PD	\$ 20,000
Support for New Haven PD	\$ 20,000
Support for New London PD	\$ 5,000
Support for West Hartford PD	\$ 5,000
Support for Windsor PD	\$ 5,000
Support for New Britain PD	<u>\$ 5,000</u>
Total Annual	\$ 80,000
<i>CIT Training for Police Departments and Clinical Staff Annual Cost</i>	
Three trainings - 150 people total; 5-day 40 hours each training	\$ 36,000
One Refresher Course	<u>\$ 9,000</u>
Total Annual	\$ 45,000
	(11/05)

Appendix 12: Women's Treatment and Support Diversion Programs

Women are a rapidly growing segment of the incarcerated population and yet alternative programs have not kept pace with this new demand. Effective strategies for women in the criminal justice system must be gender-specific since the factors contributing to criminal behavior by women often differ significantly from men. Treatment for trauma is key in that many female offenders have experienced physical, sexual, and/or emotional abuse. Women who have participated in these programs have significantly reduced recidivism which results in fewer incarcerations.

These programs have identified and described a previously underserved population and have developed a treatment model that improves lives and reduces arrests and incarcerations. Each program (with three staff) can serve 40-50 women per year, with a usual treatment duration of 4-7 months, at a projected cost of about \$5,600.00 per client and a success rate of approximately 60 percent.

Program Description:

These nationally recognized model programs provide gender specific, culturally appropriate, trauma-informed services to women who experience psychiatric consequences of trauma, have abused substances, and are often at high risk of re-offending.

Trauma-informed services and treatment for trauma are key for women offenders, as many have experienced sexual, physical, or emotional abuse. The effects of this abuse directly influences substance use and other behaviors. The programs use a highly flexible approach to service delivery in order to accommodate each woman's strengths, assets, and needs and rapid changes in their situations.

Services include tenacious outreach and engagement, extensive support in the community, trauma treatment, integrated mental health and substance abuse treatment, training in life skills and relationship skills, medication management, emergency housing, and financial and logistic assistance in procuring basic necessities. Staff also link women to other community services such as parenting classes, methadone maintenance, entitlements, housing, medical services, battered women services, education/vocational training, and transportation.

Early evaluation data indicates that women who participate in the programs experience increased stability in their lives, continued engagement with treatment beyond the end of their court cases, and reduced rates of re-arrest and re-incarceration. This is especially notable because most of the women who enter the programs have had extended periods of instability in their lives, inconsistent participation in various treatment programs, and multiple arrests.

Staff attributes program effectiveness to active efforts to adapt the program to the clients rather than expecting clients to adapt to the program. Specific services are determined by individual need rather than program preference. This approach is particularly effective when a woman does not maintain contact with staff, often because of difficult or unpleasant experiences that are common results of participation in treatment. In cases where standard treatment programs would end up discharging a client, staff in these programs are able to go into the community to find a woman and assist her in finding a way to remain engaged.

Program philosophy and resources allow staff to provide incentives like clothing and basic necessities. This increases engagement because the women see the staff as caring professionals who are willing and able to assist in meeting immediate needs. When immediate

needs are met, the women are better able to focus on treatment issues because they are not distracted by basic survival issues. Engagement is also improved when staff spends informal (but still therapeutic) time with the women in the community to assist with applying for entitlements and other services, purchasing necessities, and providing support at court.

PROGRESS SINCE PROGRAM IMPLEMENTATION

Program Duration

- The federal Substance Abuse and Mental Health Service Administration (SAMHSA) awarded two three-year Jail Diversion grants to DMHAS, one in 2002 for the Hartford Courts and one in 2003 for the New Britain and Bristol Courts.

Current Program Funding

- SAMHSA grants provide \$240,000 per year for each program (does not include program evaluation).
- The programs also include significant in-kind contributions by DMHAS and the local agencies.
- Hartford program funding ends in April 2006.
- Bristol/New Britain program funding ends in June 2006.

Services Funded

- Each of the two programs employs a clinician and two clinical case managers.
- Staff evaluates potential clients in court lock-up and provides a treatment recommendation to the court for consideration for diversion.
- Programs also accept referrals from Adult Probation.
- Compliance reports provided to the court (or probation) on a regular basis.
- Trauma-informed care in the office and in the community.
- Formal treatment for trauma issues, mental health, medications, substance abuse, life skills, spiritual recovery.
- Limited funds for clothes, toiletries, basic necessities, one dedicated shelter bed, etc., until entitlements can sustain the client.
- Tenacious outreach and engagement to distinguish between barriers to receiving services (transportation, child care, DCF obligations, medical treatment, fear, increased psychiatric symptoms, etc.) and refusal of services (infrequent).

Program Status

- The Hartford program began in March 2003 and the New Britain/Bristol program began in November 2003.
- Women accepted into the program have needed significantly more community and clinical support than originally expected when DMHAS applied for the grants.
- Program staff has used SAMHSA technical assistance funds to receive multiple trainings in treatment/service models that address engagement, the psychiatric results of trauma, substance abuse, mental health, community support, and violence against women. These trainings have increased the expertise of professionals in the DMHAS system for serving this population.
- Program staff, in collaboration with external consultants and DMHAS consultation, has developed a wrap-around program model that effectively serves the need of this population.
- The lessons learned from these programs are informing future program development by DMHAS.

- The SAMHSA-funded Technical Assistance and Policy Analysis Center has provided funding for program staff to present at national conferences and meet with agencies in other states to disseminate information about this program model.

Preliminary Outcome Data

- Preliminary data indicate that the program reduces arrest and incarceration rates for these women.
- As of September 2005, the two programs have served a total of about 155 women, and discharged about 110 women.
- All of the women would have been incarcerated on bond if not diverted to the program. Because many of the women have prior arrests and convictions they would have likely also been sentenced to a period of incarceration.
- Most of these women do not present a serious risk to the community. The most serious charge was a misdemeanor or a probation violation for two-thirds of the women admitted into the programs.
- Only about 15 percent of the women admitted to the programs had a charge of violence, minor in most cases.
- As of September 2005, women in the Hartford program averaged 1.7 arrests in the 12 months prior to admission to the program and 1.0 arrests in the 12 months after admission to the program. This is a significant reduction in arrest rate. Numbers are not yet available for the newer New Britain/Bristol program.
- As of September 2005, the percentage of women admitted to the programs who recently drank to intoxication dropped from 39 percent at admission in Hartford to 3 percent 12 months later, and 29 percent in New Britain/Bristol at admission to 9 percent 12 months later.
- Program analysis is not complete but preliminary numbers (excluding women who are referred to a different program due to clinical need) indicate that approximately 60 percent of the women complete the program and their legal charges are disposed without further incarceration. All of these women were diverted at arraignment or after a brief period of incarceration on bond. All would have likely been incarcerated for many months or longer if not diverted.

Recommendations for SFY07

- State funding for the current two WTSD programs to replace federal funding that will end in May 2006 and June 2006.
 - 2 programs, 6 staff
 - GA-14 and Community Court Hartford, GA-15 New Britain, GA-17 Bristol
- Expand WTSD programs for other urban courts
 - 3 programs, 9 staff
 - GA-23 New Haven, GA-2 Bridgeport, GA-4 Waterbury.
- Expand WTSD programs for other courts that have a large enough need to justify a program
 - 10 programs, 11 staff
 - GA-1 Stamford, GA-3 Danbury, GA-5 Derby, GA-7 Meriden, GA-10 New London, GA-11 Danielson, GA-12 Manchester, GA-13 Enfield, GA-19 Rockville, GA-20 Norwalk, GA-21 Norwich.

Women's Treatment and Support Diversion Programs Annual Cost

State funding for the current two WTSD programs to replace federal funding that will end in May 2006 and June 2006. 2 programs, 6 staff, 80-100 women per year (GA-14 and Community Court Hartford, GA-15 New Britain, GA-17 Bristol)	\$ 505,000
Expand WTSD programs for other urban courts 3 programs, 9 staff, 120-150 women per year - \$250,000 per program (GA-23 New Haven, GA-2 Bridgeport, GA-4 Waterbury)	\$ 750,000
Hire a half-time DMHAS Manager to coordinate budgeting, initiation, implementation, management, and evaluation of the expansion of WTSD in Connecticut.	\$ 50,000
Expand WTSD programs for other courts that have a large enough need to justify a program 10 programs, 11 staff, 160-200 women per year - \$105,000 per staff (GA-1 Stamford, GA-3 Danbury, GA-5 Derby, GA-7 Meriden, GA-10 New London, GA-11 Danielson, GA-12 Manchester, GA-13 Enfield, GA-19 Rockville, GA-20 Norwalk, GA-21 Norwich)	\$ 1,155,000
Total Annual	\$ 2,460,000 (11/05)

Appendix 13 Specialized Staff for Probation and Parole

To achieve this recommendation, the following staffing pattern and funding is proposed.

PROBATION:

Number of Officers	Location	Cost
10	Based on number of split sentence Mental Health score 4s. TBD by CSSD/DOC	10X \$50,000
Total annual cost:		\$500,000

PAROLE

Number of officers	Location	Cost
5	Statewide	5X\$60,000
Total annual cost:		\$300,000 (11/05)

Appendix 14: BPP Comprehensive Discharge Services

Under this recommendation, the Board of Pardons and Paroles requires the services of a psychiatric social worker at a cost of \$107,900. (11/05)

FISCAL SUMMARY OF RECOMMENDATIONS

1.	<i>Alternatives to Incarceration</i>	\$ 2,186,240
2.	<i>Sexual Offender Management</i>	\$ 2,713,750
3.	<i>Parole Violation Reduction Program</i>	\$ 250,000
4.	<i>DOC's Comprehensive Re-Entry Strategy</i>	\$ 10,457,424
5.	<i>Social Services Accessibility</i>	\$ 324,403
6.	<i>Comprehensive Substance Abuse Strategy</i>	\$ 3,125,000
7.	<i>Behavioral Health</i>	\$ 6,510,000
8.	<i>BPP Discharge Services</i>	\$ 107,900