Evolution of Forensic Services in Connecticut

IRCC Conference

New Haven, CT May 14, 2015

Michael Norko MD, Madelon Baranoski PhD

Background History

- "Forensic" Statutes
  - Competency to stand trial at least 1949
  - Insanity Defense at least 1969
- System pre 1970
  - 3 Large state hospitals, each of which treated forensic patients from local courts and sometimes prisoners/detainees from local correctional facilities
  - Norwich Hospital had special forensic service- "Security Treatment Center" at least since 1957 by statute (P.A. 650, S. 3, 1957)
- System 1970's – early 80's
  - Each of the "Big 3" had "forensic teams" who did evaluations/reports/testimony
  - Forensic patients scattered or clustered on special forensic units

Whiting Forensic Institute

- Constructed ~ 1970
- PA 73-245, changed “Security Treatment Center” to “Whiting Forensic Institute,” recognizing the move to the CVH campus
  - Specified a “diagnostic unit” and any other subdivisions the director would establish
- PA 75-603 moved forensic services for minors to DCYS

1970's – early 1980's

- Four of six units occupied; others used for office space (professionals did not have offices on patient units)
- MDs were contracted from group practice in Springfield, MA; visited weekly
- Direct care staff wore white uniforms
- WFI overall focus varied from security to treatment depending on Director at time
  - Problems encountered with one pendulum swing led to the next

Evolution of WFI

- 1986 – appointment of first Director of Forensic Services for DMH
  - Who also replaced then current director of WFI
  - Plan supported by Commissioner and Governor to transform WFI from a custodial setting to an accredited hospital
    - Resources increased
    - Psychiatrists/psychologists/social workers hired and placed on treatment units
    - Specific intent to create consistent combined security-treatment focus

Further Development

- 1988 – two new units added with intent to serve inmates with acute mental illness
  - DOC insisted on security enhancements to building
  - Bond funds for enhancements acquired in 1993
- 1989 – Achieved Joint Commission accreditation on first attempt
- PA 91-121 – permitted admission of women at Whiting; Whiting/DMH lobbied for this change
- Early 90's – achievements consolidated; various QI efforts

PA 95-257

- Effective July 1, 1995
- Directed closure of Norwich and Fairfield Hills Hospitals
- Placed WFI within CVH as “Whiting Forensic Division of CVH”
- Created DMHAS
- Expressed purpose: “administrative efficiencies” and budget concerns

Post-Consolidation

- All NH & FHH patients discharged to community or transferred to CVH
- All forensic care transferred to CVH
- 1999 – All competency restoration patients at CVH made part of WFD
- ~ 2000 – all state hospital level PSRB patients at CVH made part of WFD
- This resulted in 3 subdivisions of WFD across 3 buildings

Other Developments in Forensic System

- Court clinics – 1980's
- Consulting Forensic Psychiatrists – result of consent decree in 1989
- Community Forensic Services
  - Diversion and Re-entry programs initiated from 1996 to present
    - See next chart for dates of individual programs

Program Name	Location	Pre-arrest	Arraignment	Pre-trial In Community	Pre-trial In Jail	Sentenced In Jail/Prison	Parole In Community	Probation In Community	Post Crim. Just. Involvement
Crisis Intervention Team	15 locations	2004							
Alt. Drug Intervention	New Haven		2005						
Women's Jail Diversion	Bristol, New Britain, New Haven		Bristol/NB – 2003 New Haven - 2008						
Jail Diversion Sub Abuse	Hartford		2011						
Jail Diversion	**State-wide**		2001						
JD Vets	**SMHA & RVS**		2009 & 2012						
Transitional Case Mgmt	Wtby, Htfd, Nrwch/NLondon, NBritain/Bristol					2005			
DOC-DMHAS Referral Program	**State-wide**					1996			
CT Offender Reentry Program	8 locations					2004			
ASIST (clinicians collaborating with AICs)	9 locations			2007					
Mental Health Day Reporting Center (CREST)	New Haven		2007						
Residential Supports Program	B'port, Htfd, NHaven		2009						
Pretrial Intervention Program	**Serves all courts**			1997					

On the workbench…

- Forensic Peer Bridgers
- Forensic Citizenship Projects
- Forensic Research
- Forensic recovery language
- Enhanced system capacity to respond to individuals' criminogenic needs

Forensic Program Brief Descriptions

[for handouts only]

Programs for Diversion

- Crisis Intervention Teams
  - > 1,450 police officers trained from 99 departments to deal with persons in psychiatric crisis
  - CIT clinicians assist police with > 1,600 persons/yr face to face; plus approx. 1,400 consults/ phone contacts
- Jail Diversion
  - Jail Diversion in all arraignment courts in state
    - 3,249 evaluations & 1,391 diversions in SFY13
    - 2,750 evaluations & 1,346 diversions in SFY 14
  - *plus* special programs: Women's JD, JD Substance Abuse, JD Vets, Pre-trial intervention (SA)
    - > 500 evaluations; large majority diverted

Re-Entry & Community Integration

- CT Offender Re-entry Program (**CORP**)
  - Referrals 9-18 months before discharge from DOC for sentenced people with SMI
  - Comprehensive pre-release assessment and skills building program including the development of a community support network
  - Intensive case management, integrated mental health and substance abuse treatment services
  - After discharge, continuing services are provided through the Local Mental Health Authorities in those communities.
  - 60-70 admissions per year
  - In 12 months after release, 32% re-arrested, compared to 37% for inmates who do not participate in CORP

Re-Entry (cont'd)

- **DOC-DMHAS Referral Program**
  - Promotes recovery and re-integration for people with SMI transitioning from state correctional facilities to the community, through a comprehensive referral program.
  - Referred to the program 3-6 months prior to their release from the DOC and meet with a representative from the appropriate Local Mental Health Authority to arrange for services in the community.

Re-Entry (cont'd)

- Advanced Supervision and Intervention Support Team (**ASIST**)
  - Alternative in the Community Centers with clinical support/recovery services
  - Coordinated effort of DMHAS, DOC and Judicial Branch court support services
  - Admits approx. 400 clients per year
  - 80% completed program without incarceration in SFY14; 85% in SFY 13

Re-Entry (cont'd)

- Community Recovery Engagement Support and Treatment Center (**CREST**)
  - Intensive day reporting program with skill-building and clinical services
  - Clients who could not be released from incarceration otherwise
  - 45 admitted per year
  - 82% completed without incarceration in SFY14; 83% in SFY 13

Re-Entry (cont'd)

- **Sierra** Pretrial Center
  - Transitional housing program for those in jail awaiting court disposition of charges who can be safely released to the community in a structured residential program
  - Services offered include case management, psychiatric and medication monitoring, motivational enhancement, cognitive restructuring and training, consistent supervision and supportive services
  - 80% of SMI clients completed without being re-incarcerated in SFY 14; 91% in SFY 13

Re-Entry (cont'd)

- Transitional Case Management (**TCM**)
  - Serves sentenced male inmates with substance use disorders
  - Services begin 3-4 months before release: discharge planning, housing assistance, application for entitlements
  - Post-release services: community support, substance abuse counseling, employment, housing
  - 5% arrested while in community program SFY 14 & SFY13

Forensic Consultation

- Team of independent consulting psychiatrists
  - Participate in regular management of forensic population
  - Provide risk management consultations to DMHAS inpatient and outpatient teams, private agencies and hospitals
  - Provide other forensic consultations as needed

Evolution of Forensic Services in Connecticut
IRCC Conference
New Haven, CT May 14, 2015

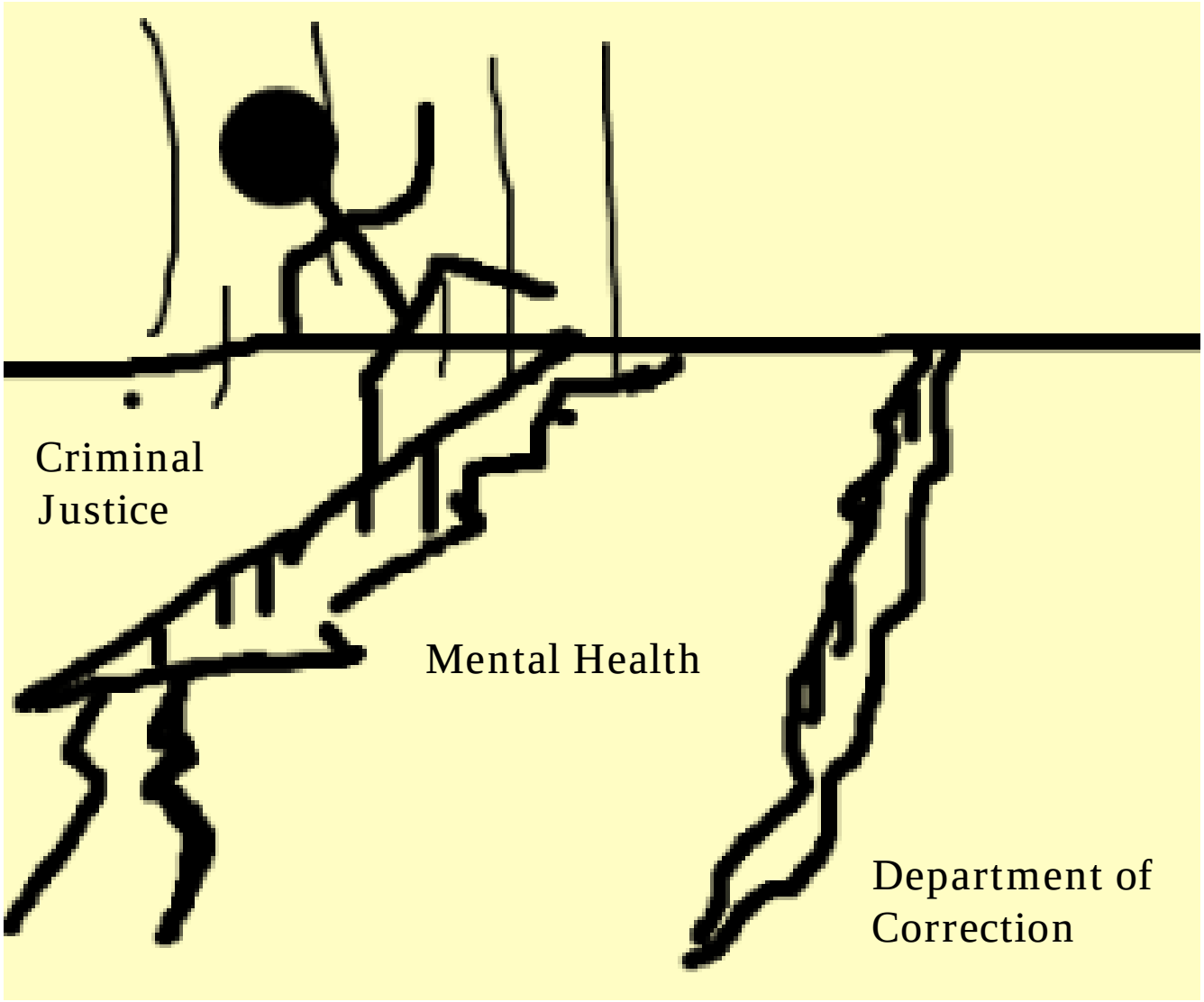
Evolving Definitions, Roles, and Boundaries in Forensic Services

Madelon V. Baranoski, PhD
IRCC Conference
New Haven, CT May 14, 2015

Yale SCHOOL OF MEDICINE

In the Beginning

- Professional silos maintained strict boundaries: *law* was law; *mental health* was mental health
- Forensic patients defined by legal standing
- Focus of care for forensic clients determined by legal classification
- Interaction between law and psychiatry in court and in hospital, not in community


Criminal
Justice
Mental Health
Department of
Correction

What were the effects? *Cracks to fall through*

- Patients "belonged" to one domain or another
- Care fragmented
- Professionals minded their own professions
- Inequity
- High cost

What changed?

- Bridging the cracks: coordinated, comprehensive care for the forensic client
- Role and skill enhancement for all professionals
- Removing barriers to comprehensive services

Where are we now?

- Comprehensive, seamless services for forensic clients
  - Jail diversion
  - Supervised release programs
  - Re-entry programs
- Client focused approaches
  - Criminal justice involvement as a clinical issue
  - Expanded services for forensic clients
- Inter-agency collaboration
  - Shared responsibility
  - Collaborative approach
- Impact of Recovery on mental health movement

What's next?


OK...ON THE COUNT OF THREE, WE EVOLVE INTO PIRANHA
STRATEGY VS REALITY
© Wiley Ink, Inc./Distributed by Universal Uclick via Cartoonstock

Challenges

- Community based forensic services
- Broadening “forensic” to address “at-risk-to-become-forensic” client
- Single-point-entry to care models of access
- Community-based and translational research
- Social media and public opinion

Goals for the Next Revolution

PRESENT

- Moved from legal focus to client centered programming
- Integration of services to close the gaps
- Interagency collaboration
- From in-patient to community based programming
- Integration of services across criminal justice tenure

FUTURE

- From *client* centered to life-goals focus on programming
- Integration of skills for living beyond client-hood
- Single entry service based on acuity and level-of-service needs
- Collaboration with community partners – partnerships for living
- Recovery-research environments to establish effective care models based on acuity and recovery potential

If we looked to past progress we would perish in our satisfaction; if we looked to the future task, we would perish in our despair. We celebrated our daily achievement as a sign we were capable of tomorrow's burden.

We chose to embark on this journey; now we must choose to go forward or to turn back. Remaining here is no option.

Thor Heyerdahl on a 101-day, 4948 mile journey on a raft cross the Pacific

Contact Information

michael.norko@yale.edu

madelon.baranoski@yale.edu