COMPREHENSIVE STUDY

Connecticut Department of Correction
(CTDOC) Restrictive Housing System Study

Comprehensive Study, Program Validation, and Best Practice Recommendations

FINAL SUBMITTED
NOVEMBER 27, 2024

Independent Report Created by Falcon Inc.
Commissioned by the CTDOC

FALCON®

Connecticut Department of Correction (CTDOC) Restrictive Housing System Study

Comprehensive Study, Program Validation, and Best Practice Recommendations

SUBMITTED TO:
Commissioner Angel Quiros, CTDOC
24 Wolcott Hill Road
Wethersfield, CT 06109
Email: angel.quiros@ct.gov

FINAL REPORT 11.27.24

155 North Wacker Drive, Suite 4250, Chicago, IL 60606
Tel: 312.803.5666 | www.falconinc.com

Cover Letter

Dr. Elizabeth M. Falcon
PsyD, CCHP-MH, MBA
CEO and Founder
Falcon Correctional and
Community Services, Inc.

November 15, 2024

Commissioner Angel Quiros,
Connecticut Department of Correction (CTDOC)
State of Connecticut
24 Wolcott Hill Road
Wethersfield, CT 06109

Re: CTDOC Restrictive Housing System Study

Dear Commissioner Quiros,

I write on behalf of the Falcon team of experts engaged in studying the CTDOC Restrictive Housing System Study.

Falcon's Restrictive Housing System Study report is enclosed and includes our Key Observations and Recommendations for your consideration.

Senior Expert and Falcon Principal, Dr. Steven Helfand, PsyD, CCHP, has taken the lead for Falcon and assembled interdisciplinary team of national experts to conduct this study and develop observations and recommendations. They include Falcon Chief Expert Rick Raemisch, JD; Senior Corrections Experts, Christopher Fallon and Shirley Moore Smeal; Senior Behavioral Health Experts, Dr. Robin Timme, PsyD, Dr. David Stephens, PsyD, Dr. Corey Brawner, PhD, and Senior Project Manager and Behavioral Health Technical Expert, Harmony Goorley, MA, LCPC.

This seven-member team has worked collaboratively with your executive and senior staff members to 1) conduct a focused review of data and population trends, 2) review and assess CTDOC's existing systems and restrictive housing practices, 3) facilitate a series of workshops with internal and external stakeholders to include advocacy and special interest groups, 4) tour eleven of your facilities to include interactions and interviews with both staff and incarcerated individuals, 5) identify and analyze observations, and, 6) develop the enclosed set of recommendations.

Thank you for the opportunity to assist you and the CTDOC. Please feel free to contact me or Dr. Helfand if you would like more information about the enclosed report.

Sincerely,

Elizabeth Falcon

Dr. Elizabeth Falcon
PsyD, CCHP-MH, MBA

Executive Summary

The CTDOC has long sought to be a leader in correctional policy and practice across the United States consistent with its stated mission to "… protect the public, protect staff, and provide safe, secure, and humane supervision of offenders with opportunities that support successful reintegration…"

…protect the public, protect staff, and provide safe, secure and humane supervision of offenders with opportunities that support successful reintegration…

Reflecting efforts to improve, CTDOC posted in October 2023 a Request for Proposal (RFP) authorizing a study designed to assess its use of restrictive housing (RH), "seeking improvements to significantly reduce the use of restrictive housing, that improve conditions within restrictive housing, and that increase out-of-cell time for individuals housed in segregated environments." CTDOC leadership has focused on validating their system's successes as well as suggested advancements in policy and practice that can lead to the Department's use of RH in a way that reflects best correctional and clinical practices going forward.

The CTDOC Commissioner made clear that Falcon was expected to evaluate the Department with the goal of improving from "a good to a great state of operating." The leadership articulated that the Department is not just interested in knowing the right thing to do, but also taking comprehensive actions to improve RH practices. As the study got underway, discussion focused on positive changes that would create a less punitive and safer system while keeping the population accountable and the staff positively engaged.

Based on the stated purpose of the RFP, Falcon Correctional and Community Services, Inc. ("Falcon") was tasked with three primary domains of inquiry:

1. Design and conduct a comprehensive review of CTDOC's existing RH program, including policies, procedures, processes, and operations.
2. Conduct a thorough analysis of the RH System for the purposes of program development and validation.
3. Provide a range of actionable short- and long-term solutions if the Falcon team finds that areas of improvement are possible to achieve.

This independent assessment was conducted by an interdisciplinary team of Falcon consultants, which includes those with expertise in the administration of jail and prison operations, correctional medical and behavioral health, assessment of criminogenic risk, large-scale system studies, RH reform, and leadership and organizational change. The purpose of this independent report and assessment is to serve as a tool to collectively navigate recommendations and system improvements. The seven-member Falcon team reviewed CTDOC leadership's current and past efforts to improve the treatment of those individuals involved in the disciplinary process (DP). The team both validated some initiatives and results and identified opportunities for further evolution and outright change, while specifying recommendations based on information learned throughout the process.

In this report, the Falcon team suggests adjustments and potential alternatives to RH-related practices, while simultaneously supporting system-wide safety and security. It should be noted that all observations, conclusions, and recommendations presented in this report are done so with a reasonable degree of professional certainty, based on the information available when this report was written.

Falcon would like to thank everyone at CTDOC who participated in assisting with the content of this

report. From data collection, site visit preparation, workshop involvement, and the time and energy dedicated to completing this project, Falcon greatly appreciates, not only your assistance on this project, but also what you do on a day-to-day basis.

Key Observations

The CTDOC had numerous strengths that the Falcon team recognized while collecting data, visiting the facilities, attending meetings with CTDOC staff, and facilitating workshops. While there were too many to list, the following are the strengths and characteristics the Falcon team wanted to highlight:

1. Executive and senior leadership are motivated and attuned to worldwide correctional practice reforms and demonstrates interest and action through engagement in proactive initiatives, such as the Amend program and the current Restricted Housing System Study.
2. CTDOC does not have a working governance structure or project oversight and accountability system to drive integration and the sustainability of projects and reforms.
3. Though CTDOC is generally seen as responsive to requests for information, there is a mistrust of CTDOC from several public advocacy groups resulting in a lack of collaborative problem solving and agreed-upon reform.
4. CTDOC has achieved lower overall utilization of Administrative Segregation (AS) and Punitive Segregation (PS) units in the past decade, though use of Chronic Discipline (CD) remained relatively consistent during the period and rose above its ten-year average in 2023 and 2024.
5. CTDOC has reduced the Average Length of Stay (ALOS) for individuals placed in Restrictive Housing Unit (RHU) PS and AS over the past decade, especially since 2021, while ALOS in CD remained relatively flat with an apparent increase in 2024.
6. CTDOC has successfully increased out-of-cell time secondary to the Protect Act.
7. Providing tablets for incarcerated individuals across all levels of classification has improved operations though opportunities for proactive programming and supplements to treatment remain unrealized.
8. The experience of the incarcerated individual within Special Management Status (SMS) (e.g., AS, CD, Security Risk Group (SRG)) is marked by frustration and a lack of engagement in interventions. This situation may lead to behaviors and staff encounters that result in a disciplinary report (DR) and prolonged lengths of stays.
9. The purpose of sanctions appears outmoded and primarily grounded in consequences and enforcement. The DP can benefit from 1) fully prioritizing the risks and needs of the individual and 2) reducing the reliance on formalized sanctions and penalties that, at times, create extended periods in RHUs.
10. The use of in-cell restraints has reformed to some extent over the past four years leading to an initial decline in confinement. The practice has continued with a varied staff understanding of the purpose, absence of outcome data, and a negative public perception.
11. The CTDOC lacks programming for criminogenic and mental health needs for all RH statuses, including PS that could improve the quality of time-out-of-cell for meaningful interaction and address factors/behaviors that result in RHU placement.
12. RH and related statuses are all time-based and lack meaningful out-of-cell time and meaningful in-person programming.
13. A likely a result of systemic pressures (including resource prioritization) in incarcerated individuals experiencing mental health assessments are often identified as either “mental health” or “behavioral” resulting in missed opportunities for mental health integration with CTDOC counselors and programs.
14. The mental health department has several

interventions that result in restrictive conditions of confinement without concurrent short-term treatment and programming.

15. The CTDOC lacks measurement-based care or objective consideration of outcomes for mental health treatment, while also lacking outcome data regarding RH incidence, length of stay, and programming.

Recommendations

1. Governance Structure
    - Establish a governance structure for special projects.
    - Activate a team for implementation.
2. Communication & Stakeholder Engagement
    - Enhance stakeholder communication plan.
3. Staffing & Staff Development
    - Conduct a comprehensive staffing analysis.
    - Align initial, annual, and continuous learning and development opportunities to philosophical and operational changes.
    - Introduce formal staff wellness initiatives building upon University of Connecticut (UConn) and Amend partnerships.
4. Operations
    - Optimize the classification process.
    - Use the DP to assess criminogenic and clinical needs that may have contributed to the requirement for increased restrictions.
    - Redefine RH as a behavioral assessment and intervention strategy.
    - Memorialize New Practices in Policy.
    - Evaluate the need for additional programming spaces.
    - Consider technological companion to strip searches.
    - Consider terminating the use of in-cell restraints.
5. Programming
    - Expand capacity for evidence-based programming.
    - Expand access to substance use treatment programs.
6. Mental Health
    - Conduct a full evaluation of mental health practices of Suicide Watch, Behavioral Observation Status (BOS) and Programmatic Intervention Cell (PIC) to include health record reviews and relapse data.
    - Expand and enhance treatment and intervention for individuals interfacing with the DP and RH settings by integrating behavioral health treatment with programming and eliminating a categorical approach to disposition.
    - Introduce a treatment/programming model that engages individuals, even during short-term RHU stays, and continues post release from RHUs.
7. Data Collection and System Monitoring
    - Implement a modern data system with live time and retrospective tracking and monitoring of all RHU-related practices to include suicide watch, BOS, PIC, Refusing to House, and in-cell restraints available at site and departmental levels. The record system should also be developed with capability to identify high-frequency or high-risk individuals for screening and additional assessment as warranted.
    - Implement Scheduled, Offered, Accepted, Refused (SOAR) out-of-cell tracking (OOCT) and analysis for all restrictive statuses.
    - Create public-facing disciplinary and RHU data dashboards.

Table of Contents

SECTION 01:

Assessment and Methodology

TOC
I. _____
A. ____
i. ___

Assessment and Methodology - Section 1

The Falcon team conducted a systematic study of CTDOC's RH System, identified as inmate housing in which inmates on Restrictive Statuses (e.g., Administrative Detention (AD), PS, Transfer Detention (TD)) and inmates on SMSs (SRG, AS, CD, Special Needs Management (SNM)) are placed.[1, 2] The study also included related practices to include the DP, in-cell restraints, and other conditions of confinement (e.g., Suicide Watch, BOS, PIC, Refusing Housing) that may share similarities with RH. The team engaged in a multi-phase approach to study CTDOC's RH System, which included:

Phase 1: Project Initiation & Visioning

Phase 2: Data Gathering and Review

Phase 3: Group Workshops

Phase 4: Site Visits

Phase 5: Supplemental Stakeholder Meetings

Phase 6: Formulation and Analysis

Phase 7: Report Development

1 Restrictive Housing as defined in the Personal Service Agreement., dated May 3, 2024.

2 A.D. 9.4 Special Management (2023.04.21).

Project Initiation & Visioning

Falcon's work formally began in May of 2024 by assembling a Core Working Group (CWG), which included Falcon consultants, CTDOC's Commissioner, Deputy Commissioners, and other CTDOC Department leaders responsible for the oversight of custody operations, programming, health care, and data. The CWG met initially to define the scope, preview project phases, establish the meeting cadence, and designate points of contact for upcoming phases and project tasks. The group remained engaged and collaborative via bi-weekly CWG meetings, and as-needed email and telephonic communications.

Department's Position on Disciplinary Process and Restrictive Housing Practices

Based on the Falcon team's interaction with CTDOC leadership and the CWG for almost six months, CTDOC leadership views this study as an opportunity to not only confirm what is done well, but also to address a proactive system change and the implementation of best practice correctional and rehabilitative models. This proactive approach appears driven in part by a desire to use their

Core Working Group

- **Angel Quiros,** *Commissioner*
- **Ronald Cotta,** *Chief of Staff*
- **William Mulligan**, *Deputy Commissioner for Operations and Rehabilitation*
- **Sharonda Carlos,** *Deputy Commissioner for Administration*
- **Eulalia Garcia,** *District Administrator of Programs and Treatment*
- **Nick Rodriguez,** *District One Administrator*
- **Craig Washington,** *District Two Administrator*
- **Captain Carmen Vicenty,** *Operations-Atlas Unit*
- **Lieutenant Todd McNeil,** Operations-Data Unit
- **Kirsten Shea,** *Health Services Administrator*
- **Jason Gaudet,** *Counselor Supervisor at Central Office Operations*

Falcon Consulting Team

- **Steven Helfand, PsyD, CCHP,** *Principal and Senior Expert for Behavioral Health*
- **Rick Raemisch, JD,** *Chief Expert for Restrictive Housing*
- **Robin Timme, PsyD, ABPP, CCHP-MH, CCHP-A**, *Principal and Senior Expert for Integrated Healthcare and Restrictive Housing*
- **Harmony Goorley, MA, LCPC, CCHP,** *Senior Project Manager and Technical Expert for Behavioral Health*
- **David Stephens, PsyD,** *Partner and Senior Expert for Behavioral Health*
- **Corey Brawner, PhD,** *Senior Expert for Data and Statistics*
- **Chris Fallon,** *Senior Expert for Correctional Practice and Administration*
- **Shirley Moore Smeal**, *Senior Expert for Correctional Practice and Administration*

expertise, industry knowledge, and collective wisdom to drive meaningful change as opposed to responding to legislation. Executive and senior leaders recognize the evolving nature of correctional practices and embrace the issue of RH reforms. This is reflected in the palpable openness that leadership displayed to potential reforms, such as ultimately phasing out in-cell restraints and making program phases less dependent on time and more determined by participation in and response to programs and treatment.

While CTDOC has been reactive to outside legislative and executive requirements, the Department has proceeded with in-house generated initiatives to address conditions of conferment, such as the closing of the Northern Correctional Institution in 2021 and a stepwise limitation of the use of in-cell restraints in 2021 and 2023. Examples remain, however, of a punitive environment with conditions of confinement marked by isolation and restraint.

Leadership is cautious about taking away tools from staff or summarily eliminating RH, but they are open to more novel ideas, such as a revamping the DP to include risk and needs assessments, programming for RH / PS, and continued programming and prevention following RH placement. They are also committed to the idea of meaningful programming within multiple programs and across classification statuses. While site leadership (e.g., wardens) appear to generally accept recent and forthcoming RH-related changes and reforms, the middle management (e.g., captains, lieutenants) and line staff often expressed the dilemma of understanding recent changes while also preserving those tools officers use to respond to certain behaviors.

A fundamental question and discussion for the Falcon team and CTDOC leadership is how effective disciplinary and RH practices are in achieving the varied philosophical constructs of incapacitation, deterrence, rehabilitation, and retribution – and what constructs they hope to emphasize through reforms. CTDOC has initially experienced the "Isolated Confinement" requirements as a balancing act, seeking increased empowerment to control their own operations with the limited RH population to address root causes and reduce utilization.

After CWG and CTDOC discussions, CTDOC has emphasized its commitment to evidence-based

CTDOC's Commitment

CTDOC has emphasized their commitment to evidence-based rehabilitation practices that secondarily deter rules violations, minimize incapacitation, and eliminate actions based on retribution.

rehabilitation practices that secondarily deter rules violations, minimize incapacitation and eliminate actions based on retribution

Data Gathering and Review

The Falcon team engaged in a phase of discovery by formally gathering data and initiating a review processes consisting of comprehensive data inquiries and extensive document and policy reviews. An Initial Data Request and then a Supplemental Data Request were sent to the CWG and primarily managed by CTDOC's Data Unit. The Falcon team's data requests sought information pertaining to:

- Organizational structure.
- Statutes or regulations governing RH practices.
- Policies, procedures, or directives pertaining to RH practices, treatment programs, and any other related operational aspects of RH.
- Prior studies of RH practices in CTDOC.
- Housing units or statuses in which conditions of confinement include placing an incarcerated individual in a cell for an average of 22 or more hours per day and/or are considered to operate as RH per statute or policy.
- Training materials.
- Post orders for those working RH.
- Overview of healthcare services.
- Staffing matrices.
- System-wide population trends.
- RH population trends.
- RH utilization trends.
- In-cell Restraints.
- BOS.
- PIC Status.
- RH-related program curriculums.

To establish a collective understanding of the system, the Falcon team reviewed the data and documents in weekly internal meetings and engaged the CWG and/or Data Unit team for any necessary clarification or follow-up. The CTDOC leadership remained responsive to the Falcon team throughout the project's life cycle.

Group Workshops

In addition to regular meetings with the CWG, Falcon held five virtual workshops, using a semi-structured approach, which ranged from 60-90 minutes with subject matter experts representing the following domains: 1) Custody Operations & Disciplinary Process, 2) Classification & Programming, 3) Healthcare, 4) Legal & Policy, and 5) Legislative Matters. These workshops occurred in May of 2024.

Following this initial series of workshops that oriented the team to the system, Falcon conducted a second series of virtual workshops from August to November of 2024 with subject matter experts from; 1) Mental Health leadership;2) Supervising Psychologists; 3) Behavioral Health Clinicians; 4) Front line Correctional Supervisors; 5) Amend Leadership; 6) Facility staff holding Amend roles; 7) Office of Policy and Management: Criminal Justice Planning Division; 8) Office of the Child Advocate; 9) Stop Solitary CT; 10) Correctional Advisory Committee; 11) Yale Law School. Falcon extended invitations to meet with representatives from the American Civil Liberties Union (ACLU), The Corrections Ombuds, Connecticut Hall of Change, and the Connecticut Sentencing Commission. These stakeholders, however, did not accept invitations to meet.

Site Visits

The seven-member Falcon team visited eleven CTDOC facilities over two separate weeks in June 2024. The team used a planned approach and expert experience to study the system and to concisely capture the system, validate existing processes and procedures, and identify areas of concern that require the team's further attention. Specifically, Falcon engaged in observations and interviews of the following system elements across facilities to understand RH practices within the larger context of the prison system: 1) admission and processing; 2) classification; 3) general population (GP) housing;

4) RHUs and cells; 5) medical care; 6) mental health care; 7) treatment and programming spaces; 8) indoor and outdoor recreation spaces; 9) general custody operations. The following facilities with RH were toured:

- Bridgeport Correctional Center (BCC)
- Cheshire Correctional Institution (CCI)
- Corrigan Correctional Center (CCC)
- Garner Correctional Institution (GCI)
- Hartford Correctional Center (HCC)
- MacDougall-Walker Correctional Institution (MWCI)
- Manson Youth Institution (MYI)
- New Haven Correctional Center (New Haven CC)
- Osborn Correctional Institution (OCI)
- Robinson Correctional Institution (RCI)
- York Correctional Institution (YCI)

While on-site, the Falcon team also conducted on-the-unit interviews with front line correctional and healthcare professionals as well as a combination of out-of-cell, and cell front interviews with individuals currently incarcerated, including the GP, those currently residing in RHUs, those on restrictive mental health statuses, and those recently released from RHUs.

Throughout the site visits, the Falcon team was provided access to all requested areas and engaged stakeholders who provided lived experience perspectives of both currently incarcerated individuals and multiple types of staff.

Formulation and Analysis

Throughout this study, the team has reviewed documents and existing data sources, conferring weekly to discuss key observations, validate areas of strength, and identify where improvements could be made. Falcon's multidisciplinary team of experts engaged in weekly cross-sharing and processing of information and compared impressions with nationwide best practices and data trends, as well as to the developing goals and vision of the Department.

The Falcon team analyzed quantitative data, data trends, data anomalies, and data quality / limitations and assessed how CTDOC is tracking and monitoring its own RHU-related practices. During weekly formulation meetings, Falcon experts processed their understanding of qualitative observations and sentiments accumulated from virtual workshops, on-site interviews, on-site process observations, policy review, program material review, and CWG statements. The Falcon team regularly shared preliminary findings and developing impressions with the CWG, including midpoint project feedback, so the group could provide reactions and contributions to Falcon's formulations.

Report Development

With all formulation and analysis complete, the Falcon team turned to developing the written report throughout October and November of 2024. Falcon team members submitted verbal and written reactions and contributions. A technical writer and copy editor were also used for overall quality assurance.

SECTION 02:

Restrictive Housing: Legal and Operational Discussion

TOC
I. _____
A. _____
i. ____

Restrictive Housing: Legal and Operational Discussion - Section 2

According to the Protect Act No. 22-18, *Restrictive Housing status* means, "[the designation] any classification of an [inmate] incarcerated person by the Department of Correction that [provides for] requires closely regulated management and separation of such [inmate from other inmates] incarcerated person from other incarcerated persons, including, but not limited to, AS status, PS status, TD status, AD status, SRG status, CD status, special needs status, and protective custody status."[3] According to A.D. 9.4, Restrictive Status may consist of, but is not limited to AD, PS, and TD.[4] A.D. 9.4 defines a RHU as a housing unit that is physically separated from other inmate housing in which inmates on AD, PS, or TD are placed.[5]

Definitions of Restrictive Housing[6] can represent both a status and a place. The definitions used by the CTDOC approximate those used by accreditation bodies governing correctional standards. The American Correctional Association's (ACA) Restrictive Housing Expected Practices (January, 2018), defines RH as "a placement that requires an inmate to be confined to a cell at least 22 hours per day for the safe and secure operation of the facility."[7] This two-hour threshold is most commonly used as a marker of RH, including in the Nelson Mandela Rules related to solitary confinement as

Guides to an Operational Definition:

- *Protect Act*
- *A.D. 9.4. Restrictive Housing Unit*
- American Correctional Association & National Commission on Correctional Health Care
- Quantitative and qualitative aspects of isolation
- World Health Organization, United Nations, Mandela Rules

3 Substitute Senate Bill No. 459. Public Act No. 22-18.[(2)](10).

4 A.D. 9.4 Special Management (2023.04.21). p. 3.

5 Ibid.

6 For this report, Falcon considers terms such as segregation, solitary confinement, isolation, and any other condition that requires confinement to one's cell for an average of 22 hours per day, without the written order of a healthcare provider, analogous to the term Restrictive Housing.

7 American Correctional Association. ACA Performance-Based Standards and Expected Practices for Adult Correctional Institutions, 5th Edition. (2021, March). pp. 155.

well as the ACA[8] as defined above. Similarly, in a 2022 collaboration between Correctional Leaders of America and the Liman Center at Yale Law School, RH was defined as, "separating prisoners from the GP and holding them in cell for an average of 22 or more hours per day, for 15 or more continuous days."[9]

Organizations frequently focus heavily on qualitative aspects of meaningful human contact as well. The National Commission on Correctional Healthcare (NCCHC) standards[10] [11] base the health professional's monitoring on the degree of isolation based on individuals having either little/no contact with others or having limited contact with others. For the purposes of the standards, it is the living and confinement conditions that define the segregated status regardless of the reason the individual was placed in a segregation setting.[12]

It is therefore paramount to focus on the qualitative experience of the incarcerated individual and not simply the time out-of-cell. NCCHC defines Solitary Confinement qualitatively as the housing of a person with minimal or rare meaningful contact and references sensory deprivation and access to few or no educational, vocational, or rehabilitative programs.[13] NCCHC's Position Statement on Solitary Confinement highlights that federal courts found the solitary confinement of mentally ill persons to be unconstitutional.[14] The World Health Organization and United Nations (UN) recognize solitary confinement as harmful to individuals' health and wellbeing as evidenced by gastrointestinal and urinary problems, insomnia, deterioration of eyesight, profound fatigue, heart palpitations, migraines, back and joint pains, weight loss, diarrhea, and aggravation of preexisting medical problems, and exaggeration of mental health symptoms. The "very nature of prolonged social isolation is antithetical to the goals of rehabilitation and social integration."[15]

The International Guiding Statement on Alternatives to Solitary Confinement references the Essex Papers - Essex Paper 3: Initial Guidance on the Interpretation and Implementation of the UN Nelson Mandela Rules, which included as its guidance on *meaningful human contact*, the following: "such interaction requires the human contact to be face to face and direct (without physical barriers), more than fleeting or incidental, enabling empathetic interpersonal communication, and contact must not be limited to those interactions determined by prison routines, the course of (criminal) investigations or medical necessity."[16] This guidance is useful to systems that currently emphasize tours and use brief through-the-door cell-side clinical and programming encounters.

Falcon recognizes that these qualitative components and the impact of varied degrees of isolation from others are critical to appreciating the impact of RH on individuals. Quantitative definitions are necessary to modify and assure flexible physical conditions of confinement across various restrictive settings. Understanding the qualitative and quantitative elements of these definitions helps to identify individuals assigned to RHUs/locations that may not be subject to conditions equating to RH, as well as identifying individuals who are not assigned to RHUs whose housing may be operating under conditions that equate to RH.

8 Ibid.

9 Correctional Leaders Association & Arthur Liman Center for Public Interest Law at Yale Law School. Time-In-Cell: A 202 Snapshot of Restrictive Housing Based on a Nationwide Survey of U.S. Prison Systems. (2022, August). pp. 3. law.yale.edu/liman/solitary2020

10 National Commission on Correctional Health Care, Standards for Health Services in Jails (2018).

11 National Commission on Correctional Health Care, Standards for Health Services in Prisons (2018)..

12 Ibid.

13 Solitary Confinement (Isolation) (2016) - National Commission on Correctional Health Care.

14 Ibid.

15 Ibid.

16 Penal Reform International / The Human Rights Centre, Essex University. Essex Paper 3: Initial Guidance on the Interpretation and Implementation of the UN Nelson Mandela Rules. (2017, February). Penal Reform International. pp. 88-89.

History of Restrictive Housing Changes within the CTDOC

Disability Rights Connecticut Lawsuit

At the beginning of 2021, Disability Rights Connecticut filed a lawsuit against the CTDOC on behalf of the mentally ill inmates in system, focusing on their treatment and their placement in isolation.

> "DOC's failure to make reasonable modifications in policies and practices to avoid trapping these prisoners in a downward spiral of isolation and retribution also denies them virtually all opportunities for rehabilitative and other programming in violation of Title II of the Americans with Disabilities Act, 42 U.S.C. § 12132 et seq. ("ADA") and Section 504 of the Rehabilitation Act, 29 U.S.C. § 794 ("Section 504"), and their respective implementing regulations. DOC routinely subjects individuals with mental illness to prolonged isolation. For example, DOC assigns individuals with mental illness to isolative statuses where they face prolonged isolation and abuse. Many prisoners with mental illness, including most prisoners with mental illness at Northern, spend at least 22 hours per day on weekdays, and 24 hours per day on weekends, in concrete cells where they live in a world of near total social and sensory deprivation. Their primary connection to the outside world is a small opening, or "trap," at the bottom of a solid steel door. The only daylight and view of the outdoors comes through a narrow four inch-wide slot at the back of each cell. Meaningful social interaction is nonexistent. DOC also routinely subjects individuals with mental illness to in-cell shackling." (Amended Complaint filed 02/18/2021)

Governor Vetoes Legislation- Executive Order Issued

The Connecticut legislature passed S.B. 1059, The Protect Act, in 2021. The legislation would have severely limited the use of solitary confinement and in-cell restraints in the CTDOC and created an ombudsman for the Department. At the urging of Commissioner Quiros and in the belief the bill went too far and was dangerous to staff and other inmates, the governor vetoed the bill. However, the governor recognized that some reform was needed and issued Executive Order 21-1 on the very same day he vetoed the SB 1059, June 30, 2021. Among other items, the executive order mandated the following:

- By September 1, 2021, the Department of Correction shall guarantee that, outside of extraordinary circumstances, incarcerated persons in the GP shall be held in isolated confinement only due to disciplinary status.
- By October 1, 2021, the Department of Correction shall guarantee that, outside of extraordinary circumstances: a) Any incarcerated person in isolated confinement shall have a meaningful opportunity to be out of such person's cell for two hours each day; and b) No person shall be held in prolonged isolated confinement due to disciplinary status.
- By December 1, 2021, the Department of Correction shall guarantee that, outside of extraordinary circumstances: a) Incarcerated persons, including those in restrictive status programs, shall be held in isolated confinement only due to disciplinary status; b) No person shall be held in prolonged isolated confinement.
- By October 1, 2021, the Department of Correction shall make policy changes to limit the use of isolated confinement on members of vulnerable populations to the greatest extent possible. For the purposes of this paragraph, "member of a vulnerable population" means a person who: a) Is under eighteen years of age, or sixty-five years of age or older; b) Has a mental health needs score of four or five; c) Has a developmental disability, as defined in section 17b-28; d) Has a serious medical condition that cannot be

effectively treated in isolated confinement; e) Is pregnant, is in the postpartum period, or has recently suffered a miscarriage or terminated a pregnancy; or f) Has a significant auditory or visual impairment.

- By October 1, 2021, the Department of Correction shall report on steps taken and to be taken to increase access to contact visits for incarcerated persons.
- By October 1, 2021, the Department of Correction shall report on steps taken and to be taken to decrease the use of in-cell restraints.

Prior to this legislation, in 2017, Connecticut had passed SB 7302, which required annual reports regarding inmates on RH status.

Senate Bill 459

In 2022, perhaps in recognition that the governor's Executive Order was limited in terms of the temporary nature of its enforceability, the Connecticut legislature passed SB 459. Secondary to collaboration between CTDOC and Stop Solitary CT, this legislation was more consistent with the governor's executive order and was signed into law by the governor that year.

This bill limits the amount of time and circumstances under which an incarcerated person may be held in isolated confinement and places new requirements on its use. It also does the following:

1. Establishes a nine-member Correction Advisory Committee to, among other things, submit a list of correction ombuds candidates to the governor and meet quarterly with the ombuds;
2. Expands the current correction ombuds program to serve everyone in the CTDOC custody (rather than only those under age 18), requires it to provide additional services (e.g., evaluations of CTDOC services to incarcerated individuals), and grants it additional powers (e.g., to privately communicate with anyone in DOC custody and to access additional materials);
3. Relocates the correction ombuds program from CTDOC to the Office of Governmental Accountability (OGA) and adds the ombuds or his or her designee to the Governmental Accountability Commission (GAC); and
4. Requires CTDOC's report to the Criminal Justice Policy and Planning Division about inmates on RH and AS status, which contains aggregated and anonymized data, to instead require similar, disaggregated data on those in isolated confinement.

Regarding "Isolated Confinement," the bill limits and places new requirements on CTDOC's use of isolated confinement on incarcerated individuals, including those in pretrial, pre-sentencing, or post-conviction confinement. Under the bill, "isolated confinement" means any form of confinement in a cell (except during a facility-wide emergency or lockdown or the provision of medical or mental health treatment) with less than the following time out of a cell for all incarcerated individuals: 1) Four hours per day, beginning July 1, 2022; 2) in the GP, four-and-a half-hours per day, beginning October 1, 2022; and 3) In the GP, five hours per day, on and after April 1, 2023. The bill requires that any use of isolated confinement must maintain the least restrictive environment needed for the safety of incarcerated individuals, staff, and facility security.

If CTDOC holds an incarcerated person in isolated confinement, it must do the following: 1) ensure, within 24 hours of initiating the process, that (a) a medical professional (i.e., licensed physician, physician assistant, advanced practice registered nurse (APRN), registered nurse, or practical nurse) conducts a physical examination and (b) a therapist (i.e., licensed physician who specializes in psychiatry, psychologist, APRN, clinical social worker or master social worker, or licensed professional counselor) conducts a mental health evaluation on the person; 2) ensure the person's safety and well-being is regularly monitored, including through a daily check-in from a therapist; 3) provide the person access to (a) reading

materials, paper, and a writing implement; (b) at least three showers per week; and (c) at least two hours out of the cell per day, including at least one hour for recreational purposes; and 4) continue de-escalation efforts when applicable and appropriate to the situation.

Additionally, the bill prohibits CTDOC from placing an individual in isolated confinement until after it has considered less restrictive measures. It also prohibits placing an individual in isolated confinement: 1) for longer than is necessary, or for more than 15 consecutive days or 30 total days within any 60-day period; 2) more than once based on the same incident that was previously used for the placement; and 3) for PC (however, it may use isolated confinement for up to five business days while determining whether PC status is appropriate).

To comply with these requirements, in 2023 the Department issued Directive 9.4 related to Special Management and inclusive of all RH statuses.

SECTION 03:

Review of Existing Systems

TOC
I. _____
A. ____
i. ___

Review of Existing Systems - Section 3

To thoroughly understand the RH System, the Falcon team developed an understanding of the broader systems that interconnect with the CTDOC RH System. This included the study of the CTDOC's intake, classification and housing, programming, mental health, and data collection and monitoring systems and processes. This section provides an overview of these systems, addressing the most salient elements of each system as it relates to RH.

Capturing a high-level review of an individual's initial flow through the CTDOC is depicted below and represents significant areas of our study. An individual will first engage with the CTDOC through custody's admission and processing screenings and activities. The individual will then receive a medical screen. If screenings at this point indicate a mental health history or current concerns, the individual will further be assessed by a qualified mental health professional. All individuals incarcerated in the CTDOC for the first time shall receive a mental health assessment by a licensed mental health clinician. Using the CTDOC's classification tool, the individual's security risk level and treatment needs will be identified. Finally, all relevant information gathered about this individual during these initial stages of incarceration will result in his/her housing assignment.

Figure 1: Intake, Assessment, Classification Process

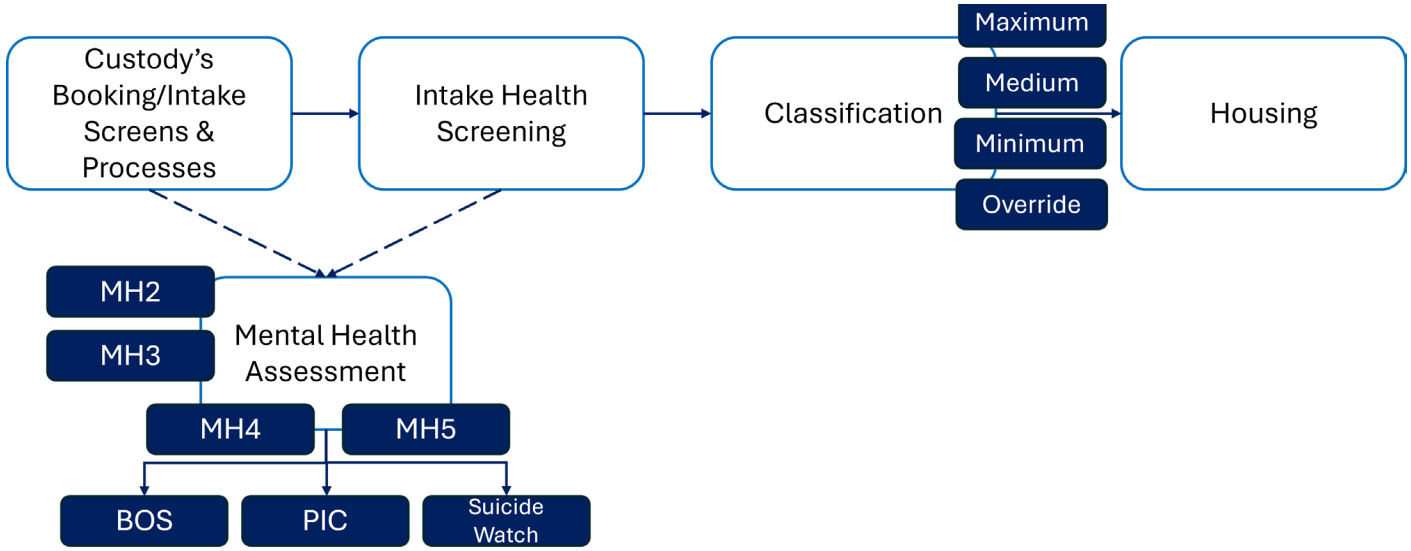


Figure 1 is a high-level illustration of major system decision points and cannot visually capture all system nuances.

To obtain a deeper understanding of CTDOC's RH System and its intersection with connected systems, Falcon's study focused on the following areas: experienced by those who are alleged to have committed offenses, referral to and placement of individuals into RH, conditions of confinement, role of and referral to mental health for the determinations of individuals to be diverted from RH, access to care and treatment interventions, programming, and overall governance of the professionals and special projects serving the RH System.

Due Process

How, when, and to whom discipline is applied reflects the culture and values of the organization applying the discipline. The discipline process is a ubiquitous process within the prison system where safety and security are the key. As reported by the CWG in May 2023, approximately 72% of individuals in RH are there secondary to non-violent acts.[17] This results in RH conditions for many individuals found responsible for non-violent rule violations that may carry lower risks of actual harm.

The CTDOC uses a two-pronged, graduated system of discipline. When an individual residing in the GP is alleged to have committed an offense, informal disposition (discipline) can be applied by an officer for the qualifying offense. The informal process is voluntary, and an incarcerated person can choose to engage in the formal DP, and/or officers will frequently apply the formal process immediately for a qualifying offense. If the incarcerated individual accepts the informal process, the officer will determine an appropriate penalty, and no disciplinary ticket will be created. The informal process can be applied for up to three penalties in seven days for an individual. A supervisor reviews the circumstances of the informal process and will determine if the sanction/penalty was appropriate and in proportion to the misconduct. There is no formal record of the informal disposition, and unit officers are responsible for knowing and enforcing sanctions. The CWG reported and interviews with staff and incarcerated individuals reflected that the use of informal disposition has been reduced since the Protect Act went into effect.

When an individual residing in GP is alleged to have committed an offense warranting removal from GP for the investigation and potential formal DP, he/she

17 As stated on 5.3.24 in the Core Working Group Kickoff Meeting.

is placed on AD status and typically removed from his/her housing unit and placed in an RHU setting. All inmates shall be evaluated by a CTDOC registered nurse, APRN, or physician who shall consult as needed with a mental health provider.[18] Those with a mental health score of four or higher are evaluated by mental health staff to determine if placement in RHU is contraindicated.[19] If it is determined that an individual requires more clinical services than what is available within a RHU, then staff will recommend alternative housing and treatment intervention. If no clinical contraindications are found to be present, then the individual is placed or remains in AD where he/she awaits the disciplinary hearing and disposition. If an individual is found guilty of an offense, select sanctions and/or penalties will be applied proportionate to the seriousness of the offense and the individual's disciplinary record.[20] The following sanctions may be imposed: PS, Forfeiture of Good Time, and Forfeiture of Risk Reduction Earned Credit (RREC).[21]

The current Code of Penal Discipline (A.D. 9.5) policy statement notes that the purpose of sanctions is to "... serve to teach the inmate the consequence of the misconduct and to enforce staff authority and to maintain safety, security and order." Penalties will be initiated "once punitive segregation is completed or if punitive segregation was not issued."[22] The following penalties may be imposed: reprimand, loss of recreation privileges up to 30 consecutive calendar days, loss of telephone privileges up to 45 consecutive calendar days, loss of commissary privileges up to 90 consecutive calendar days, loss

18 E. 9.01 Evaluation for Contraindication to Placement of Inmates in RHU (2001.04.01).

19 A.D. 9.5, Code of Penal Discipline (2019.10.01). pp. 12.

20 A.D. 9.5, Code of Penal Discipline (2019.10.01). pp.6.

21 A.D. 9.5 Code of Penal Discipline (2019.10.01). pp. 9. Refer to A.D. 9.5 for nuances around the imposing of sanctions.

22 Ibid.

Figure 2: Overview of the Discipline to Restrictive Housing Process

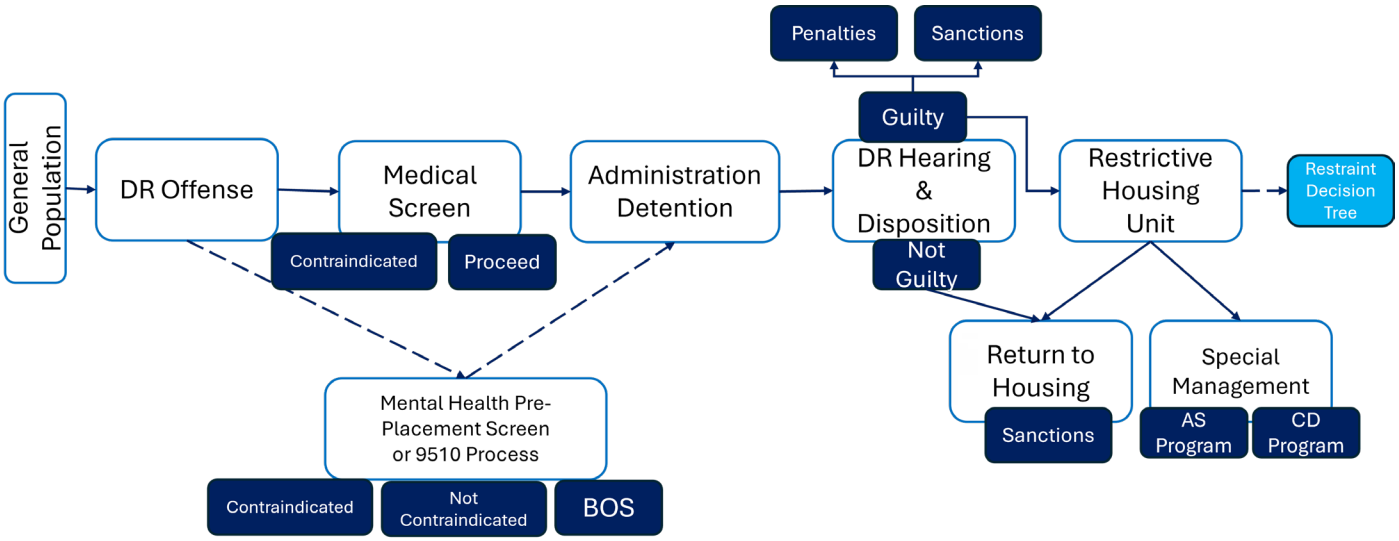


Figure 2 is a high-level illustration of major system decision points and cannot visually capture all system nuances.

or modification of social visiting privileges up to 30 consecutive calendar days, extra duty up to 24 hours which will be completed within one week of disposition, confinement to quarters (CTQ) up to seven consecutive calendar days, loss of social correspondence privileges up to 60 consecutive calendar days, restitution for property theft or damage, restriction on tablet (recreational media and entertainment) privileges up to 90 consecutive calendar days.[23]

The DP has three categories of formal discipline:

- Category A: For the most egregious acts; individual would receive PS.
- Category B: Individual could receive PS and forfeiture of good time.
- Category C: Individual will not lose good time or be placed in RH; disposition will go on their permanent record.

During the CWG in-person meeting on June 3, 2023, it was reported that most disciplinary dispositions result from a Class A offense, which aligns with correctional professionals' anecdotal reports during the on-site visits.

Restrictive Status Types & Conditions

Conceptualizing conditions of confinement as safe and humane requires an evaluation of the sensory (e.g., natural light, control of in-cell light, temperature, noise level, odor, cleanliness), physical (e.g., showers, restraints, out-of-cell time), social (e.g., double-celling, congregate out-of-cell time, access to phones and visits), psychological (e.g., experience of fear, Prison Rape Elimination Act (PREA) announcement, contact with clinician), service delivery (e.g., confidential contacts, segregation rounds, medication passes), penalties (e.g., loss of communications, loss of programming, incentive system) and experience of a placement. CTDOC utilizes three Restrictive Statuses (AD, PS, TD), and four Special Management Statuses (AS, CD, SRG, and SNM). Some notable aspects of these statuses conditions of confinement are outlined below.

Administrative Detention (AD): Refers to the removal of an incarcerated individual from GP and placement in a RHU that results in segregation of the

23 A.D. 9.5, Code of Penal Discipline (2019.10.01). pp. 9-10. Refer to A.D. 9.5 for nuances around privilege losses.

Length of Stay Snapshot for Individuals in Restrictive Housing Status, System-Wide

	AS			CD			PS			Total		
	Mean	Med.	Mode	Mean	Med.	Mode	Mean	Med.	Mode	Mean	Med.	Mode
2015	377	236	236	41	27	1	9	7	7	89	7	7
2016	413	253	119	60	49	46	8	7	7	80	7	7
2017	295	179	110	70	64	64	8	7	7	65	7	7
2018	241	151	61	46	33	6	9	7	7	54	7	7
2019	310	226	17	42	29	41	9	7	7	67	7	7
2020	272	118	48	48	27	13	9	7	7	91	10	7
2021	417	287	16	39	39	-	8	7	7	98	7	7
2022	402	226	268	36	30	7	6	5	5	87	5	5
2023	310	124	31	29	25	22	6	5	5	49	5	5
2024	138	114	96	45	40	6	5	5	5	31	5	5
Δ	-63.40%	-51.69%	-59.32%	9.76%	48.15%	500.00%	-44.44%	-28.57%	-28.57%	-65.17%	-28.57%	-28.57%

**Current Length of Stay was calculated as of July 1st of each year for all individuals in RH status.*

individual.[24] The person remains on AD while awaiting a disciplinary hearing. An incarcerated individual can be placed on AD for violent offenses or other serious considerations.[25]

Punitive Segregation (PS): A restrictive status for an incarcerated individual who is found guilty of violating Administrative Directive 9.5. Individuals cannot be on PS status longer than 15 consecutive days.[26]

Transfer Detention (TD): A restrictive status for an individual who has been reclassified to a higher security level, and placed in RH while awaiting transfer to another facility.[27] TD is also used for an individual who is waiting transfer to another facility for their own protection or the protection of others.[28] An individual is removed from TD upon completion of the transfer to a higher security level. The Falcon team notes that two incarcerated individuals at GCI reported that they were downgraded from a MH4 to MH3 classification and were placed in TD while awaiting transfer out of GCI with limited out-of-cell time although they had subsequently more out-of-cell time when classified as MH4. This experience is one in which the individual has resolved some mental health issues and is able to function in the GP as a mental health outpatient, however, they are subject to restrictive conditions of confinement depending on their progress in their mental health treatment. While TD seemingly has a short length of stay (e.g., hours to approximately three days), the RH like confinement conditions for those who are being transferred and not found responsible for an offense can lead to extreme frustration and distress. The latest Annual Report to the Criminal Justice Policy and Planning Division[29] indicated that zero to eight (average = 3.58) individuals were on this status on the first day of each month in 2023.

Administrative Segregation (AS): This Special Management Status results in removal from GP due to the individual's behavior or management factors that pose a threat to the security of the facility, and/or the safety of staff, the individual, or other incarcerated individuals.[30] This three-phase program – assignment results from a hearing disposition – is based on the type of behavior an individual is found guilty of engaging in (e.g., major assault). AS is a one-year program currently provided at Walker and Garner, completion of the three phases is based on temporal milestones without a new offense. For the male population, AS Phase 1 is at MWCI while AS Phase 2 and Phase 3 are at GCI. Throughout the study, between 16 and 25 individuals were on AS status statewide with 24 individuals reported on July 1, 2024. This is the only status for which individuals are single-celled. Reviews are conducted every six months or upon completion of the AS time-based programming requirements. At MWCI, two individuals on AS status can recreate together. CTDOC shall not place any individual under the age of 18 on AS. Most of the mental health assessments and treatments for AS Phase 1 in MWCI are provided at the cell side through the closed cell door. While interest to program individuals together in a group has been expressed, "Keep Separates" classification status makes it difficult to cohort AS individuals. Individuals on AS are allowed four hours out-of-cell time daily.

Chronic Discipline (CD): Under this Special Management Status, an individual's behavior is a threat to the security and orderly operation of the facility, or a risk to the safety of staff or others due to the individual's repetitive disciplinary offenses.[31] The two-phase program is based on the amount of repetitive DRs an individual has received. Individuals are assigned to the CD program following disposition of a hearing and Director of Offender Classification and Population review to determine the CD placement. CD is managed at level four facilities. Individuals between 14-17 years old will not be placed on CD. Completion of the program/removal from this status is based on the achievement of temporal

24 A.D. 9.4 Special Management (2023.04.21). p.2.

25 A.D. 9.4 Special Management (2023.04.21). p. 11.

26 A.D. 9.4 Special Management (2023.04.21). p. 3.

27 A.D. 9.4 Special Management (2023.04.21). p. 4.

28 Ibid.

29 Connecticut Department of Correction (2023). Report to the Criminal Justice Policy and Planning Division.

30 A.D. 9.4 Special Management (2023.04.21). p. 2.

31 Ibid.

milestones without new offenses. CD Phase 1 is 30 days and individuals are allowed four hours out-of-cell time per day.[32] CD Phase 2 is 60 days and individuals are allowed four hours out-of-cell time per day.[33] CD status is considered under any of the following:

- Three or more Class A disciplinary offenses within 180 calendar days.
- Three or more Class A/Class B combination of disciplinary offenses within 120 calendar days.

Security Risk Group (SRG): This Special Management Status is designated by the Commissioner and deemed for individuals who jeopardize the safety of the public, staff, or other individuals and/or the security and order of the facility.[34] These individuals will need to complete five program phases in six months to one year with positive program performance and no SRG-related offenses before being considered for removal from this status. There is discretion and periodic reviews that inform decision-making. Individuals can be considered for reunification after six consecutive months. Individuals referred to the program multiple times may remain in the program for 1.5 years. Individuals on SRG status can recreate in cohorts, usually 8-10 individuals. SRG individuals who are also on Protective Custody (PC), referred to as SRG-PC, are reported as a difficult population to effectively manage. Individuals on SRG status receive at least five hours out-of-cell time daily. Individuals on SRG-PC status receive at least four hours out-of-cell time. *Note: Given these conditions of confinement, the SRG status/program did not remain a focus of the Falcon study.*

Special Needs Management (SNM): This Special Management Status is for individuals who have demonstrated behavioral qualities either through the serious nature of their crime, behavior, or through the reasonable belief that they pose a threat to the safety and security of staff, other inmates, themselves, or the public.[35] An individualized facility management plan shall be developed collaboratively between custody and mental health staff.[36] Individuals are assigned an overall risk level of four.[37] SNM individuals are reviewed at a minimum of every six months and reevaluated by a mental health professional 30 business days after initial placement and every 90 days after that.[38]

Review of RHU Related Mental Health Practices

Mental Health Classification

CTDOC uses scores of one to five to classify the acuity of mental health need:

Mental Health 1 (MH1)–Reflects no need for mental health services or medications.

Mental Health 2 (MH2)–Reflects no need for services or medications but individual has a history of mental health treatment.

Mental Health 3 (MH3)–Reflects the clinical need for some forms of medication or mental health treatment with housing in the GP or RHU settings.

Mental Health 4 (MH4)–Reflects the clinical need for placement into mental health housing at GCI or YCI. Individuals are further housed by functional level within GCI's Level 4 units.

Mental Health 5 (MH5)–Reflects the clinical need for psychiatric infirmary or Inpatient Psychiatric Unit (IPM) level of care.

When an individual with a mental health designation of a 4[39] or above is referred to the DP (or when otherwise initiated by staff), a qualified mental health clinician will conduct the Disciplinary Review through the 9510 process. The clinician will evaluate the individual to determine if clinical contraindications to his/her placement into an RHU are present, and if so,

32 A.D. 9.4 Special Management - Provisions and Management Standards CD Attachment D (2024.0813). p2.

33 Ibid.

34 A.D. 9.4 Special Management (2023.04.21). p. 2..

35 A.D. 9.4 Special Management (2023.04.21). p. 4.

36 A.D. 9.4 Special Management (2023.04.21). p. 17.

37 A.D. 9.4 Special Management (2023.04.21). p. 16.

38 A.D. 9.4 Special Management (2023.04.21). p. 17.

39 At times, Falcon encountered staff who identified a Mental Health designation of 3 or above that flags the 9510-review process.

alternatives to RH will be recommended. The clinician will determine if the alleged offense was 1) secondary to an existing mental illness or other functional impairment, and / or 2) if delivery of the disciplinary sanction would exacerbate or create a mental health condition. Clinical contraindications may result in placement into the IPM or another intensive mental health services status including BOS.

Serious Mental Illness (SMI)

Generally, behavioral health disorders, including substance use disorders, are often overrepresented in jails and prisons across the country.[40] Individuals living with a SMI are also disproportionately represented in correctional settings.[41] Individuals with SMI are at greater risk for placement into RHUs and are especially vulnerable to the negative effects of isolation and psychiatric decompensation upon placement, including exacerbation of psychiatric symptoms, self-injury, and suicide. It is common in progressive systems to have processes in place to identify those with SMI and provide alternative placements to RHUs.

CTDOC does not have a formal definition of SMI. The Office of Protection and Advocacy (OPA) settlement agreement[42] of 2004 used a definition of SMI characterized by a list of diagnoses, history or current risk of suicide, and severe and debilitating symptoms. Previous CTDOC leadership, however, stopped using a SMI designation approximately 13 years ago. Since the sunset of the OPA agreement, clinical assessment, operational diagnoses, and functional abilities guide service provision and housing decisions based on mental health classification scoring. A study conducted by the Connecticut Sentencing Commission released in 2023[43] estimated that 17.9% of the population was diagnosed with an SMI based on those with psychotic and mood disorders. The study found that not all SMI individuals were classified as MH3 or higher and therefore found that 14.7% of the population was in treatment for an active SMI.

Mental Health Statuses

With respect to CTDOC's health care system, Falcon was particularly interested in studying mental health levels and special statuses whereby assignment may result in an individual being placed in conditions of confinement similar to RH. It was observed that acute or sub-acute mental health patients with current decompensation or self-injury / suicide risk experience conditions of confinement that are often more restrictive than RHU practices. The Falcon team not only observed these statuses and conditions during the facility tours and discussed them with CTDOC mental health workgroups, but they were prominently raised as an issue by two advocacy groups.

Mental Health Level 5 IPM Placement

MH5 focuses on individuals who require the equivalent of psychiatric inpatient hospitalization. MH5 individuals are placed in an IPM at GCI or YCI to provide stabilization, assessment, and transition to other levels of care.

As part of the operating procedures for the IPM, individuals will be housed in the infirmary, wearing correctional attire, have access to authorized items and/or privileges, and may be eligible for up to four hours out-of-cell time. Individuals on Suicide Watch may be on Constant Watch or staggered checks (not to exceed 15 minutes), will be dressed in a safety gown, provided a safety blanket, generally are not granted access to recreation or programs, and cell items will be highly restricted for safety. The intent of this level is to promote the individual's safety and stabilization. No structured interventions are assigned

40 Committee on Psychiatry and the Community. (2016). People with Mental Illness in the Criminal Justice System: Answering a Cry for Help. American Journal of Psychiatry, 173:10, pp. 1048. *People With Mental Illness in the Criminal Justice System: Answering a Cry for Help*

41 Bonfine, N., Wilson, A. B., & Munetz, M. R. (2020). Meeting the Needs of Justice-Involved People With Serious Mental Illness Within Community Behavioral Health Systems. Psychiatric Services, 71(4), 355–363, pp. 355. https://doi.org/10.1176/appi.ps.201900453

42 Conn. Office of Protection and Advocacy v. Choinski 3:03-cv-01352

43 Mental Health Disorders in Connecticut's Incarcerated Population, Connecticut Sentencing Commission, (January 2023).

to this status: however, individuals are assessed and monitored by mental health clinicians; psychologists and psychiatrists can determine discharge from this status. Contacts with mental health professionals may be cell side or in confidential settings.

Behavioral Observation Status (BOS)

BOS "may be initiated for inmates who are using maladaptive behaviors, such as threatening self-harm without intent or destroying property to avoid compliance with custody requirements such as housing or disciplinary actions."[44] While "BOS is not used as a punishment or as an alternative to disciplinary action," individuals on this status are generally housed within an RHU setting in closer proximity to the officers' station. The intent is for BOS to serve as "an intervention to extinguish maladaptive behaviors while maintaining safety and security of the inmate." Reliable data on BOS length of stay was not available because this status is mental health order-based within the electronic health record (EHR) – and not within the CTDOC Offender Management System (OMS) system. However, the policy requires a documented plan after seven days and a written Behavioral Management Plan (BMP) after 14 days. One reason for the placement, based on discussions with mental health staff, is to prevent transfer to the MH5/IPM with the status conceptualized by CTDOC professionals as a behavioral and not a psychiatric intervention.

While the status requires daily evaluations by a licensed mental health clinician, the policy does not require treatment, programming or other structured interventions other than potential use of a safety gown and blanket, limitation of in-cell items, and restrictions to out-of-cell time/movement. The Falcon team's understanding is that the conditions of confinement equate to Suicide Watch or RH with more than 22 hours per day in-cell. The daily evaluations tend to be brief and occur cell-side through the closed cell door. While it may vary by facility, generally an individual's RH time is deferred and cannot be run concurrent to a BOS placement.

44 CTDOC Correctional Health Services Unit Policy G 4.04 Behavioral Observation Status (BOS) Rev. 2/7/2024

The Falcon team reviewed BOS data that included 974 individual BOS orders for 694 individuals since January 1, 2022, as well as facility-level data for the period, including the number of BOS by facility, the number of individuals placed on BOS multiple times, and length of time between start and end of BOS orders. An initial assessment of BOS data indicated that 204 individuals were on BOS status over five days, and seven facilities averaged BOS stays over five days. However, BOS ALOS data were sourced from medical orders, signifying when BOS orders started and ended, which do not necessarily align with the actual time spent on BOS. For example, if an individual is placed on BOS and then transfers facilities, the order could remain open, in error. Thus, the actual ALOS for BOS could not be determined due to limitations in data availability.

Programmatic Intervention Cell (PIC)

PIC status "is intended to minimize stimulation and increase support/monitoring in order (to) increase services or regarding a change in presenting symptoms."[45] The status is typically implemented for individuals on a MH4 housing unit. PIC status typically occurs on an individual's existing MH4 unit in a cell recommended by mental health staff near to the officers' station. While there is a daily assessment and an unstructured treatment component, individuals maintained on PIC status for seven days shall be reviewed by the interdisciplinary treatment team for further care/treatment considerations including possible MH5/IPM admission. As this is a mental health practice, reliable data on PIC length of stay was not available due to this status being mental health based within the EHR and not within the CTDOC OMS. Based on discussion with mental health staff, the status is often used as a quick stabilization and preventative intervention without using the IPM. The staff has described this status as a "respite." Conditions of confinement generally include more than 22 hours in cell per day, dressing in a safety gown, and a cell that does not include a chair or desk stool. Some described this as roughly equivalent to the former CTQ.

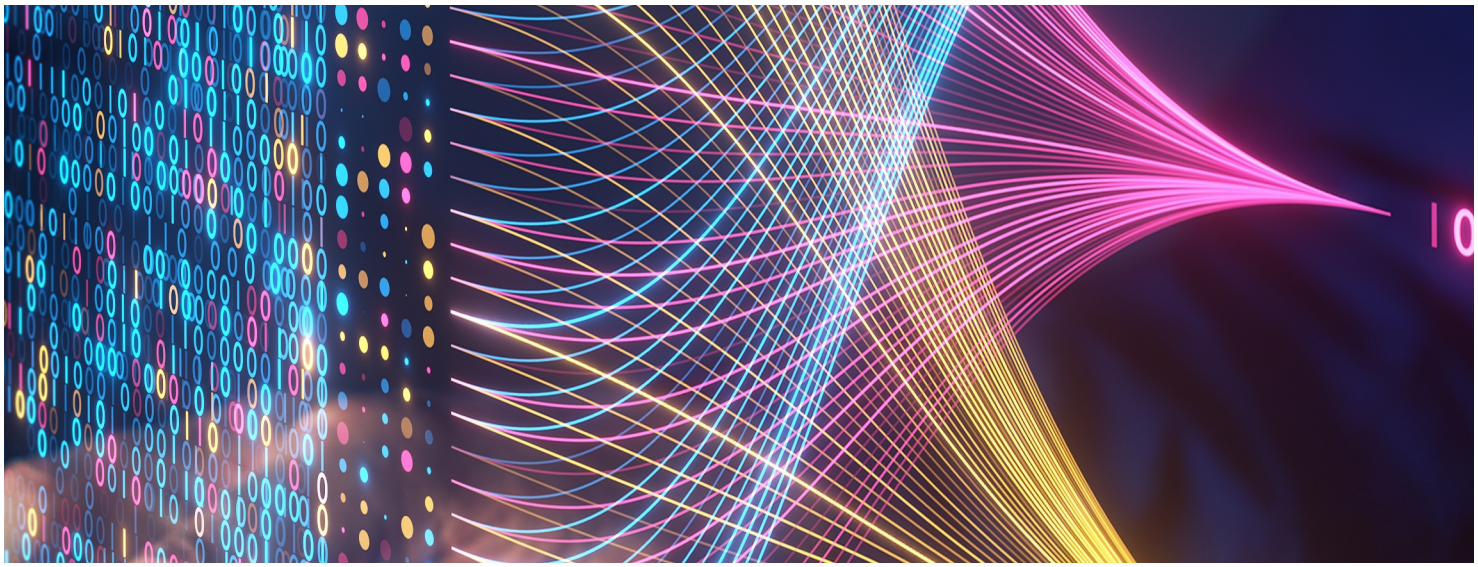
45 CTDOC Correctional Health Services Init Policy G 4.04a Programmatic Intervention Cell Stat Rev. 2/7/2024

SECTION 04:

Population Study

TOC
I. _____
A. ____
i. ___

Population Study - Section 4

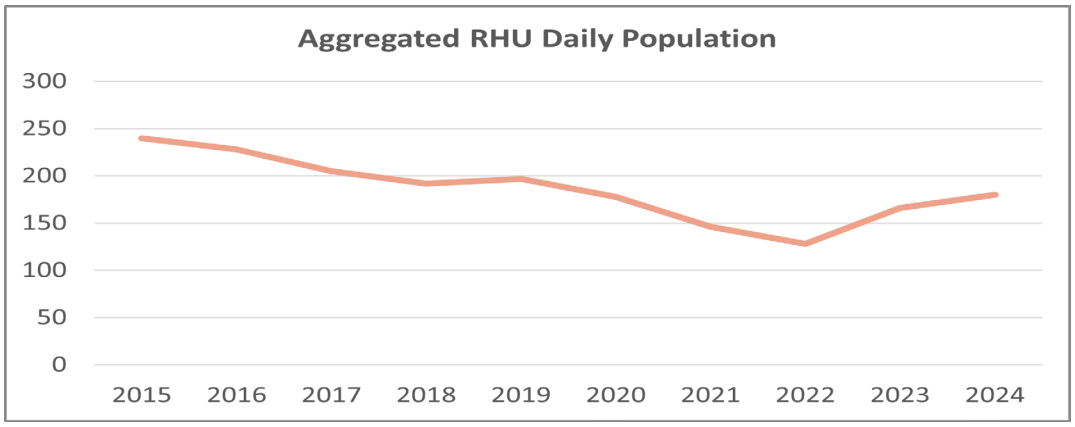


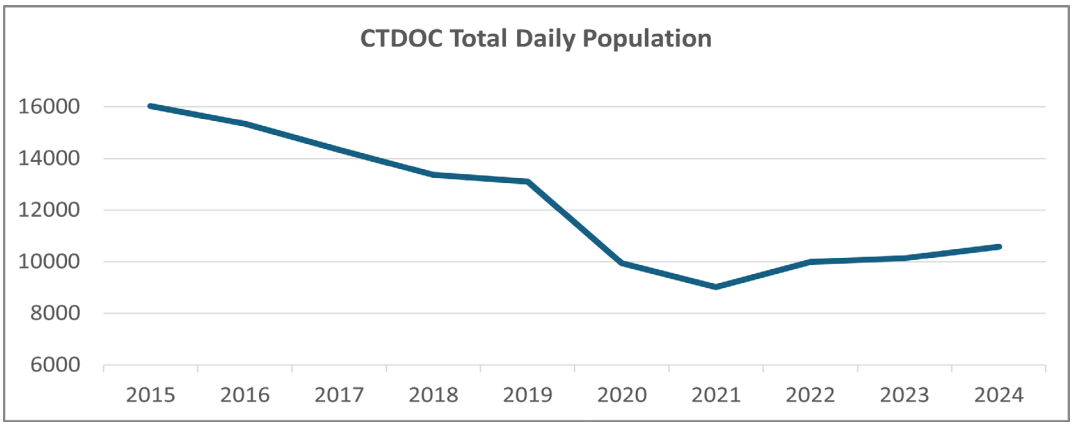
The Falcon team requested and received access to individual, facility, and system-wide data regarding populations placed in RH or otherwise separated from the GP (e.g., AS, PS, CD, BOS, etc.), most of which was provided for fiscal years 2015-2024. Demographic variables, mental health classifications, length of stay, and additional relevant data were analyzed to identify utilization patterns and trends in RH settings.

Population Size

Based on a review of system-level data and daily population snapshots for July 1, 2015-2024:

CTDOC has substantially reduced the total population over the past decade from 16,025 individuals in 2015 to 9,020 in 2021, with a slight uptick in the most recent two years to 10,584 on July 1, 2024. Likewise, CTDOC has also reduced the number of individuals placed in RH settings (AS, CD, and PS) over the past decade, again with an apparent trend reversal in 2023 and 2024.





A comparative analysis of the cumulative year-over-year changes in Total Population and RHU (AS, CD, and PS) Population demonstrates that the decrease in RHU population over the past decade has strongly correlated with Total Average Daily Population (ADP) (Correlation (r) = .80, p=.005), though the RHU population seems to have rebounded disproportionately to ADP in 2023 and into 2024. The following graph and table depict the close relationship between the RHU population and total ADP. Analysis of up-to-date and future data would be required to further clarify or confirm the apparent recent trend shift.

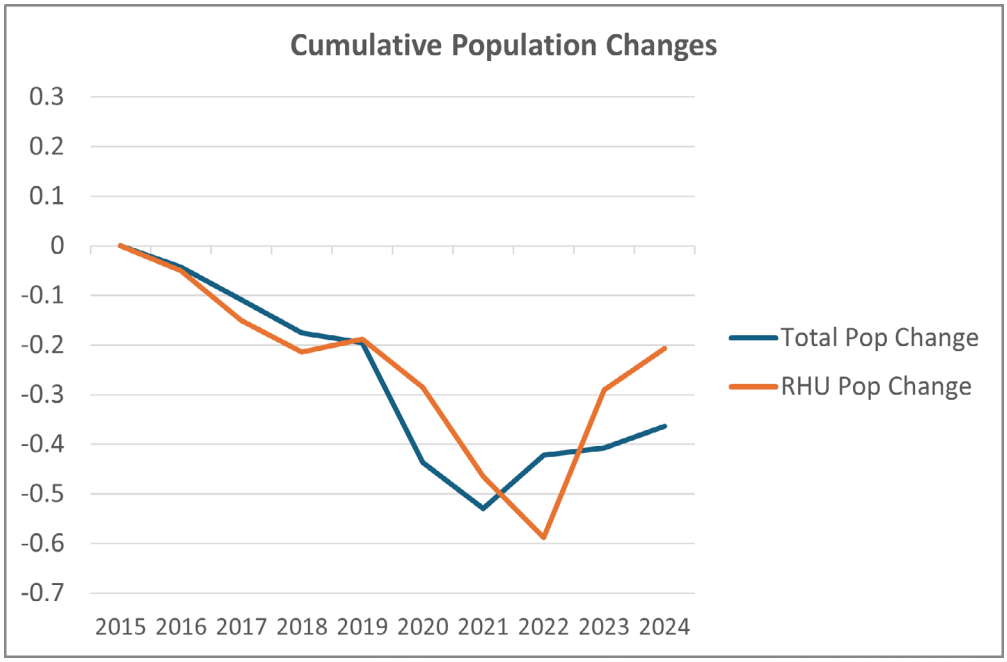


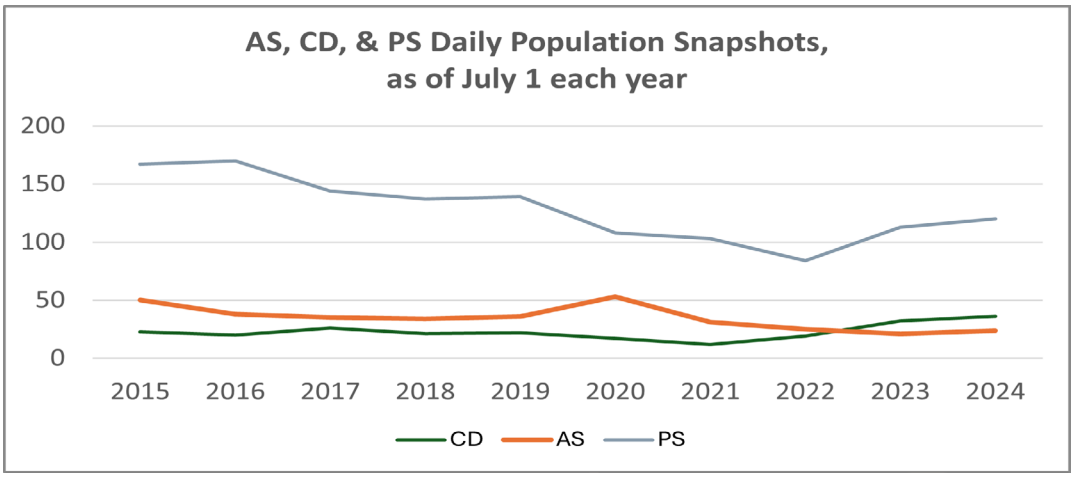
Table 1 RHU and TOTAL Population Reduction, 2015 - 2024						
	RHU Pop	Year-over-Year Change	Cumulative Change	Total Pop	Year-over-Year Change	Cumulative Change
2015	240	na	0.00%	16025	na	0.00%
2016	228	-5.00%	-5.00%	15342	-4.26%	-4.26%
2017	205	-10.09%	-15.09%	14335	-6.56%	-10.83%
2018	192	-6.34%	-21.43%	13371	-6.72%	-17.55%
2019	197	2.60%	-18.83%	13107	-1.97%	-19.52%
2020	178	-9.64%	-28.47%	9946	-24.12%	-43.64%
2021	146	-17.98%	-46.45%	9020	-9.31%	-52.95%
2022	128	-12.33%	-58.78%	9990	10.75%	-42.20%
2023	166	29.69%	-29.09%	10139	1.49%	-40.71%
2024	180	8.43%	-20.65%	10584	4.39%	-36.32%
*RHU population counts were pulled as a single day snapshot on July 1st of each year.						
** Total Population count is the fiscal year ADP for each year.						

Restricted Housing Population Composition, by Restrictive Status

Within RHU, the great majority of individuals are classified into PS. As of the July 1, 2024, snapshot, 120 individuals were placed in PS while 36 were placed CD and 24 in AS.

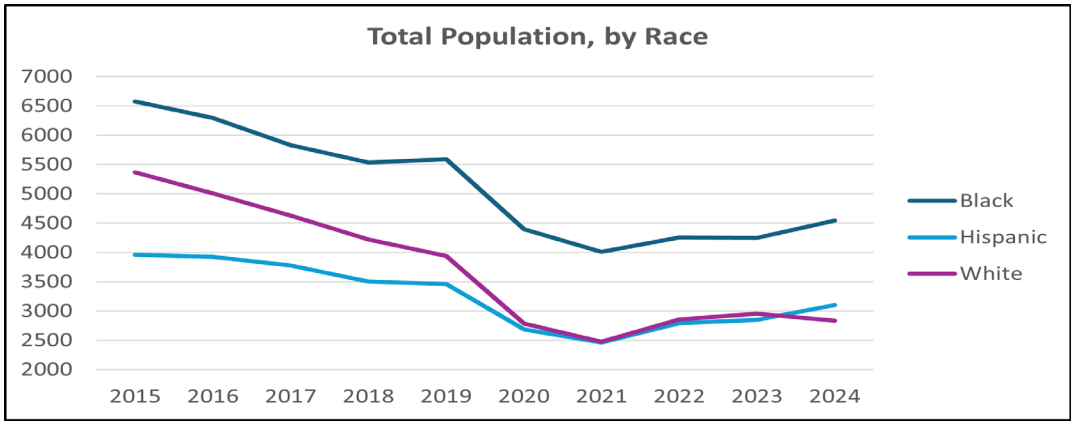
Table 2 Restrictive Housing Daily Population Snapshots, System-Wide											
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	Δ**
AS	50	38	35	34	36	53	31	25	21	24	-52.00%
CD	23	20	26	21	22	17	12	19	32	36	56.52%
PS	167	170	144	137	139	108	103	84	113	120	-28.13%
*Each population count was pulled as a single day snapshot on July 1st of each year.											
** Δ = percentage difference between 2015 and 2024 population size											

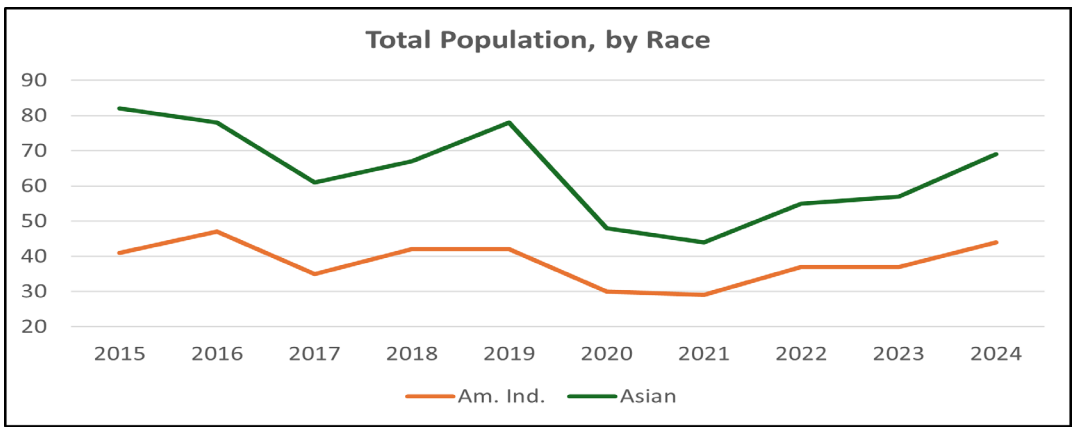
Shifts in the PS population size have closely mirrored the overall CTDOC and RHU-specific population trends over the past ten years. Yearly snapshot data demonstrate a 28.14% reduction in PS population overall but also indicate an apparent trend reversal in 2022. CD population size remained relatively consistent from 2015 to 2022, aside from a dip roughly 2020-2021, but has also increased in the past two years. In comparison, AS population size has reduced by 52.00% over the decade and has not rebounded to the same extent. Again, ongoing analysis of up-to-date and future data are warranted to clarify or confirm recent population trend shifts.



Restricted Housing Population Composition, by race

Based on a review of daily snapshot data for July 1st of each year 2015-2024, total population sizes for each racial group (White, Black, Hispanic, American Indian, and Asian) have generally reduced on trend with the overall population reduction. The two graphs below depict reductions in these populations, demonstrating a correlated trend. The graphs were broken out due to the significant difference in population size for American Indian and Asian populations, however, the general downward trend over the past decade, with an uptick since 2022, is consistent across populations. *Note: Racial groups and terminology used in this report were derived directly from the CTDOC data.*



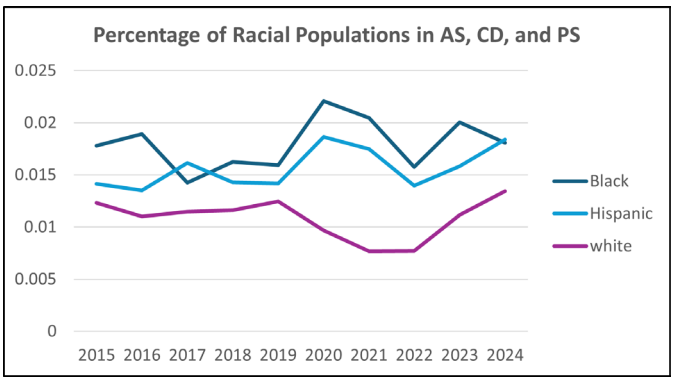


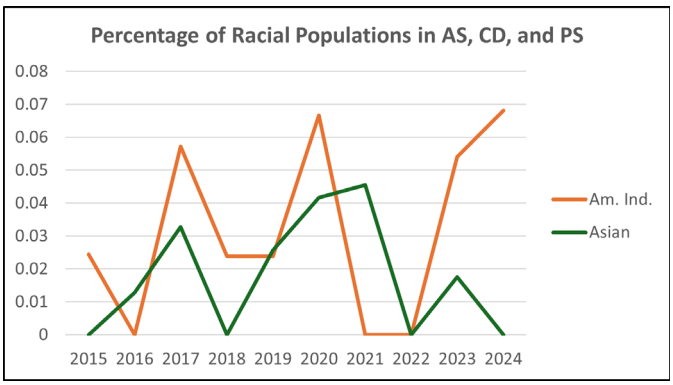
TOC
I. _____
A. _____
i. ____

SECTION 4: POPULATION STUDY

Direct analysis of the RH population composition is greatly impacted by the overall population size of each group. Because of the differences in overall population size distribution among the groups, a meaningful comparison of the racial composition of RH (AS, CD, and PS) required an assessment of proportional data versus raw data. Again, Daily Population Snapshot data for July 1st of each year was available for analysis. See Table 3a below for summary of analysis for all groups, and see Table 3b in Appendix B for full detailed analysis.

On average in the past decade, 1.11% (Min of 0.77% in 2021 and Max of 1.34% in 2024) of the overall White population was housed in RH, compared to 1.55% (Min of 1.86% in 2020 and Max of 1.35% in 2016) of the Hispanic population, and 1.78% (Min of 1.42% in 2017 and Max of 2.21% in 2020) of the Black population. Data for American Indian and Asian populations varied substantially more year-to-year but averaged 3.13% and 1.56%, respectively. Across groups, three-year averages were nearly equivalent to ten-year averages despite some year-to-year variability. Yearly data are depicted below, separated to improve clarity.





Group comparison analysis (ANOVA) of yearly data demonstrated a statistically significant mean difference ($\mu\Delta$) between White, Black, and Hispanic populations placed in RH ($F=29.088$, $p<.001$), such that on average, the percentage of White individuals was lower than that of Black individuals ($\mu\Delta$ = -.71%, $p<.001$) and Hispanic individuals ($\mu\Delta$ = -48, $p<.001$). While the proportion of Black individuals placed in RH was marginally higher than that of Hispanic individuals, the difference was not statistically significant.

Direct statistical comparisons for American Indian and Asian populations relative to Black, Hispanic, and White populations are not recommended and could be misleading, because of the significant difference in population sizes. Further, the low overall population size for American Indian and Asian populations results in significant variability in proportional data year by year. However, full data for each group is included in Tables 3a and 3b. Table 3a follows; Table 3b is in Appendix B.

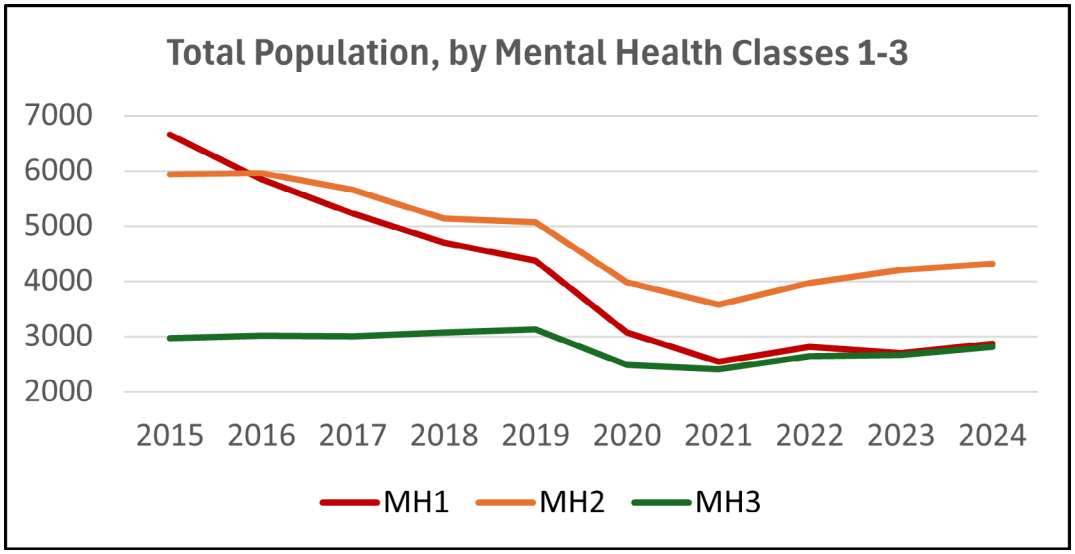
Table 3a
Population Snapshots and Comparison, by Race (Truncated)

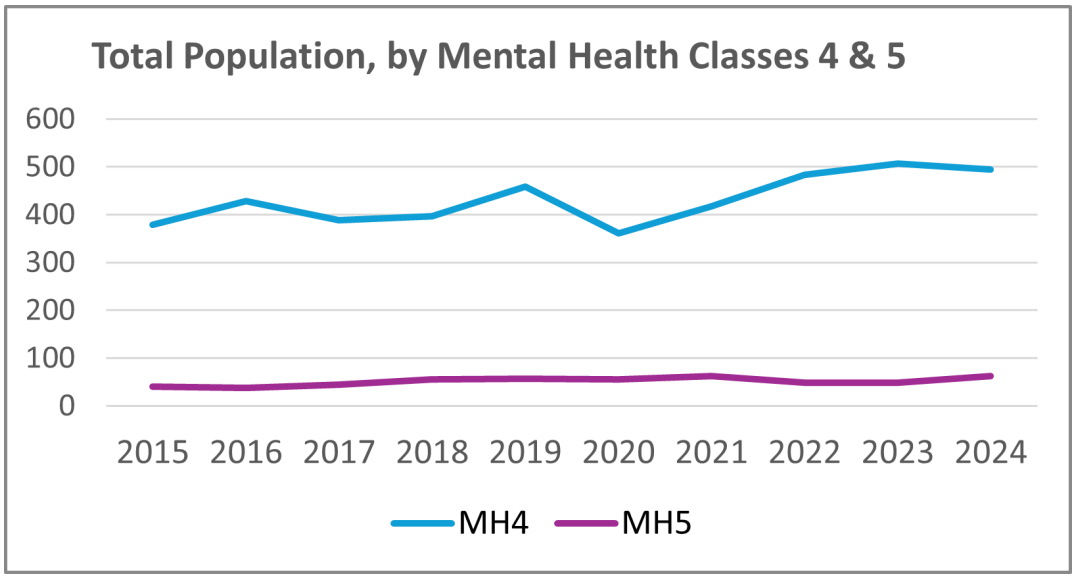
		2021	2022	2023	2024	10 year avg	3 year avg.
American Indian	RH Pop	0	0	2	3	1.2	1.67
	Total Pop	29	37	37	44	38.4	39.33
	% in RH	0.00%	0.00%	5.41%	6.82%	3.13%	4.24%
	% of RH	0.00%	0.00%	1.20%	1.67%	0.64%	0.96%
	% of Total Pop	0.32%	0.37%	0.36%	0.42%	0.32%	0.38%
	Raw Difference	-0.32%	-0.37%	0.84%	1.25%	0.32%	0.57%
	RH to Total Ratio	0.00	0.00	3.30	4.01	2.00	2.49
Asian	RH Pop	2	0	1	0	1	0.33
	Total Pop	44	55	57	69	63.9	60.33
	% in RH	4.55%	0.00%	1.75%	0.00%	1.56%	0.55%
	% of RH	1.37%	0.00%	0.60%	0.00%	0.55%	0.20%
	% of Total Pop	0.49%	0.55%	0.56%	0.65%	0.53%	0.59%
	Raw Difference	0.88%	-0.55%	0.04%	-0.65%	0.02%	-0.39%
	RH to Total Ratio	2.81	0.00	1.07	0.00	1.05	0.34
Black	RH Pop	82	67	85	82	91.1	78
	Total Pop	4009	4256	4245	4540	5127.3	4347
	% in RH	2.05%	1.57%	2.00%	1.81%	1.78%	1.79%
	% of RH	56.16%	52.34%	51.20%	45.56%	49.32%	49.70%
	% of Total Pop	44.45%	42.60%	41.87%	42.89%	42.28%	42.46%
	Raw Difference	11.72%	9.74%	9.34%	2.66%	7.05%	7.25%
	RH to Total Ratio	1.26	1.23	1.22	1.06	1.17	1.17
Hispanic	RH Pop	43	39	45	57	50.3	47
	Total Pop	2463	2791	2844	3099	3250.6	2911.33
	% in RH	1.75%	1.40%	1.58%	1.84%	1.55%	1.61%
	% of RH	29.45%	30.47%	27.11%	31.67%	27.40%	29.75%
	% of Total Pop	27.31%	27.94%	28.05%	29.28%	26.88%	28.42%
	Raw Difference	2.15%	2.53%	-0.94%	2.39%	0.52%	1.33%
	RH to Total Ratio	1.08	1.09	0.97	1.08	1.02	1.05
White	RH Pop	19	22	33	38	41.1	31
	Total Pop	2475	2851	2956	2832	3705.7	2879.67
	% in RH	0.77%	0.77%	1.12%	1.34%	1.11%	1.08%
	% of RH	13.01%	17.19%	19.88%	21.11%	21.42%	19.39%
	% of Total Pop	27.44%	28.54%	29.15%	26.76%	29.99%	28.15%
	Raw Difference	-14.43%	-11.35%	-9.28%	-5.65%	-8.57%	-8.76%
	RH to Total Ratio	0.47	0.60	0.68	0.79	0.71	0.69
	Total RH	146	128	166	180	186	158
	CTDOC ADP	9020	9990	10139	10584	12185.9	10237.67

**Each population count was pulled for July 1st of each year.*
*** % in RH: percentage of total individuals within each group currently housed in RH as of July 1 snapshot.*
**** Raw Difference: mathematical difference between the percentage of Total Pop and RH Population, for each group*
***** RH to Total Ratio: The ratio of the % of individuals housed in RH to the % of Total Population for each group*

Restrictive Housing Population Composition, by Mental Health Class

Overall, CTDOC has significantly reduced populations of individuals classified as MH1 and MH2 in the past decade, by 56.95% and 27.20%, respectively. These reductions also follow the general trend of year-over-year reductions in total population before leveling or reversing somewhat in 2021-2022. The MH3 population size, however, has reduced only marginally, by 5.42%, and the MH4 and MH5 populations have increased by 30.61% and 57.50%, respectively. Analysis of up-to-date and future data would be required to further clarify the potential trend shift for MH1-MH3. The two graphs below depict the shifts in these populations. To improve clarity, the graphs were broken out due to the significant difference in population size for MH4 and MH5 populations.

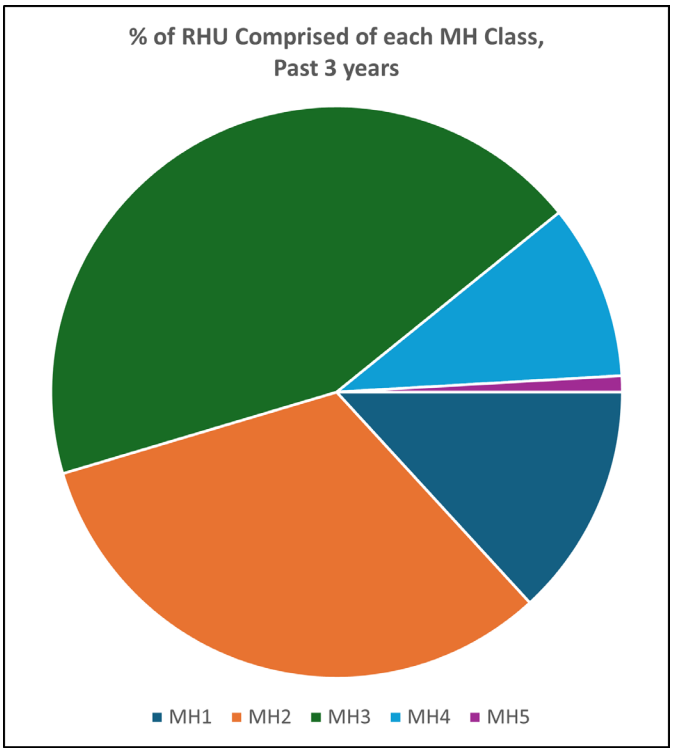




TOC
I. _____
A. _____
i. ____

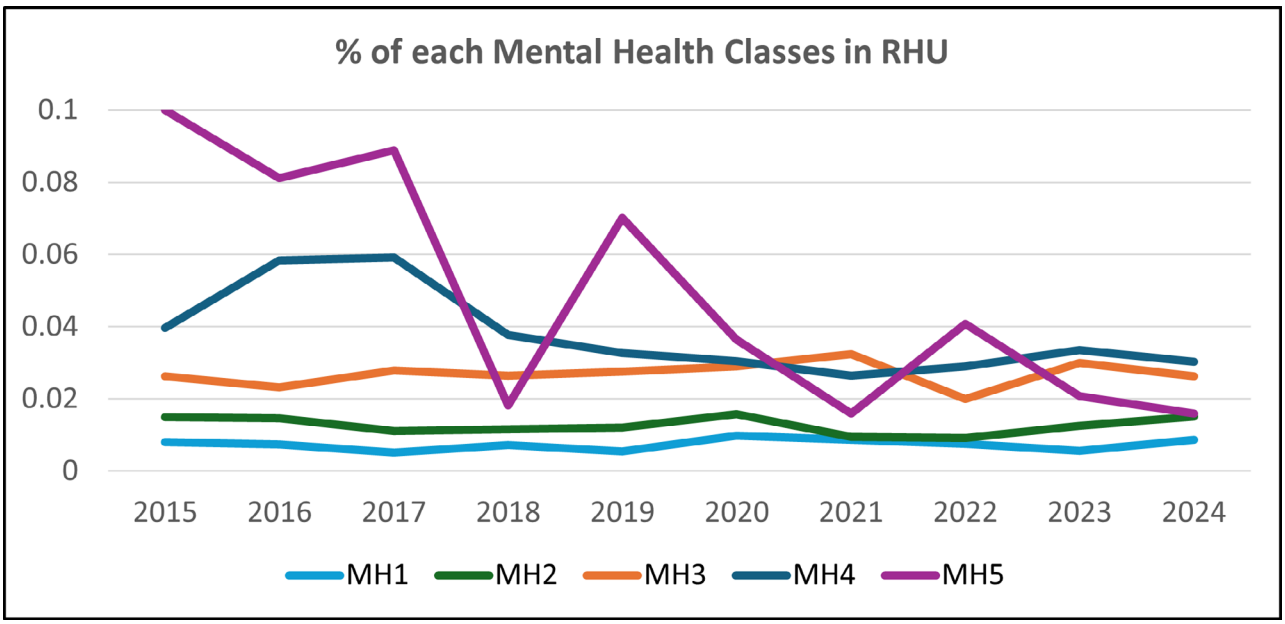
SECTION 4: POPULATION STUDY

An initial assessment of RHU population three-year averages indicated that almost half of individuals in RHU are classified as MH3 (43.57%), followed by MH2 (32.05%), MH1 (13.11%), MH4 (9.84%), and MH5 (0.91%). Critically, the data for these populations indicate that almost half of the population placed into RHU concurrently present with a "mild to moderate mental health disorder (or several mental health disorder under good control)" and an additional third of individuals have a "history of mental health disorder that is not currently active or needing treatment," per the departmental classification manual.



However, due to significant variability in overall population size distribution among the mental health groups, a meaningful comparison of trends in the mental health composition of RH over time requires assessment of proportional data versus raw data. Again, Daily Population Snapshot data for July 1st of each year were available for analysis.

Though the overall population of individuals classified as MH1 and MH2 has reduced significantly in the past ten years, the percentage of each group placed in RH has changed by only 9.58% and 0.03%, respectively. Similarly, while the overall population of MH3 classified individuals decreased slightly (5.41%), the percentage of MH3s placed in RH has not changed (.03% increase). However, the number of MH4 and MH5 individuals placed in RH have reduced substantially by 23.43% and 84.13%, respectively.



The sustainability of this trend is also demonstrated by aggregated data. That is, despite some year-to-year variability, three-year averages were near-equivalent to ten-year averages for MH1, MH2, and MH3 populations housed in RH. However, the three-year average for proportion of MH4 population placed in RH decreased by 17.99%, and the MH5 population decreased by 47.06%. See Table 4a below for summary of analysis for all groups, and see Table 4b in Appendix B for full detailed analysis.

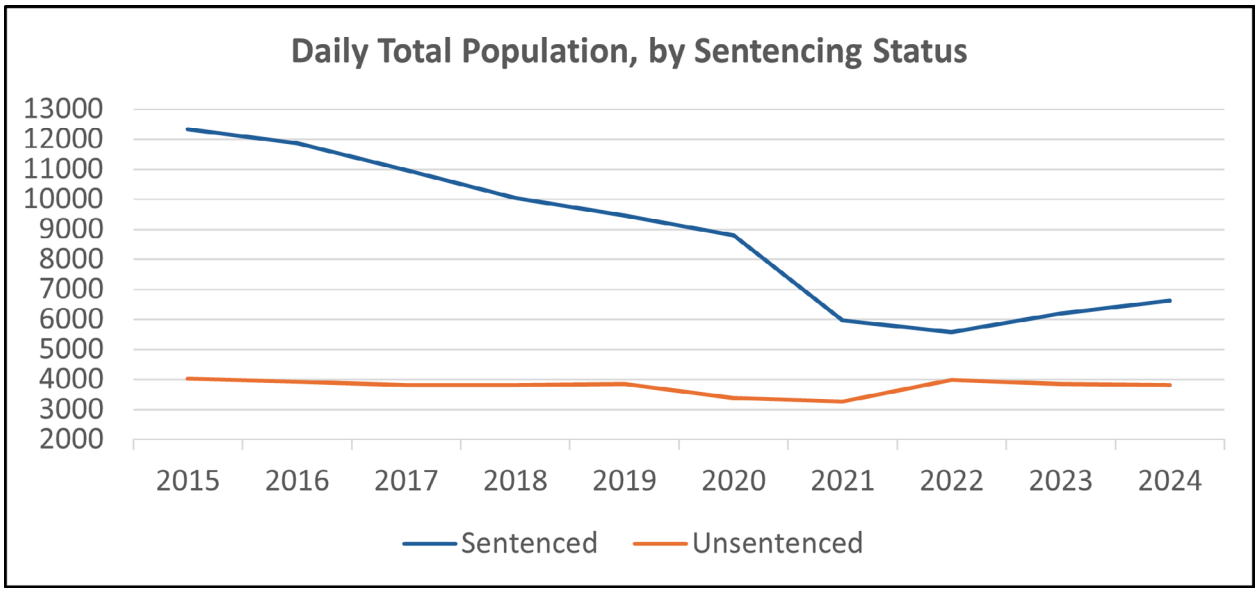
Table 4a. - Population Snapshots and Comparison, by Mental Health Classification (Truncated)

		2021	2022	2023	2024	10 year avg	3 year average
MH1	RH Pop	22	21	15	25	29.4	20.33
	Total Pop	2545	2815	2696	2863	4077	2791.33
	% in RHU	0.86%	0.75%	0.56%	0.87%	0.73%	0.73%
	% of RH	15.07%	16.41%	9.04%	13.89%	15.53%	13.11%
	% of Total Pop	28.22%	28.18%	26.59%	27.05%	32.54%	27.27%
	Raw Difference	-13.15%	-11.77%	-17.55%	-13.16%	-17.01%	-16.77%
	RH to Total Ratio	0.53	0.58	0.34	0.51	0.48	0.48
MH2	RH Pop	34	36	53	65	61	51.33
	Total Pop	3572	3964	4207	4320	4779	4163.67
	% in RHU	0.95%	0.91%	1.26%	1.50%	1.26%	1.22%
	% of RH	23.29%	28.13%	31.93%	36.11%	32.25%	32.05%
	% of Total Pop	39.60%	39.68%	41.49%	40.82%	39.40%	40.66%
	Raw Difference	-16.31%	-11.55%	-9.57%	-4.71%	-7.14%	-7.86%
	RH to Total Ratio	0.59	0.71	0.77	0.88	0.82	0.79
MH3	RH Pop	78	53	80	74	75.6	69
	Total Pop	2405	2645	2669	2810	2818	2708.00
	% in RHU	3.24%	2.00%	3.00%	2.63%	2.69%	2.54%
	% of RH	53.42%	41.41%	48.19%	41.11%	41.46%	43.57%
	% of Total Pop	26.66%	26.48%	26.32%	26.55%	23.68%	26.45%
	Raw Difference	26.76%	14.93%	21.87%	14.56%	17.78%	18.16%
	RH to Total Ratio	2.00	1.56	1.83	1.55	1.75	1.65
MH4	RH Pop	11	14	17	15	16.1	15.33
	Total Pop	417	483	507	495	432	495.00
	% in RHU	2.64%	2.90%	3.35%	3.03%	3.77%	3.09%
	% of RH	7.53%	10.94%	10.24%	8.33%	8.71%	9.84%
	% of Total Pop	4.62%	4.83%	5.00%	4.68%	3.71%	4.84%
	Raw Difference	162.97%	226.22%	204.80%	178.18%	5.00%	5.00%
	RH to Total Ratio	1.63	2.26	2.05	1.78	2.35	2.03
MH5	RH Pop	1	2	1	1	2.3	1.33
	Total Pop	63	49	48	63	51	53.33
	% in RHU	1.59%	4.08%	2.08%	1.59%	4.88%	2.58%
	% of RH	0.68%	1.56%	0.60%	0.56%	1.20%	0.91%
	% of Total Pop	0.70%	0.49%	0.47%	0.60%	0.45%	0.52%
	Raw Difference	-0.01%	1.07%	0.13%	-0.04%	0.76%	0.69%
	RH to Total Ratio	0.98	3.19	1.27	0.93	2.69	1.74
	Total RH	146	128	166	180	186	158
	Total Pop	9020	9990	10139	10584	12185.9	10237.67

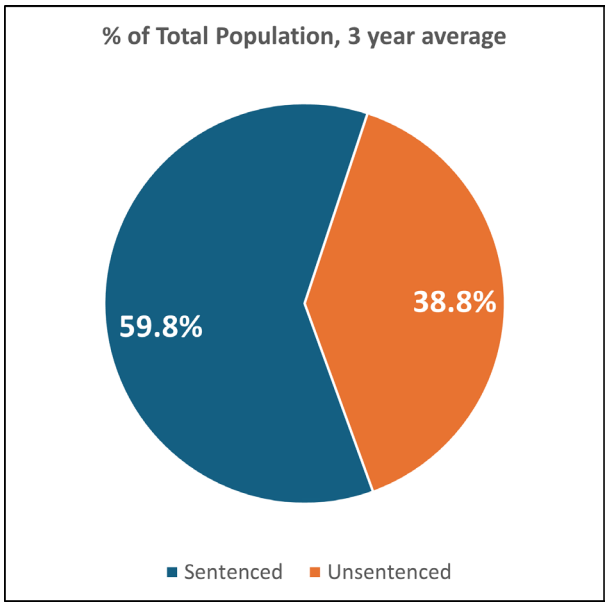
**Each population count was pulled for July 1st of each year.*
*** % in RH: percentage of total individuals within each group currently housed in RH as of July 1 snapshot.*
**** Raw Difference: mathematical difference between the percentage of Total Pop and RH Population, for each group*
***** RH to Total Ratio: The ratio of the % of individuals housed in RH to the % of Total Population for each group*

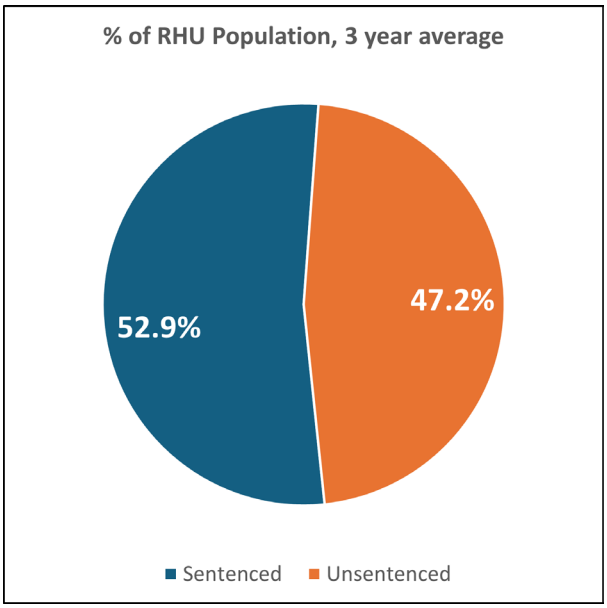
Restrictive Housing Population Composition, by Sentencing Status

Daily snapshot data from July 1st of each year 2015-2024 were analyzed to determine population trends by sentencing status. In 2024, the sentenced population comprised the majority (6,622, 62.57%) of individuals in CTDOC facilities. However, the gap has decreased over the past decade as the population of sentenced individuals has reduced by almost 50%, closely mirroring the reduction in total population, including the slight rebound in the past two years (Correlation (r) = .931, p<.001). In comparison, the unsentenced (i.e., pre-trial) population has remained nearly constant.



While the sentenced population still comprises a majority of the total population in CTDOC facilities, though to a lesser extent in more recent years, an assessment of RHU population three-year averages indicates that the RHU population is split almost equally.





That is, while the overall sentenced population has decreased, the number of sentenced individuals in RHU also decreased. However, while the unsentenced population remained largely constant over the past decade, the percentage of unsentenced individuals placed in RHU has nearly doubled. Again, ongoing analysis of up-to-date and future data are warranted to clarify or confirm recent population trend shifts. See table 5a below for summary of analysis for all groups, and see Table 5b in Appendix B for full detailed analysis.

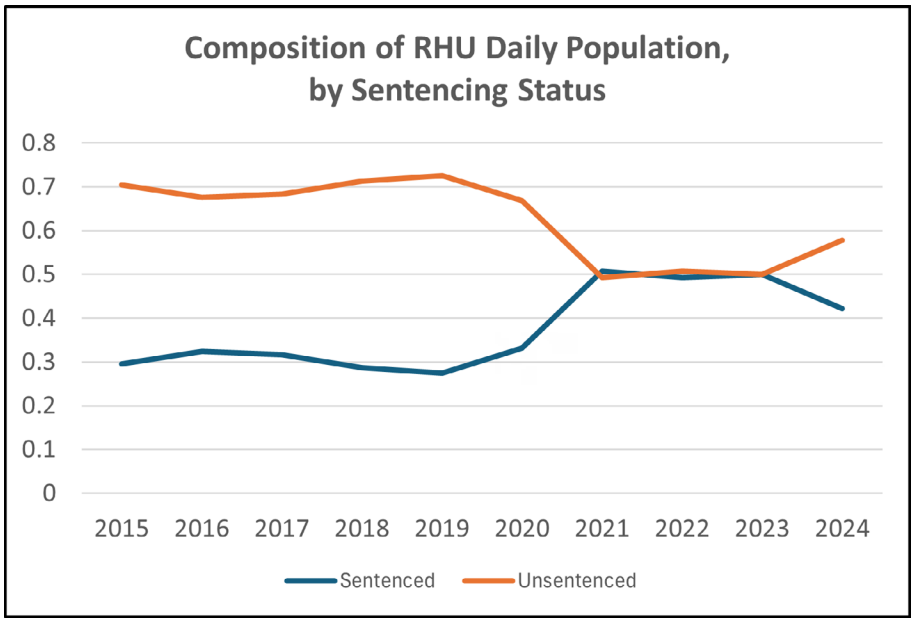


Table 5a.
Population Snapshots and Comparison, by Sentencing Status (Truncated)

		2021	2022	2023	2024	10 year avg	3 year average
Unsentenced	RH Pop	74	63	83	76	74	74.00
	Total Pop	3264	3986	3847	3813	3728	3882
	% in RHU	2.27%	1.58%	2.16%	1.99%	2.00%	1.91%
	% of RH	50.68%	49.22%	50.00%	42.22%	48.03%	47.15%
	% of Total Pop	36.19%	39.90%	37.94%	36.03%	37.51%	37.96%
	Raw Difference	14.50%	9.32%	12.06%	6.20%	10.52%	10.52%
	RH to Total Ratio	1.40	1.23	1.32	1.17	1.28	1.24
Sentenced	RH Pop	72	65	83	104	81	84.00
	Total Pop	5964	5576	6198	6622	6090	6132
	% in RHU	1.21%	1.17%	1.34%	1.57%	1.32%	1.36%
	% of RH	49.32%	50.78%	50.00%	57.78%	51.97%	52.85%
	% of Total Pop	66.12%	55.82%	61.13%	62.57%	61.41%	59.84%
	Raw Difference	-16.80%	-5.03%	-11.13%	-4.79%	-9.44%	-9.44%
	RH to Total Ratio	0.75	0.91	0.82	0.92	0.85	0.88
	Total RH	146	128	166	180	155	158
	Total Pop	9020	9990	10139	10584	12186	10238

**Each population count was pulled for July 1st of each year.*
*** % in RH: percentage of total individuals within each group currently housed in RH as of July 1 snapshot.*
**** Raw Difference: mathematical difference between the percentage of Total Pop and RH Population, for each group*
***** RH to Total Ratio: The ratio of the % of individuals housed in RH to the % of Total Population for each group*

SECTION 05:

Neuroscience Effect of Trauma and Incarceration

Neuroscience Effect of Trauma and Incarceration - Section 5

When reviewing a system's disciplinary, RH, and related practices, an understanding of neuroscience, as related to trauma and incarceration, is informative to fully understand the experience of incarcerated individuals within a system like CTDOC's.

Incarcerated people have a much higher incidence of concussions or traumatic brain injury than do people in the GP.[46] Estimates place the prevalence of traumatic brain injury among incarcerated people at approximately 50% to 75%.[47] [48] In addition to concussions and traumatic brain injuries, incarcerated people have experienced physical, sexual, and emotional abuse at high rates as well. It is estimated that 68% of incarcerated males and 80% of incarcerated females have experienced physical or sexual abuse.[49]

Neuroscience Effect of Trauma and Incarceration

- Neuroscience Impact of RH.
- Experience of those who are incarcerated.
  - Lack of programming.
- Experience of Correction Professionals.
  - Emphasis on tools and deterrence.

Brain injuries and psychological trauma (physical, sexual, emotional abuse) have identical effects on brain function.[50] These effects include (among other things):

46 de Geus EQJ, Milders MV, van Horn JE, Jonker FA, Fassaert T, Hutten JC, Kuipers F, Grimbergen C, Noordermeer SDS. Acquired Brain Injury and Interventions in the Offender Population: A Systematic Review. Front Psychiatry. 2021 May 7;12:658328. doi: 10.3389/fpsyt.2021.658328. PMID: 34025480; PMCID: PMC8138134.

47 Ibid.

48 Centers for Disease Control, 2024. TBI and Correctional Facilities: Traumatic Brain Injury and Concussions. www.cdc.gov/traumatic-brain-injury/health-equity/correctional-facilities.html.

49 https:www.ojp.gov/pdffiles/fs000204.pdf. Words From Prison – Did You Know...? | American Civil Liberties Union (aclu.org).

50 Bremner JD. Traumatic stress: effects on the brain. Dialogues Clin Neurosci. 2006;8(4):445-61. doi: 10.31887/DCNS.2006.8.4/jbremner. PMID: 17290802; PMCID: PMC3181836.

- Difficulty sleeping.
- Difficulty controlling behavior.
- Difficulty communicating.
- Difficulty regulating or controlling emotions.
- Difficulty with thinking, memory, and attention.
- Irritability, anger, or impulsive behavior.
- Difficulty learning.
- Physical symptoms like headaches, ear-ringing, difficulty with balance.
- Suicidality.
- Depression, low self-esteem.
- Difficulty with motor skills and speech.
- Sensitivity to light or sound.
- Difficulty with organization or planning.[51]

Clearly, people who enter correctional facilities for committing crimes do so, at least in part, because of brain and psychological trauma that have resulted in difficulty controlling their behavior and emotions. They are often impulsive, angry, and react to perceptions of failure and disrespect.

Once incarcerated, the effects of prior trauma - as well as adjusting to the stressful correctional environment - continue to influence the person's functioning and behavior, as noted above.

Essentially, people who become incarcerated bring significant histories of trauma to the initial incarceration, and the trauma and symptoms are only increased during incarceration and the transition back to the community. Beginning with the arrest, the person's sympathetic nervous system (fight or flight or freeze system) is activated. Then the difficult aspects of court, conviction, transfer and intake to prison, along with the effects of living in the traumatic prison environment and returning to the community only compound the trauma and drive the symptoms discussed earlier. The reduction in behavior and emotional regulation, impulsivity, and difficulty in planning set the person up for greater likelihood to offend again and return to prison.

Neuroscience Impact of Restrictive Housing

All the elements of trauma that have been experienced before and during incarceration can be exacerbated when the individual is confined to RH. The person experiences the sympathetic nervous system (fight/flight/freeze) activation when they are charged with a rule violation or crime within the prison. The DP inside the prison mirrors that of the trial process before incarcerated, which is stressful and traumatic in its own right. When an incarcerated person has been "convicted" during the internal DP, the next step is in many systems is to go to an RHU, or what is often called the "jail within the jail." The conditions in the RHU are austere, with many of the features that exacerbate poor brain function.

A review of the conditions follows:

Lighting. As noted, people who are incarcerated often have histories of concussive or traumatic brain injuries, which frequently result in light sensitivity. Fluorescent and other artificial lights in RHUs, therefore, can increase headaches, anxiety, agitation, dizziness, balance problems, and other difficulties.[52] It is well known in the architectural field that the use of natural lighting is important in the design and operation of correctional facilities because natural lighting diminishes many of the symptoms from concussions and traumatic brain injuries,[53] however, few external windows are found in RHUs.

Sound. Incarcerated people with histories of brain injuries and trauma are often sound sensitive, and experience pain and discomfort with even normal levels of noise. Most RHUs are noisier than GP units, with yelling and banging on cell doors, pipes, bunks, or anything else that can agitate vulnerable individuals. This noise generation intensifies

51 TBI and Correctional Facilities | Traumatic Brain Injury & Concussion | CDC

52 https://www.optometrists.org/vision-therapy/neuro-optometry/vision-and-brain-injuries/traumatic-brain-injury-and-neuro-optometry/light-sensitivity-after-a-brain-injury/

53 H. Salonen, M. Lahtinen, S. Lappalainen, N. Nevala, L.D. Knibbs, L. Morawska, K. Reijula Physical characteristics of the indoor built environment that affect health and wellbeing in healthcare facilities: a review. Intell. Build. Int., 5 (1) (2013), pp. 3-25.

symptoms of trauma and mental illness.

Absence of biophilic building elements. Biophilic design recognizes the importance of placing plants in the built environment, the presence of nature murals, and the ability to see outside to nature and green places.[54] As with light and sound, prison administrators have not known about the importance of biophilic design for those with histories of brain injuries. As such, RHUs have incorporated the worst elements of design, making these units places where mental health, physical health, and brain function deteriorate.

With a basic understanding of neuroscience and trauma, we can view the experiences and behaviors of incarcerated individuals – and those further confined in RHU settings and/or in-cell restraints – as something beyond disobedience or volitional misconduct to better inform assessments, systemic responses, and interventions.

54 Turning over a new leaf: The health-enabling capacities of nature contact in prison. Moran, Dominique, Turner, Jennifer. Social Science & Medicine, 231. (2019).

SECTION 06:

Key Observations

TOC
I. _____
A. ____
i. ___

Key Observations - Section 6

During the study period, the Falcon team was able to engage multiple stakeholders within and outside of the CTDOC to develop a well-rounded impression of the system and culture with a specific focus on the experience of discipline and restrictive settings. Stakeholders represented current staff, the currently incarcerated, several formerly incarcerated,[55] and specific CTDOC employees in leadership, security, and mental health roles, as well as those in advocacy and special interests.

The interactions during site visits, workshops, and meetings enhanced the team's understanding and interpretation of available policies and data to develop key observations, opinions, and feasible recommendations.

Leadership & Governance Structure

Vision & Mission

CTDOC senior leaders recognize the evolving nature of correctional practices, embrace the issue of RH reforms, and represent as flexible and adaptable. Specifically, the CTDOC swiftly responded to the Executive Order and Protect Act requirements and requested the current study. Similarly, site leadership is generally in sync with RH-related changes with expectations for additional reforms. Supporting forward movement, many quantitative advancements related to length of stay in RHUs and time out-of-cell have been achieved, as well as the closure of the Northern Correction Institution and the stepwise limitation of in-cell restraints. Qualitative enhancements, such as expanded, meaningful, and effectual programming and treatment, on the other hand, have not been realized.

Culture

CTDOC is interested in transitioning from a traditional prison system to one that employs progressive and rehabilitative principles such as normalizing the prison experience, utilizing dynamic security principles used in Norwegian prisons,[56] and actively identifying and minimizing the effects of trauma that incarcerated people experience. The Department is working with a number of external entities, such as UConn, Amend,

55 *Note: The formerly incarcerated were members of the CT Correction Advisory Committee and experiences in CTDOC were not always relative to more recent and current CTDOC practices.*

56 Kilmer, A., Abdel-Salam, S., & Silver, I. A. (2023). "The Uniform's in the Way": Navigating the Tension Between Security and Therapeutic Roles in a Rehabilitation-Focused Prison in Norway. Criminal Justice and Behavior, 50(4), 521-540.

Falcon and several state level special interest groups to help make the transition.

A consistent observation throughout Falcon's extensive evaluation is the Department's reliance on categorizing and implementing processes with little individualization in both correctional practices and mental health services. Interested in the staff experience, the Falcon team gathered that correctional staff often feel burned out and overwhelmed with a lot of messages and initiatives coming to them. They feel that the tools to address and curb behavior are being altered, such as the in-cell restraints and disciplinary system operations such as 9510 Mental Health Disciplinary Review process related to dismissals of DRs.

In fact, the concept of preventing offenses and DRs seemed quite foreign to facility staff at the mid-management and line staff levels. Though the Falcon team heard from several correction officers who reported a wish for more mental health staff and support, there was an expressed sentiment that incarcerated individuals are empowered secondary to the Protect Act. Some staff described this as "a tough pill to swallow" though this openness does provide an opportunity to more optimally communicate as initiatives are developed and implemented.

Amend / UConn Overview

Amend[57] is a nonprofit public health and human rights program that works in prisons to reduce their debilitating health effects on residents and staff. They facilitate the training of U.S. corrections officers by having them travel to Norway and other jurisdictions in the U.S. to observe dynamic security practices. The CTDOC has partnered with the UConn Institute for Municipal and Regional Policy (IMRP) to bring Amend staff training into two facilities (GCI and YCI) as a pilot to improve staff wellness and reduce violence through dynamic security principles. Amend has partnered with the Norwegian Correctional Service to import such principles to U.S. prisons. The work is intended to reduce the frustration and negative experiences of correction officers as they shift from not just controlling (e.g., meals, showers, movement) and participating in disciplinary actions to assisting incarcerated individuals in preparing for a return to the community.

Amend's approach in CTDOC is high level - to introduce ideas and concepts about a different way to work. While Amend may not establish a long-term relationship with CTDOC, their interest is to expose staff to progressive principles and to empower UConn to facilitate changes that impact the Department. Amend is attuned to the staff experience at CTDOC - that staff feels blamed, that there seems to be a scarcity of rapport and trust with leadership, and that the Department wants to take safety and security tools away from them.

With Amend focused on the ground level to provide ideas and exposure to principles and values, and less involved with Departmental leadership, it is questionable how the movement to dynamic security principles will be implemented and sustained without a dedicated project management and oversight structure.

Project Governance

The CTDOC can benefit from more robust and intentional project governance to align special to efficiently manage project activities and resources that are efficiently managed and produce desired deliverables within desired acceptable timeframes. Effective governance structures establish clear lines of authority and reporting, clarify roles and responsibilities, structure decision-making processes, improve communications and stakeholder alignment, and provide project controls and accountability.

The Department previously had a Best Practices Unit (BPU) that worked to promote evaluation and results-based policies and practices. But special projects – such as the revamping of the CD and AS Programs, integration of the Amend pilots at GCI and YCI, and implementation of the Falcon recommendations – are likely to produce higher quality and more sustainable results with a clear governance and project management framework in place.

57 https://amend.us/

Communication & Stakeholder Engagement

Relationships between departments of correction and public advocacy groups and legislators are often characterized by divergent interests, varying priorities, and misunderstandings. These difficulties are often about the complexities of budgetary constraints, policy and procedures, the requirements and priorities of labor unions, organizational culture and best practices, and mandates around public safety. Important outcomes from well-organized advocacy initiatives and proactive working relationships with the Department will require higher levels of system inquisitiveness, critical thinking, adaptive responses to evolving realities, accountability, social justice awareness, and enhanced civic engagement.

Falcon consistently finds that it is difficult to communicate the plan and process of organizational changes internally and externally, especially when systems are in the earlier stages of transformation. Providing a detailed implementation roadmap to follow greatly increases the effectiveness of the process and reduces the angst that staff feel as they are learning to view corrections and their profession differently. Having champions of the process in administration, custody operations, medical services, mental health services, case management, classification, inmate programs and services, data collection, research, and public information greatly facilitate the process and help it succeed.

The CTDOC created no barriers to Falcon's engagement of advocacy with legislative and other special interest groups. These engagements, which occurred in October and November of 2024, included virtual workshops with representatives from:[58]

- CT Office of Policy and Management: Criminal Justice Planning Division
- CT Office of the Child Advocate (OCA)
- Stop Solitary CT
- CT Correction Advisory Committee
- UConn IMRP
- Yale Law School

The Falcon team detected a general mistrust of CTDOC from public advocacy groups with a reliance on legislative solutions as opposed to collaboration with CTDOC. While the work to date has been somewhat effective in raising public awareness and generating interest in RH requirements, the resulting relationships do not optimally facilitate RH-related reform that would include the Department's operational expertise in developing standards, operations, and monitoring.

The tone of the relationships between the Department and individual stakeholder groups varies, ranging from highly collegial to acutely strained. Nevertheless, some public advocacy and special interest group stakeholders are aligned with the CTDOC in several critical areas: the safety and rehabilitation of individuals who are currently incarcerated, the promotion of successful re-integrations into the community, and the importance of effective programming.

A commonly expressed concern is the limited planned engagement with the CTDOC leadership as well as limited data sharing and ongoing meetings with senior and executive leadership. The Falcon team believes that CTDOC is responsive to requests but that neither the groups nor CTDOC meet in proactive forums that would address the RH dilemmas and other aspects of the system.

Staffing & Staff Development

Custody staffing has increased in recent years to align with an evolving incarcerated population residing within the CTDOC that presents higher risk and more acute clinical needs. However, recruitment and retention issues are a challenge for CTDOC as they are for many state systems.

It is noteworthy that de-escalation and Substance Abuse and Mental Health Services Administration (SAMHSA) trauma training have been made available

58 Falcon extended invitations to meet with the ACLU of Connecticut, Connecticut Hall of Change, Ombuds, and the Connecticut Sentencing Commission, however, the organizations did not accept the invitation or did not respond to the invitation.

to custody and healthcare professionals. The CTDOC has provided additional professional development opportunities for select professionals, allowing groups to visit other state and international prison systems with exemplary correctional practices, including visits to facilities in Washington State, Oregon, and Norway. Those who participated in the visits were inspired and accepted normative principles for the care of incarcerated individuals.

The CTDOC's procedure for selecting and assigning correction officers to RHUs is well intended. Officers are reviewed for competency and temperament as part of the selection process and are required to have worked within the Department for a minimum of two years. Qualified officers are assigned to RHUs where enhancements to existing training should be made to include Amend and other principles that reflect a more rehabilitative approach to discipline and RH.

Operations

Classification

A clear process of assessment and re-assessment is critical to align an individual's custodial, treatment, and programming needs – to provide an incarcerated experience most conducive to rehabilitation. The rehabilitation ideal is best achieved when jurisdictions incorporate principles of risk, need, responsivity, and possible overrides to the classification system.

Classification is initially conducted at intake and then every six months until the individual is sentenced. If this duration is less than five years, reclassification is conducted every six months. If the duration is greater than five years, the reclassification is conducted once a year. The CWG reports that approximately 50% of its total population is assigned to Maximum Security, 25% to Medium Security, and 25% to Minimum Security or other housing.

The CTDOC has been using the same classification scoring tool (used for both men and women) for over 30 years, which has not been re-validated since implementation. The use of classification overrides is rare and typically used for medical reasons. There are five levels to the classification system, with five reflecting the highest security need.

Discipline Process

CTDOC can benefit from refinements to its disciplinary system that will provide a more rehabilitative approach to operations. The cumulative impact of a RH placement, along with disciplinary penalties and sanctions, can have a significant impact on individuals. While it varies across facilities, it is common for individuals to lose work and programming opportunities secondary to DR sanctions, potentially triggering RHU returns. Since most individuals are in RH for non-violent acts, there is an opportunity to safely introduce rehabilitative responses for this cohort.

CTDOC's use of informal disposition offers flexibility in the DP. The use of informal disposition, however, varies across facilities. It is important to have clear criteria and supervision outlining and monitoring the appropriate use of informal disposition.
Falcon's assessment: informal disposition allows for reasonableness, an appreciation of context, and an assessment of individual factors within the DP as a potentially effective tool in helping to regulate an individual's behavior and maintain a safe environment. A tracking and review process, however, must exist to assure fidelity.

Restrictive Housing

CTDOC has demonstrated a willingness to rethink its RH System and practices, already reducing the length of stay in most RHUs and increasing time of out cell. While CTDOC has excellent examples of facilities (e.g., YCI, Corrigan, MYI) with a risk-need-responsivity approach to the discipline process, these principles are not universally applied throughout the system.[59] The Risk-Need-Responsivity (RNR) model[60] supports matching a level of service to the individual's risk of reoffending based on static and dynamic factors with an assessment to determine the intensity of treatment tailored to the individual.

59 As evidenced in facilities' programming and/or incentive frameworks, specifically evident in (but not limited to) Chronic Discipline, Worth Unit, Reflection, Accountability, Mediation Program (RAMP).

60 https://info.nicic.gov/transition-jail-community/module-5-targeted-intervention-strategies/section-2-risk-need

Out-of-Cell Time

CTDOC has made progress in the quantifiable areas of RH beyond the 2022 Protect Act and adoption of Isolated Confinement practices. This progress includes a much lower number of individuals in a formal RHU setting, the provision of at least two hours of out-of-cell time, and RHU confinement that generally does not exceed 15 consecutive days (though several outliers were identified through data review). Qualitative areas such as programming, treatment, relapse prevention, meaningful in and out-of-cell programming, tone of interactions and a non-reactive approach, and personal item access have not been realized.

Out-of-cell time is tracked differently across facilities, and all officers are supposed to log if an individual accepts, refuses, or returns to his/her cell early. Out-of-cell time is tracked manually through officer logbooks.

Architecturally, older facilities were not built to meet these out-of-cell time requirements. RHUs in particular were not built for meaningful congregate activity. The newest CTDOC facilities were built 30 years ago, predating major philosophical and operational paradigm shifts. CTDOC facilities have added separation barriers in recreation yards to accommodate more time out-of-cell for security level 4 and 5 facilities. The quality and quantity of these recreation spaces varies by facility; they generally do not include seating.

Faced with similar architectural challenges, the Washington State Department of Corrections has implemented a proof-of-concept model, aimed at reducing the use of solitary confinement,[61] with a strong focus on increasing meaningful out-of-cell time through structured congregate activities, requiring the updating of recreational spaces, procurement of programming chairs, and enhanced staffing to support increased movement within RHUs.[62]

In-Room Restraints

In-room restraint is part of a larger behavioral health management philosophy and process that is most often labeled "Seclusion and Restraint" (SR) in the professional literature. SR was commonplace in public and private psychiatric (and other) hospitals in the United States and other countries until the late 1990s and early 2000s. Seclusion is defined in the literature as, "a control measure that confines an individual to a location for a specific period of time and from which the person may not leave freely." Restraint is defined as, "a control measure that consists in preventing or limiting a person's freedom of movement by using human strength, any mechanical means or by depriving the person of an instrument used to offset a handicap."[63]

SR has largely been eliminated from psychiatric or other hospitals because of the universally acknowledged negative physical and emotional outcomes from its use (most of the professional literature documenting the harmful effects were published in the late 1990s and early 2000s).[64] Most of the current literature discussing SR is found in studies done in adolescent mental health facilities, which is where the practice continues, albeit minimally. In fact, the professional literature has deemed SR "an intervention of last resort."[65]

61 Defined by the Washington State Department of Corrections as an operational status in restrictive housing where the individual is confined to a single-occupancy cell for more than 20 hours a day without meaningful contact, out-of-cell activities, or opportunities to congregate.

62 Washington State's 2023 Solitary Confinement Transformation Project: Requirements for Sustainable Reduction Plan can be found here Solitary Confinement Transformation Project Plan.

63 Post-Seclusion and/or Restraint Review in Psychiatry: A Scoping Review, Goulet, Marie-Hélène, Larue, Caroline, Archives of Psychiatric Nursing, 30(1), 2016m https://doi.org/10.1016/j.apnu.2015.09.001

64 E.M. Weiss, D. Altimari, D.F. Blint, K. Megan Deadly restraint: A nationwide pattern of death. Hartford Courant (11998); G. Bonner, T. Lowe, D. Rawcliffe, N. Wellman Trauma for all: A pilot study of the subjective experience of physical restraint for mental health inpatients and staff in the UK. Journal of Psychiatric and Mental Health Nursing, 9 (2002), pp. 465-473; W.A. Fisher, Elements of successful restraint and seclusion reduction programs and their application in a large, urban, state psychiatric hospital, Journal of Psychiatric Practice, 9, (2003), pp. 7-15 (doi: 00131746-2003010000-00003 (pii))

65 Worker and perceived team climate factors influence the use of restraint and seclusion in youth residential treatment centers: Results from a mixed-method longitudinal study, Geoffrion,

It is difficult to find any research or professional literature discussing the use of in-room restraints in correctional facilities, because it is such a rare event. Human Rights Watch published a report in 2015 entitled, "Callous and Cruel: Use of Force Against Inmates with Disabilities in U.S. Jails and Prisons," which discussed the use of force with inmates in the following statement:

> U.S. court rulings, human rights standards, and corrections experts agree that staff should use force only when necessary, should use only the minimum amount of force necessary, and should use force only for so long as is necessary to attain a legitimate objective.[66]

There has been a lot of litigation surrounding the use of in-room restraints throughout the country over the last few decades.[67] Although in-room restraints are not illegal per se, they are highly disfavored, and their incorrect use raises legal risks. Courts generally look at the following factors when evaluating the use of in-room restraints (chairs):

1. Medical clearance needed.
2. Vitals monitored.
3. Were the manufacturers warnings followed?
4. Were the chairs used as punishment?[68]
5. Mental health staff involvement.
6. Duration of use.

CTDOC In-Cell Restraints

In-cell restraints in CTDOC are understood differently by many staff members. Reasons for use include:

- "It's a way for the Department to handle emergency situations and keep the prisoners and corrections staff safe."
- "We use in-cells until the inmate calms down."
- "In-cells are to learn your lesson."
- "The goals of in-cell restraint is to have them think about and to deter behavior."

Those staff who use in-cell restraints seem proud that they follow the policy, although Falcon believes that they may be losing sight of the reasons for and the restrictive nature of the practice, and the impact on the incarcerated individual. Those who defended its use made statements about safety of the incarcerated individual to include "We always assure…," "We have to make sure…," "We absolutely put health first," "We make sure they can still function and wipe themselves," "They can still do everything," "When they calm down, we remove it." Falcon sees this an example of serving the policy at the potential expense of the individual's needs.

Executive leadership expressed the intention to eliminate in-cell restraints as a practice through a strategic plan with accountability and governance. Several significant operational changes have been made since November 2021 regarding the Department's use of in-cell restraints. In-cell practices now require more meaningful engagement from staff. This approach changed from requiring notification of the Facility Unit Administrator after 24 hours with extension to 72 hours to requiring notification to the District Administrator after four hours to determine if an extension is warranted. After eight hours, the Deputy Commissioner's or designee's consultation with the Director of Behavioral Health may authorize continued in-cell restraint status.

There have also been reductions in the practices with 305 instances in 2021, 285 in 2022, and 225 in 2023; 2024 appears to be tracking similarly to 2023. In

Steve, Lamothe, Josianne, Fraser, Sarah, Lafortune, Denis, Dumais, Alexandre, Child Abuse & Neglect, 111, (2021), https://doi.org/10.1016/j.chiabu.2020.104825

66 Human Rights Watch, 2015

67 LeMaire v. Maass, 745 F. Supp. 623 (D. Or. 1990); Bell v. Kane County Jail et al, No. 1:2012cv07058 (N.D. Ill. 2016) U.S. Dist. LEXIS 17750; Smith v. McNesby, 2007 U.S. Dist. LEXIS 83520 * (N.D. Fla. Sept. 28, 2007).

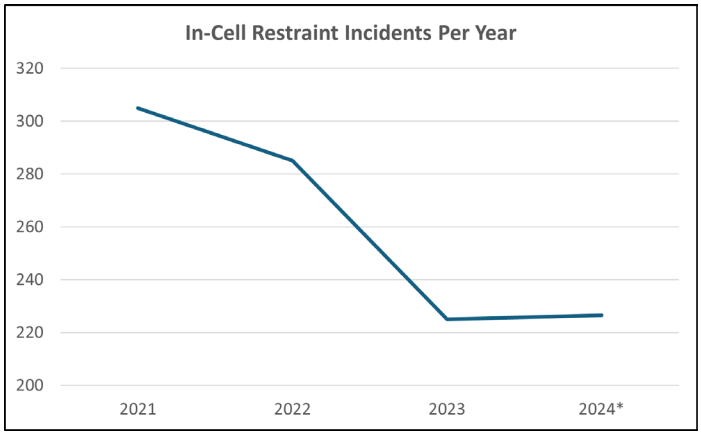
68 Most cases-literature regarding in cell restraints surround the use of the restraint chairs. In Hope v. Pelzer, 536 U.S. 730 (2002), the US supreme court looked at the use of tying someone to a hitching post. The Court held that cuffing an inmate to a hitching post for a period of time extending past that required to address an immediate danger or threat is a violation of the Eighth Amendment.

Falcon's review of 966 in-cell restraint incidents since 1/1/2021, 874 or 90.5% included obstructing windows though that was not necessarily the only precipitating factor in these cases. This data is compelling to drive alternative interventions for those individuals who assert control by obstructing the view into their cell.

Table 6.
Use of In-Cell Restraint

	2021	2022	2023	2024	Average
Jan	23	35	26	21	26
Feb	22	27	20	28	24
Mar	15	19	26	12	18
Apr	19	23	17	15	19
May	18	21	20	28	22
Jun	26	24	13	14	19
Jul	24	20	25	16	21
Aug	26	18	21	17	21
Sep	34	37	14		28
Oct	27	24	15		22
Nov	41	21	16		26
Dec	30	16	12		19
Total per year	305	285	225	151	242
Weighted total*	305	285	225	227	260
Average per month	25	24	19	19	22

*Weighted total calculated to account for truncated 2024 data, projecting a 12-month total based on the first eight months data.



While other practices have been considered such as the restraint chair, the leadership is cautious about implementing a new practice with different safety risks. The Falcon team commends the reduction, however, views CTDOC as unique in using this rare practice and therefore recommends the thoughtful elimination of in-cell restraints.

Refusing to House

Through observations and discussions, the Falcon team noted that there are some incarcerated individuals who may refuse GP housing assignments though data was not available specifically for this phenomenon. This results in a DR for Refusing to House defined as "disobeying staff direction to be or remain housed in a certain location within a correctional facility." The outcome of this situation is explained in what CTDOC leadership describes as "Self PC" (Protective Custody). These few individuals may sit within RH for months in high deprivation conditions of confinement. Upon observations of and discussions with several long-term Refusing to House individuals, the team was told by staff that "we offer GP every day." However, the Falcon team did not come across any specific programming or mental health treatment interventions put in place for these individuals. Departmental staff told the team that "it's very behavioral, they self PC." Mental health treatment for these individuals remains based on the mental health classification score, meaning that a MH2 does not receive mental health interventions and that a MH3 receives limited services akin to outpatient treatment that does not necessarily target the issue of self-isolating in restrictive conditions with extremely limited out-of-cell time. While the team did hear about instances of individualized plans that include a graduated placement strategy, such coordinated practices between custody and mental health staff appear to be the exception rather than the norm.

Disciplinary and RHU Experience

Based on the observations and interviews of those currently and recently in RH settings, the Falcon team developed an understanding of the prevailing experience – the sentiment was frustration with the disciplinary review process and the sanctions and penalties. Most individuals noted that they plea to the offense to simply receive a lesser sanction of approximately five days in PS, although they often feel that the DRs for disobeying a direct order or security tampering were not warranted.

Once in a RH setting, the incarcerated individuals generally complained of lack of staff engagement and boredom and frustration. Those in the AS and CD programs said, "there is no programming" and "how am I expected to change," with one noting that "it makes you feel like a seed planted in concrete." Most felt that no one even spoke to them about what happened to facilitate the placement so they could learn and improve. Individuals generally indicated that RHU programs are not a deterrent and generally reported an interest in more programming and mental health treatment. The lack of programming and conditions of confinement facilitate frustration in the incarcerated individuals' experience and may lead to encounters with CTDOC staff that result in a DR and regression to an earlier CD or AS phase. These conditions result in prolonged lengths of stay within AS and CD programs that are theoretically designed to reduce such behaviors. The Falcon team observed that the RHU settings were marked by limited property and were depressing with most individuals choosing to sleep for much of the day.

The experience of penalties enacted after a PS or other RH stay is profound. The impact of even a brief PS placement is often the loss of school and job, which is a more long-term and impactful result than the placement. All individuals the Falcon team spoke to complained about the post RHU loss of telephone access on their tablet resulting in limited and non-private phone time in the common area.

Programming

Upon sentencing, individuals are eligible for programming. Programs are assigned to individuals through their Offender Accountability Plan (OAP) which looks at the totality of their circumstances including criminal history. There is generally a wait list for core programming, and referral is triaged based on release date, eligibility for early release, and sentencing stipulations.

Most of the programming offered within the CTDOC (and prisons across the country) is aimed at reducing criminogenic needs associated with re-offending after incarceration, prioritizing participation for those closer to their release date. The CTDOC, however, has shown itself capable of rethinking the role of institutional programming for those who commit offenses within CTDOC. The executive leadership is interested in programming that gets to the root of the issues and develops prosocial solutions. It is open to considering RH programs that are not entirely time-based. Currently, there appears to be a lack of meaningful incentives for program engagement. The leadership is aware that undesirable behaviors are resolved at least temporarily over time rather than addressing what originally led the individual into the situation.

Programming, when 1) it is evidence-based; 2) accessible in earlier stages of an individual's incarceration; and 3) available in GP, can address the unmet needs[69] that led to disciplinary eligible offenses in the first place. This kind of programming mitigates the likelihood of violent or seriously disruptive events that ultimately result in RH placement. Enhanced programming reduces the reliance on such tools as RH, in-cell restraints, facility lockdowns, etc. while simultaneously creating safer communities for those who live and work inside prisons. Matching programs with structures that achieve positive behavior incentives can further shape behavioral and cognitive change.

In looking at data from 2010 to 2023, only 51 individuals received over 100 DRs during the 13-year period. The 51 individuals received between 101 to 283 reports per individual, and as a group accounted for 7,868 reports during that time. As it is often the same cohort who receives DRs, CTDOC is eager for guidance and views this study process as an opportunity to implement modern and evidence-based programming models specifically for AS and CD.

As evidenced in the Population Study, Falcon found that an over representation of those with current (MH3) and past mental health (MH2) treatment which suggests the need for interventions specific to this

69 Unmet needs can be expressed through a lack of constructive coping skills; maladaptive trauma responses; impulsivity; rigid, pro-criminal thinking patterns; lack of a healthy, prosocial support network; lack of a sense of belonging; little to no meaningful engagement in education or vocational activities; limited pursuit of prosocial hobbies/leisure activities; substance misuse; poor physical health; unmanaged mental health needs.

population, ideally offered prior to contact with RH but certainly upon engagement with the RH system.

Programming access for those residing in RHUs, or immediately released from RHUs, is another critical component of modern institutional programming frameworks. While expanded programming in GP can significantly reduce the number of individuals who enter RH, an individual's engagement with the DP is a prime opportunity to reassess criminogenic and treatment needs and reinvigorate his/her interest in / commitment to meaningfully participate in programming.

Despite CTDOC's interest in evidence-based practices (EBP) and best efforts, there is a general lack of current evidence-based or evidence-informed programming that addresses the etiology of problematic behavior across the CTDOC system. While the CTDOC compendium of Programs and Treatment includes some criminogenic-focused evidence-based programs, such as "Good Intentions, Bad Choices," existing programs within RH are time-based and focus on days completed rather than results or individual readiness. Notably, programs appear do not explicitly emphasize Motivational Interviewing (MI) principles and techniques, which does not prevent reactive and variable interventions from CTDOC staff. There is also no clear connection to a trauma-informed model of programming. However, it is evident that the CTDOC programming leadership appreciates the impact of trauma on the incarcerated population and is capable of integrating trauma-informed principles.[70] SAMHSA offers numerous resources[71] that could support programming alignment with trauma-informed care (TIC). Current[72] and past initiatives, dating back to 2018,[73] reflect the CTDOC's interest in elevating institutional programming. Data is not available regarding the outcomes of programming.

Six Guiding Principles to TIC

1. Safety
2. Trustworthiness & Transparency
3. Peer Support
4. Collaboration & Mutuality
5. Empowerment, Voice, Choice
6. Cultural, Historical, and Gender Issues

Within the past year, CTDOC established an internal CD Committee to develop a comprehensive program for CD with the intention of expanding it to AS. While the CD Committee met its goal of creating a curriculum-based program for both Phase 1 and Phase 2 of CD, the programming is not corrections specific and is primarily reliant on handout and independent in-cell review and work by the incarcerated individual. CTDOC reported that behaviors of concern have been historically addressed through in-cell programming. While this newly created CD program has many elements including: a program contract, facilitator resources, performance evaluation, program activity logs, and group facilitator tips, it does not appear to provide group activities. The 13 Phase 1 and 12 Phase 2 modules and related paper handouts primarily are drawn from Therapist Aid LLC,[74] an online repository of free therapy-related tools for mental health professionals. A variety of topics are included in the CD programming to include goal setting, distress tolerance, mindfulness, grounding, and communication skills. While there are weekly "check-ins" between CTDOC counselors where "participants bring worksheets/assignments from the previous week," there is no manual for engagement nor any examples of how interventions can be individualized.

70 Of note, York CI leadership expressed a desire to incorporate a greater focus on trauma within the Chronic Discipline program.

71 Including but not limited to: SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach, Practical Guide for Implementing a Trauma-Informed Approach, TIP 57 Trauma-Informed Care in Behavioral Health Services

72 In 2024, a Chronic Discipline revamping committee completed its efforts around elevating and standardizing the program statewide. A similar initiative is underway in regard to the Administrative Segregation Program.

73 As reflected in the 2018 Proposed Changes and Enhanced Programming and Management for the AS Program, focusing on front loading program opportunities, program progression vs. time, and content areas of anger management, communication, problem-solving, and conflict resolution.

74 https://www.therapistaid.com/

The Falcon team reviewed a mental health department PowerPoint proposal from 2018 for a new approach to AS that was not solely time based. The Falcon team found it to be a promising model and was heartened to hear that it is being revisited parallel to the Falcon assessment. The proposal offers enhanced programming that focuses on minimizing the time before an individual can engage in out-of-cell programming. What's more, engagement in programming is the expectation for progress rather than time. It has counselor-based group programming (but not mental health). While it can be further enhanced for coordination between mental health and programming staff, this is an example of a flexible approach through which the length of the (AS) program is based on the completion of programming and a period of practice or demonstration.

The Falcon team noted several facilities that have created the most structure and multidisciplinary collaboration regarding the CD program. YCI social workers are reportedly highly engaged in the CD program and do, at times, run groups for this population,[75] exemplifying a collaborative and responsive approach to programming that appears to permeate the culture at YCI. At CCC, a collaborative approach to CD placement and program decision-making appears in place as well. For instance, CCC holds "Warning and Advise" meetings to inform individuals that their next infraction will result in CD status placement. The unit manager, counselor, and mental health staff members attend these meetings.[76] CCC leadership appears to emphasize the consideration of an individual's history and circumstances to make sure CD placement is appropriate and productive. At MYI, it was reported that 90% of individuals considered for CD are not added to the program and that the program is only used as a last resort.[77] Positive models of multi-disciplinary team engagement, person-centered and restorative approaches to discipline, and incentivization for pro-social behavior exist within these facilities with an opportunity to identify best practice components for statewide implementation. The CTDOC is primed to capitalize on its most promising examples of program structures while also enhancing and expanding programming statewide, especially to those residing in RHUs.

CTDOC facilities, however, were not designed to support the delivery of criminogenic or clinical programs or services. While programming and treatment space is limited statewide such as at YCI and within MWCI RH setting, facility spaces often offer more opportunities than are currently being utilized. Self-guided, evidence-based tablet programming can serve as an adjunct but not as a replacement for in-person, congregate programming, especially in RHUs to include the limited PS placement. CTDOC can also expand tablet programming as they do not currently offer criminogenic/substance misuse programming on tablets.

Finally, there is a noticeable separation between CTDOC programming and mental health department treatment per DOC leadership, "Mental health runs its own programs." This dynamic is not uncommon in correctional systems and presents opportunities for better collaboration and success in addressing the needs of individuals within the disciplinary and RH processes. Bringing these services together will help develop a post-RHU, AS, and CD intervention program that works to prevent recidivism.

Mental Health

While the philosophy of mental health care within special population (e.g., MH5 IPM, BOS, PIC) policies is generally sound, the actual practices results in conditions of confinement that are often more restrictive than RHU practices which include elimination of most out-of-cell time, limited if any access to personal items, and no or limited short-term treatment and programming with assessments typically provided at cell-side through a closed door. While the ALOS for these status does not

75 Per staff interviews during the June 6, 2024, site visit.

76 Ibid.

77 Per staff interview during the June 27, 2024 site visit; anecdotal statistical information provided.

typically exceed 15 days, there are outliers, and the experience typically includes 23 or 24 hours in-cell time, removal of all personal items including standard clothing, provision of a suicide prevention gown and blanket, limited recreation time, limited showers, and interventions once per day by mental health staff for the purpose of reassessment.

There appears to be a systemic understanding by all departments and levels that some behaviors (if not incarcerated individuals) are "behavioral" and some are "mental health." This is language that statewide and facility staff use, and it appears to have been absorbed into the culture. This dichotomous thinking and application often results in separate rather than collaborative responsibilities for interventions. For instance, when the mental health staff deems an action "behavioral" it is left to CTDOC custody practices and programs such as PS, AS, CD to focus on interventions and if something is deemed "mental health" CTDOC counselors do not coordinate to offer programming that could address the behavioral manifestations. Behavioral manifestations often reflect a level of distress and potentially maladaptive problem solving that regardless of etiology often can benefit from mental health interventions integrated with facility practices and programming. There should be healthy friction between mental health and correctional staff that generates advocacy and a prevailing "do no harm" ethos. CTDOC is a system vulnerable to dual loyalty[78] as the mental health service provider often participates in practices where they may be expected to "clear" individuals for RH or evaluate to continue in-cell restraints against pressures from a rigid directive-based system. It is important for the mental health staff to continue their connections to the broader national and global correctional mental health best practices and related correctional reforms.

78 Dual loyalty is an ethical dilemma encountered by healthcare providers working within settings of confinement that create a conflict between professional duties to the patient, and the interests of another party, such as that accompanying delivery of care in a setting consecrated to security (i.e., the State). See: Pont, J., Stover, H. & Wolff,H. (2012). Dual loyalty in prison health care. American Journal of Public Health, 102(3), 475-480. DOI: 10.2105/ AJPH.2011.300374.

A study conducted by the Connecticut Sentencing Commission released in 2023[79] found that 95.5% of the incarcerated population had a history of mental health disorders, substance abuse disorders, or both. The same study found that 32% of the incarcerated population was classified as having an active mental health disorder requiring treatment (MH3 or higher) whereas an additional 41% of the population was classified as having a history of mental health disorders not requiring active treatment (MH2).

The Falcon team finds it limiting that the mental health service is no longer using a definition of SMI since the close of a settlement agreement and has moved to a solely numeric classification model. Although SMI criteria and designations can be double-edged, the CTDOC mental health department clearly operates more functionally than conceptually to provide needed treatment and placement. By operating as a system that assesses mental health classification levels, the Department appears to determine the level of care needed and is potentially less attuned to the level of distress that is impacting the individual. Without such a framework, mental health, medical, and custody staff may not be conceptualizing the patient through the lens of the diagnosis and potential SMI. Instead the focus is on the level of classification and placement setting (MH3 GP, MH4 Mental Health Housing, YCI, MH5 IPM). This emphasis on classification labels is in line with the Falcon team's observations about the larger CTDOC and the mental health service - that assessment tends to be about classifying rather than tailoring an individualized plan.

Inpatient Psychiatric Unit (IPM)

The Falcon team's observation of the IPM units at GCI and discussions with such staff and incarcerated individuals indicates that the incarcerated individuals or "patients" were confined to their cells for approximately 23 plus of 24 hours per day. The out-of-cell time may be recreation or a shower that is offered on the first shift. According to a supervising

79 Mental Health Disorders in Connecticut's Incarcerated Population, Connecticut Sentencing Commission, (January 2023).

psychologist, individuals on MH5 suicide watch who are on 15 minute checks do not come out of their cells other than to meet with the psychiatric provider. A review of the log sheets show that the 15 minute checks may not typically be staggered. While other MH5's not on suicide watch may be eligible for up to 4 hours out-of-cell time per day, this did not seem to be the case based on our discussions.

Individuals did not have tablets while in the IPM, and most cells did not have personal items like books. Meals are eaten within the cell often without utensils, which is based on the mental health staff guidance. While there is furniture in the IPM common areas, which includes table / seat combos (aka spider table) and psychiatric inpatient unit type chairs with ballast, the furniture was clustered together and used for storage on both IPMs with piles of laundry/clothing, suicide prevention gowns, and supplies on them. Interviews with staff and patients noted that those common areas are not utilized for socialization or therapeutic activities.

The mental health staff sees each individual daily for the purpose of reassessment without a formal treatment session, typically at cell side. The psychiatric provider typically sees the patient at least once a week with the patient secured in a "therapeutic cubicle." At the time of the GCI tour, the Falcon team noted that one recreation therapist was assigned to the IPMs though the person in that position was on a leave of absence. Upon inquiry, it seems that individualized treatment plans are not routinely completed and utilized based on the often short stay in the IPM.

Individuals are always cuffed except when in a therapeutic cubicle or in an outside recreation area. All recreation is outside in a fenced area. Like other toured facilities, the Falcon team observed that there was no chair or other seating in the outside fenced area. The length of stay in the IPM unit is often less than 15 days, however, it has been as long as one year. The prevailing conclusion is that the IPM environment is experienced as restrictive and barren with conditions of confinement that do not align with the intention or goals of an inpatient psychiatric treatment unit. The patients appear to be treated more like those who have received a DR report though DRs are reportedly dismissed for 100% of those placed on an IPM for mental health needs.

It was observed that the IPM at YCI appeared less restrictive though programming can be enhanced. YCI's medical infirmary and mental health infirmaries are bright with solid doors. Individuals in the Medical Infirmary receive two hours out-of-cell time daily, with staff citing operational limitations as a barrier to offering more recreation time.[80] The Partial Hospitalization unit is operated like GP with intensive programming and a modified recreation schedule.

Behavior Observation Status (BOS)

The BOS practices are devoid of meaningful intervention other than the restrictive conditions of confinement. Despite the understandable goals of the policy, the approach seems to be about waiting individuals out until they deny intent to harm themselves. The approach was described as breaking their maladaptive energy and "riding through a moment of impulsivity" in a safe environment. While this application of the policy may solve the immediate concern, it does not reflect active treatment and prevention other than reliance on behavioral psychology principles. Exploring and treating the root causes during and after placement could maximize the intervention and prevent recurrence.

Programmatic Intervention Cell (PIC)

While the policy seeks to provide a temporary respite to increase support and monitoring without transferring the individual off the unit to an IPM, the conditions of confinement generally include 22 to 23 hours in cell per day in a barren cell that does not include a chair or desk stool. With the limited treatment in place, this status feels akin to a RH setting similar to the formerly used CTQ status. While data was not available for length of stay, this status appears less therapeutic than intended.

80 Per staff interview during the June 6, 2024 site visit.

Data Collection and System Monitoring

The CTDOC lacks a modern, wholistic inmate management system and utilizes an over 60-year-old mainframe, making it time-intensive to collect, clean, and analyze data. There was a previous exploration and investment into a new OMS but the project ultimately ended without implementation. The CTDOC relies on its OMS for the majority of its data collection. The OMS' aging mainframe creates significant limitations to the overall tracking key indicators related to RH, programming outcomes, and the integration of health care information. A newly developed Data Team has been established within the Department with a goal of enhancing the system and data utilization.

Outcome data is not available for RH incidence, length of stays, or programming. There also appears to be no measurement-based care or objective consideration of outcomes for mental health. Despite challenges, the Data team is able to compile impressively useful data to the system though it is often a time intensive process to collect, clean, and analyze. Given the infrastructure, only snapshot in time data can generally be compared and reported. For instance, there is an automated dashboard that flags consecutive PS time using snapshots from the previous day. This dashboard potentially safeguards against prolonged periods in PS although it is currently utilized more as a reporting than an operational decision making tool.

The system is limited in tracking data trends over time. It is important that the CTDOC, at the statewide and facility-level, understands its data system and data trends. While the central office is building usable data systems, there seems to be a lack of awareness of data capabilities at the facility level, and a general lack of accountability to make sure data is reported across all facilities. With a heightened understanding of its data trends, state and site leaders can 1) assign responsibility around intervention strategies when unexpected or concerning trends are observed, and 2) celebrate positive data trends to encourage replication of effective processes, interventions, or programs.

CTDOC realizes the limitations of its current data systems, however, seeks to be data driven to include emphasizing RHU relapse prevention / recidivism prevention through survival data to track who returns to and who remains out of RHU and for how long, and informs them of individuals who require continued interventions even when not in RHU settings.

System Validations

The CTDOC has been actively creating positive changes throughout its system for years and is enduring the challenges that come with systemic changes. Department leaders demonstrate resilience and fortitude, and invariably appear to be change ready.

While it would be difficult to highlight all positive practices and initiatives occurring within the CTDOC, the following page is an overview of the most remarkable impressions of the Falcon team.

Summary

The CTDOC has strong classification and assessment functions, however, is not progressive with treatment and programming flexibilities to improve the behavior of incarcerated individuals. The disciplinary and RH processes are generally marked by rigidity and strict adherence to Administrative Directives and an existing facility-based culture that do not always appreciate the context or the distress/challenges facing the incarcerated individual. Said differently, it is a system that checks boxes well, but does not always address outliers who may not positively respond to the system and directives. The prevailing conclusions are that CTDOC directives and mental health policies, while often philosophically sound and well-intended, result in the work as imagined often far from the work as actually done with the resulting experiences and outcomes that are less than desirable.

Growth will involve qualitative changes, flexibility, and addressing practices that are detrimental to incarcerated individuals, staff wellness, and the overall system. It is a legitimate concern that some practices such as in-cell restraints and BOS status are perceived as punitive and out of proportion to those

SYSTEM VALIDATIONS

• Capable change leaders are present at the statewide and site level.	• The CTDOC has expanded its out-of-cell opportunity for those residing in RHU.
• Individuals are generally residing in RHUs for a shorter period of time compared to the experience in many other prison systems across the country.	• The CTDOC has created greater administrative oversight over the in-cell restraint process with reductions in total in-cell restraint time and some reductions in usage.
• The CTDOC leadership values staff wellness and physical safety.	• Gender-responsive practices permeate through the discipline and programming systems at YCI.
• The CTDOC leadership values rehabilitation of those who are incarcerated.	• The CTDOC has made great strides in increasing the availability of Medication Assistant Treatment (MAT) inside facilities, supporting the long-term recovery of substance misuse disorder for many.
• Principles of normalization and dynamic security are beginning to infuse select facilities through the presence of Amend teams.	• SAMHSA grant for 400 slots for staff trauma training as a result of the serious staff assault at GCI.
• The CTDOC appears to have a sound intake system.	• Significant expansion of in-cell tablets for most incarcerated individuals.
• The CTDOC has a solid process for identifying acute mental health needs at intake and during the DP.	• Facility based initiatives at MYI, YCI, and CCI to modify and improve the disciplinary and RH process.
• The Commissioner and Senior staff are interested in and appreciate the value of data to inform decision making.	• Recent revision of de-escalation training.

who experience it and to the public. This is further validated against other DOC systems that have moved away from more punitive conditions of confinement and practices.

The Department would benefit from implementing upstream rehabilitative solutions rather than simple incapacitation to drive deterrence and to shift away from reactive responses that do not address the root cause of behaviors and may exacerbate or inadvertently reinforce the likelihood that they will recur. The internal and Falcon-proposed reforms indicate that some training and directives /responses are not working as intended and that treating incarcerated individuals with dignity and emphasizing rehabilitation can prevent harm, which is ultimately beneficial for staff's well being.

CTDOC has soundly responded to the operational impacts of the Executive Order and Protect Act, the closures of lower-level facilities, and COVID-19, as well as population changes (national trend of more violent individuals in jails/prisons). Several facilities, such as YCI and MYI, provide proof of concept and examples of flexibilities that could be expended throughout the system, though Falcon understands that those facilities may have enhanced staffing plans. There are also increasingly less punitive and rigid options to explore by continuing to look at other state and international systems. Falcon believes that CTDOC possesses the current readiness for change among the collective executive team and is poised to find opportunities for thoughtful and timely improvements and reform.

SECTION 07:

Recommendations

TOC
I. _____
A. _____
i. ____

Recommendations - Section 7

Governance Structure

Establish a governance structure for special projects.

Falcon's analysis of the CTDOC system shows a need for a comprehensive plan, with logistics and the overall change management process grounded in an effective project governance structure. This plan may include special projects intended to implement RH reforms, standardize and expand Amend teams across the state, overhaul and standardize program frameworks, manage extensive collaboration needs between project stakeholders, and provide clarity and alignment across interdependent projects. Falcon recommends establishing a governance framework with project management roles assigned to oversee the planning, execution, and management of special projects. It is recommended that project management is built large enough to effectively manage complex projects, yet small enough to remain nimble and avoid unnecessary layers of bureaucracy.

Activate a team for implementation.

It is recommended that an interdisciplinary team is created to oversee the RH implementation process with representation from administration, correctional officers, health, mental health, programs, and any other internal stakeholders. For disciplinary and conditions of confinement initiatives there must be project oversight and accountability supported by strategic leadership in all departments, including healthcare and mental health services, to survey the challenges, chart a course, and implement stepwise improvements.

In the absence of an established, internal governance structure, it is also recommended that the CTDOC consider engaging an implementation specialist/firm to guide and support implementation activities. The implementation specialist would provide expertise around correctional and clinical complexities related to recommendations, engage stakeholders through a consensus-oriented approach and support the mediation of various viewpoints and interests, help with the prioritization of solutions to maximize current resources and prevent value loss, design feasible work plans and schedules, and devise alternate plans if the implementation team is faced with unexpected changes at the state or facility-level. The implementation specialist would work side-by-side with the Department's implementation team and project managers throughout the implementation process to create a sustainable framework of quality

and control once the implementation specialist's scope of work is fulfilled. The implementation specialist would provide interim support as the Department's governance structure and project management roles and responsibilities are fully realized.

When system-wide changes impact women who are incarcerated, it is essential that representation from YCI is included to ensure gender-responsive planning and design.

Communication and Stakeholder Engagement

Enhance stakeholder communication plan.

The CTDOC has two overarching stakeholder groups – individuals who are internal and external to the Department.

As change initiatives are underway, it is recommended that professionals working within the Department are recipients of relevant data that is shared, informed of the reasons behind system enhancements, and invited into project planning stages as much as possible. These recipients must be adequately informed and trained in policy and procedure changes, and that their constructive feedback on implementation and post-implementation activities are heard by leadership. The development of a transparent, two-way communication plan for all levels of staff, incarcerated individuals and the public – with mechanisms for updates as implementation is underway – will generate informed discussions. CTDOC should consider an internal and external "living" FAQ document to update on "What's going on here?" which would communicate the goals and operations of the disciplinary and RH practices.

It is also recommended that the CTDOC take a proactive approach to engagement with relevant external stakeholders, particularly those engaged during the Falcon team's study. Proactive engagement would include identifying clear points of contact, regularly updating on change initiatives, including Executive staff, and sharing transparent data on key performance indicators (KPI).

On a more granular and local level, procedures such as informing a unit officer of sanctions can reduce officer frustration.

The staff will be able to embrace changes because there is communication around CTDOC pilots and results of the changes, impact on reduced incidents, staff safety and overall feelings of wellness.

Staffing & Staff Development

Conduct a comprehensive staffing analysis.

The CTDOC should consider a comprehensive staffing analysis for RHU practices (and potentially beyond) to understand allocated positions and vacancies, evaluate scheduling and assignment practices, and identify how to best align staffing resources to current needs of the system to ensure meaningful out-of-cell time, programming, and integrated mental health treatment. A staffing analysis could recommend adjustments to the recruitment and retention processes (if needed), as it relates to custody and health care positions, across all shifts and facilities, to best manage its special populations. It is further recommended that the full-time Curriculum Manager and Curriculum Developer (serving under the Academy) be utilized for ongoing curriculum assessments to ensure that contemporary best practices align with the needs of RH populations and are integrated into trainings.

Align initial, annual, and continuous learning and development opportunities to philosophical and operational changes.

The world of corrections is ever changing. One only needs to look at the evolution of prison philosophies – from confinement to deterrence, to retribution, to incapacitation, to rehabilitation to restoration – to understand that change is inevitable. As the philosophy changes, so does the need to stay current with best practices on how to achieve safety and security both internally and externally.

The use of body cameras, body scanners, the increase in the mental health and elderly populations, a growing female population and implementation of PREA and the recognition of transgender males and females all demonstrate the need to properly equip staff with the requisite knowledge, skills and abilities

to completely and confidently execute their duties and responsibilities.

This necessity exists when staffing levels are sufficient but gets exacerbated with a lack of staffing, at which time the need for training gets elevated if one wants to ensure safe, secure and orderly operations. The proper onboarding, education and training of new recruits and existing staff is critical to sustainable recruitment and retention. It's important to ensure that checks and balances are in place to make sure staff are learning and retaining the necessary information to demonstrate job competency. Having adequate trainers is key to carrying out the training curriculum. Trainers must believe in and be able to share the curriculum in a manner that is engaging and reflects adult learning. Having a multi-generational workforce is also a crucial consideration for evaluating training curriculums and the methods of training delivery.

Research shows that people don't leave positions, they leave people. That's why supervisors, managers, and leaders must know how to interact with, develop, and motivate staff. Opportunities should be available for leadership staff to grow and develop. Leadership must set the table of expectations by being explicitly clear on the organization's vision, mission, and values and that training and policy align to show consistency throughout all levels of the organization. How this gets communicated to staff through initial training and continued interactions with leadership will have a definite impact on how well staff buy in and support the overall mission.

CTDOC can further enhance training initiatives, including matching Amend trained staff to RH-related programs.

Introduce formal staff wellness initiatives building upon UConn and Amend partnerships.

Applying the Amend principles will provide an improved day-to-day experience as well as employee-centric experiences to include enhanced dining and recreational spaces.

Operations

Optimize the classification process.

A good classification operation is the driving force[81] of any correction facility. A robust classification system will accurately identify risk and need, allowing for the most responsive housing, programming, and treatment decisions. It is recommended that the classification tool is re-validated on a regular basis, for the male and separately for the female population. Training should be updated to align with ongoing study and re-validation of the tool. There should also be consideration for the consolidation and simplification of RH statuses with AD 9.4.

Use the DP to assess criminogenic and clinical needs that may have contributed to the requirement for increased restrictions.

It is recommended that the CTDOC use the DP to assess criminogenic and clinical needs that may have contributed to the requirement for increased restrictions, shifting away from a traditional, punitive model of discipline. The CTDOC would benefit from more effective mechanisms of prevention by meaningful identification of at-risk individuals and addressing the current needs of those individuals through targeted and coordinated treatment and programming between mental health and counselor staff.

When an individual encounters the DP, a multi-disciplinary team should conduct necessary assessments to identify dynamic risk factors, develop programming and intervention plans, and match the individual to timely programming opportunities aligned with identified needs.

If the CTDOC chooses to adopt this recommendation, it is further recommended that programming leadership consult with the Special Programs Division of the Massachusetts Department of Correction (MADOC) regarding their Behavioral Assessment Unit-Secure Adjustment Unit (BAU-SAU) model.

81 Horgan, G. (2012, November 5). Classification – The Engine that Makes Correctional Facilities Go. Corrections.com. Classification – The Engine That Makes Correctional Facilities Go

MADOC's BAUs house individuals removed from GP who posed unacceptable risk to facility safety and operations. These individuals receive an assessment from an interdisciplinary appraisal team to identify the underlying causes of their behavior, define potential needs, and refer for placement to an appropriate[82] programming setting. MADOC's SAUs provide individuals with a structured program intervention to help reduce the risk for future disruptive or violent behavior.[83]

Redefine Restrictive Housing as a behavioral assessment and intervention strategy.

An Evidence Brief from Vera Institute of Justice (2021)[84] indicates that group-level research consistently shows that the practice of solitary confinement does not decrease institutional misconduct or violence, including assaults on staff, nor does it decrease the risk of recidivism, but may increase risk in certain instances. It is recommended that the CTDOC bases its RH redesign on the RNR model, leaning on the wealth of expertise from leaders at the statewide and site-level. By emphasizing assessment and treatment (to address criminogenic risk and mental health needs) instead of simple isolation, it is expected that violence (between incarcerated individuals and between incarcerated individuals and staff) will decrease.

Through this model, higher-risk individuals will be identified, an attitude of curiosity will guide staff's evaluative processes, and evidence-based core programming will be available. The CTDOC can use the MADOC model as a general blueprint when implementing an RNR model, however, philosophical, operational, population, and other differences between jurisdictions underscores the importance of tailoring model elements to the needs and preferences of the CTDOC.

The YCI and MYI practices that employ flexibility and the underutilization of restricted conditions of confinement can be further reviewed and considered for expansion to other facilities.

Memorialize new practices in policy.

To sustain system improvements, it is recommended that operational and philosophical changes are institutionalized through policy (AD), training, authorization, and funding, and cultural mechanisms to survive inevitable changes in leadership.

Evaluate the need for additional programming spaces.

It is important that individuals residing in RHUs (and other settings where conditions equate to RH) have opportunities for meaningful, purpose-driven congregate activity, including enhanced quality of recreation, out-of-cell programming, and greater access to confidential behavioral health services. To achieve this, it is recommended that the CTDOC identify ways to maximize programming/classroom spaces adjacent to RHUs by developing operational means for escorting individuals to ensure programming and treatment provision. Once the utilization of existing spaces is maximized, it is recommended that the CTDOC evaluate the need for additional capital investments to create spaces to meet the new out-of-cell requirements. It is further recommended that CTDOC consider reducing the number of counts per day, especially during hours when counselors and mental health staff are available to increase potential programming time.

Consider technological companion to strip searches.

To ensure strip searches are not deterring individuals from engaging in congregate, out-of-cell activity, it is recommended that the Department consider using contemporary body scanners to and from programming or recreation. When funding and staff resources are available, this technology can provide a more humane, trauma-informed approach to the necessary security checks required when moving individuals across the facility. If strategically desired, expanding the use of a body scanner beyond intake can be a CTDOC pilot approach in a facility with frequent on-unit searches.

82 Behavior Assessment Unit (BAU) Monthly | Mass.gov

83 Secure Adjustment Unit (SAU) Monthly | Mass.gov

84 https://vera-institute.files.svdcdn.com/production/downloads/publications/the-impacts-of-solitary-confinement.pdf

Consider terminating the use of in-cell restraints.

The Falcon team believes that the use of in-cell restraints is largely outside of common correctional practice and places those housed in CTDOC facilities at risk of physical or emotional harm. It further places CTDOC in legal risk, as lawsuits pertaining to its practice could reasonably occur due to the uncommon nature of the practice across the United States and the history of psychiatric hospital restraint and seclusion reform., Finally, it has the potential to create a negative public and political impression of the Department in general, because of its potential for misuse and harm.

It is recommended that the CTDOC incrementally terminate the use of in-cell restraints through a strategic plan, prioritizing the elimination of use for those with SMI and including transparency in data sharing and inclusion of stakeholders in the discussion. Focused de-escalation and MI training must be offered to staff as the elimination of the tool occurs.

Programming

Expand capacity for evidence-based programming.

Programming for criminogenic needs in RHU should be enhanced, to improve the quality of time-out-of-cell for meaningful interaction. This should be extended to PS, AS, and CD as well as post-RHU placements.

To more adequately address the criminogenic needs of its incarcerated population, the CTDOC needs to enhance its programming in GP. Proactive solutions to decrease misconduct in GP reduce the pipeline into the DP, ultimately subjecting fewer individuals to RH conditions of confinement. Core programming should be results-driven, flexible in delivery, and evidence-based or evidence-informed. Taking a wholistic approach to programming, it is recommended that the CTDOC also augment its core programming with self-study booklet activities, custom-made groups, religious groups, twelve-step groups, and movement and body-based activities like yoga and recreation therapy.

The Department will need to invest in manualized programs and associated training; required supplemental staffing to facilitate groups; and necessary equipment and technology (i.e., chairs, tables, tablets, computers). The Department must also evaluate the need for capital projects or facility improvements to create physical spaces needed for program delivery in GP and RHUs. Quality assurance processes should be in place to evaluate program outcomes and maintain program quality and fidelity to curriculums.

It is recommended that programs designed for the RH system, CD and AS, be standardized across facilities and reflect a more robust, programmatic model . When designing a program, the CTDOC should clearly identify the following elements:

1. A clear program mission.
2. Acceptance criteria to ensure the target population is prioritized.
3. Guidelines around acceptable delivery formats (e.g., group, in-cell, hybrid).
4. A program structure outlining staff roles and responsibilities, types of meetings (e.g., multidisciplinary team meetings/progress reviews, decision-making meetings for progression/regression determinations, and staff-participant check-ins), expected multidisciplinary representation at program meetings, expected meeting cadence, and frequency of group sessions.
5. Approved curriculum and facilitator guides.
6. Expected orientation activities and/or handouts for new participants.
7. Incentives for progress towards desired, incremental behavioral/cognitive change.
8. Indicators of progress.
9. Indicators of program content mastery and completion.

In evaluating evidence-based programs, special consideration is encouraged for the following programs that have been vetted by the Falcon team:

Moral Reconation Therapy (MRT): MRT is a systematic, step-by-step rehabilitation system for treatment-resistant clients.[85] The system is designed to alter how incarcerated individuals think, how they make judgments and decisions about the right and wrong thing to do in situations, and promotes actions and behaviors focused on changing negative relationships. In 2008, MRT was given the status of an "Evidence-Based Program" by the SAMHSA.

Cognitive Behavioral Intervention (CBI) Curricula: Developed by the University of Cincinnati Corrections Institute, CBI offers cognitive-behavioral approaches to teach people strategies for identifying and managing risk factors, these programs place heavy emphasis on skill building activities to assist with cognitive, social, emotional, and coping skill development.[86] CBI provides a suite of curriculums, which are closed group formats, and which demonstrate strong outcomes.

Breaking Free from Substance Abuse: Breaking Free is an evidence-based digital behavior change program through which people can recognize and actively address the psychological and lifestyle issues that are driving their use of alcohol and/or drugs.[87] The program is supported by an online dashboard that demonstrates return on investment by tracking uptake, reach and clinical impact in real-time, and by stratifying the anonymized, aggregated data to show performance against KPIs.

Stand-Alone Skills Training from Dialectical Behavior Therapy (DBT): The DBT component of skills training[88] has been shown to be effective as a stand-alone treatment,[89] and its utility as an open group format without the need for a mental health diagnosis makes it well-suited to transient housing areas in need of wellness and support groups.

Anger Management for Substance Use Disorder and Mental Health Clients: The Anger Management program published by the SAMHSA is a closed, 12-session semi-structured cognitive-behavioral group series that recognizes the intersections of anger, violence, traumatic stress, and substance use.[90]

It is also recommended that RHU interventions are connected to the Amend initiative to bring meaningful and positive environmental practices to the DP and RHU experiences, emphasizing help and assistance over control and punishment. Amend trained staff can be matched to RH-related programs.

Expand access to substance use treatment programs.

Substance use is a significant contributor to the reasons why individuals enter RHUs across the country. While the practice varies by facility, it is not uncommon for individuals in the CTDOC to receive a Class A DR for a positive screen on a urine analysis. Creating a comprehensive substance use disorder treatment program specifically for those who use drugs or alcohol while incarcerated, in conjunction with its existing Medication Assisted Treatment (MAT) services, would align the Department with the community standard of diversion for low-level drug and alcohol offenses.

Mental Health

Conduct a full evaluation of Mental Health practices of Suicide Watch, BOS, and PIC to include health record reviews and relapse data.

The evaluation should include conditions of confinement for those receiving intensive mental health services (e.g., IPM/Suicide Watch, BOS,

85 For more information, visit Moral Reconation Therapy – MRT® distributed exclusively by Correctional Counseling, Inc. (ccimrt.com)

86 For more information visit Group Interventions | University of Cincinnati (uc.edu)

87 For more information, visit About Us (breakingfreegroup.com)

88 Linehan, M. (2015). DBT Skills Training Manual (2nd Ed.). New York: Guilford Press.

89 Valentine, S., Bankoff, S.M., Poulin, R.M., Reidler, E.B. & Pantalone, D.W. (2015). The use of Dialectical Behavior Therapy Skills Training as stand-alone treatment: A systematic review of the treatment outcome literature. Journal of Clinical Psychology, 71(1), 1-20. 58 Linehan, M. (2015). DBT Skills Training Manual (2nd Ed.). New York: Guilford Press.

90 Reilly, P.M. & Shopshire, M.S. Anger Management for Substance Use Disorder and Mental Health Clients: A Cognitive-Behavioral Therapy Manual. SAMHSA Publication No. PEP19-02-01-001. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2019.

PIC). Consider elimination or changes to mental health practices to promote improvements in the quantitative and qualitative meaningful out-of-cell time and services to include treatment and programming.

Expand and enhance treatment and intervention for individuals interfacing with the DP and RH settings, by integrating behavioral health treatment with programming and eliminating a categorical approach to disposition.

This can be accomplished by expanding the role and target populations of the mental health department. For instance, while a MH2 or MH3 may be assessed as responsible for the offense and able to receive a DR, that individuals should still be considered for mental treatment specific to the behaviors of concern, supplemented by CTDOC programming. There is an opportunity to redevelop Mental Health and Counselor Supervisor leadership positions to assure a focus on identifying and rehabilitatively intervening with individuals who receive DRs and experience PS, AS, CD and other isolating conditions of confinement. Given the over representation of individuals with current or past mental health treatment in RHUs, the mental health department has the responsibility to consider treatment and programming to meet this population's current needs.

Introduce a treatment/programming model that engages individuals, even during short-term RHU stays, and continues post release from RHUs.

Those in short-term RHU PS settings should receive short-term therapy rather than simple check-in assessments. The expectation should be set that the interventions will continue upon release with an emphasis on identifying individual risks for committing a new in-facility offense and providing a combination of treatment and programming.

Data Collection and System Monitoring

Implement modern data system with live and retrospective tracking and monitoring of all RHU-related practices to include suicide watch, BOS, PIC, Refusing to House, and in-cell restraints available at site and departmental levels. Create an active self-monitoring system to identify high-frequency individuals for further assessment, and to identify utilization trends at the system and facility level.

The Department should consider shifting fully from paper logs on-unit to an electronic record system that will allow for active monitoring and management of out-of-cell time, including unintended impacts of ancillary system and facility factors. A live electronic data system that provides real time data feedback on high-risk individuals and high-utilizers of the restrictive housing system and related programs would enable CTDOC leaders to understand metrics that most characterize this segment of the population. This knowledge of the characteristics of persistent users of restrictive housing will support the identification of needs for targeted and effective interventions. Systems in place to identify upstream needs and implementing targeted programming and effective interventions helps to decrease risk of incidents and improve individual outcomes downstream.

CTDOC lacks a system that automatically flags instances where individuals are approaching the 15-day mark in RHU, or 30 days within a 60-day period. Features like this are necessary to ensure data is easily accessible to leadership and those engaged in quality assurance processes at the facility-level so data can be incorporated into decision-making.

Implement SOAR OOCT tracking and analysis for all restrictive statuses.

The Department may also consider adopting policy changes that include tracking out-of-cell time beyond simply how much time each person spent outside the cell. By creating and publishing a schedule of activities, programming and otherwise, individuals on each unit better understand how daily operations are expected to unfold. Then specific types of out-of-cell time and programming can be documented and tracked as scheduled, offered, and accepted, or received (SOAR), for each person, housing unit, and facility. SOAR tracking can also be introduced for tablet programming that will serve as an adjunct to in-person individual and group

programming. This system and process enables facilities to self-monitor and report a more detailed and instructive understanding of out-of-cell time, including trends in utilization and hindrances to meeting requirements. Each SOAR component involves specific responsibilities on the parts of the facility and the incarcerated individual, and allows for active monitoring of each factor. From a Continuous Quality Improvement perspective, a SOAR model and electronic record system allow more targeted ongoing self-assessment of what is working and where challenges exist.

Create public-facing disciplinary and RHU data dashboards.

To assure collaboration and gain public trust, CTDOC should consider developing public facing dashboards that provide real-time and historical data for types of DRs and RH data for number of individuals and length of stay. Accessible dashboards that demonstrate changes over time help demonstrate the positive efforts that are being made in-house. For example, as in-cell restraints are phased out, public facing access to the number on the status and the duration can build community trust rather than primarily providing data through an adversarial legal process. The Wisconsin Department of Corrections (WIDOC) offers an example of publicly available "Restrictive Housing: Disciplinary Separation and Administrative Confinement Dashboards"[91] that can serve as a model for CTDOC.

91 https://doc.wi.gov/Pages/DataResearch/RestrictiveHousingDashboard.aspx

SECTION 8:

Appendix A Acronyms

TOC
I. _____
A. ____
i. ___

Appendix A: Acronyms

ACA - American Correctional Association
ACLU - American Civil Liberties Union
AD - Administrative Detention
ADP - Average Daily Population
APRN - Advanced Practice Registered Nurse
ALOS - Average Length of Stay
AS - Administrative Segregation
BAU - Behavior Assessment Unit
BMP - Behavioral Management Plan
BOS - Behavioral Observation Status
BPU - Best Practices Unit
CAC - Correctional Advisory Committee
CBI - Cognitive Behavioral Intervention
CD - Chronic Discipline
CQI - Continued Quality Improvement
CTDOC - Connecticut Department of Correction
CTQ - Confinement to Quarters
CWG - Core Working Group
DBT - Dialectical Behavior Therapy
DP - Disciplinary Process
DR - Disciplinary Report
EBP - Evidence - Based Practice
EHR - Electronic Health Record
GAC - Governmental Accountability Commission
GP - General Population
IMRP - Institute for Municipal and Regional Policy
IPM - Inpatient Psychiatric Unit
KPI - Key Performance Indicator
MADOC - Massachusetts Department of Correction
MAT - Medication Assisted Treatment
MH - Mental Health
MI - Motivational Interviewing
MRT - Moral Reconation Therapy
NCCHC - National Commission on Correctional Health Care
OAP - Offender Accountability Plan
OCA - Office of the Child Advocate
OGA - Office of Governmental Accountability
OMS - Offender Management System
OOCT - Out-of-cell Tracking
OPA - Office of Protection and Advocacy
PC - Protective Custody
PD - Progressive Discipline
PIC - Programmatic Intervention Cell
PREA - Prison Rape Elimination Act
PS - Punitive Segregation
RFP - Request for Proposal
RH - Restrictive Housing
RHU - Restrictive Housing Unit
RNR - Risk-Need-Responsivity
RREC - Risk Reduction Earned Credit
SAMHSA - Substance Abuse and Mental Health Services Administration
SAU - Secure Adjustment Unit
SMI - Serious Mental Illness
SMS - Special Management Status
SNM - Special Needs Management
SOAR - Scheduled, Offered, Accepted, Refused
SR - Seclusion and Restraint
SRG - Security Risk Group
TD - Transfer Detention
TIC - Trauma-Informed Care

SECTION 9:

Appendix B
Population Study Data

TOC
I. _____
A. _____
i. ___

Appendix B: Population Study Data

Table 3b

Table 3b.
Full Table: Population Snapshots and Comparison, by Race

		2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	10 year avg	3 year avg.
American Indian	RH Pop	1	0	2	1	1	2	0	0	2	3	1.2	1.67
	Total Pop	41	47	35	42	42	30	29	37	37	44	38.4	39.33
	% in RH	2.44%	0.00%	5.71%	2.38%	2.38%	6.67%	0.00%	0.00%	5.41%	6.82%	3.13%	4.24%
	% of RH	0.42%	0.00%	0.98%	0.52%	0.51%	1.12%	0.00%	0.00%	1.20%	1.67%	0.64%	0.96%
	% of Total Pop	0.26%	0.31%	0.24%	0.31%	0.32%	0.30%	0.32%	0.37%	0.36%	0.42%	0.32%	0.38%
	Raw Difference	0.16%	-0.31%	0.73%	0.21%	0.19%	0.82%	-0.32%	-0.37%	0.84%	1.25%	0.32%	0.57%
	RH to Total Ratio	1.63	0.00	4.00	1.66	1.58	3.73	0.00	0.00	3.30	4.01	2.00	2.49
Asian	RH Pop	0	1	2	0	2	2	2	0	1	0	1	0.33
	Total Pop	82	78	61	67	78	48	44	55	57	69	63.9	60.33
	% in RH	0.00%	1.28%	3.28%	0.00%	2.56%	4.17%	4.55%	0.00%	1.75%	0.00%	1.56%	0.55%
	% of RH	0.00%	0.44%	0.98%	0.00%	1.02%	1.12%	1.37%	0.00%	0.60%	0.00%	0.55%	0.20%
	% of Total Pop	0.51%	0.51%	0.43%	0.50%	0.60%	0.48%	0.49%	0.55%	0.56%	0.65%	0.53%	0.59%
	Raw Difference	-0.51%	-0.07%	0.55%	-0.50%	0.42%	0.64%	0.88%	-0.55%	0.04%	-0.65%	0.02%	-0.39%
	RH to Total Ratio	0.00	0.86	2.29	0.00	1.71	2.33	2.81	0.00	1.07	0.00	1.05	0.34
Black	RH Pop	117	119	83	90	89	97	82	67	85	82	91.1	78
	Total Pop	6578	6292	5832	5536	5590	4395	4009	4256	4245	4540	5127.3	4347
	% in RH	1.78%	1.89%	1.42%	1.63%	1.59%	2.21%	2.05%	1.57%	2.00%	1.81%	1.78%	1.79%
	% of RH	48.75%	52.19%	40.49%	46.88%	45.18%	54.49%	56.16%	52.34%	51.20%	45.56%	49.32%	49.70%
	% of Total Pop	41.05%	41.01%	40.68%	41.40%	42.65%	44.19%	44.45%	42.60%	41.87%	42.89%	42.28%	42.46%
	Raw Difference	7.70%	11.18%	-0.20%	5.47%	2.53%	10.31%	11.72%	9.74%	9.34%	2.66%	7.05%	7.25%
	RH to Total Ratio	1.19	1.27	1.00	1.13	1.06	1.23	1.26	1.23	1.22	1.06	1.17	1.17
Hispanic	RH Pop	56	53	61	50	49	50	43	39	45	57	50.3	47
	Total Pop	3961	3921	3779	3504	3458	2686	2463	2791	2844	3099	3250.6	2911.33
	% in RH	1.41%	1.35%	1.61%	1.43%	1.42%	1.86%	1.75%	1.40%	1.58%	1.84%	1.55%	1.61%
	% of RH	23.33%	23.25%	29.76%	26.04%	24.87%	28.09%	29.45%	30.47%	27.11%	31.67%	27.40%	29.75%
	% of Total Pop	24.72%	25.56%	26.36%	26.21%	26.38%	27.01%	27.31%	27.94%	28.05%	29.28%	26.88%	28.42%
	Raw Difference	-1.38%	-2.31%	3.39%	-0.16%	-1.51%	1.08%	2.15%	2.53%	-0.94%	2.39%	0.52%	1.33%
	RH to Total Ratio	0.94	0.91	1.13	0.99	0.94	1.04	1.08	1.09	0.97	1.08	1.02	1.05
White	RH Pop	66	55	53	49	49	27	19	22	33	38	41.1	31
	Total Pop	5363	5004	4628	4222	3939	2787	2475	2851	2956	2832	3705.7	2879.67
	% in RH	1.23%	1.10%	1.15%	1.16%	1.24%	0.97%	0.77%	0.77%	1.12%	1.34%	1.11%	1.08%
	% of RH	27.50%	24.12%	25.85%	25.52%	24.87%	15.17%	13.01%	17.19%	19.88%	21.11%	21.42%	19.39%
	% of Total Pop	33.47%	32.62%	32.28%	31.58%	30.05%	28.02%	27.44%	28.54%	29.15%	26.76%	29.99%	28.15%
	Raw Difference	-5.97%	-8.49%	-6.43%	-6.05%	-5.18%	-12.85%	-14.43%	-11.35%	-9.28%	-5.65%	-8.57%	-8.76%
	RH to Total Ratio	0.82	0.74	0.80	0.81	0.83	0.54	0.47	0.60	0.68	0.79	0.71	0.69
	Total RH	240	228	205	192	197	178	146	128	166	180	186	158
	CTDOC ADP	16025	15342	14335	13371	13107	9946	9020	9990	10139	10584	12185.9	10237.67

Each population count was pulled for July 1st of each year.
*** % in RH: percentage of total individuals within each group currently housed in RH as of July 1 snapshot.*
**** Raw Difference: mathematical difference between the percentage of Total Pop and RH Population, for each group*
***** RH to Total Ratio: The ratio of the % of individuals housed in RH to the % of Total Population for each group*

TOC
I. _____
A. _____
i. ___

Table 4b

Table 4b.
Full Table: Population Snapshots and Comparison, by Mental Health Classification

		2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	10 year avg	3 year average
MH1	RH Pop	53	43	27	34	24	30	22	21	15	25	29.4	20.33
	Total Pop	6651	5846	5225	4695	4367	3068	2545	2815	2696	2863	4077	2791.33
	% in RHU	0.80%	0.74%	0.52%	0.72%	0.55%	0.98%	0.86%	0.75%	0.56%	0.87%	0.73%	0.73%
	% of RH	22.08%	18.86%	13.17%	17.71%	12.18%	16.85%	15.07%	16.41%	9.04%	13.89%	15.53%	13.11%
	% of Total Pop	41.50%	38.10%	36.45%	35.11%	33.32%	30.85%	28.22%	28.18%	26.59%	27.05%	32.54%	27.27%
	Raw Difference	-19.42%	-19.24%	-23.28%	-17.40%	-21.14%	-13.99%	-13.15%	-11.77%	-17.55%	-13.16%	-17.01%	-16.77%
	RH to Total Ratio	0.53	0.49	0.36	0.50	0.37	0.55	0.53	0.58	0.34	0.51	0.48	0.48
MH2	RH Pop	89	87	63	59	61	63	34	36	53	65	61	51.33
	Total Pop	5934	5956	5651	5134	5071	3979	3572	3964	4207	4320	4779	4163.67
	% in RHU	1.50%	1.46%	1.11%	1.15%	1.20%	1.58%	0.95%	0.91%	1.26%	1.50%	1.26%	1.22%
	% of RH	37.08%	38.16%	30.73%	30.73%	30.96%	35.39%	23.29%	28.13%	31.93%	36.11%	32.25%	32.05%
	% of Total Pop	37.03%	38.82%	39.42%	38.40%	38.69%	40.01%	39.60%	39.68%	41.49%	40.82%	39.40%	40.66%
	Raw Difference	0.05%	-0.66%	-8.69%	-7.67%	-7.72%	-4.61%	-16.31%	-11.55%	-9.57%	-4.71%	-7.14%	-7.86%
	RH to Total Ratio	1.00	0.98	0.78	0.80	0.80	0.88	0.59	0.71	0.77	0.88	0.82	0.79
MH3	RH Pop	78	70	84	81	86	72	78	53	80	74	75.6	69
	Total Pop	2971	3011	3006	3065	3122	2479	2405	2645	2669	2810	2818	2708.00
	% in RHU	2.63%	2.32%	2.79%	2.64%	2.75%	2.90%	3.24%	2.00%	3.00%	2.63%	2.69%	2.54%
	% of RH	32.50%	30.70%	40.98%	42.19%	43.65%	40.45%	53.42%	41.41%	48.19%	41.11%	41.46%	43.57%
	% of Total Pop	18.54%	19.63%	20.97%	22.92%	23.82%	24.92%	26.66%	26.48%	26.32%	26.55%	23.68%	26.45%
	Raw Difference	13.96%	11.08%	20.01%	19.26%	19.84%	15.52%	26.76%	14.93%	21.87%	14.56%	17.78%	18.16%
	RH to Total Ratio	1.75	1.56	1.95	1.84	1.83	1.62	2.00	1.56	1.83	1.55	1.75	1.65
MH4	RH Pop	15	25	23	15	15	11	11	14	17	15	16.1	15.33
	Total Pop	379	428	389	397	459	361	417	483	507	495	432	495.00
	% in RHU	3.96%	5.84%	5.91%	3.78%	3.27%	3.05%	2.64%	2.90%	3.35%	3.03%	3.77%	3.09%
	% of RH	6.25%	10.96%	11.22%	7.81%	7.61%	6.18%	7.53%	10.94%	10.24%	8.33%	8.71%	9.84%
	% of Total Pop	2.37%	2.79%	2.71%	2.97%	3.50%	3.63%	4.62%	4.83%	5.00%	4.68%	3.71%	4.84%
	Raw Difference	3.88%	8.18%	8.51%	4.84%	4.11%	2.55%	2.91%	6.10%	5.24%	3.66%	5.00%	5.00%
	RH to Total Ratio	2.64	3.93	4.13	2.63	2.17	1.70	1.63	2.26	2.05	1.78	2.35	2.03
MH5	RH Pop	4	3	4	1	4	2	1	2	1	1	2.3	1.33
	Total Pop	40	37	45	55	57	55	63	49	48	63	51	53.33
	% in RHU	10.00%	8.11%	8.89%	1.82%	7.02%	3.64%	1.59%	4.08%	2.08%	1.59%	4.88%	2.58%
	% of RH	1.67%	1.32%	1.95%	0.52%	2.03%	1.12%	0.68%	1.56%	0.60%	0.56%	1.20%	0.91%
	% of Total Pop	0.25%	0.24%	0.31%	0.41%	0.43%	0.55%	0.70%	0.49%	0.47%	0.60%	0.45%	0.52%
	Raw Difference	1.42%	1.07%	1.64%	0.11%	1.60%	0.57%	-0.01%	1.07%	0.13%	-0.04%	0.76%	0.69%
	RH to Total Ratio	6.68	5.46	6.22	1.27	4.67	2.03	0.98	3.19	1.27	0.93	2.69	1.74
	Total RH	240	228	205	192	197	178	146	128	166	180	186	158
	Total Pop	16025	15342	14335	13371	13107	9946	9020	9990	10139	10584	12185.9	10237.67

**Each population count was pulled for July 1st of each year.*
*** % in RH: percentage of total individuals within each group currently housed in RH as of July 1 snapshot.*
**** Raw Difference: mathematical difference between the percentage of Total Pop and RH Population, for each group*
***** RH to Total Ratio: The ratio of the % of individuals housed in RH to the % of Total Population for each group*

TOC
I. _____
A. _____
i. ___

Table 5b

Table 5b.
Full Table: Population Snapshots and Comparison, by Sentencing Status

		2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	10 year avg	3 year average
Unsentenced	RH Pop	71	74	65	55	54	59	74	63	83	76	67.4	74.00
	Total Pop	4018	3918	3803	3802	3845	3389	3264	3986	3847	3813	3769	3882
	% in RHU	1.77%	1.89%	1.71%	1.45%	1.40%	1.74%	2.27%	1.58%	2.16%	1.99%	1.80%	1.91%
	% of RH	29.58%	32.46%	31.71%	28.65%	27.41%	33.15%	50.68%	49.22%	50.00%	42.22%	37.51%	47.15%
	% of Total Pop	25.07%	25.54%	26.53%	28.43%	29.34%	34.07%	36.19%	39.90%	37.94%	36.03%	31.90%	37.96%
	Raw Difference	4.51%	6.92%	5.18%	0.21%	-1.92%	-0.93%	14.50%	9.32%	12.06%	6.20%	5.60%	5.71%
	RH to Total Ratio	1.18	1.27	1.20	1.01	0.93	0.97	1.40	1.23	1.32	1.17	1.18	1.24
Sentenced	RH Pop	169	154	140	137	143	119	72	65	83	104	118.6	84.00
	Total Pop	12329	11875	10981	10042	9465	8794	5964	5576	6198	6622	8785	6132
	% in RHU	1.37%	1.30%	1.27%	1.36%	1.51%	1.35%	1.21%	1.17%	1.34%	1.57%	1.35%	1.36%
	% of RH	70.42%	67.54%	68.29%	71.35%	72.59%	66.85%	49.32%	50.78%	50.00%	57.78%	62.49%	52.85%
	% of Total Pop	76.94%	77.40%	76.60%	75.10%	72.21%	88.42%	66.12%	55.82%	61.13%	62.57%	71.23%	59.84%
	Raw Difference	-6.52%	-9.86%	-8.31%	-3.75%	0.38%	-21.56%	-16.80%	-5.03%	-11.13%	-4.79%	-8.74%	-8.96%
	RH to Total Ratio	0.92	0.87	0.89	0.95	1.01	0.76	0.75	0.91	0.82	0.92	0.88	0.88
	Total RH	240	228	205	192	197	178	146	128	166	180	186	158
	Total Pop	16025	15342	14335	13371	13107	9946	9020	9990	10139	10584	12186	10238

**Each population count was pulled for July 1st of each year.*
*** % in RH: percentage of total individuals within each group currently housed in RH as of July 1 snapshot.*
**** Raw Difference: mathematical difference between the percentage of Total Pop and RH Population, for each group*
***** RH to Total Ratio: The ratio of the % of individuals housed in RH to the % of Total Population for each group*

FALCON®

155 North Wacker Drive, Suite 4250, Chicago, IL 60606
Tel: 312.803.5666 | www.falconinc.com