



# STATE OF CONNECTICUT

DEPARTMENT OF MENTAL HEALTH  
AND ADDICTION SERVICES  
*A HEALTHCARE SERVICE AGENCY*

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GOVERNOR

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COMMISSIONER

## **Testimony of Thomas A. Kirk, Ph.D., Commissioner Department of Mental Health and Addiction Services Before the Judiciary Committee March 13, 2006**

Good morning, Senator McDonald, Representative Lawlor, and distinguished members of the Judiciary Committee. I am Dr. Thomas A. Kirk, Commissioner of Mental Health and Addiction Services, and I am here today to speak in support of **S.B. 359, An Act Concerning Competency to Stand Trial**. This bill would amend Sec. 54-56d of the Connecticut General Statutes regarding individuals with mental illness who are judged not competent to stand trial.

Three years ago, the Connecticut General Assembly decided that some people with mental illness were being arrested because of behaviors related to their disability, not because they were criminals. You indicated that such instances were better treated within the mental health system, rather than by criminalizing these behaviors. That legislative response led to the creation of what has come to be known as **Track II** – a process by which defendants who are deemed not competent to stand trial may be converted to a civil legal status and allowed the opportunity to participate in treatment, with their criminal charges dropped if they do well in treatment. This was a significant, qualitative step forward in how we as a state treat such persons.

By means of S.B. 359, we now hope to take a quantitative step forward. In many cases, the court does not have the information available – at least initially – that would permit it to order that a mentally ill defendant be transferred to a civil status, which means that those individuals are not able to profit from what we accomplished three years ago. We ask that you consider this proposal, which would allow Connecticut Valley Hospital to identify defendants who have been sent there for restoration as individuals who can profit from civil commitment rather than criminal prosecution. This amendment would give the hospital 120 days in which to determine whether patients are more appropriate for civil commitment and make that recommendation to the criminal court. We have also added language about attempting to encourage more clients to participate in a civil treatment status. We expect this to significantly increase the numbers of individuals for whom this statute would then have a positive result.

We have also added language to clarify the hospital's responsibility regarding the content of the reports it submits to the criminal court, as well as clarifying some potentially confusing language about the court's options in those hearings.

Finally, we have recommended one small technical correction in the bill by adding language from the current C.G.S. § 54-56d (k)(1) and 54-56d(k)(2) to § 54-56d (h)(2)(A) for purposes of uniformity.

I would also like to take this opportunity to comment on **H.B. 5651, An Act Concerning the Report of the Commission on Prison and Jail Overcrowding**. Our experience as a member of the Commission has been invaluable. We, along with the Judicial Branch and DOC, have developed a good track record of collaboration that has included:

- Developing joint protocols to better utilize existing resources (such as the Discharge Planning for Sentenced Inmates with Mental Health Needs Protocol, 1996-present).
- Jointly seeking federal grants (Byrne [aka JAG]), SAMHSA, DOJ) to: (a) foster creative program development for persons with behavioral health needs in the criminal justice system (e.g., CIT, Women's Jail Diversion, Offender Re-entry, Transitional Case Management, Alternative to Drug Court); and (b) enhance the quality and quantity of behavioral health services through such across-agency initiatives as collaborative contracting, Access to Recovery, and the recently awarded federal Transformation grant.
- Jointly funding and contracting (MHAIC, collaborative contracting).
- Support of the Governor and General Assembly on successful programs (Jail Diversion).

There are a number of initiatives in this legislation that have been addressed by the Commission. They are as follows:

1. **Mental Health Alternative to Incarceration and Day Reporting Center**: DMHAS, DOC, and CSSD have provided funds to develop a specialized alternative to incarceration program -- including both residential and day reporting components for pre-trial defendants and inmates who are eligible for community supervision. This program provides a similar community placement option that is routinely available to defendants/inmates without psychiatric disabilities, but is unique in that it integrates supervision/monitoring/reporting required of the courts or DOC with on-site clinical programming oriented to successful community transition, providing ongoing clinical and social support to accomplish this. The Day Reporting component was established in Hartford in June 2005 and has been very successful with clients who would otherwise certainly have remained incarcerated. The residential component has not yet been implemented due to serious zoning difficulties, which have necessitated that the whole program be re-bid.
2. **Expand Specialized Day Reporting Programs**: Based on evidence supporting the success of the above-mentioned specialized Day Reporting program for persons with serious psychiatric disabilities, the PJOC recommended the establishment of such programs in

Hartford, Waterbury, New Haven and Bridgeport. [One of these locations will be supported by the MHAIC budget]. Each such program is estimated to cost \$470,000 and includes supervision, clinical treatment and programming, and supports, such as housing. Each program would serve 40 inmates/defendants annually. Our experience with this model shows that the typical client referred by the court has significant co-occurring disorders, has had numerous prior arrests, lacks basic social supports, and is otherwise ineligible for existing alternative programs as a result. Our program has been successful in engaging such clients in treatment, assisting them to comply with court-mandated supervision, and developing a stable community living plan.

3. **Crisis Intervention Teams (CIT):** CIT is a partnership program between local police departments and the local mental health provider to designate specially trained staff from each agency to collaboratively respond to community crises, improve the response to persons with behavioral health needs, decrease arrests by providing expedited access to evaluation and treatment, thus achieving safer outcomes. While this approach was developed in the early 1990s in Memphis and has since expanded across the nation, Connecticut's model is unique in that not only are select members of the participating police force specially trained, but the DMHAS- funded mental health agency designates clinicians to this program to ensure timely access to community treatment, services and follow-up. In the event an arrest is necessary despite the joint effort, this clinician can facilitate medication in the police lock-up and provide further follow-up. This program has been shown to reduce arrests, lower workers' comp injuries for the police, result in safer outcomes for citizens and police and, importantly, increase the likelihood that families of persons in crisis will seek police assistance, knowing that their loved one will be treated in a humane and dignified manner by trained officers. Current programs (funded by federal grant dollars) exist in New London/Norwich, New Haven/West Haven, Hartford, and Waterbury. Many other departments have had some officers participate in the training, even without a formal program in their town. Given the uncertainty of continued federal funding and the importance of these programs, the PJOC recommended not only funding current programs with state funds, but also identifying funds so that the program can be expanded to additional municipalities. We have just recently received a letter from OPM Secretary Genuario that all, of the funding for the current programs will be available for the next fiscal year.
4. **Women's Treatment and Support Diversion Programs:** DMHAS has two specialized women's jail diversion programs -- one in the Hartford court and another in Bristol/New Britain courts. These nationally recognized model programs provide gender-specific, trauma-informed outreach, engagement, treatment and community support as an alternative to incarceration for female defendants who, by their history, have a high rate of recidivism. Research shows that women who become criminally involved have different motivations and needs than do men. While it is clear that a different approach is needed to reduce their recidivism, there is little research available on what works. Despite this, the outcome

evaluation of our programs indicates that the women who participate experience an increased stability in their lives, continued engagement in treatment beyond the end of their court cases, and reduced rates of arrest and re-incarceration. Federal funding for these programs will expire in the next few months.

5. **Jail Re-interviewers:** CSSD's Jail Re-interview program (JRIP) has demonstrated significant success in reducing incarceration time for pre-trial defendants who did not make bond at arraignment and were incarcerated. The jail re-interviewers reevaluate the defendant in jail and develop a community release plan when possible, and can re-docket the case for an expedited hearing for the court to reconsider bond, based on the pretrial release plan.  
**Jail/Prison Re-Entry Programs:** Community support is essential to the successful re-entry into the community of persons who have been incarcerated. For those with mental health and/or addiction problems whose conditions have improved with treatment during incarceration, the challenge is to sustain that recovery while overcoming the obstacles to community re-entry faced by all inmates: i.e., finding housing, jobs, and relationships. The PJOC has recommended that the state sustain a comprehensive array of case management options for offenders with significant behavioral health disorders who are nearing release from DOC in order to promote successful re-entry and reduce recidivism for this special needs population. Currently, there are two grant-funded programs: (1) the **Connecticut Offender Re-entry Program** (CORP), which provides intensive case management and pre-release programming for one year prior to the end of sentence for inmates with serious psychiatric disabilities who are at high risk of recidivism. Federal funding will continue until 12/06, at which point the continuation of this successful collaborative program is uncertain; and (2) **Transitional Case Management** provides for intensive pre- and post-release discharge planning and community case management for inmates with significant substance abuse histories and a resulting high risk of recidivism. The Governor's 2006 budget includes \$400,000 for DMHAS to continue these programs with state funding.
6. **Specialized Probation and Parole Officers:** Persons with significant behavioral health problems may be at increased risk of violating the conditions of their probation or parole. Often such violations include failure to report, "dirty urines", or non-compliance with a condition of probation/parole for treatment, rather than an arrest for a new crime. In order to strengthen the ability of probation/parole to effectively work with such clients and to provide graduated interventions and sanctions that consider the behavioral health issue, the PJOC recommends that CSSD and Parole employ specially trained and/or clinically licensed professionals to provide community supervision to offenders with psychiatric disabilities or co-occurring disorders, and to collaborate with theaters for those persons for whom treatment is a condition of probation/parole;
7. **Review of Existing Programs & Contracts:** As important as the development of new programs is in addressing the disproportionate representation of persons with psychiatric

disabilities in jails and prisons, we also need to identify ways by which current and future state-funded alternative-to- incarceration and community supervision programs can be modified to accommodate persons with some psychiatric disabilities. The PJOC recommends that current programs and services (as well as contract language) be reviewed to identify obstacles and limitations to accessing such programs for persons with psychiatric disabilities and co-occurring disorders. While some persons have such significant psychiatric problems that specialized programs are necessary and appropriate, many others have mild to moderate mental health needs that could be addressed by adding services or establishing formal relationships with community treatment providers. Both approaches -- specialized programming when necessary, and accommodation within general programs whenever possible -- will have a significant impact on the number of incarcerated persons with behavioral health disorders, reduce recidivism, and improve the quality of life for such persons, their families, and communities.

One final point: I know that this issue is not specifically included in the prison and jail overcrowding bill, but I strongly believe that we need to think about how to address the issue of siting, because we can have all the best ideas in the world about how to provide services, but if we are not able to convince communities to allow the services in, then our efforts will be fruitless.

Thank you for the opportunity to speak in support of **S.B. 359** and give you our update on the efforts of the PJOC. I would be happy to take any questions you may have at this time.