



STATE OF CONNECTICUT

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

A HEALTHCARE SERVICE AGENCY

M. JODI RELL
GOVERNOR

THOMAS A. KIRK, JR., Ph.D.
COMMISSIONER

Testimony of Thomas A. Kirk, Jr., Ph.D., Commissioner Department of Mental Health & Addiction Services Before the Appropriations and Judiciary Committees April 10, 2008

PRISON OVERCROWDING COSTS FORUM

Good afternoon, Sen. Harp, Sen. MacDonald, Rep. Merrill, Rep. Lawlor and distinguished members of the Appropriations and Judiciary Committees. I am Commissioner Tom Kirk of the healthcare services agency formally known as the Department of Mental Health and Addiction Services. I am pleased to be given the opportunity to provide a picture of the direction my agency has been taking, and continues to take, on the issues before you today – individually, and so often in linkage with the Department of Correction (DOC) and the Judicial Branch (JB), both in terms of our service focus and through the fiscal support of the Governor. Further, I wish to leave with you some “key take-home messages” which, in my judgment and professional experience, should be considered, and in some instances must be weighed, as part of the overall comprehensive review of issues confronting all of us in government.

In response to the questions forwarded from the Committees relative to the various service initiatives we have in place and the fiscal expenditures associated with them, I have attached to my testimony a detailed summary and would welcome any questions or comments you may have regarding the material. The format is such that DMHAS state-operated or private nonprofit funded services and costs are divided into three main categories: (1) Diversion, Pre-Arrest or Pre-Trial, (2) Within DOC or while an adjudicated offender is in the community, and (3) Re-entry services. Suffice to say that review of the attached summary reflects a wide band of traditional and newer innovative services, significant expenditures and cross state agency/branch collaborations, as well as evidence of effective outcomes and positive return on investment. Quite simply, mental health and/or addiction issues are not the sole drivers in the criminal justice system, yet they must be a critical part of the criminal justice agenda and strategy.

Let's proceed to key fiscal allocations for DMHAS already approved by the Governor and the General Assembly in support of the criminal justice agenda, and those proposed by the Governor for FY09, and often also included in the Appropriations Committee's recommended budget.

(AC 860) 418-7000

410 Capitol Avenue, P.O. Box 341431 • Hartford, Connecticut 06134

www.dmhas.state.ct.us

An Equal Opportunity Employer

ATTACHMENT TO DMHAS TESTIMONY APRIL 10, 2008

What services do inmates receive when they are released? How do you connect services that inmates receive while in the correctional facility to the services they receive post release?

I. PRE-ARREST

Crisis Intervention Team Program (CIT)

CIT provides DMHAS-employed CIT clinicians to assist police departments with serving persons with psychiatric needs in the following locations – Waterbury, Hartford, New Haven, West Haven, Stamford, New London, Norwich, and Groton (Bridgeport is hiring a CIT clinician).

- CIT clinicians assisted police with over 1,700 persons in SFY07.
- Starting in 2004, DMHAS received a three-year, \$1.5 million grant in SFY05 from the U.S. Dept. of Justice to allow diversion to treatment prior to arrest for persons with psychiatric needs who are the subject of a call to local police.
- Beginning in SFY08 the project is fully state funded and has expanded to include DMHAS-employed clinicians in Stamford (active) and Bridgeport (before end of SFY08)
- CIT provides a five-day, 40-hour training and one-day refresher course for police officers on dealing with persons with psychiatric disorders.
- In SFY07, over 135 police officers and other responders from 20 police departments and 24 Correctional and Probation Officers, and 8 mental health staff attended the five-day, 40-hour training.
- In SFY07, over 68 police officers and other responders and 3 mental health staff attended the one-day refresher courses.
- As of Jan 2008, over 400 officers representing 23 municipal police departments, State Police, and over 6 college and hospital departments have received CIT training – mostly funded by DMHAS.
- CIT-trained officers report that they use their CIT knowledge and skills on all calls, whether or not the call involves a person with a psychiatric disorder.
- Assistance by the CIT clinicians has improved engagement in services and interagency collaboration for persons with psychiatric disorders.

II. JAIL DIVERSION PROGRAMS (mostly pretrial)

A. Jail Diversion Program (JD). (Serious Mental Illness).

- JD program funding expanded to all 20 GA courts in 2001 (Hartford and a few others started in 1994 or later).
- Clinically screen approximately 4,300 individuals with serious psychiatric disorders annually.
- Court diverts approximately 1,500 of screened individuals annually, JD refers to DMHAS services; number diverted has declined from 2,300, probably due to effects of recent high profile crimes. At this time, we do not have specific data as to the number of diversions that could not be accomplished due to housing not being available. A new data system being implemented will yield that information.

- Coordinate and monitor community services for diverted individuals,
- Forward clinical information to jails for defendants held on bond,

B. Women's Jail Diversion Programs (JDW). (primarily non-Serious Mental Illness).

Women with substance use disorders who experience serious psychiatric consequences from emotional, physical, and/or sexual abuse.

- Coordinate and monitor community services for diverted individuals.
- Serves New Britain/Bristol and New Haven courts
- Provides intensive outreach, engagement and comprehensive community support.
- Capacity of 20 individuals in each location, serving up to 50 annually.
- Over half of participants successfully complete the program and are not incarcerated.
- Annual program costs to serve 50 women equals 6 months' incarceration for 20 women.
- For all participants, completers and non-completers, arrest rates were cut by approximately 50% in the year following admission to the program.
- This innovative program has received national attention.
- The Hartford program received a new SAMHSA grant to expand (described below).

C. Specialized Trauma-Informed Jail Diversion Program (JDT). (primarily non-SMI).

DMHAS received a third SAMHSA three-year, \$1.2 million grant in 2006 to expand the Women's JD program in Hartford to also serve men.

- Men and women who have experienced the psychiatric consequences of trauma.
- Services similar to JDW, above
- Coordinate and monitor community services for diverted individuals

D. Alternative Drug Intervention (ADI) (primarily non-Serious Mental Illness)

- Intensive outpatient substance abuse treatment to New Haven court .
- Serve 100-120 clients/yr.
- Intensive case management, basic needs, employment, education, and linkage to 12 step groups.
- Individual and group treatment including Motivational Enhancement Therapy, Cognitive Behavioral Therapy, Dialectical Behavior Therapy.
- Coordinate and monitor community services for diverted individuals.
- 85% successfully completed 6 month treatment program without re-arrest.

III. MIXED PRETRIAL AND REENTRY PROGRAMS

A. Access to Recovery (ATR)-August 2004-August 2007

The Access to Recovery (ATR) Program was a three-year grant funded by the federal Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) to expand the Department's treatment and recovery support services. DMHAS received over \$22.8 million dollars over the course of three years to operate the program, which was completed in August 2007. The department collaborated with the Judicial Branch, Court Support Services Division and the Departments of Children & Families, Correction and Social Services

What did we accomplish in the Access to Recovery (ATR) Program?

- **Individuals Served.** Between 1/2005 and 8/2007: ATR served over 18,000 unduplicated individuals with substance use disorders. The original projection was to serve 17,000 individuals over the life of the grant. Participants were provided genuine choice for each
- service. 45% of individuals served were involved with the criminal justice system (approximately 7,500 individuals).
- ATR offered the following clinical services: Clinical Assessment, Brief Treatment, Intensive Outpatient, Matrix Intensive Outpatient Program (for cocaine/methamphetamines) Methadone Maintenance, and Ambulatory Detox and the following recovery support services: Two months of Housing support, Transportation, Vocational/Employment, Peer and Faith-based supports, Basic Needs, and Case Management.
- Evaluation data from CSSD's Technical Violation Units (TVU) reflect better outcomes for individuals who received additional supports through the TVU unit + ATR clinical and/or recovery support services.
- Strengthened collaborative partnerships with other state agencies, including the Judicial Branch, and the Departments of Correction, Social Services, and Children and Families in order to provide services to individuals involved with multiple agencies.

B. Access to Recovery II-September 2007-September 2010

In September of 2007, through a competitive application process, DMHAS was awarded \$14.5 million (over 3 years) for Access to Recovery II. DMHAS has once again targeted CSSD-Judicial Branch, DOC and DCF involved individuals with substance use disorders as the target population for ATR II.

ATR offers the following clinical services:

- Buprenorphine Treatment Services (**capacity for 150 individuals annually**),
- Co-occurring Intensive Outpatient Treatment (**capacity for 200 individuals annually**), and
- Clinical Recovery Management Check-ups (**capacity for 800 individuals annually**).

In addition to the clinical services offered, ATR II offers a variety of recovery support services, such as:

- Sober Housing (**1,000 individuals annually**),
- Case Management (**capacity for 1,600 individuals annually**),
- Faith-based services (**capacity for 1,200 individuals annually**),
- Peer-based services (**capacity for 500 individuals annually**),
- Transportation (**capacity for 1,500 individuals annually**),
- Basic Needs (food, clothing, and personal care items) (**capacity for 1,600 individuals annually**), and
- Vocational/Educational services (**capacity for 428 individuals annually**).

Beginning April 30, 2008, ATR Outreach/Intake Staff will be deployed to Correctional Facilities, Parole Offices, and Probation Offices to ensure that individuals are being linked to clinical and/or recovery support services.

To date (from December 2007-March 31, 2008), **827 unduplicated individuals were served through ATR II, of which 90% were individuals involved with the criminal justice system. It is anticipated that over the course of the 3-year initiative, we will serve over 7,000 individuals, with approximately 85% of these individuals having involvement with the criminal justice system.**

C. Alternative Supervision and Intervention Support Team (ASIST) (SMI & non-SMI)

- Developed and funded collaboratively with DMHAS, DOC and CSSD.
- Located in Bridgeport, Hartford, Middletown, New Britain, New Haven, New London, and Waterbury.
- Coordinate and monitor community services for diverted individuals.
- Designed for Capacity = 175, and annually 525.
- Places DMHAS clinical staff in existing AIC to expand population able to be served by this resource. AIC supervision increases numbers who can be diverted/released.
- Increases clinical capacity in Hartford, New Haven, Bridgeport.
- Includes funds for transitional housing.
- Implementing innovative skills training model to reduce recidivism for persons with psychiatric illnesses.

D. Community Recovery Engagement Support and Treatment Center (CREST) (SMI).

Provides intensive case management, skill development and supervision for criminal justice involved individuals who might otherwise be incarcerated

- Capacity of 30 individuals in New Haven.
- Coordinate and monitor community services for diverted individuals.
- Program sited on grounds with access to long-term vocational, educational, social and psychiatric rehabilitation services.
- Also funds clinical positions for CMHC.

IV. RE-ENTRY PROGRAMS

A. DMHAS-DOC Interagency Program (SMI)

Initiated in April 1996 to facilitate referrals of sentenced inmates with serious psychiatric disorders to appropriate community services after release.

Statewide SFY07 DMHAS processed 228 referrals through LMHAs for those not eligible for CORP

3- 6 months prior to release UConn Health Center Correctional Managed Health Care staff in the prisons forward a referral form to the DMHAS Division of Forensic Services (DFS). The UConn staff also forward an application for entitlements to the DOC-funded staff in DSS so that the inmate has entitlements upon release and can access appropriate services and medication.

DFS reviews the referral from UConn staff and forwards it to the appropriate LMHA Staff from the DMHAS-funded Local Mental Health Authority (LMHA) visits the inmate in prison 3-6 months prior to release to begin development of discharge plans.

LMHA staff arrange for services for the inmate upon release

The monthly Inter-agency meeting, chaired by DMHAS, has greatly expanded its scope by pulling together DOC, UConn Health Center Correctional Managed Health Care, CSSD, Parole,

and LMHA representatives to discuss quality improvement, policy development and discharge planning for difficult disposition cases:

- Developed protocol for continuity of care at discharge for sentenced inmates with SMI
- Developed protocol for continuity of care at discharge for un-sentenced inmates with SMI
- Developed protocol to resolve differences in treatment plans between community and DOC
- Developed procedure for continuity of care for SMI inmates discharging to DOC Half Way Houses (Wtby, NHaven)
- Ongoing general case planning for discharging SMI inmates
- Case specific discharge planning for high risk and high need inmates
- Developed use of video conferencing WFD-Garner CI to 1) assess for WFD admissions, 2) diagnostic clarifications, 3) consultation re high risk clients
- Identify discharging SMI inmates to be assigned to MH Parole and MH Probation Officers
- Ongoing review of DOC census of SMI inmates to plan for care
- Assist with implementation of ASIST and CREST programs
- Assist with implementation of MH Parole and MH Probation Officers and MH JRIs

B. Connecticut Offender Reentry Program (CORP) (SMI)

Assists with reentry of sentenced male and female inmates with severe psychiatric disabilities, or co-occurring disorders who are returning to Bridgeport, Hartford and New Haven.

Staff begins working with inmates in Garner and York Correctional Institutions six to twelve months prior to release. DMHAS-led skills groups twice a week in the two DOC facilities. Provides comprehensive pre-release assessment and skills building program including the development of a community support network.

In FY07, CORP accepted 54 individuals; 27 individuals were discharged to the community; of all clients served in SFY07, **7% were re-arrested and 11% were re-incarcerated** during the fiscal year. The individuals served in CORP are in addition to the 228 individuals served in the DMHAS-DOC Interagency Program described above.

- Expansion late SFY08 with SFY08 PJOC funds – also serve Osborne CI for inmates returning to Bridgeport, Hartford and New Haven
- Expansion with SFY09 Governor's budget \$566,346 – serve Garner, Osborne, York for individuals returning to Waterbury, New Britain, Bristol, Stamford, New London, Norwich.

C. Transitional Case Management Program (TCM) (men; non-SMI)

The program assists with reentry of sentenced male inmates with substance use disorders who are returning to Hartford and Waterbury.

Staff begins working with inmates in the DOC facilities 3 to 4 months prior to release by providing discharge planning, assistance with housing, and application for entitlements.

After release, staff provides continued community support, assistance with housing, outpatient substance abuse counseling, and assistance with employment.

SFY07 - TCM served 110 individuals, transitioned 80 to the community. SFY07 – during their time in the program **only 2% of participants re-arrested and 2% re-incarcerated.**

Expansion SFY09 with PJOC funds – individuals returning to New Britain, Bristol, New London, and Norwich

V. STATE ADMINISTERED GENERAL ASSISTANCE BEHAVIORAL HEALTH PROGRAM (SAGA BHP)

The \$73M SAGA BHP provides a full continuum of clinical treatment and recovery support services to individuals who are SAGA eligible. **It is estimated that approximately 30% of individuals (31,714 unduplicated individuals in FY07) served through SAGA are involved with the criminal justice system.**

KEY TAKE HOME MESSAGES

FUND ONLY TRUE EXPANSION OF CAPACITY

The CT behavioral health system is a multi-funded system of care. DMHAS, DOC, CSSD and DSS each are part of this complex system. Many of the same private nonprofit agencies are funded by each of the aforementioned state agencies or funders. This is particularly important for licensed residential treatment levels of care. There has been no increase in this level of care since 2004 and minimally prior to that.

LEARN FROM LESSONS OF DMHAS \$73M GA BEHAVIORAL HEALTH PROGRAM (GABHP)

The DMHAS GABHP is an extraordinary example of efficacy (e.g. re-arrests and incarcerations, and so on). Thirty percent of all GABHP clients are persons associated with the criminal justice system. The five bulleted points noted below are examples of GABHP's successes in terms of both cost and quality of outcomes:

*** PAY ATTENTION TO FREQUENT USERS OF HIGH-COST SERVICES**

Too often, a very small percent of individuals with mental health and/or substance use disorders are accounting for a disproportionate share of healthcare and other service expenditures. That result implies the person is being underserved or ineffectively served in current care format. GABHP has targeted interventions that are innovative, cost contained and effective for the highest cost service users.

*** RE-INVEST IN SERVICES THAT SUPPORT RECOVERY**

GABHP has targeted and progressively invested the "savings" from the above approach in services that resulted in individuals moving into a "recovery zone" of sustained stability in the community or the least restrictive living environment.

*** KEY SERVICES IMPROVE OUTCOMES**

GABHP has supported services that help move a person into a recovery zone. These have included **case management, decent housing** – sometimes with or without supervision, **transportation vouchers, short term housing support, personal care support**, initial support for **educational and/or employment** related areas. Some of the former are also supported through the federal Access to Recovery Grant.

*** CONTINUING CARE RATHER THAN ACUTE MODEL**

Understand that persons with psychiatric and/or substance use disorders, as is the case with anyone with serious healthcare conditions, have continuing care rather than acute care disorders. A continuing care approach is usually much more cost contained, stabilizing and effective than focusing on repetitive high cost, acute care services with limited sustained benefits such as repeat ER presentations, residential or inpatient psychiatric hospital admissions. Again, a positive GABHP service model.

*** CONTROL COSTS TO SERVE MORE PEOPLE**

Include control of the rate of growth of healthcare and service expenditures as one essential measure of the overall quality and funding strategy of the service system and funding strategy. Accept the fact that overall costs may increase but the service cost per person should at least be

stable or decrease. In so doing, more persons can receive services. That has been the case with GABHP.

STATEWIDE COMPREHENSIVE DATA IS CRITICAL

Based upon the provider case finding used in the Access to Recovery program, the percent of criminal justice related cases in the total DMHAS system is 45% of the 45,000 cases. Connecticut statute requires that, whether funded privately or by a state agency, all licensed substance abuse treatment programs report all their admissions into the DMHAS data system.

HOUSING, EMPLOYMENT AND TRANSPORTATION ARE GREATEST NEEDS

The demand for suitable housing exceeds the supply. Yet, housing and employment are probably the **most important factors for stable and sustained living in the community** during and post treatment and post release from the criminal justice system. We have insufficient housing that is **safe, affordable, and appropriate**. This impairs engagement in community services, increases the risk of arrest, prevents diversion from incarceration, and prevents early release from incarceration. Our attempts to site a 20-bed residential component as part of an Alternative to Incarceration Center were blocked in both Waterbury and Hartford. As noted in the attachment to this testimony, we have just started to use funds associated with the ASIST initiative, have limited housing funds in the Targeted Case Management and Connecticut Offender Re-Entry Program and can support two months of housing expenses per qualified individual through the Access to Recovery Program.

DON'T CONFUSE NEED FOR SERVICES WITH DEMAND

A very large proportion of persons with substance use and sometimes mental health issues are not "knocking down the door" to secure such. Yet, earlier interventions can be most cost effective and stem the advance of the disorder. This is one of the reasons why services focusing on motivational interviewing, specialized outreach strategies and related service engagement approaches are critical and being increasingly used. Special attention to gender, culture and other demographics must occur and have proved to be effective.

INPATIENT VS. RESIDENTIAL TREATMENT VS. RESIDENTIAL PLACEMENT

"Inpatient care" is licensed, intensive, medically managed care which is reserved for persons with the more severe substance use and/or mental health disorders which, in the DMHAS state operated hospitals costs \$800 - \$1,000 per day.

"Residential Treatment" programs are licensed, with specific staff and service requirements, vary in lengths of stay, and have an average cost of \$155 per day in the private nonprofit sector.

"Residential Placement" is not licensed and is provided in a setting in which there is 24/7 supervision, little if any formal treatment and the person may or may not have movement to and from the community at the cost range of \$30 to \$50 per day.

REMOVE BARRIERS TO SUCCESS

Criminal conviction can be a barrier to housing and employment for many years. The resulting inability to obtain stable housing and employment often is a contributing factor to relapse and criminal recidivism.

COLLABORATION YIELDS NEW FEDERAL DOLLARS AND IMPROVED SERVICE MODELS

From 2004 through present, DMHAS, in partnership with CSSD, DOC, and other state and community and academic entities, has successfully garnered over **\$45 million in new funding from federal agencies** to support the development and testing of new service models for treatment and recovery support services including for individuals involved with the criminal justice system. A recent example of a grant targeting individuals involved with the criminal justice system is the \$14.5 million Access to Recovery II Program, which expands clinical treatment and recovery support services for individuals with substance use disorders. Of the current 800 unduplicated individuals served under this grant, 90% are individuals involved with the criminal justice system (End of Sentence, Probation or Parole).

WORKING TOGETHER

In order to maximize the impact of the various funding streams and system components it is essential that state agency and Judicial Branch partners effectively work together and ensure linkage mechanisms to maximize use of the existing system capacity, especially because many people become involved with each of these agencies at the same or different times in the course of their recovery.

Thank you for the opportunity to testify before you today. I will be happy to answer any questions you may have about this testimony or to any of your previous inquiries I may have missed.