SENATOR OSTEN (19TH): And first up is Roland Bishop. And just so everybody knows, if you need to get out of the room, you go out those two exits on either side. If they close the doors and they’ve locked us IN, we don’t go out until they say it’s safe.

And Roland, you are first up and each speaker will have three minutes. Thank you so much.

MR. ROLAND BISHOP: Good evening Representative Candelaria, Senator Osten, members of the committee. My name is Roland Bishop. I am primarily a state school teacher in the Department of Correction. I am also secretary treasurer of CSEA, SCIU, local 2001. We represent close to 25,000 active and retired public and private sector workers.

And more important than that, I’m elected president of the P3B Bargaining Unit and I represent those 100, plus 100 certified staff in the Department of Correction at work in the Unified School District.

And I am here today to talk about that school district and prerelease education. I believe a lot
of emphasis has been on, and rightly so, post release reentry education and programming. But the school district in Corrections is a feeder for that programming.

If the student or the inmate doesn’t have a GED, high school diploma or vocational certification, the pool is severely constricted for the reentry program. And I believe that the prerelease education becomes even more important especially when you are talking about Pell college grants and other reentry programming as we move forward.

So to give a little bit of background, these figures aren’t timely but they're close. The current population is about 13,000. The current enrollment in the school district is about 1200 non duplicated. That means that we are only counting students that come once a day.

Of that pool of students, right now there is about 5800 on the sidelines. But they are doing other things in the prison. They're doing jobs, they're doing other programming that allows them to access our rec program and leave. But these students also don’t have a GED or vocational certification.

So even if we captured 20 percent that’s almost another 1200 students. And I think everybody here agrees that education and it's been proven by the Rand Study, is the key to lowering recidivism.

So it gives you good metrics if we can sustain the school district. And that's why I’m here. Most of our school district funding comes from federal grants or Title I funding. As the priorities of the department differ, and rightly so as I said, you
know, our funding has declined over the years by students.

So go back to 2011, '12, it was 1.85 million. The last number I have for 2016, 2017 was 640,000. So we mainly operate on grants and we apply for grants and as you know, it takes time for the grant application process and actually for the money to hit the books. So what I’m here to ask for is a line item in the budget for the Unified School District and here is how I -- and the teachers and vocational instructors and members look at it.

There is a delay in getting funding. However, we do need materials, we are operating on XP and Windows XP 2007. We don’t have internet in the classroom. But we are very flexible staff to meet the needs of our student population. So as our needs arise, the money may not be there at the strategic time.

So if we had a line item in the budget for the school district, we could access that money at the strategic time until the grant funding is either approved or received.

SENATOR OSTEN (19TH): So, Roland, what is the grant amount that you’re looking for because you’re at five minutes now so just want you to know.

MR. ROLAND BISHOP: Oh, I’m sorry.

SENATOR OSTEN (19TH): I’m sorry, I got a timeline here.

MR. ROLAND BISHOP: Okay.

SENATOR OSTEN (19TH): I apologize. But what are you looking for, Roland? Because I know you know this like the back of your hand.
MR. ROLAND BISHOP: For a number?

SENATOR OSTEN (19TH): Yes.

MR. ROLAND BISHOP: Start of at 250,000.

SENATOR OSTEN (19TH): Okay. Did you submit anything in writing, Roland?

MR. ROLAND BISHOP: I will. I can follow up and email --

SENATOR OSTEN (19TH): That would be great.

MR. ROLAND BISHOP: -- everybody’s office with that information.

SENATOR OSTEN (19TH): Well, just send, all you have to do is send it to Sue Keen (phonetic - 00:06:06) who is the administrator for this and just give an outline on the bullet points on what you would like to see or that written testimony. There, Danny can help you out with it. And that way we can get some numbers.

I don’t know that we agree or disagree right now but I think that would give us something to look forward to. And we will be able to bring it up in some of the workshops that we have on appropriations.

MR. ROLAND BISHOP: Okay.

SENATOR OSTEN (19TH): All right.

MR. ROLAND BISHOP: I would be glad to --

SENATOR OSTEN (19TH): Don’t go anywhere. Let me see if there’s any questions. Comments or questions? No. All right. Thanks, Roland, appreciate it.
MR. ROLAND BISHOP: Thank you, everybody, for your time.

SENATOR OSTEN (19TH): Melissa Winiarz. You can start as soon as you are ready.

MS. MELISSA WINIARZ: Okay. Good evening, Senator Osten, Representative Walker and members of the committee. My name is Melissa Winiarz and I have been working as a clinical social worker for the Department of Corrections and UConn's Correctional Managed Healthcare for the past nine years.

This was not the path I saw myself on when I was started my masters in social work program but it is exactly where I belong. I truly love the work I do. Working with incarcerated individuals is both challenging and rewarding. It is absolutely exhausting, invigorating and most importantly it is life changing.

I have seen the impact that strong mental health treatment can have on an inmate’s life helping them overcome addiction, trauma and a criminal lifestyle. I have had my life threatened as well as the life of my family and witnessed a man attempt suicide right in front of my eyes. It is not easy work but I am committed to the work I do.

Deficits to the budget have changed the work I have been able to do for the past nine years. My coworkers and I have been told work smarter, not harder and been pushed far past our limits. We work below minimum staffing and have less resources available while the work remains the same no matter how much money is allotted to complete it.
While my facility Cybulski Correctional Institution is full -- well to be considered fully staffed, the need for mental health services and demands by administration have increased.

Nine years ago my function unit had another psychologist position, a mental health prescriber and five more clinical social workers slash professional counselors to complete the same work.

In order to manage the budget, positions were eliminated. The lack of funds have meant less mental health staff to the point where we are now past minimum staffing as an everyday norm.

My coworkers and I have had to decrease our facilitation of mental health groups and other duties related to the reintegration unit at Cybulski in order to cover Northern Correctional Institution which is experiencing a critical shortage of mental health staff.

Northern is in desperate need. They have a mental health infirmary and more acute mental health patients. The deceased budget has crippled our ability to provide quality mental health treatment in exchange for statistics and saving money.

To quote a coworker of mine, we can work less with less or more with more but we cannot work more with less. We have come to the point where we cannot manage working with any less and be expected to provide quality inmate healthcare.

As an imperative for this committee to recognize the need for changes into the budget in order to provide important mental health treatment to this inmate population. Please give me the opportunity to
provide the treatment I was trained to do instead of being overworked with limited resources. Thank you.

SENATOR OSTEN (19TH): Thank you. Any comments or questions? Seeing none. Thanks so much. Next up is Rebecca Simonsen.

MS. REBECCA SIMONSEN: Okay. Good evening, Senator Osten and members of the committee. My name is Becky Simonsen and I’m a lead organizer with the SCIU 1199 New England. Our union represents 26,000 healthcare workers across the public and private sectors in Connecticut. This includes all 600 front line healthcare workers in the Connecticut Department of Corrections.

Our members working in Connecticut’s prisons are doctors, nurses, psychiatrists, social workers and other healthcare professionals who care for a population with acute medical and mental health illnesses.

1199 members’ help inmates cope with histories of trauma, abuse and addiction and help to best give them the tools that they need to reenter our communities, find work and provide for their families.

Tonight, you will hear from several of our members advocating for a significant expansion to the budget for DOC inmate health services. Years of insufficient funding have led to a crisis staffing levels and substandard conditions within the agency.

Under UConn CMHC, the budget has been cut over 25 percent over the last 10 years despite skyrocketing medical costs and an increasingly medically acute and aging inmate population.
Accordingly, staffing ratios and policies including the number of nurses on a shift, the ratio of inmates to prescribers or the number of times a social worker should see a mentally ill inmate per month, have been determined by the bottom line rather than what is necessary for patient care and safety.

Our members have identified two main issues with this trend. First, underfunding has led to an extreme shortage of the number of mental -- of healthcare staff and relatedly, underfunding has led to system wide staffing ratios to fall so low they are unsafe for our member and inmates alike.

The scope of this shortage is severe. There are approximately 140 vacant positions statewide. The department ran deficit this past year despite limited hiring. The governor’s budget of 85 million for inmate medical services is simply not enough funding to fill these vacancies.

We need the legislature to take action to expand the funding for our services. The decision to underfund and understaff medical services has serious consequences for people’s lives. Staffing ratios are so unsafe for the incarcerated population that 1199 members are working under protest in several facilities.

They are mandated to stay at work over and over again, required to triage crises rather than act proactively and frequently work below the already unsafe minimum staffing levels.

1199 members are raising their voices because they refuse to continue to see inmates waiting six months to see a doctor, only for their illnesses to become
more emergent, painful and expensive. They are raising their voices because they want to provide adequate preventative and rehabilitative care that can reduce recidivism.

They are raising their voices because the underfunding of inmate medical services is inconsistent with our common goal of being a national leader of -- in criminal justice reform.

The United States is the highest incarceration rate in the world and prison healthcare in this -- is in crisis nationwide. Litigation has most often been the catalyst for enforcement of correctional healthcare standards. Even the current constitutional mandate to provide adequate healthcare in prison was the result of a Supreme Court decision in the 1976.

But in Connecticut, we have a choice to make. Are we going to continue to underfund inmate health services and wait for lawsuits to produce system overhaul, allowing for the suffering of both inmates and staff that would proceed it? Or are we going to make a real investment in DOC health services which would expand preventative care for inmates, create a safer environment for staff and produce healthier communities for all of us?

Just like 1199 healthcare workers aim to prevent rather than react to emergencies, it is time for Connecticut to take action now in following through on its progressive vision for quality correctional healthcare.

SENATOR OSTEN (19TH): Thank you. Any comments or questions? What’s the dollar amount that you want to see?
MS. REBECCA SIMONSEN:  We would like to see at last what the commissioner requested.

SENATOR OSTEN (19TH): Which is?

MS. REBECCA SIMONSEN:  98 million.


MR. ANDERSON CURTIS: Good evening, Representative Walker, Senator Osten and other distinguished members of the Appropriations Committee. I am Anderson Curtis, a field organizer with the ACLU Connecticut Smart Justice Campaign. With my colleague is Gus Hamilton here. And we are here to testify regarding a current healthcare crisis in Connecticut’s prisons and jails.

The message that I am here to deliver today is that Connecticut residents value safe and healthy communities. We are asking the Appropriations Committee to strongly consider those values when reviewing how to adequately fund healthcare services in the Department of Corrections.

When it comes to health services in the Department of Correction, the vast majority of people who are the direct recipients and in need of quality healthcare are keenly aware that the current level of medical care in DOC does not meet their needs.

This is simply not an issue for people in prison. This is a public health crisis that affects everyone in our state. Untreated health conditions follow formerly incarcerated people back into their communities affecting us all.
I have served time in Connecticut prisons where I witnessed and experienced not only my own suffering from inadequate healthcare but also heard the anguished cries of people suffering from opioid withdrawal and trauma. Here is Gus to finish up.

MR. GUS HAMILTON: More than half the people who are incarcerated in Connecticut’s prisons and up to 90 percent of people who are detained in Connecticut’s jails suffer from drug dependence compared with only two percent of the general population.

Hepatitis C is 9 to 10 times more prevalent in Connecticut’s correctional facilities than in other communities. Chronic health conditions such as asthma and hypertension and mental health disorders also affect incarcerated people at rates that far exceed their prevalence in the general population.

Often, people view the healthcare and health status of prisoners as something insular, of no concern to and uniquely disjointed from the general population. But more than 95 percent of people who are incarcerated will eventually return to their communities and their health problems and needs will often flow.

Incarceration is often counterproductive to people’s health and wellbeing. If our state is going to incarcerate people however, then our state also has the constitutional obligation to provide people it has chosen to imprison with the screening, diagnosis, treatment and other health resources they need to live healthy lives inside and out of prison.

I have experienced the inadequacies of the mental health system in Connecticut prisons and know firsthand how frustrating it can be to actively seek
out mental health services but wait months for treatment.

Smart Justice strongly urges this committee to expand the healthcare services available to incarcerated people by increasing the healthcare budget of the Department of Correction, including its budget for preventive care.

Currently, the focus of care within the Department of Corrections is only on managing and triaging crises. People are not sentenced to die or suffer from lack of adequate healthcare.

Untreated mental health conditions and other medical conditions will follow people back into the community ultimately affecting all of us.

Smart Justice testifies today to strongly urge this committee to align DOC's healthcare staffing ratios to fall within the proven community standards of care. Thank you.

SENATOR OSTEN (19TH): I thank you. Any comments or questions? I only have one comment. I am assuming that you are going to go talk to the Finance Revenue and Bonding Commission.

MR. ANDERSON CURTIS: Absolutely.

SENATOR OSTEN (19TH): And talk to them about revenue? Thank you very much.

MR. ANDERSON CURTIS: Thank you.

SENATOR OSTEN (19TH): Up next is Judge Beverly Streit Kefalas followed by Judge Cliff Graves.

MS. BEVERLY STREIT KEFALAS: Thank you. Good evening.
SENATOR OSTEN (19TH): You're all coming up together? (Laughter) No, one at a time, okay.

MS. BEVERLY STREIT KEFALAS: They can be my moral support for the moment. Thank you.

SENATOR OSTEN (19TH): Okay, All right. I don’t --

MS. BEVERLY STREIT KEFALAS: Good evening, Senator Osten, Representative Walker. I am Judge Beverly Streit Kefalas, probate judge of the Milford Orange Probate Court. I have been probate judge for the Milford Probate Court since my election in 1998 and have served as the judge for the consolidated Milford-Orange probate court since 2010.

A little over a year ago, the probate court administrator appointed me as the administrative judge of the New Haven Regional Children's Probate Court. I am an originating judge of the state’s first regional children’s probate court established in 2004 and have served as temporary administrative judge for additional courts as we expanded that model throughout the state.

I am here to respectfully ask the committee to approve funding for the probate courts in the amount of $7.2 million for fiscal year 2019 to 2020 and for $12.5 million for fiscal year 2020, 2021 as set forth in the Judicial Branches proposed budget for this two year budget.

These funding requirements meet the needs of 6,700 children with relative guardians, 20,000 adults under conservatorship and thousands of adults with intellectual disabilities who need continued decision making assistance after attaining the age of 18 years.
We are no longer the courts of just trust and estates. Approximately 50 percent of our workload and cases involve social service needs. In just the New Haven Children’s Court, we serve the families of 10 towns and cities.

The statewide probate court system has appointed relative guardians for approximately 6700 children whose parents cannot care for them due to incarceration, mental illness and or addiction. These guardianships saved the state $66 million per year in foster care expenses that would otherwise be incurred.

And I would estimate they also save millions more in dollars and psychological costs by preserving a family unit as best as possible without placing a child in foster care.

The number of such guardianships has increased over the years but also notably, the complexity of these cases are on the rise. In the last quarter of 2018, 30 percent of the cases in the probate court system involve DCF child protective services. In this, in the past, this number rarely approached 20 percent of the cases.

I would like to introduce to you by way of example three individuals that I have worked with in the probate court. I would like you to meet Aliana. I have changed the names of each of these individuals to protect their privacy and confidentiality.

She is 16 years old. We have had 50 hearings since her guardian was first appointed six years ago. She has multigenerational DCF involvement, mental illness, sexual abuse including her own as a preschooler by mother’s partners.
She has been hospitalized on multiple occasions for psychiatric stabilization, suicidal ideation and suicide attempts. She is diabetic, diagnosed with chronic post-traumatic stress disorder and ADHD.

Two years ago she ran away to her father’s home and returned and a toxicology report revealed she was on three different benzodiazepines since being at that home. Visits with mother have resulted in psychiatric decompensation and resulting hospitalizations.

Her guardian through all of this continues to be her safety net. Respite and kinship funds grant her the financial support to allow that to happen. May I continue? I know the buzzer went off? Thank you.

David is a 58 year old man who is intellectually disabled. He loves football, shopping at Aldi’s with his girlfriend. He likes to share photos of puppies and kittens on Facebook.

His mom had died many years ago and his elderly father had cared for him until he became diagnosed with dementia and was unable to care even for himself. Harry, his dad needed a court appointed conservator and now so did David.

Harry ended up in a nursing home and soon passed away. Their home, over mortgaged and full of the stuff of a hoarder burned down due to alleged arson of a squatter Harry had allowed to move into other garage. David lost not only his dad but his home.

This story has happy ending, however, because through the assistance of a court appointed conservator, David continues to live in the
community and has since learned how to shop with his SNAP benefits.

This past week, the conservator petitioned that I encountered was filed by the Department of Social Services Eligibility Protective Services Unit. Amy is a 76 year old divorced woman whose children have long since severed their relationship with her.

She was physically abused by her husband. Previously as a child by her own father. Her daughter was alleged to have been sexually abused by her husband.

This lifetime of repeated trauma has made Amy ripe for manipulation by so called friends. For the past four years, Amy has been giving her pension and Social Security benefit to a number of sweepstakes.

She told me that her $32 million winnings are just temporarily tied up, for the past four years as she continues to send them her money. And that it will all come back to her when her winnings and her Mercedes Benz are delivered.

The sweepstakes company employees call her frequently and she has become close friends with them. Sheila called her the other day, held captive in a hotel. And she needed Amy, her good friend to help her escape.

Sheila is no longer held captive and is working again with the company to get Amy’s winnings and her car delivered. If only the cash and the car winnings were true.

Amy’s home is in foreclosure, she has no heat because she can't pay for oil. She goes to the food
bank for food. She has no physical illnesses but obviously a history of psychiatric disorders.

Her court appointed conservator however, will step in and engage the appropriate resources to get her alternative housing to live in the community. Her court appointed attorney and her conservator are just part of the millions of dollars of costs in the probate court system to meet the needs of our indigent constituents.

They saved $66 million a year in nursing home care costs by allowing low income seniors to remain living in the community.

In my 20 years as probate judge, I could tell you hundreds of more stories of individuals just like Aliana, David and Amy. They are in desperate need of the services of the probate courts in the state of Connecticut.

Our population is aging, the opioid crisis is not slowing down, the gap between those who have wealth and those who are indigent is growing. And through it all, the 54 local probate courts and six regional children’s probate courts are here to meet these needs.

We cannot however, financially support these services that continue to grow in volume and complexity without the funding that’s set forth in the judicial branch budget.

I respectfully urge your approval of the budget as presented. Thank you.

SENATOR Osten (19TH): Thank you. Any comments or questions? No.
MS. BEVERLY STREIT KEFALAS: Thank you.

SENATOR OSTEN (19TH): Next is Judge Graves and followed by Judge Norris.

MR. CLIFF GRAVES: Good evening, Senator Osten, to Representative Toni Edmonds Walker, to Senator Winfield, Representative Candelaria and for the members -- honorable members of the Appropriations Committee.

Supreme Court Justice Louis Brandeis admonished us over a century ago that if we desire respect of the law that we must first make the law a respectable -- if we desire respect for the law then we must first make the law respectable.

The prophet Micah Chapter 6 Verse 8 challenges us further. Which does the Lord requires was for what to do justly, show mercy and walk humbly with our God.

Every day in this, in our state, 54 probate court judges and our respective staffs do our collective best to adhere to the mantras issued by Justice Brandeis and the prophet Micah. This manifests itself in ways already illustrated by Judge Streit Kefalas and later by Judge Norris.

As for my district, I am honored to preside over the busiest probate court in the state, the New Haven district. I have served now for nearly 14 months succeeding the legendary Judge John Jack Keys who dutifully served our state for over 32 years.

In any given week, we mediate, referee, oversee often heated family disputes over wills, trust and estates, assist adult children navigate the intricacies of being a conservator for their ailing
parents, commend grandmothers for seeking guardianship for their neglected grandchildren.

Solemnly hold court in a Yale or New Haven hospital room for doctors, lawyers, family members and the patient distraught and agonizing over the do not resuscitate petition before me. And yet struggle to balance the emotional distress and cries for help of parents and their children patients battling discourage and mental illness and or substance abuse riveting our communities at Connecticut Mental Health and Yale Psychiatric Hospital.

But this is what we do. This is who we are. Adhering to the legacy of Judge Keys, 14 months ago I was elected on the platform of competence, compassion and connectedness. Competence, compassion and connectedness.

Competence, the ability and professional experience to do the job. Again quoting Brandeis, knowledge is essential to understanding and understanding should precede judging, compassion, empathy. Genuine concern for those who come before us seeking fairness and justice.

And yes, connectedness. Being a part of a connection with the families, the neighborhoods, the cultures we serve.

To that end, we in New Haven have conducted a series of public forums entitled probate court and you. These have been held in all of the public libraries, hospitals, schools and churches. Informational sessions to advocate and enlighten our community on the work we do and how probate court works for them.
If we desire respect for the law then we must make the law respectable. What the Lord required was but to do justly, show mercy and walk humbly.

Daily the 54 probate judges in our state strive to make the law respectable and to do justly by those we are charged to serve.

May I continue please just quickly? On their behalf I thank you for your past support and increased support to help us do our best to be our best. So I stand with my colleagues including Judge Kunerum [phonetic] and ask you to support and approve the fiscal year budget for 2019, 20 of 7.2 million and soon for fiscal year 2021, 12.5 million so again we and do what we do.

And so I ask you to do justly and show mercy and show support for our budget request. Thank you.

SENATOR OSTEN (19TH): Thank you. Any comments or questions? I knew that Representative Tony Edmonds Walker was going to be responding to that.

REP. WALKER (93RD): It just happens to be my cousin. (Laughter)

MR. CLIFF GRAVES: Just saying.

REP. WALKER (93RD): Thank you. Thank you guys for all you do and, Clifton, thank you for taking up the gauntlet after jack. That’s a heavy, heavy gauntlet to do and we all support probate court. It’s a fantastic program and especially children’s probate court. So thank you very much for your testimony.

MR. CLIFF GRAVES: Thank you. Thank you Representative Tony Edmonds Walker. (Laughter)
SENATOR OSTEN (19TH): Thank you. And up next is Judge Norris from Norwich. Did you hear that? Judge Norris from Norwich. (Laughter)

MR. CHUCK NORRIS: Good evening, members of the Appropriations Committee. My name is Charles Norris. I’ve been the Norwich probate judge now for over eight years.

Before becoming probate judge, I had an opinion about what the probate court did on a day to day basis. I was under the mistaken belief that the probate court spent a majority of its time dealing with wills, trusts, and what might, we might think of as typical estate matters.

I quickly learned that my opinion was far different from the reality I faced as I sat in the judges seat. At times, I feel as my judge as -- my job as probate judge is closer to a social services agency rather than running a court.

Norwich is a community in need and I spend about 80 percent of my time in hearings on what lawyers would often refer to as family law issues.

In the typical day, I might start my hearings at the local hospital handling psychiatric commitments and by the end of the day I’m often at a local nursing facility or the home of an elderly person holding a conservatorship hearing.

The common thread though all these matters is the involvement of a person who is no longer able to take care of themselves, whether it is the psychiatric commitment patient at the hospital or the elderly person at home, the case is in my court because someone needs help.
I understand my time is brief today and I have supplied you with a written statement but I would like to give you just one example of a typical matter handled in my court.

One of the first cases I was asked to address as a new judge involved an elderly woman from Franklin, Connecticut who I will refer to as Mrs. F. Mrs. F. lived alone in Franklin but at one time, she ran a dairy farm with her husband who had died years earlier. Since her husband had passed way, she was now alone.

Mrs. F. had went down to a local mall to buy a sweater. She had drove herself to the mall and as she was leaving, she fell and injured herself and was taken by ambulance to the hospital.

By the time the case came before my court, she had been in the hospital for over 30 days. The hospital had applied for a conservator in order to have Mrs. F. transferred to a nursing home.

She apparently had suffered other falls in the past and had not been able to call for help. So the hospital was worried that she could not go home, living alone with no family or other people to assist her.

In this case, we held the hearing down at the hospital in her room so she could participate. And Mrs. F. wanted to go home. She didn’t Care whether she fell at home or not. She just wanted to get out of the hospital.

With the involvement of the probate court, we arranged for one of our local attorneys who was
willing to serve as conservator and get Mrs. F. out of the hospital and back to her home.

The court appointed conservator was able to arrange for in home services and for people to stop in and visit Mrs. F. Through the probate court, and the continued monitoring of the case, Mrs. F. was ultimately able to live in her own home until the day she died.

Now it was the right thing to do for Mrs. F. but I am certain that if the probate court had not been there to arrange for all of this and monitor the situation for the years after the appointment of a conservator, Mrs. F. would have went from the hospital to a nursing home which would have been disastrous for her and for all of us.

This type of situation happens on an almost a daily basis in my court and is just one example of how the probate court system serves the people in my area and all of Connecticut.

I hope this gives you and my -- this testimony and my written submission gives you some insight into what the probate court does and thank you for your continued support and your time.

SENATOR OSTEN (19TH): Thank you very much, Chuck. Appreciate it.

MR. CHUCK NORRIS: Thank you.

SENATOR OSTEN (19TH): Any comments or questions? Yes, Representative Gonzalez.

REP. GONZALEZ (3RD): Thank you. Good afternoon.

MR. CHUCK NORRIS: Thank you.
REP. GONZALEZ (3RD): Yes. I got a question. Mrs. F., did she have any family?

MR. CHUCK NORRIS: In this situation she had had family but they were not anywhere near Connecticut. They were in upstate New York as I recall.

REP. GONZALEZ (3RD): Okay. And in your situation that a person like that have family, what is the process?

MR. CHUCK NORRIS: As far as appointing a conservator?

REP. GONZALEZ (3RD): Yes.

MR. CHUCK NORRIS: In her case the family wasn’t really involved in her living situation. And typically though if the family had been involved, we would typically look to appoint a family member if one was available to help out.

REP. GONZALEZ (3RD): And in your court, if any member of the family had involved and they want to be a conservator, do they have first choice?

MR. CHUCK NORRIS: Under the law we would typically, depending on the condition of the person who is the subject of the conservatorship application, we would ask that person if they had a preference. Maybe in many cases people have already designated someone to be. But we would certainly if we can make every effort to appoint a family member during the conservatorship hearing process.

REP. GONZALEZ (3RD): And if your court appoint a family member to be a conservator, do you also appoint an attorney or like a Guardian Ad Litem in the case?
MR. CHUCK NORRIS: No. There’s automatically in the involuntary conservatorship process, there is automatically an attorney appointed to represent the person whose is potentially going to be conserved.

But they are not the conservator. The conservator that would be a separate, if there was no family member in this situation, there was two lawyers involved. The lawyer for the conserved person and then the lawyer who we appointed as a conservator.

But we don't laws appoint a lawyer as a conservator. For instance in your example when there is a family member, we would not appoint an attorney in addition to the family member.

REP. GONZALEZ (3RD): And my last question is if that person has a conservator that is not a family member, but that person have family that would like to get involved. Any kind of decision is made by the conservator even though the family get involved and say it is not the right decision, I’m a family member I want to be involved. What is the process?

MR. CHUCK NORRIS: So again, I mean, every situation is different. Sometimes we have family members who are disagreeing with each other. But if we were in a situation where we have appointed a non-family member which again if we have family members that are willing to do it, that would be the first choice.

But in a situation where we may have appointed a non-family member to serve as conservators, sometimes we often even insure when we make those initial orders that the family members are kept informed of medical condition of somebody or they certainly, they're included in every hearing and
every notice of every hearing and encouraged actually to participate in any decision making processes.

REP. GONZALEZ (3RD): And if that member of family is not, doesn’t agree with any decision made by the conservator, what happens then?

MR. CHUCK NORRIS: Again it’s hard to say. You know, sometimes I have family members who may not agree with a situation or with what a conservator is doing but the person conserved might feel differently or other family members might be -- feel differently.

But as you now the probate court is a somewhat informal court and so people are typically able to sit at a table and express their interests and tell me at least what they think is important. Certainly wouldn’t prohibit them and would in fact encourage them to give me any information that they think is relevant.

REP. GONZALEZ (3RD): Thank you for your answers. Thank you.

SENATOR OSTEN (19TH): Thank you very much. Any other comments or questions? Seeing none, thank you very much, Judge.

MR. CHUCK NORRIS: Thank you.

SENATOR OSTEN (19TH): Appreciate it. Coleen Dobo followed by Julia Wilcox. You can start as soon as you sit down.

MS. COLLEEN DOBO: Thank you. Good evening distinguished members of the Appropriations Committee and thank you for the opportunity to voice
my support for the governor’s proposal to phase in medication assisted treatment for all inmates with opioid use disorder in Connecticut correctional facilities.

The governors proposing $2.1 million in fiscal year '20 and $6 million in fiscal year '21 which would be ample funding to provide full implementation of these services at a cost of $100 per week per inmate for 52 weeks.

My name is Colleen Dobo. I am a licensed psychologist working as a senior vice president at Community Health Resources, the most comprehensive behavioral health center in Connecticut.

Medication assisted treatment and methadone in particular has over 50 years of research support demonstrating its success in the treatment of opioid use disorder. I'd encourage Connecticut legislatures to ensure that the resources necessary to provide this life saving care is represented in the final budget.

To date, only Rhode Island and Vermont offer MAT in its correctional -- in all of its correctional facilities. In fact, less than one percent of prisons in our country provide medication assisted treatment even though it is widely accepted as the expected standard of care for treatment of opioid use disorder in the community.

Doing so would be the single most effective and impactful intervention to quell the continued rise in deaths by opioid overdose that are seizing the country. For example in 2016, Rhode Island implemented a groundbreaking program to screen all
inmates for opioid use disorder and provide MAT for those in need.

The results were astounding. 61 percent decrease in post incarceration deaths and an overall 12 percent reduction in accidental overdoses across the state.

Over half of the men and women who die of an overdose in Connecticut have a history of incarceration representing 500 lives lost each year. Data from the chief medical examiner in DOC revealed that accidental overdose is probably the most single most common cause of death among prisoners within 60 days of release.

As fatalities mounted among this high risk population, DOC forged partnerships with community providers to bring MAT in correctional facilities in New Haven, Bridgeport, Hartford, York, Torrington and Osborne.

These programs can treat only 35 individuals at a time and regularly turn people away. Eligible inmates are a very small percentage of those in need. An inmate must be stable on methadone in the community at the time of incarceration to participate.

The vast majority of those however, who enter the system are not on MAT but are physically addicted to heroin or fentanyl. DOC does not have the resources to provide the required complement of services to start or induct people on medication assisted treatment such as laboratory work, physicals, toxicology screens.

Hence the most -- those in most need who are suffering the most withdrawal have and are having
the most severe psychological dependence or not receiving the care they need. I applaud the governor for taking steps to apply the same standard of medical care in our community and our correctional facilities as we respect for the general population.

I appeal to you this evening to make Connecticut known as one of the first three states in the union to offer this standard of care.

SENATOR OSTEN (19TH): Thank you. Are there any comments or questions? Representative Gonzalez.

REP. GONZALEZ (3RD): Thank you. Thank you Madame Chair. Can you clear something for me? When you said that you supporting the governor’s budget to bring MAT to each prison, that means that every prisoner will get methadone in prison, is that?

MS. COLLEEN DOBO: It is a possibility that methadone would be the treatment that the inmate would choose. Another possibility would be Buprenorphine and another would be Vivitrol.

REP. GONZALEZ (3RD): Okay.

MS. COLLEEN DOBO: So there are one of three options approved by the FDA.

REP. GONZALEZ (3RD): Okay. And maybe you don’t know either because I don’t much about methadone but what I hear out there day after day that methadone really hurt the person in the long turn. That methadone really hurts, you know, their bones, their structure, everything that they said that they -- that medication really hurt the person at the long run. What do you think about that?
MS. COLLEEN DOBO: I’m -- thank you for your question. I think it is very important to address that myth. In fact, methadone does not cause long standing negative side effects.

What does happen is that when people are using opioids, they are not connected to the typical pains and dental pain, physical pain that would lead most of us to seek medical care.

And therefore when they stop using opioids and they can again reconnect with their bodies, it is not uncommon for people to have untreated medical conditions that results in the pain that you are talking about.

REP. GONZALEZ (3RD): Methadone, if -- I know people that have been in methadone treatment for years and years and years. If methadone is so good for them, why is it so addicting that they can't get rid of it and they are on methadone for years and years and years?

So it got to be a better way. Because it seems like methadone it’s very addictive to these people that can't get rid of it and the best thing for these people is getting treatment and they believe it will get rid of the, you know, that disease.

So if methadone is so well you said it’s just a myth but it doesn’t help either because they don’t get rid of, you know, using drugs and their need of the drugs.

MS. COLLEEN DOBO: Thank you again for that question. So methadone is, does have the potential to be habit forming. The thing to understand is that people with an opioid use disorder is a chronic
health condition, not unlike diabetes in that there are changes in the brain that occur when people use opioids over a long period of time. And when opioids are discontinued, it causes severe withdrawal symptoms.

People who are on methadone are more likely to not use substances, opioids particularly more than the general population. People who discontinue methadone use are very highly likely to relapse. And in fact only 13 percent are likely to stay clean and sober from opioid use when they discontinue methadone treatment.

REP. GONZALEZ (3RD): So again, if they continue use of methadone, that -- they're not going to get rid of opioid problem.

MS. COLLEEN DOBO: So the difference between methadone and opioid is that methadone is a longer acting medication. It can be the treatment that goes along with it is very highly regulated. People are expected to be in psychotherapy. They're given toxicology screens.

So it does not result in the same level of criminal behavior, re-incarceration that using substances on the street does result in. So it is still a highly effective treatment.

REP. GONZALEZ (3RD): Thank you.

SENATOR OSTEN (19TH): Comments or questions? Representative Porter.

REP. PORTER (94TH): Thank you, Madame Chair. Just quickly to piggy back off of Representative Gonzalez, I’m just looking over some information on that and it actually says and I want to know if you
agree with this. That CDC reported 22 percent increase in methadone related deaths each year.

And this was 2002 and 2006 but then it said it only dropped six percent between 2006 and 2014. And it estimates that methadone abuse and accidental overdose account for up to 5,000 deaths a year. Though methadone can be a saving grace for many people, it seems to be a danger for many others because I to have heard much of what the Representative just stated.

So I do have concerns around treating methadone in general populations for everyone and not really paying attention to the few that it helps and the many that it may hurt. And the reports that I have gotten back is it is addictive and it states that in this, that it is highly addictive. That it leaves an individual vulnerable to dependence. It is classified as a schedule II substance.

In other words, it is a medically accepted drug with a high potential for abuse. So can you speak to that?

MS. COLLEEN DOBO: Yes, I can. So methadone does create a physical dependency. However, the way that it is regulated in a treatment program is highly regulated, has very profound regulations by the federal government.

People are required to participate in different treatments in addition to taking methadone so that the increase -- the reason for funding for the Department of Corrections is because to make a decision of what medication assisted treatment to offer an inmate is dependent on that inmates other medical conditions.
So for somebody who has COPD, for somebody who has asthma, for somebody who has, you know, liver abnormalities, those people may not -- methadone may not be the drug of choice for them. But having the opportunity to provide buprenorphine or to provide Vivitrol which is not habit forming would be much more positive.

So at this point, there are more people coming into prisons addicted to heroin than addicted to methadone and that group is not being provided any treatment at all.

And still, people who discontinue methadone treatment are more likely to overdose than those who continue with methadone treatment.

REP. PORTER (94TH): Okay. Thank you for that. And then my last question to you, Madame Chair, is to piggyback off of Representative Rosario who had a question for the DOC commissioner when he was before us. How do you feel about Suboxone? Is that how you pronounce it?

MS. COLLEEN DOBO: Buprenorphine, Suboxone?

REP. PORTER (94TH): Yes.

MS. COLLEEN DOBO: Suboxone is another name for buprenorphine. I think that is a -- it is now used for medication assisted treatment as much as methadone. Many men and women are entering the correctional facilities on buprenorphine which is very highly effective.

And when they enter the Department of Corrections, unless they’re a pregnant woman, they are withdrawn from that medication. So it is actually, you know,
it's a really positive, it has very positive effects for people.

REP. PORTER (94TH): And that’s what it's stating here and the only thing that I will read from it is that it is a positive effect on the lives of people recovering from addiction and it actually appears to be a better option than methadone. So I guess my -- are we going to look at Suboxone?

MS. COLLEEN DOBO: I have been asked right now for the first time to foresee a chart to look at bringing in Suboxone and we would be happy to do that.

REP. PORTER (94TH): Okay. Thank you. And thank you, Madame Chair.

SENATOR OSTEN (19TH): Representative Rosario.

REP. ROSARIO (128TH): Thank you, Madame Chair. Good evening. Just piggybacking on Rep. Porter, Suboxone has become big on the black market in the correctional institutions.

And one of the reasons why I think people are shying away from Suboxone, it's much more expensive than all of the other options that are out there.

But with that being said, do you know in Rhode Island if that’s part of the medicated assistant treatment plan and also are there any other naturopathic methods that are available for inmates should they want to wean off of opiates?

MS. COLLEEN DOBO: So Rhode Island does offer the three FDA approved medications. It gives the inmate an opportunity to choose which one they would like to participate in.
Right now I would say that half of inmates would probably chose Suboxone and it actually is the better choice of the two because it -- because the people who really need the treatment are not only the people coming in but are the people who are in the weeks before they return to the community so that they're not as at risk of overdosing.

In terms of naturopathic treatments, acupuncture has been shown to be highly effective in helping people deal with cravings. It's something that we use at CHR. It’s not something that I’m aware of that the Department of Correction uses at this point. Although I would also recommend that as an option.

REP. ROSARIO (128TH): Everybody has their way of wanting to get whatever treatment they prefer. But I have experience. I have a CASA that’s in my district, a chemical abuse substance agency and a lot of the patients that are on methadone, they're experiencing some severe side effects.

Many of them lose their teeth, they get brittle bones and in treatment, treating their opiate addiction now they have another issue which the state is going to end up paying for anyway in physical disabilities.

So again, not that I want to toot the horn for Suboxone but it's, I believe it is much safer for treatment. Thank you. Thank you, Madame Chair.

SENATOR OSTEN (19TH): Any other comments or questions?

REP. JOHNSON (49TH): Yes.

SENATOR OSTEN (19TH): Representative Johnson.
REP. JOHNSON (49TH): Thank you so much, Madame Chair, and thank you for your testimony and information.

I just wanted to know aside from the other types of treatments, are we evaluating people who have addiction to see what might better suit them to help them become no longer addicted to drugs and the impact of the neurotransmitters and that kind of thing that are changed by the addiction?

Do we have any technology that can help people when they are incarcerated for these things? And is there something we should be looking at and studying for the future?

MS. COLLEEN DOBO: I’m not aware of anything. Perhaps someone else might be.

REP. JOHNSON (49TH): Thank you so much. Thank you, Madame Chair.

SENATOR OSTEN (19TH): Thank you. Comments or questions? Seeing one, thank you very much. Appreciate everything you brought to our attention.

MS. COLLEEN DOBO: Thank you.

SENATOR OSTEN (19TH): Julia Wilcox followed by Gerard Gagne.

MS. JULIA WILCOX: Good evening, Senator Osten, Representative Walker, Senator Formica, Representative Lavielle and distinguished members of the committee. My name is Julia Wilcox manager of Advocacy and Public Policy at the Connecticut Community Nonprofit Alliance.

The alliance is the statewide advocacy organization representing nonprofits with a membership of more
than 300 community organizations and associations. Nonprofits deliver essential services to more than half a million people each year and employ almost 14 percent of Connecticut’s work force. And I appreciate the opportunity to testify this evening.

Governor Lamont’s proposed budget largely recognizes the critical role of community nonprofits in delivering vital services to the people of Connecticut. Despite a difficult budget year, the governor would maintain funding for most of the programs operated by nonprofits that serve our residents.

It’s a good starting point and we thank him for that. But there is much work to be done to make sure that payments to nonprofits cover the true costs of the services they provide.

We urge your continued support of reentry services within the community which are essential to the ongoing success of the Second Chance Society Initiative.

As of December 2018, there were 3,935 citizens of our state who were receiving community supervision from nonprofits who contract with the Department of Corrections. This represents an 18 percent increase since December of 2015 while the prison population was simultaneously reduced by 16 percent. And thousands more receive services through providers who contract with CSSC and judicial.

I have submitted my written testimony and I would like to just highly a few quick points. With regard to the portsworts (phonetic - 00:58:36) services division, this afternoon Judge Carroll spoke to the
impact of the transfer of juvenile justice services from DCF to CSSD.

In 2017, funding for JJ services was transferred from DCF to CSSD. The transfer included a cut in funding to both CSSD and DCF leaving both departments with inadequate resources needed to maintain these essential services.

At the time CSSD estimated a need of 28 million to adequately develop an array of community based residential and secure services and we urge the committee to fully fund CSSD to fulfill the mission.

Additionally, we support the governor’s proposal to annualize the cost of toxicology services at 434,000 each fiscal year. And we strongly support the governor’s proposal to annualize the one percent cost of living adjustment for private providers.

This proposal increases funding in a number of state agencies including DOC and CSSD. And we greatly appreciate your efforts, the efforts the legislature to pass this legislation last session.

Within the Department of Corrections, may -- I'll very briefly just mention a few. We do support the expansion of medication assisted treatment and I did want to mention that I believe there are quite a few numbers down but there is some researchers from Yale who will be presenting this evening who I believe might be able to speak to some of the questions that folks have.

And finally, we support the governor’s proposal to reduce prison capacity to the closure of select buildings and units but we urge the committee to reinvest these cost savings into the network of
community nonprofit providers who partner with DOC and the Second Chance Society Initiative and the proposed cost savings of 4 million in each fiscal year. And thank you so very much for all you do.

SENATOR OSTEN (19TH): Thank you. Don’t go anywhere. Representative Walker.

REP. WALKER (93RD): Good evening Julie.

MS. JULIE WILCOX: Good evening.

REP. WALKER (93RD): You’ve been here several times now.

MS. JULIE WILCOX: Yes, I have.

REP. WALKER (93RD): Guess I’ll see you the rest of the week huh. Okay. I just wanted to speak to the juvenile justice comment that you had in here. I agree with you that the, when the juvenile justice kids were transferred over to CSSD, the money was held back by DCF. It was not that DCF was shorted. The money that was supposed to go to CSSD was held back by $11 million and then also another lapse to that funding was also another five million.

It was because part -- I just, the main reason is that DCF does not identify JJ kids individually when they do their claims in their nonprofit groups. That they do is the blend them in to everybody else so juvenile justice kids always tended to get less money. But when they moved over, they claimed that a lot of that money was used for foster care and prevention. And so --

MS. JULIA WILCOX: We appreciate that.
REP. WALKER (93RD): -- therefore what they did was they pulled it back and denied CSSD the additional dollars. So we are going to fight for those but DCF is going to have to make some adjustments also because they're responsible for prevention and mental health so we will do that and we will make sure that that, the right amount of money goes over to them.

MS. JULIA WILCOX: Thank you so very much. Thanks.

SENATOR OSTEN (19TH): Thank you. Any more comments or questions? No. Up next is Gerard Gagne.

MR. GERARD GAGNE: Good evening, Senator Osten, Representative Walker and members of the Appropriations Committee. My name is Gerard Gagne and I work at Carl Robinson Correctional Institution and Corrigan Correctional Institution where I function as the only psychiatrist at both facilities.

I have worked for the state of Connecticut within the Connecticut Department of Corrections since June of 2008. I strive to provide high quality mental healthcare to those Connecticut citizens who have been remanded to the Connecticut Department of Corrections.

Although it is unfortunate that a person has come to me in the prison system for treatment as opposed to finding care at liberty with outpatient providers, I do believe I have the capacity to help those who are motivated for change.

While I see a disproportionate amount of substance abuse, I also see quite ill patients suffering with
bipolar disorder, significant depression and schizophrenia to name but three.

Corrections is an environment that unfortunately sees some of the most ill patients I have ever treated and I do think my teams at the several prisons at which I work provide high quality healthcare in a manner that not only treats underlying substance abuse and mental illness but that finally stabilizes people and prepares them to move forward in their lives, to reconnect with society in a way that they are better fathers and better husbands, better workers and generally better citizens.

That goal which generally I have in mind with all the inmates who I manage within the Connecticut Department of Correction is certainly made more challenging when I am responsible for more and more inmates.

That means the care shifts from a chronic management model to more of an acute management model in which simple stabilization and not rehabilitation becomes the focus. And that’s been touched on by several people already.

I absolutely appreciate the very challenging financial environment under which the legislature and the governor work. After all, being a Connecticut resident means I know full well what the burden of increased taxes and simultaneously shrinking monies for basic services means to the state of Connecticut.

But I do view careful, thoughtful and robust funding of healthcare in prison system as a long term investment in the state and citizens who find
themselves in the unfortunate position of being incarcerated and also in the families who are no longer supported by their incarcerated family members and in society that must reintegrate the many inmates who eventually return to the streets. I thank you for your time this evening.

SENATOR OSTEN (19TH): Thank you. Any comments or questions? Representative Johnson.

REP. JOHNSON (49TH): Thank you, Madame Chair. You did mention some of the more severe mental illnesses and what about post-traumatic stress disorder? Do you see a lot of people there and are you able to treat them?

MR. GERARD GAGNE: Yes. I do see post-traumatic stress disorder. It's becoming a more common diagnosis and even when -- I sort of I guess I take the approach with people I’m not so much concerned with the diagnosis as much as I am treating the whole person.

So do I see people with a variety of illnesses? Certainly. And then I target mediation therapy related to that. But I guess when I think about the care of patients, I think of a whole model and we talk about even basic things like sleeping properly, eating properly, proper weight, proper exercise, those kinds of things.

And it becomes more challenging to do that but I do think that that in part is part of their treatment for many people no matter what illness they suffer with.

REP. JOHNSON (49TH): Thank you for that. And what about socialization especially for people who have
addiction and that’s my last question. Thank you, Madame Chair.

MR. GERARD GAGNE: I actually -- it’s funny that you mention that. I actually talk about that a lot. So when I see folks in the prison system, it’s you would assume that because I’m a psychiatrist my primary responsibility is medication. But I think that’s a small part of what I can offer people.

And I do believe that proper socialization in the prison system be that in their dorms, be that in programs like Tier II or Tier IV where they’re working on substance abuse problems in addition to or as a sole problem, I think that’s actually really important.

So you look at the person from a whole model as opposed to just a substance problem or just bipolar disorder or something of that nature.

REP. JOHNSON (49TH): Thank you so much. Thank you, Madame Chair.

SENATOR OSTEN (19TH): Thank you. Comments, questions? Seeing none, thanks so much.

MR. GERARD GAGNE: Thank you. Thank you for your time.

SENATOR OSTEN (19TH): Appreciate it. Melinda. Hi, Melinda. How do you say that name?

MS. MELINDA MYSLIWIEC: M.

SENATOR OSTEN (19TH): Melinda M.

MS. MELINDA MYSLIWIEC: Melinda M. Yes.

SENATOR OSTEN (19TH): All right. Introduce yourself.
MS. MELINDA MYSLIWIEC: Yes. Thank you for listening. My name is Melinda Mysliweic and I’m a licensed clinical social worker. I have been working with DOC for over 11 years, all of which have been at Manson Youth Institute, better known as MYI located in Cheshire.

Here we hold inmates ages 15 to 21 so every correctional facility is unique. MYI has several additional qualities. We are the only facility in the state that houses juvenile males with adult charges. Nearly all of these youths have exhausted the juvenile and community systems.

Currently, we hold just under 475 inmates. Of those inmates, we have approximately 150, that’s one third of our population alone, that are being treated by a clinical for a mental health or a psychiatric condition.

We are tasked with treating and accommodating all mental health needs including those requiring psychiatric hospitalization. Specific to MYI, a clinician individually assesses every inmate that comes through our door for both past and present mental health issues and treatment needs. Uniquely, we also assess every inmate that has a serious disciplinary issue warranting segregation.

On that note, for having one of the lowest census numbers in the state, MYI has one of the highest numbers of incidents in DOC statewide. Not by any fault of DOC or our custody staff, but by default of this highly reactive, impulsive, immature, and quite frankly reckless and aggressive teenage population.

What you hear on the news is their charges, their victims and communities and families their actions
have affected. What neither you nor the public often hear are the stories of these inmates of having been victimized themselves.

Statistically, these inmates have dealt with and will continue to struggle with profound trauma and loss, almost all being lifelong witnesses to if not direct victims of domestic violence, street violence, community violence and an intense lack of both safety and basic needs.

Many have been homeless. Many have been victims themselves of unfathomable sexual and physical abuse and neglect. Many have been victim to more criminal acts than what they’re currently incarcerated for.

These young inmates may phase -- age out to another facility but at some point almost all of them return back to the community. Even those at MYI who have been convicted of murder are young enough that they will return back to the community. The same community in which we all live.

They are young, they are highly impressionable, they are vulnerable and they are a high risk population. My job, our jobs is to work with them, to help them, to stabilize them, to teach them.

Our DOC inmate population is undeserved and grossly underfunded. It is easy to say they are not when you look at their charges, their track records and watch the news every day.

Their past struggles do not make them any less responsible for their actions but it gives us the additional responsibility of teaching them skills to deal with their complex challenges as well as their mental health issues and needs.
We are tasked with providing stability and consistency while teaching them a sense of responsibility, respect and human value. Not just of others, but of themselves. Not an easy task given the environment in which our work begins.

We do this with the intention and hope that they can return to society, their families, their communities which are also our communities being better, more mentally healthy, stable and educated. Successful reintegration into society as independent people should be a shared goal for this population.

Funding us inappropriately does not allow us the stability to address the enormous needs of this unique population requires and ultimately defeats the entire purpose of being a correctional system.

Thank you.

SENATOR OSTEN (19TH): Thank you. Comments or questions? Representative Gonzalez followed by Representative Porter.

REP. GONZALEZ (3RD): Thank you, Madame Chair. Can you tell me what is the difference between the inmate medical and medication assistance? What is the difference here? Inmate -- that inmate medical, okay. What is their duties?

MS. MELINDA MYSLIWIEC: I work in the capacity as a social worker in the mental health unit so I don’t treat them for necessarily medical or medical assisted therapy. We don’t have that at MYI specifically.

But we treat them for psychiatric and mental health. My role is to treat them as a clinician for mental health and psychiatric issues.
REP. GONZALEZ (3RD): Okay. I received a lot of phone calls from family members, they called, they said they have family members in jail. And their complaint is that the member, their families when they went to jail, they were getting medical assistance like they were getting some medication because they have a problem.

Now when they go to jail, they don’t provide that medication to that, to you know, to the member of the family. They don’t get the medication.

And I got mothers that they have been calling and calling and calling and pleading that they want the member of the family to receive this medication. And they deny that medication.

And my question is, I know that after 18 years old, me as a mom, I can’t say well, I want my son -- I want to be admitted in the hospital because they got -- because he got mental problems. Because after he becomes an adult, I don’t have that kind of right.

Now if I call in as a parent to jail and I said my son or my brother or whoever, it would get a medication and they're not providing that kind of medication.

I would like to know what is -- if you see a lot of new people like let’s say from 18 maybe to 21, what is the difference of age that you providing medication for those patients? Or treatment to those patients?

MS. MELINDA MYSLIWIEC: So I think you are talking about a couple of different issues. So I’ll answer what I can. If anybody calls with a concern, a parent calls in concerned, for example, that their
child or their family member was on a medication, you know, every inmate gets seen by a nurse and those are common questions. Those are standard questions that are asked of any inmate when they come in to any of the jails facilities.

It is -- speaking from my role in our facility, if you were a parent calling and saying that we would assess the inmate or have the inmate assessed for that, and we would obtain any history as most facilities would if that’s required to verify any medication that they were on in the community by their community provider.

REP. GONZALEZ (3RD): So even if I provide that information, then why then some inmates are getting the medication and some inmates are not getting those medications?

MS. MELINDA MYSLIWIEC: I can't specifically speak to all of that.

REP. GONZALEZ (3RD): Okay. Thank you. Thank you.

SENATOR OSTEN (19TH): Representative Porter.

REP. PORTER (94TH): Thank you, Madame Chair. And thank you for your testimony. First I just want to thank you for acknowledging the profound trauma and loss that these youth have when they come into the system.

And as you said, not to discount or mitigate what they’ve done, but to simply acknowledge that they are damaged themselves and have been victims themselves and have chosen to be victimizers.

Two questions for you. The ages, you -- I know its 15 to 21 in MYI.
MS. MELINDA MYSLIWIEC: Yes.

REP. PORTER (94TH): But who, that are the ages of the 150 that you’re treating for mental health illnesses?

MS. MELINDA MYSLIWIEC: 15 to 21.

REP. PORTER (94TH): 15 to 21.

MS. MELINDA MYSLIWIEC: Those are just and that number is just specifically the current identified inmates that have either current mental health needs, not necessarily on medication. If they are on medication for or on a psychotropic medication, they’re automatically assigned a clinician.

But many don’t have medication that we follow as well. So those are just on our caseloads but we -- any other inmate within the facility statewide. If there’s a need or a request for service, they can be seen also.

REP. PORTER (94TH): So what I’m asking, I’m really trying to drill down are they younger, are they older, are they more teenagers? Are they over 18?

MS. MELINDA MYSLIWIEC: Honestly we -- I don’t have the --

REP. PORTER (94TH): It varies.

MS. MELINDA MYSLIWIEC: -- exact number.

REP. PORTER (94TH): Okay.

MS. MELINDA MYSLIWIEC: But we serve everybody at our facility.

REP. PORTER (94TH): Okay. And then last thing I wanted to ask you, are they a part of the general
population or are they part of the population that is kept under what I like to call seg.

MS. MELINDA MYSLIWIEC: Both. It depends on what their needs are and who the inmates are. If they're identified as a gang member, they are held in the gang, you know, which is the segregation unit. But they're treated the same. We tour the units every day too so we are very visible to them if they need.

REP. PORTER (94TH): Okay. Thank you for that. And thank you, madam chair.

SENATOR OSTEN (19TH): Are there any other comments or questions? Representative Dathan.

REP. DATHAN (142ND): Thank you very much, Madame Chair. And thank you for all the work that you do at Manson that’s challenging.

Just a question. If you, if I were to ask you what programs do you think we could invest in as a government to prevent kids having to end up at Manson. What would you say those programs were?

MS. MELINDA MYSLIWIEC: You know, I would say a lot more community involvement honestly before they come to us. We do, you know, obviously when they come to us, it's done at the appointment for, you know, for lack of a better term.

But also when they leave it would be in my opinion it would be helpful to have a connection of treatment or support when they leave such a structured environment where there is so many access to different treatment forms and support there to go back into the communities where there is not as much.
REP. DATHAN (142ND): Great, thank you very much. Thank you, Madame Chair.

SENATOR OSTEN (19TH): Any other comments or questions? Seeing none. Thank you. Okay, I’m not even going to try the next name so. (Laughter) I’m really glad you all know who I’m talking about. (Laughter) Please go ahead.

MR. SOHRAB ZAHEDI: Can you hear me? All right. Good evening, Senator Osten, Representative Walker and members of the committee. I thank you for the opportunity to speak today.

My name is Sohrab Zahedi. I am a physician and I am a psychiatrist by training and I completed my residency at UConn and I finished a fellowship in forensic psychiatrist at UCLA before coming back to Connecticut. I am board certified in both fields.

Since 2009, I have worked in the Department of Correction in some capacity or another, either at Garner, Hartford, Walker, and Manson Youth Institutions. I am currently housed at Manson Youth and Walker.

In June of 2018, I was elected by the eight other psychiatrists who are in the system. It's seven now, one of them has left for Demus. Six of these are board certified and four of them including myself provide the after hour coverage for the entire state.

It wasn’t until 1976 that the Supreme Court upheld the prisoner’s right to medical treatment or have their serious medical needs treated as a constitutional guarantee and protection for the 8th Amendment.
Since then, there has been this uncomfortable relationship been DOC correctional staff as well as professional clinical staff. Each of us have our ethical guidelines and sometimes these are at odds with each other.

The physician is supposed to provide trusting care to the patients and be an advocate for the patient. However, correctional institutions are not healthcare institutions and yet the inmate is entitled to medical care.

Now, my colleagues are pointing out some of the deficiencies in the staffing needs at the institutions the Department of Correction needs right now. I want to reflect on some of the seismic changes that I have undergone on the last few months.

As you know now, in July of 2018, UConn and DOC parted ways. UConn's role as a contractor of inmate medical care came into existence in the 1990's. That service is now under the care of DOC. I want to highlight three changes that reflect on the psychiatrists experience since that split.

UConn's model relied heavily on a robust and supported nursing service via -- excuse me. Be it routine or an emergency situation, any inmate in need of medical care is encounters a nurse.

From the land of psychiatrist there was this concept of a nurse clinician, an individual who was well versed in nursing and therapy. This was the cornerstone of every mental health service. Now to be honest, UConn was the first to get rid of an entire class of clinicians.
These individuals were not just taken off orders but they were quarterbacking an entire service. I’m not even halfway right now. (Laughter) They were quarterbacking an entire service not just to take off orders but just to make sure that nobody falls quote unquote under the radar.

Again, that concept has been abandoned. We have hoped that with the DOC taking over, we could get that back. However today that hasn’t happened.

In fact, I have to rely on pretty busy nurses who are providing medical services to take on some of my orders. Now what happens to the quarterbacking? I’m not sure.

The second point. UConn, being an academic institution translated into a managerial hierarchy that was populated by highly accomplished physicians. Our executive director didn’t just oversee the administration of the organization, but he also produced the first textbook of correctional psychiatry.

Our chief psychiatrist was a forensic psychiatrist in training with a depth of knowledge and wealth of experience and who was available to us any hour of the day.

I recall specifically when I had to take him up at three in the morning when an ER colleague was upset with me for discharging a patient to his ER.

Other than these high profile and well trained physicians, we also had access to UConn's online library. Even though we didn’t make it to the UConn health campus, resources that are world class and teaching activities in the form of webinars were
available to us and important to us in terms of maintaining our CME's which is continuing medical education.

My third point is since I completed my psychiatric residency at UConn I have maintained some form of affiliation with the department of psychiatry there. Not only do I teach there sometimes but I supervise psychiatrists in training who are in residency in various clinics in the DOC in various DOC facilities.

Whenever I get one of these residents or fellows from the child department, the number of inmates that I can see nearly doubles. However, that’s contingent on a dedicated nurse who can quarterback that service.

However, it was only recently that I realized that while before DOC was providing funding for these residents to come and rotate while they get educated at the same time, that funding has been cut.

I just want to finish with this. To practice in medicine is an honor and it’s a privilege. I didn’t graduate from medical school thinking that my office would be a converted jail cell, but it is. And I love it.

The reward of correctional psychiatry lies in the use of all clinical skills that are at the disposal of the psychiatrist in a system that is resource scarred. This system cares for a sick population that society has otherwise forsaken.

I would leave you with the words of the late neurologist and author, Oliver Sacks. A little known fact about Dr. Sacks was that as a neurologist
he had spent over 30 years at the Bronx Psychiatric Center.

In 1991, he penned an editorial in the New York Times titled forsaking the mentally ill. He was lamenting the fact that while the institutionalization was a noble aim, it was in fact an error. That population needs residential treatment and they were emptying the asylum.

In the process, Dr. Sack lost his job. In his words, the state asylum that once provided the residential care for this vulnerable part the patient population had become underpopulated and began to lay off staff under the quote costly burden of a huge administrative non-medical machinery. Those patients who were released have ended up in prison. Let's not forsake them anymore. Thank you.

SENATOR OSTEN (19TH): Thank you. Representative Walker.

REP. WALKER (93RD): Thank you. Thank you for your testimony. So when you -- were you working for UConn or were you working for DOC during your tenure there? Or are you working there?

MR. SOHRAB ZAHEDI: UConn had the contract with DOC since the 1990’s.

REP. WALKER (93RD): Right. I understand that.

MR. SOHRAB ZAHEDI: And that contract fell apart in July of 2018

REP. WALKER (93RD): But what I’m trying to find out is who did you work for? Did you work for DOC?

MR. SOHRAB ZAHEDI: I was an employee of UConn.
REP. WALKER (93RD): You were an employee of UConn, okay. I see.

MR. SOHRAB ZAHEDI: I’m an employee of DOC now.

REP. WALKER (93RD): You’re an employee of DOC. Okay. Thank you. Thank you for your testimony.

SENATOR OSTEN (19TH): Comments or questions? So I just have to say one thing. I worked in the Department of Corrections at seven of its correctional facilities as a custody supervisor. And I have said for years that all's we have done with the mentally ill is changed geography so that we could feel better about it.

And that’s something that I find to be a little bit despicable because we have made it harder for them to get public housing. We have made it harder for them to find a place to live, to get a job and they can't get to see a doctor if they don’t have a place to live.

So when they get out, it’s far easier for them to recidivise because we have made it very difficult for them to be there. So thank you very much for coming. Appreciate it. Ellen Durko followed by Kelly Schafer.

MS. ELLEN DURKO: Thank you for this opportunity of letting me speak. Good evening, members, committee members. My name is Ellen durko and I’m an RN at Functional Unit 10. Consists of Northern, Carl Robinson, Willard-Cybulski.

I’m mainly at Northern. We all float to other facilities as needed which is a disservice to the patient population. When we float to other
facilities, we don’t know the patients, the facility layout and routine.

Correctional officers do not float to other facilities for above reasons as it is not safe. We float because we don’t have enough staff at each facility.

Northern is a super max facility with a high mental health acuity former death row special needs. I.e. highly assaultive inmates that cannot survive in general populations.

Also Northern has a four bed infirmary. The patients are on camera and we have the capacity to use four point full leather restraints for those patients that are self-harming and they require one on one nursing observation.

We also have on occasion the need to administer forced medication for patients in acute psychosis.

When I started in 2015, we had three nurses on the day shift and now we only have two. Any crisis sets us back pretty much the entire shift. The two nurses on the day shift and evening shift and one nurse on third shift have full accountability of approximately 230 patients.

In the past, the doctor came to Northern three times per week and a nurse practitioner came every three months to monitor patients with chronic disease. We now have a doctor who sees patients once per week and no nurse practitioner has been to Northern for over two years.

The other three units, Carl Robinson, Willard-Cybulski have large general populations of inmates.
Carl Robinson is the largest of the functional unit 10 has approximately 1600 inmates.

The medication line is the length of a football field for the two nurses passing meds. They have approximately one hour and 20 minutes to get the medications ready for this large amount of patients.

When there’s a nursing crisis the unit has run with two nurses on the 7 to 3 shift. The doctor waiting list is from six to eight months for routine only emergencies and the sickest patients are seen by the doctor in a timely manner.

The most egregious, medically unsafe potential disaster is that elder patients, given massive nightly insulin doses are left overnight with no nurse on the 11 to 7 shift. These working conditions are so unsafe that it is a threat to our licenses.

During our press conference in September 2018 I was quoted as saying that Jesus is taking the wheel at Carl Robinson, a Carrie Underwood song. Well, Jesus is still at the wheel as it has been six months and there is still no nurse on the night shift at Carl Robinson.

The lack of mental healthcare in the state of Connecticut and the opioid epidemic has created the perfect storm of borderline neglect in both mental health and medical and corrections.

When Heather Locklear has legal problems due to her addiction, she has a high priced lawyer to shoo away a jail sentence and the ability to pay for the best rehab money can buy. When the low income and middle
class people have the same problems as Heather, they come to corrections.

On a personal note, I will attend a funeral at the end of the week for someone who lost their battle with addiction. His mother said many times how she just wished he would have ended up in jail so at least he would have been safe.

I believe in our mission to restore health and provide help for the addicted in our care and ask you to please increase staffing for the correctional facilities in this state.

We believe those who are serving a sentence shouldn’t have to lose their life in our system. Thank you.

SENATOR OSTEN (19TH): Thank you. Any comments or questions? Seeing none, thank you very much. Kelly Schafer followed by Steve Swan.

MS. KELLY SCHAFER: Good evening, Senator Osten, Representative Walker and members of the committee. My name is Kelly Schafer. I have been a social worker for the past 12 years for the Department of Corrections.

I went to school to be a social worker because I wanted to do something in a helping profession. Since 2007 I have been the sole social worker providing mental health treatment to inmates at Carl Robinson, a medium security facility that houses roughly 1500 men.

I have watched a tangible decrease in mental health staffing that has been a direct result of budget cuts during my time employed by the department.
In my work unit in the past 10 years we have lost roughly half our positions for social workers and counselors due to the reductions in the budget for health services. Our unit had 10 social workers for approximately 3,000 inmates. Today the same unit now only has five social workers for the same number of inmate.

In the Department of Corrections, licensed clinical social workers and professional counselors not only manage seeing a case load but they are dealing with crises, threats of suicide, psychiatric admissions due to psychosis and evaluations for parole for release back into society.

I will share with you why these services are crucial to the inmate population. Incarceration for many can be a very isolating experience. Many families can't afford to put money on the phone to talk with their incarcerated family member and many can't visit either due to transportation issues.

Mental health services become an outlet for these individuals to have a sense of support to help them through their sentence.

Many inmates are also getting clean and sober at this time. With a sober mind, the guilt and the shame many of them feel regarding the conduct that landed them in prison can be a huge monumental burden of them to bear.

When we strip people’s access to these services during incarceration, the risks of suicide become higher, mental health issues such as anxiety and depression become more prevalent, inmates may be more likely to return to prison after release and
the workers also begin suffering from compassion fatigue.

And I haven’t even spoken about the large number of individuals who truly suffer from mental illness. Schizophrenia, bipolar disorder, depression and anxiety. These individuals need consistent care and support to assure they are compliant with medication and counseling so they remain stable while incarcerated.

I am asking for the committee to please consider increasing the funding to the health services budget. By increasing the funding to the health services budget for corrections, it would help us return to staffing levels that will allow us to provide the treatments so necessary for this population. Thank you for your time.

SENATOR OSTEN (19TH): Comments or questing? Seeing none, thank you very much. Steve Swan followed by Sandy Pepin.

MR. STEVE SWAN: Good evening, Senator Osten, Representative Walker and members of the committee. My name is Steve Swan. I’m an LPN. I have worked in DOC facilities for nearly 17 years.

Currently I’m assigned to Corrigan-Radgowski in Brooklyn as part of the infectious disease team. My primary focus is HIV and Hepatitis C.

I have had many different assignments over the years, one of which was being the health service review coordinator. The HSRC is the first step in addressing formal inmate complaints related to health services.
During my time as HSRC, appropriately 50 percent of all health service review requests were related to wasting time to see a provider. We did not always have wait time issues.

When I first started at Corrigan we had a physician that worked six hours per day, six days a week. Now we have a part time APRN as the sole medical prescriber for privately 1600 inmates.

At one point, over one third of the gang affiliated population at Corrigan had been wanting longer than six months to see a dentist. Corrigan had no dentists.

The information was provided to the dental director. The response was the new dentist starts in three weeks. For the next nine months, the answer never changed. The new dentist was going to start in three weeks.

As HSRC I often dealt with the attorney general’s office. I was called about an inmate who was suing over losing a tooth. His medical record had a dentist note saying that the tooth in question needed restoration. A year later it had decayed to a point that it had to be pulled.

Being that the inmate had followed all the proper steps to get his dental problem corrected, I told him I think that they should just pay him out for his tooth. I was -- it was suggested I don’t say that in court.

Over the years, it seems the focus has changed from providing proper care to merely avoiding settlements. We cannot provide the mandated level
of care without providers. And without providers, there will be more large suits and more settlements.

So I ask that you fund us to the level that we can provide the care that we are required to give. Thank you.

SENATOR OSTEN (19TH): Thank you. Any comments or questions? Seeing none, thank you very much. Sandy Pepin followed by Lydia Rostkowski.

MS. SANDY PEPIN: Good evening, Senator Osten and Representative Walker and members of the committee. My name is Sandy Pepin and I’m a registered nurse at Cheshire Correctional Institution and Manson Youth.

I have worked at both facilities for the past six years and I am here tonight to ask you to consider properly funding the desperately needed services that we provide to the inmate population.

Often we have been forced to work below minimum staffing levels causing delays in medication administration, having orders accurately noted and causing delays and follow-ups.

We cannot provide the standard of care expected of us without the appropriate staffing. In fact, yesterday I worked 18 hours straight. Three times in the last 30 days we have had to shut down the medical unit and the infirmary at Manson Youth because we did not have nursing staff to fill those positions. None. No nursing.

Sometimes we have only one or two nurses available to work because the other nurses have already worked 16 hours. When nurses have to work in a prison without another nurse as often happens, it creates unsafe settings for the nurse and for the patient.
During the day and night we have to respond to medical emergencies, fights, and be ready to treat the inmates. Many nurses feel they're putting their nursing license on the line working in these unsafe conditions.

Shutting medical down over night means diabetics don’t get their insulin in the morning before their meals and they don’t get their ADD meds before they go to school. This can trigger a whole chain of events.

For example, inattention in school, might mean a fight that school which requires medical to immediately respond.

Constantly working short staffed is impacting the quality of care given to the inmate population. It causes longer wait times to be seen by a nurse which can mean sicker inmates by the time they are seen. We often do not have the time needed to do what is needed for each patient like educating them on STD prevention, wound care, health and hygiene for the youth, et cetera.

Our chronic disease clinics are no longer in operation to include but not limited to hypertension, diabetes and asthma clinics. These all require monitoring, teaching and labs that don’t get done leading to a potentially sicker population requiring more money to treat them in the long run.

Each year when a new reduced budget for health services comes out, we all wonder what services will be cut.
In the last two years, we have lost two record specialists and a secretary. In the last year we have lost seven nurses all without replacements.

I will say the positions have been posted however, due to chronic understaffing and unsafe work environments, nurses don’t stay or they don’t apply. So now I or another nurse answer the phones, we make calls to cover staffing needs while attempting to pass medications, do dressing changes, and assess inmates during nurse triage.

Due to years of understaffing, and budget cuts to the DOC health services, health services has been left severely understaffed. Please consider the necessary funding required to appropriately staff the positions that are currently vacant. Thank you for your time.

SENATOR OSTEN (19TH): Thank you. Comments or questions? Seeing none, thank you. Lydia Rostkowski fooled by Lisa Simo-Kinzer. And I know I didn’t say that last one right. (Laughter)

MS. LYDIA ROSTKOWSKI: Good evening. Good evening, Senator.

SENATOR OSTEN (19TH): You’ve got to push that button. It’s got to be yep, there you go.

MS. LYDIA ROSTKOWSKI: Thank you.

SENATOR OSTEN (19TH): You're all set.

MS. LYDIA ROSTKOWSKI: Good evening, Senator Osten and members of the committee. My name is Lydia Rostkowski and I am from New Britain. I am a nursing supervisor at MacDougall Walker CI in
Suffield and have been employed as a correctional nurse for 10 and a half years.

I am here to advocate for my staff to gain increased attention and funding to improve staffing levels and patient care.

Correctional nursing is a specialty in which you not only have to rely on good clinical skills, but also have sound judgment and people skills.

Additionally, you have to be able to work within the walls and confines of a prison and be cognizant of safety and security concerns while providing routine and emergency medical care to the inmate population.

Our facility is considered the largest in New England, housing nearly 2,000 inmates between two buildings. New have a 24 bed infirmary and house and provide services for all of the sentenced dialysis patients in the state.

We are a maximum security prison and our population is aging. We have many inmates that are serving life sentences in prison with a variety of chronic diseases including diabetes, hypertension and chronic kidney disease along with all of the comorbidities that go along with those diseases, as well as a variety of infectious disease such as HIV or hepatitis.

In the MacDougall building alone on a daily basis, we prepare and pass medications to approximately 300 inmates in the morning and 400 in the evening. This is along with treating approximately, excuse me, approximately 120 diabetics and administering insulin to them twice a day.
Additionally, we have a variety of scheduled treatments and dressing changes to tend to, routine sick call visits and responding to medical emergencies such as seizures, low blood sugars or inmate fights.

On any given day, you may just provide basic first aid, a Band-Aid, respond to a psychiatric emergency, revive someone from an overdose or actually perform CPR.

We are chronically short-staffed. Nurses are working short and at minimum staffing nearly every day. And this has been going on for years even prior to the transition but has now reached a critical point. And our nurses are getting burnt out and leaving.

Nurses in our facility are being routinely involuntarily mandated to stay at work for 16 plus hours at least one to two times a week, sometimes double drafted two days in a row. And it is worse in some of the other facilities.

There are only so many people you can see in a day in order to provide quality care, properly document and provide appropriate follow up.

My nurses want to provide quality care but are constantly rushed and aren’t able to give each patient the adequate time and attention they need to perform a thorough assessment and follow through.

Nurses aren’t even taking breaks or eating lunch because they feel pressured to get all of the work done. This chronic short staffing leads to a backlog of inmates awaiting assessment of whatever issue they are having. And then even if nursing has
seen and assessed them, and initiated nurse protocols, we don’t have enough medical providers to provide the follow up care.

Inmates may write and see nurses several times before seeing a provider, waiting months for a provider appointment which leads to anger and frustration being taken out on the nursing staff. This short staffing can potentially create an unsafe and volatile situation for staff.

Morale is at an all-time low and the staff are showing signs of stress and burnout. There’s only so long that you can work understaffed with no end in sight without having the stress affect you and those around you.

Even in community or hospital nursing, it is known that inadequate staffing leads to poor patient outcomes and it is no different in prison. Please help us. This is a public health issue. Thank you.

SENATOR OSTEN (19TH): Thank you. Any comments or questions? Representative Dathan followed by Representative Porter.

REP. DATHAN (142ND): Thank you, Lydia, and thank you, Madame Chair. I really appreciate your testimony and hearing everybody this evening it made me think, you know, is there no oversight of the medical staff at the prisons? And to -- I saw on the website each of the prisons have an audit for the facilities, the care, the ratio of correction officials to inmates. But I didn’t see anything in regards to medical oversight in terms of adequate staffing.
And the theme that I’m hearing this evening is there is a lot of deficiency it sounds like with the ratios and nurses are getting overworked and it’s not good for anybody. It, are you aware of any oversight or any reporting that’s done by anybody to --

MS. LYDIA ROSTKOWSKI: Well, they changed the entire structure so we no longer have a health service administrator in the building. They're not called RCOOS, R-C-O-O’S and they handle four to five buildings so they're not there every day. So as a supervisor, it’s up to myself and my partner to staff the facility.

So there’s not a direct oversight. We report back to them. I mean, we make our needs known but it's the state across the board is understaffed. I mean, we are sharing nurses between facilities and they're sending out emails on the weekends because there is no staff to be had at a facility.

REP. DATHAN (142ND): Do you think that if we expanded the auditing report to include medical function that issues might help be, you know, issues might be averted and attention would be drawn to the deficiencies? Do you think that would help or?

MS. LYDIA ROSTKOWSKI: I mean, potentially. I mean, we have a shortage of providers. We don’t have enough doctors. We are sharing them between facilities as well. Our infectious disease doctor is now traveling across the state.

So we have agency APRN's that have been recently hired to cover our facility of nearly 2,000 inmates. These are part time agency workers. They’re not full time staff and I just think there is a shortage
across the board. There’s not enough nurses, not enough doctors, not enough of anything.

REP. DATHAN (142ND): Okay. Thank you very much for your time. Thank you, Madame Chair.

SENATOR OSTEN (19TH): Representative Porter.

REP. PORTER (94TH): Thank you, Madame Chair and then you for your testimony. A couple of questions. You work at MacDougall, is that correct? And you are the nursing supervisor?

MS. LYDIA ROSTKOWSKI: Um-hum.

REP. PORTER (94TH): Okay. Can you tell me as far as hospice goes, how many hospice patients you serve at that facility?

MS. LYDIA ROSTKOWSKI: Right now currently we don’t have any. We did have an inmate pass away probably two or three weeks ago. It fluctuates, it depends. We have a lot of sick patients, cancer patients, but if it’s -- if they have less than six months to live, they go on the hospice program and we have hospice volunteers. But currently right know I don’t have any.

REP. PORTER (94TH): So all on hospice would have six months or less to live, is that correct?

MS. LYDIA ROSTKOWSKI: Generally, yes.

REP. PORTER (94TH): Generally. Okay. And I had another question but it has escaped me so I will keep an eye on you just in case it comes back to my memory.

MS. LYDIA ROSTKOWSKI: Okay.

REP. PORTER (94TH): Thank you, Madame Chair.
MS. LYDIA ROSTKOWSKI: Thank you all.

SENATOR Osten (19TH): Questions or comments?
Representative Johnson. Nice try. (Laughter) Sit back down.


SENATOR Osten (19TH): Yes. Representative Johnson.

REP. JOHNSON (49TH): Thank you so much, Madame Chair, and thank you for your testimony. And what about so my concern really has to do with the medical conditions that might be maybe somebody who had brill diabetes where they might have, need a different type of medication or you don’t have somebody there all the time to address that sort of thing. Or epileptic seizures, those types of things that may require, you know, medical care that’s right there.

How do those kinds of things or I was just recently we read, you know, about a woman who was pregnant and didn’t get the care in the facility that had hosts females. You know, that she ended up delivering in the bathroom. So that, you know, was nobody on call? Even though she complained that there was a, you know, a need for someone to provide a service in that circumstance.

So it seems to me that if we’re, you know, that those types of situations might go uncovered and maybe cause damage to the person and I just wondered what you thought about that?

MS. LYDIA ROSTKOWSKI: I would say not exactly. We do have physicians on call. We can call and access a physician 24 hours a day. Our facility does have nursing 24 hours a day. I have three, four, five,
five nurses in one building and one nurse next door in the Walker building at night. So we are covered all the time.

We don’t go below minimum or at least we try not to. We have not reached a point where we close the facility like Cheshire has to close the unit.

And as far as the females, I have never worked in a female prison. I have only dealt with the males but if it’s a chronic or an issue such as diabetes or somebody has a seizure, we do call an on call. We do send inmates out to the hospital.

The nurses are there and especially emergencies are handled, I mean, I think everyone comes together and participates. If there is a code called, everybody goes running for that emergency. But that makes routine care behind.

REP. JOHNSON (49TH): Thank you for that clarification. Thank you, Madame Chair.

SENATOR OSTEN (19TH): Thank you. Representative Porter for the second time. (Laughter)

REP. PORTER (94TH): I do remember and this will be quick because Representative Johnson kind of touched on it. I just need to confirm yay or nay.

I have been told that with diabetic inmates, you’re supposed to have 24/7 coverage, is that correct?

MS. LYDIA ROSTKOWSKI: Right. And we do have nurses in our building 24/7.

REP. PORTER (94TH): So you do have --

MS. LYDIA ROSTKOWSKI: We don’t lack overnight nursing, no.
REP. PORTER (94TH): You don’t lack overnight nursing.

MS. LYDIA ROSTKOWSKI: No, not in my facility, no.

REP. PORTER (94TH): Okay. Thank you. Thank you, Madame Chair.

SENATOR OSTEN (19TH): Thank you. Lisa, I’m not going to try it a second time. (Laughter)

MS. LISA SIMO-KINZER: That’s okay, I got you.

SENATOR OSTEN (19TH): And Bianca Stedman after that.

MS. LISA SIMO-KINZER: Okay. Good evening Senator Osten, Representative Walker and members of the Appropriations Committee. My name is Lisa Simo-Kinzer and I’m licensed clinical social worker for the Connecticut Department of Corrections.

I current work full time including weekends and holidays in the mental health department at Cheshire Corrections which is a level four maximum secure facility for male inmates 18 and older.

I started with DOC approximately 13 and a half years ago after working nearly 20 years in the private sector. DOC currently is a system that is unfortunately becoming a catchall for the chronic mentally ill since the state hospitals closed down.

My goal in being a therapist there is this, and I tell it to every inmate that I work with. To teach you the skills you need to maintain in the community and never return to DOC.

So let me tell you a little bit about what my day is like. I arrive to work by 7:20 most mornings and
check in with our understaffed nursing team. I read the log book to see if anyone has been placed on a specialized mental health status in segregation, has declared a hunger strike or is on in cell restraints, all things that require a clinician to go to Seg to assess how they are doing daily.

At present, the total population of Cheshire is approximately 1300 inmates. Of that, 235 are in active mental health treatment which means among other things, they need to see a mental health clinician every 30 days for treatment.

I currently have 105 inmates assigned to me. Think about that. Almost 50 percent of the inmates in mental health treatment, I have on my caseload. I see at least six people a day for my caseload in addition to meeting with new intakes, inmates who submit requests asking to be seen, respond to crisis calls, complete seg clearances, get treatment plans written and updated and maybe occasionally get to eat lunch and go to the bathroom.

Our supervising psychologist works four days a week and our licensed professional counselor who retires in four weeks, have equally busy schedule. We are also down on full time evening clinician and have been for almost one year.

So as of April 1, you are looking at the only regular full time social worker for Cheshire Corrections.

At present, my supervisor is filling the vacant staff positions with overtime. Now you would think that’s a good thing, right? Wrong. Because we have OT staff filling in, inmates who are currently not
assigned to clinicians are being seen by a different therapist every single session.

So think about it. You go to see a therapist to discuss issues, intensely personal issues. You need to resolve these. Every month you get a new therapist to talk to. There is no therapeutic alliance. There is no continuity of care. You ultimately feel like your treatment really doesn’t matter.

Because every month it's the movie Groundhog Day with the inmate having to repeat his story and his issues to a new person every time.

Groups can't happen and this includes sex offender treatment for the approximately 300 identified sex offenders because it is impossible to do with so few staff. 300 inmates who in some cases are being discharged to the community at the end of their sentence without having begun or finished sex offender treatment.

I am imploring you please consider these issues when you make a final decision on DOC's budget and I ask you to please look at restoring DOC's budget to a minimum, we will even take more, the minimum amount requested (laughter) by the commissioner of DOC. Thank you for listening.

SENATOR OSTEN (19TH): Representative Walker.

REP. WALKER (93RD): Thank you. And thank you for your testimony. Thank you for your job. Thank you for what you do. I really and, I mean, if nobody says thank you enough, I couldn’t begin to. Question, how long have you been working for DOC?

MS. LISA SIMO-KINZER: 13 and half years.
REP. WALKER (93RD): So has this been the standard method of operations since you’ve been there?

MS. LISA SIMO-KINZER: No.

REP. WALKER (93RD): When did this happen? When did this evolution happen?

MS. LISA SIMO-KINZER: It started several years ago as UConn started finding budgetary cuts we slowly started seeing our services and our staff getting cut.

REP. WALKER (93RD): Okay.

MS. LISA SIMO-KINZER: And it started slowly. And at first you didn’t even notice it. And then I think a coworker of mine said it best they’re like how are we ever going to go get people who want to come here with the caseloads we have?

Right now we have a position available and we are going to have two positions available but I’m really trying hard not to think about that. And I had a coworker who I was trying to lure over and I said come on, it’s great, we are an awesome team, we're a small team. Literally emphasis on small. And he is like I can't do it. Your case load is too high.

He’s like, Lisa, you’re taking 105 people and you’re seeing them constantly on top of everything else you have to do. He is like I can't deal with that amount of stress. And he is right. He is right.

REP. WALKER (93RD): It’s hard.

MS. LISA SIMO-KINZER: So it is hard. So the issue really does become looking back as the cuts were made slowly and slowly and slowly and groups stopped happening and as positions were being vacated for
whatever reason, people retiring, people moving, whatever it was. These weren't getting filled.

And again it was very quiet. It wasn’t happening and then we were being told you can do more. Just do a little bit more. You can handle this. And then you realize how exhausted you are at the end of the day because you have been handling it, because I am proud of my work ethic and I am proud of the work ethic of everybody who is sitting here behind me because we are killing ourselves trying to provide good care and that's all we want to do. We want to provide good care. So we are begging you please help us.

REP. WALKER (93RD): We hear you. We hear you. And thank you. I’m -- thank you.

SENATOR OSTEN (19TH): Yes, Representative Horn.

REP. HORN (64TH): Thank you, Madame Chair. Just quickly, what would your regard as a case load that would be workable and provide the kind of level of service that you would like to, you know, care.

MS. LISA SIMO-KINZER: What a great question. Ideally I would love a case load that would enable me to see people at least every other week. So for me figuring numbers, you’re making me do math, I don’t do well with math. I would say maybe 50 people on my caseload. I would be able to manage to see them possibly twice a month instead of once a month.

Because if think about it, if you’re in therapy are you seeing you therapist -- not that I’m asking you personally, but would you be going once a month to talk to somebody? No. Really to effect some
meaningful change, they need to be involved in more than that.

So even if I had 50 people and I had them personally once a month to do individual, and I was able to get them into some group therapy, that would be fantastic. Let’s teach them communication skills. Let’s teach them anger management skills and relaxation techniques. And let’s teach them ways that they can better reintegrate back in other community.

So to be able to combine multiple services. If we had a more physician time to be able to do maybe a med group with them and sit and talk with them about the importance of medication, the importance of compliance in addition to following up with some supportive therapies around depression because it is not all about the pill. It’s not going to just fix it. You have to make some real behavioral changes to affect long term change.

REP. HORN (64TH): And just quickly in follow up, have you ever had a case load like that?

MS. LISA SIMO-KINZER: Once upon a time. (Laughter) In a land far, far away, I actually had 30 people on my caseload. And it was wonderful because we got to do real meaningful treatment. We got to really know our caseload.

It’s sad, some days I can’t remember inmates name who is on my caseload. Because there’s so many people it just starts to blur. So and it is sad and I take ownership of that and they just kind of laugh and they go Miss Lisa, we know you see a lot of people.
But there was a time I had 30 and then it went to 40 and then it went to 50 and then it went to 75 and then we hit 100 so I’m at an all-time high right now of 105, pat myself on the back, but I can't keep doing this. It’s exhausting. And as of April 1 I am the only social worker at Cheshire Corrections. It's all on me.

REP. HORN (64TH): Thank you and thank you for the work you are doing.

MS. LISA SIMO-KINZER: You are very welcome.

REP. HORN (64TH): Thank you, Madame Chair.

SENATOR OSTEN (19TH): Any questions? Thank you.

MS. LISA SIMO-KINZER: Okay.

SENATOR OSTEN (19TH): Up next is Bianca Stedman followed by Matt Eggen or Eggen. And at the end of the night 'I'll know how to pronounce everybody’s name. (Laughter)

MS. BIANCA STEDMAN: Good evening, Senator. Good evening, Senator Osten, Representative Walker and members of the Appropriations Committee. It is indeed an honor and a pleasure that I Bianca Stedman, a nurse at Garner Correctional Center or institution rather, have a chance to speak to all of you tonight.

Upon interviewing multiple nurses at my facility, two issues communicated as priority from all my staff are the following.

One nurse assigned to two infirmary housing units and the lack of coverage due to open vacancies create a lot of overtime and frequent mandations
causing staff burnout and undue costs to our taxpayers.

All of these examples create a downward spiral and a trickledown effect into our work areas affecting proper nursing care and a decrease in the continuity of care.

The infectious disease nurse who is trained and specialized in that assignment would be directed to leave the assignment, causing her work obligations to be unfulfilled for an entire seven hour period for that work day. Her duties include court decree duties that the state is liable for.

Second, example, our infirmary houses up to 27 acutely mentally ill inmates in two separate units meaning one located upstairs and one located downstairs, separated by an elevator and approximately 20 to 30 steps in between both infirmary units.

Currently there is one RN to care for all these inmates. Prior to budget cuts here at Garner, these two units had four nurses caring for this complicated population.

Our infirmary houses many of the mentally ill patients that are normally found in hospitals. But with half of the nurses these are deemed safe in that setting. This includes alcohol detox that is potentially life threatening if not corrected -- if not treated correctly.

All of us have family, neighbors and friends that have found themselves in precarious situations of the law and it is scary that they may not be given proper care because of the staffing crisis we are in
since the transition of services from UConn health center.

The role of each staff nurse at DOC is to provide holistic, person centered therapeutic nursing care to promote educational health skills to inmates preparing them for release back into the community.

A lack of adequate funding and staffing prevent nurse from doing what they are educationally trained to do, to provide quality care to the most vulnerable and medically compromised population.

Thank you all for taking the time to allow me to explain why extending the budget would be an excellent idea that would benefit us all.

SENATOR OSTEN (19TH): Thank you. Are there any comments or questions? Seeing none, thank you. Matt Eggen, Eggen.

MR. MATT EGGEN: Eggen.

SENATOR OSTEN (19TH): Thank you. Followed by Deb Cruz.

MR. MATT EGGEN: Good evening, Senator Osten, Representative Walker and members of the committee. My name is Matt Eggen and I have been employed by the DOC for seven years all at Corrigan-Radgowski correctional center in Uncasville Connecticut.

Corrigan-Radgowski is spilt into two buildings. The Corrigan building which is a maximum security level four housing roughly 400 sorry, 750 inmates and Radgowski is a level three facility housing roughly 400 inmates.

I am here speaking to you today because of the grave concerns I have about staffing levels at our
facilities. Years of being told to do more with less has left inmates with a level of care that is shameful, inconsistent and overwhelming to staff.

This environment is exceptionally challenging. These chronic and seriously -- the chronic and seriously ill all find their way to jail and when they arrive, they come to find that getting treatment for preventive care and the minimized progression of chronic and serious illness is hampered by long waits.

These long waits at Corrigan are exacerbated by a lack of staff. If you are an inmate, and you have an illness and want to be seen by a medical professional the process is you write and wait to be called by a triage nurse.

Some of these requests can be managed by nurses. Motrin, creams, Band-Aids, et cetera. Others need to be referred to a doctor.

Currently at Corrigan there are no medical doctors on site. Only one part time APRN and this APRN is spread over three facilities. Brooklyn, which houses 450 inmates, Corrigan and Radgoswki. So you have one APRN who covers 1600 inmates by himself without direct M.D. supervision.

I want to restate that. You have one APRN who covers 1600 inmates without a doctor.

If you can imagine if you needed care for something say serious or chronic how difficult it would be to access care. It’s challenging to say the least.

Having more staff would allow us to prevent small problems from turning into large ones which allows
for better care and fewer lawsuits due to long waits to other road blocks.

I’m a social worker by trade and these staffing levels in my department have reduced our ability to provide even minimal care. We used to run groups which allowed for quality care that adapted to everyone's style of learning.

The current staffing levels at my facility prevent groups as well as even meeting the most minimum of standards the department has set. I am unable to see my patients at least every 30 days as required. I am currently working under protest, a protest I and my department colleagues signed 16 months ago due to staffing levels at Corrigan preventing minimal care. This is unacceptable.

My colleagues, the people in this room and those who couldn't make it tonight are good, hardworking, dedicated employees who are asking for your help.

Our patients are the reason we show up and our compassion for improving the lives of some of the most vulnerable in the state has buoyed us to weather these poor staffing levels.

We are here to all appeal to your desire to help us help you. Please consider a significant increase in budget which would allow us to properly and effectively care for this population we work with daily. Thank you.

SENATOR OSTEN (19TH): Thank you. Are there any comments or questions? Representative Porter followed by Representative Walker.

REP. PORTER (94TH): Thank you, Madame Chair. Quick question. Any diabetic patients at your facility?
MR. MATT EGGEN: Many.

REP. PORTER (94TH): And you are saying it is only one APRN is their doctor?

MR. MATT EGGEN: No.

REP. PORTER (94TH): No. So my last question is diabetics require 24/7 care.

MR. MATT EGGEN: Correct.

REP. PORTER (94TH): Do you have 24/7 care at this facility for diabetics?

MR. MATT EGGEN: We do.

REP. PORTER (94TH): Thank you.

SENATOR OSTEN (19TH): Representative Walker.

REP. WALKER (93RD): Thank you. Thank you and I heard you when you said it I felt what you were trying to say. Its, have you ever heard of consent to (inaudible - 02:07:23) 1F consent decree?

MR. MATT EGGEN: I am not familiar with that.

REP. WALKER (93RD): It's something that was -- it was a suit that brought against Department of Children and Families and one of them was caseloads. And they are under this consent decree now that they have to otherwise they get penalized. They're supposed to have 49 cases. And that’s where they have set the standard so as Representative Horn was asking what would be a comfortable, 49 is the comfortable because that is what is set up by this consent decree. That’s what we should be striving for. Thank you.

MR. MATT EGGEN: Um-hum. Thank you.
SENATOR OSTEN (19TH): Any comments or questions? Representative Johnson.

REP. JOHNSON (49TH): Thank you, Madame Chair, and thank you for your testimony. I am just I’m concerned in terms of the proportionality of people with behavioral health disorders that require medication, diabetes, perhaps other medical conditions that are chronic, do you have a sense for what the proportion is in terms of the overall population that you’re serving?

MR. MATT EGGEN: I can't speak to medical issues specifically. In terms of mental health cases who are ongoing mental health issues, I would say roughly 130 of our 750 are people that we see on a regular basis, at least every 30 days. But everybody in that facility is also entitled to write a request irrespective of your mental health score or your mental health level rather. And we are supposed to respond to those requests and have a visual interview within three days. That doesn’t happen either.

Treatment plans are due every 90 days. That doesn’t happen either. These are in AD Section 8.5 Section 5, 6 and 7 (laughter) that was also listed in our protest. So I can't speak about medical issues.

REP. JOHNSON (49TH): Okay. Very good. Thank you so much for that. Thank you, Madame Chair.

SENATOR OSTEN (19TH): Any comments or questions? Thank you. Thank you very much. Up next is Deb Cruz followed by William Longo.

MS. DEB CRUZ: Good evening, Senator Osten, Representative Walker and members of the committee.
My name is Deb Curtis, I am a correctional nurse working at Cheshire Correctional and Manson Youth Institution for the past 12 years.

I provide medical care to a population that many have disparaged or chosen to simply forget. Whether they're incarceration is 2 or 200 years, health services needs to be provided to them all.

The recent staffing crisis has impacted us all no matter what shift you work or what job you do. Currently medical is barely providing the basics and that is not how we as professionals want to operate.

We take great pride in our jobs and want to do the best we can. Unfortunately, when you are expecting four nurses to run the shift, and there is only one available, a lot of things will not get done that shift.

That is exactly what happened a few weekends ago at the Cheshire and Manson Youth. The infirmary at Manson had an inmate needing round the clock observation, he was a mental health inmate, by nursing and no one to work in the infirmary on the 11p to 7a shift.

That inmate had to be moved to Garner on Friday night and returned to Manson on Tuesday when we had sufficient staffing. Manson Youth medical -- Manson Youth medical was closed for that shift.

The same night across the street at Cheshire, the one nurse that was working 11p to 7a was told that she would be responsible to respond to any codes or medical emergencies at Manson Youth also.

The time it would take for her to respond to the ill or wounded would have been at least 15 to 20
minutes. Thankfully nothing happened at Manson that night.

Since Cheshire was also running down one person again, a whole side of the prison was not medicated until the day shift arrived. This happens frequently.

Lack of staffing forcing those available to work 16 hour shifts day after day and in some cases 24 hours straight is dangerous for all involved, both staff and patients. This is happening all over the state at all our facilities.

Chronic care clinics, we used to see those with asthma, hypertension and diabetes every three to six months for physical assessments, lab work evaluation and refer any abnormalities to the physician.

We have not done a clinic in over a year. We manage these populations by crisis only.

The last commissioner wanted to move towards preventative care to the inmates as well as Hep C treatment to those who need it. None of that can be accomplished when our staffing is in such crisis and the budget is falling short.

We implore you to consider our public statements as a desperate cry for help to increase that budget so we can get the professional staff on board to get the job done right. Thank you.

SENATOR OSTEN (19TH): Representative Porter.

REP. PORTER (94TH): And I know we’re trying to move them along and not ask questions but I have to. Very concerned. MYI, how old was that inmate?

MS. DEB CRUZ: I think he was 17.
REP. PORTER (94TH): Do you know?

MS. DEB CRUZ: Or was he 17? 18.

REP. PORTER (94TH): He was 18?

MS. DEB CRUZ: Um-hum.

REP. PORTER (94TH): Moved to garner?

MS. DEB CRUZ: Yes.

REP. PORTER (94TH): And how was he housed at Garner?

MS. DEB CRUZ: He was in segregation then. In the IPM.

REP. PORTER (94TH): He was in the infirmary.

MS. DEB CRUZ: Um-hum.

REP. PORTER (94TH): Okay. And returned from infirmary back to MYI.

MS. DEB CRUZ: Yes, on Tuesday because it happened to have been a long weekend.

REP. PORTER (94TH): And how many hours, how many days?

MS. DEB CRUZ: Three.

REP. PORTER (94TH): Three days in solitary confinement.

MS. DEB CRUZ: No, no, on.

REP. PORTER (94TH): Infirmary, I'm sorry.

MS. DEB CRUZ: Infirmary.

REP. PORTER (94TH): Infirmary. All right.

MS. DEB CRUZ: He was well cared for there.
REP. PORTER (94TH): 16 hour shifts.

MS. DEB CRUZ: Um-hum.

REP. PORTER (94TH): But the thing that disturbs me IS you said there are 24 hour shifts.

MS. DEB CRUZ: Um-hum. There are some --

REP. PORTER (94TH): You have --

MS. DEB CRUZ: There are some infirmaries in the facilities that have been forced to work 24 hours before they have relief.

REP. PORTER (94TH): That's illegal.

MS. DEB CRUZ: Um-hum.

REP. PORTER (94TH): Okay. I just want to make sure we get this on the record.

MS. DEB CRUZ: We all know it.

REP. PORTER (94TH): 24 hour shifts.

MS. DEB CRUZ: But we also can't walk way and leave our patients.

REP. PORTER (94TH): I understand. But you shouldn't have to work 24 hours a day.

MS. DEB CRUZ: Correct. We agree. (Laughter)

REP. PORTER (94TH): I'm going to stop there. Thank you, Madame Chair.

SENATOR OSTEN (19TH): Representative Perone.

REP. PERONE (137TH): Thank you very much, Madame Chair. I'll pick up where you left off. The -- thank you for your testimony and just consistently with just everybody else, I mean, I just want to
thank you all for your selflessness and the jobs that you do.

It’s -- you’re working -- you’re doing not only more with less, you are doing triple the amount and, you know, in cases you are doing it for 24 hours.

So but my concern is, you know, we talk a lot about overtime and, you know, efforts to cut back overtime. But last I checked you guys are human and there’s only so much that you can take and I’m just wondering if you can speak to, you know, what kind of impact it has had on, you know, sick outs.

Basically people just, you know, the impact on the staff. Because I have to think that just, you know, there is only so much you can do before more people start calling in sick just because they have to.

MS. DEB CRUZ: That is correct. We have an 11 to 7 nurse, actually 3 to 11 nurse who happens to be left to be the only one that can be mandated to the next shift. And she has been -- one of her worst weeks has been five in a row.

And one time we just went to custody and said well, we are sorry, we are sending her home. And they looked at us and said we have to she is too tired. We even offered her a ride, custody offered her a ride home because they were unaware that they were -- that we were saying that often.

Mistakes can happen. We could miss something. We don’t want to work like that and she is a phenomenal nurse. And yes, she did have to take a few days off not too long ago. She has a small son and they both went down with the flu and she didn’t have anything to fight it off with. But she is back, just spent
two 16 hour shifts over the weekend, staying again tonight. That will be her third.

REP. PERONE (137TH): Thank you very much.

MS. DEB CRUZ: Um-hum.


MS. LISA CANDELARIO: Good evening, Senator Osten and Representative Walker and members of the committee. I would like to take this opportunity to thank the members of the Appropriations Committee for having this forum and allowing me to share with you my views and concerns about the upcoming budget decisions of the Connecticut Department of Corrections.

My name is Lisa Candelario. I am a licensed practical nurse for the Department of Corrections. I work at MacDougall Walker facility and have for nine and a half years. MacDougall Walker is a maximum security prison with approximately 2,000 inmates.

MacDougall is known as one of the medical hubs in Connecticut because we get inmates that are acutely ill and medically compromised. MacDougall has a 24 bed infirmary that is consistently full and many days we have to turn inmates away because we don’t have enough beds to accommodate them.

To demonstrate what is expected of my colleague and I, allow me to illustrate what a common day consists of as a correctional nurse at MacDougall Walker and other correctional institutions across the state of
Connecticut. My list, on a daily basis will consist between 30 and 40 inmates on my assignment alone which is only from part of the building because there are so many inmates, we split the building into different assignments.

My list consists of wound care, weekly vital sign checks, equipment checks, diabetic blood sugar checks, insulin administration. All of this is done while having to stop for facility emergencies such as inmate fights and medical emergencies.

We pass out medications twice daily to appropriately 600 inmates that must be given by a nurse because they are restricted meds. There is also approximately 135 inmates that receive insulin two times daily and some of them are seen three to four times a day.

My efforts in illustrating a fraction of what our responsibilities and expectations are as a correctional nurse is for the public and people in your position to have a better understanding of how busy our days are and how it is at an unsustainable pace to try to provide high quality care.

The current doctor list at MacDougall Walker is over six months long and we are at very short medical prescribers. Our medical staff are leaving to other state agencies and are always looking for other jobs because we are exhausted and tired of working in an unhealthy working climate.

I would like to express upon the members of this committee that everyone I work with in the medical department comes to work and provides the best care we possibly can to a population of people that most
people in the medical field do not want to treat or serve.

We provide this care with minimal supplies, outdated equipment in an environment that most nurses or doctors would not take part in.

I have watched the decline in the number of medical staff on each shift over the nine years I have worked in DOC which has led to the decline in care we can provide safely and accurately.

If we do not have the resources to provide the care they and, they will end up being paid out in lawsuits and other forms of legal action.

When making the decision on the budget for DOC, please consider our position and what we are trying to express to you in this public hearing. The inmate population that we care for could be your brother, your son, your neighbor, and they have a constitutional and human right to quality care. Thank you.

SENATOR OSTEN (19TH): Any comments or questions? Representative Porter followed by Representative Perone.

REP. PORTER (94TH): Really quick. You have a 24 bed infirmary. What happens when you turn them away?

MS. LISA CANDELARIO: A lot of times they try to shuffle them across the state to other infirmaries. It becomes an issue because some of the inmates have different security levels. Usually they end up finding a bed somewhere. Sometimes they have to stay in UConn for a longer amount of time because there is no infirmary bed for them.
REP. PORTER (94TH): Has there ever been outcomes where someone has actually died as a result of not receiving medical care and being turned away from the infirmary?

MS. LISA CANDELARIO: I can't answer that to be honest with you.

REP. PORTER (94TH): All right, thank you. Thank you, Madame Chair.

SENATOR OSTEN (19TH): Representative Perone.

REP. PERONE (137TH): Thank you, Madame Chair. I’m just, just curious. And thank you for your testimony. How many patients would you say you see a day? (Laughter) What’s all that laughing?

MS. LISA CANDELARIO: On my assignment in the morning is between usually between 30 to 40 inmates and those guys I usually have to see between 8 and 11:30.

REP. PERONE (137TH): Really?

MS. LISA CANDELARIO: Yes.

REP. PERONE (137TH): And what kind of care conceivably could you give to each patient? Or did I answer my own question?

MS. LISA CANDELARIO: It’s very -- (laughter) I’m an LPN so usually I’m doing things like treatments which could be wound care, vital signs, blood sugars. It’s not, they're not usually complete say assessments because I’m an LPN.

REP. PERONE (137TH): Right.

MS. LISA CANDELARIO: But it still its quick care. I am moving quickly --
REP. PERONE (137TH): Speed Care.

MS. LISA CANDELARIO: -- and a lot of times I don’t document as I’m treating the inmate. I usually have to go back, sit and eat my lunch if I’m lucky and document.

REP. PERONE (137TH): So --

MS. LISA CANDELARIO: To get the stuff done.

REP. PERONE (137TH): So then what you are saying is that because you can only do much in such a short amount of time that, you know, by and large a lot of the patients they may continue to have these maladies and may continue to have issues going forward.

Some of them may get treated, some may not. Some may get worse. I mean, like what kind of follow up is it, do the patients have at their disposal if any?

MS. LISA CANDELARIO: If I notice something abnormal then I would take care of it immediately. I would go back and I would stop whatever I was doing and I would treat whatever is going on.

But again follow up. I can put them in for a doctor’s appointment and cross my fingers and hope and pray they get seen but.

REP. PERONE (137TH): Well, what do you think you would need to make your, make you feel that it would make you -- what do you feel would help you deliver the kind of care you think you should be delivering? You know.

MS. LISA CANDELARIO: We need more nursing staff on all shifts. We need more doctors in the building.
REP. PERONE (137TH): What kind of work do you do regularly? You know, in hours wise?

MS. LISA CANDELARIO: I normally work three 12 hours shifts a week. The last four weeks I, usually every time I go into work I’m staying usually about a 16 hour shift.

REP. PERONE (137TH): How many of those a week?

MS. LISA CANDELARIO: I do three 12 hour shifts a week.

REP. PERONE (137TH): Okay. All right. Thank you very much.

MS. LISA CANDELARIO: You’re welcome.

SENATOR OSTEN (19TH): Representative Candelaria.

REP. CANDELARIA (95TH): Thank you, Madame Chair. Lisa, just a quick question. And you just mentioned that you see between 30 and 40 patients from -- yes, you stated 11:30. So what time do you start?

MS. LISA CANDELARIO: Usually about eight o’clock. Because we are in a prison we have to wait for count to clear and then we would have to see our patients before they count again. So it leaves us a limited amount of time.

REP. CANDELARIA (95TH): So how much time are you spending with each inmate?

MS. LISA CANDELARIO: It depends if they have a longer treatment it could be 15 minutes.

REP. CANDELARIA (95TH): 15

MS. LISA CANDELARIO: If it's something as simple as a blood pressure it could be two to three minutes.
REP. CANDELARIA (95TH): So is there a specific allotted time with each patient?

MS. LISA CANDELARIO: No.

REP. CANDELARIA (95TH): No.

MS. LISA CANDELARIO: No I’m -- we just kind of --

REP. CANDELARIA (95TH): Well, we try. We try to provide the best care we can. So okay. So -- and so then -- so your shift ends at what time? Usually? Eight hours.

MS. LISA CANDELARIO: I have different assignments. Within the morning I will have one assignment --

REP. CANDELARIA (95TH): So within an eight hour span you see what 80 patients? 80 inmates?

MS. LISA CANDELARIO: No. We do sick call and say treatments in the morning, that’s where the bulk of my 30 to 40 inmates are and then in the afternoon we usually have different responsibilities.

We could be doing transfers, sometime in the afternoon we are seeing more patients. We have a ton of emergencies also of times those 30 to 40 patients sometimes can be pushed over in the afternoon because we don’t get everything done.

REP. CANDELARIA (95TH): So you have an electronic chart system.

MS. LISA CANDELARIO: Yes.

REP. CANDELARIA (95TH): You do. And you said sometimes you are not able to document everything. How do you recall everything? How do you recall to document and then put all that into the system after seeing 40 patients and know who is who?
MS. LISA CANDELARIO: A lot of times I’d take quick little notes especially vital signs obviously I can't remember all that stuff so I’ll write it down quickly. Because our electronic health record isn’t very user friendly it takes a long time to document so there is no way that could see the patients and document at the same time.

REP. CANDELARIA (95TH): Okay. Thank you. Thank you, Madame Chair.

SENATOR OSTEN (19TH): Any comments or questions? Seeing none, thank you, Lisa. Mark Morin followed by Krystal Jackson.

MR. MARK MORIN: Good evening, Senator Osten, Representative Walker, and members of the committee. My name is Mark Morin. I work as a medical laboratory assistant of the Department of Corrections and I worked in this capability for over 20 years.

Previously I was a DOC medic. I am currently assigned to the Cheshire Complex Connecticut Institution Cheshire and the Manson Youth Institution.

Allow me to predicate my remarks about medical funding within the DCO by sharing some truths about my colleague and coworkers. The correction officers I work with are mostly awesome. They, they are brave and dedicated. These peace officers work the toughest beat in the criminal justice system, they deserve our gratitude and respect.

I also want to talk to you about the medical healthcare professional’s that I am humbled to call my peers. I am privileged to work with so many
outstanding doctors, dentists, dental assistants, hygienist, x-ray techs and medical laboratories.

But the group that deserves special accolades is our nurses. The nurses respond to every incident in our prisons. Disturbances, riots, fires, altercations and medical emergencies. What most people don’t know is how great our correctional nurses are. These are some of the best people in our society. Many of them are heroes and I am here to advocate for them.

Simultaneously I also want to advocate of our inmate patients and their care and I also want to advocate for our citizens and tax payers. I am here to ask the legislature to fully fund the medical and mental health services within our prisons. Unfortunately dear legislatures rewriting a bill will not fix this. It needs to be funded.

And you need to allocate necessary funding to credit medical services within our prisons. The accrediting organization could be the National Commission on Correctional Healthcare of some like organization that will provide DOC a standard. A standard, a metric.

Currently the standard is set by litigation. By failing to embrace an accrediting standard, we are allowing our ethics, standards and practice to be determined by lawsuits and judicial mandates.

Abdicating our reasonability set or adopted a standard has not precluded a standard from emerging. The standard proven by litigation and implemented by response to judicial mandates. What emerges is management that is reactionary, not thoughtful, not proactive.
We have programmed inefficiency that is wasteful, slow and expensive. What I observe within our institutions is not acceptable. DOC nurses are repeatedly being ordered to work 16 hour shifts. It takes a truly dedicated person to report to work within one of our institutions on a holiday like Thanksgiving or Christmas knowing that by coming to work for your eight hour shift you will likely be going to be ordered to work a second shift and stay for 16 hours.

Thankfully, we have dedicated nurses that report to work in these very circumstance. Why is this happening? Because our budget is limited to hiring front line positions. These people’s dedication and work ethic have really saved our state. We owe these incredible people to do much better, much better.

We have many nurse working double shifts. This becomes problematic. This contributes to burnout, absence and creates certain concerns about safety. Safety of the nurses, their coworkers and the medical safety of our inmate patients.

I have had many nurses tell me that they work four and five double shifts per week. We need to fill all the vacant medical healthcare positions in the DOC immediately. We need to fully fund inmate medical healthcare. We need to fund medical accreditation for all DOC facilities.

As a medical healthcare professional, I am advocating for my patients. That union members -- union member I am advocating for my peers and coworkers but I also want to advocate for our fellow citizens and tax payers. My concern for us is liability.
The inmates are litigious but our liability is not limited to inmate lawsuits of those also about judicial mandates. If we do not fully fund healthcare within the Connecticut DOC, a federal judge could order a federal magnitude to assume management of inmate healthcare in Connecticut.

And if anybody believes that adequately funding healthcare is expensive now, the burden to taxpayers could be much, much greater.

We need to fully fund healthcare within our prisons and I thank you for listening to me and letting me come here to talk to you guys tonight.

SENATOR OSTEN (19TH): Thank you. And is there any comments or questions? Thank you very much, Mark. Appreciate it. Krystal Jackson followed by Armando Cruz.

MS. KRISTAL JACKSON: Hello, good evening, Senator Osten, Representative Walker and members of the committee. I would like to take this opportunity to thank the members of the Appropriations Committee for having this forum for us to share with you our feelings and concerns about the upcoming budget decisions for the Connecticut Department of Corrections.

My name is Krystal Jackson and I am a licensed professional counselor for the Connecticut Department of Corrections. I currently work full time at Garner Correctional Institution which is a level four security facility with male inmates 18 and older. And as you know, it is considered the mental health facility.
I started working with DOC seven years ago after leaving the private sector where I served many of the same population due to contracts with state probation and parole, DCF and federal parole. Many of the clients I helped during that time were ambivalent about treatment due to them being mandated to attend or they had a lack of understanding as to what it means to be mentally well.

Because most of the 500 plus inmates at Garner Correctional had received a mental health diagnosis ranging from mild to chronic forms and many of them consider our treatment to be mandated as well.

When I’m not addressing crises, I am educating these individuals about mental health, mental wellness and encouraging them to identify what it means to take care of themselves while incarcerated. And if they have the opportunity in returning to the community.

Unfortunately I find many of these individuals have come back to the system again and again because of the lack of resources and ambivalence about mental health care.

And if I can say, I am probably one of the most consistent people in their lives and when they come back, they greet me like they're coming home. (laughter)

In my seven years, I have watched the acuity of the population increase with many individuals carrying a chronic health diagnosis what would have been treated and probably better treated in area psychiatric hospitals in the past.
I currently have a caseload of 30 inmates who are categorized as mental health four and need to be seen weekly. This does vary by unit. My unit is considered for lower functioning inmates so I have 30. Some people have 40 or 50 on their caseload. I am required to conduct a group each day.

Over the last seven years at Garner, I have seen the second shift staff dwindle form eight to five. On a good day, we have four mental health clinicians covering eight units including the infirmary and restrictive housing unit.

Many of the emergent issue tend to happen later in the day which means I can spend a good part of my shift addressing crises, assessing someone for placement and restrictive housing, providing verbal intervention and any other case management needs.

There are approximately 300 inmates classified as mental health four. The infirmary which has about 25 to 27 beds is typically full which means I have to assess if someone can go on a safety status in the unit or will they need to be placed on a one to one status if there are no available infirmary beds.

Because Garner is the mental health facility, it is first in line to receive mental health four inmates or mental health five inmates for the infirmary.

Because we have four mental health clinicians on second shift and the acuity is higher, we have to prioritize the crises overseeing our caseload. We have been working at minimum staffing for most days of the week on second shift for much of the last two years.
Only have a few more paragraphs to go. (Laugher) Minimum staffing is three clinicians and so for the most part, three clinicians we have every single day to cover the entire building. That means I have to maintain my caseload and address the crises of the units.

I would be honest and say much of my day is putting our fires, verbally deescalating and monitoring the newer inmates and providing support as they adjust.

I would like to provide psycho education groups each day but it is difficult to make that happen. It can feel burdensome and overwhelming to walk into the building each day. In the last six months we have had two clinicians leave second shift and seek employment elsewhere.

The supervising psychologists have had to take on a small caseload and are now the primary management for mental health services in the facility since the transition to DOC from UConn.

Although some inmates will benefit from psychological testing, the psychologists have not been able to prioritize this because of the needs of the facility and increased demand to cover units when we are short staffed.

I believe we would see a change in recidivism if we were able to provide treatment and teach skills to support the inmates with mental health diagnosis as they transition to the community.

I am asking you to consider these issues when you make a final decision on DOC's budget and I ask you to look at restoring DOC's budget to the amount
SENATOR OSTEN (19TH): Thank you. Any comments or questions? Thank you. Representative Johnson.

REP. JOHNSON (49TH): Thank you, Madame Chair. Just what kind of training do you think that we should do in terms of socialization for inmates to help them prepare to be in the community once they're discharged?

MS. KRYSTAL JACKSON: So I will say I do a lot of education throughout the day, not just for inmates but also for the staff because people do not understand what it means to be mental health and I tell them we have, we all have mental health just as well as we have spiritual and physical health, but we don’t all have a mental health diagnosis or a mental illness.

And so doing that education will help people to understand and normalize it for them so that when they go back to the community they can see the benefit of continuing with the treatment.

Because we are doing in a sense mandated care, they come to corrections and they automatically get placed back on the same care and there is limited transition.

They only have 30 days’ worth of medication for a prescription once they leave the correctional facility. And oftentimes, they both have the resources to get to appointments, nor do they desire to go to these appointments.

And so to answer the question earlier about how are people continuing on with medications and if we have
family members who are contacting and things like that, it’s important for us to get as much of a history as we can but sometimes our people we serve are not good historians. And so we do take into account what the family members are saying and we do our best to try to include them in the discharge planning.

But I think definitely the education of the staff and of the inmates as to what it means to take care of themselves as a whole person moving forward from this will be beneficial.

REP. JOHNSON (49TH): Just one quick follow up questions. Yale University has created an emotional intelligence program for education, for our educational system for our superintendents. Is that something that might be on the horizon for corrections do you think?

MS. KRYSTAL JACKSON: I am -- I can’t speak to the emotional intelligence, that’s not my forte but I do think having people who have a better knowledge in a sense of what we provide and what would be beneficial would be helpful to the cause.

REP. JOHNSON (49TH): Great. Thank you so much for your work and being here this evening. Thank you, Madame Chair.

MS. KRYSTAL JACKSON: Thank you.

SENATOR OSTEN (19TH): Any other questions? Seeing none, thank you very much.

MS. KRYSTAL JACKSON: Thank you.

SENATOR OSTEN (19TH): Armando Cruz followed by Lynne Munday.
MR. ARMANDO CRUZ: Good evening, Senator Osten, Representative Walker and the members of the committee.

Before I continue, I just wanted to put something in perspective, maybe you guys can let this marinate in your minds as I read my testimony and already listened to the testimony of my colleagues.

Just imagine coming into to the doors of the LOB building and knowing that you have 45 percent of your workforce that has been cut. Just think about that as I read my testimony please.

My name is Armando Cruz. I am a radiological technologist for the state of Connecticut, Department of Corrections. I have worked seven years at Osborne, Northern, Carl Robinson, Willard Cybulski, in the field for seven years.

For 13 years I worked at Hartford County Corrections and for the last four years I've worked at New Haven, Manson Youth and Cheshire. So, Senator Osten, I got you beat by 11 facilities. (Laughter)

SENATOR Osten (19TH): Well, I worked at seven of them.

MR. ARMANDO CRUZ: I got 11. (Laughter) Tonight, if I may I will speaking as an 1199 delegate serving for the past 13 years. I have been working in corrections for 23 plus years and I have encountered, seen and been told by man of my coworkers of staffing issues statewide.

In providing professional and basic healthcare to the inmate population my coworkers and I have given an external -- I’m sorry, extraordinary amount of time and effort in the basic care of the inmates.
The staffing crisis that the Department of Corrections has inherited not only affects my coworkers but also the wards of the state known as our inmates.

As a whole, a professional staff of approximately 600 or so is only a Band-Aid on a hemorrhage issue that should be fixed with adequate staff. Even stated earlier, when the commissioner was speaking to the panel, even if we did hire the 92 positions that were posted, even though we requested 140 vacancies, that still will just give us breathing room. It still does not fix the staffing crisis.

Let me give you an example. If any of you walked into a clinic or a hospital and asked for medical care, you're told -- and you are led that you are being placed on a wait list and will be called when it is your turn.

Naturally, you ask how long that will be. The response in this instance is two to three weeks. How would you feel?

I’m going to go back in my timeline of my employment for the state of Connecticut. When I first started in 1996 as a member of Department of Corrections, there was approximately 1100 healthcare professionals in the mental and medical health field.

In my opinion and my opinion only, health services for inmates were done in an adequate fashion back then. Fast forwarding to the year 2006, when UConn Health was at the helm of overseeing the care of the inmates, allegedly due to budget crisis they dwindled our staff down to 750.
This was the beginning to the downfall of care that we have yet to recover from. That brings us to the present staffing levels as I stated earlier of 600.

It’s not feasible to perform all these duties that have to be provided and performed in the correctional atmosphere with these numbers.

We have been told as a whole to do more with less which we have. With the current numbers of staff, the state and the public have seen an increase in legal issues in many causes that could have been prevented.

I stand here before you as a professional, a proud state employee to ask you to allocate the funding for this department direly needs.

And like I said earlier imagine walking through those doors and out of all 10 people that walk through, only six of you have to do the job of the other 10. Is that feasible? Thank you.

SENATOR OSTEN (19TH): Thank you. Any comments or questions? Thank you so much. What, I’m sorry. Senator Perone.

REP. PERONE (137TH): Thank you very much. Thank you, Madame Chair. I just had a question. You know, if you were able to bring the levels -- let me ask you this.

How long, provided you had the funding and everything else that you needed, would it take to onboard all of the people that you feel you would need to? Basically to bring the system up to a point where you feel it was, you know, it was adequately staffed and well run?
I’m just trying to get a sense of, you know, time here because it's one thing to just say okay, we are going to improve, you know, funding for these people but it’s another thing to hire them, interview them, train them, you know, and bring them in.

So, you know, if you were going to say, you know, bring in another say 50 people, how long do you think that would take?

MR. ARMANDO CRUZ: Well, Representative Perone, its -- I’m going to answer that with this statement. It’s easier to tear things down then it is a lot harder to build things back up.

REP. PERONE (137TH): Well, that’s kind of my point. It’s like because so it's really like I’m talking about really the time it is going to take to, you know, unwind a lot of the impact that these cuts have had.

And so with that in mind, I mean where do you feel that the, you know, that the need is most urgent? Is it staff? Is it, you know, consistency in funding? I mean, where do you think the impact --

MR. ARMANDO CRUZ: Well, I think it is hand in hand. The inconsistency in funding drastically affects the hiring of people.

REP. PERONE (137TH): Sure.

MR. ARMANDO CRUZ: So.

REP. PERONE (137TH): All right. Well, thank you very much for your testimony.

MR. ARMANDO CRUZ: Thank you very much.

MS. LYNNE MUNDAY: Hello. Good evening, Senator Osten, Representative Walker and members other committee. My name is Lynne Munday. I’m a registered nurse. Currently I’m employed by the Department of Corrections at Bridgeport. Bridgeport is a Community Correctional Center also known as a jail.

My background in the department consists of having worked in two of the three intake facilities, New Haven and Bridgeport, as well as Garner, our level health -- level five mental health facility and Cheshire, both of which are prisons that house sentence offenders currently serving out their time as well as Manson Youth which is a combination jail and prison for youthful male offenders.

With my testimony tonight, I offer 12 and a half years of correctional nursing experience in addition to several years of acute care hospital nursing.

Connecticut state employees work for the residents of the state of Connecticut. I believe the tax payers who are funding state services and the legislators who decide the amount of funding will ultimately -- that we will ultimately receive should have a clear understanding of what we do and the obstacles that we face.

I am here tonight to give testimony with the expectation the information presented will provide a glimpse into the world of correctional healthcare which will helpfully assist in understanding the resources correctional healthcare professionals need in order to do our job.
I am also here to give testimony as an advocate for a significantly underserved part of the population that's at high risk for illness and they don't have much of a voice or a choice in regards to their healthcare once they're incarcerated.

The offender population has for the most part severe challenges to their medical and mental health prior to being arrested. This population has many distinct features that we as healthcare workers must be aware of when providing care.

When compared to societal averages, this population tends to have much higher rates of medical and mental illness, infectious disease concerns, substance abuse and are thereby prone to have undiagnosed medical conditions such as heart disease, liver toxicity, or respiratory compromise.

For example, an inmate who suffers from substance abuse is prone to significant withdrawal concerns. Some conditions of withdrawal if not treated within a timely manner could be fatal. There is also a significantly increased risk of suicidal behavior within this population and other forms of self-abuse that must be carefully assessed and supervised closely to ensure their safety.

Although there are many aspects of correctional healthcare, my focus tonight will primarily discuss the role of acute inpatient care within the health services division of the Department of Corrections.

May I continue? Bridgeport -- thank you. Bridgeport is one of three dedicated intake facilities within the department. This facility is where accused offenders are first booked and then housed while awaiting their scheduled court dates.
At this first contact, it's imperative that we as medical and mental healthcare providers have the appropriate staffing, time and resources needed to address their needs.

As of tonight’s testimony, we have a 1.5 full time medical providers and only one part time psychiatrist slash prescriber. This fact along with the shortage of nursing staff and mental health clinicians makes for addressing the needs of this most destitute population a near impossibility.

Bridgeport is the only inpatient hospital unit that serves three main jails. It’s a 24 bed secure hospital unit that houses the states sickest offenders of which have not been charged with a crime but are still going to court and have not yet been sentenced.

The offender population is classified on a different levels of care, a scale of one through five with level five being considered as needing the highest level of care of both medical and mental health offenders.

At Bridgeport, any offender housed in this inpatient hospital unit is at five, either medical or mental health.

Our patients come in directly from the street, having just been arrested, from other facilities, some of our facilities do not have an inpatient unit, the local emergency rooms or other community hospitals and inpatient facilities.

We also will receive patients just discharged after having surgery that if for not being arrested, would have been discharged to a rehab facility.
Our patient population at any given time has individuals with a plethora of different medical and mental health needs. From head to toe, orthopedic to cardiac, post op to hospice, those on suicide watch, all within the same 24 bed unit that provides everything from IV services to wound care to psych emergencies.

We have a 24 bed capacity staffed with one nurse. 24 to one. No support staff. We are in desperate need of additional resources and staff to provide the care that our inmates need. Please help us to do that.

SENATOR OSTEN (19TH): Thank you. Any comments or questions? Representative Johnson.

REP. JOHNSON (49TH): Thank you. Just quickly, what do you do in an emergency where you might need more than one nurse in that circumstance? Does that ever occur?

MS. LYNNE MUNDAY: Yes. It occurs all the time. There are nurses doing other jobs. Some are working with the doctor up front. There’s other people around in another area. We call for help.

REP. JOHNSON (49TH): Thank you so much for being here. Thank you, Madame Chair.

SENATOR OSTEN (19TH): Thank you. Shirley Watson followed by Kristin Fernandez.

MS. SHIRLEY WATSON: This is in such great font, I don’t need my glasses. Good evening, Senator Osten, Representative Walker and members of the committee.

My name is Shirley Watson, I’m a licensed clinical social worker at the MacDougall Walker Correctional...
Institution. I am speaking with you today because of the critical need for additional funding and additional staffing in inmate medical and mental health services.

Like my colleagues have already said, we are committed to the jobs that we do. We went through our education and we came into the system wanting to make change. We wanted to improve the lot of the folks that we work with, the marginalized members of society.

We wanted to be able to give them a voice, to make sure that they’re needs are addressed and that they get the adequate care that they deserve.

I have already submitted my written testimony and I do hope that you take the time to read it. I am going to actually do a little bit different than I think what you have been hearing over the past evening and I’m just going to give you two examples of why we do the work that we do.

And these are personal to me but I’m sure my colleagues, hopefully they have a tale that they could have told as well.

The first one is when I first came in to corrections -- I have been in state service for over 20 years. I just dated myself but over 20 years. And when I came into corrections which was five years ago, I worked for a while and I was out grocery shopping in the community.

And a former inmate that I worked with at MacDougall identified me. He recognized me and he came up and he started talking to me and he said, you know, are you Ms. Watson? Do you work at McDougall? And I’m
like yes. And he is like you know what, he goes you have helped me.

He goes when you saw me I was in fights I was, you know, in -- basically I was in a bad place. And you took the time to listen to me and you took the time to work with me and I just wanted to thank you. And I wanted to let you know I’m in recovery.

I have got a job, I’m trying to take care of my family and I was gob smacked. I was like wow, this is amazing.

And then a couple months ago I was in Garner, I was in the waiting area and an inmate came out, he was doing some work and he recognized me. He said, Ms. Watson, he goes are you still at Walker? Which is where I am. I said yeah. He goes well, you know, basically how you doing?

And I was like I’m so sorry, I don’t remember your name. He goes don’t worry about it. He goes I never forget a face. He goes I was stressed, I was anxious, you talked to me, you gave me materials, you helped me and I just wanted to say thank you.

And that’s -- those are anomalies and they shouldn’t be. They really should be the standard of what we do and how we are able to see the work that we provide germinate.

So and lastly, I promise I won’t hold you guys up. The UConn game is over. (Laughter) I just, you know, like I said at one of the meetings that we had is like my colleagues, we didn’t come into service to do drive through therapy. We came here because we wanted to make a difference and we have done it with very little resource.
And I think we are here to make an appeal because we need to be able to express the fact that we want to do our jobs but the folks that we serve need us to do our jobs and we want to bring that to you and hopefully you will help us in making sure that these goals are met. I thank you very much for allowing me to testify.

SENATOR OSTEN (19TH): Thank you. Representative Porter is taking your picture. (Laughter) Any questions or comments? Seeing none, thank you.

MS. SHIRLEY WATSON: Thank you.

SENATOR OSTEN (19TH): Kristin Fernandez. She had to leave. Julie Wright? So Julie left also?

So I just want to ask one question of all of you that came to talk about this one issue. There are no, nobody here from York Correctional Institution? Do you -- did any of you work there?

SPEAKER: That was Julie Wright.

SENATOR OSTEN (19TH): Okay.

SPEAKER: Probably got help.

SENATOR OSTEN (19TH): (laughter) maybe. I’m just curious, do they have the same kind of conditions with the female inmates?

SPEAKER: Yes, yes. Oh yes. They submitted, Julie submitted her testimony.

SENATOR OSTEN (19TH): okay, great. Thank you. So could you just say that on the mic for me? That they submitted written testimony on the female inmate issue?
MS. REBECCA SIMONSEN: So Julie Wright, the supervising psychologist at York Correctional has submitted written testimony.

SENATOR OSTEN (19TH): Thank you very much. Appreciate it. Okay. Thank you very much for coming. I don’t know if you’re all staying for the next group but Patrick Hulin. Is Patrick here? Followed by Rob Heimer.

MR. PATRICK HULIN: Good evening, Senator Osten, members of the committee. My name is Patrick Hulin, I’m a law student at Yale Law School.

I am here to testify in strong support of the funding in the governor’s budget for evidence based treatment for opioid addiction in Connecticut jails and prisons.

Many of the members of this committee have led on this issue in past sessions, and I want to thank you all for your critical work and I want to thank the governor for including this funding.

This program if its funding is preserved throughout the budget process will save lives, it will reduce recidivism and it will ultimately save the state money.

So I just want to start by saying you all have heard the numbers on the opioid addiction crisis before. There are more than 1,000 people who died of accidental drug poisoning in 2017. It’s almost triple the number from 2012. It’s more than car accidents, homicides, and suicides combined.

More than half of those people have been incarcerated at some point in their lives so we are really talking about a population of people. The
people at risk of dying of this disease who are in and out of the criminal justice system and it’s a key factor in this issue and one that we really need to address.

But right now, incarcerated people are critically underserved by treatment except for there’s a small pilot program but except for that, the state does not offer the community standard of care which involves medications combined with other therapeutic supports.

Most people who are already on treatments if you’re on say buprenorphine, Suboxone, like Representative Rosario talked about this afternoon, are forcibly withdrawn from that medication when they enter jail or prison.

Even those who are only detained pretrial haven’t been convicted of anything, not that medical care should be used as punishment, but I think that’s just important to understand what we’re doing here right now.

So Rhode Island instituted a comprehensive program to offer evidence based care in their correction system two years ago. They saw a 61 percent decrease, so that’s cutting more than in half the number of overdose deaths among recently incarcerated people, so people who had just been released in the past six months.

Similar results here would mean saving 100 to 150 lives every year. That’s just a huge number. I mean that’s a huge number.

And while they couldn’t be here in person, Rhode Island, two Rhode Island state officials have filed
written testimony detailing the programs positive results for on a variety of different metrics and for a variety of different reasons.

So I understand how critical a concern the state budget is right now but this is exactly the kind of small, targeted evidence based investment that we should preserve right now.

At our preliminary modeling indicates that a program like this like spending in other parts of the inmate health line would save money in the out years in the DOC budget and in the medicated budgets. We are working with some modeling folks at the Yale School of Public Health on that.

Finally, I just wanted to make the point, as many of the folks who came before me did, that provision of the community, the community standard of care for medical treatment is required by the U.S. Constitution and in this case it is also required by the Americans with Disabilities Act.

Courts in Massachusetts have required jails there to provide treatment. Thank you for your time. I’m happy to take any questions.

REP. WALKER (93RD): Thank you and thank you for your testimony. Thank you, have a good day.

MR. PATRICK HULIN: Thank you.


MR. ROB HEIMER: Good evening. Committee members, my name is Robert Heimer and I am a professor of
epidemiology and pharmacology at DL Schools of Public Health and Medicine.

In my capacity as a researcher in the field of substance abuse, I have led two studies pertinent to the proposed legislation on expanding opiate treatment in the correction system. Both involved pilot programs that provided treatment with methadone for individuals with opiate use disorder.

The earlier two studies was conducted over 15 years ago in Puerto Rico, Los Maldines, the largest prison on the island was rife with contraband, heroin. Three and five prisons reported access while incarcerated. Two in five within the last month.

In the prison, a small pilot program was established to provide daily methadone up to 24 inmate volunteers, all of whom reported using heroine validated by urine testing.

This program reduced contraband heroin use by 95 percent measured both by urine testing and by self-report.

Although the pilot population was subsequently doubled, the successful pilot was terminated when the next election resulted in the change in the commonwealths ruling party.

Similarly in Connecticut, contraband opioids are rife in correctional facilities but here the major contraband item is Suboxone, a wafer thin formulation of buprenorphine.

For the better part of five years, pilot programs to provide medication for some inmates suffering from opioid disuse -- opioid use disorder have been
operating in correctional centers in New Haven and Bridgeport.

The programs provide continuing treatment with methadone to newly incarcerated men who had been receiving methadone in the community prior to being jailed.

We are in the midst of an evaluation of the positive and negative impacts of participating in this program comparing individuals who are able to continue. About 40 percent of those eligible who we'll call the cases with the other 60 percent who did not continue treatment we'll call them the controls.

At this stage of the evaluation, we can present preliminary results on overdoses among the cases in the controls following their release from custody.

Though 2017, there were 36 fatalities among both groups, 28 among the controls, 8 among the cases. The statistical analysis suggests that continuing to receive methadone was perceptive, cutting the risk of fatal overdoses by a little more than half.

Though 2016, all the data we have to date, there were 248 episodes in which first responder’s efforts prevented fatal overdoses, 161 among the controls and 87 among the cases.

Again, continuing methadone appears to be protective cutting the risk of non-fatal overdoses by 15 percent. The students who are working with me on this project and I will be updating there numbers as more recent data on fatal overdoses and non-fatal overdose become available and we expect to release a full report by the summer.
Unlike Puerto Rico, here in Connecticut we have an opportunity to scale up rather than eliminate effective programs to treat opioid use disorder in the correctional system and thereby reduce the negative consequences for individuals once released back into the community.

The proposed allocation of $2 million to provide medication based treatment for fiscal year 2020 and an increase to $6 million for fiscal year 2021 will allow expansion not just for those who become incarcerated while already receiving treatment but will include those not currently receiving treatment for their diagnosed opioid use disorder.

This increases vital and responding to the states opioid crisis by moving individuals into evidence based gold standard treatment and overcoming the stigma that is associated with both the diagnosis and curiously the best treatment of the disease of opioid use disorder. Thank you for your attention.

REP. WALKER (93RD): Thank you and thank you for your testimony. Thank you very much. Any questions? Have a good day, sir. Thank you.

JaLeesa Freeman.


REP. WALKER (93RD): Oh, Shelby Henderson. Oh, okay. I’m sorry, I didn’t hear you. Good, come on up.

MR. ARMANDO CRUZ: Sorry. This is my first time here. I’m kind of nervous but -- thank you. All right. So I guess good evening.

My name is Shelby Henderson and I am a graduate student at John J. College of Criminal Justice. I
am studying for a master’s in public administration with a concentration in public accountability.

So before I delve into the heart of my testimony, I guess I would like to recognize the governor's generosity in allocating funds support -- to support incarcerated individuals and families in his budget, particularly pertaining to the DOC.

However, I propose that the state takes this one step further. So I have like three points that I would like to discuss.

In September of 2008, the Office of Policy Management published a monthly indicator report and what they found was that former prisoners face heightened risks to die from drug overdoses and this is something that has basically been increasing.

So in 2017, 55 percent of the persons who died from a drug overdose had previously been incarcerated. In the same report, they basically disclosed that in 2017, 54 percent of Connecticut’s homicide victims were between the ages of 16 and, I’m sorry, 18 and 66 and they also had a DOC record.

So I think that both statistical revolutions require (inaudible - 03:04:28) from the state and I think that it is important to disclose that these travesties affect different populations.

So for the individuals who were dying due to a drug overdose, 70 percent of those individuals were white. For the individuals who were dying from -- as a result of a homicide, 61 percent of those individuals were black.

So I just think that this -- we need to basically look for -- I think that these are two different
epidemics and they require the states attention. And I think we need to be proactive in ways that we can number one, curve recidivism and two, basically respond to the epidemics of gun violence and the opioid crisis within both communities.

So basically there is a statute that I found is, it is in the Connecticut General Statutes which is 18-81W and I think this came out of a public act which was implemented in 2014 which basically said that as the state deincarcerates, the money that the state is going to be saving is going to basically be reinvested back into the communities and it’s also going to be reinvested back into basically implementing stronger reentry programs.

And I noticed that the, there was a reentry report that came out and I don’t see any of the suggestions that were in the reentry report, they’re not being discussed in the budget.

So things that I thought were very crucial, number one is the report calls for additional family support for a subsidized transportation to prison and jails. Number two, it calls for low cost of phone services for between parents and children. Now I also would like to disclose that New York correctional facilities, all of the phone calls are free so --

REP. WALKER (93RD): Keep going, keep going, keep going.

MS. SHELBY HENDERSON: All right, I’m sorry. And basically number four is it expands family services for counseling and parent initiatives.
They also asked for expanded reentry reintegration unit models to all level two and three facilities and assign a reentry counselor for all jails and prisons.

Number four -- the last thing I think is very important is they talk about forensic mentors for people who are being released back into the community. So those are things that I would like to see implemented.

And also I think there is a large body of evidence that shows that education, a lot of college to prison programs, they curve recidivism. So the recidivism rate in Connecticut is very high. I don’t think that 60 percent recidivism rate is anything to -- it’s just not good.

So I think that just as you guys discuss the budget, that you consider some of these things and I think housing and employment so if there is any money that could get allocated I think that they're very important.

REP. WALKER (93RD): Thank you. And thank you for your testimony. Did you submit anything in writing to us?

MS. SHELBY HENDERSON: I do have something in writing but my notes --

REP. WALKER (93RD): Okay, so you are going to submit it us tomorrow after you finish rewriting it okay.

MS. SHELBY HENDERSON: Yes, absolutely.

MS. JALEESA FREEMAN: Good evening.

REP. WALKER (93RD): Good evening. Pretty soon it will be good morning. Go ahead. (Laughter)

MS. JALEESA FREEMAN: Right. Thank you for yielding the floor. Good evening, Senators, Representatives, and members of the Appropriations Committee. My name is JaLeesa Freeman and I am the development officer at Solar Youth which is located in New Haven, Connecticut.

This isn’t my first time presenting in front of you all and it won’t be my last. Despite where my future takes me I will always be a supporter of Solar Youth.

If you want to know what impact Solar Youth truly has on New Haven and the youth that we serve, then just take a look at me. I am only one of tons of youth that can speak to the importance of this program.

We are indeed in a moment of crisis as an organization due to recent governmental funding cuts, yet we continue to serve and empower each and every day.

At the same time, we hope to make an ambitious jump to serve more youth in a deeper way. We face challenges raising resources to sustain despite our success in increasing revenue from individuals and finding several new sources of funds.

We have an enormous challenge ahead to fill the gap. Reliable funding will ensure we can keep our commitment to the community and run our programs with more predictably.
We provide our youth with the tools they need to be resilient and to be successful in life. How do I know this? Because I grew up in the housing development down the hill from our main office. I experienced the same challenges our youth face each day.

Without Solar Youth being present in my early years I don’t think I would be the same woman I am today. I am the woman that you see because Solar Youth has been a part of my life since I was 10 years old.

Because of our long term relationship, I was able to return to them for support during every critical moment in my life. Now a successful college graduate from New Haven -- college graduate, I returned to Solar Youth to ensure that we are able to provide this same experience for the youth in New Haven.

On the surface, on social media and our website you see the joy and excitement of youth exploring the outdoors and learning about the environment. But there is way more to Solar Youth than just that.

Solar Youth lays the foundation and provides the tools for our youth to be successful and success is defined by four major indicators. One, that our youth are able to have and maintain positive healthy relationships, that they are physically and mentally healthy, and that they're stewards of their community and they become economically self-sufficient.

Solar Youth division includes not only building on our current core programs but also continuing to provide opportunities for teens and enhancing our system of support for youth to one, help them
address crises and two, ensure graduation from high school and not just graduation but gradation with a concrete plan for college and or a career.

To best serve the community and for us to expand and maximize the amount of youth we can serve, we need reliable, consistent, financial support. This can only happen with continued and additional funding.

And I’m going to ad lib here just a little bit but earlier the question the was asked what programs should you guys invest in to prevent our youth from ending up in places like MYI? And I would like to say it would be investing in programs like solar youth.

I respectively urge the Appropriations Committee to pass a budget that restores funding for all youth development programs that support our most at risk youth in the state. Indeed the future of the state depends on it. Thank you.

REP. WALKER (93RD): Thank you. And thank you for your testimony and thank you for being --

MS. JALEESA FREEMAN: You’re welcome.

REP. WALKER (93RD): -- a true supporter and you just, you beam Solar Youth and it’s a great program. I love the program all for like the last 10 years. You guys do a great job.

MS. JALEESA FREEMAN: Thank you.


REP. PORTER (94TH): She’s being mean. She ain't the only one from New Haven in this committee. (Laugher) JaLeesa, hi.
MS. JALEESA FREEMAN: Hi.

REP. PORTER (94TH): And thank you so much. Real briefly, I just wanted to say thank you for being a model example of what an at risk youth can be when we take it to at promise. And I believe that you are reaching your full potential and I wish you all the best.

MS. JALEESA FREEMAN: Thank you.

REP. PORTER (94TH): So thank you for coming back to pour into those young folks the same thing that you got as a participant. So thank you.

MS. JALEESA FREEMAN: Of course. I wouldn’t do anything else.

REP. PORTER (94TH): All right. Thank you, Madame Chair.

REP. WALKER (93RD): Thank you. Have a wonderful and be careful driving home.

MS. JALEESA FREEMAN: Thank you.


SPEAKER: He is here, I think he is stepped out in the hall for a second.

REP. WALKER (93RD): Okay. Steven Andrews here?

Okay.

SENATOR OSTEN (19TH): Nice try that you’re trying to get rid of people. (Laughter)

REP. WALKER (93RD): No.

SENATOR OSTEN (19TH): That’s far enough. You don’t need to go through the whole list.
REP. WALKER (93RD): I’m sorry.

SENATOR OSTEN (19TH): Cathy is there.

REP. WALKER (93RD): I know. How many drivers do we got up here? (Laughter) Cathy, go right ahead.

MS. CATHY CAMERA: Good evening. Well, I guess unlike most of the house tonight I am here on behalf of the man that I love, Patrick Camera. He recently completed the seventh year of 14 year sentence at MacDougall.

As an inmate under the care and supervision of the Connecticut Department of Corrections, Pat was denied medial evaluation or treatment until he had become extremely physically and cognitively compromised while Enfield.

While serving his time within the DOC in Enfield and Cheshire, tumors began aggressively to grow in Patrick’s nasal cavity and into his brain. The tumors caused him to have severe headaches, proptosis and recurrent, persistent nose bleeds often accompanied by large clots up to the size of a baseball.

These symptoms persisted for more than nine months. These symptoms would and should have led any reasonable medical professional to initiate advanced emergency medical evaluation.

Despite Pat's numerous trips to the medical infirmary he would merely be given Tylenol and be sent back to his cell.

Ten months later, he was emergency transported to UConn Hospital when he became cognitively impaired in his cell.
Despite being listed as HIS medical emergency contact, I was not notified of his condition Nor the fact that he had been transported.

He was recently diagnosed with stage VI A nasal pharyngeal carcinoma. At this point the cancer has invaded his brain and cranial nerves. Any hopes of surgical options to treat the cancer in the beginning when he was first diagnosed were lost because of delays in treatment.

While he bled in his cell, tumors were aggressively growing and dramatically roting his brain and in turn, his functional ability across all aspects of his body system.

He remains significantly compromised from disease progression. After his diagnosis there was no follow up through from the DOC on critical medical tests deemed necessary by a medical team at UConn. And as specified to occur following his chemo which ended in early June.

Pat has recently been granted a compassionate parole. Upon his arrive to 60 West, a convalescent home in Rocky Hill, we are heartbroken to learn that the Department of Corrections has cancelled all of his medical appointments without notice.

The explanation provided through the attorney general’s office was that because -- was because Pat is receiving Medicaid the DOC is no longer responsible for his care. He now has to wait weeks to reschedule these appointments for care he desperately needs now.

The correctional managed healthcare annual report stated as determined by the U.S. Supreme Court the
only population with a constitutional right to healthcare, generalized medical and mental health is incarcerated offenders whether sentenced or sentenced.

In general, these rights include access to competent and professional medical care that is equivalent to the community standard.

I cannot see the actions of the DOC being defined in any way other than criminal recklessness. They have withheld treatment and placed road blocks in Pat's quest for care essentially leaving him to die.

Not only does the law say that this is wrong but reasonable measures, a fundamental human decency defined it as wrong.

The Connecticut DOC has the system and the employees individually identified as being responsible for his care and supervision have failed to provide his basic medical needs which is their duty and responsibility.

As human beings employed by and in service to this state and its residents, it is a disgrace. I am requesting that the legislature fully fund the medical care for inmates and create the necessary changes.

Pat's life and other inmate's lives depend on your action. Thank you for your time.

SENATOR OSTEN (19TH): Thank you very much for coming and explaining everything to us. Appreciate it. Any comments or questions? Thank you very much. Ben Howell followed by Dieter Tejada.
MR. BEN HOWELL: All right. Dear Senator Osten, Representative Walker and the other members of the Appropriations Committee, my name is Benjamin A. Howell. I’m a primary care physician at the West Haven VA where I take care of homeless veterans. And a health services research fellow at the Yale School of Medicine focusing on the health effects of incarceration.

These views are my own as a concerned citizen and physician and do not Representative those of the Veteran's Health Administration or the Yale School of Medicine.

I am here to testify in strong support of providing funding for a program providing access to medications for addiction treatment or MAT in our states prison and jails as currently included in the governors recent budget proposal.

As you all know in 2017, in Connecticut over 1,000 people died due to opioid overdose. More than half of those people had been detained in the Connecticut Department of Corrections.

Treatment for opiate use disorder with MAT saves lives. Data from our program in Rhode Island that’s treated all incarcerated individuals for opiate use disorder alongside increased treatment access demonstrated a 60 percent decrease in overdose deaths among those recently incarcerated.

Treatment for opiate use disorder with MAT is also cost effective. It has been estimated that every dollar spent on addiction treatment can yield at least $4 in reducing drug related crime.
This past summer I had the chance to spend several weeks in the Rhode Island Department of Corrections learning about their prison and jail based MAT program.

I saw how medical providers and correctional officers there were working closely with community addiction treatment providers and Brown University researchers to ramp up their MAT program.

I learned how they worked through securities concerns, learned from patients and strive to improve that program. While there, I also was able to talk to people incarcerated in their system, now able to access treatment.

I heard stories of near fatal overdoses and stories of friends who were not as lucky. I heard stories about the fear of the continued chaos and lack of control of opiate addicting and fear about the danger of elicit fentanyl in the community.

More importantly, I heard about people now in treatment who felt hopeful about the future. People that knew that access to treatment would help them move towards recovery and leaving the chaos of addiction behind.

People hopeful about reconnecting with family and getting jobs. I will not pretend that it was easy for them to implement their program and I was impressed at how all members of their correctional system and their community partners were working together towards such an important goal.

Saving lives and offering a chance at sustained recovery for the vulnerable population in their correctional system.
Their important efforts have led to a decrease in overdose deaths in their state and more importantly and offer people with addiction caught in the criminal justice system a path towards recovery, a path away from the chaos of addiction and towards reconnecting with families and stable employment.

A path away from the revolving door of criminal justice system and towards healing and rehabilitation.

Please provide an opportunity for this vulnerable populating in our state. Those incarcerated in our prisons and jails get access to the addiction treatment we know works and saves lives.

We have the tools to cut opiate overdose deaths and treat addiction. We just need the courage and fortitude to provide them to the people who need them. Thank you for this opportunity to testify in this support of the budget. I will take any questions.

SENATOR OSTEN (19TH): Thank you very much for staying as late as you have tonight. Are there any comments or questions? Seeing none, thank you very much. Dieter, followed by Steven Andrews.

MR. DIETER TEJADA: Good evening. Senator Winfield, Representative Porter, Representative Candelaria, Representative Rosario and distinguished members of the Appropriations Committee.

My name is Dieter Tejada and I come before you today to offer testimony in support of fully funding MAT or medication assisted treatment in our states corrections facilities as provided for in the governor’s recent budget.
I come to you today not to offer any more numbers. There has been a number of phenomenal experts that have provided you with the statistics and figures that bear out -- that bear out the evidence that I think proves that treatment works.

And that proves that it saves money, it saves lives, and it provides better justice outcomes including reducing recidivism.

Numbers is not my forte. I’m a lawyer. I am a lifelong Connecticut resident. I am also a justice impacted individual. And that begins where my evidence is. My evidence comes from a story, comes in the form of a story. And the story is this.

Last year, a little over a year ago I got involved in providing treatment services within Bridgeport Correctional Center. And during that time, I met a gentleman that I will call -- I won’t name him, but call him Jay.

Jay came in on a robbery charge and he was -- it was a crime that was clearly correlated to his addiction to opioids. And during the six months or so that I have been meeting him at, during my treatment facilitation, I saw him change. I saw him become somebody who might have a chance of getting out there and being -- not recidivating.

And during -- and at the end of the six months, he told me that he was going to have his sentencing hearing. So I asked him if I could come and he said he would love that. So I spoke to his attorney, showed up and he said if you could speak on his behalf and I could. Because I saw a change.
Because I know what it is like to be an addict because I’m recovering addict myself. And I can sort of sense when somebody seems sincere in their desire to change.

I'll finish off really quick. So I went to his hearing and the judge, who actually happened to be the judge who sentenced me around 12 years ago to a period of incarceration, when spoke to him I suggested that treatment could work and he decided to lower the sentence from his previously prescribed three years to a suspended sentence.

I recently spoke to jay. Jay is out, Jay is doing great. Jay is working nonstop at a restaurant. Jay is providing for his family and he is getting to see his doting daughter who he credits for his recovery.

I suggest to you that please give this a chance. You are going to save the money and you are going to also like -- there will be more Jay's if you do this. There will. So I cede the rest of my time. Thanks.

SENATOR OSTEN (19TH): Thank you very much for coming and sharing personal stories. Anybody have any comments or questions? Representative Porter.

REP. PORTER (94TH): I didn’t catch it and you may have stated but what is your job at DOC

MR. DIETER TEJADA: Oh, my job at DOC? No, no.

REP. PORTER (94TH): Do you work at DOC?

MR. DIETER TEJADA: No, I brought, I started doing AA treatment there. I also do lawyers concern for lawyers.
REP. PORTER (94TH): So you're an attorney? I'm just trying to figure out what your profession is.

MR. DIETER TEJADA: Yes, I’m an -- oh, so yes I am an attorney. I’m an attorney.

REP. PORTER (94TH): Okay.

MR. DIETER TEJADA: I work with Smart Justice.

REP. PORTER (94TH): Okay.

MR. DIETER TEJADA: Is the main thing.

REP. PORTER (94TH): So you are an attorney and you were doing AA work within DOC.

MR. DIETER TEJADA: Yes. This story happened while I was doing AA work within DOC.

REP. PORTER (94TH): All right, thank you. And thank you, Madame Chair.

SENATOR OSTEN (19TH): Any other comments or questions? Seeing none, thank you very much. Stephen Andrews followed by Jerry Smart.

MR. STEPHEN ANDREWS: Hi.

SENATOR OSTEN (19TH): Hi, how are you?

MR. STEPHEN ANDREWS: I’m doing well. My name is Stephen Andrews. I’m a second year Yale Law student. I am also a recovery drug addict. I was born in a prison, spent my early years in the foster care system. By 17 I was arrested and by 18 I had a full blown opiate addiction.

So I’m here to voice my support for the governor’s bills $2 million for medically assisted treatments. And to share with you guys my experience.
So I have withdrawn in jail multiple times. To describe it as how really doesn’t need capture it. Physically there is puking, shaking, there is no sleep, there's kicking. It got so bad, I felt so sick sometimes I felt like I was hallucinating yet the jails only gave me over the counter medication.

When I was in my general holding cell I was kicking so bad that my celly had to hit me to get me to shut up. You know, emotionally I was in jail so that’s not a real happy place.

And then withdrawing, the anxiety was though the roof. To talk about it as rock bottom really doesn’t even being to capture it. I really hope you guys can't empathize with me.

Second, I have had many, many friends and family members going to jails or high and then leave sober. All too often they overdose and die. The problem is one of dosage.

They go into jail accustomed to a certain dose, they have a tolerance to a certain dose but when they're in jail they lose that tolerance. So they go to leave, they might have an honest intention to stay clean.

But turns out that when you leave and you have no home and no help, no family and no job, the parole is really hard and you have no hope. So you seek something, anything to help you escape it.

And so you, they use it the same dose they used to use that but they don’t have the same tolerance they used to have so they overdoes. They die.

All too often we think that we can discipline addiction out of people. That if only they hit rock
bottom the thinking goes they will be driven to recovery. But they won’t. Addiction isn’t a moral failing. It’s a disease.

What is so tragic about it is that it is also unnecessary. You have heard testimony and you will hear more testimony that the scientific, there is scientific evidence for the efficacy of addiction treatments. They work. And in the long run they will save the state money.

They'll lower overdoses, increase post prison sobriety, decrease recidivism and ultimately preserve the dignity of people with addiction. Thank you.

SENATOR OSTEN (19TH): Thank you very much for coming and again sharing personal stories. Any comments or questions? Seeing none, thank you.

I heard Jerry Smart did not come, is that what you were all saying? Lauren Ruth. Followed by Falisha Gilman.

MS. LAUREN RUTH: Good evening, Senator Osten, Senator Formica, Representative Lavielle and distinguished members of the Appropriations Committee.

My name is Lauren Ruth. I am testifying tonight on behalf of Connecticut Voices for Children, a research based child advocacy organization that works to ensure that all children in Connecticut have an equitable opportunity to achieve their full potential.

At Connecticut Voices for Children, I do research on child welfare and juvenile justice. And my juvenile justice research works to align Connecticut's
Juvenile justice system with the empirical research that promotes positive outcomes for at risk youth and increased public safety.

So today I want to testify in opposition to the governor’s proposed budget for the judicial branch. And given what you heard from Judge Carol and from Gary Roberge today, I am going to go off of my written testimony a little bit to talk first about additional services that they didn’t talk about that Connecticut is at risk of losing. And if I have time why extra funding is needed to support the services that Gary discussed earlier.

So in transferring juvenile justice services from DCF to CSSD last year, a number of important diversionary programs were left with unstable funding.

Prior to the transfer, DCF used money from its juvenile justice outreach services line item to provide funding for behavioral health and diversionary service including the local interagency service teams otherwise called LIST that facilitate coordination between state agencies and community level agencies and the juvenile review boards that connect children who have committed status offenses and a number of first time offenses with community based services.

DCF no longer provides funding for these programs because they do not clearly fall within DCF’s mandate and last year’s budget which only appropriated 17 million of the 28 million requested by CSSD just didn’t provide CSSD with the funds for these diversionary services.
LIST and JRV's are key components of the JJPOC's community based diversion plan to increase diversion of youth from the juvenile justice system and provide youth with developmentally informed care within their communities.

For 2019, OPM was able to carry forward funding from a federal grant to fund a portion of JRB as had previously been funded by DCF. But this funding is one time and currently JRV's don't have any guaranteed state funding past 2019.

CSSD also was able to use some funding for LIST through July of 2019 because they were not able to contract for a secure hardware facility.

It’s unclear at this time whether CSSD will have the funding this year but they have indicated that they don’t have funding for both hardware secure facilities and diversity services.

So a large chunk of Connecticut’s diversionary structure is in peril of collapse this year because CSSD received too little funding last year to support the juvenile justice transfer.

May I have one second? To preserve these services, that help keep children out of the detention centers, the 2020 and 2021 budget would need an additional 1.65 million each year and a line item meant for diversionary services.

Otherwise come July 2019 it may be too late to save Connecticut’s juvenile diversion structure. And I can answer any questions.

SENATOR OSTEN (19TH): Any comments or questions?

MS. LAUREN RUTH: Thank you.

MS. FALISHA GILMAN: Good evening, Madame Chair, distinguished members of the Appropriations Committee.

My name is Dr. Falisha Gilman and I am a psychiatrist in training at Yale School of Medicine. I am here tonight in support of Governor Lamont’s budget proposal for medication assisted treatment in correctional facilities.

Medication assisted treatment also called MAT includes things like buprenorphine also known as Suboxone, methadone, as well as naltrexone, also known as Vivitrol.

MAT is the gold standard treatment for opiate use disorder. And I just wanted to share the definition of how we define that in psychiatry so it is when a patient has a problematic pattern or clinically significant impairment that lets them not able to do their daily activities like take care of their kids or go to work.

The substances sort of take over all aspects of their life which is different than physical dependence on a medication. That means that there is withdrawal if you stop the medication.

So many things like blood pressure medications or even antidepressants can have withdrawal but they're not something you would have a substance use disorder from which is important when we think about methadone if someone is addicted to it. First we
think about methadone when we treat someone for opiate use disorder.

I wanted to share a story with you of a patient who I had taken care of in the emergency department at first. I don’t work in the DOC, I don’t see people when they’re incarcerated but I saw this woman in the emergency department.

She is a 54 year old woman with opiate use disorder who had years of abstinence on buprenorphine from heroine on buprenorphine. During her remission, she was able to get a job at a local supermarket and rebuild relationships with her children.

Last year she was incarcerated after a domestic violence incident. The buprenorphine she was prescribed by her physician as an outpatient was abruptly stopped when she entered the correctional system and she was not released on any treatment for opiate use disorder.

Not only did this lead to her having to endure an incredibly uncomfortable withdrawal, this placed her at increased risk for unintentional lethal overdose when she was released due to her diminished tolerance.

We know that in the week after release inmates are 40 times more likely to die than the general population and 90 percent of those deaths are related to drugs.

Ms. R. did have an unintentional overdose. Fortunately EMT's were called and she was given NARCAN and she survived. However, since that relapse she has been struggling to reengage in opiate use disorder treatment.
I believe that her accidental overdose could have been prevented and she could have had more successful reentry if she had been treated for her opiate use disorder while she was incarcerated.

Besides the medications that we use to treat opiate use disorder, I think it is important to think about the and I, this is not my area of expertise but how we think about reentry into the community from the community side of things.

So I would just say that the planning for someone to be released from prison and if we are going to be treating them with MAT, we really need to make sure that they are going to have outpatient follow up to continue that medication assisted therapy once they're released.

And hearing from all the social workers and nurses tonight, I just would support the funding for those aspects as well because it is not just medication, it’s still much more than that. Thank you.

SENATOR OSTEN (19TH): Thank you very much. Thanks for waiting. Any questions, comments? Thank you. James Jeter followed by DeVauhn Ward. Doesn’t matter, either one.

MR. JAMES JETER: Thank you, ma'am.

SENATOR OSTEN (19TH): Wherever you are comfortable.

MR. JAMES JETER: All right. Thank you, ma'am.

Good evening, Senator Osten and the rest of the Appropriations Committee. My name is James Jeter, I am a Tao Fellow at Yale (inaudible - 03:37:17) initiative. I’m a student at Trinity and I am formerly incarcerated.
I have served 19 and a half years in a Connecticut prison system from the age of 17 to 36. And I thank you for the opportunity of allowing me to come before you to speak tonight.

I am here because I have several concerns about this DOC budget which I will submit to you. I will not read one of them tonight but I will submit them to you.

In many regards, I believe that we have allowed Connecticut Department of Corrections to operate as a black site and therefore their budget to be approved as a black site budget as well with the language is general and very loose, leaving up to interpretation how funding will be dispensed.

Today you have heard from medical staff and mental health staff the challenges of their job and with that you have a clear conundrum before you. You have a dedicated -- you have a dedicated people who have taken an oath to do no harm. Whom as a formerly incarcerated person having served 19 and a half years from the age of 17 to 36, I stand with them.

They understand that the corrosive and toxic culture that DOC administration can and will abuse this vulnerable population. They understand the culture in which they as skilled workers are forced to work in. And it is in direct contract with their oath.

This creates harm for the staff that you see here today because due to underfunding the system is inherently not supportive.

More so, I am the son of a social worker who worked in emotionally and mentally brought her work home no
matter how she tried to hide it, we knew. So I can only imagine the effect on home life the cultures DOC is doing to these workers and their homes.

I am under the belief and conviction that a lack of scrutiny as to how DOC request funds. Requested funds are being allocated allow DOC to move with impunity to the negligence’s.

So I submit questions that I hope this committee will take into consideration before approving the budget. I ask you to hear these voices today not as line items but as people crying out to do their job and servicing other people regard to their allotment as prisoners.

I also ask to be taken to consideration some of the tertiary effects or the rippling effects of the culture of medical and DOC. The fact the they are so understaffed its often contentious.

So having done over two decades of my life in prison, I have a very, very bad relationship with healthcare today. I have a hard time going to see a doctor.

I pay for medical coverage, I pay for healthcare, but I don’t go because I got so used to not being called. I got so used to a system that, you know, whatever issue I had I was subscribed ibuprofen and I was -- and the wait list was six to nine months all the time.

But I never got to see doctors. I had one dentist visit in 19 and a half years. So I came home and had a lot of dental work to get done. Right.

And so you, there is so much that prevents the reentry process around medical because it becomes
bills and stuff that you have to pay for coming home, underemployed.

However, medical is not the only issue that I want to present concerning the budget. But I will submit this to you. Thank you.

SENATOR OSTEN (19TH): Thank you very much for coming. Does anybody have mean comments or questions? You’re all set.

MR. DEVAUGHN WARD: Thank you.


MS. EMMA LO: Good evening, Senator Osten, Representative Walker and members of the Appropriations Committee. My name is Dr. Emma Lo and I am a medical doctor completing training in psychiatry with experience treating opioid use disorder.

I am here tonight to support Governor Lamont’s budget proposal application for full funding for medication assisted treatment in correctional facilities. Also called MAT, medication assisted treatment as you have heard is the combination of therapy and medications to treat opioid use disorder.

One of my patients who I will call Zach for confidentiality is a young man whose story starts with a car crash in 2005. This caused a back injury and chronic pain. He was treated with oxycodone, an opioid pain pill.
But like many others, he found the need to use more and more pills over time to ease the pain. When doctors suspected he was abusing his pain pills, he began buying heroin on the streets. In his mind, the only way to relieve his pain.

One day he nearly died from an accidental heroin overdose. He realized he was addicted to opioids and needed help. He was successfully treated with Suboxone, a type of MAT which keeps cravings at bay and prevents the high created when opioids are used.

But when he was incarcerated last year, he was taken off of Suboxone despite its clear benefit to keeping him clean. Correctional facilities in Connecticut routinely do not provide access to MAT. This needs to change.

Months after Zach’s release he had relapsed on heroin in part due to the interruption in his treatment. We were able to restart his Suboxone and he is now in early recovery. But this lapse in treatment was unacceptable.

Not only was he in danger of overdose, he was denied the medical treatment known to work for opioid use disorder.

The opioid crisis is worsening every year. Three people die in Connecticut every day from an opioid overdose and over half of deaths are people who are formerly incarcerated.

Zach was almost one of those statistics. But there is hope. MAT works and it is a medically proven treatment for opioid use disorder.

People on the opioid treatment Suboxone are 85 percent less likely to die from an opioid overdose,
are also much less likely to use illicit drugs or commit crimes.

Rhode Island's new MAT program in correctional facilities has reduced opioid overdose death among formerly incarcerate people by 60 percent. Massachusetts has shown that MAT is also a good investment showing $6.27 saved for every dollar invested in a program for MAT in their jails and prisons.

An MAT program in Connecticut is projected to save an estimated $5 million by year five due to cost savings in Medicaid expenses and recidivism. MAT should be guaranteed to all people under the care of jails and prison.

Let’s take a step toward full funding for life saving treatment for patients like Zach and toward ending the opioid crisis.

Thank you for the opportunity to provide testimony and I would be happy to answer any questions.

SENATOR OSTEN (19TH): Any -- Representative Rosario.

REP. ROSARIO (128TH): Thank you, Madame Chair. Good evening, doctor. I am glad you brought up the whole case on Suboxone.

As I mentioned before, my conversation with a loved one that I have that’s incarcerated. I’m not sure if everybody can see this but a stamp sized sheet of Suboxone goes on the black market in prison for $50. And just a thumbnail amount can give you 24 hours of basically no symptoms, you have no craving whatsoever for opiates whatsoever and doesn’t have the damaging effects of methadone.
So thank you for bringing that up. Thank you, Madame Chair.

MS. EMMA LO: And thank you, I agree.

SENATOR OSTEN (19TH): Any other comments or questions? Representative Porter.

REP. PORTER (94TH): Thank you, Madame Chair. Question. You mentioned Rhode Island and Massachusetts. Do they use Suboxone as part of their MAT?

MS. EMMA LO: So Rhode Island uses Suboxone, methadone and Vivitrol. Massachusetts only uses Vivitrol which actually the most expensive version of the three medications.

REP. PORTER (94TH): Okay. Thank you for that. Thank you, Madame Chair.

SENATOR OSTEN (19TH): Comments, questions? Seeing none. Raphe, you’re up. Followed by Anthony Eller, is Anthony Eller here?

MR. RAPHAEL PODOLSKY: Thank you, Senator Osten, Senator Formica, Representative Lavielle and members of the committee. My name is Raphael Podolsky, I’m a lawyer with the Connecticut Legal Services and I am here on behalf of the legal aid programs. In some sense it is like a different hearing I’m coming to.

I’m here to talk about the foreclosure mediation program which is a little bit -- it's on topic but it's off topic compared to what you’ve been listening to.

It’s -- the message I want to convey is it's really important that you preserve the program and that
means you have to do something because the
governor’s budget did not put in the funding for the
program apparently based on the assumption that
because it has an expiration date it doesn’t need to
be funded.

But I think there is a real intention that this
program be funded and be continued. The program
expires at the end of June unless it's extended.
It’s been extended numerous times. It started in
2008 and what it does is it helps people who are
home owners who are facing foreclosure, work out
through in court mediation a way to save their
homes. Or if they can't, then to leave in a sort of
a humane and civil way.

It has been an extraordinarily good program and has
a national reputation. It has -- you’ve got data
that was given to you by judicial department. It
has an 87 percent settlement rate for some 30,000
cases that have been handled since 2008.

It has a 71 percent retention rate which is to say
that 71 percent of the cases in which there is
mediation results in the homeowner staying in the
home.

And you have to realize how hard it is to have that
kind of a wait because the lenders have already
chosen not to make a settlement because they
wouldn't have brought the foreclosure otherwise. So
nevertheless, it opens up a line of conversation in
a means of working out an agreement.

It is certainly true as was pointed out earlier
during the day that we don’t have as many
foreclosures now as we did when the program started.
But, you know, in the last year, 2008, there were
2,500 new mediations under the program and that's a big number.

Other programs that do this kind of work within the Connecticut courts are permanent program. Housing court has mediators. Permanent, it was permanent form the beginning. Family court has family relations officers. Permanent, permanent from the beginning.

In -- to my mind I hope in the long run that this will become a permanent program but certainly now is not the time to stop it. It is funded out of the banking fund. It is not funded under the general fund. So you don’t need general fund money for this.

It was in last years I guess to maintain it at last year’s level, the budget indicates it would take $2.93 million. But because the programs use of the fund various with the number of cases, the judicial branches testimony says that for 20, fiscal year 2020 it needs 1.88 million. For 2021 needs 1.99 million which means that you can keep it going at its current level with the million dollars less than the governor took out. So essentially it would be a one third cut in the funding of the program.

And finally, I want to say that there is -- I’ll try to be very quick with this. There is data, it’s on the last page of my written testimony that shows which town -- how many foreclosures mediations there have been in each town in 2016 and 2017 which was data we got from judicial.

That is well past the peak of the program. And it is interesting to note two things about it. One is
every single town in the state had at least one mediation in that two year period.

And second, the numbers are not necessarily the towns you would expect. And you can look up your own town there but just as an example, a town like New Britain had a 161. Bridgeport had 459. Norwalk 202. But look at these other towns. Fairfield had 105. Stratford had 203. Torrington had 785. Even Westport had 48.

The numbers show the spread of the program and how many homeowners within those communities made use of that program and we know there is a 70 percent rate in -- program wide in which people get to stay.

This really impacts people lives, their ability to own a home, their home and home ownership. So I hope very much you will put the money in to maintain this program.

There are two bills that are pending right now. One in judiciary, one in banking that would extend the program for four years. And I think, I hope that those bills are going to pass and move forward.

Thank you for the opportunity to speak to you. I am happy to answer any questions I can. But this is exactly the kind of program you don’t want to lose.

SENATOR OSTEN (19TH): Thank you very much, Attorney Podolsky for coming and staying with us all night. Appreciate it. Any comments or questions? Seeing none -- all those -- Representative Johnson.

REP. JOHNSON (49TH): I just want to thank you for your testimony on this. I think it is a very important program. So thank you.

MR. RAPHAEL PODOLSKY: Thank you.
SENATOR OSTEN (19TH): Thank you very much. Next up is Anthony --

MR. RAPHAEL PODOLSKY: Thank you.


MS. VIVIEN BLACKFORD: Good evening. It’s an honor to testify here even if it’s the middle of the night. (Laughter) I appreciate the opportunity, Senator Osten and Representative Porter, members of the committee, dedicated members of the committee.

I am going to describe a fairly young, quite small and somewhat unusual program that’s a, it’s a little nonprofit. By the way I am a retired person. I used to be a consultant and before that I was a psychotherapist.

I served on the steering committee of the sentencing commission for eight years and now I’m a founder of this organization, the Phoenix Association.

And it’s a little confusing what it does. It doesn’t -- it’s not your usual enterprise and so if you have any trouble kind of catching what I’m talking about, stop me, ask me about it.

So this is the Phoenix Association and just briefly it’s about trying to make Connecticut’s prisons even better. We think that Connecticut’s prison system certainly is the best in the country. But there's certainly a lot of room for improvement.

And so this is program that has formerly incarcerated people as its members and it delivers programs to correctional staff in the Department of
 Corrections with the objective of engaging the correctional staff in a way -- by the members, in a way -- in such a way that correctional staff come to understand the importance, the possibility and importance of their roles on helping incarcerated people turn their lives around. It’s a powerful program.

So let me read my testimony and I have submitted this. So the Phoenix Association operates on the assumption that prisons should be safe places for both staff and incarcerated people, but further that they can and should also be rehabilitative environments supporting positive changes in incarnated people, engendering success and lessening recidivism when those people leave prison.

This requires that frontline prison staff understand the ways that they themselves impact inmates and that their actions and their attitudes can be key factors in whether inmates become motivated to turn their lives around.

The Phoenix Association exists to enable groups of mature and successful formerly incarcerated people, those are our members, to work with prison staff in small group meetings to help those staff understand the powerful influences of staff members -- what staff members can do in their daily interactions.

May I continue just a bit? Every formerly incarcerated person who is now a Phoenix member has at least one powerful story about how satisfying interactions with one or more prison staff was a key factor that enabled him or her to develop new directions and become a successful and law abiding citizen.
Our brief programs form connections, they're small programs that we do them with six correctional staff at a time and six of our members. They form connections between our members and the staff through structured interaction and they -- I’m going to leave my testimony here and just say that they produce inevitably and always very powerful responses from the DOC staff.

They tend at the end of their three hour session to say this was a transformative experience for me.

My time is up. I have much more to say but we come to you to ask for a little bit of money. We can't continue, we are currently running on a $78,000 budget. The -- when Scott Semple was, who went through our very first program was very eager for this to continue.

We have worked with all the wardens, all of the deputy wardens, almost all the department heads. We are now working systematically through Osborne correctional facility with the staff there and it was Commissioner Semple's intention that this just continue through one facility after the other with the front line staff.

However when we go to private funders, foundations and so on and seek support, we get -- we have gotten a little bit but they tend to say why should we fund your training correctional staff at a state facility. Why doesn't the state pay you if they want this?

And so I come to you and tell you that we really need your help to do this work. We are doing the research of course to demonstrate impact. Demonstrating more effectively the impact is going
to take some very expense research and we will get private funding for that.

And I’ll just say one other thing. We have been very honored by the Kaplan Foundation that is a very large family foundation based in New York, they have invited us to apply for their national innovation prize which would be a very big deal.

So there are other, I can tell you other stories about who is excited about this. But it’s just, it doesn't happen anywhere else. It’s just a home grown idea. Any questions?

SENATOR Osten (19TH): Are there any comments or questions? Thank you very much. And you’ll turn your testimony in? You will email us some information?

MS. VIVIEN BLACKFORD: I have submitted it already.

SENATOR Osten (19TH): Okay, great.

MS. VIVIEN BLACKFORD: And thank you very much for having me and for staying up so late.

SENATOR Osten (19TH): (Laughter) Keith Berrell. Is Keith here?

MS. VIVIEN BLACKFORD: He had to go.

SENATOR Osten (19TH): Okay.

MS. VIVIEN BLACKFORD: He works early.

SENATOR Osten (19TH): Paul Garlinghouse. Followed by Noel Rodriquez. That will be it.

MR. PAUL GARLINGHOUSE: Good evening, members of the committee. I thank you for staying so late and for your attention.
I am speaking about inmate healthcare and I am actually speaking about the very many inmates who aren’t addicted to drugs but who are sick and aging in prison under very long sentences and getting sicker every day.

Taking care of these inmates to the standard required by the constitution, never mind moral requirements, but it is the constitution, is very, very expensive.

We know that the failed regime that was administered formerly by UConn was completely ineffective in providing the constitutionally required standard of care.

Now since them, the contract with UConn has been terminated obviously and we have a brand new commission who I had the chance to hear the things he had to say. I thought he had a lot of very good things to say and I a lot of things I support.

But the bottom line is, it’s a broken system now. He is walking in the door to a system that fails to provide care for all of these inmates, especially the sickest and the oldest. We have grandmas and grandpas in prison who need a lot of care.

It will not be provided without a lot more money than what is in your budget. That’s just common sense. You can't just provide basically the same amount of funding, change the name of programs, introduce electronic records and some other innovations and suddenly this completely broken system is providing the required amount for care. That’s illogical.
You can provide a lot more money to meet the constitution or you can dramatically and much more expeditiously reduce the number of elderly sick people.

Now I know this is the case in prison because I recently got a client who is a grandmother who has cancer and a number of other mental health and other issues. And then to top it all off, a short while ago, broke her leg while carrying out her garbage detail duties as ordered by the CO's.

Now, they did transport her to the hospital so that would appear to be she got care, but unlike other people with broken legs who show up in the hospital, they didn’t fix her leg. They x-rayed it. And then they wrapped it up in something and they sent her back to jail without fixing her leg. That is not care but is written up in a way that appears to be care.

The young man who talked about black sites wasn’t far off. This is a matter of creating records that appear, give the appearance of care without actual care. Her leg is still twisted and broken.

And then when I went to go see her because her family contacted me, she had a family who was able to get a lawyer there. So she is the tip of the iceberg. Vast majority of these folks don’t ever get to see a lawyer and are just suffering and dying early in silence, okay. That is the reality of the system.

When I went to see her, you know, they at least gave her a wheelchair instead of the crutches she was supposed to somehow get to the toilet and do whatever with her broken leg, not fixed.
And then after I filed the lawsuit, they took away the wheelchair and they took away her cast saying she was somewhat going to make it into a weapon, her little -- you cannot be fooled by a misleading self-serving report.

You have to face the facts that either a lot more money or taking these people who have family support, who have grandkids that they can be taking care of, jobs they can be doing, in some other community setting and put them in not car -- incarceration but put them somewhere.

My client could go home with her family and she would be on Medicare and Medicaid. No money cost to the state for Connecticut. If there are any questions I'll answer them.

SENATOR OSTEN (19TH): Don’t forget to say your name for the record.

MR. PAUL GARLINGHOUSE: Paul Garlinghouse.

SENATOR OSTEN (19TH): Thank you very much.

MR. PAUL GARLINGHOUSE: You said it Senator Osten so I thought --

SENATOR OSTEN (19TH): No, I don’t count in regards to the record.

MR. PAUL GARLINGHOUSE: I’m an attorney.


REP. GONZALEZ (3RD): Thank you. Thank you for coming and to sharing that information with us. Do you think that she didn’t get the proper treatment because it’s not enough staff?
MR. PAUL GARLINGHOUSE: Oh, obviously. It’s so few staff okay. It’s a terrible crisis. And the commission couldn’t avoid this. And it’s not so few staff because they didn’t advertise enough on Linked In.

It’s because this is a terribly difficult job. And unless you are going to pay a whole lot more money to these doctors and APRN's, and provide an adequate level of staffing, you would have to be very, very desperate or very, very saintly to take that job up.

So it is absolutely clear, Representative Gonzalez, it is not enough staff in the prisons. It’s not enough money to pay for care out in the hospitals. There is not enough money.

If too many people who are too old and to sick and these grandpas and grandpas, they're not the ones who are likely to recidivate. These people who are so ill, even if they wanted to, they’re too sick.

These are the people who need to be gotten out of the system and into Medicare and Medicaid, whatever. Some other thing where they're not a burden on the state and that’s required by the Constitution.

I’m suing, okay. We will win a judgement. And if they don’t fix her leg it will be a bigger judgment. There’s an expense. But that’s no solution. That’s one person and one expense.

The bigger solution is we have to seriously look at these very unlikely to harm anybody sick old grandmas and grandpas and why are we paying to keep them in jail where we can't afford to even give them basic constitutional care?
REP. GONZALEZ (3RD): Do you think that after the lawsuit do you think that any retaliation that’s why they took the wheelchair? If she don’t have a cast, is she stable to walk?

MR. PAUL GARLINGHOUSE: Representative Gonzalez, every time I find out about her situation from the family its worse. I can't prove that it was retaliation. I know that her situation got worse from the more we pressed the lawsuit and complained.

I know her -- I don’t know what you call it, an air cast, it was this black thing on her leg that had maybe some stiff rods in it that was supposed to keep it in place. That’s taken away. The wheelchair then was taken away.

I don’t think she can get to the bathroom without a lot of excruciating pain. I also know that they don’t give her her medication for pain because it is considered to be, you know, a risk for the addicts in the prison.

Its -- I do know this. It is clearly well below the required constitutional standard of care. And the reason is money. She is one person. She is not the only one. She is not some outlier. This is the way the system works now.

REP. GONZALEZ (3RD): But other than money, can -- I think that they can provide better services.

MR. PAUL GARLINGHOUSE: They could, obviously they can and I’m hoping a federal judge orders them to fix her leg and to treat her cancer and whatever else she needs.
But the problem is, the problem is we simply, I mean, you guys know better than me how ridiculous it is to drastically increase the appropriation, okay.

The only other way is to seriously look at in a safe way reducing the oldest, sickest populations out of our prisons and into someplace else that is not incarcerated and getting care somewhere else. That’s got to be.

REP. GONZALEZ (3RD): Thank you.

MR. PAUL GARLINGHOUSE: Thank you, ma'am.

SENATOR OSTEN (19TH): Thank you very much. Noel Rodriguez. And is there anybody else after Mr. Rodriguez comes and speak that would like to speak? I don’t see anybody else in here. I think Noel Rodriguez, you are our last speaker tonight.

MR. NOEL RODRIGUEZ: It is a pleasure. (Laughter) I first want to thank all the legislators who are here today. And I hope I can be succinct and get us out of here as quick as possible.

But that client that Attorney Garlinghouse is speaking about, that’s my mother. And regardless of what crime she has committed, I think as human beings, there needs to be a standard of healthcare that our inmate population, and excuse my language, our people who are incarcerated, should be able to obtain.

It is not unreasonable for someone to break their leg to receive a cast. That is not some grand prize. It is not a grand prize for someone who is sick to get medication. It is not a grand prize for someone who has cancer to get radiation therapy.
All these things are not happening to my mother who before she went into prison was getting infusion treatment. Who has a spinal disc being removed from her back. That’s serious.

And if we are not going to, you know, look at the people, not inmates, the people in prison then what are we doing?

As legislators are we just going to keep giving money to a system that has proven to be systematically disgraceful at the least?

Mediocrity would be okay here in the prison system. It would be okay, if it was mediocre care. That’s sad.

And I forgot the gentleman’s name that left, who spoke, who said they -- these are black sites and we don’t know what happens here.

And I can tell you from my perspective, you know, when I go come and look at my brothers and sisters, and let them know that I’m doing my very best to make sure that, you know, mommy gets to, you know, have a wheelchair once in a while. Not all the time, let’s not get carried away, but once in a while she has a wheelchair to go to the bathroom. That’s not okay.

And the new commissioner, you know, he can say whatever he likes about, you know, changing the system but this system has been in place for so long, for a tremendous amount of time.

It will be nearly impossible. We can be, even if the most progressive commissioner came in and made some changes, it's not going to be sufficient.
My mom is lucky that she has a, the oldest son to fight. She is lucky because the majority of people there don’t. And they don’t know what it is like to not receive the most basic, basic of services. Don’t pour more money into a system that has failed already. I thank you for your time.

SENATOR OSTEN (19TH): Thank you. Comments, questions? Representative Gonzalez?

REP. GONZALEZ (3RD): Thank you for coming. Did you get in touch with Department of Corrections and find out what was happening with you mom?

MR. NOEL RODRIGUEZ: I am the legal conservator for my mother. My mother is not able to make basic medical decisions or give consent to her medical concerns.

DOC has completely ignored me for three years. I the only reasons I found out she broke her leg was because an attorney, not Paul Garlinghouse, contacted me saying that my mother broke her leg.

That’s how I know, you know, through third parties until we actually, you know, contact DOC to get some level of information.

REP. GONZALEZ (3RD): And she broke her what, her knee or her ankle?

MR. NOEL RODRIGUEZ: Her knee is fractured. Yes.

REP. GONZALEZ (3RD): Just her knee.

MR. NOEL RODRIGUEZ: Her knee and part of her leg.

REP. GONZALEZ (3RD): And part of her leg.

MR. NOEL RODRIGUEZ: Is broken. It's broken.
REP. GONZALEZ (3RD): And right now how is she, if she don’t have a wheelchair, she don’t have a cast, how she is managing inside?

MR. NOEL RODRIGUEZ: I like to believe that she is managing the best she can. But that’s just me telling myself it’s going to be okay if I keep trying. I don’t know how she is doing.

REP. GONZALEZ (3RD): You just said that she also has cancer.

MR. NOEL RODRIGUEZ: Yes.

REP. GONZALEZ (3RD): Do you know if she getting the proper medication and attention?

MR. NOEL RODRIGUEZ: It has been nearly impossible to get in contact with DOC even as a legal conservator. I have filed, I have faxed and mailed and went up to DOC myself and gave them the court order by a judge that hey, comply with this guy’s request. And I am completely ignored, kept out of the picture.

I don’t -- I have to -- I have to, you know, subpoena records in order to get them. I am the last person to know even though I’m supposed to be the first. I am supposed to give consent for my mom’s medical decisions. I am the one that is supposed to give consent.

And so either they're grossly not following the law and giving medical treatment to someone who can't give consent, or that’s it. That’s what’s happening. There is no other alternative.

REP. GONZALEZ (3RD): Your attorney has said that maybe because, you know, it is not enough funding to
hire more staff and I believe that you’re saying that you don’t exactly agree with him.

Do you think that she can get proper attention because it’s not enough staff or because they don’t care?

MR. NOEL RODRIGUEZ: I don’t want to get into the motivation of why people do things because I think it's very simple. I want to simplify things.

It's healthcare. And these are people. I think no matter the reason why they don’t provide it, it's inefficient.

They're not giving proper healthcare. People deserve healthcare. That’s it.

REP. GONZALEZ (3RD): So you don’t agree that they need more money so they can provide more healthcare?

MR. NOEL RODRIGUEZ: We can look back at the past couple of decades and see what money have done, what has money, more money have done to DOC and what has been the outcome?

I mean with the mission of trying to reduce recidivism rates it’s a failure. It’s at 80 percent. It has risen or, you know, and has fallen around that same number.

And what other profession or job can you have where you could fail at 80 percent of the time? You can't. It’s a failure. You'd lose your job.

If you failed at 80 percent of your job responsibilities, you wouldn't have a job in the private sector.
So we allow DOC to fail at 80 percent of our inmates at the cost of tax payer dollars? That’s one of the most insane things I have ever heard.

I mean, you can pay me half the price you pay the commissioner and I can assure you I will do a better job. So I’m just calling it what it is and I’m sorry if I offend someone by talking so abruptly. I don’t mean to offend anybody.

REP. GONZALEZ (3RD): Thank you. Thank you for your answers.

SENATOR OSTEN (19TH): Representative Rosario.

REP. ROSARIO (128TH): Thank you, Madame Chair. I’ll be very brief. I’m sorry to hear about what is happening what your mother. What facility is she in? Is she in a medical unit? Is she in general population? Do you have any idea?

MR. NOEL RODRIGUEZ: From what I believe my mother is at York Correctional Center and she is in the medical unit. But don’t be fooled by the term medical unit. It’s a cell. It’s a brick, its four walls and there is a bed.

REP. ROSARIO (128TH): Have you -- when was the last time you visited mom?

MR. NOEL RODRIGUEZ: I haven’t seen my mom in years.

REP. ROSARIO (128TH): Do you know who the warden is of that facility

MR. NOEL RODRIGUEZ: I don’t know, have her name off the top of my head.

REP. ROSARIO (128TH): Okay. Thank you. If you can get that information I am pretty sure we can get it
as well. But I would like to connect with you offline. Thank you, Madame Chair.

MR. NOEL RODRIGUEZ: Thank you.

SENATOR OSTEN (19TH): Anybody else have any questions or comments? Seeing none.

MR. NOEL RODRIGUEZ: Thank you guys again.

SENATOR OSTEN (19TH): Thank you. Have a nice night. Thanks for coming. We are now completed with the public hearing.