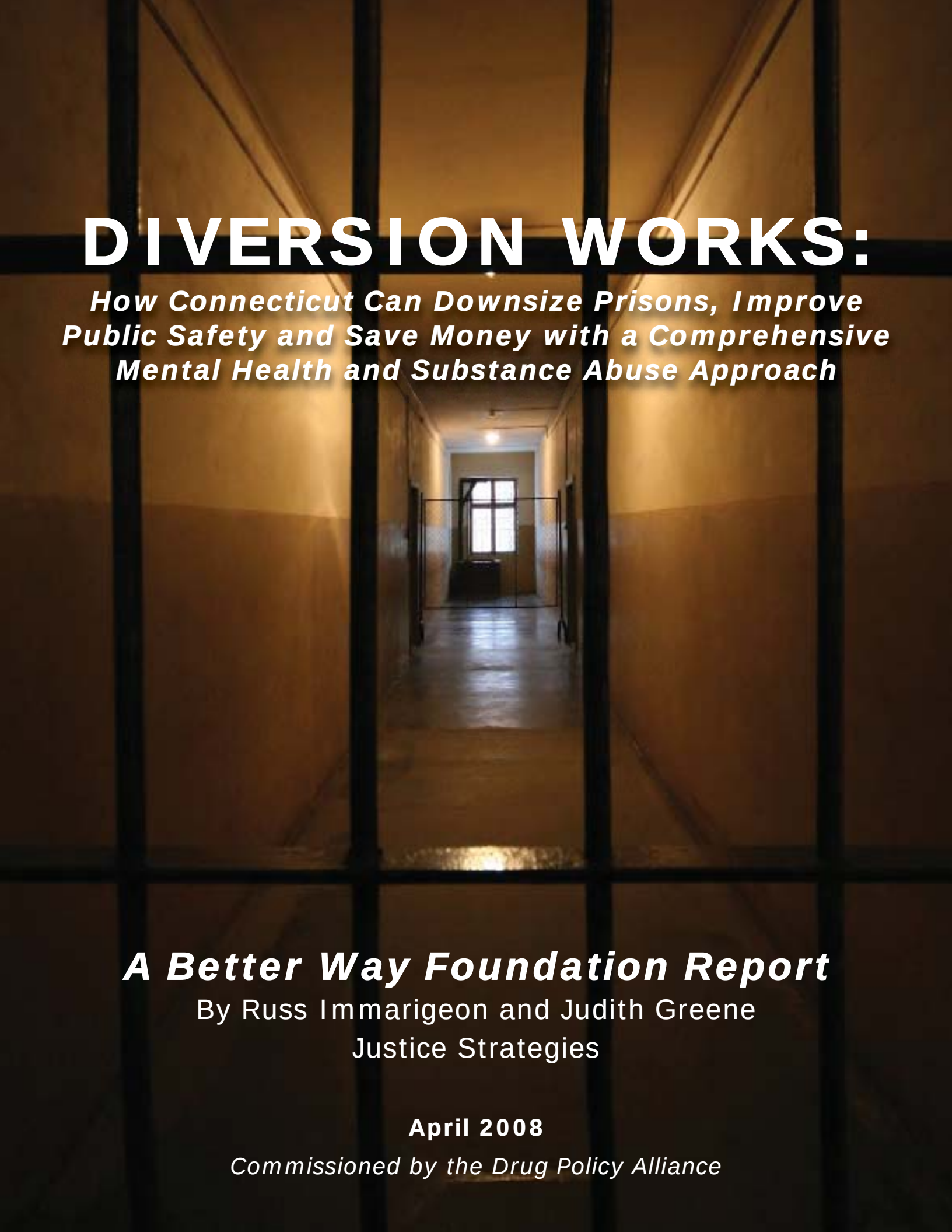


DIVERSION WORKS:

How Connecticut Can Downsize Prisons, Improve Public Safety and Save Money with a Comprehensive Mental Health and Substance Abuse Approach

A Better Way Foundation Report

By Russ Immarigeon and Judith Greene
Justice Strategies

April 2008

Commissioned by the Drug Policy Alliance

Executive Summary

It is time for Connecticut officials to renew their efforts to reduce the size of the state's exploding prison population. Connecticut's prison system continues to take in thousands of nonviolent offenders with mental health and/or substance abuse problems who would fare much better in alternative settings that draw on community resources. Two-thirds of Connecticut's prisoners have serious addiction problems and the number of prisoners with moderate to severe mental health impairment has risen by four percent in the last five years.

After leading the nation in prison population reduction in 2003, Connecticut's prison population reached record high levels this year, with more than 19,800 men and women behind bars. A recent prison population forecast by the Connecticut Statistical Analysis Center indicates that, unless measures are quickly taken to bring prison population levels back under control, taxpayers are likely to be burdened with excessive and rising costs to pay for capacity expansion.

State officials are struggling to avoid costly prison expansion. In the process, policymakers are starting to address the need for full-scale community interventions for offenders experiencing mild to severe mental health problems. National studies peg the proportion of mentally ill prisoners at 10-20 percent. As Connecticut's prison population inches closer to the historic 20,000 mark, strategies for lowering the prison population and strengthening treatment services in the community are looking more attractive.

A new consensus is emerging that community-based treatment options for mental illness, substance abuse problems and co-occurrence are more likely than civil or criminal confinement to achieve the twin objectives of increasing public safety and reducing recidivism. Many prisoners with mental illness can be treated more effectively in community settings. They do not require incarceration for public safety reasons. Two practices exist to minimize the use of imprisonment: diversion keeps defendants or convicted persons out of prison in the first place; decarceration deinstitutionalizes or displaces them from confinement once they have been put behind bars. Diversion programs and "alternatives to incarceration" aim to divert those persons subject to pretrial release or sentencing decisions.

The public safety advantages of sending people convicted of low-level drug crimes to treatment instead of prison are well established. A University of Connecticut poll taken in 2004 showed strong support for such sensible policies. Sending people convicted of nonviolent crimes who have mental illness to treatment instead of prison in order to reduce prison crowding was supported by 89 percent of Connecticut residents. Gov. Rell has called for decarceration of some 1,200 people who she says can be safely released to halfway houses and other community programs. Funding should be allocated to pay for intensive behavioral health services and supportive housing needed to make work the "supervised diversion program" for people with mental health treatment needs, established by legislators in January 2008.

To make these approaches work, critical information must be shared between and among criminal justice decision makers, including judges and correctional authorities, who make in/out custody decisions for men and women facing pretrial detention, criminal sentencing, or transitional and parole release. Also, continuous assessment is needed to identify gaps in services compared with what client

populations actually need, which may include counseling, substance abuse treatment, mental health services, supportive housing, vocational training and employment.

Conversely, recent research and meta-studies conclude that punitive measures and increased sanctions produce less constructive, more harmful consequences for people convicted of low-level crimes, for their families and communities, and ultimately for the victims of crime. While intensive services and supportive housing do not come cheap, these services can be provided at a small fraction of the cost required to imprison mentally ill people.

This report offers a brief overview of the current state of incarceration of mentally ill people, many with co-occurring substance abuse problems. It identifies effective program models that could be used to ease the state's prison population pressures and reverse the growth trend. "Downsizing" the prisons could improve prospects for long-term increases in public safety through "Justice Reinvestment," making strategic investments of correctional savings to build healthier families and safer communities.

Connecticut is currently embroiled in an extended public discussion about criminal justice practices. If policymakers are serious about bringing prison populations back under control, they need to turn to the work that legislators intended when they established the sentencing task force. Sentencing code revision and restructuring should lead to abolition of mandatory minimum drug sentencing laws, including the harsh and ineffective "drug-free zone law," that drive the state's high rate of racial disparity in the prisons.

Introduction

In February 2008, Connecticut's prison population reached record high levels, holding more than 19,800 men and women. Just a few years ago, this would have seemed an unlikely development. In 2003, Connecticut led the nation in prison population reduction with a drop of 4.2 percent, a remarkable turn-around, given that just the year before the state saw a 7.9 percent *increase* in its prison population, the third highest growth rate in the nation.

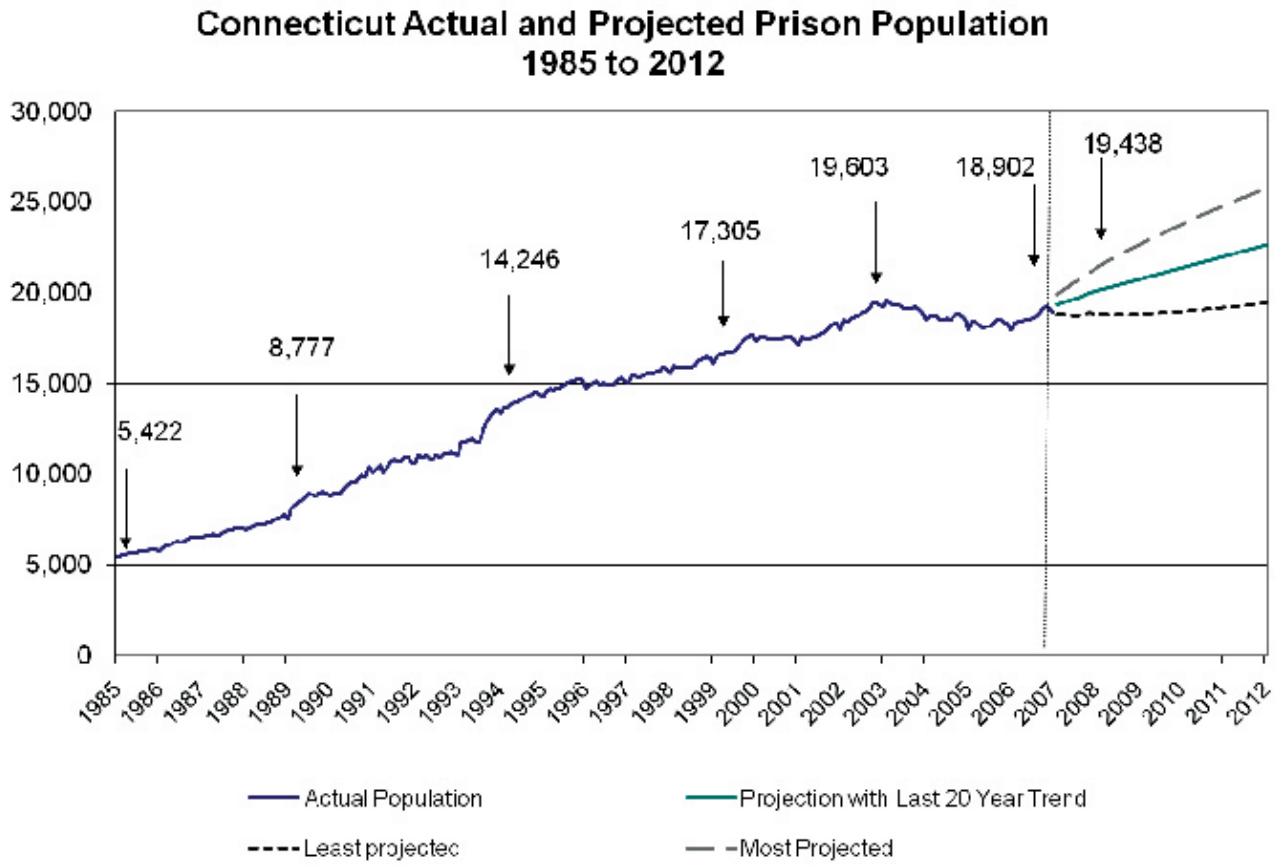
In January 2003, the Council of State Governments (CSG) released a report on Connecticut's prison crisis that called for sweeping reform of the state's parole policies and practices. The authors proposed a new approach called "Justice Reinvestment," arguing that if a portion of expenditures on imprisonment were instead reinvested in the communities where prisoners return upon release, the prison population could be reduced and recidivism curtailed (Austin, Jacobson and Cadora, 2005). Rep. Michael Lawlor (D-East Haven), co-chair of the Joint Committee on Judiciary, and a long-time champion of sentencing reform, joined Rep. William Dyson (D-New Haven), then co-chair of the House Appropriations Committee, in welcoming the concept of Justice Reinvestment.

With strong support from community activists and A Better Way Foundation, sweeping reforms addressing prison overcrowding were enacted in 2004. In 2005, activists won a landmark victory when legislators agreed to equalize penalties for "crack" and powder cocaine. Between 2003 and 2005, the state prison system's 18 correctional facilities experienced overall reductions in their population counts, reflecting the state's new penal philosophy. Connecticut had turned over a new correctional leaf. Instead of a myopically constructed "law and order" approach, the state stepped to the forefront of criminal justice reform in the United States, embracing correctional interventions designed to be more effective in terms of improving public safety as well as producing cost savings.

Prison population figures increased at a modest rate after the beginning of 2006[1] until July 2007, when two men recently released on parole broke into the home of Dr. William Petit and his family in Cheshire, Connecticut. Over the course of this home invasion, Dr. Petit was brutally assaulted, his wife Jennifer Hawke-Petit was sexually assaulted and murdered, and their teenage daughters Hayley and Michaela (who was also assaulted) suffocated in smoke from a fire set by the two burglars.

Two months later, after another recently released parolee was charged with stealing a car at knifepoint from a 65-year-old man in Wethersfield, Gov. Jodie Rell established a task force to conduct a comprehensive examination of Connecticut's criminal justice and corrections systems, and she ordered a moratorium on the parole of prisoners convicted of violent offenses. The state's prison population immediately experienced significant gains, negating the advances made in recent years through reliance on less costly and more constructive correctional policies and practices.

A recently completed prison population forecast suggests that, unless measures are quickly taken to bring prison population levels back under control, taxpayers are likely find themselves burdened with excessive costs for capacity expansion:



SOURCE: Connecticut Statistical Analysis Center

Spurred by the brutal murders in Cheshire, state legislators engaged in a crash course on parole policies, prison reentry options and related practices. During a one-day special session held in January they rejected, at least for the moment, proposals for a so-called "three strikes" law. But calls for "three strikes" continue. Critics charge that the prison system is already dangerously overcrowded, while some policymakers have advocated construction of new prisons, including a new 1,200-bed "mental health treatment prison." Amid this clamor, it is vital to step back for a

moment to take stock of the current state of Connecticut's still-evolving approach to incarceration and effective alternatives.

Tragedies such as the one that unfolded in Cheshire too often give rise to ill-conceived, overly broad legislative responses. Silver-bullet legislation like "three strikes" and "truth in sentencing" provide relatively little protection from crime, but they waste enormous state resources that are sorely needed for implementing evidence-based interventions and for mounting more fundamental efforts to revitalize high-risk communities. Strategies with real promise for improving and sustaining public safety over the long run go starving for funds, while prison budgets spiral to the sky. Critical issues about mental illness and co-occurring substance abuse problems[2] require careful consideration of whether building capacity in the public health system – rather than the prison system – is the best way to deal with problems such as these.

As the state's prison population inches closer to the historic 20,000 mark, most state officials are struggling to avoid costly prison expansion and devise strategies for lowering prison population levels and strengthening reentry services for people returning to their home communities from prison. Gov. Rell has said that as many as 1,200 prisoners convicted of nonviolent offences could be released to halfway houses or other alternative programs in the community (Hladky 2007a).

Many community residents are acutely aware of the shortsightedness and ineffectiveness of proposals for further prison expansion. Those who live in Connecticut's high-risk neighborhoods are intimately aware that the burden of excessive reliance on incarceration-based sanctions falls most heavily on urban communities of color. Connecticut's prison system already ranks among the highest in the nation in terms of racial disparity.

This brief report summarizes recent developments in criminal justice policy and practice in Connecticut, and offers some observations and – we hope – useful information about effective approaches for diversion of mentally ill people, many of whom suffer with co-occurring substance abuse disorders, from the state's prison system.[3]

Recent developments

On the heels of the tragedy in Cheshire, state political and criminal justice officials seemed to reach consensus that the criminal justice system in Connecticut was "broken" in certain respects. Following the Cheshire murders the state parole board blocked release of over 300 offenders while scrambling to obtain sentencing transcripts, presentence reports and other related documents. Executive branch officials and legislators held hearings and expanded efforts to review criminal justice policies and practices. In December 2007, Dr. Petit himself wrote the legislature's Judiciary Committee observing that, "it is so urgently important that you, as our legislative body, learn from these awful events and take full advantage of this opportunity to better protect other innocent members of our society" (Hladky, 2007b).

Community activists expressed deep concern about Gov. Rell's moratorium on parole release. They held meetings with her legal counsel and with Corrections Commissioner Theresa Lantz to demand an end to the moratorium and to press for stronger reintegration and support services. They argued that, with the highest rate of incarceration in the New England region, Connecticut does not lack lengthy sentences for those convicted of serious crimes. They insisted, instead, that the state needs to develop additional community-based resources, including such basic services as education and vocational training, community treatment and rehabilitation programming, affordable housing and gainful employment.

During the special session convened on January 22, 2008, legislators created a new crime of home invasion, which mandates that those convicted of the offense would serve 85 percent of their prison sentence. They authorized development of a comprehensive information technology system to allow criminal justice agencies to share a broader range of information. They voted to upgrade the parole board to provide full-time, professional members and added a forensic psychologist and two victim advocates to its staff. They also voted to increase use of electronic monitoring for parolees, and to provide more halfway house beds and "staff secure" residential treatment for people convicted of sex crimes. And they authorized creation of a "supervised diversion program for persons with psychiatric disabilities accused of a crime or crimes or a motor vehicle violation or violations for which a sentence to a term of imprisonment may be imposed, which crimes or violations are not of a serious nature."[4]

Mental illness in Connecticut's prison population

Prison population data obtained from the Department of Correction (DOC) indicates that on February 1, 2008, 19,894 prisoners were incarcerated in Connecticut's prisons, a figure that is nearly the highest level in DOC history. Gov. Rell's recent directives on parole policy and practice in the wake of "the Cheshire murders" have undoubtedly helped accelerate the state's prison population growth, but prison population changes (reduction, growth, stabilization) usually occur because of an accumulation of factors.

A March 2007 study of prison population projections concluded that changes in Connecticut's general population, demographics, incidents of crime and other factors have little or no effect on the expanding state prison population. Rather, population growth is due to policy changes within the criminal justice system. This study identified three leading factors with a significant effect on prison population size: "the number of people arraigned; the number of people arraigned with charges requiring them to serve 85% of their prison sentence if convicted; and the number of people sentenced to prison" (Office for Policy and Management and Connecticut Statistical Analysis Center, 2007).

National studies indicate that estimates of the number of mentally ill in state prison populations vary from jurisdiction to jurisdiction and from one period of time to another. According to a recent article, one researcher suggested that 10-15 percent of state prisoners are seriously mentally ill, a second researcher felt the range covered 10-20 percent, and other researchers argue for 15-16 percent (Lurgio and Snowden, 2008).

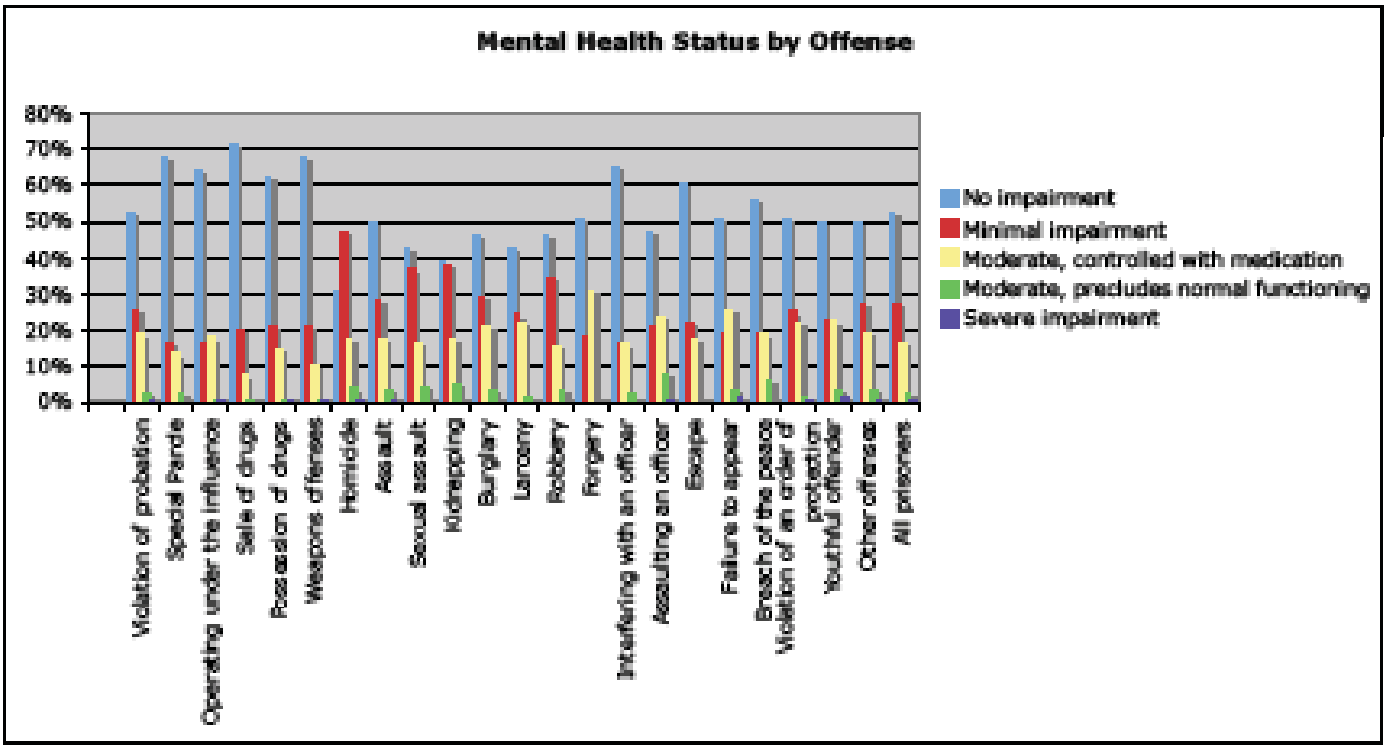
The DOC classification system places prisoners on a five-level scale according to their mental health needs. Current data indicate that almost 4,000 people – 19.3 percent of the people in Connecticut's prison – suffer from moderate impairment (16.8 percent whose impairment is "controlled with medication," and 2.5 percent whose impairment "precludes normal functioning"), while less than one percent are severely impaired. Since 2003 the number of prisoners with moderate to severe mental health impairment has grown by four percent, from 2,803 to 3,894:

Prisoners' Mental Health Status in 2003 and 2008

	2003		2008	
No impairment	11,514	60.3%	10,421	52.4%
Minimal impairment	4,721	24.7%	5,439	27.3%
Moderate, controlled with medication	2,382	12.5%	3,347	16.8%
Moderate, precludes normal functioning	359	1.9%	493	2.5%
Severe impairment	62	0.3%	54	0.3%
No score	65	0.3%	140	0.7%
Total	19,103	100.0%	19,894	100.0%

SOURCES: Office of Legislative Research (2003) and DOC (2008)

The following chart provides a breakdown of the mental health status of Connecticut's prisoners by major offense categories:



SOURCE: DOC

Developments in mental health treatment for correctional populations

Thirty-five years ago, researchers started recognizing the growing number of mentally ill persons in American criminal justice systems (Abramson, 1972). In the 1980s, criminal justice interest groups such as the National Coalition for Jail Reform acknowledged that jails were inappropriate places for persons with mental illness. Since the 1990s, states from Florida to Washington have experienced growth not only in their prison populations but also in the number of offenders they incarcerate with serious mental health problems.

As state policymakers have started to grapple with the costs and consequences of confining offenders with mental health problems, many of them – while examining their sentencing and release practices – have begun to recognize that mental health treatment systems can fruitfully serve the functions of sentencing offenders to community-based options, diverting offenders from incarceration, and preparing offenders for release from confinement.

In the process, policymakers are starting to address the need for full-scale community-based social interventions for offenders experiencing mild to severe mental health problems, the former because they can be better served in community settings, and the latter because they present public safety risks if released without such planning and supervision.

Working toward continuous impovement

In 2002, the Council of State Governments launched an initiative known as the "Criminal Justice/ Mental Health Consensus Project," which aims to convene a mix of criminal justice and mental health professionals with mental health advocates and consumers to improve interventions for mentally ill men and women who become involved with the criminal justice system.

The Criminal Justice/ Mental Health Consensus Project proposes a range of collaborative criminal justice system responses for people with mental illnesses, including law enforcement-mental health partnerships that assist police officers in understanding the behaviors of mentally ill people; technical assistance to local jurisdictions that wish to establish mental health courts; collaboration between corrections and mental health organizations to improve continuity of care between these systems; and a criminal justice mental health information network to serve as a source of information about methods of improving outcomes for people with mental illness. The project promotes research-based policy and program designs, and provides a handbook for mental health advocates who wish to reach out to criminal justice, mental health and legislative partners to collaboratively address these challenges.

In recent years, Connecticut has been building a comparable approach toward mentally ill persons in the state's criminal justice system. Some aspects of this approach have been innovative, research-based or at least research-informed, and others, such as the state's women's jail diversion program, have served as award-winning examples of "best practices." Overall, Connecticut has begun to forge a comprehensive and collaborative approach, blending the strengths of formerly disparate functions and services. In the course of this evolution, the state has accepted some, and rejected other, components of the Council of State Government's Criminal Justice/ Mental Health Consensus Project. Specialty courts for the mentally ill (mental health courts), for instance, appear to have little support in the state.

What is needed, we believe, is continuous assessment to identify gaps in services between what is needed and what is in place, and evaluations that locate gaps between what appears on paper and what is *actually* in place. This tension between what is available and what is not is common to any criminal justice system, including those in the midst of reform efforts. However,

it is rare that a system will identify its weaknesses, or even failures, even when the purpose of doing so is to improve its practices, that is, to learn and apply the lessons gleaned from experience (Immarigeon, 2008).

Connecticut's continuum of programs

Connecticut has been building a relatively rich and comprehensive continuum of alternatives to incarceration and mental health programming for pretrial and sentenced populations in the state's criminal justice system. These options are made available, at various discretionary decision-making points of the criminal justice process so that there are programs available at the arrest, arraignment, bail setting, detention, sentencing, probation, incarceration, pre-release and parole stages of the criminal justice process. Often, especially in the past few years, these programs have been making an effort to divert or displace offenders from confinement.

These options include the following:

- *Crisis Intervention Teams (CIT)*
- *Accelerated Pretrial Rehabilitation*
- *Alternative Drug Intervention*
- *Pretrial Alcohol Education System (PAES)*
- *Pretrial Drug Education Program (PDEP)*
- *Pre-Trial Decision Tool Aid*
- *Specialized Diversion Program for Trauma Survivors (JDT)*
- *Probation Transition Program (PTP)*
- *Technical Violation Unit (TVU)*
- *Access to Recovery/Recovery Support Services*
- *Jail Re-Interview Program*
- *Jail Diversion Programs*
- *Mental Health Day Reporting Center (MHDRC)*
- *Substance Dependency Evaluation (SDE)*
- *Women's Jail Diversion Programs*
- *Mental Health Diversionary Program*
- *Connecticut Offender Re-entry Program (CORP)*
- *Transitional Case Management (TCM)*

Worthy of special note is the collaboration between Connecticut's Court Support Services Division (CSSD) and the Division of Mental Health and Addiction Services (DMHAS) to provide specialized supervision and services for probationers with psychiatric disabilities. Ten "mental health probation officers" with specialized training from DMHAS and the National Alliance of Mental Illness provide case management and supervision for a reduced caseload of clients.

Common to all of these programs is the central function of providing critical information to criminal justice decision makers, including judges and correctional authorities, who make in/out custody decisions for men and women facing pretrial detention, criminal sentencing, or transitional and parole release. The information provided at these stages is much like that offered through traditional pre-sentence reports, except that it is focused more intently on specific release or supervision conditions, and needs for counseling, substance abuse treatment, mental health services, as well as community support services related to such concerns as housing, vocational training and employment.

Effective program and policy options

In the mid-1970s, some criminal justice researchers expressed deep skepticism about the ability of intervention programs to improve the rehabilitation of people convicted of crimes.

Those less skeptical were largely ignored during a period when a "law and order" mentality held sway. Over the past three decades, however, extensive research by social scientists and criminologists has helped to spur reconsideration of rehabilitation as a viable correctional intervention. Using "meta-analysis" studies and cost-benefit techniques, researchers have identified effective approaches and principles for design and implementation of treatment interventions.

In the most up-to-date of these studies, researchers Mark W. Lipsey of Vanderbilt University and Francis T. Cullen of the University of Tennessee reviewed empirical evidence on the effects of sanctions and supervision on recidivism. Lipsey and Cullen (2007) identify three key findings that ought to guide those seeking to improve correctional system performance:

- *Every meta-analysis done to date has found that increasing the severity of sanctions at best produces only modest reductions in recidivism; at worst, it results in increased recidivism;*

- *Every meta-analysis of large sample studies finds greater reductions in recidivism for programs that offer rehabilitation treatment, as opposed to those that do not; and*

- *Nearly every meta-analysis of "specific rehabilitation treatments or approaches" finds reduced levels of recidivism.*

These findings suggest that jacking up sanctions (that is, being more punitive) produces less constructive, more harmful consequences for people convicted of crimes, for their families and communities, and, ultimately, for victims of crime.

Program and policy initiatives aimed at diverting those with mental illness, those with substance abuse problems, or those with co-occurring disorders, share the objectives of increasing public safety and reducing recidivism. A new consensus is emerging that community-based options are more likely than civil or criminal confinement to achieve these twin objectives.

In some respects, Connecticut appears ahead of the national curve in its embrace and use of mental health services for behaviorally troubled people in the criminal justice system. Most notably, the state is developing and funding programs across the state to provide a comprehensive continuum of services, developing specialized training for staff, and supporting empirical research to monitor and assess the delivery of services.

Yet a large number of people with mental illness remain incarcerated. A DOC official has estimated that among the nearly 4,000 people in Connecticut's prisons identified as having a moderate to severe mental health problem, there are more than 1,700 prisoners who have either not been sentenced for, or are not held in pretrial custody for, a violent or other serious crime. This suggests that a large pool of prisoners could be released to the community if appropriate supervision and mental health services were readily available.

Diversion and decarceration

Though corrections officials say that despite population increases the prisons are safe and secure, critics charge that Connecticut's prison system is "overcrowded." This term has a significant shortcoming: it is more a measure of the system's capacity to house detainees and prisoners than a measure of how many men and women it should actually confine. As Gov. Rell has rightly pointed out, the prison system holds many people who do not require confinement.

Two practices exist to minimize the use of imprisonment: *diversion* keeps defendants or convicted persons out of prison in the first place; *decarceration* deinstitutionalizes or displaces them from confinement once they have been put behind bars. Diversion programs and "alternatives to incarceration" aim to divert those persons subject to pretrial release or sentencing decisions.

A common problem with diversion services, however, is that resources are often wasted on serving persons who would not have been incarcerated in the first place. To solve this problem, CSSD operates a diversion mechanism that was designed decades ago, when Connecticut's prisons were hit with a severe overcrowding problem in the mid-1980s.

The Jail Re-Interview process (JRIP) was created to reduce the number of people held in pretrial detention prior to disposition of their cases. Research from various jurisdictions around the nation indicates that people who are unable to post bail to gain release from pretrial detention are more likely to be sentenced to jail or prison if they are convicted. People who have been unable to post the cash bail or bail bond required by the court are screened by bail commissioners to determine if placement in a CSSD alternative to incarceration program would offer an effective option for their release. If a workable supervision plan (typically involving substance abuse treatment) can be developed, judges are asked to reconsider the bail requirement.

When budget cuts hit the Judicial Branch in 2003, the JRIP program was temporarily suspended, but by January 2004 the project had been re-established in three DOC facilities. With additional funding appropriated by the legislature in 2004, the program was renewed in all pretrial facilities. In fiscal year 2004-2005, JRIP staff screened more than 6,000 pretrial defendants. Judges agreed to release 64 percent of them to the community. In fiscal year 2006-2007 the number of people screened increased to 10,885 and the percentage of community release plans approved by judges reached 69 percent.

JRIP's success in winning release for defendants with substance abuse needs holds great promise as a diversion model for unsentenced defendants with psychiatric disabilities who are detained and cannot make bail. Well-tailored release plans with appropriate community mental health treatment placements and supportive services could provide significant relief for detention and prison population pressures.

Successful diversion programs and decarceration practices do more than just keep people out of prison. They involve community resources with the care, treatment and resettlement of substance abusers and the mentally ill. The following is true for decarceration as well as diversion:

> For diversion programs to be successful, they must include timely and accurate mental health screening and evaluation and link people to appropriate community-based services. Comprehensive community-based services are necessary to meet the complex needs of diverted individuals. Individual treatment plans should be focused on individual recovery and choice and should include mental and physical healthcare, case management, appropriate housing, supported education, integrated substance abuse treatment, peer support, and psychosocial services. *All services should be delivered in the least restrictive environment.* In addition, the specific needs of each community must be considered when designing a diversion program. (NMHA, 2003; emphasis added)

New Supervised Diversionary Program (SDP)

During the special legislative session in January 2008, state legislators authorized a collaborative effort between CSSD and DMHAS to expand the JRIP model to provide diversion with a new level of services for mentally ill people. The purpose of this program is to divert (or avoid the prosecution of) men and women with psychiatric disabilities who are charged with nonviolent crimes and are either incarcerated or receiving inadequate services to aid their recovery. SDP caseworkers and social workers will provide services, counseling and assistance to persons who have difficulty functioning or simply require specific care and treatment.

Community treatment plans will be prepared and presented to judges for approval. Those released from custody will be placed under community-based supervision for up to two years with probation officers who have a reduced caseload and are trained in working with people with mental health disabilities. The Court will take appropriate steps if those diverted are non-compliant with the terms of their treatment plan. Successful completion will result in the criminal case being dismissed.

CSSD staff have estimated that more than 1,300 people could be granted an SDP diversion each year. The agency will require an additional 17 probation officers to handle SDP caseloads. An expanded array of behavioral health services will be required, including intensive residential and outpatient treatment, plus services for those with co-occurring mental health and substance-abuse disorders. Supportive housing will be needed for many SDP clients.

While intensive services and supportive housing do not come cheap, these services can be provided at a small fraction of the cost required to imprison mentally ill people at the Garner Correctional Institution, where hundreds of them are typically held. Annual costs at Garner total $62,000 per prisoner per year, compared to just $10,463 estimated for the full array of services proposed by DMHAS.

Exemplary program models from other jurisdictions

Over the next few months Connecticut's policymakers will continue to debate the most effective ways to respond to problems associated with mental illness and co-occurring substance abuse disorders in the community and the prison system. In this section, we describe three program models that have been field-tested in other jurisdictions, offering concrete evidence that people suffering from these debilitating problems can be successfully diverted or released from prison to treatment services in the community.

The Nathaniel Project

In January 2000, the Center for Alternative Sentencing and Employment Services (CASES) inaugurated the Nathaniel Project as a method of diverting persons with psychiatric disabilities from lengthy state prison terms. Men and women are eligible for diversion through this New York City-based program, if they face a felony indictment, are "prison-bound" (likely to receive a prison sentence in the absence of intervention), have significantly impaired functioning, and are eager to enter treatment. The program accepts both persons charged with violent and nonviolent offenses.

CASES has many years of experience managing programs that serve as an alternative to incarceration while addressing specific aspects of criminal behavior. In the 1980s and 90s, for instance, CASES operated a community service sentencing project after a program evaluation showed that community service sentences could be designed for offenders who were otherwise likely to go to jail. Typically, CASES-based programs emphasize a pro-active intake process, court advocacy, pre-release planning, and post-release case management and supervision.

The intake process of the Nathaniel Project, like many CASES programs, starts prior to disposition, often at the time of arraignment. Referrals come from defense attorneys as well as community mental health workers; potential program clients are interviewed only with the approval of defense council. Those being referred to the program are usually incarcerated because of their inability to make bail. Program staff assess the risk of potential clients through a semi-structured interview process. They ask about psychiatric, substance abuse and housing background matters. In addition, Nathaniel Project staff inform potential clients about the program's goals and the responsibilities of those accepted into the program.

Acceptance into the program often comes quickly, although program staff continue obtaining important medical, mental health and related information about new clients. Violent offenders are not typically rejected. According to a recent report on the program, "[t]he Project's staff believes that it is by serving clients charged with violent crimes that the program makes the greatest system impact by demonstrating to both the criminal justice system and community mental health providers that these individuals can be treated safely in the community. Moreover, community safety is improved by linking to treatment those offenders most likely to commit violent offenses who have previously failed in treatment" (National GAINS Center, 2005).

Once accepted, program staff inform judges, prosecutors, defense attorneys and community and jail-based mental health care providers about program participants' psychiatric needs and push for court decisions that "evince a better outcome for the client and the community than sending the person to prison" (National GAINS Center, 2005). Program staff advocate in court on behalf of their clients as many times as is necessary to obtain a favorable ruling.

Treatment plans, which include arrangements for housing, employment and health care needs, are at the center of the program's work. Program staff assemble the key components of these plans before participants are released to the program, and closely monitor their progress after release. "Staff members have high expectations for every client and will go to any lengths necessary to help each client succeed. This includes not giving up even if a client has multiple failures in treatment" (National GAINS Center, 2005).

Research on the impact of the Nathaniel Project focused on the issues of public safety, retention, treatment and housing (National GAINS Center, 2005). Key findings included the following:

- *A significant decline in the number of arrests (program participants had 101 arrests in the year before being in the program, and only seven arrests in the year following entry into the program);*
- *A high level of program retention (at six months, 88 percent of participants remained in the program; at two years, 80 percent were still in the program);*
- *Full (100 percent) participant engagement in the program;*
- *Homelessness among program participants was reduced from 92 percent to 79 percent after one year.*

Fuse Supportive Housing

Connecticut relies too heavily on shelters for temporarily housing the homeless, including those with mental health problems and criminal justice involvement. More supportive, permanent housing options are needed, including "homelessness prevention" services that address problems typically resulting in homelessness; teaching "tenant skills" required to maintain rental or other housing units; supportive housing with intervention services; and permanent housing.

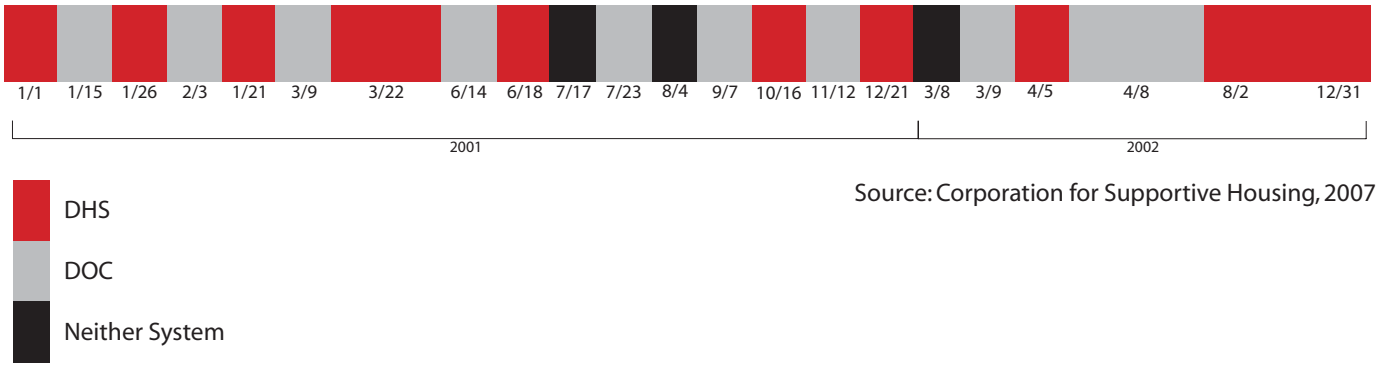
In New York City, a reentry support initiative was designed to enhance collaboration between corrections and mental health systems for improving the discharge planning done in jails on Rikers Island. The Frequent Users of Jail and Shelter Program, sponsored by the Corporation for Supportive Housing (CSH), focuses on high need/high cost populations, including the mentally ill, who are chronically homeless and routinely bounce back-and-forth between jail and community shelters and other institutions. The purpose of this program is to "break the cycle of homelessness and incarceration among frequent users" (Cho, 2007).

Research in the late 1990s found that chronically homeless persons with severe mental illness routinely traversed a range of institutionalized settings from jails and hospitals, to detoxification centers, in-patient programs, community-based shelters and the streets. The cost of caring for this population is often high, even six- and seven-figure price tags are not unheard of.[5]

Through partnerships between public agencies and non-profit organizations, New York City established a total of 100 units of supportive housing (50 scattered sites and 50 within single-site developments). The 100 units are operated by eight non-profit providers of housing and services who receive lists of eligible individuals on a weekly basis. Each provider is granted Frequent User Service Enhancement (FUSE) fundings ($6,500 per tenant) to enhance exciting support services. The enhancement is provided for the first year that each tenant is housed. After the first year, the tenant's service level is reduced back to the baseline level of services.

The FUSE initiative defined eligibility criteria for its target population as those who had at least four jail and four shelter stays in the past five years. Program planners identified 850-1,100 persons who fit these criteria. Most of their stays in each institution were short-term, averaging 40 jail days and 63 shelter days a year, but the most "frequent users" (the top quarter) averaged 59 jail days and 134 shelter days. The following graphic shows the patterns and lengths of one frequent user's alternating jail (DOC) and shelter (DHS) stays over a two-year period (January 2001-December 2002):

New York City's Frequent Users of Jail and Shelter



Source: Corporation for Supportive Housing, 2007

Among the FUSE population, upwards of 50 percent had mental health problems, with 25 to 40 percent suffering serious mental illness; 80 percent were abusers of alcohol and other drugs; and many had extensive histories of high-level involvement with multiple intervention systems. The target group for this program was highly mobile and needy with numerous behavioral issues, a low level of independent living skills, and a high level of mistrust for providers in any service-delivery system.

Intensive case management and service programs help lower both criminal recidivism and transient homelessness. Moreover, research suggests that economic assistance, such as housing and jobs, is as successful as mental health program intervention in lowering recidivism and homelessness. Not surprisingly, supportive housing, which effectively combines these services, reduces the jail- and prison-involvement of homeless persons, including those with serious mental health issues.

Spurred by New York City's Commissioners for the Department of Correction and the Department of Homeless Services, private non-profit groups joined with governmental agencies, academic institutions, and private foundations to plan and administer the program, which includes both single- and scattered-site supportive housing that comes with "front-loaded intensive services." Program staff arrange in-take interviews, psychosocial assessments, pre-placement stabilization and assistance, resolution of eligibility restrictions, and services such as mental health services, independent living skills training, and intensive case management. Recreation and support groups are also established for program participants.

Frequent user service enhancements and the use of peer mentors allow for more intensive services because caseloads are reduced. Intensive case management includes motivation interviewing and cognitive behavioral therapy, both found to be highly successful in recent program effectiveness studies. Significantly, regular meetings are held among academic researchers and service providers to examine specific program evaluation measures, such as the number of days of jail and shelter use, the time program participants take to return to jails or shelters, and the stability of housing options used in the program.

Preliminary research indicates that the FUSE option is working: 92 percent of program participants retain their housing, and 89 percent avoided jail, after being housed for six months. FUSE participants had a 99.5 percent reduction in the number of days they spent in shelters, and a 52 percent reduction in the number of days they were jailed. The study's comparison group, which did not receive FUSE services, experienced an *increase* in their jail use by 39 percent.

The preliminary evaluation suggests lessons similar to those found in other successful "alternative to incarceration" programming: it is vital to think creatively about the use of resources for individual clients; and collaborative work among agencies and institutions can overcome the propensity of people with unmet needs to cycle through revolving doors.

The FUSE program is ripe for replication in Connecticut. CSH is conducting initial planning in New Haven, Hartford, Bridgeport and Waterbury – urban sites with large numbers of their residents in state prisons. Project partners have been identified, data are being collected, sources of funding are being sought, and target group criteria are being developed. At this point, according to CSH project staff, critical issues include the availability of affordable housing, and identification of the types of support that fit people's needs (not just our expectations about those needs).

Washington State's Dangerous Mentally Ill Offender program

In 1999, the Washington state legislature enacted a "dangerous mentally ill offender" (DMIO) law that enhances interagency collaboration and expands funding community treatment for released mentally ill prisoners who may pose a high public safety risk. Washington's DMIO legislation provides for the payment of costs related to fostering and supporting interagency collaboration and pre-release planning. Specifically, the state corrections and the social and health services departments were assigned to work with Regional Support Networks (RSNs) and local treatment providers to plan appropriate intervention and service delivery for persons released from prison.

The DMIO program uses the Department of Corrections computer system to identify mentally ill offenders nearing prison release. The department reviews each person's psychiatric and criminal backgrounds to assess the severity of their mental illness and dangerousness. A multi-agency Statewide Review Committee (SRC) makes final decisions about classifying offenders as DMIO program participants.

Responsibility for planning and delivering DMIO treatment and support services is assigned to a team that includes representatives from corrections, mental health, substance abuse, developmental disability, the RSNs, and treatment providers. This planning team recommends whether DMIOs should be referred for evaluation under the state's mental health involuntary treatment laws or receive voluntary or supervised treatment in the community. In the community, DMIOs are assigned to mental health caseworkers.

Funds offered through the DMIO program are based on the number of clients served each month rather than on a fee-for-service basis. Contract agencies can bill the state as much as $6,000 for transitional and other pre- and post-release costs. Post-release costs cover only the first three months of release. After this point, DMIO agencies received fixed fees, which are based on Medicaid eligibility ($700 a month for those who are, and $900 a month for those who are not).

DMIO-related funds are generally used for housing and for mental health treatment for those who are Medicaid-eligible. Also, these funds provide for such clinical services as substance abuse and sex offender treatment. A recent evaluation of this initiative shows that 94 percent of available funding is used for either housing or personal expenses (82.4 percent for housing; 11.1 percent for personal expenses). Less than seven percent of the funding was spent on treatment-specific interventions (Lovell and Mayfield, 2007).

Selection of DMIO participants by an interagency Statewide Review Committee has greatly improved the working relationships between corrections and social service staff, who have gained a more appreciative understanding of each party's role in the overall treatment process. Research findings (Phipps and Gagliardi, 2003) indicate that DMIOs are actually receiving the array of intensive pre- and post-release services that the original legislation envisioned:

- *81 percent of DMIOs receive "pre-release" mental health services from community providers;*
- *87 percent of DMIOs received community mental health services in the first three months "post-release";*
- *93 percent of DMIOs received community mental health services in the first 12 months "post-release"; and*
- *29 percent of DMIOs received drug and alcohol treatment post-release.*

Recidivism research conducted by the Washington State Institute for Public Policy (WSIPP) found positive outcomes for those who participated in the program, as opposed to those who did not. In particular, DMIO program participants were less likely to recidivate than non-participants. WSIPP researchers found that DMIO services resulted in a 20 percent reduction in criminal activity (Aos, 2006). Moreover, DMIO participants were less likely to be reconvicted of felonies than non-participants (Mayfield, 2007).

Other positive outcomes were also documented. People who participated in the DMIO program were nearly five times as likely as non-participants to start receiving mental health services as soon as they were released from prison. They were five times as likely to receive mental health care in the community in their first year of being released. And they received more substance abuse treatment and were granted quicker access to Medicaid and other social services (Lovell and Mayfield, 2007).

Back to basics

Funding for community-based initiatives such as those reviewed in this report is typically soft and unreliable. President George W. Bush's proposed FY2009 budget sharply cuts possible federal expenditures for community mental health services. Proposed cuts amount to approximately $144 million (half in discretionary funding), including school violence prevention programs, jail diversion programs, post-traumatic stress-related programs, mental health consumer support technical assistance centers, and comprehensive planning to alleviate the fragmentation of state mental health care systems (Bazelon Center, 2008).

"The conversation that can't be lost," says Maureen Price-Borland, executive director of the Hartford-based Community Partners in Action and a member of Gov. Rell's sentencing and parole task force, "is that at the end of the day, creating and maintaining comprehensive reentry services for individuals is a better way of increasing safer communities" (Simpson, 2007). The same can be said for comprehensive services at all stages of the criminal justice system.

This report addresses the need to divert and decarcerate people with mental illness from Connecticut's prison system. Significant components of such a comprehensive approach have already been established. Criminal justice practitioners from police officers to parole officers have experience working with mentally ill people and the community agencies that provide services to them. We have cited model programs from other jurisdictions that provide concrete evidence that treating such people in the community will both save money and improve public safety. However, these initiatives will have only modest effects on the size of the state's prison population as long as the state's sentencing code places improper restrictions on the exercise of judicial discretion.

Before the Cheshire tragedy, Connecticut was making exemplary progress toward resolving the problems of prison overcrowding and racial disparity. In 2004 legislators enacted the nation's first experiment with Justice Reinvestment. In 2005 they stepped up to lead a national movement to eliminate sentencing disparities between "crack" and powdered cocaine offenses. In 2006 they endorsed Public Act 06-193, establishing a sentencing task force, and charged it with reviewing the state's criminal justice and sentencing policies and laws to create a more just, effective and efficient system of sentencing. In June 2007, task force members established four subcommittees, each created to address a critical aspect of their legislative charge, as follows:

- Community Supervision/ Alternative Sanctions subcommittee was asked to describe the general availability of these programs in the state, the characteristics of persons sentenced to these programs, the overlap of probationers and parolees in these programs, the length of stay of persons monitored through these terms of supervision, and the nature and results of evaluation methods used to "determine the effectiveness of these programs."

- Disparity subcommittee was given the task of assessing the impact of "current and proposed sentencing policy" on "racial, gender and geographic disparity" in the criminal justice system.

- Offense Classification subcommittee was assigned to review the possibility of classifying certain unclassified crimes and to determine the proportional relationship of various classified crimes to one another.

- A Sentencing Structure subcommittee was chosen to compare the structure of Connecticut's sentencing practices, including the use of mandatory sentences, with those of other states.

In the months since the tragedy in Cheshire, public officials and others have given earnest attention to critically important criminal justice issues. At a conference held at Eastern Connecticut State University in January 2008, for example, public officials reported that they have learned much since July 2007 about prisoner reentry and related issues.

Connecticut is in the midst of an extended public discussion about criminal justice practices. We believe this is entirely for the better but, if policymakers are serious about bringing prison populations back under control, they need to turn to the work that legislators intended when they established the sentencing task force. Sentencing code revision and restructuring should lead to abolition of mandatory minimum drug sentencing laws, including the harsh and ineffective "drug-free zone law," that drive the state's high rate of racial disparity in the prisons.

---

[1] In February 2007, analysts at the Council of State Government's Justice Center observed that Connecticut's pretrial population was growing, at least in part because it was not subject to the state's Justice Reinvestment initiatives of 2003 and 2004 (Pew Charitable Trusts and Council of State Governments, 2007).

[2] The term co-occurring disorders (COD) refers to people who are said to have one or more substancerelated disorders as well as one or more mental disorders. Depending on the severity of their symptoms, these individuals may require the same full range of services that are needed when they meet the individual criteria for both conditions established independently (Center for Substance Abuse Treatment, 2007).

[3] Justice Strategies has gathered descriptive and narrative data from official state reports, research evaluations, program descriptions, and newspaper reports. We interviewed state officials, nongovernmental professionals and community residents. We attended legislative hearings and executive committee meetings.

[4] Public Act No, 08-1.

[5] Journalist Malcolm Gladwell once reported about a homeless person who cost New York City approximately $1 million in jail and shelter expenditures.

References

Abramson, M.F. (1972). "The Criminalizing of Mentally Disordered Behavior: Possible Side Effects of a New Mental Health Law." *Hospital and Community Psychiatry*, 23, 101-107.

Aos, S., Miller, M. and Drake, E. (2006). "Evidence-Based Public Policy Options to Reduce Future Prison Construction, Criminal Justice Costs, and Crime Rates." Olympia: Washington State Institute for Public Policy. Available online at *http://www.wsiip.wa.gov/rptfiles/06-10-1201.pdf.*

Austin, J., Jacobson, M. and Cadora, E. (2005). "Building Bridges From Corrections to Employment." Available online at *http://justicereinvestment.org/files/Building.Bridges.pdf.*

Cho, R. (2007). "The New York City Frequent Users of Jail & Shelter Initiative." New York: Corporation for Supportive Housing.

Culhane, D.P.; Metraux, S.; and Hadley, T. (2001). "The New York/ New York Agreement Cost Study: The Impact of Supportive Housing on Service Use for Homeless Mentally Ill Individuals." Washington, D.C.: Corporation for Supportive Housing.

Hladky, G.R. (2007a). "Prisons rife with mentally ill." *New Haven Register*. September 30.

Hladky, G.R. (2007b). "Petit asks lawmakers to fix justice flaws." *New Haven Register.* November 27.

Houghton, T. (2001). "The New York/ New York Agreement Cost Study: The Impact of Supportive Housing on Services Use for Homeless Mentally Ill Individuals." New York, NY: Corporation for Supportive Housing.

Immarigeon, R. (2008). "What Does Not Work? Lessons from the Center for Court Innovations Failure Roundtable." *Offender Programs Report*, 11(5): 65, 78-79.

Lipsky, M.W. and Cullen, F.T. (2007). "The Effectiveness of Correctional Rehabilitation: A Review of Systematic Reviews." Annual Review of Law and Social Science. 3: 297-320. Available online at *http://lawsocsci.annualreviews.org.*

Lovell, D. and Mayfield, J. (2007). "Washington's Dangerous Mentally Ill Offender Law: Program Costs and Developments." Olympia, WA: Washington State Institute for Public Policy. Available online at *http://www.rptfiles/07-03-1901.pdf.*

Lurgio, A. and Snowden, J. (2008). "Prison Culture and the Treatment and Control of Mentally Ill Offenders." In: J.M. Bryne, D. Hummer and F.S. Taxman, eds., *The Culture of Prison Violence.* Boston, MA: Allyn & Bacon, 164-179.

Mayfield, J. (2007). "The Dangerous Mentally Ill Offender Programs: Cost Effectiveness 2.5 Years After Participants' Prison Release." Olympia, WA: Washington State Institute for Public Policy. Available online at *http://www.rptfiles/07-01-1902.pdf.*

National GAINS Center for People with Co-Occurring Disorders in the Justice System (2002). "The Nathaniel Project: An alternative to incarceration program for people with serious mental illness who have committed felony offenses." Program Brief Series. Delmar, NY: Author. Available online at *http://gainscenter.samhsa.gov/pdfs/jail_diversion/nathaniel_project.pdf.*

National Mental Health Association (2003). *Jail Diversion for People with Mental Illness: Developing Supportive Community Coalitions*. Delmar, NY: The TAPA Center for Jail Diversion.

Office of Policy and Management (2007). "Connecticut Sentencing Task Force." Hartford, CT: Criminal Justice Policy and Planning Division. Available online at *http://www.ct.gov/opm/cwp/view.asp?a=2976&Q=383706&opmNav_GID=1797&opmNav=|46658|.*

Pew Charitable Trusts and Council of State Governments (2007). "Connecticut: Case Study." Philadelpia, PA: Pew Charitable Trusts and Council of State Governments. Available at *http://www.pewcenteronthestates.org/uploadedFiles/CT%20case%20study%202-22-07.pdf.*

Phipps, P. and Gagliardi, G.J. (2003). "Washington's Dangerous Mentally Ill Offender Law: Program Selection and Services Interim Report." Olympia, WA: Washington State Institute for Public Policy.

Reinhart, Christopher (2007). "Inmates and mental health." Office of Legislative Research Report. Available online at *http://www.cga.ct.gov/2007/rpt/2007-R-0418.htm.*

Vogel, W.M., Noether, C.H., and Steadman, H.J. (2007). "Preparing Communities for Re-entry of Offenders with Mental Illness: The ACTION Approach." *Journal of Offender Rehabilitation,* 45(1/2): 167-188.

About the Authors

Russ Immarigeon is a consultant for Justice Strategies as well as the editor of various national criminal justice publications, including Offender Programs Report and Women, Girls & Criminal Justice for the Civic Research Institute, and of Justice Connections for the Victim Offender Mediation Association. He is the editor of the volume Women and Girls in the Criminal Justice System: Policy Issues and Practice Strategies (CRI, 2006) and the Co-Editor (with Shadd Maruna) of After Crime and Punishment: Pathways to Offender Reintegration (Willan Publishin, 2004).

Judith Greene is a criminal justice policy analyst and the founding director of Justice Strategies. Her essays on criminal sentencing issues, police practices, and correctional policy have appeared in numerous books and publications, including The American Prospect, Corrections Today, Crime and Delinquency, Current Issues in Criminal Justice, The Federal Sentencing Reporter, The Index on Censorship, Judicature, The Justice Systems Journal, Overcrowded Times, Prison Legal News, The Rutgers Law Journal, and The Wake Forest Law Review.

■ *Justice Strategies* is a nonprofit research organization dedicated to the proposition that grass-roots movements can win real criminal justice reforms if given access to the right information and public education tools. Our mission is to provide high quality "action research" to advocates and policymakers pursuing more humane and cost-effective approaches to criminal justice and immigration law enforcement.

■ The Drug Policy Alliance works to advance those policies and attitudes that best reduce the harms of both drug misuse and drug prohibition, and to promote the sovereignty of individuals over their minds and bodies.

■ *A Better Way Foundation* is dedicated to a shift in Connecticut drug policy from a paradigm that prioritizes criminal sanctions and incarceration, to one that supports public health and treatment.

A Better Way Foundation
127 Martin Street
Hartford, CT 06120
860.293.0626
www.abwf-ct.org

Drug Policy Alliance
70 West 36th Street, 16th fl.
New York, NY 10018
212.613.8020
www.drugpolicy.org

Justice Strategies
139 Washington Avenue
Brooklyn, NY 11205
718.857.3316
www.justicestrategies.net


A BETTER WAY
FOUNDATION


DRUG POLICY ALLIANCE
Reason. Compassion. Justice.


JUSTICE
STRATEGIES