Evolution of Forensic Services in Connecticut

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Background History

• "Forensic" Statutes
  – Competency to stand trial at least 1949
  – Insanity Defense at least 1969

• System pre 1970
  – 3 Large state hospitals, each of which treated forensic patients from local courts and sometimes prisoners/detainees from local correctional facilities
  – Norwich Hospital had special forensic service- "Security Treatment Center" at least since 1957 by statute (P.A. 650, S. 3, 1957)

• System 1970’s – early 80’s
  – Each of the "Big 3" had "forensic teams" who did evaluations/reports/testimony
  – Forensic patients scattered or clustered on special forensic units
Whiting Forensic Institute

• Constructed ~ 1970

• PA 73-245, changed “Security Treatment Center” to “Whiting Forensic Institute,” recognizing the move to the CVH campus
  – Specified a “diagnostic unit” and any other subdivisions the director would establish

• PA 75-603 moved forensic services for minors to DCYS
1970’s – early 1980’s

• Four of six units occupied; others used for office space (professionals did not have offices on patient units)

• MDs were contracted from group practice in Springfield, MA; visited weekly

• Direct care staff wore white uniforms

• WFI overall focus varied from security to treatment depending on Director at time
  – Problems encountered with one pendulum swing led to the next
Evolution of WFI

• 1986 – appointment of first Director of Forensic Services for DMH
  – Who also replaced then current director of WFI
  – Plan supported by Commissioner and Governor to transform WFI from a custodial setting to an accredited hospital
    • Resources increased
    • Psychiatrists/psychologists/social workers hired and placed on treatment units
    • Specific intent to create consistent combined security-treatment focus
Further Development

• 1988 – two new units added with intent to serve inmates with acute mental illness
  – DOC insisted on security enhancements to building
  – Bond funds for enhancements acquired in 1993

• 1989 – Achieved Joint Commission accreditation on first attempt

• PA 91-121 – permitted admission of women at Whiting; Whiting/DMH lobbied for this change

• Early 90’s – achievements consolidated; various QI efforts
PA 95-257

- Effective July 1, 1995
- Directed closure of Norwich and Fairfield Hills Hospitals
- Placed WFI within CVH as “Whiting Forensic Division of CVH”
- Created DMHAS
- Expressed purpose: “administrative efficiencies” and budget concerns
Post-Consolidation

• All NH & FHH patients discharged to community or transferred to CVH
• All forensic care transferred to CVH
• 1999 – All competency restoration patients at CVH made part of WFD
• ~2000 – all state hospital level PSRB patients at CVH made part of WFD
• This resulted in 3 subdivisions of WFD across 3 buildings
Other Developments in Forensic System

• Court clinics – 1980’s

• Consulting Forensic Psychiatrists – result of consent decree in 1989

• Community Forensic Services
  – Diversion and Re-entry programs initiated from 1996 to present
    • See next chart for dates of individual programs
<table>
<thead>
<tr>
<th>Program Name</th>
<th>Location</th>
<th>Pre-arrest</th>
<th>Arraignment</th>
<th>Pre-trial In Community</th>
<th>Pre-trial In Jail</th>
<th>Sentenced In Jail/Prison</th>
<th>Parole In Community</th>
<th>Probation In Community</th>
<th>Post Crim. Just. Involvement</th>
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<tbody>
<tr>
<td>Crisis Intervention Team</td>
<td>15 locations</td>
<td>2004</td>
<td>2005</td>
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<td>Alt. Drug Intervention</td>
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<td>Women’s Jail Diversion</td>
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<td>Bristol/NB – 2003</td>
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<td>JD Vets</td>
<td>SMHA &amp; RVS</td>
<td>2009 &amp; 2012</td>
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<td>Transitional Case Mgmt</td>
<td>Wtby, Htfd, Nwch/NLondon, NBritis/Brst</td>
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<td>DOC-DMHAS Referral Program</td>
<td>State-wide</td>
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<td>CT Offender Reentry Program</td>
<td>8 locations</td>
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<td>ASIST (clinicians collaborating with AICs)</td>
<td>9 locations</td>
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<td>Mental Health Day Reporting Center (CREST)</td>
<td>New Haven</td>
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<td>Residential Supports Program</td>
<td>B’port, Htfd, NHaven</td>
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<td>Pretrial Intervention Program</td>
<td>Serves all courts</td>
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On the workbench...

• Forensic Peer Bridgers
• Forensic Citizenship Projects
• Forensic Research
• Forensic recovery language
• Enhanced system capacity to respond to individuals’ criminogenic needs
Forensic Program Brief Descriptions

[for handouts only]
Programs for Diversion

• Crisis Intervention Teams
  – > 1,450 police officers trained from 99 departments to deal with persons in psychiatric crisis
  – CIT clinicians assist police with > 1,600 persons/yr face to face; plus approx. 1,400 consults/phone contacts

• Jail Diversion
  – Jail Diversion in all arraignment courts in state
    • 3,249 evaluations & 1,391 diversions in SFY13
    • 2,750 evaluations & 1,346 diversions in SFY 14
  – plus special programs: Women’s JD, JD Substance Abuse, JD Vets, Pre-trial intervention (SA)
    • > 500 evaluations; large majority diverted
Re-Entry & Community Integration

- **CT Offender Re-entry Program (CORP)**
  - Referrals 9-18 months before discharge from DOC for sentenced people with SMI
  - Comprehensive pre-release assessment and skills building program including the development of a community support network
  - Intensive case management, integrated mental health and substance abuse treatment services
  - After discharge, continuing services are provided through the Local Mental Health Authorities in those communities.
  - 60-70 admissions per year
  - In 12 months after release, 32% re-arrested, compared to 37% for inmates who do not participate in CORP
Re-Entry (cont’d)

• **DOC-DMHAS Referral Program**
  
  – Promotes recovery and re-integration for people with SMI transitioning from state correctional facilities to the community, through a comprehensive referral program.

  – Referred to the program 3-6 months prior to their release from the DOC and meet with a representative from the appropriate Local Mental Health Authority to arrange for services in the community.
Re-Entry (cont’d)

• Advanced Supervision and Intervention Support Team (ASIST)
  – Alternative in the Community Centers with clinical support/recovery services
  – Coordinated effort of DMHAS, DOC and Judicial Branch court support services
  – Admits approx. 400 clients per year
  – 80% completed program without incarceration in SFY14; 85% in SFY 13
Re-Entry (cont’d)

• Community Recovery Engagement Support and Treatment Center (CREST)
  – Intensive day reporting program with skill-building and clinical services
  – Clients who could not be released from incarceration otherwise
  – 45 admitted per year
  – 82% completed without incarceration in SFY14; 83% in SFY 13
Re-Entry (cont’d)

• **Sierra** Pretrial Center
  – Transitional housing program for those in jail awaiting court disposition of charges who can be safely released to the community in a structured residential program
  – Services offered include case management, psychiatric and medication monitoring, motivational enhancement, cognitive restructuring and training, consistent supervision and supportive services
  – 80% of SMI clients completed without being re-incarcerated in SFY 14; 91% in SFY 13
Re-Entry (cont’d)

• Transitional Case Management (TCM)
  – Serves sentenced male inmates with substance use disorders
  – Services begin 3-4 months before release: discharge planning, housing assistance, application for entitlements
  – Post-release services: community support, substance abuse counseling, employment, housing
  – 5% arrested while in community program SFY 14 & SFY13
Forensic Consultation

• Team of independent consulting psychiatrists
  – Participate in regular management of forensic population
  – Provide risk management consultations to DMHAS inpatient and outpatient teams, private agencies and hospitals
  – Provide other forensic consultations as needed
Evolving Definitions, Roles, and Boundaries in Forensic Services

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In the Beginning

- Professional silos maintained strict boundaries: *law* was law; *mental health* was mental health
- Forensic patients defined by legal standing
- Focus of care for forensic clients determined by legal classification
- Interaction between law and psychiatry in court and in hospital, not in community
What were the effects? *Cracks to fall through*

- Patients “belonged” to one domain or another
- Care fragmented
- Professionals minded their own professions
- Inequity
- High cost
What changed?

• Bridging the cracks: coordinated, comprehensive care for the forensic client
• Role and skill enhancement for all professionals
• Removing barriers to comprehensive services
Where are we now?

• Comprehensive, seamless services for forensic clients
  – Jail diversion
  – Supervised release programs
  – Re-entry programs

• Client focused approaches
  – Criminal justice involvement as a clinical issue
  – Expanded services for forensic clients

• Inter-agency collaboration
  – Shared responsibility
  – Collaborative approach

• Impact of Recovery on mental health movement
What’s next?

OK...ON THE COUNT OF THREE, WE EVOLVE INTO PIRANHA

STRATEGY VS. REALITY

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Challenges

- Community based forensic services
- Broadening “forensic” to address “at-risk-to-become-forensic” client
- Single-point-entry to care models of access
- Community-based and translational research
- Social media and public opinion
Goals for the Next Revolution

PRESENT

• Moved from legal focus to client centered programming
• Integration of services to close the gaps
• Interagency collaboration
• From in-patient to community based programming
• Integration of services across criminal justice tenure

FUTURE

• From client centered to life-goals focus on programming
• Integration of skills for living beyond client-hood
• Single entry service based on acuity and level-of-service needs
• Collaboration with community partners – partnerships for living
• Recovery-research environments to establish effective care models based on acuity and recovery potential
If we looked to past progress we would perish in our satisfaction; if we looked to the future task, we would perish in our despair. We celebrated our daily achievement as a sign we were capable of tomorrow’s burden.

We chose to embark on this journey; now we must choose to go forward or to turn back. Remaining here is no option.

Thor Heyerdahl on a 101-day, 4948 mile journey on a raft cross the Pacific
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