

# RELEASE



*A student news collaborative focusing on  
the impact of incarceration in Connecticut*

[ FOCUS ON ]  
*mental health*



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# *welcome to* **RELEASE**

Welcome to Release, a publication devoted to collecting stories about citizens with criminal histories and the organizations that serve them. Produced by the Institute for Municipal and Regional Policy (IMRP) and created by students from Central Connecticut State University, the newsletter provides profiles, general features, interviews, videos, informative graphs and more. Our goal: to empower ex-offenders and to educate the larger Connecticut community on what it can do to stem recidivism. Release covers employment, housing, education, children of incarcerated parents and other subject areas that relate to building a productive life with a criminal history. For your free subscription to Release, which will be distributed online on a monthly basis and also published in print on a quarterly basis, please register at [www.releasenews.org](http://www.releasenews.org).

# Providing STABILITY

*Training law enforcement to  
better handle mental illness*

By Dave Baker



*Louise Pyers, Founder of Connecticut Alliance to Benefit Law Enforcement*

It wouldn't be far reaching to say that Connecticut prisons have become de-facto housing for those suffering from mental illnesses. The facts speak for themselves: 16 percent of all individuals held in Connecticut prisons suffer from mental illness, with only one in five receiving treatment for their conditions. Connecticut's 2010 annual recidivism report determined that inmates with mental health problems presented significantly higher rates of recidivism, ultimately resulting in higher costs of inmate healthcare and a further strain on an already struggling state economy.

In response, a number of measures have been taken within the criminal justice system to identify and properly

handle suspects and inmates affected by mental illness; a process that begins first with law enforcement.

Louise Pyers is the founder and Executive Director of CABLE [Connecticut Alliance to Benefit Law Enforcement]. A clinician with over 30 years of experience, she specializes in counseling law enforcement and other emergency response personnel. Pyers also serves as statewide CIT [Crisis Intervention Team] program coordinator and is certified to offer training in stress management and suicide intervention.

Brought to Connecticut in 2000, CIT training was first offered to police departments in 1988 using a model developed by a joint effort between the Memphis Police Department and the University of Memphis. The program was developed in response to the community's outrage following the shooting of an armed suspect by Memphis police officers. It was learned that the suspect was in fact mentally ill, raising awareness for a need in improved tactics in dealing with mentally ill suspects, pushing treatment over incarceration. Captain Kenneth Edwards of the New London, CT Police Department went to Memphis and received CIT training, establishing New London as the first department in Connecticut and the second in the region to deploy the

CIT program.

Collaborating with Capt. Edwards and CABLE, Pyers expanded the CIT program throughout the state with aid from the State Mental Health Authority and non-profit funding. Since 2003, 72 state and federal law enforcement agencies in Connecticut have sent officers to receive CIT training, roughly 1500 officers statewide. "We added 12 new departments in 2011 alone," Pyers said. Teaching officers to recognize the behavioral cues of a mentally ill person and how to deescalate a given situation, the Connecticut model of CIT takes a systemic approach, working closely with mental health providers in the state. Trained officers will notify mental health agencies following an arrest to determine whether or not the recently charged individual is already documented in the system and if they should be turned over to a mental health agency, potentially qualifying for mental health jail diversion.

Officers participate on a largely volunteer basis, with some selected by their department for training in CIT. The program teaches officers to recognize certain cues in a mentally unstable suspect. Their training teaches them to identify the symptoms of a mental illness and co-occurring disorders, which is a term used to describe mental illness

paired with the influence of drugs or alcohol. CIT aims at using less lethal force and giving officers a number of suicide prevention techniques. Family members of suspects play a pivotal role in working with officers to provide firsthand knowledge and experience

with their relative's condition. Officers are also given a basic overview of psychiatric medications and the legal issues that arise in dealing with a mentally ill person.

A unique aspect of CIT training is immersing officers in the plight of a mentally ill person; giving them a general idea of the difficulties they face everyday. One example of such is "Hearing Voices," a training exercise designed to simulate the symptoms of schizophrenia by having an officer deal with a hypothetical situation while wearing headphones playing various recorded voices. Sgt. Steve Smith of the Groton Town PD told CABLE's CIT newsletter of the valuable perspective he gained from the training. "It was

and learned that a rash of personal problems drove him to such extreme measures. The officers successfully

alleviated the situation and the man was brought to the William H. Backus Hospital for a psychological evaluation.



As Pyers said, "Somebody has to speak for people who don't have the voice. People don't take mental illness seriously enough and they should."



*stay*  
**CONNECTED**



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***"Somebody has to speak for people who don't have the voice. People don't take mental illness seriously enough and they should."***  
●●●

very disconcerting and distracting trying to function on a personal level during the simulation and I've gained valuable insight," Smith said.

An incident that occurred in November 2011 in Norwich, CT saw the use of CIT strategies to talk down a potential jumper from the roof of a parking garage. Officers Damian Martin and Kenneth Nieves spoke with the man

The CIT program experienced initial success in Memphis, with the police department seeing reductions in arrests, incarceration, injuries to suspects and officers, and SWAT team callouts. CIT has proved cost effective, ultimately benefiting the state and taxpayers. It's most noteworthy achievement, however, remains raising awareness for mental health issues within the criminal justice system.

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# A Holistic APPROACH

*Dan Abreau of The GAINS Center Gives  
RELEASE an Insider's Perspective of  
Mental Health and Reentry Issues*

## Q/A

By Jesse Duthrie



*Dan Abreau is the Associate Director of the SAMHSA National GAINS Center in Delmar, New York. The GAINS Center is a national agency focused at expanding access to community-based services for adults with co-occurring mental illness and substance use disorders in connection with the justice system. The GAINS Center is operated by Policy Research Associates. Dan Abreau has worked in correctional facilities since the 1970's, and now works to strengthen the resources and success of reentry programs on a national level.*

**JESSE DUTHRIE:** What are the major projects you are working on with your agency?

**DAN ABREAU:** Most of the work that we do is funded by SAMSHA. The work focuses more on jail diversion. The work we do takes place before reentry. Since 2002 we've been the technical provider for around 40 to 50 cases around jail diversion. Perhaps the most related publication we have around reentry is called the Assessment Planning and Identification Coordination (APIC) model. It's a model that helps jails and prisons in a timely way identify people with mental illness, assess their needs, and identify the appropriate providers for their needs for when they get out.

Companion to the APIC model is a reentry checklist that was developed. This checklist has 10 domains that reflect different needs that the reentry population has so that people working at those sites can easily look at those needs and whether or not they're met. If they're not, they can develop a plan so they can be.

**JESSE DUTHRIE:** Of those 10 domains, what would you say are the most pressing for offenders with mental illness returning home from prison?

**DAN ABREAU:** Here's the issue with that question. Reentry planning is a little like putting up Christmas tree lights: if one lights goes out they all go out. For example, if you have everything handled but a person doesn't get their medication when they get out, well then the person decompensate and they end up in the hospital. Or say they get everything handled but they don't get adequate housing and they end up in a shelter where there's a lot of fragmented services and it's harder to get the multiple types of services they need. Maybe the person has co-occurring disorders and they're being treated for the mental illness but not adequate attention to the substance abuse, so the plan falls apart.

-where the providers are or the community supervision people. We



***“You really have to look at this holistically, and sometimes you can't get all of the needs fulfilled for people getting out of prison. But it's important to be aware of what those things are once you're released”***



need to figure out alternate plans to making those referrals so we can move beyond the inadequacy.

**JESSE DUTHRIE:** What it sounds like is each person has their own set of criteria that they're going to have to deal with when they are released from prison. How do you guys provide that one-on-one attention for a massive returning population?

**DAN ABREAU:** We're not the only technical assistance provider. One of the issues prison systems around the country face, and some are better than others, is having the resources to do this work. It really is a specialty type of resource that's required and a lot of state prisons still don't have the resources still to devote to make these reentry plans work well. So first off there is a resource issue.

Then you have to remember that in most states, with maybe Rhode Island and Connecticut being an exception, those prisoners aren't located anywhere near where people live. So you're doing the reentry planning from a remote location, trying to get services in a number of communities across your state. And in many states you have multiples prisons, so you've got multiple referrals, multiple communities, and it gets to be a pretty resource intensive process.

**JESSE DUTHRIE:** Are there any particular instances where you've seen the work you've been doing has been incredibly effective? What caused it to work so well?

**DAN ABREAU:** I'll give you an example that is directly tied to the APIC model. Alaska did use the APIC

model to educate their legislature about reentry planning and the need for dedicated resources. Not only did that include prison-based resources, but also transition resources and community resources. They used the APIC model to get additional resources that could include reentry planning. This included things like finding health benefits prior to release and making referrals to providers before release.

Case managers came into the prisons to either provide transportations for the prison back to the community- you'd be surprised how many people get lost on a bus ride- and to provide that direct kind of service right from prison back into the community. Then there was an increase in available funding so Medicaid gets approved, and some payment to providers to treat people immediately upon release so that there is no reason why anybody should get lost among the population if they have a serious mental illness. Payment of services upon that critical time of reentry became another important push. Reentry got APIC legislation passed in Alaska to fund those last pieces of service. They've done a really nice job with it.

**JESSE DUTHRIE:** How long have you been working in the field of mental health and prisoner reentry?

**DAN ABREAU:** Mental health and prisoner reentry and mental health since I started my career in the early 70s, which was when de-institutionalization was just starting. I've always worked in prisons, and I eventually became an administrator and with the last 10 years of my career I worked with reentry. I retired and

came to work at the Gaines Center in 2005.

**JESSE DUTHRIE:** Seeing as you've been involved within prison systems since the 1970s, how have you seen the change in attitudes and stigmas within the system towards offenders with mental health issues?

**DAN ABREAU:** Back in the '70s nobody was prepared for how complex it was going to be for people with mental illness to return to the communities. There were issues in every community. It wasn't just de-institutionalization, it was change in



mental health laws, which made it harder to lock people up because of a mental health problems and granted people with mental illness a full range of civil liberties.

It wasn't just public policy; it was the way the laws changed.

And then there was the issue of having co-occurring disorders and how



that complicates recovery for people with mental illness. Then there was an issue of resources. I still think we haven't reached a point yet where community mental health treatment is adequately funded. So that's one issue, but there are improvements. Now there's targeted grant programs to help agencies do a better job and they have invested millions of dollars, but in the end it's still a very complicated thing.

**JESSE DUTHRIE:** Where do you see the future of this mental health issue going, and what changes needed to be made in order to reduce recidivism in the long run?

**DAN ABREAU:** If you look state level and then service level, a lot of people got caught up in the war with drugs. People with mental illness, like people without mental illness, use drugs. There was a pretty broad net and people with mental illness got caught up in that. So that's one issue that states are beginning to address.

Another problem is the three strikes laws. We've gone through a couple of decades now with different approaches to crimes. States cannot afford the level of incarceration that they've legislated any more. You've got multiple funding streams to address these issues: Department of Corrections, Department of Community Supervision Agency, The Office of Mental Health Agencies, and The Substance Abuse Agencies. In some states these agencies can be badly coordinated.

**JESSE DUTHRIE:** If you had anything to add to the readers of RELEASE who might not be familiar with this issue, what would you add?

**DAN ABREAU:** Trauma is a huge issue that gets overlooked; I think

Connecticut is one of the leading states in looking at issues of trauma and incarceration, whether it's dealing



*“Connecticut across the justice and mental health system, is doing a lot these things that we’ve talked about. It’s not just because it’s a small state. There really are a lot of quality people there ”*



with veterans or mental illness. There are actually higher rates of incarcerated people that have experienced trauma than mental illness. Connecticut's done a lot of training and is one of the top states in preventing and treating trauma.

I think that people understand that it's important to be holistic in the approach, it's important to establish partnerships, and that additional funding may be required but it's kind of a “pay me out, pay me later” situation because people we're talking about are high users of expensive services: emergency room services, cycling through jail, etc. These people are going to cost money, but by working in an organized way it may be more cost effective in the long run.

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# *The Opposite End* **OF THE SPECTRUM**

*The rising issue of suicide among law enforcement*

**By Dave Baker**

When it comes to ranking the most stressful jobs, policemen are always right up there with coal miners, oil rig workers, and firemen. The physical toll is obvious, but the hidden cost of mental stress is reflected in a disturbing statistic: police have an alarmingly high rate of suicide. More officers kill themselves each year than die from any job-related incidents. “Police officers operate at what we call hyper vigilance, meaning they are constantly on edge and looking over their shoulders. You can only maintain that for so long before you crash,” Louise Pyers, Executive Director and founder of CABLE [Connecticut Alliance to Benefit Law Enforcement] explained. A study conducted by the mental health support group, the Badge of Life, concluded that police officers have a suicide rate of 17 per every 100,000 versus the national average of 11 per 100,000.

For police officers, going through a traumatic experience on the job isn't always the catalyst for such an extreme action as suicide. It can be the smaller things that build and resonate in their minds. Pyers recalled one officer she worked with who took a call at an elderly man's home on Christmas Day. The man died of natural causes, but when his family appeared on the scene they immediately began arguing over his possessions; handpicking what they believed they were entitled to and not giving their deceased relative

a second thought. “The little things build up and stick in their minds. Police officers see things that you or I wouldn't dream of. To say they're not affected by those things is erroneous.” Officers who handle a critical situation on the job are offered critical incident stress debriefing, a process used to prevent or limit any post-traumatic stress. “We train them [peer support officers] in how to help their peers after a critical event; an event that would blow anyone's mind, really. Police are often told “suck it up, this is your job.” What happens with all that emotion and stress later? It accumulates and over time it can spiral out of control,” Pyers said.

In response, Pyers worked in conjunction with the Badge of Life in 2007 to begin using peer support groups as a means of getting officers the help they need. While they may be hesitant to discuss life on the job with a civilian, the theory behind peer support reinforces the notion that policemen are more apt to talk with a fellow officer, someone empathetic to what they are going through.

“Being a police officer changes a person, not necessarily for the better. We train peer officers to teach fellow officers how to have a balance in their life. Spend time with your family, invest in relationships with friends who aren't police officers, those types of things create a balance and when

they don't have that balance, things can go haywire.” It is when these stresses linger, Pyers pointed out, that a number of issues arise, resulting in an officer's personal and professional life spiraling to the point of no control from negative coping mechanisms, such as substance abuse, gambling, and hyper-sexuality – not to mention long term implications on their well-being.



“Most people don't see a dead body until grandma or grandpa die, but we see them all the time,” said Sgt. Clarke Paris of the Las Vegas, NV Metropolitan Police Department. Sgt. Clarke spoke at a conference held at Central Connecticut State University in March of 2009 sponsored by CABLE and CCSU's Institute for the Study of Crime and Justice. Lisa Backus of the New Britain Herald reported on the story. “This has nothing to do with how strong you are. If you need help, you can't do it yourself.” Sgt. Paris has served as a police officer for over 25 years and produced the documentary *The Pain Behind the Badge*, a film detailing the accounts of three officers

pushed to the brink of suicide due to job-related stress, unraveling personal lives, and PTSD. In 2011, Sgt. Paris, who continues to work in the LVMPD, published *My Life for Your Life*, the first book focusing exclusively on police suicides.



Peer support training among Connecticut law enforcement has been very well received, with 92 state troopers qualifying to offer peer support. The number grows each year. Utilizing organizations such as State Troopers Offering Peer Support [STOPS], a program headed by Sgt Troy Anderson, significant

Britain's Captain Matthew Tuttle, and Rocky Hill's Sergeant Leonard Kulas. Pointing to the fact that Tchorzky, Forbes, and Tuttle were nearing retirement before they took their lives, Pyers said, "We do know that police officers nearing retirement are at higher risk. Some officers put all their identity into being a police officer, and then when it comes time to retire they don't feel they have a purpose." Careers are, at times, integral parts of a person's identity; however, veterans of law enforcement and the military are more apt to experience difficulty adjusting to life after the force or service than retirees from other professions. CABLE and CCSU organized another conference in August of 2011 in response to this rash of suicides, drawing over 300 officers from across the state.

There is no concrete explanation for why these four police officers

jobs that people have to deal with, in terms of exposure to stress and trauma. They're expected to be robots and we're trying to humanize them. The better they take care of themselves, the better they'll be able to cope over time."

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***"It's [police work] one of the toughest jobs that people have to deal with, in terms of exposure to stress and trauma. They're expected to be robots and we're trying to humanize them. The better they take care of themselves, the better they'll be able to cope over time."***

improvements have been made in giving police officers a better outlet to voice their frustrations and discontent.

Suicide among Connecticut law enforcement came to the forefront in 2011 when four police officers committed suicide between the months of April and June: Southbury officer Anton Tchorzyk Jr, Groton's Lieutenant Thomas Forbes, New

killed themselves. Law enforcement is a complex profession, exposing officers to numerous traumatic events. However, advancing the quality of mental health care for all those involved in criminal justice, both inside the system and out, remains a vital objective. Pyers feels that the STOPS program and peer support are essential to making positive strides. "It's [police work] one of the toughest



*Next issue,*  
***From Streets to Courts:***  
**AUGUST 2012**

# Drawing

## THE SYSTEM

*Loel Meckel of DHMAS Illustrates the Reentry Process for Incarcerated Citizens with Mental Illness*

**By Jesse Duthrie**

When Loel Meckel explains the prison reentry process, he works best with a pen in hand and blank paper at his disposal. He's free to illustrate the process aesthetically rather than orally. It's complex, he says, and after the first page is filled with branched titles and acronyms for state agencies, it's hard to remember where it first started: the word "arrest."

Loel Meckel is the Assistant Director of the Division of Forensic Sciences for the Department of Mental Health and Addiction Services (DHMAS). He's tall, thin, and with his horn rimmed glasses he radiates an air of calm intelligence; somebody working within a challenging program with the patience and ability to explain his work clearly.

Meckel's office looks archaic: it's old tan stone is weathered and gothic entrance indicates that prior to becoming the head offices of the Department of Mental Health and Addiction Services (DHMAS), it could have been used for Masonic meet ups or old Catholic institutions.

Beyond the heavy steel doors, on the second floor, Meckel works with a team of men and women targeting offenders with mental illness or addiction whose risk of recidivism can be reduced by providing appropriate community services.

"Tell me about the issues men and women with mental illness face upon release from prison," I ask Loel.

"Well first, Jesse, do you know how the incarceration process works?"

I pause. I'm caught off guard.

"Sure. A man or woman is arrested, then they are brought into court where they can either post bail or are kept in custody. Then, depending on their circumstances, are brought back to court for a hearing"

"I think I should show you how it works a little clearer. It's a very complex process."

He pulls out his pen and begins the first of several drawings. Starting with "arrest," he makes a line down to "court." "Court" then splits to "jail" and "diversion." Jail is tracked down with several arrows, indicating an ambiguous amount of time between jail and sentencing. Next written is "sentenced to incarceration." Finally, another arrow and underneath, the word "release."

By the time he arrives at release, the process is lengthy yet manageable to comprehend. But when he shifts the discussion to mental health reentry services, the process grows significantly more complex.

Upon entrance to incarceration, men and women are given mental health screening. They are given a Mental Health Care Need (MH) rating between 1 and 5; 1 indicates no mental health history of current need and may be characterized as emotionally stable, 2-4 represent little to some mental illness severity, and 5 indicates crisis level mental disorder (acute conditions,

temporary classification) that requires 24 hour nursing care.

"These numbers don't necessarily represent the type of mental illness a man or woman has upon entering prison," Loel explains. "Say a person with no history of mental illness commits a serious crime and comes into prison with serious distress or depression, he or she may be given a 4 or 5 MH rating. On the other hand, a person with history of schizophrenia may be relatively calm when they enter a corrections facility, and even though there's a history of mental illness, they may not require the more intensive mental health services provided by Department of Corrections."

Prior to release, inmates are given the opportunity to receive reentry aid from the University of Connecticut Health Center's prison-based Correctional Managed Health Care Services, and DHMAS. This planning stage gives men and women extended medication after release, as well as counseling, psychiatric services, and discharge planning. Because the therapeutic effect of psychiatric medication may diminish in as little as a few days, it's imperative that they continue the medication they've been on during incarceration. Loel explains the two types of reentry planning in the state based on presence of a Serious Mental Illness (SMI). The first is called the DMHAS-DOC Interagency Program. Within this program, incarcerated men and women with SMI are prepared three to six months prior to release

through a referral system which includes DHMAS, UCONN's Health Center's prison-based Correctional Managed Health Care Services, and DMHAS-funded Local Mental Health Authorities (LMHA).

It's impressive to see the amount of agencies working together to help these men and women being released.

The second planning set is called Connecticut Offender Reentry Program (CORP). CORP also provides services for men and women returning from prison with serious mental illness but is much more intensive than the DMHAS-DOC Interagency Program. The aim of CORP is primarily to maximize the chance of successful reentry to the community and secondarily to reduce recidivism by helping those with severe mental health needs. Using extensive resources inside and outside of incarceration, men and women are given intensive case management, integrated mental health and substance abuse services, and linkages to supportive men and women in their communities. The DHMAS website adds that men and women are given "pre-release assessment and skills building programs including the development of a community support network."

Loel explains to me that men and women coming out of the DMHAS-DOC Interagency Program have a recidivism rate around 50% after a year of release. When I ask what the CORP recidivism rate is, he blows me away. "Somewhere around 18%. But that number is not exact."

How is it, then, that two programs targeted at the same objective have such greatly contrasting effects on recidivism? I trace my mind back a few weeks to a phone interview I conducted

with Dan Abreau of the GAINS Center in New York. [Insert Link for Q&A with Dan Abreau]. In our conversation, Dan frequently stressed that the greatest factor to providing adequate care for returning men and women is to give them the appropriate amount of resources to have a successful transition process from prison to community.

It seems that CORP, with a greatly significant percentage of recidivism rates, uses a larger margin of resources, which comes at a cost to the state. Yet the two program use the same number of agencies but with CORP the LMHAs have CORP staff who only serve CORP clients, so the intensity of services is higher than for the DMHAS-DOC Interagency Program.

When I asked Loel to explain why there isn't more investing into the expansion of CORP programs, the answer comes back the same as any other state



***"Of course there is the issue of funding for reentry programs. Where the standard DMHAS-DOC Interagency Program utilizes resources from several agencies, the level of involvement is lessened potentially due to cost"***



agencies: the funding is not there. Grants are dispersed at the capitol and programs more or less have to make do with what they are given.

This isn't the first time I've encountered reentry programs facing this same issue. In Waterbury, the CT Renaissance House's dual-diagnosis program showed how successful reentry programs can be

for people with both mental illness and substance abuse treatment; however, the CT Renaissance House was only one of two dual-diagnosis programs in the state. All of the academic research that had been conducted within the psychology and sociology fields has proven that dual-diagnostic treatment is the next step in the advancement of reducing recidivism and providing adequate treatment. I can remember being in the offices, seeing the long list of counseling services, and asking why there weren't more of these programs in the state. Again, it was a problem of finance.

Loel hurries to his computer to print out info graphics from the GAINS Center. He prints out an info graphic similar to the one he's drawn out short hand, except this one is vastly more intricate. Then he prints out the DHMAS list of services for mental health release programs in Connecticut. It's as confusing as it is complex. As we go through the info graphs, names of state and national agencies like the Substance Abuse and Mental Health Services Administration (SAMHSA) pop up. While there was once funding from national agencies, Loel explains how DHMAS has been able to run its programs solely off of state funding. But after awhile it's hard to keep up with the money trail- specifically who's receiving the money and what it's being used for.

The process is not streamline, I deduce, and vast array of financiers and recipients makes it complex to track how the process itself works. I look down at the papers Loel has printed, and the white computer paper he's drawn several illustrations on. I remember the first thing he said when he started to discuss the mental health reentry process: "It's more complicated then you think."

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