

## **Department of Correction**

### **Appropriations Committee Follow Up Q&A**

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**Q: How many vacancies in your department?**

A: 629. See Attached HR spreadsheet for additional information.

**Q: How many filled positions?**

A: 5,936. See Attached HR spreadsheet for additional information.

**Q: Position vacancy rate?**

A: 11%. See Attached HR spreadsheet for additional information.

**Q: How many retirements are you expected to have (by 07/01/2022)?**

A: 203: 66 COs, 14 in Inmate Medical Services. See Attached HR spreadsheet for additional information.

**Q: How many applications to HR have been filed? How many have been filled?**

A: FY TD 5965 filed, 401 filled. See Attached HR spreadsheet for additional information.

**Q: How long does it take to get people in place to actually work/perform a job they are hired for in your agency?**

A: The state does not have a measurement tool or dashboard and this is not reliably measured. There is an appetite to have this data and DAS is in the process of building a dashboard to do so.

**Q: How many applications for positions has the agency submitted to DAS (Human Resources)?**

A: 5,965

**Q: How many positions have been filled since DAS (Human Resources) began this responsibility?**

A: 658

**Q: How many officers are out on long-term disability?**

A: 321

**Q: Provide a breakdown of mental health staff by facility by positions.**

A: See Attached HR spreadsheet for additional information.

**Q: What is the racial and gender make up of DOC staff by position.**

A: See Attached HR spreadsheet.

**Q: What are the staffing levels for Inmate Medical (by position – filled and vacant).**

A: See Attached HR spreadsheet.

**Q: Leave use of staff – by leave type for the past few FYs.**

**A:**

	2017	2018	2019	2020	2021
FMLA	311,327	330,552	378,548	426,542	467,929
Sick	474,677	576,242	515,802	507,370	573,107
Unpaid	501	5,417	5,169	5,491	5,641
WC	166,620	224,298	129,385	177,522	77,387
<b>Total</b>	<b>953,125</b>	<b>1,136,509</b>	<b>1,028,905</b>	<b>1,116,925</b>	<b>1,124,063</b>

See Attached HR spreadsheet for additional information.

**Q: What is the current CO count.**

**A:** 3,306

CO Staffing – 5-year history:

	Required	Filled	Avg # of Vacancies	Avg. Vacancy Rate
2016	3996	3519	476	11.9%
2017	3915	3363	551	14.1%
2018	3866	3387	479	12.4%
2019	3942	3496	436	11.3%
2020	3918	3468	450	11.3%
2021	3791	3390	401	10.5%

**Q: What type of air filters are used in the housing units?**

**A:** All air filters used are a 13 MERV rating

**Q: Are you considering hemp oil and CBD as non-opioid treatment options.**

**A:** Regarding cannabis, cannabis-derived drug products and synthetic cannabis-related drug products, the US Food and Drug Agency (FDA) has stated:

“To date, the FDA has not approved a marketing application for cannabis for the treatment of any disease or condition. The agency has, however, approved one cannabis-derived drug product: Epidiolex (cannabidiol), and three synthetic cannabis-related drug products: Marinol (dronabinol), Syndros (dronabinol), and Cesamet (nabilone)... FDA has approved Epidiolex, which contains a purified form of the drug substance cannabidiol (CBD) for the treatment of seizures associated with Lennox-Gastaut syndrome or Dravet syndrome in patients 2 years of age and older... The agency also has approved Marinol and Syndros for therapeutic uses in the United States, including for nausea associated with cancer chemotherapy and for the treatment of anorexia associated with weight loss in AIDS patients... Another FDA-approved drug, Cesamet, contains the active ingredient nabilone, which has a chemical structure similar to THC and is synthetically derived. Cesamet, like dronabinol-containing products, is indicated for nausea associated with cancer chemotherapy.”

Importantly, at this time, the FDA has not approved any other cannabis, cannabis-derived, or cannabidiol (CBD) products currently available on the market, nor has it approved any

other clinical indications beyond what is stated above. Notwithstanding these approved drug products and clinical indications, others have cited significant potential risks including drug-drug interactions as well as suppression of the immune system. Indeed, a recent medical review (Khoury et al., 2022) has stated that "... cannabis may promote the progression of a range of malignancies, interfere with anti-cancer immunotherapy, or increase susceptibility to viral infections and transmission." Accordingly, any risks vs. benefits would be evaluated by the treating primary care providers and/or consulting medical specialists. As the scientific evidence, clinical guidelines, regulatory authorizations, and national drug formularies evolve, CTDOC will take steps to ensure its patients are getting what their primary care providers and/or consulting specialists agree is medically necessary.

REFERENCES: <https://www.fda.gov/news-events/public-health-focus/fda-and-cannabis-research-and-drug-approval-process#:~:text=The%20agency%20has%2C%20however%2C%20approved,from%20a%20licensed%20healthcare%20provider>. <https://www.mdpi.com/1999-4923/14/2/389/pdf>

**Q: Who is/are the vendor(s) that provide(s) methadone services for DOC?**

**A:** Vendors are as follows:

MOUD VENDOR	FACILITY	MAX DAILY CAPACITY		FY22 ANNUAL COST		TOTAL MAX CONTRACT	FUNDING SOURCE	EXPIRATION DATE
APT Foundation, Inc.	NHCC	150	\$	1,068,474	\$	2,768,891	STATE	6/30/2023
	CRCC	75	\$	883,218	\$	2,491,757	STATE	6/30/2023
	CRCI	110	\$	763,293	\$	2,886,536	STATE	6/30/2023
	HCC	150	\$	1,130,000	\$	1,771,138	FEDERAL	9/29/2022
	OCI	160	\$	790,077	\$	2,312,819	STATE	6/30/2023
	WRC	30	\$	253,168	\$	1,218,339	STATE	6/30/2023
	WCCI	110	\$	719,652	\$	2,680,307	STATE	6/30/2023
Recovery Network of Programs, Inc.	BCC	130	\$	965,605	\$	2,622,978	STATE	6/30/2023
	GCI	50	\$	180,243	\$	180,243	FEDERAL	9/29/2022

Note: York CI is its own OTP.

**Q: Please provide a breakdown of mentally ill inmates.**

**A:** As of 2/9/2022 .... total population MH1-MH5 (9719) in correctional facilities. MH2-5 are considered either actively involved in MH services (3,4,5) or are on our radar (MH2) and MH staff need to be available to provide care. This is, obviously, also the case for all inmates within DOC, but the MH2 population have a clearly identifiable past need, and potentially need services in the future (past predicts future).

MH Service Level	# of individuals	% of population
5	45	.5%
4	480	5%
3	2607	27%
2	3911	40%
1	2675	28%

**Q: Provide the offender to mental health provider ratio.**

A: Per our existing policy psychiatry providers have a maximum expected caseload 1 psychiatry provider to 150 inmate/patients

There are no BHS ratios. Based on acuity, this fluctuates based on the clinical needs of the inmate population. MH4 inmate caseloads are roughly 25-30 for a BHS clinician, while MH3 (GP) can be 60+ based on facility needs, inmate need etc...also, facilities such as Walker, serving the AS/SN population will have lower caseloads because of crisis calls etc...intake facilities also have varying caseload assignments so 2nd shift clinicians can be free to see incoming inmates for intake assessments.

**Q: Who conducts mental health testing for DOC?**

A: If this references psychological testing, only a licensed clinical psychologist (or a trainee under the direct supervision of a licensed psychologist) can conduct psychological testing. If "testing" references assessments in general, all MH clinicians are able to conduct assessments, intake, suicide risk, crisis etc...Psychiatry providers can only provide initial psychiatric evaluations.

**Q: Which facilities do offenders w/ Mental Health issues got to**

A: All facilities, except Brooklyn CI, have inmates with MH needs. GCI, York and MYI are the sole providers of MH4 level services. Most other facilities have at least a couple MH infirmary beds, jails have more infirmary beds as well. MH3 (GP inmates) are seen in all facilities.

MH5 beds exist in:

- o GCI
- o York
- o MYI
- o HCC (4 only)
- o NHCC (4 only)
- o BCCC (8)
- o MWCI (2 only)
- o Corrigan (4 only)

**Q: Who are you discharging mental health inmates to?**

A: If this references community release, we have collaborative relationships with DMHAS, DCF, DDS as well as numerous community not-for-profit agencies who we schedule

appointments for follow up care with. This can occur with direct inmate calls to schedule (for most GP inmates), and through MH discharge planners for GCI and York (previously OCI when MH4 inmates were housed there as well). The MH DC Planners work with state sister agencies, SSA, VA etc...to establish durable discharge plans, and will coordinate with probation and/or parole should post-incarceration supervision be a part of the plan. Housing is also sometimes established for those with severe mental health issues, where the extra supportive housing is needed to insure clinical stability and continuity of care is maintained post-release. Within DOC, any infirmary or MH4 setting can lower a service need score, should that be clinically appropriate, and those inmates would then be moved to the appropriate housing environment (MH5 discharge options to GP or MH4 housing), MH4 can go to GP if their treatment team believe they are no longer in need of that level of care.

**Q: Describe the program where inmates stay in hotels after they're discharged.**

A: CT Coalition to End Homelessness (CCEH) DRHAP (DOC Reentry Housing Assistance Program) provided financial assistance for motel and rental costs, as well as case management services to offenders discharging from prison to the community at end of sentence (EOS) and at-risk of homelessness. CCEH's contract was extended to 1-31-2022. Many challenges arose with DRHAP during the pandemic, including location of housing resources and landlords willing to work with this population which led to extension of motel stays. Subcontractor case managers' compliance with internal agency COVID 19 protocols also reduced the level of in person contact with participants. CAN providers provided additional financial resources for participants that needed further help upon exiting this program. Although, the project has reached its end, CT DOC passionately believes there is a need to continue this work. Changing the scope of the project would be essential and suggests a collaboration with another State Agency such as Connecticut Department of Housing (DOH). A barrier CT DOC encountered this quarter, that was unlike previous quarters was the responsibility of supervising and overseeing the work of our Contracted Provider, CCEH. This created an uncomfortable position for CT DOC as the discharging population is no longer under our jurisdiction.

**Q: Where do discharging offenders go after the hotel is no longer an option?**

A: As stated above, CT Coalition to End Homelessness DRHAP Program not only provided financial assistance for motel and rental costs. They also provided case management services to offenders discharging from prison to the community at end of sentence to transition them into other means of housing. Their case managers worked with The Department of Housing and CCAD to explore other avenues for financial assistance until they secured employment and were able to pay rent themselves.

**Q: Provide the number of people under DOC care in AS or restrictive housing.**

A: There are currently 20 offenders in AS at this time. AS units are located at Walker CI, Corrigan CC and Garner CI.

**Q: Who goes to AS?**

A: Pursuant to agency Administrative Directive 9.2 (Inmate Classification) assignment to Overall Risk Level 5/Administrative Segregation shall be considered when any totality of facts, information or circumstances which indicates an immediate threat to safety and/or security of the public, staff or other inmates. An inmate shall be automatically placed in

Administrative Detention and be reviewed for placement on Overall Risk Level 5/Administrative Segregation, under any of the following conditions:

1. Level 1 assault on a Department of Correction employee as defined in Administrative Directive 6.6, Reporting of Incidents; (*direct intentional assault*)
2. Hostage holding of a Department of Correction Employee;
3. Riot;
4. Homicide while confined;
5. An inmate is sentenced to death; (*Note: this no longer applies as the death penalty has been eliminated*)
6. Escape from the security perimeter of a facility;
7. Continues to present a threat to safety, security and/or orderly operation after one (1) year in Close Custody for Security Risk Groups;
8. Continues to present a threat to safety security and/or orderly operation after six (6) months in Close Custody for Chronic Discipline; and,
9. An inmate is in pretrial or pre-sentence status for a Capital Felony Murder charge. (*Note: this no longer applies due to elimination of death penalty*)

All increases to Overall Risk Level 5/Administrative Segregation shall be made by the Director of Offender Classification and Population Management.

**Q: Provide a commissary markup explanation.**

A: Pursuant to agency Administrative Directive 3.8 most merchandise sold in the commissary is marked up a percentage not to exceed 35 percent (35%). Some items may be marked up at a reduced percentage or sold at cost to increase availability to the inmate population. The mark up is calculated by multiplying the purchase cost of each item by the set percentage or by the appropriate value. Fractions are rounded to the next highest cent level. Sales tax is applied to all taxable items, as determined by the Department of Revenue Services, after the mark-up has been determined. The markup percentage is set by the Commissary in consultation with the Commissioner. The Commissary has held the markup to 30% for most items sold.

The Commissary is not funded through the General Fund. It is self-supporting. Revenues generated by Commissary Sales pay Commissary staff salaries, the salaries of ancillary and support staff (i.e. accountants, procurement support and Inmate Banking staff), working capital (used to procure the goods sold by the Commissary), equipment (such as the trucks used to transport Commissary goods), equipment and premises upkeep and maintenance, the computers and software used to process orders and for and inmate banking.

Excess revenue (revenue that is in excess of the cost of operating the Commissary) is transferred to the Correctional General Welfare fund (which is used to provide the inmate population with goods and services not covered by the agency's operating - General Fund – budget). Any shortfalls in revenue (from reducing the markup or loss of sales) will require subsidy from the General Fund to cover all of the above costs.

**Q: What is the Status of the three ARPA funded projects in the FY22 budget?**

A: For the three ARPA project, no funds have been expended as of yet as the DOC is currently doing its due diligence and developing project plans for the use of the ARPA funds. DOC has submitted project plans and proposed budgets to OPM for their review.

The three projects are as follows:

1. TRUE Unit (FY22 \$500K; FY23 \$500K)
2. WORTH Unit (FY22 \$250K; FY23 \$250K)
3. Vocational Village (FY 22 \$20 million)

**Q: Gate Money**

**A:** Pursuant to Agency Administrative Directive 3.11 (Gate Money):

Gate Money is a predetermined amount of money given to an inmate upon discharge

1. Gate money is an earned privilege and is not be considered an entitlement. Each facility may provide gate money based on the following criteria:
  - a. Any inmate who has completed a minimum of 24 continuous months of sentenced incarceration and is discharged directly to the community without benefit of supervision shall be eligible to receive gate money.
  - b. Gate money shall be given, not mailed, to the inmate by the releasing facility at the time of discharge, except in those instances in which an inmate is discharging from a correctional facility outside of the State of Connecticut. The gate money request shall be forwarded to the Fiscal Services Unit at least 10 business days, but not more than 30 days, prior to an inmate's release. The gate money shall normally be in the form of a check. Each inmate may receive gate money only once during a continuous term of incarceration.
  - c. Disciplinary or security problem inmates may be excluded from receiving gate money at the discretion of the Unit Administrator.
  - d. Gate money distribution shall be based on the inmate's account balance for a minimum of 60 days prior to the inmate's release date, upon which distribution of gate money shall originate as follows:
    - i. Inmates with savings of \$50 or more receive \$0; or
    - ii. Inmates with savings of less than \$50 may receive \$50.
  - e. The maximum amount of gate money issued shall be \$50.

**Q: ID and Discharge Planning**

**A:** Number of Inmates discharging w/out ID – This number is rather difficult for us to track. The Department of Correction considers discharge as an offender's end of sentence date however the Community also identifies those discharging from court as a DOC discharge. With that said, this number is difficult for DOC to track due to the pre-trial population who are often released directly from Court making it extremely challenging for DOC to query this data.

Number of IDs secured annually - Since January 2021 a total number of 4,712 ID's were initiated and secured by The Department of Correction (this includes birth certificates, social security replacement cards, replacement driver's license & non driver ID)

- o Birth Certificates: 1,598
- o Social Security Card: 1,666
- o Driver's License: 356
- o Non Driver ID: 1,092

Number of EOS Annually – For the year end of 2021 there were 4,935 offenders released from a Department of Correction including individuals under the supervision of Parole and Community Services

Discharge Planning Process – Per Directive 9.3, Discharge Planning begins when an offender is first admitted into our Custody. However, our Discharge Planning Checklist shall be initiated by the Records office 60 days prior to each inmate's discharge. The checklist shall be forwarded to the unit counselor for completion. If an offender is identified as homeless, the unit counselor notifies the Reentry Counselor in order for the appropriate services and referrals to be made. Below is a breakdown of the various reentry services that are provided:

- Identification Procurement – Reentry Counselor's run weekly list's to identify those who are eligible or in need of ID procurement. As stated above we are restricted by Memorandums of Understanding and Policy as to when we are able to initiate ID procurement.
  - Birth Certificates can be requested 3 years prior to release.
  - Social Security Cards can be requested 6 months prior to release.
  - New DMV ID's can be requested only when the offender has a birth certificate and social security card and is within 6 months of release this also includes all of our community release mechanisms.
  - Additionally, DL/ID renewals and duplicates can be requested.
- Medical Insurance - Reentry counselors activate / apply for medical insurance on behalf of offenders within 2 months of release. This applies to those with medical and mental health scores of 1 & 2. Our Medical Discharge Planners work with those with a higher need; level's 3 and above.
- Housing – 211 calls are provided to all offenders identified as homeless. Referrals are made to the below community agencies who assist with housing:
  - Hartford Reentry Welcome Center
  - New Haven Project Welcome Home
  - Waterbury Reentry Welcome Center
  - DOMUS Invictus Program
  - OPP – Behind the Walls Program

Additionally, if the offender has Probation to follow, Reentry works closely with Probation to ensure housing referrals are made.

Veteran's – Referrals and connection to services are provided to those who are confirmed and eligible for VA services.

Reentry Counselors participate in monthly Reentry Roundtable Meetings to network and gather resources from the community providers.

The pandemic has severely impacted our community in-reach process and our abilities to offer a warm transitional hand-off.