Addendum C

Appendix: Summary of Data Reviewed Regarding Youthful Offenders Confined at Manson Youth Institution on July 6th, 2016.

After a review of available data OCA concluded that while the DOC staff and administrators have continuously worked to improve and expand programming opportunities for youthful offenders, at the time the review was conducted, youth at MYI did not receive rehabilitative or mental health treatment services commensurate with their needs.

1. Despite the national data regarding the prevalence of mental health disorders among incarcerated youth[1], and the number of youth at MYI with current or historical mental health diagnoses, the majority of youthful offenders were classified as not in need of individual clinical contact. The DOC classifies offenders' mental health treatment needs by Mental Health levels 1-5.[2] All offenders are screened at the time of admission.[3] Though records indicate that 71 of the 74 youth had a current or historical mental health diagnosis, 66% of youth were classified as Mental Health levels 1 and 2 and were not identified as needing regularly scheduled individual clinical contact at the time of the review.[4] Only 3 youth were classified as requiring weekly contact with clinicians. (See addendum). Data provided by the DOC indicates that clinical staffing is extremely limited throughout the facility and that typically, there are only two DOC clinical professionals available 8 a.m. through Midnight for the entire population.

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[1] Research has shown that between 50 and 75 percent of youth in the juvenile justice system meet criteria for a mental health disorder. Rates may be higher for youth who are actually incarcerated. Underwood, L. A., & Washington, A. (2016). Mental Illness and Juvenile Offenders. *International Journal of Environmental Research and Public Health, 13*(2), 228. http://doi.org/10.3390/ijerph13020228https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4772248/

[2] Level 1 is defined by DOC policy to mean that a youth or other offender "has no mental health history or current need and may be characterized as emotionally stable." See DOC Classification Manual, pg. 30, found on the web at:
http://www.ct.gov/doc/lib/doc/PDF/PDFReport/ClassificationManualLibraryCopy.pdf
Level 2 is defined as "history of mental health disorder that is not currently active or needing treatment; or current mild mental health disorder, not requiring treatment by a mental health professional." Id.

[3] Screens are assessing youth for suicidality, medical needs, and other mental health treatment needs. Records regarding a youth's mental health diagnoses and history of treatment is not always available at the time of admission.

[4] Offenders classified as Mental 1 and 2 are not scheduled for regular clinical intervention or treatment, per correspondence from UConn Correctional Managed Health Care, referencing the DOC Mental Health Classification system. Only youth classified as MH3 or higher receive regularly scheduled clinical intervention.

2. Just over half of youth participated in rehabilitative/clinical groups, but the majority of un-sentenced youth did not participate.[5] At the time of OCA's review un-sentenced youth's length of confinement ranged from 4 to 19 months.[6] Rehabilitative/clinical groups include, but are not limited to, a victim-impact course, parenting skills, domestic violence, and stress management. Groups are time-limited and for some youth groups are required prior to their release. Youth may not have continuous access to rehabilitative groups during their confinement.

3. Youth had access to MYI's educational programming, which is offered Monday through Friday, up to 5 hours per day. Though 46% of youth were *not* identified as eligible for special education and related services, OCA concludes that the majority of youth have extensive needs for intensive educational supports, transition and life skills instruction. An in-depth analysis of the educational programming delivered at MYI was not part of this review.

4. The vast majority of youth were not permitted "contact" visits with family, meaning their visits with parents or guardians were conducted through a phone and glass divider. Previous research confirms the importance of meaningful contact with family for incarcerated youth. Family visitation has a "positive impact on incarcerated youth's behavior and school performance," and researchers have recommended that correctional programs implement policies to promote youths' frequent visitation with their families.[7] Though the DOC has worked to increase youth's access to physical time with their families, the majority of youth do not have such privileges. Size of MYI and the number of inmates, as well as the size of the visitation area, further limits youth and families' opportunity for meaningful visitation time.

5. It is important to note that programming for youth can be interrupted in the adult correctional system for a variety of reasons. For example, when there is disruption in another part of the facility, all movement of offenders *across all units* stops. Security measures can last for extended periods of time, impacting youths' access to any kind of programming. The adult nature of the correctional facility carefully regulates and limits the movement of youth throughout the day. All movement in the facility is tightly scheduled,

[5] Reasons for non-participation vary but do include youth refusal.
[6] Data created based on review of individual youth's date of admission.
[7] See Joint Study by the Vera Institute of Justice and the Ohio Department of Youth Services: *The Impact of Family Visitation on Incarcerated Youth's Behavior and School Performance-Findings from the Families as Partners Project*, by Sandra Villalobos Agudelo, April 2013, found on the web: The vast majority of youth were not permitted "contact" visits with family, meaning their only contact with parents or guardians was through a phone and glass divider. Another study of family visitation in a secure juvenile facility for serious adolescent offenders age 14 – 17 showed that youth who received visits from parents reported declines in depressive symptoms compared to youth who did not receive parental visits. Monahan, K., et al, *The Effects of Visitation on Incarcerated Juvenile Offenders: How Contact with the Outside Impacts Adjustment on the Inside*, American Psychology-Law Society (April 2010).

limiting the flexibility of staff and administrators to respond to youth's individual needs for programming, recreation, and other pro-social activities. MYI houses over 500 offenders between the ages of 18 and 21 and the youthful offender units are only small components of this maximum security complex.

The DOC has made many efforts and accommodations over the last several years to try and meet the needs of youthful offenders in the DOC. However, despite the concerted effort of administration and staff, the inherent limitations created by housing youth in an adult correctional system are numerous and difficult to mitigate. The DOC's resources are extremely limited with regard to the provision of individual mental health supports and the provision of pro-social opportunities for youth.

CHART A: Summary: 74 Youth who were incarcerated at MYI on 7/6/16

Town of residence:	84 % of youth were from urban settings (62) 16 % were from suburban settings (12)
Ethnicity:	81% were African American (60) 11 % were Caucasian (8) 8 % were Hispanic (6)
Education:	54 % of the youth were Special Education (40)
Prior Admission to CJTS:	30% of the youth had prior Delinquency Commitments (23) 25 % of the Youth had been at CJTS (18/23)
Past DCF Protective Service Involvement[8]	12 % of the youth had prior Commitments to DCF on the Protective Service Side 89% of the youth had Prior DCF Involvement
Youth who are Un-sentenced	36 Youth are not sentenced
Youth who are Sentenced	38 Youth are Sentenced
MH Classification (see below for description)	17% of youth were designated MH 1 at time of sample(13) 49% of youth were designated MH 2 at time of sample (36) 30% of youth were designated MH 3 at time of sample (22) 4% of youth were designated MH 4 at time of sample (3)
Diagnoses:	51 % Cannabis Abuse (38) 37% Conduct Disorder (28) 31% ADHD (23) 16% Adjustment Disorder (12) 15% ODD (11) 13% PTSD (10) 9% Mood Disorder (7) 14% Other (3 Mild Intellectual;3 Anxiety;3 Impulse Control;1 Dysthymic; 1 Anti-social) (11)
Visiting Status	22 youth at the time of the sample were allowed contact visits 29%

[8] Information obtained from DCF/DOC liaison and cross-checked with DCF database by OCA.

CHART B: Sentenced Youth (38/74) Data from 7/6/16

Mental Health 1 Status[9] (*no clinical needs currently)	Diagnosis [10]	Groups Received[11]	Visitation Status[12] Non-contact visit= phone visit only.	Education[13]	LOS[14]
7 youth	R/O Cannabis Abuse (3); R/O Conduct Disorder (1); Alcohol Use (2); Cocaine Use (1); ADHD (1) 1 youth had no MH diagnosis	Voices (5 youth) Unlock your Thinking (7) Life Skills (2) Anger Management(3) New Direction (3)	6 youth have contact visits **1** youth on Non-Contact Status	**2**/7 Youth special education	1 year-5 years (average 3.2) (1 youth DC 8/16)

Mental Health 2 (*history of MH needs but none currently identified)	Diagnosis	Groups Received	Visitation Status	Education	LOS
22 Youth	ODD (1); Cannabis Use (6); Alcohol Use (2); History of ADHD(5); Conduct Disorder (7); R/O ODD; R/O Conduct (2); Cannabis Abuse (3);Mood Disorder(2); Adjustment Disorder NOS (1); ADHD(2); R/O Adjustment Disorder with Depressed and Anxious Mood(2); Anxiety Disorder(2);Impulse Control DO(1); R/O Disruptive Mood; Intermittent Explosive Disorder(1);	Unlock Your Thinking (11) Anger Management(5) Voices (9) Tier 2 AS(3) New Direction(3) Life Skills(2) SRG Phase 3&4 (2) Wait list for Sex Program (2)* 3 Youth have not participated in any Groups.	3 Youth have contact visits **18** youth on Non-Contact Status	**12**/21 Youth are Special Education	1 year- 4 years (average-2.2 years) (7 Youth DC since 7/2016- I youth returned 9/16

Mental Health 3 (*Out-patient care clinical bi-weekly)	Diagnosis	Groups Received	Visitation Status	Education	LOS
8 Youth	PTSD (2); Complex Developmental Trauma Disorder (1); ADHD (4); Cannabis Abuse (3);Conduct	Unlock Youth Thinking (6) Voices(4) New Direction (2)		**5**/8 Youth Designated	1 year to 20 years (average 1.8 years

[9] Classification information obtained from UConn Correctional Managed Health Care, under contract with DOC.

[10] Diagnosis: Is determined by Mental Health Screening at Intake/ Records Received and Information provided by other Agencies. See Attachment A for Details of Screening tools and MH classification. Diagnoses obtained by OCA from UConn Correctional Managed Health Care.

[11] Groups Received- Attachment A shows all the Groups that can be provided to youth as needed or as part of their sentencing requirements. OCA obtained information from DOC staff/records.

[12] Information obtained from DOC staff/records.

[13] Education- Attachment A is information provided by the DOC as to how school staff obtain information and determine eligibility for special education services.

[14] LOS calculated by OCA after review of youthful offenders' Mittimus records.

	Disorder (3); Adjustment Disorder(2); R/O Mood Disorder(1):Learning Disability(1);Mood Disorder(1)	Tier 2 AS (1) Anger Management (2) Life Skills (1) 1 youth none	All **8/8** Youth on Non-Contact Status	Special education	(W/O 20 year sentence included) 2 Yo's DC

Mental Health 4 (*seen weekly by clinical and most likely on medication)	**Diagnosis**	**Groups Received**	**Visitation Status**	**Education**	**LOS**
1 youth	Impulse Control Disorder (1); Cannabis Use (1); Borderline Traits (1);	Unlock Your Thinking	**1 Non-Contact** Visits	**1** Special Education	3 years
Total: 29 youth identified as having no clinical treatment needs.		**4/38 youth have not participated in any groups**	**28/38 youth are on non-contact visit status.**	**20/38 youth have been identified as eligible for special education.**	1 year is shortest sentence-20 most. **Average 2.4 years**

CHART C: Un-Sentenced Youth (36/74) Data from 7/6/16

Mental Health 1 Status[15] (*no clinical needs currently)	Diagnosis[16]	Groups Received[17]	Visitation Status Non-contact visit= phone visit only.[18]	Education[19]	LOS[20]
7 youth	Cannabis Use (5); Disruptive Impulse Control (2); Conduct Disorder (3): Communication Disorder (1); ODD(1); 2 youth had **no diagnosis**	6/7 youth have **not participated** in any groups. 1 youth is currently in a New Direction	**4/7 of the youth are on Non-contact status**	1/7 youth has been identified by DOC as eligible for special ed.	Range of 5 months to 15 months. (Avg: 8 mos

Mental Health 2 (*history of MH needs but none currently identified)	Diagnosis	Groups Received	Visitation Status	Education	LOS
14 youth	Conduct Disorder(4); R/O Conduct (2); ADHD(4); Cannabis Abuse(5); Cannabis Use (3); Alcohol Abuse(1); ODD (2); Mood Disorder(1); Personality change due to ABI (1); Adjustment Disorder (1); Depressed Mood (1); Bereavement Issues (1)	2/14 youth participated in New Direction 1/14 youth participated in SRG **10/14 Youth have not participated** in any groups	**7/14 youth are on Non- Contact Status**	9/14 Youth have been identified by DOC as eligible for special ed. 1 youth has his HS diploma. **2 Regular Education**	Range of 4 months to 10 months. (Avg. 7 mos.)

[15] Classification information obtained from UConn Correctional Managed Health Care, under contract with DOC.
[16] Diagnosis: Is determined by Mental Health Screening at Intake/ Records Received and Information provided by other Agencies. See Attachment A for Details of Screening tools and mental health classification. Diagnoses obtained from UConn Correctional Managed Health Care.
[17] Groups Received- Attachment A shows all the Groups that can be provided to youth as needed or as part of their sentencing requirements. OCA obtained information from DOC staff/records.
[18] Information obtained from DOC staff/records.
[19] Education- Attachment A contains information provided by DOC staff as to how they obtain information.
[20] LOS obtained by OCA through review of youth admission records.

Mental Health 3 (*Out-patient care clinical bi-weekly)	Diagnosis	Groups Received	Visitation Status	Education	LOS
13 Youth	ADHD (5); Reaction to Severe Stress (1); Cannabis Abuse (8); Conduct Disorder (7); Disruptive Mood Dysregulation (3); Cognitive Limitations (1); PTSD (1); Mild Intellectual Disabilities (1); Other Disruptive Impulse Control Disorder (2); ODD (2); Adjustment Disorder with Mixed disturbance of emotions (3); ADD (1) R/O PTSD (1); Provisional Diagnosis of Depression (1); Adjustment Disorder (3).	1 Youth in New Direction 1 Youth in Voices 1 in SRG **<u>10/13 youth have not participated in any groups</u>**	**11/13 youth are on Non-Contact Status**	8/13 youth have been identified by the DOC as in need of special ed. Services.	Range of 5 months- 19 months. (Avg. 7.5 mos)

Mental Health 4 (*seen weekly by clinical and most likely on medication)	Diagnosis	Groups Received	Visitation Status	Education	LOS
2 Youth	PTSD (2); ADHD (1); Conduct Disorder (1); Dysthymic Disorder (1); Sexual Abuse of Child (1); Anti-Social Traits (1)	Unlock Your Thinking (2) Life Skills (1)	1 youth has contact visits; **1** youth on Non- Contact Status	2 youth identified by DOC as in need of Special Education services.	Range 9-14 months (average 11.5)
Total: 21/36 youth identified as having no clinical treatment needs.		**Total: 26/36 youth have not participated in any groups**	**Total: 23/36 youth are on non-contact visit status.**	**Total: 20/36 youth have been identified as eligible for special education.**	**Range 4 – 19 months.**

ATTACHMENT A

Service Overview at MYI (Compiled by OCA based on information received from DOC staff)

EDUCATION

When a student enters the facility, an individual intake interview is conducted. The school staff member conducting the interview channels each student to the next step in the assessment process. A student with English as a Second Language (ESL) is assessed by an ESL instructor. If it's determined that the student would best benefit from receiving instruction from an ESL teacher, he is placed accordingly. If a student is an emerging reader, he is assessed by an instructor who specializes in lower level learners. We use two standardized tests, the Test of Adult Basic Education (TABE) and the Employability Competency System (ECS). The TABE provides grade level equivalencies in reading, math, language and spelling. These scores help determine a student's strengths and the areas that need to be strengthened. The ECS test helps determine a student's employability strengths. Upon arrival in the individual classrooms, teachers administer their own assessments to determine students' aptitudes. Just this year, we began administering the CMT test and CAPT Science.

If a student is identified as special education, he will receive triennial testing every 3 years. Depending on where the student is in this three year period, he may be tested as part of the PPT process while he is at MYI. The PPT team, in collaboration with a parent or guardian, would determine which assessments would be best suited to determine if a student continues to qualify for special education. Often, academic and cognitive testing is conducted. Behavior rating scales are also often used.

Students under the age of 18 attend school for 5 hours a day, unless a specialized plan has been developed.

A student under the age of 17 may participate in vocational education. Because students attend a full day (5 hours), attendance in a vocational program would take the place of an academic area. Students are also able to explore vocational education to assess interest without being enrolled in a specific vocational program.

USD #1 has an extension curriculum that focuses on life skills related skills. Those modules are Family Education, Transition Skills, HIV/AIDS, Sexual Harassment, and Suicide Prevention. Classroom teachers instruct on the extension curriculum. The school also offers a Parenting Program.

Students have the opportunity to explore the 4 vocational classes we have. Those classes are Culinary Arts, Auto-body Repair, Automotive Technology, and Computer Support Technology.

Educational Staffing

36 Certified Staff, 29 are Certified Teachers. Inclusive in the 39 certified staff are 4 School Psychologists, 2 School Guidance Counselors, 1 Library Media Specialist

Students in general population switch classes receiving instruction in content related subject areas from 7 Certified Academic Teachers, 1 of which is a Physical Education Teacher. Students in the HSD Program receive Library services from a Library Media Specialist. Additionally, we have a transition teacher who works with students who are transitioning back to the community. We have 7 Special Education Teachers, and 4 School Psychologists.

In addition to the 7 special education teachers, we have 4 school psychologists, 2 guidance counselors (one is assigned exclusively to the 17 and under population), 1 transition teacher, and vocational instructors. Speech and Language services are contracted when needed.

Mental Health/Medical (based on information received from DOC staff)

Upon Admission to MYI, each youth will receive a comprehensive mental health assessment which includes a mental status examination, a psychiatric history, a suicide risk assessment, and an evaluation for major mental health disorders including sexual paraphilia's. For juveniles under the age of 18, they will be administered the Massachusetts Youth Screening Instrument-2 (MAYSI-2) with attention to suicide risk. If the individual produces elevated scores, supplemental questions will be administered to further determine level of current suicide risk and further intervention is clinically appropriate. Offenders requiring mental health treatment shall have it initiated or continued at J.R. Manson Youth Institution. The mental health assessment component is responsible for assigning mental health scores and reviewing sex offender scores.

Other Records Available

: HROO1- Intake Screening Form; Detainee Behavior Questionnaire; Court Mittimus; Prior Health Record if admission within past year to MYI(able to access if not on site). DOC may have juvenile detention discharge summary sent within 72 hours. Sometimes records include prior diagnostic information. However, information often cumulative and may not reflect current diagnosis. Depending on timing of admission, client may or may not have been assessed by mental health staff prior to transfer to MYI.

MH Staffing for Entire Facility @ 600 youth under age 21:

MH staff work a 35 hr week.

- 1 x0.6 FTE consulting psychiatrist 0.6 FTE 1 x 0.6 FTE APRN
- 1 X 1.0 Supervising psychologist
- 2 x 1.0 FTE LCSW (Tues- Sat 8a.m. 3 p.m.)
- 1 x 0.6 FTE LPC (Sun – Thurs, 8a-3p) (shift Sun, Mon, and alternating Thursdays)
- 1 x 1.0 mental health nurse (8a-3p M-F) (Vacant- to transfer 10/26)
- 1 x 1.0 FTE LCSW/LPC Sun-Thurs 8a-3P (vacancy position on hold)
- Second shift
- 1x 1.0 FTE LCSW (Mon- Fri 5p.m.- 12a)
- 1 x 1.0 FTE LPC (Sun-Thurs 2:30 p.m.-9:30 p.m.)
- 1 x 1.0 FTE LPC (Tue-Sat 2:30 p.m.-9:30 p.m.)

MH Classification Based on CT DOC:

MH 1 has no history of prior mental health treatment nor current medical needs

MH 2 has a history of prior mental health treatment but does not have any current clinical needs

MH 3 is similar to outpatient level of care; he may or may not be prescribed medication by a psychiatrist or APRN; he will have a primary clinician who will see him typically bi-weekly unless clinically indicated of a different treatment frequency schedule

MH 4 is someone who typically has more severe history of mental health treatment, prior hospitalizations; suicide attempts or self-injury, more frequent mood or psychotic disorder. These individuals are seen weekly by their clinician and are most frequently on prescribed psychotropic medication. If placed on CTQ status, they are monitored twice a day for any potential changes in mental status.

MH 5 is an individual who is currently residing in the infirmary, essentially a skilled nursing setting for mental health monitoring for suicidal ideation, potential self-injury, substance detoxification and withdrawal, psychosis and those at risk of decompensation.

Nursing assesses the inmate upon intake. Vital signs, eye exam, urine collection, and TST administration.

The Physical Exam is done within 30 days of admission, but frequently occurs in the early part of the 30 day window. A Dental evaluation is also conducted. Eye exams depend on the nursing eye exam. If the inmate is 20/20….no exam needed. Attempt to get them scheduled within 2-3 weeks from admission.

GROUPS OFFERRED at MYI

Adjustment Issues

This six session cognitive behavioral therapy is provided over the course of three weeks and is designed to address many of the difficulties young offenders experience when adjusting to incarceration. The program presents a pragmatic approach with an emphasis on development of appropriate coping skills. It includes topics such as "Setting Goals", "Anger Management", "Relationships", and "Exercise & Mental Health". The target populations is predominantly for individuals with first-time or limited incarceration histories. The sessions are about one hour each and are typically given twice a week.

The number of inmates desired in this 3-week group is between 8-15 inmates and their mental health levels can range from 1 to 4. The group has approximately a 90% completion rate and the most common reason for attrition is released from court.

Stress Management

This is an eight week group that meets once a week for an hour. The purpose of this group is to teach the group members what causes stress and the negative effects stress has on their daily lives. The group is CBT based where the group members will be taught various stress management skills and gain a better understanding of how stress affects their thoughts, feelings and behavior. The

group members will learn the importance of time management, mindfulness, exercise, sleep, diet and relaxation in managing their stress.

The number of inmates desired in this 8-week group is between 7-11 inmates and their mental health levels can range from 1 to 4. This group has approximately an 82% completion rate and a waitlist of 8 potential participants between group cycles.

Getting Along and Keeping Cool

An evidenced-based, manual-guided 10- session cognitive behavioral therapeutic intervention designed for adolescents to learn anger management coping skills. This program was designed based upon research regarding what works for Anger Management. Programs. This 10-week program includes skill building, cognitive techniques, relaxation techniques and role play. The youth specific version was developed in regards to the principles of youth specific programming for male youthful offenders. In addition, an assessment tool to ensure program fidelity audits this program. The number of inmates desired in this 10-week group is between 6-8 inmates and their mental health levels can range from 1 to 4.

Start Now

An evidence-informed, manual-guided skills training program for offenders with behavioral disorders. It is a 32 session integrative skills training model which incorporates theoretical aspects from cognitive-behavioral therapy, dialectical behavioral therapy, motivational interviewing, gender-specific while incorporating trauma-informed and neurocognitive rehabilitative principles into the design The four primary treatment units focus on: 1) My Foundation: Starting with Me; Unit 2: My Emotions: Dealing With Upset Feelings; Unit 3: My Relationships: Connecting With Others; and Unit 4: Setting and Meeting My Goals.

The number of inmates desired in this 32-week group is between 6-12 inmates and their mental health levels can range from 1 to 4, but is geared toward inmates with higher acuity. The group can be scheduled to occur either once a week or twice a week depending both on space availability and coverage needs. At present there is a group which remains pending with 7 participants and 4 individuals on the waitlist.

Trauma Recovery

We are in the process of adapting the trauma empowerment model to young men. This manualized, evidenced-based model is supported by SAMHSA'S Evidence-based programs and practices at www.nrepp.samhsa.gov and has been used with adult men, women, and teen- aged girls. However, the intervention was never adapted to young men. With input from some of the original authors, we are working toward adapting the curricula to this population in an effort to pilot the material with a sample of incarcerated youth The Trauma Empowerment Model is a psychoeducational and skills oriented group divided into four parts: Empowerment, Trauma Recovery, Advanced Trauma Recovery Issues, and Closing Rituals.

Mood Disorder

Mood Disorder Group is an 8 week program meeting one a week for an hour at a time. Mood disorder group provides psychoeducation to inmates regarding the symptoms and causes of Mood Disorders as well as the importance of effective self-care. Inmates explore the role of emotions and self-esteem on depression as well as effective coping skills using Cognitive Behavioral Therapy and Dialectical Behavioral Therapy approaches. In addition, participants are given homework assignments and interactive activities during group to practice the new skills. Inmates are also educated about how to access effective mental health care when they transition to the community.

Anger Management**:** 10-week program includes skill building, cognitive techniques, relaxation techniques and role play. In addition, an assessment tool to ensure program fidelity audits this program. This program can be modified for special populations.

Unlock Your Thinking**:** This 4 session program is designed as a brief intervention for those offenders who are serving short periods of incarceration. Participants are encouraged to think about how they know the difference what they are feeling and thinking, and how feeling based distortions can get in the way of productive communications. Participants are introduced to common thinking patterns that lead to frustration, distortion and avoidance of personal responsibility.

Life Skills/ A New Freedom**:** This program is offered to the youth population at MYI and York. A New Freedom is a 24 hour curriculum specific to juvenile offenders that will discuss educational subject matter in nutrition and better hygiene, managing money as well as social/behavioral subjects such as criminal values, friends and peers, use of leisure time and how to connect to your community. The program will explore anger management skill building and stress management while teaching coping skills to the participants.

VOICES: 15 session program. Victim Offender Institutional Correctional Educational Services. This program is designed to use volunteer support to broaden inmates' understanding and sensitivity to the impact of their crime on others.

Sex Treatment Program: 36 session program. The Sex Treatment Program is a specialized program for inmates who have committed a sexual assault. The program is provided by mental health staff with specialized training in the treatment of sex offenders. The overall goal of the program is to decrease sexual violence. The program teaches inmates about the nature of sexual assault, helping them develop an individualized relapse prevention strategy for themselves, helping them improve the quality of normal interpersonal relationships, helping them better manage their anger, and helping them develop victim empathy.

A New Direction: An Addiction Services program to meet the needs of the sentenced and un-sentenced offenders
at the direct admission facilities. Addiction Services units shall offer a short-term drug and Alcohol education program using the evidenced based Cognitive-Behavioral Treatment Curriculum "A New Direction" by Hazelden. This curriculum addresses criminal and addictive Thinking based on real life experiences of incarcerated addicts.

Youth Specific Facility Based Domestic Violence Program: This group is designed for inmates who have committed a domestic violence offense.
Successful completion of this program is a requirement for those inmates who enter into the Department's community-based transitional supervision program for domestic violence offenders. The youth specific version was developed in regards to the principles of youth specific Programming for male youthful offenders.

Other Programs offered:

Fresh Start Youth Mentoring Program (Bridgeport) (12 sessions):

Family Re-entry program offers a comprehensive re-entry program to help individuals and their families make a successful transition from incarceration into the community. A re-entry plan is designed with each individual 3 months before the scheduled release date.

Who qualifies?
Bridgeport area residents with 3 to 6 months to discharge, firm parole or Transitional Supervision date. Family Re-entry coordinates youthful offender mentoring programs for young men and women aged 14-18. Services offered: Individual and family therapy, specialized domestic violence offender programs, substance abuse recovery counseling, life skills programs, parenting education, anger management, Fathers Helping Fathers groups, connections to service providers for housing, employment and job skills development, health care and financial aid and legal assistance.

Inside / Outside Dad (10 sessions):

This program teaches parenting skills and is facilitated by staff from the Families in Crisis agency. The program addresses issues of manhood, spirituality, anger, emotions, communication, relationships, parenting and discipline. The group meets weekly for twelve weeks.

Thresholds (16 sessions)

This is a community-based therapeutic counseling system specifically designed for delivery by Trained volunteers. It focuses on developing decision-making and problems-solving skills.

Tutoring

Yale students come in on the weekends to help tutor the young men with their GED studies.

Youthful Offender Mentoring Program
A contract agency, Family Re-Entry, Inc., conducts this program. Mentoring is a positive and supportive relationship with a responsible and dependable adult volunteer. Mentors are committed and caring individuals who assist inmates and their family with transition back to the community.