Connecticut Sentencing Commission

Mental Health Disorders in Connecticut's Incarcerated Population

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Alex Tsarkov, J.D.
Executive Director
Connecticut Sentencing Commission

Reena Kapoor, M.D.
Associate Professor of Psychiatry
Yale School of Medicine

Viviana Alvarez-Toro, M.D.
Psychiatrist and Associate Program Director
Saint Elizabeth's Hospital

Patricia O'Rourke, PhD
Research Associate
Connecticut Sentencing Commission

Connecticut Sentencing Commission
University of Connecticut
Hartford Campus, Room 550
10 Prospect Street
Hartford, CT 06103
ctsentencingcommission.org

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EXECUTIVE SUMMARY

In 2019, Senator Catherine Osten requested the Connecticut Sentencing Commission undertake a study on mental health in the state's incarcerated population. In 2020, the Commission published an initial memorandum on the Department of Correction's (DOC) mental health care need classification system. This study serves as a continuation of that research.

On January 7, 2022, the DOC exported mental health diagnoses from its electronic medical record (EMR) and merged these diagnostic data with information from its administrative database. A team of psychiatrists then sorted the diagnoses in the resulting database into categories based on the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Revision* (DSM-5-TR), the standard authority for psychiatric diagnoses.

Sentencing Commission researchers then analyzed this dataset. The Commission analyzed DOC mental health care need classifications and substance abuse treatment need classifications, along with specific mental health diagnoses, demographics, and sentence length information. This report details the findings of these analyses.

Mental Health Care Need Classifications (DOC MH Scores)

- 32% of the incarcerated population was classified as having an active mental health disorder requiring treatment (MH-3 or higher).
- An additional 41% of the population was classified as having a history of mental health disorders not requiring active treatment (MH-2).
- The percentage of women with active mental health disorders requiring treatment (81%) was significantly higher than that for men (28%).
- The rate of active mental health disorders varied significantly across racial groups: Native American (53%), White (41%), Asian (35%), Hispanic (30%), and Black (26%).[1]
- The rate of active mental health disorders was significantly higher in the unsentenced population (39.7%) than in the sentenced population (25.8%).
- This rate of active mental health disorders was higher than average for individuals under 26 years old (37.6%).[2]

[1] At the time of the study, there were 36 Native American and 40 Asian individuals in the incarcerated population. Accordingly, the percentages for these groups reflect a relatively small number of observed cases.

[2] 97% (1,239 individuals) of the under 26 subgroup was between the ages of 18 and 25. 3% (41 individuals) of this subgroup was individuals between the ages of 15 and 17.

Mental Health Disorder Diagnostic Categories

- The table below summarizes the six most common mental health diagnostic categories observed in the incarcerated population.
- Mood disorder diagnoses were the most common diagnostic category, affecting 24% of the incarcerated population. This rate is higher than the rate of diagnosed mood disorders for the general U.S. population, which is around 9.7%.[3]
- The rate of psychotic disorders, 8%, was also higher than the reported prevalence for the general U.S. population rate, which is less than 1%.[4]
- Individuals with psychotic disorders had particularly high treatment needs, with 43% classified as having "severe" or "crisis-level" disorders (MH-4 or 5).

Diagnostic Category	# of Individuals	% of Population
Mood Disorders	2,241	23.62
Posttraumatic Stress Disorders (PTSD)	1,200	12.65
Personality Disorders	893	9.41
Psychotic Disorders	760	8.01
Anxiety Disorders	729	7.68
Adjustment and Acute Stress Disorders	704	7.42

Substance Abuse Treatment Need Classifications (DOC T Scores) [5]

- 89% of the incarcerated population was classified as having a history of or current substance abuse problem (T-2 or higher).
    - 15% had a slight history of substance abuse, with a recommendation for voluntary recovery support services (T-2).
    - 34% had a moderate substance abuse problem requiring treatment (T-3)
    - 40% of the population had a serious or an extremely serious substance abuse problem requiring residential or intensive outpatient treatment (T-4 and 5).
- The prevalence of substance abuse problems requiring treatment (T-3 or higher) was significantly higher for women (84.4%) than for men (73%).
- This rate varied across racial groups and was higher for White individuals (78.5%) than for Black (73%), Hispanic (71%), Native American (67%) and Asian individuals (60%).
- This rate was also higher for individuals aged 26 to 55 (77.7%).

[3] *Any Mood Disorder*, National Institute of Mental Health (last visited Dec. 15, 2022). https://www.nimh.nih.gov/health/statistics/any-mood-disorder

[4] *Schizophrenia*, National Institute of Mental Health (last visited Dec. 15, 2022). https://www.nimh.nih.gov/health/statistics/schizophrenia

[5] For the purposes of this study, substance use disorder was not considered a mental health disorder.

Mental Health Care Need and Substance Abuse Classifications

- Individuals classified as having substance abuse problems requiring treatment were significantly more likely to be classified as requiring mental health treatment.
- 95.5% of the incarcerated population had at least one or more of:
  - (1) a history of mental health disorders,
  - (2) an active mental health disorder requiring treatment,
  - (3) a history of substance abuse, or
  - (4) an active substance abuse problem requiring treatment.
- 80.8% of the incarcerated population had either an **active** mental health disorder requiring treatment or an **active** substance abuse disorder requiring treatment.
  - 24.5% of the population had both.

Mental Health & Sentence Length[6]

- Individuals diagnosed with mood, anxiety, or posttraumatic stress disorders had shorter-than-average sentences compared to the overall sentenced population.
  - These individuals were also less likely to be serving a 60+ year sentence.
- Individuals with personality or adjustment/acute stress disorder diagnoses were serving longer-than-average sentences
- There were no significant differences in sentence length for individuals with psychosis compared to overall sentenced population.
- Individuals with higher mental health care needs (MH-3, 4, and 5) were generally serving shorter sentences than those with lower mental health care needs (MH-1 and 2).

Future Research

- The General Assembly has appropriated up to $500,000 to conduct further research on mental health in the criminal justice system.
- The Commission intends to use this funding to produce a more comprehensive study in order to:
  - Further explore the findings and questions prompted by the current study and the work that started in the 2020 project.
  - Expand the study's focus to include probation, parole, and youths convicted as adults.
  - Include a study of diversion, pretrial outcomes, sentencing, and early release.
  - Incorporate qualitative analyses.
  - Solicit input from community stakeholders.
  - Link data systems across agencies and assess possible improvements to data collection and reporting.
  - Incorporate the framework of the National Judicial Task Force to Examine State Courts' Response to Mental Illness.
- It is important to note that the associations identified in this report do not imply causation. Future research will need to explore the overlapping social determinants of

[6] As is the case with all the statistics in this report, these figures are descriptive findings and do not control for other relevant variables, such as the convicted offenses or the individual's prior criminal history.

mental illness and criminal justice system involvement so as to understand more accurately and fully the associations identified in this report and their common antecedent pathways.

I. INTRODUCTION AND BACKGROUND

In 2019, the Connecticut Sentencing Commission received a request from State Senator Catherine Osten to study various aspects of mental health in Connecticut's incarcerated population. Specifically, Senator Osten requested the Commission study the prevalence of mental health disorders in the state's incarcerated population, trends in sentencing and early release of persons with mental health disorders, and the utilization of reentry programming by these individuals.

In response, the Commission formed a subcommittee to explore issues surrounding mental health in the incarcerated population. In 2020, the subcommittee published a memorandum addressing the first of Senator Osten's three research topics. The memorandum analyzed the mental health needs of the incarcerated population using the Department of Correction's (DOC) classification system. The memorandum, available online,[7] found that over 28% of the incarcerated population had a mental health disorder requiring active treatment. An additional 40% were classified as having a history of mental health disorders that did not require active treatment.

Since publishing the 2020 memorandum, the Commission has worked with the DOC to obtain diagnostic data on specific mental health disorders in the incarcerated population. While the onset of the COVID-19 pandemic, staffing changes, and data access issues produced delays, the Commission received diagnosis data in early 2022.

This study serves as the Commission's first analysis of these diagnostic data. It aims to help policymakers better understand the prevalence of mental health disorders in the state's incarcerated population. In looking at specific diagnoses, demographics, controlling offenses, and sentence length, the Commission seeks to provide helpful background as policymakers consider ways to serve incarcerated individuals with mental health needs.

Section II provides an overview of the relevant literature on mental health in carceral settings. Section III describes the data used for this study. Section IV presents the results of Commission's analysis. Section V concludes and outlines future research.

[7] Michael Chase et al., *Memorandum on Mental Health Care Need Classifications in Connecticut's Incarcerated Population*, Connecticut Sentencing Commission (June 24, 2020). https://ctsentencingcommission.org/wp-content/uploads/2020/09/Mental-Health-Memo1.pdf

II. LITERATURE REVIEW

With evolving views on mental health, treatment for individuals with mental illness has also changed. In the 1940s and 50s, a movement began to deinstitutionalize individuals with mental illness from psychiatric hospitals into community settings. However, deinstitutionalization encountered challenges, as community services were not adequately funded or implemented. Some individuals with mental illness found their way into other settings, such as shelters, supervised housing, or correctional facilities.[8] Due to a great increase in incarcerated individuals with mental illness, correctional facilities have been referred to as the "new asylums," and incarcerated individuals with serious mental illness now exceed those in state psychiatric hospitals tenfold.[9] At the same time, researchers have called for a more rigorous analysis of the relationship between deinstitutionalization and the overrepresentation of individuals with mental illness in jails and prisons. These researchers have emphasized that effective policy and practice solutions require a nuanced and data-driven understanding of mental illness in carceral settings, and caution against oversimplified narratives.[10]

In the general U.S. population, 5% of adults have serious mental illness and 20% experience any mental illness.[11] By contrast, data shows that 15-20% of the incarcerated population in the U.S. has serious mental illness, while almost half have a history of any mental illness.[12] However, other sources estimate that these rates might be much higher. For example, according to a more recent study by the National Judicial Task Force to Examine State Courts' Response to Mental Illness, approximately 70% of people involved in the criminal justice system have a mental health disorder.[13] Common diagnoses among state and federal incarcerated individuals are major depressive disorder, bipolar disorder, post-traumatic stress disorder, anxiety disorders, personality disorders, and psychotic disorders.[14] Individuals with substance use disorders also account for a significant percentage of the incarcerated population. According to the National Institute on Drug Abuse, 85% of the incarcerated population have an active

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[8] Ashley Primeau et al., *Deinstitutionalization of the Mentally Ill: Evidence for Transinstitutionalization from Psychiatric Hospitals to Penal Institutions*, 2 COMPREHENSIVE PSYCHOLOGY (2013).

[9] E. Fuller Torrey et al. *The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey,* Treatment Advocacy Center (April 8, 2014). https://www.treatmentadvocacycenter.org/storage/documents/treatment-behind-bars/treatment-behind-bars.pdf

[10] Seth J. Prins, *Does Transinstitutionalization Explain The Overrepresentation Of People With Serious Mental Illnesses In The Criminal Justice System?* 47(6) COMMUNITY MENTAL HEALTH (2011).

[11] *Mental Health by the Numbers,* National Alliance on Mental Illness (last visited Dec. 15, 2022). https://www.nami.org/mhstats

[12] *Serious Mental Illness Prevalence in Jails and Prisons,* Treatment Advocacy Center (September 2016). https://www.treatmentadvocacycenter.org/storage/documents/backgrounders/smi-in-jails-and-prisons.pdf

[13] *Findings and Recommendations of the National Judicial Task Force to Examine State Courts' Response to Mental Illness* (July 27, 2022). https://www.ncsc.org/__data/assets/pdf_file/0027/80847/Findings-and-Recommendations.pdf

[14] Laura M. Maruschak, *Indicators of Mental Health Problems Reported by Prisoners: Survey of Prison Inmates*, U.S. Department of Justice Office of Justice Programs Bureau of Justice Statistics (June 2021). https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/imhprpspi16st.pdf

substance use disorder or were convicted for drug related crimes.[15] These data highlight the marked overrepresentation of mental illness in correctional facilities and how U.S. jails and prisons have become *de facto* mental health institutions. However, according to the National Alliance on Mental Illness, approximately 63% of individuals with psychiatric illnesses do not receive mental health treatment while in prisons and 55% do not receive treatment in jails.[16] Thus, psychiatric services in correctional facilities are lacking, leaving many without the necessary treatment.

It is important to note that these data do not demonstrate causation. The demographics do not imply that people are involved in the criminal justice system because of mental illness. Research demonstrates that in only 7% of people with mental illness who are arrested are symptoms of their illness directly related to the criminal activity.[17] Most people who experience mental illness are arrested for the same reasons as people who do not experience mental illness.[18] And most people living with mental illness are not violent and are not arrested. The risk factors for mental illness and criminal justice involvement largely overlap, with social determinants contributing substantially to both outcomes.[19] The frameworks of syndemics,[20] the analysis of biosocial connection in health and social research, clinical care, and prevention; and intersectionality,[21] interaction of multiple social categories/status on individual experience, are important to an understanding of the root causes of these convergent and co-occurring outcomes, which warrants further attention and research to appreciate productive avenues for public policy.

The prevalence of mental illness in jails and prisons varies by demographic. According to a U.S. Department of Justice Special Report, the frequency of serious psychological distress and history of mental illness was higher in women than in men.[22] In addition, serious psychological distress and a history of mental illness were least common in incarcerated individuals 65 and

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[15] *Criminal Justice DrugFacts,* National Institute on Drug Abuse (June 1, 2020). https://nida.nih.gov/download/23025/criminal-justice-drugfacts.pdf?v=25dde14276b2fa252318f2c573407966

[16] *Mental Health by the Numbers,* National Alliance on Mental Illness (last visited Dec. 15, 2022). https://www.nami.org/mhstats

[17] Peterson J. et al., *Comparing the Offense Patterns of Offenders With and Without Mental Disorders: Exploring the Criminalization Hypothesis*. 61 PSYCHIATR SERV (2010).

[18] Peterson J. et al., *Comparing the Offense Patterns of Offenders With and Without Mental Disorders: Exploring the Criminalization Hypothesis*. 61 PSYCHIATR SERV (2010); Skeem J.L. et al. *Correctional Policy for Offenders with Mental Illness: Creating a New Paradigm for Recidivism*. 35 LAW AND HUMAN BEHAVIOR (2011); Peterson J.K. et al., *How Often and How Consistently do Symptoms Directly Precede Criminal Behavior Among Offenders With Mental Illness?* (38) 5 LAW HUMAN BEHAVIOR (2014).

[19] Rotter M. et al. Criminal Legal Involvement: *A Cause and Consequence of Social Determinants of Health*. 73(1) PSYCHIATR SERV (2022); Ashekun O. et al. *Adverse Childhood Experiences and Arrest Rates Among Individuals With Serious Mental Illnesses*. J AM ACAD PSYCHIATRY LAW. (In press, 2023).

[20] Singer M. et al. *Syndemics and the Biosocial Conception of Health*. 389 LANCET (2017).

[21] Bowleg L. The Problem With the Phrase *Women and Minorities:* Intersectionality – an important Theoretical Framework for Public Health. 102 (7) AM J PUB HEALTH, (2012).

[22] Jennifer Bronson et al., *Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-12,* U.S. Department of Justice Office of Justice Programs Bureau of Justice Statistics (June 2017). https://bjs.ojp.gov/content/pub/pdf/imhprpji1112.pdf

older.[23] When taking race into consideration, White individuals in jails and prisons were more likely to display serious psychological distress or have a history of mental illness than their Black and Hispanic counterparts.[24] However, it is important to note that historically, racial and ethnic biases have led to the underdiagnosis of people of color.[25] There are also cultural differences in sharing symptoms of mental illness and seeking treatment that are further compounded by historically negative experiences interacting with the healthcare system.[26] As reported by the U.S. Department of Justice (DOJ), people of color are less likely to be identified as having a mental illness and to receive treatment for mental illness while incarcerated.[27]

Some associations also exist between mental illness and type of crime. Incarcerated individuals who serve time for violent and property crimes are more likely to exhibit serious psychological distress or have a history of a mental health disorder than those serving time for drug offenses, driving under the influence, or other public order violations.[28] However, according to the DOJ Report, there were no significant correlations between sentence length and history of mental illness.[29] In contrast, criminal recidivism was closely linked to history of a mental health disorder.[30] This may occur due an individual's difficulty adjusting to life in the community after confinement, especially considering that those leaving incarceration face a higher risk of mental health decompensation.[31] Similarly, after release, substance use and mental illness can contribute to higher rates of recidivism, returning this same population to the correctional setting.[32]

Researchers have attempted to understand the effects of incarceration on individuals with mental illness and, similarly, the effect of having so many individuals with mental illness involved in the correctional system. One aspect that has garnered attention is length of stay. Do individuals with mental illness spend longer periods of time in pretrial detention? Recent data from other jurisdictions suggests they do. For example, on average, incarcerated individuals at the Florida Orange County Jail stay for 26 days, while those with mental illness stay for 51

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[23] *Id.*

[24] *Id.*

[25] Lonnie R. Snowden, *Bias in Mental Health Assessment and Intervention: Theory and Evidence,* 93(2) AMERICAN JOURNAL OF PUBLIC HEALTH (2003).

[26] *Racial/Ethnic Differences in Mental Health Service Use among Adults*, Substance Abuse and Mental Health Services Administration (February 2015).
https://www.samhsa.gov/data/sites/default/files/MHServicesUseAmongAdults/MHServicesUseAmongAdults.pdf

[27] Jennifer Bronson et al., *Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-12,* U.S. Department of Justice Office of Justice Programs Bureau of Justice Statistics (June 2017).
https://bjs.ojp.gov/content/pub/pdf/imhprpji1112.pdf

[28] *Id.*

[29] *Id.*

[30] *Criminal Justice DrugFacts,* National Institute on Drug Abuse (June 1, 2020).
https://nida.nih.gov/download/23025/criminal-justice-drugfacts.pdf?v=25dde14276b2fa252318f2c573407966

[31] *Findings and Recommendations of the National Judicial Task Force to Examine State Courts' Response to Mental Illness* (July 27, 2022).
https://www.ncsc.org/__data/assets/pdf_file/0027/80847/Findings-and-Recommendations.pdf

[32] Kristen M. Zgoba et al., *Criminal Recidivism in Inmates with Mental Illness and Substance Use Disorders,* 48 (2) JOURNAL OF THE AMERICAN ACADEMY OF PSYCHIATRY AND THE LAW (2022).

days.[33] Similarly, incarcerated individuals at Rikers Island in New York stay on average for 42 days, while those with mental illness stay for an average of 215 days.[34] Studies have identified various factors that may contribute to this disparity in incarceration length of stay. For example, incarcerated individuals with mental illness might have difficulty understanding or following rules in correctional settings, leading to disciplinary infractions or additional criminal charges that lengthen an individual's incarceration. For example, in 2011-2012, 4.1% of incarcerated individuals with no indicators of mental health problems were written up or charged for assault, while this number was 14.2% for those exhibiting serious psychological distress.[35]

In addition, individuals with mental illness often have their competency to stand trial questioned. This may prolong their detainment while awaiting psychiatric treatment and competency restoration. In some cases, individuals with mental illness stay in custody during the competency determination process for longer than they would have if convicted of the crime.[36]

Overall, research regarding mental illness and incarceration is limited, so many questions remain regarding the diagnoses and treatment needs of incarcerated individuals. The current study aims to fill this knowledge gap, particularly about individuals incarcerated in Connecticut.

III. DATA

On January 7, 2022, the DOC exported International Classification of Diseases (ICD) codes and diagnosis descriptions for all mental health disorders recorded in its electronic medical record (EMR) system. The DOC then assigned identifiers to the data, anonymized the records, and paired the dataset with its administrative database. The resulting dataset contained information on each individual's demographics, sentence, controlling offense, mental health care need and substance abuse treatment need classifications, and mental disorder diagnoses. These data were accurate at the time of the query. The resulting dataset contained information about 9,489 incarcerated individuals. The dataset contained 15,552 mental health diagnoses text fields for 5,352 individuals; the remaining 4,165 individuals did not have diagnoses.

A team of psychiatrists analyzed each unique diagnosis entry in the dataset and sorted the diagnosis into one of seventeen categories. These categories correspond to chapters in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (DSM-5-TR), the standard authority for psychiatric nosology. Sixteen of these categories are used in the

[33] Laura M. Maruschak, *Indicators of Mental Health Problems Reported by Prisoners: Survey of Prison Inmates*, U.S. Department of Justice Office of Justice Programs Bureau of Justice Statistics (June 2021). https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/imhprpspi16st.pdf

[34] *Id.*

[35] *Findings and Recommendations of the National Judicial Task Force to Examine State Courts' Response to Mental Illness* (July 27, 2022). https://www.ncsc.org/__data/assets/pdf_file/0027/80847/Findings-and-Recommendations.pdf

[36] *Findings and Recommendations of the National Judicial Task Force to Examine State Courts' Response to Mental Illness* (July 27, 2022). https://www.ncsc.org/__data/assets/pdf_file/0027/80847/Findings-and-Recommendations.pdf

analysis below: Psychotic Disorders, Mood Disorders, Anxiety Disorders, Posttraumatic Stress Disorders (PTSD), Cognitive Disorders, Neurodevelopmental Disorders, Personality Disorders, Sexual Disorders, Adjustment and Acute Stress Disorders, Gender Dysphoria, Grief/Bereavement, Impulse Control Disorders, Attention-Deficit/Hyperactivity Disorders (ADHD), Eating Disorders, Somatoform Disorders, and Obsessive-Compulsive Disorders.[37] Certain diagnoses were further assigned a subcategory. The coded dataset contained 15,552 categorized mental health diagnoses. Appendix C describes each diagnostic category.

Diagnostic data were then aggregated at the individual level. Consequently, for each individual in the dataset, there were sixteen indicator variables, one for each diagnostic category. Each of these sixteen variables indicated whether an individual had at least one diagnoses in the given diagnostic category.

[37] Some diagnoses were categorized in a seventeenth category, substance use disorders. Because the DOC treats substance use disorders through its Addiction Services Unit, rather than its Health Services unit, this report addresses substance use needs separately in section IV.E.

IV. ANALYSIS

This section analyzes mental health care need classifications, substance abuse treatment need classifications, demographic data, and offense and sentencing information. Because of the numerous factors that affect mental health, substance abuse, and sentence length, the statistics in the following section are descriptive in nature. These analyses do not endeavor to make broader generalizations about incarceration and mental health disorders, nor do they attempt to draw causal conclusions. Any comparisons across different diagnoses or demographics are not "all else equal" analyses. To the extent regression is used, it seeks to describe differences in the data without speculating about cause-and-effect mechanisms. More information on the regression techniques used to measure statistical significance is available in Appendix D.

A. MENTAL HEALTH CARE NEED CLASSIFICATIONS

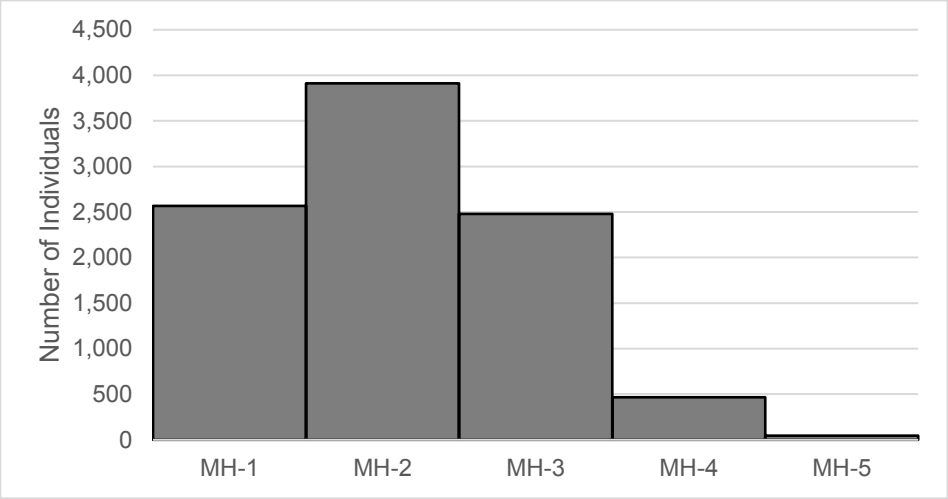
As the Commission described in its 2020 memorandum, the DOC uses a five-point scale ("MH Scores") to classify individuals based on their mental health care treatment needs. This scale is reproduced in Appendix A.

Table 1 and Figure 1a below report the distribution of MH scores in Connecticut's incarcerated population as of January 7, 2022.

Table 1 – Distribution of MH Scores

Classification	# of Persons	Percent
MH-1	2,566	27.10
MH-2	3,912	41.32
MH-3	2,478	26.17
MH-4	468	4.94
MH-5	44	0.46
Total	**9,468**	**100.00**

Figure 1a – Distribution of MH Scores



2,990 persons were classified as MH-3 or higher. This corresponds to 31.58% of the incarcerated population having some mental health disorder requiring active treatment. This reflects a three-point increase from when the Commission last studied mental health in 2020 (see Figure 1b below).

468 individuals were classified as having a severe mental health disorder (MH-4), and 44 were classified as having a crisis-level disorder (MH-5). Both figures reflect increases from 2020.

41.32% of the incarcerated population was classified as having a reported history of a mental health disorder but not requiring active treatment (MH-2). Lastly, 27.10% were classified as having no history of mental health disorders (MH-1).

Figure 1b – MH Score Distributions, 2020 and 2022

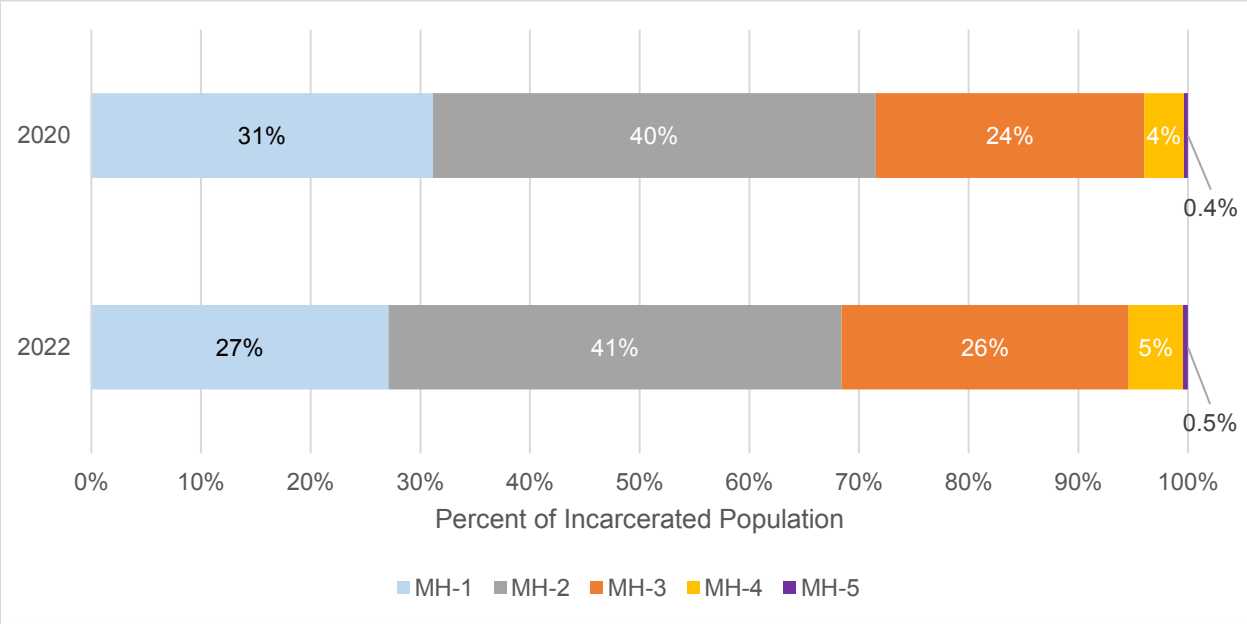


Table 2 and Figure 2 below present the distribution of MH scores by gender. On average, women were classified as having higher mental health care needs than men. Over 80% of women were classified as having a mental health disorder requiring active treatment (MH-3 or higher), compared to 28% of men. This difference is statistically significant.

Table 2 – Distribution of MH Scores by Gender

Classification	Female	Male
MH-1	22	2,544
MH-2	94	3,818
MH-3+	484	2,506
Total	**600**	**8,868**

Figure 2 – Distribution of MH Scores by Gender

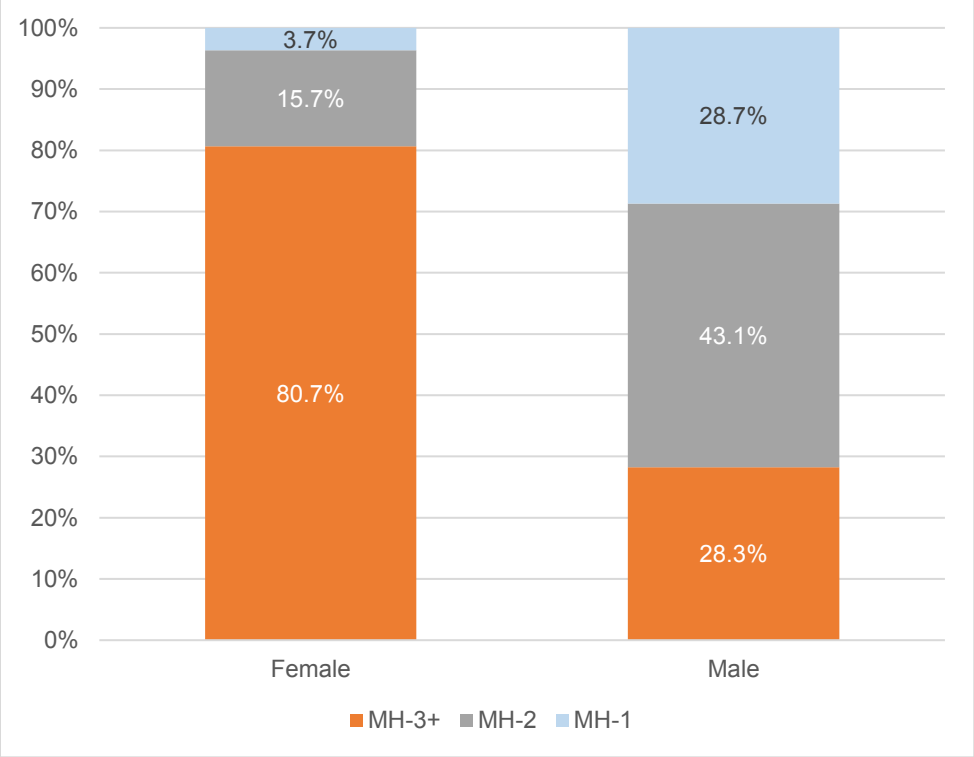


Table 3 and Figure 3 below present the distribution of MH scores by race. There was statistically significant variation in mental health scores across different races. As a group, Native Americans were classified as having the highest mental health care need. 53% of the incarcerated Native American subpopulation was classified as having a mental health disorder

requiring active treatment (MH-3 or higher), though, given the small size of this subpopulation (36 individuals), this statistic should be interpreted cautiously. White individuals had the next highest prevalence of identified mental health disorders requiring treatment (41%), followed by Asian individuals (35%), Hispanic individuals (30%), and Black individuals (26%).

Table 3 – Distribution of MH Scores by Race

Classification	Native Amr.	Asian	Black	Hispanic	White
MH-1	6	7	1,410	715	428
MH-2	11	19	1,605	1,144	1,133
MH-3+	19	14	1,076	800	1,081
Total	**36**	**40**	**4,091**	**2,659**	**2,642**

Figure 3 – Distribution of MH Scores by Race

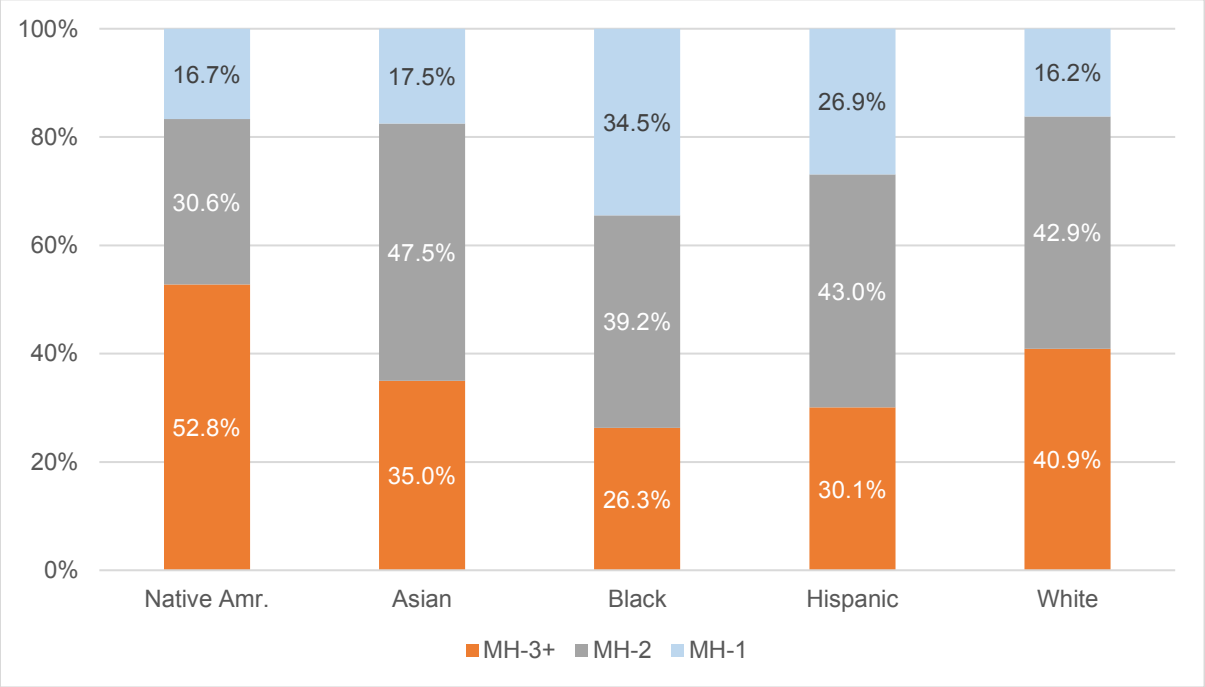


Table 4 and Figure 4 below present the distribution of mental health care need scores by legal status. There were statistically significant differences in the distribution of mental health needs scores across different statuses. Overall, the unsentenced population had a significantly higher rate of mental health disorders requiring treatment (39.7%) than the sentenced population (25.8%). The "Other" population consists of special parole remandees and individuals in DOC custody serving sentences imposed by other jurisdictions. In this "Other" population, 34.4% had MH scores of 3 or higher.

Table 4 – Distribution of MH Scores by Status

Classification	Other	Sentenced	Unsentenced
MH-1	66	1,560	940
MH-2	81	2,481	1,350
MH-3+	77	1,408	1,505
Total	**224**	**5,449**	**3,795**

Figure 4 – Distribution of MH Scores by Status

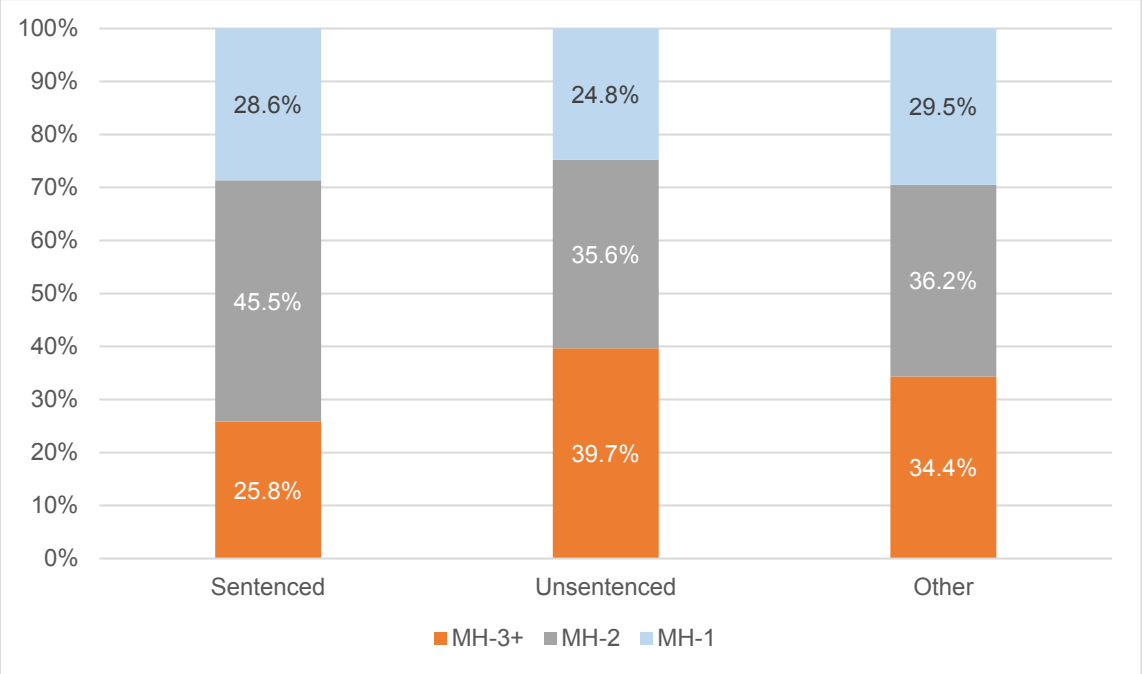


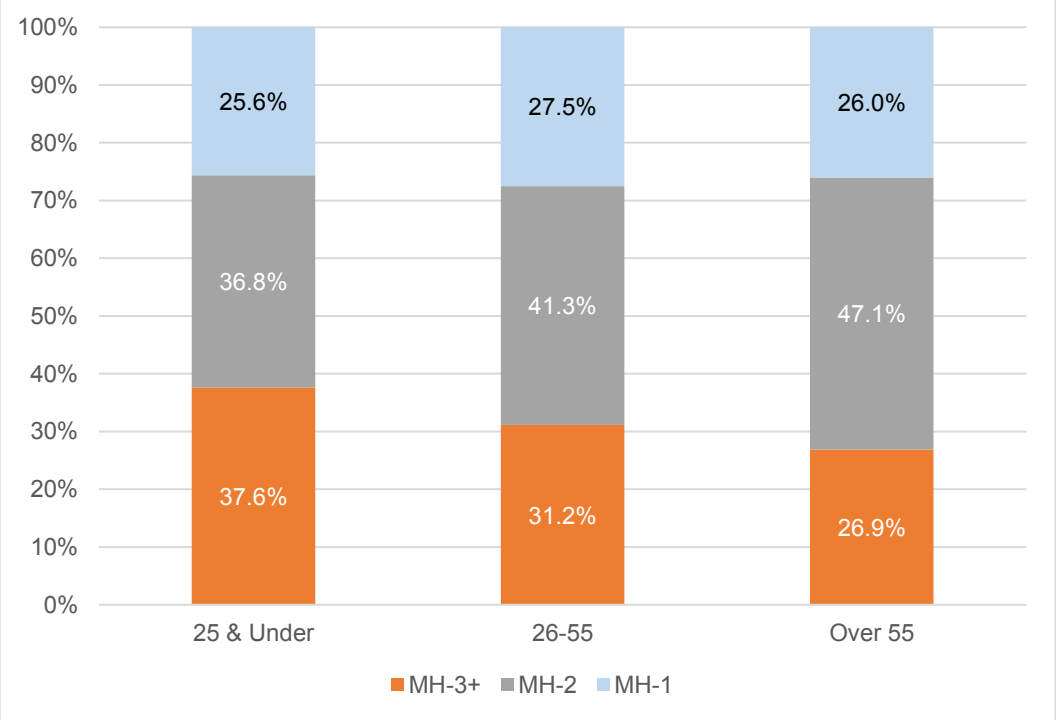
Table 5 and Figure 5 below present the distribution of mental health care need scores by age group. There was significant variation across different age groups. In particular, the youngest age bracket (under 26 years old) had a significantly higher percentage of individuals with MH scores of 3 or higher compared to the middle bracket; the oldest bracket had significantly fewer.[38]

[38] There were 1,280 individuals under the age of 26 in the data set. Of this group, 1,239 were between 18 and 25. This is 97% of the incarcerated population under 26, and 13% of the overall incarcerated population.
41 individuals were between 15 and 17 years old. This is 3% of the incarcerated population under 26, and 0.4% of the overall incarcerated population.

Table 5 – Distribution of MH Scores by Age

MH Score	Under 26	26-55	Over 55
MH-1	327	1,976	263
MH-2	469	2,967	476
MH-3+	480	2,238	272
Total	**1,276**	**7,181**	**1,011**

Figure 5 – Distribution of MH Scores by Age



B. Mental Disorder Diagnostic Categories

Table 6a below tabulates the prevalence of various mental health disorders, grouped into the sixteen diagnostic categories described in Appendix C. Because individuals may have multiple diagnoses, these categories are not mutually exclusive. A given individual may be represented in multiple rows in Table 6a.

Table 6a – Mental Health Diagnostic Categories

Diagnostic Category	Number of Individuals	Percent of Population
Psychotic Disorders	760	8.01
Mood Disorders	2,241	23.62
Anxiety Disorders	729	7.68
Posttraumatic Stress Disorders (PTSD)	1,200	12.65
Cognitive Disorders	147	1.55
Neurodevelopmental Disorders	124	1.31
Personality Disorders	893	9.41
Sexual Disorders	70	0.74
Adjustment and Acute Stress Disorders	704	7.42
Gender Dysphoria	38	0.40
Grief/Bereavement	97	1.02
Impulse Control Disorders	159	1.68
Attention Deficit/Hyperactivity Disorders	304	3.20
Eating Disorders	15	0.16
Somatoform Disorders	12	0.13
Obsessive-Compulsive Disorders	34	0.36

Psychotic disorders, mood disorders, anxiety disorders, posttraumatic stress disorders (PTSD), personality disorders, and adjustment and acute stress disorders were the six most frequently observed diagnostic categories in the incarcerated population. These six diagnostic categories will receive primary focus for the remainder of this study. Of these six categories, mood disorders were the most common, with nearly 1 in 4 members of the incarcerated populations receiving a mood disorder diagnosis.

Many individuals' medical records contained more detailed descriptions of their mental health disorder beyond the high-level categories enumerated above. Tables 6b through 6f below tabulate diagnostic subcategories within each category. Note that because individuals can receive multiple diagnoses within the same diagnostic category, percentages may sum to more than 100%.

Table 6b – Diagnostic Subcategories for Psychotic Disorders

Subcategory	Number of Persons	Percent of those with psychosis
Primary (Schizophrenia, Schizoaffective, Delusional, Brief)	615	80.92
Substance-Induced	41	5.39
Unspecified Psychosis or Psychosis Not Otherwise Specified (NOS)	209	27.50

Of the 760 individuals diagnosed with psychotic disorder, 81% were diagnosed with primary psychoses, such as schizophrenia or schizoaffective disorder. Smaller numbers were diagnosed with substance-induced psychoses or "not otherwise specified" (NOS) psychoses.

Table 6c – Diagnostic Subcategories for Mood Disorders

Subcategory	Number of Persons	Percent of those with mood d/o
Major Depressive Disorder	514	22.94
Other depressive disorders (including dysthymia, depressive disorder NOS, and unspecified)	830	37.04
Bipolar Disorder (I or II)	625	27.89
Substance-Induced Mood Disorder	147	6.56
Unspecified Mood Disorder or Mood Disorder NOS	532	23.74

Of the 2,241 individuals diagnosed with mood disorder, 23% were diagnosed with major depression, 37% with other forms of depression, and 28% with bipolar disorder. 7% were diagnosed with substance-induced mood disorder, and 24% were diagnosed with unspecified mood disorder.

Table 6d – Diagnostic Subcategories for Cognitive Disorders

Subcategory	Number of Persons	Percent of those with cognitive d/o
Traumatic Brain Injury	112	76.19
Major Neurocognitive Disorder (Dementia)	16	10.88

Of the 147 individuals diagnosed with a cognitive disorder, 76% were diagnosed with traumatic brain injury, and 11% were diagnosed with a major neurocognitive disorder (commonly called dementia).

Table 6e – Diagnostic Subcategories for Neurodevelopmental Disorders

Subcategory	Number of Persons	Percent of those with neurodevelopmental d/o
Intellectual Developmental Disorder	90	72.58
Autism-Spectrum Disorder	39	31.45

Of the 124 individuals diagnosed with neurodevelopmental disorder, 73% were diagnosed with intellectual developmental disorder (IDD), and 32% with autism spectrum disorder.

Table 6f – Diagnostic Subcategories for Personality Disorders

Subcategory	Number of Persons	Percent of those with personality d/o
Antisocial Personality Disorder	417	46.70
All others, including unspecified or NOS	553	61.93

Of the 893 individuals diagnosed with personality disorder, 47% were diagnosed with antisocial personality disorder. Other personality disorders included borderline, narcissistic, histrionic, dependent, obsessive-compulsive, schizoid, schizotypal, avoidant, and paranoid.

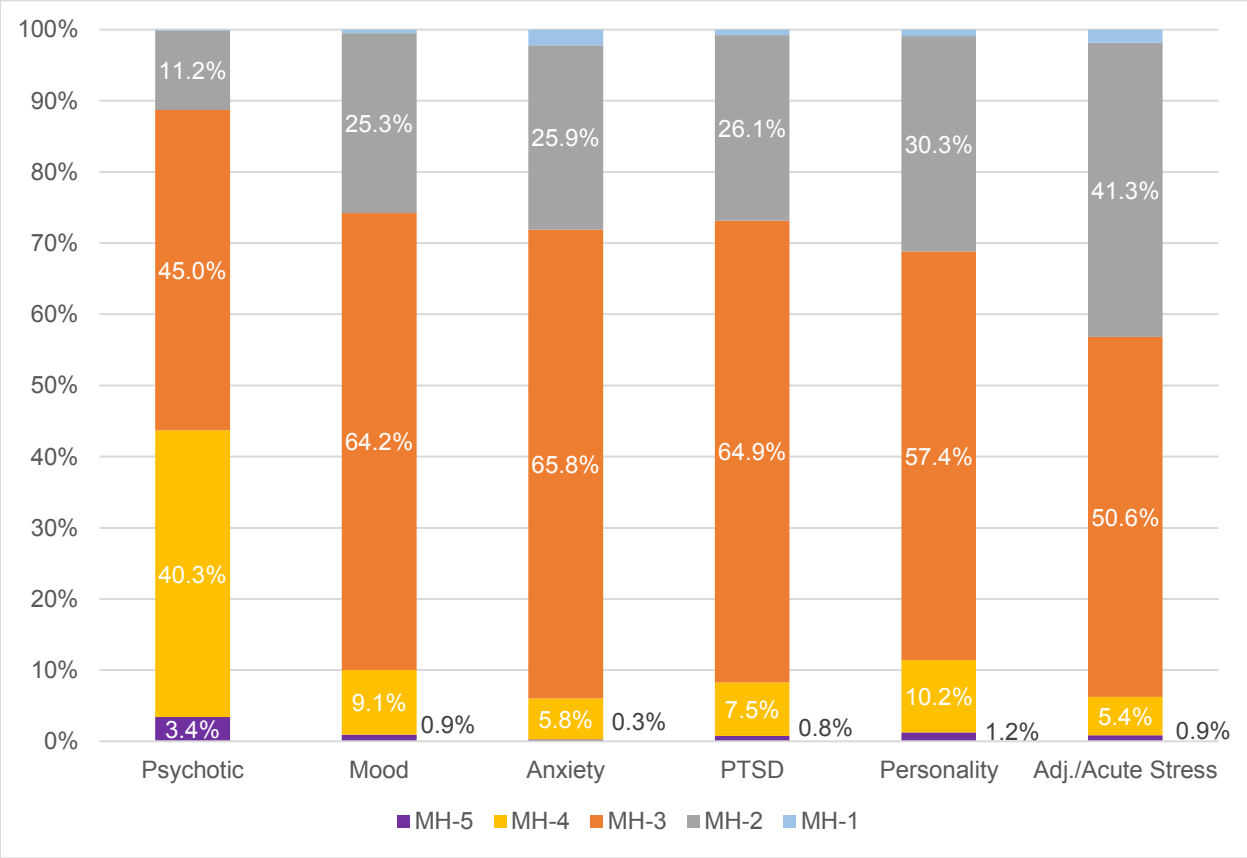
C. Interaction Between MH Score and Diagnostic Categories

Table 7a and Figure 7 below present the interactions between mental healthcare scores and diagnostic categories.

Table 7a – Distribution of MH Scores within Diagnostic Categories

Diagnostic Category	MH-1	MH-2	MH-3	MH-4	MH-5
Psychotic Disorders	1	85	342	306	26
Mood Disorders	11	567	1,439	203	21
Anxiety Disorders	16	189	480	42	2
PTSD	9	313	779	90	9
Personality Disorders	8	270	512	91	11
Adjustment and Acute Stress Disorders	13	291	356	38	6

Figure 7 – MH Scores, By Diagnostic Category



Individuals with psychosis had the highest mental healthcare needs. Over 43% of these individuals had MH scores of 4 or 5. Individuals with adjustment/acute stress or anxiety disorders had the lowest classified treatment needs of these six diagnostic categories. Fewer than 6% of these individuals had MH scores above 3. It is unclear why some of these individuals carry MH-1 classifications, as any individual with a mental disorder diagnosis should be classified as MH-2 at the lowest (see Appendix A).

Offering a slightly different perspective, Table 7b below presents the prevalence of these six diagnostic categories in the population of individuals whom the DOC has identified as having the highest mental health treatment needs, those with MH-4 or MH-5 classifications. The most common diagnostic category in the MH-4 and MH-5 population was psychotic disorders. Nearly 65% of MH-4- and MH-5-classified individuals had psychosis disorder diagnoses.

Table 7b – MH-4+ Scores by Diagnostic Category

Diagnostic Category	% of MH-4 and MH-5 population
Psychotic Disorders	64.8
Mood Disorders	43.7
Anxiety Disorders	8.6
PTSD	19.3
Personality Disorders	19.9
Adjustment and Acute Stress Disorders	8.6

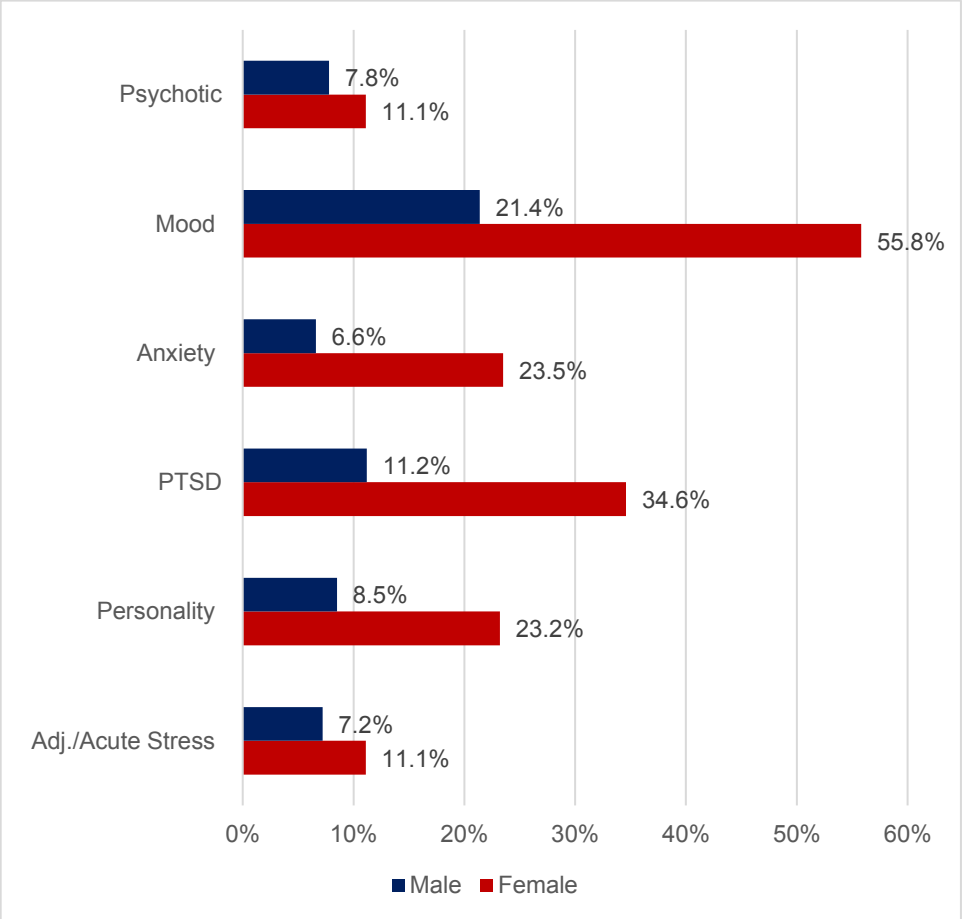
D. Demographic Trends for Common Mental Disorder Diagnostic Categories

Table 8 and Figure 8 below present data on the prevalence of the six most common mental health diagnostic categories by gender.

Table 8 – Gender Composition of Diagnosis Categories

Diagnostic Category	Female	Male
Psychotic Disorders	67	693
Mood Disorders	337	1,904
Anxiety Disorders	142	587
PTSD	209	991
Personality Disorders	140	753
Adjustment and Acute Stress Disorders	67	637

Figure 8 – Gender Composition of Diagnosis Categories



The prevalence of all six diagnostic categories were significantly higher for women than for men. This disparity was particularly large for mood disorders (34.4%-point differential), PTSD (23.4%-point differential), anxiety disorders (16.9%-point differential), and personality disorders (14.7%-point differential). These differences were all statistically significant. The gender gap was smaller for psychotic and adjustment/acute stress disorders, but still statistically significant.

Table 9 and Figure 9 below provide the interactions between individuals' mental disorder diagnostic category and their race.

Table 9 – Racial Composition of Diagnostic Categories

Diagnostic Category	Native Amr.	Asian	Black	Hispanic	White	Total
Psychotic Disorders	3	8	386	195	168	760
Mood Disorders	12	7	702	648	872	2,241
Anxiety Disorders	4	7	203	182	333	729
PTSD	6	5	440	365	384	1,200
Personality Disorders	10	2	346	226	309	893
Adjustment and Acute Stress Disorders	3	4	275	212	210	704

There was statistically significant variation across race for five of the six diagnostic categories. There was no significant racial variation in the prevalence of adjustment and acute stress disorders.

Native American individuals had higher rates of mood disorders and personality disorders compared to other racial groups. By contrast, Native Americans had comparatively low rates of ADHD. This atypicality is likely a function of the relatively small number of incarcerated Native Americans (36 individuals) and should be interpreted cautiously.

Asian individuals had a higher rate of psychotic disorders, over double that of other racial groups. Asian individuals also experienced higher rates of anxiety disorders. As was the case with Native American individuals, these higher rates could be a function of the particularly small number (40) of Asian individuals in the incarcerated population.

White individuals had particularly higher rates of mood disorders and anxiety disorders, while Black individuals had comparatively lower levels of mental health disorders generally. Hispanic individuals typically had a slightly higher prevalence of mental health diagnoses compared to Black individuals, though, with a few exceptions, Hispanic individuals had a lower prevalence of mental health disorders than Whites.

Figure 9 – Prevalence of Diagnostic Category by Race

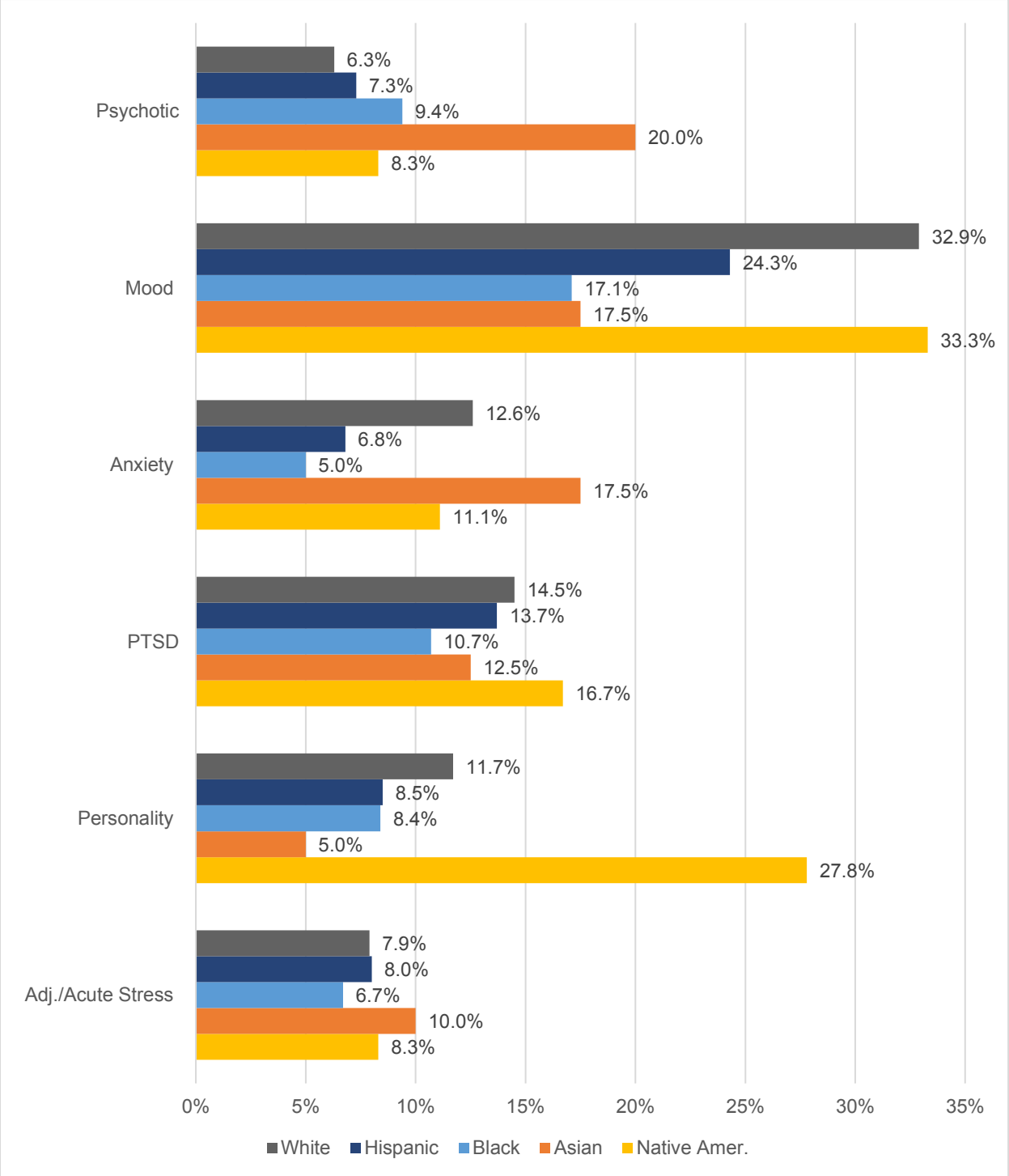
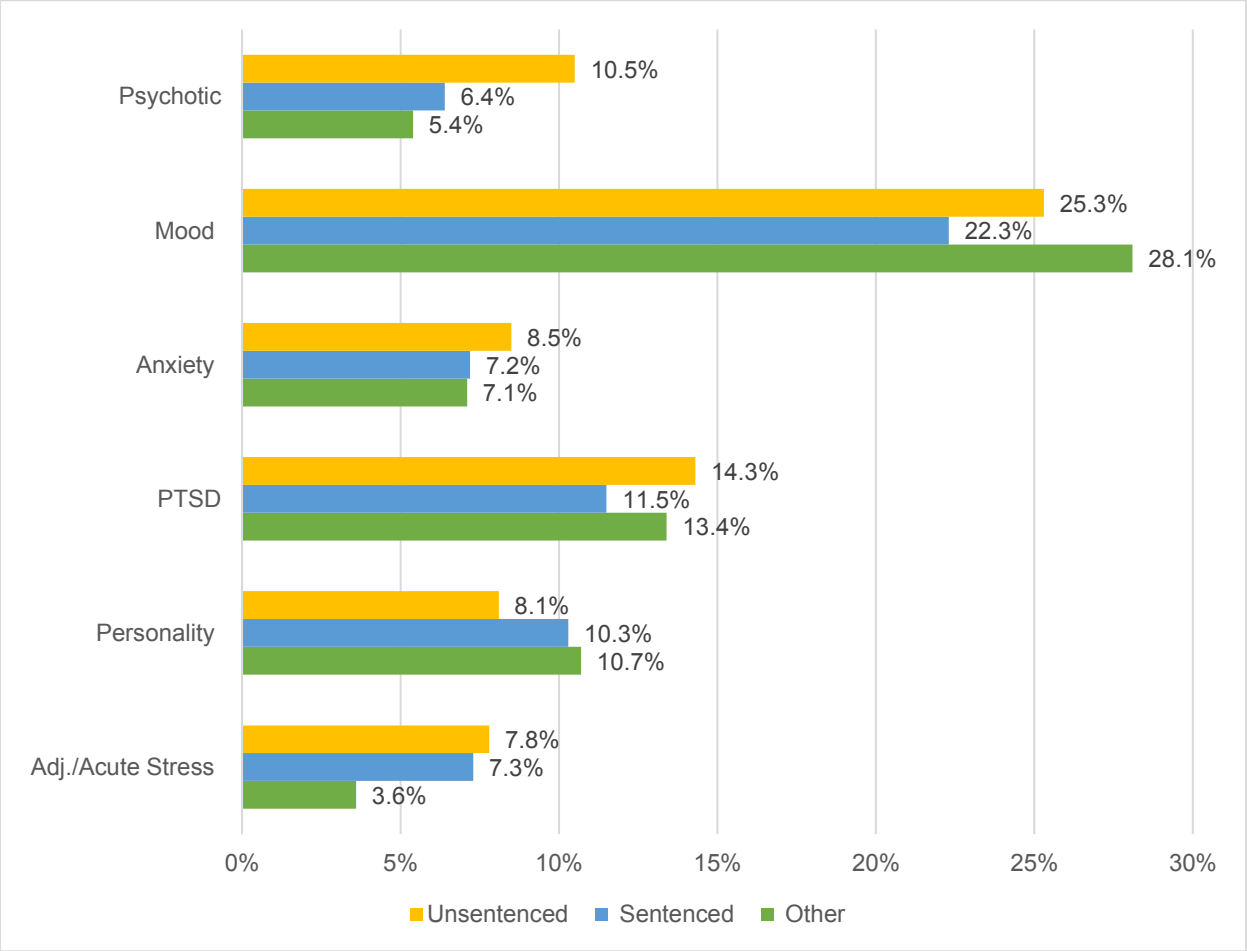


Table 10 and Figure 10 below provide the interactions among individuals' mental diagnostic category and their legal status.

Table 10 – Legal Status within each Diagnostic Categories

Diagnostic Category	Other	Sentenced	Unsentenced	Total
Psychotic Disorders	12	349	399	760
Mood Disorders	63	1,215	963	2,241
Anxiety Disorders	16	391	322	729
PTSD	30	627	543	1,200
Personality Disorders	24	562	307	893
Adjustment and Acute Stress Disorders	8	400	296	704

Figure 10 – Prevalence of Diagnostic Categories by Status



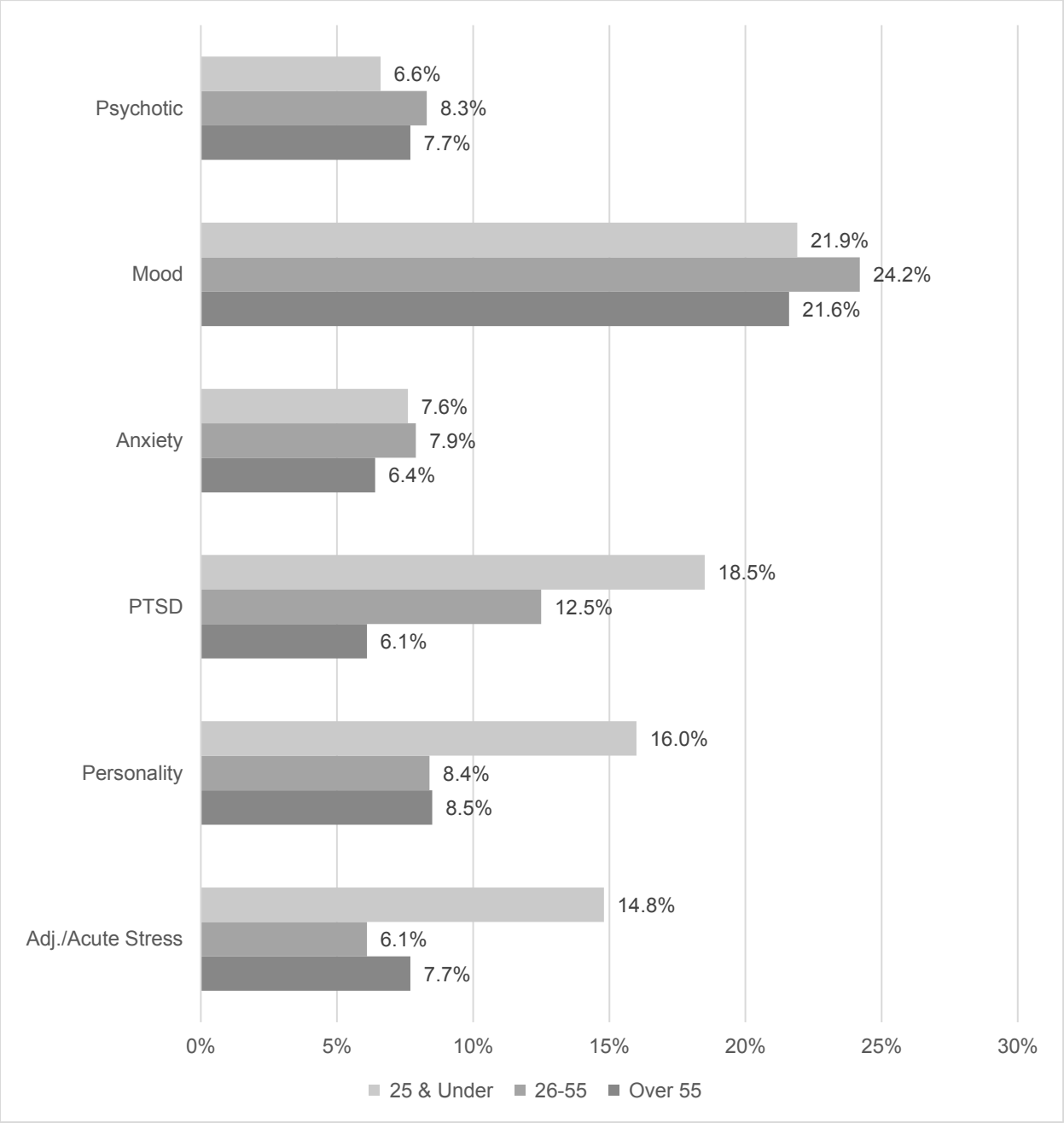
Unsentenced individuals had a significantly higher incidence of psychotic, mood, anxiety, and posttraumatic stress disorders than sentenced individuals. By contrast, unsentenced individuals were significantly less likely to be diagnosed with a personality disorder. There were no statistically significant differences in the rate of adjustment and acute stress disorders between sentenced and unsentenced individuals, but the prevalence of this diagnostic category was significantly lower for the "Other" population.

Table 11 and Figure 11 below detail the interactions between mental disorder diagnostic category and individuals' age brackets. Individuals under age 26 had a significantly higher prevalence of PTSD, personality disorders, and adjustment and acute stress disorders. Individuals in the 26-55 age bracket had significantly higher rates of psychosis.

Table 11 – Diagnostic Categories by Age

Diagnostic Category	Under 26	26-55	Over 55	Total
Psychotic Disorders	85	597	78	760
Mood Disorders	280	1,742	219	2,241
Anxiety Disorders	97	567	65	729
PTSD	237	901	62	1,200
Personality Disorders	205	602	86	893
Adjustment and Acute Stress Disorders	189	437	78	704

Figure 11 – Prevalence of Diagnostic Categories by Age



E. Substance Abuse Treatment Needs

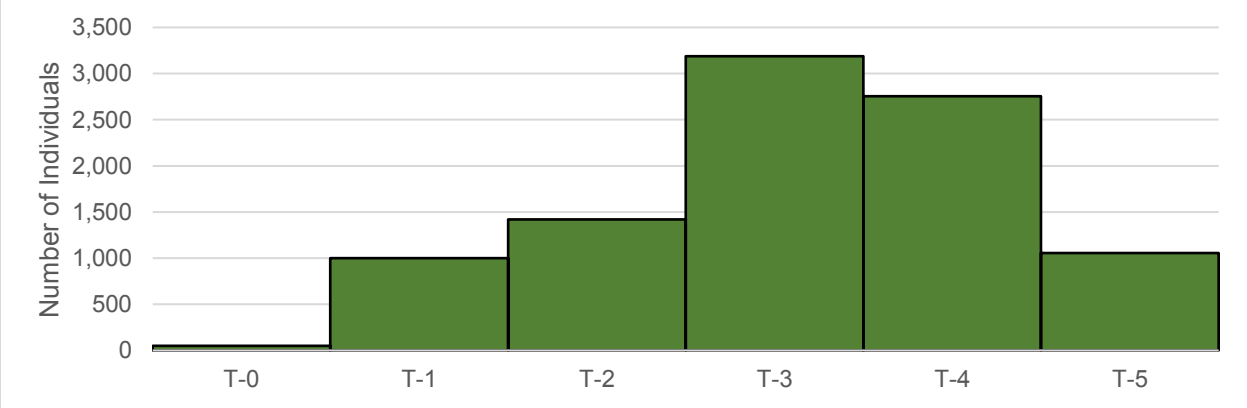
Separate from its mental healthcare services, the DOC also administers addiction treatment services to individuals with substance use disorders. Substance use disorder treatment is not reflected in the DOC's MH score, but rather in a separate "Substance Abuse Treatment Need Classification" (T score).[39] A summary of this scale is provided in Appendix B.

Table 12 and Figure 12 below report the distribution of T scores in Connecticut's incarcerated population as of January 7, 2022.

Table 12 – Distribution of T Scores

Classification	# of Persons	Percent
T-0	50	0.53
T-1	1,000	10.56
T-2	1,421	15.01
T-3	3,187	33.66
T-4	2,755	29.10
T-5	1,054	11.13
Total	**9,467**	**100.00**

Table 12 – Distribution of T Scores



[39] AMERICAN PSYCHIATRIC ASSOCIATION, *THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS,* 5th ed. DSM–5 (2013). While the DSM-5-TR uses the term "substance use disorder" to describe addiction, DOC uses the DSM-IV's "substance abuse." Because this report uses DOC classification data, the latter term is used in this report.

6,996 individuals were classified as T-3 or higher, corresponding to 73.89% of the incarcerated population having some substance abuse problem requiring active treatment. Of these, 2,755 individuals were classified as having a "serious" substance abuse problem (T-4), and 1,054 were classified as having an "extremely serious" problem (T-5).

15.01% of the incarcerated population was classified as having a "slight substance abuse history," (T-2) while 10.56% were classified as having no substance abuse problem (T-1). 50 individuals were pending a T-score classification (T-0).

Table 13 and Figure 13 below present the distribution of substance abuse treatment need scores broken down by gender. On average, women were classified as having higher substance abuse treatment needs than men. Over 84% of women were classified as having a substance abuse disorder requiring active treatment (T-3 or higher), compared to 73% of men. This difference is statistically significant.

Table 13 – Distribution of T Scores by Gender

Classification	Female	Male
T-0	6	44
T-1	42	958
T-2	46	1,375
T-3+	507	6,489
Total	**601**	**8,866**

Figure 13 – Distribution of T Scores by Gender

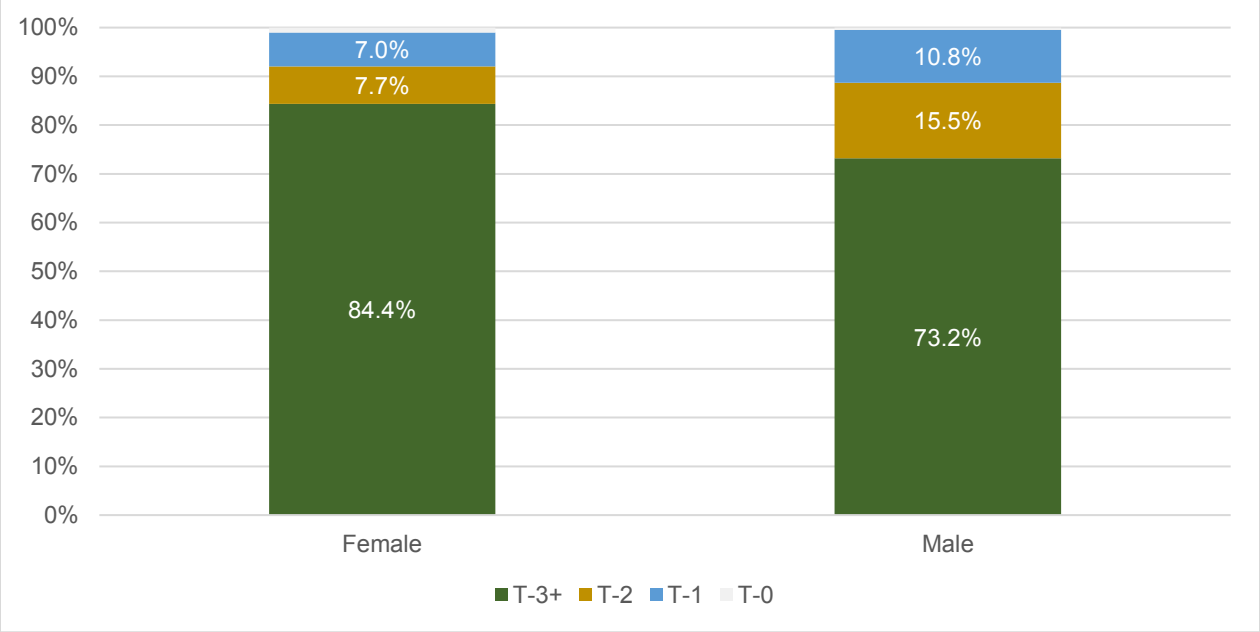


Table 14 and Figure 14 below present the distribution of T scores by race. There was statistically significant variation in substance abuse treatment need scores among racial groups. As a group, Whites were classified as having the highest substance abuse treatment need. 78% of the incarcerated White subpopulation was classified as having a substance abuse problem requiring treatment (T-3 or higher). Black individuals had the next highest prevalence of addiction requiring treatment (73%), followed by Hispanic individuals (71%), Native American individuals (67%), and Asian individuals (60%).

Table 14 – Distribution of T Scores by Race

Classification	Native Amr.	Asian	Black	Hispanic	White
T-0	0	0	15	17	18
T-1	6	7	425	323	239
T-2	6	9	673	421	312
T-3+	24	24	2,979	1,896	2,073
Total	**36**	**40**	**4,092**	**2,657**	**2,642**

Figure 14 – T Scores by Race

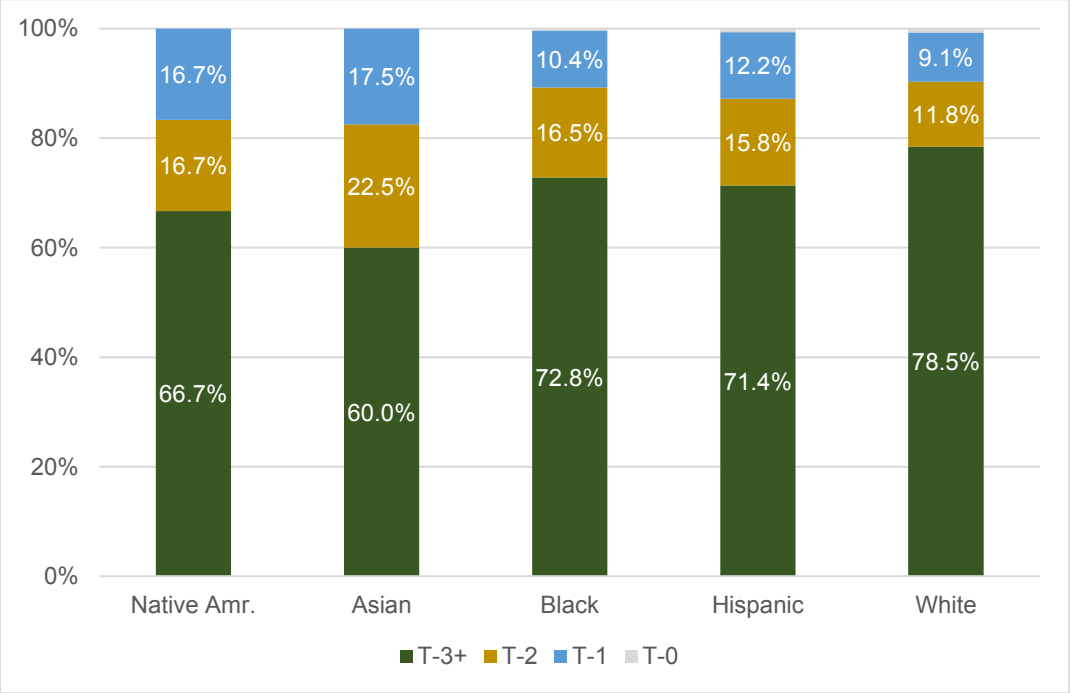


Table 15 and Figure 15 below present the distribution of substance abuse treatment need scores by legal status. There was no significant variation in the percentage of individuals with T scores of 3 or higher from one status subpopulation to the next.

Table 15 – Distribution of T Scores by Status

T Score	Other	Sentenced	Unsentenced
T-0	3	11	36
T-1	20	580	400
T-2	29	853	539
T-3+	172	4,005	2,819
Total	**224**	**5,449**	**3,794**

Figure 15 – T Scores by Status

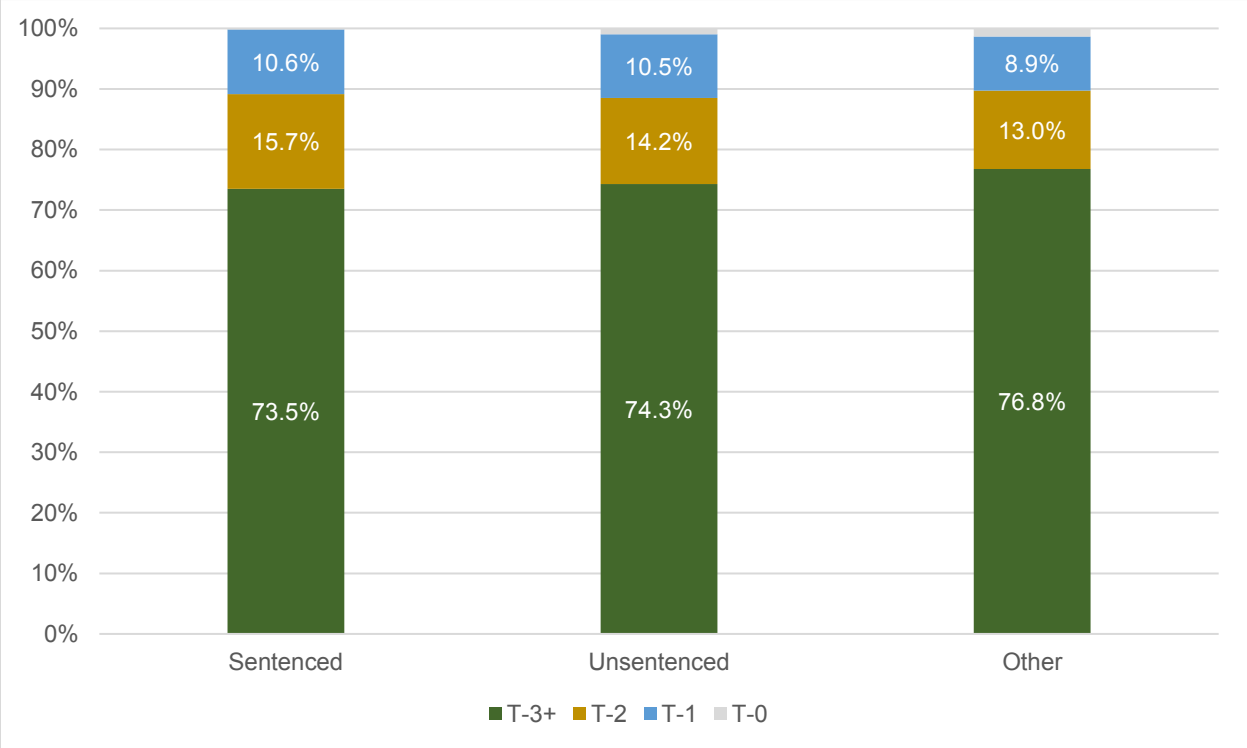


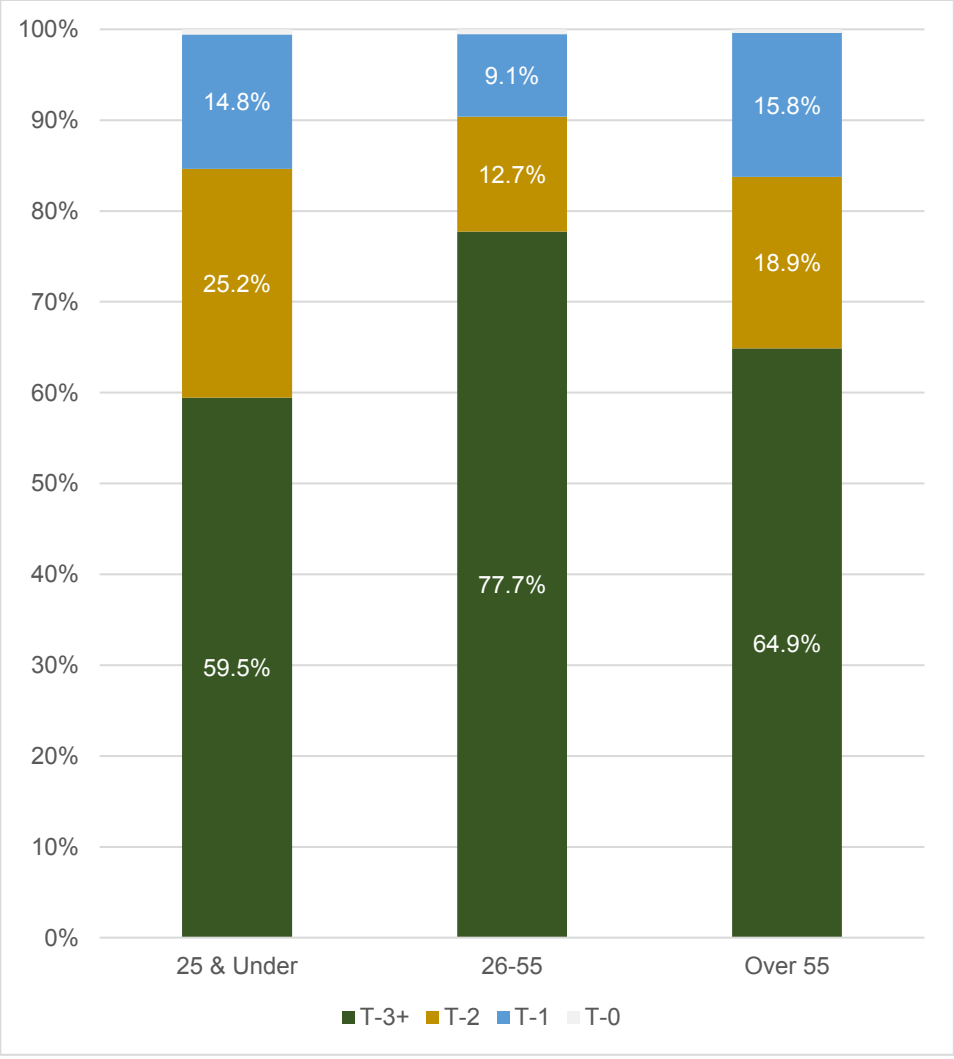
Table 16 and Figure 16 below present the distribution of substance abuse treatment need scores by age group. There was significant variation across different age groups. Compared to the oldest age bracket (over 55), the middle bracket had a significantly higher percentage of T-

scores over 3, and the youngest age bracket (25 and under) had a significantly lower percentage.

Table 16 – Distribution of T Scores by Age

T Score	Under 26	26-55	Over 55
T-0	7	39	4
T-1	189	651	160
T-2	321	909	191
T-3+	758	5,582	656
Total	1,275	7,181	1,011

Figure 16 – T Scores by Age



F. Interaction Between MH and T Scores

Tables 17a and 17b and Figure 17 below display the cross-tabulation of MH scores and T scores.

Table 17a – Cross-Tab of MH and T Scores

	T-0	T-1	T-2	T-3	T-4	T-5
MH-1	18	375	508	988	516	160
MH-2	16	341	544	1,375	1,194	441
MH-3	12	199	277	687	897	403
MH-4	2	75	86	125	135	45
MH-5	2	9	5	11	12	5

Table 17b – Cross-Tab of MH and T Scores (percentages, consolidated)

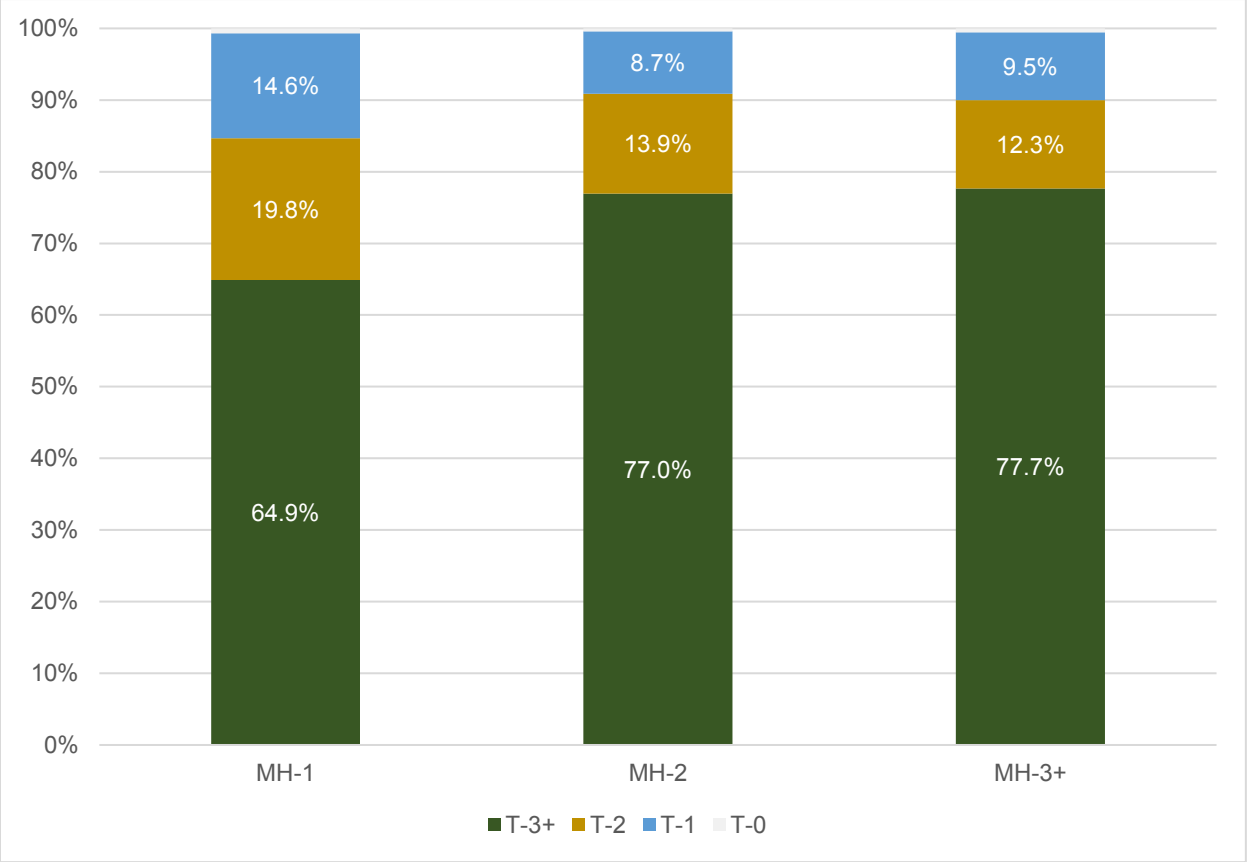
	T-1	T-2	T-3+	Total
MH-1	4.0%	5.4%	17.6%	27.0%
MH-2	3.6%	5.7%	31.8%	41.1%
MH-3+	3.0%	3.9%	24.5%	31.4%
Total	10.6%	15.0%	73.9%	99.5%

Only 4% of the incarcerated population had no history of substance abuse and no history of mental health disorders. Put differently, 95.5% of the incarcerated population was classified as having at least one of the following: (1) a history of mental health issues, (2) an active mental health issue requiring treatment, (3) a history of substance abuse, or (4) an active substance abuse problem requiring treatment.

80.8% of the incarcerated population was classified as having an active mental health disorder requiring treatment or a substance abuse disorder requiring treatment. 24.5% of the population was classified as having both.

Relative to having a T-score under 3, having a T-score of 3 or higher was correlated with a 5-percentage-point higher probability of having an MH-score of 3 or higher. This difference was statistically significant and is consistent with community samples, where comorbidity between mental illness and substance use disorders is common.

Figure 17 – T Score, by MH Score



G. Interactions Between Diagnostic Categories and Sentence Length

This section analyzes correlations among mental disorder diagnostic category and sentence lengths.

Methodological Notes

The following analyses utilize the "Sentence Length in Days" value from the DOC's administrative database, converted to years. Due to data limitations in the database, it is not possible to adequately control for every conviction in an individual's docket when analyzing sentence length. Consequently, the calculations in this section are not "all else equal" analyses. Any observed trends are simply correlations that describe segments of the incarcerated population. They cannot and do not support causal inferences. Additionally, because this section analyzes sentences, only the sentenced population is considered. The Unsentenced and "Other" populations are excluded.

Analysis

Figure 18a and Table 18 below present the distribution of sentence lengths across different diagnostic categories.

Figure 18a is a *box plot*. In the figure, each box represents the middle 50% of sentence lengths. The horizontal line across the middle of each box represents the median (the 50th percentile). The lines extending off the top and bottom of the boxes span the lower and upper fourths of the data (the 1st to 25th percentiles and 75th to 100th percentiles), excluding outliers.[40] The leftmost box represents the distribution of sentence lengths for the overall sentenced population. The six other boxes represent the sentence length distributions for individuals with a given mental disorder diagnosis.

Table 18 presents the median sentence length for each diagnostic category. Because the DOC's administrative database codes life-without-release sentences as an extremely large integer, medians are used instead of averages in order to mitigate skew caused by this coding.

The rightmost column of Table 18 presents the findings from a regression of sentence length on diagnostic category. A significant *negative* correlation means that having a given diagnosis was correlated with a higher probability of being sentenced to a *shorter* term of incarceration.

Compared to the overall sentenced population, there were not significant differences in sentence length for individuals with psychotic disorders. By contrast, individuals with mood, anxiety, and posttraumatic stress disorders had relatively shorter sentences. Individuals with personality or adjustment/acute stress disorders had longer total sentences.

[40] Outliers are defined as any data point that is more than 1.5 times the interquartile range (e.g., 1.5 "box-lengths") above the third quartile (e.g., the top edge of the box). Under this definition, life and life-without-release sentences are considered outliers, even though they are relatively prevalent (7.4%) in the incarcerated population.

Figure 18a – Sentence Length Distribution, by Diagnostic Category

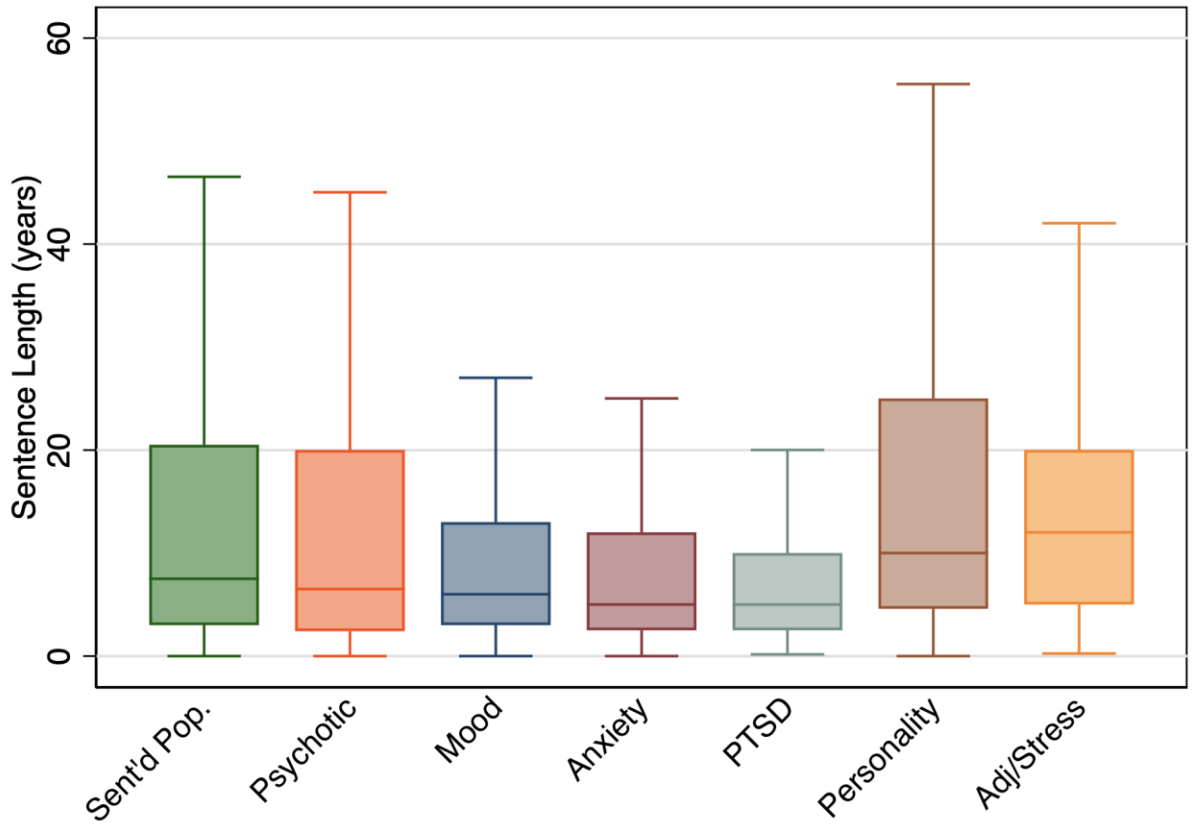
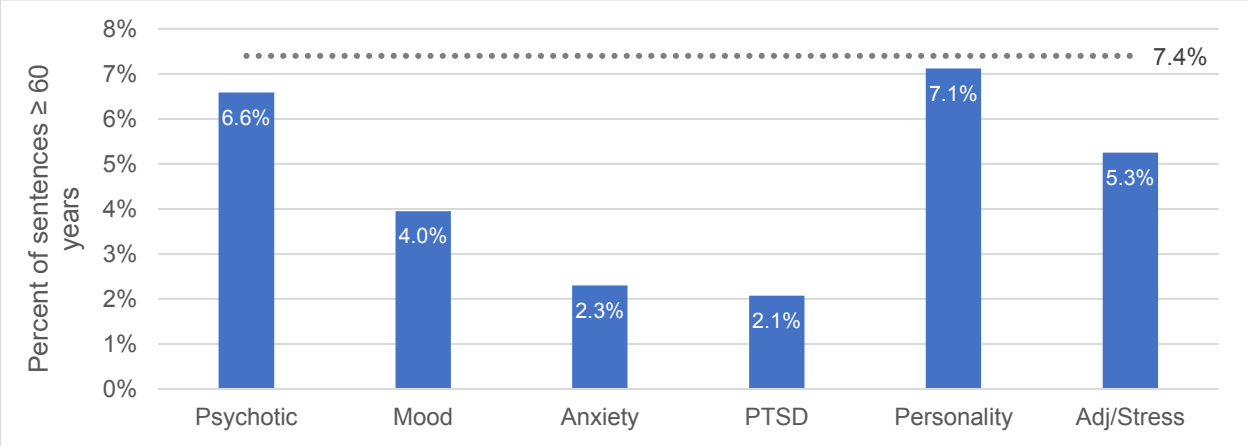


Table 18 – Median Sentence Length by Diagnostic Category

Diagnostic Category	Sentence (Years)	Difference from Overall Pop.
Overall Sentenced Population	7.5	–
Psychotic	6.5	Not significant
Mood	6.0	**Negative**
Anxiety	5.0	**Negative**
PTSD	5.0	**Negative**
Personality	10.0	**Positive**
Adjustment and Acute Stress	12.0	**Positive**

Figure 18b presents the percent of individuals in each diagnostic category with total sentences of 60 years or longer. The dotted grey line reflects the proportion of 60+ year sentences in the overall sentenced population, 7.4%. Compared to the overall sentenced population, individuals with mood, anxiety, or posttraumatic stress disorders had a significantly lower proportion of 60+ year sentences, holding all other diagnostic categories equal. Individuals with personality disorders had a significantly higher probability of serving a 60+ year sentence relative to the overall sentenced population.[41]

Figure 18b – Percent with 60+ Year Sentences, by Diagnostic Category



H. Interactions Between Mental Health Classifications and Sentence Length

This section analyzes correlations between MH scores and sentence lengths. The methodological notes from the previous section also apply to this section.

Figure 19a and Table 19 below present the distribution of sentence length across MH scores.

Table 19 presents the median sentence length for MH-1, MH-2, and MH-3+ individuals. The rightmost column of Table N presents the results of a regression of sentence length on MH classification.[42]

Relative to having an MH score of 1, having an MH score of 3 or higher was correlated with a significantly higher probability of receiving a shorter sentence. There were no significant differences in sentence length between individuals classified as MH-1 and MH-2.

[41] Individuals with personality disorders often had multiple diagnoses, and those other diagnoses were negatively correlated with 60+ year sentences. When the correlation between personality disorder and 60+ year sentences is isolated from the correlations of other diagnostic categories, there is an overall positive correlation. The percentage of individuals with a personality disorder with a 60+ year sentence, 7.1%, was lower than the overall proportion because those with personality disorders tended to have other, negatively-correlated diagnoses.
[42] See Appendix D.

Figure 19a – Sentence Length Distribution, by MH Classification

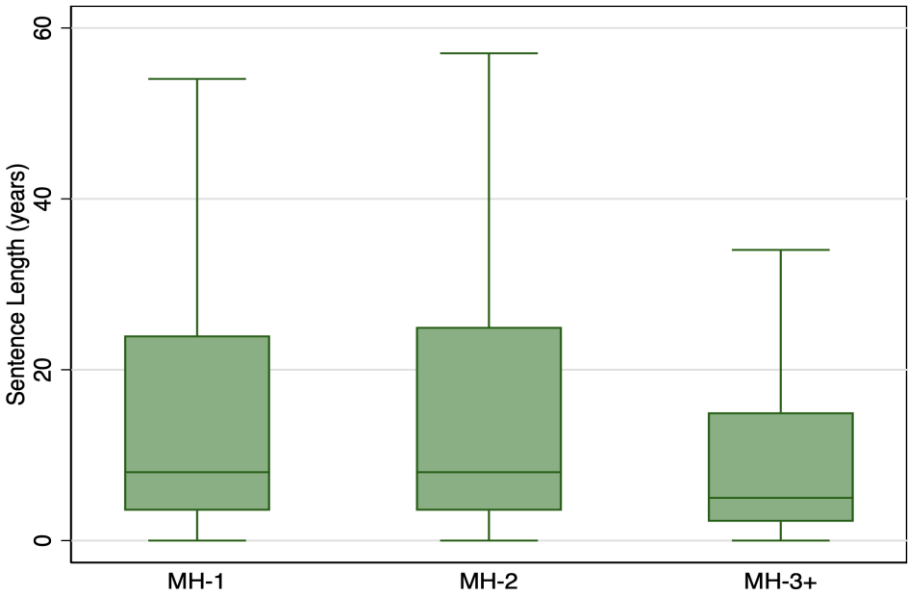


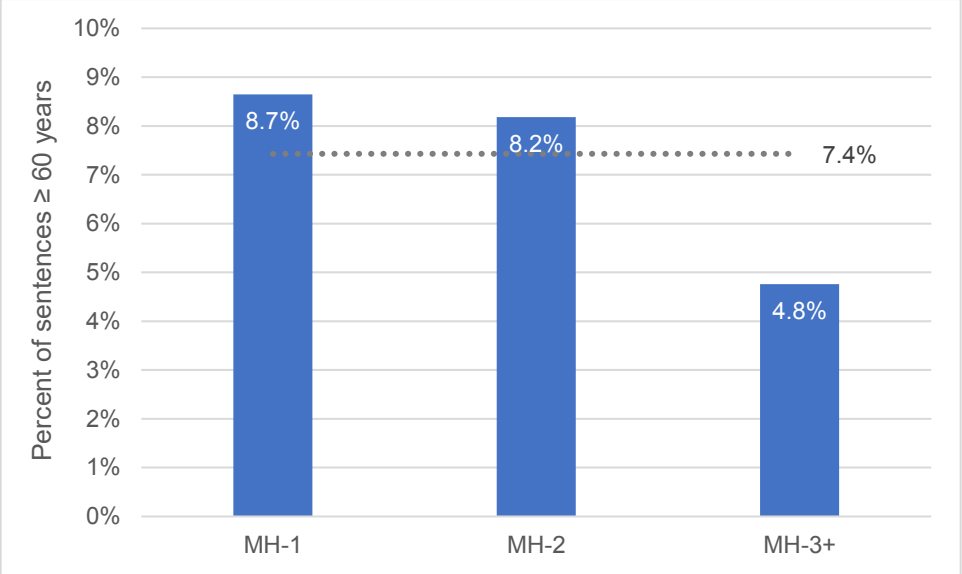
Table 19 – Median Sentence Length by MH Score

Diagnostic Category	Sentence (Years)	Difference from MH-1
MH-1	8.0	—
MH-2	8.0	Not significant
MH-3+	5.0	**Negative**

Figure 19b below presents the percent of individuals in each MH score group with sentences of 60 years or longer. The dotted grey line reflects the proportion of 60+ year sentences in the overall sentenced population, 7.4%.

The proportion of MH-3+ individuals with 60+ year sentences was significantly lower than that for MH-1 or MH-2 individuals.

Figure 19b – 60+ Year Sentences by MH Score



V. CONCLUSION & FUTURE RESEARCH

This report represents an important step in expanding the Connecticut Sentencing Commission's research on mental disorders in the criminal justice system. The incorporation of mental disorder diagnostic categories and Substance Abuse Treatment Needs scores into the discussion has allowed for a more detailed analysis of the incarcerated population, building upon the 2020 memorandum. The high prevalence of mental health and substance use disorder treatment needs supports pursuing continued research and policy work in this area.

This report's findings of high rates of mental health and substance use disorders in the incarcerated population highlights the importance of behavioral health services in Connecticut's jails and prisons. In light of the National Judicial Task Force to Examine State Courts' Response To Mental Illness (National Task Force) finding that "coordination between the behavioral health and justice systems in states and communities is often lacking and ineffective in providing care that reduces recidivism and improves public safety and treatment outcomes," it is essential to assess the efficacy of correctional mental health services in promoting successful long-term outcomes. Similarly, it will be critical to evaluate the availability and flow of information regarding individual needs and treatment.[43]

This study found that 95.5% of the incarcerated population had a history of mental health disorders, substance use disorders, or both. In its report, the National Task Force highlighted co-occurrence of substance use and mental health disorders as having potential to negatively impact justice outcomes. The correlation of mental health with justice outcomes such as pretrial release, sentence outcomes, sentence length, length of supervision, and service availability warrants continued investigation in Connecticut. Moreover, future research should also consider the ways in which the state uses incarceration as a response to behavioral issues that might stem from mental health disorders or substance abuse.

The National Task Force reported that individuals with mental health and substance abuse disorders are more likely to have histories of trauma than those who do not have those disorders. Implications of this for all individuals working in and impacted by the criminal justice system should be considered in future studies, including the role of trauma in an individual's involvement with the system and the extent to which carceral experiences worsen or exacerbate mental health disorders.[44]

Further research should also be conducted on the variation in mental health and substance abuse disorders across different gender and racial groups. Specifically, the Commission should explore the underlying factors that contribute to the racial and gender disparities identified in this study. These may include the higher likelihood for women's behavior to be perceived as

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[43] *Findings and Recommendations of the National Judicial Task Force to Examine State Courts' Response to Mental Illness* (July 27, 2022). https://www.ncsc.org/__data/assets/pdf_file/0027/80847/Findings-and-Recommendations.pdf

[44] Katie Rose Quandt & Alexi Jones, *Research Roundup: Incarceration Can Cause Lasting Damage to Mental Health (*May 13, 2021). https://www.prisonpolicy.org/blog/2021/05/13/mentalhealthimpacts/

related to mental health disorders than aggression by staff, the higher rate of trauma experienced by women, and the underreporting of symptoms of mental health disorders and trauma by men.[45] Likewise, the racial disparities in reported need for mental health care treatment likely represent a confluence of dynamics. White individuals had the highest reported rate of active mental health disorders requiring treatment (40.9%), in comparison to Black (26%) and Hispanic (30%) individuals. The seriousness of these trends is compounded by the overrepresentation of people of color in the criminal justice system.[46]

Finally, future research should explore more directly the common social determinants of mental illness and criminal justice involvement in order to understand the upstream factors that should be addressed in an effective public policy.

Next Steps

In section 1 of *Special Act 21-15*, the General Assembly appropriated up to $500,000 funding for future research on this topic by the Sentencing Commission and the Institute for Municipal and Regional Policy. This appropriation provides the Commission an opportunity to further its work on mental health disorders by conducting a more comprehensive study. This study will expand on the current work to include pretrial diversion, probation, and parole populations, as well as mental health treatment, services, and programs in the DOC.

Three foundational objectives will shape this next project:

1. Utilizing the findings and recommendations of the National Judicial Task Force to Examine State Courts' Response to Mental Illness. This includes the recommendation that "a comprehensive response must also consider the role of trauma, traumatic brain injury, and developmental disabilities . . . and the intersectionality between mental illness and special populations, such as juveniles, emerging adults, women, people of color, veterans, and those who are LGBTQ+."[47]
2. Complementing quantitative analyses with qualitative data components in consultation with a broad range of stakeholders to provide a deeper understanding of the intersection between mental health and criminal justice.

[45]Melissa Thompson, *Gender, Race, and Mental Illness In The Criminal Justice System*, 1 (1) Corrections and Mental Health. https://www.cdcr.ca.gov/ccjbh/wp-content/uploads/sites/172/2020/06/Gender-Race-Mental-Illness_2_3.pdf

[46] *Inmate Race*, Federal Bureau of Prisons (last visited 12/15/22. https://www.bop.gov/about/statistics/statistics_inmate_race.jsp

[47] National Judicial Task Force to Examine State Courts' Response To Mental Illness, *Leading Change Guide for State Court Leaders: Improving the Court and Community's Response to Mental Health and Co-Occurring Disorders,* (June 2022). https://www.ncsc.org/__data/assets/pdf_file/0025/78073/Leading-Change-Guide-for-State-Court-Leaders.pdf

3. Establishing working relationships and agreements with agencies and practitioners to link data across systems, strengthen the network of relevant and useful information, and engage in ongoing system and data collection assessment.

The National Task Force recently released its final report of recommendations. This report builds upon information provided in its June 2022 publication, *Leading Change Guide for State Court Leaders: Improving the Court and Community's Response to Mental Health and Co-Occurring Disorders* and its July 2022 summary of Findings and Recommendations. This guidance becomes available as the Sentencing Commission embarks on its next and most comprehensive study of mental health, and as the nation and state confront urgent mental health issues within and beyond the incarcerated population. Connecticut Chief Justice Robinson co-chaired the Criminal Justice Work Group of this Task Force, and the Commission looks forward to partnering with him and other stakeholders in its study.

The National Task Force organized its recommendations using the categories of Lead, Examine, Educate, and Advocate. The Commission will adopt this framework for its future study. As the Commission develops the study scope, it will draw directly from the "Examine" pillar, which is comprised of the following points of examination:

1. System Evaluation and Leading Change
2. Data, Information Sharing, and Program Evaluation
3. Behavioral Health and Equity
4. Deflection and Diversion
5. Collaborative Case flow Management
6. Competence to Stand Trial Systems
7. Children and Families
8. Juvenile Justice
9. Domestic Relations
10. Civil Responses
11. Trauma and Trauma-informed Responses
12. Peers in the Courts
13. Voice of People with Lived Experience and Families
14. Mental Health and Well-Being for Judge and Court Personnel

The fourteen points of examination, along with information available on current issues in our state serve as a guide for identifying potential areas of focus. At this point in the study's formulation, there are several areas of initial interest for qualitative study in connection with quantitative analysis that will result in a series of reports as part of the final presentation of findings and recommendations.

Qualitative analysis and engagement from stakeholders and community partners will add depth to the research, expanding the scope of who and what is studied. This includes groups not previously addressed in earlier analyses, such as individuals on probation or parole. According

to the findings of the National Task Force, 63% of judges have at least one symptom of secondary or vicarious trauma.[48] The Commission will also consider the current practices for supporting the mental health of judges and other criminal justice personnel in their essential roles in the overall health of the system.

A major focus of the next study will be improving linkages across systems to strengthen the network of relevant and useful data. These linkages will allow for a more robust identification of key issues and recommendations for change. According to the National Task Force findings, shortcomings in information sharing within and across systems "undermine[s] opportunities to identify issues, target resources, and improve system responses."[49]

One particular issue that needs to be addressed is that the state does not currently collect enough data to facilitate robust sentencing analyses. At present, data on individuals' total sentence lengths are only recorded on a defendant's mittimus and in the DOC's administrative database. The mittimus only exists in paper format, and the DOC's administrative database only includes the "controlling" or most serious conviction for a given individual. While data on *all* offenses in a defendant's docket are available through the Judicial Branch's case management system, this database does not contain the aggregate sentence listed on a defendants' mittimus. Sentences are only recorded at the charge-level, and because charge-level sentences can be served concurrently or consecutively, the Judicial Branch's database cannot offer defendant-level sentencing information. A robust analysis of sentencing will only be possible when the Commission has access to a database that contains both defendant-level sentence data and charge-level offenses. Accordingly, an important next step in the exploration of sentencing and behavioral health will be expanding data access.

Lastly, while the Commission intends to focus on the points of examination identified by the National Task Force, the opportunity of this time and funding to study mental health in the criminal justice system will also be used to support the development of activities in the other three areas identified in the Task Force recommendations related to leadership, education, and advocacy. This includes supporting dialogue across agencies and systems; providing and supporting educational opportunities for practitioners and the public; making the tools, resources, and recommendations developed by the Task Force more readily available; and encouraging the growth of a more humane and cost-effective public health model that includes diversion programs, treatment, and related services in support of public safety.

[48] *Findings and Recommendations of the National Judicial Task Force to Examine State Courts' Response to Mental Illness* (July 27, 2022).
https://www.ncsc.org/__data/assets/pdf_file/0027/80847/Findings-and-Recommendations.pdf
[49] *Id.*

Appendix A – DOC Mental Health Care Need Classification Definitions

Classification	Description	Response
MH-1	These individuals have no mental health history or current need and may be characterized as emotionally stable.	Individuals deny any mental health history, denies any suicidal ideation or suicide attempts with no evidence of anxiety, depression or psychosis.
MH-2	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.	Individuals with a history of mental health treatment for adjustment disorder, depression, anxiety, attention-deficit hyperactivity disorder, conduct disorder, phobias, eating disorders, brief psychotic episodes, post-traumatic stress disorder, or developmental disorders with no current symptoms and no need for medication or follow-up services.
MH-3	Mild or moderate mental health disorder (or severe mental disorder under good control); may or may not be on psychotropic medication.	Individuals with chronic schizophrenia or bipolar disorder who are compliant with medications and may have periodic psychotic exacerbations requiring hospitalization yet are able to function in a general population setting; Individuals with major depression who may have a history of suicidal behavior and need supportive services and/or medications and may require periodic hospitalizations; Individuals with personality disorders, e.g. borderline personality disorder and require supportive services and crisis intervention to prevent self-mutilation or suicidal gestures
MH-4	Mental Health disorder severe enough to require specialized housing or ongoing intensive mental health treatment; usually on psychotropic medications.	Individuals with chronic schizophrenia or bipolar disorders with frequent psychotic exacerbations, who need medication and assistance with activities of daily living; Individuals with borderline personality disorder with frequent suicidal gestures or episodes of self-mutilation, who, due to chronic mood instability and impulsiveness, require daily contact and support; Individuals with intellectual disability in need of assistance with activities of daily living and self-care.
MH-5	Crisis level mental disorder (acute conditions, temporary classification). Requires 24-hour nursing care.	Acute psychosis, severe depression, suicidal ideation, suicidal gestures or attempts, and overwhelming anxiety. Actively suicidal or self-mutilating individuals. Require suicide watch, 15 minutes watch or one-to-one monitoring.

Appendix B – DOC Substance Abuse Treatment Classification Definitions

Classification	Description	Response
T-0	Inmate has not been assessed. A Substance Abuse Treatment (t) score has not been established.	Addiction Services Unit staff shall complete a formal assessment. Any new admission to the DOC will be assigned a 0 T score.
T-1	These inmates do not appear to have a substance abuse problem.	These individuals do not require any substance abuse intervention.
T-2	These individuals have a slight substance abuse history and would benefit from a brief substance abuse intervention.	The appropriate level of intervention is voluntary participation in recovery support services.
T-3	Individuals receiving this rating have a moderate substance abuse problem that requires treatment.	The appropriate level of intervention is completion of a Tier 2 Intensive Facility Based Outpatient Treatment program where available, and community-based aftercare services. If the inmate has not completed Tier 3 or Tier 2 during this period of incarceration, community based intensive outpatient substance abuse treatment is recommended.
T-4	Individuals receiving this rating indicate a serious substance abuse problem and require residential or intensive outpatient treatment.	The appropriate level of intervention is completion of a Tier 4 (Therapeutic Community) program a Tier 3 Recovery/Re-entry Unit program, or community residential substance abuse treatment and community based aftercare services. If a Tier 4 or Tier 3 residential program is not available, completion of Tier 2 Intensive Facility Based Outpatient Treatment program followed by community- based aftercare services is recommended. If the inmate has completed Tier 4 or Tier 3 during this period of incarceration, community based outpatient services are still recommended.
T-5	These individuals have an extremely serious substance abuse problem and require a high level of intensive treatment of extended duration, such as DOC residential treatment. These individuals have a very high probability of relapse into active substance abuse.	The appropriate level of intervention is completion of a Tier 4 (Therapeutic Community) program, a Tier 3 Recovery/Re-entry Unit Program, or long-term community residential substance abuse treatment. If the inmate has completed Tier 4 or Tier 3 during this period of incarceration, reevaluation by Addiction Services is recommended for community based outpatient services

Appendix C – Diagnostic Category Descriptions[50]

Diagnostic Category	DSM 5-TR Descriptions
Psychotic Disorders	Include schizophrenia and other psychotic disorders. They are defined by abnormalities in one or more of the following five domains: delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behavior (including catatonia), and negative symptoms
Mood Disorders	Include disruptive mood dysregulation disorder, major depressive disorder (including major depressive episode), persistent depressive disorder, premenstrual dysphoric disorder, substance/medication-induced depressive disorder, depressive disorder due to another medical condition, other specified depressive disorder, and unspecified depressive disorder. The common feature of all these disorders is the presence of sad, empty, or irritable mood, accompanied by related changes that significantly affect the individual's capacity to function. For this study, mood disorders also include bipolar and related disorders. These include bipolar I disorder, bipolar II disorder, cyclothymic disorder, substance/medication-induced bipolar and related disorder, bipolar and related disorder due to another medical condition, other specified bipolar and related disorder, and unspecified bipolar and related disorder.
Anxiety Disorders	Include disorders that share features of excessive fear and anxiety and related behavioral disturbances, such as generalized anxiety disorder, panic disorder, and specific phobias.
Posttraumatic Stress Disorder (PTSD)	The development of characteristic symptoms following exposure to one or more traumatic events. The clinical presentation of PTSD varies. In some individuals, fear-based reexperiencing, emotional, and behavioral symptoms may predominate. In others, anhedonic or dysphoric mood states and negative cognitions may be most prominent. In some other individuals, arousal and reactive-externalizing symptoms are prominent, while in others, dissociative symptoms predominate. Finally, some individuals exhibit combinations of these symptom patterns.
Cognitive Disorders	Include disorders in which the primary clinical deficit is in cognitive function, and that are acquired rather than developmental. The NCDs are those in which impaired cognition has not been present since birth or very early life, and thus represents a decline from a previously attained level of functioning. The category includes Alzheimer's disease, vascular NCD, NCD with Lewy bodies, NCD due to Parkinson's disease; frontotemporal NCD, NCD due to traumatic brain injury, NCD due to HIV infection; substance/medication-induced NCD; NCD due to Huntington's disease; NCD due to another medical condition; NCD due to multiple etiologies; and unspecified NCD.

[50] This appendix contains brief descriptions that are designed to give the reader a preliminary understanding of the diagnostic categories. Readers should refer to the DSM-5-TR for complete descriptions and diagnostic criteria.

Neurodevelopmental Disorders	A group of conditions with onset in the developmental period. The disorders typically manifest early in development, often before the child enters school, and are characterized by developmental deficits or differences in brain processes that produce impairments of personal, social, academic, or occupational functioning. The range of developmental deficits or differences varies from very specific limitations of learning or control of executive functions to global impairments of social skills or intellectual ability. This category includes Autism Spectrum Disorders.
Personality Disorders	Enduring patterns of inner experience and behavior that deviate markedly from the norms and expectations of the individual's culture, are pervasive and inflexible, have an onset in adolescence or early adulthood, are stable over time, and lead to distress or impairment.
Sexual Disorders	Any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners. Include voyeuristic disorder, exhibitionistic disorder, frotteuristic disorder, sexual masochism disorder, sexual sadism disorder, pedophilic disorder, and fetishistic disorder, among others.
Adjustment and Acute Stress Disorders	The development of characteristic symptoms lasting from 3 days to 1 month following exposure to one or more traumatic events (acute stress), or in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s) (adjustment). Typically involves an anxiety response that includes some form of reexperiencing of or reactivity to the traumatic event. Presentations may include intrusion symptoms, negative mood, dissociative symptoms, avoidance symptoms, and arousal symptoms
Gender Dysphoria	A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by various symptoms. The condition is associated with clinically significant distress or impairment in social, school, or other important areas of functioning.
Grief/Bereavement	The development of a persistent grief response characterized by intense yearning/longing for the deceased person or preoccupation with thoughts or memories of the deceased person
Impulse Control Disorders	Conditions involving problems in the self-control of emotions and behaviors. While other disorders may also involve problems in emotional and/or behavioral regulation, impulse control disorders are unique in that these problems are manifested in behaviors that violate the rights of others (e.g., aggression, destruction of property) and/or that bring the individual into significant conflict with societal norms or authority figures.
Attention-Deficit/ Hyperactivity Disorder (ADHD)	A persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development.
Eating Disorders	A persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning. Examples include anorexia nervosa and bulimia nervosa.
Somatoform Disorders	Include the diagnoses of (conversion disorder, psychological factors affecting other medical conditions, factitious disorder, other specified somatic symptom and related disorder, and unspecified somatic symptom and related disorder. All the disorders in this category share a common feature:

	the prominence of somatic symptoms and/or illness anxiety associated with significant distress and impairment.
Obsessive-Compulsive Disorders	The presence of obsessions and/or compulsions. Obsessions are recurrent and persistent thoughts, urges, or images that are experienced as intrusive and unwanted, whereas compulsions are repetitive behaviors or mental acts that an individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.

APPENDIX D – Serious Mental Illness

To facilitate comparison with other studies on mental health disorders in carceral settings, Sentencing Commission researchers classified a subset of diagnoses as *serious mental illness* (SMI). For this study, SMI included all diagnoses that were categorized as a psychotic disorder and all mood disorders that were subcategorized as major depressive disorder or bipolar disorder (types I and II).

1,695 individuals were diagnosed with SMI, reflecting 17.9% of the population. Of these, 1,393 were classified as MH-3 or higher, indicating an active treatment need. This corresponds to 14.7% of the incarcerated population having active SMI.

Demographic Analysis

Figures D-1 through D-4 below present demographic data on the incidence of SMI. The prevalence rate of SMI was significantly higher for females. There was also significant variation in SMI prevalence across race, with Asian, Native American, and White individuals having higher rates than Hispanic and Black individuals. SMI prevalence was significantly higher for the unsentenced population. There was no significant variation in SMI across different age groups.

SMI & DOC Classifications

Figure D-5 illustrates the interaction between SMI and MH scores. Individuals with SMI had significantly higher mental health care treatment needs compared to those who did not. 4.7% of individuals with MH scores below 3 had SMI, compared to 46.3% of individuals with MH scores of 3 or higher. 81.4% of individuals with MH scores of 4 or 5 had SMI.

Figure D-6 below illustrates the interaction between SMI and T scores. Individuals with SMI had significantly higher substance abuse treatment needs, as well.

SMI & Sentence Length

Figures D-7a and D-7b below illustrate the interaction between SMI and sentence length. The median sentence length for individual without SMI was 8.0 years. The median sentence length for individuals with SMI was 6.0 years. In aggregate, individuals with SMI were serving significantly shorter sentences than individuals without SMI. Individuals with SMI were 2.4 percentage points less likely to be serving a 60+ year sentence than individuals without SMI. This difference was statistically significant.

Figure D-1 – Prevalence of Serious Mental Illness, By Gender

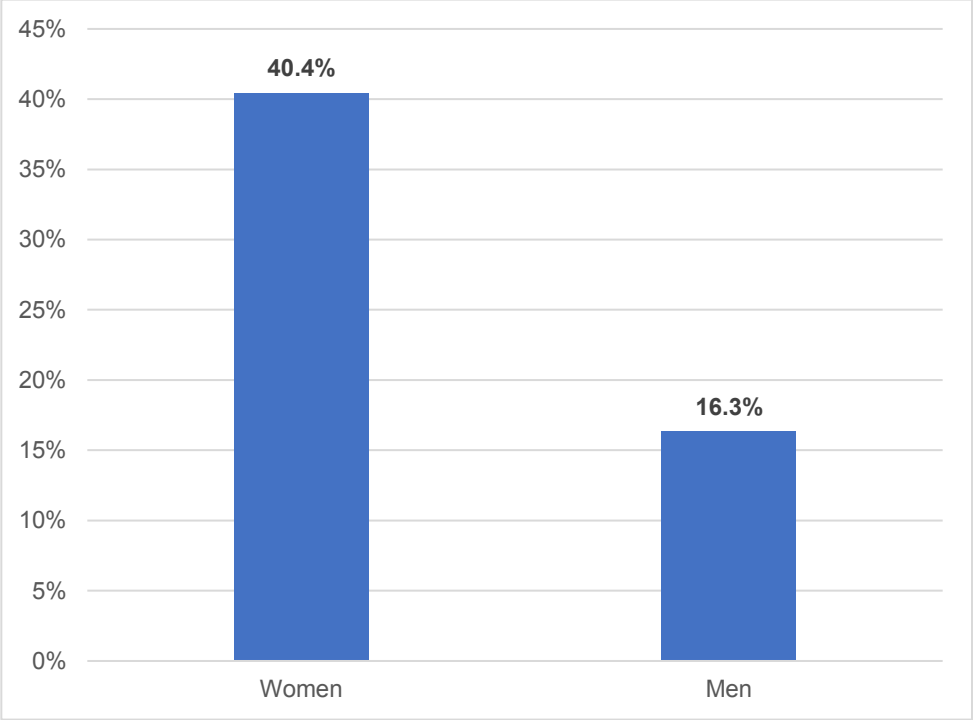


Figure D-2 – Prevalence of Serious Mental Illness, By Race

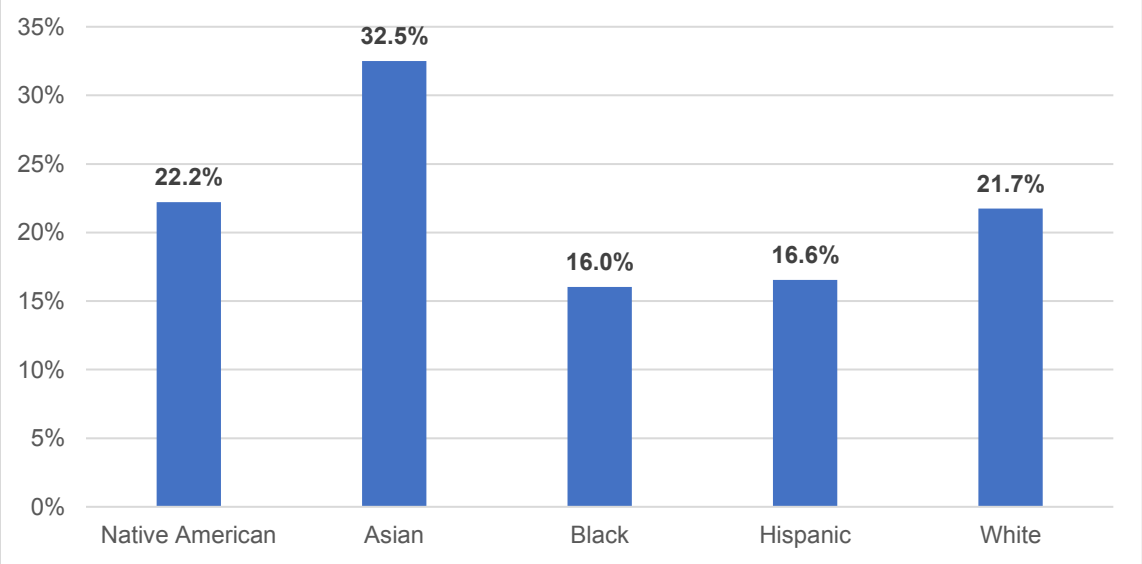


Figure D-3 – Prevalence of Serious Mental Illness, By Status

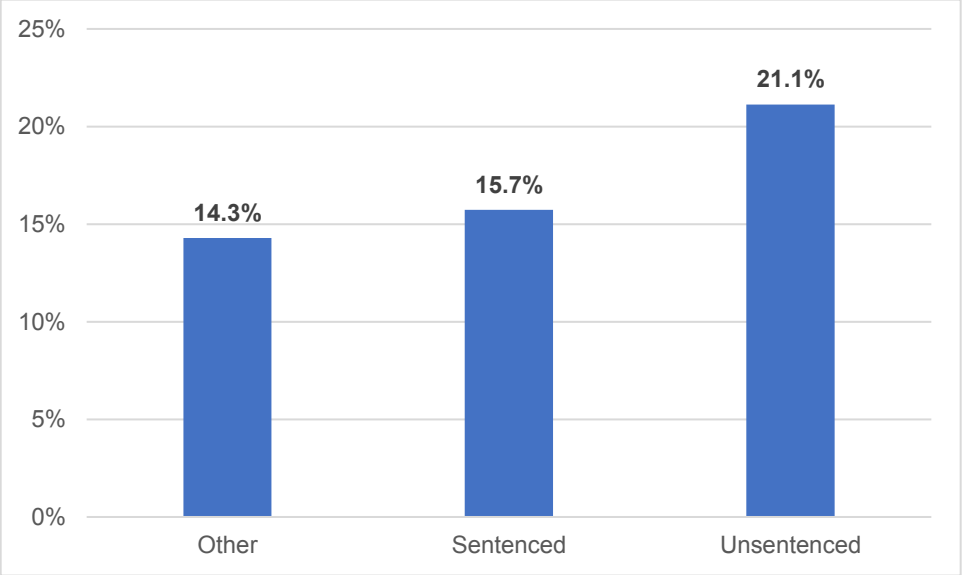


Figure D-4 – Prevalence of Serious Mental Illness, By Age

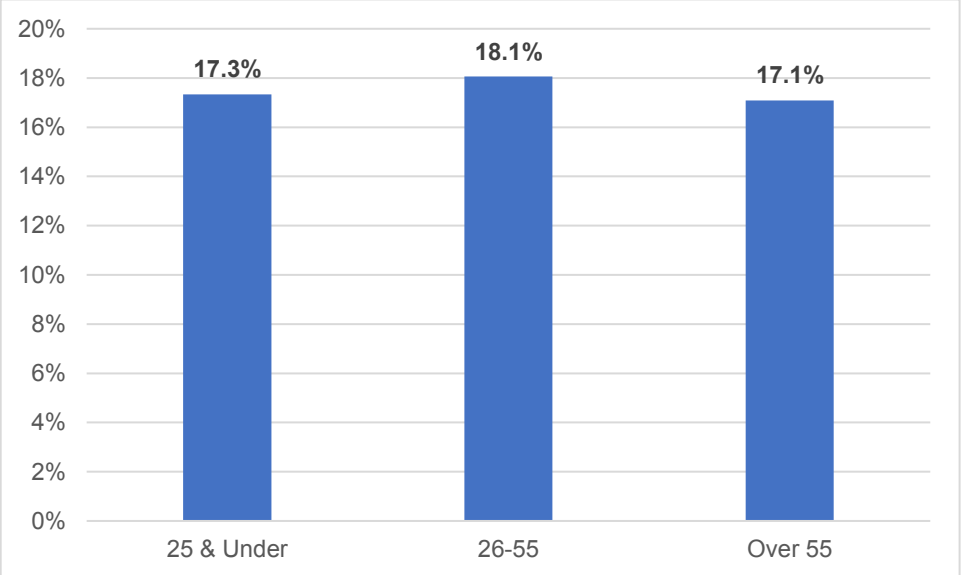


Figure D-5 – Prevalence of Serious Mental Illness, By MH Score

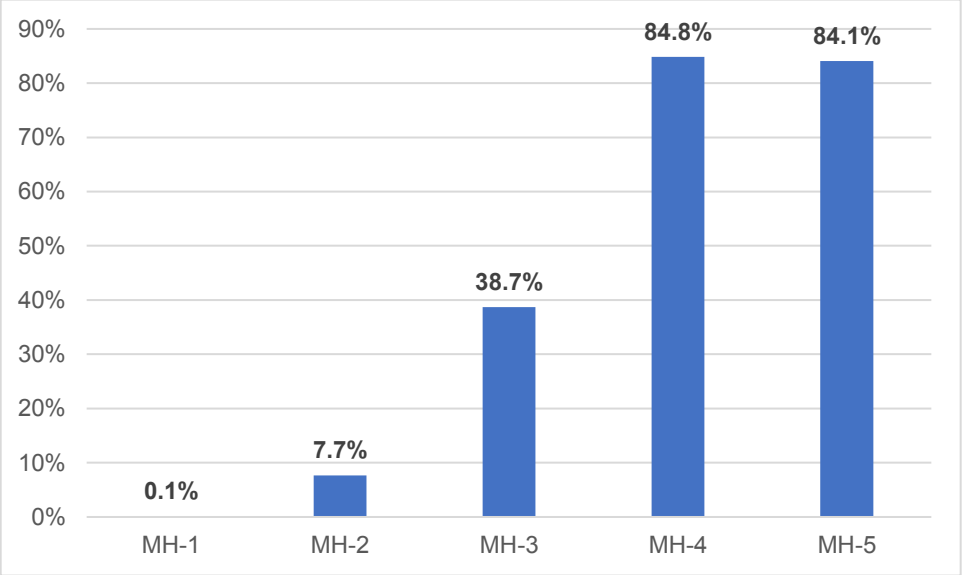


Figure D-6 – Prevalence of Serious Mental Illness, By T Score

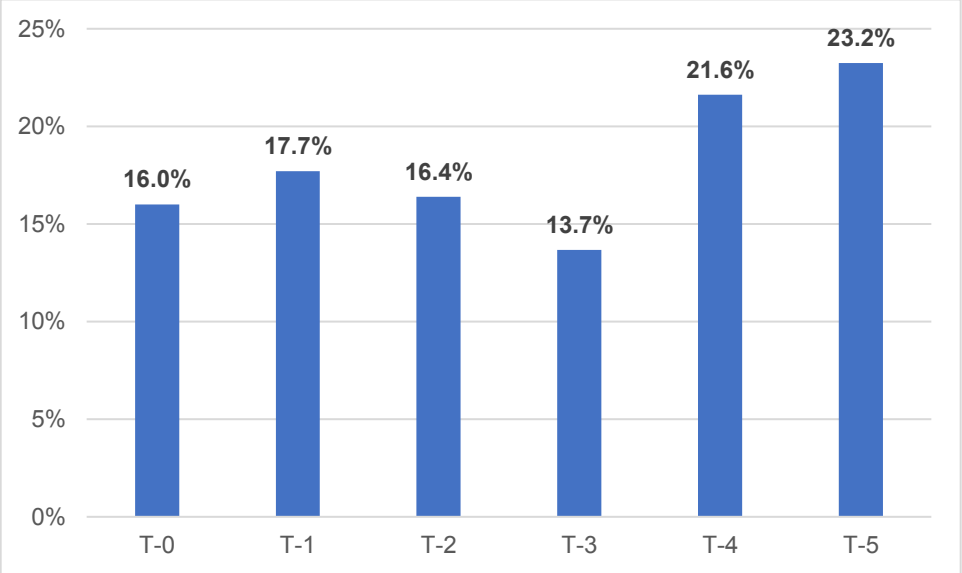


Figure D-7a – Sentence Length, by SMI

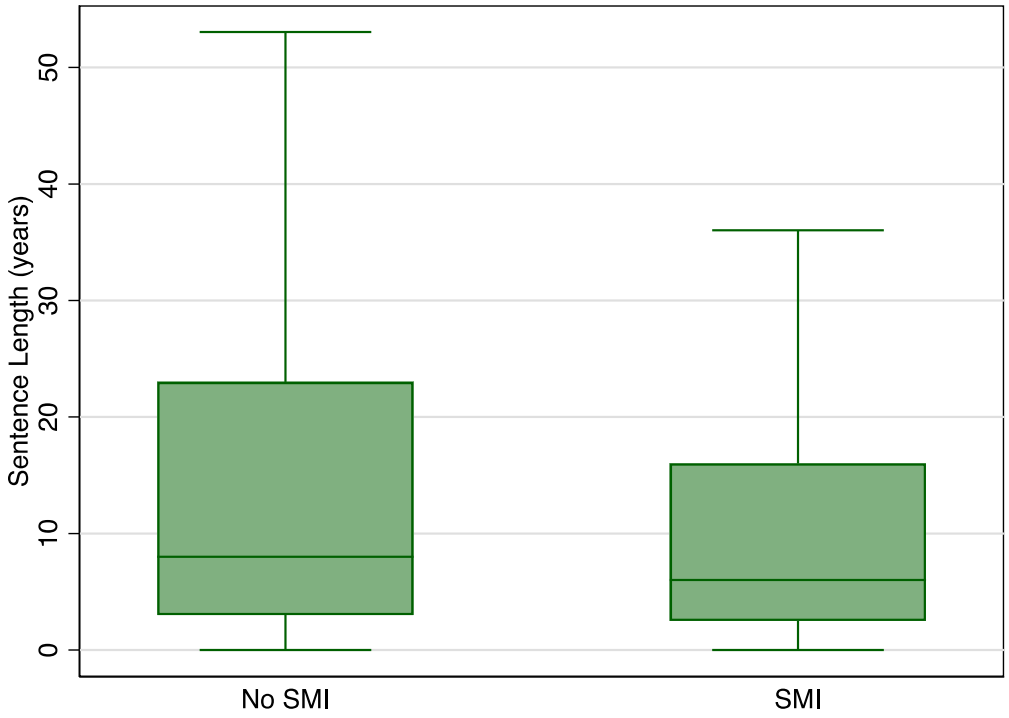
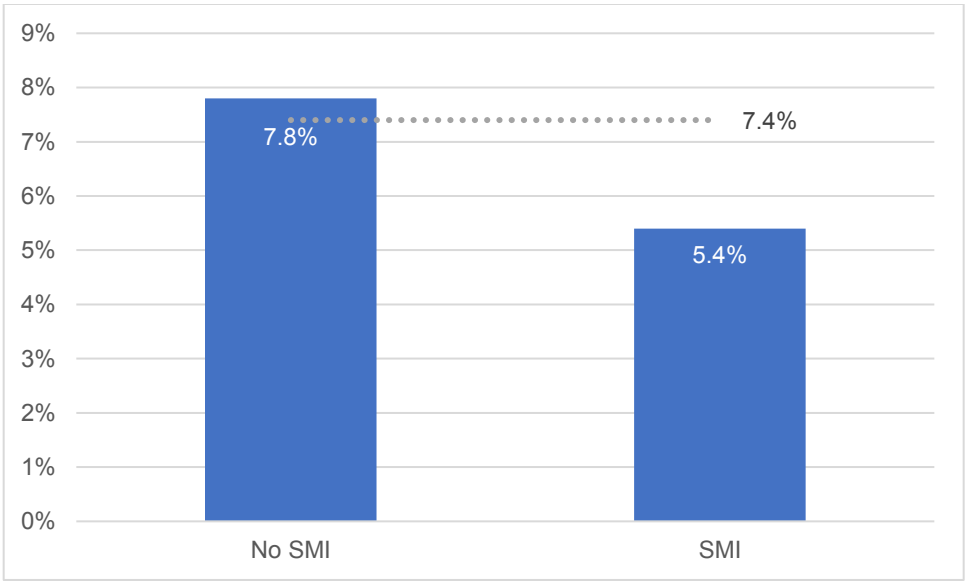


Figure D-7b – Proportion with 60+ Year Sentences, by SMI



Appendix E – Variable Coding and Regression Methods

This appendix discusses the variable coding and methods used in this study to assess statistically significant differences and correlations.

Variable Coding

One indicator variable was used for gender. The variable was coded one for women and zero otherwise. Five indicator variables were used for race, one each for White, Black, Asian, Native American, and Hispanic. Each indicator was coded one for an individual of that race and zero otherwise. In all regressions, White was the omitted category.

For legal status, three indicator variables were used, one each for sentenced, unsentenced, and other. Each indicator was coded one for an individual of that status and zero otherwise. In all regressions, sentenced was the omitted category.

Three indicator variables were used for age. One each for under 26, 26-55, and over 55. Each indicator was coded one for an individual of that status and zero otherwise. In all regressions, over 55 was the omitted category.

When MH scores or T scores were used as dependent variables, they were coded as indicator variables. The dependent variable was an indicator variable that was one if the score was 3 or higher, and zero otherwise.

Diagnostic categories, when used as dependent variables, were indicator variables that were coded one if an individual had a diagnosis within that category and zero otherwise.

Regression Methods

For assessing differences across gender, age, and legal status, ordinary least squares regression with heteroskedastic-robust standard errors was used. If the relevant coefficient estimate was significant at the 5% alpha level, the report describes the difference as statistically significant.

For assessing differences across race, ordinary least squares regression with heteroskedastic-robust standard errors was used. An F-test was used to assess whether all racial coefficients were jointly equal to zero. If the F-test rejected the null hypothesis at the 5% level, the report describes the racial variation as statistically significant

For assessing the correlation of T and MH scores, T scores were used as an independent indicator variable coded one if the score was 3 or higher, and zero otherwise. MH scores were the dependent variable and coded the same way. Ordinary least squares regression with heteroskedastic-robust standard errors was used to assess the correlation's significance at the 5% significance level.

For assessing the correlation of diagnostic categories and sentence length, the dependent variable was an ordinal variable coded for one of five sentence-length bins: less than 1 year, 1 to 5 years, 5 to 10 years, 10 to 20 years, and over 20 years. The independent variables were sixteen indicator variables for each diagnostic category. Ordered logit regression was used to assess the significance of the indicators for the six most common diagnostic categories at 5%.

For assessing the correlation of MH scores and sentence length, the dependent variable was an ordinal variable coded for one of five sentence-length bins: less than 1 year, 1 to 5 years, 5 to 10 years, 10 to 20 years, and over 20 years. The independent variables were two indicator variables for MH-2 and MH-3+ scores. Ordered logit regression was used to assess the significance of the MH indicators at 5%.

For assessing the correlation of diagnostic categories and MH scores with 60+ year sentences, the dependent variable was an indicator variable that was coded one for 60+ year or life sentences, and zero otherwise. The independent variables were sixteen indicator variables for each diagnostic category and indicator variables for MH-2 and MH-3+ scores, respectively. Ordinary least squares regression with heteroskedastic-robust standard errors was used to assess significance at 5%.

Appendix F – Letter from Senator Catherine Osten

SENATOR CATHY OSTEN
Nineteenth District

Legislative Office Building
Room 2700
Hartford, CT 06106-1591
Tel. 860-240-0579
Toll-free 1-800-842-1420
www.senatedems.ct.gov/Osten

State of Connecticut
SENATE

Chair
Appropriations Committee
Vice Chair
Labor & Public Employees Committee
Public Safety & Security Committee
Member
Legislative Management Committee
Regulation Review Committee
Transportation Committee
Veterans' Affairs Committee

September 4, 2019

Honorable Robert J. Devlin, Jr.
Chair, Connecticut Sentencing Commission
185 Main Street, Room 212
New Britain, CT 06051

RE: Study concerning Inmates established as Chronically Mentally Ill

Dear Judge Devlin,

I am writing to respectfully request that the Connecticut Sentencing Commission undertake a study to provide data on the number of inmates in Connecticut prisons who are identified as chronically mentally ill, ascertain if this class of inmates is completing a longer portion of their sentences as compared to other inmates, and if so, the reasons why, and determine if this class of inmates accesses programs which allow for a smooth transition into the community at the same percentage rate as other inmates access such programs. To assist the Commission's efforts with this study, I am enclosing a copy of my Proposed Bill No. 760 from the 2019 regular legislative session for your reference.

Thank you for undertaking this important task. I look forward to your Commission's findings. Please don't hesitate to contact me with any questions.

Sincerely,

Catherine A. Osten
State Senator, 19th District

Enclosure