

**The Connection, Inc.**  
**Program Description**  
**Re-Entry Assisted Community Housing**

**General Program Information**

Re-Entry Assisted Community Housing (REACH )provides supportive, scattered site housing for males and females under the remand of the Department of Correction in New Haven, Meriden, New Britain, Bristol, Danbury, Torrington and Bridgeport CT. Currently there are a total of 108 beds, comprised of 34 beds in Bridgeport, 24 in New Haven, and 10 beds in each remaining town. Accommodations are provided in scattered, two-bedroom apartments, located throughout the community, that meet specific housing code requirements, and are not concentrated in one area of a municipality. Estimated length of stay for program participants is four to six months.

**Program History**

In May of 2004 the Connecticut State Legislature adopted policies to reduce overcrowding in state prisons. One policy was to streamline release processes, increase releases and improve parole supervision. A second policy was to reduce technical parole and probation revocations and the third was a directive for DOC, DMHAS, DSS, the Labor Dept., the Board of Parole and the Judicial Branch to collaborate in developing and implementing “a comprehensive reentry strategy.” In this political environment The Connection Inc. responded to a DOC RFP for halfway house beds with the concept of a community supported housing program. The contract was awarded to The Connection Inc. and in January 2005 the first units in New Haven were brought on board. By February, twelve two bedroom apartments had been secured and the first clients were admitted. The key persons involved in this programs inception have been Bob Gillis from DOC and Carl Rodenhizer and Randy Braren from The Connection Inc.

In October of 2006 TCI responded to a DOC RFP for community justice beds in specific communities. It was decided, to utilize the REACH model to be able to meet the needs in these communities. TCI was awarded an expansion of 50 beds, 10 beds each in Torrington, Meriden, New Britain, Bristol, and Danbury bringing the total capacity of REACH to 74 beds. In January of 2007 25 new apartments were secured and 10 new staff members were hired. By March of 2007 the expansion was completed and the program provided housing to a total of 136 individuals in FY 2006-2007. During this time 4 new offices were also established in Torrington, Danbury, New Britain and Meriden, with the Bristol case manager sharing office space in New Britain. In January 2008 TCI was awarded another expansion of 34 beds in the Bridgeport area increasing our total capacity of REACH to 108 beds. Presently space is being located and secured to establish our Bridgeport office.

The Re-Entry Assisted Community Housing Program operates on the belief that change is possible but that it must be directed by the individual who must make the change themselves. Our responsibility as human service workers is to provide the skills, resources and knowledge to enhance the motivation of individuals who must do the difficult work of changing often times their attitudes, friends, living situations, behaviors, and work environments. It is through the formation of therapeutic relationships and the belief in success that this process begins but never ends.

Re-Entry Assisted Community Housing is designed to meet the specific needs of individuals leaving the correctional system and re-entering the community. Ending the intergenerational cycles of poverty, crime and addiction is a key component to reducing recidivism and enhancing individual lives and communities. Individuals being released from prison frequently have no place to live; they are without clothing, money and jobs and sometimes have no family or friends willing or able to assist them. As a result individuals are released and end up at homeless shelters. Lack of skills, knowledge, motivation, and resources often lead to a return to criminal behavior, either to escape reality, or to provide for essential needs, or both.

The goals of the Re-Entry Assisted Community Housing Program are the:

1. Provision of transitional, supportive, affordable housing to the program participants;
2. Ensuring public safety and supervision through intensive and frequent case management and telephone contacts with the client and through close contact with other service providers, probation and parole officers;
3. Provision of linkages for transitional employment opportunities with local employers along with employment skills training, and job placement assistance;

4. Assistance to residents to develop or recover the life skills, support systems, and motivation necessary to sustain a positive, sober, pro-social, and independent lifestyle;
5. Provision of family strengths based counseling to involve the family or other intimates in helping the individual ex-offender to develop positive, healthy relations with family and other community supports;
6. Provision of motivational and cognitive behavioral therapy to help clients overcome substance abuse and other barriers to a successful re-entry into the community.

### **Services Offered**

The service package assists the offender with intensive supports to successfully re-enter the community as fully participating and valued members of society. REACH provides intensive case management which addresses the specific criminogenic needs of each individual as determined by the Level of Service Inventory (LSI) and the Adult Substance Use Survey (ASUS) assessment tools. An Individualized Service Plan is created to address at minimum the top 3 criminogenic issues. In addition clients are required to attend a Cognitive Behavioral Therapy (CBT) curriculum addressing Criminal and Addictive Thinking twice a week and an employment group once per week. Referrals are made for mental health treatment, substance abuse treatment, and vocational training as necessary. Housing is provided for the transition from incarceration to community living and individuals are assisted with finding safe, affordable, permanent housing. Clients are assisted with obtaining identification such as birth certificates, Social Security Cards, and DMV photo ID's. In addition clients are assisted with the process of applying for State Administered General Assistance (SAGA) medical and food stamps in order to provide for basic health and nutrition needs. Until these things are in place REACH provides grocery store gift cards so that individuals can buy their own food.

### **Eligibility and Exclusions**

Referrals must come from Department of Corrections or any other DOC contracted residential program. All eligible participants must be 18 years of age or older. Participants must be on or eligible for Parole or Transitional Supervision and in need of housing. Their lifestyle must be characterized by criminal and anti social behavior, lack of goals and or overall inability to manage stress of daily living. They must demonstrate motivation to attain a responsible role in society and they will be assessed to determine their ability to function appropriately within the community in a manner that does not interfere with or compromise the safety of members of the community. They must show willingness to abide by program rules and sign a treatment contract. They must also have a minimum of three months to end of sentence.

The Connection Inc. (TCI) program will review all referrals on a case by case basis and may deny admission to inmate / offender for the following reasons:

1. Conviction for charges involving arson
2. Demonstrated pattern of violent behavior
3. Current physical addiction to drugs and / or alcohol requiring detoxification
4. Sex offenders who are determined ineligible by CTPSB due to risk level
5. Assessed inability to function appropriately within the less restrictive group living environment
6. Applicant demonstrates acute or chronic psychiatric instability
7. Current medical condition(s) that would prohibit full program participation
8. Insufficient time (less than 3 months)

Any denials by TCI will be collaboratively discussed with the Department of Correction / Community Enforcement Division Personnel.

### **Staffing**

Staffing for REACH program consists of one Program Director centrally located in New Haven who will oversee entire operation and to whom all program staff will directly report. Three Program Managers each assigned their own territory; New Haven/ Danbury region, Torrington, Meriden, Bristol and New Britain areas and one overseeing Bridgeport location. Duties include responsibility for day to day operations of the program and supervision of case managers and program development. There are eleven case managers; three operating out of New Haven office, three based in Bridgeport, two centralized in New Britain covering both New Britain and Bristol and one each in Meriden, Torrington and Danbury sites. They will provide intensive case management for their caseload of individuals re-entering the community in their respective areas. Included on staff is one Administrative Assistant situated in our New Haven office that provides administrative support to the Program Director, as well as the entire staff, and works on

multiple projects and assignments having to do with all aspects of program operations. Staff also consists of one Intake Specialist that covers assessments for all existing areas as well as two part time Housing Coordinators who provide housing, housing advocacy, perform quarterly inspections, and coordinates the subsidy and lease up process. A Quality Assurance specialist is also on hand to assist in creating a quality improvement plan and to audit our services to assure that we continue to meet contractual obligations and provide the supports necessary to assist individuals in successfully reentering the community.

All staff are oriented to the agency and trained in MI, Strength Based case management and CPI.

### **Admission Process**

Clients must have not less than 3 months left on their sentence in order to be considered for admission to REACH.

- 1) A pre-release assessment will be completed using the following instruments to comprehensively determine if Re-entry Assisted Community Housing Program is the correct level of care for the individual, and if deemed appropriate what the client's area of risks/needs are that must be concentrated on during the clients participation in the program
  - i. Level of Service Inventory - Revised (LSI-R) - will be completed on each client to assess risk / need factors associated with recidivism
  - ii. Functional Literacy Test – will be completed to determine client's ability to read, write, and do basic math
  - iii. Adult Substance Use Survey (ASUS) – a self-report measure used in conjunction with the LSI to assess overall risk to recidivate
- 2) Intake/Orientation: Once participant is released, all clients receive an orientation at the office or apartment the day they are admitted. This orientation includes a thorough review of the client handbook, which includes the rules, visitor rules, expectations, rights and responsibilities, and the infractions which may cause an individual to be discharged. Also included are the description of the grievance procedure, rent collection policy and a tour of both the office and apartment. Clients are introduced to their roommate and their case manager. The client is given a gift card for a local grocery store and is transported to the parole officer for their first meeting. Clients are provided with a bus pass, linens, and when available a voucher for clothes. They are given directions and advised to apply for both identification and DSS the next day. When available case managers also provide transportation to these appointments.
- 3) Socialization: Following the assessment and intake process, a client profile is developed. The client profile will reflect client's risk factors for recidivating and relevant behavioral health needs. Information obtained about the client through the assessment process will be incorporated into the development of the Individual Service Plan (ISP). Each ISP will reflect service plans that are responsive to each offender's need and risk factor goals. The client signs off on these goals, with a review of the goals on at least a quarterly basis. Progress is monitored through an internal agency structure for quality control. In addition, this stage of the program involves the socialization, or introduction, to the Cognitive/Behavioral Treatment (CBT) Model. The primary goal at this stage is to have clients be able to distinguish between: thoughts, feelings, and attitudes/beliefs.....as they relate to specific situations – and the exploration of potential alternative behavioral resolutions/outcomes.
- 4) Restructuring: Beginning of treatment tracks that target dynamic criminogenic factors directly associated with criminal behavior. The major programmatic objective during this stage is to have clients achieve a readiness or motivation to change. Offenders will recognize the connection between antisocial cognitions, values, and behaviors with such negative outcomes as arrest, incarceration, homelessness, etc. Relevant evidenced-based interventions being delivered include the following:
  - a) Substance Abuse Cognitive Behavioral Treatment Curriculum (Curricula: Hazleton's New Direction – Criminal and Addictive Thinking and Najavit's Seeking Safety)
  - b) Motivational Interviewing
  - c) Vocational Skills
- 5) Vocational Preparation: A client's ability to secure and maintain employment will be assessed. Clients will receive vocational skills training that will concentrate on such areas as: resume writing and development, interviewing skills, locating potential employers, networking, etc.
- 6) Job Search: Clients are to secure employment and establish a savings account at a local bank. Program staff will continue to emphasize CBT life skills development and encourage clients to take responsibility for their choices and actions. The underlying objective is to instill self-worth, self-reliance and to help client develop positive

support systems, at home, work, and in the community, so the roots of a healthy and productive life style can take hold. Vocational skills training can be continued in this phase of programming for clients having difficulty finding employment – or for clients pending admission to a vocational program.

- 7) Integration: Clients are encouraged to maintain sobriety, employment, and compliance with behavioral health treatment plan. Program staff will assess the global needs of the client in the development of a Community Transition Plan. The Community Transition Plan will include: a summary of the offender's participation in the program, recommendations for level of supervision and risk factor prioritization in the areas of: (education/employment, financial, family, companions, accommodation, leisure/recreation, alcohol/drug problem, attitude/orientation), recommended treatment level for aftercare, supportive housing, social isolation, co-occurring substance abuse disorders, medical, case management, referral, advocacy and brokerage / collaboration of services to address these multiple issues. In addition, family as a potential positive support system will be explored. Family counseling will be offered to strengthen families and to facilitate the reintegration of the ex-offender back into the family unit. Attempts will be made to include significant others in order to enhance the client's connection to the community. This provides an opportunity for the client, and family, to share expectations, concerns, and anxieties regarding return to home.

### **Specific Program Policies**

Once clients begin working or securing some form of income they will be expected to pay 30% of their net weekly income towards the rent and utilities of the apartment in which they are residing. This amount is not to exceed \$255 weekly. Once participant begins working the case manager will make a copy of their first paycheck and complete a rental calculation sheet with client. This will determine the rental contribution which participant will be responsible for each time they receive a paycheck. If paycheck amount changes, case manager will figure out a new calculation based on your income for the week. Re-entry Assisted Community Housing staff will contact employers for confirmation of income periodically to confirm rental contribution amounts.

Other program expectations are;

1. Client will be compliant with conditions of release
2. Client remains arrest free
3. Client is compliant with all Program Rules and Guidelines
4. Client is compliant with Individual Service Plan
5. Client is compliant with Substance Abuse Treatment Plan
6. Client remains drug / alcohol free
7. Client maintains a legitimate and non-criminal means of support.  
(financial, medical, social)
8. Client secures adequate housing
9. Client reconnects with family supports where feasible and appropriate
10. Client develops a Community Transition Plan at discharge and complies with aftercare.

### **Discharge Planning and Aftercare**

REACH is designed to transition offenders from Correctional Facilities into communities. As a result, all of the interventions at REACH are designed with the end in mind and discharge planning is an ongoing component of the program. Offenders are introduced back into the communities that they came from, when considered appropriate, and provided with the resources, learning opportunities, and support necessary to transition successfully into independent living. This is accomplished by all the steps mentioned previously. Benchmarks are set and monitored, individual goals are identified and tasks created to move forward. Individuals are supported emotionally, challenged mentally and monitored behaviorally. Discharge planning always includes identification of both strengths and weaknesses. This process helps individuals utilize their unique strengths to overcome issues that arise in the future or that have not yet completely resolved by the time they discharge from REACH. Case Managers maintain an excellent knowledge of the community and make referrals for all individuals prior to their discharge when a need is present and the individual is willing to address the issue.

Furthermore, REACH currently provides for aftercare and follows up with an "open door policy" to any client who has left the REACH program for an unlimited period of time. Currently , both successful and unsuccessful program participants come back to visit program staff for various reasons, including resume writing and printing assistance, access to telephones and employment resources, referrals for mental health services, and sometimes just to visit and chat for a "cup of coffee" or to share something with their case managers. This supports the need to have a local program office, where clients can visit and continue to have access to staff and their resources.

**Family Re-Entry, Inc.**  
**Fresh Start Enterprise House**

**I. General Program Description**

- a. **Name of Program:** Fresh Start Enterprise House (FSEH)
- b. **Location of Program:** 532 West Avenue Bridgeport, CT
- c. **Total Number of Beds:** 8 total (DOC contracted)
- d. **Gender Specific:** Males
- e. **Length of Program:** 6 months (average)

**II. Program History**

- a. **Length of Operation:** Fresh Start Enterprise House is a new program
- b. **Background of Program:**  
The FSEH is designed to pilot and potentially expand a Delancey Street Foundation-like model. Integral to the model are the linkages among:

- (1) residence
- (2) employment and training
- (3) supportive services
- (4) community leadership and mentoring

Ideally, employment and training occur in “work-crews.” These crews are the structure of the ex-offender businesses and use work and entrepreneurship as a context for learning and creating pro-social mentoring relationships and community-based support systems. The model also provides linkage to a comprehensive array of reentry services provided through Family ReEntry’s Fresh Start Community Reentry Pilot Program (FSCRPP) and/or through linkages and referrals to existing reentry services in Bridgeport.

- c. **Philosophy of Program:**  
The program philosophy shifts the formerly incarcerated person (FIP) from incarceration/criminal justice system dependence to community integration and self-sufficiency. The community of successful ex-offenders is viewed as a sustainable resource used to create a web of supportive, role-model, mentoring relationships to ensure successful reentry. The program is based in part on the Delancey Street Foundation philosophy of creating a culture that supports positive pro-social behavior, motivation for work, mentorship (“*each one, teach one*”), and sustainable self-governance. Expectations are clear and evident throughout the program. It is believed that purposefully linking the work-culture and the residential-culture FIPs will create a culture of pride, expectations for success and excellence, mentorship, and service to others and the community.

- d. **General Goals of Program:**  
The resident-members will be in a congregate, supportive housing home at a single site for eight male, ex-offenders. Employment in one of FSCRPP’s four employment tracks immediately upon leaving a facility or shortly thereafter is a primary objective.

- (1) traditional open market job seeking and preparation
- (2) screening and placement with employer partner organizations (area companies that have an existing relationship with FSCRPP)
- (3) screening and placement in ex offender entrepreneurial business partner organizations in the local community
- (4) screening and placement in Fresh Start Enterprises, LLC

The ultimate goals are to:

- (1) reduce recidivism ( Recidivism can be operationalized in various ways. Although we expect the program to have a positive impact on all forms of recidivism, for the purposes of evaluation, recidivism will be defined as reconviction for a new crime.)
- (2) increase public safety
- (3) create a self-sustaining network of successful FIPs who will continue to assist others with successful reentry and become roles models and mentors to at-risk youth.

FSEH will train and support resident-members as they develop into crew-members and supervisors/crew-chiefs (capable of starting their own business) and role models (capable of mentoring others). The two key axes, vocational and mentoring skills, will be woven into most activities of FSEH. Whenever possible, successful FIPs from the community and from the resident-membership will be involved in teaching others and in managing the house.

### III. Services Offered

The program is inextricably linked to the FSCRPP. The design calls for comprehensive and coordinated efforts of FSEH, FSCRPP, CT DOC, and the network of Bridgeport community providers. FIPs will be active members of FSCRPP and will have received pre-release assessments and services prior to entering FSEH through the FSCRPP and/or other area providers. FSCRPP begins with client/inmate prerelease (3 to 6 months prior to release) at Webster CI.

The following is a list of services available to resident-members:

**1. All Services Required as a Participant in FSCRPP, which can include:**

- a. Counseling
- b. Job Readiness Group and Individual Job Coaching
- c. Reentry Support Group
- d. Substance Abuse Counseling and Relapse Prevention
- e. Mentoring for their Children (via Champions Mentoring Program)
- f. Family Events, Family Counseling, and Case Management
- g. Parenting Education
- h. Life Skills
- i. Domestic Violence Treatment and Prevention
- j. Health Screenings
- k. Referrals to Needed Service and Treatment Providers

**2. Case Management (FSEH)**

The FSEH Coordinator, with the assistance of the FSCRPP Reentry Coordinator, will provide all case management services. The FSEH Coordinator will focus specifically on issues related to employment and, if applicable, the resident-member will work within one of Fresh Start Enterprise's micro-business work-crews. The Reentry Coordinator will be responsible for case management related to services provided under FSCRPP.

**3. Employment (FSEH, FSCRPP, and other area providers)**

FIPs will be assessed for job readiness immediately upon release or if possible during the prerelease phase of the program. Family ReEntry, working in concert with Career Resources and Street Smart Ventures (Fresh Start Enterprises, LLC), will build on their existing relationships with large Fairfield County employers to develop work crews with experienced leaders to fulfill various paid employment projects, in concert with employer partners. As soon as possible, residents of FSEH will be employed in one of the four employment tracks (see Section II.d).

**4. Contingency Management (FSEH)**

Case Manager will implement a Contingency Management Program to identify and reward specific behaviors that lead to success.

**5. Activities for Families of Resident-Members (FSEH and/or FSCRPP)**

In conjunction with or independent of FSCRPP, FSEH will sponsor periodic events and activities to bring families and support systems together.

**6. Transportation (FSEH and/or FSCRPP)**

While used occasionally, at times it may be necessary for the case manager or other staff to drive a client to appointments or pick him/her up for treatment sessions. Resident-members involved in one of the businesses of Fresh Start Enterprises, LLC will have transportation to and from the work site provided.

### IV. Eligibility and Exclusions

**a. Eligibility Requirements:**

- (1) Males 18 years and older, from a Connecticut correctional institution
- (2) Eligible for CTDOC supportive housing
- (3) Under CTDOC supervision
- (4) Compliant client of Fresh Start: Community Reentry Pilot Program
- (5) Willing to sign, and comply with Fresh Start Enterprise House Participant Agreement. (a copy of the Participant agreement is on file with CTDOC) Failure to comply with the agreement may result in review of eligibility to continue or immediate discharge from FSEH, depending on severity of non-compliance. CTDOC will be notified prior to discharge and included in the decision-making process.
- (6) Resident-members selected to join the work-crews of Fresh Start Enterprises, LLC must be able and willing to undertake the physical work required by the job.

**b. Exclusionary Criteria:**

- (1) Serial violent and/or predatory offenders will be reviewed on a case by case basis
- (2) Those with arson as their controlling charge, and/or those previously convicted of arson in the 1<sup>st</sup> or 2<sup>nd</sup> degree (53a-111 and 53a-122 respectively) or arson murder (53a-54d). Arson is defined as ‘any willful or malicious burning or attempt to burn, with or without intent to defraud, a dwelling house, public building, motor vehicle, aircraft, or personal property of another’.
- (3) No sex offenders convicted of predatory and/or violent sexual offense and/or those convicted of sexual assault 1<sup>st</sup> or 2<sup>nd</sup> (53a-70 and 53a-71 respectively) or sexual assault with a deadly weapon (53a-70(1)) will be accepted.
- (4) Clients with serious psychiatric illness requiring a high level of care. Clients with psychiatric illness and/or on psychotropic medication will be assessed for admission on a case-by-case basis (medication compliance is required).

## **V. Admission Process**

### **a. Length of Consideration for Admission:**

One week to 10 business days (maximum) depending on access to offender and the active waiting list. Ideally, offenders will be located at Webster CI and already enrolled in Fresh Start: Community Reentry Pilot Program.

### **b. Protocol Followed During Admission Process:**

Given the requirement that potential residents participate in the FSCRPP, the admissions protocol will follow those of the FSCRPP. Potential candidates will also be interviewed to discuss the FSEH philosophy, rules and requirements. They will/can be interviewed by FSEH Coordinator, Business Development/Job Development staff, senior resident-members, and/or FSCRPP staff. All clients must agree to and sign the “Participant Agreement”.

## **VI. Specific Program Policies**

### **Client Rent:**

Up to 30% of gross salary/wages based on a sliding scale and in consideration of each client’s particular financial circumstances.

## **VII. Discharge Planning and Aftercare**

A goal of the FSEH model is for resident-members to prepare to live independently upon discharge. As resident-members of FSEH near completion, they will be assisted in finding suitable housing and will be reassessed for level of continued services needed. The FSCRPP discharge plan will be incorporated with the FSEH discharge plan. Clients are encouraged to continue as a member of the “work-crew” and may have already moved into a leadership role. Discharge plans will be developed with the resident-member and discussed with any community supervision officials.