From Custody to Care: Advancing Trauma-Informed, Person-Centered Reentry Models

Prepared by: Joe Gallant

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An Advocacy White Paper on Transformative Reentry Policy and Practice

Executive Summary

Across the United States, reentry systems remain anchored in supervision-heavy, compliance-driven models that have demonstrated limited effectiveness in reducing long-term recidivism. While there have been modest national declines in certain reincarceration metrics over the past decade, fundamental vulnerabilities in the system persist. In Connecticut, the 2026 recidivism study reveals that exactly 50% of the 2022 release cohort returned to Department of Correction (DOC) custody within three years. This figure signifies a persistent and systemic failure in current reentry practices, mirroring rates seen prior to the pandemic.

This white paper argues for a decisive paradigm shift away from surveillance and toward trauma-informed, person-centered, and harm-reduction-based reentry frameworks. Drawing upon emerging research, federal best-practice guidelines, and comparative state-level data, the evidence suggests that without structural reform, recidivism will remain stable. High rates of return to custody are driven not only by individual behavior but by system design—specifically, fragmented care, punitive responses to behavioral health needs, and an overreliance on technical enforcement.

By moving from a framework of "custody" to one of "care," policymakers and practitioners can build a reentry infrastructure that prioritizes healing, practical support, accountability, and continuity of care. Implementing evidence-based practices—such as Medication for Opioid/Alcohol Use Disorder (MOUD/MAUD), intensive case management, and peer navigation—offers a pathway to significantly improve public safety, reduce systemic costs, and honor the dignity of justice-involved individuals.

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Introduction: A System at a Crossroads

The transition from incarceration to the community is one of the most critical and precarious periods in the criminal justice continuum. For decades, the dominant approach to reentry has been characterized by strict supervision, rigid compliance monitoring, and punitive responses to instability. While intended to promote public safety, this framework has frequently functioned as a revolving door, capturing individuals in administrative technicalities and unresolved behavioral health crises rather than fostering sustainable independence.

As we evaluate the landscape in 2026, the necessity for a transformed approach has never been more apparent. State and national data consistently demonstrate that surveillance alone does not equate to safety. When systems prioritize monitoring over practical support and trauma recovery, they inadvertently manufacture recidivism. This paper synthesizes the latest data from Connecticut, regional peers, and national bodies to advocate for a systemic overhaul. It charts a course toward trauma-informed, person-centered models that recognize justice-involved individuals as human beings requiring holistic support—housing, healthcare, and employment—rather than mere subjects of state control.

Section I: The Status Quo in Connecticut

The 2026 Connecticut Office of Policy and Management (OPM) Criminal Justice Policy and Planning Division (CJPPD) Recidivism Study provides critical insight into current reentry outcomes. Analyzing the 2022 release cohort, which consisted of 5,809 sentenced individuals (a 25% increase from 2021 reflecting post-pandemic normalization), the data paints a stark picture of stagnation.

According to the report, exactly 50% of the individuals released in 2022 returned to Department of Correction custody within three years. This cumulative recidivism rate is remarkably similar to the 2021 cohort and remains just below the pre-pandemic benchmark established by the 2015 cohort. Sub-population data is even more concerning: 45% of women released in 2022 returned to the DOC within 36 months, and an alarming 64% of individuals under the age of 25 returned over the three-year period.

These findings highlight a structural equilibrium that policy reforms and reduced incarceration populations have failed to disrupt. Recidivism in Connecticut is not declining. The persistent return-to-custody rates suggest that the mechanisms designed to facilitate successful reintegration are fundamentally mismatched with the realities of the populations they serve. It indicates a systems failure rooted in the very design of the state's reentry infrastructure.

Section II: Regional Comparisons: What State Data Do—and Do Not—Show

To contextualize Connecticut's outcomes, it is vital to examine the broader regional landscape in the Northeast. Recent data reveals a complex picture of reentry success and failure across neighboring states. However, it is imperative to apply a critical lens to cross-state comparisons.

Methodology Note: The Council of State Governments (CSG) Justice Center strongly cautions that differences in how states define and measure recidivism limit the precision of cross-state comparisons. States vary in their follow-up periods, the populations included, and the outcome measured (rearrest, reconviction, or reincarceration). Thus, the data below should be interpreted as directional indicators of state-level trends rather than direct peer-to-peer rankings.

Table 1: Northeast Regional Recidivism Reporting (Most Recent Available Data)

State	Cohort / Year	Reported Rate	Definitional Context & Caveats
Connecticut	2022 Cohort	50%	Return to DOC custody for any reason within 3 years.
Rhode Island	CY2021 Cohort	46%	Sentenced recidivism rate using a newer, holistic method; includes returns to sentenced and awaiting-trial status.
Vermont	CY2021 Cohort	42%	Narrow definition: return to prison within 3 years for new conviction or supervision violation resulting in 90+ days incarceration (for sentences >1 year).
Massachusetts	2019 Cohort	26%	Overall 3-year recidivism. Drops to 20% if excluding technical violations. Defined as reincarceration for a criminal sentence within 3 years.
New York	2020 Cohort	19%	Returned to custody within 3 years. Framed by DOCCS as a record-low return-to-custody rate.

Despite the definitional variances, regional clustering suggests that standard correctional systems operating with heavy reliance on traditional supervision (like Connecticut and Rhode

Island) maintain high recidivism equilibriums. States like Massachusetts and New York, which have aggressively redefined their metrics or shifted focus toward limiting technical reincarcerations, report lower aggregate rates. The variability reinforces that policy design, metric definitions, and programmatic focus heavily dictate the "success" of a reentry system.

Section III: Supervision as a Driver of Reincarceration

A major finding across national and state-level research is that a significant portion of recidivism is driven by system responses to administrative rules, rather than new criminal behavior. Millions of individuals navigate the U.S. probation and parole systems, where supervision frequently acts as a "tripwire to reincarceration."

According to a 2024 report by the CSG Justice Center, approximately 44% of all prison admissions nationally in 2021 were of people who violated the terms of their parole or probation sentences. More critically, about one-third of all prison admissions stemmed purely from technical violations—infractions such as missed appointments, curfew violations, or failed drug screens that are not inherently new crimes. When systems measure compliance rather than functional stability, they penalize the symptoms of trauma and poverty.

Key Takeaway: Why Technical Violations Matter

Technical violations disproportionately punish instability rather than intent. When an individual misses a curfew due to erratic work schedules, or fails a drug test due to an untreated substance use disorder, revoking their community status interrupts housing, employment, and familial bonds. The staggering statistic that one-third of all prison admissions relate to technical violations demonstrates that our systems are exceptionally efficient at catching failure, but poorly designed to cultivate success.

Section IV: National Trends and the Limits of "Progress" Narratives

National conversations around criminal justice reform often highlight declining incarceration rates as evidence of systemic progress. The CSG Justice Center notes that national three-year reincarceration rates declined from 35% for the 2008 release cohort to 27% for the 2019 cohort—a 23% decrease. While this represents a policy-driven reduction in re-imprisonment, it does not necessarily indicate behavioral transformation or successful community integration.

To understand the limits of this progress narrative, one must look at rearrest data. A landmark Bureau of Justice Statistics (BJS) study of state prisoners released in 34 states in 2012 revealed that 62% were arrested within 3 years, and an overwhelming 71% were arrested within 5 years. Furthermore, among the 21 states with complete return-to-prison data in that study, 46% returned to prison within 5 years.

This analytical breakdown illustrates a critical divergence: while policy shifts have lowered formal reincarceration rates in some jurisdictions, behavioral interactions with the justice

system (rearrests) remain alarmingly high. Progress is partial and misleading when systems merely expand community surveillance rather than adequately funding community-based support. Recidivism metrics often reflect systemic measurement criteria rather than genuine human rehabilitation.

Section V: Trauma, Behavioral Health, and Instability as Core Reentry Realities

Justice-involved populations experience disproportionately high rates of childhood adversity, exposure to violence, substance use disorders, and chronic instability. Traditional correctional and reentry models are fundamentally ill-equipped to handle these realities. Custodial environments often reinforce hypervigilance, trigger trauma responses, and systematically strip individuals of their autonomy.

The Substance Abuse and Mental Health Services Administration (SAMHSA) emphasizes that the transition from incarceration to the community requires immediate, targeted intervention. Their guidance stresses that the first hours, days, and weeks after release are critical vulnerabilities. Without continuity of care and direct linkages (warm hand-offs) to community providers, individuals with behavioral health needs face a high risk of relapse, overdose, and re-arrest.

Critical Window: The First 72 Hours and 30 Days

The immediate post-release period is a high-risk window for mortality and recidivism. SAMHSA transition guidelines underline that navigating the first 72 hours requires securing safe housing, accessing medications, and finding transportation. The first 30 days dictate whether an individual will stabilize or fall back into survival-driven behaviors. Reentry models that fail to provide intensive, front-loaded support during this window are effectively abandoning individuals at their most vulnerable moment.

Section VI: Why Custody-Centered Reentry Models Fall Short

Custody-centered halfway houses and traditional reentry facilities are often extensions of the prison environment. They replicate institutional control mechanisms, prioritizing rule enforcement, drug testing, and curfews over relationship-building, therapeutic intervention, and practical skill acquisition.

These system-level failures manifest in several distinct ways:

- **Compliance Over Capacity:** Systems measure how well a person follows rules, not whether they have secured living-wage employment or stable housing.

- **Punitive Responses to Behavioral Health Needs:** Relapse is treated as a disciplinary infraction resulting in reincarceration, rather than a clinical event requiring treatment adjustments.
- **Lack of Integrated Services:** Individuals are forced to navigate labyrinthine bureaucracies to secure identification, healthcare, and employment, often with little systemic coordination.
- **Fragmented Care Continuity:** Medical and mental health care received inside facilities rarely translates seamlessly to the community, resulting in perilous gaps in medication and therapy.

The result is a population that may be technically compliant for a short period but remains functionally unstable, inevitably leading to a relapse into the justice system.

Section VII: The Case for Trauma-Informed, Person-Centered Reentry

A transformed reentry model shifts the primary objective from surveillance to stabilization. SAMHSA's evidence-based reentry guide highlights that the strongest interventions for justice-involved individuals with behavioral health conditions include Medication for Opioid/Alcohol Use Disorder (MOUD/MAUD), intensive case management, and peer/patient navigation. Implementing these requires a trauma-informed infrastructure.

Trauma-informed care (TIC) acknowledges the widespread impact of trauma and integrates this knowledge into policies, procedures, and practices to actively resist re-traumatization. A person-centered approach ensures that reentry planning is collaborative and individualized, beginning well before the release date. When agencies share information across systems, cross-train staff in trauma responses, and center housing and employment as foundational rights, the system shifts from expecting failure to facilitating success.

Section VIII: What a Transformed Reentry Model Looks Like in Practice

Transitioning to this new paradigm requires fundamentally rethinking how state agencies, community providers, and individuals interact. The table below contrasts the prevailing compliance model with the evidence-backed person-centered model.

Table 2: Paradigm Shift in Reentry Frameworks		
Domain	**Current Compliance-Centered Model**	**Trauma-Informed, Person-Centered Model**
Primary Objective	Surveillance, monitoring, and risk management.	Stabilization, recovery, and capacity building.
Success Metrics	Absence of technical violations; clean drug screens.	Sustained housing, employment retention, health continuity.
Response to Relapse	Punitive sanctions; revocation of community status.	Harm reduction; clinical intervention and treatment adjustment.
Care Coordination	Fragmented; individual is responsible for navigating silos.	Integrated; warm hand-offs, peer navigators, and shared data.
Staff Role	Enforcer of rules and conditions.	Case manager, advocate, and resource navigator.

Section IX: Data-Informed Policy Recommendations

To move from custody to care, state legislatures, DOCs, and community partners must implement actionable, structural changes. Evidence suggests that adopting the following recommendations will yield directional improvements in public safety and individual stability:

- **Redefine Success Metrics:** Shift agency funding and performance metrics from "violation rates" to "stability indicators" such as 6-month housing retention, employment acquisition, and continuity of medical care.

- **Limit Technical Reincarcerations:** Restrict the use of prison admissions for technical violations. Mandate graduated, community-based clinical sanctions for infractions rooted in substance use or mental health crises.
- **Expand Evidence-Based Interventions:** Universally adopt SAMHSA-recommended practices, including the uninterrupted provision of MOUD/MAUD across the facility-to-community threshold, and the funding of peer navigators with lived experience.
- **Reengineer Halfway Houses:** Transition transitional housing from quasi-custodial environments to therapeutic, community-based stabilization hubs staffed by behavioral health professionals rather than correctional officers.
- **Mandate Cross-System Integration:** Require data-sharing agreements and cross-training among correctional staff, parole officers, and public health providers to ensure seamless, warm hand-offs prior to release.

Section X: Implementation Roadmap for Connecticut and Similar States

Transforming a deeply entrenched system requires a phased approach. The following roadmap outlines a realistic trajectory for states currently exhibiting high recidivism equilibriums.

Near-Term Actions (0–12 Months)

Establish cross-agency task forces explicitly focused on the first 72 hours of release. Institute immediate policies requiring warm hand-offs for individuals with behavioral health diagnoses, ensuring pre-release Medicaid activation and medication continuity. Begin tracking and publicly reporting technical violation drivers separately from new criminal convictions.

Medium-Term Actions (1–3 Years)

Overhaul the contracting and procurement processes for halfway houses and community providers. Tie state funding to trauma-informed training requirements and stability outcomes rather than bed-filling quotas. Launch pilot programs utilizing peer navigators in high-return jurisdictions.

Long-Term Actions (3–5 Years)

Achieve legislative codification of harm-reduction principles in parole and probation standards, legally restricting reincarceration for non-violent technical violations. Fully integrate state data systems between justice, health, and housing departments to create a unified support net, ultimately driving the 50% recidivism baseline down to match or exceed the most progressive regional peers.

Final Call to Action

The 2026 data from Connecticut confirms what frontline practitioners and directly impacted communities have long known: the current reentry system is designed in a way that produces failure consistently. A 50% return-to-custody rate is not an anomaly; it is the predictable output of a compliance-heavy, trauma-blind apparatus. Despite years of superficial reform efforts, recidivism remains stable because the underlying philosophy of surveillance remains unchanged.

A trauma-informed, person-centered approach offers a rigorous, evidence-supported alternative. By integrating harm-reduction principles, funding intensive case management, prioritizing the critical post-release window, and dismantling the technical violation tripwire, we can build a public safety strategy rooted in genuine stability.

The question facing policymakers, corrections leaders, and advocates is no longer whether reform is needed—the data makes that unequivocally clear. The question is whether we possess the political will to move beyond the illusion of control, to invest meaningfully in human care, and to redesign reentry as an authentic pathway to healing, dignity, and sustainable community reintegration.

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Written by: *Joe Gallant-Reentry Reform*

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