



STATE OF CONNECTICUT

OFFICE OF PROTECTION AND ADVOCACY FOR
PERSONS WITH DISABILITIES
60B WESTON STREET, HARTFORD, CT 06120-1551

Testimony of the Office of Protection and advocacy for Persons with Disabilities
before the Judiciary Committee

Presented by: James D. McGaughey
Executive Director
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Good afternoon and thank you for this opportunity to comment on several of the bills on your agenda today.

The first three I want to address reflect increasing awareness of the large number of people with psychiatric disabilities who are caught up in the criminal justice system. It is estimated that between 12 to 16 % of DOC inmates have mental illnesses serious enough to require treatment. In fact, as is true across the country, the number of inmates in Connecticut prisons with significant mental illnesses has grown significantly over the past 15 years, and now far exceeds the number confined in state hospitals.

Incarceration has an enormous impact on the lives of those individuals, and they, in turn, significantly impact the resources of the judicial, correctional and mental health service systems. So it is encouraging to see attention being paid to this issue. However, it is also clear that there are many facets to the problem, and that we must be careful that in addressing one issue, we are not inadvertently creating an adverse impact somewhere else. For instance, making it easier to divert people whose competency to stand trial is in question directly into treatment will help to secure more timely treatment and keep many of them out of prison. But, if, in our enthusiasm for this approach, we lean too far in the direction of encouraging coercive practices in treating this population, we may inadvertently hamper the mental health service system's laudable efforts to transform its organizational culture in the direction of non-coercive, recovery-oriented practices, and actually wind up discouraging these same people from continuing in voluntary treatment once court oversight ends. Similarly, while we want to secure and protect the civil rights of incarcerated inmates with mental illnesses, we do not want to create the inevitably false impression that prisons can ever become good treatment environments. Above all, we cannot lose sight of the reality that many (though admittedly not all) of the people with mental illness who are now being charged and convicted of offenses would never have gotten into trouble in the first place if relevant community-based services were more readily available.

Raised Bill No. 5651, AN ACT ADOPTING THE RECOMMENDATIONS OF THE REPORT OF THE COMMISSION ON PRISON AND JAIL OVERCROWDING identifies specific funding that is to be appropriated for each of a number of distinct programs or initiatives. I profess no expertise regarding the sufficiency of the expenditures it calls for, but, in general, the programmatic directions the bill would expand or initiate reflect those that, in our Office's experience, would help meet the needs of many people with psychiatric disabilities who become

entangled with the criminal justice system. These include expanding and intensifying pre-trial supervision alternatives and re-entry programs, including residential and day-reporting options specifically intended to meet the needs of people with psychiatric disabilities. It is also gratifying to see attention paid to increasing the competency with which the parole and probation systems can accommodate people with mental illness. We find that people with psychiatric disabilities who are accused of crimes are more likely to be incarcerated prior to disposition because courts are uncomfortable releasing them to loosely supervised situations. We have also observed that after sentencing, they stay in correctional institutions longer than other offenders convicted of comparable offenses because the current array of community supervision alternatives has difficulty accommodating their needs. I know that DMHAS has long wanted to establish a residential AIC as called for in this bill, but that it has experienced citing difficulties. It is heartening to hear they are now considering scattered site program models, and we hope they will go even further to explore some of the successful models from neighboring states - models that look to find permanent housing and provide intensive supports that can gradually fade as ex-offenders begin to experience successes in their own homes.

Raised Bill No. 359, AN ACT CONCERNING COMPETENCY TO STAND TRIAL, would allow psychiatric hospitals conducting competency assessments of criminal defendants to identify more individuals as candidates for voluntary treatment or, in some cases, civil commitment. It also gives courts more clarity regarding treatment-oriented alternative dispositions. In general terms these are good things. However, the underlying statute provides a mechanism for hospitals to report non-compliant voluntary patients back to the court, and the bill expands on this feature, requiring that the report include an opinion as to the person's current state of competency, the clinical findings of the person filing the report (and the facts upon which they are based), and information on methods of treatment and type, dosage and effect of medications. I would recommend a further requirement that such reports also include information concerning: 1) any objections stated by the person to the proposed treatment plan; and, 2) the efforts of the facility to address those objections and negotiate an acceptable treatment plan.

In our Office's experience there are usually two sides to a "non-compliance" issue. Sometimes a person has had prior bad experiences with a particular drug or combination of drugs, and sometimes they feel, with justification, that their concerns are not being heard or taken seriously. Although one can question the level of voluntariness with which any person who is subject to this statute agrees to treatment, there is no question that the technologies employed in treatment - principally the use of psychotropic drugs - can powerfully affect fundamental interests involving thought processes, emotional responsiveness and long term physical health. Under this statutory scheme, treatment facilities are supposed to make "reasonable efforts to encourage compliance". Requiring the report described in Section 1 (h) (2) (A) to include information reflecting the patient's perspective may prompt facilities to redouble their efforts to develop a mutually

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agreeable treatment plan, and may also help the court to recognize that its decision should consider both the perspectives of professional treaters and the fundamental interests of individuals.

Raised Bill No. 5542, AN ACT CONCERNING THE RIGHTS OF INMATES WITH PSYCHIATRIC DISABILITIES, would amend the definition of "facility" in the Patients' Bill of Rights for persons with psychiatric disabilities to include any correctional facility in which inmates with psychiatric disabilities are treated. In deference to the impracticality of recognizing inmates' rights to personal property, clothing and private communications, and other rights that arguably cannot be reconciled with correctional realities, the bill calls for only certain sections of the Bill of Rights to apply in those facilities.

The concept advanced in this bill is much needed and long overdue. In the process of becoming the single largest provider of residential services to people with mental illness in the State, the Correction Department has begun to encounter the inherent difficulty involved in drawing lines between what is considered to be acceptable correctional practice and what is considered humane treatment for someone with a mental illness. The biggest problems involve: 1) reconciling disciplinary procedures and safety considerations with responses to inmates whose non-conforming behaviors are a result of mental illness; and, 2) problems with the availability, quality and formats of mental health services in different environments. Underlying these issues is fundamental ambiguity regarding the identities of inmates with mental illnesses as "prisoners" or "patients", and at least some confusion as to what we are expecting of the prison system. In fact, because correctional practices and prison environments are so fundamentally different than those of the treatment facilities around which the Patients' Bill of Rights were constructed, it may prove more advantageous to develop provisions that specifically apply in the prison context. If our Office can be of assistance in pursuing this approach, please let me know.

Lastly, but hardly least, our Office supports Raised Bill No. 456, AN ACT CONCERNING THE ELECTRONIC RECORDING OF INTERROGATIONS. This bill would require that custodial interrogations of persons suspected of serious felonies be recorded whenever feasible. I understand that there are many jurisdictions where recording custodial interrogations is routine and considered good practice.

The recordings called for in this bill would help safeguard the rights of people with cognitive or psychiatric disabilities who may be subject to custodial interrogations. Many people who have mental retardation, non-verbal learning disabilities, autism-spectrum disabilities, brain injuries and mental illnesses find themselves at a significant disadvantage when being questioned by authorities. Although generalizing is risky and often unfair, there is strong evidence to the effect that people with mental disabilities are often more easily talked into agreeing to do or say things.

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Some of this is a survival strategy: people who have intellectual disabilities or who experience difficulty reading social cues often cultivate a sense of how to please authority figures and “pass” in situations where they do not fully understand what is happening. In the context of custodial interrogation, relying on such a strategy can prove disastrous. But there is more involved than a desire to pass for “normal” and to please others. Some of the problem also has to do with naiveté and confusion: if you have a mental disability, it is easy to become confused or insecure as to your own recollections of past events, and you are quite likely to accept interpretations offered by others. Unfortunately, interrogation techniques designed to undermine the resistance of intellectually and socially typical suspects can so confuse people with mental disabilities that they falsely confess, perhaps even without recognizing that they have done so. Across the country evidence is mounting that people with mental disabilities are particularly susceptible to falsely confessing when confronted by exhausting, aggressive interrogation tactics.

Knowing what was actually said by such persons and by their interrogators during custodial interrogations would go a long way toward preventing wrongful convictions and assuring that our criminal justice system treats persons with cognitive and psychiatric disabilities fairly. Our Office urges your support for this measure.

Thank you for your attention. If there are any questions, I will try to answer them.