STATE OF CONNECTICUT

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PERSONS WITH DISABILITIES
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Testimony of the Office of Protection and Advocacy for Persons with Disabilities
Before
The Judiciary Committee
Hearing on Criminal Justice Reform Proposals

Presented by James D. McGaughey
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Good afternoon. I am Jim McGaughey, Executive Director of the Office of Protection and Advocacy for Persons with Disabilities. Thank you for this opportunity to present our Office's views on the various proposals you are considering today.

As most of you know, OPA is a small, independent State agency that operates pursuant to both State and federal mandates to protect and advocate for the civil rights of people with disabilities. Part of our role involves investigating and advocating in situations where people with disabilities are victims of abuse and neglect. This means that we often must make referrals to law enforcement agencies, and sometimes assist victims of abuse or exploitation to understand and exercise their rights to file reports about things that have happened to them with police agencies. Because people with disabilities are, as a group, frequent victims of crimes involving exploitation, coercion and violence, it is clear that our justice system must be capable of effectively protecting them and other particularly vulnerable people. So we very much appreciate the serious attention being paid to how well our system is working, and what can be done to correct any gaps or "holes" that may exist.

However, my principal reason for testifying today arises from experiences we have advocating for a number of individuals with disabilities – primarily psychiatric disabilities, but some with cognitive and developmental disabilities as well – who wind up on the other side of the criminal justice system. I am not speaking of people who commit truly serious crimes, but rather of individuals who are arrested and incarcerated because they are engaging in some sort of problematic behavior that indicates a need for more support services, or different kinds of support services than are available to them. In prison, these individuals often run afoul of the disciplinary rules, become easy victims of others, and they often emerge traumatized, with even greater levels of anger and frustration than before they entered. At a minimum they acquire additional stigmatizing labels and experiences that make the road to recovery more difficult.

Given adequate, relevant supports, which in some cases would include some form of supportive housing, many of those individuals would not be incarcerated, and, in fact, could become contributing members of their communities. It would be more cost effective, and, from a humanitarian perspective, much more appropriate to expand community-based support programs targeted to this population than to continue to send them to prison, where they occupy space that would be better used to house individuals who represent real threats to public safety. I am hoping that you will consider making some recommendations that would help this respect.

I realize that the fate of this group is not the primary focus of this hearing. In fact, like other advocates I have spoken with, I was initially concerned that even testifying here today might contribute to some confusion about the identities and needs of the people I am speaking about, or be misconstrued as an effort to excuse criminal conduct. There are a lot of lingering misperceptions about mental disability and, despite considerable progress in treatment and support approaches over the past 30 years, there remains a great deal of social stigma associated with psychiatric and developmental disabilities. Part of what perpetuates this stigma is the quite inaccurate perception that people with psychiatric and developmental disabilities are likely to be violent or dangerous. And, as the concerns that gave rise to this hearing involve our ability to protect society from genuinely dangerous individuals, there is some risk that saying anything about psychiatric or cognitive disability in the context of your discussion will fuel further confusion as to the identities and needs of people that we, as advocates, are concerned with. Nevertheless, there are so many people with psychiatric disabilities and developmental disabilities and brain injuries who are on the incarceration merry-go-round – often for relatively minor offenses - that I feel compelled to raise this issue.

How many people are we talking about? It depends on which study or set of statistics you refer to. The Office of Legislative Research recently released a report indicating that approximately 20 % of the incarcerated population in Connecticut has significant mental illness. Based on data gathered in the 1990s, earlier studies had estimated that between 8% to 16% of the prison population had significant mental illnesses. Nationally, the estimates appear to be a quite a bit higher – up to 50% of the jail population according to the Department of Justice's numbers – but most states maintain separate jail and prison systems, so that figure is not especially meaningful in Connecticut where the Department of Correction operates a unified system. The important point is that these raw numbers point to an alarming trend: as the total number of incarcerated individuals has risen over the past decades, so has the relative percentage of those individuals who have serious and persistent metal illnesses. Across the country, prison systems have become the single largest provider of residential services to people with psychiatric disabilities.

Given the vagaries of correctional classification schemes, it is difficult to get a handle on how many of those incarcerated individuals with mental disabilities were arrested for minor offenses and are being held in jail largely because the supports they need to make it in the community aren't available. However, using measures involving length of sentence, charged offenses and the relative amount of bond assigned, our Department of Correction is now attempting to do that. Their reports indicate that somewhere between one-third to one-half of "unsentenced" (accused) inmates with Mental Health screening scores of 4 or 5 (indicating a significant mental illness) are being held on relatively low bonds, charged with offenses like possession, harassment, disorderly conduct, criminal trespass, criminal mischief, failure to appear, etc. Based on their data, a similar picture emerges with respect to the sentenced population – approximately 15% - 20% of sentenced inmates with high mental health scores (MH 4 & 5) were charged with relatively low level offenses and have low security screening scores (Security Level 2).

At some point in the near future, DOC expects to be able to expand its ability to produce data to include specific information about inmates with mental retardation and brain injury – most of whom are currently lumped into the MH 3 category. Given the scarcity of services for people with those types of disabilities, I would expect a similar picture to emerge.

While the data are preliminary and imperfect, their implications are clear: from the perspective of public safety, a significant percentage of people with mental disabilities who are in prison in Connecticut do not

need to be there. In the course of advocating for a number of these individuals, our Office had numerous discussions with State's Attorneys and Public Defenders, and with mental health service system staff who work with jail diversion and jail re-interview programs. Based on what we have learned, I believe it is safe to say that most courts would happily decide not to incarcerate people who fall into these categories if they were reasonably assured whatever problems that resulted in their arrests would be adequately addressed through provision of services, supports and supervision.

It is also clear that DOC is feeling stressed both by raw numbers and by its growing awareness of the treatment needs these individuals present. However, while it has attempted to respond by dedicating a particular facility to housing some of these inmates, the experience at Garner has proven somewhat problematic. In fact, it is difficult to imagine how any attempt to retrofit a correctional facility as a mental health program could be anything other than problematic. Prison systems must operate according to tight rules and procedures in order to protect the safety of all involved. They are geared to looking at a person's behavior, not at what might underlie that behavior. Did the inmate comply with an order or not? Did the inmate commit an infraction or not? The presumption is that people need to be held accountable for their behavior, and the fact that some people's behavior is a manifestation of a mental disability sounds suspiciously like an excuse to evade accountability. Prison environments generally do not afford the kind of flexibility, individuality and relationship building needed to provide real treatment. Further, in prison culture, seeking mental health treatment is often interpreted as a sign or weakness, or even as evidence of "malingering". Creating specialized units and facilities may sound progressive, but, in the context of an overall system established for quite different purposes, these units bring their own problems: Who does and does not deserve to be there, and for how long? What happens to the commitment to therapeutic goals when there are serious violations of the rules and safety is compromised? Given that only a small percentage of inmates needing mental health care can be housed in specialized units, will moving staff with mental health expertise and other resources to the specialized facility take away from what is needed in other jails and prisons where the majority of prisoners with psychiatric histories still live, and where symptoms are most likely to first appear amongst newly admitted individuals. And what about the "if you build it, they will come" phenomenon? There is a real risk that establishing such a facility tends to create the impression that there is a "good place" in the prison system for people with mental illness or other mental disabilities, making it seem more acceptable to send them to jail.

So, as I guess you may have gathered, along with other advocates you will hear from, we cannot support the proposal in Section 15 of Draft Bill No. 4 to build a 1200 bed medical and mental health correctional facility. Rather than investing in such an expensive facility in the correction system, it would be more cost effective and decidedly better social policy to invest in specific community-based support systems, including various supported housing models.

There are, however a number of other initiatives that have recently commenced that help address the problem of people with mental disabilities in prison. These are very worthy of expanded support. Special parole and probation officers have been hired and trained, and DMHAS has some promising pilot programs such as the Community Re-entry Program and Transitional Case Management program. In addition to the established jail diversion and re-interview programs, DOC is moving to ensure that people with mental health needs are considered eligibility for space in Half-Way Houses, and CSSD (Court Support Services Division) is making similar attempts to ensure access to Alternative to Incarceration Centers.

These approaches are hopeful, but they are small, tentative and underfunded. And, there are several critical components still missing: housing, active involvement by the Department of Developmental Services (formerly DMR), and some modifications to the general rules for compliance that would allow for the sometimes steep learning curve that accompanies the process of recovery.

With respect to housing, I would just point out that while having a case manager, a specially trained probation or parole officer, and ready referrals to nursing and psychiatric services are really good things, if a person is essentially homeless, without a permanent and legitimate place to call his or her own, surrounding that person with vigilant services remains a limited strategy. Housing, and in many cases supportive housing is desperately needed. By "supportive housing" I am not talking about creating congregate residences, except perhaps for some "sobering" or "sober houses", which seem to have real value. I am talking about the type of supportive housing where people get frequent checking and help to maintain their homes and their places in the world. Finding permanent homes – individual apartments - for people who would otherwise be sent to prison is one of the core strategies being successfully employed by the "Nathaniel Project" in New York City, which is considered a national model for alternatives to incarceration for people with significant mental illnesses. To have a home – a place that is really yours - is fundamental to mental health, to personal recovery, to having a stake in your community and to any successful policy strategy that purports to address this problem. We need to invest considerably more in this area.

The policy gaps confronting people with intellectual disabilities who run afoul of the criminal justice system is lesser known, but equally compelling to that affecting people with psychiatric disabilities. Few people realize that simply having a diagnosis of mental retardation does not entitle a person to public services through the Department of Developmental Services. In fact, unless a defendant has been found incompetent to stand trial and is subsequently committed to DDS, it is highly unlikely that he or she will receive any services. Our Office has advocated for a number of defendants with intellectual disabilities for whom alternatives to incarceration would have been readily accepted by all parties in the criminal justice system, but for whom DDS would not provide any services. Even sadder than seeing these people go to jail unnecessarily, is seeing them released at the end of their sentences without supports. Predictably, some reoffend, and face even stiffer penalties. DDS explains that it only has sufficient resources to serve people for whom it has legal responsibility. If, like the supportive housing issue, this is a resource issue, we need to resolve it.

Regarding the need for some mechanisms to allow for the steep learning curve sometimes associated with efforts by people with psychiatric disabilities to recover their lives, especially when they experience a co-occurring substance abuse problem, I would point out that a proposal is currently being discussed for a form of Accelerated Rehabilitation that would anticipate and allow for predictable lapses by an individual without automatically escalating penalties. At the back end of the system, a similar concept is being explored by the specialized parole program. These ideas may require some adjustments to our usual "zero tolerance" expectations, and to our statutes, but they probably represent more realistic thinking than rigidly adhering to traditional patterns of consequences, and offer greater hope that we can keep greater numbers of people out of the criminal justice system. I would urge you to seriously consider these types of proposals as you proceed.

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