SUPREME COURT

OF THE

STATE OF CONNECTICUT

JUDICIAL DISTRICT OF HARTFORD

S.C. 16988

ELAINE WISEMAN
PLAINTIFF-APPELLEE

v.

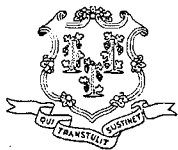
JOHN ARMSTRONG, ET AL.
DEFENDANTS-APPELLANTS

BRIEF OF THE AMICUS CURIAE

FOR THE AMICUS CURIAE:

NANCY B. ALISBERG
STATE OF CONNECTICUT
OFFICE OF PROTECTION AND
ADVOCACY FOR PERSONS
WITH DISABILITIES
60B WESTON STREET
HARTFORD, CT 06120

Telephone: 860.297.4397
Facsimile: 860.566.8714



STATE OF CONNECTICUT

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

October 2, 2003

Tammy Seltzer
Bazelon Center for Mental Health Law
1101 15th Street, NW
Suite 1212
Washington, DC 20005-5002

Dear Tammy:

Enclosed you will find a copy of the Amicus Brief we filed in the Wiseman case along with the Appendix. It is a very exciting case. Along with our brief, briefs were filed on behalf of the Connecticut Civil Liberties Union Foundation, the National Prison Project of the American Civil Liberties Union Foundation, and the Connecticut Legal Rights Project; the Connecticut Psychiatric Society, Mental Health Association of Connecticut; the State of Connecticut Commission on Human Rights and Opportunities; and the Connecticut State Medical Society; and the Correctional Lieutenant's Union of the State of Connecticut.

The case has already generated a lot of press attention, and I'm sure will continue to do so as the argument approaches. Thank you all very much for your support. I will let you know what happens.

Very truly yours,

Nancy B. Alisberg
Managing Attorney

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STATEMENT OF THE ISSUE

Is the Mental Health Unit of the Garner Correctional Institution a "facility" within the meaning of the Patients' Bill of Rights, such that Bryant Wiseman and other mentally ill persons being treated on the Unit, or being treated at other Department of Correction facilities that "diagnose," "observe," and "treat" persons with psychiatric disabilities, are guaranteed the same humane and dignified treatment, specialized treatment plans and periodic examinations that are statutorily guaranteed to every other psychiatric patient in the State?

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INTEREST OF AMICUS CURIAE

Protecting the rights of individuals with mental illness is central to the mission of the *amici*. The Office of Protection and Advocacy for Persons with Disabilities was established by statute in 1977. Conn. Gen. Stat. § 46a-7. The State of Connecticut recognized that it "has a special responsibility for the care, treatment, education, rehabilitation of and advocacy for its disabled citizens" and The Office of Protection and Advocacy has the authority to "represent, appear, intervene in or bring an action on behalf of any person with a disability...in any proceeding before any court...in this state in which matters related to this chapter are in issue...." Conn. Gen. Stat. § 46a-11(7). Individuals with disabilities are traditionally discriminated against in the provision of mental health services. In the case before this Court, The Office of Protection and Advocacy has a special interest in seeing that the Patients' Bill of Rights is broadly applied and that all citizens of Connecticut with mental illness are treated with humanity and dignity regardless of where they reside.

The Judge David L. Bazelon Center for Mental Health Law is a national public interest organization founded in 1972 to advocate for the rights of children and adults with mental disabilities. Bazelon has written model laws, advocated for protective legislation, and participated either as counsel or *amicus curiae* in virtually all civil cases concerning mental disability law that have come before the U.S. Supreme Court, such as *Olmstead v. L.C.,* 119 S.Ct. 633 (1998), as well as in cases involving medication issues such as *Riggins v. Nevada*, 504 U.S. 127 (1992) and *Washington v. Harper,* 494 U.S. 210 (1990). Bazelon has also frequently participated as *amicus curiae* in similar state court actions. The Center has extensive expertise regarding people with mental illnesses who are in the criminal justice system, providing extensive technical assistance to states and advocates, producing

numerous publications on the topic, and participating in nationwide reform efforts such as the recent Council of State Government's *Criminal Justice-Mental Health Consensus Project*.

The National Association of Protection and Advocacy Systems (NAPAS) is the membership organization for the nationwide system of protection and advocacy (P&A) agencies. Located in all 50 states, the District of Columbia, Puerto Rico, and the federal territories, P&As are mandated under various federal statutes to provide legal representation and related advocacy services on behalf of all persons with disabilities in a variety of settings. The P&A system comprises the nation's largest provider of legally based advocacy services for persons with disabilities. NAPAS facilitates coordination of P&A activities and provides training and technical assistance to the P&A network. The case is of interest to NAPAS because P&As provide legal advocacy to prisoners with disabilities in order to protect their rights.

Advocacy Unlimited, Inc. (AU), is a consumer-operated program that prepares persons with psychiatric disabilities to be effective advocates for themselves and others, and provides education and advocacy support for individuals in recovery. It is operated and directed by mental health "consumers" -- persons who have psychiatric disabilities or who have received psychiatric treatment. It was founded in 1994 with the support of the federal Substance Abuse and Mental Health Services Administration (SAMHSA), under a Community Support Program Grant from the Center for Mental Health Services, and the Department of Mental Health and Addiction Services. An internationally recognized innovator, AU is involved in advocacy education programs in Connecticut, Massachusetts, Rhode Island, Pennsylvania, and Illinois. It has served as amicus curiae in several cases,

including *Phoebe G. v. Solnit*, 252 Conn. 68 (1999), and *In re Eden F.*, 250 Conn. 674 (1999); rearg. den., 251 Conn. 924 (1999). Advocacy Unlimited staff, as well as the program's students, graduates, and those individuals they serve, are troubled by the increasing trend of our society to criminalize persons with psychiatric disabilities, relegating them to jails and prisons. AU promotes the accessibility of appropriate mental health services, which is a huge problem facing more and more Connecticut prisoners. Once inside a DOC facility, persons with mental disabilities should have the right to be treated with dignity and respect.

The National Alliance for the Mentally Ill of Connecticut (NAMI-CT), is an organization of over 3000 people with mental illnesses and their families, and those concerned with providing the necessary treatment and care for people with brain disorders. NAMI-CT is part of the National Alliance for the Mentally Ill which has chapters in every state, Puerto Rico, and the District of Columbia. The mission of NAMI-Ct is to provide education, support and advocacy to both those affected by these neurobiological illnesses and to the public, legislators, and opinion leaders. The National Alliance was founded almost 25 years ago, and NAMI-CT will celebrate its 20th anniversary in 2004. NAMI-CT works in collaboration with other family, consumer, and advocacy groups to advocate for the protection of the rights of people with serious mental illnesses, and has participated in several amicus curiae cases. NAMI-CT has advocated directly for prisoners with severe mental illnesses who have been treated improperly. NAMI-CT has members whose loved ones face improper treatment, and who are in prison because there were no programs to help them manage their illnesses in the community.

The National Association of Rights Protection and Advocacy (NARPA) was formed in 1981 to provide support and education for advocates working in the mental health arena. It monitors developing trends in mental health law and identifies systemic issues and alternative strategies in mental health service delivery on a national scale. Members are attorneys, people with psychiatric histories, mental health professionals and administrators, academics, and non-legal advocates -- with many people in roles that overlap. Central to NARPA's mission is the promotion of those policies and strategies that represent the preferred options of people who have been diagnosed with mental disabilities. Approximately 40% of NARPA's members are current or former patients of the mental health system.

NARPA has submitted amicus briefs in many cases in federal and state courts in cases affecting the lives of persons with psychiatric disabilities, including Phoebe G. v. Solnit, 252 Conn. 68, 743 A.2d 606 (1999); Olmstead v. L. C., 527 U.S. 581, 144 L. Ed. 2d 540, 119 S. Ct. 2176 (1999); Washington v. Harper, 494 U.S. 210, 108 L. Ed. 2d 178, 110 S. Ct. 1028 (1990); and T.D. v. New York State Office of Mental Health, 91 N.Y.2d 860, 668 N.Y.S.2d 153, 690 N.E.2d 1259 (1997).

NARPA members were key advocates for the passage of Federal legislation such as the Americans with Disabilities Act (42 U.S.C. §§ 12101 et seq.) and the Protection and Advocacy for Individuals with Mental Illness Act of 1986 (42 U.S.C. §§ 10801-51). The rights of the growing population of persons with mental disabilities who are confined in jails and prisons to non-discrimination and treatment with dignity and respect is an abiding concern of NARPA's membership. Because every aspect of their lives is under the rigid control of these institutions, prisoners face enormous obstacles in their efforts to achieve

humane and decent treatment, and the barriers and discrimination confronting them is pervasive.

INTRODUCTION

This case involves the rights of individuals with mental illness to be accorded the right to be treated with humane and dignified treatment despite the fact that they are prisoners and are residing in facilities operated by the Connecticut Department of Correction [DOC]. Specifically, this case asks the question whether the Connecticut Patients' Bill of Rights, [the Act] Conn. Gen. Stat. §§17a-540-550 shall apply to these prisoners. It is the position of amici, with the understanding that while certain specific provisions of the Act may not apply in their entirety to the prison population[1], the provisions of § 17a-542 requiring humane and dignified treatment of persons with psychiatric disabilities must apply to this population.

It is the position of amici that given the exploding mental health population of prisons, prisons have become the leading treatment venue in many communities, including Connecticut. Prisons in Connecticut have accepted this role, perhaps initially unwittingly and or unwillingly but now quite directly, and have entered the business of providing treatment to individuals with mental illness. Without stating an opinion as to how appropriate or adequate those services may be[2], given the fact that DOC is a provider of mental health services, it should be held to the same standard of care as other providers of

[1] Certainly, provisions regarding communication by mail and telephone, for example, as described in § 17a-546 of the Act must be tailored to comport with the security restrictions of the prison setting.

[2] Indeed in the instant case they appear to have been woefully inadequate. Additionally, the Office of Protection and Advocacy [OPA] authored a report dated August 2001entitled The Death of Tim Perry regarding the death of an individual with mental illness in DOC custody where asphyxiation death could not be ruled out. In fact, OPA recently filed a case, OPA v. Choinski, No. 303-CV- 1352 (RNC) (D. Conn, filed Aug. 6, 2003), where one of the allegations is the failure of DOC to provide adequate mental health treatment at the IMHU at Garner.

care, and be required to comply with the Patients' Bill of Rights and provide humane and dignified treatment.

ARGUMENT

1 Individuals with Mental Illness Comprise Between Twelve and Sixteen Percent of the Connecticut Prison Population.

The website of the DOC reports that as of July 1, 2003 there were 19,121 incarcerated prisoners in Connecticut prisons. [3] Additionally, in July 2003 the Bureau of Justice Statistics released a study entitled Prisoners in 2002. Paige M. Harrison and Allen J. Beck, *Prisoners in 2002*, July 2003, NJC 200248. In that report the authors stated that Connecticut experienced a growth of 7.9% from 2001 – 2002, joining Colorado and Minnesota as the three states with the third highest growth rate in their prison population in the country for that period.

Keeping these numbers in mind, the percentages of this population that have a serious mental illness are significant. In 2000, The Department of Mental Health and Addiction Services [DMHAS], the Chief Court Administrator and The Department of Correction jointly submitted a report to the Connecticut State Legislature. Albert J. Solnit, M.D., *The Costs and Effectiveness of Jail Diversion, A Report to the Joint Standing Committee of the General Assembly*, February 1, 2000 [hereinafter DMHAS Report]. In this report the authors stated that at that time, approximately 12% of the prison population had a "mental illness serious enough to warrant treatment." Id. at i. At the time this report was written, DOC housed approximately 17,000 prisoners, meaning that in 2000, over

[3] http://www.doc.state.ct.us/report/supervised.htm

2,000 prisoners required mental health services. Id. at 2-3. In 2003, the number is now approximately 2,294.

Compare these figures with the current census at the two state civil facilities for individuals with mental illness. At Connecticut Valley Hospital, as of August 1, 2003, the census of the General Psychiatry Division was 155. At the Whiting Division, where a number of the residents are sentenced or unsentenced DOC prisoners, the census was 253. At Addiction Services the inpatient census was 140. Telephone call from Susan Werboff, Office of Protection and Advocacy to CVH Admission Unit, CVH, 8/1/2003. At Cedarcrest Hospital, the census was 104. Telephone call from Susan Graham, Superintendent, Cedarcrest Hospital to Connecticut Legal Rights Project, 8/1/2003. It is quite clear that DOC is the major provider of mental health services to a confined population in this state.

However, these figures may be conservative. In a report issued by the United States Department of Justice Bureau of Justice Statistics, it was determined that in Connecticut, as of July 30, 2000, of the 85% of facilities that reported data to the Department of Justice, nearly 18% (2,596) of Connecticut state prisoners received therapy or counseling and 11.4% (1,659) received psychotropic medications. Allen J. Beck and Laura M. Maruschak, *Mental Health Treatment In State Prisons*, 2000, July 2001, NCJ 188215 at 6.

These figures, while striking, are even more compelling when compared to the national statistics. Nationally it was found that "one in every 8 State prisoners was receiving some mental health therapy or counseling services at midyear 2000. Nearly 10% were receiving psychotropic medications." Id. at 1. These numbers break down to an

estimate that 150,900 state inmates were in mental health therapy/counseling programs and that 114,400 inmates were receiving psychotropic medications. Id. Additionally, [n]early 13% of state inmates (or about 79% of those mentally ill) were receiving mental health therapy or counseling services from a trained professional on a regular basis." Id. at 3. It is significant to note that "[t]he majority of inmates receiving therapy/counseling and medications were housed in facilities without a mental health specialty. Nearly 70% of all inmates receiving therapy and 65% of those receiving psychotropic medication were in general confinement or community-based facilities." Id. at 4.

2. Prisons have become a major provider of mental health treatment for the State of Connecticut, thus entitling those consumers of services to the same Dignified and Humane Treatment as consumers receiving services from providers in the civil context.

The number of people with mental illness in prisons and jails has increased because they are not receiving appropriate community services when they are released from institutions serving individuals with mental illness. See DMHAS Report at 1. "Mental health professionals speculate that the jails have become a repository for the severely mentally ill. Often referred to as the criminalization hypothesis, this trend is thought to be the unintended consequence of policy modifications, e.g., deinstitutionalization and more stringent commitment criteria." Linda A. Teplin, *The Prevalence of Severe Mental Disorder Among Male Urban Jail Detainees: Comparison with the Epidemiologic Catchment Area Program*, 80 Am. J. of Pub. Health. 663 (1990).[4] The fact that jails and prisons have become such a repository, and in fact play a significant role in the care of individuals with

[4] Because Connecticut operates under a unified system where DOC facilities contain both sentenced and unsentenced prisoners, it is appropriate to consider the literature from the jail context. For example, Tim Perry, referred to in footnote 2, supra, was not sentenced and died in Hartford Correctional Center, a facility that holds primarily pretrial prisoners. http://www.doc.state.ct.us/facility/Hartford.htm

mental illness in Connecticut given the lack of community supports and resources, leads naturally to the conclusion that prisoners should not be singled out to receive less than the dignified and human treatment required by the Patients' Bill of Rights.

Individuals with mental illness enter the criminal justice system at a higher rate than do individuals without a mental illness as shown by their significantly higher arrest records. While some individuals may be diverted to the mental health system at a pretrial hearing, often judges are not trained in psychological issues and individuals with mental illness may not be so identified. Linda A. Teplin, *Criminalizing Mental Disorder, The Comparative Arrest Rate of the Mentally Ill*, 39 Am. Psychologist 794, 800 (1984) [hereinafter Teplin, *Criminalizing Mental Disorder*]. See also H. Richard Lamb and Linda E. Weinberger, *Persons with Severe Mental Illness in Jails and Prisons: A Review*, Community Treatment of Severe Mental Illness 8,10-11 [hereinafter Lamb and Weinberger]. Lamb and Weinberger argue that "two of the more persuasive arguments that a higher proportion of persons with severe mental illness can be found in the criminal justice system since deinstitionalization are the presence of large number of such person now residing in our jails and prisons" and the impressions of clinicians that "a large proposition the severely mentally ill persons they see in jails and prisons are similar in almost every way to long-term patients in state hospitals before deinstitionalization. Lamb and Weinberger at 11.

As Teplin states, "[t]his trend is of concern because the criminal justice system was not designed to be a major point of entry into the mental health system." Teplin, *Criminalizing Mental Disorder* at 800. Yet, it has turned out to be such an entry point. It is because of major changes within the civil mental health system that individuals have been forced into the criminal system. "[T]he jails and prisons may have become the long-term

repository for mentally ill individuals who, in a previous era, would have been institutionalized within a psychiatric facility." Id. at 795. One of these major changes within the mental health system includes the lack of community supports.

However, it is both facile and wrong to blame the crowding of prisons with individuals with mental illness on deinstitutionalization. It is rather a combination of factors which include "substance abuse, lack of adequate social support, medical complications (such as HIV), and the difficulty of maintaining long-term engagement in treatment." DMHAS Report at 1. See also Lamb and Weinberger who state that it is important to note that it is not deinstitionalization itself that is responsible for the increased numbers of individuals with mental illness entering the criminal justice system, but rather the lack of community supports and resources. Id. at 11-12.

In Connecticut the severe lack of community supports and resources has been termed a crisis. In July 2000, Governor John Rowland issued a report entitled *Report of The Governor's Blue Ribbon Commission on Mental Health*.[5] In that report, the following were listed as example of the crisis in access to appropriate services:

- In Connecticut, during a single year, there are an estimated 600,000 adults with mental illness (including 135,000 with serious mental illness)...yet it is estimated that only about half receive any form of pubic or privately funded treatment.
- Spending on publicly funded community-based services has not kept pace with the influx of new client groups entering the system....
- The closure of two major state hospitals during the past four years has placed demands on the community system beyond its capacity to respond effectively.... Id. at vii.

The crisis has not improved since this report was written in 2000. In February 2003, DMHAS' Community Mental Health Strategy Board submitted a report entitled *Opportunities for Improving Community Mental Health Services in Connecticut,* Strategic

[5] Available on the DMHAS website at http://www.dmhas.state.ct.us/PDF/fullreport.pdf.

Financial Assistance Plan, STATUS REPORT.[6] It was reported that due to the state deficit and the resultant budget rescissions and layoffs, mental health services and programs have been affected throughout the state. "In addition, the question of sustainability for new and expanded programming and services created with resources from the Community Mental Health Strategic Investment Fund was called into question." Id. at 3. Not only was new programming affected, but there was a reduction of $967,000 in the allocation for the Intensive Supportive Community Services and a reduction of $573,000 in the Mobil Crisis and Community Respite program. Id.

Finally, On August 23, 2003, the Hartford Court reported that "[f]or people without private insurance, the state's overburdened outpatient mental health system has gone from bad to worse." Hilary Waldman, *Budget Woes Take Toll on State's Mental Health System,* Htfd Courant, Aug. 23, 2003 at A6. The Courant reported that DMHAS lost 450 staff to layoffs and early retirement, and that the director of community clinics in eastern Connecticut would advise a client to not even bother calling for an appointment if not coming from a hospital or coming from a crisis. This agency turned away 700-800 adults a year, before laying off four people this spring. Id. Unfortunately, therefore, the individuals who are left without these services are often then left for the criminal justice system to care for. Lamb and Weinberger at 12.

3. The Connecticut Department of Correction Provides Treatment for Prisons with Mental Illness at Garner Correctional Institution Thus Requiring that those Prisoners be subject to the Patients' Bill of Rights.

[6] Available on the DMHAS website at http://www.dmhas.state.ct.us/pdf/cmhsb2003.pdf.

Prisoners identified by DOC as having serious mental illness are treated at Garner Correctional Institution [GCI].[7] It describes itself on the DOC website as the level 4 high-security facility which "operates an intensive mental health program for inmates who are assessed with serious mental health concerns." [8] One of the programs at GCI is called the Intensive Mental Health Unit, and is a three-phase program designed to "reduce the number and severity of episode of behavioral dyscontrol exhibited by mentally ill inmates of who demonstrated a pattern of behavioral disturbance or severe aggression." Brett S. Rayford and Robert L. Trestman, *The Intensive Mental Health Unit in Connecticut's Department of Correction: A Model Treatment Program*, Mental Health Outcomes 2 (2002). [hereinafter Rayford and Trestman]. [9] The IMHU program is a collaboration between custody and mental health care staff that offers behavioral and psychiatric intervention to prisoners with "persistent and several mental illness." Id.

Prisoners successfully completing the program transition to the general mental health units at GCI, confirming that Garner provides a multifaceted program for individuals with mental illness[10]. The other programs at GCI include the Acute Unit, which is an 18 bed crisis/admissions unit, a prolonged and severe mental health unit, an intermediate mental health unit, a transitional mental health unit and outpatient services. Mental Health

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[7] Amici do not admit that DOC adequately nor appropriately identifies all prisoners with a serious mental illness, but only that those so identified may be transferred to GCI. See OPA v. Choinsky, supra n. 2.

[8] http://www.doc.state.ct.us/facility/Garner.htm

[9] At the time he wrote the article, Dr. Rayford was the director of health and mental heath services for the Connecticut Department of Correction, and was responsible for overseeing the prisoner service delivery system for medical, mental health and addiction treatment. Dr. Trestman was the mental health services director for Connecticut's Correctional Managed Health Care system. Rayford and Treatment at 3.

[10] Again, amici make no judgment as to the quality of the care provided to the prisoners. See OPA v. Choinski, supra n. 2.

Programs and Services at Garner Correctional Institution. See *Mental Health Programs and Services at Garner Correctional Institution*. Appendix at 10.

Given the fact DOC is the primary repository of individuals with serious mental health needs in the state of Connecticut, and given the fact that DOC provides what it considers to be treatment for these prisoners, it belies reason to fail to apply the Patients' Bill of Rights. While on the one hand these individuals may be prisoners, on the other, they are at GCI because they have a mental illness and need treatment. They need to be accorded the same humane and dignified treatment as others who have a mental illness but are not currently involved in the criminal justice system.

The Department of Mental Health and Addiction Services [DMHAS] has adopted a broad vision of recovery described in the Recovery Institute section of their website.[11] See also The Commissioner's Policy Statement No. 83, *Promoting a Recovery-Oriented Service System, September 16, 2002.*[12] This vision of recovery is consistent with *Guidelines for Recovery Oriented Services* of the American Association of Community Psychiatrists.[13] Id. at 1.

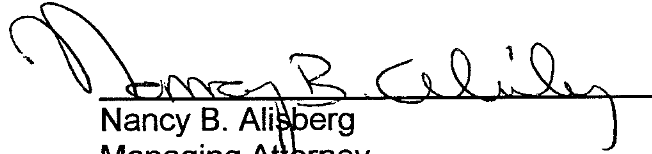
The DOC's goals for their prisoners with mental illness seek recovery as well. The goals of the IMHU program are to help "severely behaviorally disturbed inmates learn tools to help them more successfully integrate into their environment." Rayford and Trestman at 3. Prisoners on the other mental health units receive treatment ranging from psychopharmacology, individual therapy, group counseling, psycho educational groups recreational therapy, and receive discharge planning and coordination with DMHAS for

[11] http://www.dmhas.state.ct.us/recovery.htm
[12] http://vvv.dmhas.state.ct.us/policies/policy83.htm
[13] http://www.wpic.pitt.edu/aacp/finds/ROSGuidelines.pdf

aftercare services. See *Mental Health Programs and Services at Garner Correctional Institution*. None of these services can be successful without according the individual dignity or humanity.

CONCLUSION

We therefore urge this Court to affirm the Judgment of the trial court and to declare that the definition of "facility" of Conn. Gen. Stat. § 17a-540(a) included the Garner Mental Health Unit and all other facilities of the Department of Correction that diagnose, observe and treat persons with psychiatric disabilities.



Nancy B. Alisberg
Managing Attorney
Office of Protection and Advocacy for
Persons with Disabilities
60B Weston Street
Hartford, CT 06120
Tel. 860-297-4397
Fax 860-566-8714

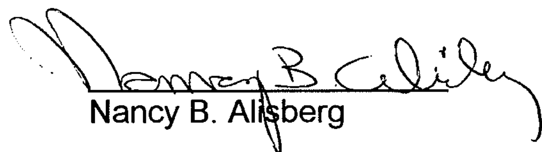
CERTIFICATION

The undersigned attorney hereby certifies that this brief complies with all provisions of Connecticut Rules of Appellate Procedure 67-2 and that a copy of the foregoing was mailed, first class postage prepaid, this 29 day of September, 2003 to:

Antonio Ponvert, Esquire
Koskoff, Koskoff and Bieder
350 Fairfield Avenue
Bridgeport, CT 06604

Ann E. Lynch, Esquire
Assistant Attorney General
Office of the Attorney General
110 Sherman Street
Hartford, CT 06105
Tel: 860-808-5450
Fax: 860-808-5591

Terrence M. O'Neill, Esquire
Assistant Attorney General
Office of the Attorney General
110 Sherman Street
Hartford, CT 06105
Tel: 860-808-5450
Fax: 860-808-5591



Nancy B. Alisberg