Prisoners with Disabilities

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A majority of American prisoners have at least one disability. So how jails and prisons deal with those prisoners' needs is central to institutional safety and humaneness, and to reentry success or failure. In this chapter, I explain what current law requires of prison and jail officials, focusing on statutory and constitutional law mandating non-discrimination, accommodation, integration, and treatment. Jails and prisons have been very slow to learn the most general lesson of these strictures, which is that officials must individualize their assessment of and response to prisoners with disabilities. In addition, I look past current law to additional policies that could improve medical and mental-health care for prisoners with disabilities. What is needed are programs that bridge the wall separating the inside and outside of prison, with respect to record-keeping, personnel, and finances; together, these have the potential to greatly improve care, and the lives and prospects, of prisoners with disabilities.

INTRODUCTION

Most American prisoners have at least one disability. The most recent national study, by the U.S. Department of Justice's Bureau of Justice Statistics, found that 10% report a mobility impairment, over 6% report that they are deaf or low-hearing, and over 7% report that they are blind or low-vision (uncorrectable with glasses). Depending on the facility and the definition, 4% to 10% have an intellectual disability. And over half report symptoms that meet the criteria for various mental illnesses; mania and depression predominate, but 15% of state prisoners have symptoms of psychosis such as delusions or hallucinations.[1] Forty percent of prisoners have some kind of chronic medical condition—diabetes, cancer, heart disease, high blood pressure, etc. All these statistics are for post-conviction prisoners; in jails, which house both pretrial detainees and post-conviction prisoners, the rates of disability are substantially higher. Table 1 summarizes some of the data.

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1. More generally, see Stephen J. Morse, "Mental Disorder and Criminal Justice," in Volume 1 of the present Report.

Table 1: Estimates of Disability in Jails and Prisons

	Prisons			Jails		
	All	Men	Women	All	Men	Women
Vision[2]	7.1%	7.1%	6.4%	7.3%	7.6%	5.1%
Hearing[3]	6.2%	6.2%	5.3%	6.5%	6.6%	6.0%
Ambulatory[4]	10.1%	9.9%	12.1%	9.5%	8.9%	13.5%
Chronic condition[5]	41%			40%		
Age 65+[6]	2.3%	2.3%	1.2%	NA		
Intellectual or developmental disability[7]	4-10%			NA		
Mental illness symptoms: All[8]	49%	48%	62%	60%	59%	70%
Mania[9]	43%			54%		
Major depression[10]	23%			30%		
Psychotic disorder[11]	15%			24%		

Some have even claimed that the massive run-up from the 1970s to the 1990s in prison and jail population was largely the result of "transinstitutionalization"—the effect of housing people with mental illness in jails and prisons rather than

2. Jennifer Bronson et al., Bureau of Justice Statistics, U.S. Dep't of Justice, Disabilities Among Prison and Jail Inmates, 2011-12, at 4–5 tbls.4 & 5 (2015), http://www.bjs.gov/content/pub/pdf/dpji1112.pdf. The data in this survey are self-reported in response to the following questions: "Hearing—Are you deaf or do you have serious difficulty hearing? Vision—Are you blind or do you have serious difficulty seeing even when wearing glasses? Ambulatory—Do you have serious difficulty walking or climbing stairs?"

3. *Id.*

4. *Id.*

5. *Id.* at 4–6 tbls.4-6 ("Chronic conditions include cancer, high blood pressure, stroke-related problems, diabetes, heart-related problems, kidney-related problems, arthritis, asthma, and cirrhosis of the liver."). I used the material in all three source tables to calculate the data in text.

6. E. Ann Carson, Bureau of Statistics, U.S. Dep't of Justice, Prisoners in 2014, app. tbl.3 (2015), https://www.bjs.gov/content/pub/pdf/p14.pdf.

7. Joan Petersilla, Doing Justice? Criminal Offenders with Developmental Disabilities 1 (2000), http://files.eric.ed.gov/fulltext/ED465905.pdf.

8. *See* Dorris J. James & Lauren E. Glaze, Bureau of Justice Statistics, U.S. Dep't of Justice, Mental Health Problems of Prison and Jail Inmates 1, 4 (2006), https://www.bjs.gov/content/pub/pdf/mhppji.pdf. The data in the table are for state prisoners and local jails; this study finds a lower rate among federal prisoners.

9. *Id.* at 1.

10. *Id.*

11. *Id.*

mental hospitals.[12] This is only partially true—Raphael and Stoll demonstrate persuasively that deinstitutionalization has made only a "relatively small contribution to the prison population growth overall" (they estimate 4% to 7% of the growth).[13] But as they note, it is certainly the case that "in years past," "a sizable portion of the mentally ill behind bars would not have been" jailed.[14]

The numbers mean that how jails and prisons deal with disability is far from a niche issue. Rather, choices relating to disability are central to the operation of U.S. incarcerative facilities—their safety and humaneness, and their success or failure in facilitating the pro-social community reentry of prisoners who get out. In this chapter, I begin by explaining what difference disability makes in jail and prison—how disability affects prisoners' lives and institutional operations. I next explain how current law instructs prison and jail officials, focusing on the Americans with Disabilities Act and constitutional requirements of non-discrimination, accommodation, integration, and treatment. Jails and prisons have been very slow to learn the most general lesson of these requirements, which is that officials must individualize their assessment of and response to prisoners with disabilities. I make some recommendations along these lines. I also suggest that as a policy matter, individualization would be helpful not just for prisoners with disabilities but for other prisoners, as well. That is, lessons learned (or lessons that should be learned) in the disability arena could fruitfully be applied more broadly.

The learning point works in converse, too; general lessons learned about incarceration can and should be applied to prisoners with disabilities in particular. For example, abundant evidence demonstrates that prisoners' successful reentry—their transition to productive and pro-social lives in their communities after release from jail and prison—is aided by programs that bridge the separation of prison from the outside world. This broad insight has specific application to prisoners with disabilities. Though the point is pertinent in many ways, I focus in the chapter's final section on its import for medical and mental-health care, a very significant concern for people with disabilities. To improve care, and the lives and prospects of prisoners with disabilities, what is needed are bridging techniques addressing record-keeping, personnel, and finances. I make some recommendations toward this end.

12. For a literature review, see Dae-Young Kim, *Psychiatric Deinstitutionalization and Prison Population Growth: A Critical Literature Review and Its Implications*, 27 Crim. Just. Pol'y Rev. 3 (2016).

13. Steven Raphael & Michael A. Stoll, *Assessing the Contribution of the Deinstitutionalization of the Mentally Ill to Growth in the U.S. Incarceration Rate*, 42 J. Legal Stud. 187, 190 (2013).

14. *Id.*

I write this chapter informed by scholarship, policy research, and advocacy reports—the various sources cited, among others. But I bring to it, as well, two decades of experience in prison and jail reform; investigating allegations of civil-rights violations; collaborating with varied stakeholders on reform standards;[15] working with different prison and jail officials on reform efforts in their facilities; and, most recently, monitoring the implementation of a statewide settlement agreement in Kentucky governing policy and practice for deaf and hard-of-hearing prisoners.[16] The chapter's recommendations thus draw on both written and lived sources of knowledge.

I. WHY IS DISABILITY A CHALLENGE?

Incarceration isn't easy for anyone. But sharply limited control over one's own routines and arrangements make life behind bars particularly difficult for prisoners with disabilities. Prisoners with mobility impairments, for example, "cannot readily climb stairs, haul themselves to the top bunk, or walk long distances to meals or the pill line."[17] Prisoners who are old may "suffer from thin mattresses and winter's cold"[18] but often cannot obtain a more comfortable bed or an extra blanket. Prisoners who are deaf may not hear, and prisoners with intellectual disabilities may not understand, the orders they must obey under threat of disciplinary consequences that include extension of their term of incarceration. And prisoners with intellectual disabilities may be unable to access medical care or other resources and services, because officials require written requests and they are illiterate.[19]

Moreover, many prisoners with either mental or physical disabilities face grave safety threats. They may be vulnerable to extortion, exploitation, threats, and physical and sexual abuse by other prisoners. Prisoners with mental disabilities in particular may be "manipulated by other prisoners into doing

15. *See, e.g.*, Am. Bar Ass'n, Standards for Criminal Justice: Treatment of Prisoners (2011).

16. *See Case Profile:* Adams v. Kentucky, Civ. Rts Litig. Clearinghouse, http://www.clearinghouse.net/detail.php?id=13462 (last visited Apr. 3, 2017) (describing case and posting monitoring reports).

17. Human Rights Watch, Old Behind Bars: The Aging Prison Population in the United States 4 (2012), https://www.hrw.org/sites/default/files/reports/usprisons0112webwcover_0.pdf.

18. *Id.*

19. *See generally* Human Rights Watch, Callous and Cruel: Use of Force against Inmates with Mental Disabilities in US Jails and Prisons (2015), https://www.hrw.org/report/2015/05/12/callous-and-cruel/use-force-against-inmates-mental-disabilities-us-jails-and (describing neglect of and inappropriate use of force against prisoners with severe mental health problems).

things that get them into deep trouble."[20] As Hans Toch summarized, prisoners with mental illness can be "disturbed and disruptive," "very troubled and extremely troublesome."[21] They are far more likely to be injured in a fight, and to be disciplined for assault.[22] In the words of prisoners' rights advocate Jamie Fellner, they may:

> engage in symptomatic behavior that corrections staff find annoying, frightening, and provocative, or which, in some cases, can be dangerous. For example, they may refuse to follow orders to sit down, to come out of a cell, to stop screaming, to change their clothes, to take a shower, or to return a food tray. They may smear feces on themselves or engage in serious self-injury—slicing their arms, necks, bodies; swallowing razor blades, inserting pencils, paper clips, or other objects into their penises. Sometimes prisoners refuse to follow orders because hallucinations and delusions have impaired their connection with reality. An inmate may resist being taken from his cell because, for example, he thinks the officers want to harvest his organs or because she cannot distinguish the officer's commands from what other voices in her head are telling her.[23]

Solitary confinement is a particular concern. Across the country, constitutional litigation has led to orders excluding prisoners with serious mental illness from solitary confinement.[24] Nevertheless, people with mental disabilities remain vastly overrepresented in prison and jail restrictive housing units,[25] because they are frequently difficult to manage in general population

20. Human Rights Watch, Ill-Equipped: U.S. Prisons and Offenders with Mental Illness 57 (2003), https://www.hrw.org/reports/2003/usa1003/usa1003.pdf (quoting Terry Kupers, Prison Madness: The Mental Health Crisis Behind Bars and What We Must Do About It 20 (1999)).

21. Callous and Cruel, *supra* note 19 (quoting Hans Toch, *Humpty Dumpty in the Prison*, 16 Corr. Mental Health Rep. 51 (2014)).

22. *See* James & Glaze , *supra* note 8, at 1.

23. Callous and Cruel, *supra* note 19.

24. For a compilation of extant orders, see *Special Collection: Solitary Confinement*, Civ. Rts. Litig. Clearinghouse, http://www.clearinghouse.net/results.php?searchSpecialCollection=40 (last visited Apr. 3, 2017).

25. *See* Allen J. Beck, Bureau of Justice Statistics, U.S. Dep't of Justice, Special Report: Use of Restrictive Housing in U.S. Prisons and Jails, 2011-12, at 6–7 (2015), http://www.bjs.gov/content/pub/pdf/urhuspj1112.pdf (relating that prisoners with mental illness reported having spent time in restrictive housing at about twice the rate of other prisoners); *see also* Ass'n of St. Corr. Adm'rs & Arthur Liman Program at Yale L. Sch., Aiming to Reduce Time-In-Cell: Reports from Correctional Systems on the Numbers of Prisoners in Restricted Housing and on the Potential of Policy Changes to Bring About Reforms 48–53 (2016), https://www.law.yale.edu/system/files/area/center/liman/document/aimingtoreducetic.pdf (tracing the placement of prisoners with a serious mental health issue in restrictive housing).

and because they often decompensate once in solitary and commit further disciplinary infractions. Two decades ago, U.S. District Judge Thelton Henderson emphasized the toxic effects of solitary confinement for inmates with mental illness.[26] In *Madrid v. Gomez*, a case about California's Pelican Bay prison, Judge Henderson wrote that isolated conditions in the Special Housing Unit, or SHU, while not amounting to cruel and unusual punishment for all prisoners, were unconstitutional for those "at a particularly high risk for suffering very serious or severe injury to their mental health, including overt paranoia, psychotic breaks with reality, or massive exacerbations of existing mental illness."[27] Vulnerable prisoners included those with pre-existing mental illness, intellectual disabilities, and brain damage.[28] Henderson concluded that "[f]or these inmates, placing them in the SHU is the mental equivalent of putting an asthmatic in a place with little air to breathe."[29] Their resilience compromised by their disability and the jail or prison's unaccommodating response to it, prisoners with mental illness face a much higher risk for suicide both in and out of solitary confinement.[30]

Sometimes officials affirmatively discriminate against prisoners with disabilities—bar them from programs or jobs,[31] lock them down in their cells or isolate them in an infirmary[32] or administrative segregation housing,[33] even deny them parole as a matter of policy.[34] For example, in *Armstrong v. Brown*,

26. *See* Madrid v. Gomez, 889 F. Supp. 1146 (N.D. Cal. 1995).
27. *Id.* at 1265
28. *Id.*
29. *Id.*
30. *See, e.g.*, Ill-Equipped, *supra* note 20, at 178.
31. *See, e.g.*, Rachael Seevers, AVID Prison Project, Making Hard Time Harder: Programmatic Accommodations for Inmates with Disabilities Under the Americans with Disabilities Act 28 (2016), avidprisonproject.org/Making-Hard-Time-Harder/assets/making-hard-time-harder---pdf-version.pdf (describing involuntary status of "medically unassigned," which barred prisoners from programming necessary to earn credit towards early release).
32. *See id.* at 35 (describing housing of inmates with serious medical conditions in a prison's infirmary, even though they were medically stable).
33. *See, e.g.*, AVID Jail Project, Disability Rights Wash., Cruel but not Unusual: Solitary Confinement in Washington's County Jails 14, 17 (2016), http://www.disabilityrightswa.org/sites/default/files/uploads/CruelbutNotUnusual_November2016.pdf (noting that certain county jails in Washington state "automatically" place individuals with physical disabilities or mental illness in solitary confinement); *see* ACLU, Caged In: Solitary Confinement's Devastating Harm on Prisoners with Physical Disabilities 6 (2017), https://www.aclu.org/sites/default/files/field_document/010916-aclu-solitarydisabilityreport-single.pdf ("[P]risoners with disabilities are placed into solitary confinement even when it serves no penological purpose. Corrections officials have put prisoners with physical disabilities into solitary confinement because there were no available cells that could accommodate them in a less restrictive environment.").
34. *See* Seevers, *supra* note 31, at 31.

U.S. District Judge Claudia Wilken held that the state was "regularly housing [prisoners with mobility impairments] in administrative segregation due to lack of accessible housing."[35] Physical barriers—steps, inaccessible cell features, and the like—frequently exclude prisoners with disabilities from programs and resources.[36] But physical barriers are just the most visible example of the key general problem: When the ordinary rules and ways of incarceration hit prisoners with disabilities harder than others, prisons and jails fail to accommodate their needs.

What is to be done? Four categories of intervention are needed: diversion, accommodation, integration, and treatment (including discharge planning). The first, diversion, is beyond the scope of this chapter, but it should be obvious that one solution to the damage jail and prison cause people with disabilities is to use alternative responses to their offending behavior, reserving incarceration for when it is truly necessary.[37] I address accommodation, integration, and treatment below.

II. WHAT DOES THE LAW REQUIRE?

The welfare of prisoners with disabilities is protected by both the Constitution and the two principal federal disability anti-discrimination statutes, the Rehabilitation Act and the Americans with Disabilities Act (ADA). Taken together, the requirements are robust: prison and jail officials must avoid discrimination; individually accommodate disability; maximize integration of prisoners with disabilities with respect to programs, service, and activities; and provide reasonable treatment for serious medical and mental-health conditions. In this section, my interspersed recommendations, accordingly, are consistent with existing law—at least a muscular reading of existing law.

35. Order Granting Motion for Further Enforcement, Armstrong v. Brown, No. 94-cv-2307, 2015 WL 496799 (N.D. Cal. Feb. 3, 2015), http://www.clearinghouse.net/chDocs/public/PC-CA-0001-0040.pdf.

36. *See, e.g.*, Seevers, *supra* note 31, at 19 (architectural barriers in Alabama prisons), 29 (specialized residential trauma treatment for New York women prisoners in a room reachable only via stairs), 32 (Iowa chapel and auditorium accessible only via stairs), 34 (New York commissary in inaccessible building).

37. *See, e.g.*, Rebecca Vallas, Ctr. for Am. Progress, Disabled Behind Bars: The Mass Incarceration of People with Disabilities in America's Jails and Prisons (2016), https://cdn.americanprogress.org/wp-content/uploads/2016/07/15103130/CriminalJusticeDisability-report.pdf. For a discussion of diversion, see Michael Tonry, "Community Punishments," in the present Volume.

A. THE RULE AGAINST DISPARATE TREATMENT

Absent some other constitutional harm, the Constitution often allows officials to discriminate against people with disabilities—"so long as their actions toward such individuals are rational."[38] Statutory law, however, is less lenient. Section 504 of the 1973 Rehabilitation Act[39] and Title II of the 1990 ADA[40] prohibit discrimination on the basis of disability in federally conducted or supported services, and state and local government services, respectively.[41] Both statutes protect from exclusion or discrimination prisoners with disabilities[42] who are "qualified" to participate in the relevant program. The Rehabilitation Act does not define "qualified individual with a disability," but the ADA does. That definition is:

> an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the

38. Bd. of Trs. of the Univ. of Ala. v. Garrett, 531 U.S. 356, 367 (2001).

39. 29 U.S.C. §§ 794 et seq. (2012). The Rehabilitation Act provides, in relevant part, "No otherwise qualified individual with a disability ... shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance or under any program or activity conducted by any [Federal] Executive agency." *Id.* § 794(a).

40. 42 U.S.C. §§ 12131 et seq. (2012). Title II provides, in relevant part, "[N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." *Id.* § 12132.

41. A very useful summary of the overall statutory framework and its application to prisons and jails is included in the United States' Memorandum of Law as Amicus Curiae on Issues under the Americans with Disabilities Act and Rehabilitation Act that are Likely to Arise on Summary Judgment or at Trial, Miller v. Smith, No. 6:98-cv-109-JEG (S.D. Ga. June 21, 2010), http://www.ada.gov/briefs/miller_amicus.pdf. Note that this brief was filed in June 2010, and there were new regulations—though not very different in pertinent part—published September 2010.

42. Under both the ADA and the Rehabilitation Act, a person has a disability if: (i) a physical or mental impairment substantially limits one or more of his or her major life activities; (ii) he or she has a record of such an impairment; or (iii) he or she is regarded as having such an impairment. 29 U.S.C. § 705(20)(B); 42 U.S.C. § 12102(1). Particularly relevant here, "mental" impairments are expressly included if they substantially limit major life activities. The ADA regulations on the definition of disability, 28 C.F.R. § 35.108, are quite capacious. Moreover, in the ADA Amendments Act of 2008, Congress clarified and broadened the definition. Under the Amendments Act, an impairment constitutes a disability even if it: (1) only substantially limits one major life activity; or (2) is episodic or in remission, if it would substantially limit at least one major life activity if active. ADA Amendments Act of 2008, Pub. L. No. 110-325, § 3, 122 Stat. 3553, 3556.

> provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity.[43]

The key source for understanding what constitutes disability discrimination is the ADA's Title II regulations; as legislative regulations, these are entitled to substantial deference.[44] Most simply, discriminating against prisoners "because of" their physical disability, serious mental illness, or intellectual disability, violates the statutory ban against disparate treatment. The ADA regulations explain that public entities must afford qualified people with disabilities the same opportunity as non-disabled people to benefit from the entity's services. This means a prison or jail may not, because of an inmate's disability, deny the inmate the "opportunity to participate" in a service offered to other inmates, may not provide an alternative service "that is not equal to that afforded others," and must provide aids, benefits, or services that would enable the inmate to "gain the same benefit, or to reach the same level of achievement as that provided to others."[45] A prison violates this regulation, for example, if simply because of their disability, it excludes prisoners with disabilities from a program or assigns prisoners with disabilities to segregation cells—where prisoners are denied most prison privileges, programs, activities, and services. As described in Part I, this kind of discrimination is far from unheard of.[46]

There are, however, defenses. Prison and jail officials can exclude a prisoner with a disability from a program, service, or activity if the exclusion is "necessary for the safe operation of its services, programs, or activities."[47] Safety requirements must, however, be "based on actual risks, not on mere speculation, stereotypes, or generalizations about individuals with disabilities."[48] Similarly,

43. 42 U.S.C. § 12131(2).

44. *See* 42 U.S.C. § 12134(a); *see also* Olmstead v. L.C., 527 U.S. 581, 597–98 (1999) ("Because the Department is the agency directed by Congress to issue regulations implementing Title II, ... its views warrant respect. We need not inquire whether the degree of deference described in [*Chevron*] is in order."). ADA regulations are also consistent with—but newer, more detailed, and sometimes stricter than—Rehabilitation Act regulations. *See* 42 U.S.C. § 12201(a) ("nothing in this chapter shall be construed to apply a lesser standard than the standards applied under title V of the Rehabilitation Act of 1973 [29 U.S.C. §§ 790 et seq.] or the regulations issued by Federal agencies pursuant to such title"); 42 U.S.C. § 12134(b) ("regulations ... shall be consistent with ... the coordination regulations under part 41 of title 28, Code of Federal Regulations (as promulgated by the Department of Health, Education, and Welfare on Jan. 13, 1978), applicable to recipients of Federal financial assistance under section 794 of Title 29.").

45. 28 C.F.R. § 35.130(b)(1).

46. *See supra* notes 32-36 and accompanying text.

47. 28 C.F.R. § 35.130(h).

48. *Id.*

government officials may exclude prisoners with disabilities from programs "when that individual poses a direct threat to the health or safety of others."[49] But the Supreme Court has emphasized that under the ADA, "direct threat defense[s] must be 'based on a reasonable medical judgment that relies on the most current medical knowledge and/or the best available objective evidence.'"[50] And correspondingly, the regulation again requires substantial individualization:

> In determining whether an individual poses a direct threat to the health or safety of others, a public entity must make an individualized assessment, based on reasonable judgment that relies on current medical knowledge or on the best available objective evidence, to ascertain: the nature, duration, and severity of the risk; the probability that the potential injury will actually occur; and whether reasonable modifications of policies, practices, or procedures or the provision of auxiliary aids or services will mitigate the risk.[51]

Thus the ADA's general ban on disparate treatment has a safety valve—but the safety valve is not satisfied by generalized concern about the abilities or risks of prisoners with disabilities. Disparate treatment is lawful only where participation in a particular program by a particular prisoner with disabilities raises particular—individualized, and proven not assumed—safety risks to others, and only where those risks cannot be mitigated by some kind of tailored modification of the program's policies, practices, or procedures.

This kind of individualization does not come easily to prisons and jails. Rules behind bars tend to be inflexible. Prisons and jails are mass institutions, and it's easier for them to implement simple rules, without either case-by-case or more formalized exceptions. Officials occasionally emphasize that special treatment can provoke hard feelings and even violence by other prisoners. But in my experience, inflexibility is often an automatic rather than thoughtful response to a request. In any event, prisons and jails are not left to their own preferences with respect to the general choice of how much individualization is appropriate. The ADA insists on a high degree of particularization.

49. 28 C.F.R. § 35.139(a).

50. Chevron U.S.A., Inc. v. Echazabal, 536 U.S. 73, 86 (2002); *see also* Bragdon v. Abbott, 524 U.S. 624, 649 (1998) ("[T]he risk assessment must be based on medical or other objective evidence.").

51. 28 C.F.R. § 35.139(b).

RECOMMENDATION: Jail and prison officials should not exclude prisoners with disabilities from particular housing units, jobs, or any other programs absent an individualized finding that a prisoner's participation poses significant safety risks that cannot be mitigated.

B. THE REQUIREMENT OF REASONABLE MODIFICATION AND EFFECTIVE COMMUNICATION

Notwithstanding the misgivings of prison and jail officials, the Rehabilitation Act and the ADA require even more individualization[52] under the conceptual category of "reasonable modification"—the ADA Title II's (and Title III's) equivalent of the more familiar "reasonable accommodation" requirement in Title I of the ADA, which addresses employment discrimination.[53] The Title II ADA regulations state:

> A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.[54]

A failure to implement a reasonable modification needed by a person with a disability is a type of discrimination; under the ADA, a prison must "take certain pro-active measures to avoid the discrimination proscribed by Title II."[55]

In addition, both the Rehabilitation Act and the ADA's regulations require prisons and jails to "take appropriate steps to ensure that communications with … participants … are as effective as communications with others."[56] The effective-communication mandate protects prisoners with a variety of communication-impairing disabilities—among them, blindness or low vision, deafness or low hearing, and speech impediments. It cashes out as a requirement for provision of "auxiliary aids and services"[57]—interpreters, computer-aided

52. *See, e.g.*, Wright v. N.Y. St. Dep't of Corr., 831 F.3d 64, 78 (2d Cir. 2016) ("Title II of the ADA, therefore, requires that once a disabled prisoner requests a non-frivolous accommodation, the accommodation should not be denied without an individualized inquiry into its reasonableness.").

53. *See* 42 U.S.C. § 12111(8)–(9).

54. 28 C.F.R. § 35.130(b)(7)(i). The separate requirement of program accessibility has a similar defense that no "fundamental alteration in the nature of the service, program or activity or ... undue financial or administrative burdens" are required. 28 C.F.R. § 35.150(a)(3).

55. Chisolm v. McManimon, 275 F.3d 315, 324–25 (3d Cir. 2001); *see also* Tennessee v. Lane, 541 U.S. 509, 529 (2004) (describing the reasonable modification requirement as prophylactic).

56. 28 C.F.R. § 35.160(a)(1); 28 C.F.R. § 39.160(a); 28 C.F.R. 42.503(e).

57. 28 C.F.R. § 35.160.

transcription services, assistive listening systems, open and closed captioning, various telephonic communications devices for the deaf, videophones, visual and other non-auditory alert systems, and more.

Federal case law has emphasized that the application of disability-rights law in the prison setting must take account of "[s]ecurity concerns, safety concerns, and administrative exigencies."[58] Even so, both reasonable modification and effective communication are robust and broadly relevant requirements. Consider a list of potential problems and ADA-required solutions:

- A prisoner with a mobility impairment cannot walk quickly enough to get to meals on time. Potential modifications: house the prisoner closer to the chow hall; allow additional time for movement and/or meals; if the prisoner uses a wheelchair, provide an aide to push it.
- In a prison that provides indigent prisoners with paper and stamps for letters home, a prisoner with an intellectual disability cannot write such letters because he is illiterate. Potential modifications: allow (and equally subsidize) communication by voice recordings or phone; provide a writer/reader (of his choice) to assist him.
- Successful completion of substance-abuse programming is persuasive evidence of rehabilitation in parole hearings, and requires academic-type coursework a prisoner with a learning disability cannot manage. Potential modifications: provide tutoring or one-on-one instruction.
- Announcements are made over an audio intercom that deaf and hard-of-hearing prisoners cannot understand. Potential modifications: a non-auditory alert system (vibrating pager, or strobe lights); housing a mildly hearing impaired prisoner in a quiet unit, where ambient noise poses less of an obstacle.
- Prison jobs are either required or offer prisoners compensation, but many of the jobs include tasks that a prisoner with a mobility impairment cannot perform. Potential modification: adjust job tasks or provide adaptive equipment to allow the prisoner to do the job.

Anyone familiar with disability law outside of prison would consider these run-of-the-mill accommodations. Similar responses to disability are regularly sought from, and granted by, employers and non-incarcerating government agencies. And yet, observers report—and my own experience confirms—that 27 years after the ADA's passage, prisons and jails do not yet fully understand that this kind of individualization is required by law. When prisoners seek these

58. Love v. Westville Corr. Ctr., 103 F.3d 558, 561 (7th Cir. 1996).

kinds of reasonable modifications, prison and jail officials frequently deny the request simply by pointing to the general rule.

An example from my work as a settlement monitor illustrates the point. A deaf prisoner, who communicated using sign language, faced disciplinary sanctions for assaulting a correctional officer. As required by the settlement agreement I was monitoring, the prison made arrangements for sign-language interpretation for him. This was accomplished using video remote interpretation—a video communication setup where the remote sign-language interpreter hears the person speaking through a computer microphone, and signs the interpretation to the deaf listener, and vice versa. In this case, however, the inmate had been assigned "max assault status"—which meant that whenever he was out of his cell, prison rules required him to be handcuffed, rendering him unable to sign. Rather than altering the restraint rule, prison officials conducting the hearing asked him only yes or no questions, so he could nod or shake his head to respond. My intervention was simply to ask the warden if there was some way to safeguard everyone's safety but also provide the prisoner effective communication. The warden and his staff quickly developed such a method; the prisoner's belly chain was tethered to a bolt in a wall, so he couldn't move very far; under those conditions, everyone was comfortable unhandcuffing him. This accommodation allowed him to access both interpretation for various communication needs and also to use a videophone. It was not expensive or difficult; it merely required individualized consideration.

Accommodation failures seem to me even more prevalent with respect to less familiar accommodations that have fewer analogues outside of jail and prison. Along these lines, I have argued in prior work that the ADA's reasonable-modification requirement compels individualization with respect to disciplinary and restrictive housing policy. For example, the ADA's reasonable-modification mandate, properly understood, compels jail and prison officials to take account of mental illness or intellectual disability in making housing decisions, which often assign disabled prisoners to double cells in which conflict and violence are likely.[59] It forbids use of solitary confinement as a routine management technique to cope with the difficulties presented by prisoners with disabilities.[60] And it requires jails and prisons to treat behavior that manifests serious mental illness or intellectual disability as a mental-health or habilitation matter, rather

59. *See, e.g.*, Madrid v. Gomez, 889 F. Supp. 1146, 1221 (N.D. Cal. 1995).

60. *See* U.S. Dep't of Justice, Investigation of the State Correctional Institution at Cresson and Notice of Expanded Investigation 1, 32–33 (2013), https://www.justice.gov/crt/about/spl/documents/cresson_findings_5-31-13.pdf.

than an occasion for force or discipline.[61] Thus far, these kinds of claims have been raised only occasionally. Nonetheless, anti-discrimination remedies along these lines have been incorporated in the dozen or so major solitary-confinement settlements in recent years.[62] In addition, there is some, albeit limited, support in federal district court opinions: In a couple of cases, district courts have held that the ADA requires modification of disciplinary procedures.[63] Similarly, at least one court has held that administrative classification processes used to put prisoners into solitary confinement must be reasonably modified to take account of the needs of prisoners with disabilities.[64] And finally, a recent district court opinion accepted a reasonable-modification argument seeking greater access for prisoners with disabilities to a solitary confinement "step-down" program.[65]

61. *See, e.g.*, Private Settlement Agreement at 12, Disability Advocates, Inc. v. N.Y. St. Off. of Mental Health, No. 1:02-cv-04002-GEL (S.D.N.Y. Apr. 27, 2007), http://www.clearinghouse.net/chDocs/public/PC-NY-0048-0002.pdf; Settlement Agreement and General Release at 16, Disability Rights Network of Pa. v. Wetzel, No. 1:13-cv-00635-JEJ (M.D. Pa. Jan. 9, 2015), http://www.clearinghouse.net/chDocs/public/PC-PA-0031-0003.pdf.

62. *See, e.g.*, *supra* note 61. For a more complete timeline listing and linking to the key cases, and their settlements, see Amy Fettig & Margo Schlanger, *Milestones in Solitary Reform*, Solitary Watch, http://solitarywatch.com/resources/timelines/milestones/ (last visited Apr. 3, 2017); and for court documents, see *Special Collection: Solitary Confinement*, Civ. Rts. Litig. Clearinghouse, http://www.clearinghouse.net/results.php?searchSpecialCollection=40 (last visited Apr. 3, 2017).

63. *See* Scherer v. Pa. Dep't of Corr., No. 3:04-cv-00191-KRG, 2007 WL 4111412, at *44 (W.D. Pa. Nov. 16, 2007) (because the prisoner's misconduct may have been a result of his mental illness, "the lack of modification of its disciplinary procedures to account for ... [his] mental illness ... possibly resulted in a violation of Title II of the ADA."); Purcell v. Pa. Dep't of Corr., No. 3:00-CV-00181-LPL, 2006 WL 891449, at *13 (W.D. Pa. Mar. 31, 2006) (finding a genuine issue of material fact as to whether a "reasonable accommodation" was denied when the Department of Corrections refused to circulate a memo to the staff concerning a prisoner's Tourette's Syndrome to explain that some of his behaviors were related to his condition, not intentional violations of prison rules).

64. *See* Biselli v. Cty. of Ventura, No. 09-cv-08694 CAS (Ex), 2012 U.S. Dist. LEXIS 79326, at *44–45 (C.D. Cal. June 4, 2012) (placement in administrative segregation based on conduct specifically linked to mental illness, without input from mental health staff, may constitute a violation of the ADA).

65. *See* Sardakowski v. Clements, No. 12-cv-01326-RBJ-KLM, 2013 WL 3296569, at *9 (D. Colo. July 1, 2013) (rejecting a motion to dismiss for failure to state a claim given plaintiff's argument "that he has been unable to complete the requirements of the leveling-out program successfully because of his mental impairment and because CDOC officials have prevented him from obtaining adequate treatment and accommodation so that he may progress out of solitary confinement"); *see also* Reporter's Transcript: Hearing on Motion for Summary Judgment and Final Trial Preparation Conference at 41, Sardakowski v. Clements, No. 12-cv-01326-RBJ-KLM (D. Colo. Feb. 25, 2014), http://www.clearinghouse.net/chDocs/public/PC-CO-0024-0002.pdf (rejecting defendants' motion for summary judgment on the same claim).

Still, implementation of this kind of individualized approach to housing and discipline remains rare. I don't think jails' and prisons' reluctance to embrace individualized approaches to housing and discipline, or to operations more generally, can be justified doctrinally. True, the ADA's obligation to make "reasonable modifications in policies, practices, or procedures" is not unbounded; a modification is not required if it would "fundamentally alter the nature of the service, program, or activity."[66] The nature of the requested change matters. As in so many situations, whether it is considered "fundamental" turns in part on the level of generality used to describe the program and its "essential aspect[s]."[67] Is the essence of solitary confinement its restrictive nature, or that it adequately safeguards safety and security? Is the essence of prison discipline that it punishes misconduct, or that it punishes culpable misconduct? And so on. But again, the ADA pushes towards individualization and flexibility. The very idea that some aspects of a program or policy are fundamental—but others are not—means that prisoner restrictions that have been treated as irrevocably bound together are conceptually untied. And the assertion of the defense—that a particular change to a prison policy or practice a prisoner with a disability seeks is a fundamental alteration that a prison is not required to undertake, rather than a reasonable modification that it must—puts the onus on the jail or prison to justify why it cannot make a requested change, if not for everyone, than for this particular disabled prisoner. As Professors Brittany Glidden and Laura Rovner summarized the point, "Because the accommodations should be specific and individualized, prison officials must demonstrate why in each case the particular prisoner cannot receive the requested services. As a result, it becomes more difficult for the prison to rely on generalized assertions of 'safety' to support the deprivations and instead forces an articulation of the reason for the particular condition."[68]

Constitutional requirements may frequently also play a role. True, the requirement of reasonable modification is not itself constitutional in stature. The Supreme Court explained in *Board of Trustees v. Garrett* that the Equal Protection Clause does not require states "to make special accommodations for the disabled, so long as their actions toward such individuals are rational."[69] However, when reasonable modification to a prison policy or practice is necessary to avoid serious harm to a prisoner, both the Eighth Amendment's Cruel and Unusual Punishments Clause (for convicted prisoners) and the

66. 28 C.F.R. § 35.130(b)(1)(7)(i).

67. *See* PGA Tour, Inc. v. Martin, 532 U.S. 661, 683 (2001).

68. Brittany Glidden & Laura Rovner, *Requiring the State to Justify Supermax Confinement for Mentally Ill Prisoners: A Disability Discrimination Approach*, 90 Denv. U. L. Rev. 55, 69 (2012).

69. Bd. of Trs. of the Univ. of Ala. v. Garrett, 531 U.S. 356, 367 (2001).

Fourteenth Amendment's Due Process Clause (for pretrial detainees) compel such modification. Under both, government officials must "respond[] reasonably to … risk[s]"[70] to prisoners, where those risks threaten the "minimal civilized measure of life's necessities."[71] This obligation includes, for example, nutrition, sanitation, large-muscle exercise, and protection from harm by other prisoners. So if some overarching prison policy or practice, applicable to prisoners with and without disabilities alike, poses an obstacle to a prisoner with a disability getting enough food, or living in sanitary conditions, or avoiding assaults by other prisoners, modification of that policy is required not just by the ADA but also by the Constitution.[72]

RECOMMENDATION: Jail and prison officials should embrace the ADA's requirement of individualized modifications to policies and practices when useful for prisoners with disabilities' equal participation in and access to services.

C. THE INTEGRATION MANDATE

The ADA regulations include a provision, usually termed the "integration mandate," that directs that "A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities."[73] The regulation that deals specially with program access in prisons and jails adds some detail to this general mandate. It provides, in pertinent part:

> (b)(2) Public entities shall ensure that inmates or detainees with disabilities are housed in the most integrated setting appropriate to the needs of the individuals. Unless it is appropriate to make an exception, a public entity—
> (i) Shall not place inmates or detainees with disabilities in inappropriate security classifications because no accessible cells or beds are available;
> (ii) Shall not place inmates or detainees with disabilities in designated medical areas unless they are actually receiving medical care or treatment; [and]
> (iii) Shall not place inmates or detainees with disabilities in

70. Farmer v. Brennan, 511 U.S. 825, 844 (1994).
71. *Id.* at 834 (quoting Rhodes v. Chapman, 452 U.S. 337, 347 (1981)).
72. *Cf.* United States v. Georgia, 546 U.S. 151, 157 (2006) ("Goodman's claims for money damages against the State under Title II were evidently based, at least in large part, on conduct that independently violated" the Cruel and Unusual Punishments Clause).
73. 28 C.F.R. § 35.130(d).

> facilities that do not offer the same programs as the facilities where they would otherwise be housed.[74]

Prisons often house prisoners with disabilities in various kinds of special housing that are, if not quite solitary confinement, at least close to it; they impose far more locked-down time than ordinary housing, restrict access to property, limit various privileges, etc. This kind of dedicated housing for people with disabilities (as well as infirmary assignments for prisoners not actually in need of in-patient medical care) violate the plain dictates of the ADA's regulations if the housing area is not "the most integrated setting appropriate" to the prisoners' needs.[75] As the DOJ further explained in a brief filed in 2013, "[P]risoners with disabilities cannot be automatically placed in restrictive housing for mere convenience … the individualized assessment should, at a minimum, include a determination of whether the individual with a disability continues to pose a risk, whether any risk is eliminated after mental health treatment, and whether the segregation is medically indicated."[76]

Similarly, a prison violates the ADA regulation if, for example, all the mental-health housing is high security, so that prisoners who would otherwise have access to gentler conditions in minimum or medium security are forced into harsher environments in order to get treatment.[77] As already described, in *Armstrong v. California*, the U.S. District Court for the Northern District of California found that the plaintiff prisoners, who had mobility impairments, were being housed in solitary confinement simply because there were no accessible cells available elsewhere.[78] This, Judge Wilken held, violated the clear terms of the provisions quoted above.[79]

More commonly, though, confinement of prisoners with disabilities to restrictive housing is not because of a shortage of accessible cells elsewhere, but rather because prisons choose to manage difficult, disability-related

74. 28 C.F.R. § 35.152.

75. 28 C.F.R. § 35.130(d).

76. Response of the United States of America to Defendants' Motion in Limine No.4: To Exclude the Statement of Interest at 4, Coleman v. Brown, 2:90-cv-00520-LKK-DAD (E.D. Cal. Nov. 12, 2013), http://www.clearinghouse.net/chDocs/public/PC-CA-0002-0041.pdf (and Appendix).

77. This argument was made in some detail by the plaintiffs in the pioneering case *Disability Advocates, Inc. v. N.Y. State Office of Mental Health*, 1:02-cv-04002-GEL (S.D.N.Y. 2007), http://www.clearinghouse.net/detail.php?id=5560.

78. *See* Order Granting Motion for Further Enforcement, Armstrong v. Brown, No. 94-cv-02307-CW, 2015 WL 496799 (N.D. Cal. Feb. 3, 2015), http://www.clearinghouse.net/chDocs/public/PC-CA-0001-0040.pdf.

79. *Id.* at 1.

behavior with solitary confinement rather than less harsh housing assignments and services. In *Olmstead v. L.C.*, the Supreme Court required states to deinstitutionalize people with disabilities who had been unjustifiably assigned to receive various state-provided services in segregated institutions rather than in the community.[80] In prison or jail, when solitary confinement is triggered by a prisoner's disability (and resulting conduct), that means that prison services are provided in a setting that lessens the prisoner's contact with other, non-disabled prisoners. This is "segregated" not only in the way the term is used in prison, but also in the way the term is used in the *Olmstead* opinion to describe civil institutionalization, which the Court held can be a form of unlawful discrimination.[81]

The ADA's integration mandate presumes that such segregation is harmful. That is, the regulation itself bans an under-justified decision to isolate people with disabilities from other, non-disabled people; plaintiffs need not demonstrate how that decision hurts them. In addition, a decade of litigation under *Olmstead* in other settings has established that the solution for violations of the integration mandate is the provision of services in integrated settings that avoid the need to segregate.[82] For example, in *United States v. Delaware*, an *Olmstead* settlement between the DOJ and the state of Delaware required statewide crisis services to "[p]rovide timely and accessible support to individuals with mental illness experiencing a behavioral health crisis, including a crisis due to substance abuse."[83] The settlement detailed numerous items that would form a "continuum of support services intended to meet the varying

80. 527 U.S. 581 (1999). For more on *Olmstead* and its implementation, see U.S. Dep't of Justice, Civ. Rts. Div., Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and *Olmstead v. L.C.* (2011), http://www.ada.gov/olmstead/q&a_olmstead.pdf.

81. *Olmstead*, 527 U.S. at 598. The plaintiffs in California's *Coleman* litigation, a class action on behalf of prisoners with serious mental illness, have made the fullest version of this argument. *See* Notice of Motion & Motion for Enforcement of Court Orders & Affirmative Relief Re: Improper Housing & Treatment of Seriously Mentally Ill Prisoners in Segregation, Coleman v. Brown, 2:90-cv-00520-LKK-JFM (E.D. Cal. May 6, 2013), http://www.clearinghouse.net/chDocs/public/PC-CA-0002-0066.pdf; Plaintiffs' Post-Trial Brief Regarding Enforcement of Court Orders and Affirmative Relief Regarding Improper Housing and Treatment of Seriously Mentally Ill Prisoners in Segregation, Coleman v. Brown, 2:90-cv-00520-LKK-DAD (E.D. Cal. Jan. 21, 2014), http://www.clearinghouse.net/chDocs/public/PC-CA-0002-0065.pdf. In the end, the District Court did not address the argument, ruling entirely on constitutional grounds. Coleman v. Brown, 28 F. Supp. 3d 1068 (E.D. Cal. 2014).

82. *See generally* Samuel R. Bagenstos, *The Past and Future of Deinstitutionalization Litigation*, 34 Cardozo L. Rev. 1 (2012).

83. Settlement Agreement at 3, United States v. Delaware, 1:11-cv-00591-LPS (D. Del. July 6, 2011), http://www.clearinghouse.net/chDocs/public/PB-DE-0003-0002.pdf.

needs of individuals with mental illness."[84] This included Assertive Community Treatment teams—multidisciplinary groups "including a psychiatrist, a nurse, a psychologist, a social worker, a substance abuse specialist, a vocational rehabilitation specialist and a peer specialist"—to "deliver comprehensive, individualized, and flexible support, services, and rehabilitation to individuals in their homes and communities," and various kinds of case management.[85] And it provided for "an array of supportive services that vary according to people's changing needs and promote housing stability" and "integrated opportunities for people to earn a living or to develop academic or functional skills."[86] Other *Olmstead* decrees contain similar provisions.[87]

The Delaware settlement and other *Olmstead* cases provide a very helpful model for how prisons could comply with the integration mandate, managing the needs of prisoners with disabilities to keep them out of the segregated solitary-confinement setting. The possibilities are broad: provision of coaching and mental-health treatment and other supports, perhaps assignment to a one-person cell to minimize intra-cell conflict, and many more.

RECOMMENDATION: Prisons and jails should avoid separating prisoners with disabilities from other prisoners, and should implement supports helpful to avoid the need for such separation, including coaching, mental-health treatment, single cells where useful, and others.

D. KEY FEATURES OF IMPLEMENTATION PROCESSES

As I've already argued, individualization and integration do not come naturally to jails and prisons—total institutions that prefer standardized to singular treatment. It may be helpful, then, to explore briefly how a jail or prison could maximize its ability to implement the recommendations I've just made by using four procedural components: interaction with the prisoner, notice to the prisoner of available services and accommodations, structured consideration, and concentrated development of expertise and responsibility.

Because disability-related needs are so varied, disability-rights statutes often require what is often called an "interactive process" for the development of accommodations. The ADA's Title I (employment) regulation urges that an "informal, interactive process" "may be necessary" to "identify the

84. *Id.* at 6.
85. *Id.* at 5–6.
86. *Id.* at 7–8.
87. *See Special Collection: Olmstead Cases*, Civ. Rts. Litig. Clearinghouse, http://www.clearinghouse.net/results.php?searchSpecialCollection=7 (last visited Apr. 3, 2017) (listing cases).

precise limitations resulting from the disability and potential reasonable accommodations that could overcome those limitations."[88] The EEOC's guidance explains that the procedure should be "flexible [and] interactive" and should "involve[] both the employer and the [employee] with a disability."[89] And, as one federal appellate court has explained, this approach is not "especially burdensome." The idea is simply to:

> meet with the employee who requests an accommodation, request information about the condition and what limitations the employee has, ask the employee what he or she specifically wants, show some sign of having considered employee's request, and offer and discuss available alternatives when the request is too burdensome.[90]

Similarly, the Individuals with Disabilities Education Act (IDEA) requires that a child's individualized education program be developed in a process that is calculated to understand the child's needs and goals, and that includes his or her parents.[91] Particularly under the IDEA, part of the process is providing information to the parent on rights and available services and accommodations.[92]

ADA Title II's regulations do not include "interactive process" language, but courts have nonetheless imported the approach, which is sensibly geared toward assessing individualized needs and solutions.[93] In a prison or a jail, an interactive process has two advantages. First, it involves the prisoner, who is best equipped to know his own needs and circumstances. Second, it structures a focused consideration of the disability issues—the situation, the potential solutions, and their pros and cons.

It's useful to designate who as well as what the process includes. Disability accommodation requires knowledge of what the law requires—the content of the sections preceding this one. Equally important, it requires knowledge of multiple technologies and techniques. Take a relatively easy question: What can be done to provide access to telephone communication to a prisoner who is too hard of hearing to use a regular phone, but who doesn't sign? To answer

88. 29 C.F.R. § 1630.2(o)(3).
89. 29 C.F.R. pt. 1630, App.
90. Taylor v. Phoenixville Sch. Dist., 174 F.3d 142, 162 (3d Cir. 1999).
91. 20 U.S.C. § 1414(d)(1)(B).
92. On parental involvement in the IEP process in general, see Mark C. Weber, Special Education Law and Litigation Treatise § 5.2 (citing 34 C.F.R. §§ 300.343(c)(iii), 300.346(a)(1)(i), 300.346(b)).
93. *See, e.g.*, Vinson v. Thomas, 288 F.3d 1145, 1154 (9th Cir. 2002).

requires awareness of the range of devices available—for example, amplifiers (including their interaction with hearing aids), or devices such as captioned telephones.[94] In correctional facilities, there are added complications. What kinds of amplifiers are sturdy enough for congregate facilities and capable of use with (usually low-tech and analog signal) prison pay phones? How can a captioned telephone be linked to the prison phone-billing system? And so on. In the case I am monitoring, a variety of obstacles to the state's first installation of a captioned telephone took several months to solve. The point is, it is essential for each facility to designate a disability or ADA coordinator who can develop the requisite regulatory and practical expertise. The ADA Title II regulations require designation of a "responsible employee" at the agency level,[95] but in my experience, few prisons or jails have anyone playing this role.

All this is the base for a procedural recommendation:

RECOMMENDATION: Jails and prisons should create a process for consideration of disability issues, which should include notice to prisoners with disabilities of their rights and available resources, services, and accommodations; and individualized consideration of the prisoners' requests and any alternatives. A designated ADA coordinator should develop appropriate expertise in disability, legal requirements, and technical solutions for disability-related needs.

E. TREATMENT—INCLUDING INTAKE AND DISCHARGE PLANNING

People with disabilities frequently have chronic and serious medical/mental-health treatment needs. Jails and prisons are constitutionally required to meet those needs.[96] That requirement extends not only to treatment in jail and prison (including prompt medical and mental-health assessment and management), but the period of time post-release before a released prisoner can reasonably

94. *See Internet Protocol (IP) Captioned Telephone Service*, FCC, https://www.fcc.gov/consumers/guides/internet-protocol-ip-captioned-telephone-service (last visited Apr. 3, 2017) ("CTS [captioned telephone service] allows a person with hearing loss but who can use his or her own voice and has some residual hearing, to speak directly to the called party and then listen, to the extent possible, to the other party and simultaneously read captions of what the other party is saying.").

95. 28 C.F.R. § 35.107(a). On what an effective ADA coordinator needs to know and be empowered to do, see U.S. Dep't of Justice, ADA Best Practices Tool Kit for State and Local Governments (2006) https://www.ada.gov/pcatoolkit/chap2toolkit.pdf.

96. Estelle v. Gamble, 429 U.S. 97, 104 (1976).

obtain external treatment.[97] In addition, the ADA and Rehabilitation Act require, at the very least, elimination of obstacles to treatment: As the Supreme Court noted in *Pennsylvania Department of Corrections v. Yeskey*, medical care is among the "services, programs, or activities" encompassed by the statutory text.[98] The Court confirmed the point in *United States v. Georgia*, when it deemed "quite plausible" the plaintiff's claim that "deliberate refusal of prison officials to accommodate [his] disability-related needs in such fundamentals as mobility, hygiene, medical care, and virtually all other prison programs constituted 'exclu[sion] from participation in or … den[ial of] the benefits of' the prison's 'services, programs, or activities.'"[99]

But the statutory disability claims may reach further. After all, without treatment, prisoners with both physical and mental disabilities are more likely to run into trouble of various kinds, leading them to disciplinary or administrative exclusions from facility programs, services, and activities. A prisoner who needs but does not have a hearing aid may face disciplinary consequences for noncompliance with directives he cannot hear—and will certainly be unable to benefit from many programs. The latter is also true for a prisoner whose abilities are compromised by an untreated chronic illness. The ADA and Rehabilitation Act don't require most government entities to provide medical care. But it seems to me a plausible argument that in prison and jail,

97. *See* Wakefield v. Thompson, 177 F.3d 1160, 1164 (9th Cir. 1999) ("[T]he state must provide an outgoing prisoner who is receiving and continues to require medication with a supply sufficient to ensure that he has that medication available during the period of time reasonably necessary to permit him to consult a doctor and obtain a new supply."); Lugo v. Senkowski, 114 F. Supp. 2d 111, 115 (N.D.N.Y. 2000) ("The State has a duty to provide medical services for an outgoing prisoner who is receiving continuing treatment at the time of his release for the period of time reasonably necessary for him to obtain treatment on his own behalf."); *see also* Brad H. v. City of New York, 712 N.Y.S.2d 336 (Sup. Ct. 2000), *order aff'd*, 716 N.Y.S.2d 852 (Sup. Ct. App. Div. 2000) (similar outcome under state law).

98. Pa. Dep't of Corr. v. Yeskey, 524 U.S. 206 (1998).

99. United States v. Georgia, 546 U.S. 151, 157 (2006) (alterations in original).

where medical and mental-health care are among the services provided, denial of particular treatments needed by people with disabilities also constitutes actionable discrimination.[100]

In any event, the resulting recommendation is a simple one to state, though complex to comply with:

RECOMMENDATION: Jails and prisons should provide appropriate intake assessment, treatment, and discharge planning for the medical and mental-health needs of people with disabilities.

F. THE LARGER LESSON

It's not only prisoners with disabilities who can benefit from individualization. I've just argued, for example, that a prisoner with an intellectual disability that renders him illiterate, and therefore unable to take advantage of subsidies for letters home, should receive an accommodation—subsidized phone calls, a reader/writer, or something similar. Such an accommodation is equally useful to any prisoner who is illiterate, even if he does not have an intellectual disability. Likewise, for anyone who is in segregated housing because of a security risk, it only makes sense for prison officials to limit the restrictions to what is actually necessary. There's no reason, for example, to restrict access to phone calls, books, or television for a prisoner temporarily locked down because of threats against her. Even when the ADA is not requiring the more individualized approach, it's sensible to unbundle the potential privilege restrictions and apply only the ones that are necessary.

III. BRIDGING THE PRISON WALLS

Abundant evidence demonstrates that prisoners' successful reentry—their transition to productive and pro-social lives in their communities after release from jail and prison—is aided by programs that bridge the walls that separate

100. *See, e.g.*, Plaintiff's Response to Motion for Summary Judgment, Anderson v. Colorado, No. 10-cv-01005-WYD-KMT (D. Colo. July 21, 2011), http://www.clearinghouse.net/chDocs/public/PC-CO-0017-0006.pdf; Plaintiff's Trial Brief, Anderson v. Colorado, No. 10-cv-01005-WYD-KMT (D. Colo. Apr. 23, 2012), http://www.clearinghouse.net/chDocs/public/PC-CO-0017-0007.pdf. In these pleadings, the plaintiff argued that the ADA and Rehabilitation Act barred the prison's "refus[al] to provide the reasonable accommodation (in the form of treatment and medication) necessary to permit Mr. Anderson to be integrated with other prisoners," and, in the alternative, that "if—even with proper medication and treatment—his mental illness requires that he be kept in ad seg, he is qualified for a number of programs and benefits that he is now being denied based solely on that placement. Because that is tantamount to denying him these programs and benefits based on his disability, it constitutes illegal discrimination under the ADA and RA." Plaintiff's Response to Motion for Summary Judgment, *supra*, at 42. The court denied these claims on the facts. Anderson v. Colorado, 887 F. Supp. 2d 1133, 1146–48 (D. Colo. 2012).

prison from the outside world. We know that effective reentry planning "starts on the inside and continues upon release."[101] Among the most effective bridging methods is when "[t]he same re-entry planner or case manager works with the detainee on the inside and on the outside and serves as an advocate for his successful re-entry."[102] Mentor programs often use a similar strategy; mentors begin working with prisoners prerelease, and continue through a reentry period.[103]

This broad insight has specific application to prisoners with disabilities and their medical and mental-health care. To improve care, and the lives and prospects of prisoners with disabilities, what is needed are wall-bridging techniques addressing record-keeping, personnel, and finances. The idea is not complicated. If jail and prison health care could be integrated with community health care in these three arenas, the result would not be merely improved health behind bars but improved community health.

1. Health records

Transitions are a dangerous time for health services. At hospitals, the most dangerous hours of the day are the shift changes. For prisoners with acute health needs, one dangerous time is arrival at a new facility—when medication is often confiscated, skipped, or lost; health histories can be hazardously incomplete; and (particularly in jail) the prisoner is often in crisis. Another dangerous time is release—when prisoners usually leave with only a few days' worth, if that, of any medication, without a doctor's appointment to get a refill, and often far from their families without transportation home.[104]

101. Robert Wood Johnson Found., Linking Re-Entry Planning to Community-Based Correctional Care 2 (2009), http://www.thebridginggroup.com/pdf/Linking_Re-Entry_Planning_to_Community-Based_Correctional_Care_Zack_2009.pdf. *See generally* Susan Turner, "Reentry," in the present Volume.

102. Robert Wood Johnson Found., *supra* note 101, at 2.

103. *See* Shawn Bauldry et al., Mentoring Formerly Incarcerated Adults: Insights from the Ready4Work Reentry Initiative 7 tbl.2 (2009), http://ppv.issuelab.org/resources/1948/1948.pdf; *see also* Byron R. Johnson & David B. Larson, The InnerChange Freedom Initiative: A Preliminary Evaluation of a Faith-Based Prison Program 16 (2008), http://www.baylor.edu/content/services/document.php/25903.pdf ("It was hoped that the mentoring relationship that was developed while the offender was still in prison would continue during the difficult months following release from prison.").

104. *See, e.g.*, Jacques Baillargeon et al., *Accessing Antiretroviral Therapy Following Release from Prison*, 301 JAMA 848, 855 (2009) ("In this 4-year study of HIV-infected inmates released from the nation's largest state prison system, we found that only 5% of released inmates filled a prescription for ART medications soon enough ... to avoid treatment interruption.")

An integrated system of health records shared between community and jail health providers doesn't altogether solve the problem, but it can help. For example, when medications are needed right away on incarceration, an existing prescription record could be an enormous help. More generally, to quote the talking points from one innovative county's presentation on their implementation of such a system, integrated records "improve access to timely and appropriate health care information during clinical encounters" and "improve the overall clinical care of the client by the connection with community providers."[105]

RECOMMENDATION: Health records in jails and prisons should be electronic and integrated with community health records.

2. Personnel

In medical and mental-health care as in other areas, people are the best bridges. There are a variety of models.[106] In both New York City and Washtenaw County, Michigan, for example, mental-health care in the jail is provided by the same agency, and sometimes the same people, as mental-health care outside.[107] In two Rhode Island programs for HIV-infected inmates, the personnel who stay constant are not the treating professionals but case managers.[108] In another Michigan county program, a "medical navigator" and community health workers begin meeting with prisoners months prior to their release, and continue with case-management services post-release.[109]

Community service providers are useful for three reasons: continuity of care; expertise in available community services; and non-prison attitude. The

105. SAMHSA-HRSA Ctr. for Integrated Health Solutions, Bridging Criminal Justice Systems and Community Healthcare: Integration's Role in Reentry (2013), http://www.integration.samhsa.gov/Presentation_FINAL.pdf. The program described is for the Multnomah County Health Department; see also Ben Butler, Cmty. Oriented Corr. Health Servs., Jails And Health Information Technology: A Framework For Creating Connectivity (2013), http://www.cochs.org/files/HIT-paper/cochs_health_it_case_study.pdf, for a case study of this and several other projects.

106. I lean here largely (though not entirely) on programs cited in Kavita Patel et al., *Integrating Correctional And Community Health Care For Formerly Incarcerated People Who Are Eligible For Medicaid*, 33 Health Aff. 468 (2014), http://content.healthaffairs.org/content/33/3/468.long.

107. *See* Butler, *supra* note 105, at 14; *Correctional Services Description*, eWashtenaw, http://www.ewashtenaw.org/government/sheriff/divisions/corrections/correctional-services (last visited Feb. 15, 2017).

108. Patel et al., *supra* note 106, at 469-70.

109. *Michigan Pathways Project Links Ex-Prisoners to Medical Services, Contributing to a Decline in Recidivism*, Agency Healthcare Res. & Quality (Feb. 2, 2009), https://innovations.ahrq.gov/profiles/michigan-pathways-project-links-ex-prisoners-medical-services-contributing-decline.

first two are self-explanatory. The third is equally important. Correctional facility doctors and nurses can be expert and compassionate providers. But sometimes prisons and jails become the employers of last resort for subpar clinicians. A number of states have a practice of granting "restricted licenses" to doctors who work in prisons but do not meet the requirements for full licensure.[110] And in some states, doctors whose disciplinary records make them unattractive employees elsewhere find jobs in the prison system.[111] Even when clinicians have unrestricted licenses and clean records, research establishes that prison doctors and nurses tend to be more jaded and less empathetic toward their patients when compared with their civilian counterparts.[112] As experienced correctional physician Robert Greifinger has summarized: "There is far too much cynicism regarding inmates among correctional health care professionals, who work in environments of constant tension. Too often these professionals are skeptical about inmates' concerns and complaints, believing that the inmates (who do often exaggerate) are malingering for secondary gain. Correctional health care staff also frequently incorporate the custody staff's fear that humane responsiveness is coddling that can lead to anarchy."[113]

When medical and mental-health staff work both in and out of correctional facilities, that counteracts both the tendency toward lower hiring standards and lower levels of compassion toward the patients. Even if in a particular setting it makes sense to hire people who work only in a correctional facility, it is helpful in terms of hiring, supervision, and mindset if their employing organization is focused on community as well as correctional care.

RECOMMENDATION: Medical and mental-health staff in jails and prisons should have employing organizations whose focus is on community in addition to correctional care.

110. *See* John J. Gibbons & Nicholas De B. Katzenbach, *Confronting Confinement: A Report of The Commission on Safety and Abuse in America's Prisons*, 22 Wash. U. J.L. & Pol'y 385, 443–44 (2006).

111. *See* Cindy Chang, *Many Doctors Treating State's Prisoners Have Disciplinary Records Themselves*, The Times-Picayune (July 29, 2012), http://www.nola.com/crime/index.ssf/2012/07/many_doctors_treating_states_p.html.

112. *See* Naveen Dhawan et al., *Physician Empathy and Compassion for Inmate-Patients in the Correctional Health Care Setting*, 13 J. Corr. Health Care 257, 264 (2007) ("[C]orrectional physicians describe a developmental course in which they become increasingly able to empathize with inmates during a period of years of working in a correctional setting."); Kristine E. Shields & Dorothy de Moya, *Correctional Health Care Nurses' Attitudes Toward Inmates*, 4 J. Corr. Health Care 37, 37 (1997).

113. Robert B. Greifinger, *Inmates As Public Health Sentinels*, 22 Wash. U. J.L. & Pol'y, 253, 262 (2006).

3. Finances and discharge planning

Finally, there is simply no justification for the current law and practices governing the financing of inmate health care. As so often in health law, this issue is technically complicated. Since its inception, Medicaid has excluded "inmates of public institutions" from "federal financial participation"—which is to say, coverage.[114] That exclusion has never affected inmate eligibility to enroll, just their actual receipt of Medicaid benefits.[115] Nonetheless, even prisoners who were eligible, because of age or disability, have most often had their Medicaid enrollment terminated rather than merely suspended, during their time in jail and prison. The result was months of delay for former inmates to be reapproved for Medicaid on release from incarceration.[116]

In the past, the use of Medicaid termination rather than suspension did not affect most prisoners, however, because they were not Medicaid-eligible in any event. As adults without dependent children and without a Social Security Administration-recognized disability, they did not meet their states' eligibility criteria notwithstanding their low income. The Affordable Care Act (ACA) changed that part of the picture when it allowed states to expand Medicaid coverage to everyone who earns up to 138% of the federal poverty level and is under 65 (People 65 and older are covered under Medicare).[117] As of January 2017, 31 states and the District of Columbia had signed up for the ACA's Medicaid expansion funding.[118] The result is that nearly all inmates in those states are now Medicaid-eligible. Enrollment comes with two benefits for them and their jailers: First, Medicaid will cover a large portion of the cost of care delivered outside the institution—at a hospital, for example—when the prisoner has been admitted to that hospital for 24 hours or more. Second, Medicaid enrollment greatly smooths the transition to community health care on release. To realize these benefits, however, states need to enroll their inmates—and to suspend rather than terminate prisoner participation in the

114. 42 C.F.R. § 435.1009(a)(1).

115. *See* Letter from Glenn Stanton, Acting Dir., Disabled & Elderly Health Programs Grp., to State Medicaid Directors, CMS Assoc. Reg'l Adm'rs for Medicaid (May 25, 2004), https://www.medicaid.gov/medicaid/ltss/downloads/community-living/ending-chronic-homelessness-smd-letter.pdf (discussing ending chronic homelessness).

116. *See* Nat'l Ass'n of Ctys., Health Coverage and County Jails Suspension vs. Termination 1 (2014), http://www.naco.org/sites/default/files/documents/Suspension-termination-DEC2014(2).pdf; *see also* 42 C.F.R. § 435.912 (capping Medicaid eligibility determinations based on disability at 90 days and other applications at 45 days).

117. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, 271 (2010) (codified at 42 U.S.C. § 1396a).

118. *Current Status of State Medicaid Expansion Decisions*, Kaiser Family Found. (Jan. 1, 2017), http://kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision/.

program while they are housed in jail or prison. States have been making real though not complete progress on these fronts.[119]

Much more broadly (and admittedly unrealistically in the current political climate), to my mind, the exclusion of prisoners from Medicaid makes no sense at all. If the federal government is going to be responsible for health-care costs for poor people, why exclude prisoners? I suppose there's an argument that since the states and local governments are constitutionally required to pay for medical care, Medicaid coverage would not increase access to care, but merely shift the payer (of course, if that's the logic, the exclusion from the exclusion for hospital stays is an oddity). But even if Medicaid continues to exclude prisoners, there is no reason at all that prisoners shouldn't be enrolled, to facilitate coverage for them when they leave. The absence of Medicaid coverage is one of the reasons that the death rate for released prisoners is several times higher than for others of similar age, race, and sex.[120] The availability of insurance makes discharge planning possible: case managers can connect inmates heading toward release with providers in their community and can even schedule necessary post-release appointments.

RECOMMENDATION: Congress should extend Medicaid coverage for Medicaid-eligible prisoners. In the alternative, jails and prisons should enroll all eligible prisoners in Medicaid, and suspend rather than terminate Medicaid coverage for prisoners.

RECOMMENDATION: Jail and prison case managers should undertake systematic discharge planning for medical and mental-health care; prisoners should be released with sufficient medication to get them to a scheduled appointment with an appropriate provider.

119. *See* Sachini N. Bandara et al, *Leveraging the Affordable Care Act to Enroll Justice-Involved Populations in Medicaid*, 34 Health Aff. 2044 (2015); *Medicaid Eligibility for People Leaving Incarceration Is Smart Policy*, Families USA (July 12, 2016), http://familiesusa.org/sites/default/files/product_documents/ENR_Suspension%20v.%20Termination%20Map%20Infographic_07-12-16.pdf. In addition, in April 2016, the Obama Administration issued guidance on "facilitating access to covered Medicaid services for eligible individuals prior to and after a stay in a correctional institution." That guidance provided that individuals in halfway houses would often be covered by Medicaid (if they had a certain degree of freedom of movement). Ctrs. for Medicare & Medicaid Servs., U.S. Dep't of Health & Human Servs., State Health Official Letter No. 16-007 (Apr. 28, 2016).

120. Ingrid A. Binswanger et al., *Release from Prison—A High Risk of Death for Former Inmates*, 356 New Eng. J. Med. 157, 157 (2007).

RECOMMENDATIONS

Here is a summary of this chapter's recommendations:

1. Jail and prison officials should not exclude prisoners with disabilities from particular housing units, jobs, or any other programs absent an individualized finding that a prisoner's participation poses significant safety risks that cannot be mitigated.
2. Jail and prison officials should embrace the ADA's requirement of individualized modifications to policies and practices when useful for prisoners with disabilities' equal participation in and access to services.
3. Prisons and jails should avoid separating prisoners with disabilities from other prisoners, and should implement supports helpful to avoid the need for such separation, including coaching, mental-health treatment, single cells where useful, and others.
4. Jails and prisons should create a process for consideration of disability issues, which should include notice to prisoners with disabilities of their rights and available resources, services, and accommodations; and individualized consideration of the prisoners' requests and any alternatives. A designated ADA coordinator should develop appropriate expertise in disability, legal requirements, and technical solutions for disability-related needs.
5. Jails and prisons should provide appropriate intake assessment, treatment, and discharge planning for the medical and mental-health needs of people with disabilities.
6. Health records in jails and prisons should be electronic and integrated with community health records.
7. Medical and mental-health staff in jails and prisons should have employing organizations whose focus is on community in addition to correctional care.
8. Congress should extend Medicaid coverage for Medicaid-eligible prisoners. In the alternative, jails and prisons should enroll all eligible prisoners in Medicaid, and suspend rather than terminate Medicaid coverage for prisoners.
9. Jail and prison case managers should undertake systematic discharge planning for medical and mental-health care; prisoners should be released with sufficient medication to get them to a scheduled appointment with an appropriate provider.