

NOTE

Behind Bars and in the Hole: Applying *Olmstead* to Incarcerated Individuals with Mental Illness

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Mental illness is pervasive in American prisons and jails. Individuals who, prior to deinstitutionalization efforts in the 1960s, would have been committed to state hospitals are now unable to access the appropriate services in the community. Consequently, individuals with mental illness are excessively entangled in the criminal justice system and frequently incarcerated. Conversely, many individuals without a recorded history of mental illness develop such conditions while in correctional facilities.

Despite the enormous number of detainees and inmates with mental illness, U.S. prisons and jails lag behind in the provision of adequate mental health treatment: staffing levels are low, screenings are subpar, and treatment plans are neglected. Ill-equipped to address the needs of this population, correctional facilities frequently further isolate inmates with mental illness in solitary confinement—a response that often exacerbates the person’s condition and prolongs their stay. Litigation involving inmates with mental illness has heavily relied on Eighth Amendment cruel and unusual punishment claims, often arguing “deliberate indifference” to incarcerated or detained individuals’ needs. This cause of action places a high burden on prisoner-plaintiffs to demonstrate prison officials’ subjective knowledge and a conscious disregard of inmates’ needs. Courts give deference to correctional officers’ decisions about when and how to respond to inmates with mental illness. Litigants also rely on the Americans with Disabilities Act, which poses a similar subjective-knowledge burden.

*This Note attempts to introduce how the *Olmstead v. L.C. ex rel. Zimring* decision can be used as an alternative to traditional “deliberate indifference” claims. It focuses on some of the advantages of *Olmstead* litigation, both in terms of burdens of proof and possible long-term policy goals. Given the movement towards community-integration of people with disabilities, it is important that we consider how the principles of integration and non-isolation apply even in the context of incarceration.*

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I. INTRODUCTION

The once-shrouded world of U.S. prisons is now under long-overdue public scrutiny. Americans are increasingly aware of the widespread issue of mass incarceration, particularly its effects on disadvantaged groups.¹ We are learning about how systemic deficiencies in our communities mean certain groups—like those with mental illness—are destined to become entangled in the criminal justice system.² Contraband footage from inside prisons shows the public what life behind bars is truly like.³ These conditions are particularly poor for individuals with mental illness, who frequently cannot access appropriate mental health treatment and are routinely punished for it.⁴

Much of the litigation around treatment services in prisons has centered around the Eighth Amendment’s proscription against cruel and unusual punishment. This Note suggests a new basis for such claims: *Olmstead*.⁵ In interpreting the integration mandate of the Americans with Disabilities Act, the *Olmstead* Court opened a new route for individuals with mental and physical disabilities to receive care in the least restricted setting.⁶ A year after the decision, Professor Michael Perlin suggested that *Olmstead* could reform the way prisons treat inmates with disabilities.⁷ Still, nearly twenty years later, no case has successfully relied on *Olmstead* as the basis for providing adequate and continuous mental health services to incarcerated individuals with mental illness.

This Note will outline how a complainant might bring an *Olmstead* claim to request injunctive relief in the form of mental health services, while also exploring the shortcomings of the hypothetical complaint. Part I will illustrate the scope of

1. See Zak Cheney-Rice, *How America’s Health-Care System Makes Mass Incarceration Worse*, NEW YORKER (Oct. 1, 2019), <http://nymag.com/intelligencer/2019/10/health-care-mass-incarceration.html> (people with high medical costs); BECKY PETIT & BRYAN SYKES, STANFORD CTR. ON POVERTY & INEQUALITY, STATE OF THE UNION 2017: INCARCERATION (2017), https://www.treatmentadvocacycenter.org/storage/documents/bp_law_enforcement.pdf (people of color).

2. These deficiencies are sometimes a result of hidden pipelines within our communities: inadequate community-based treatment programs, lack of affordable housing, school-to-prison pipelines, and unnecessary encounters with police. See Robert D. Dinerstein and Shira Wakschlag, *Using the ADA’s “Integration Mandate” to Disrupt Mass Incarceration*, 96 DEN. L. REV. 917, 935–938 (2019) (school-to-prison pipeline); TREATMENT AND ADVOCACY CENTER, LAW ENFORCEMENT AND PEOPLE WITH SEVERE MENTAL ILLNESS 1 (2017), https://www.treatmentadvocacycenter.org/storage/documents/bp_law_enforcement.pdf (encounters with law enforcement); Ann-Marie Louison, *The Mentally Ill Need Affordable Housing*, N.Y. TIMES (May 9, 2016), <https://www.nytimes.com/roomfordebate/2016/05/09/getting-the-mentally-ill-out-of-jail-and-off-the-streets/the-mentally-ill-need-supportive-affordable-housing> (affordable housing).

3. Deanna Paul, *An inmate’s secretly recorded film shows the gruesome reality of life in prison*, WASH. POST (Oct. 7, 2019), <https://www.washingtonpost.com/nation/2019/10/07/an-inmates-secretly-recorded-film-shows-gruesome-reality-life-prison>.

4. See U.S. DEP’T OF JUSTICE, OFFICE OF THE INSPECTOR GEN., REVIEW OF FEDERAL BUREAU OF PRISONS’ USE OF RESTRICTIVE HOUSING FOR INMATES WITH MENTAL ILLNESS 4 (2017), <https://oig.justice.gov/reports/2017/e1705.pdf> [hereinafter BOP’S USE OF RESTRICTIVE HOUSING] (noting that inmates with serious mental illness may be confined to restrictive housing units).

5. *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999).

6. See *id.* at 607 (“[W]e conclude that, under Title II of the [Americans with Disabilities Act], States are required to provide community-based treatment for persons with mental disabilities. . . .”).

7. See Michael Perlin, *“Their Promises of Paradise”: Will Olmstead v. L.C. Resuscitate the Constitutional “Least Restrictive Alternative” Principle in Mental Disability Law*, 37 HOUS. L. REV. 999, 1042 (2000) (noting that the Court’s endorsement of “least restrictive setting” means that courts will increasingly consider “restrictivity” in civil commitment hearings).

the problem—that is, the massive need for mental health services in U.S. prisons. Then Part II will survey therapeutic jurisprudence, beginning with the landmark cases *Brown v. Plata*⁸ and *Estelle v. Gamble*⁹ and ending with some opinions from the last year. Finally, Part III will introduce the *Olmstead* decision and outline how it may apply to a complaint for mental health treatment in the prison setting.

II. THE NEED FOR REFORM

A. Population Profile: Prisoners with Mental Illness

The decline in rates of institutionalization has been accompanied by a rise in the prevalence of mental illness in correctional facilities.¹⁰ While psychiatric institutions closed their doors and released patients, community-based services lagged behind;¹¹ as a result, individuals with mental illness are disproportionately entangled in the criminal justice system.¹² Some explanations for this phenomenon are “punitive sentencing laws and aggressive policing practices” of substance abuse disorders, a side-effect of the War on Drugs.¹³ Unable to access appropriate treatment in the community, individuals with mental illness continue to have recurring run-ins with the law. Take the story of Michael Megginson, as an example.¹⁴ Michael, who had a long family history of mental illness and substance abuse, was admitted to the Bronx Children’s Psychiatric Center four times by age twelve.¹⁵ He had a history of aggressive behavior and uncontrollable rage, and he spent his teenage years in a group home with other young adults with behavioral issues.¹⁶ When he turned nineteen, however, Michael was arrested for attacking his mother. He spent three months at Rikers Island.¹⁷ Michael had another altercation after his release, this time with his father, and was civilly committed to a hospital for five months.¹⁸ Although physicians warned against his release, his psychiatrist was hopeful, and the court ordered Michael’s release.¹⁹ Almost immediately following his release, Michael stopped his medication regiment, did not attend treatment sessions, and began abusing alcohol and marijuana. Less than

8. 563 U.S. 493 (2011).

9. 429 U.S. 97 (1976).

10. Vera Institute of Justice, *The Burden of Mental Illness Behind Bars*, VERA.ORG (June 21, 2016), <https://www.vera.org/the-human-toll-of-jail/inside-the-massive-jail-that-doubles-as-chicagos-largest-mental-health-facility/the-burden-of-mental-illness-behind-bars>.

11. See Coy C. Morgan, *Three Generations of Injustice are Enough: The Constitutional Implications Resulting from the Criminalization of the Mentally Ill*, 45 S. U. L. REV. 29, 32–35 (2017).

12. *Id.*

13. Vera Institute of Justice, *supra* note 10.

14. Michael Winerip & Michael Schwartz, *For Mentally Ill Inmates at Rikers Island, a Cycle of Jail and Hospitals*, N.Y. TIMES (Apr. 10, 2015), <https://www.nytimes.com/2015/04/12/nyregion/for-mentally-ill-inmates-at-rikers-a-cycle-of-jail-and-hospitals.html>.

15. *Id.*

16. *Id.*

17. *Id.*

18. *Id.*

19. *Id.*

two months later, Michael was back at Rikers for theft.²⁰ Although he was only supposed to serve a maximum of a three-year sentence (and was immediately eligible for parole), lack of treatment during his incarceration led to further disciplinary action.²¹

The data is astonishing. In 2005, over half of all incarcerated individuals had some type of mental health condition—over 705,000 in state prisons, 78,000 in federal prisons, and 479,000 in local jails.²² Just four years later, an estimated twenty percent of jail inmates nationally and fifteen percent of inmates in state prisons had a serious mental illness, amounting to about 383,000 people with severe psychiatric disease in U.S. prisons and jails.²³ In the majority of states there are more individuals with mental illness in prisons and jail than there are in the largest state psychiatric facilities.²⁴ This is demonstrative of the fact that individuals with mental illness are often sucked into a hospital-to-jail cycle, where they do not receive adequate treatment and become lifelong participants in the criminal justice system.²⁵

B. Prisons as “de facto mental healthcare providers”²⁶

Despite the number of inmates with mental illness, prisons lag behind in the provision of mental health services.²⁷ The high costs associated with housing

20. *Id.* (noting that Michael was later transferred to Downstate Correctional Facility). Even the prosecutors, judges, and prison officials involved in Michael’s cases were frustrated by the cycle that Michael, and others like him, were subject to. *Id.*

21. *Id.*

22. U.S. DEP’T OF JUSTICE, OFFICE OF JUSTICE PROGRAMS, BUREAU OF JUSTICE STATISTICS SPECIAL REPORT: MENTAL HEALTH PROBLEMS OF PRISONS AND JAIL INMATES 1 (2006), <https://www.bjs.gov/content/pub/pdf/mhppji.pdf>.

23. TREATMENT ADVOCACY CTR., OFFICE OF RESEARCH & PUB. AFFAIRS, SERIOUS MENTAL ILLNESS (SMI) PREVALENCE IN JAILS AND PRISONS 2 (2016), <https://www.treatmentadvocacycenter.org/storage/documents/backgrounders/smi-in-jails-and-prisons.pdf> [hereinafter SMI IN JAILS AND PRISONS 2016].

24. *Id.* at 1 (forty-four states). A 2006 study by DOJ reported that ten percent of state prisoners had psychotic disorders, but this is likely a conservative estimate. *Id.* at 2.

25. See, e.g., Renee Gruber, Note, *A Civil Prison—Fear or Reason? Unbiased Reform of Involuntary Commitment Proceedings for Non-Criminals Admitted into Mental Facilities*, 90 U. DET. MERCY L. REV. 204 (2013); Barack Obama, *The President’s Role in Advancing Criminal Justice Reform*, 130 HARV. L. REV. 811, 848 (2017); Naomi M. Weinstein & Michael Perlin, “Who’s Pretending to Care for Him?” *How the Endless Jail-to-Hospital-to-Street-Repeat Cycle Deprives Persons with Mental Disabilities the Right to Continuity of Care*, 8 WAKE FOREST J.L. & POL’Y 455, 455–58, 469–473 (2018) (providing New York law as an example of this phenomenon); see also THE WHITE HOUSE, FACT SHEET: LAUNCHING THE DATA-DRIVEN JUSTICE INITIATIVE: DISRUPTING THE CYCLE OF INCARCERATION (June 30, 2016), <https://obamawhitehouse.archives.gov/the-press-office/2016/06/30/fact-sheet-launching-data-driven-justice-initiative-disrupting-cycle>.

26. Alisa Roth, *A ‘hellish world’: the mental health crisis overwhelming America’s prisons*, THE GUARDIAN (Mar. 31, 2018), <https://www.theguardian.com/society/2018/mar/31/mental-health-care-crisis-overwhelming-prison-jail>.

27. See Christie Thompson & Taylor Elizabeth Eldridge, *Treatment Denied: The Mental Health Crisis in Federal Prisons*, MARSHALL PROJECT (Nov. 21, 2019), <https://www.themarshallproject.org/2018/11/21/treatment-denied-the-mental-health-crisis-in-federal-prisons> (noting that in response to the Federal Bureau of Prisons’ recent regulations requiring improved treatment for prisoners with mental illness, prison psychologists were more likely to downgrade inmate’s care levels to avoid the administrative burden).

inmates with mental illness and understaffing at correctional facilities—particularly of appropriately trained mental health staff—contribute to prisons’ inability to provide any meaningful mental health treatment.²⁸ Ashoor Rasho—an inmate with severe mental health conditions, including schizophrenia, depression, and borderline personality disorder—explained: “Even if they would label us schizophrenic or bipolar, we would still be considered behavioral problems . . . [s]o the best thing for them to do was keep us isolated. Or they heavily medicate you.”²⁹

Prisons around the country have different procedures for identifying prisoners with mental disorders and providing subsequent treatment. Federal prisons use a system to classify prisoners by the inmates’ mental health care needs, called Mental Health Care Levels (MHCLs).³⁰ For example, an inmate classified as MHCL 1 is identified as having no significant functional impairments due to mental illness, while one classified as MHCL 4 is identified as requiring inpatient acute psychiatric care and cannot function in the general prison population.³¹ Under the jurisdiction of the Bureau of Prisons, these facilities are also subject to the federal Mental Health Care Policy which mandates identifying prisoners with mental disorders (by requiring staff to report unusual behavior to the leading psychologist), imposing additional diagnostics for MHCLs 2–4, requiring a minimum of monthly treatment interventions, and drafting a regularly-reviewed treatment plan.³²

In actuality, however, the delivery of mental health treatment in U.S. prisons is grossly lacking. The Marshall Project, through a Freedom of Information Act (FOIA) request, learned that the Bureau of Prisons (BOP) decreased the number of prisoners with mental illness receiving care by cutting the budget for treatment and reducing the number of inmates receiving care by thirty-five percent.³³ Through a recent investigation, the U.S. Department of Justice (DOJ) found that the Pennsylvania Department of Corrections was severely deficient in its provision

28. See C. Holly. A. Andrilla et al., *Geographic Variation in the Supply of Selected Behavioral Health Providers*, 54 AM. J. PREVENTATIVE MEDICINE 199, 200 (2018) (lack of psychologists and psychiatrists in rural areas); KIDEUK KIM ET AL., URBAN INST., *THE PROCESSING AND TREATMENT OF MENTALLY ILL PERSONS IN THE CRIMINAL JUSTICE SYSTEM* 11 (2015), <https://www.urban.org/sites/default/files/publication/48981/2000173-The-Processing-and-Treatment-of-Mentally-Ill-Persons-in-the-Criminal-Justice-System.pdf> (cost); Kevin Johnson, *Exclusive: As federal prisons run low on guards, nurses and cooks are filling in*, USA TODAY (Feb. 13, 2018), <https://www.usatoday.com/story/news/politics/2018/02/13/ill-equipped-and-inexperienced-hundreds-civilian-staffers-assigned-guard-duties-federal-prison-secur/316616002> (low staffing).

29. Christine Herman, *Most Inmates with Mental Illness Still Wait for Decent Care*, NPR (Feb. 3, 2019), <https://www.npr.org/sections/health-shots/2019/02/03/690872394/most-inmates-with-mental-illness-still-wait-for-decent-care>.

30. See BOP’S USE OF RESTRICTIVE HOUSING, *supra* note 4.

31. *Id.* An inmate with MHCL 1 may still have a serious mental illness, but it may not interfere with his ability to function (e.g., through medication medications). *Id.*

32. *Id.* at 8–9. In addition to evaluations and treatments, federal and state prisons often have policies surrounding suicidal inmates—although not always adequate ones. Prisons have phenomenally high rates of suicide, amounting to nearly 90% of prison deaths. See Meghan Gallagher, *Suicide in Prisons and Jails: A Growing Concern*, O’NEILL INST. (Nov. 16, 2018), <https://oneill.law.georgetown.edu/suicide-in-prisons-and-jails-a-growing-concern>. See Thompson & Eldridge, *supra* note 27 (telling the story of a West Virginia inmate who was initially placed on suicide watch after attempting suicidal ideations but was returned to the general population and classified as having “no significant mental health needs” after an evaluation).

33. Thompson & Eldridge, *supra* note 27.

of mental health services: mental health staff failed to coordinate with each other, there was confusion about diagnoses, treatment plans were not followed (e.g., switching psychiatrists with no explanation to the inmate), and the facility had virtually no recordkeeping, meaning inmates routinely lacked information about diagnosis, prior treatment, and medication information in their charts.³⁴ These problems are pervasive in U.S. jails as well, which often fail to adequately screen for mental illness and face extremely high rates of suicide by inmates with mental illness.³⁵

C. Segregation of inmates with mental health conditions

*“Yet conditions in some American facilities are so obscene that they amount to a form of extrajudicial punishment.”*³⁶

As if serving additional punishment for their condition, mentally-ill prisoners are frequently restricted in solitary confinement.³⁷ Federal prisons contain three forms of segregated housing: special housing units (SHU), special management units (SMU), and penitentiary administrative maximum security facilities (also referred to as ADX).³⁸ Inmates are segregated in these settings for disciplinary reasons, if they “demonstrate[] violent, disruptive, and/or escape-prone behavior,” or because they “cannot be safely housed in the general population.”³⁹ Last year, the DOJ concluded that the standards for placing inmates in solitary confinement were subpar, and that the conditions of such confinement were practically “a form of torture.”⁴⁰ Moreover, in 2005, 25,000 prisoners were in “supermax” prisons and over 80,000 in some form of segregation—a forty percent increase from 2000.⁴¹

34. Letter from Jocelyn Samuels, U.S. Dep’t of Justice, Civil Rights Division, and David J. Hickton, United States Attorney for the Western District of Pennsylvania, to the Honorable Tom Corbett, Governor of Pennsylvania 14 (Feb. 24, 2014), https://www.justice.gov/sites/default/files/crt/legacy/2014/02/25/pdoc_finding_2-24-14.pdf.

35. Gennady N. Baksheev et al., *Identification of mental illness in police cells: a comparison of police processes, the Brief Jail Mental Health Screen and the Jail Screening Assessment Tool*, 18 PSYCHOLOGY, CRIME, & LAW 529, 529 (2012) (arguing that the lack of a standardized screening process leads to “false negatives,” meaning jail detainees with mental illness are not identified); Sharon Cohen and Nora Eckert, *AP Investigations: Many US jails fail to stop inmate suicides*, ASSOCIATED PRESS (June 18, 2019), <https://www.apnews.com/5a61d556a0a14251bafbeff1c26d5f15>.

36. James Ridgeway & Jean Casella, *America’s 10 Worst Prisons: ADX*, MOTHERJONES (May 1, 2013), <https://www.motherjones.com/politics/2013/05/10-worst-prisons-america-part-1-adx>.

37. Even the Policy Statement issued by the Bureau of Prisons for the purpose of remedying prolonged isolation of inmates with serious mental illness states that “sometimes [restricted] placement is required due to safety and security needs.” U.S. DEP’T OF JUSTICE, FED. BUREAU OF PRISONS, NO. 5310.16, TREATMENT AND CARE OF INMATES WITH MENTAL ILLNESS 15 (2014), https://www.bop.gov/policy/progstat/5310_16.pdf [hereinafter TREATMENT AND CARE OF INMATES WITH MENTAL ILLNESS]; *but see* BOP’S USE OF RESTRICTIVE HOUSING, *supra* note 4, at 7 (noting, however, that the number of inmates with mental illness in federal prisons decreased slightly between 2010 and 2015).

38. BOP’S USE OF RESTRICTIVE HOUSING, *supra* note 4, at 2–3. State prisons similarly have different forms of isolated units which go by various names: administrative segregation, management control units, communications management units, and security threat group management units. American Friends Service Committee, *Solitary confinement facts*, AFSC.ORG (last visited Jan. 22, 2020), <https://www.afsc.org/resource/solitary-confinement-facts>.

39. BOP’S USE OF RESTRICTIVE HOUSING, *supra* note 4, at 2.

40. *Id.* at 16.

41. Jean Casella & James Ridgeway, *How Many Prisoners Are in Solitary Confinement in the United States?*, SOLITARY WATCH (Feb. 1, 2012), <https://solitarywatch.org/2012/02/01/how-many-prisoners-are->

The theoretical purpose behind solitary confinement is two-fold: disrupting organized crime within prisons and isolating dangerous inmates to promote safety among the general prison population.⁴² In reality, solitary confinement is frequently used to isolate inmates with mental illness who prison officials are not equipped to handle.⁴³ For example, a 2013 investigation of the Pennsylvania Department of Corrections concluded unequivocally that the state “unnecessarily and inappropriately places prisoners in solitary confinement *because* they have [serious mental illness/intellectual disabilities]” and that the state “uses isolation to control prisoners with mental illness.”⁴⁴ Just this year, in a case heard by the Sixth Circuit, officers at an Ohio county jail admitted that they placed a suicidal pre-trial detainee in the jail’s receiving area—loud, with bright lights, and without a mattress or blanket—because the officers “did not know how to deal with someone like [him]: ‘They are not equipped to handle him’”⁴⁵

Individuals with mental health needs are disproportionately confined to restricted housing compared to their non-mentally ill counterparts. A 2017 investigation by the DOJ revealed the extent of the disparate treatment: one inmate with mental illness was left in restrictive housing for four years, another for nineteen before finally being transferred to a residential mental health treatment program.⁴⁶ The DOJ’s report found that inmates with mental disorders were confined to solitary confinement for longer periods of time—an average of 896 consecutive days—than their non mentally-ill counterparts.⁴⁷ The United States Penitentiary at Lewisburg, Pennsylvania for example, is an overcrowded supermax (and the target of multiple lawsuits) where prisoners are locked down for twenty-

in-solitary-confinement-in-the-united-states/ (stating that in supermax, solitary confinement is the norm); Jon Schuppe, *One of American’s harshest isolation units was exposed by a desperate, handwritten account from the inside*, NBC NEWS (Feb. 19, 2019), <https://www.nbcnews.com/news/us-news/one-america-s-harshest-isolation-units-was-exposed-desperate-handwritten-n969531>.

42. Jessica Knowles, “*The Shameful Wall of Exclusion*”: *How Solitary Confinement for Inmates with Mental Illness Violates the Americans With Disabilities Act*, 90 WASH. L. REV. 2015 at 893, 904 (stating that it is important to note that solitary confinement has not been successful in promoting safety within prisons); *see id.*; ACLU, *THE DANGEROUS OVERUSE OF SOLITARY CONFINEMENT IN THE UNITED STATES* 8 (2013).

43. *See, e.g.*, *Brown v. Plata*, 563 U.S. 493, 519 (2011) (“Mentally ill prisoners are housed in administrative segregation while awaiting transfer to scarce mental health treatment beds for appropriate care.”).

44. Samuels, *supra* note 34, at 2–3, 14 (emphasis added).

45. *Cooper v. Montgomery Cty., Ohio Sheriff’s Dep’t*, 68 F. App’x 385, 388 (6th Cir. 2019).

46. BOP’S USE OF RESTRICTIVE HOUSING, *supra* note 4, at i–ii. Although the 2017 report does not address whether inmates with mental illness commit more serious infractions than their nonmentally ill counterparts, other studies suggest that often the reasons that mentally ill inmates are confined to restricted housing is the inherent inability to conform to certain prison rules due to their conditions. *See* KIDEUK KIM ET AL., *supra* note 28 (finding that inmates with mental illness have higher rates of misconduct and accidents); *see also* TREATMENT AND CARE OF INMATES WITH MENTAL ILLNESS *supra* note 37, at 21 (“An inmate’s mental health symptoms may contribute to institution rule infractions that could result in disciplinary sanctions, including [solitary confinement] placement or the extension of [solitary confinement] placement.”).

47. BOP’S USE OF RESTRICTIVE HOUSING *supra* note 4, at 29–30 (noting that the Bureau of Prisons does not track how long inmates spend in solitary confinement by any measure); *see also* Knowles, *supra* note 42, at 895 (the average length of solitary confinement being four to seven years). Although some states do limit the amount of time inmates with mental disorders spend in solitary confinement (e.g., Massachusetts, Mississippi, and New York) and some have a prohibition on placing such prisoners in solitary confinement at all (e.g., Colorado, Maine, and Pennsylvania). BOP’S USE OF RESTRICTIVE HOUSING, *supra* note 4, at ii.

three to twenty-four hours a day in the company of a cellmate.⁴⁸ In fact, in some states as many as a third or even half of the people in solitary confinement are severely mentally ill or cognitively disabled.⁴⁹

One reason for this phenomenon may be that inmates with mental illness have difficulty conforming to prison rules and are sent to solitary confinement for disciplinary or administrative reasons.⁵⁰ Conversely, some inmates may develop mental illness as a result of frequent or prolonged isolation in solitary confinement.⁵¹ In either case, the fact remains that inmates with serious mental illness do not receive the treatment they require, instead they are segregated to solitary confinement because of their mental illness. It goes without saying that prolonged periods of isolation also have the effect of deteriorating inmates' psychological conditions.⁵² Inmates in solitary confinement are exposed to mechanized cameras and doors instead of in-person contact, 24/7 fluorescent lights instead of natural sun, and caged recreational areas instead of time outdoors.⁵³ Solitary confinement naturally leads to inability to socialize or participate in prison programming, such as educational and job training opportunities.⁵⁴ For inmates

48. Jean Casella and James Ridgeway, *The 10 Worst Prisons in America*, TYPE INVESTIGATIONS (May 1, 2013), <https://www.typeinvestigations.org/investigation/2013/05/01/10-worst-prisons-america>.

49. ACLU, *supra* note 42, at 8 (2013) (noting that fifty percent of Indiana prisoners in solitary confinement are mentally ill, and thirty percent nationwide).

50. Some courts, however, have held that an inmate's inability to conform to prison rules negates a claim of discrimination under the Americans with Disabilities Act (ADA). *See e.g.*, O'Guinn v. Nev. Dep't of Corrs., 468 F. App'x 651, 654 (9th Cir. 2012).

51. Knowles, *supra* note 42, at 896.

52. According to the federal Bureau of Prisons (BOP) policies, inmates with serious mental health needs should continue to receive treatment even when confined to solitary confinement. *See* BOP'S USE OF RESTRICTIVE HOUSING, *supra* note 4, at 5. In fact, a 2014 statement by the BOP listed "reduc[ed] . . . placement in restrictive housing" as one goal of improved interventions for inmates with serious mental illness. TREATMENT AND CARE OF INMATES WITH MENTAL ILLNESS, *supra* note 37. Some initiatives deriving from the 2014 Policy Statement include remote review of individuals in restricted housing by other BOP divisions, mental health personnel qualified to identify and treat serious mental health conditions, and community treatment services. *Id.* 3–5. The Policy Statement specifically emphasized the BOP's commitment to caring for federal inmates with serious mental illness in restricted housing with some specific goals of avoiding prolonged isolation, conducting assessments in private areas with face-to-face contact, and enhanced mental health review for such inmates in extended placement in restricted housing. *Id.* 15–16. Despite the BOP's presumably good-faith attempt, the Policy Statement falls short in remedying the widespread problem of isolating inmates with mental health needs: review of extended restricted housing placements are too infrequent (not occurring until an inmate is isolated for 6 months in the SHU, 18 months in SMU); only applying only to those conditions the BOP defines as "serious mental illness" (excluding conditions such as eating disorders and generalized anxiety disorder); and not making bright-line rules regarding sanctions that limit social support. *Id.* 1–2, 20–22. Moreover, the Policy Statement has not been completely effective in ensuring provision of mental health treatment for inmates in restricted housing. A class action complaint representing a class of inmates at the U.S. Penitentiary at Lewisburg with mental illness held in the special management units: "tiny cells, frequently with another individual, for at least 23 hours a day." *Rodriguez v. Federal Bureau of Prisons, Class Action Complaint 2* (M.D. Penn. June 9, 2017). The complaint alleged that despite the facility's obligations under the Policy Statement (and the Eighth Amendment), the inmates in the proposed class did not receive mental health counseling while in restricted housing. *Id.* at 4. For example, it noted that medications for mental illness are sometimes discontinued (sometimes as a form of punishment), inmates received coloring books and puzzles in lieu of treatment, and the infrequent counseling sessions are in public areas. *Id.* at 4–5.

53. *See* David H. Cloud et al., *Public Health and Solitary Confinement in the United States*, 105 AM. J. PUB. HEALTH 18, 19–20 (2015), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4265928>.

54. *Id.*

with existing mental illness, solitary confinement exacerbates symptoms; for inmates without existing mental illness, solitary confinement could trigger psychological conditions.⁵⁵ For detainees in U.S. jails, solitary confinement may as well be a death sentence due to the high rates of suicide.⁵⁶ Despite the overwhelming evidence of the negative effects of solitary confinement—and the growing recommendation against its use⁵⁷—U.S. prisons and jails continue to use isolation to further separate inmates with mental illness from the general population.

III. LITIGATION AS IT STANDS

Prisons, and prisoners, have long been the subject of litigation and policy reform efforts. Our notions of liberty and fairness urge us against using government authority to abuse and torture the convicted and against imposing truly “cruel and unusual” punishments under the Eighth Amendment.⁵⁸ The growth of the prison-industrial complex, accompanied by growing recognition of mental illness, has led to extensive therapeutic jurisprudence: an examination of how the legal system and mental illness interact.⁵⁹ Eighth Amendment jurisprudence has developed significantly since its early roots in British common law; the Supreme Court in 1958 held that it prohibits punishments determined by “*evolving* standards of decency that mark the progress of maturing society.”⁶⁰ These standards as interpreted by the courts, however, have not quite caught up to our societal standards for mental health.⁶¹ Although physicians, psychologists, and lay people

55. *See id.*; Stuart Grassian, *Psychiatric Effects of Solitary Confinement*, 22 WASH. U. J.L. & POL'Y 325, 333–336, 356 (2006) (noting that symptoms experienced by inmates in solitary confinement include hyperresponsivity to external stimuli; perceptual distortions, illusions, and hallucinations; panic attacks; difficulties with thinking, concentration, and memory; intrusive obsessional thoughts; overt paranoia; problems with impulse control).

56. Fatos Kaba et al., *Solitary Confinement and Risk of Self-Harm Among Jail Inmates*, 104 AM. J. PUB. HEALTH 442, 444–45 (2014) (finding strong correlations between solitary confinement in jails and potentially fatal acts of self-harm).

57. *See, e.g.*, STANDARDS ON TREATMENT OF PRISONERS § 23–3.8(b) (AM. BAR ASS'N 2018) (recommending that extreme isolation not be allowed); Nat'l Commission on Correctional Health Care, *Position Statement: Solitary Confinement (Isolation)*, NCCHC.ORG (Apr. 19, 2016), <https://www.ncchc.org/solitary-confinement> (recommending complete elimination of solitary confinement as a means of punishment).

58. In addition to the Eighth Amendment, deprivation of care in prisons can amount to a Fourteenth Amendment violation as it can result in deprivation of life itself. *See McCollum v. Mayfield*, 130 F. Supp. 112, 115 (N.D. Cal. 1995).

59. This term—therapeutic jurisprudence—has developed a special meaning through the works of scholars such as David Wexler, Michael Perlin, Bruce Winick, and others. Through this lens, the law is viewed as a social mechanism to that produces certain results: sometimes therapeutic, and sometimes not. *See* Symposium, *Therapeutic Jurisprudence: An Overview*, THOMAS COOLEY L. REV. (Oct. 29, 1999). Specifically, these scholars look at the (anti)therapeutic results of “the law in action, not simply the law on the books.” *Id.* This Note summarizes cases involving incarcerated individuals, the outcomes of which may or may not achieve therapeutic results for the clients involved. Although this Note does not engage in a substantive therapeutic-jurisprudence analysis of each case, it is important to keep in mind that the legal mechanisms in these cases can lead to decisions that directly impact the mental and physical health of each plaintiff.

60. *Trop v. Dulles*, 356 U.S. 86, 101 (1958) (emphasis added).

61. By no means are inmates constitutionally guaranteed “state-of-the-art medical and mental healthcare” or that “conditions be comfortable.” *See Coleman v. Schwarzenegger*, 922 F. Supp. 2d 882,

alike view mental health treatment as an integral part of medical care,⁶² courts still do not view lack of such treatment to amount to cruel and unusual punishment.

A. Case Law Under the Eighth Amendment

The Supreme Court first recognized the right to medical care in *Estelle v. Gamble*.⁶³ In that case, a prisoner was badly injured on the job.⁶⁴ Although the prison physician ordered him to rest and prescribed medication, after several weeks the correctional officers moved him to administrative segregation for refusing to go back to work.⁶⁵ On the inmate's Eighth Amendment claim, the Court recognized that inmates rely on the prison for all of their medical treatment and thus a failure to treat could amount to cruel and unusual punishment in some cases.⁶⁶ The Court established the rule that prisons cannot be *deliberately indifferent* to inmates' serious medical needs.⁶⁷

A year later, the Fourth Circuit applied *Estelle's* reasoning in the context of psychiatric care in prisons for the first time.⁶⁸ The court held that a correctional facility must provide psychiatric care if a professional concludes with reasonable certainty that (1) the prisoner has a serious disease; (2) such disease is curable or may be substantially alleviated; and (3) there is substantial risk of harm if care is delayed.⁶⁹ However, it limited the right to treatment to "that which may be provided upon a reasonable cost and time basis and the essential test is one of medical necessity and not simply that which may be considered merely desirable."⁷⁰ The Third Circuit, a few years later, held that *Estelle's* requirements are not met when seriously mental ill prisoners are "effectively prevented from being diagnosed and treated by qualified professionals."⁷¹

887 (E.D. Cal. 2009). *But see* Ohlinger v. Watson, 652 F.2d 775, 779 (9th Cir. 1980) (holding that civilly-committed individuals, unlike prisoners, have a right to adequate and effective treatment that realistically gives them an opportunity to be cured of the disorder that was the cause of their commitment).

62. *See generally* Peter J. Cunningham, *Beyond Parity: Primary Care Physicians' Perspectives on Access to Mental Health Care*, 28 HEALTH AFFAIRS 490, 493 (2009) (finding that two-thirds of primary care physicians reportedly could not obtain mental health treatment for their patients).

63. Fred Cohen, *The Limits of the Judicial Reforms of Prisons: What Works; What Does Not*, 40 CRIM. L. BULL. Part. VI.E 421, 429 (2004).

64. *Estelle v. Gamble*, 429 U.S. 97, 99 (1976).

65. *Id.* at 99–100.

66. *Id.* at 103–105.

67. Under the deliberate indifference test, an individual must establish objectively that he has a serious medical need and that the prison officials had subjective knowledge of it, but consciously disregarded it. *See* Coleman v. Rahija, 114 F.3d 778, 785 (8th Cir. 1997) (citing *Estelle*, 429 U.S. at 105).

68. *Bowring v. Godwin*, 551 F.2d 44, 47 (4th Cir. 1977).

69. *Id.*

70. *Id.* at 48. *But see* Lay v. Norris, No. 88-5757, 1989 WL 62498, at *5 (6th Cir. June 13, 1989) (refusing to adopt the *Bowring* test, but applying it in the case nonetheless).

71. *Inmates of Allegheny Cty. Jail v. Pierce*, 612 F.2d 754, 763 (3d Cir. 1979). On remand, the district court was tasked with determining whether inmates with serious mental illness had access to treatment. *Inmates of Allegheny Cty. Jail v. Pierce*, 487 F. Supp. 638, 640 (W.D. Pa. 1980). It found that the inmates were severely deprived of treatment and were often sent to the "hospital" for it—a thirty-foot room with twenty cots lined up around it, where inmates were kept in restraints—and the rest were left in special housing units (the "SHU"). *Id.* at 641. The court ordered the jail to staff at least one nurse on every shift, hire an administrator with significant psychiatric experience to develop a working mental health treatment program (including a "program for identifying and segregating from the general population those inmates in need of care"), and establish a screening center. *Id.* at 644 (emphasis added).

In 2011, the Court in *Brown v. Plata* ordered California to release over 400,000 prisoners because the medical services—including mental health care—that the State provided did not reach the minimum level of care required by the Eighth Amendment.⁷² The class consisted of seriously mentally ill inmates, many of whom were suicidal, who were placed in administrative segregation (and sometimes in telephone-booth sized cages) while waiting for care, sometimes for up to twelve months.⁷³ The California facility was extremely overpopulated, housing approximately double the number of inmates it was designed to hold; the lower court had effectively ordered the prison to reduce its population by releasing some inmates.⁷⁴ Ultimately, the Court held that the Eighth Amendment requires prisons to provide mental health care that meets “*minimum* constitutional requirements.”⁷⁵

This holding begs the question: What *is* the minimum constitutional requirement for mental health treatment?⁷⁶ Although the *Brown v. Plata* Court did not articulate a test for the constitutional floor, subsequent courts view the minimum as requiring a “system of ready access to adequate medical care,” which involves competent medical staff, diagnosing and treating medical problems, referring inmates to other physicians within or outside the facility when necessary, and prompt emergency responses.⁷⁷ The “minimum constitutional requirement” is no misnomer—courts have interpreted the requirement to provide only minimal protection, for example finding that failure to respond to an obvious medical emergency,⁷⁸ prolonged isolation of inmates without any evaluation of their mental health needs,⁷⁹ and prison overcrowding that resulted in “needless suffering and death” fell short.⁸⁰

Despite these advances, *Estelle*’s progeny have unfortunately limited its capacity to expand prisoner’s rights and instead enlarged deference to prison

72. *Brown v. Plata*, 563 U.S. 493, 502 (2011).

73. *Id.* at 503–04.

74. *Id.* at 510. The Court noted that “[p]risoners are dependent on the State for food, clothing and necessary medical care. . . . Just as a prisoner may starve if not fed, he or she may suffer or die if not provided adequate medical care. A prison that deprives prisoners of basic sustenance, including adequate medical care, is incompatible with the concept of human dignity and has no place in civilized society.” *Id.* at 510–11.

75. *Id.* at 501–02 (emphasis added) (holding also that the remedial order was appropriate under the Prison Litigation Reform Act).

76. Note that the Supreme Court previously held that prisons must provide “humane conditions of confinement” which at a minimum includes shelter, food, clothing, medical care, and protection from violence. *Farmer v. Brennan*, 511 U.S. 825, 832–33 (1994) (citing *Hudson v. Palmer*, 468 U.S. 517, 526–27 (1984)).

77. *Hoptowit v. Ray*, 682 F.2d 1237, 1253 (9th Cir. 1982), *abrogated on other grounds by Sandin v. Conner*, 515 U.S. 472 (1995). Importantly, courts have recognized that such requirements also apply to mental health care needs. *E.g.*, *Doty v. Cty. of Lassen*, 37 F.3d 540, 546 (9th Cir. 1994). The District Court for the Southern District of Texas identified six requirements for mental health treatment in the Texas Department of Corrections: (1) systematic program for screening and evaluating inmates for mental health needs; (2) treatment must be more than segregation and close supervision; (3) employing sufficient number of trained mental health professionals; (4) accurate, complete, and confidential recordkeeping; (5) no dangerous administration of medication; and (6) basic program for identifying, treating, and supervising suicidal inmates. *See Ruiz v. Estelle*, 503 F. Supp. 1265, 1339 (S.D. Tex. 1980), *aff’d in part, rev’d in part by Ruiz v. Estelle*, 679 F.2d 1115 (5th Cir. 1982).

78. *See Hoptowit*, 682 F.2d at 1259.

79. *Coleman v. Wilson*, 912 F. Supp. 1282, 1320–22 (E.D. Cal. 1995).

80. *Brown*, 563 U.S. at 501.

systems and administrators.⁸¹ In 1996, the Court clarified that inmates must have standing to challenge prison conditions and called for a showing of “actual injury,” as opposed to mere allegations that a program “is subpar in some theoretical sense,” as a precondition to an access-to-the-courts claim.⁸² A year prior, it had held that punitive segregation did not implicate prisoners’ due process liberty interests, and so they are not entitled to minimum procedural due process protections.⁸³ Most onerous of all, the Court in *Farmer v. Brennan* held that the deliberate indifference test required inmates to show the prison official’s *actual* knowledge of the inmate’s a serious medical problem.⁸⁴

These cases demonstrate the unachievably high standard that the Eighth Amendment demands of inmates. The Court has limited its applicability to include “only those deprivations denying ‘the minimal civilized measure of life’s necessities’ are sufficiently grave to form the basis of an Eighth Amendment violation.”⁸⁵ Decisions relating to inmates with mental illness demonstrate that lack of mental health treatment is not “sufficiently grave” in the eyes of the Court.⁸⁶ In terms of prison programming for example, the Court held that even banning visitation rights for inmates’ with substance-abuse disorders was not cruel and unusual punishment.⁸⁷ Moreover, it has held that diminished opportunities to participate in prison programming do not amount to an Eighth Amendment violation.⁸⁸

The deliberate indifference test applied in these cases requires the prisoner to show that: (a) he had an objectively serious medical need; and (b) that the prison official subjectively knew about the need and consciously ignored it.⁸⁹ Even the

81. See Cohen, *supra* note 63, at Part VII.C.

82. *Lewis v. Casey*, 518 U.S. 343, 351 (1996).

83. *Sandin v. Conner*, 515 U.S. 472, 486 (1995).

84. *Farmer v. Brennan*, 511 U.S. 825, 845 (1994). Moreover, the Court in *Turner v. Safley* refused to apply heightened scrutiny to prisoners’ constitutional claims and homogenized all the inmates’ claims into the easily met “reasonably related” test. 482 U.S. 78, 91 (1987). Finally, in *Wilson v. Seiter*, it added a subjective element to the existing objective element in assessing a condition-of-confinement claim and rejecting cumulative challenge to prison conditions, instead requiring a separate constitutional violation for each allegation. 501 U.S. 294, 305 (1991).

85. *Seiter*, 501 U.S. at 298 (citation omitted).

86. *Id.* Deliberate indifference was established, however, in *Hope v. Pelzer* where correctional officers handcuffed an inmate (after he was already subdued) for seven hours in the direct heat, without bathroom breaks or access to water. 536 U.S. 730, 741 (2002).

87. *Overton v. Bazzetta*, 539 U.S. 126, 134 (2013). Although the Court noted that the case might have turned out differently if the ban was permanent. *Id.*

88. *Rhodes v. Chapman*, 452 U.S. 337, 348 (1981) (holding that not only were the double-celling conditions not a constitutional violation, but also that decreased opportunity to participate in educational and job programs in the prison did not amount to “unnecessary and wanton pain”).

89. See *Estelle v. Gamble*, 429 U.S. 97, 106 (1976); see, e.g., *Senty-Haugen v. Goodno*, 462 F.3d 876, 890 (8th Cir. 2006) (applying the test to inmate with broken leg); *Williams v. Kelso*, 201 F.3d 1060, 1064–65 (8th Cir. 2000) (applying the test to a suicidal inmate). Similarly, the conditions-of-confinement claims brought under the Eighth Amendment must not only demonstrate an objective “serious deprivation,” but also subjective knowledge by the prison official. *Farmer v. Brennan*, 511 U.S. 825, 837–38 (1994) (applying the deliberate indifference test to prison conditions-of-confinement claims) (citing *Wilson v. Seiter*, 501 U.S. 294, 299–300 (1991)); Fred Cohen, *Captives’ Legal Right to Mental Health Care*, 17 L. & PSYCHOLOGY REV. 1, 22 (1993). While the Supreme Court in *Bell v. Wolfish* declared that treatment of pre-trial detainees is governed under Fourteenth Amendment substantive due process standards, the circuit courts are split as to how they apply this test: a majority of courts view the Eighth and Fourteenth Amendment protections to be coextensive, and apply the subjective deliberate indifference to pre-trial

first prong of this analysis can set a high bar. For example, in the Eighth Circuit, “a serious medical need is ‘one that has been diagnosed by a physician as requiring treatment, or one that is so obvious that even a layperson would easily recognize the necessity for a doctor’s attention.’”⁹⁰ Moreover, the Eighth Circuit has held that failure to provide medical treatment does not automatically amount to deliberate indifference “unless prison officials knew that the condition created an excessive risk to the inmate’s health and then failed to act on that knowledge.”⁹¹ Some courts have interpreted the subjective knowledge prong as being a “reckless-in-a-criminal-sense formulation,” essentially meaning the prison official has to not care whether the inmate lives or dies for it to count as deliberate indifference.⁹² The Supreme Court, however, has held that isolation in solitary confinement can constitute deliberate indifference,⁹³ but it has never gone so far as to say that failure to provide mental health treatment (that would have prevented solitary confinement) constitutes deliberate indifference.

Finally, the treatment services afforded under constitutional claims are grossly inadequate. The right to care, as articulated under *Estelle*, has not been transformative—it merely identifies the right to *minimal* care.⁹⁴ A dispute between an inmate and a prison physician about what level of care is required will not sustain an Eighth Amendment claim.⁹⁵ Even a prison physician’s negligence in diagnosis or treatment does not rise to the level of a constitutional violation.⁹⁶ Courts have held that these minimal levels of care are sufficient: cell-block bullpens for exercise in lieu of outdoor recreation;⁹⁷ keeping suicidal inmates in

detainees. Compare *Bell v. Wolfish*, 441 U.S. 520 (1979); *Youngberg v. Romeo*, 457 U.S. 307 (1982) (applying the “reasonable care” test under Fourteenth Amendment due process to civil detainees), with *Butler v. Fletcher*, 465 F.3d 340, 344 (8th Cir. 2006) (“[We] have repeatedly applied the deliberate indifference standard of *Estelle* to pretrial detainees claims that prison officials unconstitutionally ignored a serious medical need or failed to protect the detainee from a serious risk of harm.”).

90. *Coleman v. Rahija*, 114 F.3d 778, 784 (8th Cir. 1997) (citing *Camberos v. Branstad*, 73 F.3d 174, 176 (8th Cir. 1995)); see also *Aswegan v. Henry*, 49 F.3d 461, 464 (8th Cir. 1995) (“[T]he need or the deprivation alleged must be either obvious to the layperson or supported by medical evidence, like a physician’s diagnosis.”).

91. *Long v. Nix*, 86 F.3d 761, 765 (8th Cir. 1996).

92. Cohen, *supra* note 89, at 25.

93. For example, in *Hutto v. Finney* where between four and eleven inmates were confined to a 8’x10’ cell at any given time. 437 U.S. 678, 685–86 (1978). See also *Sardakowski v. Clements*, No. 12-cv-01326-RBJ-KLM, 2013 WL 3296569, at *7–8 (D. Colo. July 1, 2013) (holding that a prisoner with mental illness and several suicide attempts who was kept in administrative segregation for a prolonged period of time without adequate mental health treatment alleged sufficient facts to survive a motion to dismiss on his Eighth Amendment claim).

94. See Cohen, *supra* note 63, at Part VI.E (“There are debates on genuine access to and appropriate levels of care, and on inmate malingering, but the basic right to adequate medical care is in place.”).

95. *E.g.*, *Flint v. Wainwright*, 433 F.2d 961 (5th Cir. 1970) (holding that an inmate’s constitutional rights were not violated when prison physician prescribed medications despite the inmate’s preference for another medication with less severe side effects); see also *Davis v. Grase*, No. 1:18-cv-01668-DAD-SAB (PC), 2019 WL 2637955, at *6 (E.D. Cal. June 6, 2019) (holding that prison was not deliberately indifferent when it denied plaintiff’s request to transfer to an acute care treatment program and left him in an inpatient crisis bed).

96. See *Estelle v. Gamble*, 429 U.S. 97, 105–06 (1976). But see *Boretti v. Wiscomb*, 930 F.2d 1150, 1154 (6th Cir. 1991) (holding that denial of fresh bandages and prescribed pain medication to a prisoner with a gunshot wound for five days constituted deliberate indifference).

97. *Clay v. Miller*, 626 F.2d 345, 347 (4th Cir. 1980).

jail's receiving area with bright lights and loud noises;⁹⁸ keeping suicidal inmates in a single-person holding cell with four other inmates;⁹⁹ lack of a mattress and forced to sleep on a cold floor;¹⁰⁰ and crisis management cells with blood and excretion on the walls and floor.¹⁰¹

B. Other Claims: ADA and State Law

Inmates with mental health needs have also attempted to obtain treatment under other causes of action. Title II of the Americans with Disabilities Act (ADA) has the potential to provide relief in instances of discrimination in the form of segregation. To bring a claim under the ADA, an inmate must demonstrate that (1) he is a qualified individual with a disability, (2) who was denied the benefits of or excluded from participating in a program, service, or activity of a public entity, (3) on account of his disability.¹⁰² Similar to the limitations in the Eighth Amendment described above, ADA claims require inmates to prove that they were denied treatment *because* of their disability (i.e., the prison official *knew* or *should have known* that the plaintiff had a mental illness).¹⁰³ Again, it is this subjective-knowledge element that restricts the success of claims for accommodations under the ADA.¹⁰⁴ Moreover, like Eighth Amendment claims, the ADA does not prescribe any particular type or level of treatment and frequently, minimum levels of care are viewed as sufficient under the ADA.¹⁰⁵

Prisoners may also seek to bring claims for damages under state tort laws: negligence (e.g., for intentional failure to perform a duty in reckless disregard of the consequence to the life of the inmate)¹⁰⁶ and wrongful death.¹⁰⁷ A major limitation on the success of tort claims is that prison officials may be protected by qualified immunity and/or the claims require a high showing of knowledge.¹⁰⁸ Moreover, these claims may fail if the inmate cannot sufficiently allege causation between the correctional facility's failure to provide mental health treatment and the alleged harm suffered by the plaintiff.¹⁰⁹

98. *Cooper v. Montgomery Cty., Ohio Sheriff's Dep't*, 68 F. App'x 385, 392–93 (6th Cir. 2019).

99. *Williamson v. Carpenter*, No. 19-254, 2019 WL 3719761, at *1, *8, *13 (E.D. La. July 15, 2019).

100. *Id.* at *10 (noting that “serving time in prison ‘is not a guarantee that one will be safe from life’s occasional inconveniences.’”).

101. *Davis v. Scott*, 157 F.3d 1003, 1004, 1006 (5th Cir. 1998).

102. 42 U.S.C. § 12132 (2012).

103. *Shields v. Prince George’s Cty.*, No. GJH-15-1736, 2019 WL 3536800, at *12 (D. Md. Aug. 2, 2019) (finding schizophrenic inmates’ symptoms were “readily observable”).

104. *See, e.g., Brown v. Pa. Dep’t Corr.*, 290 F. App'x 463, 467 (3d Cir. 2008) (holding that merely ignoring an inmate’s disability was insufficient to amount to a subjective intent to discriminate under the ADA).

105. *Id.* (“Mere disagreements over the course of medical treatment do not support a claim for a violation of the Eighth Amendment.”).

106. *See, e.g., Shields*, 2019 WL 3536800, at *13.

107. *See, e.g., id.* at *13–14.

108. *See Germaine-McIver v. Cty. of Orange*, No. SACV 16-01201-CJC(GJSx), 2018 WL 6258896, at *15, *17–18 (C.D. Cal. Oct. 31, 2018) (finding that there was no evidence to show that the prison officials knew the inmate was committing suicide in that moment, despite his history of suicidal behavior at the jail, and therefore were immune to the claim).

109. *See id.* at *17 (“A failure to summon immediate medical care is not the proximate cause of [inmate’s] death.”).

*C. Cases in the Last Year*¹¹⁰

Over the last twelve months, the courts of appeals and district courts have heard numerous cases involving prisoners and mental health conditions.

1. Cooper v. Montgomery County, Ohio Sheriff's Department,¹¹¹ Sixth Circuit

This case involved a pre-trial detainee in a county jail who had a long history of mental health disorders.¹¹² Following his arrest, he received a mental health assessment but was still placed in the general jail population.¹¹³ After an altercation with another inmate, he self-harmed (including cutting himself with a spoon and swallowing a bolt) and was subsequently hospitalized.¹¹⁴ When he returned, he was placed in the receiving area of the jail—correctional officers constantly monitored him, the area was loud with bright lights, and he had no mattress or blankets.¹¹⁵ The jail staff admitted that they did not know how to handle an inmate that self-harmed.¹¹⁶ The lower court focused on the fact that the jail officials followed the medical and mental health professionals' advice on how to address the pre-trial detainee's psychiatric needs.¹¹⁷ The only issue on appeal was whether the defendants, the county sheriff's department and jail officials, were "deliberately indifferent" to his psychiatric needs.¹¹⁸ The Sixth Circuit, however, interpreted the facts and concluded that "[i]ndeed, [the detainee] did not suffer from a lack of attention by medical and mental-health staff."¹¹⁹ The court focused only on the fact that medical personnel interacted with the inmate after his behavioral problems but not on the substance of the interactions.¹²⁰ Moreover, it noted that *Barber v. City of Salem* held that a facility's failure to take precautions when a prisoner shows a strong likelihood of suicide can amount to deliberate indifference; the *Cooper* court, on the other hand, concluded that leaving an inmate in the receiving area was a sufficient precaution.¹²¹

110. The following cases involve isolation of both pre- and post-trial detainees. Although the experience within the facility is similar for both populations, the legal standards that govern evaluation of the conditions are different. Namely, pre-trial detainees are not protected under the Eighth Amendment's proscription against cruel and unusual punishment. See *Bell v. Wolfish*, 441 U.S. 520, 535–39 (1979). Rather, their conditions are subject to due process analysis: The court must determine whether the condition is imposed as a punishment or for some other legitimate purpose. *Id.* at 538. A majority of circuit courts, however, essentially apply Eighth Amendment analysis to pre-trial detainees. See David C. Gorlin, *Evaluating Punishment in Purgatory: The Need to Separate Pretrial Detainees' Conditions-of-Confinement Claims From Inadequate Eighth Amendment Analysis*, 108 MICH. L. REV. 417, 425, 433 (2009) (arguing that substantive due process protections exceed Eighth Amendment protections and should apply to pre-trial detainees).

111. 768 F. App'x 385 (6th Cir. 2019).

112. *Id.* at 387.

113. *Id.*

114. *Id.*

115. *Id.*

116. *Id.* at 388.

117. *Id.* at 390.

118. *Id.* at 391.

119. *Id.* at 392.

120. See *id.*

121. *Id.* at 393 (citing *Barber v. City of Salem*, 953 F.2d 232, 240 (6th Cir. 1992)).

2. *Coleman v. Brown*,¹²² Ninth Circuit

California prisoners with serious mental disorders alleged that the mental healthcare provided at most California correctional facilities were so inadequate that they violated the Eighth Amendment.¹²³ The U.S. District Court for the Eastern District of California found that the state violated the Eighth Amendment by not adhering to a 2013 remedial plan and failing to transfer inmates to mental health crisis beds, acute inpatient mental health placements, or intermediate care facilities within the court-ordered time frames.¹²⁴ The defendant-State opposed the order and accompanying penalty for noncompliance, arguing that it went beyond the Prison Litigation Reform Act's standards.¹²⁵ On appeal, the State argued that the lower court should not have treated the remedial plan as an inappropriate standard and that the lower court should have applied the Eighth Amendment's "deliberate indifference" standard.¹²⁶ The Ninth Circuit disagreed and affirmed the district court's decision.¹²⁷

3. *Charles v. Orange County*,¹²⁸ Second Circuit

In *Charles*, two plaintiffs challenged the post-discharge procedures used by U.S. Immigration and Customs Enforcement (ICE). The first plaintiff had an existing history of bipolar and schizoaffective disorder, and the second developed signs of mental illness after detainment.¹²⁹ While both plaintiffs received some mental health treatment while detained—including meeting with a psychiatrist, receiving daily medication, and going to inpatient treatment—neither received a mental health discharge plan after they were released from detainment.¹³⁰ Since neither plaintiff knew the type of treatment or medication they received, they had no way of ensuring continuity of care post-discharge: one plaintiff immediately began "psychologically decompensating," according to the court.¹³¹ The plaintiffs brought a claim under Fourteenth Amendment substantive due process, arguing that their right to adequate medical care during detention includes discharge planning that contemplates continuity of mental health treatment as the person transitions sources of treatment.¹³² The lower court granted the defendant's motion to dismiss the entire complaint, contending that the plaintiffs were seeking treatment *after* discharge.¹³³ The Second Circuit noted it had previously recognized *Estelle* protections for detainees upon discharge by providing medication to take with them but had never gone as far as to require discharge

122. 756 F. App'x 677 (9th Cir. 2018).

123. *See* *Coleman v. Brown*, No. 2:90-cv-0520 KJM DB P, 2017 WL 1105904, at *1–2 (E.D. Cal. Mar. 24, 2017).

124. *See* *Coleman*, 756 F. App'x at 679.

125. *See id.* at 678–79.

126. *Id.*

127. *Id.*

128. 925 F.3d 73 (2d Cir. 2019).

129. *Id.* at 77–79.

130. *Id.*

131. *Id.* at 79.

132. *Id.* at 80.

133. *Id.* at 80–81.

planning for mental health.¹³⁴ In acknowledging that it presented a question of first impression, the appellate court looked at various medical associations to conclude that the plaintiffs had a plausible claim.¹³⁵

4. *Crocker v. Glanz*,¹³⁶ Tenth Circuit

A pre-trial detainee alleged that officers at the Tulsa County jail knew of his serious mental health disorders (including schizophrenia) when they booked him, but nonetheless he did not receive an initial evaluation and was sent to the general population of the jail.¹³⁷ He was then assaulted by his cellmate and alleged that the assault resulted from “longstanding, systemic deficiencies in the medical and mental health care” at the county jail.¹³⁸ Although the lower court denied the sheriff’s motion to dismiss because the detainee alleged enough facts for a plausible claim, and the sheriff had not clearly established that the detainee lacked a constitutional right, the Tenth Circuit reversed by reasoning that the sheriff did not have the adequate knowledge required for a deliberate indifference claim.¹³⁹ The court posed this example: “[A] jail may have a defective policy regarding admission of intoxicated persons; but it would not be liable with respect to suicide by such a person unless it was shown that jail personnel ‘were deliberately indifferent to the *specific risk* of suicide, and not merely at the risk of intoxication.’”¹⁴⁰

5. *Disability Rights Montana, Inc. v. Batista*,¹⁴¹ Ninth Circuit

The Montana Protection and Advocacy Agency (P&A) made system-wide and individual allegations about treatment of inmates with serious mental illness, the risks of which the defendant-facility had on notice.¹⁴² The complaint made nine specific notes of constitutionally suspect practices including: placing prisoners with serious mental illness in solitary confinement (for twenty-two to twenty-four hours per day) for months or years at a time and placing them on behavior management plans that involve solitary confinement and extreme restrictions of privileges; having no standards for determining whether placing such inmates in confinement will be harmful to their mental health; having a pattern of refusing to properly diagnose prisoners and to provide medication; failing to have a system of review and evaluation on the mental health staff’s diagnosing and prescribing, a

134. *Id.* at 82.

135. *See id.* at 82, 84. The Second Circuit vacated the district court’s judgment and remanded on May 24, 2019. *Id.* at 90. Although the plaintiffs were permitted to bring the claim, it remains to be seen how the district court will apply the standard.

136. 752 F. App’x 564 (10th Cir. 2018).

137. *Id.* at 566.

138. *Id.* at 567.

139. *Id.* at 568.

140. *Id.* at 569 (internal citations omitted) (emphasis in original).

141. 930 F.3d 1090 (9th Cir. 2019). The Ninth Circuit reversed the judgement and remanded on July 19, 2019; although the plaintiffs were permitted to bring the claim, it remains to be seen how the district court will apply the standard.

142. *Id.* at 1094. Disability Rights Montana is the federally mandated protection and advocacy organization for the state of Montana.

system to classify prisoners according to mental health needs, and failing to adequately consider prisoners' serious mental illness when making decisions about housing and custody; and having no system for auditing, evaluating, or ensuring effectiveness of mental health care programs in treating prisoners with serious mental illness.¹⁴³ The P&A focused primarily on the fact that the defendant-prison kept inmates with serious mental illness in solitary confinement and brought Eighth Amendment claims against the correctional facilities.¹⁴⁴ The lower court granted the defendant's motion to dismiss, finding that the P&A's pleadings did not meet the *Twombly-Iqbal* standard.¹⁴⁵ The Ninth Circuit reversed and remanded, after finding that the P&A alleged sufficient facts to state a claim.¹⁴⁶

6. *Germaine-McIver v. County of Orange*,¹⁴⁷
U.S. District Court for the Central District of California

Upon his arrest, the inmate was taken to a unit specifically for seriously mentally ill inmates for immediate behavioral issues but was released back into the general population the next day following an evaluation.¹⁴⁸ For several months, he continued to engage in self-harm and attempted suicide.¹⁴⁹ He was kept in the "chronic unit" where he met with a psychiatric technician several times but was not permitted to attend group therapy or to return to general housing.¹⁵⁰ The inmate ultimately committed suicide in his isolated cell.¹⁵¹ The court found that although a reasonable juror could determine that the two supervisor-defendants acted with deliberate indifference in refusing to stop a series of acts by others that they knew could cause injury and failing to evaluate the jail's programming for inmates with mental illness, they were protected by qualified immunity and could not be individually liable.¹⁵² It did, however, find a genuine dispute of material fact in regard to whether the county had a custom of not providing medical care that would have addressed the detainee's suicide attempt and thus found that the county itself could be liable under *Monell*.¹⁵³

143. *Id.*

144. *Id.* at 1095. Initially the Eighth Amendment claims were part of a larger due process lawsuit against the state health and human services agency, but the court ordered them to separate the claims in separate suits. *Id.*

145. *Id.* at 1098. Under the *Twombly-Iqbal* standards, federal courts may dismiss a claim that fails to plead facts that do not give rise to a "plausible" claim. *Ashcroft v. Iqbal*, 556 U.S. 662, 678–79 (2009); *Bell Atlantic v. Twombly*, 550 U.S. 544, 556 (2007).

146. *Id.* at 1101.

147. *Germaine-McIver v. County of Orange*, No. SACV 16-01201-CJC(GJSx), 2018 WL 6258896 (C.D. Cal. Oct. 31, 2018).

148. *Id.* at *1–2.

149. *Id.* at *1

150. *Id.* at *2

151. *Id.* at *3.

152. *Id.* at *10–12 (finding that there is "no clearly established right to proper suicide prevention protocols"). The deliberate indifference claims in this case were analyzed under the Fourteenth Amendment due process. *Id.* at *8.

153. *Id.* at *8. Under *Monell*, local governments can be held liable for their frequent, consistent, and long-term informal customs. *Monell v. Dep't of Soc. Servs. of City of New York*, 436 U.S. 658, 690–91 (1978).

7. *Geness v. Cox*,¹⁵⁴ Third Circuit

In 2018, a pre-trial detainee brought an action against the arresting officer, assisted living facility, city, and county, alleging violations of the ADA among other claims.¹⁵⁵ The plaintiff is an adult with mental illness and cognitive impairments. He was charged for a crime that may not have occurred and was detained awaiting trial for nearly a *decade*, even though it was determined early in the process that he was incompetent and unlikely to improve.¹⁵⁶ The court noted that, because of “inexcusable delays and dilatory discovery efforts,” most of his claims were barred by statute of limitations, but it permitted leave to amend the complaint on the ADA claims.¹⁵⁷ The court found that, despite the lower court’s reasoning, a request to amend was not futile because (a) the inmate was not barred by the *Rooker-Feldman* doctrine to challenge a state court’s order; and (b) the request to amend was not otherwise futile, because the plaintiff’s factual allegations about discrimination and isolation were “more than sufficient to state a claim under the ADA.”¹⁵⁸ In making the second finding, the court focused on the ADA regulations specific to correctional facilities, which prohibit placing “inmates . . . with disabilities in inappropriate security classifications because no accessible cells or beds are available,” and reasoned that failure to comply with such provisions indicated noncompliance with the state’s integration obligations under *Olmstead*.¹⁵⁹

D. *Overcoming the Subjective-Intent Hurdle*

The courts thus far have largely failed inmates with mental health needs. Claims under the Eighth Amendment place a high burden on plaintiffs to demonstrate not only a clear need for treatment, but also a subjective disregard of that need by the prison’s officials.¹⁶⁰ ADA claims are similarly onerous, requiring a showing of discrimination *by reason of* the inmate’s disability, which again requires facts that reflect prison officials’ state of mind.¹⁶¹ These claims also give unfair deference to the prison when it provides minimal treatment—even if the care is infrequent, subpar in quality, or does not actually address the inmate’s needs.¹⁶²

154. *Geness v. Cox*, 902 F.3d 344 (3d Cir. 2018).

155. *Id.* at 344.

156. *Id.* at 348, 351 (finding in several examinations that his “prognosis for improvement was poor”).

157. *Id.* at 349.

158. *Id.* at 360–64. The *Rooker-Feldman* doctrine prohibits “federal district courts from exercising appellate jurisdiction over state court actions” when the federal plaintiff did not prevail in state court, the plaintiff’s injuries were allegedly caused by the state-court’s judgement and was issued before the federal suit was filed, and the plaintiff is asking the federal district court to reject the state-court judgement. *Id.* at 360.

159. *Id.* at 361–62 (citing 42 C.F.R. § 35.152(b)(2)(i) (2018)). The court also noted Pennsylvania state mental health laws that permit involuntarily treatment for persons accused of murder only if commitment is limited to one year and the person is likely to regain capacity to stand trial. *Id.*

160. *Estelle v. Gamble*, 429 U.S. 97, 104 (1976); *Coleman v. Rahija*, 114 F.3d 778, 784 (8th Cir. 1997). See *supra* note 90.

161. 42 U.S.C. § 12132 (2012); see *Brown v. Pa. Dep’t of Corrs.*, 290 F. App’x 463, 467 (3d Cir. 2008).

162. The Seventh Circuit in *Allison v. Snyder*, articulated that what the Constitution requires for civilly contained sex offenders is: “(a) committed persons are entitled to *some* treatment, and (b) what that

The remainder of this Note will propose a new basis for claims by inmates who require mental health treatment: *Olmstead*.¹⁶³ Unlike the causes of action described in this section, *Olmstead* places the burden on the public entity to ensure that individuals with disabilities are able to participate fully in the programs, services, and activities of their community without being unnecessarily segregated.¹⁶⁴ Courts have interpreted *Olmstead* to require the state to provide certain services or programming if it will enable the individual to (re)integrate into the general population.¹⁶⁵ In the next section, I suggest that *Olmstead* may require prisons to provide adequate and continuous mental health treatment to inmates to prevent them from being sent to solitary confinement. *Olmstead* claims may also shift the focus of courts in determining what type and level of treatment is required; rather than deferring to the prison's determination, they may consider the inmate's articulation of his or her own needs.¹⁶⁶

IV. A NEW EXTENSION OF *OLMSTEAD*

A. Introduction to *Olmstead*

The purpose of the American with Disabilities Act is to provide a “clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities.”¹⁶⁷ Title II of the ADA governs state and local governments, prohibiting such entities from discriminating against individuals with disabilities in the services, programs, and activities they offer.¹⁶⁸ Pursuant to his authority, the Attorney General introduced the integration mandate: a regulation that requires state and local governments to “administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.”¹⁶⁹ The “most integrated setting” is one that

treatment entails must be decided by mental-health professionals.” Allison v. Snyder, 332 F.3d 1076, 1081 (7th Cir. 2003) (emphasis added).

163. *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999).

164. *Id.* at 596–97, 605–606. States can comply with the *Olmstead* decision by demonstrating that they have a “comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings;” most states now have a written, and publicly available *Olmstead* plan that demonstrates their commitment to this obligation. See *Olmstead*, 527 U.S. at 605–606. For an example of an *Olmstead* Plan, see OFFICE OF DISABILITY RIGHTS, 2017–2020 OLMSTEAD COMMUNITY INTEGRATION PLAN FOR WASHINGTON, D.C. (2017), <https://odr.dc.gov/page/olmstead>.

165 See, e.g., *Davis v. Shah*, 821 F.2d 231, 263–64 (2d Cir. 2016) (holding that once New York decided to offer orthopedic footwear and compression stockings under its Medicaid program, it had to provide them to certain people with disabilities to avoid institutionalization).

166. *Olmstead* and person-centeredness are highly intertwined: “[T]here is arguably now a legal incentive to invest in person-centered planning” Sean Burke, *Person-Centered Guardianship: How the Rise of Supported Decision-Making and Person-Centered Services Can Help Olmstead’s Promise Get Here Faster*, 42 MITCHELL HAMLIN L. REV. 873, 893–4 (2016). Medicaid’s home- and community-based services waiver programs have been instrumental in reaching *Olmstead*’s goals by reallocating funds for institutional care to community services, but these programs require (by law) that the disabled individual’s choices about the services and providers be considered. 42 C.F.R. § 441.301(c)(4)(iv) (2018).

167. 42 U.S.C. § 12101(b)(1) (2012).

168. United States Department of Justice Civil Rights Division, *Information and Technical Assistance on the Americans with Disabilities Act*, ADA.GOV, https://www.ada.gov/ada_title_II.htm (last visited Feb. 2, 2020).

169. 42 C.F.R. § 35.130(d) (2018).

allows individuals with disabilities to interact with the nondisabled people and to live a lifestyle similar to the general population as much as possible.¹⁷⁰

Following promulgation of the ADA, federal agencies signified their commitment to ensuring community integration. For example, the Centers for Medicare and Medicaid Services sent advisory letters to state Medicaid agencies directing them to provide home- and community-based long-term care services.¹⁷¹ The Department of Justice has been steadily enforcing the obligation to move away from institutionalization and provide community-based services through investigations and settlement negotiations with various states.¹⁷² The Department of Housing and Urban Development (HUD) has also issued a guidance letter emphasizing its efforts to fund integrated housing units and to improve accessibility for individuals with disabilities receiving federal financial assistance from HUD.¹⁷³

In 1999, the Supreme Court interpreted the integration mandate for the first time in *Olmstead v. L.C. ex rel. Zimring*.¹⁷⁴ The case was brought by two women with mental illness and intellectual disabilities confined in a Georgia hospital.¹⁷⁵ The two women wished to leave the hospital and their treating physicians agreed that reintegration in the community was appropriate—yet they remained institutionalized.¹⁷⁶ The women brought an action against the State seeking community-based care.¹⁷⁷

Justice Ginsburg, writing the opinion, recognized the purpose of the integration mandate under the ADA: preventing or remedying unnecessary institutionalization.¹⁷⁸ The opinion laid out the three-part test used to determine whether a state is required to provide services to an individual with disabilities in order to avoid unnecessary institutionalization.¹⁷⁹ First, the state's treatment professionals must determine that a less restrictive setting is appropriate for that particular individual.¹⁸⁰ Second, the individual herself must not oppose placement in a less restrictive setting.¹⁸¹ The final prong, joined only by a four-Justice plurality, asks whether the requested setting is "reasonable"—meaning that the state could raise a "fundamental alterations defense" to avoid placing the

170. BAZELON CENTER FOR MENTAL HEALTH, MAKING YOUR LIFE YOUR OWN 1–2 (2011).

171. See Letter from Sally K. Richardson, Director of the Health Care Finance Administration, to State Medicaid Director (July 29, 1998).

172. The Civil Rights Division began this effort in 2009 to enforce the integration mandate as interpreted by the *Olmstead* Court. 527 U.S. 581 (1999). To view the settlement agreements, see U.S. Dep't of Justice, Civil Rights Division, *Information and Technical Assistance on the Americans with Disabilities Act*, https://www.ada.gov/olmstead/olmstead_cases_by_issue.htm (last visited Jan. 22, 2020).

173. HUD, STATEMENT OF THE DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT ON THE ROLE OF HOUSING IN ACCOMPLISHING THE GOALS OF *OLMSTEAD*, <https://www.hud.gov/sites/documents/OLMSTEADGUIDNC060413.PDF>.

174. 527 U.S. 581 (1999).

175. *Id.* at 593.

176. *Id.*

177. *Id.* at 593–94.

178. *Id.* at 600–01 (deferring to the Department of Justice's interpretation of the regulation to conclude that unnecessary institutionalization constitutes discrimination by reason of disability in violation of Title II of the Americans with Disabilities Act).

179. *Id.* at 607.

180. *Id.*

181. *Id.*

individual in a less restrictive setting.¹⁸² This final prong is the greatest area of dispute, and subsequent courts have parsed out when a request for a less restrictive setting is “reasonable” and when it is a “fundamental alteration.”¹⁸³

The *Olmstead* principles have expanded far beyond the facts of that case. Most notably, subsequent circuit courts (and the Department of Justice in guidance documents) have recognized the right of an individual with a disability to bring an *Olmstead* claim even if he is not currently institutionalized, so long as he is at risk of institutionalization.¹⁸⁴ *Olmstead* has also been applied beyond just the context of psychiatric patients in mental hospitals, for example to individuals with developmental disabilities in group homes or individuals with intellectual disabilities seeking competitive employment.¹⁸⁵

Scholars have proposed—and some litigants have attempted to argue—for even greater expansion of *Olmstead*’s applicability. A recent wave of *Olmstead* expansion proposals has been in the context of nursing facilities, arguing that seniors should instead receive in-home health services as they age.¹⁸⁶ Additionally, many recognize the possibility of applying *Olmstead* in the context of civil commitment.¹⁸⁷ Some have suggested applying *Olmstead* in the context of segregation of students with disabilities in separate classrooms.¹⁸⁸ The *Olmstead* principles have begun to seep into the context of incarceration as well. For example, the DOJ has used its general enforcement authority to require prison-diversion programs in some settlements,¹⁸⁹ and class actions in Georgia relied on

182. *Id.* at 603–06.

183. For example, in the *Olmstead* case, twenty states filed amicus briefs arguing that reallocation of resources to community-based placement would result in inequity for other Medicaid beneficiaries. The Court recognized that a requested alteration that unduly burdens the rest of the program could constitute a fundamental alteration and thus remanded the case back to the Eleventh Circuit. *Id.* at 607. The Second Circuit has held that it cannot require a state to provide a community-service when it does not already provide an institutional service. *Rodriguez v. City of New York*, 197 F.3d 611, 618 (2d Cir. 1999) (“New York cannot have unlawfully discriminated against appellees by denying a benefit that it provides to no one.”).

184. *See Fisher v. Okla. Heath Care Auth.*, 335 F.3d 1175, 1181 (10th Cir. 2003) (holding that Medicaid beneficiaries who are at a “high risk for premature entry into a nursing home” could bring a claim under the integration mandate); U.S. DEP’T OF JUSTICE, STATEMENT OF THE DEPARTMENT OF JUSTICE ON THE ENFORCEMENT OF THE INTEGRATION MANDATE OF TITLE II OF THE AMERICANS WITH DISABILITIES ACT AND *OLMSTEAD V. L.C.* 3 (2011).

185. *Ball v. Kasich*, 30 F. Supp. 3d 701 (S.D. Oh. 2018); Press Release, U.S. Dep’t of Justice, Dep’t of Justice Reaches Landmark Ams. with Disabilities Act Agreement with R.I. (Apr. 8, 2014), <https://www.justice.gov/opa/pr/departments-justice-reaches-landmark-americans-disabilities-act-settlement-agreement-rhode>.

186. *See Brown v. District of Columbia*, 928 F.3d 1070, 1073 (D.C. Cir. 2019).

187. *Seth v. District of Columbia*, No. 18-1034 (BAH), 2018 WL 4682023 (D.D.C. Sept. 28, 2018); Perlin, *supra* note, 7, at 1049 (suggesting that *Olmstead* had the potential to shift the focus of civil commitment hearings towards community treatment).

188. *See Save Access Acad. v. Multnomah Cty. Sch. Dist.*, No. 1J, No. 3:18-cv-00928-MO, 2019 WL 1186843 (D. Or. Mar. 3, 2019); *M.C. through R.C. v. Knox Cty. Bd. of Educ.*, No. 3:17-CV-337, 2018 WL 2746014 (E.D. Tenn. June 7, 2018).

189. *E.g.*, Proposed Settlement Agreement at 33, *United States v. City of Portland*, No. 3:12-cv-02265-SI (D. Or. Dec. 17, 2012).

Olmstead to challenge the state's school-to-prison-pipeline practices.¹⁹⁰ Over the last twenty years, a few inmates have actually brought lawsuits under *Olmstead*.

1. *Brown v. Washington Department of Corrections*,¹⁹¹
U.S. District Court for the Western District of Washington

A 2015 case alleging, among other things, an *Olmstead* violation in a prison context, was brought in the U.S. District Court for the Western District of Washington.¹⁹² The plaintiff had spent most of his time incarcerated in solitary confinement for violating several prison rules, primarily for committing acts of self-harm, which the magistrate judge inferred were a result of his untreated mental illness.¹⁹³ The plaintiff-prisoner alleged that he was being punished for his disability through segregation; the defendant-prison countered that the basis for the isolation was solely disciplinary.¹⁹⁴ The magistrate judge's recommendation (which the court adopted) not only reasoned that the plaintiff alleged enough facts related to discrimination on the *Olmstead* claim to survive summary judgement, but also that the a jury could find that prison did not violate the ADA because it treated the plaintiff as it would any other prisoner whose behavior was inappropriate.¹⁹⁵ The parties settled in early 2017.¹⁹⁶

2. *Davila v. Pennsylvania*,¹⁹⁷
U.S. District Court for the Middle District of Pennsylvania

In a 2014 case in the U.S. District Court for the Middle District of Pennsylvania, an inmate brought a *pro se* action alleging, among other things, that the Lackawanna Court of Common Pleas violated the ADA's integration mandate by sending him for a psychological evaluation at a state correctional institute as opposed to some other less restrictive facility.¹⁹⁸ The magistrate judge concluded that the plaintiff's allegations, under the more relaxed Federal Rule of Civil Procedure 12(b)(6) standard for *pro se* plaintiffs, stated a claim upon which relief could be granted—but noted that “[w]hether Davila will be able to prove his claim

190. See Complaint at 1–2, *United States v. Georgia*, No. 1:16-CV-03088-MHC (N.D. Ga. Aug. 23, 2016); Class Action Complaint, *Georgia Advocacy Office v. Georgia*, No. 1:17-cv-03999-SCJ (N.D. Ga. Oct. 11, 2017).

191. Report and Recommendation Re: Plaintiff's Motion for Partial Summary Judgment and Defendant State of Washington's Motion for Summary Judgment, *Brown v. Wash. Dep't of Corrs.*, (No. C13-5367 RBL-JRC), 2015 WL 4039322 (W.D. Wash. May 13, 2015).

192. *Id.* at *11.

193. *Id.* at *1–2, *8.

194. *Id.* at *11–12.

195. *Id.*; *Brown v. Wash. Dep't of Corrs.*, No. C13-05367 RBL, 2015 WL 4039270 (W.D. Wash. July 2, 2015) (adopting report and order). Two years later the plaintiff stipulated to dismiss the case with prejudice.

196. Order on Stipulation 126 Dismissing This Matter With Prejudice and Without Costs or Attorneys' Fees to Either Party, *Brown v. Washington Dep't of Corr.*, No. C13-5367 RBL/JRC (W.D. Wash. Feb. 28, 2017).

197. Report and Recommendation, *Davila v. Pennsylvania*, (No. 3:11-CV-01092), 2014 WL 1321331 (M.D. Pa. Feb. 28, 2014).

198. *Id.* at *1–3.

must wait for another day.”¹⁹⁹ Ultimately, the district court judge did not adopt the magistrate judge’s report and recommendation in regards to the integration mandate claim, finding that holding for plaintiff would run afoul of the *Heck* decision.²⁰⁰

3. *McClendon v. City of Albuquerque*,²⁰¹
U.S. District Court for the District of New Mexico

In 2016, the U.S. District Court for the District of New Mexico, in reviewing a motion for additional remedial relief, noted that the integration mandate under *Olmstead* could require community-based treatment in place of jails; however, it held that the county-defendant’s existing agreement to implement jail diversion programs was sufficient and no further relief was necessary.²⁰²

4. *Reid v. Hurwitz*,²⁰³ D.C. Circuit

In 2019, a prisoner brought an action in the D.C. Circuit, alleging that the BOP violated its own policy by failing to deliver him his magazine subscription, depriving him of outside exercise while confined in special housing unit, and depriving him of meaningful access to administrative remedy procedures.²⁰⁴ The plaintiff had been in and out of solitary confinement over twenty times in his nine-year detention (a total of 764 days).²⁰⁵ Defendant sought to dismiss on mootness, but on the capable-of-repetition defense, the court reasoned that the plaintiff reasonably expected to be subject to the same actions because the BOP placed him in solitary confinement in every facility that he was transferred to (including four instances after the start of this litigation).²⁰⁶ Although the parties did not bring an *Olmstead* argument, the court found *Olmstead* instructive on the issue of mootness.²⁰⁷ There, the issue of discrimination by isolation was not moot when the petitioners were currently receiving community treatment due to the multiple

199. *Id.* at *11.

200. *Davila v. Pennsylvania*, No. 3:11-1092, 2014 WL 1321010 (M.D. Pa. Mar. 28, 2014) (adopting report and order in part). The *Heck* decision prohibits collateral attacks on a criminal conviction: A person cannot use a civil lawsuit to challenge a conviction. *See id.* at *6; *Heck v. Humphrey*, 512 U.S. 477 (1994).

201. No. 95 CV 24 JAP/KBM, 2016 WL 9818311 (D.N.M. Nov. 9, 2016).

202. *Id.* at *15.

203. 920 F.3d 828 (D.C. Cir. 2019).

204. *Id.* at 830.

205. *Id.* at 830–31.

206. *Id.* at 832–34. Per the mootness doctrine, a court may not adjudicate a claim if a decision will not affect the plaintiff’s rights in the present or if the decision only has a speculative chance of affecting the plaintiff’s rights in the future. *Reid*, 920 F.3d at 832 (citing *Clarke v. United States*, 915 F.2d 699, 701 (D.C. Cir. 1990)). The capable-of-repetition defense trumps a claim of mootness if the complainant can demonstrate that the action she is challenging was too short to be litigated before it terminated and there is a “reasonable expectation” that she will be subject to the action again. *Id.* at 832–33. It was important for the court in *Reid* to recognize that even prolonged isolation (up to 120 days in *Reid*’s case) is still too short for a trial and subsequent appellate review. *Id.* at 833. A case that makes it way to the Supreme Court may be litigated for several years before resolved—it would be absurd for courts to require that an inmate be isolated for that much time before accessing the court. *See generally* *Fisher v. Okla. Heath Care Auth.*, 335 F.3d 1175, 1184 (10th Cir. 2003) (applying the same reasoning in “risk of institutionalization” analysis for *Olmstead* claims).

207. *Reid*, 920 F.3d. at 834.

institutional placements they had experienced, thus making the claims capable of repetition.²⁰⁸ The D.C. Circuit found that prisoner's claim here was not moot because, despite the fact that he was not currently in solitary confinement, he was likely to be isolated in the near future.²⁰⁹

Judge Katsas dissented, focusing on lack of standing and ripeness and stating that "it is not enough merely to assert that unlawful policies exist" without specific facts.²¹⁰ Judge Katsas also noted the warden's authority to restrict inmates based on misconduct or a matter of classification, relying on a BOP document that stated that "denial of exercise is not used as a punishment" and that BOP may limit exercise time if the inmate's use of these "privileges threatens safety, security, and orderly operation of a correctional facility or public safety."²¹¹

B. *Argument and Recommendation*

It is clear that U.S. inmates with serious mental illness are in desperate need of better mental health treatment while incarcerated. Constitutional claims—due to the Eighth Amendment's high bar and focus on minimum levels of care—have been unsuccessful in securing adequate and continuous levels of treatment for these inmates. Given recent expansions of *Olmstead*'s applicability and courts' recognition that it can apply in the prison context, *Olmstead* claims may be an effective cause of action when mental health treatment is necessary to prevent unnecessary solitary confinement.²¹²

The Eighth Amendment does not guarantee anything beyond minimal mental health treatment and the ADA does not guarantee an inmate's preferred treatment—but *Olmstead* might. On its face, *Olmstead* requires integration of individuals with disabilities.²¹³ In practice this means that a public entity may have to provide the services and supports that make integration possible; in the prison context, it may be adequate and continuous mental health treatment that enables an inmate to avoid solitary confinement. An *Olmstead* claim may be preferable to traditional Eighth Amendment claims because it does not impose a difficult-to-meet knowledge requirement; moreover, it does not require the inmate to allege particular harm beyond (risk of) institutionalization.²¹⁴ An additional advantage of an *Olmstead* claim is that it can be applied to both pre- and post-conviction

208. *Id.*

209. *Id.*

210. *Id.* at 838 (Katsas, C.J., dissenting).

211. *Id.* at 839 (Katsas, C.J., dissenting).

212. Professor Michael Perlin made a similar observation in the year immediately following the *Olmstead* decision, arguing that its "least restrictive environment" principle can be used in civil commitment hearings. *See generally* Perlin, *supra* note 7. There has also been an increased reliance on the ADA in general in prison litigation. *See generally* Knowles, *supra* note 42, at 920–23 (outlining the advantages of an ADA claim over the Eighth Amendment).

213. *See generally* *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999).

214. ADA claims in general have some added benefits over the Eighth Amendment: qualified immunity is not an issue and there is an opportunity to get attorney's fees. *See* Knowles, *supra* note 42, at 919–23. It is necessary to distinguish the integration claim presented in this Note from a general ADA claim for accommodations. *Olmstead*'s holding was clear: unnecessary institutional segregation can be a form of discrimination under Title II of the ADA. *See Olmstead*, 527 U.S. at 600.

detainees equally.²¹⁵ Long-term, it may also shift the landscape of how we approach prison litigation: focusing on a person-centered approach that values treatment, rather than meeting constitutional minimums.

Professor Emeritus Fred Cohen argues that litigation efforts should aim for reform—an overhaul of the overuse, misuse, and inequalities in the prison system—rather than discrete and isolated forms of relief.²¹⁶ *Olmstead* is increasingly used as the basis for systemic litigation in search for services and supports to enable community-integration of individuals with disabilities.²¹⁷ Cohen breaks down prison reform litigation into three phases: (1) the complaint-resolution phase, i.e., the lawsuit itself; (2) the remedy phase, i.e., the injunctive relief with prospective effect; and (3) the implementation phase, which can take many forms, including developing new policy and hiring appropriate personnel.²¹⁸ This Note focuses on the first phase: the complaint.²¹⁹

Inmates that are segregated, or at risk for segregation, can bring a claim under *Olmstead* to remain in the general prison population. The basis and end goal for such a claim is that, in order to be or remain integrated in the general prison population, some inmates require adequate and continuous mental health services. This section will explore how a hypothetical plaintiff could make a *prima facie* case under the proposed litigation. Following the schematic provided by Justice Ginsburg in *Olmstead*, this Note will introduce the argument in four steps.

1. **Step Zero:** Establishing mental health treatment in prisons as a service, activity, or program offered by a public entity.
2. **Step One:** Establishing institutionalization or risk of institutionalization.
3. **Step Two:** Establishing that a professional has determined an integrated setting is appropriate.²²⁰

215. The Eighth Amendment’s proscription against cruel and unusual punishment does not apply to pre-trial detainees; rather, the conditions for such individuals are evaluated under the Fifth Amendment’s due process analysis. See *Bell v. Wolfish*, 441 U.S. 520, 535–39 (1979).

216. Cohen, *supra* note 63, at Part II. Cohen does note, however, that when a prison system completely lacks medical or mental health treatment, even “unevenly implemented” solutions are notable. *Id.*

217. See, e.g., Plaintiff’s Motion for Class Certification, *Alexander v. Mayhew*, No. 4:18-cv-00569-RH-MJF (N.D. Fla. Mar. 12, 2019) (in-home nursing care); *Brown v. District of Columbia*, 928 F.3d 1070 (D.D.C. 2019) (community based care); Class Action Complaint, *Georgia Advocacy Office v. Jackson*, No. 1:19-cv-01634-WMR-JFK, 2019 WL 1577340 (N.D. Ga. Apr. 10, 2019) (therapeutic relief in county jails).

218. Separation of powers does limit the Court’s ability to effectuate broad reform. After all, the ability to appropriate funds is under the purview of the Legislature and not the Court. But Courts can and do play an important role in the specifics of the remedy, as stated by Professor Cohen: “A trial court need not directly order the appropriation of tax dollars, but may require the hiring of dozens of doctors, the availability of hundreds of hospital beds, the availability of a new jail, and the closing of an old facility as a safety hazard.” Cohen, *supra* note 63, at Part II. Whether a court’s mandate to hire personnel is meaningful when the prison system lacks the funds to effectively effectuate that remedy is an important question, but beyond the scope of this Note.

219. A note on the Prison Litigation Reform Act (PLRA). The PLRA (a “mean-spirited” statute according to Professor Cohen) seeks to make it difficult for inmates to litigate other claims (e.g., through exhaustion requirements, imposing filing fees and a “three strikes” rule for litigants proceeding *in forma pauperis*, limiting the availability of attorney’s fees, and creating physical injury requirement). Cohen, *supra* note 63, at Part VIII. The PLRA requires courts to impose remedies which are “narrowly drawn” from the violations at issue and give “substantial weight” to public safety when ordering that prison populations be reduced. 18 U.S.C. § 3626(a) (2012). Although this Note does not discuss the effect of the PLRA on an attempted *Olmstead* claim, the PLRA could be a barrier to a plaintiff’s success.

220. The three-part test under *Olmstead* requires both a showing that (a) the individual does not oppose integrated placement and (b) a treating professional has determined integrated placement to be

4. Step Three: Establishing that the requested mental health treatment is *reasonable* and not a *fundamental alteration* of the prison's existing services.

1. Step Zero: Mental Health Treatment as a Service, Activity, or Program

Title II of the ADA applies to services, activities, and programs offered by public entities, defined as federal, state, or local governments.²²¹ As a preliminary matter, an inmate must establish that mental health services in prisons and jails do in fact fall within the purview of Title II. We can expect a defendant-prison to contest this based on the fact that services, activities, or programs are only those that are typically associated with being in prison (i.e., the shelter, food).

However, our hypothetical plaintiff has a strong argument that mental health treatment is a qualifying program or service offered in U.S. prisons. Most illustrative of this point is that correctional facilities are the largest provider of mental health services in the United States—even more so than state hospitals.²²² Furthermore, one of the four justifications for incarceration is rehabilitation.²²³ Finally, courts have defined the term “services, programs, and activities” broadly under the ADA.²²⁴ In fact, in a letter to the Pennsylvania Department of Corrections, the DOJ noted that the state was in violation of the ADA when it warehoused its prisoners with mental illness in solitary confinement, noting that it denied them the opportunity to participate in and benefit from the correctional facility's services including mental health treatment—signifying that the agency views mental health care at correctional facilities as being one of its programs, activities, or services.²²⁵

appropriate. *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 607 (1999). In many cases, the first prong is not at issue—after all, data suggests that most individuals prefer to remain in their communities. *See, e.g.*, Frederick L. v. Dep't of Pub. Welfare of Com. Pennsylvania, 364 F.3d 487 (3d Cir. 2004); PENN SCHOEN BERLAND, THE UNITED STATES OF AGING SURVEY 4 (2012) (finding that ninety percent of seniors prefer to age in their home). However, this prong may present an issue relating to inmate autonomy: What if the inmate prefers to remain in restricted housing?

221. 42 U.S.C. §§ 12131(1), 12132 (2012).

222. Ronald M. Hager et al., *Unfinished Business: The Enforcement of Civil Rights for Persons with Disabilities*, 48 CLEARINGHOUSE REV. 11–12 (2014) (noting further that states continue to vehemently oppose this interpretation). In fact, courts routinely have recognized that inmates rely on correctional facilities for *all* services. *See, e.g.*, *Estelle v. Gamble*, 429 U.S. 97, 103 (1976).

223. The others being retribution, isolation, and prevention. *Mayu Miyashita, City of Boerne v. Flores and its Impact on Prisoners' Religious Freedom*, 25 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 519, 523 (1999).

224. *See e.g.*, *Noel v. New York City Taxi & Limousine Comm'n*, 687 F.3d 63, 68 (2d Cir. 2012) (quoting *Innovative Health Sys v. City of White Plains*, 117 F.3d 37, 45 (2d Cir. 1997) (“[T]he phrase ‘services, programs, or activities’ has been interpreted to be ‘a catch-all phrase that prohibits all discrimination by a public entity.’”); *Kiman v. N.H. Dep't of Corrs.*, 451 F.3d 274, 286–87 (1st Cir. 2006) (holding that providing prescription medications—as one part of a prison's overall medical services—constitutes a service, program, or activity under the ADA); *Johnson v. City of Saline*, 151 F.3d 564, 569 (6th Cir. 1998) (holding that “services, programs, and activities include all government activities” and that “the phrase ‘services, programs, or activities’ encompasses virtually everything that a public entity does”).

225. Samuels, *supra* note 34, at 17.

2. Step One: (Risk of) Institutionalization

Olmstead stands for the proposition that individuals with disabilities cannot be unnecessarily institutionalized; it follows that a person bringing an *Olmstead* claim must demonstrate that he or she is in fact institutionalized. Under a DOJ guidance and subsequent jurisprudence, litigants can bring an *Olmstead* claim even if they are merely “at risk” of institutionalization.²²⁶ This presents an interesting question in the prison context: Can an inmate, who is by virtue of incarceration isolated from the community, ever establish their institutionalization? What this section attempts to establish is that certain prisoners are even *further* isolated in restricted housing conditions (i.e., solitary confinement) when they could remain in the general prison population with the appropriate mental health services.

The concept of segregation-within-isolation is not totally novel. In *Henderson v. Thomas*,²²⁷ the district court held that, under *Olmstead*, HIV-positive inmates cannot be categorically segregated from the rest of the prison population.²²⁸ Similarly, in *Stiles v. Judd*, the court found that the inmate-plaintiff’s complaint alleged enough facts demonstrating “unjustifiabl[e] isolat[i]on] from other prisoners on the basis of his mental illness” for the case to proceed to the jury.²²⁹

The *Olmstead* Court recognized that the objective of the ADA was to remedy the historical isolation of people with disabilities. The conditions of solitary confinement for individuals with disabilities are exactly the type of unnecessary segregation that the Attorney General intended to prevent when he promulgated the integration mandate. Most demonstrative of this point is that the 2014 investigation by the DOJ’s Civil Rights Division of the Pennsylvania Department of Corrections concluded that the routine solitary confinement of individuals with mental illness and intellectual disabilities constituted a violation of Title II of the Americans with Disabilities Act.²³⁰ In that investigation, the DOJ unequivocally stated that Pennsylvania “uses solitary confinement often [to] discriminate against prisoners with [serious mental illness or intellectual disabilities].”²³¹ There the DOJ concluded that Pennsylvania violated Title II by denying prisoners with serious mental illness the “opportunity to participate in and benefit from correctional services and activities, such as classification, security housing, and mental health services.”²³²

A 2017 DOJ investigation revealed conditions of solitary confinement around the nation. One man, who had been incarcerated for ten years, stated he was only permitted to leave his cell for three hours per week—never more than one hour at a time—spending the remaining 165 hours of the week in isolation.²³³ An inmate

226. U.S. DEP’T OF JUSTICE, STATEMENT OF THE DEPARTMENT OF JUSTICE ON THE ENFORCEMENT OF THE INTEGRATION MANDATE OF TITLE II OF THE AMERICANS WITH DISABILITIES ACT AND *OLMSTEAD v. L.C.* 5 (2011).

227. 913 F. Supp. 2d 1267 (M.D. Ala. 2012).

228. *Id.* at 1288–1311 (finding that categorically housing HIV-positive inmates in a separate facility and excluding them from food service and work release and violates integration mandate).

229. No. 8:12-cv-02375-T-27EAJ, 2013 WL 6185404 (M.D. Fla. Nov. 25, 2013).

230. *Id.* at 14.

231. Samuels, *supra* note 34, at 3.

232. *Id.* at 17.

233. U.S. DEP’T OF JUSTICE, OFFICE OF THE INSPECTOR GEN., REVIEW OF FEDERAL BUREAU OF PRISONS’ USE OF RESTRICTIVE HOUSING FOR INMATES WITH MENTAL ILLNESS 17 (2017).

at a federal facility in Pennsylvania was incarcerated for nearly twenty-five years, spending almost the entirety of that sentence in solitary confinement and receiving practically no mental health treatment.²³⁴ A psychologist at a federal correctional facility explained what it is like to be in solitary confinement: “[Y]ou don’t talk to anyone, you don’t speak to anybody . . . they don’t really get a chance to see anyone.”²³⁵ Although inmates are supposed to be afforded recreation time, wardens have the authority to deny exercise privileges for a variety of reasons.²³⁶ At some facilities, the SHU is only 58.8 square feet in size.²³⁷

Since inmates with mental illness are at higher risk for infractions,²³⁸ they are routinely sent to solitary confinement. According to Part I of this Note which outlined the rates at which such inmates are sent to restricted housing, we can conclude that inmates with mental illness are perpetually at “risk of institutionalization” under the *Olmstead* standard.

3. Step Two: The Less-Restrictive Setting is Appropriate

a. Whose opinion?

In the prison context, inmates are often sent to solitary confinement as a result of an infraction or dangerous behavior—including attempted self-harm. One question under *Olmstead*’s three-part test is whether a professional has concluded that community-placement is appropriate for the individual. How does this prong apply to a prison official who decides to place an inmate in a more restricted setting?

Presumably, an inmate will argue that an integrated setting is in fact appropriate. However, courts are not always receptive to this argument and tend not to defer to the person’s own evaluation of what is appropriate. In *Youngberg v. Romeo*,²³⁹ the Court held that choices made by a professional about a civil detainee’s treatment are “presumptively valid.”²⁴⁰ And decisions made by treatment providers are only constitutional if they show “such a substantial departure from accepted professional judgement.”²⁴¹ The Seventh Circuit in *Allison v. Snyder*²⁴² articulated what the Constitution requires for civilly-contained sex offenders: “(a) committed persons are entitled to *some* treatment, and (b) what the treatment entails must be decided by mental-health professionals.”²⁴³ The same court held in 2018 that, based on *Youngberg* and *Allison*, a civil detainee did not adequately demonstrate why his treatment professional’s opinion was a departure

234. Samuels, *supra* note 34, at 13.

235. *Id.* at 16.

236. *Id.* at 18.

237. *Id.* at 18. This is over twenty square feet smaller than what is mandated by the American Correctional Association’s standards. *Id.*

238. SMI IN JAILS AND PRISONS 2016, *supra* note 23, at 2 (finding that jail inmates with mental illness are twice as likely as their nonmentally ill counterparts to be charged with facility rule violations; another study found that forty-one percent of infractions were committed by inmates with mental illness).

239. 457 U.S. 307 (1982).

240. *Id.* at 323.

241. *Id.*

242. *Allison v. Snyder*, 332 F.3d 1076 (7th Cir. 2003).

243. *Id.* at 1081 (emphasis added).

from accepted standards or why his own opinion should trump the professional's.²⁴⁴

One possibility is to argue that a decision, if made by a non-physician (e.g., a correctional officer), is undeserving of the court's deference. In *Olmstead*, the treating professionals at the Georgia Regional Hospital concluded that the plaintiff-appellees could be reasonably cared for in a community-based setting.²⁴⁵ The appellees there relied heavily on the notion that only the appropriately qualified professionals deserve deference—in that case, “mental retardation professionals.”²⁴⁶ Justice Kennedy in his concurring opinion noted that “[i]t is of central importance . . . that courts apply today's decision with great deference to the medical decisions of the responsible, treating physicians. . . .”²⁴⁷

Another option is to introduce expert opinion to challenge the prison official's determination. It is not unfathomable for courts to consider other opinions outside of the correctional facility's staff. For example, in *Charles v. Orange County*,²⁴⁸ the Second Circuit looked at the American Psychiatric Association and the National Commission on Correctional Health Care's views on discharge in concluding that “[s]uch expert medical opinion supports the plausibility of Plaintiffs' claim of a deprivation of in-custody care.”²⁴⁹

b. Discrimination

Relatedly, a correctional officer's determination that an inmate should be in solitary confinement may create issues with regard to the “discrimination” element that is common in all ADA claims. If an inmate with mental illness is sent to solitary confinement for an infraction, is he really being treated differently than his non-mentally ill counterparts?

A San Quentin State Prison inmate brought an action under the ADA, alleging that the facility failed to accommodate his peanut allergy by subjecting him to a standardized diet that included peanut butter three times per week.²⁵⁰ The court dismissed this claim, stating that:

[h]e alleges that Defendants failed to accommodate his alleged “disability,” but he does not allege that they did so because he was disabled. He does not allege that he was treated differently than similarly-situated non-disabled inmates and he does not allege that he was excluded from participation in a prison program or service because of his disability.²⁵¹

244. *Powers v. Block*, 750 F. App'x 480, 484 (7th Cir. 2018). Even in *Estelle*, the Court agreed that the prison physician's decision not to order an X-ray for the injured inmate was a “classic example of a matter for medical judgement” and that the physician's decision not to pursue it did not amount to cruel and unusual punishment. *Estelle v. Gamble*, 429 U.S. 97, 107 (1976).

245. *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 593 (1999).

246. Brief of Appellees at *6, *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999) (No. 97-8538), (1997) WL 33493440, at *49.

247. *Olmstead*, 527 U.S. at 610 (1999) (Kennedy, J., concurring).

248. *Charles v. Orange County*, 925 F.3d 73 (2d Cir. 2019).

249. *Id.* at 84.

250. *Ramirez v. Tilton*, No. C 07-04681 SBA (PR), 2010 WL 889988, at *4 (N.D. Cal. Mar. 8, 2010).

251. *Id.* at *8.

The same court heard a case by a prisoner with asthma who alleged an ADA violation by the facility because smoke and fumes lingered in the facility.²⁵² Again, the court stated that “[p]laintiff does not allege that he was treated differently than similarly-situated non-disabled inmates and he does not allege that he was excluded from participation in a prison program or service because of his disability. Therefore, he does not appear to have a cognizable disability discrimination claim.”²⁵³

Other courts, however, have been more willing to recognize disparate treatment when individuals with mental illness are sent to solitary confinement.²⁵⁴ For example, in *Brown v. Washington Department of Corrections*,²⁵⁵ (discussed in Section IV.A.1.) the court realized that what the prison identified as being a typical response to inmates who exhibit behavioral problems might be perceived as discrimination against an individual with disabilities by a jury.²⁵⁶ Like many reform-litigation efforts, this may be an issue of framing. A plaintiff-prisoner may be able to demonstrate that only those inmates with mental illness are found to violate prison rules, even when a prison maintains that inmates are only segregated for infractions.²⁵⁷ By emphasizing the overlap of inmates with mental illness and inmates who are sent to solitary confinement, one may be able to show that a prison’s defense of equal treatment is actually a discriminatory practice in disguise.²⁵⁸

4. Step Three: Reasonable Modification or Fundamental Alteration?

Incarcerated plaintiffs in these claims will be arguing that they require adequate and continuous mental health treatment in order to remain in—or return to—the general prison population. The *Olmstead* Court recognized that a public entity’s obligations to integrate are not boundless—if the requested services will fundamentally alter its program, it does not have to provide them.²⁵⁹

Courts have found various requests to expand community-programing to be “reasonable” under *Olmstead*,²⁶⁰ and the DOJ, as a result of its *Olmstead* investigations, has entered into numerous settlement agreements that expand

252. *Sims v. Sayre*, No. C 08-01691 SBA (PR), 2010 WL 934115, at *6 (N.D. Cal. Mar. 15, 2010).

253. *Id.*

254. *See generally* Knowles, *supra* note 42, at 919–20 (noting that a mere showing of disparate treatment may be sufficient for ADA claims).

255. Report and Recommendations, *supra* note 191.

256. *Id.* at 29.

257. Importantly, circuit courts have not interpreted *Olmstead* to necessarily require a showing of disparate impact to show a violation of the integration mandate. *E.g.*, *Henrietta D. v. Bloomberg*, 331 F.3d 261, 276 (2d Cir. 2003) (noting that the ADA does not require a literal showing of discrimination, rather just a showing of denial of benefits).

258. The facts of a recent class action lawsuit in Georgia seem to point to this strategy. Class Action Complaint, Georgia Advocacy Office v. Jackson, No. 1:19-cv-01634-WMR-JFK, 2019 WL 1577340 (N.D. Ga. Apr. 10, 2019). The complaint, discussed further in the Conclusion, implies that solitary confinement in Georgia jails is entirely made up of female inmates with mental illness. *Id.* at *23.

259. *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 596–97, 603–04 (1999).

260. *Steimel v. Wernert*, 823 F.3d 902 (7th Cir. 2016) (remanding to lower court to determine whether, in light of a budget cut, plaintiffs’ request for more than twelve hours of home health services hours constituted a fundamental alteration); *M.R. v. Dreyfus*, 697 F.3d 706 (9th Cir. 2012) (enjoining state from reducing in-home personal care aide hours).

community services.²⁶¹ Moreover, courts will not accept generic cost-based arguments as a reason not to provide the requested service.²⁶² Assuming that a defendant-prisoner raises cost as the basis of its fundamental alterations defense, it will need to put forth enough facts to demonstrate its lack of success in obtaining additional funding or how reallocation of funds would adversely affect other prisoner populations.²⁶³

However, there are many instances where courts did not require the public entity to provide the requested service. For example, courts are unlikely to require a state to create an entirely new program or service based on an individual's *Olmstead* claim.²⁶⁴ The *Olmstead* Court itself stated: "We do not in this opinion hold that the ADA imposes on the States a 'standard of care' for whatever medical services they render, or that the ADA requires States to 'provide a certain level of benefits to individuals with disabilities.'"²⁶⁵ This no-standard-of-care element may be a major obstacle in compelling prisons to make mental health treatment available, particularly if the prison already provides some level of treatment—no matter how minimal. In *Carpenter-Baker v. Ohio Department of Medicaid*, a disabled adult alleged that the state's attempt to reduce her in-home nursing care placed her at risk of institutionalization.²⁶⁶ The Sixth Circuit held that it was not an ADA violation, noting that the case was an example of what *Olmstead* does not require.²⁶⁷ Moreover, courts have interpreted the ADA to mean that a plaintiff cannot rely on *Olmstead* to compel an accommodation of their choosing.²⁶⁸

261. See Interim Settlement Agreement, U.S. v. Rhode Island and the City of Providence (No. 1:13-CF-00442), 2013 (competitive employment); Settlement Agreement, United States v. North Carolina (No. 5:12-CV-00557-F), 2012 (community housing slots); Interim Settlement Agreement, Steward v. Perry (No. 5:10-CV-1025-OLG), 2013 (service planning teams).

262. See Penn. Prot. & Advocacy, Inc. v. Penn. Dep't of Pub. Welfare, 402 F.3d 374, 383 (3d Cir. 2005) ("budgetary constraints alone are insufficient to establish a fundamental alterations defense").

263. See *id.* ("the District Court's opinion here does not disclose additional relevant factors such as unsuccessful attempts at fund procurement, evidence that [the Department of Public Welfare] responsibly spent its budgetary allocations, evidence of a favorable bed closure rate, defendants' ability to increase the number of community care placements in light of community opposition to further expansion, or the potential diminution of services for institutionalized persons.").

264. See *Rodriguez v. City of New York*, 197 F.3d 611, 616 (2d Cir. 1999) ("[The ADA] does not require a state to fund a benefit that it currently provides to no one."). While a public entity may not be required to create some *new* program, the entity's decision to cut back an existing program is actionable under *Olmstead*. Hager, *supra* note 222, at 9–10 ("Federal courts have interpreted the ADA to suggest that when a state offers a benefit, a reduction in that benefit may violate the integration mandate if it places people at risk of institutionalization."). Unsurprisingly, states continue to vehemently oppose this interpretation. *Id.*

265. See *Olmstead v. L.C. ex rel. Zimring.*, 527 U.S. 581, 603 n.14 (1999).

266. 752 F. App'x 215, 216 (6th Cir. 2018).

267. The court there focused on the fact that decision to reduce her nursing services was based on an individualized assessment of her needs, noting that public health official's medical determinations deserved deference—not the individual's own assessment of her needs. *Id.* at 220 (citing *Sch. Bd. of Nassau Cty. v. Arline*, 480 U.S. 273, 288 (1987)) ("[C]ourts normally should defer to the reasonable medical judgements of public health officials.").

268. See generally, e.g., *Woods v. Tompkins Cty.*, No. 5:16-CV-0007 (LEK/TWD), 2019 WL 1409979 at *31–32 (N.D.N.Y. Mar. 28, 2019) (holding that the seventy-year-old disabled plaintiff was not entitled to receiving in-home nursing care from provider of her choosing); *Douris v. Bucks Cty. Office of the Dist. Attorney*, No. Civ.A. 03-CV-5661, 2004 WL 1529169 at *8 (E.D. Pa. July 6, 2004) (citing *Olmstead*, 527 U.S. 5 at 602 (1999)) ("The regulation does not compel Defendants to provide Plaintiff the accommodations which he chooses.").

C. Counterarguments to Using *Olmstead*

Aside from the fact that the analysis above has not been fully tested, there are many reasons why using *Olmstead* in prison-reform litigation may be unfavorable. Such claims might be unsuccessful simply because, as a society, we do not prioritize the integration of individuals with mental illness.²⁶⁹ Illustrative of this point is that, since the beginning of the Trump Administration, the DOJ has de-emphasized enforcement of *Olmstead*²⁷⁰ and even withdrawn its Guidance Statement.²⁷¹

Even if successful, this approach may result in *only* prisoners with mental illness avoiding unnecessary segregation, unduly affecting other prisoners who do meet the ADA's definition of disability.²⁷² Prison-reform litigation should arguably focus on an overall reform of the overpopulation and poor conditions caused by mass incarceration, rather than focusing on the interests of discrete groups.²⁷³ Clearly, issues in the provision of mental health treatment are reflective of much broader issues surrounding mass incarceration. This Note discussed one possible solution for a small subset of inmates. It did not, however, discuss solutions to prevent individuals with mental illness from becoming unnecessarily entangled in the criminal justice system: prison-diversion programs, disrupting the school-to-prison pipeline, community-based treatment, and affordable housing.²⁷⁴

269. See generally TOM HARKIN, U.S. SENATE, HEALTH, EDUC., LABOR & PENSION COMM., SEPARATE AND UNEQUAL: STATES FAIL TO FULFILL CMTY. LIVING PROMISE OF THE AM. WITH DISABILITIES ACT 2 (2013), <https://www.help.senate.gov/imo/media/doc/Olmstead%20Report%20July%2020131.pdf> (“Progress in providing [home and community-based services] for persons with . . . mental illnesses has lagged significantly behind efforts for individuals with intellectual and developmental disabilities.”).

270. See Robyn Powell, *Disabled People Have Had the Legal Right to Live in Their Communities for 20 Years. But That's Still Not the Reality for Many*, REWIRE NEWS (June 19, 2019), <https://rewire.news/article/2019/06/19/disabled-people-have-had-the-legal-right-to-live-in-their-communities-for-20-years-but-thats-still-not-the-reality-for-many> (noting that the DOJ is investigating sixty percent fewer civil right cases, including disability rights, under the Trump Administration compared to the Obama Administration).

271. Compare U.S. Dep't of Justice, Civil Rights Div., *Withdrawal of the Statement of the Dep't of Justice on the Application of the Integration Mandate of Title II of the Am. with Disabilities Act and Olmstead v. L.C. to State and Local Governments' Emp't Serv. Sys. for Individuals with Disabilities*, ADA.gov (Dec. 21, 2017), https://www.ada.gov/withdrawn_olmstead.html, with U.S. Dep't of Justice Archives, *Brief Filed in Three States to Enforce Supreme Court's Olmstead Decision*, (Dec. 2, 2009), <https://www.justice.gov/archives/opa/blog/briefs-filed-three-states-enforce-supreme-courts-olmstead-decision> (highlighting that the Obama Administration declared 2009 as “The Year of Community Living” and directed the DOJ to “redouble its [*Olmstead*] enforcement efforts.”).

272. This sentiment may also be true in the Eighth Amendment context. See generally Cohen, *supra* note 63, at Part III.B (“Today, an inmate who wants or needs more than minimal conditions of human survival and medical care guaranteed by the Eighth Amendment’s proscription of cruel and unusual punishment must depend on the goodwill of the administrators or fit himself or herself into the various ‘special needs’ groups housed in prison systems.”).

273. See *id.* at Part II.

274. The National Alliance of Mental Illness (NAMI) advocates for diversion to avoid what it considers to be the “criminalization” of mental illness. Press Release, National Alliance of Mental Illness, *NAMI Warns Senate About Criminalization of Mental Illness; Supports Cornyn Bill* (Feb. 10, 2016), <https://www.nami.org/Press-Media/Press-Releases/2016/NAMI-Warns-Senate-about-Criminalization-of-Mental>.

V. CONCLUSION

Lawsuits for improved mental health treatment have over-relied on the Constitution and general ADA anti-discrimination prohibitions as the basis for claims. This practice has the effect of separating two concepts that are, in reality, intertwined: isolation and adequate medical treatment. The two concepts are arguably inseparable because, unfortunately, inmates lacking mental health treatment *are* the ones that are subject to (prolonged and frequent) solitary confinement.

A recent class action filed in Georgia is illustrative.²⁷⁵ As of January 2020, the Georgia Advocacy Office filed a class action complaint on behalf of Georgia jail detainees who are deemed “mentally disordered” and are subject to the State’s practice of segregation—particularly women.²⁷⁶ The State has a practice of placing its inmates with mental health disorders in separate pods where they are kept indefinitely and have “few opportunities to leave their cells or engage in meaningful social interaction.”²⁷⁷ These cells are also subpar in quality.²⁷⁸ The Office focused on the fact that the women’s psychological health deteriorates significantly when in solitary confinement.²⁷⁹ The Office did not indicate an intent to bring a claim specifically under *Olmstead* in its pleading—despite the fact it focused almost exclusively on the fact that female inmates with mental illness are being disproportionately isolated.²⁸⁰ Although briefs have not yet been filed, the facts of this case seem perfectly situated for an *Olmstead* claim.

275. Class Action Complaint, Georgia Advocacy Office v. Jackson, No. 1:19-cv-01634-WMR-JFK, 2019 WL 1577340 (N.D. Ga. Apr. 10, 2019).

276. *Id.* at *16–17, *19–20.

277. *Id.* at *23.

278. *Id.* at *29 (noting that due to frequent plumbing issues the women often have little access to water and are forced to sleep on cold metal bunks after using their bedding to clean up flooding).

279. *Id.* at *45–59.

280. *Id.* at *75–82 (including claims for relief under Eighth Amendment for conditions of confinement and solitary confinement, Equal Protections Clause for sex discrimination, and ADA for general discrimination by public entities, but not specifically including a claim under the ADA’s integration-mandate).