

CAGED IN

SOLITARY CONFINEMENT'S
DEVASTATING HARM ON PRISONERS
WITH PHYSICAL DISABILITIES



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EXECUTIVE SUMMARY

Every day, in prisons and jails across America, prisoners with physical disabilities are held in conditions of near-total isolation—also known as solitary confinement. Locked in cages roughly the size of a regular parking space, prisoners held in solitary confinement are kept alone in their cells for approximately 22 hours a day or more. While in solitary, they have little or no human interaction, access to light, rehabilitative programming, or constructive activity. In 2015, the ACLU sought to expose the harms of solitary confinement by investigating the challenges facing prisoners with physical disabilities subjected to this devastating practice. The current and formerly incarcerated people with disabilities who we spoke with described their experiences of enduring extreme isolation for days, months, and even years. They shared the pain and humiliation of being left to fend for themselves in solitary confinement without wheelchairs, prosthetic limbs, or other necessary accommodations to carry out life’s basic daily tasks. Without these vital accommodations, many of them were left without the means to walk, shower, clothe themselves, or even use the toilet. Deaf and blind prisoners reported that prison officials failed to provide them with access to hearing aids, Braille materials, certified sign language interpreters, or other auxiliary aids and services that are necessary to facilitate meaningful communication. As a result, many prisoners reported being left completely isolated without any ability to communicate with other prisoners, staff, family members, and other visitors.

The devastating psychological and physical harms of solitary confinement are well known. Mental health experts studying the issue agree that solitary confinement is psychologically harmful. People subjected to solitary confinement may experience hallucinations, depression, paranoia, anxiety, and thoughts of suicide, among other negative reactions. In fact, prisoners held in solitary confinement account for nearly 50 percent of all completed suicides by incarcerated people. Beyond this, solitary confinement can

also be physically debilitating. Stress, enforced idleness, and limited access to health care, including medically necessary prescriptions and physical therapies, among other factors, can lead to severely diminished health outcomes for prisoners.

Locked in cages roughly the size of a regular parking space, prisoners held in solitary confinement are kept alone in their cells for approximately 22 hours a day.

Our own research and interviews with incarcerated and formerly incarcerated people with physical disabilities, as well as medical experts and disability rights advocates, confirmed these harms and more. Alarming, we’ve found that for prisoners with physical disabilities, solitary confinement *imposes additional harms*. Prisoners with mobility disabilities, such as those resulting from spinal cord injuries, often rely on regular physical therapy, exercise, and access to proper prescription medications to maintain a healthy existence. Yet the highly restrictive environment of solitary confinement runs completely counter to these health goals. Held in tiny cells for upwards of 22 hours per day, prisoners with physical disabilities in solitary confinement are either completely denied or seldom provided the regular exercise

necessary to prevent muscle deterioration. They are also denied or seldom provided the physical therapy necessary to support muscle strength and conditioning.

Similarly, blind and/or deaf prisoners experience unique harms when held in solitary confinement, and many experience this isolated condition more acutely than seeing or hearing prisoners. These prisoners often experience a heightened form of sensory deprivation while trapped in the mind-numbing emptiness of solitary confinement. Not only are these prisoners locked in their cells for most or all of the day, they are also frequently denied access to in-cell constructive or recreational activities, such as reading, writing, or watching television, which can be used to help stimulate the mind while in isolation. Instead, many are left to languish in a state of total idleness for weeks, months, and even years at a time.

Prisoners with physical disabilities are not only acutely and uniquely harmed by solitary confinement, but they have also been effectively *shut out* from participating in critical aspects of daily prison life. Drawing from research,

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50%
OF ALL SUICIDES
BY INCARCERATED PEOPLE
ARE COMPLETED IN
SOLITARY CONFINEMENT**



Photo: Andrew Burton/Getty

we know that prisoners with physical disabilities in solitary confinement are frequently denied necessary accommodations to ensure they have equal access to prison medical and mental health care, as well as prison programs and services—including educational and vocational classes, visitation, telephone calls, and exercise yards. For example, prison authorities have failed to provide accommodations—such as sign language interpreters for deaf prisoners or text-to-audio devices for blind prisoners—in all prison programs, thus actively thwarting effective communications with these prisoners. The exclusion of prisoners with physical disabilities from the routine aspects of prison life is compounded by the fact that the highly restrictive environment of solitary confinement *already limits* opportunities for social interaction and environmental stimulation. Prisoners with physical disabilities are in some cases shut out from even the barest of opportunities for engagement and constructive activity afforded to other prisoners, and as a result are left in near-total isolation.

Given the damage to the human psyche and physical health, the United Nation’s Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment strongly urges corrections systems to ban solitary confinement beyond 15 days. Beyond that point, the Special Rapporteur has concluded that solitary confinement *can amount to torture*. Yet, despite these clearly identified harms and calls to end the practice, prison officials continue to rely on solitary confinement in American prisons and jails across the nation. On any given day, approximately 80,000 to 100,000 people are held in conditions amounting to solitary confinement.

Prisoners with disabilities are placed in solitary confinement even when it serves no penological purpose.

Contributing to the overuse of solitary confinement in the United States is the fact that this harsh condition is inflicted on prisoners for a host of reasons beyond the most serious of crimes of violence or attempted escape, such as for a minor infraction like disobeying a routine order or failing to keep a tidy cell. As with all incarcerated persons, those with physical disabilities can be placed into solitary confinement for many reasons, including where the prisoner:

- Poses a general threat to the safety or security of the facility (i.e., administrative segregation, or “ad seg”);
- Is at risk of serious physical harm or death due to the threat posed by other prisoners (i.e., protective custody);
- Violates a prison rule (i.e., disciplinary segregation);
- Has a communicable disease (i.e., medical isolation); or
- Has a disability and prison officials determine it is more convenient to place them in solitary confinement until permanent housing is identified.

What is most troubling is the fact that prisoners with disabilities are placed into solitary confinement *even when it serves no penological purpose*. Corrections officials have put prisoners with physical disabilities into solitary confinement because there were *no available cells that could accommodate them in a less restrictive environment*. The lack of available cells that can accommodate prisoners with physical disabilities can also contribute to prolonged placements in solitary confinement. One blind prisoner was held in solitary confinement for six weeks without any explanation until corrections officials determined where to place him. During that time he was denied access to showers, clean clothing, telephone calls, commissary, visitation, job assignments, and writing materials. Corrections officials have also placed deaf prisoners into solitary confinement for failing to respond to spoken commands they *could not hear*. Deaf prisoners also reported being disciplined for communicating in American Sign Language—actions which were interpreted by corrections staff as threatening.

This report draws from interviews with currently and formerly incarcerated people with disabilities, disability rights advocates, prisoner rights’ advocates, medical experts, legal scholars, and correctional officials and examines the conditions of confinement, harms, and challenges facing prisoners with physical disabilities in solitary confinement. In addition, this report fills some of the gaps in data and, where possible, builds on existing data to provide a snapshot of (1) the number of people with physical disabilities; (2) the number of prisoners with physical disabilities in solitary confinement; and (3) the volume of grievances filed by prisoners with disabilities in 10 state prison systems: California, Florida, Georgia, Illinois, Louisiana, Nevada, Ohio, Pennsylvania, Rhode Island, and Virginia. Finally, the report closes by discussing the available legal protections and by offering a set of recommendations to federal, state, and local officials and policymakers to guide reforms for prisoners with physical disabilities in solitary confinement.

KEY FINDINGS

The large population of prisoners with physical disabilities makes it imperative that we address the challenges they face in prisons and jails lest the needs of this sizable group go unmet. The large proportion of people with disabilities in prisons and jails nationwide likely means that this group makes up a significant share of those held in solitary confinement. However, there is *no publicly available data on the number of prisoners with disabilities in solitary confinement* or any other form of restrictive housing. With few exceptions, corrections departments have no data, incomplete data, or inaccurate data on people with disabilities in their systems. Without accurate data, there is no way to tell exactly how many are subjected to the harms of solitary confinement and no way to properly ensure that their basic human needs—food, water, shelter, and medical and mental health care—are met.

TABLE 1: PRISONERS AS A PERCENTAGE OF TOTAL CUSTODY POPULATION¹ BY STATE AND DISABILITY

	Blind* and/or Deaf	Total Disability	Mobility, Assistive Devices, and Special Passes**
California	2.03%	8.07%	5.38%
Florida	≤1.0%	2.29%	20.93% [†]
Georgia	≤1.0%	3.28%	3.10%
Illinois	Does not track data	Does not track data	Does not track data
Louisiana	1.08%	1.21% [†]	2.55%*
Nevada	≤1.0%	Did not provide data	Did not provide data
Ohio	1.45%	3.98% [†]	N/A
Pennsylvania	4.46%	7.06% [†]	7.07%*
Rhode Island	≤1.0%	1.47% [†]	1.31% [‡]
Virginia	≤1.0%	N/A	N/A

* Does not include persons whose vision can be corrected with prescription glasses.
** We cannot be certain how reflective this category may be of total population numbers, as prisoners with disabilities might have multiple devices or none.
[†] Refers to where public records responses resulted in incomplete data, or data that was inconsistent across categories of disability.
[‡] Refers to assistive devices and special passes, such as access to lower bunks or assistance from an attendant.

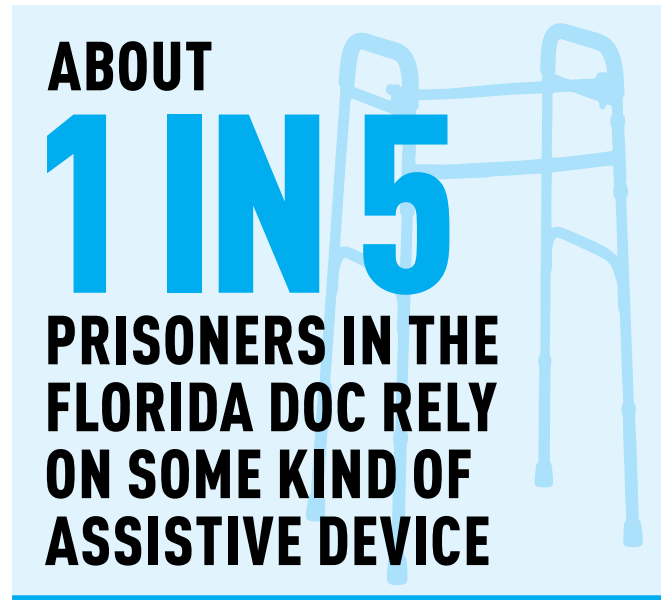
Population Data

A few findings with respect to population numbers are important to highlight:

- Almost 1 out of 10 prisoners in the state of California report or have been identified as having a hearing, visual, and/or mobility-related disability.
- Approximately 21 percent of prisoners in the Florida Department of Corrections (DOC) have been assigned some kind of assistive device or special pass (e.g., access to lower bunks, assistance from an attendant, etc.).
- Almost 1 in 20 prisoners in state-run prisons in Pennsylvania have been identified as blind or low vision and/or deaf or hard of hearing.
- The Illinois DOC does not track data on the number of prisoners who have disabilities or the nature of their disabilities.

Grievances

Corrections departments have not developed systems to monitor grievances or formal complaints filed by prisoners with disabilities. Grievances are one of the only means by which prisoners can seek help, notify corrections staff of their individual needs, or raise other issues with corrections staff and officials. By not monitoring the number of grievances filed or keeping records of whether a particular grievance was addressed and resolved, corrections officials limit their ability to properly address the challenges and meet the needs of prisoners with physical disabilities.



Denied the opportunity to seek help and shut off from systems of redress, prisoners with physical disabilities are left *even more vulnerable* in these correctional institutions. The responses as relate to the grievances filed by prisoners with physical disabilities produced some notable findings:

- The Florida DOC reported 792 grievances filed by prisoners with disabilities from January 2013 through January 2015. However, the department reported that only 44 of those grievances were resolved during that same time period.³
- The Ohio Department of Rehabilitation and Correction reported that approximately 1,839 prisoners in its state-run facilities have a disability, but reported only three grievances filed by prisoners with disabilities from January 2013 through January



2015. It reported that all three grievances were resolved.⁴

- The Pennsylvania DOC reported that 132 grievances were filed by prisoners with disabilities from January 2013 through January 2015. It did not have records to track whether those grievances were resolved or pending as of January 2016.
- The Louisiana DOC reports that 186 grievances were filed by prisoners with disabilities from January 2013 through December 2015. According to the department's reported data, only 10 grievances were resolved during the same time period.
- The Illinois and Virginia DOCs do not maintain records that track information on grievances filed by prisoners with disabilities.

Key Recommendations

To address the challenges faced by prisoners with physical disabilities and to end the overreliance on solitary confinement by correctional systems, this report offers the following key recommendations:

TO CORRECTIONAL OFFICIALS:

- End all placements of prisoners with physical disabilities into solitary confinement where their disabilities will be worsened by such placements.
- Prohibit all placements of prisoners with physical disabilities into solitary confinement due to a lack of accessible cells.
- Provide all accommodations, including assistive devices and auxiliary aids, to prisoners with physical disabilities who are held in solitary confinement, unless a substantial and immediate security threat is documented. In such cases, alternative arrangements must be made and documented.
- Establish data procedures to improve tracking and monitoring of prisoners with physical disabilities in prisons and jails, including the number of people with disabilities and those in solitary

confinement, or other forms of restrictive housing, and the reasons for their placement.

TO THE DEPARTMENT OF JUSTICE:

- Audit prisons on an annual or biannual basis to evaluate whether corrections facilities have completed building and programming evaluation plans or are otherwise in compliance with the regulations governing public entities under Title II of the Americans with Disabilities Act.
- Augment existing guidelines on the treatment of prisoners in solitary confinement, or restrictive housing, found in the DOJ Report and Recommendations Concerning the Use of Restrictive Housing, to include prisoners with physical disabilities consistent with the recommendations in this report.

TO CONGRESS:

- Enact appropriate legislation requiring state and local jurisdictions to track the number of people with disabilities and those in solitary confinement, or other forms of restrictive housing, and the reasons for their placement, in their state and local corrections institutions.
- Enact appropriate legislation to provide increased federal funding for Protection & Advocacy organizations to engage in monitoring and oversight of correctional institutions to increase their capacity to advocate on behalf of prisoners with physical disabilities more broadly.
- Pass the Solitary Confinement Reform Act (S. 3432) introduced by Senator Dick Durbin (D-IL) to reduce the use of solitary confinement, improve conditions of confinement, and provide protections that limit time spent in solitary confinement for prisoners held in the custody of the Federal Bureau of Prisons (BOP). This bill also prohibits BOP officials from placing prisoners with physical disabilities into solitary confinement, unless certain conditions are met, in cases where a licensed medical professional has determined that solitary confinement would exacerbate existing disabilities.

I. INTRODUCTION

Robert Dinkins is paralyzed from the waist down and uses a wheelchair. Prison officials confiscated his wheelchair when he was placed in solitary confinement, “forcing him to crawl” around on the ground and “eat [his] meals on the floor.”⁵

Damon Wheeler is hard of hearing. He alleged that he was unable to access his hearing aids for 86 days after prison officials confiscated them prior to transferring him into the Special Housing Unit, a form of solitary confinement.⁶

Abdul Malik Muhammad is blind. He alleges that he was kept in solitary confinement for six weeks in part because prison officials did not know where to place him.⁷ During those six weeks, he was denied access to showers, fresh clothes, recreation, telephone calls, and visitation.⁸

J.M. is a deaf prisoner.⁹ He reports that he was held in solitary confinement for two weeks for failing to respond to an oral command that he could not hear and that was spoken behind his back by a corrections staff member.¹⁰

Solitary confinement past 15 days can amount to torture.¹¹ Locked in cells roughly the size of a parking space, prisoners are confined alone in their cells for approximately 22 hours a day or more, in a maximum-security environment, with little to no human interaction or access to natural light. Most of life’s daily activities—from dressing to grooming to using the toilet—take place within the confines of a small cell. On those rare occasions when prisoners are permitted to leave their cells—for example, to go to the exercise yard—they must be escorted by prison security staff, often while shackled with chains tied tightly around the ankles, waist, and wrists. Many are strip-searched every time they

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IN THE U.S.

leave their cells. Prisoners are typically unable to participate in work opportunities or rehabilitative programming, such as educational courses or vocational training programs.

Given these highly restrictive and isolating conditions, it is not surprising that solitary confinement is known to inflict acute and devastating mental and physical harms upon prisoners.¹² Yet, despite these harms, corrections officials

continue to overuse solitary confinement in prisons and jails across the nation. On any given day, approximately 80,000 to 100,000 persons¹³ are held in conditions amounting to solitary confinement in the United States. Some languish in isolation for months, years, and even decades.¹⁴ This continued overuse of solitary confinement is an affront to one of the foundational and professed goals of incarceration: rehabilitation. Solitary confinement prevents prisoners from participating in rehabilitative programming. Instead, solitary confinement ruins lives. It often leaves those subjected to its harms worse off or irrevocably damaged.

Recent advocacy focused on ending solitary confinement has sought to roll back more than four decades of “tough on crime” rhetoric and policies, which have led to mass incarceration,¹⁵ hyper-incarceration,¹⁶ and the overemphasis on punitive rather than rehabilitative approaches to crime and punishment. The movement to end solitary confinement has had tremendous success in recent years—and calls for reform have come from the highest offices in the land, including from both President Barack Obama¹⁷ and Supreme Court Justice Anthony Kennedy.¹⁸ Legislative campaigns and litigation at the state and local levels have been successful in ending indefinite placements in solitary confinement;¹⁹ enacting state laws and policies that limit the use of solitary confinement for vulnerable groups,²⁰ such as youth, pregnant women, and persons with mental disabilities; and garnering national attention on the practice through human rights reports²¹ and congressional hearings.²² Perhaps the most poignant message has come from prisoners themselves after thousands participated in a 60-day hunger strike beginning in July 2013 to protest the long-term isolation of prisoners at California’s Pelican Bay State Prison.²³

Despite these successes, considerably less attention has been paid to one of the most vulnerable groups harmed by the pervasive use of solitary confinement: people with physical disabilities. People with physical disabilities are often placed into solitary confinement for the same reasons as those who do not have disabilities: they were deemed a risk to the safety and security of the corrections institution; they violated a rule; they were identified as a member of a vulnerable group and separated from the general population; or they have a communicable disease. But some people with physical disabilities are placed in solitary confinement for

reasons that have *nothing to do with the safety and security of the corrections institution*. Prisoners and detainees with disabilities may be placed in solitary confinement because there are no accessible housing units in which to hold them, as is the case for prisoners who use wheelchairs. Some have even been punished with solitary confinement for rule violations that were *caused by their disabilities*.

“When I asked why I was being isolated and held in seclusion, I was told that they [would] put me wherever they want whenever they want. All because I had a physical disability, not because I had broken any rules and certainly not because of my financial crime that was the reason I was incarcerated. Simply because I had a physical disability I was made to endure isolation and abuse at an indescribable level.”²⁴

—DEAN WESTWOOD, FORMERLY INCARCERATED AT COFFEE CREEK CORRECTIONAL FACILITY IN OREGON

The placement of people with disabilities into solitary confinement is deeply troubling. People with physical disabilities constitute one of the most vulnerable groups living in isolation in prisons and jails across America. Although all prisoners and detainees rely on staff to provide for their basic human needs—nutritious food, clean water, medical care, and mental health treatment—for people with physical disabilities, their needs and reliance on corrections staff are even greater. People with physical disabilities not only rely on corrections staff to meet their basic human needs, but they also may require additional support to perform everyday tasks, be it support in eating meals, taking showers, getting dressed, or attending medical appointments.²⁵ In addition, prisoners and detainees with physical disabilities typically require accommodations that will provide them with equal access to programs, services, and activities offered in the corrections facility.²⁶ This may include providing them with assistive devices (e.g., canes,

Despite the passage of the Americans with Disabilities Act over 25 years ago, the needs of people with disabilities are not being met in prisons and jails.

wheelchairs, hearing aids, etc.) and services (e.g., sign language interpreters, assistance with dressing, etc.) and/or modifying a set program or curriculum.

In solitary confinement, all are vulnerable to the devastating psychological and physical effects of near-total isolation, and social and sensory deprivation. But, for those with physical disabilities, the harmful effects of solitary confinement may be *even worse*. As explained in greater detail below, people with physical disabilities have unique medical and mental health needs, but many are denied regular access to such care while in solitary confinement. Limited access to health care can exacerbate some existing physical disabilities, and limited to no access to regular physical activity—whether indoor exercise or outdoor recreation—can also be detrimental.

Federal law, most notably the Americans with Disabilities Act (ADA), which was enacted in 1990, establishes comprehensive protections for people with disabilities, including protections from discrimination on the basis of disability and guarantees of equal access. Yet, despite these robust protections, the needs of people with disabilities are not being met in prisons and jails nationwide. Although it has been over 25 years since the passage of the ADA,²⁷ recent litigation and media reports show that by failing to remove architectural barriers, prison officials continue to deny people with disabilities equal access to critical areas in corrections facilities, including housing units, medical centers, recreation yards, law libraries, and visitation rooms. Even

where states have facilities that provide equal access to prisoners with physical disabilities, these facilities have become woefully overcrowded and understaffed.²⁸ In addition, recent court complaints allege that corrections systems continue to deny people with disabilities equal access to prison programs, services, and activities, including educational and vocational courses²⁹ and telephone privileges.³⁰

Beyond this, the barriers preventing equal access to prison programs, services, and activities are heightened for those persons with physical disabilities held in solitary confinement. When held in solitary confinement, all prisoners may be prohibited from participating in programming, including educational and vocational programs, and may be outright denied visitation or telephone privileges. However, even in those corrections systems where prisoners in solitary confinement are offered access to programming, people with physical disabilities are effectively barred from participating due to architectural barriers that can prevent them from accessing the physical location where the programming takes place. Moreover, people with sensory disabilities such as deafness or blindness are often effectively excluded from programming in cases where the materials are not provided in a format that is accessible to them. Locked away and locked out of opportunities to engage in any constructive activity offered by programming, the sensory and social deprivation experienced by these prisoners is magnified. As a result, they languish behind bars in a state of idleness, unable to engage in mental stimulation and constructive activity, leaving them in an environment of near-total isolation.

This report draws from interviews with current and formerly incarcerated people with disabilities, disability rights advocates, prisoner rights' advocates, medical experts, legal scholars, and correctional officials and examines the conditions of confinement, harms, and challenges facing prisoners with physical disabilities in solitary confinement. In addition, this report fills some of the gaps in data and, where possible, builds on existing data to provide a snapshot of (1) the number of people with physical disabilities; (2) the number of prisoners with physical disabilities in solitary confinement; and (3) the volume of grievances filed by prisoners with disabilities in 10 state prison systems: California, Florida, Georgia, Illinois, Louisiana, Nevada, Ohio, Pennsylvania, Rhode Island, and Virginia. Finally, the



Photo: shepard sherbell/Getty

report closes by discussing the available legal protections and by offering a set of recommendations to federal, state, and local officials and policymakers to guide reforms for prisoners with physical disabilities in solitary confinement.

A. WHY WE MUST ACT NOW

People with disabilities comprise a large proportion of the prison and jail populations. What's more, crowded, decrepit, unsanitary, and violent prisons heighten the vulnerabilities, unmet needs, and serious pain and suffering inflicted on those persons with disabilities. The challenges they face will only increase as the prison population ages, as will the magnitude of the harms experienced if these issues

go unaddressed. This calls for a complete reexamination—and in some cases, overhaul—of prison and jail policies governing the treatment of people with disabilities.

1. Disabilities Are Common in Prisons and Jails

A recent study by the U.S. Department of Justice estimates that 32 percent of prisoners and 40 percent of jail detainees report having at least one physical or cognitive disability.³¹ The data shows that the proportion of people with disabilities far outnumbers the incidence rates in populations outside prisons and jails, where about 10.9 percent of persons report having a disability.³² Given the large proportion of prisoners with physical disabilities, it is even more imperative to address the challenges they face in prisons and jails to ensure that the needs of this group do not go unmet.

2. Heightened Vulnerabilities

America's prisons and jails are dangerous and dehumanizing places.³³ Recent media exposés and court cases tell stories of deplorable living conditions,³⁴ woefully inadequate medical and mental health care,³⁵ sexual abuse and rape,³⁶ and allegations of purposeful starvation.³⁷ Gripping accounts of neglect,³⁸ abuse,³⁹ riots,⁴⁰ suicides,⁴¹ and violence⁴² amongst prisoners and by corrections staff⁴³ reveal—with few exceptions—nationwide failures of epic proportions and systems ill-suited to manage the task of true rehabilitation. These accounts fly in the face of our constitutional protections against cruel and unusual punishment and contribute to human suffering on a massive scale.

Hidden among these systemic failures are people with disabilities—mental and physical—left to languish in despair, isolated, shut off, and prohibited from gaining equal access to programs and services. The brutality of prison and jail life in America means that prisoners face a serious risk of physical and psychological harm, especially in those facilities that are overcrowded and understaffed.⁴⁴ In these environments, those with physical disabilities may be just as susceptible to sexual assault as are those prisoners with mental illnesses or psychiatric disabilities,⁴⁵ as well as physical and mental abuse⁴⁶ due to their perceived vulnerabilities.

**32%
OF PRISONERS AND
40%
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REPORT HAVING AT
LEAST ONE DISABILITY**



Though there is limited research on the prevalence of sexual abuse among incarcerated people with disabilities, if rates mirror those found in the free world, there is reason to believe that people with disabilities experience victimization at disproportionately higher rates. According to one report, people with disabilities were three times more likely than non-disabled people to be victims of violent crime.⁴⁷ This is particularly true for people with physical disabilities, who are even more vulnerable in corrections environments. The high level of violence in corrections facilities exposes all prisoners to a heightened risk of physical harm. In turn, corrections officials may turn to solitary confinement as a means to protect prisoners from harm.

According to court complaints, human rights reporting, and media accounts, people with physical disabilities have been the subject of harassment, taunting, and ridicule both by other prisoners and even by corrections staff.⁴⁹ For instance, people who are blind or low vision face acute vulnerabilities in prisons and jails.⁵⁰ They may be vulnerable to physical violence,⁵¹ including stabbings and sexual assaults, as well as robbery and theft. They are often the subject of harassment and ridicule.⁵² Some are even taunted for purportedly “faking” their disability, which in turn exposes them to serious

harm due to the failure of corrections staff to take seriously and properly accommodate those disabilities.

The harms experienced by people with disabilities due to their heightened vulnerabilities are morally untenable and practically unnecessary, especially considering that people with physical disabilities are often held in protective custody, a version of solitary confinement, on account of these heightened vulnerabilities to physical violence, sexual assault, and harassment. Though some prisoners may have to be separated from the general population to protect them from harm, these same prisoners should not be forced to endure the extreme social and sensory deprivation of solitary confinement as a condition of their safety. Reducing the number of prisoners with disabilities exposed to solitary confinement will require addressing and ending the violence and abuse that have tragically come to characterize prisons and jails across the country.

B. WHY IT CAN GET WORSE

1. Crowded Prisons

Overcrowding is a serious problem in corrections institutions across the country. According to the most recent data from the Bureau of Justice Statistics, prison overcrowding—above 100 percent capacity—remains a serious issue in many states, including Alabama (192.7%),⁵³ California (136.6%),⁵⁴ Colorado (115.1%),⁵⁵ Delaware (161.7%),⁵⁶ Hawaii (159.2%),⁵⁷ Idaho (109.3%),⁵⁸ Illinois (171.1%),⁵⁹ Iowa (112.8%),⁶⁰ Kansas (104.1%),⁶¹ Kentucky (104.5%),⁶² Louisiana (119.3%),⁶³ Maine (103.1%),⁶⁴ Massachusetts (130%),⁶⁵ Minnesota (101.3%),⁶⁶ Missouri (100.7%),⁶⁷ Nebraska (159.6%),⁶⁸ New Hampshire (124.3%),⁶⁹ New York (102.8%),⁷⁰ Ohio (131.9%),⁷¹ Oklahoma (115.7%),⁷² Pennsylvania (101.2%),⁷³ Vermont (117%),⁷⁴ Virginia (117.6%),⁷⁵ Washington (102.6%),⁷⁶ West Virginia (126.3%),⁷⁷ and Wisconsin (131.4%),⁷⁸ as well as the Federal Bureau of Prisons (128%).⁷⁹

Prison overcrowding compromises the quality of care for and safety of people with disabilities. First, prisoners held

Deaf-Blind Prisoner Faces Abuse

One report sheds light into the abuse experienced by a deaf-blind prisoner in Florida—abuse that can later serve as the justification for placements into solitary confinement:

One deaf-blind prisoner at [Tomoka Correctional Institution] has the intellectual capacity of a young child. He is constantly subjected to sexual assault. Multiple elderly (70+ years old) wheelchair users are housed [t]here and are beaten by their impaired assistants.

These impaired assistants regularly withhold food and refuse to take blind or wheelchair bound prisoners to the bathroom or shower if these individuals do not perform sexual acts for or with these and other persons. They have been known to spend days in their own feces and urine, afraid or unable to leave their cells. Two of our deaf prisoners attempted to help the blind guys when they could by helping them get showers from time to time. These prisoners (blind and wheelchair users) are beaten (bones have been shattered and heads split open) when they complained to guards.⁴⁸

in overcrowded prisons are often exposed to decrepit and unsanitary living conditions⁸⁰ and have limited access to medical care⁸¹—even in cases involving serious health emergencies. Second, overcrowded prisons can contribute to an increase in incidents of violence,⁸² particularly for prisoners with psychiatric disabilities who cannot cope with the stress of incarceration and/or are unable to control their behavior.⁸³ Increased violence may lead to rule violations by prisoners, which in turn leads to greater reliance on punitive forms of punishment for those violations using sanctions like solitary confinement. Third, overcrowded prisons place an additional financial strain on corrections systems already struggling with limited funding⁸⁴ and/or staffing shortages.⁸⁵ As a result, though people with disabilities are entitled to equal access under the ADA, in practice overcrowding limits the ability of corrections systems to provide such access.⁸⁶ Criminal justice and disability rights advocates alike should be concerned that overcrowded prisons will result in people with disabilities continuing to be denied equal access to programs, services, and activities in prisons and jails nationwide.

2. Aging Prisoners

Research indicates that as the prison population ages, the number of prisoners living with physical disabilities in American prisons will also increase significantly.⁸⁷ From

2007 to 2010, the “number of sentenced prisoners aged 65 or older increased by 63 percent, while the overall population of sentenced prisoners grew only 0.7 percent in the same period.”⁸⁸ Lengthy prison sentences and an increase in the age of prisoners entering the system, as well as parole policies that offer limited chances for release,⁸⁹ have all contributed to the growth of the elderly prison population. As the elderly prison population grows, so too will the cost of providing adequate medical care to meet the needs of these prisoners.⁹⁰ With each passing year, it will become even more imperative that prison and jails nationwide work to address the needs of prisoners with disabilities—without excluding them from prison programs, services,

**Prison overcrowding
compromises the quality
of care for and safety of
incarcerated people with
disabilities.**

and activities, and without resorting to harmful practices like solitary confinement.

C. SCOPE OF THE REPORT AND DEFINITIONS

This report discusses the challenges facing prisoners with physical disabilities in solitary confinement—why prisoners with physical disabilities are placed into solitary confinement and the harmful effects of the conditions of their confinement. In addition, this report captures some of the general challenges and hardships faced by people with disabilities in correctional settings, such as lack of access to proper medical and mental health care, as well as rehabilitative therapy, programming, visitation, and other necessities.

An initial challenge of studying prisoners with disabilities is that the definition of what constitutes a disability is broad.⁹¹ There are a variety of physical disabilities, and each one manifests itself uniquely in each individual. Another limitation is that there is no precise definition of disability across state and federal corrections institutions.⁹² The broad diversity and scope of physical disabilities cannot be covered adequately in one report. Given that, the report focuses on physical disabilities commonly found in correctional settings: hearing, vision, and mobility-related disabilities.

This report uses the following definitions:

Accommodation: Any (1) alterations to the physical plant, structure, or environment of a building; (2) modification to a program curriculum, format, or schedule; or (3) equipment, aide, assistance, or support that is provided to allow a person with a disability to gain access to a program, service, or activity.

Mobility-related disabilities: Disabilities that affect one’s ability to ambulate, or move around. This includes disabilities that result from “congenital conditions, accidents, or progressive neuromuscular diseases [and] may include conditions such as spinal cord injury

(paraplegia or quadriplegia), cerebral palsy, spina bifida, amputation, muscular dystrophy, cardiac conditions, cystic fibrosis, paralysis, polio/post polio, and stroke.”⁹³ For example, prisoners with mobility-related disabilities would include those who use wheelchairs (including manual or electric wheelchairs), walkers, prosthetic devices, or special shoes.

Deaf or hard of hearing: Persons who are deaf have “hearing loss so severe that there is very little or no functional hearing.”⁹⁴ The lowercase “deaf” will be used to refer to “the audiological condition of not hearing,” and the uppercase “Deaf” will be used to “refer[] to a particular group of Deaf people who share a language—American Sign Language (ASL) [or other signed languages] and a culture.”⁹⁵ People who are hard of hearing have hearing loss, but “there may be enough residual hearing that an auditory device, such as a hearing aid or FM system . . . provides adequate assistance to process speech.”⁹⁶

Blind or low vision: *Legally blind* is “[a] level of visual [disability] that has been defined by law to determine eligibility for benefits. It refers to central visual acuity of 20/200 or less in the better eye with the best possible correction, or a visual field of 20 degrees or less.”⁹⁷ *Low vision* refers to “[v]ision loss that may be severe enough to impede a person’s ability to carry on everyday activities, but still allows some functionally useful sight. Low vision may be caused by macular degeneration, cataracts, glaucoma, or other eye conditions or diseases. Low vision may range from moderate impairment to near-total blindness.”⁹⁸

Deaf-blind: People with combined visual and hearing loss that “cause difficulties with communication, access to information[,] and mobility.”⁹⁹

Assistive devices: Devices that help facilitate access to programs, services, and activities by helping to “maintain or improve an individual’s functioning and independence . . . [and] prevent impairments and secondary health conditions.”¹⁰⁰

Assistive devices for persons with spinal cord injuries include manual wheelchairs, motorized wheelchairs, ramps, and lower bunks.¹⁰¹ Additional assistive devices include crutches, walkers, artificial limbs, canes, orthotics, special footwear, bottom bunks, shower chairs, grab bars in the shower, and special bedding.¹⁰²

Auxiliary aids and services: Auxiliary aids and services are devices that facilitate effective communications with people with sensory or communication disabilities (e.g., hearing, seeing, speaking, etc.). Auxiliary aids and services for people who are blind or low vision include Braille material, books on tape, glasses, canes, readers, access to magnifiers, large-print material, closed-circuit TV, talking computers, zoom text software, scanners, talking watches, electronic vending, and TDD Telephones.¹⁰³ Auxiliary aids and services for people who are deaf or hard of hearing include video phones, visual notification systems, TTDs, TTY phones, hearing aids and batteries, cochlear implants and chargers, sign language interpreters, closed captioning, strobe lights, flashing alarms, shake awake alarms, and pocket talkers.¹⁰⁴

D. METHODOLOGY

This report draws from evidence obtained from a variety of sources, including firsthand interviews with prisoners, formerly incarcerated individuals, lawyers, disability rights advocates, service providers who work in prisons and jails, and current and former corrections personnel; policies and data obtained through public records requests submitted to state Departments of Corrections; court pleadings and judicial opinions; articles from news outlets; and academic journals.

The report includes data gathered from 10 state Departments of Corrections. Public records requests were submitted to 10 jurisdictions for information on the numbers of prisoners with mobility, hearing, and visual disabilities. Responses were obtained from 10 jurisdictions; the responses ranged

in scope and comprehensiveness. These 10 jurisdictions are discussed in order to provide a glimpse into the practices of state Departments of Corrections and were chosen to provide variation in prison population size, geography, and capacity.

There are a few limitations with the methodology for this report. First, because there is no single definition of disability across state Departments of Corrections, the definitions of disability provided in the public records requests may not have captured all the prisoners with disabilities in a particular state prison system. For instance, if the public records request sought records for all persons with “mobility impairments” and the state Departments of Corrections instead tracks persons with “spinal cord injuries,” the responsive documents may not have included the full range of mobility-related disabilities. As a result, the records produced in response to the request may have been under-inclusive. To address this problem, where possible, the public records requests were drafted to include the state’s own definition of disability, or multiple definitions of disability, to ensure the broadest coverage possible.

Second, the data on incidence rates in this report reflects estimates based on self-reported data from 10 state Departments of Corrections. In some cases, the data responses received from the state Departments of Corrections were inconsistent across states. For instance, where states did provide data on mobility-related disabilities, there were some that collected data on all mobility-related disabilities represented in the state prison system, others that tracked only the number of assistive devices distributed as a way to capture the number of prisoners with mobility-related disabilities, and still others that tracked some mobility-related disabilities and not others. These variations in data collection make it somewhat difficult to standardize results across states. Where possible, the data charts and analyses note where distinctions exist in the self-reported data.

E. A NOTE ON LANGUAGE

This report adopts both “people-first” language and “identity-first” language when discussing people with disabilities. As prominent disability rights scholars and activists have noted, “[p]eople first language [aims] to avoid perceived and subconscious dehumanization when discussing people with disabilities[.]”¹⁰⁵ “The basic idea is to improve a sentence structure that names the person first and the condition second, i.e. ‘people with disabilities’ rather than ‘disabled people,’ in order to emphasize that they are people first.”¹⁰⁶ Alternatively, the identity-first language rejects people-first language as an attempt to separate a person’s disability from that person’s identity.¹⁰⁷ Advocates for identity-first language contend that a person’s disability cannot be separated from that person’s identity and that “disability plays a role in who the person is, and reinforces disability as a positive cultural identifier.”¹⁰⁸ According to experts in disability rights and culture, “[i]dentity-first language is generally preferred by self-advocates in the autistic, deaf, and blind communities.”¹⁰⁹ Accordingly, identity-first language will be used when referring to deaf or blind people. Finally, the report is grounded in the perspectives of disability scholars who argue that “disabled people have redefined the problem of disability as the product of a disabling society rather than individual limitations or loss[.]”¹¹⁰

It is also important to note that effective reforms aimed at removing barriers and ensuring equal access for prisoners with disabilities must adopt an intersectional lens. An intersectional lens recognizes that people with disabilities have a diversity of lived experiences¹¹¹ and possess multiple identity traits¹¹² that may intersect and overlap to compound the forms of marginalization and oppression they experience while incarcerated. Due to the well-known racial disparities¹¹³ of mass incarceration, it is not surprising that many disabled persons identify as members of historically marginalized racial minority groups.¹¹⁴ They may also identify as gay, lesbian, bisexual, transgender, or gender non-conforming.¹¹⁵ Furthermore, according to the most recent report by the Bureau of Justice Statistics, it is estimated that 56 percent of state prisoners, 45 percent of federal prisoners, and 64 percent of jail detainees have a mental health issue.¹¹⁶ Given that, it is likely that incarcerated persons with physical disabilities will also have a history of psychiatric disability. Taken together, it is not surprising

that those with physical and mental disabilities struggle to adapt to the frequently harsh conditions of prison life—in some cases, leading to tragic outcomes.¹¹⁷ Reforms that address the challenges facing people with disabilities must provide intersectional solutions that acknowledge the many ways that they may be marginalized in prisons and jails nationwide.

II. SPOTLIGHT ON TARGET JURISDICTIONS

There is no publicly available data on the numbers of people with disabilities in solitary confinement.¹¹⁸ Information is also limited as to the types of physical disabilities that exist within state and federal prison populations. Although data on the exact number of prisoners with disabilities in jails, prisons, and detention centers across the nation is difficult to locate, by some estimates *at least* 26 percent of state prisoners nationwide report possessing a hearing, visual, or physical disability.¹¹⁹ Including cognitive disabilities and disabilities that limit the ability to independently care for oneself increases the proportion of people with physical disabilities in prisons and jails to 32 percent and 40 percent percent, respectively.¹²⁰ Moreover,

People with disabilities are overrepresented in prisons and jails.

as noted, over half of state prisoners, 45 percent of federal prisoners, and 64 percent of jail detainees have a mental health issue.¹²¹ By contrast, among non-institutionalized persons, approximately 12.6 percent of the U.S. population

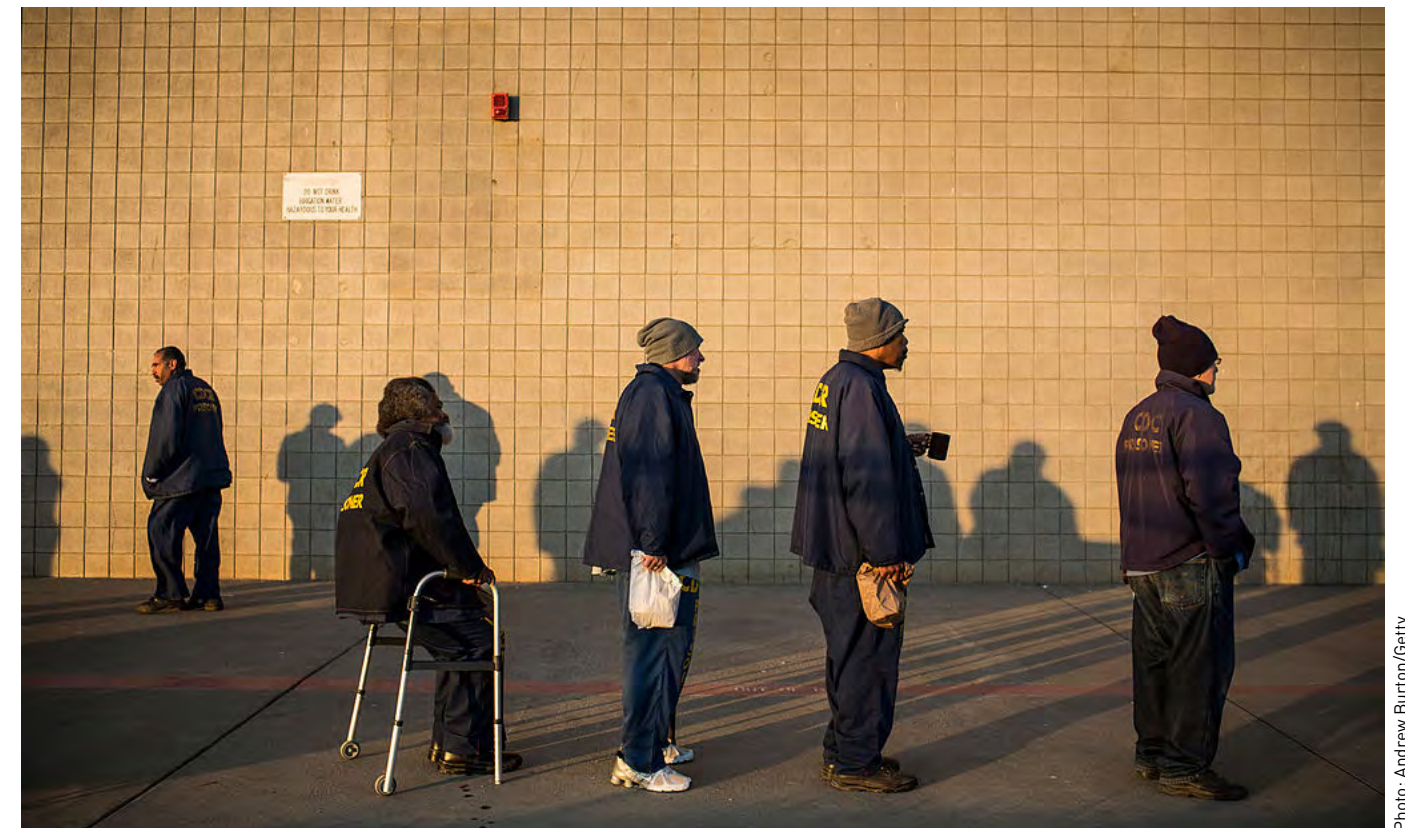


Photo: Andrew Burton/Getty

reports possessing a disability.¹²² Based on this data, it is clear that people with disabilities are overrepresented in prisons and jails.

The lack of publicly available data on the number of prisoners with disabilities is concerning. Reforms to end solitary have emphasized that is it overused and unjustified, especially for vulnerable populations including prisoners with disabilities. Yet, without data to track the number of prisoners with disabilities, their location within the local, state, or federal correctional system, or the nature of their disabilities, it will be nearly impossible to provide accommodations for these prisoners,¹²³ determine the extent to which this group is subjected to the overuse of solitary confinement, or whether reform efforts, in the states that have pursued them, have been effective in removing prisoners with disabilities from solitary confinement. For the corrections systems, such information is essential to measure the effectiveness of efforts to reform solitary confinement. For outside advocates, such data will be necessary in order to provide transparency and hold correctional systems accountable. Finally, without data on the volume of prisoners with disabilities, or the nature of their disabilities, it will be difficult to ensure that their needs—whether access

to critical areas in a correctional facility, assistive devices, or other accommodations—are met while in prison. At a minimum, correctional systems must be accountable for keeping careful, comprehensive, and accurate records that identify the number of persons in solitary confinement, or any other type of restrictive housing, and their specific disabilities and corresponding needs.

This report aims to fill some of the gaps in data and builds on existing data by providing a snapshot of both the number of prisoners with physical disabilities and the volume of grievances filed by prisoners with disabilities in 10 state Departments of Correction: California, Florida, Georgia, Illinois, Louisiana, Nevada, Ohio, Pennsylvania, Rhode Island, and Virginia.

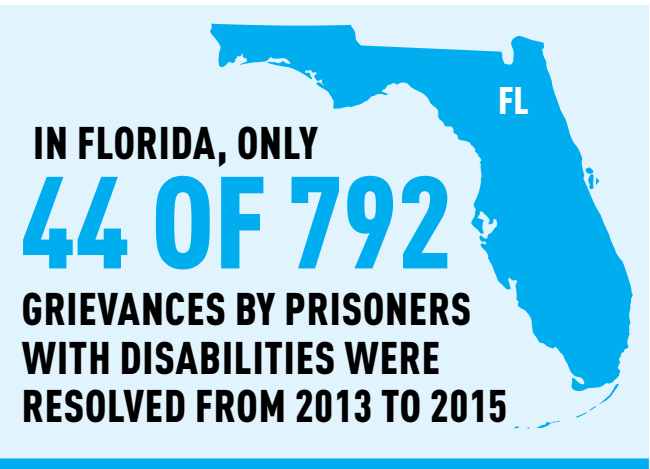
A. POPULATION DATA

The information below provides a snapshot of the number of persons with physical disabilities in 10 state prison systems, along with other indicators, such as the number of

assistive devices and special passes (e.g., for lower bunks or for an attendant) distributed.

A few state-specific findings are important to highlight:¹²⁴

- Approximately 1 out of 10 prisoners in the state of California reports, or has been identified as, having a hearing, visual, and/or mobility-related disability.
- Approximately 21 percent of prisoners in the Florida DOC have been assigned some kind of assistive device or special pass (e.g., passes providing access to lower bunks or permitting the prisoner to have support from an attendant or assistant, etc.).
- Almost 1 in 20 prisoners in state-run prisons in Pennsylvania have been identified as blind or low vision and/or deaf or hard of hearing.
- The Illinois DOC does not track or keep data on the number of prisoners who have disabilities or the nature of their disabilities.
- Although we asked all 10 states to provide data on the numbers of prisoners with physical disabilities in solitary confinement, only two states (Nevada and Georgia) provided records with this information.



physical disabilities means that corrections officials are limited in their ability to adequately respond to the needs of this group. Given the well-known harms of solitary confinement, failure to track and monitor data on grievances filed by prisoners with physical disabilities suggests that prisons have no effective way of knowing about the harms caused by solitary confinement, or addressing those harms. Ultimately, prisoners with physical disabilities are left with little recourse in corrections institutions, leaving them even more marginalized and isolated.

Grievance procedures are administrative processes that allow prisoners to present their requests, complaints, individual needs, or other issues to correctional staff and officials and to seek administrative resolution of those concerns. To initiate the grievance process, a prisoner will fill out a grievance form¹²⁷ and submit the form to the corrections staff member responsible for collecting grievances.

Corrections staff and officials will then review the grievance and submit a response to the prisoner, usually granting or denying the prisoner’s specific request. For instance, if the prisoner requests a shower chair or vibrating alarm, corrections staff and officials may respond by granting the request, or rejecting the request. If the prisoner is dissatisfied with the response from corrections staff, the prisoner may appeal to a higher official within the prison facility. These processes typically require multiple levels of appeal to complete.

There are strict guidelines governing grievance procedures and the specifics of those policies vary by state.¹²⁸ Grievance procedures may set forth strict time limits for filing an

TABLE 2: PRISONERS AS A PERCENTAGE OF TOTAL CUSTODY POPULATION¹²⁵ BY STATE AND DISABILITY

	Blind* and/or Deaf	Total Disability	Mobility, Assistive Devices, and Special Passes**
California	2.03%	8.07%	5.38%
Florida	≤1.0%	2.29%	20.93%†
Georgia	≤1.0%	3.28%	3.10%
Illinois	Does not track data	Does not track data	Does not track data
Louisiana	1.08%	1.21%†	2.55%*
Nevada	≤1.0%	Did not provide data	Did not provide data
Ohio	1.45%	3.98%†	N/A
Pennsylvania	4.46%	7.06%†	7.07%*
Rhode Island	≤1.0%	1.47%†	1.31% ¹²⁶
Virginia	≤1.0%	N/A	N/A

* Does not include persons whose vision can be corrected with prescription glasses.
** We cannot be certain how reflective this category may be of total population numbers, as prisoners with disabilities might have multiple devices or none.
† Refers to where public records responses resulted in incomplete data, or data that was inconsistent across categories of disability.
‡ Refers to assistive devices and special passes, such as access to lower bunks or assistance from an attendant.

Failure to meet the needs of prisoners with physical disabilities exposes them to an increased risk of harm in correctional institutions.

appeal,¹²⁹ specific criteria for what may be included in a grievance form,¹³⁰ or what types of matters may or may not be raised.¹³¹ Additionally, the procedures and policies governing grievance systems—again, the primary mechanism for notifying prison officials of a problem, need, or other concern—are notoriously complex procedures that are too difficult for some prisoners to fully understand.¹³²

At the same time, grievances can provide a vehicle for systematically examining the issues faced by prisoners in a local, state, or federal correctional system. Grievances can provide an overview of common issues arising from prisoners, the responsiveness of the correctional system to those concerns, and the efficacy of any implemented reforms.¹³³ For example, corrections systems with a high proportion of pending or unresolved grievances as compared to resolved grievances will raise concerns about the system’s responsiveness to the issues affecting people with disabilities. In this way, grievances help corrections officials evaluate the effectiveness of specific facilities, or the entirety of their correctional systems, on an aggregate level. Additionally, public access to data on grievances can allow for greater public monitoring and oversight of corrections systems.

Yet, despite the importance of comprehensive tracking mechanisms to monitor the volume and nature of grievances filed by prisoners with disabilities, not only have some corrections systems declined to publish data on the volume and nature of grievances filed by all prisoners, let alone prisoners with disabilities, but some have also failed to track and maintain internal records containing this information.

Ten target jurisdictions were each sent open records requests for information on all grievances filed by persons with disabilities, and the number of those grievances that remain pending or were resolved, in a two-year period. Although the responses varied, overall, the data provided by the jurisdictions was nonexistent, incomplete, or inaccurate. The responses from the 10 jurisdictions as relates to the grievances filed by prisoners with physical disabilities included some notable findings:

- The Florida DOC reported 792 grievances filed by prisoners with disabilities from January 2013 through January 2015. However, the department reported that only 44 of those grievances were resolved during that same time period.¹³⁴
- The Ohio Department of Rehabilitation and Correction reported that approximately 1,839 prisoners in its state-run facilities have a disability, but reported only three grievances filed by prisoners with disabilities from January 2013 through January 2015 and reported that all three grievances were resolved.¹³⁵
- The Pennsylvania DOC reported that 132 grievances related to the ADA were filed by prisoners with disabilities from January 2013 through January 2015. It did not have records to track whether those grievances were resolved or pending as of January 2016.

IN LOUISIANA, FROM
JAN. '13 TO DEC. '15, ONLY
10 OUT OF 186
GRIEVANCES FILED
BY PRISONERS
WITH PHYSICAL
DISABILITIES
WERE RESOLVED



TABLE 3: GRIEVANCES FILED, RESOLVED, AND PENDING FROM JANUARY 2013 TO JANUARY 2015

	No. of grievances filed by prisoners with disabilities, Jan. '13–Dec. '15	No. of grievances filed by prisoners with disabilities that were resolved, Jan. '13–Dec. '15	No. of grievances filed by people with disabilities that are currently pending ¹³⁶
California	No data provided	No data provided	No data provided
Florida	792	44	41 ¹³⁷
Georgia	29	25	8 ¹³⁸
Illinois	Does not maintain or possess records	Does not maintain or possess records	Does not maintain or possess records
Louisiana	186 ¹³⁹	10	0
Nevada	No data provided	No data provided	No data provided
Ohio	3 ¹⁴⁰	3 ¹⁴¹	Does not maintain or possess records ¹⁴²
Pennsylvania	132	Does not maintain or possess records	Does not maintain or possess records ¹⁴³
Rhode Island	1 ¹⁴⁴	1	0
Virginia	Does not maintain or possess records	Does not maintain or possess records	Does not maintain or possess records

- The Louisiana DOC reported that 186 grievances were filed by prisoners with disabilities from January 2013 through December 2015. According to the department’s reported data, only 10 grievances were resolved during the same time period.
- The Illinois and Virginia DOCs do not maintain records that track information on grievances filed by prisoners with disabilities and do not monitor whether those records were pending or resolved.

Failure to track and monitor the volume and nature of grievances—including those filed, resolved, or pending—impedes the ability of the correctional institutions to meet the needs of prisoners with disabilities. By not responding to grievances, or failing to monitor the status of filed grievances to ensure that they are resolved in a timely manner, Departments of Correction effectively cut off prisoners with disabilities from one of the only available mechanisms for seeking assistance or raising even serious concerns

regarding necessary accommodations, safety risks, and medical and mental health care, to name a few.

This failure to meet the needs of prisoners with physical disabilities exposes them to an increased risk of harm in correctional institutions. Cut off from responsive grievance systems, prisoners with physical disabilities are made even more vulnerable to physical injury in cases where the grievance involves threats posed by other prisoners or dangerous conditions due to architectural barriers in facilities. Similarly, unresponsive grievance systems may even result in worsening disabilities where grievances challenging inadequate medical care and the failure to provide proper accommodations, physical therapies, or proper prescription medications go unaddressed by correctional authorities. In light of these harms, it is imperative for corrections systems to develop robust databases with comprehensive information on prisoners with disabilities that can equip systems to address the acute and diverse concerns of this group.

III. SOLITARY CONFINEMENT HARMS PRISONERS WITH PHYSICAL DISABILITIES

Decades of research establishes that solitary confinement inflicts devastating mental and physical harms on human beings.¹⁴⁵ Current research suggests that solitary confinement can not only destroy the human psyche, but it can also result in physical deterioration due to the limited access to exercise, physical therapies, as well as quality medical and mental health care.¹⁴⁶ The physical harms of solitary confinement cannot be easily undone and may lead to long-term disabilities and increased health care

“Back in 2009, I was placed in solitary confinement, a young, healthy man. [T]he disability . . . created, [m]entally and [p]hysically from long term isolation IS inhumane, they are creating animals. . . . The lack of mobility and human contact over a long period of time has destroy[ed] my mind and health[.] I have an unhealthy weight gain and severe lower back pain from only having a 2 foot by 4 foot of space in the cell to move around[.] For 23 hours a day I’m confin[e]d to this place. I have develop[ed] extreme paranoia of others around me and violent thoughts. In the past few years I started having really bad anxiety attacks when I have human to human contact[.] I’ve lost the ability to interact with others.”¹⁴⁹

—D.R., LOUISIANA STATE PENITENTIARY-ANGOLA

costs once the prisoner is released from prison—and over 95 percent of prisoners will be.¹⁴⁷ The result is that prisoners are made worse off by incarceration, and then are released back into the community with greater needs for medical and mental health services due in part to the lack of care or low-quality treatment they received in prison.¹⁴⁸ Prisoners with disabilities are uniquely harmed by the negative health effects of solitary confinement. What’s more, they receive even less access to programs available to prisoners held in solitary confinement because they are not provided with accommodations to allow them to participate in these programs. Due to their disabilities, they are neglected and even more isolated while in solitary confinement.

A. PSYCHOLOGICAL HARM

Prolonged isolation has a devastating effect on human beings. Locked in a cell that is roughly the size of a regular parking space for upwards of 22 hours per day, prisoners in solitary confinement engage in most of life’s basic activities—whether eating, washing, using the toilet, or dressing—all within a few square feet of space. It is no wonder that some, suffering from the psychological harms of solitary, have “become so desperate for relief that they [have] set their mattresses afire,” “[torn] their sinks and toilets from the walls, ripp[ed] their clothing and bedding, and destroy[ed] their few personal possessions,” all in order “to escape the torture of their own thoughts and despair.”¹⁵⁰ In light of these devastating harms, many major U.S. health organizations, including the National Commission on Correctional Health Care, the American Psychiatric Association, Mental Health America, the American Public

Health Association, the National Alliance on Mental Illness, and the Society of Correctional Physicians, have all issued formal policy statements that oppose prolonged solitary confinement, particularly for prisoners with mental illnesses.¹⁵²

Mental health experts studying the issue by and large agree that long-term solitary confinement is psychologically harmful.¹⁵³ A series of scientific studies dating back to the mid-1960s concluded that solitary confinement is psychologically damaging. Persons subjected to solitary confinement have displayed the following: negative attitudes and affect;¹⁵⁴ insomnia;¹⁵⁵ anxiety;¹⁵⁶ panic;¹⁵⁷ withdrawal;¹⁵⁸ hypersensitivity to stimuli;¹⁵⁹ ruminations;¹⁶⁰ cognitive dysfunction;¹⁶¹ hallucinations;¹⁶² loss of control;¹⁶³ irritability, aggression and rage;¹⁶⁴ paranoia;¹⁶⁵ chronic apathy;¹⁶⁶ lethargy;¹⁶⁷ depression;¹⁶⁸ self-mutilation;¹⁶⁹ suicidal ideation and behavior;¹⁷⁰ and lower levels of brain function, including a decline in electroencephalogram (EEG) activity,¹⁷¹ which were observed after only seven days in isolation.¹⁷²

Solitary confinement inflicts psychological and physical damage on human beings.

The astonishingly high rate of completed suicides alone reveals the dangers of solitary confinement. Shockingly, approximately 50 percent of all suicides in prisons happen among the 5 percent to 6 percent¹⁷³ of all prisoners held in solitary confinement.¹⁷⁴ According to a 2014 study, detainees held in solitary confinement in New York City jails were nearly seven times more likely to harm themselves than were those in the general population—youth and people



Photo: Andrew Burton/Getty

with serious mental illness were particularly susceptible to self-harm.¹⁷⁵

The devastating effects of solitary confinement do not end after release. In June 2015, the tragic consequences of solitary confinement came to a head. Kalief Browder, a 22-year-old who was imprisoned on Rikers Island in New York for three years, two of which he spent in solitary, and who was never convicted of a crime, took his own life approximately two years after his release.¹⁷⁶ Like so many prisoners exposed to the horrors of solitary, the harms inflicted upon Kalief extended well beyond release from prison.

Prisoners with physical disabilities are not spared from the devastating toll solitary confinement inflicts upon the human psyche. For those prisoners with existing psychiatric disabilities, the harms of solitary confinement can be compounded.¹⁷⁷ In solitary confinement, access to mental health professionals is usually limited, if offered at all. Even where offered by the correctional institution, prisoners with physical disabilities may be unable to participate in individual and group mental health-focused classes where they require accommodations to facilitate meaningful communications in the classes, or access class locations, and such accommodations are not provided by corrections staff. People with physical disabilities will suffer even greater psychological harms in correctional systems where they do not receive these accommodations that allow them to communicate effectively with mental health professionals.

For example, barriers to communication may make it difficult for prisoners with sensory disabilities to communicate their symptoms or other pertinent information effectively. Prisoners with sensory disabilities may have “increased mental health care needs.”¹⁷⁸ Deaf prisoners or prisoners with severe speech impediments, groups that both experience harassment and abuse in the corrections environment, may lack the accommodations to communicate their needs to mental health professionals, thereby increasing their vulnerabilities to harm in correctional institutions. Without effective communication between mental health professionals and regular access to mental health treatment and therapies, prisoners who are deaf or hard of hearing, and/or blind or low vision, may experience mental and psychological deterioration, diminishing their ability to function in prison.

B. PHYSICAL HARMS

Beyond the damaging psychological effects of solitary confinement, there is also evidence to suggest that the practice can be physically debilitating. Movement in solitary confinement is highly controlled. There is almost no out-of-cell time, and movement outside of one’s cell is usually impeded by required restraints and strip-searches. Beyond this, architectural barriers prevent prisoners with physical disabilities from not only accessing critical areas of the prison, but also from even moving around within their cells. Blanket security policies banning the use of assistive devices within their cells can leave prisoners with physical disabilities with limited ability to care for themselves, perform exercises to avoid total inactivity, or even access food or necessary medications.

Stress and limited access to regular, appropriate health care, including medically necessary prescription and physical therapies, among other factors, can lead to diminished health outcomes for all prisoners.¹⁷⁹ This is especially true for prisoners with physical disabilities. Prisoners with physical disabilities are particularly susceptible to worsening physical health while in prison,¹⁸⁰ as they are likely to “have particular health care needs related to their disability, such

“What I see time and time again is that our clients with disabilities deteriorate rapidly during incarceration. They leave prison in worse condition and with a reduced ability to function independently as compared to how they were when they arrived. Solitary confinement is a big part of this problem. Confining persons with physical disabilities to a cramped cell with no access to assistance from other prisoners and no access to real recreation or programming only serves to impede their progress[.]”

—MAGGIE FILLER, STAFF ATTORNEY, PRISONERS’ LEGAL SERVICES OF MASSACHUSETTS

as physiotherapy, regular eyesight and hearing examinations and occupational therapy.”¹⁸¹

Prisoners with physical disabilities held in solitary confinement are often denied access to the very physical and pharmacological therapies that will help them maintain their health or prevent physical deconditioning. This type of care is difficult to obtain while incarcerated—but the difficulties multiply when prisoners are placed into solitary confinement. For example, a stroke survivor will typically require regular physical, occupational, and speech therapies in order to fully recover from a stroke.¹⁸² Similarly, people with quadriplegia will need specific prescription regimens and routine physical therapies in order to maintain healthy living. Yet, strict schedules in solitary confinement result in disrupted treatment plans where corrections officials refuse to modify schedules to allow these prisoners with mobility-related disabilities to take medications at specific times.

Short Stays in Solitary Confinement Can Be Harmful

Even short stints in solitary confinement can lead to serious physical consequences for people with disabilities. Dean Westwood has quadriplegia. He relies on a motorized wheelchair to ambulate and a host of assistive devices to maintain healthy living and prevent physical decline. He reported that while being booked into an Oregon jail, he was rough-handled by jail staff, pulled from out of his wheelchair, and dressed in clothes that were approximately three times smaller than his normal clothing size. Following the booking process, he was placed alone in a cell and denied access to his anti-spasm prescription medications, as well as medications to prevent him from urinating on himself, for approximately 48 hours.

The combination of the rough handling by staff, tight clothes, and lack of medications resulted in Dean experiencing autonomic dysreflexia. Autonomic dysreflexia occurs when the nervous system goes into overdrive due to the presence of an irritating stimulus

Prisoners with physical disabilities are particularly susceptible to worsening physical health while in prison.

Doctors and health care professionals agree that solitary confinement is harmful to one’s physical health. The National Commission on Correctional Health Care (NCCCHC) has explicitly acknowledged the adverse physical health effects of prolonged solitary confinement. The NCCCHC observed that:

in areas of the body that are paralyzed and, if untreated, may result in a stroke or heart attack. Dean began to experience violent seizures and urinated on himself. For nearly 48 hours, he endured painful muscle spasms alone in an isolation cell in the jail infirmary, where he was placed flat on his back on a bed that neither contained a slide board nor a hoist lift, an assistive device that would have allowed him to get onto and off of the bed. Only after repeated complaints to corrections and medical staff was he finally able to receive his prescription medications to end the painful seizures.

In total, Dean reports that he remained in virtual isolation for a total range of 6-7 days, where he was confined to his cell for 24 hours per day, while Oregon state prison officials worked to find a facility to place him. He was not provided with any materials to occupy the time and states that the only human interaction he had was with corrections staff, and even then those interactions were rare. For Dean, the experience in isolation resulted in an “incalculable mental toll” that continues to trouble him to this day.¹⁸⁵

The inherent restriction in meaningful social interaction and environmental stimulation and the lack of control adversely impact the health and welfare of all who are held in solitary confinement. . . . The World Health Organization (WHO), United Nations, and other international bodies have recognized that solitary confinement is harmful to health. The WHO notes that effects can include gastrointestinal and genitourinary problems, diaphoresis, insomnia, deterioration of eyesight, profound fatigue, heart palpitations, migraines, back and joint pains, weight loss, diarrhea, and aggravation of preexisting medical problems.¹⁸³

Failure to meet the important health care needs of people with disabilities can result in deconditioning, such as the loss of physical fitness or muscle due to limited exercise. In some cases, failure to respond to the health care needs of people with disabilities, even in the short term, can lead to death.¹⁸⁴

1. Architectural Barriers in Facilities

Architectural barriers¹⁸⁶ to access are magnified in solitary confinement. Wheelchairs are often too large to fit inside isolation cells, which are typically no larger than the size of an average bathroom. Even in cases where a wheelchair could pass through the front door of an isolation cell, once inside the cell, a wheelchair user will likely be unable to maneuver within it.¹⁸⁷ Moreover, even where wheelchairs could fit within isolation cells, prison officials have

Architectural barriers to access in prisons and jails are magnified in solitary confinement.

banned wheelchairs where they have decided that having a wheelchair or another assistive device, such as a walker or cane, poses a security risk. Such security policies can result in prisoners with physical disabilities who rely on assistive devices having absolutely no accommodations that will enable them to move around their cell while held in solitary. Finally, because prisoners in solitary have such limited time outside, architectural barriers can keep them inside of their cells even where they are permitted to leave for brief shorts or excursions to the “recreation” yard or cell.

Court cases have captured horrific allegations by prisoners with mobility-related disabilities in solitary confinement. In one case, Tony Goodman “claimed that he was confined for 23–to–24 hours per day in a 12–by–3–foot cell in which he could not turn his wheelchair around.”¹⁸⁸ Goodman also alleged that he was “unable to use the toilet and shower without assistance,” “injured himself in attempting to transfer from his wheelchair to the shower or toilet on his own,” and as a result, was “forced to sit in his own feces and urine while prison officials refused to assist him in cleaning up the waste.”¹⁸⁹ In another case, Jerome Crowder, a federal prisoner, alleged that while in administrative detention, he was unable to use his wheelchair to ambulate in his cell, which led to bedsores and muscular discomfort.¹⁹⁰ Phillip Jaros, who used a walking cane to move around, alleged that he was able to take only four showers per month because the showers at the facility where he resided did not have grab bars and he feared injury.¹⁹¹

Even more troubling is that, though contrary to federal disability law, prisons and jails have placed people with disabilities into solitary confinement because accessible cells were not available. As explained in further detail below, the law requires that accessible cells be provided at every security classification or custody level.¹⁹² In practice, this means that prison officials may not hold prisoners with low security classifications in cells that are located in higher security units simply because those are the only units with cells that can fit wheelchairs. Despite this mandate, not all prison facilities have accessible cells to accommodate prisoners who use wheelchairs at every security level.¹⁹³ And some corrections officials have placed prisoners with disabilities into solitary confinement because cells in less restrictive housing that could safely hold these prisoners were not readily available.

Prisoners with physical disabilities are placed into solitary confinement due to a lack of accessible cells.

The allegations in a recent court complaint demonstrate this problem. Due to a spinal cord injury, Richard Trevino required a wheelchair to move around, along with readily available diapers to manage his incontinence.¹⁹⁴ Trevino was placed in solitary confinement because the Woodbury County Jail where he was booked did not have any cells that could fit his wheelchair.¹⁹⁵ The facility also did not

have any guardrails to allow safe movement around his cell and did not have any assistive apparatus, such as a hoist or transfer board, which would allow him to safely transfer himself into and out of his wheelchair.¹⁹⁶ The toilet and showers in the jail were similarly inaccessible and did not have guardrails, chairs, or other accommodations to ensure his safe use.¹⁹⁷ Trevino’s cell was also not equipped with an emergency call button to allow him to communicate with staff during emergencies.¹⁹⁸ In fact, staff largely ignored Trevino’s request for clean clothes or access to showers, refusing to provide him with a container to house his soiled diapers, which caused his cell to reek with a strong odor.¹⁹⁹ Prison authorities denied him access to programming and prevented him from communicating with other prisoners.²⁰⁰ Isolated and mistreated, Trevino became depressed and started cutting himself.²⁰¹

2. Self-Care

Certain physical disabilities may limit one’s ability to engage in self-care and tend to personal hygiene needs. For example, prisoners with ambulatory disabilities may require assistance and support from health care professionals, or trained corrections staff, to engage in daily tasks, such as showering, dressing, or relieving oneself. The need for assistance with self-care may be temporary or long term depending on the nature of the disability. For instance, prisoners with quadriplegia or paraplegia may have specific medical needs that require regular access to clean medical equipment, such as colostomy and/or urostomy bags that remove urine and other waste in cases where the colon or bladder is no longer functional.²⁰² Without accessible facilities and assistance from health care professionals or corrections staff, people with disabilities often struggle to meet these basic needs in prisons and jails.²⁰³

In solitary confinement, there are limitations on the number and kinds of property that prisoners may keep in their cells. In addition, prisoners have limited access to medical personnel and assistance from correctional staff. These restrictions are purportedly in place for safety and security reasons, but they can create considerable challenges for persons who require regular access to sterile and durable medical equipment and supplies—catheters, pressure socks, colostomy bags, soap to cleanse after handling colostomy

GENERAL PROBLEMS WITH WHEELCHAIR ACCESSIBILITY

1. Broken wheelchairs or lengthy wait times for repair
2. Improper wheelchair size (e.g., wheelchair or foot rest is too small, too large, too heavy, etc.)
3. Architectural barriers (e.g., lack of ramps or elevators, stairs, high curbs, etc.)
4. Failure to provide assistants to push wheelchairs if needed

bags—to properly perform self-care. However, in some cases, access to clean medical equipment has been outright denied, or the equipment provided has been unsterile, improperly maintained, or otherwise not suitable for use.

3. Disrupted Medical Therapies

In solitary confinement, prisoners often have limited access to necessary medical care. To begin with, staffing shortages and limited budgets across correctional systems have in some cases resulted in egregious denials of appropriate medical care.²¹¹ Beyond this, medical therapies are often disrupted in solitary confinement.²¹² Prisoners with disabilities may also come to prison with specific medications and schedules for taking those medications, which are necessary to ensure the efficacy of a particular treatment program. However, prisoners are usually not permitted to keep prescription drugs with them at all times and may only access these prescription drugs at certain times. When it is time to access prescription drugs, medical staff will often come by and observe the prisoner digest the prescription drug.

Such stiff schedules and regulations can impose barriers to optimal therapeutic outcomes for prisoners with physical disabilities. For example, certain prisoners may require prescription medications to assist with chronic muscle pain. The optimal time to take those prescription drugs may be immediately prior to bed time. However, that particular prison facility may have policies and/or practices that allow for medication distribution only during normal business hours—9 a.m. to 5 p.m.—and may not allow the prisoner a modification to the policy to accommodate that circumstance.²¹³ Thus, that prisoner would not be allowed to take their prescription medications at the optimal time. Without modifying the prisoner’s specific medical regimen to accommodate the schedule change, prison authorities can seriously disrupt the prisoner’s treatment program, which may lead to deleterious health effects.²¹⁴

4. Limited to No Physical Activity

Exercise is vital for the physical health of all people.²¹⁶ Limited to no physical activity contributes to a whole host of adverse health outcomes, including decreased muscle mass

Prisoner With Disabilities Denied Proper Prosthetics and Wheelchair in New York State Prison

According to a lawsuit filed in 2014, Mark Gizewski was born with severe disabilities due to side effects of the drug Thalidomide, offered as an antidote to treat morning sickness among pregnant women.²⁰⁴ The drug left Gizewski with hands that were missing fingers, deformities in his limbs, anal abnormalities that caused difficulties with bowel movement, and a left leg that was seven inches shorter than the right.²⁰⁵ New York State correctional officials placed Gizewski into solitary confinement, where he was denied access to necessary cleaning tools and denied the right to shower for approximately six days.²⁰⁶ Gizewski complained that prison staff denied him access to proper pain medications to handle his chronic pain,²⁰⁷ denied him an accessible shower and shower brush to allow him to properly clean himself,²⁰⁸ and refused to replace his prosthetic leg that was too big.²⁰⁹ Prison authorities also refused to provide Gizewski with a lightweight wheelchair, and instead placed him in a heavy wheelchair, which proved difficult to maneuver due to his missing limbs.²¹⁰

and strength (deconditioning),²¹⁷ osteoarthritis in older adults,²¹⁸ and increased risk of developing or worsening hypertension, as well as other diseases, such as cardiovascular disease, heart failure, kidney disease, and even death.²¹⁹

Prisoners with disabilities require regular exercise to maintain overall health or prevent a decline in their physical health. For instance, prisoners with mobility-related disabilities require regular access to physical exercise to maintain proper physical functioning and prevent muscular atrophy, decubitus ulcers, or other problems.²²⁰

“My cell is so small that I can only make four steps forward until I touch the door. . . . [E]ach time that I sit up off the bed I have to watch how I stand up because I’ll hit my hip on the table. It’s just that close. As far as moving about, there is no movement. I have to wait until I go in the yard three days a week in order to stretch my legs out and oil up the joints in my knees. [I have] arthritis, and that has come from me being in this cell.”²¹⁵

—HERMAN WALLACE, FORMERLY INCARCERATED AT LOUISIANA STATE PENITENTIARY-ANGOLA

However, even though the benefits of regular access to physical exercise are well known, prisoners held in solitary confinement have been denied regular access to physical activity. Prisoners typically have limited time out of their cells and little access to outdoor recreation, if any. If outdoor recreation is available, it usually takes place in a small cage located on a yard that offers minimal protection from baking hot or freezing cold weather and limited access to seating and water. This may mean that prisoners must spend one to two hours outside in the freezing cold or unbearably hot weather—sometimes without access to water, shaded areas, or benches to sit on.²²¹

These “recreation” cages are often inaccessible to people with disabilities. Recreational areas may be riddled with structural deficiencies—potholes in the asphalt, cracks in the concrete—all of which create barriers to persons who rely on mobility devices to ambulate. Wheelchairs may not fit into the small cages, and persons who rely on assistive devices like walking canes may not be able to navigate the pathway to and from the recreation cages, particularly where the ground surface surrounding the recreation spaces is uneven, cracked, or otherwise creates unnavigable barriers for people with disabilities. Furthermore, when assistive devices are confiscated for security reasons, prisoners with mobility-related disabilities are prevented from engaging in even therapeutic exercise.²²²

Recent court victories have resulted in prisoners in solitary confinement winning access to exercise and recreational facilities previously denied to them.²²³ Prisoners with physical disabilities have also filed lawsuits challenging exclusion from exercise and recreational facilities. In one such case, Marc Norfleet, a wheelchair user housed in Menard Correctional Center, filed a lawsuit against the Illinois Department of Corrections for allegedly denying him regular access to exercise and recreational facilities, while at the same time “non-disabled inmates receive[d] five to seven hours of exercise and recreation time a week.”²²⁴ The appeals court reviewing Norfleet’s case found that he stated a claim for relief and vacated a district court judge’s decision dismissing the case.²²⁵

5. Physical Therapy

Prisoners with mobility-related disabilities may depend on regular access to physical therapy to maintain proper health and prevent muscular deconditioning. Routine physical therapy, ranging from once per week to multiple times per week, may be needed to prevent deformation of the legs or back.²²⁶ In such cases, proper health care access is needed in order to prevent debilitation, or “further functional decline.”²²⁷

For example, one advocate reported that her client required routine physical therapy to rehabilitate muscles damaged by a gunshot wound and to regain his ability to walk short distances. Despite requests to prison officials, her client struggled to obtain proper physical therapy. After he ended up in segregation, the physical therapy abruptly stopped for months.²²⁸

Prisoners in solitary confinement are often denied access to regular physical activity.

C. REHABILITATIVE HARMS

When held in solitary confinement, prisoners with physical disabilities are often prohibited from participating in any rehabilitative programming, including educational and vocational programs and activities. However, even in those corrections systems where limited access to rehabilitative programming is offered to prisoners in solitary confinement, architectural barriers prevent prisoners who rely on assistive devices from even accessing the physical location where programs and services are held. Prisoners may also be effectively excluded from these programs if they are not provided with assistive devices to allow them to ambulate in the certain areas of the facility where such programs are held, with or without the assistance of custodial staff. Moreover, materials and communications provided in rehabilitative programs are seldom provided in a format that all persons with sensory disabilities can understand.

By failing to provide people with disabilities with reasonable accommodations, or by failing to remove the architectural barriers that may keep them out of designated program areas, prison authorities have effectively barred them from participating in rehabilitative programs. As a result, these prisoners languish behind bars in a state of idleness, unable to engage in rehabilitative programming designed to offer mental stimulation and constructive activity. Locked away and locked out of opportunities to engage in constructive activity or maintain contact with the outside world, the sensory and social deprivation experienced by these prisoners is magnified, leaving them in an environment of near-total isolation. This exclusion is contrary to the purpose and aims of the ADA and other laws protecting the rights of people with disabilities.

Prisoners in solitary confinement are denied access to programs aimed at rehabilitation.

Brian Follmer is a prisoner with neuropathy, which causes pain and weakness and limits his ability to walk.²²⁹ While incarcerated, he has relied on a cane, wheelchair, and wheelchair assistant to move around the facility.²³⁰ After being transferred to Santa Rosa Correctional Institution in Florida, he was placed into solitary confinement and prison authorities confiscated his wheelchair.²³¹ Over Follmer's objections, prison authorities provided him with a walker, which he claimed worsened his condition.²³² Without his wheelchair, he has had difficulty participating in services and activities offered by the prison, including mental health groups offered to prisoners.²³³

D. SOLITARY CONFINEMENT INFLECTS ACUTE HARMS ON PRISONERS WITH SENSORY DISABILITIES

In solitary confinement there is often little to no access to natural light. Some solitary confinement cells have no windows. Artificial lights can be kept on for 24 hours a day. Most cells have a solid steel door with a narrow viewing window and small slot. Communication is highly curtailed, mainly occurring through these small slots designed for food trays, passing mail or medications, or cuffing prisoners prior to their exiting their cells. These harsh and isolating conditions are especially harmful for prisoners with sensory disabilities who experience profound and heightened isolation due not only to the sensory and social deprivation experienced by all prisoners subjected to solitary, but also because they face huge barriers to meaningful communication in correctional environments.

1. Deaf and Hard of Hearing Prisoners

Solitary confinement inflicts acute harms on prisoners who are deaf or hard of hearing. Deaf and hard of hearing people make up a significant portion of state prisoners. Research estimates that “between 35 and 40 percent of all inmates experience some degree of hearing loss, including 13 to 20 percent with significant hearing loss.”²³⁴

Deaf prisoners frequently find themselves isolated and marginalized in correctional institutions due in part to misconceptions about Deaf culture and communication barriers caused by the failure on the part of corrections systems to ensure effective and meaningful communications between deaf prisoners and corrections staff, health care providers, and where permitted, visitors, including family and friends.

Language barriers pose considerable communication challenges. There is a low literacy rate among deaf individuals. Only “[a]bout 10 percent of the deaf school age population grows up to be literate adults reading at the tenth grade or above.”²³⁵ Studies indicate that approximately 30 percent of deaf persons who finish school at age 18 or above read at a 2.8 grade level or below—or are otherwise functionally illiterate.²³⁶ Moreover, approximately 60 percent of deaf adults have a third- to fourth-grade reading comprehension level.²³⁷

In correctional institutions, these low literacy rates are compounded by other language deficiencies, such as “difficulty with all or part of language including grammar, syntax, vocabulary, the social use of language, and using communication effectively.”²³⁸ This results in a disproportionately high rate of people with language deficits in prisons, jails, and juvenile centers.²³⁹

That said, for many Deaf people, American Sign Language (ASL) is their primary language. ASL is a “visual language” through which the “brain processes linguistic information through the eyes,” and where the “shape, placement, and movement of the hands, as well as facial expressions and body movements, all play important parts in conveying that information.”²⁴⁰ Deaf people use their eyes to collect and process information in the same way hearing people use their ears.²⁴¹ Some studies have even found that deaf people have enhanced vision.²⁴² In this way, sighted Deaf people rely on vision to communicate with the outside world. Vision is therefore a vital communication tool for sighted Deaf people.

The bleak and highly restrictive environment of solitary confinement strips sighted Deaf prisoners of the opportunity to communicate with other human beings in any meaningful way. Prisoners who experience hearing loss

Solitary confinement strips sighted Deaf prisoners of the opportunity to communicate with other human beings in any meaningful way.

while incarcerated may face particularly harsh conditions in solitary confinement, as they “may feel even more isolated than other inmates experiencing the same conditions of confinement, since those in isolated confinement with [typical] hearing may be able to have informal conversations by yelling, whereas this opportunity may not be available to those who are [deaf or hard of hearing].”²⁴³ Beyond this, Deaf prisoners most likely arrive at prisons *already* having experienced social isolation. Researchers have discovered that “[deafness] is . . . a significant contributor to social isolation,” and “[e]ven mild hearing loss can impair language processing, negatively affecting health care access and use and leading to changes in cognitive and emotional status.”²⁴⁴ Furthermore, in a typical isolation cell, there is

**BETWEEN
35% AND 40%
OF ALL PRISONERS
EXPERIENCE SOME
DEGREE OF HEARING LOSS**

almost no visual stimulation. Cell walls are gray, windowless, concrete and steel-enforced spaces with few air vents. As a result, deaf or hard of hearing persons in solitary are left without the ability to engage their sense of sight, occupy

Blind or low vision prisoners are denied the chance to engage in prison programming when they are not provided with auxiliary aids and services.

their minds, and connect with the outside world. Taken together, all of these factors can contribute to a heightened sense of isolation for Deaf prisoners and make it such that solitary confinement is experienced much more intensely.

Finally, communication barriers pose huge challenges for Deaf people held in solitary confinement and can further marginalize them in correctional environments. Without accommodations like sign language interpreters, deaf prisoners will be left absolutely isolated, resulting in what some advocates refer to as a “prison in a prison.”²⁴⁵ Isolation and communication barriers will severely undermine deaf prisoners’ ability to adapt and survive the harsh conditions of prison life. This inability to adapt to the harsh conditions of prison life can lead to tragic results. In one case, a 23-year-old deaf man committed suicide after being held in solitary confinement for one month during which he was denied access to a sign language interpreter.²⁴⁶



Photo: Skyward Kick Productions/Shutterstock

2. Blind and Low Vision Prisoners

Prisoners who are blind or low vision rely mainly on their sense of hearing to engage with the world around them. However, in solitary confinement, opportunities to interact and communicate with the outside world are severely limited. These harsh restrictions are particularly severe for blind or low vision prisoners who communicate primarily using hearing and speech. While in solitary confinement, blind or low vision prisoners are unable to regularly engage in verbal communications with other prisoners and have limited meaningful verbal communications with staff—save for the limited and superficial interactions at cell front. Beyond this, in solitary confinement the disorienting and jarring sounds—ranging from prisoners shouting, to industrial fans, to the loud banging sounds that cell doors make when opening and closing—are constant. Such exposure can result in auditory overload, clogging their only means for obtaining information from their surroundings with senseless cacophony.

Moreover, in correctional systems where prisoners in solitary confinement are allowed to occupy the day by reading books, writing, watching television, or participating in hobby craft, blind or low vision prisoners are denied the chance to engage in these constructive activities when they are not provided with auxiliary aids and services, such as audio books or captioned television, to facilitate meaningful participation. With few opportunities for mental stimulation, these blind and low vision prisoners face even harsher conditions in solitary confinement, which can lead to extreme idleness.

Finally, even for sighted prisoners, the austere conditions in solitary confinement may have adverse effects. Due to reduced reliance on eyesight inside the tiny spaces where prisoners in solitary confinement are held, seeing prisoners have even reported diminished eyesight after extended stays in solitary. Uzair Paracha described the experience as follows:

I had Lasik surgery a few years before my arrest and it went well. Yet my eyesight deteriorated threefold in the nine years I was in isolation. We couldn’t see anything beyond a few feet in front of our doors and nothing at all from our window. . . .

I met several prisoners who had to get prescription eyeglasses for the first time in their lives while in the SHU. I mentioned this to the ophthalmologist in ADX and he told me that having your entire world just a few feet away weakens the eyesight.²⁴⁷

3. Communication Barriers

“The public needs to know about [the] limitations Deaf [prisoners] face in [gaining] access to inmate programs & psychological services, needs for staff training for visual communication[,] our need for equal access to outside communication (TDD & Deaf Videophone), or difficulty in daily communication with correctional officers.”²⁴⁸

—DEAF PRISONER, FORMERLY INCARCERATED AT MARYLAND CORRECTIONAL INSTITUTION-JESSUP

In solitary confinement, prisoners are dependent on staff to meet a myriad of basic human needs. When issues or challenges arise, prisoners held in solitary confinement must have the ability to communicate their needs and concerns to corrections staff, particularly during critical encounters such as medical or mental health appointments and emergencies. Communication barriers can be particularly harmful—and magnified—in solitary confinement if corrections staff do not follow measures to ensure effective communications with all prisoners, especially prisoners with sensory disabilities.

For example, in one case, a deaf prisoner alleged that he was placed into solitary confinement following an altercation with another prisoner.²⁴⁹ Robin Valdez claimed that “he was unable to express himself to corrections officers during these incidents due to the lack of sign language interpreters.”²⁵⁰ He “testified that he had poor eye sight,” but required a sign language interpreter to communicate effectively.²⁵¹ He alleged that he was sprayed with chemical

agents on one occasion, was “unable to communicate his injuries to prison staff,” and as a result, received no medical attention.²⁵² During the disciplinary hearing, Valdez also alleged that he was “required to sit in his cell without any way of knowing what was being said, and without any method of communicating his version of events to the hearing officers.”²⁵³ Following the hearing he was found guilty of misconduct.²⁵⁴ In the prison facility where Valdez was held, Vaughn Correctional Center in Delaware, there were allegedly “no policies for accommodating the needs of deaf inmates.”²⁵⁵

“MCI-J has an interpreter onsite Mon–Fri. But when we have appointments (e.g. medical), there is no interpreter. ‘Sorry! We forgot.’ So we reschedule for a second appointment three weeks later, and the interpreter is there. . . . Often officers and staff try to use other inmates to interpret for Deaf inmates.”²⁵⁶

—LETTERS FROM FIVE DEAF PRISONERS, MARYLAND CORRECTIONAL INSTITUTION-JESSUP

In another case, William Pierce, a deaf person²⁵⁷ held in the District of Columbia’s Correctional Treatment Facility,²⁵⁸ was awarded \$70,000²⁵⁹ in damages after a jury found the jail liable for not providing Pierce with any accommodation for his hearing disability, denying him the ability to properly communicate for approximately 51 days. Pierce had alleged that he was denied access to a sign language interpreter during critical interactions with medical staff, and rehabilitative programs, including classes on anger management and graphic design, for approximately 51 days.²⁶⁰ After Pierce submitted multiple requests for an interpreter, he alleged that they retaliated against him by putting him in solitary confinement for two weeks.²⁶¹

Prisoners with sensory and communication disabilities also reported being denied access to services and programs because they were not properly notified. Most—if not all—of

the services received by prisoners in solitary confinement take place within the confines of a cell. Services in prisons are often provided according to rigid schedules, especially for prisoners who are housed in solitary confinement. Prisoners are placed on rigid schedules by notifications—commands from staff, alarms, and other alerts. Failure to see or hear the alert signaling the start of a particular activity may mean losing out on the chance to participate. Given the volume of prisoners that must be served, failure to respond to a cue, alert, or alarm may mean that a prisoner does not receive the proper dosage of prescription drugs that day, misses a meal,²⁶² or is denied exercise.

Yet, not all prisons notify prisoners in a manner that takes into account their sensory disability—especially in solitary confinement.²⁶³ For example, Darren Morris, who is hard of hearing, sued Wisconsin prison officials for failing to accommodate his hearing disability. Morris, who was held in segregation at the Waupun Correctional Institution, claimed that he missed meals, showers, recreation time, and medications because he could not hear the audio alerts that notified prisoners of meals, showers, and other important daily activities. At the time, Morris had only one functional hearing aid and so could not always hear the auditory alerts.²⁶⁴ After several days, DOC officials placed a placard in front of his door to note his hearing disability, but Morris still continued to miss meals.²⁶⁵

IV. FAILURES TO PROVIDE ACCOMMODATIONS AND ASSISTIVE DEVICES

When a person is incarcerated, every activity—every minute of daily life—is monitored and controlled by prison authorities. Daily schedules control when a prisoner may eat, sleep, shower, visit with family, use the telephone, or attend educational programs. For prisoners with disabilities, proper accommodations and staff assistance and support are critical to ensure that they have the opportunity to participate in all aspects of prison life. For example, depending on the nature and type of disability, prisoners with mobility-related disabilities will be unable to engage in the full range of movements required for daily or routine tasks, such as dressing or showering. Similarly, blind prisoners will be unable to write and submit grievances,²⁶⁶ or participate in educational programs, where materials are not provided in Braille or text-to-audio formats. Without proper accommodations and assistance from corrections staff, prisoners with disabilities have been forced to rely on assistance from other prisoners.²⁶⁷ In the best-case scenario, these prisoners may assist prisoners with disabilities out of kindness or compassion, or at worst, another prisoner might use assistance as a mechanism to later extort from the prisoner with a disability.

Prisoners are even more reliant on corrections staff to meet their basic human needs in solitary confinement. Each day, prisoners in solitary rely on corrections staff to escort them to showers, notify them of meals or medical appointments, and distribute legal and personal mail. In solitary, most interactions take place at the front of each prisoner’s cell, where prisoners receive important items such as meal trays and dosages for medications. Prisoners are typically required to get cuffed at the cell front—behind the back while standing with their hands through the narrow, cell-front slot—before they may be permitted to exit the cell for programming, outdoor recreation, or showers.²⁶⁸

For prisoners with disabilities, accommodations and support are critical to ensure access to all aspects of prison life.

Yet, for many persons with ambulatory disabilities, walking to the cell front door for these routine interactions is no simple task. Spinal cord injuries may render tasks such as walking or kneeling for handcuffing at the cell front door impossible, or nearly impossible, without serious pain or serious injury.²⁶⁹ Without assistive devices or assistance, prisoners with disabilities may be hindered in their ability to move around, care for themselves, or engage in critical encounters at their cell front.²⁷⁰

The rigid schedules governing life in solitary confinement will exclude some prisoners with physical disabilities if facilities do not recognize and respond to their unique needs. In some cases, an appropriate response will require modifications to routine procedures and policies governing the daily activities of the prison to ensure that prisoners with disabilities are kept safe and have equal access to prison programs, activities, and services. In addition, prisoners with physical disabilities must have access to assistive devices in order to engage in routine activities such as showering, dressing, using the toilet, or simply moving around inside their cells. To ensure that prisoners with physical disabilities

Prisoners with mobility-related disabilities have brought lawsuits alleging that they have been forced to crawl around on the floor, hop on one leg, or endure serious pain just to engage in routine, daily activities.

are able to participate in these tasks, prison authorities must provide proper wheelchairs, assistive devices—in good working condition—or other assistance.

However, not all prisons have provided the assistive devices and assistance required under law. Consequently, prisoners with mobility-related disabilities have brought lawsuits alleging that they have been forced to crawl around on the floor, hop on one leg, or endure serious pain just to engage in routine, daily activities.²⁷¹ Even where assistive devices have been provided, prison officials have confiscated them on the grounds that those devices pose a security risk and could be used as weapons.²⁷²

Robert Dinkins sued the Missouri Department of Corrections, challenging the adequacy of the medical services provided to him. After he was diagnosed with pernicious anemia, he alleged that prison officials failed to prescribe him appropriate treatment for the disease, resulting in paralysis below the waist.²⁷³ He alleged that he began to experience “blackouts, weakness, and difficulty walking,” and that he did not receive a proper examination for approximately six months.²⁷⁴ Due to his worsening condition, prison officials transferred Dinkins to the Transitional Care Unit and placed him in administrative segregation.²⁷⁵ While

in the Transitional Care Unit, he alleged being denied access to a wheelchair and being forced to crawl on the floor, where he also ate his meals.²⁷⁶ He claimed that his requests for assistance with his wheelchair and related accessories, placement into a wheelchair-accessible cell, physical therapies, and preventive treatment, along with other accommodations, were all ignored by prison officials.²⁷⁷

A prisoner in Washington state prison reported being denied access to a wheelchair for almost two years while held in segregation.²⁷⁸ The prisoner had been provided with a wheelchair while at his previous housing unit, but prison authorities confiscated the device when he was transferred to solitary confinement. As a result, the prisoner was left without the means to ambulate, which meant that he had to “drag[] himself across the floor in order to conduct his daily activities.”

Randall Jackson alleged that he did not have access to a wheelchair for over a year while he was in solitary confinement.²⁷⁹ He also alleged that he was held in almost continuous lockdown for 24 hours per day, 7 days per week, and permitted to leave his cell for only one hour, three times per week.²⁸⁰ According to his federal complaint, for the year that he was in solitary confinement, “[h]e was forced to drag himself across the dirty and abrasive cell floor, where it was very difficult to transfer to the bed, toilet, and wash basin.”²⁸¹ Lloyd Brown claimed that he was denied access to recreation and showers for over two months after prison officials confiscated his crutches. Prison officials conceded to taking Brown’s crutches, but they argued in court that medical records concluded that his “crutches were not medically required” once he was transferred to the Special Housing Unit where he was held for 65 days.²⁸² The appellate court determined that “the medical records [were] insufficient to show that Brown was ambulatory without assistance.”²⁸³ The court further reasoned that if it were true that Brown’s need for crutches was obvious and that he was unable to walk without crutches, prison officials could not simply confiscate his crutches, but had an obligation to further investigate Brown’s condition to determine whether the medical records were correct.²⁸⁴

Following an alleged assault with a correctional officer, California prison officials placed Onofre Serrano, a partially paralyzed prisoner, into administrative segregation, also

known as the secure housing unit, or the “SHU.” Serrano’s SHU cell was not accessible for wheelchair users, and prison officials confiscated Serrano’s wheelchair. Serrano alleged that he was forced to “crawl into his bunk, hoist himself onto the toilet by the toilet seat, avoid the shower because the facility lacked an appropriate shower seat, and sit idle for outdoor exercise because the outdoor yard was not handicapped-accessible.”²⁸⁵ Serrano remained in the SHU cell without access to his wheelchair for approximately two months.²⁸⁶

Two prisoners with paraplegia, Bobby Simmons and Ricky Marshall, filed a lawsuit against the Arkansas Department of Corrections after they were held in solitary confinement for 32 hours, denied meals, and rendered unable to use restroom facilities.²⁸⁷ Simmons and Marshall were placed into segregation pursuant to prison policy after corrections staff determined that the two men had consumed alcohol. Prior to placing them into their segregation cells, prison officials “consulted” with medical staff to “ensure that no medical reason” prevented their confinement, and then “inspected the confines of the maximum security area to ensure that both Simmons and Marshall could be housed there safely.”²⁸⁸ According to the trial transcript, the nurse approved placement for Simmons and Marshall on the condition that they would be provided “access to the hospital for treatments . . . egg crate mattresses, and . . . other medical requirements[.]”²⁸⁹

Despite these detailed arrangements, neither Simmons nor Marshall received their requested accommodations while in segregation. Both were denied their egg crate mattresses and missed four consecutive meals because their wheelchairs could not access the area where staff placed food trays. Simmons and Marshall were also denied “necessary medical supplies, appropriate access to a handicapped-assistive toilet, and all other necessary assistance in using the toilet.”²⁹⁰ Simmons and Marshall filed a lawsuit challenging these actions and were awarded compensatory damages in the trial court.²⁹¹

Failure to provide accommodations and assistance to prisoners with physical disabilities in solitary confinement may lead to devastating consequences. Following amputation surgery at the end of 2005, Martinique Stoudemire contracted MRSA, a serious bacterial infection.²⁹² Prison

policy required that Stoudemire be quarantined in a segregation unit due to her infection, and she was quarantined in the segregation unit at Huron Valley Women’s Facility.²⁹³ Stoudemire claimed that prison officials managing the Huron Valley Women’s Facility held her in solitary confinement for two weeks with limited medical assistance and absolutely no contact with a prison doctor.²⁹⁴ She alleged that she received “extremely poor medical care while in segregation,” and that the “cells were not equipped to accommodate” her disability.²⁹⁵ Specifically, she alleged that she “was never provided with any assistive devices that might have allowed her to safely move between her bed, wheelchair, toilet, and shower,” and that “[t]here was no call button, so Stoudemire had to shout when she needed assistance.”²⁹⁶ Stoudemire was “forced to crawl from her bed to the toilet.”²⁹⁷ On one occasion, she defecated on herself when staff failed to respond to her requests for assistance.²⁹⁸ During her two weeks in segregation, Stoudemire “received only one shower . . . and was required to dress her wounds herself, which put her at risk of infection.”²⁹⁹ The Michigan Department of Corrections settled the suit with Stoudemire in May 2016, awarding her over \$200,000 for the harm caused.³⁰⁰

V. HOW PRISONERS WITH PHYSICAL DISABILITIES END UP IN SOLITARY CONFINEMENT

A. WHAT WE KNOW ABOUT PRISONERS WITH PHYSICAL DISABILITIES IN SOLITARY CONFINEMENT

There is limited research and data³⁰¹ on the number of persons with physical disabilities in prisons and jails and no concrete data on the numbers of persons with physical disabilities in isolation. In fact, until recently, there was little by way of data on the numbers of incarcerated people with disabilities period. In December 2015, the Bureau of Justice Statistics (BJS) produced a groundbreaking report that discussed the prevalence rates for six categories of disabilities—hearing, vision, cognitive, ambulatory, self-care, and independent living—in prison and jail prisoners from 2011 to 2012.³⁰² BJS researchers report that from 2011 to 2012, “about 3 in 10 state and federal prisoners... reported having at least one disability.”³⁰³ Of this population, approximately “40 percent of females and 31 percent of males in prison... reported a disability.”³⁰⁴ This data reveals that prisoners are

40% of females and 31% of males in prison report having a disability.

“nearly three times more likely... than the general population to report having at least one disability.”³⁰⁵

Cognitive disabilities were the most commonly reported disability.³⁰⁶ Ambulatory disability—defined as difficulty walking or climbing stairs—was the second most common disability.³⁰⁷ Older prisoners were most likely to report a disability in U.S. prisons and jails. Researchers report that 44 percent of prisoners aged 50 or older reported a disability as compared to 27 percent of prisoners aged 18 to 24.³⁰⁸ As the numbers indicate, by sheer volume alone, the substantial

**PRISONERS ARE
3X
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numbers of prisoners with disabilities currently held in prisons and jails warrant greater attention not only to the challenges they face while incarcerated, but also potential solutions to address these “complicated . . . health concerns for modern correctional systems.”³⁰⁹

Given the high incidence rates of people with disabilities in prison and jails, it is very likely that a significant proportion of those persons in solitary confinement are disabled. The number of prisoners held in isolation on a yearly basis is staggering. In 2011-2012, almost one in five prisoners and 18 percent of detainees in jail were held in some type of restrictive housing in the previous 12 months or less for those persons who were admitted to prison less than a year earlier.³¹⁰ For prisoners under the age of 30, the rates of persons held in restrictive housing increase. According to another BJS report, “[a]mong inmates ages 18 to 19, 31 percent of those in prison and 25 percent of those in jail had spent some time in restrictive housing,” and “[a]mong inmates ages 20 to 24, 28 percent of those in prison and 23 percent of those in jail had been in restrictive housing at some time during the past year.”³¹¹

B. HOW DO PRISONERS WITH PHYSICAL DISABILITIES END UP IN SOLITARY CONFINEMENT?

Although there is no precise data on the number of people with physical disabilities in isolation, there is information on how they end up in solitary confinement. Corrections authorities have justified the use of solitary confinement for all prisoners based on the following:

1. Administrative Segregation

Prisoners can be placed into administrative segregation for a variety of reasons, but the most common justification is that the individual poses some type of threat to the safety of persons and security of the institution.³¹² Prisoners can

HOW DO PRISONERS WITH PHYSICAL DISABILITIES END UP IN SOLITARY CONFINEMENT?

1. Administrative Segregation
2. Protective Custody
3. Medical Isolation
4. Disciplinary or Punitive Segregation
5. Lack of Accessible Housing

be held in administrative segregation for a short period of time (e.g., during an investigation for an alleged offense,³¹³ or while they wait for the corrections facility to find a cell that is wheelchair accessible), or in some cases, an indefinite period of time (e.g., due to an alleged gang affiliation).³¹⁴

2. Protective Custody

Segregating prisoners to protect them from harm is generally referred to as protective custody.³¹⁵ Some adult corrections systems automatically place persons from vulnerable populations—youth,³¹⁶ elderly,³¹⁷ and LGBT prisoners³¹⁸—into protective custody. Prisoners with physical disabilities are placed into protective custody due to vulnerabilities, often as a default solution after being harmed or threatened. In many state systems, conditions in protective custody are tantamount to placement into solitary confinement—that is, prisoners are held in small, concrete cells for approximately 22 hours or more per day with little to no access to natural light and almost total sensory and social deprivation.³¹⁹ In

some cases, prisoners in protective custody are held in the very same units as prisoners held in solitary confinement for serious disciplinary infractions. For example, a victim of assault may be placed in the same unit as the person who assaulted them.

3. Medical Isolation

Prisoners may be placed into isolation for medical reasons. For example, prisoners experiencing suicidal thoughts may be placed into medical isolation, where they can be observed, also known as “suicide watch,” until they are healthy enough to return to less restrictive housing. In addition, prison officials often place persons who have been diagnosed with contagious diseases, or who may be at risk of contracting these diseases, into medical isolation to prevent the spread of the disease.³²⁰

As a general matter, corrections authorities may not segregate people with disabilities into medical facilities unless the prisoner is actually receiving medical care.³²¹ Furthermore, placement into medical facilities is not permitted simply

because accessible housing is not available, or because prison authorities believe that it is more convenient to place prisoners into those facilities. These policies are not always followed and prisoners with physical disabilities have been placed into designated medical areas even when they were not receiving medical treatment.³²²

4. Disciplinary or Punitive Segregation

The primary objective of corrections institutions is to maintain security and control of their facilities and the persons they house. As part of the effort to maintain order, institutions have rules and regulations that govern the behaviors of persons held within their walls. When prisoners break the rules of the prison, they are given disciplinary infractions, or tickets. Disciplinary infractions can range from failing to maintain proper hygiene or sanitary living conditions to more serious offenses like assault or escape. Failure to adhere to prison rules and regulations can result in placement into solitary confinement.³²⁵ Prisoners with physical disabilities, like non-disabled prisoners, can end up in solitary after being found guilty of disciplinary infractions that violate the institution’s disciplinary policies.³²⁶

I. PATHWAYS INTO SOLITARY: UNIQUE CHALLENGES FOR PERSONS WITH PHYSICAL DISABILITIES

Prisoners with physical disabilities have been punished because of actions—or inactions—caused by their disabilities.³²⁷ For example, prisoners with physical disabilities that “cause problems such as vomiting or incontinence too often get disciplined for soiling their clothing instead of being evaluated by medical care staff.”³²⁸ Such treatment is fundamentally unfair. Maintaining the safety and security of a prison does not require punishing someone for actions beyond their control. Rather, punishing someone on this basis reflects a disregard for the needs of people with disabilities and a lack of sensitivity to their lived experiences.

In addition, prisoners with sensory disabilities have been charged with failing to obey staff orders they could not hear or see and subsequently disciplined with segregation.³²⁹ For example, one deaf prisoner reported being held in solitary

“Our prison system does very little to effectuate rehabilitative goals where prisoners with disabilities are concerned. These prisoners live in a precarious limbo where they are punished for disability-related behaviors often without access to accommodations that would facilitate adjustment to the demands of prison life. Placing prisoners with disabilities in solitary confinement for reasons associated with their disability is precisely what the ADA and its regulations seek to protect against.”

—WALLIS NADER, ATTORNEY, TEXAS CIVIL RIGHTS PROJECT

confinement for two weeks for “failing to respond to an oral command spoken behind his back.”³³⁰ He reported that he did not receive a statement of reasons and that no hearing was held prior to his placement into solitary confinement. Only when he was provided with an ASL interpreter did it become clear to prison officials that the charges were unfounded: “I received a hearing aid two weeks into my solitary. They had an interpreter. They understood that the officer made a mistake and I was exonerated and released.”³³¹

Finally, prisoners with sensory disabilities face another hurdle in that they may not be able to understand the orientation manual or prisoner handbook that governs behaviors in the correctional institution. Violations of relatively minor prison rules can lead to placement in solitary. For example, prisoners may be punished for seemingly innocuous behaviors like posting on Facebook,³³² failing to make the bed,³³³ or having expired toothpaste.³³⁴ Providing information in a format that is inaccessible to blind or deaf



Photo: Wavebreak Media Ltd/Bigstock

Prison officials have sentenced prisoners to time in solitary confinement for alleged disciplinary violations even where the prisoner could not understand or participate in the disciplinary hearing to raise a defense.

prisoners means that they will remain largely unaware of the rules, processes, and procedures governing life in their particular prison. As such, deaf and blind prisoners can violate prison rules—and face solitary confinement—because they lacked full understanding of the prison rules and regulations. For deaf prisoners, there are additional barriers to communication. Deaf individuals, on the whole, have lower literacy rates and educational levels as compared to hearing individuals.³³⁵ Due to low literacy rates and limited education, deaf prisoners may face serious difficulties in trying to understand complex disciplinary procedures.

ii. DISCIPLINARY PROCEEDINGS

In some cases, prisoners charged with a disciplinary infraction may have the right to a disciplinary hearing along with other due process protections. These rights ensure that prisoners are not further deprived of their liberties—for example, by placement into punitive segregation and the accompanying loss of privileges—without appropriate due process. The precise nature and scope of the procedural

rights given to prisoners during these disciplinary hearings will depend on the nature of the disciplinary action or punishment.³³⁶ Generally, in cases involving a loss of good time credits or property, prisoners will have the right to (1) receive written notification of the charges against them at least 24 hours prior to the hearing; (2) obtain information on the evidence brought against them and the basis for the punishment;³³⁸ and (3) call witnesses and present documentary evidence at a disciplinary hearing, subject to limitations.³³⁹ There is no recognized right to legal counsel during disciplinary proceedings; however, prisoners who are illiterate, or who require language or other assistance because of their disability, may be entitled to assistance.³⁴⁰

Even where prisoners are provided with certain procedural protections during disciplinary proceedings, prisoners with physical disabilities will be denied their rights if hearings are not accessible—either because of structural barriers for prisoners with ambulatory disabilities or communication barriers for prisoners with sensory disabilities.³⁴¹ For instance, persons who use wheelchairs will face significant obstacles if the location of the disciplinary hearing is not accessible to them. Moreover, if the evidence presented during the hearing is not accessible to prisoners who are blind or low vision, or deaf or hard of hearing, they will be unable to fully understand the charges against them and prepare a proper defense.³⁴² For example, only providing notice of the disciplinary hearing and summary of the charges against a blind or low vision prisoner in small font, rather than in a format accessible to the prisoner such as large font (or Braille, if the prisoner can understand Braille) will render meaningless any right guaranteeing advance notice of the hearing and a description of charges.

Similarly, not providing a sign language interpreter or real-time captioning during a disciplinary hearing will prevent a deaf prisoner from understanding the proceedings or communicating with the officers conducting the hearing and investigators.³⁴³ Because the failure to provide auxiliary aids and services to persons with sensory disabilities compromises their ability to successfully defend themselves in a disciplinary hearing, which could result in placement into solitary confinement, it is imperative that prisoners with physical disabilities be afforded necessary accommodations during the investigatory phase, disciplinary hearing, and any appeals process.³⁴⁴

Without these accommodations, prisoners with sensory disabilities will be unable to benefit from any procedural protections provided during disciplinary hearings. In *Dunn v. Thomas*,³⁴⁵ plaintiffs, a class of prisoners held in the custody of the Alabama Department of Corrections (ADOC) filed suit against ADOC, challenging constitutionally inadequate medical care and violations under the ADA due to ADOC's failure to provide them with accommodations and services. The complaint also details stories of prisoners denied meaningful access to disciplinary hearings due to the ADOC's failure to provide interpreters and assistive devices to facilitate communication.

For example, Plaintiff Daniel Tooley, a deaf prisoner, alleged that prison officials failed to provide him with a sign language interpreter despite numerous requests.³⁴⁶ Tooley alleged that “he d[id] not understand certain ADOC policies,” “[could not] participate in any programs offered by the prison” because of communication barriers, and that ADOC “often relie[d] on other prisoners with limited sign language ability to ‘communicate’” with him.³⁴⁷ Tooley also alleged that ADOC officials failed to provide him with a sign language interpreter for a disciplinary hearing.³⁴⁸ Following a hearing that he did not understand, he was sentenced to a 30-day term in segregation.

Plaintiff Donald Turner raised similar claims, alleging that he was unable to adequately defend himself in a disciplinary hearing where he was charged with unauthorized use of a credit card because ADOC failed to provide him with a sign language interpreter.³⁴⁹ Turner received 15 days in segregation following the hearing.³⁵⁰

Finally, Tommie Moore alleged that he was sentenced to 10 days in segregation following a disciplinary hearing.³⁵¹ According to the complaint, corrections staff gave Moore, a blind prisoner, a disciplinary ticket after he did not stand up during prison count even though “he did not know that the correctional officer telling people to stand for count was speaking to him and the standard practice in the dormitory was that the prisoners who are blind did not stand for count.”³⁵² Prison records showed that Moore pled guilty to the charge, but he alleged that he did not attend the “disciplinary hearing and did not admit to any misconduct or sign the disciplinary report.”³⁵³

5. Placements Into Solitary Confinement Due to Lack of Accessible Housing

“I have been in and out of solitary confinement several times while on transfer to the hospital for treatment or diagnosis. A [disabled] inmate can be put into solitary if there is no room in the transfer part of the prison. While there you will be treated as if you were there for disciplinary action.”³⁵⁴

—BOB FOSSETT, WALLACE PACK 1 UNIT, TEXAS

Prisoners with physical disabilities may also be placed into isolation for reasons separate and distinct from the safety of persons or the security of institutions. Abdul Malik Muhammad, who is blind, was placed in solitary confinement at the Wicomico County Detention Center in Maryland for a little over six weeks. For the majority of his time in solitary, Muhammad was without “access to showers, phone calls, recreation, [or] a change of clothes, [and was denied access to] religious services, the commissary, visitation, or the library.”³⁵⁵ When Muhammad asked a corrections official to explain why he was placed into solitary confinement, the official responded that prison authorities were trying to figure out where to house him. The lack of readily available housing units that could properly serve the needs of a blind prisoner meant that Muhammad experienced the social and environmental isolation of solitary confinement simply because of his disability.

Placement decisions similar to Muhammad's are troubling because the ADA expressly prohibits prison officials from segregating prisoners and other detained persons simply because there are no accessible beds in which to house them.³⁵⁶ Even so, prisoners with ambulatory and sensory disabilities are still placed into solitary confinement simply because there is no accessible housing available.³⁵⁷

Special Challenges for Deaf Prisoners

Deaf prisoners are particularly vulnerable to placement into solitary and are susceptible to falling into a never-ending cycle of isolated confinement. Deaf prisoners can wind up in solitary confinement because prison authorities did not provide them with prison rules and procedures—commonly referred to as a prisoner manual, or orientation handbook—in a format that they could understand. As a result, these prisoners end up with seemingly non-serious disciplinary infractions that result in their placement into solitary. For prisoners placed in solitary, getting out of isolation, where made possible through step-down programs, will require adhering to strict guidelines and procedures. If those guidelines are not in a format that deaf prisoners can understand, they may be denied access to programs that can shorten their time in solitary.

In addition, deaf prisoners who feel vulnerable or unsafe in dangerous prison facilities may voluntarily agree to placement into protective custody. However, without proper communication with corrections staff, they may do so without fully understanding what protective custody entails: lockdown in a highly restrictive isolation cell for more than 22 hours per day.

6. Trapped in Solitary

State and federal corrections systems may condition release from solitary confinement on the completion of rehabilitative programs and activities, as well as incident-free behavior. However, once in solitary confinement, prisoners with physical disabilities may find themselves unable to comply with such conditions due to the inaccessibility of prison programming. As a result, they end up isolated for extended periods of time. This is because prisoners with disabilities are excluded from the benefits of “step-down”

programs that require the successful completion of certain programming and behavioral goals to “progress” out of solitary confinement.

Prisoners with physical disabilities may be unable to reap the benefits of these step-down programs for a variety of reasons. First, where manuals specifying rules and procedures for progressing out of solitary confinement are not accessible to persons with sensory disabilities—for example, deaf persons requiring a sign language interpreter, or blind persons requiring audio text—these prisoners may not be able to understand what constitutes a violation of the step-down procedures or what actions are required to get out of solitary confinement. As a result, they may fail to progress in the step-down program and lose the opportunity to get out of solitary confinement. Similarly, program materials may not be provided in a format that prisoners with sensory disabilities can comprehend. Furthermore, programming locations may not be accessible to prisoners with ambulatory disabilities. Holding group programs, like anger management or hobby craft, in locations that do not accommodate wheelchairs, or in areas of the facility that have uneven, jagged floors that make it difficult for blind or low vision prisoners to navigate, will effectively bar them from accessing programs that can help reduce their time in solitary confinement.

VI. LEGAL PROTECTIONS FOR PRISONERS WITH DISABILITIES IN SOLITARY CONFINEMENT

Robust legal protections exist to protect the rights of prisoners with disabilities. International standards, U.S. constitutional law, federal statutes and regulations, and state laws prohibit discrimination against people with disabilities, prevent their unjustified exclusion from mainstream society, and mandate that they receive equal access to programs and services offered to all. Prisoners with disabilities held in solitary confinement should receive these protections. Although the law as it relates to incarcerated persons with disabilities is largely undeveloped in court cases, it is an area ripe for litigation and policy reform.

The following section outlines the legal protections afforded prisoners with disabilities in solitary confinement under the various legal regimes.

important protections for all persons with disabilities that must be respected in prisons and jails. In particular, the Convention sets forth basic requirements for the 160 signatories, or Member States, to end systematic discrimination and to enact appropriate legislation that will protect and promote the rights of all people with disabilities. The United States signed the convention in 2009, but disappointingly has yet to ratify it.³⁵⁹ Specifically, the Convention sets forth specific measures to ensure equal access to justice, liberty, and security of the person,³⁶⁰ as well as freedom from torture or cruel, inhuman, or degrading treatment or punishment for all people with disabilities.³⁶¹ In addition, the Convention mandates that people with disabilities be provided with reasonable accommodations when they are incarcerated.³⁶²

2. Nelson Mandela Rules

In December 2015, the United Nations General Assembly adopted an updated version of its Standard Minimum Rules for the Treatment of Prisoners (known as the “Nelson Mandela Rules”). The Nelson Mandela Rules³⁶³ establish basic principles and minimum standards for the treatment of prisoners in order to ensure that the human rights of all incarcerated persons are respected, providing standards for such aspects of prison management as medical care, mental health treatment, solitary confinement, and classification. The Nelson Mandela Rules also recognize the special challenges faced by prisoners with disabilities and set in place standards protecting them from mistreatment and inhumane conditions of confinement. Specifically, as relates to prisoners with physical disabilities in solitary confinement the Nelson Mandela Rules:

A. INTERNATIONAL LAW

International law and standards affirm the human rights of all people with disabilities and a commitment to protecting people with disabilities from cruel, inhumane, and degrading treatment when they are incarcerated.

1. UN Convention on the Rights of Persons with Disabilities

The United Nations Convention on the Rights of Persons with Disabilities (“Convention”) affirms the basic human rights of all people with disabilities.³⁵⁸ The guidelines provide

Prohibit indefinite solitary confinement and prolonged solitary confinement.³⁶⁴ The Mandela Rules defines solitary confinement as “confinement of prisoners for 22 hours or more a day without meaningful human contact.”³⁶⁵ Prolonged solitary confinement is confinement lasting beyond 15 days.³⁶⁶

Mandate that solitary confinement may only be used in “exceptional circumstances as a last resort, for as short a time as possible and subject to independent review” by a competent authority.³⁶⁷

Recommend that prison officials avoid imposing solitary confinement where doing so would worsen the health conditions of people with disabilities.³⁶⁸

Require that medical professionals have the power to review and recommend decisions to place prisoners with physical disabilities into solitary confinement to ensure that their disability is not worsened due to that placement.³⁶⁹

Encourage effective and meaningful communications with prisoners with sensory disabilities.³⁷⁰

Subjecting prisoners with disabilities to solitary confinement may conflict with the standards set forth in the Nelson Mandela Rules. To begin with, the U.N. Special Rapporteur Against Torture has determined that, beyond 15 days, solitary confinement can amount to torture.³⁷¹ Thus, after this

The Americans with Disabilities Act provides comprehensive protections for people with disabilities held in state prisons and jails.

time period, holding prisoners with disabilities in solitary confinement can violate their fundamental human right to be free from cruel, inhumane, and degrading treatment under the U.N. Convention Against Torture. Similarly, placing prisoners with physical disabilities into solitary confinement where such placement exacerbates existing disabilities, or holding prisoners with sensory disabilities in solitary confinement without providing them with the means to effectively and meaningfully communicate, would be inconsistent with the Nelson Mandela Rules.

B. CONSTITUTIONAL PROTECTIONS: THE EIGHTH AMENDMENT

The Eighth Amendment to the U.S. Constitution “prohibits the infliction of ‘cruel and unusual punishments’ on those convicted of crimes.”³⁷² Stated differently, it provides a limitation on the extent to which the government can punish its prisoners. Punishments that are barbaric or torturous,³⁷³ “involve the unnecessary and wanton infliction of pain,”³⁷⁴ or that are “grossly disproportionate to the severity of the crime”³⁷⁵ violate the Eighth Amendment. In addition, prison authorities violate the Eighth Amendment when they deny prisoners medical care,³⁷⁶ deprive them of their basic human needs,³⁷⁷ or “deprive inmates of the minimal civilized measure of life’s necessities.”³⁷⁸ In short, the Eighth Amendment mandates that corrections officials provide humane living conditions for prisoners.³⁷⁹

Although few courts have determined that solitary confinement as a practice on its own violates the Eighth Amendment, several courts have found that placing people with serious mental illness into solitary confinement is cruel and unusual punishment.³⁸⁰ As one court reasoned, placing prisoners with mental illness into solitary confinement exposed them to risk of serious psychological harm and deterioration. The court emphasized that continued placement for prisoners with psychiatric disabilities in solitary confinement would expose them to “conditions that are ‘very likely’ . . . to inflict a serious mental illness or seriously exacerbate an existing mental illness[, and] cannot be squared with evolving

standards of humanity or decency[.]”³⁸¹ Due to these prisoners’ vulnerabilities to further psychological harm, the court reasoned that placing them into solitary confinement violated the Eighth Amendment.³⁸² As with prisoners who have psychiatric disabilities, prisoners with physical disabilities are susceptible to serious harms in solitary confinement. These harms, as noted, include not only psychological damage, but also physical deterioration and deconditioning. Where placing a prisoner with a physical disability into solitary confinement makes it “very likely” for these harms to occur, the Eighth Amendment will likely bar such placement.

C. THE AMERICANS WITH DISABILITIES ACT

The passage of the Americans with Disabilities Act (ADA) was a watershed moment in the movement for equal rights for all people with disabilities.³⁸³ The landmark civil rights legislation was the result of decades-long advocacy by people with disabilities and, in particular, a fervent disability rights movement that sprang up in the 1970s.³⁸⁴ Following the “culmination of 25 years of methodical congressional study, measured legislative steps, and finely tuned negotiation regarding the problem of” disability discrimination,³⁸⁵

A Closer Look: The ADA and Individual Consideration

Public entities, including prisons and jails, are required to give “primary consideration” to the individual’s choice for a particular aid or service that serves to accommodate a communication disability. According to guidelines set forth by the U.S. Department of Justice, a public entity must “honor the person’s choice, unless it can demonstrate that another equally effective means of communication is available, or that the use of the means chosen would result in a fundamental alteration or in an undue burden[.]”³⁹⁵

Congress enacted the ADA to address the historic exclusion, segregation, and discrimination³⁸⁶ experienced by people with disabilities.

Under the ADA, “no qualified individual with a disability³⁸⁷ shall, by reason of such disability, be excluded from participation in or be denied the benefits of services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.”³⁸⁸ A plaintiff seeking to establish a claim under the ADA in court must show that (1) they are a person with a disability³⁸⁹ according to the statutory definition; (2) they are otherwise qualified for the benefit in question; and (3) they were excluded from the benefit of a program, service, or activity due to disability-based discrimination.³⁹⁰ These sweeping protections aimed at ensuring equal access to public services, programs, or activities for all people with disabilities did not stop at the prison gates. Six years after the passage of the ADA, the Supreme Court ruled in *Pennsylvania Department of Corrections v. Yeskey* that the “benefits” from “services, programs, or activities” included prisoners, who even though incarcerated, rely on the state to meet their basic needs and provide them with rehabilitation.³⁹¹

1. Reasonable Accommodations

The ADA requires public entities to “make reasonable modifications in policies, practices, or procedures[.]”³⁹² Reasonable accommodations help prevent discrimination against people with disabilities by providing them with the opportunity to “fully and equally participate in a program, service, or benefit.”³⁹³ Reasonable modifications—also known as reasonable accommodations—can vary considerably based on the specific needs of persons with a disability.³⁹⁴

For example, if a prisoner with quadriplegia requires a motorized wheelchair (or a personal assistant to help with pushing a manual wheelchair) in order to access the dining hall, showers, recreational areas, and library in the facility, then under the ADA, prison officials would be required to provide a reasonable accommodation so that the prisoner can participate fully and equally in these benefits offered at the facility. By way of another example, say that a facility permits prisoners to use the telephone for only 30 minutes per day. Deaf or hard of hearing prisoners who rely on

telecommunication devices like video phones, TTDs, or relay services may in practice receive less time for phone calls due to the additional time it takes to set up these devices, as well as delays in transmitting and receiving messages. A reasonable accommodation could be one that would allot additional time for telephone calls by deaf prisoners to ensure that they have the same time for telephone calls as hearing prisoners.

2. Effective Communications

Under the ADA, corrections officials are required to provide communications to people with disabilities that are *as effective* as the communications provided to persons who do not have disabilities.³⁹⁶ To meet this requirement, corrections officials must provide blind, low vision, deaf, and/or hard of hearing persons with auxiliary aids and services to facilitate effective and meaningful communications during critical encounters—prison orientation, educational classes, job training, work assignments, meetings with counselors, medical appointments, religious services, grievance proceedings, vocational classes, etc.—unless doing so would cause an undue burden or fundamentally alter the nature of a program.³⁹⁷

To ensure meaningful and effective communications with blind, low vision, deaf, and/or hard of hearing prisoners, prison officials must provide auxiliary aids and services, such as hearing aids, sign language interpreters, text-to-audio devices, vibrating alerts, and real-time captioning. When provided, the auxiliary aids and services must also be tailored to the specific needs of the individual. Public entities are required to give primary consideration to the particular assistive device or aid that the person with the communication disability requests. Corrections officials must provide these persons with the requested accommodation “unless it can demonstrate that another equally effective means of communication is available,” or that the requested accommodation “would result in a fundamental alteration or in an undue burden.”³⁹⁸ Even where the requested accommodation “would result in an undue burden or a fundamental alteration,” prisons must still “provide an alternative aid or service that provides effective communication if one is available.”³⁹⁹

Furthermore, the auxiliary aids provided must properly function to be effective. Hearing aids that are broken⁴⁰⁰ or that do not fit well will not provide effective communications. Similarly, effective communication requires that auxiliary services such as sign language interpreters be qualified to complete the job. A qualified interpreter is one “who is able to interpret effectively, accurately, and impartially both receptively and expressively, using any necessary specialized vocabulary.”⁴⁰¹ Permitting other prisoners to serve as sign language interpreters places deaf prisoners at risk by infringing upon their privacy, particularly during confidential medical visits, and creating a reliance on other prisoners, which can lead to exploitation.⁴⁰² If interpreting services are not available, video remote interpreting services may be used, particularly in emergency situations.⁴⁰³

3. Limits to the ADA

The comprehensive protections and guarantees provided to people with disabilities are not without limitation. Even where an individual can establish that they have a disability as defined by the statute, are otherwise qualified, and were excluded from the benefit of a program, service, or activity provided by a public entity, the public entity is not required to provide an accommodation where doing so constitutes an undue burden.⁴⁰⁴ Specifically, a prison can defend against a lawsuit alleging a violation under the ADA for failing to provide a reasonable accommodation where providing the

Corrections officials must provide communications to people with sensory disabilities that are as effective as those provided to people who do not have disabilities.

requested accommodation “would result in a fundamental alteration in the nature of a service, program or activity, or in undue financial and administrative burdens.” The ADA defines “undue burden” as an “action requiring significant difficulty or expense[.]”⁴⁰⁵ Moreover, prison authorities are not required to provide reasonable accommodations where doing so would pose a “direct threat” or a “significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices or procedures, or by the provision of auxiliary aids or services.”⁴⁰⁶ Additionally, “[a] public entity may impose legitimate safety requirements necessary for the safe operation of its services, programs, or activities.”⁴⁰⁷ Although this provision may limit the extent to which the public entity must provide reasonable modifications, the provision also calls for assessments based on actual risks rather than speculation, stereotypes, or generalizations, which suggests that public entity must offer written justifications or actual evidence before alleging safety risks.⁴⁰⁸

D. PRISON LITIGATION REFORM ACT

The Prison Litigation Reform Act (PLRA) applies to all lawsuits filed pursuant to federal law by prisoners, including prisoners with disabilities. Under the PLRA, prisoners are prohibited from filing a lawsuit in federal court until they have attempted to resolve their dispute using the administrative procedures for the particular prison in which they are held.⁴⁰⁹ In other words, prisoners must demonstrate that they have complied with and received no relief from the prison’s own grievance system prior to filing a lawsuit in court. Failure to do so will result in the prisoner’s complaint, even a meritorious one, being dismissed from court.

For example, if a blind prisoner brings a lawsuit under the ADA alleging that prison officials failed to provide them with any accommodations so that they could participate in vocational classes, religious services, and recreation, and there is no evidence that they submitted a request to prison authorities for these accommodations, their complaint will be dismissed. Thus, where administrative remedial procedures are not strictly followed, prisoners with physical disabilities in solitary confinement may not be able to

obtain relief in court even where constitutional, ADA, or other violations of federal law have occurred.⁴¹⁰

E. PROTECTION & ADVOCACY MONITORING AND OVERSIGHT

Protection & Advocacy (P&A) organizations “provide legal representation and other advocacy services to all people with disabilities (based on a system of priorities for services).”⁴¹¹ Federal statutes allow P&A organizations a right of access to records and related information during their investigations.⁴¹² P&A organizations have the authority under federal and state laws to provide legal representation and other advocacy services to individuals with physical, mental, developmental, and intellectual disabilities living in correctional institutions, among other facilities. These P&A agencies maintain a presence in both public and private facilities that house individuals with disabilities, and these agencies are responsible for investigating and monitoring institutions for violations of disability laws and pursuing remedial action to address violations when found.⁴¹³ In recent years, several P&A organizations have filed lawsuits on behalf of prisoners with physical disabilities challenging their mistreatment while held in solitary confinement.⁴¹⁴

F. STATE LAW

In addition to federal law and regulations, state laws and regulations provide protections to people with disabilities, including incarcerated persons. Though state laws prohibit discrimination on the basis of disability and offer protections similar to the ADA,⁴¹⁵ each state court’s interpretation of that state’s disability laws controls. A review of the specific state laws and cases is necessary to determine the nature and scope of protections offered under these state statutes.

VII. RECOMMENDATIONS FOR ENDING SOLITARY CONFINEMENT OF PRISONERS WITH DISABILITIES

Solitary confinement is an overused, ineffective, and harmful practice. Despite the claims that solitary confinement is used only when necessary, the research detailed in this report shows how some prisoners with physical disabilities are held in conditions amounting to extreme and, in some cases, prolonged isolation for reasons that are unrelated to maintaining the safety and security of the facility. Prisoners with disabilities may be placed into

solitary due to lack of accessible cells, miscommunication leading to disciplinary charges, or for their own protection. These prisoners with disabilities languish in highly restrictive conditions where they are deprived of meaningful social interaction and almost all constructive activity with little to no actual justification for their continued placement. As noted, there is no evidence that long-term isolation makes prisons and jails safer. Indeed, most of the evidence suggests

the opposite effect—that solitary confinement can increase the incidence of violence and contributes to increased recidivism amongst persons subjected to its use.⁴¹⁶ Prolonged isolation for persons with physical disabilities, such as persons with quadriplegia, other spinal cord injuries, or stroke survivors coping with paralysis, may result in physical deterioration, especially where regular physical therapy is not provided. Moreover, failing to accommodate prisoners who use wheelchairs, or other assistive devices like walking canes or walkers, may mean the denial of access to even the limited programming that is sometimes available to prisoners in solitary confinement. Without accommodations to permit effective communication for deaf and hard of hearing prisoners, and access to accessible reading materials for blind and low vision prisoners, the extreme conditions of social isolation in solitary are compounded.

This report highlights a set of guiding principles and specific reforms that generally address the challenges faced by incarcerated persons with physical disabilities, and that specifically address the challenges of those in solitary confinement.⁴¹⁷ These principles and recommendations build on the guiding principles set forth in the Department of Justice’s *Report and Recommendation Concerning the Use of Restrictive Housing* released in January 2016.⁴¹⁸ The report was produced in response to a directive by President Obama calling on the Department of Justice to review the overuse of solitary confinement in federal prisons nationwide and identify potential alternatives to its use. The DOJ report and its recommendations set forth over 50 guiding principles for solitary reform writ large and a host of specific policy changes for the Federal Bureau of Prisons (BOP) and other detention agencies within the DOJ, including banning youth in solitary, diverting those with serious mental illness out of solitary, reforming protective custody, prohibiting the use of solitary confinement for low-level disciplinary infractions, and shortening mandatory lengths of stay in solitary confinement units. While the department’s guiding principles are a move in the right direction, they did not address the unique issues prisoners with physical disabilities face in solitary confinement. Accordingly, more rigorous requirements are still necessary to make correctional systems safer and more humane.

A. RECOMMENDED ACTION

The recommendations below are offered to serve as guidance to corrections and state officials legally obligated to follow the ADA and to federal officials tasked with enforcing the ADA’s mandates in prisons and jails nationwide. The recommendations provide potential reforms for common challenges encountered by incarcerated persons with physical disabilities. In practice, implementing the ADA for individual prisoners with physical disabilities may require case-by-case assessments into their needs, as well as the needs and resources of each correctional entity. The proposed reforms are aimed at reducing the overuse of solitary confinement and ensuring that in those systems where solitary confinement continues to be used, the rights of persons with physical disabilities are respected.

1. Correctional Systems

Recommended actions for federal, state, and local correctional systems:

- Amend existing, or adopt new, administrative policies to reflect the recommendations made in the model policies section discussed below.
- Establish data procedures to improve tracking and monitoring of incarcerated persons with physical disabilities. This will include adopting formal definitions of types of disabilities, as well as collecting data on people with disabilities within the corrections system on an annual basis. The data systems should be designed to ensure ease in searching for key terms and filtering data.
- Create policies, procedures, and systems to permit both medical and security/custody to be apprised of all relevant information related to a prisoner’s disability or reasonable accommodation.
- Complete a systemwide self-evaluation of each facility to determine whether facilities are compliant with the ADA.⁴¹⁹ Buildings should be assessed to see whether they comply with the 2010 ADA Standards for Accessible Design.⁴²⁰ Assign a competent and knowledgeable ADA Coordinator to each facility in the jurisdiction.

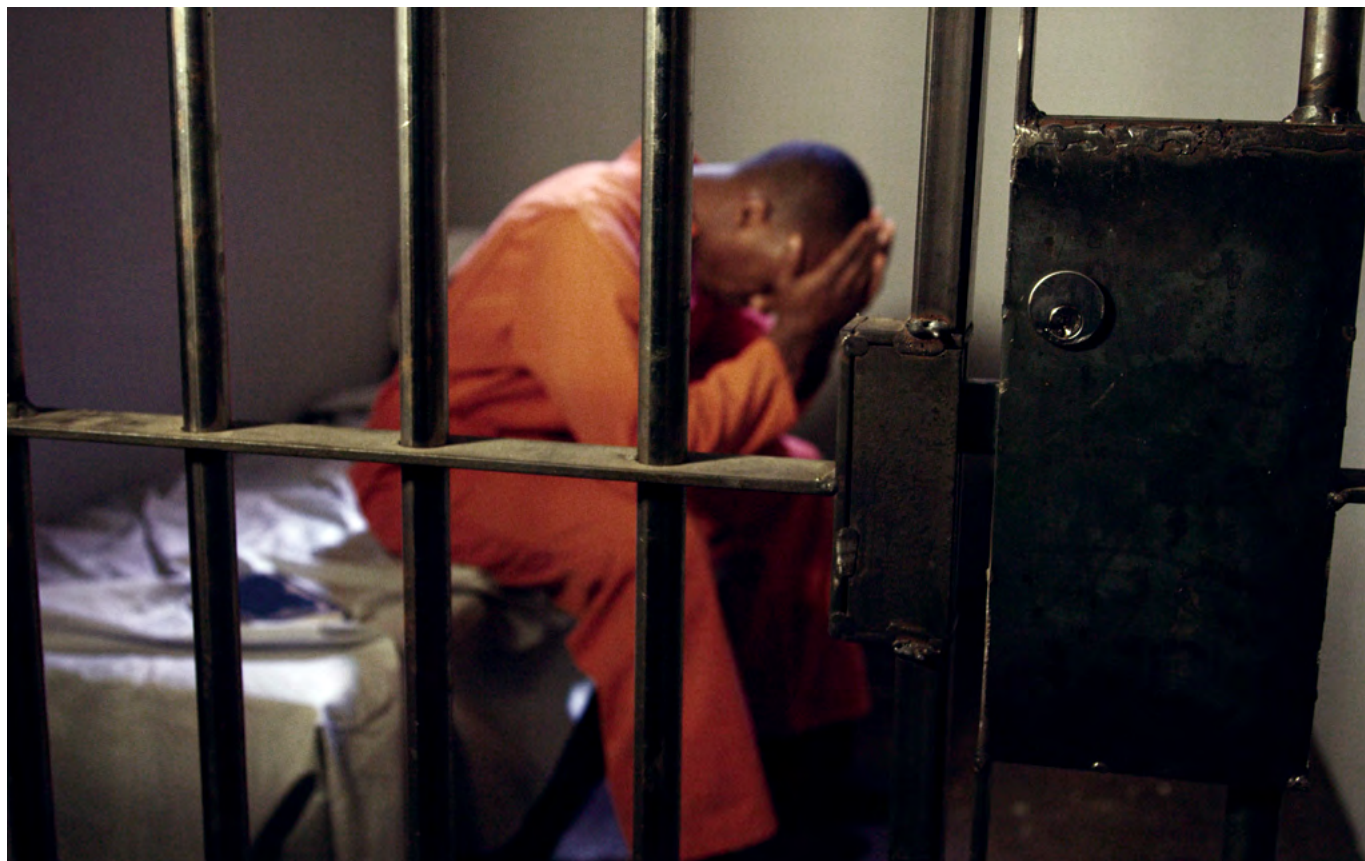


Photo: Skyward Kick Productions/Shutterstock

The ADA Coordinator should be responsible for serving as the facility expert on the ADA, leading training programs for corrections staff on ADA compliance, coordinating with medical and mental health professionals to understand the needs of people with disabilities, managing all requests for accommodations from people with disabilities, and working with the appropriate officials to establish the budget for ADA-related compliance, accommodations, and other measures. The ADA Coordinator should be a full-time staff member and be provided with the autonomy, time, and authority to complete their required duties. To the extent feasible, corrections institutions should seek to hire people with disabilities to fill these roles to provide an opportunity for those who have personal knowledge and a deep understanding of the issues facing this group.

- Establish an ADA Committee to be comprised of corrections officials and staff from all aspects of prison services and management (e.g., custody, programming, visiting, classification, medical and mental health, etc.), as well as prisoners. The ADA Committee is responsible for addressing existing disability-related challenges, identifying policies to prevent ongoing and future ADA violations, and handling all other issues related to managing and accommodating prisoners with disabilities, particularly those held in solitary confinement systemwide.
- Provide training and support for medical personnel and custody staff on working with people with disabilities (e.g., Deaf culture and sensitivity training, etc.). Where feasible, training sessions should be led by, or in partnership with, people with disabilities, or individuals and organizations with expertise in working with people with disabilities.
- Develop robust systems to gather information on incarcerated persons with disabilities to ensure that medications and accommodations remain with the person even following a transfer within the corrections system and despite security classification.

- Develop a clear and comprehensive process by which prisoners may request accommodations or seek review of any decision denying a request for an accommodation. The procedure for requesting accommodations should be available in formats accessible to prisoners who are blind, low vision, and/or deaf or hard of hearing.

2. Federal

“At some point or another, the federal government is going to have to abide by [its] own law. When will the Deaf community receive . . . justice? The Deaf community is continuously overlooked.”

—SCOTT HUFFMAN, DEAF ACCESS TO JUSTICE ACTIVIST

CONGRESS

- Pass the Solitary Confinement Reform Act (S. 3432) introduced by Senator Dick Durbin (D-IL) to reduce the use of solitary confinement, improve conditions of confinement, and provide protections that limit time spent in solitary confinement for prisoners held in the custody of the Federal Bureau of Prisons. This bill also prohibits BOP officials from placing prisoners with physical disabilities into solitary confinement, unless certain conditions are met, in cases where a licensed medical professional has determined that

solitary confinement would exacerbate existing disabilities.

- Congress should enact appropriate legislation to ban the placement of prisoners with physical disabilities into solitary confinement, except in rare and exceptional cases, for a short duration, and only where the prisoner “poses a credible continuing and serious threat to the security of others or to the prisoner’s own safety[.]”⁴²¹
- Congress should enact legislation requiring the BOP, state, and local jurisdictions to collect data on the number of incarcerated persons with disabilities, as well as those in solitary confinement or other forms of restrictive housing, reasons for placement in solitary confinement, and average length of stay.
- Congress should appropriate additional funding for Protection & Advocacy organizations to increase their capacity to engage in monitoring and oversight of corrections institutions and to increase their capacity to advocate on behalf of incarcerated persons with physical disabilities more broadly.

DEPARTMENT OF JUSTICE

- The Office of the Inspector General of the Department of Justice should investigate the conditions of confinement for incarcerated persons with disabilities held in BOP facilities.
- The Department of Justice should audit state and federal prisons on an annual or biannual basis to evaluate whether corrections facilities have completed self-evaluation plans or are otherwise in compliance with the regulations governing public entities under Title II of the ADA.
- The Department of Justice should augment its existing guidelines on the treatment of prisoners in solitary confinement or restrictive housing in the *DOJ Report and Recommendations Concerning the Use of Restrictive Housing* to include prisoners with physical disabilities consistent with the recommendations in this report.

3. State and Local

State legislatures and municipal bodies should:

- Ban the placement of incarcerated persons with physical disabilities in solitary confinement, except in rare and exceptional cases, for a short duration, and only where the prisoner “poses a credible continuing and serious threat to the security of others or to the prisoner’s own safety.”⁴²²
- Require state corrections entities to report on the numbers of incarcerated persons with physical disabilities held in solitary in each facility within the state and the nature of their disabilities.
- Collect and monitor data on the provision of accommodations to persons with physical disabilities in solitary confinement, including but not limited to the rates of removal/refusal of accommodations, use of uncertified interpreters or other prisoners, and the rates of denial for accommodations due to cost, etc.

B. MODEL POLICIES AND PROCEDURES

1. General Principles

- Placements into solitary confinement must not last longer than 15 days at a time.⁴²³
- Solitary confinement must only be used in rare and exceptional cases, for a short duration, and only where the prisoner “poses a credible continuing and serious threat to the security of others or to the prisoner’s own safety[.]”⁴²⁴ All placement decisions must be reviewed by an independent authority within 48 hours of placement.
- Vulnerable populations must be expressly excluded from solitary confinement, including youth, pregnant women, persons with psychiatric disabilities, and persons whose mental or physical

disabilities will be exacerbated by placement into solitary. If placed in solitary confinement, these vulnerable populations should be consistently monitored for deterioration in physical and mental health, and diverted from solitary confinement and provided with appropriate medical or mental health treatment where deterioration occurs.

- All placement decisions must be supported with specific and concrete justifications that are supported by objective evidence.

2. General Principles Regarding Incarcerated Persons With Physical Disabilities

- Solitary confinement must be “prohibited in the case of prisoners with mental or physical disabilities when their conditions would be exacerbated by such placement.”⁴²⁵ Incarcerated persons with physical disabilities should never be placed into solitary confinement because the facility lacks accessible cells for people with physical disabilities, or for protective custody purposes, such as after reporting sexual assault.
- Reasonable accommodations must be provided to all incarcerated persons with physical disabilities who are held in solitary confinement. These accommodations are necessary to ensure equal access to all programs, services, and activities that are available to non-disabled prisoners.

3. Process Prior to Placement

- All prisoners must receive adequate and meaningful process prior to placement into solitary confinement. All placement decisions should be evaluated by a multidisciplinary team that includes custody staff, medical personnel, mental health professionals, and the warden or deputy warden. Officials in charge of reviewing placement decisions must have objective, written evidence of reasons justifying placements into solitary. Adequate and meaningful process includes:

- **Notice** of the reasons for placement into solitary confinement, including the evidence used in making the placement decision. Notice should be written and provided in a format that is accessible to all persons, including those with sensory disabilities. Ensuring that decisions are accessible includes providing qualified sign language interpreters to deaf persons who sign and who are placed into solitary, or require providing materials in Braille, large text, or audio formats.
- A **hearing** before a neutral arbiter whereby the prisoner can offer evidence, as well as present and confront witnesses, where doing so would not pose a substantial threat to the safety and security of the prisoner, other prisoners, or the facility. The hearing must include accommodations (i.e., auxiliary aids and services) to ensure effective communications with prisoners with sensory disabilities and must be housed in a location that can be accessed by prisoners with mobility-related disabilities.
- An opportunity to **appeal** all placement decisions to a neutral arbiter. The appeals process must be provided in a format that is accessible to prisoners with sensory disabilities.
- **Periodic review** of all placement decisions by the warden, or a designated official, with recommendations from the multidisciplinary team, for all placements that exceed the 15-day limit. Review should occur every 14 days. The purpose of periodic review is to ensure that the reasons justifying placement remain, and that housing the prisoner in a less restrictive setting would not avoid the risks to the prisoner’s personal safety, and the safety and security of other prisoners, staff, and the facility.
- Prisoners must be afforded a process to progress out of solitary confinement and acquire access to programming and increased privileges. This process should include clear and specific criteria for progressing to less restrictive housing. Prisoners should be afforded increased privileges as they progress from solitary and into less restrictive

housing. The policies governing progression out of solitary must be provided in accessible formats to all persons with sensory disabilities.

4. Disciplinary Segregation

- Prisoners should be placed into solitary confinement only where the prisoner “poses a credible continuing and serious threat”⁴²⁶ to safety and security, and only where other sanctions (including the removal of certain privileges for a limited period of time) are not appropriate.
- Prisoners must be afforded the opportunity to appeal all convictions to a neutral arbiter. The appeals process must be provided in a format that is accessible to prisoners with sensory disabilities.
- Disciplinary segregation should not extend beyond a brief period—i.e., not more than 15 days. Segregation beyond a brief period should be imposed only in cases where the prisoner “poses a credible continuing and serious threat.”⁴²⁷
- Placement into disciplinary segregation should occur only after a disciplinary hearing whereby the prisoner is presented with the nature of and evidence supporting the charges, is permitted to offer evidence, and is permitted to present and confront witnesses, where doing so would not pose a substantial threat to the safety and security of the prisoner, other prisoners, or the facility. All information provided at the disciplinary hearing must be in an accessible format.
- Under no circumstances should a prisoner with sensory disabilities (hearing, sight, speech) be disciplined for failure to respond to a command that the prisoner is unable to comprehend via the communication method used. For example, disciplining a deaf or hard of hearing prisoner for failing to respond to an audio alarm or alert, disciplining a blind or low vision prisoner for failing to respond to a visual alarm or alert, or disciplining persons with speech disabilities for failing to orally respond to a command, should not be permitted.

5. Protective Custody

- Prisoners who are separated from general population for protective reasons must not be placed into solitary confinement. At a minimum, these prisoners should be held in the least restrictive conditions possible to ensure their safety while also maximizing their out-of-cell time, and access to meaningful social interaction and constructive activity.
- Privileges such as telephone use, visitation, and commissary access must not be removed for prisoners placed in protective custody.

6. Conditions

- Accessible cells must be provided in housing units for all security levels. At a minimum, the law requests that 3 percent—but no fewer than one cell—must be designed to accommodate wheelchair users.⁴²⁸
- Under no circumstances should a prisoner with a physical disability be denied access to reasonable accommodations as a form of punishment.
- No prisoner should be denied access to durable medical equipment or assistive devices while in isolation for an indefinite period of time. If the removal of durable medical equipment or an assistive device would exacerbate the prisoner’s disability, then the assistive device is necessary and removal should be avoided unless in exceptional circumstances and then only for a limited period of time. Corrections staff should presume that a

“We are not asking for additional services, we are asking for equal access.”

—TALILA A. LEWIS, FOUNDER AND EXECUTIVE DIRECTOR, HEARD

prisoner can safely possess their assistive device unless the prisoner has misused the assistive device in the past. If there is a reason to believe that the prisoner will pose a threat to themselves or others with the assistive device, then the prisoner should be placed under continuous watch when the device is in their possession.⁴²⁹ Absent specific, concrete, and objective evidence that providing such a device would pose a credible and serious risk to the prisoner’s own safety, other prisoners, staff, or the safety and security of the institution, assistive devices should be provided to prisoners in solitary confinement where requested. The denial of accommodations for security reasons should last no longer than necessary to prevent the threats to safety and security that justify the placement into solitary confinement, and must be supported by specific and concrete evidence. Any denials must be approved in writing by the warden or another high-level official of the facility.

- Decisions denying requests for accommodations, or removing accommodations previously provided, must be in writing, in accessible formats, and must be made with input from medical professionals and ADA Coordinators, where necessary, and submitted to the warden or another ranking official for final approval.
- Factors to consider when determining whether the requested assistive device or medical equipment poses a threat to the safety of persons and the security of the facility:
 - The need for the accommodation;
 - Whether the accommodation is necessary;
 - Whether the prisoner’s disability would be exacerbated by the removal of the assistive device;
 - Whether the prison accommodation was previously provided to the prisoner in general population or less restrictive housing;
 - Whether the prisoner’s accommodation was previously determined to be appropriate by staff at another correctional facility within the state’s jurisdiction;

- The prisoner’s custody level;
 - The specific circumstances justifying placement into solitary confinement;
 - The likelihood that the prisoner may use the assistive device to cause physical harm; and
 - Whether a temporary removal of the device would address the safety and security concerns.
- Prisoners must be afforded out-of-cell time and access to individual programming; group programming; recreation time; outdoor exercise time; face-to-face interaction with corrections, medical, and mental health staff; visitation; telephone calls; radio; correspondence; reading materials; and commissary. Where these privileges are provided, accommodations must be made for persons with physical disabilities to ensure that access is at least commensurate with that of non-disabled persons.
 - Accessible programming means removing structural barriers that obstruct physical access to locations where programs and services are housed (e.g., uneven floors, narrow doorways, uneven pavement, etc.) or moving programming to an accessible location. It also includes providing accommodations to facilitate effective communications (e.g., videophones, video relay services, sign language interpreters, audio text for blind or low vision prisoners, visual alerts for deaf and hard of hearing prisoners, etc.) so that persons with physical disabilities can participate in programs and services offered at the facility.
 - Prisoners should not be subjected to extreme isolation and total sensory deprivation. Prisoners should not be placed in housing that subjects them to complete auditory isolation (e.g., soundproof cells) and a total lack of visual stimuli (e.g., complete darkness, limited access to natural light, and/or 24-hour access to white light, etc.).

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IX. APPENDICES

- I. List of Resources for Advocates
 - A. List of Organizations (National Disability Rights Organizations and P&As)
 - B. A Quick Guide to the ADA Regulations
- II. Know Your Rights: Legal Rights of Prisoners With Disabilities
- III. The Time for Change Is Now: Reflections From Advocates

ENDNOTES

1. Custody population data was obtained from the Bureau of Justice Statistics. *See* E. ANN CARSON, PRISONERS IN 2014, U.S. DEP’T OF JUSTICE, OFFICE OF JUSTICE PROGRAMS, BUREAU OF JUSTICE STATISTICS (2015), *available at* <http://www.bjs.gov/content/pub/pdf/p14.pdf> [hereinafter PRISONERS IN 2014].

2. The Rhode Island DOC’s response includes only mobility devices.

3. The Florida DOC reported that as of March 23, 2016, 41 grievances remained pending. The Florida DOC records did not provide an explanation for what happened to the remaining 751 grievances that were neither resolved nor remained pending as of March 23, 2016.

4. The Ohio DOC reported that from January 2015 to January 2016, 43 accommodations were approved by Ohio DOC officials, 10 were partially approved, and 30 were denied. This response from the Ohio DOC does not specify if the requests for these accommodations were filed separately from the grievances process.

5. *Dinkins v. Corr. Med. Servs.*, 743 F.3d 633, 634 (8th Cir. 2014); *see also* Compl. for Declaratory & Injunctive Relief ¶ 370, *Disability Rights Florida v. Jones*, Civil Action No. 4:16-cv-00047-WS-CAS (Jan. 26, 2016), *available at* <http://www.floridajusticeinstitute.org/wp-content/uploads/2016/01/drf-complaint.pdf> [hereinafter *Disability Rights Florida* Complaint] (“From October 2012 through December 2013, Mr. Jackson was not permitted to have his wheelchair in his CM cell. He was forced to drag himself across the dirty and abrasive cell floor, where it was very difficult to transfer to the bed, toilet, and wash basin.”).

6. *Wheeler v. Butler*, No. 04-1834-pr, 2006 WL 3770830, at **1 (2d Cir. Dec. 13, 2006).

7. Compl. ¶ 20, *Muhammad v. Wicomico Cnty. Dep’t of Corr.*, Civ. Action No. 15-cv-02679 (D. Md. Sept. 10, 2015) [hereinafter *Wicomico Cnty. Compl.*].

8. *Id.* ¶ 2.

9. J.M. did not provide his full name.

10. Survey Responses from Five Deaf Prisoners, Maryland Correctional Institution-Jessup, to author 7 (Apr. 22, 2016) [hereinafter Survey Responses from Five Deaf Prisoners] (on file with author).

11. *See* Special Rapporteur of the Human Rights Council on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, *Interim Report of the Special Rapporteur of the Human Rights Council on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, ¶ 76-78, U.N. Doc. A/66/268 (Aug. 5, 2011), *available at* <http://solitaryconfinement.org/uploads/SpecRapTortureAug2011.pdf>.

12. *See* discussion *infra* Part III.A-B.

13. THE LIMAN PROGRAM, YALE LAW SCHOOL, ASS’N OF STATE CORR. ADM’RS, TIME-IN-CELL: THE ASCA-LIMAN 2014 NATIONAL SURVEY OF ADMINISTRATIVE SEGREGATION IN PRISON 3 (2015), *available at* https://www.law.yale.edu/system/files/area/center/liman/document/asca-liman_administrativesegregationreport.pdf. The data collected does not include those prisoners who are “held awaiting trial or in military or immigration detention.” *Id.* at 3.

14. *See, e.g.*, Matt Pearce, *Last “Angola 3” Prisoner Is Freed After Decades in Solitary Confinement*, L.A. TIMES, (Feb. 19, 2016, 7:01 p.m.), <http://www.latimes.com/local/lanow/la-na-last-angola-3-prison-released-20160219-story.html> (discussing case of Albert Woodfox, who was released in February 2016 after being held for over three decades in solitary confinement in the Louisiana State Penitentiary at Angola).

15. *See generally* MICHELLE ALEXANDER, THE NEW JIM CROW 4 (2010) (observing that “mass incarceration in the United States had, in fact, emerged as a stunningly comprehensive and well-disguised system of racialized social control that functions in a manner strikingly similar to Jim Crow.”).

16. Loïc Wacquant, *Class, Race & Hyper-incarceration in Revanchist America*, DÆDALUS 78 (2010), *available at* http://loicwacquant.net/assets/Papers/CLASS_RACEHYPERINCARCERATION-pub.pdf (arguing that incarceration is concentrated in, and targeted against, certain classes, races, and geographic locales, with its primary target being low-income Black men in urban settings).

17. In his historic op-ed for the *Washington Post* on this

issue, President Obama remarked, “[h]ow can we subject prisoners to unnecessary solitary confinement, knowing its effects, and then expect them to return to our communities as whole people? It doesn’t make us safer. It’s an affront to our common humanity.” Barack Obama, *Why We Must Rethink Solitary Confinement*, WASH. POST (Jan. 25, 2016), https://www.washingtonpost.com/opinions/barack-obama-why-we-must-rethink-solitary-confinement/2016/01/25/29a361f2-c384-11e5-8965-0607e0e265ce_story.html. In the summer of 2015, the president ordered then-Attorney General Eric Holder to conduct an audit of the overuse of solitary confinement in federal prisons. The outcome of the review was an extensive report along with a set of recommendations and guiding principles—that the president adopted—that will inform the Federal Bureau of Prisons’ ongoing efforts to reform solitary confinement. *See* U.S. DEP’T OF JUSTICE, U.S. DEP’T OF JUSTICE REPORT & RECOMMENDATIONS CONCERNING THE USE OF RESTRICTIVE HOUSING (2016), *available at* <http://www.justice.gov/dag/file/815551/download> [hereinafter DOJ REPORT & RECOMMENDATIONS].

18. *Davis v. Ayala*, 135 S. Ct. 2187, 2210 (2015) (Kennedy, J., concurring) (“[R]esearch still confirms what this Court suggested over a century ago: Years on end of near-total isolation exact a terrible price. . . . In a case that presented the issue, the judiciary may be required, within its proper jurisdiction and authority, to determine whether workable alternative systems for long-term confinement exist, and, if so, whether a correctional system should be required to adopt them.”).

19. *See, e.g.*, Settlement Agreement, *Ashker v. Brown*, Civ. Action No. 4:09-5796-CW (Aug. 31, 2015), *available at* http://ccrjustice.org/sites/default/files/attach/2015/09/2015-09-01-ashker-Settlement_Agreement.pdf.

20. *See, e.g.*, Settlement Agreement, *Peoples v. Fischer*, et al., Civil Action No. 1:11-cv-02694-SAS (Dec. 16, 2015), *available at* http://www.nyclu.org/files/releases/20151216_settlementagreement_filed.pdf [hereinafter *Peoples Settlement Agreement*].

21. *See, e.g.*, THE BRONX DEFENDERS, VOICES FROM THE BOX: SOLITARY CONFINEMENT AT RIKERS ISLAND (2014), *available at* <http://www.bronxdefenders.org/wp-content/uploads/2014/09/Voices-From-the-Box.pdf>; NEW YORK CIVIL LIBERTIES UNION, BOXED IN: THE TRUE COST OF EXTREME ISOLATION IN NEW YORK’S PRISONS (2012), *available at* http://www.nyclu.org/files/publications/nyclu_boxedin_FINAL.pdf.

22. *See* Erica Goode, *Senators Start a Review of Solitary Confinement*, N.Y. TIMES (June 19, 2012), http://www.nytimes.com/2012/06/20/us/senators-start-a-review-of-solitary-confinement.html?_r=0.

23. *Ashker v. Governor of California: Case Timeline*, CTR. FOR CONSTITUTIONAL RIGHTS, [https://ccrjustice.org/home/what-](https://ccrjustice.org/home/what-we-do/our-cases/ashker-v-brown)

[we-do/our-cases/ashker-v-brown](https://ccrjustice.org/home/what-we-do/our-cases/ashker-v-brown) (last visited Oct. 6, 2016); *see also* Sal Rodriguez, *One Year Anniversary of Pelican Bay Hunger Strike Against Solitary Confinement*, SOLITARY WATCH (July 3, 2012), <http://solitarywatch.com/2012/07/03/one-year-anniversary-of-pelican-bay-hunger-strike-against-solitary-confinement/>.

24. Email from Dean Westwood, formerly incarcerated, Diversity and Inclusion Consultant, to author (July 29, 2016, 9:38 p.m.) (on file with author).

25. *See, e.g.*, Class Action Compl. ¶ 93, Lewis, et al., v. Cain, et al., Civ. Action No. 3:15-cv-00318-BAJ-RLB (May 20, 2015), *available at* <http://www.clearinghouse.net/chDocs/public/PC-LA-0015-0001.pdf> (alleging failures by Louisiana DOC to provide assistance to prisoners unable to feed themselves, engage in self-care, or perform personal hygiene tasks without assistance from staff).

26. Although Title II specifically mentions reasonable modifications, *see* 42 U.S.C.A. § 12131(2) (West 2016), this report will use the more commonly known term “reasonable accommodations.”

27. 42 U.S.C.A. §§ 12101-213 (West 2016).

28. *See, e.g.*, 2d Amend. Compl. ¶¶ 15, 25-26, 41-45, *Wilson v. Livingston*, Civ. Action No. 4:14-cv-01188 (Jan. 26, 2015) (alleging that the Texas Department of Criminal Justice assigned only one specialist trained in serving prisoners with disabilities to handle the entire Estelle facility and required Blind prisoners to reside in transitory housing because there were no accessible beds available in permanent housing units). To see a video of the Estelle Unit, visit here: <https://www.youtube.com/watch?v=lyEkTbqlpxw>.

29. *See, e.g.*, Amend. Compl. ¶¶ 2, 11-25, *Williams v. Baldwin*, Civ. Action No. 3:16-50055 (N.D. Ill. Apr. 19, 2016).

30. *See, e.g.*, *Disability Rights Florida*, *supra* note 5, at ¶ 21(c).

31. JENNIFER BRONSON, ET AL., U.S. DEP’T OF JUSTICE, OFFICE OF JUSTICE PROGRAMS, BUREAU OF JUSTICE STATISTICS, DISABILITIES AMONG PRISON AND JAIL INMATES, 2011-12, 1 (2015), <http://www.bjs.gov/content/pub/pdf/dpji1112.pdf> [hereinafter BJS DISABILITY REPORT]. The report defines disability to include “hearing, vision, cognitive, ambulatory, self-care, and independent living, which refers to the ability to navigate daily life schedules, activities, and events without assistance.” *Id.*

32. *Id.* at 3. According to the BJS DISABILITY REPORT, prisoners were about two times more likely than persons in the general population to report independent living, ambulatory, and hearing disabilities; about three times more likely to report a visual disability; and four times more likely

to report a cognitive disability. Forty percent of jail inmates, compared to 9 percent of those in the general population, reported having a disability (table 2). When compared to the general population, jail inmates were about 2.5 times more likely to report an ambulatory and independent living disability, more than three times more likely to report a visual and hearing disability, and 6.5 times more likely to report a cognitive disability[.]

33. *See, e.g.*, Andrew Cohen, *One of the Darkest Periods in the History of American Prisons*, THE ATLANTIC (Jun. 9, 2013), <http://www.theatlantic.com/national/archive/2013/06/one-of-the-darkest-periods-in-the-history-of-american-prisons/276684/>.

34. *See, e.g.*, Press Release, Am. Civ. Liberties Union, Civil Rights Groups File Lawsuit Alleging Massive Civil Rights Violation at Mississippi Prison (May 30, 2013), <https://www.aclu.org/news/civil-rights-groups-file-lawsuit-alleging-massive-human-rights-violations-mississippi-prison?redirect=prisoners-rights/civil-rights-groups-file-lawsuit-alleging-massive-human-rights-violations>.

35. *See, e.g.*, Eyal Press, *Madness*, THE NEW YORKER (May 2, 2016), <http://www.newyorker.com/magazine/2016/05/02/the-torturing-of-mentally-ill-prisoners>; Danny Robbins, *Women’s Deaths Add to Concerns About Georgia Prison Doctor*, ATL. J. CONSTIT. (Mar. 28, 2015), <http://investigations.myajc.com/prison-medicine/womens-deaths-add-concerns/>; Brian Joseph, *Jailhouse Medicine - A Private Contractor Flourishes Despite Controversy Over Prisoner Deaths*, PRISON LEGAL NEWS (Apr. 1, 2016), <https://www.prisonlegalnews.org/news/2016/apr/1/jailhouse-medicine-private-contractor-flourishes-despite-controversy-over-prisoner-deaths/>.

36. *See, e.g.*, NATIONAL PRISON RAPE ELIMINATION COMM’N, NATIONAL PRISON RAPE ELIMINATION COMMISSION REPORT 3-5 (2009), *available at* <https://www.ncjrs.gov/pdffiles1/226680.pdf>.

37. Eyal Press, *Madness*, THE NEW YORKER (May 2, 2016), <http://www.newyorker.com/magazine/2016/05/02/the-torturing-of-mentally-ill-prisoners>.

38. *See, e.g.*, Julie K. Brown, *Disabled Inmate Sues Florida Over Bathroom Ban*, THE MIAMI HERALD (Apr. 6, 2016, 1:30 p.m.), <http://www.miamiherald.com/news/special-reports/florida-prisons/article70290622.html> (describing allegations by a prisoner, a wheelchair user, who reported being denied access to a restroom and then being ridiculed by corrections staff after he urinated on himself).

39. *See, e.g.*, CALIFORNIA OFFICE OF THE INSPECTOR GENERAL, 2015 SPECIAL REVIEW: HIGH DESERT STATE PRISON, SUSANVILLE, CA 42 (2015), *available at* <https://www.prisonlegalnews.org/media/publications/Special%20Review%20-%20>

[High%20Desert%20State%20Prison,%20Office%20of%20the%20Inspector%20General.%202015.pdf](https://www.prisonlegalnews.org/media/publications/Special%20Review%20-%20High%20Desert%20State%20Prison,%20Office%20of%20the%20Inspector%20General.%202015.pdf) (describing case involving a prisoner with mobility-related disabilities who was picked up from out of his wheelchair and thrown into his cell after he “resisted being placed in a cell”); Benjamin Weiser & Michael Schwirtz, *U.S. Inquiry Finds a ‘Culture of Violence’ Against Teenage Inmates at Rikers Island*, N.Y. TIMES (Aug. 4, 2014), <http://www.nytimes.com/2014/08/05/nyregion/us-attorneys-office-reveals-civil-rights-investigation-at-rikers-island.html>; Joe Coscarelli, *8 Appalling Stories of Inmate Abuse from Rikers Island’s Teen Jails*, NEW YORK MAG. (Aug. 1, 2014, 3:19 p.m.), <http://nymag.com/daily/intelligencer/2014/08/8-appalling-stories-of-abuse-from-rikers-island.html>; David M. Reutter, *Abuse and Assaults Continue at Pennsylvania Jail*, PRISON LEGAL NEWS (Feb. 15, 2011), <https://www.prisonlegalnews.org/news/2011/feb/15/abuse-and-assaults-continue-at-pennsylvania-jail/>.

40. *See, e.g.*, Kenneth Lipp, *Alabama Prisoners Use Secret Cell Phones to Protest—and Riot*, THE DAILY BEAST (Mar. 21, 2016), <http://www.thedailybeast.com/articles/2016/03/21/alabama-prisoners-use-secret-cell-phones-to-protest-and-riot.html>; Matthew Teague, *DOJ to Investigate Alabama Prisons in “Possibly Unprecedented” Move*, THE GUARDIAN (Oct. 6, 2016, 5:17 p.m.), <https://www.theguardian.com/us-news/2016/oct/06/alabama-prison-doj-investigation>.

41. AP, *DOC: Arizona Prison Inmate Found Unresponsive in Cell Dies*, THE WASH. TIMES (July 20, 2016), <http://www.washingtontimes.com/news/2016/jul/20/doc-arizona-prison-inmate-found-unresponsive-in-ce/>; Hillel Aron, *Why Are So Many Inmates Attempting Suicide at the California Institution for Women?*, LA WEEKLY (July 20, 2016), <http://www.laweekly.com/news/why-are-so-many-inmates-attempting-suicide-at-the-california-institution-for-women-7156615>; Ames Alexander, *NC Prisons Hit with Year’s 5th Inmate Suicide*, THE CHARLOTTE OBSERVER (July 6, 2016, 11:58 a.m.), <http://www.charlotteobserver.com/news/local/article87947232.html>.

42. Rebecca Boone, *Private Prison Company CCA to Face Trial in Violence Lawsuit*, U.S. NEWS (July 7, 2016, 5:22 p.m.), <http://www.usnews.com/news/us/articles/2016-07-07/private-prison-company-cca-to-face-trial-in-violence-lawsuit>; Stephanie Stokes, *Gang Violence Prompts Georgia State Prison Lockdowns*, WABE.ORG (July 6, 2016), <http://news.wabe.org/post/gang-violence-prompts-georgia-state-prison-lockdowns>; *What We Know About Violence in America’s Prisons*, MOTHER JONES (July/August 2016), <http://www.motherjones.com/politics/2016/06/attacks-and-assaults-behind-bars-cca-private-prisons>; C1 Staff, *CO Union Calls on DOC to Address Violence at Auburn Correctional Facility*, CORRECTIONSONE.COM (Mar. 18, 2015), <http://www.correctionsone.com/officer-safety/articles/8466463->

CO-union-calls-on-DOC-to-address-violence-at-Auburn-Correctional-Facility/; *Ohio’s Prisons Grow Less Violent Despite More Assaults on Guards*, PRISON LEGAL NEWS (June 11, 2015), <https://www.prisonlegalnews.org/news/2015/jun/11/ohios-prisons-grow-less-violent-despite-more-assaults-guards/>.

43. See, e.g., *Disability Rights Florida* Complaint, *supra* note 5, ¶¶ 368-372 (alleging assault by a corrections officer on a prisoner, a wheelchair user, in retaliation for that prisoner’s pro se lawsuit naming other corrections officers as defendants).

44. See *infra* note 82 and accompanying text.

45. See, e.g., Nancy Wolff & Jing Shi, *Contextualization of Physical and Sexual Assault in Male Prisons: Incidents and Their Aftermath*, J. OF CORR. HEALTH CARE, Jan. 2009, at 1, 9 (“Sexual orientation and mental illness/disability of the victim were identified as motivating the sexual assault of one-quarter of victims who were assaulted by other inmates.”). Indeed, the Prison Rape Elimination Act (PREA) includes affirmative obligations on the part of prison officials to make sure that prisoners with disabilities are protected from sexual abuse and harassment. Specifically, PREA regulations require that information relating to sexual abuse resources and services be made accessible to people with disabilities. 28 C.F.R. § 115.16 (2016); *see also* SANDRA HARRELL ET AL., MAKING PREA AND VICTIM SERVICES ACCESSIBLE FOR INCARCERATED PEOPLE WITH DISABILITIES: AN IMPLEMENTATION GUIDE FOR PRACTITIONERS ON THE ADULT & JUVENILE STANDARDS, NAT’L PREA RESOURCE CENTER 6-9 (2015), <http://www.vera.org/sites/default/files/resources/downloads/prea-victim-services-incarcerated-people-disabilities-guide.pdf> [hereinafter GUIDE ON MAKING PREA ACCESSIBLE].

46. Talila A. Lewis, *#DeafInPrison Campaign Fact Sheet*, HEARD 3 (June 26, 2014), <http://www.behearddc.org/images/pdf/deafinprison%20fact%20sheet%20.pdf> (discussing reported abuses of deaf prisoners).

47. See, e.g., GUIDE ON MAKING PREA ACCESSIBLE, *supra* note 46, at 5-6 (“[P]eople with disabilities were three times more likely to be the victims of violent crimes than their counterparts without disabilities, and those with multiple disabilities experienced higher rates of violent victimization than those with one disability.”).

48. James Ridgeway & Jean Casella, *Deaf Prisoners in Florida Face Abuse and Solitary Confinement*, SOLITARY WATCH (May 21, 2013), *available at* <http://solitarywatch.com/2013/05/21/deaf-prisoners-in-florida-face-brutality-and-solitary-confinement/> (quoting HEARD, REPORT ON TOMOKA CORRECTIONAL INSTITUTION IN DAYTONA BEACH, FLORIDA (2013), *available at* <http://www.behearddc.org/images/pdf/heard%20report%20on%20abuse%20and%20retaliation%20>

[2013%20.pdf](https://www.behearddc.org/images/pdf/heard%20report%20on%20abuse%20and%20retaliation%20).

49. See, e.g., Compl. ¶¶ 73-77, *Gizewski v. New York State Dep’t of Corr. & Cmty. Supervision*, Civ. Action No. 9:14-cv-124-GTS-DJS (N.D.N.Y. Feb. 4, 2014) (describing allegations by New York state prisoner that a corrections officer pushed him out of his wheelchair and kicked him in his abdomen, resulting in the prisoner losing consciousness); CRUEL CONFINEMENT: ABUSE, DISCRIMINATION AND DEATH WITHIN ALABAMA’S PRISONS, SOUTHERN POVERTY LAW CENTER 18 (2014), https://www.splcenter.org/sites/default/files/d6_legacy_files/downloads/publication/cruel_confinement.pdf [hereinafter CRUEL CONFINEMENT] (“A hearing-impaired prisoner reports being hit by a corrections officer for not responding to an order he couldn’t hear.”); Maurice Chammah, *Report: Blind, Deaf, Disabled Inmates Abused in Prison*, THE TEXAS TRIBUNE (Jan. 27, 2015), <https://www.texastribune.org/2015/01/27/report-blind-deaf-disabled-inmates-abused-prison/> (describing letters written by prisoners alleging attacks by corrections staff resulting in “serious injuries, including missing teeth, busted skulls, broken bones, ruptured eyeballs and prolonged hospitalizations.”).

50. Relying on data gleaned from a survey to prisoners at the facility, the Prison Justice League concluded that 46 percent of prisoners who identified as deaf, blind, or as possessing a physical disability have been victims of assault at the hands of other prisoners and corrections staff. ERICA GAMMILL & KATE SPEAR, CRUEL & UNUSUAL PUNISHMENT: EXCESSIVE USE OF FORCE AT THE ESTELLE UNIT, PRISON JUSTICE LEAGUE 6 (2015), *available at* https://static.texastribune.org/media/documents/Cruel_Usual_Punishment_-_PJL_Final.pdf.

51. *Id.* at 9-10.

52. See, e.g., *Casey v. Lewis*, 834 F. Supp. 1569, 1581 (D. Ariz. 1993) (describing legally blind prisoner who reported incidents where urine and feces were thrown into his cell).

53. By the end of 2014, Alabama prisons were at 192.7 percent of the design capacity for which those prisons were designed. PRISONERS IN 2014, *supra* note 1, at 12. Design capacity refers to the “number of beds that the facility was originally designed to hold.” *Id.* at 11.

54. By the end of 2014, California operated it prisons at 136.6 percent of the capacity for which those prisons were designed. *Id.* at 12.

55. Colorado operated it prisons at 115.1 percent of the design and operational capacity by year-end 2014. *Id.* Operational capacity is “based on the ability of the staff, programs, and services to accommodate a certain size

population[.]” *Id.* at 11.

56. Delaware prisons were at 161.7 percent of design capacity for the state’s prison facilities by the end of 2014. *Id.* at 12.

57. By the end of 2014, prisons in Hawaii were at 159.2 percent of design capacity. *Id.*

58. Idaho prisons were at 109.3 percent of operational and design capacity at the end of 2014. *Id.*

59. In 2014, Illinois prisons operated at 171.1 percent of their design capacity. *Id.*

60. Iowa prisons in 2014 operated at 112.8 percent of design and operational capacity. *Id.*

61. Kansas prisons were at 104.1 percent of that state’s design capacity in 2014. *Id.*

62. Kentucky prisons in 2014 operated at 104.5 percent of operational capacity. *Id.*

63. Louisiana prisons in 2014 operated at 119.3 percent of operational capacity. *Id.*

64. Maine prisons in 2014 operated at 103.1 percent of operational capacity. *Id.*

65. Massachusetts prisons in 2014 operated at 130.1 percent of design capacity. *Id.*

66. Minnesota prisons ran at 101.3 percent of operational capacity in 2014. *Id.*

67. Missouri prisons ran at 100.7 percent of operational capacity in 2014. *Id.*

68. Nebraska prisons in 2014 operated at 159.6 percent of design capacity. *Id.*

69. New Hampshire prisons in 2014 operated at 124.3 percent of design capacity. *Id.*

70. In 2014, New York prisons operated at 102.8 percent of design capacity. *Id.*

71. In 2014, Ohio prisons operated at 131.9 percent of rated capacity. *Id.* Rated capacity “measures the number of beds assigned by a rating official to each facility[.]” *Id.* at 11.

72. Oklahoma prisons operated at 115.7 percent of design capacity in 2014. *Id.* at 12.

73. Pennsylvania operated it prisons at 101.2 percent of the design and operational capacity by year-end 2014. *Id.*

74. Vermont prisons operated at 117 percent of the design capacity in 2014. *Id.*

75. Virginia prisons operated at 117.6 percent of the design

capacity in 2014. *Id.*

76. Washington prisons ran at 102.6 percent of operational capacity in 2014. *Id.*

77. In 2014, West Virginia prisons operated at 126.3 percent of rated capacity. *Id.*

78. In 2014, Wisconsin prisons operated at 131.4 percent of design capacity. *Id.*

79. The Federal Bureau of Prisons operated at 128 percent of rated capacity. *Id.*

80. See, e.g., *Coleman v. Schwarzenegger*, 922 F. Supp. 2d 882, 931 (E.D. Cal. 2009) (“Crowding generates unsanitary conditions, overwhelms the infrastructure of existing prisons, and increases the risk that infectious diseases will spread.”); CRUEL CONFINEMENT, *supra* note 49, at 10 (“The conditions within the state’s prisons, which are grossly overcrowded, make spread of disease nearly inevitable. Prisoners in every facility report the presence of vermin, especially rats and spiders. At the Fountain Correctional Facility in Atmore, there were large amounts of what appeared to be rat droppings on cans of food in the kitchen. At Holman, the SPLC was informed that a bird had been flying around in the kitchen for several weeks. What appeared to be bird droppings were found on a bed in a prison dorm.”).

81. See, e.g., *Dealing with California’s Overcrowded Prisons*, NATIONAL PUBLIC RADIO (May 26, 2011), <http://www.npr.org/2011/05/26/136685989/dealing-with-californias-overcrowded-prisons>.

82. See, e.g., BUREAU OF PRISONS: GROWING INMATE CROWDING NEGATIVELY AFFECTS INMATES, STAFF, AND INFRASTRUCTURE, U.S. GOV’T ACCOUNTABILITY OFFICE (2012), *available at* <http://www.gao.gov/assets/650/648123.pdf> (noting that overcrowding contributes to “increased inmate misconduct, which negatively affects the safety and security of inmates and staff”); *see also* HANDBOOK ON PRISONERS WITH SPECIAL NEEDS, UNITED NATIONS OFFICE ON DRUGS AND CRIME 45 (2009) [hereinafter HANDBOOK ON PRISONERS WITH SPECIAL NEEDS] (“[P]risoners with disabilities are easy targets for abuse and violence from other prisoners and prison staff.”).

83. See, e.g., Jeffrey L. Metzner & Jamie Fellner, *Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics*, 38 J. AM. ACAD. PSYCHIATRY L. 105 (2010), *available at* <http://www.jaapl.org/content/38/1/104.full.pdf+html> (“Persons with mental illness are often impaired in their ability to handle the stresses of incarceration and to conform to a highly regimented routine. They may exhibit bizarre, annoying, or dangerous behavior and have higher rates of disciplinary infractions than other prisoners. Prison officials generally respond to them as they do to other prisoners who break the rules. When lesser

sanctions do not curb the behavior, they isolate the prisoners in the segregation units, despite the likely negative mental health impact. Once in segregation, continued misconduct, often connected to mental illness, can keep the inmates there indefinitely.”).

84. Grant Schulte, *Nebraska Prison Funding a Priority Despite Budget Shortfall*, THE WASHINGTON TIMES, (Sept. 18, 2016), <http://www.washingtontimes.com/news/2016/sep/18/nebraska-prison-funding-a-priority-despite-budget-/>.

85. See, e.g., Michael Dresser, *Maryland has severe shortage of correctional officers, union says*, THE BALTIMORE SUN (Jun. 30, 2016, 7:28 p.m.), <http://www.baltimoresun.com/news/maryland/bs-md-afscme-prisons-20160630-story.html>; Patrick Marley & Jason Stein, *Facing Staffing Shortage, Wisconsin Raises Prison Workers’ Wages*, GOVERNING (May 9, 2016), <http://www.governing.com/topics/public-justice-safety/tns-wisconsin-prison-workers.html>; Mark Peters, *Prison Guards Are Hard to Capture as Jobless Rates Fall*, WALL ST. J. (March 19, 2016, 6:01 p.m.), <http://www.wsj.com/articles/prison-guards-are-hard-to-capture-as-jobless-rates-fall-1458597678>; Jen Fifield, *Many States Face Dire Shortage of Prison Guards*, THE PEW CHARITABLE TRUSTS (Mar. 1, 2016), <http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/03/01/many-states-face-dire-shortage-of-prison-guards>.

86. In Michigan, prison overcrowding is one of the factors limiting the ability of staff at Huron Valley Correctional Facility to meet the health care needs for women, contributing to shocking accounts of neglect and substandard care for people with physical disabilities. See Riyah Basha, *At Huron Valley Correctional Facility, Reflections of Statewide Prison Woes*, THE MICH. DAILY (June 1, 2016, 8:40 p.m.), <https://www.michigandaily.com/section/news/huron-valley-correctional-facility-reflections-statewide-prison-woes>.

87. See HUMAN RIGHTS WATCH, OLD BEHIND BARS: THE AGING PRISON POPULATION IN THE UNITED STATES 73-75 (2012), available at https://www.hrw.org/sites/default/files/reports/usprisons0112webwcover_0.pdf [hereinafter OLD BEHIND BARS]; see also AT AMERICA’S EXPENSE: THE MASS INCARCERATION OF THE ELDERLY, AM. CIVIL LIBERTIES UNION (2012), available at https://www.aclu.org/sites/default/files/field_document/elderlyprisonreport_20120613_1.pdf. The population of elderly prisoners is expected to increase significantly. From 1995 to 2010, “the number of state and federal prisoners age 55 or older nearly quadrupled (increasing 282 percent), while the number of all prisoners grew by less than half (increasing 42 percent).” OLD BEHIND BARS at 6; see also *Accommodation of Wheelchair-Bound Prisoners*, 10 AMERICANS FOR EFFECTIVE LAW ENFORCEMENT MONTHLY L. J. 301, 301 (2009), available at <http://www.aele.org/law/2009all10/2009-10MLJ301.pdf> (“A growing population of aging prisoners, as a result of a number of

factors, including sentencing changes with more lifetime or effectively lifetime sentences, along with denial of parole for repeat offenders or offenders with more serious crimes, also has presented correctional officials with many more disabled prisoners.”).

88. OLD BEHIND BARS, *supra* note 87, at 75-77.

89. According to Human Rights Watch, “[e]leven percent of federal prisoners age 51 or older are serving sentencing ranging from 30 years to life.” OLD BEHIND BARS, *supra* note 87, at 6.

90. OLD BEHIND BARS, *supra* note 87, at 72-79.

91. For example, under the ADA, “[t]he term ‘disability’ means, with respect to an individual--(A) a physical or mental impairment that substantially limits one or more major life activities of such individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment (as described in paragraph (3)).” 42 U.S.C. § 12102(1). The term “major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working.” 42 U.S.C. § 12102(2)(A).

92. BJS DISABILITY REPORT, *supra* note 31, at 2.

93. JOHNS HOPKINS UNIV., HOMEWOOD STUDENT AFFAIRS, STUDENT DISABILITY SERVS., <http://studentaffairs.jhu.edu/disabilities/about/types-of-disabilities/> (last visited Sept. 27, 2016).

94. *How are the terms deaf, deafened, hard of hearing, and hearing impaired typically used?* WASH. UNIV. (Aug. 24, 2015), <http://www.washington.edu/doit/how-are-terms-deaf-deafened-hard-hearing-and-hearing-impaired-typically-used> [hereinafter *Deaf Terminology*].

95. *Community and Culture—Frequently Asked Questions*, NATIONAL ASS’N. OF THE DEAF, <http://nad.org/issues/american-sign-language/community-and-culture-faq> (last visited Sept. 27, 2016).

96. *Deaf Terminology*, *supra* note 94.

97. *Glossary of Eye Conditions*, Am. Found. for the Blind (last visited Sept. 27, 2016), <http://www.afb.org/info/living-with-vision-loss/eye-conditions/12>.

98. *Id.* Low vision “cannot be fully corrected by eyeglasses, contact lenses, or surgery. However, a person with low vision may benefit from any of a variety of available optical devices, such as electronic magnifying glasses or eyeglass-mounted telescopes. In addition, special software developed for computer users with low vision can

display type in large size or read text aloud.” *Id.*

99. Definitions of deafblindness, SENSE, <https://www.sense.org.uk/content/definitions-deafblindness> (last visited Sept. 27, 2016).

100. *Assistive devices and technologies*, WORLD HEALTH ORG., <http://www.who.int/disabilities/technology/en/> (last visited Sept. 27, 2016).

101. Jessie L. Krienert, et al., *Inmates with Physical Disabilities: Establishing a Knowledge Base*, 1 SOUTHWEST J. OF CRIM. JUSTICE 20 (2003), available at http://www.swacj.org/swjcj/archives/1.1/Krienert_et_al.pdf [hereinafter *Inmates with Physical Disabilities*].

102. *Id.*

103. *Id.* at 19.

104. *Id.* at 20.

105. *People First Language*, Nat’l Black Disability Coalition, <http://blackdisability.org/content/people-first-language-0> (last visited Sept. 27, 2016).

106. *Id.*

107. See Lydia X. Z. Brown, *Identity-First Language*, AUTISTIC SELF ADVOCACY NETWORK, <http://autisticadvocacy.org/home/about-asan/identity-first-language/> (last visited Sept. 27, 2016) (providing a comprehensive overview of the arguments supporting and opposing people-first language); Rosemarie Garland-Thomson, *Becoming Disabled*, N.Y. TIMES (Aug. 19, 2016), <http://www.nytimes.com/2016/08/21/opinion/sunday/becoming-disabled.html> (discussing debate around the “politics of self-naming”).

108. *Portrayal of People with Disabilities*, ASS’N OF UNIV. CTR. ON DISABILITIES, <https://www.aucd.org/template/page.cfm?id=605> (last visited Sept. 27, 2016).

109. *Id.* At the same time, simply asking people for their preferences for terminology is also recommended. *Id.*

110. See, e.g., JANE CAMPBELL & MIKE OLIVER, DISABILITY POLITICS: UNDERSTANDING OUR PAST, CHANGING OUR FUTURE 105 (1996); Phil Smith, *There Is No Treatment Here: Disability and Health Needs in A State Prison System*, 25 DISABILITY STUDIES QUARTERLY (2005), available at <http://dsq-sds.org/article/view/571/748> [hereinafter *Disability & Health Needs in a State Prison System*]; see also Subini Ancy Annamma, et al., *Dis/ability Critical Race Studies (DisCrit): Theorizing at the intersection of race and dis/ability*, 16 RACE ETHNICITY & EDUCATION 1, 12-13 (2013).

111. See, e.g., Vilissa Thompson & Alice Wong, *#GetWokeADA26: Disabled People of Color Speak Out, Part Two*, RAMP YOUR VOICE!/DISABILITY VISIBILITY PROJECT (July

26, 2016), <https://disabilityvisibilityproject.com/2016/07/26/getwokeada26-disabled-people-of-color-speak-out-part-two/> (capturing perspectives of disabled people of color).

112. See CAROL GILL & WILLIAM CROSS, JR., DISABILITY IDENTITY AND RACIAL-CULTURAL IDENTITY DEVELOPMENT: POINTS OF CONVERGENCE, *in* RACE, CULTURE, AND DISABILITY: REHABILITATION SCIENCE AND PRACTICE 49 (Fabricio E. Balcazar et al. eds., 2010) (“Disability status intersects with multiple axes of diversity and marginalization, including race, gender, sexuality, class/caste, and age. Moreover, varieties of impairment—physical, sensory, learning, psychiatric—contribute to disabled people’s diversity of experience and perspectives.”); Subini Ancy Annamma et al., *supra* note 110, at 12 (“DisCrit emphasizes multidimensional identities . . . rather than singular notions of identity, such as dis/ability, social class, or gender.”).

113. See generally ASHLEY NELLIS, THE COLOR OF JUSTICE: RACIAL & ETHNIC DISPARITY IN STATE PRISONS, THE SENTENCING PROJECT (2016), available at <http://www.sentencingproject.org/wp-content/uploads/2016/06/The-Color-of-Justice-Racial-and-Ethnic-Disparity-in-State-Prisons.pdf>; THE WAR ON MARIJUANA IN BLACK & WHITE: BILLIONS OF DOLLARS WASTED ON RACIALLY BIASED ARRESTS, AM. CIV. LIBERTIES UNION (2013), available at <https://www.aclu.org/report/report-war-marijuana-black-and-white>.

114. MATTHEW W. BRAULT, AMERICANS WITH DISABILITIES: 2010, HOUSEHOLD ECONOMIC STUDIES, U.S. CENSUS BUREAU 6 (2012), available at <http://www.census.gov/prod/2012pubs/p70-131.pdf> (listing age-adjusted and unadjusted disability rates by gender and race).

115. Karen I. Fredriksen-Goldsen et al., *Disability Among Lesbian, Gay, and Bisexual Adults: Disparities in Prevalence and Risk*, 102 AM. J. OF PUB. HEALTH e16 (2012), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3490559/> (finding higher rate of disability among lesbian, gay, and bisexual adults); Tracy Garza, *Why out community should fight for disability rights, too*, TRANSGENDER LAW CTR. (Dec. 28, 2012), available at <http://transgenderlawcenter.org/archives/2923>.

116. DORIS J. JAMES & LAUREN E. GLAZE, MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES, U.S. DEP’T OF JUSTICE, OFFICE OF JUSTICE PROGRAMS, BUREAU OF JUSTICE STATISTICS, 1 (2006), <http://www.bjs.gov/content/pub/pdf/mhppji.pdf> [MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES].

117. *Blind Prisoner Dies After Confrontation with the Guards*, PRISON LEGAL NEWS (Feb 15, 2011), <https://www.prisonlegalnews.org/news/2011/feb/15/blind-texas-prisoner-dies-after-confrontation-with-guards/>.

118. Out of the 10 public records requests sent to the targeted jurisdictions, only three produced the requested data

on the number of persons with physical disabilities in solitary confinement or restrictive housing. The Nevada Department of Corrections reported that 3 blind or low vision prisoners, 5 deaf or hard of hearing prisoners, and 23 prisoners with mobility-related disabilities were held in some form of restrictive housing. *See* Letter from Brooke Keast, Public Information Officer, Nev. Dep’t of Corr. to author (Aug. 26, 2016) (on file with author). Georgia reported that between 15 and 21 prisoners with a hearing disability, 703 and 731 prisoners with a visual disability, and 5 and 7 prisoners listed as having another type of “impairment” are held in some form of restrictive housing, with conditions similar to solitary confinement, as of the date of the response. *See* Email from Jason Mitchell, Assistant Counsel, Georgia Dep’t of Corrections, Office of Legal Services (Sept. 27, 2016, 11:58 a.m.). The Pennsylvania Department of Corrections reported 56 prisoners with vision disabilities, 12 prisoners with hearing disabilities, and 28 prisoners with mobility disabilities. *See* Email from Andrew Filkosky, Agency Open Records Officer, Office of Chief Counsel, Pa. Dep’t of Corr., to author (Oct. 31, 2016). The remaining states did not possess or maintain records with that information. *See, e.g.*, Email from Dianne Houpt, Public Information Specialist, Florida Dep’t of Corr. (Aug. 15, 2016, 3:17 p.m.) (on file with author); Email from Trina Hirsig, Assistant Gen. Counsel, Class Actions, California Dep’t of Corr. & Rehabilitation to author (Aug. 12, 2016, 6:43 p.m.) (on file with author); Email from Kathleen Kelly, Chief Legal Counsel, Rhode Island Dep’t of Corr. (July 28, 2016, 10:05 a.m.) (on file with author) (noting that there were no records related to the request and that Rhode Island DOC did not identify any prisoners having the disabilities in some form of solitary confinement); Letter from Susan Wall Griffin, Atty. for the Secretary, Louisiana Dep’t of Public Safety & Corr. to author 2 (July 25, 2016) (“The Department does not track the housing locations of these categories of offenders beyond to which institution the offender is assigned.”); Email from Roger Wilson, Chief Inspector, Ohio Dep’t of Rehabilitation and Corr. (Jun. 10, 2016) (on file with author); Letter from Lisa Weitekamp, FOIA Officer, Illinois Dep’t of Corr. to author (Feb. 2, 2016) (on file with author); Email from Michele S. Howell, Legal Issues Coordinator, Virginia Dep’t of Corr. (Oct. 24, 2016) (on file with author).

119. *Inmates with Physical Disabilities*, *supra* note 101, at 13.

120. BJS DISABILITY REPORT, *supra* note 31, at 1.

121. MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES, *supra* note, at 1.

122. LEWIS KRAUS, 2015 DISABILITY STATISTICS ANNUAL REPORT, INSTITUTE ON DISABILITY/UCED 3 (2015), *available at* <http://www.disabilitycompendium.org/docs/default->

[source/2015-compendium/annualreport_2015_final.pdf](http://www.disabilitycompendium.org/docs/default-source/2015-compendium/annualreport_2015_final.pdf).

123. *See, e.g.*, Brief in Supp. of Pl.’s Mot. for Specific Performance at 8, Langford, et al., v. Bullock, et al., Civ. Action No. 6:93-cv-00046-DWM-JCL (D. Mont. June 24, 2013), *available at* https://www.aclumontana.org/sites/default/files/field_documents/1494_brief_in_support.pdf [hereinafter *Langford* Brief] (“MSP does not track disabled prisoners. . . . Accordingly, even if a disabled individual is properly identified, it is unlikely he will receive the necessary accommodation.” (citing Program Access Assessment & Facility Accessibility Survey Report at 11, Langford, et al., v. Bullock, et al., Civ. Action No. 6:93-cv-00046-DWM-JCL (D. Mont. June 27, 2013))); *see also id.* at 11 (“[Montana State Prison] has failed to establish a comprehensive screening process to identify prisoners with . . . mobility, vision, speech and hearing disabilities, as the ADA requires. . . . As a result, Defendants fail to accommodate disabled prisoners in programs and facilities[.]”).

124. Jurisdictions were asked to report on data from January 2013 through the present (or the date of the public records requests).

125. Custody population data was obtained from the Bureau of Justice Statistics. *See* PRISONERS IN 2014, *supra* note 1, at 3.

126. Rhode Island DOC’s response includes mobility devices only. Letter from Susan Lamkins, Programming Services Officer, Rhode Island Dep’t of Corr. to author (Apr. 26, 2016) (on file with author).

127. *See, e.g.*, *State of Iowa, Department of Corr. Offender Grievance Compl.*, UNIV. OF MICH. LAW SCHOOL, *available at* https://www.law.umich.edu/special/policyclearinghouse/Documents/Iowa_Sample_Grievance_Form.pdf (last visited Oct. 13, 2016).

128. *See, e.g.*, *Prison and Jail Grievance Policies*, UNIV. OF MICH. LAW SCHOOL, *available at* <https://www.law.umich.edu/facultyhome/margoschlanger/Pages/PrisonGrievanceProceduresandSamples.aspx> (last visited Oct. 13, 2016) (listing sample grievance policies and procedures for state prisons and local jails).

129. *See, e.g.*, *Administrative Policies & Procedures*, Tenn. Dep’t of Corr., *Index # 501.01* at 2-3 (May 1, 2004), UNIV. OF MICH. LAW SCHOOL, *available at* https://www.law.umich.edu/facultyhome/margoschlanger/Documents/Resources/Prison_and_Jail_Grievance_Policies/Tennessee_Policy.pdf (last visited Oct. 13, 2016).

130. *See, e.g.*, *Administrative Regulation*, Colo. Dep’t of Corr., *Regulation No. 850-01* at 3-4 (Dec. 15, 2015), *available at* https://www.law.umich.edu/facultyhome/margoschlanger/Documents/Resources/Prison_and_Jail_Grievance_Policies/Colorado_Policy.pdf (last visited Sept.

27, 2016).

131. *See, e.g.*, *Administrative Directive, Inmate Grievance Procedure*, Ark. Dep’t of Corr., No. 04-01 2 at 2-3 (Feb. 1, 2004), *available at* https://www.law.umich.edu/facultyhome/margoschlanger/Documents/Resources/Prison_and_Jail_Grievance_Policies/Arkansas_Policy.pdf (list visited Sept. 27, 2016) (listing types of complaints by prisoners that are prohibited).

132. For example, a study of five prison handbooks determined that each handbook included text at or above an eleventh grade English reading level, which is well above the reading level for the average deaf person. Jean F. Andrews, *Deaf Inmates: Cultural and Linguistic Challenges and Comprehending the Inmate Handbook*, 36 CORR. COMPENDIUM 14 (2011), *available at* <https://deafinprison.com/2012/03/09/136/>.

133. *See, e.g.*, Press Release, Virginia Dep’t of Corr., Virginia’s Restrictive Housing Reforms Highlighted by the U.S. Department of Justice: Few Offenders Remain in Restrictive Housing in Virginia Prisons (Mar. 3, 2016), *available at* http://vadoc.virginia.gov/news/press-releases/16mar3_DOJ.shtm (noting 71 percent reduction in prisoner grievances since reforms to reduce population in restrictive housing at Red Onion State Prison).

134. The Florida Department of Corrections reported that as of March 23, 2016, 41 grievances remained pending. The records did not specify what happened to the remaining 751 grievances that were neither resolved nor remain pending from January 2013 through March 23, 2016. *See* Email from Donna Beard, Office of General Counsel, Florida Dep’t of Corr. to author (Mar. 24, 2016) (on file with author).

135. Ohio reported that from January 2015 to January 2016, 43 accommodations requests were approved by DOC officials, 10 were partially approved, and 30 were denied. *See* Email from Roger Wilson, Chief Inspector, Ohio Dep’t of Rehabilitation & Corr. to author (June 21, 2016) (on file with author). It is not clear whether the requests for these accommodations were filed separately from the grievances.

136. Grievances that are noted as “pending” are marked from the date listed on the state Department of Corrections’ letter responding to the public records request.

137. As of March 23, 2016.

138. As of March 17, 2016.

139. According to the Louisiana Department of Corrections, the total number “includes accommodations requested or recommended through medical call outs in additional to formal grievances during the relevant time period.” Letter from Susan W. Griffin, Att’y for the Sec’y, Louisiana Dep’t of Public Safety & Corr. to author 2 (Mar. 17, 2016) (on file

with author).

140. The records submitted from Ohio are from January 2015 to 2016 only. The Ohio DOC reported that it was unable to query the data using the precise terms of the public records request (e.g., “disabilities”), but after using the search term “handicapped facilities,” the search returned a total of three grievances filed. Email from Roger Wilson, Chief Inspector, Ohio Dep’t of Rehabilitation & Corr. to author (June 10, 2016) (on file with author).

141. The records submitted from Ohio are only from January 2015 to January 2016.

142. The Ohio Department of Corrections did not have data on the number of grievances filed by prisoners with disabilities. A public records official from Ohio stated that “[a]ll grievances are resolved within 14 days of receipt by the inspector unless there is an extension of an additional 14 days. There are no pending grievances from 2015.” Email from Roger Wilson, Chief Inspector, Ohio Dep’t of Rehabilitation & Corr., to author (June 10, 2016) (on file with author). However, the Ohio Department of Corrections did report that from January 2015 to January 2016, there were 43 accommodations that were approved, 10 that were partially approved, and 30 that were denied. Email from Roger Wilson, Chief Inspector, Ohio Dep’t of Rehabilitation & Corr., to author (June 21, 2016) (on file with author).

143. As of May 4, 2016.

144. Rhode Island Department of Corrections reported only one complaint that was formally processed through the Governor’s Commission on Disabilities. Letter from Susan Lamkins, Programming Services Officer to author 1 (Apr. 26, 2016) (on file with author).

145. *See* Metzner & Fellner, *supra* note 83, at 104-05; Stuart Grassian, *Psychiatric Effects of Solitary Confinement*, 22 WASH. U. J.L. & POL’Y 325, 333-338 (2006), *available at* http://openscholarship.wustl.edu/law_journal_law_policy/vol22/iss1/24/.

146. Expert Report of Brie Williams 8-13, *Parsons v. Ryan*, No. 2:12-cv-00601-NVW (MEA) (D. Ariz. Nov. 8, 2013), *available at* <https://www.aclu.org/legal-document/parsons-v-ryan-expert-report-brie-williams-md-ms> [hereinafter Dr. Brie Williams Expert Report]; *see also* Class Action Compl. ¶ 75(c), *Lewis v. Cain*, Civil Action No. 3:15-cv-00318-BAJ-RLB (May 20, 2015), *available at* https://www.laaclu.org/resources/2015/lewis/052015Lewis_FiledComplaint.pdf (describing prisoner who is quadriplegic who alleges he did not receive physical therapy for years).

147. Timothy Hughes & Doris J. Wilson, *Reentry Trends in the United States: Inmates Returning to the Community after Serving Time in Prison*, BUREAU OF JUSTICE STATISTICS

(last visited Oct. 14, 2016), *available at* <https://www.bjs.gov/content/pub/pdf/reentry.pdf>.

148. *See, e.g.*, Lawson v. Dallas Cnty., 286 F.3d 257, 260 (5th Cir. 2002) (“Lawson was in good health when he entered the jail. However, without proper medical care paraplegics such as Lawson are at risk of developing decubitus ulcers, caused by unrelieved pressure on the body, which can be life-threatening. Various medical equipment and personal assistance used to prevent decubitus ulcers are part of basic medical training for doctors and nurses and are standard medical procedure in caring for paraplegics.”).

149. Letter from D.R., prisoner at Louisiana State Penitentiary at Angola, to author (Jan. 26, 2016) (on file with author).

150. Frank Rundle, *The Roots of Violence at Soledad, in* THE POLITICS OF PUNISHMENT: A CRITICAL ANALYSIS OF PRISONS IN AMERICA 167 (Erik Olin Wright, ed., 1973), *available at* https://www.ssc.wisc.edu/~wright/Published%20writing/pop_c8.pdf.

151. *See* Peter Scharff Smith, *The Effects of Solitary Confinement on Prison Inmates: A Brief History of the Literature*, 34 CRIME & JUSTICE 441, 476-81 (2006) (summarizing literature discussing harms of solitary confinement).

152. *See, e.g.*, National Commission on Correctional Health Care, Solitary Confinement (Isolation) (2016), *available at* <http://www.ncchc.org/solitary-confinement> [hereinafter NCCHC Statement]; The National Alliance on Mental Illness, Public Policy Platform, *available at* https://www.nami.org/NAMI/media/NAMI-Media/downloads/Public-Policy-Platform_9-22-14.pdf; American Public Health Association, Solitary Confinement as a Public Health Issue (2013), *available at* <http://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/14/13/30/solitary-confinement-as-a-public-health-issue>; Society of Correctional Physicians, Position Statement, Restricted Housing of Mentally Ill Inmates (2013), *available at* <http://societyofcorrectionalphysicians.org/resources/position-statements/restricted-housing-of-mentally-ill-inmates>; American Psychiatric Association, Position Statement on Segregation of Prisoners with Mental Illness (2013), *available at* http://www.dhcs.ca.gov/services/MH/Documents/2013_04_AC_06c_APA_ps2012_PrizSeg.pdf; Mental Health America, Policy Position Statement 24: Seclusion and Restraints (2015), <http://www.nmha.org/positions/seclusion-restraints>.

153. *See, e.g.*, Stuart Grassian, *Psychopathological Effects of Solitary Confinement*, 140 AM. J. OF PSYCHIATRY 1450, 1451-1453 (1983); Craig Haney, *Mental Health Issues in Long-Term Solitary and “Supermax” Confinement*, 49 CRIME & DELINQUENCY 124, 130-145 (2003), *available at*

<http://www.supermaxed.com/NewSupermaxMaterials/Haney-MentalHealthIssues.pdf>; Richard Korn, *The Effects of Confinement in the High Security Unit at Lexington*, 15 SOCIAL JUSTICE 14-16 (1988), *available at* http://www.jstor.org/stable/29766384?seq=1#page_scan_tab_contents; Holly A. Miller & Glenn R. Young, *Prison Segregation: Administrative Detention Remedy or Mental Health Problem?*, 7 CRIMINAL BEHAVIOUR AND MENTAL HEALTH 85, 89-93 (1997).

154. *See, e.g.*, Michael Bauer et al., *Long-Term Mental Sequelae of Political Imprisonment in East Germany*, 181 J. NERVOUS & MENTAL DISEASE 257, 258-61 (1993); Korn, *supra* note 153, at 8-19; Miller & Young, *supra* note 153, at 85-94; Peter Suedfeld et al., *Reactions and Attributes of Prisoners in Solitary Confinement*, 9 CRIMINAL JUSTICE & BEHAVIOR 303, 315-318 (1982).

155. *See, e.g.*, Bauer et al., *supra* note 154, at 259.

156. *See, e.g.*, Henrik Andersen et al., *A Longitudinal Study of Prisoners on Remand: Repeated Measures of Psychopathology in the Initial Phase of Solitary Versus Nonsolitary Confinement*, ACTA PSYCHIATRICA SCANDINAVICA 19, 20-25 (2000); Stuart Grassian & N. Friedman, *Effects of Sensory Deprivation in Psychiatric Seclusion and Solitary Confinement*, 8 INT’L J. L. & PSYCHIATRY 49, 54 (1986); Grassian, *supra* note 153, at 1452; Haney, *supra* note 153, at 133.

157. *See, e.g.*, Grassian, *supra* note 145, at 335.

158. *See, e.g.*, Haney, *supra* note 153, at 134; Miller & Young, *supra* note 153, at 93.

159. *See, e.g.*, Grassian, *supra* note 153, at 1452; Haney, *supra* note 153, at 134.

160. *See* Haney, *supra* note 153, at 134; Miller & Young, *supra* note 153, at 89-91.

161. *See, e.g.*, Grassian, *supra* note 153, at 1452-53; Haney, *supra* note 153, at 133-34; Korn, *supra* note 153, at 15; Miller & Young, *supra* note 153, at 90.

162. *See, e.g.*, Grassian, *supra* note 153, at 1451-53; Haney, *supra* note 153, at 134; Korn, *supra* note 153, at 15.

163. *See, e.g.*, Grassian, *supra* note 153, at 1453; Haney, *supra* note 153, at 138-39.

164. *See, e.g.*, Bauer et al., *supra* note 154, at 259-60; Grassian, *supra* note 153, at 1453; Haney, *supra* note 153, at

134; Miller & Young, *supra* note 153, at 90-91.

165. *See, e.g.*, Grassian, *supra* note 153, at 1453.

166. *See* Haney, *supra* note 153, at 139.

167. *See, e.g., id.*

168. *See, e.g.*, Andersen et al., *supra* note 156, at 22; Haney, *supra* note 153, at 134; Korn, *supra* note 153, at 14-15.

169. *See, e.g.*, Grassian, *supra* note 153, at 1453.

170. *See, e.g.*, Grassian, *supra* note 153, at 1453; Haney, *supra* note 153, at 134.

171. Paul Gendreau, et al., *Changes in EEG Alpha Frequency and Evoked Response Latency During Solitary Confinement*, 79 J. OF ABNORMAL PSYCHOLOGY 54, 57-58 (1972).

172. *Id.*

173. This figure is based on the findings from the ASCA/ Liman *Time in Cell* Report, which estimates approximately 80,000-100,000 prisoners are held in solitary confinement. *See* Time In Cell, *supra* note 13, at 3. Data on the total numbers of persons held in state and federal prisons in the United States (1,561,500) was taken from the 2014 Bureau of Justice Statistics Report. *See* DANIELLE KAEBLE, ET AL., CORRECTIONAL POPULATIONS IN THE UNITED STATES, 2014 at 5 (Jan. 21, 2016), *available at* <http://www.bjs.gov/content/pub/pdf/cpus14.pdf>.

174. Stuart Grassian & Terry Kupers, *The Colorado Study vs. the Reality of Supermax Confinement*, 13 CORR. MENTAL HEALTH REPORT 1, 11 (2011), *available at* https://www.probono.net/prisoners/stopsol-reports/416638.The_Colorado_Study_vs_the_Reality_of_Supermax_Confinement; *see also* Jennifer R. Wynn & Alisa Szatrowski, *Hidden Prisons: Twenty-Three-Hour Lockdown Units in New York State Correctional Facilities*, 24 PACE L. REV. 497, 516 (2004), *available at* <http://digitalcommons.pace.edu/cgi/viewcontent.cgi?article=1202&context=plr> (“More than half of prison suicides in New York take place in twenty-three-hour lockdown units, although less than 10 percent of the inmate population is housed in them.”).

175. *See, e.g.*, Homer Venters et al., *Solitary Confinement and Risk of Self-Harm Among Jail Inmates*, 104 AM. J. PUBLIC HEALTH, 442, 445-446 (2014), *available at* <http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2013.301742>. Similarly, in California prisons in 2004, 73 percent of all suicides occurred in isolation units, even though these units make up approximately 6 percent of the state’s total prison population. Expert Report of Professor Craig Haney at 45-46 n.119, Coleman v. Schwarzenegger, No. CIV S-90-0520 LKK JFM P (E.D. Cal. 2010), *available at* http://rbgg.com/wp-content/uploads/_Haney.%20Dr.%20Craig%20

[\(3201\).%2010-30-08.%20OCR.PDF](https://www.bjs.gov/content/pub/pdf/cpus14.pdf).

176. Jennifer Gonnerman, *Kalief Browder, 1995-2015*, THE NEW YORKER (June 7, 2015), <http://www.newyorker.com/news/news-desk/kalief-browder-1993-2015>. In July 2016, the New York State Legislature passed “Kalief’s Law” to reduce the time spent in jail pre-trial and to ensure a speedy trial. *See* Stephon Johnson, *State Assembly Passes ‘Kalief’s Law’ to Reform Pretrial Detention*, N.Y. AMSTERDAM NEWS (June 9, 2016, 12:18 p.m.), <http://amsterdamnews.com/news/2016/jun/09/state-assembly-passes-kaliefs-law-reform-pretrial-/>.

177. *See, e.g., Wicomico Cnty. Compl., supra* note 7, ¶ 27 (noting that plaintiff was in an “extremely emotionally fragile state during his five and a half week stay in solitary confinement” due to the recent death of his 12-year-old son); Bruce A. Arrigo & Jennifer L. Bullock, *The Psychological Effects of Solitary Confinement on Prisoners in Supermax Units: Reviewing What We Know and Recommending What Should Change*, 52 INTERNAT’L J. OF OFFENDER THERAPY & COMPARATIVE CRIMINOLOGY, 622, 627-29 (2008) (discussing negative psychological consequences of long-term solitary confinement).

178. HANDBOOK ON PRISONERS WITH SPECIAL NEEDS, *supra* note 82, at 46 (“Increased mental health care needs have been noted for example among prisoners who have sensory disabilities—conditions which are isolating in themselves and more so in prisons, where the special needs of such persons are rarely taken into account and where they can be victims of psychological abuse and bullying.”).

179. *See, e.g.,* Maurice Chammah, *Do You Age Faster in Prison?*, THE MARSHALL PROJECT (Aug. 24, 2015, 7:15 a.m.), <https://www.themarshallproject.org/2015/08/24/do-you-age-faster-in-prison#.0dguWhdbC>; *see also* HANDBOOK ON PRISONERS WITH SPECIAL NEEDS, *supra* note 82, at 44 (“The difficulties people with disabilities face in society are magnified in prisons, given the nature of the closed and restrictive environment and violence resulting from overcrowding, lack of proper prisoner differentiation and supervision, among others. Prison overcrowding accelerates the disabling process, with the neglect, psychological stress and lack of adequate medical care, characteristic of overcrowded prisons.”).

180. *See, e.g.,* Compl. ¶¶ 6-8, Fox v. Peters, Civil Action No. 6:16-cv-01602-MC, ECF No. 1 (Aug. 8, 2016) (“Plaintiff entered the Oregon Department of Corrections in late 2010. On July 11, 2015, Plaintiff collapsed in his segregation cell at Two Rivers Correctional Unit. As a result he went into spinal shock, and suffers from a central cervical cord injury. Plaintiff is now physically paralyzed and uses a wheelchair for mobility. He has very limited use of his upper extremities, and no use of his lower extremities.”); *see also* Order 2, Fox v. Peters, Civil Action No. 6:16-cv-

01602-MC, ECF No. 14 (Aug. 11, 2016), *available at* <https://docs.justia.com/cases/federal/district-courts/oregon/ordce/6:2016cv01602/128326/14> (“Upon beginning his prison term in 2010, Fox was an able-bodied individual. . . . Due to the neglect of prison officials, Fox sustained injuries in July 2015. . . . While the cause of Fox’s injuries is likely disputed, no one disputes that Fox has severe limitations with mobility.”).

181. HANDBOOK ON PRISONERS WITH SPECIAL NEEDS, *supra* note 82, at 46; *see also* Mem. Order on Pl.’s Mot. for Prelim. Inj. at 5, *Reaves v. Dep’t of Corr.*, Civil Action No. 4:15-cv-40100-TSH (D. Mass. Jul. 15, 2016) (“Reaves’s condition has significantly deteriorated during his twenty years of incarceration. When he was in rehabilitation shortly after his injury, he was able to shave the left side of his face, brush his teeth, and feed himself. He could sit in a wheelchair and take a shower on a shower stretcher. Now, he is unable to do any of those things. His hip and knee joints are frozen and can no longer be bent to sit in a wheelchair, while his elbows cannot be unlocked from a bent position. He cannot open his hands and fingers from clenched fists. The skin on his legs is susceptible to long-lasting open wounds and requires daily care and bandaging. He is underweight. He testified that his condition continued to worsen during his most recent stay at SBCC, during which he lost weight, muscle tone, and flexibility in his lower extremities, and incurred increased tightness in his arms and left wrist. He testified that he does not understand what it means to be ‘healthy’ as a quadriplegic.”).

182. *See, e.g.*, Letter from A.C., prisoner, to author (Jun. 22, 2016) (on file with author) (reporting that he was not offered any physical therapy after he had a stroke on Aug. 29, 2015). A.C. has not provided permission to be identified.

183. National Commission on Correctional Health Care, *supra* note 152.

184. For example, people with quadriplegia may be at risk of death due to a condition known as autonomic dysreflexia, particularly if they are rough handled, placed into tight clothing, or subjected to other mistreatment that leads to overstimulation in the area of the body that is below the spinal cord injury. Autonomic dysreflexia is a common and dangerous side effect of spinal cord injuries:

Autonomic dysreflexia means an over-activity of the Autonomic Nervous System. It can occur when an irritating stimulus is introduced to the body below the level of spinal cord injury, such as an overfull bladder. The stimulus sends nerve impulses to the spinal cord, where they travel upward until they are blocked by the lesion at the level of injury. Since the impulses cannot reach the brain, a reflex is activated that increases

activity of the sympathetic portion of autonomic nervous system. This results in spasms and a narrowing of the blood vessels, which causes a rise in the blood pressure. Nerve receptors in the heart and blood vessels detect this rise in blood pressure and send a message to the brain. The brain sends a message to the heart, causing the heartbeat to slow down and the blood vessels above the level of injury to dilate. However, the brain cannot send messages below the level of injury, due to the spinal cord lesion, and therefore the blood pressure cannot be regulated.

Other Complications of Spinal Cord Injury: Autonomic Dysreflexia (Hyperreflexia), LOUIS CALDER MEM’L LIBRARY, UNIV. OF MIAMI/JACKSON MEM’L MED. CTR., <http://calder.med.miami.edu/pointis/automatic.html> (last visited Oct. 17, 2016).

185. Telephone Interview with Dean Westwood, formerly incarcerated, Diversity and Inclusion Consultant (July 20, 2016).

186. Architectural barriers include things like narrow hallways or doorways; stairs not equipped with handrails; showers, toilets, or cells that do not include grab bars; uneven or jagged floor surfaces; protruding objects on walls or floors; high food counters or sinks; and door knobs that require full-fisted twisting, pushing, or pulling. Architectural barriers may make it difficult for prisoners to access prison cells, recreation yards, showers, and sleeping areas, particularly when no other accommodations, such as assistive devices or staff support, are provided to the prisoner to facilitate access through other means. *See, e.g., Disability & Health Needs in a State Prison System, supra* note 110 (describing prisoner in Northwest State Correctional Facility—St. Albans who reported that, following a stroke that rendered him partially paralyzed, he was not provided with access to grab bars in the shower). These barriers have exposed prisoners with physical disabilities to a heightened risk of physical harm and some have sustained serious injuries.

A review of reports, court cases, and stories from advocates reveal that many prison facilities remain inaccessible to wheelchair users. *See, e.g.,* Phipps v. Sheriff of Cook Cnty., 681 F. Supp. 2d 899, 904 (N.D. Ill. 2009) (noting allegations by plaintiffs who were wheelchair users and were denied access to showers, toilets, and sinks, and as a result were unable to maintain proper hygiene, developing bed sores and rashes); *Casey*, 834 F. Supp. 1569 at 1575 (noting that the cell door was too narrow to fit a wheelchair in the units in Florence’s Central Unit in Arizona); *ADA/Section 504 Design Guide: Accessible Cells in Correctional Facilities*, U.S. DEP’T OF JUSTICE, CIVIL RIGHTS DIVISION, DISABILITY RIGHTS SECTION 1 (last visited Sept. 27, 2016), [http://www.](http://www.ada.gov/accessible_cells_prt.pdf)

[ada.gov/accessible_cells_prt.pdf](http://www.ada.gov/accessible_cells_prt.pdf) [hereinafter *ADA/Section 504 Design Guide*] (“[M]any correctional facilities do not have enough cells that are accessible to inmates with disabilities.”). The Design Guide also notes that security is *not* compromised by making cells accessible to wheelchair users: “Accessible cells do not compromise the security of prison personnel. In fact, having accessible cells increases security because they allow inmates with mobility disabilities to function independently, minimizing the need for assistance from guards.” *ADA/Section 504 Design Guide, supra*, at 1.

The lack of physical access to prison facilities poses a real danger and raises the risk of potentially serious injuries to prisoners with physical disabilities. *See, e.g.,* Johnson v. Hardin Cnty., 908 F.2d 1280, 1282-84 (6th Cir. 1990) (alleging injury due to fall from elevated and inaccessible shower). In Texas, blind and low vision prisoners at the Estelle Unit brought suit against the Texas Department of Criminal Justice after several prisoners alleged suffering injuries on account of their cells being improperly suited to house persons with visual disabilities. *See* Compl. ¶¶ 33, 47, 58-60, 66, *Wilson v. Livingston*, Civil Action No. 4:14-1188 (Jan. 26, 2015). Inaccessible features, such as overhead lockers, made it such that blind or low vision prisoners were forced to climb up to reach important legal documents or medications, predictably leading to injury. *Id.* ¶¶ 27-34. Such injuries likely could have been avoided if blind and low vision prisoners had been placed in units with proper accommodations, such as units with lockers located on the ground, and provided with other assistance.

187. *See, e.g.,* RACHAEL SEEVERS, MAKING HARD TIME HARDER: PROGRAMMATIC ACCOMMODATIONS FOR INMATES WITH DISABILITIES UNDER THE AMERICANS WITH DISABILITIES ACT, DISABILITY RIGHTS WASHINGTON 16-17 (2016), *available at* <http://www.disabilityrightswa.org/making-hard-time-harder>.

188. *See, e.g.,* United States v. Georgia, 546 U.S. 151, 155 (2006).

189. *Id.*; *see also* Bradley v. Puckett, 157 F.3d 1022, 1024 (5th Cir. 1998) (alleging that prison officials denied prisoner access to a shower for months, forcing him to wash up with toilet water, which led to a fungal infection).

190. *Crowder v. True*, No. 91 C 7427, 1993 WL 532455, *1 (N.D. Ill. Dec. 21, 1993).

191. *Jaros v. Illinois Dep’t of Corr.*, 684 F.3d 667, 669 (7th Cir. 2012).

192. 28 C.F.R. § 35.152(b).

193. *See, e.g.,* Crayton v. Hedgpeth, No. C 08-00621 WHA (PR), 2013 WL 4496714, *2 (E.D. Cal. Aug. 22, 2013) (alleging that plaintiff fell multiple times while in his cell in solitary confinement because it was not equipped with grab

bars).

194. *Trevino v. Woodbury Cty. Jail*, No. C14-4051-MWB, 2015 WL 300267, at *1, *2 (N.D. Iowa Jan. 22, 2015), *report and recommendation adopted*, No. C14-4051-MWB, 2015 WL 2254931 (N.D. Iowa May 13, 2015), *aff’d per curiam*, No. 15-2179 (8th Cir. Dec. 1, 2015).

195. *Id.* at *1.

196. *Id.*

197. *Id.*

198. *Id.* at *2.

199. *Id.*

200. *Id.*

201. *Id.*

202. *See generally* *Noland v. Wheatley*, 835 F. Supp. 476 (N.D. Ind. 1993) (denying defendant’s motion to dismiss detainee’s ADA claims where he alleged jail officials denied him access to sufficient water to take his medications to sustain his kidney functioning and refused to provide him with any soap and enough water to clean his hands when he changed his colostomy and urostomy bags).

203. *See, e.g., Bradley*, 157 F.3d at 1024 (“[Prisoner Mondric Bradley] testified that, because of his disability, he needs assistance to dress and undress himself and that he needs a shower chair to prevent him from falling in the shower. He stated that after he was locked down, he complained about his inability to clean himself, but that the prison officials ignored his complaint. Bradley testified that in order to clean himself he used the toilet in his cell, which ultimately gave him a fungal infection and blisters. He stated that after he came down with the infection and after several complaints, his infection was treated and officials began to take him to the medical clinic to use the bathtub and special shower facilities. Bradley testified that he had gone several months without being able to clean himself before he was provided with the opportunity to bathe.”).

204. Compl. ¶ 12, *Gizweski v. New York State Dep’t of Corr. & Cmty. Supervision*, Civ. Action No. 9:14-cv-124 (N.D.N.Y. Feb. 4, 2014) [hereinafter *Gizweski* Complaint]; *see also* James Ridgeway, *Severely Disabled Man Sues New York State Prisons for Neglect, Abuse*, SOLITARY WATCH (Mar. 27, 2014), <http://solitarywatch.com/2014/03/27/severely->

[disabled-man-sues-new-york-state-prisons-neglect-abuse/](#).

205. *Gizweski* Complaint ¶ 13.

206. *Id.* ¶¶ 67-70.

207. *Id.* ¶ 23.

208. *Id.* ¶ 15.

209. *Id.* ¶¶ 24-25.

210. *Id.* ¶¶ 16, 38, 50.

211. *See, e.g.*, Danny Robbins, *Women’s deaths add to concerns about Georgia prison doctor*, ATLANTIC J. CONSTIT., <http://investigations.myaic.com/prison-medicine/womens-deaths-add-concerns/> (last visited Oct. 17, 2016).

212. *See, e.g.*, Hightower v. Tilton, No. C08-1129-MJP, 2012 WL 1194720, at *2 (E.D. Cal. Apr. 10, 2012) (“Following his assignment to Ad–Seg, his seizure, heart, pain, and stomach medications were confiscated; no replacement medications were issued for several days. A month later, his medications were confiscated again.”); Torres v. Doe, No. 2377 C.D. 2010, 2011 WL 10858421, *1 (Pa. Commw. Ct. Aug. 2, 2011) (prisoner alleged being denied access to asthma medications while in the restricted housing unit).

213. For example, a detainee in county jail raised a similar type of claim, alleging that even though he took his “pain medications at least four times per day to treat nerve damage in his back,” the jail where he was housed failed to provide him with the pain medications at the appropriate times. Civ. Class Action Compl. for Declaratory & Injunctive Relief ¶ 97, Hernandez v. Cnty. of Monterrey, Civil Action 13-02354 (May 23, 2013), *available at* <http://www.clearinghouse.net/chDocs/public/JC-CA-0107-0001.pdf> [hereinafter *Hernandez* Compl.].

214. Interview with Dean Westwood, formerly incarcerated, Diversity and Inclusion Consultant (Feb. 26, 2016).

215. HELL IS A VERY SMALL PLACE 94 (Jean Casella et al., eds., 2016). Herman Wallace spent 41 years in solitary confinement. He died three days after his release from prison. John Schwartz, *Herman Wallace, Freed After 41 Years in Solitary, Dies at 71*, N.Y. TIMES (Oct. 4, 2013), http://www.nytimes.com/2013/10/05/us/herman-wallace-held-41-years-in-solitary-dies-at-71.html?_r=0.

216. Courts have recognized that regular physical exercise is vital for physical health. *See, e.g.*, Patterson v. Mintzes, 717 F.2d 284, 289 (6th Cir. 1983) (“Inmates require regular exercise to maintain reasonably good physical and psychological health.”). Denying prisoners access to physical exercise can violate the Eighth Amendment. *See, e.g.*, Ruiz v. Estelle, 679 F.2d 1115, 1152 (5th Cir. 1982) (“[C]onfinement

of inmates for long periods of time without opportunity for regular physical exercise constitutes cruel and unusual punishment.”).

217. Dr. Brie Williams Expert Report, *supra* note 146, at 4 (“Leading causing of deconditioning include prolonged bed-rest and the absence of regular physical activity.”).

218. Dr. Brie Williams Expert Report, *supra* note 146, at 9 (“Physical inactivity exacerbates disability in osteoarthritis patients.”).

219. Dr. Brie Williams Expert Report, *supra* note 146, at 9-10.

220. *See, e.g.*, *Lawson*, 286 F.3d at 260 (“Lawson is a paraplegic who is paralyzed from the chest down.... Lawson was in good health when he entered the jail. However, without proper medical care paraplegics such as Lawson are at risk of developing decubitus ulcers, caused by unrelieved pressure on the body, which can be life-threatening. Various medical equipment and personal assistance used to prevent decubitus ulcers are part of basic medical training for doctors and nurses and are standard medical procedure in caring for paraplegics.”).

221. *See, e.g.*, Suppl. Expert Report of Brie Williams, M.D., M.S. 2-3, Parsons v. Ryan, No. 2:12-cv-00601-NVM (MEA) (D. Ariz. Sept. 8, 2014), *available at* <http://www.clearinghouse.net/chDocs/public/PC-AZ-0018-0026.pdf> (opining that exercise cages in the isolation units at the Arizona DOC were too small and provided no chairs or benches for sitting, no source of drinking water, and ventilation or cooling).

222. *See, e.g.*, Bane v. Virginia Dep’t of Corr., No. 7:12-CV-159, 2012 WL 6738274, at *1 (W.D. Va. Dec. 28, 2012) (“Because these items were confiscated, Bane allegedly had great difficulty maneuvering around the cell and could not perform the therapeutic walking exercises that eased the pain in his legs and prevented deterioration of his condition.”).

223. *See, e.g.*, Susan Greene, *Legal Settlement Ends Colorado’s Practice of Denying Inmates Fresh Air*, COLO. INDEP. (July 5, 2016), <http://www.coloradoindependent.com/160085/colorado-settlement-inmates-fresh-air> (describing settlement with Colorado DOC that requires the state to provide prisoners at Colorado State Penitentiary and Sterling Correctional Facility with access to outdoor exercise facilities); *Peoples* Settlement Agreement, *supra* note 20, at 21 (“DOCCS will ensure that even under the most restrictive form of disciplinary housing, 16 and 17 year-old inmates shall, 5 days per week (excluding holidays), be offered out-of-cell programming and outdoor exercise, limiting time in their cells to 19 hours a day, except in exceptional

circumstances referred to Central Office.”).

224. Norfleet v. Walker, No. 3:09-cv-00347-JPG-PMF, 2011 WL 55772834, at *1 (S.D. Ill. Nov. 16, 2011).

225. Norfleet v. Walker, 684 F.3d 688, 691 (7th Cir. 2012).

226. *See, e.g.*, Hilde Haualand, *Punished and Isolated: Disabled Prisoners in Norway*, 17 SCANDANAVIAN J. OF DISABILITY RESEARCH 74, 78 (2015), *available at* https://www.researchgate.net/publication/265914027_Punished_and_isolated_disabled_prisoners_in_Norway (describing story of prisoner who required regular physical therapy to prevent deformation but did not receive physical therapy for the first five months of incarceration and received treatment only once every several weeks after that).

227. *Id.*

228. Telephone Interview with Maggie Filler, Staff Attorney, Prisoners’ Legal Services of Massachusetts (October 15, 2015).

229. *Disability Rights Florida* Complaint, *supra* note 5, ¶ 340.

230. *Id.*

231. *Id.* ¶ 341.

232. *Id.* ¶ 342.

233. *Id.* ¶ 344.

234. *Inmates with Physical Disabilities*, *supra* note 187, at 15.

235. Jean Andrews et al., *The Bill of Rights, Due Process and the Deaf Suspect/Defendant*, J. OF INTERPRETATION 9, 12 (2007), *available at* <http://njdc.info/wp-content/uploads/2014/10/Bill-of-Rights-Due-Process-and-the-Deaf-Suspect-Defendents-JOI-2007.pdf>.

236. *Id.*

237. *Id.*

238. Michele LaVigne & Gregory J. Van Rybroek, *Breakdown in the Language Zone: The Prevalence of Language Impairments Among Juvenile and Adult Offenders and Why It Matters*, 15 U.C. DAVIS J. OF JUVENILE LAW & POLICY 37, 48 (2011), *available at* <http://jilp.law.ucdavis.edu/archives/vol-15-no-1/LaVigne%20and%20Rybroek.pdf>.

239. *Id.* at 96-97.

240. *What is American Sign Language?*, NAT’L ASS’N OF THE DEAF (last visited Oct. 17, 2016), <https://nad.org/issues/american-sign-language/what-is-asl>. It is also important to recognize that American Sign Language is a language distinct from English. Just as it would be impossible for a

non-Portuguese-speaker to try to understand a Portuguese-speaker by lip reading, it will also be impossible for a deaf person who does not understand English to try to use lip reading to understand an English-speaker. Lip reading, which is a challenging task even for individuals who speak the same language, is therefore a highly ineffective way of communicating with deaf prisoners.

241. Interview with Talila A. Lewis, Founder and Executive Director of HEARD (Nov. 18, 2015) (on file with author).

242. *See, e.g.*, Laura Sanders, *Being Deaf Can Enhance Sight*, WIRED (Oct. 11, 2010, 12:10 p.m.), <http://www.wired.com/2010/10/deaf-sight-enhancement/>.

243. Dr. Brie Williams Expert Report, *supra* note 146, at 11.

244. Dr. Brie Williams Expert Report, *supra* note 146, at 10.

245. Talila A. Lewis, *#DeafInPrison Campaign Fact Sheet*, HEARD 1 (June 26, 2014), <http://www.behearddc.org/images/pdf/deafinprison%20fact%20sheet%20.pdf>.

246. *See* 2d Amend. Compl., Ulibarri et al. v. City & Cnty. of Denver, 07-cv-01814-WDM-MJW (D. Colo. Feb. 25, 2008), *available at* <http://www.clearinghouse.net/chDocs/public/DR-CO-0008-0006.pdf>; *see also* Philip A. Janquart, *Judge Orders Relief for Deaf California Prisoners*, COURTHOUSE NEWS SERV. (Jun. 7, 2013, 9:34 a.m.), <http://www.courthousenews.com/2013/06/07/58332.htm> (noting order by federal district court to California Department of Corrections and Rehabilitation to provide sign language interpreters to deaf prisoners in solitary confinement).

247. HELL IS A VERY SMALL PLACE, *supra* note 215, at 48-49; *see also* Joseph Stromberg, *The Science of Solitary Confinement*, SMITHSONIAN (Feb. 19, 2014), <http://www.smithsonianmag.com/science-nature/science-solitary-confinement-180949793/?no-ist> (“His eyesight also deteriorated to the point where he was nearly blind, though it’s gradually improved since he was released.”).

248. Survey Responses from Five Deaf Prisoners, *supra* note 10, at 13.

249. Valdez v. Danberg, No. 13-4259, *98 (3d Cir. filed Aug. 4, 2014).

250. *Id.* at 99.

251. *Id.*

252. *Id.*

253. *Id.*

254. *Id.*

255. *Id.*

256. Survey Responses from Five Deaf Prisoners, *supra*

note 10, at 5.

257. The federal district court described Pierce’s disability as follows:

Pierce can make sounds that are audible, but he cannot speak words, and American Sign Language (“ASL”) is his native language. Pierce relies on ASL to communicate with others—either by interacting directly with other persons who are using ASL themselves, or through the use of a video conferencing device that involves a remote interpreter. Pierce cannot, and does not, use a traditional telephone; instead, he ordinarily uses ASL via videophone to communicate with hearing individuals. Moreover, because Pierce’s proficiency in reading and writing English is far below that of a hearing person, he rarely writes notes and only uses cellphone texting to convey simple, short messages. Also, as with many deaf individuals, Pierce has limited lip-reading ability.

Mem. Op. 4-5, *Pierce v. Dist. of Columbia*, Civil Action No. 13-0134 (KBJ) (D.D.C. Sept. 11, 2015), *available at* <http://law.justia.com/cases/federal/district-courts/district-of-columbia/dcdce/1:2013cv00134/158123/90/> [hereinafter *Pierce* Memorandum Opinion].

258. The Correctional Treatment Facility (CTF) is a subset of the D.C. Jail and is managed by a private entity, the Corrections Corporation of America. Only low to medium security detainees can be held at CTF.

259. Press Release, Am. Civ. Liberties Union of the Nation’s Capital, ACLU Victory in Deaf Rights Case (May 12, 2016), <http://aclu-nca.org/news/aclu-victory-in-deaf-rights-case>; Spencer S. Hsu, *U.S. Jury Orders D.C. Corrections to Pay \$70,000 to Deaf Inmate in ADA Claim*, WASH. POST (May 11, 2016), https://www.washingtonpost.com/local/public-safety/us-jury-orders-dc-corrections-to-pay-70000-to-deaf-inmate-in-ada-claim/2016/05/11/6bf30a0a-1797-11e6-9e16-2e5a123aac62_story.html.

260. Compl. ¶¶ 15, 27, 46, *Pierce v. Dist. of Columbia*, Civil Action No. 13-0134 (KBJ) (D.D.C. Feb. 1, 2013), *available at* <http://aclu-nca.org/sites/default/files/docs/Pierce.1.Complaint.pdf>.

261. *Id.* ¶¶ 30, 45. The federal judge presiding over the case found that the D.C. Jail was aware that Pierce was deaf, but made no attempt whatsoever to assess the nature and scope of Pierce’s disability. Specifically, the court found that “no staff person ever assessed Pierce’s need for accommodation or otherwise undertook to determine the type of assistance that he would need to communicate effectively with others during his incarceration.” *Pierce* Memorandum Opinion, *supra* note 257, at 1. The court was emphatic in its

conclusion that such conduct violated the ADA:

[T]he District’s employees and contractors did nothing to evaluate Pierce’s need for accommodation, despite their knowledge that he was disabled. They did not ask Pierce what type of auxiliary aids he needed. They did not hire an expert to assess Pierce’s ability to communicate through written notes or lipreading as opposed to sign language. They did not even consult the Department of Corrections’ own policies to figure out what types of accommodations are ordinarily provided to inmates with hearing disabilities. Instead, they figuratively shrugged and effectively sat on their hands with respect to this plainly hearing-disabled person in their custody, presumably content to rely on their own uninformed beliefs about how best to handle him and certainly failing to engage in any meaningful assessment of his needs. This Court finds that, in so doing, the District denied Pierce meaningful access to prison services and intentionally discriminated against him on the basis of his disability in violation of Title II of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.

Pierce Memorandum Opinion, *supra* note 257, at 2.

262. *See, e.g., Jaros*, 684 F.3d at 669, 671 (noting that prisoner missed meals due not being able to move fast enough to the cafeteria); *Rainey v. County of Delaware*, No. 00-548, 2000 WL 10564556, at *2 (E.D. Pa. Aug. 1, 2000) (prisoner alleged that he missed meals on 15 occasions because his cell was the farthest distance from the cafeteria on the cell block and because he was unable to reach the cafeteria in time for meals).

263. For example, prisoners held in prisons run by the Illinois DOC brought suit challenging the department’s failure to provide even emergency alarms in an accessible manner. *See* Class Action Compl. for Declaratory & Injunctive Relief ¶¶ 3, 5, *Holmes v. Godinez*, Civil Action No. 11-02961 (N.D. Ill. May 4, 2011) (alleging that deaf and hard of hearing persons missed emergency alarms and other alerts for meals and visits due to Illinois DOC’s failing to accommodate deaf prisoners).

264. *Morris v. Kingston*, No. 09-3226, *1 (7th Cir. Mar. 10, 2010).

265. *Id.*

266. *See, e.g., Amend. Compl. ¶¶ 32-47, Blue v. Dep’t of Public Safety & Corr. Servs.*, Civil Action No. 1:16-cv-00945-RDB (Sept. 6, 2016) (describing claims brought by class of blind prisoners who alleged that they were not

provided with materials for grievance forms and procedures in an accessible format).

267. For example, a blind or low vision prisoner may be forced to pay another prisoner to help write letters to family members, or complete grievance forms. In solitary, blind or low vision prisoners may not even have that option, as interaction with other prisoners can be limited or completely prohibited.

268. George Curly sued the Arizona DOC for failing to provide handrails that would ensure his safety while showering. *See Casey*, 834 F. Supp. at 1575. Curly had an amputation below his knee and used a prosthetic device and crutches to move around. *Id.* The Echo Unit in Tucson where Curly was held did not have any handrails in the shower stalls. *Id.* As a result, on several occasions, Curly fell while showering and suffered injury. *Id.* The Echo Unit eventually installed handrails. *Id.*

269. *See, e.g., Bane*, 2012 WL 6738274, at *1 (“Another effect of the increased security in Ad Seg is that whenever a prisoner is allowed to leave the cell—for example, for showers or recreation—he must kneel, with hands behind his back, facing away from the cell door so that prison staff can place him in restraints. Staff forced Plaintiff’s compliance with this requirement, despite Plaintiff’s protests that he had been exempted from kneeling by the VDOC Health Services Director. The kneeling allegedly caused Plaintiff great pain; in addition to the nerve damage in his legs, he suffers from osteoarthritis in the hips and knees.”).

270. *See, e.g., Lawson*, 286 F.3d at 260 (noting that detainee often missed dressing changes for his ulcer wounds because he did not make it to the cell front door in time to receive care from the jail nurses).

271. *See, e.g., Hernandez* Compl., *supra* note 213, ¶¶ 184-88 (alleging that Monterrey County Jail failed to provide assistive devices such as walkers and canes to prisoners with ambulatory disabilities). The case settled on May 7, 2015. The settlement agreement includes provisions that require Monterrey County Jail to provide persons with ambulatory disabilities with access to programming, including but not limited to outdoor recreation, religious services, and educational classes. Settlement Agreement ¶ 31(l)(vi), *Hernandez v. Cnty. of Monterrey*, Civ. Action No. 13-2354 (May 7, 2015), *available at* <http://rbgg.com/wp-content/uploads/2015-05-11-Settlement-Agreement-Executed-by-All-Parties-in-Counterpart.pdf>.

272. *See, e.g., Defreitas v. Montgomery Cnty. Corr. Facility*, No. 12-3305, 2013 WL 1878842, at *1 (3d Cir. filed May 7, 2013) (prohibiting prisoner from bringing crutches to the general population yard, gym, and weight room when other prisoners were present); *Johnson v. Snyder*, 444 F.3d 579, 582 (7th Cir. 2006), *overruled on other grounds by*

Hill v. Tangherlini, 724 F.3d 965 (7th Cir. 2013) (permitting prisoner to use a crutch but only if he agreed to be housed in administrative segregation); *Kiman v. New Hampshire Dep’t of Corr.*, 451 F.3d 274, 285-86 (1st Cir. 2006) (confiscating cane during stay in maximum security facility); *Serrano v. Francis*, 345 F.3d 1071, 1078 (9th Cir. 2003) (denying use of wheelchair in administrative segregation); *Evans v. Dugger*, 908 F.2d 801, 802 (11th Cir. 1990) (confiscating prisoner’s braces, crutches, orthopedic shoes, and other personal items, but permitted only the use of a wheelchair); *Bane*, 2012 WL 6738274, at *1 (W.D. Va. Dec. 28, 2012) (“In light of the increased security in Administrative Segregation (“Ad Seg”), staff confiscated [Bane’s] Canadian crutch and the leg sleeves he wore underneath the rigid leg braces. The leg sleeves, nothing more than socks with the toes cut off, protected his skin from the intense rubbing caused by the leg braces. Staff also denied Bane use of a wheelchair while his sleeves and crutch were confiscated.”).

273. *Dinkins*, 743 F.3d at 634.

274. *Id.*

275. *Id.*

276. *Id.*

277. *Id.* On appeal, the Eighth Circuit held that *Dinkins*’ allegations that he was denied meals and adequate housing due to his disability amounted to “viable” claims under the Americans with Disabilities Act and the Rehabilitation Act. *Id.* The court reversed the district court’s dismissal of claims for injunctive relief against defendants on these grounds. *Id.* at 635.

278. *MAKING HARD TIME HARDER*, *supra* note 187, at 16-17.

279. *Disability Rights Florida* Compl., *supra* note 5, ¶ 368.

280. *Id.* ¶ 370.

281. *Id.*

282. *Brown v. Lamanna*, No. 08-6840, 2008 WL 5396507, at *2 (4th Cir. Dec. 29, 2008); *see also Weeks v. Chaboudy*, 984 F.2d 185, 187 (6th Cir. 1993) (finding that prison officials were deliberately indifferent to prisoner’s serious medical needs stemming from paraplegia by placing him in “administrative control,” “security control,” or “local control” areas in the facility that did not permit wheelchairs).

283. *Brown*, 2008 WL 5396507, at *2.

284. *Lamanna*, 2008 WL 5396507, at *2. The Fourth Circuit remanded the case for further proceedings to determine if in fact it was medically necessary for *Brown* to have access to crutches or a wheelchair in order to move around, take showers, and participate in recreation activities without pain

and without further harm. *Id.* at *5.

285. Serrano v. Francis, 345 F.3d 1071, 1074 (9th Cir. 2003).

286. *Id.* at 1078. What is notable about this case is the Ninth Circuit’s finding of a protected liberty interest given Serrano’s status as a prisoner with a physical disability. Although the Ninth Circuit found that the defendants were entitled to qualified immunity with respect to Serrano’s due process claim, the court concluded as follows: “Serrano’s disability—coupled with administrative segregation in a SHU that was not designed for disabled persons—gives rise to a protected liberty interest. That is, the conditions imposed on Serrano in the SHU, by virtue of his disability, constituted an atypical and significant hardship on him.” *Id.* at 1079.

287. Simmons v. Cook, 154 F.3d 805, 806 (8th Cir. 1998).

288. *Id.*

289. *Id.* at 807.

290. *Id.*

291. The Eighth Circuit upheld the jury award on appeal and held that Simmons and Marshall had presented sufficient evidence to show a violation of the Eighth Amendment. *Id.* at 809.

292. Stoudemire v. Mich. Dep’t. of Corr., No. 14-1742, *799 (6th Cir. May 22, 2015).

293. *Id.*

294. *Id.* at 800.

295. *Id.*

296. *Id.*

297. *Id.*

298. *Id.*

299. *Id.*

300. Paul Egan, *Double-amputee Who Had to Crawl to Toilet Settles Suit*, DETROIT FREE PRESS (May 12, 2016, 10:33 p.m.), <http://www.freep.com/story/news/local/michigan/detroit/2016/05/12/michigan-pays-200000-settle-lawsuit-ex-prisoner/84284926/>.

301. Data collection can be a useful tool for assessing the quality of programs and services provided to prisoners with disabilities. *See e.g.*, HANDBOOK ON PRISONERS WITH SPECIAL NEEDS, *supra* note 82, at 49 (“Data collection and assessments should be undertaken on a regular basis, bearing in mind especially the scarcity of information and record keeping on prisoners with disabilities, to identify shortcomings and good practices, and to improve the

situation of prisoners with disabilities.”).

302. *See generally* BJS DISABILITY REPORT, *supra* note 31.

303. BJS DISABILITY REPORT, *supra* note 31, at 1.

304. *Id.*

305. *Id.*

306. *Id.* at 3.

307. *Id.*

308. *Id.* at 4.

309. *Disability & Health Needs in a State Prison System*, *supra* note 110.

310. ALLEN BECK, USE OF RESTRICTIVE HOUSING IN U.S. PRISONS AND JAILS 2011-12, U.S. DEP’T OF JUSTICE, OFFICE OF JUSTICE PROGRAMS, BUREAU OF JUSTICE STATISTICS 1 (2015), *available at* <http://www.bjs.gov/content/pub/pdf/urhuspj1112.pdf>.

311. *Id.* at 4.

312. *See, e.g.*, Northern Correctional Institution, Administrative Segregation Program, *available at* <http://www.ct.gov/doc/lib/doc/pdf/northernascc.pdf> (“Placement of an inmate on a Restrictive Housing Status that results in a segregation of the inmates whose behavior while incarcerated poses a threat to the security of the facility or a risk to the safety of staff or other inmates. This inmate has demonstrated through his behavior that he is not appropriate for continued placement in general population and that he can no longer be safely managed in general population.”).

313. *See, e.g.*, *Bane*, 2012 WL 6738274, at *1 (“To protect Bane from the assaulting prisoner while they investigated the attack, PSCC staff transferred Bane to Administrative Segregation.”).

314. *See, e.g.*, Rios v. Tilton, No. 2:07-CV-0790 WBS KJN, 2013 WL 4541825, at *6 (E.D. Cal. Aug. 27, 2013), *report and recommendation adopted*, No. 07-CV-0790 WBS KJN P, 2013 WL 6053815 (E.D. Cal. Nov. 15, 2013) (prisoner placed into administrative segregation due to gang affiliation); Pl.’s 2d Amend. Compl. ¶¶1-8, Ashker v. Brown, 4:09-cv-05796-CW (May 31, 2012), *available at* <http://ccrjustice.org/sites/default/files/assets/Ruiz-Amended-Complaint-May-31-2012.pdf> (describing prisoners who had been held in solitary confinement for 11-22 years due to their alleged gang affiliation).

315. *See, e.g.*, Herron v. Meyer, 820 F.3d 860, 862 (7th Cir. 2016) (describing case of federal prisoner being placed into solitary confinement for protective reasons due to threats to

his personal safety).

316. *See, e.g.*, HUMAN RIGHTS WATCH/AM. CIV. LIBERTIES UNION, GROWING UP LOCKED DOWN: YOUTH IN SOLITARY CONFINEMENT IN JAILS AND PRISONS ACROSS THE UNITED STATES 53-57 (2012), <https://www.aclu.org/files/assets/us1012webwcover.pdf> [hereinafter GROWING UP LOCKED DOWN] (describing policies requiring youth be placed into protective custody in adult facilities).

317. Adelyn Baxter, *Ninety Years Old, Deaf, and in the Hole in a Florida Prison*, PRISON LEGAL NEWS (July 10, 2014), <http://solitarywatch.com/2014/07/10/ninety-years-old-deaf-hole-florida-prison/> (describing prisoner who was placed into solitary for protective reasons after corrections staff “observed injuries suggesting that he had been assaulted”).

318. JASON LYDON ET AL., COMING OUT OF CONCRETE CLOSETS: A REPORT ON BLACK & PINK’S NATIONAL LGBTQ PRISONER SURVEY, BLACK & PINK 5, 35 (2015), <http://www.blackandpink.org/wp-content/uploads/Coming-Out-of-Concrete-Closets.-Black-and-Pink.-October-21-2015..pdf> (reporting that over 85 percent of 1,118 respondents had spent time in solitary confinement and that protective custody is a common reason for placement).

319. *See* Haney, *supra* note 153, at 135 (“Conditions of confinement for protective custody prisoners are in many ways similar to those in supermax confinement. That is, they are typically segregated from the rest of the prison population, restricted or prohibited from participating in prison programs and activities, and often housed indefinitely under what amount to oppressive and isolation conditions. Unlike supermax prisoners per se, however, many have some control over their status as protective custody (PC) prisoners (e.g., many have ‘volunteered’ for this status) and, although they live under the stigma of being PC prisoners, they are technically housed in these units for protection rather than for punishment.”).

320. Segregation for infectious diseases is permissible if there is a direct threat to the safety of others. However, prison officials cannot simply segregate based on stereotypes or unfounded fears. Prisoners with infectious diseases have successfully sued Departments of Corrections challenging automatic placement into segregation on account of their health condition. In these cases, the perceived health risk to other prisoners was not substantiated and, in large part, was based on fear, stereotypes, and other irrational concerns. *See, e.g.*, Henderson v. Thomas, 913 F. Supp. 2d 1267, 1295 (M.D. Ala. 2012) (“[T]he ADOC is currently violating the rights of the HIV-positive prisoners within its custody by categorically segregating them because of their HIV status and excluding them from the integrated housing for which they may be qualified.”). To be lawful, prison officials must base their decision to segregate for medical reasons on

“reasonable medical judgments given the state of medical knowledge,” about “the nature of the risk (how the disease is transmitted),” “the duration of the risk (how long is the carrier infectious),” “the severity of the risk (what is the potential harm to third parties),” and “the probabilities the disease will be transmitted and will cause varying degrees of harm.” Sch. Bd. of Nassau Cty., Fla. v. Arline, 480 U.S. 273, 288 (1987).

321. 28 C.F.R. § 35.152(b)(2)(ii); *see also Report on Inspection of the Sacramento County Jail: Executive Summary*, DISABILITY RIGHTS CA. 15 (Aug. 4, 2015), *available at* <http://www.disabilityrightscsca.org/pubs/702701.pdf>.

322. *See id.* (“In the Sacramento Jail, it is policy to place prisoners with physical disabilities and mobility impairments in single cells in the medical area . . . in which prisoners have no regular access to a day room or outdoor recreation. Housing prisoners in the infirmary solely because they use assistive devices, as the jail appears to do, is not an effective use of medical resources.”).

323. *See generally* Reaves v. Mass. Dep’t of Correction, et al., No. 4:15-CV-40100-TSH, 2016 WL 4124301 (D. Mass. July 15, 2016).

324. *Id.* at *27-*31.

325. For more serious offenses, such as escape or murder, a prisoner may also face criminal charges.

326. *See, e.g.*, Administrative Directive No. 9.5, Code of Penal Discipline, State of Conn. Dep’t of Corr. (Feb. 1, 2016), *available at* <http://www.ct.gov/doc/LIB/doc/PDF/AD/ad0905.pdf>.

327. *See, e.g.*, *Parms v. Pennsylvania Dep’t of Corr.*, No. CA 14-84, 2015 WL 1326323, at *3 (W.D. Pa. Mar. 25, 2015) (“Here, Plaintiff alleges, among other things, that he was repeatedly issued misconducts and received disciplinary confinement for failing to obey orders he could not hear or comprehend, because no reasonable accommodations for his disability were provided by Defendant. In particular, Plaintiff alleges that he was housed on F block at SCI-Albion, where inmates were alerted of the time for meals and count by audible means only, such as a bell or loudspeaker, while other housing blocks at SCI-Albion have flashing lights accompanying the bell and/or moving message boards that announce movement times. . . . Because Plaintiff was unable to hear the audible announcements, he often failed to move for meals or stand for count on time, which resulted in disciplinary sanctions. Thus, Plaintiff asserts that he was essentially ‘punished for his deafness.’ . . . This claim falls within the ambit of Title II’s general prohibition against discrimination on account of one’s disability, to which Plaintiff’s allegations regarding the misconducts and discipline he received as a result of his failure to respond to

verbal orders are particularly relevant. Thus, Defendant’s motion to dismiss such allegations will be denied.” (citations omitted)).

328. Robert B. Greifinger, *Commentary: Disabled Prisoners and ‘Reasonable Accommodation,’* 25 CRIM. JUSTICE ETHICS 2 (2010), available at <http://www.tandfonline.com/doi/abs/10.1080/0731129X.2006.9992190?journalCode=rcr20#.VxfRaNUrKUK> (noting that prisoners “face an increased risk of injury in difficult and dangerous prison environments”).

329. See, e.g., Clarkson v. Coughlin, 898 F. Supp. 1019, 1030 (S.D.N.Y. 1995) (describing prisoner who was disciplined for disobeying orders from corrections staff that he did not understand); Shoshana Walter, *Disabled Prisoners’ Rights Scrutinized in California County Jails*, THE HUFFINGTON POST (Oct. 8, 2012, 12:35 p.m.), http://www.huffingtonpost.com/2012/10/08/disabled-prisoners-rights_n_1948542.html (“At Santa Rita Jail in Dublin, an inmate with 80 percent hearing loss was denied a hearing aid and then disciplined for failing to listen to deputies’ directions.”).

330. Survey Responses from Five Deaf Prisoners, *supra* note 10, at 7.

331. *Id.*

332. Dave Mass, *Hundreds of South Carolina Inmates Sent to Solitary Confinement Over Facebook*, ELECTRONIC FRONTIER FOUND. (Feb. 12, 2015), available at <https://www.eff.org/deeplinks/2015/02/hundreds-south-carolina-inmates-sent-solitary-confinement-over-facebook>.

333. GROWING UP LOCKED DOWN, *supra* note 316, at 52.

334. Conor Friedersdorf, *The Persecution of Chelsea Manning*, THE ATLANTIC (Aug. 13, 2015), <http://www.theatlantic.com/politics/archive/2015/08/the-ongoing-persecution-of-chelsea-manning/401195/>.

335. Only about 10 percent of deaf children are born to deaf parents. Melissa Peck, *Deaf Americans in the Criminal Justice System: An Overview of the Issues*, N.W. MO. STATE UNIV. 1 (2014) (on file with author).

336. Where a prisoner faces possible punishment involving the loss of good time credits, the due process protections provided in *Wolff v. McDonnell* apply. *Wolff v. McDonnell*, 418 U.S. 539, 563-72 (1974). Where the loss of good time credits is *not* a potential punishment, due process protections are only required where the punishment imposed amounts to a deprivation of liberty that is an “atypical and significant hardship . . . in relation to the ordinary incidents of prison life.” *Sandin v. Conner*, 515 U.S. 472, 484 (1995); see also *Sims v. Artuz*, 230 F.3d 14, 22 (2d Cir. 2000) (“A prisoner asserting that he was denied due process in connection with prison disciplinary hearings that resulted in segregative

confinement or a loss of privileges must make a threshold showing that the deprivation of which he complains imposed an “atypical and significant hardship on [him] in relation to the ordinary incidents of prison life.” (quoting *Sandin v. Conner*, 515 U.S. 472, 484 (1995))).

Prisoners are not afforded the full range of rights in disciplinary hearings that are provided in their criminal case. Prison systems have some discretion in deciding what rights will be given to prisoners during disciplinary hearings. *Wolff*, 418 U.S. at 556 (“Prison disciplinary proceedings are not part of a criminal prosecution, and the full panoply of rights due a defendant in such proceedings does not apply. . . . In sum, there must be mutual accommodation between institutional needs and objectives and the provisions of the Constitution that are of general application.” (citations omitted)).

337. *Wolff*, 418 U.S. at 564.

338. *Id.*

339. *Id.* at 566. Prisoners may call witnesses and present documentary evidence where doing so “will not be unduly hazardous to institutional safety or correctional goals.” *Id.* There is no explicit right to confront and cross examine witnesses in a disciplinary hearing. *Id.* at 567.

340. *Id.* at 570.

341. *Hernandez* Compl., *supra* note 213, ¶ 155 (alleging that plaintiff was not provided with a sign language interpreter during his disciplinary hearing).

342. See, e.g., *Langford* Brief, *supra* note 123, at 12-13 (“[Montana State Prison] regularly fails to take the necessary and appropriate steps to ensure effective communication by disabled prisoners during classification and disciplinary hearings in violation of the ADA.” (citation omitted)).

343. See generally *Clarkson*, 898 F. Supp. 1019 at 1031 (describing prisoner who received 15 days in restrictive housing after corrections officials at Attica Corrections Facility failed to provide him with a sign language interpreter); *Duffy v. Riveland*, 98 F.3d 447, 450-52 (9th Cir. 1996) (noting that no qualified sign language interpreter was provided and that “[t]he disciplinary hearing ultimately went forward without him, and he was sentenced to 15 days of disciplinary segregation, with eight days of time served.”).

344. *Hernandez* Compl., *supra* note 213, ¶ 174 (alleging that plaintiff lost visitation, canteen, and recreation privileges after he was charged with a disciplinary infraction, denied a sign language interpreter in the disciplinary hearing, and, subsequently, found guilty).

345. See generally 1st Amend. Compl., *Dunn v. Thomas*, Civil Action No. 2:14-cv-00601 (M.D. Al. July 25, 2014), available at [https://www.splcenter.org/sites/default/files/](https://www.splcenter.org/sites/default/files/d6_legacy_files/downloads/case/first_amended_complaint.pdf)

[d6_legacy_files/downloads/case/first_amended_complaint.pdf](https://www.splcenter.org/sites/default/files/d6_legacy_files/downloads/case/first_amended_complaint.pdf) [hereinafter *Dunn* Complaint]. Plaintiffs achieved an historic settlement in this case wherein the Alabama DOC agreed to comprehensive reforms that make sure prisoners receive accommodations and services to which they are entitled under the ADA. Press Release, Southern Poverty Law Center, Alabama Agrees to Improve Conditions for Inmates with Disabilities Following SPLC Lawsuit (Mar. 16, 2016), <https://www.splcenter.org/news/2016/03/16/alabama-agrees-improve-conditions-inmates-disabilities-following-splc-lawsuit>.

346. *Dunn* Compl. ¶ 359.

347. *Id.*

348. *Id.*

349. *Id.* ¶ 364.

350. *Id.*

351. *Id.* ¶ 367.

352. *Id.*

353. *Id.*

354. Letter from Bob Fossett, prisoner at Wallace Pack 1 Unit, to author 1 (June 22, 2016) (on file with author).

355. *Wicomico Cnty.* Compl. ¶ 2. The complaint also alleges that defendants also “denied Mr. Muhammad a job that would have shortened his time at the Detention Center and excluded him from recreational activities because of his blindness.” *Id.* ¶ 3. “In addition, the DOC refused to provide Mr. Muhammad with a slate and stylus that would have allowed him to write independently in Braille and it failed to make the modifications necessary to provide Mr. Muhammad with access to its law library.” *Id.*

356. 28 C.F.R. § 35.152(b).

357. See, e.g., *Armstrong v. Brown*, 103 F. Supp. 3d 1070, 1072 (N.D. Cal. 2015); *Trevino*, 2015 WL 300267, *1. In 2015, the judge in *Armstrong* found that the California Department of Corrections and Rehabilitation had placed persons with mobility disabilities into administrative segregation for extended periods of time due to a lack of accessible housing—in direct violation of the court’s prior orders. *Armstrong*, 103 F. Supp. 3d 1070 at 1072.

358. The United States has not signed the Convention and so the guidelines contained there are not binding. Treaties negotiated by the Executive Branch must be approved by the Senate by a two-thirds vote. U.S. CONSTIT. art. II, sec. 2, cl. 2; see also *Medellin v. Texas*, 552 U.S. 491, 504-05 (2008) (noting that not all international law obligations are binding

under federal law).

359. Human Rights Watch, *U.S.: Senate Misses an Opportunity on Disability Convention* (Dec. 5, 2012, 11:11 a.m.), THE WORLD POST, http://www.huffingtonpost.com/human-rights-watch/us-senate-misses-opportun_b_2244885.html.

360. Convention on the Rights of Persons with Disabilities, G.A. Res. 61/106, 76th plen. mtg., U.N. Doc A/RES/61/106 (Dec. 13, 2006), available at <http://www.un.org/disabilities/documents/convention/convoptprot-e.pdf>.

361. *Id.* at art. 15. Article 15 sets forth strict standards that no persons shall “be subjected to torture or to cruel, inhuman or degrading treatment or punishment[.]” and that Member States adopt “measures to prevent people with disabilities, on an equal basis with others, from being subjected to torture or cruel, inhuman or degrading treatment or punishment.” *Id.*

362. *Id.* at art. 14(2).

363. Economic and Social Council Res. 2015/20 (Sept. 29, 2015), http://www.un.org/ga/search/view_doc.asp?symbol=E/RES/2015/20 [hereinafter *Mandela Rules*].

364. Nelson Mandela Rule 43(1).

365. *Id.* at Rule 44.

366. *Id.*

367. *Id.* at Rule 45.

368. Rule 45 states that “[t]he imposition of solitary confinement should be prohibited in the case of prisoners with mental or physical disabilities when their conditions would be exacerbated by such measures.” Rule 45(2).

369. Mandela Rule 46(3) (“Health-care personnel shall have the authority to review and recommend changes to the involuntary separation of a prisoner in order to ensure that such separation does not exacerbate the medical condition or mental or physical disability of the prisoner.”).

370. This Rule states that “[p]risoners with sensory disabilities should be provided with information in a manner appropriate to their needs[.]” and that “[t]he prison administration shall prominently display summaries of the information in common areas of the prison.” Mandela Rule 55.

371. See *supra* note 11.

372. *Wilson v. Seiter*, 501 U.S. 294, 296-97 (1991) (internal quotation marks omitted). Prisoners who seek to show an Eighth Amendment violation must show both an objectively serious harm and demonstrate that prison officials had knowledge of the serious harm and intentionally disregarded the risk of harm. Specifically, prisoners must show deliberate

indifference on the part of corrections officials to “a substantial risk of serious harm[.]” *Farmer v. Brennan*, 511 U.S. 825, 828 (1994); *accord* *Estelle v. Gamble*, 429 U.S. 97, 106 (1976) (holding that deliberate indifference to prisoner’s serious medical needs constitutes cruel and unusual punishment). In *Farmer v. Brennan*, the Supreme Court held that deliberate indifference meant that the “[prison] official knows of and disregards an excessive risk to inmate health or safety . . . [and] the official . . . [is] aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and . . . draw[s] the inference.” *Farmer*, 511 U.S. at 837.

Prior to conviction, persons who are held pending trial may seek relief under the Fourteenth Amendment to the U.S. Constitution. *See generally* *Bell v. Wolfish*, 441 U.S. 520 (1979).

373. In re Kemmler, 136 U.S. 436, 933 (1890).

374. *Gregg v. Georgia*, 428 U.S. 153, 173 (1976).

375. *Rummel v. Estelle*, 445 U.S. 263, 271 (1980).

376. *Estelle*, 429 U.S. at 103-04.

377. *Rhodes v. Chapman*, 452 U.S. 337, 347 (1981).

378. *Id.*

379. “The [Eighth] Amendment . . . imposes duties on these officials, who must provide humane conditions of confinement; prison officials must ensure that inmates receive adequate food, clothing, shelter, and medical care, and must “take reasonable measures to guarantee the safety of the inmates[.]” *Farmer*, 511 U.S. at 832.

380. *See, e.g.*, T.R. et al. v. South Carolina Dep’t of Corrections, C/A No. 2005-CP-40-2925 (S.C. Ct. Comm. Pleas 5th J. Cir. Jan. 8, 2014) (finding major deficiencies in the DOC’s treatment of prisoners with mental illness, including solitary confinement, and ordering defendants to submit a remedial plan); Ind. Protect. & Advocacy Servs. Comm’n v. Comm’r, 2012 WL 6738517 (S.D. Ind., Dec. 31, 2012) (holding that the Indiana DOC’s practice of placing prisoners with serious mental illness in segregation constituted cruel and unusual treatment in violation of the Eighth Amendment); *Jones ’El v. Berge*, 164 F. Supp. 2d 1096, 1101-02 (W.D. Wis. 2001) (granting a preliminary injunction requiring the removal of prisoners with serious mental illness from “supermax” custody); *Ruiz v. Johnson*, 37 F. Supp. 2d 855, 915 (S.D. Tex. 1999), *rev’d on other grounds*, 243 F.3d 941 (5th Cir. 2001), adhered to on remand, 154 F. Supp. 2d 975 (S.D. Tex. 2001) (“Conditions in TDCJ-ID’s administrative segregation units clearly violate constitutional standards when imposed on the subgroup of the plaintiffs’ class made up of mentally-ill prisoners”); *Coleman v. Wilson*, 912 F. Supp. 1282, 1320-21 (E.D. Cal.

1995) (finding that the California Department of Corrections and Rehabilitation was in violation of the Eighth Amendment due to systemwide failure to provide adequate mental health care, and due to the deliberate indifference of prison officials to the needs of prisoners with mental illness); *Madrid v. Gomez*, 889 F. Supp. 1146, 1265-66 (N.D. Cal. 1995) (holding keeping prisoners with mental illness or those at a high risk for suffering injury to mental health in Pelican Bay isolation unit unconstitutional); *Casey*, 834 F. Supp. at 1549-50 (condemning placement and retention of prisoners with mental illness on lockdown; H.B. v. Lewis, 803 F. Supp. 246, 257 (D. Ariz. 1992) (finding Eighth Amendment violation in part because of the lack of an adequate system for referring prisoners with behavioral problems to psychiatric staff); *Langley v. Coughlin*, 715 F. Supp. 522, 540 (S.D.N.Y. 1988) (holding that evidence of prison officials’ failure to screen out from SHU “those individuals who, by virtue of their mental condition, are likely to be severely and adversely affected by placement there” states an Eighth Amendment claim).

381. *Madrid*, 889 F. Supp. at 1266.

382. *Id.* at 1267.

383. The ADA was not the first federal disability rights law. Congress passed the Rehabilitation Act of 1973 to protect persons with physical disabilities from discrimination in federal programs and any other programs receiving federal funding, including state and local governments. *See, e.g.*, U.S. Mem. of Law as Amicus Curiae on Issues Under the Americans With Disabilities Act & Rehabilitation Act That are Likely to Arise on Summ. J. or at Trial at 3 n.4, *Miller v. Smith*, Civ. Action No. 6:98-cv-109-JEG (S.D. Ga. Jun. 21, 2010), *available at* https://www.ada.gov/briefs/miller_amicus.doc [hereinafter *Miller* Amicus Brief]. In addition, the law protects people with disabilities from discrimination by federal employers, including those entities that contract with the federal government. Specifically, the Rehabilitation Act provides that “[n]o otherwise qualified individual with a disability” may because of their disability “be excluded from the participation in, be denied the benefits of, or be subjected to discrimination” by “any program or activity receiving Federal financial assistance or under any program or activity conducted by any Executive agency or by the United States Postal Service.” 29 U.S.C. § 794(a). The Rehabilitation Act was an important precursor to the Americans with Disabilities Act, providing a “regulatory foundation” and “enabl[ing] the ADA to withstand Congressional scrutiny.” EQUALITY OF OPPORTUNITY: THE MAKING OF THE AMERICANS WITH DISABILITIES ACT, THE NATIONAL COUNCIL ON DISABILITY xvii (2010), *available at* <http://files.eric.ed.gov/fulltext/ED512697.pdf> [hereinafter EQUALITY OF OPPORTUNITY].

In substance, the Rehabilitation Act and the ADA are similar and effectively provide the same legal protections for people

with disabilities. The ADA states that the related federal regulations, which implement the statute’s requirements, do not apply a “lesser standard” than the protections under the Rehabilitation Act of 1973. 42 U.S.C.A. § 12201 (West 2016) (“Except as otherwise provided in this chapter, nothing in this chapter shall be construed to apply a lesser standard than the standards applied under title V of the Rehabilitation Act of 1973 (29 U.S.C. 790 et seq.) or the regulations issued by Federal agencies pursuant to such title.”). In other words, protections under the ADA must be as comprehensive as those afforded to persons with physical disabilities under the Rehabilitation Act. *See* Elaine Gardner, *The Legal Rights of Inmates with Physical Disabilities*, 14 ST. LOUIS U. PUB. L. REV. 175, 192 (1994) (“Because Title II of the ADA essentially extends the antidiscrimination prohibition embodied in Section 504 to all actions of State and local governments, the standards adopted in this part are generally the same as those required under Section 504 for federally assisted programs.” (internal quotation marks omitted)).

384. EQUALITY OF OPPORTUNITY, *supra* note 383, at xvii.

385. Brief Amicus Curiae of the Nat’l Council on Disability in Support of Respondents, *Garrett v. Board of Trustees Univ. of Ala.*, 531 U.S. 356 (2001) (No. 99-1240) (2000), *available at* <http://www.ncd.gov/publications/2000/Aug2000> [hereinafter NCD Amicus Brief] (discussing support for findings regarding “nature and extent of discrimination”).

386. Congress collected extensive evidence of societal discrimination against people with disabilities. *See* NCD Amicus Brief ¶ I(B).

387. “The term ‘qualified individual with a disability’ means an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity.” 42 U.S.C.A. § 12131(2) (West 2016).

388. 42 U.S.C.A. § 12132 (West 2016).

389. Under the ADA,

The term “disability” means, with respect to an individual—

(A) a physical or mental impairment that substantially limits one or more major life activities of such individual;

(B) a record of such an impairment; or

(C) being regarded as having such an impairment[.]

42 U.S.C.A. § 12102 (1) (West 2016). “[M]ajor

life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working.” *Id.* ¶ 2(a). “[A] major life activity also includes the operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.” *Id.* ¶ 2(b).

390. 42 U.S.C.A. § 12132 (West 2016); *Randolph v. Rodgers*, 170 F.3d 850, 858 (8th Cir. 1999). For claims brought under the Rehabilitative Act, plaintiffs must also show that the “program or activity from which he is excluded receives federal financial assistance.” *Id.*

391. 524 U.S. 206, 210 (1998) (“Modern prisons provide inmates with many recreational ‘activities,’ medical ‘services,’ and educational and vocational ‘programs,’ all of which at least theoretically ‘benefit’ the prisoners[.]”).

392. 28 C.F.R. § 35.130(b)(7).

393. *The Americans with Disabilities Act in Jail & Prison*, EQUIP FOR EQUALITY 3 (Apr. 5, 2016), <http://www.equipforequality.org/wp-content/uploads/2016/04/Prisoner-Rights-Under-the-ADA.pdf>.

394. A modification or accommodation is reasonable if it does not fundamentally alter a program, service, or activity, or result in an undue burden. *See infra* Part VII.C.3 (“Limits to the ADA”).

395. *Effective Communication*, U.S. DEP’T OF JUSTICE, CIVIL RIGHTS DIV., DISABILITY RIGHTS SECTION 6 (2014), <http://www.ada.gov/effective-comm.pdf> [hereinafter *ADA Requirements: Effective Communication*].

396. 28 C.F.R. § 35.160 (a)(1) (“A public entity shall take appropriate steps to ensure that communications with applicants, participants, members of the public, and companions with disabilities are as effective as communications with others.”).

397. *See generally ADA Requirements: Effective Communication*, *supra* note 395.

398. *ADA Requirements: Effective Communication*, U.S. DEP’T OF JUSTICE, CIVIL RIGHTS DIV. DISABILITY RIGHTS SECTION (2014), <https://www.ada.gov/effective-comm.htm>.

399. *Id.* The Department of Justice also advises public entities that

[I]n determining whether a particular aid or service would result in undue financial and

administrative burdens, a title II entity should take into consideration the cost of the particular aid or service in light of all resources available to fund the program, service, or activity and the effect on other expenses or operations. The decision that a particular aid or service would result in an undue burden must be made by a high level official, no lower than a Department head, and must include a written statement of the reasons for reaching that conclusion.

Id.

400. *See generally* Gilmore v. Hodges, 738 F.3d 266 (11th Cir. 2013) (challenging failure to provide batteries for hearing aids); *see also* Press Release, Am. Civ. Liberties Union, ACLU Sues On Behalf of Prisoner at Lake Erie Correctional Who Was Denied Hearing Aid (Apr. 7, 2016), *available at* <http://www.acluohio.org/archives/press-releases/aclu-sues-on-behalf-of-prisoner-at-lake-erie-correctional-who-was-denied-hearing-aid>.

401. 28 C.F.R. § 35.104.

402. *See, e.g.,* Armstrong v. Brown, 857 F. Supp. 2d 919, 933 (N.D. Cal. 2012) (“Reliance on other prisoners for access to basic services, such as food, mail, showers and toilets by prisoners with disabilities leaves them vulnerable to exploitation and is a dangerous correctional practice.”); *Pressure Mounts for Oregon to Use “Qualified” Interpreters for Deaf Inmates*, OR. PUBLIC BROADCASTING (Sept. 22, 2014), www.opb.org/radio/programs/thinkoutloud/segment/pressure-mounts-for-oregon-to-use-qualified-interpreters-for-deaf-inmates/ (Interview with Talila A. Lewis, Founder and Executive Director, HEARD).

403. Video remote interpreting (VRI) uses “videoconferencing technology, equipment, and a high speed Internet connection with sufficient bandwidth to provide the services of a qualified interpreter, usually located at a call center, to people at a different location.” *Video Remote Interpreting*, NAT’L ASS’N OF THE DEAF, <https://nad.org/issues/technology/vri> (last visited Oct. 18, 2016). A public entity that chooses to provide qualified interpreters via VRI services shall ensure that it provides—

- (1) Real-time, full-motion video and audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection that delivers high-quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular pauses in communication;
- (2) A sharply delineated image that is large enough to display the interpreter’s face, arms, hands, and fingers, and the participating individual’s face, arms, hands, and fingers,

- regardless of his or her body position;
- (3) A clear, audible transmission of voices; and
- (4) Adequate training to users of the technology and other involved individuals so that they may quickly and efficiently set up and operate the VRI.

28 C.F.R. § 35.160(d).

404. *Randolph*, 170 F.3d at 858.

405. 42 U.S.C.A. § 12111(A) (West 2016). Prison officials have the burden of proving in court that the requested accommodation would fundamentally alter the nature of the service, program, or activity. 28 C.F.R. § 35.130(b) (7). Courts have adopted a list of factors to consider in determining whether an accommodation is reasonable or unduly burdensome. One court discussed the fact-intensive inquiry as follows:

Whether a requested accommodation is reasonable is highly fact-specific, and determined on a case-by-case basis by balancing the cost to the defendant and the benefit to the plaintiff. Whether the requested accommodation is necessary requires a showing that the desired accommodation will affirmatively enhance a disabled plaintiff’s quality of life by ameliorating the effects of the disability. The overall focus should be on whether waiver of the rule in the particular case at hand would be so at odds with the purposes behind the rule that it would be a fundamental and unreasonable change.

Dadian v. Village of Wilmette, 269 F.3d 831, 838–39 (7th Cir. 2001) (citations and internal quotation marks omitted). In general, determining whether a particular accommodation that is requested by a prisoner is reasonable requires case-by-case analysis into the prisoner’s disability, the specific accommodation requested, and its benefits to the prisoner, as well as the institutional interests (e.g., cost, security, administration, etc.).

406. 28 C.F.R. § 35.104(4).

407. *Id.* § 35.130(h).

408. *See, e.g.,* Wheeler v. Tinsman, No. 2:11-CV-02002, 2014 WL 1053738, at *2 (W.D. Ark. Mar. 18, 2014).

409. 42 U.S.C.A. § 1997e (a) (West 2016) (“No action shall be brought with respect to prison conditions under section 1983 of this title, or any other Federal law, by a prisoner confined in any jail, prison, or other correctional facility until such administrative remedies as are available are exhausted.”).

410. *See, e.g.,* NO EQUAL JUSTICE: THE PRISON LITIGATION

REFORM ACT IN THE UNITED STATES, HUMAN RIGHTS WATCH 16-17 (2009), *available at* <https://www.hrw.org/sites/default/files/reports/us0609web.pdf> (describing attempts by prisoners to establish good cause for failing to exhaust grievance procedures that have been rejected by courts).

411. *P&A/CAP Network*, NAT’L DISABILITY RIGHTS NETWORK, <http://www.ndrn.org/about/paacap-network.html> (last visited Oct. 18, 2016).

412. 42 U.S.C.A. §§ 10805(a)(4), 15043(a)(2)(I) (West 2016).

413. 42 U.S.C.A. §§ 10805(a)(1), 15043(a)(2)(A)-(B) (West 2016).

414. MAKING HARD TIME HARDER, *supra* note 187, at 16-17, 18.

415. *See, e.g.,* CAL. CIV. CODE § 51 (West 2016); LA. STAT. ANN. § 46:2254 (West 2016); MASS. GEN. LAWS ANN. ch. 93, § 103 (West 2016).

416. AM. CIV. LIBERTIES UNION, THE DANGEROUS OVERUSE OF SOLITARY CONFINEMENT 9 (2014), *available at* https://www.aclu.org/sites/default/files/assets/stop_solitary_briefing_paper_updated_august_2014.pdf (“A 2006 study found that opening a supermax prison had no effect on prisoner on prisoner violence in Arizona, Illinois and Minnesota. The same study found that creating a supermax had only limited impact on prisoner on staff violence in Illinois, none in Minnesota and actually increased violence in Arizona. Moreover, limiting the use of solitary confinement has been shown to decrease violence in prison. A reduction in the number of prisoners in segregation in Michigan has resulted in a decline in violence and other misconduct. Similarly, Mississippi saw a 70 percent reduction in violence levels when it closed an entire solitary confinement unit.”); *see also* LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMM, RECIDIVISM IN CONNECTICUT 41-42 (2001), *available at* <http://www.ct.gov/opm/lib/opm/cjppd/cjresearch/recidivismstudy/2001recidivismconnecticut.pdf> (discussing recidivism rates of prisoners who spent time in administrative or disciplinary segregation).

417. These guiding principles are in no way limited to persons with physical disabilities, but should apply generally to all prisoners.

418. DOJ REPORT & RECOMMENDATIONS, *supra* note 17, at 14, 46, 59-62, 86-87, 102, 106.

419. For guidance on what should be included in a self-evaluation plan, see *The Americans with Disabilities Act: Title II Technical Assistance Manual*, U.S. DEP’T OF JUSTICE, CIVIL RIGHTS DIV., *available at* <https://www.ada.gov/taman2.html> (last visited Oct. 18, 2016).

420. *2010 ADA Standards for Accessible Design*, U.S. DEP’T OF JUSTICE (Sept. 15, 2010), *available at* <https://www.ada.gov/regs2010/2010ADASTandards/2010ADASTandards.htm> [hereinafter *2010 ADA Standards for Accessible Design*]

421. ABA STANDARDS FOR CRIMINAL JUSTICE (THIRD EDITION) TREATMENT OF PRISONERS, Rule 23.2.9, *available at* http://www.americanbar.org/content/dam/aba/publications/criminal_justice_standards/Treatment_of_Prisoners.authcheckdam.pdf [hereinafter ABA STANDARDS].

422. *Id.*

423. Placement into solitary confinement should last no longer than 15 days. *See, e.g.,* Nelson Mandela Rule 44 (“Prolonged solitary confinement shall refer to solitary confinement for a time period in excess of 15 consecutive days.”).

424. ABA STANDARDS Rule 23.2.9.

425. Mandela Rule 45(2).

426. ABA STANDARDS Rule 23-2.9.

427. *Id.*

428. *2010 ADA Standards for Accessible Design*, *supra* note 420.

429. The author is indebted to Miranda Tait for her ideas on this policy formulation.

