

Robert B. Greifinger *Editor*

Public Health Behind Bars

From Prisons to Communities

Second Edition

 Springer

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Foreword by David Satcher

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Editor
Robert B. Greifinger
Correctional Health Care Consultant
New York, NY
USA

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Prisoners with Disabilities: Law and Policy

4

Margo Schlanger

Introduction

Disability rights are far from a niche issue in jail and prison. In fact, most people incarcerated in American jails and prisons have at least one disability. Table 4.1 summarizes some of the data.

Some have even claimed that the massive run-up from the 1970s to the 1990s in prison and jail population was largely the result of “transinstitutionalization”—the effect of housing people with

Table 4.1 Disability in prisons and jails^a

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

^aSources: vision, hearing, and ambulatory (Bronson et al., 2015 at tables 4 & 5. The data in this survey are self-reported in response to the following questions: “Hearing—Are you deaf or do you have serious difficulty hearing? Vision—Are you blind or do you have serious difficulty seeing even when wearing glasses? Ambulatory—Do you have serious difficulty walking or climbing stairs?”); chronic condition and age 65+ (Carson, 2015 app. Tbl. 3); intellectual disability (Petersilia, 2000 at 1); mental illness (James & Glaze, 2006 at 1, 4)

This Chapter is largely adapted from Schlanger 2016 and Schlanger 2017.

M. Schlanger (✉)
University of Michigan Law School,
Ann Arbor, MI, USA
e-mail: mschlan@umich.edu

mental illness in jails and prisons rather than mental hospitals (Kim, 2016). This is likely only partially true—Raphael and Stoll demonstrate persuasively that deinstitutionalization has made only a “relatively small contribution to the prison population growth overall” (they estimate 4% to 7% of the growth). But as they note, it is certainly the case that “in years past,” “a sizable portion of the mentally ill behind bars would not have been” jailed (Raphael & Stoll, 2013).

In any event, choices relating to disability are central to the operation of US incarcerative facilities. This chapter begins by discussing the difference disability may make in jail and prison—how disability affects prisoners’ lives and institutional operations. It next presents applicable law, focusing on disability antidiscrimination statutes and their implementing regulations.

Why Is Disability a Challenge?

Incarceration is not easy for anyone. But sharply limited control over one’s own routines and arrangements make life behind bars particularly difficult for prisoners with disabilities. Prisoners with mobility impairments, for example, “cannot readily climb stairs, haul themselves to the top bunk, or walk long distances to meals or the pill line” (Human Rights Watch, 2012 at 4). Prisoners who are old may “suffer from thin mattresses and winter’s cold” (id.) but often cannot obtain a more comfortable bed or an extra blanket. Prisoners who are deaf may not hear, and prisoners with intellectual disabilities may not understand, the orders they must obey under threat of disciplinary consequences, including extension of their term of incarceration. As well, prisoners with intellectual disabilities may be unable to access medical care or other resources and services if officials require written requests and they are illiterate (Human Rights Watch, 2015).

Moreover, many prisoners with mental or physical disabilities face grave safety threats. They may be vulnerable to extortion, exploitation, threats, and physical and sexual abuse by other prisoners. Prisoners with mental disabilities in particular may be “manipulated by other prisoners into doing things that get them into deep trouble” (Human Rights Watch, 2003 at 57, quoting Kupers, 1999). As Hans Toch has summarized, prisoners with mental illness can be “disturbed and disruptive,” and “very troubled and extremely troublesome” (quoted in Human Rights Watch, 2015). They are far more likely to be injured in a fight, and to be disciplined for assault (Id.). In the words of prisoners’ rights advocate Jamie Fellner (Human Rights Watch, 2015), they may:

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

Solitary confinement is a particular concern. Across the country, constitutional litigation has led to orders excluding prisoners with serious mental illness from solitary confinement. (For a compilation of extant orders, see Civil Rights Litigation Clearinghouse, 2020a.) Nevertheless, people with mental disabilities remain substantially overrepresented in prison and jail restrictive housing units (Association of State Correctional Administrators & Arthur Liman Program at Yale Law School, 2018 at 48–49; Beck, 2015 at 6–7) because they are frequently difficult to manage in general population and they often decompensate once in solitary and commit further disciplinary infractions. Twenty-five years ago, US District Judge Thelton Henderson emphasized the toxic effects of solitary confinement for inmates with mental illness. In *Madrid v. Gomez*, a case about California’s Pelican Bay prison, Judge

Henderson wrote that isolated conditions in the Special Housing Unit, or SHU, while not amounting to cruel and unusual punishment for all prisoners, were unconstitutional for those “at a particularly high risk for suffering very serious or severe injury to their mental health, including overt paranoia, psychotic breaks with reality, or massive exacerbations of existing mental illness” (*Madrid v. Gomez*, 1995 at 1265). Vulnerable prisoners included those with preexisting mental illness, intellectual disabilities, and brain damage. Judge Henderson concluded that “[f]or these inmates, placing them in the SHU is the mental equivalent of putting an asthmatic in a place with little air to breathe.” Their resilience is compromised by their disability and the jail’s or prison’s unaccommodating response to it; prisoners with mental illness face a much higher risk for suicide both in and out of solitary confinement (Human Rights Watch, 2003 at 178).

Sometimes officials affirmatively discriminate against prisoners with disabilities—bar them from programs or jobs, lock them down in their cells, or isolate them in an infirmary or administrative segregation housing, even deny them parole as a matter of policy (Seevers, 2016 at 28, 31, 35; Bebbler, 2016 at 14, 17; ACLU, 2017 at 6). For example, in *Armstrong v. Brown*, US District Judge Claudia Wilken held that the state was “regularly housing [prisoners with mobility impairments] in administrative segregation due to lack of accessible housing” (*Armstrong v. Brown*, 2015). Physical barriers—steps, inaccessible cell features, and the like—frequently exclude prisoners with disabilities from programs and resources (Seevers, 2016 at 19, 29, 32, 34). But physical barriers are just the most visible example of the key general problem: When the ordinary rules and ways of incarceration hit prisoners with disabilities harder than others, prisons and jails fail to accommodate their needs.

This chapter discusses both constitutional and statutory requirements, along with several reform proposals for integrative steps that would assist prisoners with disabilities.

What Does the Law Require?

The welfare of prisoners with disabilities is governed by both the Constitution and the two principal federal disability antidiscrimination statutes, the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA).

Constitutional Law

People with disabilities do not receive special antidiscrimination protection under the Equal Protection Clause (*City of Cleburne, Texas v. Cleburne Living Center*, 1985). Absent other constitutional harm, the Constitution often allows officials to discriminate against people with disabilities, “so long as their actions toward such individuals are rational” (*Bd. of Trustees of the Univ. of Alabama v. Garrett*, 2001). Of course, discrimination aside, other constitutional harm can frequently occur—for example, if government officials fail to “respond [] reasonably to . . . risk[s]” to prisoners, where those risks threaten the “minimal civilized measure of life’s necessities” (*Farmer v. Brennan*, 1994 at 834). Such harm violates the Eighth Amendment’s Cruel and Unusual Punishments Clause, applicable against state and local officials via the Fourteenth Amendment. The same logic compels the same result for pretrial detainees’ conditions claims under the Due Process Clause (*Bell v. Wolfish*, 1979; *Kingsley v. Hendrickson*, 2015). Constitutional conditions claims may address, for example, nutrition, sanitation, large-muscle exercise, and protection from harm by other prisoners.

So, if some overarching prison policy or practice, applicable to prisoners with and without disabilities alike, poses an obstacle to a prisoner with a disability getting enough food, or living in sanitary conditions, or avoiding assaults by other prisoners, modification of that policy is required under the

Constitution (*United States v. Georgia*, 2006 at 157). Perhaps most importantly, people with disabilities frequently have chronic and serious medical/mental health treatment needs. Jails and prisons are constitutionally required to meet those needs (*Estelle v. Gamble*, 1976). This requirement extends not only to treatment in jail and prison (including prompt medical and mental health assessment and management) but also to the period of time postrelease before a released prisoner can reasonably obtain external treatment.¹

The Americans with Disabilities Act and the Rehabilitation Act

The ADA and the Rehabilitation Act reach more broadly. Section 504 of the 1973 Rehabilitation Act provides, in relevant part, 29 U.S.C. § 794(a):

No otherwise qualified individual with a disability . . . shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance or under any program or activity conducted by any [Federal] Executive agency.

And Title II of the 1990 ADA, 42 U.S.C. § 12,132, provides, in relevant part,

[N]o qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.

Together, these prohibit discrimination on the basis of disability in federally conducted or supported services, and state and local government services, respectively. The Supreme Court has held specifically that ADA Title II's reference to "services, programs, or activities" encompasses the operations of prisons and jails (*Pa. Dep't of Corr. v. Yeskey*, 1998). Between the two statutes, every American prison and jail are covered.²

So, the first issue: What is a disability? Under both the ADA and the Rehabilitation Act, a person has a disability if: (i) a physical or mental impairment substantially limits one or more of his or her major life activities; (ii) he or she has a record of such an impairment; or (iii) he or she is regarded as having such an impairment (29 U.S.C. § 705(20)(B); 42 U.S.C. § 12,102(1)).

Particularly relevant here, "mental" impairments are expressly included if they substantially limit major life activities. The ADA regulations on the definition of disability (28 C.F.R. § 35.108) are quite capacious. Moreover, in the ADA Amendments Act of 2008, Congress clarified and substantially broadened the definition. Under the Amendments Act, a person has a covered disability even if his or her impairment is episodic or in remission, and if it would substantially limit at least one major life activity if active; "without regard to the ameliorative effects of mitigating measures" such as medication, prosthetics, etc., whenever someone subjects the person to prohibited action because of an actual

¹See *Wakefield v. Thompson*, 1999 at 1164 ("[T]he state must provide an outgoing prisoner who is receiving and continues to require medication with a supply sufficient to ensure that he has that medication available during the period of time reasonably necessary to permit him to consult a doctor and obtain a new supply."); *Lugo v. Senkowski*, 2000 at 115 ("The State has a duty to provide medical services for an outgoing prisoner who is receiving continuing treatment at the time of his release for the period of time reasonably necessary for him to obtain treatment on his own behalf."); see also *Brad H. v. City of New York*, 2000 (similar outcome under state law).

²The ADA's Title II covers all nonfederal jails and prisons—its definition of "public entity" includes state and local government agencies, without respect to federal support (42 U.S.C. § 12,131(1)). The Rehabilitation Act also covers most state and local prisons and jails because they receive federal financial assistance (29 U.S.C. § 794(b)(1)(A), defining "program or activity" as "a department, agency, special purpose district, or other instrumentality of a State or of a local government" (See US Department of Justice, 2015).

or perceived physical or mental impairment. Anyone with a significant chronic medical condition is classified as disabled because the Amendments Act counts as “major life activity” not just activities such as “caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, . . . , learning, . . . communicating” but also “major bodily function[s], including . . . of the immune system, normal cell growth, digestive . . . functions” (42 U.S.C. § 12,102).

And the second issue: what counts as discrimination? As quoted above, both statutes protect from exclusion or discrimination of prisoners with disabilities who are “qualified” to participate in the relevant program. The Rehabilitation Act does not define “qualified individual with a disability,” but the ADA does. That definition (42 U.S.C. § 12,131(2)) is as follows:

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.

Prior to the ADA’s enactment, the US Supreme Court explained that the Rehabilitation Act guarantees “meaningful access” to qualified individuals with a disability to each federally conducted or supported program, service, or activity (Alexander v. Choate, 1985 at 301). To figure out what “meaningful access” means, both the ADA and Rehabilitation Act regulations are key.³

There are five chief theories of liability under the ADA/Rehabilitation Act: physical access, disparate treatment, reasonable modification, effective communication, and integration mandate. This chapter does not further treat the physical access rules governing jails and prisons, which are essentially the same as those governing all other government programs.⁴ It takes the other four in turn.

Disparate Treatment

Most simply, discriminating against prisoners “by reason of” their physical disability, serious mental illness, or intellectual disability, violates the statutory bans, as quoted above, against disparate treatment. The ADA regulations explain that public entities must afford qualified people with disabilities the same opportunity as nondisabled people to benefit from the entity’s services. This means a prison or jail may not, because of an inmate’s disability, deny the inmate the “opportunity to participate” in a service offered to other inmates, may not provide an alternative service “that is not equal to that afforded others,” and must provide aids, benefits, or services that would enable the inmate to “gain the same benefit, or to reach the same level of achievement as that provided to others” (28 C.F.R. § 35.130(b)(1)). A prison violates this regulation, for example, if simply because of their disability, it excludes prisoners with disabilities from a program or assigns prisoners with disabilities to segregation cells—where prisoners are denied most prison privileges, programs, activities, and services.

The reach of this requirement is hotly contested in case law. For example, in *Wagoner v. Lemmon*, 2015 at 593, a case in which the prisoner-plaintiff was transported “in a vehicle not equipped for

³Congress itself ratified the Rehabilitation regulations in the ADA, requiring the Department of Justice to adopt them as a baseline. See 42 U.S.C. § 12,201(a) (“nothing in this chapter shall be construed to apply a lesser standard than the standards applied under title V of the Rehabilitation Act of 1973 (29 U.S.C. §§ 790 et seq.) or the regulations issued by Federal agencies pursuant to such title”); 42 U.S.C. § 12,134(b) (“regulations . . . shall be consistent with . . . the coordination regulations under part 41 of title 28, Code of Federal Regulations (as promulgated by the Department of Health, Education, and Welfare on Jan. 13, 1978), applicable to recipients of Federal financial assistance under section 794 of Title 29”).

⁴The physical access rules require that “new” (i.e., post-January 1992) construction be “readily accessible and usable by individuals with disabilities,” as specified by detailed design standards (28 C.F.R. § 35.151). Old construction must provide “program accessibility” (28 C.F.R. § 35.150).

wheelchairs—a shortcoming that led once to [his] catheter becoming dislodged and that forced him to crawl on the van’s floor in order to get out of the vehicle,” the Court of Appeals affirmed summary judgment for the defendants, noting:

Wagoner has not asserted . . . that he was ‘denied all access to some programs and activities, and his access to others was severely limited.’ Wagoner says only that he was inconvenienced with longer waits and humiliation, as when he had to crawl off the regular van because it did not accommodate his wheelchair. These disconcerting allegations do not amount to a denial of services within the meaning of either statute [the ADA and the Rehabilitation Act].

That said, many cases are more generous in applying the rule (Goren et al., 2000, catalogs cases). Even if a prisoner-plaintiff is successful at demonstrating discrimination, however, that is not the end of the matter; the statutes allow defenses. Prison and jail officials can exclude a prisoner with a disability from a program, service, or activity if the exclusion is “necessary for the safe operation of its services, programs, or activities” (28 C.F.R. § 35.130(h)). Safety requirements must, however, be “based on actual risks, not on mere speculation, stereotypes, or generalizations about individuals with disabilities.” (Id.) Similarly, government officials may exclude prisoners with disabilities from programs “when that individual poses a direct threat to the health or safety of others” (28 C.F.R. § 35.139(a)). But the Supreme Court has emphasized that under the ADA, “direct threat defense[s] must be ‘based on a reasonable medical judgment that relies on the most current medical knowledge and/or the best available objective evidence’” (Chevron U.S.A. v. Echazabal, 2002 at 86; see also Bragdon v. Abbott, 1998 at 649 (“[T]he risk assessment must be based on medical or other objective evidence”). And correspondingly, the regulation (28 C.F.R. § 35.139(b)) again requires substantial individuation:

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

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

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

Reasonable Modification

The Rehabilitation Act and the ADA require even more individuation under the conceptual category of “reasonable modification”—the ADA Title II’s (and Title III’s) equivalent of the more familiar “reasonable accommodation” requirement in Title I of the ADA, which addresses employment discrimination (42 U.S.C. § 12,111(8)–(9); *Wright v. N.Y. XE "Wright v. N.Y." State Dep’t of Corr., 2016* at 78 [“Title II of the ADA, therefore, requires that once a disabled prisoner requests a non-

frivolous accommodation, the accommodation should not be denied without an individualized inquiry into its reasonableness.”)]. The Title II ADA regulation (28 C.F.R. § 35.130(b)(7)(i)) states:

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

The separate requirement of program accessibility has a similar defense that no “fundamental alteration in the nature of the service, program or activity or . . . undue financial or administrative burdens” are required (28 C.F.R. § 35.150(a)(3)). (In addition, the “direct threat” defense described above applies to reasonable modification claims as well as disparate treatment claims.)

A failure to implement a reasonable modification needed by a person with a disability is a type of discrimination; under the ADA, a prison must “take certain pro-active measures to avoid the discrimination proscribed by Title II” (Chisolm v. McManimon, 2001 at 324–25; see also Tennessee v. Lane, 2004 at 529, describing the reasonable modification requirement as prophylactic).

Federal case law has emphasized that the application of disability rights law in the prison setting must take account of “[s]ecurity concerns, safety concerns, and administrative exigencies” (Love v. Westville Corr. Center, 1996 at 561). As Judge Richard Posner put it in a frequently cited opinion, “[t]erms like ‘reasonable’ and ‘undue’ are relative to circumstances, and the circumstances of a prison are different from those of a school, an office, or a factory” (Crawford v. Indiana Dep’t of Corr., 1997 at 487). Even so, both reasonable modification and effective communication have sometimes been read as robust and broadly relevant requirements. Consider a list of potential problems and ADA-required solutions:

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

Experts on disability law outside of prison would likely consider these run-of-the-mill accommodations. Similar individualizing responses to disability are regularly sought from, and granted by, employers and nonincarcerating government agencies. And yet, three decades after the ADA’s passage, when prisoners seek these kinds of reasonable modifications, prison and jail officials frequently deny the request simply by pointing to the general rule.

The all-encompassing nature of criminal confinement may amplify ADA/Rehabilitation Act obligations past what is required on the outside. For example, the ADA and Rehabilitation Act do not

require most government entities to provide medical care. But there is a plausible argument that in prison and jail, where medical and mental health care are among the services provided (Pa. Dep't of Corr. v. Yeskey, 1998 at 210), denial of particular treatments needed by people with disabilities also constitutes actionable discrimination (see, e.g., Anderson v. Colorado, Plaintiff's Response, 2011, Plaintiff's Trial Brief, 2012). The court denied these claims not on the law but on the facts, Anderson v. Colorado, 2012 at 1146–48. After all, a prisoner who needs but does not have a hearing aid (i.e., who has been denied audiology services) may face disciplinary consequences for noncompliance with directives he cannot hear—and will certainly be unable to benefit from many programs. The latter is also true for a prisoner whose abilities are compromised by an untreated chronic illness.

Likewise, required accommodations may be somewhat unique to the jail/prison context. Using solitary confinement litigation as an example, in recent cases, many advocates have argued and some courts have agreed that the ADA's reasonable modification requirement compels individualization with respect to disciplinary and restrictive housing policy. Antidiscrimination theories described below—seeking to narrow the route in, soften the conditions, and widen the route out of solitary—have been incorporated in the dozen or so major solitary confinement settlements in recent years. The claims have also gotten some, albeit limited, support in federal district court opinions:

Reasonable Modifications Relating to the Route into Solitary Confinement

Recent advocacy has pressed the claim that the ADA's reasonable modification mandate, properly understood, compels jail and prison officials to take account of mental illness or intellectual disability in making housing decisions, which often assign disabled prisoners to double cells in which conflict and violence are likely. Similarly, advocates have argued that the ADA forbids use of solitary confinement as a routine management technique to cope with the difficulties presented by prisoners with disabilities (US Dep't of Justice, 2013). And several courts have agreed that disciplinary and classification procedures must accommodate disability-related behavior (Scherer v. Pa. Dep't of Corr., 2007 at *44; Purcell v. Pa. Dep't of Corr., 2006 at *13; Biselli v. Cty. of Ventura, 2012 at *44–45). There have been some settlements that implement the theory that the ADA requires jails and prisons to treat behavior that manifests serious mental illness or intellectual disability as a mental health or habilitation matter, rather than as an occasion for force or discipline (Disability Advocates, Inc. v. N.Y. State Office of Mental Health 2007, at 12; Disability Rights Network of Pa. v. Wetzel, 2015, at 16).

More broadly, advocates have claimed that it violates the ADA for a prison system to provide inadequate mental health care more generally, including by interposing a variety of obstacles to obtaining treatment, because without treatment, prisoners with mental illness are more likely to run into trouble of various kinds, leading them to solitary confinement—which acts as a disciplinary or administrative exclusion from facility programs, services, and activities (Rasho v. Baldwin, 2013 at 3–4; Anderson v. Colorado, Plaintiff's Response, 2011; Anderson v. Colorado, Plaintiff's Trial Brief, 2012).

Reasonable Modifications Relating to Conditions in Solitary Confinement

There is less case law, but advocates have also pressed claims relating to conditions *in* solitary confinement. The DOJ has found, for example, for those prisoners whose disabilities mean they simply cannot be safely managed in general population, prisons retain the “obligation to provide the prisoners with the opportunity to participate in and benefit from mental health services and activities, and other services, programs, and activities to which prisoners without disabilities have access” (US Dep't of Justice, 2013 at 37, citing 28 C.F.R. § 35.130(b)). Even if a prison has a safety interest in substantial physical isolation, that should not mean that prisoners with disabilities are denied phone calls, books, education, rehabilitative programming, exercise, and the like (for an account of a litigation making this point, see Glidden & Rovner, 2012).

In addition, inside solitary confinement (as outside), the eligibility criteria for various kinds of in-unit programming or services—visits, phone calls, various property privileges, group therapy, etc.—should also be adjusted so those criteria do not deprive prisoners with disabilities the opportunity to participate in and benefit from those programs. Otherwise, such criteria unlawfully “screen out” prisoners with disabilities from “fully and equally enjoying” such programs or make it difficult for them to “obtain the same result [or] gain the same benefit” from these programs (28 C.F.R. § 35.130(b)(8) & (1)(iii)).

Finally, litigation has pursued the theory that prisons should also accommodate disabled prisoners’ particular, disability-related vulnerability to the conditions of isolated confinement by softening those conditions (*Disability Advocates, Inc. v. N.Y. State Office of Mental Health*, 2002). Prisoners with mental illness and intellectual disabilities are less resilient to the absence of social interaction and the enforced idleness of solitary confinement. Consequently, advocates suggest these features should be modified for them; they could, for example, receive controlled programming, increased recreation hours, and expanded access to educational materials and similar accommodations (*Peoples v. Fischer*, Settlement Agreement, 2015). This applies even to disabled prisoners whose path into solitary was unconnected to their disability (*Parsons v. Ryan Stipulation*, 2014 at 8).

Reasonable Modifications Relating to the Route out of Solitary Confinement

Finally, the ADA may require modifications to the *route out of solitary*—that is, to eligibility and step-down-type requirements for prisoners in solitary confinement or other high-security housing, where those requirements are ill suited or even impossible for prisoners with disabilities (*Anderson v. Colo.*, July 21, 2011; *Sardakowski v. Clements* July 1, 2013; Dec. 26, 2013; Feb. 25, 2014). Indeed, the same theory could reach denials of opportunities for a route out of prison altogether, if parole is denied on the basis of a solitary stint, or on lack of completion of rehabilitative programming that is unavailable to those in solitary.

A recent district court opinion accepted a reasonable modification argument seeking greater access for prisoners with disabilities to a solitary confinement “step-down” program (*Sardakowski v. Clements*, 2013 at *9 [rejecting a motion to dismiss for failure to state a claim given plaintiff’s argument “that he has been unable to complete the requirements of the leveling-out program successfully because of his mental impairment and because CDOC officials have prevented him from obtaining adequate treatment and accommodation so that he may progress out of solitary confinement”]; see also *Sardakowski v. Clements* 2014 at 41 [rejecting defendants’ motion for summary judgment on the same claim]).

Notwithstanding the litigation and case law just described, implementation of this kind of individualized approach to housing and discipline remains rare. I do not think that jails’ and prisons’ reluctance to embrace individualizing approaches to housing and discipline, or to operations more generally, can be justified doctrinally. But recall that the requested modification is not required if it would “fundamentally alter” the policy, practice, or procedure, or pose “undue financial and administrative burdens.” The nature of the requested change matters. As in many situations, whether it is considered “fundamental” turns in part on the level of generality used to describe the program and its “essential” aspects. See, for example, *Alexander v. Choate*, 1985 at 300. Is the essence of solitary confinement its restrictive nature, or that it adequately safeguards safety and security? Is the essence of prison discipline that it punishes misconduct, or that it punishes culpable misconduct? And so on. The answer to these questions determines what aspects of the policy, practice, or procedure are deemed “fundamental”—and the analysis is very much contested in the cases.

What is clear, however, is that the ADA pushes toward individualization and flexibility. The very idea that some aspects of a program or policy are fundamental—but others are not—means that prisoner restrictions that have been treated as irrevocably bound together are conceptually untied. And the assertion of the defense—that a particular change to a prison policy or practice a prisoner with a dis-

ability seeks is a fundamental alteration that a prison is not required to undertake, rather than a reasonable modification that it must—puts the onus on the jail or prison to justify why it cannot make a requested change, if not for everyone, than for this particular disabled prisoner. As Brittany Glidden and Laura Rovner summarized the point, “Because the accommodations should be specific and individualized, prison officials must demonstrate why in each case the particular prisoner cannot receive the requested services. As a result, it becomes more difficult for the prison to rely on generalized assertions of ‘safety’ to support the deprivations and instead forces an articulation of the reason for the particular condition” (Glidden & Rovner, 2012 at 69). Sometimes, but not always, courts agree, with the disagreement framed in terms of the degree of deference owed.

Effective Communication

Prisons are difficult auditory environments—they are noisy, and many encounters are high stakes. Failure to obey an order or respond to an auditory cue can have very bad consequences. Both the Rehabilitation Act’s and the ADA’s regulations detail more precise, and quite muscular, obligations for program participants who have communications-related disabilities—for example, blindness or low vision, deafness or low hearing, and speech impediments. For communication, what is required is not merely “meaningful” access, but equality: “A public entity shall take appropriate steps to ensure that communications with ... participants ... are as effective as communications with others” (28 C.F.R. § 35.160(a)(1); 28 C.F.R. § 42.503(e)). The effective communication mandate cashes out as a requirement for provision of “auxiliary aids and services” (28 C.F.R. § 35.160(b)(1))—interpreters on-site or through video remote interpreting services, real-time computer-aided transcription services, assistive listening systems, open and closed captioning, various telephonic communications devices for the deaf, videophones, visual and other nonauditory alert systems, and more (See 28 C.F.R. § 35.104 [defining “auxiliary aids and services”]).

The effective communication/auxiliary aid requirements are crucial for safe incarceration of people with communications disabilities. They raise two key questions: Which communications are covered? And how hard does the prison have to work in meeting the auxiliary aid requirement?

The regulations themselves answer the first question: “communications with .. participants.” There is no limit to, say, formal communication or communication about particularly important topics. The effective communication requirement covers announcements such as an audio alert for count or pill call, as well as disciplinary hearings or doctor’s appointments. On the other hand, the method of compliance may well vary across these types of communications:

The type of auxiliary aid or service necessary to ensure effective communication will vary in accordance with the method of communication used by the individual; the nature, length, and complexity of the communication involved; and the context in which the communication is taking place. In determining what types of auxiliary aids and services are necessary, a public entity shall give primary consideration to the requests of individuals with disabilities. In order to be effective, auxiliary aids and services must be provided in accessible formats, in a timely manner, and in such a way as to protect the privacy and independence of the individual with a disability

(28 C.F.R. § 35.160(b)(2)).

For an announcement that it is time for count, perhaps a flashing light provides effective communication. But for a doctor’s visit or an Alcoholics Anonymous meeting, a live sign-language interpreter might be needed, both because of the high stakes and because of the operational setting (McBride v. Michigan Dep’t of Corr., 2018 at 214).

Prisons sometimes argue that their obligations are merely to provide *some* means of communication—but the regulation and the case law clearly require that the communication be “as effective as communications with others” (28 C.F.R. § 35.160(a)(1)). As technology changes and improves, the necessary auxiliary aids likewise change. For example, there was a time when the preferred telecom-

munications device for deaf telephone access was a “teletypewriter”—a TTY. This 1970s technology allows transmittal of typed text across a standard phone line; a “relay” service provides a (live, human) communication assistant who can read the text to someone on the other end of the line, and type whatever that person says to be read by the TTY user. TTYs function like a limited instant messaging system and read across a 20-character display. They are outdated technologically.⁵ They are also inaccessible to people not proficient in written English—which includes many deaf individuals whose primary language is ASL (American Sign Language). Disability is highly individual, and so too are the auxiliary aids needed for effective communication. Using modern technology, additional—and for most prisoners, much better—options for telephonic auxiliary aids include videophones (and relay) for prisoners who sign, and captioned telephones⁶ for prisoners who can read and speak but cannot hear (*McBride v. Michigan Dept. of Corr.*, 2018).

Like telephonic equipment, other auxiliary aids depend both on the setting and the needs of the individual prisoner (*Adams v. Kentucky* 2016 to 2020).

The Integration Mandate

The ADA regulations include a provision, usually termed the “integration mandate,” that directs “A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities” (28 C.F.R. § 35.130(d)). The regulation that deals specially with program access in prisons and jails (28 C.F.R. § 35.152) adds some detail to this general mandate. It provides, in pertinent part:

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

Prisons often house prisoners with disabilities in various kinds of special housing that are, if not quite solitary confinement, at least close to it; they impose far more locked-down time than ordinary housing, restrict access to property, limit various privileges, etc. This kind of dedicated housing for people with disabilities (as well as infirmary assignments for prisoners not actually in need of in-patient medical care) violates the plain dictates of the ADA’s regulations if the housing area is not “the most integrated setting appropriate” to the prisoners’ needs (28 C.F.R. § 35.130(d); *Henderson v. Thomas*, 2012). As the DOJ further explained in a brief filed in 2013, “[P]risoners with disabilities cannot be automatically placed in restrictive housing for mere convenience ... [T]he individualized assessment should, at a minimum, include a determination of whether the individual with a disability continues to pose a risk, whether any risk is eliminated after mental health treatment, and whether the segregation is medically indicated” (*Coleman v. Brown*, Response of the United States, 2013 at 4).

⁵See 81 Fed. Reg. 33,170 (proposing regulatory amendments “to facilitate a transition from outdated text telephone (TTY) technology to a reliable and interoperable means of providing real-time text (RTT) communication for people who are deaf, hard of hearing, speech disabled, and deaf-blind over Internet Protocol (IP) enabled networks and services.”); 47 C.F.R. part 67 (new rules).

⁶See Federal Comm. Comm’n 2016 (“CTS [captioned telephone service] allows a person with hearing loss but who can use his or her own voice and has some residual hearing, to speak directly to the called party and then listen, to the extent possible, to the other party and simultaneously read captions of what the other party is saying.”).

It is plausible to conclude that a prison violates the ADA regulation if, for example, all the mental health housing is high security, so that prisoners who would otherwise have access to gentler conditions in minimum or medium security are forced into harsher environments in order to get treatment. This argument was made in some detail by the plaintiffs in the pioneering case *Disability Advocates, Inc. v. N.Y. State Office of Mental Health* 2007. And as described above, in the *Armstrong* litigation, the US District Court for the Northern District of California found that the plaintiff prisoners, who had mobility impairments, were being housed in solitary confinement simply because there were no accessible cells available elsewhere. This, the District Court held, violated the clear terms of the provisions quoted above (*Armstrong v. Brown*, Order Granting Motion for Further Enforcement, 2015).

More commonly, though, confinement of prisoners with disabilities in restrictive housing is not because of a shortage of accessible cells elsewhere, but rather because prisons choose to manage difficult, disability-related behavior with solitary confinement rather than less harsh housing assignments and services. In *Olmstead v. L.C.*, the Supreme Court required states to deinstitutionalize people with disabilities who had been unjustifiably assigned to receive various state-provided services in segregated mental health/intellectual disability institutions rather than in the community. (For more on *Olmstead* and its implementation, see U.S. Dep't of Justice, 2011.) In prison or jail, when solitary confinement is triggered by a prisoner's disability (and resulting conduct), it means that prison services are provided in a setting that lessens the prisoner's contact with other, nondisabled prisoners. This is "segregated" not only in the way the term is used in prison but, at least arguably, also in the way the term is used in the *Olmstead* opinion (*Olmstead v. L.C.*, 1999 at 598) to describe civil institutionalization, which the Court held can be a form of unlawful discrimination.

The ADA's integration mandate can be understood to presume that such segregation is harmful. That is, the regulation itself bans an underjustified decision to isolate people with disabilities from other, nondisabled people; plaintiffs need not demonstrate how that decision hurts them. In addition, a decade of litigation under *Olmstead* in other settings has established that the solution for violations of the integration mandate is the provision of services in integrated settings that avoid the need to segregate (Bagenstos, 2012). For example, in *United States v. Delaware*, an *Olmstead* settlement between the DOJ and the state of Delaware required statewide crisis services to "[p]rovide timely and accessible support to individuals with mental illness experiencing a behavioral health crisis, including a crisis due to substance abuse."

The settlement detailed numerous items that would form a "continuum of support services intended to meet the varying needs of individuals with mental illness." This included Assertive Community Treatment teams—multidisciplinary groups "including a psychiatrist, a nurse, a psychologist, a social worker, a substance abuse specialist, a vocational rehabilitation specialist and a peer specialist"—to "deliver comprehensive, individualized, and flexible support, services, and rehabilitation to individuals in their homes and communities," and various kinds of case management. And it provided for "an array of supportive services that vary according to people's changing needs and promote housing stability" and "integrated opportunities for people to earn a living or to develop academic or functional skills" (*United States v. Delaware*, Settlement Agreement, 2011 at 3, 5–6, 7–8). Other *Olmstead* decrees contain similar provisions (Civil Rights Litigation Clearinghouse, 2020b).

The *Delaware* and other *Olmstead* cases provide one model for how prisons could comply with the integration mandate, managing the needs of prisoners with disabilities to keep them out of the segregated solitary confinement setting. The possibilities are broad: provision of coaching and mental health treatment and other supports, perhaps assignment to a one-person cell to minimize intracell conflict, and many more. But so far, this is all very much a doctrine in development.

Implementation Processes

As I have already argued, individualization and integration do not come naturally to jails and prisons—total institutions prefer standardized to singular treatment. It may be helpful, then, to explore briefly four implementation components that assist jail or prisons to maximize their compliance with the above requirements: interaction with the prisoner, notice to the prisoner of available services and accommodations, structured consideration, and concentrated development of expertise and responsibility.

Because disability-related needs are so varied, disability rights statutes often require what is often called an “interactive process” for the development of accommodations. The ADA’s Title I (employment) regulation urges that an “informal, interactive process” “may be necessary” to “identify the precise limitations resulting from the disability and potential reasonable accommodations that could overcome those limitations” (29 C.F.R. § 1630.2(o)(3)). The EEOC’s guidance explains that the procedure should be “flexible [and] interactive” and should “involve [] both the employer and the [employee] with a disability” (29 C.F.R. pt. 1630, App). And, as one federal appellate court has explained, this approach is not “especially burdensome.” The idea is simply to:

meet with the employee who requests an accommodation, request information about the condition and what limitations the employee has, ask the employee what he or she specifically wants, show some sign of having considered employee’s request, and offer and discuss available alternatives when the request is too burdensome (Taylor v. Phoenixville Sch. Dist., 1999 at 162).

Similarly, the Individuals with Disabilities Education Act (IDEA) requires that a child’s individualized education program be developed in a process that is calculated to understand the child’s needs and goals and that it includes his or her parents (20 U.S.C. § 1414(d)(1)(B)). Particularly under the IDEA, part of the process is providing information to the parent on rights and available services and accommodations (Weber, 2015 § 5.2, citing 34 C.F.R. §§ 300.343(c)(iii), 300.346(a)(1)(i), 300.346(b)).

ADA Title II’s regulations do not include “interactive process” language but courts have nonetheless imported the approach, which is sensibly geared toward assessing individualized needs and solutions (Vinson v. Thomas, 2002 at 1154). In a prison or a jail, an interactive process has two advantages. First, it involves the prisoner, who is best equipped to know his own needs and circumstances. Second, it structures a focused consideration of the disability issues—the situation, the potential solutions, and their pros and cons.

It is useful for facilities to designate who, as well as what, the process includes. Disability accommodation requires knowledge of what the law requires—the content of the sections preceding this one. Equally important, it requires knowledge of multiple technologies and techniques. Take a relatively easy question already discussed above: What can be done to provide access to telephone communication to a prisoner who is too hard of hearing to use a regular phone but who does not sign? To answer requires awareness of the range of devices available—for example, amplifiers (including their interaction with hearing aids) or devices such as captioned telephones.

In correctional facilities, there are added complications. What kinds of amplifiers are sturdy enough for congregate facilities and capable of use with (usually low-tech and analog signal) prison pay phones? How can a captioned telephone be linked to the prison phone-billing system? And so on. In a case in which I served as a court-appointed monitor, a variety of obstacles to the state’s first installation of a captioned telephone took several months to solve. The point is, it is essential for each facility to designate a disability or ADA coordinator who can develop the requisite regulatory and practical expertise. The ADA Title II regulations require designation of a “responsible employee” at the agency level, but few prisons or jails have anyone playing this role (28 C.F.R. § 35.107(a)). On what an effective ADA coordinator needs to know and be empowered to do, see US Department of Justice (2006).

Policy/Law Reform: Bridging the Prison Walls

Turning from the ADA/Rehabilitation Act to policy or potential law reform, abundant evidence demonstrates that prisoners' successful reentry—their transition to productive and prosocial lives in their communities after release from jail and prison—is aided by programs that bridge the walls that separate prison from the outside world. We know that effective reentry planning “starts on the inside and continues upon release” (Robert Wood Johnson Foundation, 2009 at 2). Among the most effective bridging methods is when “[t]he same re-entry planner or case manager works with the detainee on the inside and on the outside and serves as an advocate for his successful re-entry” (Id). Mentor programs often use a similar strategy; mentors begin working with prisoners prerelease and continue through a reentry period (Bauldry et al., 2009 at 7 tbl.2; Johnson & Larson, 2008 at 16).

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

Health Records

Transitions are a dangerous time for health services. At hospitals, the most dangerous hours of the day are the shift changes. For prisoners with acute health needs, one dangerous time is arrival at a new facility—when medication is often confiscated, skipped, or lost; health histories can be hazardously incomplete; and (particularly in jail) the prisoner is often in crisis. Another dangerous time is release—when prisoners usually leave with only a few days' worth, if that, of any medication, without a doctor's appointment to get a refill, and often far from their families without transportation home (e.g., Baillargeon et al., 2009 at 855).

An integrated system of health records shared between community and jail health providers would not altogether solve the problem, but it can help. For example, when medications are needed right away on incarceration, an existing prescription record could be an enormous help. More generally, to quote the talking points from one innovative county's presentation on their implementation of such a system, integrated (and digitized) records “improve access to timely and appropriate health care information during clinical encounters” and “improve the overall clinical care of the client by the connection with community providers” (SAMHSA-HRSA Ctr. for Integrated Health Solutions, 2013). The program described is for the Multnomah County Health Department (Butler, 2013 offers a case study of this and several other projects).

Personnel

In medical and mental health care as in other areas, people are the best bridges. There are a variety of models (See, e.g., Patel et al., 2014). In both New York City and Washtenaw County, Michigan, for example, mental health care in the jail is provided by the same agency, and sometimes the same people, as mental health care outside (Butler, 2013 at 14; Washtenaw County Community Mental Health, 2015). In two Rhode Island programs for HIV-infected inmates, the personnel who stay constant are not the treating professionals but case managers (Patel et al., 2014 at 469–70). In another Michigan county program, a “medical navigator” and community health workers begin meeting with prisoners

months prior to their release, and continue with case management services postrelease (US Department of Health and Human Services, 2009).

Community service providers are useful for three reasons: continuity of care, expertise in available community services, and nonprison attitude. The first two are self-explanatory. The third is equally important. Correctional facility doctors and nurses can be expert and compassionate providers. But sometimes prisons and jails become the employers of last resort for subpar clinicians. A number of states have a practice of granting “restricted licenses” to doctors who work in prisons but do not meet the requirements for full licensure (Gibbons & Katzenbach, 2006 at 443–44). And in some states, doctors whose disciplinary records make them unattractive employees elsewhere find jobs in the prison system (Chang, 2012). Even when clinicians have unrestricted licenses and clean records, research establishes that prison doctors and nurses tend to be more jaded and less empathetic toward their patients when compared with their civilian counterparts (Dhawan et al., 2007 at 264 (“[C]orrectional physicians describe a developmental course in which they become increasingly able to empathize with inmates during a period of years of working in a correctional setting.”); Shields & de Moya, 1997 at 37). As Greifinger has summarized: “There is far too much cynicism regarding inmates among correctional health care professionals, who work in environments of constant tension. Too often these professionals are skeptical about inmates’ concerns and complaints, believing that the inmates (who do often exaggerate) are malingering for secondary gain. Correctional health care staff also frequently incorporate the custody staff’s fear that humane responsiveness is coddling that can lead to anarchy” (Greifinger, 2006 at 262).

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

Finances and Discharge Planning

Finally, there is simply no justification for the current law and practices governing the financing of inmate health care. As so often in health law, this issue is technically complicated. Since its inception, Medicaid has excluded “inmates of public institutions” from “federal financial participation”—which is to say, coverage (42 C.F.R. § 435.1009(a)(1)). That exclusion has never affected inmate eligibility to enroll, just their actual receipt of Medicaid benefits (Stanton, 2004). Nonetheless, even prisoners who were eligible, because of age or disability, have most often had their Medicaid enrollment terminated rather than merely suspended during their time in jail and prison. The result was months of delay for former inmates to be reapproved for Medicaid on release from incarceration (Nat’l Ass’n of Cts., 2014; 42 C.F.R. § 435.912, capping Medicaid eligibility determinations based on disability at 90 days and other applications at 45 days).

In the past, the use of Medicaid termination rather than suspension did not affect most prisoners, however, because they were not Medicaid eligible in any event. As adults without dependent children and without a Social Security Administration-recognized disability, they did not meet their states’ eligibility criteria notwithstanding their low income. The Affordable Care Act (ACA) changed that part of the picture when it allowed states to expand Medicaid coverage to everyone who earns up to 138% of the federal poverty level and is under 65 (people 65 and older are covered under Medicare) (42 U.S.C. § 1396a). As of January 2020, 36 states and the District of Columbia have signed up for the ACA’s Medicaid expansion funding (Kaiser Family Foundation, 2020). The result is that nearly all prisoners in those states are now Medicaid eligible. Enrollment comes with two benefits for them and

their jailers: First, Medicaid will cover a large portion of the cost of care delivered outside the institution—at a hospital, for example—when the prisoner has been admitted to that hospital for 24 hours or more. Second, Medicaid enrollment greatly smooths the transition to community health care on release. To realize these benefits, however, states need to enroll their prisoners—and to suspend rather than terminate prisoner participation in the program while they are housed in jail or prison (Centers for Medicare and Medicaid Services, 2016). States have been making real, though not complete, progress on these fronts (Bandara et al., 2015; Families USA, 2016; Kaiser Family Foundation, 2019).

Much more broadly (and admittedly unrealistically in the current political climate), to my mind, the exclusion of prisoners from Medicaid makes no sense at all. If the federal government is going to be responsible for health-care costs for poor people, why exclude prisoners? There’s an argument that since the states and local governments are constitutionally required to pay for medical care, Medicaid coverage would not increase access to care, but merely shift the payer (of course, if that is the logic, the exclusion from the exclusion for hospital stays is an oddity). But even if Medicaid continues to exclude prisoners, there is no reason at all that prisoners should not be enrolled to facilitate coverage for them when they leave. The absence of Medicaid coverage is one of the reasons that the death rate for released prisoners is several times higher than for others of similar age, race, and sex (Binswanger et al., 2007). The availability of insurance makes discharge planning possible: case managers can connect inmates heading toward release with providers in their community and can even schedule necessary postrelease appointments.

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