

## The Legality of Solitary Confinement Under the Americans With Disabilities Act (ADA)

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### Abstract

Under the Americans with Disabilities Act, individuals with “a physical or mental impairment that substantially limits one or more major life activities” (ADA Sec. 12102) are protected from discrimination and offered reasonable alternatives to navigate their physical spaces. Mentally ill prisoners fall under the protection of the ADA, making the use of solitary confinement as a punitive tool a violation of the ADA for this population. Solitary confinement is capable of shattering any healthy mind, and is associated with higher rates of self-harm. In addition, the use of solitary confinement denies confined prisoners several benefits accessible by the general prison population, ranging from access to emergency services to proper therapy and treatment. In this paper, I examine the history of solitary confinement in the United States, and assert that imposing it on the mentally ill is illegal. I conclude by presenting alternatives for addressing mentally ill prisoners in the United States, focusing on the New York and Pennsylvania prison systems.

### Overview of Prisoner Rights

Prisoners do not enjoy full constitutional rights, but are protected by Amendment VIII from cruel and unusual punishment. As a result, prisoners are to “be afforded a minimum standard of living.” Other constitutional rights include “due process in their right to administrative appeals and a right of access to the [parole] process.” The Equal Protection Clause and 14<sup>th</sup> Amendment collectively protect prison inmates from unequal treatment on the basis of sex, race and creed. The Model Sentencing and Corrections Act grants prisoners a “protected interest in freedom from discrimination on the basis of race, religion, national origin and sex.” Prisoners maintain limited rights to freedom of religion and of speech. Currently, federal prison officials have complete control over the classification of prisoners regarding their confinement (Cornell University Law School).

### Solitary Confinement: Historical Context

Solitary confinement is one of the most severe punishments that has been meted out in the history of the United State's criminal justice system. It is one of few punishments guaranteed to have a significant impact on the mental state of any individual subjected to it. The consequences are particularly perilous for mentally ill prisoners. These inmates often defy prison rules due to their illness, only to be sentenced to a program that can only worsen their mental condition. In addition, the quality of mental health treatment in prisons is notably poor. Such conditions create further burdens for a vulnerable population. Mentally ill prisoners are covered under the Americans with Disabilities Act, and should therefore be offered appropriate alternatives when they violate prison regulations.

Solitary confinement occupies a unique space in the penal history of the United States. The first documented use of solitary confinement occurred in 1829 at the Eastern State Penitentiary in Philadelphia. The rationale was religious in nature, based on a Quaker belief "that prisoners isolated in stone cells with only a Bible would use the time to repent, pray and find introspection" (Sullivan, 2006). Despite this optimism, many inmates went insane, committed suicide or were no longer capable of assimilating back into society. The infamous Alcatraz Federal Penitentiary was opened in the San Francisco Bay in 1934, designed for the nation's most dangerous criminals. They soon implemented a solitary confinement block, called the D-block, where inmates were isolated from the general population and rarely released from their cells. One cell, known as "The Hole," was a room consisting only of concrete and a hole. There was no light, inmates were naked, and sustenance was shoved under the door. It was a 1962 movie about Robert Stroud, a well-known criminal who resided in the D-block, that finally exposed solitary confinement to the general American public (Sullivan, 2006). Unfortunately, isolation would still be used.

In 1983, two correctional officers in an Illinois prison were murdered on the same day. As a result, the prison became the first to adopt "a 23-hour a day cell isolation and no communal yard for all inmates" (Sullivan, 2006). Several other prisons adopted these rules in the following years. In 1989, California built Pelican Bay "solely to house inmates in isolation" (Sullivan, 2006). These prisons are commonly referred to as "supermaximum" facilities, many of which "subject inmates to nearly complete isolation and deprivation of sensory stimuli" (Kurki & Morris, 2001, p. 385). Kurki and Morris (2001) note that at "least thirty-four American states in the late 1990s offered supermaximum security prisons or units, providing 20,000 beds and accounting for 1.8 percent of the prison population" (p. 385). This rise in supermaximum facilities has led to increased interest in their punitive measures. Today, solitary confinement is highly controversial, largely because it subjects prisoners to intense mental anguish. While specific procedures vary among prisons, the modern definition of solitary confinement is "the confinement of a prisoner alone in a cell for all, or nearly all, of the day with minimal

environmental stimulation and minimal opportunity for social interaction” (Grassian, 2006, p. 327). The conditions are challenging for all subjected to them.

### Impact and Prevalence

Solitary confinement imposes intense psychological burdens on the prison population, even individuals without any mental illness. For any isolated individual, the effects of isolation may “include anxiety, depression, anger, cognitive disturbances, perceptual distortions, obsessive thoughts, paranoia, and psychosis” (Metzner & Fellner, 2010, p. 104). Such ailments are common among isolated prisoners. Isolation also damages psyches and causes death, with a disproportionately high amount of suicides occurring in segregation units (Metzner & Fellner, 2010, p. 105). A 2013 study of the New York City jail system analyzed medical records from 2010 to 2013 and found that 2,182 acts of self-harm were committed. Despite an overall rate of only 7.3% prisoners engaging in self-harm, leading to medical admission, 53.3% of self-harm acts and 45.0% of potentially fatal self-harm acts among prisoners were committed by individuals in solitary confinement (Kaba *et al.*, 2014). After controlling for sex, age, race, serious mental illness and time incarcerated, self-harm was found “to be associated significantly with being in solitary confinement at least once” (Kaba *et al.*, 2014, p. 442).

Given recent research on the results of sensory deprivation, these statistics are not entirely surprising. United States researchers became fascinated with the effects of sensory deprivation in the 1950s, largely due to reports from prisoners of war in Korea. The media buzzed with stories of brainwashed American soldiers subjected to stimulus blocking conditions that drove them to insanity. The Department of Defense and the Central Intelligence Agency funded a study conducted primarily at Harvard and McGill University Medical Centers, eager to know the results of such conditions. Subjects exposed to sensory deprivation experienced “perceptual distortions and illusions in multiple spheres...vivid fantasies, often accompanied by strikingly vivid hallucinations in multiple spheres; derealization experiences; and hyperresponsivity to external stimuli” (Grassian, 2006, p. 345). Sensory deprivation was clearly linked to an impaired grasp of reality. Those who experienced only these symptoms were the most fortunate. Many subjects also experienced “cognitive impairment; massive free-floating anxiety; extreme motor restlessness; emergence of primitive aggressive fantasies which were often accompanied by fearful hallucinations; and a decreased capacity to maintain an observing, reality-testing ego function” (Grassian, 2006, p. 345). The subjects’ abilities to process information and emotion were crippled. Sensory deprivation, a common trend in isolation units across the country, thus leads to physical and mental defects. A healthy prisoner, completely in control of his faculties, can easily revert to a primal, delusional state after experiencing enough sensory deprivation.

With such results in mind, subjecting the mentally ill to these conditions seems illogical. Such a punishment endangers a large number of mentally ill prisoners: and a significant number of inmates suffer from mental illness, making this problem widespread. 8-19% of prisoners have some sort of psychiatric disorder resulting in significant functional disabilities, and another 15-20% require psychiatric intervention at some point during their sentence. To deprive this vulnerable population of much-needed social interaction and treatment is unjustified. High rates of mental illness make the female prison population particularly vulnerable. A recent report to the U.S. Senate from the American Civil Liberties Union (Macleod-Ball *et al.*, 2009) found that “rates of mental illness among women prisoners range from one quarter to one half of the population,” with 48-88% coping with post-traumatic stress disorder (PTSD). The prevalence of mental illness is even higher for juvenile prisoners. Roughly two-thirds of child prisoners have at least one mental illness: among juvenile prisoners, rates of post-traumatic stress disorder, major depression, borderline personality disorder, and bipolar disorder are particularly high (Macleod-Ball *et al.*, 2009). U.S. federal courts have historically agreed, as many have limited the use of solitary confinement in class action cases challenging the segregation of inmates with serious mental illness as unconstitutionally cruel (Metzner & Fellner, 2010).

Solitary Confinement and the Americans with Disabilities Act

Even beyond its counterproductive nature, use of solitary confinement to discipline the mentally ill violates the Americans With Disabilities Act (ADA). The ADA defines “disability” in three ways, one of which is “a physical or mental impairment that substantially limits one or more major life activities,” (Americans with Disabilities Act, 1990). By definition, mentally ill prisoners are considered disabled. Section 12132 of the ADA states that “no qualified individual with a disability 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.” A prison is a public entity, as a “public entity” refers to “any department, agency, or other instrumentality of a State or States or local government” (ADA Sec. 12131). Prisons serve as public entities because they are government instruments. The term “qualified individual with a disability” refers to “an individual with a disability who, with or without reasonable modifications to rules, policies or practices...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” (Section 12131). Unfortunately, prisoners with disabilities are forced to live in isolated units that cripple their recovery and aggravate their symptoms. Moreover, mentally ill prisoners are far more likely to commit infractions culminating in solitary confinement. The mentally ill often have a difficult time adjusting to prison life, a situation which leads to

excessive punishment for them. Metzner and Fellner (2010) note that those “with mental illness are often impaired in their ability to handle the stresses of incarceration and to conform to a highly regimented routine,” often resulting in “higher rates of disciplinary infractions than other prisoners” (p. 105). The issue lies in the tendency for prison staff to punish the mentally ill in the same way they do other prisoners. After enough infractions, solitary confinement is utilized as a means of punishment. Isolation imposes a variety of new psychological burdens on the vulnerable inmate, creating a damaging cycle where “continued misconduct, often connected to mental illness, can keep the inmates there indefinitely” (Metzner & Fellner, 2010, p. 105). Such circumstances should be thoroughly investigated and addressed.

Mentally ill inmates should not be held to same standards of conduct as their peers. Under Section 12131 of the ADA, these individuals have a right to “reasonable modifications” in the realm of prison policy. These modifications should extend to how they are disciplined. Conformity to a structured routine can easily be complicated by a variety of mental ailments. As of 2005, the Bureau of Justice Statistics found that about “23% of State prisoners and 30% of jail inmates reported symptoms of major depression” (James & Glaze, 2006, p. 1). Inmates suffering from depression may experience decreased energy and have difficulty concentrating and retaining information (NIMH, 2014). This lack of energy and cognitive difficulty complicate adherence to a structured schedule. Major depression is taxing both physically and emotionally, severely limiting one’s ability to adapt to a prison environment. In 2005, the Bureau of Justice Statistics also “estimated [that] 15% of State prisoners and 24% of jail inmates reported symptoms that met the criteria for a psychotic disorder” (James & Glaze, 2006, p. 1). Psychosis manifests itself in a variety of symptoms that complicate interactions with authority figures and abiding by set rules and procedures. Victims of psychosis may experience disorganized thought and speech, delusions, hallucinations and disordered thinking (Board, 2014). Miscommunications between psychotic prisoners and guards are likely, given these ailments. To punish an inmate without mental stability with solitary confinement is therefore a violation of the ADA.

Isolation also severely limits the quality of mental health care available. The American Public Health Association (2013) notes, “Many systems require that prisoners in solitary confinement be escorted in restraints by 2 or more officers,” which “often results in clinical encounters occurring at cellside through bars or through openings in solid metal doors” (p. 1). The results drastically impact the efficacy of treatment. The practice results in “limited privacy, impediments to physically assessing and communicating with patients, and hindrance of the therapeutic alliance” (APHA, 2013, p. 1). The relationship between a patient and a physician is crucial to health, and is particularly sensitive when addressing mental health issues. It is difficult to build a proper

patient-physician relationship when one party is restrained and guarded. The lack of privacy may result in the prisoner denying or neglecting to mention certain symptoms, due to his or her lack of comfort with the guards. Personal tragedies and histories are intimately linked with one's mental state, and patients are likely to feel uncomfortable sharing this information in front of guards.

Group therapy, a crucial part of learning healthy social interactions, is also denied to prisoners in solitary confinement, further violating the ADA. Group therapy is a critical component of psychotherapy, and “involves one or more psychologists who lead a group of roughly five to fifteen patients” (Johnson, 2014, p.1). For mentally ill inmates who struggle with social interaction, access to group therapy may be invaluable. Not only can group members serve as a critical source of support for the patient, but the American Psychology Association also states that “group therapy provides benefits that individual therapy may not” (Johnson, 2014, p.1). Group therapy is incredibly effective for prisoners struggling with mental disorders. Patrick O'Reilly of the American Psychology Association, PhD, who works as a clinical psychiatrist at San Quentin State Prison, notes that “[g]roup psychotherapy has been shown to be remarkably successful...leading to increased medical compliance, less severe mental illness symptoms and a decrease in suicidal ideation” (O'Reilly, 2011, p.1). Such a critical service could benefit inmates in solitary confinement. Prison, a public entity, offers group therapy as a program. The irony of the situation is that many of the mentally ill, likely those who need this help the most, are denied it because symptoms of their illness are used to justify their forced isolation. This is a violation of the ADA, which explicitly states that, “no qualified individual with a disability 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” (Section 12132). Mentally ill prisoners—the individuals who cannot function normally without clinical intervention—are unlikely to recover without access to the holistic psychotherapy offered to prisoners outside of solitary confinement.

Another crucial component of any medical treatment, particularly psychotherapy, is the assurance that the patient is safe. Ironically enough, maximum-security prisons are incredibly dangerous spaces for mentally ill inmates. The APHA (2013) notes that, “Physical isolation from other prisoners and staff may result in life-threatening medical or psychiatric emergencies going undetected,” (p. 1) another circumstance deemed inexcusable by the ADA. In psychiatric facilities across the country, it is understood that regular observation is a critical component of basic medical care. Prisons, which provide medical care, are obligated to ensure this service is available for their disabled residents. Logic dictates that a suicidal prisoner, whose condition is aggravated by the mental strain inherent to the conditions he is forced to live in, should not be left alone

for the majority of the day. The typical amount of time in isolation is 21.5 hours daily, which is plenty of time for a psychiatric emergency to progress undetected (Grassian, 2006, p. 346). The benefit of being in the general prison population is clear: an abundance of guards and fellow inmates who are able to report medical emergencies. This right should not be denied to mentally ill prisoners, who are often in solitary confinement.

Psychiatric emergencies are a constant threat for the mentally ill, and they may not be addressed properly in isolation. Within solitary confinement there may exist a lack of ready access to emergency medications (APHA, 2013). A psychiatric emergency is defined as “an acute disturbance of thought, mood, behavior or social relationship that requires an immediate intervention as defined by the patient, family or the community” (Currier *et al.*, 2002, p. 8). While in solitary confinement, inmates may only have access to such “immediate interventions” during a few hours of each day, or during the periods where food is brought to them. This is also a violation of the ADA, as the housing of other prisoners enables a far more expeditious medical response.

### Complicating Factors and Potential for Disagreement

There are several potential counterarguments to the assertion that solitary confinement constitutes a violation of the ADA. The term “mentally ill” is admittedly ambiguous. It is reasonable to claim that some mentally ill inmates may be entirely capable of following prison protocol and avoiding punishment. The nature and severity of a particular prisoner’s mental illness should be considered. It is also worth noting that the implementation of solitary confinement came about as a response to the murders of prison personnel. The safety of all parties, whether officials or inmates, is at an elevated risk when particularly volatile prisoners are part of the general population. Solitary confinement isolates such individuals. In addition, while Amendment VIII of the Constitution is not the focus of this particular essay, prison officials may argue that solitary confinement does not constitute cruel and unusual punishment. Finally, while there is clearly a relationship between rates of self-harm and solitary confinement, a direct causal link has not been empirically confirmed. However, the abundant evidence previously presented suggests that the legality of solitary confinement is questionable in the majority of cases where it is implemented.

### Judicial History

Recent judicial history indicates that these violations of the ADA are gaining more recognition within the United States. *Disability Advocates, Inc. v. New York State Office of Mental Health, et al. v. New York State Office of Mental Health, et al.* was filed in 2002, and alleged that in addition to violating the Eighth Amendment, New York’s solitary confinement policies directly violated the ADA. They alleged that the defendants “discriminate[d] against mentally disabled prisoners by failing

to provide alternative punishments as a reasonable accommodation so that punishments which exacerbate illness are not imposed,” and did so “on the basis of their disabilities in violation of the ADA” (United States District Court Southern District of New York, 2002, p. 51). The logic is sound; punishments for the mentally ill should not worsen their mental health. In failing to offer this reasonable accommodation, the prison system violated the ADA. A settlement was reached in 2007, in which the New York State Department of Correctional Offices and Office of Mental Health agreed to “establish major improvements in psychiatric treatment for New York State prisoners with mental illness” (Disability Advocates, Inc., 2014). Judge Lynch of the United States District Court for the Southern District of New York stated that solitary confinement within Special Housing Units (SHU), where prisoners were isolated 23 hours a day with no access to out-of-cell programming, was “almost guaranteed to worsen the mental condition of just about anyone but certainly those with vulnerable psyches” (Disability Advocates, Inc., 2014). The settlement requires new mental health treatments for prisoners with serious mental illness and SHU sentences, and requires at least two hours a day of out of cell treatment and programming for all seriously mental ill prisoners residing in SHU. In addition, mandatory reviews of disciplinary sentences for prisoners with serious mental illnesses have been implemented. The goal is to reduce their sentences and keep them out of solitary confinement. Taking a proactive stance, the settlement also emphasizes improved mental health screenings when prisoners are taken into state custody, and increasing the number of residential mental health treatment beds (Disability Advocates, Inc., 2014). These are examples of reasonable accommodations, which all mentally ill prisoners are entitled to under the ADA. This approach directly addresses the need for alternative punishments as well as the deprivation of proper mental health treatment in solitary confinement, and works to identify those whose mental state is too fragile to endure the solitary confinement system.

The New York City Department of Corrections permanently closed its “punitive segregations program” on December 31, 2013, indicating a growing recognition of the violations at play when the mentally ill are isolated. Prior to these changes, on any given day there were 400 mentally ill prisoners serving time in solitary confinement (Gardiner, 2014, p.1). Corrections staff reported that within the first six months of 2013, “the average punishment for a mentally ill inmate sent to punitive segregation was 53½ days,” a truly shocking amount of time (Gardiner, 2014, p. 1). For those categorized as “seriously mentally ill,” there is now the Clinical Alternative to Punitive Segregation (Gardiner, 2014, p. 1). This program will be modeled after an inpatient hospital psychiatric ward. Within this alternative program, inmates “will receive group and individual therapy in a ‘secure therapeutic setting,’ until a treatment team determines they are prepared to rejoin the jail’s general population” (Gardiner, 2014, p.1). This

approach is far more logical, and adheres to the parameters set by the ADA.

Such progress is not exclusive to New York. In May of 2013, the Department of Justice (2013) released the results of their investigation into the use of “long-term and extreme forms of solitary confinement” on prisoners with serious mental illness at the Pennsylvania Correctional Institution (p. 1). The report found that long-term solitary confinement “violates their rights under the Eighth Amendment to the U.S. Constitution and under the American Disabilities Act” (p. 1). U.S. Attorney for the Western District of Pennsylvania, David J. Hickton, stated that, “The findings in this case are disturbing and expose a serious disregard for the health and safety of prisoners with serious mental illness,” reinforcing the fact that mental health treatment is severely restricted in solitary confinement units (Department of justice, 2013, p. 1). An expanded investigation will examine “allegations that prisons throughout the Pennsylvania Department of Corrections subject prisoners with serious mental illness and intellectual disabilities to prolonged periods of isolation under conditions similar to those found at Cresson” (Department of Justice, 2013, p. 1). This response to Cresson, given its status as both a state prison and noteworthy user of solitary confinement, was groundbreaking. Various courts throughout the country are reaching a consensus that these conditions stand in defiance of the ADA.

### Conclusion

Solitary confinement is a dangerous punishment for the mentally ill. The psychological burden of solitary confinement is heavy enough to shatter the psyche of a perfectly healthy mind. When imposed upon a mentally ill inmate, the inmate is likely to experience further mental deterioration. This degradation further limits their ability to comply with prison regulations, resulting in more extended periods of isolation. The cycle is crippling, and inconsistent with the ADA. Clinical alternatives, such as the variety being instituted in the New York City Department of Corrections, address the illness directly. The ADA exists to protect disabled parties, and the circumstances of the mentally ill, in combination with the judicial history of the ADA, dictate that the act must be applied to mentally ill prisoners. The criminal justice system exists to punish and rehabilitate criminals. Condemning vulnerable members of a protected class to further mental strain and denying them medical services is unjust. In order to protect the humanity of the prisoner, who will ideally re-integrate into society, eliminating isolation as a means of punishment for the mentally ill is necessary, and improves the likelihood that they will not become a greater danger to themselves or to others.

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