Reducing Barriers

A Guide to Obtaining Reasonable Accommodations for People with Disabilities on Supervision

ACLU

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Introduction

Scores of people in the United States are under probation, parole, and other forms of post-conviction "supervision."[1] As of 2021, nearly 4 million people in the U.S. — or 1 in every 69 — were on probation or parole.[2] Supervision requires strict adherence to dozens of wide-ranging, vague, and conflicting rules — under penalty of sanctions, including incarceration — for any slip-up.[3] Thus, rather than an alternative to incarceration, supervision is often a tripwire into jail and prison. In 2017, nearly half of all prison admissions in the U.S. stemmed from supervision violations.[4]

For people with disabilities, success under supervision is particularly challenging. Substantial numbers of people on supervision have disabilities, including mental health, intellectual/developmental (ID/D), sensory, and physical disabilities. Such individuals regularly face heightened barriers to understanding and complying with supervision rules, effectively communicating with supervision authorities and other stakeholders, getting to required appointments, obtaining and maintaining employment, participating in required treatment programs, abstaining from drugs and alcohol, and adhering to electronic monitoring requirements. Given other forms of structural discrimination, these barriers are particularly high for people with disabilities who are Black and Brown, LGBTQ, and/or experiencing homelessness or poverty.

People with disabilities thus regularly need changes to the way supervision is administered, such as appointment reminders, plain-language instructions, deaf interpreters, and alternative meeting times or locations.

Title II of the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973 (Rehabilitation Act) prohibit discrimination against people with disabilities.[5] Discrimination includes failing to make "reasonable modifications"—often called "reasonable accommodations"—to "policies, practices, or procedures" that "are necessary to avoid discrimination on the basis of disability" unless "the modifications would fundamentally alter the nature of the service, program, or activity."[6] Federal disability laws apply to courts, parole boards, supervision departments, supervision officers, and other entities that administer supervision, which this Guide collectively refers to as "supervision authorities" or "authorities."

Yet in reality, supervision departments regularly fail to assess whether and what types of program modifications people under supervision need and to provide individual accommodations.[7] As a result, many people with disabilities lack an equal opportunity — which they are entitled to under both disability laws — to successfully complete supervision.

Using federal disability law as its framework, this Guide discusses barriers to success for people with disabilities who are on supervision, and offers potential reasonable accommodations. It is intended for defense attorneys representing people with disabilities who are facing, or actively serving, terms of supervision. Using information in this Guide, attorneys can advocate for their clients to receive legally-mandated reasonable accommodations. Attorneys may raise "reasonable accommodations" claims during legal proceedings, as well as through letters or informal discussions with supervision authorities. Attorneys can bring such claims throughout the supervision process — when conditions are initially imposed, over the course of supervision, and during revocation proceedings. Generally, accommodation needs should be raised as early as possible.

This Guide proceeds in four parts. Part I provides a brief overview of the prevalence of disabilities among people under correctional control.

Part II summarizes the relevant disability discrimination legal framework, with a focus on the requirement to provide reasonable accommodations.

Part III provides an overview of (A) structural obstacles confronting people with disabilities before

they even begin their supervision terms; (B) ways that supervision authorities treat people with disabilities more harshly than their nondisabled counterparts; and (C) disability-related barriers to completing supervision and reasonable accommodations that could help people succeed, which is the primary focus of this Guide.

Finally, Part IV offers concrete resources to help attorneys raise reasonable accommodations claims.

Some caveats are necessary. This Guide is not comprehensive. Supervision systems vary widely from state-to-state and county-to-county. Likewise, people's disability-related barriers and accommodation needs are inherently unique. Thus, this Guide does not cover every disability, potential barrier to following supervision rules, or possible legal claim. Instead, this Guide aims to provide a general overview of disability-related barriers to succeeding on supervision, potential reasonable accommodations, and viable legal arguments, and to point attorneys to helpful sources for further information.

I. Background

Overrepresentation of People with Disabilities Under Correctional Control

People with disabilities are overrepresented among those under correctional control, including probation and parole.[8] For example, in 2019, one in five people under supervision had a mental health disability—twice the rate of the general population.[9] These figures are even starker for women.[10] Moreover, three in 10 people on supervision in 2019 had a known substance use disorder (SUD), four times the rate of the general population.[11] And rates of cognitive disabilities and physical health conditions are higher among those under supervision than the general population.[12]

Common diagnoses among people under correctional control include mental health conditions such as post-traumatic stress disorder (PTSD),[13] anxiety,[14] depression,[15] obsessive-compulsive disorder (OCD),[16] schizophrenia and other psychotic disorders,[17] bipolar disorder,[18] and borderline and antisocial personality disorders (BPD and ASPD);[19] neurodevelopmental disorders[20] including attention-deficit/hyperactivity disorder (ADHD);[21] intellectual/developmental disabilities (ID/D)[22] including autism spectrum disorders (ASD);[23] substance use disorder (SUD);[24] and physical conditions such as chronic illnesses,[25] traumatic brain injury (TBI),[26] mobility disorders,[27] and auditory and/or vision disorders.[28]

In particular, significant numbers of people under correctional control have PTSD. In "urban, low-income communities"—where many people ensnared in the criminal legal system were raised—nearly one in four adults experience PTSD.[29] Black people and women are disproportionately likely to experience trauma,[30] and transgender people—especially transgender people of color—are more likely to experience various forms of violence throughout their lives.[31] The relationship between trauma and correctional control is cyclical: Trauma increases people's odds of arrest and incarceration, and that criminal legal system involvement further traumatizes people, making them more vulnerable to experiencing additional trauma and criminal legal system contact.[32]

Many people have multiple co-occurring disabilities, including multiple mental health disabilities or a combination of mental health, intellectual/developmental, and physical disabilities.[33] In particular, many people with disabilities have co-occurring SUD—in part because many people use drugs to manage symptoms of disabilities.[34] It is therefore important to understand the compounding barriers created by co-occurring disabilities.

Despite their prevalence, many disabilities are un- or under-diagnosed.[35] Moreover, some people with neurodevelopmental disabilities like ID and ASD engage in "masking" or "camouflaging" to conform to societal expectations of how people should behave socially, and to feel safe in response to social stigma they experience in everyday life.[36] For example, people with ASD might suppress repetitive behavior in public,[37] and people with IDs might "overrepresent their abilities."[38]

Consequently, supervision officers, judges, defense attorneys, and even people under correctional control themselves may not be aware of disabilities. It is, accordingly, important for officials within the criminal legal system, including defense attorneys, to affirmatively assess whether someone has a disability, so they can determine whether the person needs reasonable accommodations.

II. Disability Discrimination Legal Framework

Title II of the ADA provides 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."[39] Section 504 of the Rehabilitation Act similarly prohibits disability discrimination.[40]

The primary difference between the two statutes is that the ADA applies to state and local governments, while the Rehabilitation Act applies to the federal government and entities that receive federal funding.[41] Since courts largely interpret the statutes interchangeably, this Guide focuses on the ADA.

The ADA is organized into three primary sections, or titles: Title I (Employment), Title II (Public Services), and Title III (Public Accommodations). This Guide concerns Title II, public services, which includes courts, parole boards, and supervision departments. While other sections contain many provisions that are similar, the legal standards used by the other Titles are sometimes different. For example, there are strong arguments — supported by caselaw — that Title II imposes an affirmative obligation on public entities to make reasonable accommodations even absent a specific request, whereas Title I generally puts the onus on employees with disabilities to request accommodations.[42] Attorneys should therefore be careful about relying on precedents from the other Titles, and should point out the different standards to the court when needed.

A. Covered Individuals and Entities

The ADA protects "qualified" individuals with "disabilities." A "disability" is "(A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment."[43] The ADA defines disability "broadly in favor of expansive coverage to the maximum extent permitted by the terms of the ADA" and thus "[t]he question of whether an individual meets the definition of 'disability' . . . should not demand extensive analysis."[44] Under the ADA's regulations, some conditions should virtually always be considered disabilities, including deafness, intellectual disabilities, and autism.[45]

An individual is "qualified" if "'with or without reasonable modifications to rules, policies, or practices," they "mee[t] the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity."[46]

Thus, if a person has a disability and is sentenced to a term of supervision, they should be a "qualified person with a disability."

Covered entities required to comply with the ADA include jails, prisons, court systems, and supervision systems.[47]

B. Prohibition on Discrimination in Supervision

The ADA prohibits various forms of discrimination including denying an equal opportunity or equal benefit based on an individual's disability;[48] utilizing eligibility criteria that screens out individuals with disabilities;[49] failing to ensure effective communications with people who have disabilities, including through furnishing appropriate auxiliary aids and services;[50] and failing to make reasonable accommodations necessary to avoid disability discrimination.[51]

Additionally, the ADA requires entities to provide public notice of the right to be free from disability discrimination,[52] designate an employee "to coordinate its efforts to comply with and carry out its responsibilities" under the ADA,[53] and "adopt and publish grievance procedures" for alleged ADA violations.[54]

This Guide focuses on the requirement to provide reasonable accommodations.

i. REASONABLE ACCOMMODATIONS MANDATE

The ADA requires covered entities to make "reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability."[55] Thus, authorities who administer supervision systems must make reasonable accommodations that afford people with disabilities an equal opportunity to follow their supervision requirements. This may include making changes to standard supervision conditions that are otherwise required by statute or policy.[56]

Some courts have held that entities must *proactively* make needed reasonable modifications to policies and practices, even absent a specific request. For example, then-Judge Ketanji Brown Jackson held that a prison engaged in disability discrimination "as a matter of law when it failed to evaluate [a disabled individual's] need for accommodation at the time he was taken into custody."[57] Likewise, on a systemic level, courts have held that entities must have a system to track people's accommodation needs and provide necessary accommodations.[58]

Nevertheless, where feasible, individuals with disabilities, or those advocating for them, should notify the relevant authority of their disability-related limitations and accommodation needs and request specific accommodations.[59]

Individuals need not wait until they have been charged with a supervision violation to experience discrimination due to an entity's failure to accommodate their disability. Rather, courts have held that a person's inability to meaningfully participate in their supervision requirements *itself* constitutes disability discrimination — regardless of whether other harms, like incarceration, follow.[60]

People may need to show that their inability to meaningfully participate in supervision without reasonable accommodations is *due to* their disability. The specific causation standard differs by jurisdiction, and many failure-to-accommodate cases do not address causation.[61]

1. "Fundamental Alteration" Affirmative Defense

An accommodation is "unreasonable" — and therefore not legally required — if it would "fundamentally alter the nature of the service, program, or activity."[62] Thus, public entities may argue that proposed accommodations are "fundamental alterations."

Courts must "engage in an individualized inquiry when determining whether an accommodation is reasonable" or a fundamental alteration.[63] This "fact-specific, case-by-case inquiry [] considers, among other factors, the effectiveness of the modification in light of the nature of the disability in question and the cost to the organization that would implement it."[64] The overall focus is on whether the proposed accommodation "would be so at odds with the purposes behind the [entity's program, service, or activity] that it would be a fundamental and unreasonable change."[65] Moreover, while "clearly relevant, budgetary constraints alone

are insufficient to establish a fundamental alteration defense."[66]

2. "Direct Threat" Affirmative Defense

Finally, authorities may assert a "direct threat" affirmative defense. The "direct threat" regulation provides that the ADA "does not require a public entity to permit an individual to participate in or benefit from [its] services, programs, or activities" if "that individual poses a direct threat to the health or safety of others."[67] In assessing whether an individual poses a direct threat, the 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."[68]

The Supreme Court has cautioned that the "direct threat" exception is limited "because few, if any, activities in life are risk free," and "the ADA do[es] not ask whether a risk exists, but whether it is significant.'"[69]

III. Barriers to Success on Supervision for People with Disabilities

People with disabilities, especially mental health disabilities and SUD, are disproportionately likely to have their supervision revoked.[70] For example, people on parole in Texas with a dual diagnosis of a mental health disability and SUD "exhibited nearly a twofold greater risk of revocation" for a technical violation and "nearly a threefold greater risk for revocation" for a new-offense violation than peers without such diagnoses.[71] Likewise, people on supervision in California with mental health disabilities have 3.28 times the odds of returning to incarceration than people on supervision without such disabilities.[72]

There are three primary reasons for this outcome. First, at a baseline, structural obstacles for people with disabilities make daily life — and thus, also, compliance with supervision — more difficult. Second, due to stigma against people with disabilities, some supervision authorities treat people with disabilities more harshly, subjecting them to additional conditions, closer surveillance, and more sanctions. Finally, as this Guide focuses on, features of disabilities may make it more difficult to adhere to supervision rules without accommodations.

A. Structural Obstacles for People with Disabilities

At a baseline, structural barriers make many aspects of daily life harder for people with disabilities — which, in turn, means following supervision conditions is more difficult than for their nondisabled counterparts.

Many people with disabilities on supervision are multi-marginalized. For example, all people with criminal records face obstacles to re-entering their communities.[73] Black and Brown people and LGBTQ people — particularly those who are trans or nonbinary — are even more likely to experience discrimination obtaining housing,[74] employment,[75] and health services.[76] This section focuses particularly on barriers related to an individual's disabilities.

Many people enter supervision following periods of incarceration. While harmful for everyone,[77] jail and prison are particularly traumatizing for people with disabilities, as factors including inadequate health care, lack of access to needed medications, poor air quality and ventilation, and exposure to violence can create or exacerbate health conditions.[78]

Once released, people with disabilities face heightened barriers to successful re-entry.[79] For example, they are disproportionately likely to experience homelessness, with studies suggesting that nearly one-quarter of unhoused individuals have a disability.[80] Housing instability, in turn, "can worsen health outcomes and make it difficult for individuals to obtain health care and manage medical conditions."[81] Additionally, people with disabilities are disproportionately likely to be unemployed. In 2023, 22.5 percent of people with a disability were employed, compared with 65.8 percent of people without a disability.[82]

Further, some disabilities can make maintaining social supports and relationships difficult,[83] especially given societal stigma against people with disabilities.[84] In turn, "social isolation is connected to poorer mental health outcomes."[85]

Meanwhile, obtaining physical and mental health care — disproportionately important for people with disabilities — is exceedingly difficult. Given barriers to

employment for people with criminal records,[86] many people on supervision do not have health insurance. In 2019, about one-quarter of people on supervision lacked health insurance.[87] This is critical as "[c]hronic conditions, especially if left untreated, may prevent adults from successfully meeting the demands of supervision without reincarceration."[88] Additionally, the United States has a dearth of community-based mental health services and supports.[89] While some people with mental health disabilities do not want or need treatment, many others do want such services, but lack access. In 2019, nearly one-third of people on supervision with a mental health disability reported an unmet need for mental health treatment.[90]

The requirement to complete supervision on top of navigating all these other barriers *in and of itself* regularly leads to "feelings of fear, anxiety, and powerlessness" among people with disabilities on supervision.[91] Additionally, supervision can exacerbate health issues because "the demands of probation may interfere with one's ability to access needed health care, generate stress and anxiety, or create barriers to certain health promoting behaviors (e.g., exercise)."[92]

Numerous reasonable accommodations would give people an equal opportunity to re-enter their communities. For example, while the ADA may not always require entities to create *new* services, if part of the agency's mission is to help people re-enter society, reasonable accommodations could include affirmatively helping people with disabilities secure suitable housing,[93] jobs, and health services, as well as connecting people with appropriate social supports.

B. Disparate Treatment of People with Disabilities

Authorities — including courts, parole boards, and supervision officers — may also treat people with disabilities more harshly than their nondisabled counterparts.

Given widespread societal stigma, many authorities deem people with mental health disabilities, especially psychotic conditions, "as a uniformly high-risk group."[94] In particular, given structural racism, officials regularly label people with disabilities who are Black or Brown, as well as those who are transgender or nonbinary, as particularly threatening.[95] These assumptions are, of course, unfounded: Research shows that "[m]ental disorder itself is a weak predictor of recidivism"[96] and, indeed, people with mental health disabilities "are more likely to be a victim of violent crime than the perpetrator."[97]

Additionally, authorities often place more supervision conditions on people with disabilities, especially psychotic conditions.[98] This includes requirements to attend treatment programs, which often contain *their own* set of rules,[99] as well as taking medication as prescribed.[100] Thus "[b]y having more requirements to meet to successfully complete community supervision," people with mental health disabilities "may be at a disadvantage[.]"[101]

Moreover, given the "high-risk" designation, supervision authorities generally put people with mental health disabilities on more "intensive" supervision caseloads, which subjects them to closer surveillance.[102] Extra conditions and close surveillance "result[s] in a greater chance of incarceration" for such individuals.[103] Indeed, studies show that "[w]hen not paired with additional services, high levels of supervision are associated with high rates of re-arrest and technical violations because officers discover minor illegal activity they would not have under normal supervision."[104]

Finally, studies suggest that supervision officers are more likely to pursue violation proceedings against people with mental health disabilities,[105] and to endorse coercive and restrictive placements such as mandated treatment in "locked" facilities or incarceration.[106] Further, people showing signs of mental health conditions are more likely to be arrested than people who engage in the same behavior without exhibiting those features.[107]

Some supervision officers justify this treatment because they "perceive a technical violation as indication that the [individual on supervision] is decompensating, and that more serious forms of

noncompliance, such as violence, are forthcoming."[108] However, research shows that technical violations "are not proxies of new crime."[109] Additionally, some officers claim that incarceration is the best way to ensure someone receives treatment.[110] But as discussed below, people generally do *not* receive treatment while incarcerated, and being in jail or prison *demonstrably worsens* people's mental and physical health.[111]

Authorities who treat people more harshly due to their disabilities violate the ADA's "disparate treatment" prohibition.[112]

C. Disability-Related Barriers to Success on Supervision

People with disabilities often need individualized reasonable accommodations in order to adhere to supervision rules.[113] Otherwise, "the rules themselves may set [people] up for failure."[114] This section describes common disability-related barriers to success on supervision and possible reasonable accommodations.

i. BARRIERS TO UNDERSTANDING SUPERVISION OBLIGATIONS

Supervision demands adherence to dozens of rules that can be difficult to understand. Additionally, supervision conditions — particularly for people with mental health disabilities or SUD — regularly include completing mandated treatment and programming, the contents of which can be hard to comprehend.

People with auditory and visual disabilities regularly need accommodations, including sign language interpreters, written materials translated into American Sign Language (ASL) videos, brailed materials, and/or large print materials, to understand supervision authorities' oral or written communications, and to understand what is happening during required programming or treatment sessions.[115]

Likewise, people with disabilities that impact cognitive functioning — including ID/D, ADHD, TBI, and certain mental health conditions — "may need clear, written descriptions and repetitive discussions" of their supervision conditions "to fully understand their obligations."[116] For example, correctional officers in Switzerland observed that incarcerated people "with ADHD required longer and more repetitive instructions, more explanations and generally more attention compared to prisoners who did not have this disorder."[117] Additionally, memory limitations among people with TBI "can make it difficult to understand or remember rules or directions."[118]

As referenced in Section I, some people with ID/D try to hide their disability and thus might "[s]ay they understand more than they really do."[119]

As a consequence, supervision officers may perceive people to be inattentive or "blowing off" their supervision obligations — when, in reality, they cannot understand what is happening.[120]

Accordingly, authorities should explain supervision requirements both orally and in writing in plain language. To ensure comprehension, authorities should ask individuals to explain back the requirements in their own words (rather than simply asking if they understand). Other reasonable accommodations may include communicating instructions in the person's preferred style (e.g., written, verbal, typed, emailed); using iconic images to communicate key concepts (e.g., visual calendars with icons to represent important dates or drawing a stick figure walking through the door of a house with a clock above the house showing 8pm and a darkening sky to represent an 8pm curfew); speaking slowly and repeating instructions; allowing the individual to have a supporter present during meetings to help with communication and comprehension; and allowing the individual to record meetings so they can replay the discussion.

ii. BARRIERS TO EFFECTIVELY COMMUNICATING AND ENGAGING WITH AUTHORITIES

Navigating supervision requires regular communication with supervision authorities, including to ask and answer questions, accurately report required information, discuss changes to rules, access

resources available through supervision departments, and participate in required treatment/programming run by supervision agencies or third-party vendors. People with disabilities face multiple barriers to effective communication, including (1) limitations to speaking, hearing, and understanding, (2) barriers to forming trusting and productive relationships that allow for meaningful engagement, and (3) stigma against behaviors resulting from peoples' disabilities.

1. Barriers to Speaking, Hearing, and Understanding

People who are deaf or hard of hearing have varied communication needs. Many of these individuals do not use spoken or written English as their primary mode of communication.[121] Additionally, large numbers of deaf people in the criminal legal system experience language deprivation syndrome,[122] a co-occurring intellectual disability characterized by functional delays in language and comprehension that result from a lack of access to language during childhood.[123] This diminished access to language impacts deaf people's fund of knowledge,[124] which frequently includes their ability to understand legal proceedings,[125] and renders common English-based auxiliary aids, such as captioning or written notes, ineffective for communicating rules and other concepts related to supervision.

As a result, supervision authorities must provide a variety of accommodations to most deaf or hard-of-hearing people on supervision in order to ensure that communication is effective. The right communication method may differ based on the circumstances and what is being communicated. A recommended auxiliary aid for deaf individuals who experience language deprivation are deaf interpreters – deaf specialists who provide interpreting, translation, and transliteration services in ASL and other visual and tactile communication forms.[126]

In addition, people with disabilities that impact cognitive and executive functioning, such as ID/D, ADHD, TBI, and certain mental health disabilities, often have difficulties communicating with supervision authorities. For example, attention deficits among people with TBI and ADHD make it hard to respond to questions or directions from supervision officials.[127] People with such disabilities may also experience "difficulty articulating their thoughts"[128] and might respond to questions more slowly.[129] Further, "there is an abundance of literature linking ADHD and difficulties in pragmatic aspects of communication, such as speaking without thinking, interrupting others' speech or conversations and talking excessively."[130] People with speech impediments, which may stem from disabilities including brain injuries, strokes, or muscular dystrophy, likewise face barriers to clear and effective communication.[131]

Communication barriers – combined with cognitive functioning limitations that make it difficult to understand complex questions – may lead people to provide inaccurate or incomplete answers to officers' requests for information, resulting in them being considered "untruthful."[132]

Supervision authorities, therefore, should proactively ask people about their communication abilities and needs. Authorities should use simple, plain-language sentences, and other strategies discussed above in Section III(C)(i), to ensure individuals are able to understand and communicate effectively.

2. Barriers to Forming Trusting and Effective Relationships

People with disabilities often face barriers to maintaining effective, trusting, and productive relationships with authorities.[133] This is consequential, since studies suggest "that future probation violations are more likely when probationers have poor relationship quality with their officers."[134]

The inherent power imbalance between a supervision officer and the individual under supervision can make it hard for people with certain disabilities to trust and engage with their supervising officer.[135] For example, power imbalances – as well as the experience of supervision generally – can create or exacerbate anxiety, which is associated with "lower confidence that the [supervision officer] works to the [person's] best interest" and can lead "individuals to be less truthful with their [supervision officers]."[136] Likewise, people with paranoia symptoms "may be less willing or

able to trust the advice of judges, probation, and parole officers."[137] Barriers to trust are particularly high when people have co-occurring mental health disabilities or SUD, have previously experienced alienation or discrimination for behaviors related to their disability, or are from marginalized groups, such as LGBTQ individuals.[138]

At a baseline, some disabilities create heightened barriers to social interactions. For example, because of limitations in intellectual functioning, people with IDs generally experience amplified stress from social interactions, especially negative exchanges.[139] Additionally, people with depression generally "fear rejection from others" which "may lead them to avoid any social interaction."[140]

Without a trusting relationship, people with disabilities may not honestly answer authorities' questions or report required information, such as their housing or employment status. People with mental health disabilities such as PTSD, as well as disabilities with psychotic features like paranoia, may become evasive and stop responding to their supervision officer, or decline to report requested information.[141] Additionally, people with IDs may become overwhelmed by the presence of an authority figure and say what they think the authority wants to hear, whether or not it is accurate.[142]

People with certain mental health disabilities may react adversely to even well-intentioned engagement by authority figures. For example, PTSD can cause people to "see themselves as incompetent or damaged, to see others and the world as unsafe and unpredictable, and to see the future as hopeless" which "can greatly influence [their] belief in their ability to use internal resources and external support effectively."[143] Additionally, people with PTSD may perceive offers of help "as efforts to control and dominate" them, which can make interactions with the supervision officer "feel dangerous rather than safe.[144] Indeed, among people who have experienced trauma, "their attempts at help-seeking in the past may have been futile or fraught with danger, leading to beliefs that authority figures are unlikely to be constructive or helpful."[145]

Supervision authorities should be cognizant of these barriers, and should make affirmative efforts at the outset to form trusting relationships with the people they supervise based on their individualized needs. Indeed, conversations about accommodations can also help to build trust. Where disabilities create barriers to reporting required information, such as changes in housing or employment status, authorities should exercise flexibility and patience. Where possible, authorities should work with the individual to develop alternative ways of obtaining necessary information. Additionally, authorities should allow people to step out of meetings and take breaks if they are feeling overwhelmed.

3. Barriers Due to Stigma Against Disability-Related Behaviors

Given societal stigma against people with disabilities, many supervision officers react adversely to behaviors that stem from peoples' disabilities — creating further barriers to forming effective relationships.

When communicating with supervision officials, people with disabilities including ID/D, ADHD, and psychotic conditions may exhibit a range of behaviors, such as smiling, laughing, fidgeting, acting agitated, speaking loudly, erupting in anger or frustration, or ignoring the authority figure, at moments that are considered inappropriate under societal norms.[146] Authorities may interpret this behavior as acting out or not taking supervision seriously — which can hinder the formation of productive relationships.[147]

However, these behaviors can reflect individuals' disabilities. For example, people with trauma histories may display "[c]ombativeness and aggression" in correctional environments in order to "overcompensate for feelings of vulnerability."[148] People with disabilities that impact executive functioning — including ID/D, ADHD, TBI, and some mental health disabilities, such as schizophrenia, bipolar disorder, and ASPD — may experience "impulsivity, reward sensitivity, and novelty seeking"[149] which can lead to a "reduced ability to focus on the likely consequences of their conduct."[150] Additionally, some psychotic disabilities may cause "feelings of grandiosity and euphoria" which "may interfere with an individual's

willingness to follow orders from authority figures."[151] Meanwhile, people with OCD "may be outraged and distressed" when they perceive another person as "interrupt[ing] an obsession" or "break[ing] rules without justification"[152]—which can occur when supervision authorities change routines. People with OCD and ASD are "vulnerable to angry or violent outbursts" as they "commonly have a poor understanding of their own and others' mental states" and "may therefore have difficulty empathizing with the effect of their compulsions on others, may be unable to explain what they are experiencing or may be unable to deal with the situation by expressing emotions conventionally/appropriately."[153]

Better understanding of how these disabilities present could help avoid misinterpretation by supervision authorities. Reasonable accommodations can include asking the individual about the best way and place to communicate, and recognizing when the individual is experiencing impacts of their disability and providing support if the individual seeks it. Authorities should also use de-escalatory language. For instance, instead of saying "calm down" when an individual becomes agitated, authorities might say, "That sounds really challenging."[154]

iii. BARRIERS GETTING TO REQUIRED PLACES

Supervision regularly requires people to be at certain places at particular times, such as to meet with a supervision officer, to attend treatment or programming, or to perform community service. People with disabilities face greater barriers getting to required places than their nondisabled counterparts.

In many places, public transportation systems are inaccessible for people with mobility, communication, and intellectual/developmental disabilities.[155] For example, people who use wheelchairs face barriers such as a lack of building ramps, or routes that are too narrow, steep, slippery, or at difficult angles.[156] People with auditory or visual disabilities, as well as ID/D, often have difficulties "obtaining and understanding information" necessary to navigate transportation systems.[157]

Paratransit systems can help people with disabilities get to required locations. However, such systems are not always available and "require[] prior planning, can take significantly longer, may have a limited schedule or availability, and may have inaccuracies that can affect service or timing."[158]

Additionally, people with chronic illnesses may experience unexpected symptoms that render them unable to leave their home to attend their supervision obligations. Such obligations also might conflict with necessary medical appointments.[159]

Meeting locations themselves might be inaccessible for people with disabilities, including people who use wheelchairs and people with disabilities that make them sensitive to light and noise, such as ASD and ADHD.[160]

Certain disabilities impact people's ability to sleep, and some people take medication that makes them groggy—affecting people's ability to get to strictly scheduled meetings and, in particular, early morning meetings.[161] People with depression might also have difficulty getting to required places, given the lack of motivation and energy that often accompanies the condition.[162]

Additionally, some mental health disabilities, including PTSD, anxiety, and OCD, may lead people "to avoid people, places, or situations to alleviate unpleasant emotions, memories, or circumstances"[163] or, in the case of OCD, "[a]voidance of situations that can trigger obsessions or compulsions."[164] This could lead people to avoid attending meetings.

Further, cognitive disabilities, including among people with ID/D, ADHD, and TBI, may make it harder for people to recall when and where meetings will be, and to make and implement a plan to get there.[165]

As reasonable accommodations, supervision officers should schedule appointments based on people's individual needs. Meeting locations should be physically accessible as well as appropriate to people's sensory and mental health-related needs. To help people get to appointments, authorities should provide advance reminders and transportation assistance, including help signing up for paratransit systems. Where reporting to *any* location is impracticable,

authorities can permit remote reporting or conduct check-ins at the individual's home.

Authorities also should schedule meetings at times that are appropriate for people's disability-related needs (e.g., avoiding early morning appointments for people whose disabilities make them groggy in the mornings). Further, they should exercise flexibility, for instance, by permitting reporting within a larger timeframe – i.e., any time during a certain day, over the course of a week, or in a month – that works for the individual. Additionally, to reduce the burden of numerous appointments, authorities can permit any supervision-mandated contact, such as programming, treatment, or drug testing, to satisfy their "report regularly" requirement.

Where symptoms and management of an individual's chronic illness interferes with their supervision requirements, authorities should provide waivers for supervision obligations.

iv. BARRIERS TO OBTAINING AND MAINTAINING EMPLOYMENT

Many jurisdictions require people to obtain and maintain employment during their supervision. Yet as discussed in Section III(A), people with disabilities are disproportionately likely to be unemployed.

People with disabilities face heightened barriers to obtaining and maintaining employment.[166] For example, mobility, hearing, and/or vision disabilities can make it impracticable to physically access work spaces or to perform required tasks absent reasonable accommodations.[167] Chronic illnesses may require people to take days off from work for medical appointments or due to feeling unwell, making it difficult to maintain a job.[168] Many disabilities that impact cognitive functioning, such as ID/D, ADHD, TBI, PTSD, anxiety, and depression, can impede concentration, time management, working memory, organization, and multitasking.[169] Additionally, "[o] bsessions about symmetry" among people with OCD "can derail the timely completion of school or work projects because the project never feels 'just right.'"[170] Further, "[e]xcessive worrying" can make it difficult for people with anxiety to complete job-related tasks.[171]

One study showed that people with disabilities are disproportionately likely to face revocation for violating "maintain employment" conditions.[172]

As a reasonable accommodation, authorities can affirmatively support people with disabilities in identifying suitable job options that would accommodate their disabilities, with flexible or part-time scheduling as needed. Authorities can also create tools, such as daily to-do lists, step-by-step checklists, and written as well as verbal instructions, to help the individual complete required tasks. Additionally, authorities could permit the individual to engage in alternatives to traditional paid employment, such as caregiving or pursuing educational or vocational training.

v. BARRIERS TO ABSTAINING FROM DRUGS AND ALCOHOL

Substance Use Disorder (SUD) is a "covered disability" under federal disability laws only under certain circumstances. Under the ADA, "'individual with a disability' does not include an individual who is *currently* engaging in the *illegal* use of drugs[.]"[173] Nevertheless, substance use is a protected disability where, for example, the individual: is using alcohol; completed drug treatment; or is currently "participating in a supervised rehabilitation program" including medication-assisted treatment under the supervision of a licensed medical professional.[174] Additionally, an individual who is illegally using drugs is still protected if they have a co-occurring disability that *is* protected under the ADA.

Supervision conditions typically prohibit people from using drugs and/or alcohol, and subject them to regular substance use testing.[175] Depending on the jurisdiction, this may include prohibitions on medical and/or recreational marijuana, even where the substance is otherwise legal.[176]

For people with SUD, abstaining from drugs and alcohol is inherently difficult: SUD is characterized

by "intense urges to take drugs" — and "relapse" into drug use is common.[177] Unsurprisingly, each year high numbers of supervision revocations relate to drug use.[178]

Further, accessing appropriate treatment for SUD is often difficult. As discussed below in Section III(C)(vi), people with disabilities face high barriers to entering treatment programs. Many programs require abstinence and do not permit medication-assisted treatment (MAT) — which itself violates the ADA where an individual has opioid use disorder.[179]

Challenges stemming from other disabilities can also lead to drug-related violations. For example, as discussed above, co-occurring disabilities can make it harder to maintain a schedule or get to required places — creating barriers to appearing for drug-testing appointments.[180] A 2023 study revealed that people on probation who were currently using illegal drugs "were twice as likely to 'strongly agree' that probation was stressful" compared to peers who did not use illegal drugs.[181] Such stress can exacerbate mental and physical health conditions, and thus make navigating supervision even harder.

Moreover, conditions that limit executive functioning, such as PTSD, ADHD, bipolar disorder, ASPD, and anxiety, may lead people to engage in impulsive and/or risk-taking behavior, such as using drugs.[182] There also is a wide body of research suggesting that, for a variety of reasons, "the prevalence of ... SUDs[] among deaf individuals exceeds that of hearing individuals."[183]

As reasonable accommodations, where people want treatment for SUD, authorities should help them identify and enter programs that are appropriate to their cognitive abilities, trauma histories, and other disability-related needs. Since one size does not fit all, authorities should allow people to try different treatment approaches, and not penalize them for switching programs.

vi. BARRIERS TO PARTICIPATING IN REQUIRED TREATMENT AND PROGRAMMING

Note on Problems with Mandated Treatment

Mandatory treatment is not demonstrably effective. A meta-analysis concluded that "evidence does not, on the whole, suggest improved outcomes related to compulsory treatment approaches, with some studies suggesting potential harms."[184] A study of mandated SUD treatment found that "forced treatment not only did not improve outcomes for substance use, but actually leads to higher levels of mental duress . . . persistent homelessness . . . higher rates of relapse . . . and increased risk of overdose" upon discharge.[185]

There are myriad reasons why mandatory treatment is often ineffective and harmful. Supervision officials and judges are generally not clinicians, and therefore lack the training and expertise to make decisions about peoples' treatment.[186] Further, violations — such as being late, missing meetings, or testing positive for drugs — are reported back to the supervising authority, which erects barriers to forming a trusting, therapeutic relationship.[187] Indeed, "[t]he power dynamic that is inherent in the carceral system and reinforced through rigorous rules, limitations on autonomy, and constant supervision situates the individual in a position of powerlessness and creates a hostile environment that is inconducive to healing."[188] Many people thus experience mandated treatment as "punitive" rather than therapeutic.[189]

Moreover, many mandated treatment programs for SUD include requirements, such as abstinence, that are not evidence-based.[190] They also generally do not allow people to access medication-assisted treatment, which is the standard of care for people with opioid use disorder.[191]

Finally, violating treatment rules — which, as discussed below, may be difficult to avoid — can trigger incarceration sanctions. Yet, incarceration "create[s] and worsen[s] symptoms of" mental health conditions as well as heightens the likelihood of drug overdose.[192] Moreover, few people actually receive needed treatment while incarcerated,[193] and where people do receive treatment, studies show that any value gained is "far outweighed by the harms caused by incarceration."[194]

Instead of mandated treatment, experts recommend community-based programs that "provide practical assistance with housing and other challenges, set realistic expectations for participants, avoid using threats of punishment to obtain compliance, and refrain from sending participants to prison because of drug use."[195]

Many people on supervision, especially those regarded as having mental health disabilities and/or SUD, are required to complete treatment or other programming. Failing to *attend* treatment, failing to *complete* treatment, and violating any rule *within* the treatment program is itself a supervision violation—and program rules can be wide-ranging, harsh, and subjective.[196]

People with disabilities face barriers even getting into the treatment door. Enrolling in treatment is generally a lengthy process involving complicated logistics and paperwork, which can be difficult for people with cognitive or communication disabilities to navigate.[197] Further, as discussed above, it can be difficult to physically access treatment programs.[198]

Once in a program, people with some disabilities, including those who are deaf/hard of hearing or who have cognitive disabilities, face barriers to understanding, and therefore effectively engaging in, required programming.[199] For example, mental and behavioral health providers often refuse to provide sign language interpreters or captioning for people with hearing disabilities, which can make participation in treatment impossible due to the lack of effective communication.[200]

Symptoms of mental health disabilities may make it harder to engage in required treatment. For example, "a person with major depressive disorder may not benefit from participating in treatment" until "the symptoms of depression—hopelessness, lack of energy, and poor concentration—are addressed."[201] Additionally, mandated treatment "can be disempowering and oppressive" and therefore may replicate past trauma, especially childhood trauma.[202] It therefore can be difficult for people with trauma histories "to benefit from programs, perhaps in part, due to the disorientation and disconnection that trauma creates."[203] Moreover, people with mental health disabilities such as PTSD may face barriers to trusting treatment providers. People may not engage in treatment or may leave treatment when trust issues arise.[204]

During treatment sessions, people with disabilities may also "[b]ehave in ways that could be mistaken for willful non-adherence or poor motivation"—for instance, "reduced stamina may come across as laziness, impaired judgment as rebelliousness, memory problems as lack of motivation."[205] Likewise, people may appear to be disengaged from treatment, when in reality they are "numbing" their emotions as a coping mechanism.[206]

According to a California study, people on supervision with mental health disabilities were "15.6 times more likely to return to prison" for "technical violations for failing to attend treatment" than their nondisabled counterparts.[207]

As reasonable accommodations, authorities should affirmatively help people enroll in programs that are appropriate to their disability-related needs. As discussed in Section III(C)(v), given that people's learning styles and needs differ, authorities should allow people flexibility in trying different treatment approaches and programs, and not penalize people for switching programs. Authorities should also consider providing additional time for people who need it to comply with the program's requirements.

vii. BARRIERS TO COMPLETING ELECTRONIC MONITORING

Many people on supervision are subjected to electronic monitoring (EM). EM refers to GPS ankle monitors, cellphones, radio frequency technology, and other devices that authorities impose to monitor people outside of physical jails and prisons.[208] Many people on EM are subject to additional requirements, beyond their supervision conditions, including rules regarding charging the device — often for multiple hours every day — keeping the device connected to WiFi, limits on when they can leave their house and where they may go, and requirements to pay fees.[209]

People with disabilities that impact communication and/or cognitive functioning face barriers to understanding their EM requirements, including remembering to charge the device each day.[210]

Additionally, monitoring devices can interfere with physical health conditions. For example, ankle monitors may cause pain that exacerbates existing medical conditions; alerts from the device may negatively impact people with hearing disabilities; and the device may impede peoples' ability to obtain certain medical procedures, such as MRIs, mammograms, and x-rays.[211]

Ankle monitors can also create or exacerbate mental health disabilities.[212] In one study, 80 percent of people on ankle monitors pending immigration proceedings experienced anxiety from the monitor, 71 percent experienced depression, and 12 percent had suicidal thoughts.[213] People also reported that being physically shackled to an ankle monitor triggered past trauma and caused them to re-experience traumatic events.[214]

As reasonable accommodations, authorities should only utilize EM devices that do not exacerbate people's health conditions and should permit temporary removal of EM devices for necessary medical procedures. As with other supervision conditions, authorities should explain all requirements in plain language and provide appropriate auxiliary aids.

Conclusion

Federal law requires supervision authorities to avoid disability discrimination, including by affirmatively making reasonable accommodations. Nevertheless, hundreds of thousands of people across the United States are forced to navigate burdensome supervision rules without needed accommodations, setting them up for failure.

Each case is unique. Yet as a general matter, attorneys should ask clients in a simple and nonjudgmental manner if they have a disability (e.g., "Do you have any conditions like PTSD, depression, ADHD, or bipolar disorder?"), keeping in mind that clients may not always know whether they have a disability. Attorneys should also ask if there is anything they can do to help their client communicate clearly, access meetings, and otherwise succeed on supervision. Attorneys should brainstorm possible accommodations with their clients, recognizing that clients may not always know what forms of reasonable accommodations might work for them, and that this may be the first time they have used accommodations.

If a client has a disability, as soon as practicable, attorneys should engage with relevant supervision authorities to obtain needed accommodations. This advocacy can occur in legal proceedings, such as during sentencing to supervision conditions. It can also occur informally through conversations with supervision officers over the course of supervision.

More broadly, attorneys and other advocates should urge supervision authorities to enact systems to affirmatively assess the accommodation needs of people on supervision; provide such needed accommodations; and give clear notice of people's rights under federal disability law. Advocates should also encourage authorities to adopt "universal design" accommodations that would help *everyone* on supervision, such as plain-language explanations of supervision requirements; flexible meeting times, locations, and frequency based on the individual's needs; and assistance getting to required locations and enrolling in appropriate programming that provides necessary accommodations.

Expanding access to reasonable accommodations is critical to making supervision manageable for people with disabilities, but it is by no means sufficient. The United States continues to put too many people under oppressive forms of correctional control for too long, with disproportionate harms on Black and Brown people, LGBTQ people, and those experiencing homelessness and poverty. Ultimately, advocacy should aim to limit the power of the carceral state, and shift resources from supervision and incarceration into voluntary, community-based supports and services. Federal disability law offers a tool to significantly decrease the burdens of supervision in service of that goal.

IV. Appendix: Sample Forms

A. Documentation of Accommodation Needs

Individuals can use a form along the following lines to obtain documentation from a medical professional of their accommodation needs. Attorneys can then provide the form to relevant authorities when requesting reasonable accommodations.

Note that while the ADA does not require documentation of a disability from a medical professional when submitting a reasonable accommodation request, public entities can sometimes ask for documentation if they need additional information about a disability to determine if a reasonable accommodation is required. Providing documentation can help facilitate the process of obtaining accommodations.

VERIFICATION OF NEED FOR A REASONABLE ACCOMMODATION REQUEST

Patient's Name: ____

Address: ____

Phone: ____________________

I have requested the accommodation below and ask that you fill out the following certification.

Signed: ______________________________ Date: ______________

CERTIFICATION:

The individual who has signed above has requested the following reasonable accommodation(s):

____

____

____

S/he/They requested that you provide verification. Please indicate here:

Do you believe the individual has a physical or mental impairment that substantially limits a major life activity?

☐ Yes ☐ No

Do you believe the accommodation is necessary and will achieve its stated purpose?

☐ Yes ☐ No ☐ Cannot Verify

Is there any other information that would be helpful in making the right accommodation for this person?

____

____

____

____

Signature ________________________________ Date____________

Title of Physician or Professional ____________________________________

Address ____

Phone ____________________

B. Request For Reasonable Accommodations

Attorneys may use the following template language to request reasonable accommodations. This language could be translated into a letter to the relevant supervision or sentencing authority, a legal filing, or talking points to be covered in an oral request. It could be used when conditions are first imposed (for instance, at sentencing to probation), during the course of supervision, or at the revocation stage. While strategic concerns will differ based on each case, it is generally advisable to request accommodations as early as possible.

Attorneys should modify this template as needed based on the specific issues and accommodation needs presented in each case. For example, if communication access is not at issue, the "effective communication" paragraph could be excluded.

I am requesting reasonable accommodations for my client, [name], because of their disability.

Entities that impose and enforce supervision rules must comply with Title II of the Americans with Disabilities Act (ADA). Among other requirements, the ADA provides that covered entities must make "reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability." 28 C.F.R. § 35.130(b)(7). Reasonable modifications or accommodations may include making changes to standard supervision rules that are otherwise required by statute or policy.[215]

Additionally, the ADA requires entities to ensure that communication with people with disabilities is equally effective as communication with people without disabilities. Covered entities must provide auxiliary aids and services when needed to communicate effectively with people who have communication disabilities. For example, for people who are Deaf or DeafBlind, this usually includes providing a qualified sign language interpreter. A "qualified" interpreter means someone who is able to interpret effectively, accurately, and impartially, both receptively (i.e., understanding what the person with the disability is

saying) and expressively (i.e., having the skill needed to convey information back to that person) using any necessary specialized vocabulary. Moreover, people with cognitive disabilities may require alternative ways of communicating information to ensure that communication is effective.[216]

Here, [client] has [disability(ies)]. Due to their disability(ies), it is difficult for them to [summary of barrier(s), e.g., "understand their supervision conditions" or "travel to appointments"]. As a result, it is hard for my client to follow [specific condition(s) of supervision]. Because of these limitations caused by their disabilities, without modifications to these conditions or practices, my client will find it difficult to successfully complete supervision and will be at increased risk of revocation or other consequences.

[Client] is accordingly requesting reasonable accommodations necessary to have an equal opportunity to succeed on supervision, such as [proposed accommodation(s)].

Thank you for your prompt attention to this matter.

C. Letter Demanding Basic ADA Compliance

Attorneys may use a letter along the following lines to demand that supervision agencies adhere to the ADA's basic requirements: providing notice of individuals' rights, appointing an ADA coordinator, enacting a grievance procedure, and accepting and processing requests for reasonable accommodations. Such a letter is appropriate where attorneys have specific evidence of noncompliance with these requirements.

Dear X,

I am writing because [Supervision Agency] is not operating in compliance with its legal obligations under the Americans with Disabilities Act (ADA).

Title II of the ADA requires entities—including supervision agencies—to, among other requirements, (1) provide notice of people's rights to be free from disability discrimination, 28 C.F.R. § 35.106, (2) designate an employee "to coordinate its efforts to comply with and carry out its responsibilities" to comply with the ADA, 28 C.F.R. § 35.107(a), (3) "adopt and publish grievance procedures" to provide for "prompt and equitable resolution" of alleged ADA violations, 28 C.F.R. § 35.107(b), and (4) accept and process requests for reasonable accommodations, 28 C.F.R. § 35.130(7).

Agency is not [explain violations and evidence, e.g., providing notice of individuals' rights to be free from disability discrimination. There is no such public notice on the agency's website or at the agency's office.]

[Agency] must promptly remedy these violations to ensure that people's rights under the ADA are protected.

Sincerely,

[Attorney]

V. Acknowledgements

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Endnotes

1 In this Guide, "supervision" refers to sentences that require people to abide by a set of conditions outside of jail or prison. Supervision includes probation, parole, and mandatory post-prison supervision. *See* Human Rights Watch & ACLU, *Revoked: How Probation and Parole Feed Mass Incarceration in the United States* 13-14 (2020), https://www.aclu.org/report/aclu-and-hrw-report-revoked-how-probation-and-parole-feed-mass-incarceration-united-states (defining supervision). Beyond post-conviction supervision, high numbers of people are subject to "pretrial supervision" — meaning requirements to abide by rules as a condition of release pending trial. *See* Evin Mintz, Arnold Ventures, *What Works and What Doesn't in Pretrial Supervision?* (Nov. 19, 2020), https://www.arnoldventures.org/stories/what-works-and-what-doesnt-in-pretrial-supervision. While this Guide focuses on post-conviction supervision, attorneys representing people on pretrial supervision can generally use this information in their advocacy.

2 Danielle Kaeble, U.S. Dep't of Justice Bureau of Justice Statistics, *Probation and Parole in the United States, 2021* at 1 (2023), https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/ppus21.pdf.

3 *See generally* Human Rights Watch & ACLU, *Revoked*.

4 Council of State Governments Justice Center, *Confined and Costly: How Supervision Violations are Filling Prisons and Burdening Budgets* (2019), https://csgjusticecenter.org/publications/confined-costly/. This figure includes "technical" violations, meaning conduct that would not otherwise constitute a crime, and "new offense" violations, meaning conduct that could constitute a crime. *Id.*

5 42 U.S.C. § 12132 (ADA); 29 U.S.C. § 794(a) (Rehabilitation Act).

6 28 C.F.R. § 35.130(b)(7); *see also Alexander v. Choate*, 469 U.S. 287, 301 (1985).

7 *See* PEW Charitable Trusts, *Adults with Mental Illness Are Overrepresented in Probation Population: But many probation agencies lack specialized training or tools to supervise them effectively* (Jan. 10, 2024), https://www.pewtrusts.org/-/media/assets/2024/01/adults_with_mental_illness_are_overrepresented_in_probation_population_report_final_jan10-2024.pdf.

8 *See* Laura M. Maruschak, et al., Bureau of Justice Statistics, *Survey of Prison Inmates, 2016: Disabilities Reported by Prisoners* at 1 (2021), https://bjs.ojp.gov/content/pub/pdf/drpspi16st.pdf (in 2016, nearly 2 in 5 people in state and federal prison had at least one disability); Laura Hawks, et al., *Health Status and Health Care Utilization of US Adults Under Probation: 2015-2018*, 110 Am J. Pub. Health 1411 (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7427211/ (study showed "[p]ersons on probation had a higher burden of physical conditions, mental illnesses, and substance use disorders than did the general population").

9 Emily Widra & Alexi Jones, *Mortality, health, and poverty: the unmet needs of people on probation and parole,* Prison Policy Initiative (Apr. 3, 2023), https://www.prisonpolicy.org/blog/2023/04/03/nsduh_probation_parole/; *see also* Anna Preston, et al., *"I was reaching out for help and they did not help me": Mental healthcare in the carceral state*, 10 Health & Justice 2, (2022), https://healthandjusticejournal.biomedcentral.com/articles/10.1186/s40352-022-00183-9 (collecting studies showing people with mental health disabilities "are overrepresented in incarcerated and supervised populations"); Laura M. Maruschak, et al., Bureau of Justice Statistics, *Survey of Prison Inmates, 2016: Indicators of Mental Health Problems Reported by Prisoners* 1 (2021), https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/imhprpspi16st.pdf ("Forty-one percent of all state and federal prisoners had a history of a mental health problem" in 2016.).

10 *See* Leah Wang, *Chronic Punishment: The unmet health needs of people in state prisons*, Prison Policy Initiative (2022), https://www.prisonpolicy.org/reports/chronicpunishment.html (rates of post-traumatic stress disorder "are almost three times as high in women as in men" and rates of manic depression, bipolar disorder, mania, and/or depressive disorders "are double the rate compared to men"); Jennifer L. Skeem & Jennifer Eno Louden, *Toward Evidence-Based Practice for Probationers and Parolees Mandated to Mental Health Treatment,* 57 Psychiatric Serv's, 333, 333 (2006) ("The six-month prevalence rate of serious mental illness among jail detainees is nearly four times as high for men and more than eight times as high for women than in the general population"); Marion L. D. Malcome et al., *Weathering Probation and Parole: The Protective Role of Social Support on Black Women's Recent Stressful Events and Depressive Symptoms*, 45 J. Black Pysch. 661, 663-66 (2019) https://journals.sagepub.com/doi/full/10.1177/0095798419889755 (discussing higher prevalence of depression among Black women in prison and on probation or parole); Jamelia Morgan, *Disability, Policing, & Punishment*, 75 Oklahoma L. Rev. 169, 186-87 (2022), https://digitalcommons.law.ou.edu/cgi/viewcontent.cgi?article=2257&context=olr (collecting studies).

11 Widra & Jones, *Mortality, health, and poverty*.

12 *Id.*

13 *See, e.g.*, American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* 271-80 (Am. Psychiatric Ass'n eds., 5th ed. 2013) ("DSM-5") (PTSD diagnostic criteria); Wang, *Chronic Punishment* (in 2016, 14 percent of people in state prisons were ever diagnosed with PTSD, compared to 7 percent of the adult population). Additionally, while not currently recognized diagnostically in the DSM, individuals who experience "multiple traumas, prolonged and repeated trauma, or repetitive trauma in the context of significant interpersonal relationships" may experience "complex traumatic stress." SAMHSA, *Trauma-Informed Care in Behavioral Health Services TIP 57* at 85 (2014), https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816. Likewise, due to the traumas of incarceration, high numbers of people who have been incarcerated experience "post-traumatic prison disorder" — though there is currently little information about this disorder, and it is not currently recognized in the DSM. *See* Elizabeth Weill-Greenberg, *Post-Traumatic Prison Disorder Could Impact Millions. Congress Wants to Learn More*, The Appeal (May 4, 2023), https://theappeal.org/post-traumatic-prison-disorder-research-congress/.

14 *See, e.g.*, DSM-5 at 222-26 (anxiety diagnostic criteria); Maruschak, et al., Bureau of Justice Statistics, *Survey of Prison Inmates, 2016: Indicators of Mental Health Problems Reporter by Prisoners* at 5 tbl.3 (in 2016, 22 percent of people in state prison, and 10 percent of people in federal prison, had ever been diagnosed with anxiety).

15 *See, e.g.*, DSM-5 at 160-68 (depression diagnostic criteria); Maruschak et al., *Survey of Prison Inmates, 2016: Indicators of Mental Health Problems Reported by Prisoners*, 5 tbl.3 (in 2016, 27 percent of people in state prisons, and 14 percent of people in federal prisons, had even been diagnosed with major depression disorder); Adeline Nyamathi et al., *Correlates of Depressive Symptoms among Homeless Men on Parole,* 32 Issues in Mental Health Nursing 501, 9 (2011), https://www.tandfonline.com/doi/full/10.3109/01612840.2011.569111?scroll=top&needAccess=true&role=tab (in a study, people on parole experiencing homelessness reported "depressive symptoms at a rate of 40%, roughly six times that of the general U.S. population" and "substance abuse went hand in hand with depressive symptoms").

16 *See, e.g.*, DSM-5 at 237-47 (OCD diagnostic criteria).

17 *See, e.g.*, DSM-5 at 87-122 (schizophrenia and psychotic disorders diagnostic criteria); Wang, *Chronic Punishment* (in 2016, 9 percent of people in state prisons had ever been diagnosed with schizophrenia or another psychotic disorder, compared to 1 percent of the general population); Claire E. Ramsay, et al., *From Handcuffs to Hallucinations: Prevalence and Psychosocial Correlates of Prior Incarcerations in an Urban, Predominantly African American Sample of Hospitalized Patients with First-Episode Psychosis*, 39 J. Am. Acad. Psych. L. 57 (2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3612963/ ("Among all incarcerated individuals, 10% of federal prisoners, 15% of state prisoners, and 24% of local jail inmates reported symptoms that met criteria for a psychotic disorder."). It is important to note that "[h]ostility and aggression can be associated with schizophrenia, although spontaneous or random assault is uncommon" and, indeed, "the vast majority of persons with schizophrenia are not aggressive and are more frequently victimized than are individuals in the general population." DSM-5 at 100.

18 *See, e.g.*, DSM-5 at 123-39 (bipolar disorder diagnostic criteria); Wang, *Chronic Punishment* (in 2016, 23 percent of people in state prisons were ever diagnosed with bipolar disorder, compared to 2 percent of the general adult population).

19 *See* DSM-5 at 659-667 (BPD and ASPD diagnostic criteria); Maruschak et al, *Survey of Prison Inmates, 2016* at 5 tbl.3 (in 2016, 11 percent of people in state prisons, and 5 percent of people in federal prisons,

had ever been diagnosed with a personality disorder, including BPD and ASPD); Courtney Conn et al., *Borderline Personality Disorder Among Jail Inmates: How Common and How Distinct?*, 35 Corr. Compendium 6, 6 (2010), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4825675/#:~:text=Although%20borderline%20personality%20disorder%20(BPD,is%20typically%20chronic%20and%20debilitating ("Whereas prevalence rates for BPD in the community are 1 percent to 2 percent, among both male and female inmates have been estimated at 12 percent to 30 percent."). Note experts have raised concerns that ASPD is over-diagnosed among people under correctional control — in part because the diagnostic criteria include "repeatedly performing acts that are grounds for arrest" and "repeated failure to sustain consistent work behavior or honor financial obligations" which can be *products of* involvement in the criminal legal system. DSM-5 at 659; *see* Jason Schnittker et al., *Neither mad nor bad? The classification of antisocial personality disorder among formerly incarcerated adults*, Soc. Sci Med. (Nov. 2020), https://www.sciencedirect.com/science/article/abs/pii/S0277953620305074; Norman Ghiasi, et al., *Psychiatric Illness and Criminality*, StatPearls Pub. (updated Mar. 30, 2023), https://www.ncbi.nlm.nih.gov/books/NBK537064/?report=printable ("there is debate as to whether ASPD is even a psychiatric illness or just a societal moral judgment"). ASPD is highly stigmatized in society, and judges and other authorities regularly treat it as an aggravating factor. *See* Schnittker, et al., *Neither mad nor bad?.* at 6. Thus, attorneys raising disability discrimination claims with respect to ASPD should exercise discretion based on the circumstances presented in the case. Moreover, attorneys should bear in mind that ASPD often co-occurs with other disabilities, and attorneys can also challenge disability discrimination with respect to symptoms of those disabilities.

20 In 2016, 23 percent of people incarcerated in prisons reported having a cognitive disability, meaning they have "serious difficulty concentrating, remembering, or making decisions." Maruschak et al., *Survey of Prison Inmates, 2016: Disabilities Reported by Prisoners* at 1, 5.

21 *See, e.g.*, DSM-5 at 59-65 (ADHD diagnostic criteria); Maruschak et al., *Survey of Prison Inmates, 2016: Disabilities Reported by Prisoners* at 5, Tbl 5 (in 2016, 26 percent of people in state prison, and 13 percent of people in federal prison, were ever told they had ADHD); Wang, *Chronic Punishment* (in 2016, 26 percent of people in state prison were told they had ADHD compared to 9.4 percent of children under 18, and 4.4 percent of adults).

22 *See, e.g.*, DSM-5 at 33-41 (ID/D diagnostic criteria); American Association on Intellectual and Developmental Disabilities, *Defining Criteria for Intellectual Disability*, https://www.aaidd.org/intellectual-disability/definition (last accessed Mar. 7, 2024); Maruschak, et al., *Survey of Prison Inmates, 2016, Disabilities Reported by Prisoners* at 5 tbl. 5 (in 2016, 25 percent of people in state prison, and 14 percent of people in federal prison, had ever attended special education classes, and 15 percent of people in state prison, and 8 percent of people in federal prison, had ever been told they had a learning disability).

23 *See, e.g.*, DSM-5 at 50-59 (ASD diagnostic criteria); Rachel L. Fazio et al., *An Estimate of the Prevalence of Autism-Spectrum Disorders in an Incarcerated Population*, 4 J. of Forensic Psych 61, 73 (2012), https://www.semanticscholar.org/paper/An-Estimate-of-the-Prevalence-of-Autism-Spectrum-in-Fazio-Pietz/c9423ebfa2f6fbff89b1370b4d7f7b0f26ff831b (study of ASD in prisons suggested that, conservatively, "the estimated rate of ASD [among incarcerated people] would be 4.4%, which is four times more than that of the general population in the United States").

24 *See, e.g.*, DSM-5 at 483-97 (SUD diagnostic criteria); Widra & Jones, *Mortality, health, and poverty: the unmet needs of people on probation and parole*; Wang, *Chronic Punishment* (49 percent of people in state prisons met diagnostic criteria for SUD in the 12 months before entering prison, compared to 7.5 percent of adults with SUD in general population in 2016). As discussed below, SUD is only a "covered" disability under the ADA and Rehabilitation Act in certain circumstances.

25 *See, e.g.*, Laura M. Maruschak et al., Bureau of Justice Statistics, *Survey of Prison Inmates, 2016: Medical Problems Reported by Prisoners* at 1 (2021), https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/mprpspi16st.pdf (in 2016, 50 percent of people in state and federal prison had ever had a chronic health condition, and 17 percent had an infectious disease); Wang, *Chronic Punishment* ("people in state prisons have much higher rates of illness compared to the general public"); Tyler N.A. Winkelman, et al., *Physical Health and Disability Among U.S. Adults Recently on Community Supervision, 26* J. Corr. Healthcare 129, 134 (2020), https://www.liebertpub.com/doi/epdf/10.1177/1078345820915920 (study showed "[a]dults on community supervision in the past year reported a significantly higher burden of chronic conditions and disability than adults with no recent community supervision"); Hawks, et al., *Health Status and Health Care Utilization of US Adults Under Probation* tbl.2; Medicaid and CHIP Payment and Access Commission (MACPAC), *Access in Brief: Health Care Needs of Adults Involved with the Criminal Justice System* 3 (2021), https://www.macpac.gov/publication/access-in-brief-health-care-needs-of-adults-involved-with-the-criminal-justice-system/ ("Adults involved in the criminal justice system have higher rates of chronic diseases than the general population.").

26 *See, e.g.*, National Institute of Neurological Disorders and Stroke, *Traumatic Brain Injury*, https://www.ninds.nih.gov/health-information/disorders/traumatic-brain-injury-tbi (last accessed Mar. 7, 2024) (explaining TBI); Centers for Disease Control and Prevention (CDC), *Traumatic Brain Injury in Prisons and Jails*, https://www.cdc.gov/traumaticbraininjury/pdf/prisoner_tbi_prof-a.pdf (last accessed Mar. 7, 2024) (an estimated 25 to 87 percent of incarcerated people have experienced head injuries or TBI, compared to 8.5 percent of people in the general population reporting a history of TBI); Kim Gorgens et al., University of Denver Colorado Evaluation and Action Lab, 5 *Reducing Recidivism for Justice-Involved Individuals with Traumatic Brain Injury* (2020), https://coloradolab.org/wp-content/uploads/2020/08/Reducing-Recidivism-for-Justice-Involved-Individuals-with-Traumatic-Brain-Injury.pdf (estimated 41 to 82 percent of people in jail, prison, probation, or parole have a history of TBI); Tamar Sarai, *Brain injuries and 'the revolving door' of incarceration,* Prism (May 26, 2022), https://prismreports.org/2022/05/26/brain-injuries-incarceration/ ("An overwhelming percentage of the country's incarcerated population and survivors of abuse (who may also be incarcerated) live with brain injuries, many of which are undiagnosed.").

27 *See, e.g.*, *Mobility Impairments*, Univ. Wash. Disabilities, Opportunities, Internetworking, & Tech. Dep't, (last accessed Mar. 7, 2024), https://www.washington.edu/doit/mobility-impairments; Maruschak, et al., *Survey of Prison Inmates, 2016, Disabilities Reported by Prisoners* at 1 (in 2016, 12 percent of people in state and federal prisons had a mobility/ambulatory disability).

28 *See, e.g.*, Tessa Bialek & Margo Schlanger, *White Paper: Effective Communication with Deaf, Hard of Hearing, Blind, and Low Vision Incarcerated People*, Univ. Mich. L. Sch. 1 (2022), https://repository.law.umich.edu/cgi/viewcontent.cgi?article=1210&context=other (tens of thousands of incarcerated individuals have auditory and/or vision disabilities); Wang, *Chronic Punishment* (in 2016, 12 percent of people in state prison had a vision disability, compared to 2 percent of the general population; 10 percent of such prisoners had a hearing disability, compared to 4 percent of the general population).

29 Lena J. Jäggi et al., *The Relationship between Trauma, Arrest, and Incarceration History among Black Americans: Findings from the National Survey of American Life,* 6 Soc'y & Mental Health 187, 2 (2006). https://journals.sagepub.com/doi/abs/10.1177/2156869316641730. After undergoing a traumatic event, "the vast majority of individuals" experience at least some short-term PTSD symptoms. *Id.* at 3.

30 U.S. Commission on Civil Rights, Women in Prison: Seeking Justice Behind Bars 23 (2020),

https://www.usccr.gov/pubs/2020/02-26-Women-in-Prison.pdf (as many as 90 percent of women in prison previously experienced trauma); Jäggi, *The Relationship between Trauma, Arrest, and Incarceration History among Black Americans* at 6, 14 (Black people disproportionately experience trauma).

31 *See* Sandy James et al., *The Report of the 2015 U.S. Transgender Survey* 209 (2016), https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf.

32 Jäggi, *The Relationship Between Trauma, Arrest, and Incarceration History Among Black Americans* at 13; Vittoria Ardino, *Offending behavior: the role of trauma and PTSD*, Eur. J. Psychotraumatology at 1 (2012), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3402156/.

33 *See, e.g.*, J.J. McGrath, et al., *Comorbidity within mental disorders: a comprehensive analysis based on 145990 survey respondents from 27 countries*, 29 Epidemiol. Psychiatr. Sci. (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7443806/ (analysis of surveys shows people

with mental health disabilities tend to have additional co-occurring disorders); Emma Facer-Irwin et al., *PTSD in prison settings: A systematic review and meta-analysis of comorbid mental disorders and problematic behaviours,* Pub. Libr. of Sci. 5 (2019), https://journals.scholarsportal.info/details/19326203/v14i0009/nfp_pipsascmdapb.xml (meta-analysis finding PTSD among incarcerated people was "highly comorbid with other psychiatric disorders"); DSM-5 at 226 (anxiety often co-occurs with depressive disorders); Ian Freckelton, *Obsessive compulsive disorder and obsessive compulsive personality disorder and the criminal law,* 37 Psychiatry, Psyc. and L. 831 (2020), https://www.tandfonline.com/doi/full/10.1080/13218719.2020.1745497 (OCD regularly co-occurs with anxiety and depression); DSM-5 at 168 (depression often co-occurs with panic disorder, OCD, borderline personality disorder, and SUD); DSM-5 at 105 (schizophrenia often co-occurs with anxiety, OCD, panic disorder, and SUD); DSM-5 at 132 (bipolar disorder often co-occurs with anxiety, ADHD, and SUD).

34 *See, e.g.*, Fred Osher et al., Council of State Gov'ts Just. Ctr., *Adults with Behavioral Health Needs under Correctional Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery* 6 (2012), https://csgjusticecenter.org/wp-content/uploads/2020/02/9-24-12_Behavioral-Health-Framework-final.pdf ("Studies suggest that the co-occurrence of mental health and substance use disorders is [] common."); SAMHSA, *Trauma-Informed Care in Behavioral Health Settings* at 86-87 ("Alcohol and drug use can be for some, an effort to manage traumatic stress and specific PTSD symptoms. Likewise, people with substance use disorder are at higher risk of developing PTSD than people who do not abuse substances."); DSM-5 at 280 (discussing co-occurrence of PTSD and SUD); 168 (depression and SUD); 105 (schizophrenia and SUD); 132 (bipolar disorder and SUD); Maria C. Vélez-Pastrana et al., *Attention Deficit Hyperactivity Disorder in Prisoners: Increased Substance Use Disorder Severity and Psychiatric Comorbidity*, 170, 180, 186 (2020), https://pubmed.ncbi.nlm.nih.gov/32615575/ (study of incarcerated people in Puerto Rico showed prevalence of disabilities including SUD is "4-9 times higher in ADHD populations than in the general population" and ADHD is associated with both "greater risk for SUD diagnosis among prisoners" and "greater severity of SUD in prisoners").

35 *See, e.g.*, Facer-Irwin et al., *PTSD in prison settings* at 23 (PTSD "typically remains un-diagnosed and untreated within prison settings"); Freckelton, *Obsessive compulsive disorder and obsessive compulsive personality disorder and the criminal law* at 832 (OCD is often underdiagnosed, in part due to "feeling of shame, embarrassment and secrecy" among people experiencing symptoms); Thomas Fovet et al., *Individuals with bipolar disorder and their relationship with the criminal justice system,* 66 Psychiatric Servs. 348, 350 (2015) https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201400104 (Bipolar disorder is often underdiagnosed in prison settings); Drew Nagele et al., *Brain injury in an offender population: Implications for reentry and community transition*, 57 J. Offender Rehabilitation 562, 563 (2019), https://www.tandfonline.com/doi/full/10.1080/10509674.2018.1549178?scroll=top&needAccess=true&role=tab (TBI underdiagnosed in part because "there is no consistent screening at intake or surveillance for history of TBI in correctional facilities in the United States").

36 *See, e.g.*, Wenn B. Lawson, *Adaptive Morphing and Coping with Social Threat in Autism: An Autistic Perspective*, J. of Intellectual Disability, Diagnosis and Treatment 519, 520 (2020), https://www.researchgate.net/publication/344295469_Adaptive_Morphing_and_Coping_with_Social_Threat_in_Autism_An_Autistic_Perspective (discussing masking among people with ASD); Laura Hull et al., *"Putting on My Best Normal": Social Camouflaging in Adults with Autism Spectrum Conditions,* 47 J. Autism & Developmental Disorders 2519 (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5509825/(same); Alice Turnock, et al., *Understanding Stigma in Autism: A Narrative Review and Theoretical Model*, Autism Adulthood 76 (2022), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8992913/#:~:text=Autism%20stigma%20had%20a%20negative,affect%20their%20own%20well%2Dbeing (discussing stigma against people with ASD); Gary Siperstein et al., *A National Study of Youth Attitudes toward the Inclusion of Students with Intellectual Disabilities,* 73 Exceptional Children 435 (2007), https://journals.sagepub.com/doi/10.1177/001440290707300403 (discussing stigma against people with ID among school children); Lisa L. Christensen et al., *Bullying Adolescents With Intellectual Disability*, 5 J. Mental Health Rsch. in Intell. Disabilities 49, 60-61 (2012) https://www.tandfonline.com/doi/abs/10.1080/19315864.2011.637660 (similar).

37 DSM-5 at 54.

38 *See* Samson Schatz, *Interrogated with Intellectual Disabilities: The Risks of False Confession*, 70 Stanford L Rev. 643, 659-71 (2018), https://law.stanford.edu/wp-content/uploads/2018/11/Samson-Schatz-Interrogated-with-Intellectual-Disabilities-The-Risks-of-False-Confession.pdf.

39 42 U.S.C. § 12132.

40 29 U.S.C. § 794(a).

41 State and local government entities can be subject to both the ADA and the Rehabilitation Act. *See Am. Council of the Blind v. Paulson*, 525 F.3d 1256, 1260 n.2 (D.C. Cir. 2008) (collecting cases); *Randolph v. Rodgers*, 170 F.3d 850, 858 (8th Cir. 1999). As discussed below, some courts apply a stricter causation standard to Rehabilitation Act claims.

42 *See, e.g.*, *Pierce v. District of Columbia*, 128 F. Supp. 3d 250 (D.D.C. 2015).

43 42 U.S.C. § 12102(1) (ADA); *see also* 29 U.S.C. § 705(20)(B) (Rehabilitation Act). "Disability" under these laws is defined differently, and often more broadly, than it is defined with respect to some other federal programs like Social Security benefits and veterans' benefits.

44 28 C.F.R. § 35.101(b); *see also* 42 U.S.C. § 12102(4)(A). One notable exception is that "currently engaging in the illegal use of drugs" is not a qualifying disability. 42 U.S.C. § 12210. However, as discussed in Section III(C)(v), federal law makes exceptions, including for using alcohol; using medication-assisted treatment for SUD under the supervision of a licensed medical professional; or where the individual has a co-occurring disability that *is* covered under the ADA.

45 28 C.F.R. § 35.108(d)(2)(iii).

46 *Tennessee v. Lane*, 541 U.S. 509, 517 (2004) (quoting 42 U.S.C. § 12131(2)).

47 *See* 42 U.S.C. § 12131(1) (defining public entity as "any State or local government" or "any department, agency . . . or other instrumentality of a State or States or local government"); *Pennsylvania Dep't of Corr. v. Yeskey*, 524 U.S. 206, 210 (1998) (ADA applies to prisons); United States Dep't of Justice Civil Rights Division, *Ensuring Equality in the Criminal Justice System for People with Disabilities*, https://www.ada.gov/criminaljustice/ (last accessed Mar. 7, 2024) (explaining application of ADA to criminal legal system entities).

48 28 C.F.R. § 35.130(b)(1).

49 28 C.F.R. § 35.130(b)(8).

50 28 C.F.R. §§ 35.160, 35.164; *see also* U.S. Dep't of Just. *Effective Communication*, https://www.ada.gov/effective-comm.htm (last updated Feb. 28, 2020). The ADA regulations require that, "[i]n 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).

51 28 C.F.R. § 35.130(b)(7).

52 28 C.F.R. § 35.106.

53 28 C.F.R. § 35.107(a).

54 28 C.F.R. § 35.107(b).

55 28 C.F.R. § 35.130(b)(7); *see also Choate*, 469 U.S. at 301 (reasonable accommodations must be made to ensure "meaningful access" to a program or service).

56 *See Mary Jo C. v. New York State & Local Retirement Sys.*, 707 F.3d 144, 163 (2d Cir. 2013) (ADA Title II "requires preemption of inconsistent state law when necessary to effectuate a required "reasonable modification."); *Nat'l Federation of the Blind v. Lamone*, 813 F.3d 494, 508-09 (4th Cir. 2016) (same and collecting cases).

57 *Pierce v. District of Columbia*, 128 F. Supp. 3d 250, 267 (D.D.C. 2015). There, the plaintiff's disability—deafness—was "obvious" and thus the

government was plainly on notice of his need for accommodations. *See id.* at 270. Similarly, there is a compelling argument that because high numbers of people on supervision have disabilities — especially mental health disabilities — authorities are "on notice" that people may need accommodations, and thus must have a system in place to meet those needs.

58 *See, e.g.*, *Armstrong v. Davis*, 275 F.3d 849, 859 (9th Cir. 2001) (upholding injunction requiring California parole board "to identify . . . which prisoners have a disability, create and maintain a system for tracking disabled prisoners and parolees, and provide them with accommodations at parole and parole revocation proceedings"); *Lewis v. Cain*, No. 15-cv-318, 2021 WL 1219988, at *59 (M.D. La. Mar. 31, 2021) (prison violated ADA by "[f]ailing to identify and track disabilities and accommodation requests in a meaningful way"); *Tellis v. LeBlanc*, No. 18-541, 2022 WL67572, at *8-10 (W.D. La. Jan. 6, 2022) (same and denying defendants' motion for summary judgment); *Dunn v. Dunn*, 318 F.R.D. 652, 665 (M.D. Ala. 2016) (same and approving class settlement); Stipulated Order for Permanent Injunctive Relief, *L.H. v. Schwarzenegger*, No. 6-cv-2042, at 15 (E.D. Cal. June 3, 2008); Order, *L.H.*, No. 6-cv-2042 (same in parole revocation context and approving class settlement).

59 *See infra* Section IV (Appendix) for sample materials to request reasonable accommodations.

60 *See, e.g.*, *Luke v. Texas*, 46 F. 4th 301, 306 (5th Cir. 2022) ("Not being able to understand a court hearing or meeting with a probation officer is, by definition, a lack of meaningful access to those public services . . . regardless of whether any additional injury follows"); *Robertson v. Las Animas Cnty Sheriff's Dept*, 500 F.3d 1185, 1199 (10th Cir. 2007) (plaintiff was "injured" under the ADA when he "was denied the ability to participate in his probable cause hearing to the same extent as non-disabled individuals," even though he was not required to attend the court proceeding, and the hearing resulted in dismissal of all charges); *Paulone v. City of Frederick*, 787 F. Supp. 2d 360, 405 (D. Md. 2011) (plaintiff was denied meaningful access to supervision-mandated program she could not understand due to her disability, even though she was not accused of violating her supervision); *Armstrong*, 275 F.3d at 865 ("failure to make accommodations that would enable [people] to attend or comprehend parole and parole revocation hearings" "constitutes 'actual injury'" for standing purposes); Order at 15-18, *Cobb v. Georgia Department of Community Supervision*, No. 19-cv-3285 (N.D. Ga. Oct. 13, 2022) (deaf plaintiffs' inability to understand, and therefore meaningfully participate in, supervision requirements constituted "injury" for standing purposes).

61 *See, e.g.*, *Henrietta D. v. Bloomberg*, 331 F.3d 261, 291 (2d Cir. 2003) (discrimination is "by reason of" an individual's disability "'even if there are other contributory causes for the exclusion or denial, as long as the plaintiff can show that the disability was a substantial cause of the exclusion or denial"); *Wisconsin Community Serv's v. Milwaukee*, 465 F.3d 737, 752 (7th Cir. 2006) (en banc) (the "on the basis of" disability language requires the plaintiff to show that, "but for" his disability, he would have been able to access the services or benefits desired"); *Brown v. District of Columbia*, 928 F.3d 1070, 1098 (D.C. Cir. 2019) (Wilkins, J. concurring) (collecting cases); *see also* Morgan, *Policing Under Disability Law*, 73 Stanford L. Rev. at 1454-58 (discussing problems with causation analyses). Some jurisdictions apply a stricter causation standard to claims under the Rehabilitation Act (which prohibits discrimination "*solely* by reason of" disability) than to ADA claims (which prohibits discrimination "by reason of" disability). *See Drasek v. Burwell*, 121 F. Supp. 3d 143, 154 (D.D.C. 2015) (collecting cases).

62 28 C.F.R. § 35.130(b)(7).

63 *Wright v. New York State Dep't of Corrections*, 831 F.3d 64, 77 (2d Cir. 2016) (collecting cases).

64 *Mary Jo C..*, 707 F.3d at 153 (internal citation and quotation marks omitted).

65 *Dadian v. Village of Wilmette*, 269 F.3d 831, 838-39 (7th Cir. 2001) (internal citation and quotation marks omitted).

66 *Pennsylvania Protection & Advocacy v. Pennsylvania Dep't of Public Welfare*, 402 F.3d 374, 380 (3d Cir. 2005) (collecting cases).

67 28 C.F.R. § 35.139(a)

68 *Id.* § 35.139(b).

69 *Bragdon v. Abbott*, 524 U.S. 624, 649 (1998).

70 *See* Skeem & Louden, *Toward Evidence-Based Practice for Probationers and Parolees Mandated to Mental Health Treatment* at 333 ("Compared with probationers without mental illness, those with mental illness are highly likely to fail on supervision—that is, to have their probation or parole revoked for violating its terms or committing a new offense."); PEW Charitable Trusts, *Adults with Mental Illness Are Overrepresented in Probation Population*.

71 Jacques Baillargeon, et al, *Parole Revocation Among Prison Inmates With Psychiatric and Substance Use Disorders,* 60 Psychiatric Servs. 1516, 4-5 (2009), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2981345/.

72 Jennifer Louden & Jennifer Skeem, U.C. Irvine, Ctr. For Evidence-Based Corr., *Parolees with Mental Disorder: Toward Evidence-Based Practice* 5 (2011), https://ucicorrections.seweb.uci.edu/2011/04/14/parolees-with-mental-disorder-toward-evidence-based-practice/.

73 *See* Jamiles Lartey, *How Criminal Records Hold Back Millions of People*, The Marshall Project (Apr. 1, 2023), https://www.themarshallproject.org/2023/04/01/criminal-record-job-housing-barriers-discrimination; Jaboa Lake, *Preventing and Removing Barriers to Housing Security for People with Criminal Convictions*, Center for American Progress (Apr. 14, 2021), https://www.americanprogress.org/article/preventing-removing-barriers-housing-security-people-criminal-convictions/.

74 *See* National Alliance to End Homelessness, *Racial Inequalities in Homelessness, by the Numbers* (June 1, 2020), https://endhomelessness.org/resource/racial-inequalities-homelessness-numbers/; National Alliance to End Homelessness, *Trans and Gender Non-Conforming Homelessness* (last accessed Mar. 7, 2024), https://endhomelessness.org/trans-and-gender-non-conforming-homelessness/.

75 *See* Olugbenga Ajilore, Center for American Progress, *On the Persistence of the Black-White Unemployment Gap* (Feb. 24, 2020), https://www.americanprogress.org/article/persistence-black-white-unemployment-gap/; Human Rights Campaign, *Understanding Poverty in the LGBTQ+ Community* (last accessed Mar. 7, 2024), https://www.hrc.org/resources/understanding-poverty-in-the-lgbtq-community.

76 *See* Sofia Carratala, *Health Disparities by Race and Ethnicity*, Center for American Progress (May 7, 2020), https://www.americanprogress.org/article/health-disparities-race-ethnicity; Sandy James et al., *The Report of the 2015 U.S. Transgender Survey* at 93, 125 (discussing barriers to obtaining affordable, quality health care for trans people and related worse health outcomes).

77 *See* Weill-Greenberg, *Post-Traumatic Prison Disorder Could Impact Millions*.

78 *See* Margo Schlanger et al., *Ending the Discriminatory Pretrial Incarceration of People with Disabilities: Liability Under the Americans with Disabilities Act and the Rehabilitation Act*, 17 Harvard Law & Pol'y Rev. 1, 9-17 (2022) (discussing harms of incarceration for chronic health, intellectual/developmental, and mental health disabilities); https://repository.law.umich.edu/articles/2722/; Niki A. Miller & Lisa M. Najavits, *Creating trauma-informed correctional care: a balance of goals and environment*, Eur. J. Psychotraumatology 1 (2012), https://www.tandfonline.com/doi/epdf/10.3402/ejpt.v3i0.17246?needAccess=true&role=button ("The correctional environment is full of unavoidable triggers, such as pat downs and strip searches, frequent discipline from authority figures, and restricted movement" which "is likely to increase trauma-related behaviors and symptoms[.]"); Jäggi et al., *The Relationship between Trauma, Arrest, and Incarceration History among Black Americans* at 13 (similar).

79 *See* Gary S. Cuddeback, et al., *Individuals with Mental Illness in the Criminal Legal System: Complex Issues and Best Practices*, 86 Fed. Probation 1, 18 (2022), https://www.uscourts.gov/federal-probation-journal/2022/06/individuals-mental-illnesses-criminal-legal-system-complex-issues ("obtaining housing, employment, and social support are often more difficult for individuals with mental illnesses, especially those who are justice-involved").

80 Erin Vinoski Thomas & Chloe Vercruysse, *Homelessness Among Individuals with Disabilities: Influential Factors and Scalable Solution,* JPHMP Direct (July 24, 2019), https://jphmpdirect.com/2019/07/24/homelessness-among-individuals-with-disabilities/; Brian Nam-Sonenstein, Prison Policy Initiative, *Seeking shelter from mass*

incarceration: Fighting criminalization with Housing First (Sept. 11, 2023), https://www.prisonpolicy.org/blog/2023/09/11/housing-first/ ("roughly 21% of unhoused people had a 'severe' mental illness, and 16% engaged in chronic substance abuse").

81 MACPAC, *Access in Brief* at 5. Indeed, moving frequently "puts adults at greater risk for suicidal outcomes compared to those with stable housing." *Id.*

82 Press Release, U.S. Bureau of Labor Statistics, *Persons with a Disability: Labor Force Characteristics - 2023* (Feb. 22, 2024), https://www.bls.gov/news.release/pdf/disabl.pdf. *See also* Kay Evelien P. M. Brouwers, *Social stigma is an underestimated contributing factor to unemployment in people with mental illness or mental health issues: position paper and future directions* at 2, BMC Psych. (2020), https://link.springer.com/article/10.1186/s40359-020-00399-0; Gary Siperstein et al., *National Snapshot of Adults with Intellectual Disabilities in the Labor Force,* 39 J. Vocational Rehab. 157 (2013), https://ncdj.org/wp-content/uploads/2009/11/The-National-Snapshot-of-Adults-with-Intellectual-Disabilities-in-the-Labor-Force.pdf.

83 *See* Connie Longmate et al., *Social Support Among People with Mental Illnesses on Probation*, 44 Psychiatric Rehab. J. 70 (2020), https://pubmed.ncbi.nlm.nih.gov/32584072/; Susan Young et al., *Beyond the Gates: Identifying and Managing Offenders with Attention Deficit Hyperactivity Disorder in Community Probation Services,* 1 AIMS Pub. Health 33, 37 (2014)

(discussing barriers to interpersonal relationships for people with ADHD); Timon Elmer & Christoph Stadtfeld, *Depressive symptoms are associated with social isolation in face-to-face interaction networks*, Sci. Rep. Jan. 2020, at 1 (2020) https://www.nature.com/articles/s41598-020-58297-9 (discussing association between depression and social isolation).

84 *See* Sections III(B) & (C)(ii)(3) (discussing stigma against people with disabilities).

85 Longmate, *Social Support Among People with Mental Illnesses on Probation* at 74.

86 *See* Amanda Agan & Sonja Starr, *The Effect of Criminal Records on Access to Employment*, 107 Am. Econ. Rev.: Papers & Proc. 560 (2017), https://repository.law.umich.edu/articles/1892/; Greg Iacurci, *64% of unemployed men in their 30s have criminal records, a barrier to landing a job*, CNBC (Feb. 22, 2022), https://www.cnbc.com/2022/02/22/64percent-of-unemployed-men-in-their-30s-have-criminal-records-a-barrier-to-landing-a-job.html.

87 Widra & Jones, *Mortality, health and poverty*.

88 Winkelman, et al., *Physical Health and Disability Among U.S. Adults Recently on Community Supervision* at 134.

89 *See* Hemangi Modi, et al., Association of American Medical Colleges, *Exploring Barriers to Mental Health Care in the U.S.* (Oct. 10, 2022), https://www.aamc.org/advocacy-policy/aamc-research-and-action-institute/barriers-mental-health-care; Ghiasi, et al., *Psychiatric Illness and Criminality*; National Alliance on Mental Illness, *The Doctor is Out: Continuing Disparities in Access to Mental and Physical Health Care* (2017), https://www.nami.org/Support-Education/Publications-Reports/Public-Policy-Reports/The-Doctor-is-Out/DoctorIsOut; Human Rights Watch & ACLU, *Revoked* at 164 & n.701 (collecting sources).

90 Widra & Jones, *Mortality, health and poverty*.

91 Malcome, *Weathering Probation and Parole* at 664.

92 Winkelman, *Physical Health and Disability Among U.S. Adults Recently on Community Supervision* at 130; *see also* Michael Nino, et al., *The racial/ethnic health consequences of the U.S. criminal justice system: How consequential is probation and other justice system contact for self-rated and chronic conditions?*, 87 J. Crim. Just. At 10 (2023), https://www.sciencedirect.com/science/article/abs/pii/S0047235223000442?utm_campaign=news&utm_medium=miragenews&utm_source=miragenews&via%3Dihub (study showed "increase risk of chronic health conditions for Black Americans with a history of both probation and incarceration").

93 Such housing must be accessible based on the individual's disability-related needs. For instance, people with mobility disabilities typically need units that do not require stairs, and people taking medications – including pain medicine and medications for mental health conditions – cannot be in housing that prohibits using any drugs, including medications.

94 Jennifer Louden, et al., *The Role of Stigma Toward Mental Illness in Probation Officers' Risk And Case Management Decisions,* 45 Crim. Just & Behav. 573, 574, 580 (2018), https://journals.sagepub.com/doi/10.1177/0093854818756148; *see also* Sanne Oostermeijer, et al., *Stigmatising attitudes of probation, parole and custodial officers towards people with mental health issues: A systematic literature review and meta-analysis*, Legal Criminol. Psychol. at 29 (2022), https://bpspsychub.onlinelibrary.wiley.com/doi/full/10.1111/lcrp.12227; Louden & Skeem, *Probation Officers' Risk Assessments: How do officers assess and manage risk for probationers with mental disorder?* , Am. Psychol. Ass'n, 6, 24, 27, 29 (2012), https://psycnet.apa.org/record/2012-08574-001; Schnittker, et al., *Neither mad nor bad?* at 2-3 (discussing stigma against people with ASPD); J. Steven Lamberti, et al., *Psychosis, Mania and Criminal Recidivism: Associations and Implications for Prevention,* 28 Harvard Rev. Psychiatry, 179, 196 (2020), https://pubmed.ncbi.nlm.nih.gov/32251070/ (stigma against people with mental health disabilities is "due in part to the presence of symptoms that are bewildering and frightening to the general public" and popular movies and televisions that "convey the notion that all such individuals are unpredictable and dangerous"); Morgan, *Disability, Policing, and Punishment* at 175 ("Individuals showing symptoms of psychiatric disabilities are often perceived as wholly irrational, entirely unable to control themselves.").

95 *See* Morgan, *Disability, Policing, and Punishment* at 170-84; Human Rights Watch, *"I Just Try to Make it Home Safe": Violence and the Human Rights of Transgender People in the United States* (2021), https://www.hrw.org/report/2021/11/18/i-just-try-make-it-home-safe/violence-and-human-rights-transgender-people-united#8882.

96 Louden & Skeem, *Probation Officers' Risk Assessments* at 6. However, some studies indicate that "substance abuse is a reliable predictor of new offenses" and "greatly increases the risk of violence among persons with" mental health disabilities. *Id.* at 26-27.

97 Ghiasi, et al., *Psychiatric Illness and Criminality*; *see also* DSM-5 at 101 ("the vast majority of persons with schizophrenia are not aggressive and are more frequently victimized than are individuals in the general population").

98 Louden & Skeem, *Probation Officers' Risk Assessments* at 5.

99 *See* HRW & ACLU, *Revoked* at 46-7.

100 Phyllis Solomon, et al., *Predicting Incarceration of Clients of a Psychiatric Probation and Parole Service*, 53 Psych. Serv's 50, 50 (2002), https://ps.psychiatryonline.org/doi/10.1176/appi.ps.53.1.50.

101 Louden & Skeem, *Probation Officers' Risk Assessments* at 5; *see also id.* at 28.

102 *See* Baillargeon, et al, *Parole Revocation Among Prison Inmates with Psychiatric and Substance Use Disorders* at 9; Louden & Skeem, *Probation Officers' Risk Assessments* at 29; Louden, *The Role of Stigma in Probation Officers' Perceptions of Risk and Case Management Decisions* at 575.

103 Phyllis Solomon, et al., *Predicting Incarceration of Clients of a Psychiatric Probation and Parole Service* at 50; *see also* Louden & Skeem, *Parolees with Mental Disorders* at 8 ("the increased level of supervision" people with mental health disabilities "receive may account partly for the high rate of technical violations for this group").

104 Louden & Skeem, *Probation Officers' Risk Assessments* at 5; *see also* Cecelia Klingele, *Rethinking the Use of Community Supervision*, 103 J. of Crim. Law & Criminology 1015, 1038 (2013), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2232078 ("contrary to expectations, socially disadvantaged offenders who are offered rehabilitative interventions, such as counseling or drug treatment, are often more likely to be revoked than are those who are not offered treatment services," likely due to "the higher level of visibility and surveillance that attach to state-imposed interventions, however benevolent their design"); Jennifer Doleac, *Study after study shows ex-prisoners would be better off without intense supervision*, The Brookings Institute,

(2018), https://www.brookings.edu/blog/up-front/2018/07/02/study-after-study-shows-ex-prisoners-would-be-better-off-without-intense-supervision/ (collecting studies showing that more supervision requirements lead to more technical violations).

105 Oostermeijer, et al., *Stigmatising attitudes of probation, parole and custodial officers towards people with mental health issues* at 29; Seth Jacob Prins and Laura Draper, Council of State Governments Justice Center, *Improving Outcomes for People with Mental Illnesses Under Community Corrections Supervision: A Guide to Research-Informed Policy and Practice* 17 (2012), https://csgjusticecenter.org/publications/improving-outcomes-for-people-with-mental-illnesses-under-community-corrections-supervision-a-guide-to-research-informed-policy-and-practice/).

106 Oostermeijer, *Stigmatising attitudes of probation, parole and custodial officers towards people with mental health issues* at 29; Louden & Skeem, *Probation Officers' Risk Assessments* at 27-28; *see also* Human Rights Watch & ACLU, *Revoked* at 119-22 (discussing mandated treatment programs located inside jails and prisons).

107 *See* Ghiasi, et al., *Psychiatric Illness and Criminality*; Jamelia Morgan, *Policing Under Disability Law*, 73 Stanford L. Rev. 1401, 1415-1425 (2021), https://review.law.stanford.edu/wp-content/uploads/sites/3/2021/06/Morgan-73-Stan.-L.-Rev.-1401.pdf; Arthur Lurigio, *Examining Prevailing Beliefs About People with Serious Mental Illness in the Criminal Justice System,* 75 Federal Probation 1, 2 (2011), https://www.uscourts.gov/federal-probation-journal/2011/06/examining-prevailing-beliefs-about-people-serious-mental-illness.

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109 Christopher M. Campbell, *It's Not Technically a Crime: Investigating the Relationship Between Technical Violations and New Crime*, 27 Criminal Justice Pol'y Rev. 643, 651 (2016), https://journals.sagepub.com/doi/10.1177/0887403414553098.

110 Baillargeon, et al, *Parole Revocation Among Prison Inmates with Psychiatric and Substance Use Disorders* at 9; Skeem, *Toward Evidence-Based Practice for Probationers and Parolees* at 336; Louden & Skeem, *Probation Officers' Risk Assessments* at 9; Solomon, et al., *Predicting Incarceration of Clients of a Psychiatric Probation and Parole Service* at 50 (research has "found that case managers use reincarceration as a mechanism for obtaining needed treatment" and that people reported "[i]t was easier for the case managers to reincarcerate these clients on a technical violation than to hospitalize them").

111 *See infra* Section III(C)(vi)(explaining problems with mandated treatment).

112 *See* 28 C.F.R. § 35.130(b)(1).

113 *See* PEW Charitable Trusts, *Adults with Mental Illness Are Overrepresented in Probation Population* at 12.

114 Louden & Skeem, *Parolees with mental disorders* at 7.

115 *See, e.g.*, Bialek & Schlanger, *Effective Communication with Deaf, Hard of Hearing, Blind, and Low Vision Incarcerated People*; Order, *Cobb v. Georgia Dep't of Community Supervision*, No. 19-cv-3285 (N.D. Ga. Oct. 13, 2022), https://www.aclu.org/cases/cobb-v-georgia-department-community-supervision?document=cobb-v-georgia-department-community-supervision-order-denying-motion-summary.

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118 CDC, Traumatic Brain Injury in Prisons and Jails at 2; *see also* Sarai, *Brain injuries and the 'revolving door' of incarceration*.

119 SAMHSA, *Mental and Substance Use Disorder Treatment for People with Physical and Cognitive Disabilities* at 6. *See* Section I (discussing "masking").

120 *See, e.g.*, Buadze, *Perceptions and Attitudes of Correctional Staff Toward ADHD* at 12 ("inattentive symptoms" among people with ADHD "have been linked with language comprehension difficulties, a factor that often is perceived 'as not listening or following instructions'"); CDC, *Traumatic Brain Injury in Prisons and Jails* at 2 (behaviors resulting from TBI "may be interpreted by correctional officers as uncooperative behavior").

121 *See* Bialek & Schlanger, *Effective Communication with Deaf, Hard of Hearing, Blind, and Low Vision Incarcerated People*.

122 *See* Robert Pollard & Meghan Fox, *Forensic Evaluation of Deaf Adults with Language Deprivation* in *Language Deprivation and Deaf Mental Health* 101, 103-104 (Neil S. Glickman & Wyatte C. Hall eds., 2018).

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131 *See Dysarthria,* The Mayo Clinic, https://www.mayoclinic.org/diseases-conditions/dysarthria/symptoms-causes/syc-20371994 (last accessed Mar. 7, 2024).

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133 *See* Longmate, *Social Support Among People with Mental Illness on Probation* at 70-71; 74.

134 *Id.* at 74.

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142 *See* Schatz, *Interrogated with Intellectual Disabilities* at 660, 670-71.

143 SAMHSA, *Trauma-Informed Care in Behavioral Health Settings* at 67.

144 *Id.* at 114.

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147 *See* Nagele, *Brain injury in an offender population* at 3; Buadze, *Perceptions and Attitudes of Correctional Staff Toward ADHD* at 12; CDC, *Traumatic Brain Injury in Prisons and Jails* at 2 (cognitive symptoms "may be interpreted by correctional officers as uncooperative behavior"); Chan, *Rehabilitation among individuals with traumatic brain injury who intersect with the criminal justice system* at 2 (people with TBI "are more likely to incur serious disciplinary charges and behavior infractions"); *Armstrong v. Davis*, 275 F.3d 849, 867 (9th Cir. 2001) (summarizing trial court finding that individuals with hearing, learning, and developmental disabilities "engage in a range of coping mechanisms that can give the false impression of uncooperative behavior or lack of remorse" and, accordingly, it is "likely that these individuals will have difficulty interacting with the personnel who supervise their parole, explaining any innocent but non-conforming behavior, and showing remorse for otherwise minor infractions of the conditions of their parole that do not rise to the level of unlawful conduct").

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149 Velez-Pastrana, *Attention Deficit Hyperactivity Disorders in Prisoners* at 186; *see also* Gil D. Rabinovici et al., *Executive Dysfunction*, Am. Academy of Neurology Continuum Journal (2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4455841/pdf/20150600.0-0011.pdf (explaining executive functioning); DSM-5 at 101 (discussing cognitive symptoms of schizophrenia); Fovet & Thomas, *Individuals with Bipolar Disorder in the Criminal Justice System* at 350 (discussing impulsivity among people with bipolar disorder); DSM-5 at 660 (discussing impulsivity among people with ASPD).

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158 *Id.* at 29.

159 *See* Alyssa McGonagle, *How Organizations can Support Employees with Chronic Health Conditions*.

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163 SAMHSA, *Trauma-Informed Care in Behavioral Health Settings* at 73; *see also* DSM-5 at 275 (people with PTSD "commonly make deliberate efforts to avoid thoughts, memories, feelings, or talking about the traumatic event . . . and to avoid activities, objects, situations, or people who arouse recollections of it").

164 DSM-5 at 240.

165 *See, e.g.*, Rabinovici, *Executive Dysfunction* at 647-48 (explaining executive functioning's impact on working memory); CDC, *Traumatic Brain Injury in Prisons and Jails* at 2 ("Memory deficits" among people under correctional control with TBI "can make it difficult to understand or remember" obligations); Young, *Beyond the Gates* at 37 (interviews with probation staff in England and Wales revealed people on probation with ADHD have trouble "with attendance"); Buadze, *Perceptions and Attitudes of Correctional Staff Toward ADHD* at 7 (study of corrections officers in Switzerland revealed perceptions that incarcerated people

with ADHD "were unorganized and missed appointments" and "required longer and more repetitive instructions" than people without ADHD).

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168 Alyssa McGonagle, *How Organizations can Support Employees with Chronic Health Conditions*.

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171 DSM-5 at 225.

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189 *Id.* at 6-7; *see also* Human Rights Watch & ACLU, *Revoked* at 177-79 (collecting sources).

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195 Sered, *Ineffectiveness of Prison-Based Therapy* at 11.

196 *See* HRW & ACLU, *Revoked* at 46-47.

197 *See* Preston, *"I was reaching out for help and they did not help me"* at 3.

198 *See* section III(C)(iii).

199 *See* section III(C)(i), (ii).

200 *See, e.g.*, Virginia Gutman, *Ethical reasoning and mental health services with deaf clients*, 10 J. Deaf Studies & Deaf Ed. 171, 172-73 (2005) ("We may encounter unjust practices when agencies refuse to treat deaf patients, refuse to hire interpreters or provide other needed accommodations, or engage in stereotyping of deaf clients or professionals."); Maureen McEntee, *Accessibility of mental health services and crisis intervention to the deaf*, 138 American Annals of the Deaf 26, 28 (1993) (finding that in a state, 72 percent of responding agencies indicated they had served deaf clients during the past year, and "only 25% of this number [provided] certified interpreters").

201 Osher, *Adults with Behavioral Health Needs under Correctional Supervision* at 26.

202 Levenson & Willis, *Implementing Trauma Informed Care in Correctional Treatment and Supervision* at 2; *see also id.* at 12 ("Correctional programs may replicate disempowerment dynamics similar to those in abusive families, reinforcing a client's dysfunctional responses and coping styles"); SAMHSA, *Trauma-Informed Care in Behavioral Health Settings* at 17-18.

203 Miller & Najavits, *Creating Trauma-Informed Correctional Care* at 4.

204 SAMHSA, *Trauma-Informed Care in Behavioral Health Services* at 123.

205 SAMHSA, *Mental and Substance Use Disorder Treatment for People with Physical and Cognitive Disabilities* at 6.

206 SAMHSA, *Trauma-Informed Care in Behavioral Health Services* at 63-64.

207 Louden & Skeem, *Parolees with Mental Disorder* at 7.

208 *See* ACLU, *Rethinking Electronic Monitoring: A Harm Reduction Guide* 4 (2022), https://www.aclu.org/report/rethinking-electronic-monitoring-harm-reduction-guide.

209 *See id.* at 7; Electronic Frontier Foundation, *Electronic Monitoring*, https://www.eff.org/pages/electronic-monitoring (last accessed Mar. 7, 2024).

210 *See* ACLU, *Rethinking Electronic Monitoring* at 8, 14; Electronic Frontier Foundation, *Electronic Monitoring*.

211 ACLU, *Rethinking Electronic Monitoring* at 8, 14; James Kilgore & Emmett Sanders, *Ankle Monitors Aren't Humane. They're Another Kind of Jail*, Wired (Aug. 4, 2018), https://www.wired.com/story/opinion-ankle-monitors-are-another-kind-of-jail/.

212 Tosca Giustini, et al., Cardozo Law, *Immigration Cyber Prisons: Ending the Use of Electronic Ankle Shackles* 14-16, (2021), https://larc.cardozo.yu.edu/cgi/viewcontent.cgi?article=1002&context=faculty-online-pubs; *see also* SAMHSA, *Trauma-Informed Care in Behavioral Health Settings* at 114 ("[u]sing physical restraints" can result in retraumatization).

213 Giustini, *Immigration Cyber Prisons* at 14-15.

214 *Id.* at 15.

215 For examples of reasonable accommodations in the criminal legal system context, see U.S. Dep't of Just. *Criminal Justice*, https://www.ada.gov/topics/criminal-justice/ (last accessed Mar. 7, 2024); U.S. Dep't of Just., *Examples and Resources to Support Criminal Justice Entities in compliance with Title II of the Americans with Disabilities Act* (Jan. 2017), https://archive.ada.gov/cjta.html

216 For more information on effective communication, see U.S. Dep't of Just. *Effective Communication* (updated Feb. 28, 2020), https://www.ada.gov/effective-comm.htm.

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