3 Litigating for Improved Medical Care

Rhonda Brownstein and Laura Rovner

Introduction

In 1976, the Supreme Court first recognized that people in prison have a constitutional right to health care for serious medical needs (Estelle v. Gamble, 1976). In the decades that followed, both the incarceration rate and the cost of health care have skyrocketed, increasing incentives for resource-conscious institutions to restrict care in ways that harm incarcerated people and the public health. Litigation can provide an important check on the worst of those abuses at both individual and systemic levels, though in the decades since *Estelle* was decided, judicial decisions, legislation, and correctional policy have raised significant obstacles to ensuring the right to constitutionally adequate health care is realized.

In this chapter, we discuss the parameters of the Eighth Amendment right to adequate health care and provide an overview of correctional medical care litigation. After unpacking the legal standards courts use in assessing claims of constitutionally inadequate care, we review how those standards have been applied to different types of healthcare issues. We then turn our focus on institutional reform litigation, exploring how large class-action lawsuits may be used to address systemic deficiencies in correctional medical care.

Overview of Correctional Medical Care Litigation

Medical care litigation is among the four most common areas of prison litigation in federal court, along with lawsuits challenging violence, due process violations relating to disciplinary sanctions, and inadequate living conditions (Schlanger, 2003). Lawsuits over medical care are typically either filed as class actions seeking broad, injunctive relief designed to improve medical care for an entire group of prisoners or as individual cases seeking money damages for the particular inmate's untreated

R. Brownstein (✉)
Alabama Disabilities Advocacy Program, Montgomery, AL, USA
e-mail: Rhonda.Brownstein@gmail.com

L. Rovner
University of Denver Sturm College of Law,
Denver, CO, USA

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or mistreated medical problem. Both governmental entities and private contractors are legally responsible for ensuring that the care provided meets constitutional standards (*Ancata v. Prison Health Services*, 1985).

The US Department of Justice (DOJ) can also bring litigation on behalf of the federal government against state or local entities for violating the civil rights of persons institutionalized in publicly operated facilities—including the rights of prisoners to adequate medical care. The DOJ's broad authority under the Civil Rights of Institutionalized Persons Act (CRIPA) is a powerful tool for obtaining systemic changes in facilities as a whole and entire correctional systems; CRIPA does not apply to private facilities or to specific individual cases. Since the enactment of CRIPA in 1980, the DOJ has investigated hundreds of facilities, issued "findings letters" (finding unconstitutional conditions of confinement and demanding improvements), and filed suit in dozens of cases.

In 2019, the DOJ had open CRIPA matters pending in more than half the states. Since 2009, 21 out of the Department's 26 cases have involved deficient medical or mental health care (US Department of Justice, 2019).

Medical care litigation is typically based on allegations that the medical care provided falls below constitutionally required standards. The Eighth Amendment to the US Constitution, which prohibits cruel and unusual punishment, gives prisoners the right to receive adequate medical care.[1] The US Supreme Court first recognized this right in 1976, in *Estelle v. Gamble*. Justice Thurgood Marshall, writing for the Court, explained why: An "inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met. In the worst cases, such a failure may actually produce physical 'torture or a lingering death.'" In less serious cases, denial of medical care could result in pain and suffering "which no one suggests would serve any penological purpose" (Estelle v. Gamble, 1976).

Estelle and the cases that followed over the next 45 years established the following rule: Prison and jail officials violate the Eighth Amendment when they act with *deliberate indifference* to a prisoner's *serious medical needs*. The rest of this chapter will explore the meaning of that rule, that is, what is a "serious medical need" and what does it mean to be "deliberately indifferent" to it?

Elements of Medical Care Lawsuits

Serious Medical Needs

The Eighth Amendment requires only that prison officials provide care for "serious medical needs" (*Estelle*, 1976). In interpreting that standard, most courts have held that a serious medical need is "one that has been diagnosed by a physician as mandating treatment or one that is so obvious that even a lay person would easily recognize the necessity of a doctor's attention" (Hayes v. Snyder, 2008). Because the Supreme Court has held that the Eighth Amendment also prohibits the "unnecessary and wanton infliction of pain" (*Estelle*, 1976), many courts have also found that pain—especially when it is severe or protracted—constitutes a serious medical need, even where no permanent injury results from a failure or delay in providing treatment (Al-Turki v. Robinson, 2014). Incorporating all of these standards, one court has held that factors to consider in determining whether a medical need is "seri-

[1]The Due Process Clause of the Fifth Amendment gives the same right to federal prisoners, and the Fourteenth Amendment protects pretrial detainees. Courts apply the same legal standards in medical care cases brought under the Eighth, Fifth, and Fourteenth Amendments. In addition, the Americans with Disabilities Act, which is discussed in a separate chapter, mandates that prisoners with disabilities be fully accommodated in correctional settings (Americans with Disabilities Act of 1990).

ous" include "(1) whether a reasonable doctor or patient would perceive the medical need in question as 'important and worthy of comment or treatment,' (2) whether the medical condition significantly affects daily activities, and (3) 'the existence of chronic and substantial pain'" (Brock v. Wright, 2003).

Examples of conditions that courts have found to rise to the level of "serious medical needs" include: kidney stones, severe chest pain, HIV, hepatitis, diabetes and its complications, severe arthritis, severe back pain, self-inflicted burns, seizure disorders, hemorrhoids requiring surgery, and complications of pregnancy. On the other hand, courts have held that the following conditions are not sufficiently serious to violate the Eighth Amendment: mild asthma, a broken jaw, acne, slight visual impairment causing mild headaches, tinnitus, seasonal allergies, fractured teeth without pain, eczema, and scabies. That said, some courts have recognized a "serious cumulative effect" from repeated denials of care for even minor medical needs.

The seriousness of the medical need cannot be judged with the benefit of hindsight; what matters are the facts known at the time of the incident (*Al-Turki*, 2014). Prison officials will not be held liable for conditions that appeared innocuous but turned out to be serious. Finally, the harm to health does not need to have already occurred; exposure to a risk that may cause harm in the future may also be actionable (Helling v. McKinney, 1993).

Mental Illness

Mental health needs, if sufficiently serious, are also protected by the Eighth Amendment.[2] In the context of individual claims, courts have used a variety of tests to assess whether a condition is a serious mental illness, including "one that has caused significant disruption in an inmate's everyday life and which prevents his functioning in the general population without disturbing or endangering others or himself" (Tillery v. Owens, 1990). As for specific conditions, courts have held that bipolar disorder, schizophrenia, schizoaffective disorder, major depressive disorder, certain mood disorders, immediate psychological trauma, suicide attempts, and posttraumatic stress disorder are conditions warranting constitutional protection[3] (Braggs v. Dunn, 2017).

That said, particularly in individual (as opposed to systemic) litigation, courts tend to conduct an individualized assessment to determine whether a person's mental health condition is sufficiently serious rather than concluding that a given diagnosis is or is not protected by the Eighth Amendment. For example, some courts have held that claims about depression or bipolar disorder do not meet the standard while others have found that they do. To the extent that a condition of confinement exacerbates a mental health condition, this too may be actionable: for example, courts have held that solitary confinement violates the Eighth Amendment where it causes or exacerbates serious mental illness (*Braggs*, 2017).

[2] A different standard applies to people who have been found incompetent to stand trial or not guilty by reason of insanity, or who have been civilly committed as sex offenders after their criminal sentence is finished. Their rights are also protected by the Due Process Clause, but the standard governing their treatment is whether it is sufficiently related to the purpose of their confinement (Oregon Advocacy Center v. Mink, 2003). Additionally, the Americans with Disabilities Act and Section 504 of the Rehabilitation Act also may confer additional rights to people with mental illness.

[3] Simply because a condition is defined in the Diagnostic and Statistical Manual of Mental Disorders as a "major mental illness," does not necessarily mean that courts will deem it to be sufficiently serious for Eighth Amendment purposes.

Other Conditions

Dental Needs

As with other health needs, deliberate indifference to serious dental needs violates the Eighth Amendment. Whether a dental need is serious may be based on various factors, such as the extent of pain, the deterioration of the teeth due to a lack of treatment, or the inability to engage in normal activities (Chance v. Armstrong, 1998). Courts have held that serious needs include dentures (where necessary to eat properly), untreated cavities, dental pain, bleeding, swelling, and painful broken teeth. Significant delays in providing care, particularly if the condition is painful or debilitating, can also violate the Eighth Amendment.

Hearing and Visual Impairments

Depending on the nature of the person's hearing or visual impairment and the treatment sought, the legal obligation to provide care may be governed by the Eighth Amendment, the federal disability rights statutes (the Americans with Disabilities Act and the Rehabilitation Act), or both. While accommodations such as sign language interpreters for deaf prisoners or talking books for people with vision impairments tend to be covered by the disability rights statutes, courts have analyzed requests for procedures such as cochlear implants and cataract surgery under the Constitution. Courts have recognized both Eighth Amendment and disability discrimination claims for items such as hearing aids and glasses.

Pregnancy, Childbirth, and Abortion

Generally, when pregnant women are suffering from egregious complications such as obvious miscarriages, leaking amniotic fluid, or hemorrhaging, courts have held that they have a serious medical need. But courts have been less willing to classify other pregnancy-related needs as objectively serious—including prenatal care and breast pumping. Several courts have held that the Eighth Amendment prohibits shackling of pregnant women during labor or in the third trimester of pregnancy, and a number of states have enacted legislation prohibiting the practice as well. A woman's right to abortion has been deemed protected both as a matter of privacy and under the Eighth Amendment's right to medical care, and courts have held that corrections officials must provide for abortions regardless of the incarcerated person's ability to pay (although one court held that elective, nontherapeutic abortions do not constitute a serious medical need [Roe v. Crawford, 2008]).

Developing Areas

Gender Dysphoria

Most courts to consider the issue have recognized that gender dysphoria is a sufficiently serious medical need to implicate the Eighth Amendment. Whether a failure to provide a particular type of treatment constitutes deliberate indifference, however, is a separate question. (The deliberate indifference standard is discussed below.) That said, we note here that while courts have held that medical care decisions in correctional contexts are fact specific, a number of courts have required prisons to provide hormone therapy. And as of 2020, at least one court has held that correctional officials' refusal to provide gender conforming surgery (GCS) violated the Eighth Amendment (*Edmo v. Corizon,* 2019), though other courts faced with different facts held that the plaintiff had not demonstrated that GCS was medically necessary.

Hepatitis C (HCV)

With the development and increasing use of direct-acting antiviral (DAA) drugs beginning in 2013, the issue for most courts considering Eighth Amendment claims for failure to treat HCV is not whether it is a serious medical need, but whether and to what extent cost may factor into the determination of whether antiviral treatment is required (Coleman-Bey v. United States, 2007; Hoffer v. Jones, 2017). Because of the cost of direct antiviral medications, some prison systems have sought to implement protocols that prioritize people for DAA treatment based on the progression of the disease (Smith v. Corizon, Inc., 2015). Because that puts those in even the early stages of the disease at "substantial risk of serious harm"—that is, developing HCV-related complications—some courts have found the refusal to provide antiviral treatment violates the Eighth Amendment (Abu-Jamal v. Wetzel, 2017), though others have held that prioritization structures are "practical strategies for HCV care when resources are limited" (Atkins v. Parker, 2019).

Opioid Use Disorders

In the midst of the opioid epidemic, more and more people are entering correctional facilities with opioid use disorders. Blanket policies or practices that deny or delay continuing opioid agonist therapy (also known as medication-assisted treatment, or MAT) have been held to violate the Eighth Amendment (Foelker v. Outagamie County, 2005); they are also vulnerable to challenges under the federal disability rights statutes (Smith v. Aroostook Cty, 2019).

Deliberate Indifference

For inadequate medical care to rise to the level of a constitutional violation, it is not enough that the medical problem is a "serious medical need" that went untreated or mistreated. Over time, the courts have made clear that an Eighth Amendment medical claim turns on the *mental culpability* of individual prison or health-care workers. A prisoner must show that a prison official acted or failed to act with "deliberate indifference" to the serious medical need of the prisoner (Farmer v. Brennan, 1994; Wilson v. Seiter, 1991). This is because the Eighth Amendment only applies to "punishments" and the general conditions under which a prisoner is confined do not constitute part of the punishment. "If the pain inflicted is not formally meted out as punishment by the statute or the sentencing judge, some mental element must be attributed to the inflicting officer before it can qualify" (Wilson v. Seiter, 1991).

Deliberate indifference has two elements. First, a prisoner must show that a prison official (which includes medical staff) *knows* about a serious danger to the prisoner (the "deliberateness" part of the inquiry). Second, the prison official must *fail to reasonably respond* by providing adequate treatment (the "indifference" part of the inquiry).

The Supreme Court explained the deliberate indifference standard in the 1994 landmark case of *Farmer v. Brennan*. Dee Farmer, a transgender woman, was incarcerated in a federal prison with the general male population. She was repeatedly raped and beaten by the other inmates and became HIV positive as a result. Farmer sued, claiming that the prison administration failed to protect her and should have known that she was particularly vulnerable to sexual violence. The Court agreed, holding that "a prison official may be held liable under the Eighth Amendment for denying humane conditions of confinement only if he knows that inmates face a substantial risk of serious harm and disregards that risk by failing to take reasonable measures to abate it" (*Farmer,* 1994).

In a Seventh Circuit Court of Appeals decision, the court used the metaphor of a cobra to explain deliberate indifference: "If [prison officials] place a prisoner in a cell that has a cobra, but they do

not know that there is a cobra there (or even that there is a high probability that there is a cobra there), they are not guilty of deliberate indifference even if they should have known about the risk, that is, even if they were negligent—even grossly negligent or even reckless in the tort sense—in failing to know. But if they know that there is a cobra there or at least that there is a high probability of a cobra there, and do nothing, that is deliberate indifference" (Billman v. Indiana Department of Corrections, 1995).

Actual Knowledge of a Serious Medical Need

A prisoner bringing a medical care lawsuit cannot merely show that the prison officials *should have known* about the serious risk of harm from his or her medical problem. Rather, the prisoner must demonstrate that prison officials *actually knew* about the risk. A prisoner can establish this knowledge through a variety of methods—for example, sick call requests, grievances, and medical records. He or she may also establish that prison officials "knew of a substantial risk from the very fact that it was obvious." Risks of harm are obvious when the challenged conditions are "longstanding, pervasive, well-documented, or expressly noted" by officials in the past (e.g., in internal reports, audits, and the like) (Farmer v. Brennan, 1994).

Failure to Reasonably Respond

The second part of the deliberate indifference requirement is that, despite the prison official's knowledge of a serious risk of harm, the official did not *reasonably respond* to the risk. Courts evaluate the reasonableness of the response by considering the information the official possessed, any practical limitations, and alternative courses of action that would have been apparent to an official in his or her position.

Adequate medical care is extremely expensive and is often a significant drain on state and local coffers. But officials may not refuse to respond to a substantial risk of serious harm by arguing that it is too expensive to address "because prison officials may be compelled to expand the pool of existing resources in order to remedy continuing Eighth Amendment violations" (Peralta v. Dillard, 2014).

Courts have found that prison officials did not reasonably respond to a serious risk of medical harm when they deny or delay access to medical care, provide grossly inadequate treatment, or interfere with prescribed treatment (*Estelle v. Gamble*, 1976).

Denial or Delay of Medical Care

Denials of medical care are the most straightforward claims—these are claims that prison officials knew of a prisoner's serious medical needs but did nothing, and the prisoner was harmed as a result. Nonmedical personnel often play the role of gatekeepers in deciding who will be seen by medical personnel and who will not, sometimes leading to serious consequences. Likewise, correctional officers and medical personnel without the necessary training are often called upon to determine whether a prisoner should see a doctor or a specialist.

An unjustified delay in providing medical care that results in harm can also amount to deliberate indifference. In determining whether the length of a prison official's delay in treating an inmate's serious medical need violates the Eighth Amendment, courts consider the seriousness of the medical need, whether the delay worsened the medical condition, and the reason for the delay (Hill v. Dekalb Regional Youth Detention Center, 1994).

Inadequate Medical Care

The Constitution does not require that the provided medical care be "perfect" or the "best obtainable." Rather, deliberate indifference is established only if the medical care is "so grossly incompetent, inadequate, or excessive as to shock the conscience or to be intolerable to fundamental fairness" (Rhinehart v. Scutt, 2018). This can be difficult to establish. Courts will rarely second-guess the judgments of medical personnel, even if those judgments violate the standards of care of their professions. It is important to note that mere medical malpractice does not violate the Constitution; deliberate indifference requires a higher state of mind than negligence. And it is not enough to show that a different medical professional would have ordered a different course of treatment. But if the medical care provided is *grossly inadequate* or is knowingly less effective than a different course of treatment in order to save money, medical personnel may be found to be deliberately indifferent (Arnett v. Webster, 2011). And "medical care which is so cursory as to amount to no treatment at all may amount to deliberate indifference" (Terrance v. Northville Regional Psychiatric Hospital, 2002).

Interference with Prescribed Treatment

Deliberate indifference is established when prison officials interfere with or fail to carry out treatment that was prescribed by a doctor or other medical personnel (Estelle v. Gamble, 1976). In other words, prison officials may not substitute their own judgment for that of medical professionals. Likewise, a medical professional who is a generalist may not substitute his or her own judgment for that of a specialist (Jones v. Simek, 1999).

Systemic Issues

Large class-action lawsuits seeking broad, systemic changes to the provision of medical care have generally been more successful than individual monetary damages cases, particularly if they have the backing of advocacy groups and are part of a broader effort to seek legislative change and bring media attention to issues. Evidence of systemic deficiencies can establish deliberate indifference "by proving that there are such systemic and gross deficiencies in staffing, facilities, equipment, or procedures that the inmate population is effectively denied access to adequate medical care" (Ramos v. Lamm, 1980). Some of the systemic issues that apply to correctional medical care include the following.

Medical Staffing

Correctional facilities are constitutionally obligated to provide "ready access to competent medical staff" (Coleman v. Wilson, 1995). This means that widespread deficiencies in medical or mental health staffing that make unnecessary suffering inevitable may violate the Eighth Amendment (Braggs v. Dunn, 2017). It also means that those providing medical care must be competent to do so; medical staff such as nurses or physician's assistants may not be assigned tasks beyond their training and must be adequately supervised.

Correctional Staffing

If inadequate correctional staffing hinders the delivery of medical and mental health care such that it creates a substantial risk of serious harm, this too may be unconstitutional (*Braggs*, 2017). Impacts of

insufficient correctional staff include cancelation and delays of medical appointments due to a lack of available staff to transport prisoners and the inability of staff to check on prisoners who are isolated from the rest of the population and whose medical or mental health conditions may be deteriorating.

Healthcare Screening

Corrections systems must screen incoming prisoners for serious medical and mental health conditions such as infectious diseases, mental illness, substance abuse, and suicide risk[4] (Braggs v. Dunn, 2017; Jolly v. Coughlin, 1996). Prisoners may be required to submit to examinations for communicable diseases such as tuberculosis.

Sick Call and Access to Emergency Treatment

Incarcerated people must have a way to make their medical problems known to medical staff, and the failure to provide a sick call system that can effectively handle emergencies can violate the Eighth Amendment (Hoptowit v. Ray, 1982; *Thomas v. Cook Cty. Sheriff's Dept*., 2009). Additionally, prison officials may be liable if they fail to provide correctional staff with at least minimal training in recognizing and dealing with medical emergencies (*Morrison v. Washington Cty*., 1983).

Chronic Care

Given the increasing number of older adults who are incarcerated, many prisons house significant numbers of people with chronic conditions requiring ongoing care. As part of their obligation to provide constitutionally adequate care for serious medical needs, prisons must ensure that people with chronic conditions are tracked and seen by a health-care provider at clinically appropriate intervals.

Adequate Facilities and Records

Prisons and jails are required to have adequate facilities for medical examinations and treatment. There must be an organized system of medical records that include screening forms, sick call requests, treatment records, etc.

Access to Specialists and Hospital-Level Care

Denial of access to medical specialists and to hospital-level care can create a substantial risk of serious harm to prisoners in violation of the Eighth Amendment. This is an area that is frequently litigated in class-action systemic cases, given the expenses associated with referring and transporting prisoners to specialists and for hospital care and surgeries.

[4]Federal prisons are required to conduct health screenings of new prisoners within 24 hours of their arrival. 28 C.F.R. § 522.20 (2016).

Infectious Disease Control

Knowingly exposing prisoners to an infectious disease may violate the Eighth Amendment (Butler v. Fletcher, 2006). Given the high rates of infectious diseases in correctional facilities, prisons and jails should have infectious disease policies that include the identification and, when appropriate, the isolation of prisoners with infectious diseases, effective treatment protocols, measures to prevent the spread of the diseases, and educational materials for inmates and staff. With the beginning of COVID-19 in 2020, there has been a proliferation of litigation challenging the failure to adequately protect prisoners from exposure to the virus and failure to provide timely access to vaccines.

Medication

Decisions about which kinds of medication to prescribe are generally "medical judgments" that are outside the scrutiny of the Eighth Amendment. But when medical providers prioritize medication costs over patients' clinical needs, a constitutional violation may be established.

Forced Medication

Although prisoners retain some right to refuse medical care, that right is severely circumscribed as compared with the rights of "free world" patients. Prisoners may not refuse testing or treatment for a condition that would threaten the health and safety of the prison community. Prisoners may also be forced to accept treatment that is necessary to protect their health from permanent injury. Regarding involuntary psychiatric treatment, the Supreme Court has held that a prisoner may be forcibly medicated without a court hearing, so long as the decision was made by medical professionals (Washington v. Harper, 1990).

Roadblocks to Litigation

Lawsuits challenging prison medical care are notoriously difficult to bring. Proving that one has a "serious medical need" and that the failure to treat that medical need has led to harm requires expensive medical experts to which most prisoners lack access. Over the years, Congress and the courts have erected numerous procedural hurdles, most notably the Prison Litigation Reform Act of 1995 (known as the PLRA). The PLRA, enacted in 1996, required that prisoners exhaust grievance procedures, even when those procedures could not possibly result in the requested relief. It also increased prisoner lawsuit filing fees, reduced attorneys' fees (thereby deterring lawyers from filing prisoners' cases), limited monetary damages, made it more difficult to settle injunctive relief cases, and more. The law has had its desired effect of curbing inmate litigation—federal prisoner civil rights litigation had dropped from 23.3 filings per 1000 prisoners in 1996 to 10.2 filings per 1000 prisoners in 2012 (Schlanger, 2015).

Even if prisoners overcome these hurdles, they often face unsympathetic judges and juries, who either do not believe them or just do not care. In addition, most individual cases are brought *pro se* (without an attorney) and are overwhelmingly dismissed by the courts before trial because the plaintiffs are unskilled in the law and lack medical experts to establish their case. It is no wonder that, according to the latest study on the topic, prisoners only prevailed in litigation (including settlements, pretrial litigation victories, and trial victories) about 11% of the time. (Schlanger, 2015).

Litigation as a Vehicle for Systemic Reform

Despite being expensive, time consuming, and complex, impact litigation can be an effective—and sometimes necessary—vehicle for reform of correctional healthcare systems. We close this chapter by highlighting three class-action cases that resulted in significant institutional reforms.

In 2014, the lack of medical and mental health care in the Alabama Department of Corrections (ADOC) was so grave that incarcerated people would go for months or years without treatment, causing them pain, loss of function, injury, and death. With only 15 doctors for a population of 25,000 people—a direct result of ADOC's bid process for its medical services contract—the Department routinely failed to provide treatment for conditions from cancer to diabetes to hepatitis. People were placed under "do not resuscitate" orders without their knowledge or consent. Mental health care was nearly nonexistent and people with mental illness were routinely housed in solitary confinement. Unsurprisingly, ADOC had the highest suicide rate in the nation.

Advocates filed a class-action lawsuit asserting that these and other conditions violated the Constitution and federal disability rights statutes (in addition to the failure to provide medical and mental health care, ADOC also deprived prisoners with disabilities of necessary accommodations such as functioning wheelchairs and sign language interpreters). In 2016, ADOC settled the disability discrimination claims; a year later, the court found that the significant and pervasive failures of ADOC's mental health-care system were "horrendously inadequate" and violated the Constitution, and the court issued a series of remedial orders to fix those failures (Braggs, 2017). As of this writing, the medical care claims are in ongoing litigation.

A second example of institutional reform litigation is the class-action lawsuit challenging the Federal Bureau of Prisons' failure to provide adequate mental health care for the men at its supermax prison (ADX) in Colorado (Cunningham v. Bureau of Prisons, 2016). Because ADX houses people in solitary confinement, BOP policy was supposed to preclude people with serious mental illnesses from being housed there. But by 2012 it was apparent that many gravely ill people were in ADX and were not receiving constitutionally adequate care, resulting in men who would "interminably wail, scream and bang on the walls of their cells, . . . mutilate their bodies with razors, shards of glass, writing utensils and whatever other objects they can obtain, . . . swallow razor blades, nail clippers, parts of radios and televisions, broken glass and other dangerous objects," and "spread feces and other human waste" on their bodies. Many attempted suicide; some were successful.

The lawsuit asserted Eighth Amendment violations for the failure to diagnose and provide adequate mental health treatment for the men housed at ADX. After 4 years of litigation, the case was settled with the court approving a set of reforms that included new policies for the screening and diagnosis of mental illness, the provision of mental health care, suicide prevention, and conditions of confinement; the development and activation of three high-security mental health treatment units; increased out-of-cell time for men who remained at ADX; and other initiatives. The court also appointed monitors to periodically review the prison's compliance with those initiatives.

Finally, a pair of cases—*Coleman v. Brown* and *Plata v. Brown*—challenged grossly inadequate mental health care and medical care in the California Department of Corrections. *Coleman* was filed in 1990 by a prisoner with serious mental illness at Pelican Bay, where a single psychologist was assigned to treat the mental health needs of 3500 people (*Coleman*, 1995). A decade later, the *Plata* class action was filed, alleging medical care so inadequate that "an inmate in one of California's prisons needlessly dies every six to seven days due to constitutional deficiencies in the [State's] medical delivery system" (Plata v. Schwarzenegger, 2005). Despite an extensive set of court orders specifying goals and methods of improving medical and mental health care, the growing prison population made it impossible for California to comply with the orders.

Invoking for the first time a provision authorizing courts to order a population reduction where necessary to alleviate constitutional violations, the court did just that, requiring California to shrink its population over a 2-year period. In 2011, the Supreme Court upheld that decision in *Brown v. Plata*, finding the medical and mental health care in California's prisons to be so constitutionally inadequate that it "creates a certain and unacceptable risk of continuing violations of the rights of sick and mentally ill prisoners, with the result that many more will die or needlessly suffer." (*Brown v. Plata*, 2011). Following the Court's decision, California adopted a "realignment" policy that attempts to relieve overcrowding by shifting people from prisons to local jails. While this and other reforms have reduced the prison population somewhat, problems with overcrowding and inadequate health care persist.

As these and other cases show, it is critical to ensure that the resolution of systemic reform cases includes provisions for monitoring the progress of a prison system's compliance with remedial orders, and the ability to return to court for additional orders or sanctions where a correctional system has failed to address deficiencies.

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