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The Role of Culture in Advocating for Accurate Diagnosis and Rating of Veterans' Psychological Disabilities

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INTRODUCTION

The Department of Veterans Affairs Compensation and Pension system is complicated.¹ The disability claims process cannot possibly be boiled down, but one mental image helps illustrate the basic structure of VA compensation.² Picture the

1. The VETERANS BENEFITS MANUAL is a thorough and helpful volume updated each year and widely considered to be the veterans advocate's "Bible" during the disability claims process. VETERANS BENEFITS MANUAL (Barton F. Stichman & Ronald B. Abrams, eds., 2011). The 2011 Edition is 2,044 pages long. Still, the editors state that "the statutes, regulations, unpublished guidelines, and court decisions governing entitlement to, and the administration of, the VA's monthly income benefits programs are so complicated that a greater endeavor would be necessary to capture all the nuances an advocate could possibly face in representing veterans and their dependents." *See* VETERANS BENEFITS MANUAL, *supra*, at 13; *see also* Veterans for Common Sense v. Shinseki, 644 F.3d 845, 856 & note 10 (9th Cir. 2011) (calling the process of applying for disability benefits from the VA "labyrinthine" and noting that claims for mental disorders like post-traumatic stress disorder are among the most complicated for both veterans to complete and VA employees to adjudicate), *rev'd en banc on other grounds*, 678 F.3d 1013 (9th Cir. 2012).

2. This article explains the disability benefits system in more detail in Section I(A). It would be nice if the process were as simple as described here, but in a system that makes almost 5 million benefits determinations every year with cash payments of over \$25 billion, *see* VETERANS BENEFITS MANUAL, *supra* note 1, at 13, true simplicity is an impossible goal. Every part of the disability claims process has several more shades of grey than this article can concisely cover. Nevertheless, the Department of Veterans Affairs could simplify more, including its jargon-heavy publically-distributed forms and statutes; in 2012, it was the only federal agency to receive an "F" grade for compliance with the Plain Writing Act of 2010, legislation that requires federal agencies to write all new publically-distributed documents using principles of plain language. *See Plain Language Report Card*, CENTER FOR PLAIN LANGUAGE, <http://centerforplainlanguage.org/resources/plain-writing-laws/plain-language-report-card/> (last visited Aug. 23, 2012) and the press release regarding the agency report cards at *Who makes the grade? Plain Language Report Cards for Federal Agencies*, CENTER FOR PLAIN LANGUAGE,

Veterans Benefits Administration (VBA) as a large room with a long, straight line painted on the floor. The line has different percentage markers, going up by tens, from 0% to 100%.³ Each percentage marker has a counter staffed with a VBA employee who hands out envelopes containing the same amount of money.⁴ For the 100% marker, the envelopes contain \$2,816,⁵ and for each percentage marker below 100%, the envelopes contain a certain measure less; all counters are drawing from a finite pile of money.⁶ A veteran can pick up an envelope once a month from the counter that represents is the veteran's percentage of disability; if the veteran is 100% disabled, the 100% counter will give the veteran an envelope containing \$2,816. If instead the veteran is 70% disabled, the envelope will contain almost \$1,500 less for the month.⁷ The money in the envelope is intended to compensate the average person (not necessarily the individual veteran) for the amount of money he or she cannot earn through civilian work because of disability.⁸

<http://centerforplainlanguage.org/blog/government/who-makes-the-grade/> (last visited Aug. 23, 2012).

3. See VETERANS BENEFITS MANUAL, *supra* note 1, at 13 (“Unlike disability determinations for social security benefits, for which a total disability is required, disability ratings for VA benefits are made in increments of 10 percent. The higher the degree of disability, the higher is the monthly disability payment.”).

4. VETERANS BENEFITS MANUAL, *supra* note 1, at 59 (“The dollar amount of disability compensation payment at each disability level is exactly the same for everyone, whether he or she is a neurosurgeon or sanitation worker.”).

5. See *Veterans Compensation Benefits Rates Tables – Effective 12/1/12*, U.S. DEP’T VETERANS AFF., http://benefits.va.gov/COMPENSATION/resources_comp01.asp (last visited Jan. 26, 2013).

6. The Veterans Benefits Administration (VBA) requested \$59.8 billion to pay for the disability Compensation program in 2013. This amount is requested to pay out compensation benefits to 3,626,468 veterans, 356,796 survivors of veterans, and 1,151 children of veterans in 2013. *Annual Budget Submission (FY 2013): Volume III, Benefits and Burial Programs and Departmental Administration*, U.S. DEP’T VETERANS AFF., http://www.va.gov/budget/docs/summary/Fy2013_Volume_III-Benefits_Burial_Dept_Admin.pdf (last visited Aug. 23, 2012).

7. *Veterans Compensation Benefits Rates Tables*, *supra* note 5 (Table labeled “70% - 100% Without Children”).

8. See 38 C.F.R. § 4.1 (2011) (describing the “evaluative rating” in general). Section 4.1 states that a rating is designed to “represent as far as can

Before the veteran can get into one of the lines, he or she must go through a gate. The gatekeeper, a VBA employee known as a “rating specialist,” must first decide whether the veteran should be allowed through the gate,⁹ and then decide which line the veteran belongs in. To decide which line the veteran belongs in, the gatekeeper will usually require the veteran to be examined by a doctor, who will report on the veteran’s medical or psychiatric condition(s) and how well the veteran is functioning.¹⁰ The gatekeeper will rely heavily on the medical report to place the veteran in a particular line.¹¹

An advocate’s goal is to help the veteran get through the gate and into the right line, or that line leading to the envelope that most appropriately compensates the veteran for how much the

practically be determined the average impairment in earning capacity” caused by a disease or injury and its residual effects.

9. A VBA employee will first determine whether the person applying for disability compensation is eligible to receive VA benefits. This includes determining whether the person satisfies the statutory definition of “veteran.” *See* VETERANS BENEFITS MANUAL, *supra* note 1, at 23 (“The first question to ask when determining whether a person is eligible to receive benefits from the VA is—is this person a veteran?”); 38 U.S.C. § 101(2) (2006) (“The term ‘veteran’ means a person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable.”). The second hurdle for a veteran to clear before getting “through the gate” so-to-speak is to show that something happened in service to injure the veteran or cause the veteran to acquire a disease, and the veteran’s current disability can be linked to that in-service incident. *See* VETERANS BENEFITS MANUAL, *supra* note 1, at 62-63.

10. Although a veteran can (and often should) submit a private physician’s opinion in support of a disability claim, particularly for a psychological disability claim, the VA has a duty to assist the veteran in obtaining competent medical evidence in support of the claim. 38 U.S.C. § 5103A(a) (2006) (“The Secretary [of the VA] shall make reasonable efforts to assist a claimant in obtaining evidence necessary to substantiate the claimant’s claim for a benefit under a law administered by the Secretary.”). Even if the veteran submits a private physician’s diagnosis, the veteran will typically be required to submit to an examination by a Veterans Health Administration physician. *See* VETERANS BENEFITS MANUAL, *supra* note 1, at 72—73.

11. *See* VETERANS BENEFITS MANUAL, *supra* note 1, at 283—285 (“When evaluating a disability the rating activity examines the veteran’s medical records to ascertain the medical diagnosis for the particular service-connected disability at issue. The rating activity then finds the appropriate diagnostic code for the disability and selects the degree of disability that corresponds with the symptomatology of the veteran’s condition.”).

disability actually impairs his or her ability to earn income. This advocacy process is not easy.

Rather than navigating a simple straight line, advocating for a veteran while the VA is determining the percentage assigned to a veteran's disability feels more like navigating a maze with ever-changing routes. If an advocate helps a veteran develop a claim from the beginning, the advocate and veteran can expect to encounter multiple medical and psychiatric exams, unpredictable communication with ratings specialists (if they are fortunate enough to be *able* to talk with them—they are not, in reality, readily accessible “at the gate”), piles of paperwork, and complicated calculations when factoring in multiple disabilities (something most veterans must do).

If an advocate is helping a veteran develop a claim for a psychological disability, the challenges quickly compound.¹² A physical disability lends itself to diagnosis through lab results and objective observation of symptoms; a doctor can quickly see if the veteran is missing a limb or has a broken bone, for instance. The doctor will listen to the veteran describe symptoms, but will usually rely more heavily on the objective measures rather than the veteran's descriptions. But if the veteran suffers from a psychological disability, the diagnosis must be, at least in part, based on the veteran's own description of symptoms or subjective complaints. “Unlike AIDS or cancer, mental illnesses cannot be diagnosed with a brain scan or blood test. The impressions of doctors—drawn from verbal and nonverbal cues—determine whether a patient is healthy or sick.”¹³ Add to this the unique context of the VA system in that the psychiatrist examining the veteran is diagnosing for an administrative, rather than therapeutic, purpose, at the request of the VBA gatekeeper. The psychiatrist's role is less a helper and more a pseudo-gatekeeper, and he is certainly more skeptical or adversarial with a veteran seeking part

12. “[D]isability claims for mental disorders present many unique challenges for claimants and their advocates.” VETERANS BENEFITS MANUAL, *supra* note 1, at 152.

13. Shankar Vedantam, *Racial Disparities Found in Pinpointing Mental Illness*, WASH. POST, June 28, 2005, <http://www.washingtonpost.com/wp-dyn/content/article/2005/06/27/AR2005062701496.html>.

of a finite pool of money than he might be with a client he planned to treat long term.¹⁴

All of this combines to make communication between the veteran and the medical examiner a truly pivotal part of the veteran's claim.

This is where veterans' cultural backgrounds and identities can become crucial factors in their journeys through the claims process, with the potential to significantly impact which lines they get placed in. Any person's cultural identity is intimately intertwined with his or her psychology. Culture adds a layer of complexity to diagnosing a client suffering from a mental illness. That combines with yet another layer of complexity when a psychiatrist examines a veteran who has served in combat and endured one of humanity's most extreme experiences, and whose personal cultural identity has inevitably intermixed with military culture.

Imagine, for example, your veteran client, John Smith, has been examined by a psychiatrist and you are reviewing the report. John served in Vietnam and he has suffered from symptoms that you believe fit the diagnostic criteria for Post-Traumatic Stress Disorder (PTSD). Although John told you that he has a hard time interacting with co-workers who remind him of people he encountered in combat in Vietnam, you don't see any mention of this in the psychiatric report. "It doesn't look like you talked with him about your anger problems with some of your co-workers, especially those who reminded you of people you were in combat against," you say. "Why didn't you tell him about that? Remember, it is important for diagnosing PTSD," you remind him. He responds, "The psychiatrist was Asian, and ever since Vietnam, I can't bring myself to be comfortable in that situation. No way I could talk about that with him."¹⁵ In this scenario, and many others

14. See Harvey D. Lomas & Jonathan D. Berman, *Diagnosing for Administrative Purposes: Some Ethical Problems*, 17(4) SOC. SCI. MED. 241, 241-42 (1983) (exploring the differences between a physician's diagnosis for therapeutic reasons and a physician's diagnosis for purposes of disbursing public funds).

15. This example is loosely based on situations the author has seen in practice representing disabled veterans seeking disability compensation for psychological disabilities. This is an example of dominant culture mixing with military culture in a way that made it difficult, if not impossible, for the veteran to describe certain symptoms to a C&P examiner in a short and isolated (not for

like it, an important aspect of the veteran's condition is getting lost in translation due to cultural factors. That can potentially derail an accurate picture of the severity of the condition and negatively impact the VA's disability rating.

Culture seems to be "enough of an abstraction that people can be part of the same culture, yet make different decisions in the particular."¹⁶ So, what concrete things can a lawyer, untrained in multicultural psychiatric diagnosis, possibly do to make sure a veteran's condition does not get lost in translation? A lawyer assisting a veteran with a psychological disability claim will be a better advocate if the lawyer is first aware of the veteran's cultural background and identity and how it might impact the way the veteran communicates with the gatekeepers in the system, most importantly medical examiners. Awareness will make lawyers more effective at all stages of the disability claim and appeal process; it will enable them to identify ways they can make veterans' cultural backgrounds and identities a part of the record and a part of the diagnostic and rating procedures. Lawyers who appreciate cultural background and identity in their veteran clients and themselves will be agents of positive change in the VA disability system, moving it toward more culturally-sensitive and appropriate assessment, treatment, and compensation of all veterans.

treatment) encounter. A review of Board of Veterans' Appeals decisions reveals that avoidance of things related to Asian culture, including people of Asian descent, is not a unique manifestation of PTSD symptoms for Vietnam-era Veterans. *See, e.g.*, BVA Docket No. 08-23, 135A (2011), *available at* BD. OF VETERANS' APPEALS, <http://www.index.va.gov/search/va/bva.html> (search by case number 1135792) (decision granting a total disability rating in part due to the Veteran's difficulties at work related to his PTSD symptoms that manifested as disagreements with coworkers who reminded him of "Orientals" in Vietnam); *See also*, BVA Docket No. 08-14, 405 (2010), *available at* BD. OF VETERANS' APPEALS, <http://www.index.va.gov/search/va/bva.html> (search by case number 1020316) (Veteran diagnosed with PTSD reported limiting her lifestyle to avoid things and people that reminded her of Vietnam, including people, activities, and places that reminded her of Asian culture).

16. Susan Bryant, *The Five Habits: Building Cross-Cultural Competence in Lawyers*, 8 CLINICAL L. REV. 33, 41 (2001-2002).

We have steadily advanced in our understanding of culturally competent approaches to lawyering.¹⁷ This article builds on our ever-increasing understanding by focusing on the specific context of advocating for veterans who have psychological disability claims in the VA disability system, a context in which culturally aware communication can be of critical importance to the outcome of a veteran's claim and future livelihood. This article does not presume to advise mental health professionals on cross-cultural counseling practices. Much has already been written on that subject, including in the legal context.¹⁸ Instead, this article proposes that the intersection of culture and mental health is a uniquely important topic of conversation and development for lawyers representing veterans with psychological disability claims. The first section provides a brief overview of psychological disability claims in the Department of Veterans Affairs Compensation and Pension system. The second explores how culture interacts with mental health and the implications of this interaction on psychological diagnosis and treatment. After reviewing some important illustrations of culture's impact on diagnosis in the VA, the article identifies points in the VA disability claims process where veterans' advocates who are aware of and educated in their clients' cultural backgrounds and identities may advocate for culturally-sensitive psychological diagnosis, disability rating, and treatment.

17. See, e.g., Carolyn Copps Hartley & Carrie J. Petrucci, *Practicing Culturally Competent Therapeutic Jurisprudence: A Collaboration Between Social Work and Law*, 14 WASH. U. J.L. & POL'Y 133 (2004).

18. See, e.g., Tam B. Tran, *Using DSM-IV to Diagnose Mental Illnesses in Asian Americans*, 10 J. CONTEMP. LEGAL ISSUES 335 (1999) (arguing that mental health professionals should begin to use the then recently-developed DSM-IV Cultural Formulation Outline to more accurately assess and diagnose mental health issues in Asian American patients).

I. OVERVIEW OF PSYCHOLOGICAL DISABILITY CLAIMS IN THE VA DISABILITY SYSTEM

A. Disability Compensation Generally¹⁹

Individuals who meet the definition of “veteran” may apply for benefits from the U.S. Department of Veterans Affairs, known as the VA.²⁰ Veterans may file disability claims for physical or psychological disabilities or a combination of both.²¹ Veterans receive “disability compensation” as a benefit when injuries occur on active duty or active service increased the injury.”²²

Benefits compensating a veteran for a disability connected to military service are called “service-connected disability compensation benefits.”²³ Eligible applicants can receive service-connected disability compensation benefits through one of the VA’s two major benefits programs.²⁴

19. This article does not fully educate readers in the VA disability compensation system, but instead highlights a crucial consideration in advocating for veterans within that system; thus, this is a simplification of the many nuances of the VA disability compensation program. For a thorough explanation of VA disability compensation and effective advocacy for veterans filing compensation claims, the author highly recommends the Veterans Benefits Manual published by Lexis Nexis and written by staff at the National Veterans Legal Services Program. VETERANS BENEFITS MANUAL, *supra* note 1.

20. 38 U.S.C. § 101(2) (2006); 38 C.F.R. § 3.1(d) (2011). The definition of “veteran” is “a person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable.” *See also* VETERANS BENEFITS MANUAL, *supra* note 1, at 23–25.

21. A psychological disability claim may be referred to in the VA as a “nervous condition” claim. *See* VETERANS BENEFITS MANUAL § 3.5.1 155 (2011). The authors of the VETERANS BENEFITS MANUAL note the VA often calls mental disorders “nervous conditions” because of the perception that terms like “psychosis, paranoia, or dementia . . . might be offensive.” *See* VETERANS BENEFITS MANUAL, *supra* note 1, at 155, note 665.

22. *VA Disability Compensation*, U.S. DEP’T VETERANS AFF. <http://www.vba.va.gov/bln/21/compensation/index.htm> <http://www.vba.va.gov/bln/21/compensation/index.htm> (last visited Aug. 23, 2012).

23. VETERANS BENEFITS MANUAL, *supra* note 1, at 53.

24. VETERANS BENEFITS MANUAL, *supra* note 1, at 53. The other major benefits program is the non-service-connected disability pension program. Substantially more veterans receive compensation benefits than pension benefits; in fiscal year 2010, 3,181,700 veterans were receiving compensation benefits,

To show basic entitlement to service-connected disability compensation, a veteran must demonstrate that:

- (1) [the veteran was] discharged or released under conditions other than dishonorable [discharge or release],
- (2) [the veteran's] disease or injury was incurred or aggravated in the line of duty, and
- (3) the disability is not a result of [the veteran's] own willful misconduct or abuse of alcohol or drugs.²⁵

If the veteran shows basic entitlement, the veteran must prove the elements for service-connected disability compensation: “a diagnosis of current disability; evidence of in-service occurrence or aggravation of a disease, injury, or precipitating event; and competent evidence of a link or nexus between the in-service occurrence or aggravation of a disease or injury and the current disability.”²⁶

If the veteran satisfies the requirements for compensation, the VA will send the veteran a monthly payment based upon his or her ‘disability “rating.”²⁷ The rating represents an amount the “average citizen” would be impaired by or limited from earning

yet only 310,200 veterans were receiving pension benefits. VETERANS BENEFITS MANUAL, *supra* note 1, at 53.

25. VETERANS BENEFITS MANUAL, *supra* note 1, at 53 (citing 38 U.S.C.S. §§ 101(2), 1110, 1131; 38 C.F.R. § 3.12, 3.4(b)(1), 3.301); 38 U.S.C. § 101(16) (2006); 38 C.F.R. § 3.1(k) (2011); *see also* 38 C.F.R. § 3.303(a) (2011) (“Service connection connotes many factors but basically it means that the facts, shown by evidence, establish that a particular injury or disease resulting in disability was incurred coincident with service in the Armed Forces, or if preexisting such service, was aggravated therein.”).

26. VETERANS BENEFITS MANUAL, *supra* note 1, at 152.

27. VETERANS BENEFITS MANUAL, *supra* note 1, at 54. This monthly disability payment may be increased for a variety of reasons, including if the veteran has a severe disability, qualifying family members, or has special health care or other needs due to severe disabilities. VETERANS BENEFITS MANUAL, *supra* note 1, at 54.

income by the same disability the veteran has.²⁸ “Each disability must be considered from the point of view of the veteran working or seeking work.”²⁹ If the entire record³⁰ results in a reasonable doubt as to the degree of disability, the VA will resolve the doubt in favor of the veteran.³¹

Currently, a veteran with no spouse or children who is rated 100% disabled would receive \$2,816 per month, or \$33,792 per year in disability compensation.³²

If a veteran disagrees with the VBA rating specialist’s decision, the veteran may appeal that decision in a variety of ways, including to the Board of Veterans’ Appeals (BVA), which is the second level of review after the VBA Regional Office where the rating specialist is located.³³ The Veterans’ Judicial Review Act of 1988 (VJRA) established an Article I court, the United States Court of Appeals for Veterans Claims (CAVC), to review BVA decisions; it also provided for limited review of CAVC decisions in the Federal Circuit.³⁴

B. The Compensation & Pension Examination

After a veteran submits a disability claim to the Veterans Benefits Administration (VBA), the veteran is usually required to submit to a medical examination called a Compensation & Pension

28. 38 C.F.R. § 4.1 (2011) (“The percentage ratings represent as far as can practicably be determined the average impairment in earning capacity resulting from such diseases and injuries and their residual conditions in civil occupations”).

29. 38 C.F.R. § 4.2 (2011).

30. 38 C.F.R. § 4.3 (2011); 38 C.F.R. § 3.102 (2011). Section 4.2 requires a rating specialist to review and reconcile “the whole recorded history.”

31. See VETERANS BENEFITS MANUAL, *supra* note 1, at 1001.

32. *Veterans Compensation Benefits Rates Tables*, *supra* note 5. This amount may be increased by a variety of additional payments depending on the veteran’s employability, family situation, and the context of the veteran’s service. For example, a veteran who is considered 100% disabled and has a spouse and one child would receive \$3,088 per month in disability compensation.

33. See *VHA Handbook 1601E.01: Compensation & Pension (C&P) Examinations*, U.S. DEP’T VETERANS AFF., http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2094 (last visited Aug. 23, 2012).

34. See VETERANS BENEFITS MANUAL, *supra* note 1, at 1113—15.

Examination (C&P Examination).³⁵ This examination is most often performed by a physician in the Veterans Health Administration (VHA).³⁶ The VBA will rely heavily on the C&P Examination report in determining how to rate the veteran's disability.

A VBA ratings specialist will request a C&P Examination from the VHA when he is trying to identify a veteran's disability or determine the extent to which a veteran is disabled. In the request, the VBA will list specific disabilities or complaints and symptoms that may be tied to specific disabilities; the C&P examiner must address each listed disability, complaint, or symptom in the report, providing either a diagnosis or a statement that no disability or chronic illness was found connected to the listed complaint or symptom.³⁷

The VBA may request a C&P Examination if the veteran claimant has already been diagnosed with a disability, but the disability has not been rated.³⁸ The rating specialist will then use the report to match the veteran's symptoms with diagnostic criteria to determine the veteran's disability rating.³⁹ Another context when the C&P Examination becomes a factor is if the veteran has submitted a disability claim but has no current diagnosis, or the current diagnosis has yet to be tied to an event, injury, or disease from the veteran's military service.⁴⁰ The VBA may also request a C&P Examination if it needs further medical evidence to determine whether the veteran is basically entitled to disability compensation.⁴¹

35. See *VHA Handbook 1601E.01*, *supra* note 33.

36. See *VHA Handbook 1601E.01*, *supra* note 33, at 1. Depending on the circumstances of the case and how the report is presented, a private physician's report may be accepted in lieu of a VHA physician's report. However, the vast majority of claims for disability compensation must be supported by a C&P Examination performed by a VHA physician.

37. See *VHA Handbook 1601E.01*, *supra* note 33, at 4.

38. See 38 C.F.R. § 3.326 (2011); *VHA Handbook 1601E.01*, *supra* note 33, at 2.

39. See VETERANS BENEFITS MANUAL, *supra* note 1, at 302—303 (generally discussing how medical examinations are used to determine the degree of disability).

40. See *VHA Handbook 1601E.01*, *supra* note 33, at 2.

41. See *VHA Handbook 1601E.01*, *supra* note 33, at 2. This third reason acts as a catchall for the various reasons the VBA may need an examination to determine a claim.

When the C&P Examination is being requested for diagnosis or rating of a psychological disability, the VHA psychiatrist must include specific information in addition to the general evaluative information required for any C&P report. The psychiatrist must provide “[a]n up-to-date brief psychiatric and psychosocial history.”⁴² The psychiatrist must also provide a “5-axis diagnosis utilizing the most recent Diagnostic and Statistical Manual (DSM).”⁴³ The five different axes in DSM-IV are:

Axis I refers to “Clinical Disorders” such as anxiety or schizophrenia and also “Other Conditions That May Be a Focus of Clinical Attention” such as alcohol abuse;

Axis II refers to “Personality Disorders” and “Mental Retardation”;

Axis III refers to “General Medical Conditions” such as diabetes or a heart condition;

Axis IV refers to “Psychosocial and Environmental Problems” such as educational problems, financial problems, unemployment; and

Axis V refers to “Global Assessment of Functioning” (GAF) which is a numerical assessment, on a scale of 1 to 100, of the patient’s overall psychological, social, and occupational functioning.⁴⁴

42. See *VHA Handbook 1601E.01*, *supra* note 33, at 4.

43. See *VHA Handbook 1601E.01*, *supra* note 33, at 4—5. The VHA Handbook notes that a mental health diagnosis is complete only if it is “multi-axial.”

44. See *VETERANS BENEFITS MANUAL*, *supra* note 1, at 155 (citing *AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* 25 (4th ed. 1994) (DSM-IV)).

The different axes were developed to help a clinician organize the different difficulties a patient may be experiencing along with psychiatric symptoms.⁴⁵

C. Rating a Veteran's Psychological Disability

The VBA gatekeeper, called a rating specialist, will evaluate a veteran's claim for a "mental disorder," or psychological disability, using the schedule of ratings for mental disorders found at 38 C.F.R. § 4.130. The schedule of ratings for mental disorders is based on the DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, FOURTH EDITION, OF THE AMERICAN PSYCHIATRIC ASSOCIATION (DSM-IV).⁴⁶ Section 4.130 directs rating agencies to be "thoroughly familiar" with the DSM-IV in order to apply the general rating formula for mental disorders.⁴⁷

A VA rating specialist must evaluate several categories of evidence when rating a mental disorder:

- (1) the frequency of the veteran's psychiatric symptoms;
- (2) the severity of the veteran's psychiatric symptoms;
- (3) how long the veteran's psychiatric symptoms have lasted;
- (4) the length of remissions, if any, in the veteran's psychiatric symptoms; and
- (5) the "veteran's capacity for adjustment" during the times the veteran has been in remission.⁴⁸

45. See VETERANS BENEFITS MANUAL, *supra* note 1, at 155 (describing the multiple axes as "a simple way of organizing, for treatment purposes, the many problems that one person may be experiencing at the same time").

46. 38 C.F.R. § 4.130 (2011); *see also* 38 C.F.R. § 4.125(a) (2011) (providing that "if the diagnosis of a mental disorder does not conform to DSM-IV . . . the rating agency shall return the report to the examiner to substantiate the diagnosis").

47. 38 C.F.R. § 4.130 (2011).

48. 38 C.F.R. § 4.126(a) (2011).

As with physical disabilities, the rating specialist's focus will be on how much the disability limits the veteran's ability to earn income.⁴⁹ In particular, the rating specialist will look for evidence relating to "occupational impairment" and "social impairment."⁵⁰

A rating specialist will place great weight on the C&P Examination report prepared by a VHA psychiatrist. Although the rating specialist may also consider "lay" evidence, including statements from the veteran's family, friends, work supervisors and co-workers, the C&P Examination is considered an expert opinion that carries greater weight, in most cases, than lay opinions.⁵¹ In addition, the rating specialist may consider, if it has sufficient foundation, a medical opinion from a private (non-VA) doctor.⁵²

49. 38 C.F.R. § 4.126(a) (2011).

50. 38 C.F.R. § 4.126(a) (2011). In evaluating mental disorders, the "extent of social impairment" is a specific consideration; however, a rating specialist may not rest an evaluation solely on the extent of the veteran's social impairment. *See* 38 C.F.R. § 4.126(b) (2011).

51. In *Nieves-Rodriguez v. Peake*, 22 VET. APP. 295 (2008), the United States Court of Appeals for Veterans Claims examined the practice of evaluating medical opinions in determining a veteran's disability rating. The Court explained that both a VA physician's opinion (like a private physician's opinion) is "nothing more or less than [an] expert witness [] report" in a disability benefits case and appeal. *Id.* at 302. The Court identified the factors in Federal Rule of Evidence 702 as "guiding factors to be used by the Board in evaluating the probative value of medical opinion evidence." *Id.*

52. *See* *Nieves-Rodriguez v. Peake*, 22 VET. APP. 295 (2008) (noting a private medical expert may submit an opinion with proper foundation if the expert "is informed of sufficient facts upon which to base an opinion relevant to the problem at hand"). The Court in *Nieves-Rodriguez* noted that the VA physician typically reviews, in preparation for the C&P examination, the veteran's "claims file" or "C-file," which includes "all documents associated with a veteran's disability claim, including not only medical examination reports and [service medical records], but also correspondence, raw medical data, financial information, rating decisions of VA regional offices, Notices of Disagreement, such materials pertaining to claims for conditions not currently at issue and, often, Board decisions disposing of earlier claims." *Id.* at 301. Although the veteran in that case argued that the VA was required to provide every physician with the C-file before an examination, the Court held that the file "is not a magical or talismanic set of documents, but rather a tool to assist VA examiners to become familiar with the facts necessary to form an expert opinion to assist the adjudicator in making a decision on a claim." *Id.* at 302-303. The Court acknowledged that a private physician may either review the C-file or obtain "critical medical facts" through other means, and it gave the example of a private physician who has become knowledgeable in the veteran's

II. CULTURE AND MENTAL HEALTH

A. *The Intersection of Culture and Mental Health Generally*

Culture can carry different meanings in different contexts,⁵³ but one common definition is “a set of meanings, behavioral norms, values and practices used by members of a particular society, as they construct their *unique view of the world*.”⁵⁴ It is both learned and distinctive, and it impacts “how we think, how we respond to distress, and how comfortable we are expressing our emotions.”⁵⁵ Not surprisingly, then, culture has been found to impact a person’s psychological identity and experience in a variety of ways, including how an individual experiences mental illness and tells others about symptoms of mental illness, how a clinician interprets an individual’s symptoms, and a clinician’s treatment plan for an individual with mental illness.⁵⁶ In addition, culture may affect an individual’s decision to seek help from mental health professionals in the first place.⁵⁷

Although not wholly dependent on how a patient reports symptoms, psychological measurements are inevitably influenced by the patient’s description of symptoms.⁵⁸ A 2001 Surgeon

complete medical history by “treating the claimant for an extended period of time.” *Id.* at 303.

53. Susan Bryant, the author of *The Five Habits: Building Cross-Cultural Competence in Lawyers*, 8 CLINICAL L. REV. 34, 40 (2001–2002), advocates for a broad definition of culture in the context of developing cross-cultural lawyering. She writes, “[c]ulture is like the air we breathe—it is largely invisible and yet we are dependent on it for our very being. . . . We are constantly attaching culturally-based meaning to what we see and hear, often without being aware that we are doing so.”

54. Juan E. Mezzich, Giovanni Caracci, Horacio Fabrega, Jr. & Laurence J. Kirmayer, *Cultural Formulation Guidelines*, 46 TRANSCULTURAL PSYCHIATRY 383, 384 (2009) (emphasis added); *see also* Sussie Eshun & Regan A.R. Gurung, *Introduction to Culture and Psychopathology*, in CULTURE AND MENTAL HEALTH: SOCIOCULTURAL INFLUENCES, THEORY, & PRACTICE 3 (Sussie Eshun & Regan A.R. Gurung eds., 2009) (discussing several definitions of “culture”).

55. Eshun & Gurung, *supra* note 54, at 4.

56. *Id.* at 4–5.

57. *Id.* at 6.

58. Peter D. Yeomans & Evan M. Forman, *Cultural Factors in Traumatic Stress*, in CULTURE AND MENTAL HEALTH: SOCIOCULTURAL INFLUENCES, THEORY, & PRACTICE 230–231 (Sussie Eshun & Regan A.R.

General's report on culture and mental health acknowledged that "[t]he diagnosis and treatment of mental disorders depend to a large extent on verbal communication between patient and clinician about symptoms, their nature, intensity, and impact on functioning."⁵⁹ Some researchers describe psychiatric assessment as "an interpretation of an interpretation," the first critical level of interpretation being the patient's own translation of feelings, thoughts, and physical symptoms into words.⁶⁰ A patient's cultural identity and background can "profoundly affect[] how medical and mental illnesses are described."⁶¹ And when the patient's translation includes descriptions that don't easily fit into the universal diagnostic criteria for a psychological condition, the patient's symptoms may be mis-measured and the patient inaccurately diagnosed. One example from the DSM-IV is that, while universal diagnostic criteria for major depression focus on mental symptoms, some cultures have been found to describe symptoms of depression using primarily somatic, or physical, complaints.⁶² Another even more specific example comes from the American Indian Hopi tribe; Hopi suffering from major depression have consistently reported being "heartbroken," which is not easily

Gurung eds., 2009) (discussing contextual and cultural factors in how trauma symptoms are reported).

59. Dep't Health & Human Servs., *Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General* 31 (U.S. PUBLIC HEALTH SERVICE, 2001), *available for download at* NCBI, <http://www.ncbi.nlm.nih.gov/books/NBK44243/>.

60. Michelle Christensen, *Diagnostic Criteria in Clinical Settings: DSM-IV and Cultural Competence*, 10(2) AM. INDIAN & ALASKA NATIVE MENTAL HEALTH RESEARCH 52 (2001), *available at* CENTER FOR AMERICAN INDIAN & ALASKA NATIVE MENTAL HEALTH, COLORADO SCHOOL OF PUBLIC HEALTH, <http://www.ucdenver.edu/academics/colleges/PublicHealth/research/centers/CAI/ANH/journal/Documents/Volume%2010/10%282%29.pdf> (last visited Aug. 23, 2012).

61. Richard G. Dudley, Jr. & Pamela Blume Leonard, *Getting it Right: Life History Investigation as the Foundation for a Reliable Mental Health Assessment*, 36 HOFSTRA L. REV. 963, 967—968 (2008) (discussing the use of a "mitigation specialist" in capital defense work to explore a defendant's culture, among other factors, and how that culture impacts the defendant's description and experience of mental illness).

62. Christensen, *supra* note 60 at 53.

translated into any single criterion in the dominant checklist for major depression.⁶³

In addition to influencing particular words a person uses to describe psychological distress, culture may influence the symptoms a person actually admits. Some researchers refer to this as the “social desirability” factor, and describe patients reporting or failing to report symptoms based on their perception of what is socially desirable within their cultures.⁶⁴

The real potential for injustice comes when patients whose cultures heavily influence the way they communicate distress meet clinicians who use a universalist or one-size-fits-all approach to assessment and diagnosis. As a patient may report symptoms differently across cultures, a clinician may interpret what the patient reports differently depending on the clinician’s approach to assessment and diagnosis.⁶⁵ The effect is even more significant

63. *Id.* In *Diagnostic Criteria in Clinical Settings*, Christensen demonstrates that the way a patient translates distress could result in misdiagnosis and ineffective treatment. Her fictitious patient (based on a composite of many American Indian patients suffering from depression) was an enrolled member of the Northern Plains tribe who described being “bored” and “angry.” According to the dominant DSM-IV symptom cluster for major depression, the patient may not have been diagnosed with major depression based on this description. But Christensen showed how, if evaluated in cultural context, the patient’s description could be translated into the dominant criterion of “loss of pleasure or interest” corresponding to major depression. By exploring the patient’s interaction with her community on the Northern Plains reservation, including struggles in her relationships and internal conflict regarding whether to leave the reservation, Christensen showed she may ultimately determine whether the patient was generally bored or whether “boredom” actually described a symptom of depression in the patient’s cultural context.

64. Yeomans & Forman, *supra* note 58, at 232 (“Cultures vary in the extent to which expression of distress is socially sanctioned and reported.”); *see also* Yeomans & Forman, *id.*, at 230 (“Even a carefully translated and then validated measure is still subject to an effect of social desirability in which participants’ responses are influenced by their perceptions of what a favorable answer might be.”).

65. Mezzich, Caracci, Fabrega, Jr. & Kirmayer, *supra* note 54 at 384. This would be the second level of interpretation discussed by Michelle Christensen in *Diagnostic Criteria in Clinical Settings*, *supra* note 60, at 52–53 (“The second level of interpretation is the process by which a clinician . . . translates a client’s translation of his/her internal experience into the language of psychiatry.”).

when the patient and the clinician are from different cultures. The Surgeon General's report on culture and mental health points out:

The emphasis on verbal communication yields greater potential for miscommunication when clinician and patient come from different cultural backgrounds, even if they speak the same language. Overt and subtle forms of miscommunication and misunderstanding can lead to misdiagnosis, conflicts over treatment, and poor adherence to a treatment plan.⁶⁶

A clinician's assessment of a patient may not be as accurate unless the assessment instrument used was either specifically designed to measure a particular symptom in that veteran's culture or was proven to be conceptually equivalent across cultures.⁶⁷

Concepts such as anxiety, depression, aggression, anger, intrusive thoughts, and emotional numbing are central to understanding the psychological response to high-magnitude stressors. These characteristics have different meanings, and their presence has different implications for societies the world over. To assume cross-cultural conceptual equivalence of items measuring these constructs and symptoms surely would lead to mis-measurement of the important concepts related to traumatization in different societies.⁶⁸

A clinician who assesses a patient while ignoring that patient's unique cultural identity risks providing an incomplete picture of the severity of the patient's illness.⁶⁹ Experts in psychometrics, the science of measuring psychological symptoms, agree that most psychological conditions have some universal components that a

66. See Dep't Health & Human Servs., *supra* note 59, at 32.

67. Terence M. Keane, Danny G. Kaloupek & Frank W. Weathers, *Ethnocultural Considerations in the Assessment of PTSD*, in *ETHNOCULTURAL ASPECTS OF POSTTRAUMATIC STRESS DISORDER: ISSUES, RESEARCH, & CLINICAL APPLICATIONS* 188 (Anthony J. Marsella ed., 1996).

68. *Id.* at 188.

69. *Id.* at 186.

person will exhibit regardless of cultural background.⁷⁰ However, if a clinician focuses on only those universal components without regard to potential influence of culture, the clinician's error could be disastrous for the individual patient.⁷¹ In the veterans' disability claim context, the veterans are relying on accurate diagnosis not only as a guide for effective treatment, but also as the foundation for accurate disability ratings, something many of them rely on as a major part of their income.⁷²

Clinicians familiar with variations across and within different cultural groups are better equipped to spot potential factors relevant to diagnosis of clients from those groups.⁷³ A clinician's diagnosis is considered "culturally competent," and therefore more accurate, if the clinician used accepted methods to account for the patient's cultural and ethnic background.⁷⁴ This is known as "culturally-informed diagnosis."⁷⁵

Ideally, the variations form a foundation for more informed diagnosis rather than a box within which a clinician places a minority client.⁷⁶ For example, a clinician may be aware that American Indian fathers or elders often take the role of family

70. Bonnie A. Green, *Culture & Mental Health Assessment*, in *CULTURE AND MENTAL HEALTH: SOCIOCULTURAL INFLUENCES, THEORY, & PRACTICE* 22—23 (Sussie Eshun & Regan A.R. Gurung eds., 2009).

71. Roberto Lewis-Fernandez, *The Cultural Formulation*, 46 *TRANSCULTURAL PSYCHIATRY* 379, 380 (2009).

72. *See* Green, *supra* note 70, at 23 ("A test that fails to properly diagnose a person with depression will result in a person being left untreated with the consequences that follow[.]").

73. FREDDY A. PANIAGUA, *DIAGNOSIS IN A MULTICULTURAL CONTEXT* 3—13 (2001).

74. Mezzich, Caracci, Fabrega, Jr. & Kirmayer, *supra* note 54, at 384.

75. *Id.* at 384.

76. Mezzich, Caracci, Fabrega, Jr. & Kirmayer, *supra* note 54, at 393 ("Stereotyping provides a simplistic and distorted picture of the social and individual aspects of a person and in itself can have negative consequences for mental health."); *see also* Dep't Health & Human Servs., *supra* note 59, at 25—26 ("[G]eneral statements about cultural characteristics of a given group may invite stereotyping of individuals based on their appearance or affiliation. Because there is usually more diversity within a population than there is between populations (e.g., in terms of level of acculturation, age, income, health status, and social class), information [in the report] should not be treated as stereotypes to be broadly applied to any individual member of a racial, ethnic, or cultural group.").

administrator rather than “head” or “authority,” and encourage young people within the community to make their own decisions.⁷⁷ The clinician starting from this place of understanding may explore whether this client’s unique experience within his community or tribe places him in a role of independence and mutual respect rather than submission to an authoritarian figure.⁷⁸ This may then be relevant in exploring the client’s psychology within his family and community and whether external pressures contribute to the client’s symptoms.⁷⁹

B. The DSM-IV Cultural Formulation Outline

The good news is that the DSM-IV already includes a mechanism through which both VA psychiatrists and private psychiatrists can account for cultural factors in a patient’s

77. PANIAGUA, *supra* note 73, at 6 (“Contrary to the Asian and Hispanic families, in American Indian families, the father (or older adult) only administers the family; he does not control the family in the sense of being authoritarian or macho.”).

78. *Id.* at 6. Paniagua describes the difference between the authoritarian figures often seen in Asian families with the administrative figures often seen in American Indian families. Instead of submission to authority, American Indian families tend to value and reward mutual respect among family and tribal members. “Strong family relationship is emphasized, but a sense of independence among family members is rewarded, particularly among American Indian children and adolescents.” *Id.* at 6.

79. Another example is the veteran whose ongoing depression has caused the veteran to lose touch with many family members and isolate himself or herself, but who answers the examiner’s questions about close relationships by describing one close relationship the veteran has been able to maintain. If the examiner is unaware that the veteran’s cultural norms place great emphasis on community, the examiner may report that the veteran has been able to maintain close relationships and shows little social impairment, a factor in determining the severity of psychological disabilities like post-traumatic stress disorder (PTSD). The veteran’s single close relationship is more likely evidence the veteran is isolated from the majority of family and community in a way that may be indicative of significant social impairment in the veteran’s communal culture. See Aaron P. Jackson & Sherri Turner, *Counseling & Psychotherapy with Native American Clients*, in PRACTICING MULTICULTURALISM: AFFIRMING DIVERSITY IN COUNSELING AND PSYCHOLOGY 227 (Timothy B. Smith ed., 2004) (noting, for example, that American Indian communities, although the many independent tribes have different values and belief systems in the specific, are often more “communal” than individualistic majority European American communities).

psychological disability. Although the previous editions of the DSM had little cultural sensitivity, DSM-IV recognizes the importance of a patient's culture to a clinician's diagnosis of psychiatric disorders and provides an outline with which a clinician can construct a complete disability picture including appropriate cultural context.⁸⁰ It also describes potential cultural variations for many specific psychiatric disorders.⁸¹

The DSM-IV Cultural Formulation Outline, a copy of which is reprinted in Appendix A, guides a clinician through an exploration of a patient's cultural identity, including the cultural reference group, language, and other factors in development, involvement with the culture of origin and with the "host" culture.⁸² Next the clinician explores cultural explanations of the veteran's illness, including predominant idioms of distress and local illness categories, the meaning and severity of symptoms in relation to cultural norms, perceived causes and explanatory models, and help-seeking experiences and plans.⁸³ Finally, the clinician explores any cultural factors related to the patient's psychosocial environment and levels of functioning, including social stressors and social supports, and any cultural elements of the clinician-patient relationship.⁸⁴

80. See Christensen, *supra* note 60, at 52 ("DSM-IV now includes a structured outline for gathering such culturally relevant information that encourages clinicians to gather this information more routinely, and provides a systematized means of doing so."); Spero M. Manson, *Mental Health Services for American Indians & Alaska Natives: Need, Use, and Barriers to Effective Care*, 45 CAN. J. PSYCHIATRY 617, 618 (2000) ("The DSM-IV marks a dramatically new level of acknowledgment of culture's role in shaping the symptoms, expression, and course of major mental illness.").

81. Although DSM-IV does not systematically cover cultural variations for every psychiatric disorder, it covers many of the psychiatric disorders prevalent among veterans who have disorders related to trauma. See Christensen, *supra* note 60, at 14—15, 17—18 & Table 2.1 (*Summary of Psychiatric Disorders with Descriptions of Cultural Variations in the DMS-IV*, listing PTSD, Generalized Anxiety Disorder, Major Depressive Disorder, and all subtypes of Adjustment Disorder).

82. See Christensen, *supra* note 60, at 18—20.

83. See *Id.* at 20.

84. See *Id.* at 20—24; see also Theresa D. O'Neill, *Cultural Formulation of Psychiatric Diagnosis: Psychotic depression and alcoholism in an American Indian man*, 22 CULTURE, MEDICINE & PSYCHIATRY 123 (1998).

The purpose of the Cultural Formulation Outline is to guide a clinician through a comprehensive evaluation sensitive to the individualized meaning of the patient's symptoms.⁸⁵ A clinician's use of the Cultural Formulation Outline will result in a "more thorough evaluation" of the patient's unique illness and the severity of the patient's symptoms.⁸⁶ In contrast, when a busy clinician does not explore a patient's "sociocultural context" and take a more idiographic (individualized), rather than nomothetic (decontextualized), approach to the initial assessment, the resulting assessment and diagnosis may not accurately calibrate the severity of the patient's symptoms.⁸⁷

The bad news is that, despite its importance to accurate diagnosis of patients with diverse cultural backgrounds, the DSM-IV Cultural Formulation Outline is not widely used by clinicians. Even clinicians' "awareness of the availability of the Cultural Formulation has remained limited."⁸⁸ Proponents of the Cultural Formulation criticized its placement in the Appendix rather than the main axes of DSM-IV, predicting clinicians may be less aware it existed in the back of the manual.⁸⁹ Studies have shown that even clinicians who are aware of the Cultural Formulation may not use it in practice because of the time it takes during an initial assessment.⁹⁰ In addition, clinicians may believe accounting for cultural variables adds a layer of complexity to the diagnostic process that "might seem only to complicate an already arduous

85. See Lewis-Fernandez, *supra* note 71, at 380 ("The point of the Cultural Formulation is precisely that it asks clinicians to operationalize a more thorough evaluation of the sociocultural context in which illness experience is embedded.").

86. See *Id.*

87. See *Id.* ("Without this systematic contextual assessment, the meaning of much of patients' illness behavior—including valid calibration of their symptom severity—may elude a busy provider, increasing the risk of clinical mismanagement and of patient dissatisfaction, nonadherence, and poor treatment response.").

88. Mezzich, Caracci, Fabrega, Jr. & Kirmayer, *supra* note 54, at 385.

89. See Christensen, *supra* note 60, at 18 ("[P]lacing the Cultural Formulation in Appendix I would suggest to many clinicians that they are not required to consider cultural variants during the assessment of the case using the *DSM-IV*.").

90. See Lewis-Fernandez, *supra* note 71, at 379—380.

task” of formulating a patient’s case.⁹¹ In fact, observations of groups of clinicians who are aware of the Cultural Formulation Outline in the DSM-IV show it is underutilized in initial client evaluations.⁹²

The main goal of psychiatric diagnosis is to make a patient’s clinical care more effective. With effective treatment as the end goal, a clinician explores a patient’s cultural and ethnic background and experiences to encourage “an effective and helpful doctor–patient relationship.”⁹³ “Beyond issues of reliability, cultural factors play a central role in the validity and usefulness of diagnosis to fulfill its key purpose—the optimization of clinical care.”⁹⁴ Experts in DSM-IV’s Cultural Formulation Outline contemplate a comprehensive evaluation of a patient’s social and cultural “identity”⁹⁵ that includes more than just one patient interview.⁹⁶ After a clinician interviews the patient, the next source of relevant cultural information is the patient’s family, then others familiar with the patient’s culture, and finally even further exploration of background information about the patient’s culture.⁹⁷

This comprehensive evaluation is crucial to the clinician’s understanding of how to manage the patient’s condition through

91. Lisa R. Fortuna, Michelle V. Porche & Margarita Alegria, *A Qualitative Study of Clinicians’ Use of the Cultural Formulation Model in Assessing Posttraumatic Stress Disorder*, 46(3) *TRANSCULTURAL PSYCHOLOGY* 429, 443 (2009).

92. *See Id.* at 445 (“While it is highly encouraging that clinicians are willing to consider culture, it is also clear that the components of the Cultural Formulation are generally underutilized or used inconsistently in the initial evaluation.”).

93. Mezzich, Caracci, Fabrega, Jr. & Kirmayer, *supra* note 54, at 384.

94. *Id.*

95. In the context of transcultural psychiatry, social and cultural “identity” is defined as: “(1) the patient’s conception of their place in the world in which they live (e.g., their location in the network of roles and relationships that make up their personal, social and spiritual world) and (2) the meaning, rationale, or mode of operation of the world, the self, other and persons in general (e.g., the ideas, concepts, values or doctrines that make the patient’s world a meaningful one to them); and the symbolic systems and meanings that the patient uses in relation to specific communities, nations of origin, or ethnic groups.” *Id.* at 390—91.

96. *Id.* at 391.

97. *Id.*

treatment.⁹⁸ A clinician typically uses all of the information gathered during an assessment to diagnose and move into further treatment. “Performing a cultural formulation of illness requires of the clinician to translate the patient’s information about self, social situation, health, and illness into a general biopsychosocial framework that the clinician uses to organize diagnostic assessment and therapeutics.”⁹⁹ In this way, the Cultural Formulation Outline is designed to have “practical value.”¹⁰⁰

In the civilian world, a clinician looks at diagnosis with treatment and a patient’s improved functionality as the main objective; the clinician and patient are often developing a long-term relationship. But, in the VA disability system, clinicians are required to diagnose for a different reason. A VA psychiatrist’s diagnosis will either support or defeat a veteran’s application for disability compensation. As with other administrative inquiries, “[a] favorable review leads to the disbursement of cash or other benefits.”¹⁰¹ The VA psychiatrist is therefore diagnosing the veteran for an administrative purpose rather than a therapeutic purpose.¹⁰²

Since a clinician may not be considering treatment and improved functionality during the isolated initial assessment, the question becomes what role the Cultural Formulation takes in this context. The Cultural Formulation is designed to be a narrative, individualized assessment of a patient exploring the unique context within which that patient experiences psychological distress. This is all done with “accountability” to the patient who will presumably continue in treatment and expect therapeutic

98. See Lewis-Fernandez, *supra* note 71, at 379—380.

99. Mezzich, Caracci, Fabrega, Jr. & Kirmayer, *supra* note 54, at 391.

100. See Lewis-Fernandez, *supra* note 71, at 379—80 (“[A] long and complex Cultural Formulation that is mainly of scholarly interest and will not be implemented in actual practice is of little practical value.”).

101. See Harvey D. Lomas & Jonathan D. Berman, *Diagnosing for Administrative Purposes: Some Ethical Problems*, 17(4) SOC. SCI. MED. 241, 241 (1983). Veterans who are found to have service-connected disabilities may also be eligible for housing and insurance benefits, like adapted housing grants and mortgage life insurance. See *Compensation*, U.S. DEP’T VETERANS AFF., <http://www.benefits.va.gov/compensation/> (last visited Feb. 12, 2013).

102. See Lomas & Berman, *supra* note 101, at 241—42 (acknowledging the differences between a physician’s diagnosis for therapeutic reasons and a physician’s diagnosis for purposes of disbursing public funds).

progress.¹⁰³ Because the VA psychiatrist in a C&P Examination is diagnosing for administrative purposes, the Cultural Formulation would be relevant to that psychiatrist only to the extent it may impact the information used to complete the C&P claims process.

However, even though VA Compensation and Pension examiners are not likely to continue treating a veteran, the Cultural Formulation Outline will lead to a more comprehensive and accurate diagnosis during a C&P Examination. It has the potential to change or significantly impact the examiner's application of the DSM-IV diagnostic criteria. This, in turn, might change the disability rating a VBA gatekeeper assigns based on the examiner's diagnosis. If it results in a more accurate initial rating, it could help a veteran avoid a lengthy appeal process.¹⁰⁴ In addition, it may contribute information relevant to a patient's further treatment, including the doctor-patient relationship between the veteran and future treating doctors in the VA healthcare system. So it is vitally important for an advocate to press for a culturally-informed diagnosis in the early stages of a veteran's claim that will lead to an appropriate disability rating and subsequent treatment plan. Alternatively, an advocate who enters a veteran's disability claim at a later stage or on appeal should press for a culturally-informed review of the entire mental health record that will lead to either a reopened claim or an increased disability rating that more appropriately compensates the veteran.

103. See *Id.* at 242 (noting that diagnosis for administrative purposes lacks "therapeutic intent and accountability").

104. The VBA Transparency Program, known as "ASPIRE," shows the VBA takes, on average, 272.5 days to complete a compensation claim that requires a disability rating. See *ASPIRE-Benefits*, U.S. DEP'T OF VETERANS AFF., available at <http://www.app.hospitalcompare.va.gov/index.cfm> (last visited Feb. 12, 2013). The Board of Veterans Appeals' Annual Report to Congress in 2011 showed the average time between filing an appeal with the Board and the Board's ultimate disposition of the appeal was 883 days. See *Report of the Chairman*, BD. OF VETERANS APPEALS, 18, available at http://www.bva.va.gov/docs/Chairmans_Annual_Rpts/BVA2011AR.pdf (last visited Feb. 12, 2013). If a claim is sent back to the VA, the Appeals Management Center takes, on average, 313.6 days to complete the claim. See *ASPIRE-Benefits*, U.S. DEP'T OF VETERANS AFF., available at <http://www.app.hospitalcompare.va.gov/index.cfm> (last visited Feb. 12, 2013). Adding each of these phases results in an over four-year process to reach a final decision on an appealed and remanded compensation claim.

C. Culture and Mental Health at the VA

Researchers have long urged VA Compensation and Pension examiners to use culturally-informed clinical assessment procedures that fully explore potential cultural factors in psychological disabilities.¹⁰⁵ One of the disabilities most prevalent among combat veterans, Posttraumatic Stress Disorder (PTSD), is a combination of psychological symptoms associated with exposure to trauma, including witnessing or surviving violence.¹⁰⁶ Researchers have repeatedly emphasized that concepts related to major trauma can carry different meaning across groups.¹⁰⁷ Nearly twenty years ago, the National Center for Post-Traumatic Stress Disorder, a research facility within the Department of Veterans Affairs, discovered a higher incidence of PTSD among ethnocultural minorities, as well as cultural variations in the way veterans express symptoms of PTSD and other anxiety and depressive disorders.¹⁰⁸ VA researchers noted data showing “individuals from non-Western cultural traditions often fail to present classical symptoms of [anxiety and depressive disorders].”¹⁰⁹ They concluded from this data that “it is quite possible that ethnocultural minority veterans suffering from PTSD and related disorders may be wrongly diagnosed and inappropriately treated.”¹¹⁰ The data supporting these conclusions has persisted for decades.¹¹¹

105. Anthony J. Marsella, Claude Chemtob & Roger Hamada, *Ethnocultural Aspects of PTSD in Vietnam War Veterans*, 1(2) Nat'l Ctr. for Post-Traumatic Stress Disorder Clinical Newsletter, Fall 1990, at 3 (“Many questions used in clinical tests and interviews . . . are inappropriate in content for assessing ethnocultural minorities and thus do not accurately index problems that may be present.”); *see also* Keane, Kaloupek & Weathers, *supra* note 67, at 183 (rejecting a single-instrument approach to diagnosing and assessing PTSD across different cultures).

106. *See* Fortuna, Porche & Alegria, *supra* note 91, at 430.

107. Keane, Kaloupek & Weathers, *supra* note 67 at 188.

108. *See* Marsella, Chemtob & Hamada, *supra* note 105, at 3. The National Center for PTSD was created in 1989 and placed within the Department of Veterans Affairs. *See History of the National Center for PTSD*, U.S. DEP'T OF VETERANS AFF., *available at* http://www.ptsd.va.gov/about/mission/history_of_the_national_center_for_ptsd.asp (last visited Aug. 30, 2012).

109. *See* Marsella, Chemtob & Hamada, *supra* note 105, at 3.

110. *See Id.*; *see also* Fortuna, Porche & Alegria, *supra* note 91, at 443 (“[There is data showing that culture and race-specific stressors impact the

One of the diagnostic criteria for PTSD is social impairment. “Social impairment” can mean different things to people from different cultural backgrounds and experiences.¹¹² The way a veteran expresses his experiences within his social structure may be interpreted as asymptomatic of social impairment. For example, a veteran asked about his relationships with family and friends may respond by describing one close relationship with his brother and his interactions with co-workers each day. Translated into appropriate cultural context, that veteran’s experiences may reveal measurable social impairment. A clinician may view the veteran’s ability to maintain one or two close friends as evidence of social *health*, but the same description may be important evidence of social *impairment* when the clinician considers that the veteran comes from a culture in which substantial community connection and rich social interaction is the norm.¹¹³ The more socially impaired a veteran is at the time of diagnosis, the higher that veteran’s disability rating may be.

Even though research has revealed the clear impact of culture on accurate mental health diagnoses, decisions of the U.S. Court of Appeals for Veterans Claims and the Board of Veterans’ Appeals show little discussion or analysis of culture and mental health in the disability claims context. This may be at least in part because self-represented veterans and veterans’ advocates alike do not often highlight cultural factors in veterans’ psychological disability claims and appeals.

A review of Board of Veterans’ Appeals decisions shows one decision that illustrates the power of culture in adjudicating a veteran’s psychological disability claim. In 1995, the Board of Veterans’ Appeals reopened a finally denied claim from a Texas

development of PTSD and its chronicity, as well as its symptomatic presentation.”).

111. See, e.g., Fortuna, Porche, Alegria, *supra* note 91, at 443–444 (noting data showing a clinicians’ failure to account for “race-related stressors” may result in the clinician disregarding up to “20% of PTSD symptoms”).

112. See Spero M. Manson, *Ethnographic Methods, Cultural Context, and Mental Illness: Bridging Different Ways of Knowing and Experience*, 25(2) ETHOS 249, 251–252 (1997).

113. See Manson, *Ethnographic Methods*, *supra* note 112, at 251–52; see also Keane, Kaloupek & Weathers, *supra* note 67, at 188.

veteran for a “psychiatric disability.”¹¹⁴ After being discharged from the military, the veteran had filed a claim for psychiatric disability connected to his service in the Army from 1953 to 1956. During his enlistment, the veteran had been seen at the service medical facilities for “nervousness,” vision troubles, and general inability to eat or sleep. He was referred to a psychiatric examiner against his will after he reported, presumably at a service clinic, that he was under an “evil spell” from his wife that had made him impotent and that he was seeing a palmist about the issue. The medical corps psychiatric examiner diagnosed the veteran with a personality disorder (schizoid personality) and described him as a “primitive, superstitious, schizoid, unstable individual” who was “useless to the service” and beyond rehabilitation; the diagnosis did not evaluate the typical criteria for a personality disorder.¹¹⁵ The veteran was separated from the service based on this diagnosis, and he then tried to obtain compensation for this psychiatric disability. The VA ultimately denied the veteran’s claim because of the personality disorder diagnosis; personality disorders are considered “congenital” or “developmental” and are not compensable disabilities in the VA system.¹¹⁶ Over 40 years later, the veteran petitioned to have his denied claim reopened on the basis of new and material evidence, specifically his many medical encounters for “nervousness” since he was separated from the service and denied disability compensation.¹¹⁷ In deciding

114. BVA Docket No. 92-05 460 (1995), *available at* BD. OF VETERANS’ APPEALS, <http://www.index.va.gov/search/va/bva.html> (search by case number 9503179). According to Rule 1303 of the Board of Veterans’ Appeals Rules of Practice, Board decisions are not binding except in the specific case decided. 38 C.F.R. § 20.1303 (2011) (noting that prior Board decisions “may be considered in a case to the extent that they reasonably relate to the case”).

115. The Board of Veterans’ Appeals decision recounts the independent medical expert’s letter many years later that discredited the original diagnosis of personality disorder, noting that “[d]espite the diagnosis, there is no documentation in this examination of the gradual manifestation of withdrawal from social relationships, indifference to the praise or criticism of others, and flattened emotional responsiveness which have characterized this personality disorder for the almost 40 years since this diagnosis was recorded on the appellant.”

116. *See* VETERANS BENEFITS MANUAL, *supra* note 1, at 158—59 (citing 38 C.F.R. § 3.303(c), 4.9, 4.127 (2011)).

117. A claimant may reopen a previously-denied if the claimant can present “new and material evidence.” 38 C.F.R. § 3.156(a) (2011) (“New

whether to reopen, the Board of Veterans' Appeals requested an independent medical examination. This was when the veteran's cultural background finally took center stage.

The independent medical expert, reviewing the veteran's diagnoses and medical records from service, explained that the DSM-IV, unavailable in the 1950's when the veteran was in service but available now to aid in reviewing the veteran's medical records, contained an "Outline for Cultural Formulation and Glossary of Culture-Bound Syndromes." The expert noted that one particular culture-bound syndrome, "rootwork," included an interpretation of illness as a "hex" or "witchcraft" or "evil influence" from another person; this fit with the veteran's complaints that led to a diagnosis of personality disorder. Most importantly, the expert noted that culture-bound syndromes like rootwork can "overlap with conventionally understood psychiatric disorders" but actually exist in people viewed as mentally healthy in their culture. The service medical examiner had misinterpreted the veteran's description of his symptoms and use of alternative treatments as "psychosis" related to a "schizoid" personality disorder, but had ignored the veteran's actual "chronic and severe anxiety symptoms" that started during service. The expert stated: "The sequence of a commanding officer unable to understand the appellant's feeling that he was under a spell [and] the officer's revulsion and disapproval at the practice of consulting a non-'professional' practitioner . . . was probably not unusual at the time."

Ultimately, the expert suggested that the diagnosis of personality disorder, which barred the veteran from receiving disability compensation for a psychiatric disorder, was not justified by the record and "may have been due to a cultural misunderstanding." Instead, the expert opined that the veteran suffered from generalized anxiety disorder that manifested during service and persisted for 40 years. The Board of Veterans' Appeals accepted the expert's opinion as "highly probative" due to his detailed reconciliation and explanation of the personality disorder

evidence means existing evidence not previously submitted to agency decisionmakers. Material evidence means existing evidence that, by itself or when considered with previous evidence of record, relates to an unestablished fact necessary to substantiate the claim.").

diagnosis; it reopened the veteran's claim and granted service connection for generalized anxiety disorder.

This is not the only Board of Veterans' Appeals decision in which culture was raised. Board decisions mentioning culture show cases in which culture was simply acknowledged, with no apparent impact on the veteran's diagnosis;¹¹⁸ cases in which culture appears to have delayed or confused accurate diagnosis;¹¹⁹ cases in which the veteran's culture was explored in psychiatric assessment and considered by the Board increasing a veteran's disability rating;¹²⁰ and cases in which culture became a factor

118. *See, e.g.*, BVA Docket No. 07-00 573 (2012), *available at* BD. OF VETERANS' APPEALS, <http://www.index.va.gov/search/va/bva.html> (search by case number 1202272) (veteran was diagnosed with explosive personality disorder, and examiner noted the veteran "had a long history of physical assaultiveness and that he had a need for physical violence, which was deeply ingrained in his Chicano-cultural value of machismo).

119. *See, e.g.*, BVA Docket No. 10-16 510 (2011), *available at* BD. OF VETERANS' APPEALS, <http://www.index.va.gov/search/va/bva.html> (search by case number 1139589). In this case out of Texas, the veteran, who was noted as being "culturally diverse," was seen by mental health professionals several times in service due to "odd behavior and poor performance." During service, the psychiatric examiners "were unable to determine an appropriate diagnosis" and speculated that the veteran "could just be a very odd individual, but have no acquired psychiatric disability." A psychiatrist who assessed the veteran while she was in service "speculated that her presentation could be due to cultural diversity and/or childhood abuse." After she left the service, the veteran was diagnosed with schizophrenia.

120. *See* BVA Docket No. 05-34 352 (2009), *available at* BD. OF VETERANS' APPEALS, <http://www.index.va.gov/search/va/bva.html> (search by case number 0921235). This case out of Montana involved an American Indian veteran diagnosed with PTSD by a psychologist at his Tribe's Social Services office. The psychologist noted in his report that he had acknowledged the veteran was suffering from significant internal conflict, even though the veteran was unable to speak freely about that conflict. "[I]t is not a cultural practice for the Veteran to talk openly about feelings and internal conflict, but this was not [to] be interpreted as a lack of internal conflict." Another private counselor further explored the veteran's American Indian background and role as a part-time tribal veterans representative. She noted that, although the veteran was reluctant to speak of his traumatic experiences, he opened up about those experiences as a tribal veterans representative when he could "speak of them in his native language with fellow veterans." *See also* BVA Docket No. 06-01 766 (2007), *available at* BD. OF VETERANS' APPEALS, <http://www.index.va.gov/search/va/bva.html> (search by case number 0727172) (accepting the veteran's evidence from his son-in-law's testimony and private

supporting a lower disability rating because it explained symptoms that otherwise would have been evidence of a more significant psychological disability as normal within the veteran's culture.¹²¹ The Board has also remanded cases for new psychiatric examinations with specific instructions to the examiner to consider the veteran's cultural background.¹²² At a minimum, these decisions show that the Board will consider culture as a factor in a

treating physician's statement that the "veteran's cultural background as a Native American interfered with his ability to talk about his PTSD . . . [and] [t]herefore, he was incorrectly rated a lower evaluation").

121. *See, e.g.*, BVA Docket No. 07-10 359 (2010), *available at* BD. OF VETERANS' APPEALS, <http://www.index.va.gov/search/va/bva.html> (search by case number 1042930). In this case out of the VA Regional Office in San Juan, the Commonwealth of Puerto Rico, the veteran had long experienced hallucinations "of a religious nature" and heard voices calling him to be a prophet. The veteran's treating psychiatrist, who also lived in that area, explained that "followers of the Pentecostal church in San Juan experience religious hallucinations as part of their spiritual culture," and the symptoms should not be viewed as evidence of psychosis. The Board relied on this opinion to keep the veteran's disability rating for service-connected depressive disorder at 50 percent. It reasoned that "[t]he general rating formula for mental disorders refers to 'persistent delusions or hallucinations' under the criteria for a 100 percent disability rating . . . [but] given the . . . examiner's opinion that the hallucinations are manifestations of his cultural/religious beliefs rather than his mental disorder, the Board finds that the evidence most closely approximates a 50 percent rating." *See also* BVA Docket No. 06-19 821 (2008), *available at* BD. OF VETERANS' APPEALS, <http://www.index.va.gov/search/va/bva.html> (search by case number 0811920) (denying an increased disability rating for schizophrenia after dismissing the veteran's "persistent hallucinations in the form of seeing, feeling, and hearing dead people" as a normal part of the veteran's Puerto Rican culture, noting the veteran "claims to be a spiritualist, and communication with the dead appears to be a part of his belief system").

122. *See, e.g.*, BVA Docket No. 06-06 094 (2009), *available at* BD. OF VETERANS' APPEALS, <http://www.index.va.gov/search/va/bva.html> (search by case number 0928121). In this case out of Seattle, Washington, the veteran alleged in the Board proceedings that the VHA psychiatric examiner had treated him with "cultural insensitivity with civil rights overtones" and "failed to take into account the Veteran's American Indian heritage and culture, and the effect of that heritage and culture on the Veteran's presenting posttraumatic stress disorder symptomatology." Although the Board did not find the record support the veteran's claim of cultural insensitivity in the examination, it remanded for a new psychiatric examination. The Board directed the new examiner to specifically "include an assessment of the impact of the Veteran's American Indian heritage and culture on his presenting psychiatric symptomatology."

veteran's psychological disability claim, particularly if an expert opinion evaluates how culture impacts the diagnosis of or severity of the veteran's psychological disability.

In all the Board's decisions mentioning the veteran's culture, the 1995 Texas case has the most thoroughly-reasoned consideration of cultural factors in a veteran's psychological disability claim. It demonstrates both the profound consequences of misdiagnosis due to cultural misunderstanding, and the power of a thorough exploration of cultural factors in diagnosing a veteran's psychological disability. The Board of Veterans' Appeals requested the independent medical examination in that case, but an advocate could pursue the same in a case that involved similarly-significant cultural factors. Either way, the consideration of cultural as a factor could dramatically alter the outcome of a veteran's disability claim.

III. ADVOCATING FOR CULTURALLY-INFORMED ASSESSMENT, TREATMENT, AND COMPENSATION IN THE VA SYSTEM

As advocates for veterans with psychological disability claims, we can be truly effective only if we are aware of how important a veteran's culture is to psychological assessment and treatment. Culturally-informed representation is critical at every stage of the claim and appeal process.

*A. Improve Personal Cultural Awareness*¹²³

Improving our own awareness of cultural and ethnic factors in the mental health context will improve advocacy at all stages of representation in the VA system. Just as mental health clinicians must be aware of their own cultural and ethnic identity to

123. Some critics of cultural competency approaches to lawyering argue that a focus on cultural competency "raises a real risk of further perpetuating stereotypes." See Andrew King-Ries, *Just What the Doctor Ordered: The Need for Cross-Cultural Education in Law Schools*, 5:1 TENN. J. L. POL'Y 27, 51 (2009) (citing Janelle S. Taylor, *Confronting "Culture" in Medicine's "Culture of No Culture"*, 78 ACAD. MED. 555, 555 (2003)). This article attempts to remain sensitive to this risk by advocating for improved cultural awareness in advocacy for clients of all perspectives and being mindful that "culture is something that belongs to and shapes everyone." See King-Ries, *supra*, at 51—52.

accurately assess veterans,¹²⁴ lawyers representing diverse veterans should also educate themselves about how their own culture and ethnicity has shaped them so they are aware of their potential ethnocentric points of view or cultural biases. Clinicians studying culture and mental health recommend considering the following factors:

- (1) the cultural influences of the dominant society;
- (2) the cultural identity and background of the practitioner;
- (3) the institutional culture of the hospital, clinic, or other setting where diagnosis and treatment are delivered; and
- (4) the professional cultures of biomedicine and psychiatry.¹²⁵

We must embark on a similar self-evaluation at the early stages of representation, considering our own cultural identities and backgrounds, what influences our understanding of our clients' cultural and ethnic groups, and the institutional and professional culture in which our clients will be assessed, including both the legal profession and the VA.

B. Conduct a Culturally-Sensitive Initial Client Interview

Veterans' advocates should appreciate the importance of culture to the psychological context in the earliest stages of representation. The DSM-IV Cultural Formulation, reprinted in Appendix A, though designed for use by mental health professionals, offers a good starting point for constructing a culturally-sensitive initial client interview. Advocates aware of the outline could use it to construct a series of interview questions designed to elicit information about the veteran's cultural identity

124. See Mezzich, Caracci, Fabrega, Jr. & Kirmayer, *supra* note 54, at 391 ("Culture may be significant not only for the content, values, meanings, and practices of patients and families, but also for understanding the clinician's point of view.").

125. See Mezzich, Caracci, Fabrega, Jr. & Kirmayer, *supra* note 54, at 391—92.

or cultural reference groups, “stresses in the local social environment and the role of religion and kin networks in providing emotional, instrumental, and information support,” and any difficulties the veteran has had or may have in communicating with clinicians (e.g., language difficulties).¹²⁶

Advocates should also explore the veteran’s history of mental health treatment both inside and outside of the VHA system. The veteran’s cultural background may have affected whether and how often the veteran accessed mental health and other medical services, regardless of symptomatology.¹²⁷ Exploring the veteran’s personal history of treatment or lack of treatment and inquiring into the reasons for not seeking treatment, not seeking treatment as often as needed, or seeking treatment from non-traditional practitioners can lead to crucial information demonstrating the veteran’s illness was ongoing since service despite the absence of significant care.¹²⁸ For example, in a 2008 Board of Veterans’ Appeals decision out of San Diego, California, the Board noted the veteran’s treating physician’s opinion that “the veteran did not complain of symptoms in psychological terms or seek treatment for them at least partially out of a sense of shame and guilt commonly seen and perceived in his ethnic culture.” Based on the physician’s opinion and the veteran’s supporting lay

126. See DSM-IV, *infra* note 148, at Appendix I (*Outline for Cultural Formulation*) (reprinted in Appendix A).

127. See Dep’t Health & Human Servs., *supra* note 59, at 25 (“Cultural misunderstandings between patient and clinician, clinician bias, and the fragmentation of mental health services deter minorities from accessing and utilizing care and prevent them from receiving appropriate care.”).

128. This may be an important consideration in a psychological disability case, particularly if the diagnosis came after the veteran was discharged from service. See 38 C.F.R. §§ 3.303(b), (d) (2011); see also VETERANS BENEFITS MANUAL, *supra* note 1, at 119 (“Under the continuity provisions of § 3.303(b), service connection may be granted where ‘a disease manifests itself during service (or during the presumptive period) but is not identified until later, there is a showing of continuity of symptomatology after discharge, and medical evidence relates the symptomatology to the veteran’s present condition.’” (quoting *Rose v. West*, 11 VET. APP. 169, 171 (1998))); VETERANS BENEFITS MANUAL, *supra*, at 160 (“As with any other service-connected disability claim, in addition to a diagnosis of current disability, the veteran will need evidence that the mental disorder was incurred in or aggravated by military service and evidence that links the mental disorder to service as described in Sections 3.3 and 3.4 [of this Manual].”).

witness statements describing his symptoms since service, the Board held the veteran had demonstrated “a continuity of symptomatology from active service to present,” and granted service connection for an acquired psychiatric disorder.¹²⁹

In addition, an advocate should inquire into the veteran’s familial structure, looking broader than just biological family to the extended “family” that may include community elders or leaders and friends close to the family but not related by blood.¹³⁰ This could expand the list of witnesses who may be able to provide supportive observations of the veteran’s day-to-day symptoms, information about the veteran’s culture, and at times even comparative observations between the veteran’s culture and neighboring or surrounding cultures to illustrate potential cultural variables relevant to diagnosis.¹³¹

For example, an advocate may first construct the family tree, and then ask the client for a list of any other individuals the client goes to for advice or considers an authority to consult in making decisions.¹³² All of these individuals are potential witnesses who could inform and contribute to an advocate’s initial

129. BVA Docket No. 06-00 318 (2008), *available at* BD. OF VETERANS’ APPEALS, <http://www.index.va.gov/search/va/bva.html> (search by case number 0818114). An advocate planning to argue that the veteran did not seek traditional medical or psychiatric treatment since service for cultural reasons will need to sufficiently support this argument with evidence showing the veteran was still suffering from symptoms of the diagnosed mental illness or had sought non-traditional treatment. The Board of Veterans’ Appeals has rejected this argument when it has been unsupported by additional evidence. *See, e.g.*, BVA Docket No. 07-37 965A (2009), *available at* BD. OF VETERANS’ APPEALS, <http://www.index.va.gov/search/va/bva.html> (search by case number 0911261) (rejecting advocate’s apparently unsubstantiated argument that the veteran’s “cultural practices” prevented him from seeking medical treatment for his breathing symptoms and required him to use natural remedies instead); BVA Docket No. 04-16 203 (2008), *available at* BD. OF VETERANS’ APPEALS, <http://www.index.va.gov/search/va/bva.html> (search by case number 0827374) (rejecting a veteran’s claim that she had not sought treatment for depression because of her “Midwestern culture” when her record had no supporting lay or medical evidence to show she had been suffering from symptoms of depression since service).

130. *See* Christensen, *supra* note 60, at 4—5.

131. *See id.* at 5—6.

132. *See id.* (discussing *familism* and *extended family* network as critical cultural variables to consider in mental health diagnosis).

materials submitted with the claim and thus help the VHA C&P Examiner accurately assess the veteran and the VBA gatekeeper's accurately rate the veteran's disability. If the veteran's claim has already been denied, the advocate may find in these witnesses someone who can offer new and material evidence about the influence of culture on the veteran's disability that may be enough to meet the standard of reopening the claim.

C. Gather Culturally-Relevant Supportive Evidence

As the advocate gathers supportive evidence to support a claim, the advocate should also consider how evidence about the veteran's cultural and ethnic identity may help inform future psychological assessment. In order to gather reliable evidence about the veteran's cultural identity and background for this purpose, an advocate may consider involving an individual intimately familiar with the veteran's cultural background who could inform culturally-appropriate development of the veteran's claim. This type of consultant may be referred to as a "culture broker."¹³³ Culture brokers may be professional clinicians or leaders in the veterans' communities who can speak to both "(1) the health values, beliefs, and practices within [the culture broker's and veteran's] cultural group or community and (2) the health care system that they have learned to navigate effectively for themselves and their families."¹³⁴

Assessment from a civilian psychiatrist with experience or a specialty in multicultural mental health assessments may also provide crucial evidence in a case involving strong cultural factors. Richard G. Dudley, Jr., and Pamela Blume Leonard have constructed a checklist of factors to consider when selecting a mental health expert with ethno-cultural competence in the context of capital trials. This checklist could inform veterans' advocates selecting a private mental health expert to assess a veteran with psychological disability claim that has potentially-significant cultural factors:

133. The National Center for Cultural Competence at Georgetown University Center for Child and Human Development describes a culture broker as one who serves as an intermediary by "bridging the cultural gap by communicating differences and similarities between cultures." *See* Nat'l Ctr for Cultural Competence, *Bridging the Cultural Divide in Health Care Settings: The Essential Role of Cultural Broker Programs* 3 (2004).

134. *See* Nat'l Ctr for Cultural Competence, *supra* note 133, at 3.

Does [the expert] understand the ethno-cultural context of the information gathered?

Can the expert effectively engage, communicate with, and form a working relationship with a person of the defendant's ethno-cultural group . . . ?

Does [the expert] have the capacity to integrate what we know about the impact of ethnicity and culture on human behavior into what we know about the behavioral sciences?

Does the expert employ ethno-culturally appropriate theories and empirical data when rendering opinions?¹³⁵

With culture becoming a central focus in many medical training facilities, including medical schools, finding private physicians with these qualifications should only get easier in the coming decade.¹³⁶ In addition to providing a private psychiatrist with the veteran's entire VA claims file (known as a C-file), including the veteran's treatment records from service,¹³⁷ the advocate could ask the private psychiatrist to specifically apply the Cultural Formulation Outline and address potential cultural factors the

135. See Dudley & Leonard, *supra* note 61, at 978—79.

136. See Lynn M. Morgan, "Life Begins When They Steal Your Bicycle": Cross-Cultural Practices of Personhood at the Beginnings and Ends of Life, 34 J.L. MED. & ETHICS 8, 8 (2006) ("[M]edicine has recently discovered culture. Culture is the rage in medical schools and hospitals across the country, as manifested in the explosion of programs designed to teach what is called 'cultural competence.'").

137. The VETERANS BENEFITS MANUAL includes exhaustive advice on presenting a private mental health assessment that will be acceptable to the VBA rating specialist. See VETERANS BENEFITS MANUAL, *supra* note 1, at Section 17.6.5.2. It warns that the VA often discredits private medical and mental health opinions when the physician did not have access to or did not review the veteran's entire claims file. VETERANS BENEFITS MANUAL, *supra*, at 1449 ("When balancing positive and negative medical opinions, the VA tends to discredit the positive opinion if the physician providing the positive opinion did not review the veteran's claims file or at least his or her service treatment records (STRs).").

advocate identified in the initial client interview or that have been raised with past treating psychiatrists.¹³⁸

D. Advocate for Culturally-Informed Diagnosis within the VA

VA regulations recognize that an “accurate and fully descriptive medical examination []”¹³⁹ is a necessary pre-condition to accurate application of the VA disability rating schedule. Thus, a veteran’s lawyer should advocate for a culturally-competent C&P Examination as early as possible in the claim process.¹⁴⁰

After a veteran has been assessed by a C&P Examiner, the veteran’s advocate may review that clinician’s report through the lens of cultural factors the advocate knows, through research and perhaps the assistance of a culture broker, to be crucial to accurate calibration of the severity of the veteran’s disability. At least, an advocate should immediately note whether the Examiner explored potential cultural factors with the veteran using the Cultural Formulation Outline. If the report includes no apparent exploration of potential cultural factors, and the diagnosis (or lack of diagnosis) seems erroneous as a result, to the veteran’s disadvantage, the advocate may call attention to the error before the VBA rating specialist.¹⁴¹ Submitting evidence and

138. An advocate using the VETERANS BENEFITS MANUAL will find a thorough description of how to prepare for a private medical assessment, including points to include in a cover letter sent to the private medical expert. *See* VETERANS BENEFITS MANUAL, *supra* note 1, at Section 17.6.5. In addition, the MANUAL includes a sample cover letter to a medical expert requesting a medical opinion. VETERANS BENEFITS MANUAL, *supra*, at Appendix 17-C. This article proposes that veterans’ advocates should consider including in such a letter information on potential cultural factors in the veteran’s mental illness and a specific request that the medical expert apply the Cultural Formulation Outline in the DSM-IV.

139. 38 C.F.R. § 4.1 (2011).

140. This will, again, help prevent unnecessary appeals and remands, which result in veterans waiting many years for final decisions on their claims. *See* VETERANS BENEFITS MANUAL, *supra* note 1 (discussing the average number of days it takes for the VA and BVA to decide claims at various stages).

141. *See* VETERANS BENEFITS MANUAL, *supra* note 1, at 158 (“Advocacy Tip . . . If the veteran’s symptoms differ significantly from the DSM-IV criteria, and the advocate believes that the veteran is disadvantaged by the diagnosis, the advocate should consider requesting the VA to schedule another mental examination, and, if practical, suggest that the veteran obtain an independent medical diagnosis from a private physician.”).

supplemental information about potential cultural factors in the veteran's situation at this time could cause the VBA rating specialist to appropriately return the clinician's report as "inadequate for evaluation purposes."¹⁴²

E. Advocate for Culturally-Appropriate Treatment in the VA

Advocates may also consider whether cultural factors should influence the veteran's ongoing treatment. One concrete example of how crucial culturally-appropriate treatment may be to a veteran's ongoing quality of life comes from American Indian culture groups. Research in American Indian tribes has shown that a person's ties to traditional ways or cultural involvement, also known as enculturation, could predict the person's resilience in difficult life circumstances or psychological distress.¹⁴³ This includes various connections to tribal culture-like traditional health practices.¹⁴⁴ Traditional health practices are found to "buffer" stress and improve a person's coping skills.¹⁴⁵ If an American Indian veteran follows traditional ways, a treatment plan should encourage and incorporate traditional health practices to improve the veteran's resilience in living with a psychological disability; because alienation from traditional ways has been linked to mental health risks, some researchers suggest careful assessment of the extent to which an American Indian patient engages in and identifies with the traditional culture of his or her tribe in formulating an appropriate treatment plan.¹⁴⁶ This example

142. 38 C.F.R. § 4.2 (2011) ("If a diagnosis is not supported by the findings on the examination report or if the report does not contain sufficient detail, it is incumbent upon the rating board to return the report as inadequate for evaluation purposes.").

143. Carrie Winderowd, Diane Montgomery, Glenna Stumblingbear, Desi Harless & Kaycie Hicks, *Development of the American Indian Enculturation Scale to Assist Counseling Practice*, 15(2) American Indian and Alaskan Native Mental Health 1, 1—2 (2008).

144. *See Id.* at 2 ("Prominent among the resiliency factors were traditional cultural and spiritual practices; ethnic pride/enculturation; and communal mastery leading to higher life satisfaction, more adversarial growth, and lower levels of psychological distress.").

145. *See Id.* 2 (also listing identity attitudes, enculturation, and spiritual coping as "cultural buffers" to stress).

146. *See Id.* at 4 (recognizing that "[e]ach tribe has its own unique characteristics and ways of life, which must be respected in any generalized measurement result").

illustrates how advocating for a treatment plan that integrates traditional health practices for a veteran who shows a high level of enculturation rises to the level of an “ethical priority.”¹⁴⁷

CONCLUSION AND FUTURE CONSIDERATIONS

In the VA system, the psychiatrist (examining the veteran for an administrative purpose) and the rating specialist (rating the veteran’s disability based on the psychiatrist’s report) are the gatekeepers who hold the keys to the veteran’s compensation for a service-connected psychological disability. A veteran must be able to effectively communicate with these gatekeepers; this will lead the veteran into the right “line” to receive the “envelope” that most appropriately compensates the lost ability to earn an income. Communication between the veteran and the medical examiner is a truly pivotal part of the veteran’s claim, and advocates aware of how culture impacts this communication will be more effective in getting their veteran clients into the right line. An advocate fully informed of potential cultural factors in a veteran’s case will make the veteran’s cultural identity a part of the record early in the claim process; in doing so, the advocate will help the veteran obtain more accurate and appropriate diagnosis, rating, and treatment.

APPENDIX A

DSM-IV-TR Diagnostic and Statistical Manual of Mental Disorders

Appendix I

*Outline for Cultural Formulation*¹⁴⁸

The DSM-IV-TR asks the clinician to summarize, in narrative, his or her findings in each of the categories below.

Cultural identity of the individual. Note the individual’s ethnic or cultural reference groups. For immigrants and ethnic

147. *See id.* at 3.

148. Reprinted from psychiatry online DSM Library, available at <http://psychiatryonline.org/content.aspx?bookid=22§ionid=1886266> (last checked August 2012).

minorities, note separately the degree of involvement with both the culture of origin and the host culture (where applicable). Also note language abilities, use, and preference (including multilingualism).

Cultural explanations of the individual's illness. The following may be identified: the predominant idioms of distress through which symptoms or the need for social support are communicated (e.g., "nerves," possessing spirits, somatic complaints, inexplicable misfortune), the meaning and perceived severity of the individual's symptoms in relation to norms of the cultural reference group, any local illness category used by the individual's family and community to identify the condition (see "Glossary of Culture-Bound Syndromes" below), the perceived causes or explanatory models that the individual and the reference group use to explain the illness, and current preferences for and past experiences with professional and popular sources of care.

Cultural factors related to psychosocial environment and levels of functioning. Note culturally relevant interpretations of social stressors, available social supports, and levels of functioning and disability. This would include stresses in the local social environment and the role of religion and kin networks in providing emotional, instrumental, and informational support.

Cultural elements of the relationship between the individual and the clinician. Indicate differences in culture and social status between the individual and the clinician and problems that these differences may cause in diagnosis and treatment (e.g., difficulty in communicating in the individual's first language, in eliciting symptoms or understanding their cultural significance, in negotiating an appropriate relationship or level of intimacy, in determining whether a behavior is normative or pathological).

Overall cultural assessment for diagnosis and care. The formulation concludes with a discussion of how cultural considerations specifically influence comprehensive diagnosis and care.

Sane Solutions to the Crazy Lack of Mental Health Care within Prisons

LEO CASELLI*

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The medical well-being of prison inmates is frequently litigated in federal courts.¹ The United States Supreme Court, in a

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1. See William H. Danne, Jr., Annotation, *Prison Conditions as Amounting to Cruel and Unusual Punishment*, 51 A.L.R. 3d 111, 118 (1973)

line of cases beginning in the 1970s, has set guidelines for medical health care in prisons.² However, the Court has not explicitly addressed the issue of mental health care in prisons.³ This has led to a confusing series of decisions in lower courts.⁴ As a result, mentally ill prisoners often go untreated or endure shocking conditions.

This article examines the current, broken state of mental health care within prisons. One major problem is the unnecessarily high bar to § 1983 actions brought under the Eighth Amendment by mentally ill prisoners.⁵ Another issue is the common lack of training in mental health care for prison staff, which provides an unfair liability shield for their actions.⁶ And perhaps the most critical problem is the widespread lack of mental health care in

Supp. 2012) (“[M]ost landmark decisions in the medical care area have involved suits against state prison officials under the Civil Rights Act.”).

2. See *Estelle v. Gamble*, 429 U.S. 97, 106 (1978) (holding that prison officials violate the Eighth Amendment when they show deliberate indifference to the medical needs of prisoners); *infra* notes 21–40 and accompanying text (describing several decisions about prisoners’ rights).

3. See *infra* notes 60–73 and accompanying text (describing how prisoners have a right to necessary medical care).

4. See *infra* notes 44–59 and accompanying text (noting widely divergent standards for constitutionally adequate mental health care among lower courts).

5. See *infra* notes 74–140 and accompanying text (discussing several problems with the “deliberate indifference” standard); 42 U.S.C. § 1983 (2006) (providing for civil actions alleging deprivations of constitutional rights) [hereinafter § 1983]. Claims of mistreatment by pretrial detainees are generally brought under the Due Process Clause of the Fifth and Fourteenth Amendments, rather than the Eighth Amendment’s Cruel and Unusual Punishments Clause. See *Bell v. Wolfish*, 441 U.S. 520, 535–36 (1979) ([U]nder the Due Process Clause, a detainee may not be punished prior to an adjudication of guilt in accordance with due process of law.”) (citation omitted) (footnote omitted); *infra* notes 11–20 and accompanying text (discussing the scope and effect of the Eighth Amendment). Such claims are outside the scope of this article’s discussion of prisoner’s rights to medical and mental health care treatment under the Eighth Amendment.

6. See *infra* notes 76–101 and accompanying text (explaining how a lack of psychological training for prison officials prevents necessary mental health care).

most prison systems, exacerbated by overcrowding and underfunding.⁷

This article also examines possible solutions to the disturbing lack of mental health care within state and federal prisons. One proposed solution is judicial adoption of mental health guidelines developed by a federal district court in *Ruiz v. Estelle*.⁸ Refinement of the current “deliberate indifference” standard for § 1983 claims is also justified under Eighth Amendment jurisprudence.⁹ Courts would be well-served by an objective standard of reasonableness, rather than requiring subjective indifference to an inmate’s mental health needs.¹⁰

BACKGROUND

Evolving Standards of Decency

The Eighth Amendment to the United States Constitution prohibits cruel and unusual punishments.¹¹ Black’s Law Dictionary defines “cruel and unusual punishment” as “punishment that is torturous, degrading, inhuman, grossly disproportionate to the crime in question, or otherwise shocking to the moral sense of the community.”¹² The Court’s initial interpretations of the Eighth Amendment arose in the context of actual physical torture. *Wilkerson v. Utah*,¹³ decided in 1895, described several

7. See *infra* notes 103–26 and accompanying text (discussing how our criminal justice system effectively “criminalizes” the mentally ill).

8. See *Ruiz v. Estelle*, 503 F. Supp. 1265, 1339 (S.D. Tex. 1980) (describing a detailed set of guidelines to determine constitutionally adequate mental health care within prisons), *aff’d in part, rev’d in part*, 679 F.2d 1115 (5th Cir. 1982), *amended in part, vacated in part*, 688 F.2d 266 (5th Cir. 1982); *infra* notes 213–21 and accompanying text (arguing for broad application of the *Ruiz* guidelines).

9. See *infra* notes 141–83 and accompanying text (noting several problems with the “deliberate indifference” standard).

10. See *infra* notes 184–202 and accompanying text (discussing why the United States Supreme Court should require objective reasonableness with regards to inmates’ mental health needs).

11. U.S. CONST. amend. VIII (mandating that “nor cruel and unusual punishments [be] inflicted.”). Many state constitutions contain similar provisions. See, e.g., WYO. CONST. art. 1 § 14 (providing that “nor shall cruel or unusual punishment be inflicted”).

12. BLACK’S LAW DICTIONARY 582 (3d Pocket ed. 2006).

13. *Wilkerson v. Utah*, 99 U.S. 130 (1878).

unconstitutionally barbarous punishments: (1) being burned alive; (2) being disemboweled then beheaded; and (3) being dragged by horses to the place of execution.¹⁴ In a subsequent case, Justice Edward Douglass White reiterated how the Eighth Amendment prohibits inhumane, barbarous punishments.¹⁵

In *Trop v. Dulles*, the Court followed suit, describing how “[t]he basic concept underlying the Eighth Amendment is nothing less than the dignity of man.”¹⁶ *Trop* also laid out the “evolving standards of decency” framework for Eighth Amendment claims.¹⁷ With this framework, courts look to contemporary standards of morality and decency in their interpretation of the Eighth Amendment.¹⁸ Even prisoners are entitled to Eighth Amendment protection, as they “retain the essence of human dignity inherent in all persons.”¹⁹ Soon after *Trop*, the Court clarified that the Eighth Amendment applies to the states through the Fourteenth Amendment.²⁰

Medical Care for Prisoners

The Eighth Amendment first arose in the context of medical care for prisoners in the late 1970s. In *Estelle v. Gamble*, a Texas inmate was seriously injured after a bale of cotton fell on him.²¹ A medical assistant checked the inmate for injuries and found none.²² The inmate’s pain became severe and he followed up with several visits with a prison doctor.²³ The inmate was given pain pills in lieu of treatment, and refused to perform his prison

14. *Id.* at 136.

15. *Weems v. United States*, 217 U.S. 349, 411 (1910) (White, J., dissenting).

16. *Trop v. Dulles*, 356 U.S. 86, 100 (1958).

17. *Id.* at 101 (“The [Eighth] Amendment must draw its meaning from the evolving standards of decency that mark the progress of a maturing society.”).

18. *See, e.g., Roper v. Simmons*, 543 U.S. 551, 560–61 (2005) (describing how the analysis of sentencing proportionality is guided by evolving standards of decency).

19. *Brown v. Plata*, 131 S. Ct. 1910, 1928 (2011).

20. *Danne, supra* note 1, at 123 (“The Eighth Amendment is applicable to the states through the due process clause of the Fourteenth Amendment.” (citing *Robinson v. California*, 370 U.S. 660, 666 (1962))).

21. *Estelle v. Gamble*, 429 U.S. 97, 98–99 (1976).

22. *Id.* at 99.

23. *Id.* at 99–100.

work duties due to continued pain.²⁴ As a result, a prison disciplinary committee placed the inmate in solitary confinement.²⁵ He subsequently filed suit under § 1983 alleging cruel and unusual punishment in violation of the Eighth Amendment.²⁶

The *Gamble* Court first discussed the elementary principles behind the Cruel and Unusual Punishments Clause (“the Clause”), including: (1) the Framers’ intent to prohibit barbarous punishments; (2) the broad concepts of decency and dignity embodied within the Clause; and (3) how “evolving standards of decency” guide interpretation of the Clause.²⁷ The Court ultimately held the Eighth Amendment prohibits deliberate indifference to the medical needs of prisoners:

We therefore conclude that deliberate indifference to serious medical needs of prisoners constitutes the “unnecessary and wanton infliction of pain,” proscribed by the Eighth Amendment. This is true whether the indifference is manifested by prison doctors in their response to the prisoner’s needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed. Regardless of how evidenced, deliberate indifference to a prisoner’s serious illness or injury states a cause of action under s [sic] 1983.²⁸

Gamble also describes how simple negligence is insufficient to state a § 1983 claim.²⁹ “Deliberate indifference” is the key inquiry—medical malpractice alone does not rise to the level of a constitutional violation.³⁰

24. *Id.* at 100.

25. *Id.* at 101.

26. *Id.*

27. *See id.* at 102–03 (discussing several “elementary principles” in Eighth Amendment jurisprudence) (citations omitted).

28. *Id.* at 104–05 (footnote omitted) (citation omitted).

29. *See id.* at 105–06 (describing how a physician’s negligent act is not a cognizable ground for relief under § 1983).

30. *Id.* at 106 (“Medical malpractice does not become a constitutional violation merely because the victim is a prisoner.”).

The ambiguity in the *Gamble* Court's "deliberate indifference" language led to problems.³¹ *Gamble* provided the basic framework, but failed to clarify whether this was a subjective or objective standard.³² Following *Gamble*, a circuit split developed over this very issue.³³ For example, the United States Circuit Court of Appeals for the Seventh Circuit "applied an objective standard...when the risk of harm was substantial."³⁴ The Eleventh Circuit, on the other hand, described deliberate indifference as actual, subjective intent on the part of prison officials.³⁵ Eventually, the Court resolved this definitional issue with its holding in *Farmer v. Brennan*.³⁶

Farmer defined "deliberate indifference" as a subjective standard.³⁷ A prison official must be subjectively indifferent to a prisoner's serious medical needs—including conscious disregard of a substantial risk of harm.³⁸ The *Farmer* Court also reiterated that simple negligence could not amount to deliberate indifference under the Eighth Amendment.³⁹ In sum, a two-prong test has developed under the *Gamble* line of cases: (1) subjective indifference; (2) to a prisoner's serious medical needs. The first prong is subjective, whereas the second prong is objective. Courts

31. See Lori A. Marschke, Note, *Proving Deliberate Indifference: Next to Impossible for Mentally Ill Inmates*, 39 VAL. U. L. REV. 487, 512 (2004) ("[T]he [Gamble] Court failed to clearly define what constitutes deliberate indifference.").

32. *Gamble*, 429 U.S. at 116 (Stevens, J., dissenting) (discussing whether or not the Court set forth a subjective test with its "deliberate indifference" standard).

33. Marschke, *supra* note 31, at 512.

34. *Id.* (citing *Wilks v. Young*, 897 F.2d 896, 898 (7th Cir. 1990)).

35. *Id.* (citing *LaMarca v. Turner*, 995 F.2d 1526, 1535–36 (11th Cir. 1993)).

36. *Id.*; see *Farmer v. Brennan*, 511 U.S. 825, 828 (1994) ("This case requires us to define the term 'deliberate indifference,' as we do by requiring a showing that the official was subjectively aware of the risk.").

37. *Farmer*, 511 U.S. at 828 ("This case requires us to define the term 'deliberate indifference,' as we do by requiring a showing that the official was subjectively aware of the risk.").

38. See *id.* at 836 ("It is, indeed, fair to say that acting or failing to act with deliberate indifference to a substantial risk of serious harm to a prisoner is the equivalent of recklessly disregarding that risk.").

39. See *id.* at 834 (describing how a lack of due care is insufficient to show culpability).

look to several factors in determining a serious medical need: (1) the perception of a reasonable doctor or patient; (2) chronic pain; and (3) and whether the condition greatly affects daily life.⁴⁰

A LACK OF GUIDANCE FOR MENTAL HEALTH ISSUES

Many § 1983 actions brought by prisoners under the Eighth Amendment involve a denial of medical care.⁴¹ Courts often assume, *sub arguendo*, that conditions of confinement such as medical care are actionable through the Clause.⁴² However, the Court has never specifically addressed the issue of prisoners' rights to mental health treatment.⁴³ Indeed, there is a confusing morass of decisions from the lower courts in this area.

Lower Courts' Treatment of Mental Health Care in Prisons

The following cases help illustrate some of the divergent standards for mental health care within prisons. In the first case, *In re Pinaire*, a Texas prisoner filed a pro se habeas corpus petition seeking his release based on cruel and unusual punishment.⁴⁴ Nervousness and other pathological defects had plagued the prisoner throughout his life.⁴⁵ At some point during his confinement, he was wrapped in a massive cold pack that covered his whole, nude body.⁴⁶ It permitted no movement and also led to some degree of sensory deprivation.⁴⁷ The *Pinaire* court recognized the severity of this "treatment", but nonetheless denied the petition for habeas corpus, deferring to the discretion of the prison doctor.⁴⁸ At the time of this decision, the early 1940s,

40. SHELDON H. NAHMOD, ET AL., CONSTITUTIONAL TORTS 156 (3d ed. 2010).

41. See Danne, *supra* note 1, at 117 (describing medical care as the "most frequently litigated area" in assertions of cruel and unusual punishment).

42. *Id.* at 123.

43. Marschke, *supra* note 31, at 503.

44. *In re Pinaire*, 46 F. Supp. 113, 113 (N.D. Tex. 1942).

45. *Id.*

46. *Id.*

47. See *id.* (describing the effects of the treatment).

48. See *id.* at 114 ("I am not prepared to say that a cold pack...is not a real physical torture to such as have a horror of cold...but some latitude must be given the thoughtful and careful physicians who are in charge of these places and who have found beneficial results from such treatment...").

similarly horrific forms of treatment such as electroshock therapy were not uncommon.⁴⁹

Another case, *Kendrick v. Bland*, presents equally shocking facts but a very different result. In *Kendrick*, a group of mentally disturbed inmates were placed within the general population of the Kentucky State Penitentiary.⁵⁰ The assigned prison guards had not received “adequate, or apparently any, training in dealing with mentally disturbed inmates.”⁵¹ The mentally disturbed inmates were often beaten by guards for their erratic behavior.⁵² One emotionally disturbed inmate was repeatedly struck in his face and torso, and then kicked down a set of stairs.⁵³

Kendrick held these conditions at the century-old prison were unconstitutionally barbarous.⁵⁴ Not only did the guards’ training fall short of constitutional standards, but the brutal beatings also contravened contemporary standards of decency.⁵⁵ Some of the treatment of mentally inmates was not physically barbarous, but still constituted the “wanton infliction of pain” prohibited under the Eighth Amendment.⁵⁶ The court went on to implement “strict guidelines...necessary to prevent past abuses from occurring in the future.”⁵⁷

The preceding two cases exemplify the widely divergent standards for prisoners’ mental health rights. Prisoners’ rights to *medical* care are frequently litigated in federal courts, with a well-

49. See *id.* at 113 (issuing the decision on July 20, 1942); *Electroshock Therapy, FIGHTING DEPRESSION AND BIPOLAR DISORDER*, <http://www.electroboy.com/electroshocktherapy.htm> (last visited Nov. 23, 2011) (describing the history of electroshock therapy).

50. *Kendrick v. Bland*, 541 F. Supp. 21, 25 (W.D. Ky. 1981) (“The confinement of Special Needs inmates in the same area with other inmates in Cellhouse No. 3...”).

51. *Id.*

52. See *id.* (describing the recurring treatment of inmates).

53. *Id.*

54. See *id.* at 26 (“The operation of the Special Needs Unit as described in the Findings of Fact resulted in the infliction of cruel and unusual punishment in contravention of plaintiffs’ rights under the Eighth Amendment.”)

55. *Id.* (describing how the guards’ lack of training, coupled with frequent beatings, was inconsistent with “evolving standards of decency”) (quotation omitted).

56. *Id.* (quotation omitted).

57. See *id.* at 27–49 (describing, at length, several remedies designed to prevent widespread abuse of mentally disturbed inmates).

developed body of case law.⁵⁸ However, courts lack any clear consensus as to mental health care for prisoners—even “basic minimum standards” of mental treatment.⁵⁹ To date, the Supreme Court has not specifically held whether prisoners have a constitutional right to mental health care.⁶⁰ This lack of guidance is a very real and pressing issue.

Brown v. Plata

The United States Supreme Court recently declined to set any clear standards for the treatment of mentally disturbed prisoners. *Brown v. Plata* involved two separate class actions brought by groups of prisoners within California’s prison system.⁶¹ One group consisted of prisoners with serious mental disorders.⁶² The other group consisted of prisoners with serious medical needs.⁶³ The majority opinion, delivered by Justice Kennedy, described a shocking state of mental health treatment in California prisons.⁶⁴

Due to severe overcrowding, suicidal inmates were often held in small cages—approximately the size of a phone booth.⁶⁵ One psychiatrist described how such an inmate had been caged for almost twenty-four hours, “standing in a pool of his own urine, unresponsive, and nearly catatonic.”⁶⁶ Other mentally disturbed inmates were placed in administrative segregation for months at a

58. See Danne, *supra* note 1, at 118 (“Deprivations relating to inmate health, nourishment, and hygiene have commonly been asserted to constitute cruel and unusual punishment, with the most frequently litigated area being that of medical care.”); *supra* notes 21–40 and accompanying text (discussing the constitutional rights of prisoners to a certain level of medical care).

59. Marschke, *supra* note 31, at 518.

60. Marschke, *supra* note 31, at 503.

61. 131 S. Ct. 1910, 1922 (2011) (“This case arises from serious constitutional violations in California’s prison system...[t]he violations are the subject of two class actions in Federal District Court....”).

62. *Id.* This group, a class of plaintiffs with serious medical disorders, presented the issue of whether overcrowding can lead to an unconstitutional level of mental health care within a prison. Brief of Petitioner-Appellant at 1, *Brown v. Plata*, 131 S. Ct. 1910 (2011) (No. 09-1233), 2010 WL 4817515.

63. *Plata*, 131 S. Ct. at 1922.

64. *Id.* at 1922, 1923–25.

65. *Id.* at 1924.

66. *Id.*

time.⁶⁷ Suicide rates in California prisons were also exceptionally high—nearly double the national average.⁶⁸

The *Plata* Court reiterated how the basic concept behind the Eighth Amendment is “nothing less than the dignity of man.”⁶⁹ The Court ultimately held that a deprivation of prisoners’ basic sustenance, including medical care, constitutes a violation of the Eighth Amendment.⁷⁰ It also held that overcrowding was the “primary cause” of Eighth Amendment violations within California’s prison system.⁷¹ But it failed to specifically hold that prisoners have a constitutional right to mental health treatment.⁷² So although *Plata* was groundbreaking in its release of some forty-thousand prisoners,⁷³ it does not ensure any new rights for prisoners in the area of mental health care.

DELIBERATE INDIFFERENCE: A SHOCKINGLY INADEQUATE STANDARD

The Court should go beyond *Plata*’s narrow holding in the right case and expressly clarify that prisoners have a constitutional right to mental health care under *Gamble*. At least five different Circuits have already done so.⁷⁴ This kind of bright-line rule,

67. *Id.*

68. *Id.*

69. *Id.* at 1928 (“Prisoners retain the essence of human dignity inherent in all persons.” (quoting *Atkins v. Virginia*, 536 U.S. 304, 311 (2002))). *Plata* also failed to define what constitutes “adequate medical care—including whether or not “medical care” encompasses mental health care. *See id.* (discussing how prisoners have a right to adequate medical care).

70. *Id.* (“A prison that deprives prisoners of basic sustenance, including adequate medical care, is incompatible with the concept of human dignity and has no place in civilized society.”).

71. *See id.* at 1922 (“After years of litigation, it became apparent that a remedy for the constitutional *violations* would not be effective absent a reduction in the prison system population.”) (emphasis added).

72. *See id.* at 1925 n.3 (“Because plaintiffs do not base their case on deficiencies in care provided on any one occasion, this Court has no occasion to consider whether these instances in delay—or any other particular deficiency in *medical* care...would violate the Constitution...if considered in isolation.”) (emphasis added).

73. *See id.* at 1928, 1935 (upholding a three-judge court’s release of 38,000–46,000 prisoners).

74. *See Doty v. Cnty. of Lassen*, 37 F.3d 540, 546 (9th Cir. 1994) (“[W]e now hold that the requirements for mental health care are the same as those for

however, is just the first step. Applying *Gamble's* framework to the mental health care of prisoners is problematic—especially proving subjective indifference on the part of prison officials.⁷⁵ Three major problems are unique to the mental health care context: (1) a lack of mental health care training for correctional officials; (2) the resultant “liability shield” for prison officials; and (3) systematic prison overcrowding and budget deficiencies.

Prison Guards as “Gatekeepers” to Necessary Psychiatric Care

First, a lack of mental health training for prison guards presents a major hurdle to the “deliberate indifference” standard. As exemplified by *Kendrick*, this lack of training can lead to horrendous results.⁷⁶ An untrained guard may be unaware of an inmates’ psychological needs, or worse, subject an inmate to severe discipline for perceived misconduct.⁷⁷ The Eighth Amendment was directed primarily at the horrific tortures of the Stuart era—disemboweling, decapitating, drawing and quartering, and the like.⁷⁸ Contemporary treatment of mentally disturbed

physical health care needs.”) (citation omitted); *Torraco v. Maloney*, 923 F.2d 231, 234 (1st Cir. 1991) (“This circuit has recognized that deliberate indifference to an inmate’s serious mental health needs violates the eighth amendment.”); *Smith v. Jenkins*, 919 F.2d 90, 93 (8th Cir. 1990) (describing how an inmate’s right to adequate medical care “extends to an inmate’s mental-health-care needs”) (citation omitted); *Greason v. Kemp*, 891 F.2d 829, 834 (11th Cir. 1990) (“[P]sychiatric care [is] sufficiently similar to medical treatment to bring it within the embrace of *Estelle*.”); *Bowring v. Godwin*, 551 F.2d 44, 47 (4th Cir. 1977) (“We see no underlying distinction between the right to medical care for physical ills and its psychological or psychiatric counterpart.”).

75. See Marschke, *supra* note 31, at 487 (describing how proving subjective indifference is “next to impossible” for mentally disturbed inmates).

76. See *Kendrick*, *supra* notes 50–57 and accompanying text (describing the shocking conditions in a Kentucky prison where guards received no training in psychological issues).

77. See Marschke, *supra* note 31, at 487 (“For an inmate with serious illness...prison guards may simply ignore his cries for help, or even worse, may taunt or abuse him.”).

78. Danne, *supra* note 1, at 130–31. The Stuart era—a period lasting throughout the seventeenth century in England—is perhaps best known for the Court of the Star Chamber. Natalie Kijurna, *Lilly v. Virginia: The Confrontation Clause and Hearsay—“Oh What a Tangled Web We Weave”*, 50 DEPAUL L. REV. 1133, 1139 (2001). This court “employed torture to extort confessions or

prisoners is also horrific—severe beatings, solitary confinement, imprisonment within phone-booth sized cages, and even partial sensory deprivation.⁷⁹ Under the “evolving standards of decency” standard, courts should remain mindful of § 1983 claims alleging this kind of reckless treatment of mentally ill prisoners.⁸⁰

Accordingly, prison administrators should have an affirmative duty to provide psychological training for prison guards. *Gamble* described how an Eighth Amendment violation occurs when prison guards intentionally deny or delay access to medical care.⁸¹ *Farmer* reaffirmed this affirmative duty to provide for the safety of inmates, including necessary medical care.⁸² And “medical care,” according to some courts, includes a psychological component.⁸³ If the Court were to adopt this inclusive definition, prison guards would need training to detect signs of mental illness and refer such prisoners to professionals.

information from the accused.” *Id.* The Star Chamber is particularly infamous for the trial of Sir Walter Raleigh. *Id.*

79. See *supra* notes 44–57, 65–67 (describing several instances of prison conditions for the mentally ill).

80. See *Trop v. Dulles*, 356 U.S. 86, 101 (1958) (“The [Eighth] Amendment must draw its meaning from the evolving standards of decency that mark the progress of a maturing society.”).

81. *Estelle v. Gamble*, 429 U.S. 97, 104–05 (1976).

82. *Farmer v. Brennan*, 511 U.S. 825, 852 (1994) (Blackmun, J., concurring) (“I join the Court’s opinion, because...it sends a clear message to prison officials that their affirmative duty . . . to provide for the safety of inmates is not to be taken lightly.”). *Farmer* also described how, under *Gamble*, prisons must provide necessary medical care. *Id.* at 832–33 (majority opinion).

83. See, e.g., *Torraco v. Maloney*, 923 F.2d 231, 234 (1st Cir. 1991) (“The extension of the eighth amendment’s protection from physical health needs, as presented in *Estelle*, to *mental* health needs is appropriate because, as courts have noted, there is ‘[n]o underlying distinction between the right to medical care for physical ills and its psychological or psychiatric counterpart.”) (citation omitted); *Smith v. Jenkins*, 919 F.2d 90, 93 (8th Cir. 1990) (describing how an inmate’s right to adequate medical care “extends to an inmate’s mental-health-care needs”) (citation omitted); *Greason v. Kemp*, 891 F.2d 829, 834 (11th Cir. 1990) (describing how the constitutional right to medical care includes a similar right to psychological care); *Bowring v. Godwin*, 551 F.2d 44, 47 (4th Cir. 1977) (“We see no underlying distinction between the right to medical care...and its psychological...counterpart.”).

Without such training, proving subjective indifference on the part of prison officials is nearly impossible.⁸⁴ Untrained prison guards often act as the “gatekeepers...who prevent [mentally ill] inmates from getting professional assistance.”⁸⁵ At least one court has described the problem of prison guards acting as gatekeepers to mental health services. In *Dawson v. Kendrick*, psychological evaluations were subject to the approval of a Sheriff’s deputy, who had no training whatsoever in mental health issues.⁸⁶ *Dawson* held that “medical screening by a staff member wholly untrained to detect a physical or mental illness actually amounts to no screening.”⁸⁷ The *Dawson* case provides an excellent example of how prison guards often act as gatekeepers to necessary psychological treatment, barring access to such treatment due to a lack of training.⁸⁸

Farmer’s “Liability Shield” for Prison Officials

In turn, this lack of training for prison guards provides an unfair “liability shield” for their actions.⁸⁹ *Farmer* clarified that a prison official must act with actual, subjective indifference to a prisoner’s serious medical needs.⁹⁰ However, *Farmer* also

84. See Marschke, *supra* note 31, at 528–29 (“[I]n order to establish deliberate indifference, an inmate must prove that prison officials subjectively knew of the inmate’s serious mental health need and chose to ignore it.”).

85. *Id.*

86. *Dawson v. Kendrick*, 527 F. Supp. 1252, 1273 (S.D. W. Va. 1981) (“Psychological testing and evaluations for mental health purposes are performed only when an inmate so requests and only after either the Sheriff or a deputy, neither of whom has any special education in either mental or physical health, has approved the request.”).

87. *Id.*; see Connie Mayer, *Survey of Case Law Establishing Constitutional Minima for the Provision of Mental Health Services to Psychiatrically Involved Inmates*, 15 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 243, 253 (1989) (describing the *Dawson* decision) (citation omitted).

88. See *Estelle v. Gamble*, 429 U.S. 97, 110 (1976) (Stevens, J., dissenting) (describing how guards act as gatekeepers to necessary remedial treatment); NAHMOD, ET AL., *supra* note 40, at 333 (“Failure to train issues often arise in jail suicide cases.”).

89. See Marschke, *supra* note 31, at 529 (“[T]he guards who prevent the [mentally ill] inmates from getting professional assistance are shielded from the liability attached to subjective knowledge.”).

90. *Farmer v. Brennan*, 511 U.S. 825, 837 (1994) (rejecting an objective test for deliberate indifference).

provided a rough outline on how prison officials can avoid liability:

Because, however, prison officials who lacked knowledge of a risk cannot be said to have inflicted punishment, it remains open to the officials to prove that they were unaware even of an obvious risk to inmate health or safety....Prison officials charged with deliberate indifference might show, for example, that they did not know of the underlying facts indicating a sufficiently substantial danger and that they were therefore unaware of a danger, or that they knew the underlying facts but believed (albeit unsoundly) that the risk to which the facts gave rise was insubstantial or nonexistent.⁹¹

These words are especially problematic in the mental health context. Proving subjective, actual knowledge of mental health needs is difficult to say the least.⁹²

Even with an inclusive definition of “serious medical needs”—one that encompasses psychiatric needs—the burden remains unfairly high for mentally ill inmates.⁹³ In the *medical* context, many injuries are “so obvious that even a lay person would easily recognize the need for a doctor’s attention.”⁹⁴ For example, an inmate bleeding from an open wound presents an obvious, serious medical need.⁹⁵ However, recognizing a serious *psychological* need is not so readily obvious. It can be difficult for

91. *Id.* at 844.

92. *Capps v. Atiyeh*, 559 F. Supp. 894, 917 (D. Or. 1982) (“Dealing with the question of whether the inmates have met their burden on this issue [the deprivation of mental health care needs] is more difficult than on the medical care issue.”).

93. *See id.* (describing how it can be difficult for mentally ill inmates to show deliberate indifference to their mental health needs).

94. *Winton v. Bd. of Comm’rs of Tulsa Cnty.*, 88 F. Supp. 2d 1247, 1258 (N.D. Okla. 2000).

95. *See Mayer, supra* note 87, at 250 (describing what constitutes a serious medical need).

an inmate to show the kind of extreme pain prohibited under the Eighth Amendment.⁹⁶

For example, mild to moderate depression does not generally constitute a serious mental illness, whereas paranoia and schizophrenia do.⁹⁷ In addition, prison guards often lack mental health care training and cannot understand the nature of mental illness.⁹⁸ They work to ensure security above all else, resulting in a “constant tension with the vulnerabilities of prisoners who have mental illness.”⁹⁹ The bizarre symptoms of a mental illness may also be seen as misconduct, resulting in discipline or administrative segregation.¹⁰⁰ As such, *Gamble’s* standard of deliberate, subjective indifference proves unworkable in the mental health context.¹⁰¹ It provides an unfair liability shield for correctional officers who are untrained, inexperienced, or simply ignorant of the suffering of mentally disturbed prisoners.

*The “Criminalization” of the Mentally Ill*¹⁰²

The current state of American correctional institutions highlights another important problem with the *Gamble* standard. The United States prison population, well over two million people,

96. See *Gregg v. Georgia*, 428 U.S. 153, 169–73 (1976) (describing how the Eighth Amendment prohibits the “unnecessary and wanton infliction of pain”) (citation omitted); Marschke, *supra* note 31, at 520 (“[I]t is just as unclear what constitutes mental pain according to a court.”).

97. See Mayer, *supra* note 87, at 250–51 (discussing several lower court decisions about serious psychological needs). Mild to moderate chronic depression is also known as dysthymic disorder or dysthymia. See *Dysthymia*, MEDLINEPLUS MEDICAL ENCYCLOPEDIA, <http://www.nlm.nih.gov/medlineplus/ency/article/000918.htm> (last visited March 2, 2013).

98. See Jamie Fellner, *A Corrections Quandary: Mental Health and Prison Rules*, 41 HARV. C.R.-C.L. L. REV. 391, 396–97 (2006) (discussing training of correctional officials in the area of mental health care).

99. *Id.* at 395.

100. See *id.* (describing how mentally disturbed prisoners “often do behave in ways that prison systems consider punishable misconduct”).

101. See Marschke, *supra* note 31, at 490–91 (“[M]entally ill inmates face higher hurdles than physically ill inmates when seeking to remedy an Eighth Amendment violation.”).

102. See Fellner, *supra* note 98, at 393 (“The failure of mental health systems had led to what some have called the criminalizing of the mentally ill.”).

is currently the highest in the world.¹⁰³ More than one percent of Americans are currently incarcerated.¹⁰⁴ The “tough on crime” movement has quadrupled the prison and jail population over the past three decades.¹⁰⁵ Overcrowding and underfunding are rampant throughout state and federal prisons.¹⁰⁶ For example, California’s state prisons are at twice their current capacity overall, with some prisons crowded to three hundred percent of capacity.¹⁰⁷ This overcrowding extends to the judicial system, which has faced “an increasing level of cases challenging the level of health care provided to inmates.”¹⁰⁸

Our incarceration of the mentally ill is especially troubling. According to one commentator, “prisons may now be the largest mental health providers in the United States.”¹⁰⁹ More than half of all U.S. prisoners suffer from some kind of mental illness, in contrast to only ten percent of the general population.¹¹⁰ Some forty percent of adults with mental illness come into contact with

103. Kim P. Turner, Note, *Raising the Bars: A Comparative Look at Treatment Standards for Mentally Ill Prisoners in the United States, United Kingdom, and Australia*, 16 CARDOZO J. INT’L & COMP. L. 409, 415 (2008) (“The U.S. prison population [as of 2008] is the highest in the world at 2,186,230...”). The United States prison population is also the highest per capita in the world. *See id.* (describing prison statistics from various countries).

104. N.C. Aizenman, *New High in U.S. Prison Numbers*, WASH. POST, Feb. 29, 2008, <http://www.washingtonpost.com/wp-dyn/content/story/2008/02/28/ST2008022803016.html>.

105. *See* Fellner, *supra* note 98, at 394 (“These tough-on-crime approaches dominant in U.S. criminal justice policy have resulted in a quadrupling in prison and jail population in three decades.”).

106. *See* Sharon Dolovich, *Strategic Segregation in the Modern Prison*, 48 AM. CRIM. L. REV. 1, 6 (2011) (describing the state of American correctional institutes as “overcrowded, understaffed, volatile, and often violent”). “[B]y the end of 2001, 33 states, the District of Columbia, and the federal system were housing prisoners in jails and other facilities because of overcrowding.” *Id.* at 6, n.30 (citation omitted).

107. Geri Lynn Green, *The Quixotic Dilemma, California’s Immutable Culture of Incarceration*, 30 PACE L. REV. 1453, 1459–60 (2010).

108. Mayer, *supra* note 87, at 243.

109. Fellner, *supra* note 98, at 391.

110. Turner, *supra* note 103, at 415 (describing various statistics compiled by the Department of Justice). *But see* Marschke, *supra* note 31, at 492 (describing how one in six inmates suffers from mental illness, according to the Bureau of Justice Statistics).

the criminal justice system throughout their lives.¹¹¹ The war on drugs has effectively criminalized many populations at risk of mental illness, including alcoholics, drug addicts, and the homeless.¹¹² And this situation is only getting worse.¹¹³

Several cases illustrate the shockingly inadequate provision of mental health care services in our nation's prisons. In *Newman v. Alabama*, some institutions within Alabama's correctional system had no on-site medical personnel whatsoever.¹¹⁴ A single clinical psychologist was available, one afternoon each week, to diagnose and treat approximately 2,400 inmates.¹¹⁵ In *Ramos v. Lamm*, the Colorado state penitentiary experienced over seventy incidents of suicide and self-mutilation in the course of a year.¹¹⁶ "Many, if not all of these incidents could [have been] avoided by placing these inmates in a professionally-administered unit."¹¹⁷ No on-site psychologists or psychiatrists were employed at the prison.¹¹⁸ Other courts have found similar, systematic deficiencies of mental health care within state prison systems.¹¹⁹ Most notably, the *Plata* Court described how overcrowded, unsafe conditions "cause prisoners with latent mental illnesses to worsen and develop overt symptoms."¹²⁰

This kind of overcrowding and underfunding often leads to a lack of psychiatric treatment within prisons. In 2000, nearly ten

111. Turner, *supra* note 103, at 417 ("[T]he National Alliance for the Mentally Ill reports that up to 40 percent of adults who suffer from serious mental illness will come into contact with the U.S. criminal justice system at some point in their lives.").

112. Fellner, *supra* note 98, at 393.

113. *See id.* at 392 ("The proportion of prisoners with mental illness is increasing."); Turner, *supra* note 103, at 416 ("The absolute percentage of mentally ill inmates within the prison system has increased since the 1990s.").

114. *Newman v. Alabama*, 349 F. Supp. 278, 283 (N.D. Ala. 1972) (footnote omitted), *rev'd* 522 F.2d 71 (5th Cir. 1975).

115. *Id.* at 284.

116. Mayer, *supra* note 87, at 255–56 (citing *Ramos v. Lamm*, 485 F. Supp. 122, 144 (D. Colo. 1980)).

117. *Id.* (quotation omitted).

118. *Id.*

119. *See, e.g.*, *Feliciano v. Gonzalez*, 13 F. Supp. 2d 151, 206 (D.P.R. 1998) (finding systematic deficiencies in "staffing, facilities, procedures, and administration"); *Tillery v. Owens*, 719 F. Supp. 1256, 1303 (W.D. Pa. 1989) (finding gross deficiencies of psychiatric staff at a state prison).

120. *Brown v. Plata*, 131 S. Ct. 1910, 1934 (2011).

percent of all state prisons provided no screening for mental illness whatsoever.¹²¹ Prison officials often administer psychotropic medications in lieu of more meaningful treatment, such as individual therapy or group sessions.¹²² This lack of effective treatment, coupled with frequent solitary confinement, often leads to recidivism. Commentators call this effect a “revolving door”, or even a “misery-go-round.”¹²³ Basically, the mentally ill enter the correctional system, receive little or no treatment, and then re-enter the system throughout their lives.¹²⁴ Ultimately, the costs of such recidivism are borne by the taxpayers.¹²⁵ State and federal prisons cost taxpayers about fifty-five billion dollars per year.¹²⁶

Solitary Confinement

The widespread use of solitary confinement presents a special concern with mentally ill prison inmates. Due to perceived misconduct, mentally ill prisoners are disproportionately placed into solitary confinement.¹²⁷ This confinement inevitably results in

121. Marschke, *supra* note 31, at 499.

122. See Fellner, *supra* note 98, at 391 (“[P]oor mental health services leave many prisoners receiving ...inappropriate kinds or amounts of psychotropic medications that further impair their ability to function.”); Mayer, *supra* note 87, at 259 (describing how one court found “the use of medication substituted for meaningful counseling”). The term “mental health care,” used variously throughout this article, would ideally encompass various modalities such as individual therapy and group therapy, suicide prevention, crisis intervention, and psychotropic medication if necessary.

123. Sarah Kerr, *Litigation and Legislation Efforts to Improve Mental Health Treatment for Prisoners in New York State Prisons*, 224 PRISONER LAW 153, 155 (2010) (describing “the effects of isolated confinement on prisoners [as]...a ‘misery-go-round’” (quoting Dr. Stuart Grassian, an expert on solitary confinement)); Turner, *supra* note 103, at 416–17.

124. See Turner, *supra* note 103, at 416 (describing the recidivist tendencies of mentally disturbed inmates); see also *In re RB*, 2013 WY 15, ¶ 44, 294 P.3d 24, 35 (Wyo. 2013) (“Many who suffer from mental illness or addiction never completely vanquish the demons controlling their lives, but instead manage only to hold them at bay for what may be discouragingly brief periods of time.”).

125. Turner, *supra* note 103, at 416.

126. Aizenman, *supra* note 104. At least five states spend as much on corrections as higher education. *Id.*

127. See Kerr, *supra* note 123, at 155 (“Discipline in prison frequently includes punishment with placement into an isolated confinement housing

some form of psychological trauma.¹²⁸ In the late nineteenth century, the United States Supreme Court described its “serious objections” to solitary confinement:

A considerable number of the prisoners fell, after even a short confinement, into a semi-fatuous condition, from which it was next to impossible to arouse them, and others became violently insane; others still, committed suicide; while those who stood the ordeal better were not generally reformed, and in most cases did not recover sufficient mental activity to be of any subsequent service to the community. It became evident that some changes must be made in the system... [T]he system [was] somewhat modified and it is within the memory of many persons interested in prison discipline that some 30 or 40 years ago the whole subject attracted the general public attention, and its main feature of solitary confinement was found to be too severe.¹²⁹

These words, now over a century old, still ring true today.

Modern prisoners placed in solitary confinement experience stark, shocking conditions, including: (1) twenty-three to twenty-four hours a day in small, windowless cells; (2) the lack of radios, television, or contact with other prisoners; and (3) a lack of direct contact with mental health care professionals.¹³⁰ If an inmate attempts suicide to escape the mental torment of prolonged isolation, he may be “stripped naked and thrown into an empty, cold observation cell.”¹³¹ These subhuman conditions dehumanize

area...[d]isproportionately, and inappropriately, filled with the prisoners who suffer from a mental illness.”).

128. *Id.* at 157.

129. *In re Medley*, 134 U.S. 160, 168 (1890) (emphasis added).

130. *See* Fellner, *supra* note 98, at 402 (describing several common characteristics of solitary confinement in prisons across the country); Mayer, *supra* note 87, at 274 (describing a case where capital inmates received limited services from psychologists—the counseling sessions took place at the cell door with armed guards present).

131. Marschke, *supra* note 31, at 488.

a prisoner and eventually destroy his sanity.¹³² Surely this kind of treatment rises to the level of barbarous punishment which so troubled the Framers.¹³³ Punishments like prolonged solitary confinement are so inherently cruel that no crime can ever justify their imposition.¹³⁴

The Need for a New Standard

All of the aforementioned problems highlight the unfairness of the high bar to prison officials' liability set by *Gamble* and its progeny.¹³⁵ Some states have taken steps to exclude mentally disturbed prisoners from solitary confinement.¹³⁶ However, others have increasingly resorted to solitary confinement due to budget constraints and overcrowding.¹³⁷ This represents an overall failure of our society to properly care for its mentally

132. See *Wright v. McMann*, 387 F.2d 519, 526 (2d Cir. 1967) (observing how a prisoner exposed to bitter cold and deprived of basic hygienic needs eventually lost his sanity). A recent article by Drs. Craig Haney and Mona Lynch contains an excellent synopsis of the dire psychological effects of solitary confinement. See generally Craig Haney & Mona Lynch, *Regulating Prisons of the Future: A Psychological Analysis of Supermax and Solitary Confinement*, 23 N.Y.U. REV. L. & SOC. CHANGE 477, 496–535 (1997). Their research indicated that there was “not a single study of solitary confinement wherein non-voluntary confinement that lasted for longer than 10 days failed to result in negative psychological effects.” *Id.* at 531.

133. See *Weems v. United States*, 217 U.S. 349, 411 (1910) (White, J. dissenting) (describing how the Eighth Amendment was directed at the prohibition of barbarous punishments).

134. See Danne, *supra* note 1, at 121 (“[S]ome punishments are so inherently cruel that no offense against society can justify them.”).

135. See *supra* notes 103–126 and accompanying text (discussing our society’s “criminalization” of the mentally ill).

136. Kerr, *supra* note 123, at 157. New Jersey prisons mandate the release of mentally ill prisoners if continued administrative segregation would be harmful. *Id.* The Mississippi Department of Corrections provides both yearly assessments and mental health care for death row prisoners in administrative segregation. *Id.* Wisconsin completely excludes mentally ill prisoners from its “supermax” prisons. *Id.*

137. See *Brown v. Plata*, 131 S. Ct. 1910, 1924 (2011) (“Because of a shortage of treatment beds, suicidal inmates may be held for prolonged periods in telephone-booth sized cages without toilets.”); Fellner, *supra* note 98, at 402 (describing how thirty-six states, along with federal penitentiaries, use super-maximum security prisons for the long-term segregation of disruptive or dangerous prisoners).

disabled citizens. Our society has inappropriately relied on prisons as *de facto* caretakers for the mentally ill.¹³⁸ Prisons, in turn, have failed to provide adequate psychological care for prisoners.¹³⁹ Courts should therefore look beyond *Gamble's* shockingly inadequate standard for § 1983 actions brought by mentally ill prisoners.¹⁴⁰

TOWARDS AN OBJECTIVE REASONABLENESS STANDARD

“[E]ven the vilest criminal remains a human being possessed of common human dignity.”¹⁴¹ Courts should remain mindful of their duty to uphold the constitutional rights of all citizens, including even prisoners.¹⁴² In particular, the United States Supreme Court should abrogate *Farmer* and require objective reasonableness for the mental health care treatment of prisoners.¹⁴³ Chief Justice John Marshall once described how “we must never forget that it is a *constitution* we are expounding.”¹⁴⁴ And our Constitution prohibits any punishment severe enough to be “Cruel and Unusual.”¹⁴⁵ It was never meant to prohibit only the intentional infliction of cruel and unusual punishments.¹⁴⁶ Indeed, objective reasonableness is all too common in other areas of constitutional rights.¹⁴⁷ This new standard would correctly reflect

138. See Turner, *supra* note 103, at 411 (“[P]rison officials are becoming de facto ‘caretakers’ [of the mentally ill].”).

139. See *id.* (“Mental health experts view prisons as toxic environments for the seriously mentally ill because of prison overcrowding.”).

140. See Mayer, *supra* note 87, at 243 (describing how courts shape the minimum level of care required for prison inmates).

141. *Furman v. Georgia*, 408 U.S. 238, 273 (1972) (Brennan, J., concurring).

142. *Plata*, 131 S. Ct. at 1928.

143. See Marschke, *supra* note 31, at 491–92 (arguing the Court should remove *Farmer's* requirement of subjective indifference, in the mental health context).

144. *McCulloch v. Maryland*, 17 U.S. (1 Wheat.) 316, 407 (1819).

145. See U.S. CONST. amend. VIII (“[N]or cruel and unusual punishments inflicted.”); *Furman v. Georgia*, 408 U.S. 238, 274 n.17 (1972) (describing how the severity of a punishment relates to its constitutionality).

146. *Farmer v. Brennan*, 511 U.S. 825, 856 (1994) (Blackmun, J., concurring).

147. See *infra* notes 184–95 and accompanying text (describing how objective reasonableness is commonly applied in civil rights litigation).

the modern trend to prohibit extreme mental cruelty under the Eighth Amendment—rather than physical suffering alone.¹⁴⁸ A more lenient standard would also promote systemic reform of corrections through increased judicial oversight.¹⁴⁹

The True Intent of the Eighth Amendment

The Eighth Amendment was intended to prohibit unspeakable evils carried out by arbitrary monarchs. There is “very little evidence” of the Eighth Amendment’s intent from debates of the First Congress.¹⁵⁰ However, the language of the Cruel and Unusual Punishments Clause was taken directly from the English Bill of Rights of 1689.¹⁵¹ The English Bill of Rights was enacted to prevent “*arbitrary and discriminatory* penalties of a severe nature.”¹⁵² In fact, three chapters of the Magna Carta were devoted to the problem of “ameracements”—excessive and oppressive fines.¹⁵³ The Framers were concerned with torture and oppression in all forms—discrimination, absolutism, and the sheer arbitrariness of an oppressive regime.¹⁵⁴ Nowhere in the debates of the First Congress appears any concern with subjective or deliberate intent alone.¹⁵⁵

Simply put, the Cruel and Unusual Punishments Clause guards against the “abuse of power.”¹⁵⁶ The Framers certainly had concerns with physical torture, but were also mindful of horrific

148. See *infra* notes 175–82 and accompanying text (discussing why prisons are unsuitable environments for the mentally ill).

149. See Fellner, *supra* note 98, at 406 (describing how the subjective indifference standard has “significantly limited...the courts’ ability to order improvements in [mental health] services”).

150. *Furman v. Georgia*, 408 U.S. 238, 258 (1972) (Brennan, J., concurring). In *Furman*, Justice Douglas also described how “the debates of the First Congress on the bill of Rights throw little light on its intended meaning.” *Id.* at 144 (Douglas, J., concurring) (footnote omitted).

151. *Id.* at 242 (citation omitted).

152. *Id.* (citation omitted) (emphasis in original).

153. *Id.* at 243.

154. See *id.* at 255–56 (discussing the Framers’ concerns with absolutism, arbitrariness, and discrimination).

155. See *id.* at 258–64 (Brennan, J., dissenting) (discussing historical debates over the Cruel and Unusual Punishments Clause).

156. *Id.* at 266 (“[The Framers’] predominant political impulse was mistrust of power.”) (quotation omitted).

conditions of confinement due to bureaucratic indifference.¹⁵⁷ Justice Blackmun summed it up quite nicely in his concurring opinion to *Farmer*:

The responsibility for subminimal conditions in any prison inevitably is diffuse, and often borne, at least in part, by the legislature. Yet, regardless of what state actor or institution caused the harm and with what intent, the experience of the inmate is the same. A punishment is simply no less cruel or unusual because its harm is unintended. In view of this obvious fact, there is no reason to believe that, in adopting the Eighth Amendment, the Framers intended to prohibit cruel and unusual punishments only when they were inflicted intentionally.¹⁵⁸

In other words, the Framers were mindful of the atrocities that can result from indifference of all sorts.

Modern courts should similarly remain mindful of horrific conditions that can result from bureaucratic indifference or sheer ignorance. The word “punishment” means “severe, rough, or disastrous treatment.”¹⁵⁹ No culpable state of mind is required.¹⁶⁰ The constitutionality of any given prison condition “should turn on the character of the punishment rather than the motivation of the individual who inflicted it.”¹⁶¹ A mentally disturbed prisoner—for example, one badly beaten and shackled naked to a bedpost—is not any better off because of a guard’s sheer ignorance.¹⁶² The Supreme Court should give effect to the Clause’s proper meaning

157. *Farmer v. Brennan*, 511 U.S. 825, 856 (1994) (Blackmun, J., concurring) (“As Judge Noonan has observed...[The Framers] were also familiar with the cruelty that came from bureaucratic indifference to the conditions of confinement.” (quoting *Jordan v. Gardner*, 986 F.2d 1521, 1544 (9th Cir. 1993) (Noonan, J. concurring))).

158. *Id.* (emphasis added).

159. *Id.* at 854–55 (citing WEBSTER’S NEW INTERNATIONAL DICTIONARY 1843 (2d ed. 1961)).

160. *Id.* at 854 (“‘Punishment’ does not necessarily imply a culpable state of mind on the part of an identifiable punisher.”).

161. *Estelle v. Gamble*, 429 U.S. 97, 116 (1976) (Stevens, J., dissenting).

162. See Marschke, *supra* note 31, at 488–89 (describing the shocking treatment of a mentally disturbed inmate in a Georgia prison).

and abrogate *Farmer's* requirement of subjective indifference towards mentally disturbed prisoners, thereby recognizing that the Eighth Amendment "was not adopted to protect prison officials with arguably benign intentions from lawsuits."¹⁶³

A Modern Trend

The Eighth Amendment is not "static in scope."¹⁶⁴ Rather, it must "draw its meaning from the evolving standards of decency that mark the progress of a maturing society."¹⁶⁵ Early Eighth Amendment jurisprudence focused only on instances of physical torture.¹⁶⁶ Many early courts limited the reach of the Eighth Amendment to physical brutalities—punishments such as "the rack, the thumb-screw, the iron boot, the stretching of limbs, and the like."¹⁶⁷ However, even these early courts recognized the Eighth Amendment's true significance: ensuring the dignity of all human beings by prevention of inhuman punishments.¹⁶⁸

In 1952, the Court changed course with *Trop v. Dulles*.¹⁶⁹ *Trop* struck down a sentence of expatriation, even for the severe crime of wartime desertion.¹⁷⁰ This kind of punishment subjects a prisoner to an unconstitutional level of suffering; "a fate of ever-increasing fear and distress."¹⁷¹ In so holding, the Court signified a new, broader meaning for the Cruel and Unusual Punishments

163. *Farmer*, 511 U.S. at 857 (Blackmun, J., concurring).

164. Danne, *supra* note 1, at 122.

165. *Id.* (quoting *Trop v. Dulles*, 356 U.S. 86, 101 (1958)).

166. *Id.* at 130.

167. *O'Neil v. Vermont*, 144 U.S. 323, 393 (1892) (describing the scope of the Eighth Amendment). The iron boot is a gruesome device—"a pair of horizontal iron plates which tightened around the foot by means of a crank mechanism in order to lacerate the flesh and crush the bones of the foot." *The Boot Torture*, THE MIDDLE AGES WEBSITE, <http://www.middle-ages.org.uk/the-boot-torture.htm> (last visited Nov. 2, 2011). A similar method of torture, foot-roasting over hot coals, was commonly employed during the persecution of the Knights Templar. *Id.*

168. *Furman v. Georgia*, 408 U.S. 238, 258 (1972) (Brennan, J., concurring) ("The true significance of these punishments is that they treat members of the human race as nonhumans, as objects to be toyed with and discarded.").

169. 356 U.S. 86, 101–03 (1958).

170. *Id.* Expatriation is a sentence of banishment from one's home country. A *DICTIONARY OF MODERN LEGAL USAGE* 340 (2d ed. 1995).

171. *Id.* at 102.

Clause. No longer was it confined to physical suffering alone. “[T]he Eighth Amendment may be violated even when the punishment involves *no* physical mistreatment, since the primary principle behind the Amendment is not that a punishment must be painful, but that it must not be degrading to human dignity.”¹⁷²

“Cruel and unusual punishment” surely implies more than physical torture alone.¹⁷³ In fact, the modern trend is to rely less on a finding of actual physical suffering.¹⁷⁴ The American Law Institute’s Model Penal Code calls upon prisons to provide rehabilitative programs along with appropriate therapy for inmates.¹⁷⁵ In addition, the Model Act for the Protection of Rights of Prisoners, prepared by the National Council on Crime and Delinquency, recommends prevention of psychological abuse or unnecessary indignity.¹⁷⁶ Many states have both improved mental health services within prisons, and restricted the use of solitary confinement for mentally disturbed inmates.¹⁷⁷ A number of courts have followed suit.¹⁷⁸

All of this signifies a contemporary, evolving standard of decency.¹⁷⁹ Societal consensus now recognizes prisons as dangerous, toxic places for the mentally ill, and for good reason.¹⁸⁰ Many prison conditions, especially solitary confinement, can only serve to exacerbate an inmates’ serious illness.¹⁸¹ A lack of social contact and intellectual stimulation deprives a human being of his

172. Danne, *supra* note 1, at 130 (emphasis added).

173. *Torraco v. Maloney*, 923 F.2d 231, 234 (1st Cir. 1991).

174. Danne, *supra* note 1, at 130.

175. *Id.* at 120 (citing MODEL PENAL CODE §304 (1962)).

176. *Id.* at 121 (citing MODEL ACT FOR THE PROTECTION OF RIGHTS OF PRISONERS (1972)).

177. Kerr, *supra* note 123, at 157.

178. *See id.* (“Courts have approved remedies for prisoners with serious mental illness in isolation.”).

179. *See supra* notes 17–18 and accompanying text (discussing the “evolving standards of decency” analysis).

180. *See* Turner, *supra* note 103, at 411 (“Mental health experts view prisons as toxic environments for the seriously mentally ill because of prison overcrowding.”). *See generally* Mayer, *supra* note 87 (describing various holdings about the rights of mentally ill prisoners).

181. *See* Marschke, *supra* note 31, at 487 (“For an inmate with a serious mental illness, such as schizophrenia, mental torment may become exacerbated by the conditions he faces in prison confinement.”).

basic right to dignity, which can have disastrous consequences.¹⁸² This the Eighth Amendment cannot allow, regardless of any good faith justifications such as a lack of funding.¹⁸³ The Court should therefore phase out the requirement of subjective indifference in the context of mental health care.

Judicial Reform through an Objective Standard

In addition to the Framers' intent and an emerging societal consensus, an objective standard would also promote correctional reform. Objective standards are all too common in other areas of constitutional law. For example, the Fourth Amendment to the United States Constitution prohibits all unreasonable searches and seizures.¹⁸⁴ In *Graham v. Connor*, the Court held that claims of excessive force by police officers are governed by a standard of objective reasonableness.¹⁸⁵ In fact, the *Graham* Court also described how the subjective inquiry under the Eighth Amendment is far less protective.¹⁸⁶ A survey of civil rights litigation suggests this is indeed the case—"plaintiffs ... have better prospects under the 'objective reasonableness' test."¹⁸⁷

Courts have applied an objective standard of reasonableness in other areas of constitutional rights. At least one court has applied this standard to correctional officials within a mental hospital, who repeatedly punched a restrained patient in the head.¹⁸⁸ Similarly, criminal defendants have an objective,

182. Kerr, *supra* note 123, at 156 ("It has long been known that isolated confinement, the deprivation of human contact and other sensory and intellectual stimulation can have disastrous consequences.").

183. Danne, *supra* note 1, at 116 (discussing how a lack of funding is irrelevant to an Eighth Amendment violation); *see* Brown v. Plata, 131 S. Ct. 1190, 1938 (2011) (describing how an overcrowding order is appropriate to remedy ongoing Eighth Amendment violations due to inadequate funding).

184. *See* U.S. CONST. amend. IV ("The right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures, shall not be violated....").

185. *Graham v. Connor*, 490 U.S. 386, 397 (1989).

186. *See id.* ("Moreover, the less protective Eighth Amendment standard applies 'only after the State has complied with the constitutional guarantees traditionally associated with criminal prosecutions.'" (quoting *Ingraham v. Wright*, 430 U.S. 651, 671 n.40 (1977))).

187. NAHMOD, ET AL., *supra* note 40, at 182.

188. *Id.* at 159 (citing *Davis v. Rennie*, 264 F.3d 86, 91 (1st Cir. 2001)).

constitutional right to counsel.¹⁸⁹ This right to counsel means the right to *effective* assistance of counsel.¹⁹⁰ The performance of a criminal defense attorney cannot fall below “reasonable professional norms”—implying an objective standard of reasonableness.¹⁹¹

These objective standards are not only plaintiff-friendly. They are also easier for courts to apply. An objective standard of reasonableness for mental health treatment in prisons would simplify litigation.¹⁹² It would also send a clear message to prison officials that their actions must be objectively reasonable, and thereby deter unconstitutional conduct.¹⁹³ No longer would *Farmer’s* liability shield apply to untrained or ignorant prison officials.¹⁹⁴ This new objective standard would also promote correctional reform in an area where it is sorely needed. Thus, “[w]hen systematic deficiencies in [prison] staffing, facilities or procedures make unnecessary suffering inevitable, a court will not hesitate to use its injunctive powers.”¹⁹⁵

The need for correctional reform by courts, rather than legislatures, is necessary to preserve constitutional rights. Politicians often rely on a “get tough on crime” approach to win elections.¹⁹⁶ The “get tough on crime” movement has resulted in a

189. See U.S. CONST. amend. VI (“In all criminal prosecutions, the accused shall enjoy the right to...have the Assistance of Counsel for his defence.”).

190. *Strickland v. Washington*, 466 U.S. 668, 686 (1984).

191. See *id.* at 867 (“When a convicted defendant complains of the ineffectiveness of counsel’s assistance, the defendant must show that counsel’s representation fell below an objective standard of reasonableness.”). The *Strickland* Court also described how “[t]he proper measure of attorney performance remains simply reasonableness under prevailing professional norms.” *Id.*

192. See NAHMOD, ET AL., *supra* note 40, at 182 (discussing how objective standards would generally simplify civil rights litigation) (citation omitted).

193. See *id.* (describing how an objective reasonableness standard, in the Fourth Amendment context, provides clear guidance to police officers) (citation omitted).

194. See *supra* notes 76–101 and accompanying text (discussing how prison officials can avoid liability by claiming ignorance or a lack of training in mental health care).

195. *Todaro v. Ward*, 565 F.2d 48, 52 (2d Cir. 1977).

196. Shannon F. McLatchey, Note, *Juvenile Crime and Punishment: An Analysis of the Get-Tough Approach*, 10 U. FLA. J.L. & PUB. POL’Y 401, 406

substantial increase in prison populations.¹⁹⁷ Harsh legislative schemes, including the war on drugs, also increase the number of mentally ill prisoners.¹⁹⁸ Legislatures are unwilling to respond humanely to a prison system that is spiraling out of control, relying instead on increasingly punitive approaches.¹⁹⁹ The “tough on crime” movement appears to be the result of widespread fear and legislative hysteria, rather than sound, scientifically-driven policy-making, as violent crime rates have actually decreased since the mid-1990s.²⁰⁰

These legislative policies effectively criminalize the mentally ill, and courts should step in to correct the resulting Eighth Amendment violations.²⁰¹ Specifically, the United States Supreme Court should strike down *Farmer’s* liability shield for mental health care in prisons. This would remedy three decades of unsound precedent and legislative policy, along with promoting systemic, judicial reform of correctional systems.²⁰²

(1999) (“Politicians also have found that a ‘get tough on crime’ stance helps win elections....”).

197. See Fellner, *supra* note 98, at 394 (discussing the effects of the “tough on crime” approaches predominant within legislatures).

198. See *id.* (“The nation’s aggressive and punitive anti-crime policies, including its ‘war on drugs,’ have also contributed to the number of mentally ill in prison.”).

199. See *id.* (describing how punitive policies have “led to what some have called the criminalizing of the mentally ill.”); Vanessa L. Kolbe, *A Proposed Bar to Transferring Juveniles with Mental Disorders to Criminal Court: Let the Punishment Fit the Culpability*, 14 VA. J. SOC. POL’Y & L. 418, 424 (2007) (describing how politicians frequently exploit widespread fear of criminals to win support for “tough on crime” legislation).

200. See Ernestine S. Gray, *The Media—Don’t Believe the Hype*, 14 STAN. L. & POL’Y REV. 45, 45–50 (2003) (discussing how widespread media coverage of violent crime affects public policy despite the fact that “violent crime has been decreasing for both adults and juveniles”).

201. See *id.* (discussing how the war on drugs, along with other legislation, has had a disparate impact upon the mentally ill); *Brown v. Plata*, 131 S. Ct. 1190, 1928 (2011) (“If government fails to fulfill this obligation [of basic sustenance for prisoners], courts have a responsibility to remedy the resulting Eighth Amendment violation.”) (citation omitted); Erik G. Luna, *Sovereignty and Suspicion*, 48 DUKE L.J. 787, 808 (1999) (describing how the United States Supreme Court “should only intervene when the political process has malfunctioned.”).

202. See Fellner, *supra* note 98, at 394 (“These tough-on-crime approaches dominant in U.S. criminal justice policy have resulted in a quadrupling of prison

DETAILED GUIDELINES FOR LOWER COURTS

The Ruiz Bombshell

In 1972, David Ruiz filed a handwritten suit against the Texas Department of Corrections.²⁰³ This would eventually become a class action suit—one of the most “far-reaching prison conditions litigation in American history.”²⁰⁴ The complaint alleged a number of constitutional violations due to overcrowding, mental health care, and medical care.²⁰⁵ In particular, “five percent of the inmates were acutely mentally ill, and ... as many as sixty-eight percent were mentally or emotionally disturbed.”²⁰⁶ At the conclusion of a six-month trial, the court heard the testimony of hundreds of witnesses, and received over a thousand exhibits into evidence.²⁰⁷ The court handed down a 126-page opinion, taking issue with overcrowding, the improper use of force, inadequate health care and psychiatric care, and the systematic denial of inmates’ access to the courts.²⁰⁸

and jail populations in three decades.”). *But see* Turner, *supra* note 103, at 424–25 (describing recent legislative steps taken to reduce to number of mentally ill prisoners). Recent federal legislation provides funding for state and local government agencies to improve their treatment of the mentally ill, which is a step in the right direction. Mentally Ill Offender Treatment and Crime Reduction Act, 42 U.S.C. § 3711 (2004); Turner, *supra* note 103, at 424–25.

203. Carl Reynolds, *The Final Chapters of Ruiz v. Estelle*, CORRECTIONS TODAY, June 2002, *available at* <http://www.thefreelibrary.com/The+final+chapters+of+Ruiz+v.+Estelle.+%28Judicial+News%29.-a087426102>.

204. *Id.*; Turner, *supra* note 103, at 423. However, it is arguable whether *Ruiz* is the *most* groundbreaking decision about prison conditions, in the wake of *Plata*. *See* Brown v. Plata, 131 S. Ct. at 1928, 1935 (2011) (ordering the release of 38,000–46,000 prisoners within California’s state prisons).

205. *See* Ruiz v. Estelle, 503 F. Supp. 1265, 1274–75 (S.D. Tex. 1980), *aff’d in part, rev’d in part*, 679 F.2d 1115 (5th Cir. 1982), *amended in part, vacated in part*, 688 F.2d 266 (5th Cir. 1982).

206. *Id.* at 1275.

207. *Id.* at 1276 (“After 159 days of trial ... the court had heard the testimony of 349 witnesses and had received approximately 1,565 exhibits into evidence.”) (footnote omitted).

208. *See id.* at 1287–88, 1299–1307, 1327–31, 1338–40, 1370–73; Reynolds, *supra* note 203 (“Many issues were closed out and others were the subject of only global mandates, such as to maintain and enforce certain policies, e.g., use of force and to ‘employ sufficient trained security and nonsecurity staff.’”).

However, the *Ruiz* court “took a step beyond most courts.”²⁰⁹ It described a detailed set of guidelines for mental health care within prisons:

First, there must be a systematic program for screening and evaluating inmates in order to identify those who require mental health treatment Second ... treatment must entail more than segregation and close supervision of the inmate patients. Third, treatment requires the participation of trained mental health professionals, who must be employed in sufficient numbers to identify and treat in an individualized manner those treatable inmates suffering from serious mental disorders Fourth, accurate, complete, and confidential records of the mental health treatment process must be maintained Fifth, prescription and administration of behavior-altering medications in dangerous amounts, by dangerous methods, or without appropriate supervision and periodic evaluation, is an unacceptable method of treatment Sixth, a basic program for the identification, treatment, and supervision of inmates with suicidal tendencies is a necessary component of any mental health treatment program.²¹⁰

Ultimately, the *Ruiz* court held the Texas prison system failed to comply with the above standards, thereby in violation of the Eighth Amendment.²¹¹ Subsequent litigation in the *Ruiz* class action was still ongoing as of 2001.²¹²

209. Turner, *supra* note 103, at 423.

210. *Ruiz*, 503 F. Supp. at 1339 (citation omitted) (emphasis added).

211. *See id.* (adopting an expansive reading of *Gamble's* requirement of medical care—one that includes psychological care—and concluding Texas prisons failed to comply with the Eighth Amendment by denial of this right); Turner, *supra* note 103, at 423 (“The [*Ruiz*] court concluded that the ... mental health program violated the Eighth Amendment in failing to reach even a minimal level of adequacy with regard to the aforementioned components.”).

212. *See* Reynolds, *supra* note 203 (describing the ongoing *Ruiz* litigation). Subsequent litigation, however, did not affect the lower court’s mental health standards—generally referred to as the *Ruiz* guidelines. *See*

Applying the Ruiz guidelines

Many courts and organizations have applied the *Ruiz* guidelines in their assessment of correctional mental health care.²¹³ At least four courts, including the Ninth Circuit Court of Appeals, have followed *Ruiz's* requirement of adequate record-keeping.²¹⁴ Other federal courts have adhered to the *Ruiz* guidelines in their entirety.²¹⁵ In *Balla v. Idaho State Board of Corrections*, the only type of psychiatric care offered within Idaho state prisons was the prescription of psychotropic medication.²¹⁶ The *Balla* court, no pun intended, held that Idaho prisons must develop actual psychological treatment programs consistent with the *Ruiz* guidelines.²¹⁷

These guidelines provide a helpful framework to lower courts, prison administrators, and legislators in assessing the constitutionality of mental health treatment within prisons.²¹⁸ Currently, “courts vary widely as to what else, if anything, is required to achieve constitutional minima.”²¹⁹ In lieu of an objective standard for psychological treatment within prisons, federal courts should continue to follow the *Ruiz* guidelines. Adherence to these guidelines would alleviate the confusing mess of current case law dealing with the mental health care rights of prisoners.²²⁰ Courts would have a concrete, easy-to-follow

generally *Ruiz v. Estelle*, 679 F.2d 1115 (5th Cir. 1982); *Ruiz v. Estelle*, 688 F.2d 266 (5th Cir. 1982).

213. See Turner, *supra* note 103, at 424 (“To assess the adequacy of mental health services within their own prisons, certain courts and organization[sic] have applied the criteria announced in *Ruiz*.”) (alteration in original).

214. Mayer, *supra* note 87, at 268–69 (citing *Toussaint v. McCarthy*, 801 F.2d 1080 (9th Cir.1986)).

215. *Id.* at 259. See also *Capps v. Atiyeh*, 559 F.Supp. 894 (D. Or. 1983) (following the *Ruiz* guidelines throughout the decision).

216. Mayer, *supra* note 87, at 259 (citing *Balla v. Idaho State Bd. of Corrs.*, 595 F.Supp. 1558, 1568 (D. Idaho 1984)).

217. *Id.*

218. See Marschke, *supra* note 31, at 532 (describing the significance of *Ruiz*).

219. Mayer, *supra* note 87, at 275.

220. See *id.* at 275 (“There are no clear guidelines as to the quantity and quality of mental health care professionals who are necessary to create a constitutionally adequate system.”).

standard, rather than the ambiguous standard of “deliberate indifference.”²²¹

In addition to the *Ruiz* guidelines, prison guards should receive adequate training in the detection of mental illness. One commentator suggests the following addition to the *Ruiz* guidelines: “[s]ecurity staff must receive adequate training to recognize the basic signs and symptoms of mental illness and the security staff must be required to make referrals to the mental health staff if such signs or symptoms are detected.”²²² This additional requirement would address several problems. First, untrained guards could no longer act as “gatekeepers” preventing timely delivery of psychological services.²²³ Second, facilities with limited resources could rely less heavily on full-time psychiatric staff, as prison guards could deny meritless requests for psychological services.²²⁴ Finally, this would send a clear message to prison administrators—they are constitutionally obliged to provide for the basic needs of all prisoners, including the mentally ill.

CONCLUSION

One court described a fundamental issue with the current standard for psychological care within prisons: “As the law stands today, the standards permit inhumane treatment of inmates. In this court’s opinion, *inhumane* treatment should be found to be *unconstitutional* treatment.”²²⁵ The burden of proof for inmates asserting inhumane mental health treatment remains unfairly

221. *See id.* (“It seems clear that the definitions of ‘serious mental health need’ and ‘deliberate indifference’ are situational and often ambiguous.”).

222. Marschke, *supra* note 31, at 533.

223. *See supra* notes 76–88 and accompanying text (discussing how guards with little or no psychological training often prevent inmates’ access to necessary psychological care). Some claims of insanity by inmates can actually be self-motivated—to seek transfer or an incompetency finding, for example. Marschke, *supra* note 31, at 521.

224. Marschke, *supra* note 31, at 521 (discussing how this additional requirement could actually save prisons money in the long run).

225. *Ruiz v. Johnson*, 37 F. Supp. 2d 855, 907 (S.D. Tex. 1999) (emphasis added).

high.²²⁶ Instead of providing necessary treatment for the mentally ill, our society has seen fit to lock them up and throw away the key. In a shocking case out of New York state, prison officials denied the use of a wheelchair to a mentally ill and physically disabled inmate.²²⁷ He was unable to shower for thirty-three days, and used cups of water from a toilet to cleanse himself.²²⁸

Surely this kind of treatment constitutes the shocking, inhumane treatment the Framers had in mind when enacting the Eighth Amendment. The United States Supreme Court should apply an objective standard to mental health care for prisoners and vindicate the Framers' ideal of dignity in all men.²²⁹ This new standard would correctly recognize an emerging societal consensus that prisons are dangerous, inappropriate environments for the mentally ill.²³⁰ "The proscription of cruel and unusual punishments is not fastened to the obsolete, but may acquire meaning as public opinion becomes enlightened by a humane justice."²³¹

In lieu of an objective standard, lower courts should remain mindful of § 1983 suits alleging institutional indifference to the psychological needs of prisoners.²³² This is best accomplished through applying the *Ruiz* guidelines and requiring basic psychological training for prison guards.²³³ These guidelines provide a helpful, detailed remedy for the widespread lack of

226. See Turner, *supra* note 103, at 424 ("[T]he burden of proof for inmates to assert Eighth Amendment violations asserting inadequate mental health care remains exceptionally high.").

227. Beckford v. Irvin, 49 F. Supp. 2d 170, 179–80 (W.D.N.Y. 1999).

228. *Id.* at 174, 180.

229. See *supra* notes 150–63 and accompanying text (discussing the true, objective intentions of the Eighth Amendment).

230. See *supra* notes 164–82 and accompanying text (discussing how our society and psychologists view prisons as inhumane environments for the mentally ill).

231. Furman v. Georgia, 408 U.S. 238, 242 (1972) (Douglas, J., concurring) (quoting Weems v. United States, 217 U.S. 349, 378 (1910)) (internal quotation marks omitted).

232. See Marschke, *supra* note 31, at 531 ("...establishing consistent guidelines for adequate mental health care and changing the subjective deliberate indifference requirement to an objective standard."); *supra* notes 203–21 and accompanying text (discussing treatment among the lower courts of mental health care for prisoners).

233. See *supra* notes 213–21 and accompanying text (discussing why lower courts should apply the *Ruiz* guidelines).

psychological care throughout prisons today.²³⁴ Lower courts should also remain willing to order large-scale reductions of prisoner population as seen in *Plata*—an effective way to combat rampant overcrowding and underfunding.²³⁵

234. See *supra* notes 218–21 and accompanying text (describing how the *Ruiz* guidelines would assist lower courts in prison rights litigation).

235. *Brown v. Plata*, 131 S. Ct. 1910, 1942 (2011) (“Expert witnesses produced statistical evidence that prison populations had been lowered without adversely affecting public safety in a number of jurisdictions....”).

The Americans with Disabilities Act: Recording is a Reasonable Accommodation

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INTRODUCTION

When a student with a learning disability requests an accommodation for his classes, he stands at the intersection of his federal statutory protections and the university’s interests. When the university denies his procedurally-proper request it is effectively stating either that the student is not entitled to the requested accommodation, or the university is asserting that the

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university's interests outweigh the student's, or a combination of the two explanations. When a student with a learning disability such as attention deficit hyperactivity disorder ("ADHD") requests to record his classes as an accommodation for that disability, such recording is a reasonable accommodation for his disability.

Many students have ADHD or another learning disability. Of the 2.1 million disabled students enrolled in college in 2008, 591,000 to 651,000 of those individuals have one or more learning disabilities, and 424,000 to 378,000 students have ADHD.¹ These figures might be low because of "the trend of students with non-apparent disabilities...[to] choos[e] not to disclose their disabilities to their respective institutions."² There are more learning disabled students in college or vocational programs than there are people in the state of Wyoming.³

ADHD has a long, spotted history—even the name of the diagnosis has changed three times in the last several revisions of the *Diagnostic and Statistical Manual of Mental Disorders*.⁴ Many laymen still use the term "ADD" to indicate "attention deficit disorder," but this is inaccurate terminology; the former ADD

1. Advisory Commission on Accessible Instructional Materials in Postsecondary Education for Students with Disabilities, *Report on Accessible Instructional Materials in Postsecondary Education*, 15 (2011), <http://www2.ed.gov/about/bdscomm/list/aim/meeting/aim-report.pdf> [hereinafter AIM Report] (citing three different government sources for this data) *available at* <http://www2.ed.gov/about/bdscomm/list/aim/meeting/aim-report.pdf> (last visited Nov. 18, 2012). The Author calculated the numbers of students from percentages provided in the AIM Report. The percentages provided in the AIM Report are 28.16—31% learning disabled and 18—20.21% ADHD.

2. *Id.* at 16.

3. WYOMING QUICKFACTS FROM THE US CENSUS BUREAU, <http://quickfacts.census.gov/qfd/states/56000.html><http://quickfacts.census.gov/qfd/states/56000.html> (last visited Nov. 18, 2012).

4. Pooja Chhagan Vekaria, *Lecture Note-taking in Postsecondary Students with Self-Reported Attention-Deficit/Hyperactivity Disorder*, 8–9 (2011) [hereinafter Vekaria dissertation] (unpublished Ph.D. dissertation, Columbia University), *available at* COLUMBIA UNIVERSITY ACADEMIC COMMONS SITE, http://rhys.cul.columbia.edu/ac2_test/catalog/ac:132242http://rhys.cul.columbia.edu/ac2_test/catalog/ac:132242 (last visited Nov. 18, 2012). Dr. Vekaria's dissertation provides a very good background in ADHD's history and symptoms.

diagnosis is now ADHD Predominately Inattentive Type.⁵ There are two other varieties of ADHD diagnosis: Predominately Hyperactive-Impulsive Type, and Combined Type.⁶ Because ADHD is a “polygenic condition,” multiple genes are involved in its expression, and its effects on an individual and symptoms vary among sufferers.⁷ Both adults and adolescents may have the disorder.⁸ ADHD is a “chronic, disabling condition.”⁹

As a result of the different types, ADHD symptoms are varied. Inattentive-type students may have trouble with “task completion, sustained attention, memory and organization,”¹⁰ while hyperactive-type students may have trouble with “self-control[,] . . . excessive talking and impulsivity.”¹¹ The combined-type gets the “one-two punch” of presenting symptoms as this type exhibits signs of both inattention and hyperactivity/impulsivity. Combined-type sufferers are more likely to have certain personality disorders, to have attempted suicide, and to have been arrested.¹²

ADHD interest groups,¹³ mental health professionals,¹⁴ and educators recognize the value of recording class lectures for ADHD students.¹⁵ In fact, there are many such products designed

5. *Id.* at 9, 15–16.

6. *Id.* at 15–16.

7. *Id.* at 20.

8. *Id.*

9. *Id.*

10. *Id.* at 32.

11. *Id.*

12. *Id.*

13. COLLEGE ACCOMMODATIONS – ATTENTION DEFICIT DISORDER ASSOCIATION,

http://www.add.org/?page=college_accommodhttp://www.add.org/?page=college_accommod (last visited Nov. 18, 2012).

14. *See* *Kaltenberger v. Ohio College of Podiatric Medicine*, 162 F.3d 432, 434 (6th Cir. 1998) (describing psychologist’s recommendations for ADHD podiatry student including “permission to tape lectures”); *see generally* Vekaria dissertation, *supra* note 4 at 41–43. Vekaria describes lower listening comprehension for ADHD students, particularly ADHD-Predominately Inattentive types.

15. *See* Clive Thompson, *The Pen That Never Forgets*, N.Y. TIMES, Sept. 19, 2010, *available* at <http://www.nytimes.com/2010/09/19/magazine/19Livescribe-t.html?pagewanted=all>, (for comments from recording device creator and

to help students—both disabled and not—do just that. One scholar notes the benefits of recording: “[Recording] allows students to hear the lecture at least once more, and to make notes with less time pressure; students with [sic] attention deficit disorder will find this particularly helpful.”¹⁶ Yet, often recording is an accommodation denied to LD/ADHD students.

This paper gives the reader a primer in disability law, and will address comparable reasonable accommodations. Further, this paper will discuss the “hazards of being intelligent” with regard to a student’s accommodations. This paper also addresses criticisms of ADHD accommodations generally and criticism of recording specifically, concerns rooted in the interests of the non-disabled third parties—professors, classmates, and society. This paper concludes with several practical notes on how the interests of all involved may be served.

THE RISE, FALL, AND RISE AGAIN OF PROTECTIONS FOR THE DISABLED

Congress rarely legislates in a vacuum, and prior to the Americans with Disabilities Act (“ADA”),¹⁷ it passed the Rehabilitation Act of 1973¹⁸ and the 1975 Individuals with Disabilities Education Act (“IDEA”).¹⁹ Despite these older statutes, the ADA was necessary, because there were glaring gaps in the protection for the disabled. The Rehabilitation Act only prohibits discrimination by programs receiving federal funding. The IDEA only applies to elementary and secondary education. Especially in the areas of employment discrimination and in public accommodation, the disabled were largely unprotected. The ADA, passed in 1990, addressed these gaps. The ADA and the

professor of education Andrew Van Schaack on the value of his device <http://www.nytimes.com/2010/09/19/magazine/19Livescribe-t.html?pagewanted=all>). The article also discusses the effectiveness of the device at conveying more information. *See also* Susan Johanne Adams, *Leveling the Floor: Classroom Accommodations for Law Students with Disabilities*, 48 J. LEGAL EDUC. 273 (1998).

16. Adams, *supra* note 15, at 282.

17. Pub. L. No. 101-336, 101 Stat. 327 (1990) (codified at 42 U.S.C. §§ 12101–12213 (2012)).

18. 29 U.S.C. § 794 (2012).

19. 20 U.S.C. §§ 1400–1482 (2012).

Rehabilitation Act reach nearly every disabled or handicapped student.

After the passage of the ADA, a series of Supreme Court cases narrowed the class of people protected by the ADA by tweaking the definition of disability. The codified disability definition is “a physical or mental impairment that substantially limits one or more major life activities, . . . a record of such an impairment,” or when an individual is “regarded as” being disabled.²⁰ In *Sutton v. United Air Lines*, the Supreme Court held that the effect of mitigating measures must be taken into account to determine if the impairment is one that substantially limits a major life activity.²¹ In *Toyota Motor Manufacturing v. Williams*, the Supreme Court held that the use of the modifiers “substantially” and “major” in the definition create a “demanding standard for qualifying as disabled.”²² As a result of these decisions, whether an individual was disabled was the point on which most cases were decided throughout the 2000s. Cases rarely got to the question of law regarding whether a specific accommodation was reasonable or not; rather cases were dismissed for failure to state a claim—the individuals were not sufficiently disabled for statutory protection.

The ADA Amendments Act (ADAAA) expressly overrules the *Sutton* and *Williams* decisions,²³ broadens the definitions, and explicitly says that the disability inquiry should be into “whether entities . . . have complied with their obligations[.] [T]he question of whether an individual’s impairment is a disability should not demand extensive analysis.”²⁴ Congress also codified “Rules of Construction Regarding the Definition of Disability,”²⁵ which similarly underscore its intention to make the focus on the accommodation rather than on the disability status of the individual. Also, Congress added learning, reading, concentrating and thinking to the list of major life activities.²⁶ Scholars have

20. 42 U.S.C. § 12132 (1) (2012).

21. *Sutton v. United Air Lines*, 527 U.S. 471 (1999).

22. *Toyota Motor Mfg. v. Williams*, 534 U.S. 184, 197 (2002).

23. Pub. L. No. 110-325, 122 Stat. 3553, at § 2(a) (2008). The ADAAA actually calls the cases by their names, stating that the cases defined disability incorrectly.

24. *Id.* § (2)(a)(5).

25. 42 U.S.C. § 12132(4) (2012).

26. *Id.* at § 12102(2).

remarked that the ADAAA returned the ADA to its original intent, rather than truly “amending” the statute.²⁷

A SIDE-NOTE ON ‘QUALIFIED INDIVIDUALS’ AND ADMISSIONS
CASES

The ADA provides, “[N]o qualified individual with a disability shall . . . be excluded from participation in, or be denied the benefits of . . . , or be subjected to discrimination by any such [public] entity.”²⁸ It is important to note that each disabled student must be a qualified individual before he is protected by the ADA. The typical “qualified individual” case involves an admissions or readmissions decision where the student argues that with a reasonable accommodation he could complete the program. For example, in *Southeastern Community College v. Davis*, a deaf applicant sought admission to a nursing school.²⁹ The Supreme Court held that she was not a qualified individual because her physical limitations would result in a one-to-one faculty/student ratio.³⁰

“Qualified individual” also comes up when a disabled student seeks to be readmitted to a program after he has been excluded. There are two general readmission fact patterns, the most common being where a disabled plaintiff alleges that with reasonable accommodations he will be able to pass the required courses and complete the program.³¹ The less-common plaintiff’s theory is disparate treatment—the student was discriminated against specifically because he is disabled and expelled.³² Readmission cases do not appear to win very often. This is possibly because the plaintiff already had one bite at the education

27. Transcript of Conference Panel, *What the ADA Amendments and Higher Education Acts Mean for Law Schools*, 18 AM. U. J. GENDER SOC. POL’Y & L. 13, 16 (2009) (comments of Peggy Mastroianni).

28. 42 U.S.C. § 12132 (2012).

29. *Se. Cmty. Coll. v. Davis*, 442 U.S. 397 (1979).

30. *Id.*

31. *See generally*, *Wynne v. Tufts Univ. Sch. of Med.*, 932 F.2d 19 (1st Cir. 1991) [hereinafter, “*Wynne I*”].

32. *Goonewardena v. New York*, No. 05 Civ. 8554 PKC FM, 2008 WL 4090467 (S.D.N.Y. Aug. 26, 2008) (psychologically disabled student with obsessive-compulsive disorder expelled for stalking was not discriminated against, rather he was an actual danger to others.).

apple, and as a result, the school's decision to exclude the plaintiff appears more reasonable. Further, there is often a timing element in these cases, discussed below.

REASONABLE ACCOMMODATIONS

The ADA also prohibits disability discrimination in the form of "a failure to make reasonable modifications in the policies, practices or procedures, when such modifications are necessary . . . unless the modification would fundamentally alter [the nature of the service]. . . or would result in an undue burden."³³ The disabled student and the university are supposed to engage in an interactive process to determine what accommodations fit the student's needs.³⁴ Reasonable accommodations can include academic adjustments,³⁵ modification of exams,³⁶ or the provision of an auxiliary aid,³⁷ among other possibilities.³⁸

Schools do not have to "fundamentally alter" their programs or standards, or accommodate a student to the point where it would become an "undue burden."³⁹ A university that maintains grade point average ("GPA") minimums,⁴⁰ attendance requirements,⁴¹ and other such completion standards does not discriminate against the disabled student; changes to these requirements would usually fundamentally alter the program.

Undue burden comes up in relation to the amount of financial or administrative resources necessary to accommodate an

33. 42 U.S.C. § 12182 (2012).

34. *See* *Gluckenberger v. Bos. Univ.*, 974 F. Supp. 106, 141 (D. Mass. 1997) (discussing interactive process at Boston University during different time periods).

35. 34 C.F.R. § 104.44(a) (2012).

36. *Id.* § 104.44(c).

37. *Id.* § 104.44(d).

38. 28 C.F.R. § 36.309(c) (2012) (providing a somewhat duplicative list...).

39. 42 U.S.C. § 12182 (2012).

40. *See* *McGregor v. Louisiana State Univ. Bd. of Sup'rs*, 3 F.3d 850, 855 (5th Cir. 1993) (plaintiff sought, among other things, advancement without meeting the required grade point average).

41. *See* *Maczaczj v. New York*, 956 F.Supp. 403 (W.D.N.Y. 1997) (disabled student not exempt from attendance requirements and unable to attend college by phone).

individual.⁴² Schools may not shift the burden of paying for an academic adjustment to the student, not even for expensive accommodations like sign language interpreters.⁴³ At the same time, one-on-one faculty attention was an undue burden in *Davis*.⁴⁴

Regarding the relationship between the interactive process and undue burden/fundamental alteration, “Relevant officials within the institution [must have] considered alternative means, their feasibility, cost and effect on the academic program, and [have come] to a rationally justifiable conclusion that the available alternatives would result in either lowering academic standards or requiring substantial program alteration.”⁴⁵ The school has a duty here, and it must show that it is not “disguis[ing] truly discriminatory requirements” as professional judgment.⁴⁶

Whether a program would be fundamentally altered by an accommodation often comes up in cases where the student seeks a waiver of a requirement. For instance, an ADHD private high school student sought a waiver of a mathematics class requirement so that he could graduate, and the court held that his request would fundamentally alter his program.⁴⁷ While the court has been criticized for their choice in words,⁴⁸ the student in this case does

42. 28 C.F.R. § 36.104 (2012) (listing undue burden factors). *See* DEP’T OF EDUC., OFFICE OF CIVIL RIGHTS, STUDENTS WITH DISABILITIES PREPARING FOR POSTSECONDARY EDUCATION: KNOW YOUR RIGHTS AND RESPONSIBILITIES, (2011). (“May a postsecondary school charge me for providing an academic adjustment?” “No. Nor may it [charge disabled students more than not-disabled students.]”)

43. *See* DEP’T OF EDUC., OFFICE OF CIVIL RIGHTS, *supra* note 42. Schools are not required to provide “personal services” like tutors. *Id.* There appears to be a conflict between the “personal services” and the “reasonable accommodations” language that does not receive much attention. This is likely because the difference in a sign language interpreter and a tutor is that one provides the vehicle by which a deaf student is able to participate in class *at all*, whereas a tutor is merely a tool to *improve* comprehension and performance.

44. 442 U.S. at 407-08.

45. *Wynne v. Tufts Univ. Sch. of Med.*, 976 F.2d 791 (1st Cir. 1992) [hereinafter *Wynne I*].

46. *Wong v. Regents of Univ. of California*, 192 F.3d 807 (9th Cir. 1999).

47. *Axelrod v. Philips Acad., Andover*, 46 F. Supp. 2d 72, 85 (D. Mass. 1999).

48. Kristen L. Aggeler, Note, *Is ADHD A “Handy Excuse”? Remedying Judicial Bias Against ADHD*, 68 UMKC L. REV. 459 (2000).

not appear to have had much interest in completing his required coursework as without accommodation he scored in the 88th percentile on the math portion of the SAT.⁴⁹ Another waiver that would fundamentally alter a program came up when parents of a student with severe behavioral problems wanted their child to be exempted from the normal discipline rules of the school, which would involve a completely separate set of discipline standards.⁵⁰ The court characterized this as making the student “essentially immune” from school discipline, and thus the accommodation would fundamentally alter the program.⁵¹

When a student seeks an accommodation, he has to define precisely what he is seeking. In the case of *Jakubowski v. Christ Hospital*, a medical resident with Asperger’s Syndrome sought accommodation.⁵² Asperger’s Syndrome is an autism-spectrum condition known for its communication-related symptoms. Jakubowski requested for the hospital to accommodate him with “knowledge and understanding.”⁵³ The school countered by stating that the “nature of the medical profession requires solid communication skills,” and that without such skills, patients might be in danger.⁵⁴ The school offered him a position in pathology, where he would be insulated from having to communicate with patients often, and he declined.⁵⁵ His request for “knowledge and understanding” was “unduly burdensome given [the school’s] obligations to other residents, doctors, and patients,” and the Court found that he was not “otherwise qualified.”⁵⁶ This was very similar to the holding in the *Davis* nursing school case mentioned earlier, except his problem was a mental disorder, while hers was physical deafness. Both cases dealt with issues of patient safety and the feasibility of the proffered accommodation. Hers was unduly burdensome because it would require a one-to-one

49. *Axelrod*, 46 F. Supp. 2d at 85.

50. *Bercovitch v. Baldwin Sch., Inc.*, 133 F.3d 141 (1st Cir. 1998).

51. *Id.* at 153.

52. *Jakubowski v. Christ Hosp.*, No. 1:08-CV-00141, 2009 WL 2407766 (S.D. Ohio Aug. 3, 2009).

53. *Id.* at *3.

54. *Id.* at *9.

55. *Id.* at *3.

56. *Id.* at *9.

instructor/student ratio, while his was unduly burdensome because of the school's obligations to others.

PERSUASIVE FACTORS

While not an undue burden or a fundamental alteration, there are persuasive factors that repeat in reasonable accommodations cases. The most easily identifiable such factor is the element of the timing of a diagnosis and accommodations request. While a student might not experience the need for accommodation until he reaches a certain level of coursework,⁵⁷ at the same time, cases with bad timing often lose. For instance, in *Robertson v. Neuromedical Center*,⁵⁸ the eventually-losing plaintiff-doctor waited 17 years into his medical career to be diagnosed and to seek accommodation.⁵⁹ Another example of this timing element is in the case of an LSAT-taker with a graduate degree, who never sought accommodations in undergrad, "nor did he attempt to secure accommodations throughout his graduate studies."⁶⁰ While he was found not "disabled" under the pre-amendment ADA, it is likely that even with the expanded definition of disability that he would not be able to make out a case for disability discrimination.

Plaintiffs do prevail on reasonable accommodation theories. In *Miller v. Illinois Department of Transportation*, the acrophobic plaintiff requested early in his employment to be assigned to projects not involving heights and had been accommodated for several years prior to the events leading to his eventual termination.⁶¹ His accommodation request was only to be returned to where he was before; where he would be substituted for another worker when working at heights over 25 feet.⁶² The Department's previous flexibility goes to the "reasonability" of his requested accommodation.⁶³ It should be noted that (1) there was

57. See Smith, *infra* note 72 at 20.

58. *Robertson v. Neuromedical Ctr.*, 161 F.3d 292, 295 (5th Cir. 1998).

59. *Id.*

60. *Love v. Law Sch. Admission Council, Inc.*, 513 F. Supp. 2d 206, 228 (E.D. Pa. 2007)

61. *Miller v. Ill. Dept. of Transp.*, 643 F.3d 190, 197 (2011).

62. *Id.* at 199–200.

63. *Id.* at 200.

no timing issue, (2) there was no issue of the accommodation fundamentally altering his work or being an undue burden,⁶⁴ and (3) he was asking for a small, practical accommodation that he had received for some time prior.

Another plaintiff's accommodations won on appeal, but lost on remand for slightly different reasons. In *Solomon v. Vilsack*, a plaintiff with agoraphobia—the fear of being around others—and depression devised her own accommodations for her condition.⁶⁵ She purchased a screen for her cubicle and worked a somewhat odd schedule to avoid being around others.⁶⁶ One of her two supervisors allowed these accommodations on her psychiatrist's recommendation, but her other supervisor barred her from working past 6 p.m., thus rescinding the accommodations.⁶⁷ The D.C. Circuit stated that 'Plaintiff's statements were consistent with her claim that she could have fulfilled the essential duties of her position if granted the accommodations.'⁶⁸ In other words, she was "otherwise qualified" for the job. On remand, the district court held that her self-defined schedule fundamentally altered her employment.⁶⁹

The relationship between academic performance and a student's requested accommodation comes up in conversation with those who might grant such an accommodation. In situations where a student is doing well academically or where he is merely not failing, his accommodation request may fall on deaf ears. In postsecondary contexts, academic performance comes up most often in readmissions cases, discussed earlier. However, some comparison to the IDEA—as it is used as a persuasive tool in many ADA education cases—proves useful. Academic performance is always a factor under IDEA.⁷⁰ However, the Department of

64. Defendant did assert that accommodating him would fundamentally alter Plaintiff's position but it lost on this point. It is a stretch of the imagination to believe that an accommodation begins fundamentally altering a position several years into the accommodation.

65. *Solomon v. Vilsack*, 628 F.3d 555, 558 (D.C. Cir. 2010).

66. *Id.* at 558.

67. *Id.*

68. *Id.* at 566.

69. *Solomon v. Vilsack*, 845 F. Supp. 2d 61, 73 (D.D.C. 2012).

70. *See Maus v. Wappingers Cent. School Dist.*, 688 F. Supp. 2d 282, 297 (S.D.N.Y. 2010).

Education regulation on-point states that schools may not “use any single measure or assessment as the sole criterion” determining whether a child qualifies for an individualized education program and what such appropriate education might be.⁷¹ Therefore, even in the more rigid world of the IDEA’s procedural and substantive requirements, academic performance is only one factor in determining the appropriate accommodation scheme.

In higher education, there is no requirement that academic performance be a factor in whether a student receives his requested accommodation. Prior to the ADAAA, scholars arguing over whom the disabled student should be compared to cited Department of Justice and Equal Employment Opportunity Commission regulations and guidance regarding the comparators for disabled persons.⁷² But these comparisons to “most people” or the “average person” are actually part of the pre-ADAAA way to determine whether or not an individual is disabled. As a result of the Congressional findings that coverage should be broad, the comparison to the “average student” or “most students” is no longer dispositive in whether or not a student needs an accommodation.

However, academic performance is still relevant in ADA contexts in the post-Amendments world. For instance, if a student was already doing well scholastically then perhaps the school would be unfairly advantaging the student by granting an accommodation; such an accommodation is not reasonable. It is an easy argument to articulate—because the student would be over-accommodated, his degree would be granted rather than earned, and thus such accommodation is not reasonable and/or would fundamentally alter the program.⁷³ Academic performance is relevant to the reasonableness and fundamental alteration questions. However, when a student is seeking to record his classes, his accommodation does not become unreasonable merely because he is a high performing student.

71. 34 C.F.R. § 300.304 (b) (2).

72. See Kevin H. Smith, *Disabilities, Law Schools, and Law Students: A Proactive and Holistic Approach*, 32 Akron L. Rev. 1, 56 nn. 147–49 (1999) (citing DOJ/EEOC regulations that have been amended with the ADAAA).

73. *Id.* at 50.

REASONABLE ACCOMMODATIONS AND THE STUDENT RECORDING
SITUATION

Putting all the reasonable accommodations cases and factors together, is recording a reasonable accommodation for an ADHD student? Yes. Fitting the student recording situation into the accommodations framework, a student requesting to record his classes is requesting an academic adjustment in the waiver of an anti-recording policy, and an auxiliary aid in the form of a recorded lecture or tape recorder. Tape recording itself is mentioned in the Department of Education regulations on auxiliary aids;⁷⁴ and anti-tape recording rules are specifically mentioned in the regulations as well.⁷⁵ Such anti-recording rules may not affect a disabled student's participation in the program.⁷⁶

There is broad agreement that recording and reviewing lectures helps ADHD students,⁷⁷ so the link between an ADHD sufferer and recording his classes could likely be shown to be appropriate for a specific individual by appropriate experts. Because anti-recording rules are specifically mentioned in the regulations, waiver of an anti-recording rule cannot "fundamentally alter" a program as a matter of law. Finally, because tape recording or digital recording is cheap and requires no administrative oversight, it is not an undue burden. Because recording would help the student and it would not fundamentally alter the program, recording is a reasonable accommodation.

CRITICISMS OF RECORDING

Recording seems like an innocent request, yet there are many critics of classroom recording. In an effort to understand the positions, the Author interviewed several professors as well as searching faculty journals and websites for information. Professors cite a number of concerns with recording or "capturing" lectures. As a group, professors are concerned that students might not speak

74. 34 C.F.R. § 104.44 (d).

75. *Id.* at § 104.44 (b).

76. *Id.*

77. *See supra* notes 13–18.

up in class if students know they are being recorded.⁷⁸ Professors also cite attendance concerns.⁷⁹ Further, professors are concerned about protecting their intellectual interest in their work.⁸⁰ They are concerned about their students' privacy; about their own privacy.⁸¹ They are concerned about the unfairness of recording (1) if used as a tool to question professor's grading choices,⁸² or (2) not all individuals are allowed to record,⁸³ and (3) as an accommodation at all.⁸⁴ With an eye toward practicality—not always an academic's strong suit—the interests of all parties involved in this situation can all be served.

PRIVACY AND PARTICIPATION CONCERNS

Privacy and participation concerns go hand-in-hand. Essentially the argument is that because modern students live in a "Gotcha!" world where their comments and foibles may be posted willy-nilly on Facebook or YouTube, a student will be more likely to opt out of participating rather than have his privacy infringed on by that "Gotcha!" moment. There is some support for this assertion as a variety of people have experienced hidden camera recording.

To the extent that a privacy problem exists, the school should consider requiring student recorders to agree not to upload the lectures to any website. It could also consider using one of the modern methods of "lecture capture technology"—where the school self-records and uploads the lectures to a secure students-only site. Further, it could punish students who post such content online as it could be a violation of the school's honor code.

78. Interview with Professor A, Law Professor, Univ. of Memphis, in Memphis, Tenn. (October 18, 2012). (notes on file with author).

79. Jeffrey R. Young, *The Lectures Are Recorded, So Why Go To Class?*, CHRONICLE OF HIGHER EDUCATION, May 16, 2008, <http://chronicle.com/article/The-Lectures-Are-Recorded-So/10767///>.

80. Interview with Professor A, Law Professor, Univ. of Memphis, in Memphis, Tenn. (October 18, 2012) (notes on file with author).

81. *Id.*

82. Interview with Professor B, Law Professor, Univ. of Memphis, in Memphis, Tenn. (October 18, 2012) (notes on file with author).

83. *Id.*

84. Interview with Professor A, Law Professor, University of Memphis, in Memphis, Tenn. (October 18, 2012) (notes on file with author).

Participation is also a problem because of the environment rather than the thought that one might be recorded. Research suggests that women are less likely to participate in law school generally, than their male counterparts.⁸⁵ A school could also incentivize participation by having some fractional amount of the grade come from participation, and it could punish non-participants by deducting some fractional amount as a result of their failure to participate.

When looking at an ADHD student's need to record his or her classes, is this need outweighed by privacy concerns? No. The ADA is a federal civil rights statute, and while the student privacy and participation concerns are certainly valid pedagogical ideals to which professors should aspire, such ideals cannot outweigh the plain meaning of reasonably accommodating disabled students. There is no common or statutory provision that speaks to any right to not be recorded during class.

WHOSE INTERESTS ARE BEING SERVED BY NO-RECORDING POLICIES?

One final note about "privacy." During the research into the privacy argument, the Author discovered several faculty blogs and internet forums where professors discuss certain issues. On the *Chronicle of Higher Education's* forums, when discussing classroom recordings, differences abound in the choice of allowing or denying students the ability to record classes.⁸⁶ Of particular note is the topic started by username "onion" regarding his fear of being recorded.⁸⁷ Several pages into the discussion, after he accepts a position with another university, he reveals that his real reason for denying his students the ability to record was because he did not want a "student activist" to get him in trouble with the

85. Nancy Leong, *A Noteworthy Absence*, 59 J. LEGAL EDUC. 279, 288 (2009) (citing several articles for this proposition).

86. *See* Chronicle of Higher Education, Forum, available at: <https://chronicle.com/forums/index.php?topic=73587.0> (collating several recording threads).

87. Chronicle of Higher Education, Forum at 1, available at <http://chronicle.com/forums/index.php/topic,58092.0.html> [hereinafter "Onion thread"].

administration.⁸⁸ The student activist got him in trouble anyway.⁸⁹ So rather than allow his students to record his classes, he wanted to protect himself. This shows that when faculty are making these decisions, their intent is not always to reasonably look at the request and the reasonability of the request, but rather that faculty are intending to protect themselves.

As far as the unfairness to professors whose pedagogical decisions are not defended by the administration, ultimately these concerns fail in the face of the ADA. However, in the name of practicality, there are some things faculty can do to protect themselves. First, faculty can prevent certain issues, like a student recorder's unfair editing, by simply keeping a record of the entirety of the lecture. Some professors already do so using the lecture capture technology available at many schools. Second, faculty can also have their own contract with the student regarding recording and the permissible uses of such recording. Faculty can remind students of their institutions' respective codes and regulations of behavior. But, ultimately, a faculty member's interest in protecting themselves, or professor's interest in the privacy or participation of their students, does not outweigh the student's interest in recording their classes as a reasonable accommodation. The desire for "academic freedom" does not outweigh a learning disabled student's interest in reasonable accommodations for his disability.

COPYRIGHT

The copyright argument is interesting, and probably one of the stronger arguments against recording. The *prima facie* case of copyright infringement is simple;⁹⁰ plaintiff-professor must show

88. *Id.* at 4. See also Ben Wieder, *Up Close and Confidential: Celebrity Professors Take Their Teaching Off the Record*, CHRONICLE OF HIGHER EDUCATION, <http://chronicle.com/article/Celebrity-Visiting-Professors/126680/> (March 13, 2011). Interestingly the concern of "onion" is very much similar to the concern of the celebrity professors—both seek to avoid criticism. In the case of the celebrity professor it is more evident that the administrations "back the professor up" than in "onion's" situation.

89. Onion thread, *supra* note 87 at 4.

90. 17 U.S.C. § 501(a) (2012). See also *LGS Architects, Inc. v. Concordia Homes of Nev.*, 434 F.3d 1150, 1156 (9th Cir. 1996) (discussing the *prima facie* case).

“(1) ownership of the allegedly infringed material,⁹¹ and (2) violation by the alleged infringer of at least one of the exclusive rights granted to copyright holders.”⁹² In student-recording scenarios, the facts would typically involve a university professor performing a lecture, for which the student-recorder pays tuition, and the lecture is recorded by the student for personal, non-commercial use.

The first element of the *prima facie* case would be easily met by professors because as lecturers, they are “performers” and thus have a copyright in the lecture as performance,⁹³ except for one requirement of copyright ownership. A copyright is not created until, “[a work] is fixed in a copy or phonorecord for the first time.”⁹⁴ However a “work consisting of sounds that are being transmitted is fixed if a fixation of the work is being made simultaneously with its transmission.”⁹⁵ A professor broadcasting from one room to another, with a copy saved for posterity, has a copyright. A professor performing from a script has a copyright. But unless a work is “fixed in a tangible medium of expression . . . sufficiently permanent or stable to be perceived . . . for a period of more than transitory duration,” the work is not sufficiently permanent to be copyrighted.⁹⁶

Further, there can never be a copyright on an idea by itself, or on original government works like legal cases.⁹⁷ Instead it is the transmission of the idea, the method by which the idea is conveyed, that the author becomes protected.⁹⁸ However, as professors work for a university the resulting lecture is a “work made for hire” and the authorship of the work transfers to the

91. 17 U.S.C. § 201.

92. *Id.* § 106—122.

93. *C.f.* *Nutt v. Nat’l Inst., Inc.* 31 F.2d 236 (1929) (Defendant, original author of a lecture series, assigned his interest in the lectures to Plaintiff, and then performed the lecture. Plaintiff sued for infringement of copyright and prevailed.).

94. 17 U.S.C. § 101 (2012) (defining when a work is created). Note that, oddly, the definitions section of the Copyright Act does not use any pincite-able designations.

95. *Id.* § 101 (defining when a work is fixed).

96. *Id.*

97. *Id.* §§ 102(b), 105.

98. *See generally*, 18 C.J.S. *Copyright* § 121.

university.⁹⁹ This is important because this doctrine prevents a professor from directly suing a student-recorder on a copyright infringement theory; he is likely not the proper plaintiff.¹⁰⁰

Assuming proper ownership of a copyright is established, a plaintiff-university could easily establish the violation of the copyright under the facts presumed by the typical recording situation. The Copyright Act provides that the owner of a copyright has the exclusive right to, among other things, make phonorecord copies of the work.¹⁰¹

All is not lost for the defendant student-recorder, however. There is the fair use provision to the Copyright Act.¹⁰² The fair use section provides that it is not an infringement of copyright when the work is used, “for purposes such as . . . teaching, scholarship or research”¹⁰³ The statutory factors in determining fair use include, “the purpose and character of the use, including whether such use is of a commercial nature or is for nonprofit educational purposes, the nature of the copyrighted work, the amount [of the work used], and the effect of the use upon the potential market or value of the copyrighted work.”¹⁰⁴ These factors cut in favor of the student-recorder. The purpose of recording classes is to review a lecture and study from those recordings, a completely educational goal. Because the typical recording situation involves only the private use of the lecture recording, there can be no effect upon the market.

The only statutory fair use factor that does not weigh in a student-recorder’s favor in the typical recording scenario is the amount of the work used—a student records the whole lecture. However, this is not a dispositive factor as home videotaping of an entire copyrighted television broadcast is fair use,¹⁰⁵ so comparably, the in-school recording of a copyrighted lecture is also fair use despite the amount of the lecture used. The recording

99. 17 U.S.C. § 101 (2012) (defining when a work is a “work made for hire”).

100. The university would still be a proper plaintiff.

101. 17 U.S.C. § 106 (1) (2012).

102. *Id.* § 107.

103. *Id.*

104. *Id.*

105. *Sony Corp. of Amer. v. Universal City Studios, Inc.*, 464 U.S. 417 (1984). Note that case contemplates self-use as well, rather than rebroadcast.

of an in-school lecture for personal use falls under the fair use exclusion to the Copyright Act.

To the extent that the ADA and the Copyright Act conflict with each other, such conflict can be easily avoided. The goals of the ADA and the Copyright Act are not in conflict with one another. The ADA remedies the lack of civil rights for the disabled; the Copyright Act codifies decades of copyright case law so that persons can make money from their ideas and ingenuity. A court could hold that by paying tuition a student holds an implied temporary license, limited to recording and reviewing such recordings, if it did not want to rely upon the fair use principles.

Further, the university's copyright concerns can vanish with a few strokes of a pen. To protect their interest in the work, all the university has to do is have the student agree to a very basic contract stating that (1) the university owns the rights to the recording and that (2) the student may not sell or give away such a recording because he has no rights to do so. The university might have other things it would like to include in such a document, but this would protect its intellectual property.

UNFOUNDED FEARS OF RECORDING

Some professors believe that recording classes for all students will cause students to miss class; there is even an urban legend to this effect.¹⁰⁶ There is some support for this, at least anecdotally and with regard specifically to early morning classes.¹⁰⁷ This is a reasonable fear for professors, both from a "best interests of the student" perspective and from a perspective considering their own self-interest in their continued

106. Barbara Mikkelson & David P. Mikkelson, *Students Record Lecture*, SNOPE.COM, <http://www.snopes.com/college/admin/recorder.asp> (citing Reader's Digest, *Campus Comedy*, June 1963 at 217—18). This is a nearly fifty-year-old urban legend where a professor has an assistant play an audio recording of his lecture, and students respond by dropping off recorders to record the recording.

107. Jeffrey R. Young, *The Lectures Are Recorded, So Why Go to Class?*, CHRONICLE OF HIGHER EDUCATION, May 16, 2008 at A1, available at <http://chronicle.com/article/The-Lectures-Are-Recorded-So/10767/> (last visited Nov. 19, 2012).

employment.¹⁰⁸ Modernly, lecture capture technology such as those from Tegrity or Echo360 are used to capture lectures and post those lectures on the university's student site for the class. The Chronicle of Higher Education reports that while faculty had knee-jerk reactions to lectures being available to students, the expected "mass exodus" of students has not occurred.¹⁰⁹ Further, there are several good effects of the recordings named in the article:¹¹⁰ Fewer students drop out of the classes, particularly nontraditional students, and fewer students show up to office hours with questions.¹¹¹

The article also offers several practical tips to keep attendance high. These include the professor using a waiting period before lectures are viewable online, and professors having both person-specific minimum-attendance policies, and class-wide attendance policies whereby recording ceases for all students if the threshold percentage of students is not met.¹¹² The article also suggests that professors count attendance as some fraction of a student's grades.¹¹³

THE GREAT UNFAIRNESS ARGUMENT

Some professors cited the unfairness of recording. Perhaps the most easily dealt with is Professor B's concern that a recording might become used as a tool to question a professor's grading choices.¹¹⁴ Like with the copyright example, all a school would need to do is have the student waive the ability to use the recordings as evidence in grading decisions in exchange for allowing the student to record his classes. While this does let the

108. C.f. Jeffrey R. Young, *Actually Going to Class, for a Specific Course? How 20th-Century*, CHRONICLE OF HIGHER EDUCATION (Feb. 27, 2011) (doomsday article lamenting the need for teachers as so much content is available online; describing various technologies and alternatives to college), *available at* <http://chronicle.com/article/Actually-Going-to-Class-How/126519/> (last accessed Nov. 19, 2012).

109. Young, *supra* note 108.

110. *Id.*

111. *Id.*

112. *Id.*

113. *Id.*

114. Interview with Professor B, Law Professor, Univ. of Memphis, in Memphis, Tenn. (October 18, 2012) (notes on file with author).

professor off the hook for a measure of accountability, and so is not necessarily that persuasive, it also prevents the professor from being bogged down with defending administrative decisions. It is a fairly reasonable tradeoff. Further, Professor B was concerned about fairness to non-accommodated students, and he wanted to avoid this by allowing all students to record their classes, rather than just as an accommodation for a few students.¹¹⁵ It does not follow that providing recordings to all students would somehow be less fair to the student seeking the ability to record his classes. This, too, is an easy compromise.

There are people who are skeptical about accommodations for students in higher education. The John William Pope Center, an education think tank in North Carolina, put out a very critical article about accommodations for LD/ADHD students.¹¹⁶ The author, Melissa Vickers, takes issue with (1) the necessity for students with mild-to-moderate learning disabilities to have accommodations; (2) the interactive process accommodation process at most universities;¹¹⁷ and (3) the ADAAA, among other points.¹¹⁸ As a result of the problems Vickers sees in accommodations, she characterizes accommodations as unfair.¹¹⁹

Before going further with Vickers' article, note that Vickers is not a lawyer, she has no degree in education; she is a journalist with a background in economics and strategic studies. Criticism of Vickers's qualifications to opine on disability law is well-deserved because she either boldly misstates or ignorantly

115. *Id.*

116. Melissa Zyla Vickers, *Accommodating College Students with Learning Disabilities: [sic] ADD, ADHD, and Dyslexia* (John William Pope Center, March 2010), available at <http://www.popecenter.org/acrobat/vickers-mar2010.pdf> (last visited Nov. 19, 2012).

117. The interactive process is where the student and the faculty member or the student and the disability services counselor work together to determine what accommodations are appropriate for a given student. *See* *Gluckenberger v. Bos. Univ.*, 974 F. Supp. 106, 141 (D. Mass. 1997) (discussing interactive process at Boston University during different time periods).

118. Vickers also criticizes the diagnoses that LD/ADHD students go through, the rise in learning disabilities, and the rise in accommodations. *Id.* The mental health diagnostic and testing process is outside the scope of this paper and as a result will not be addressed. She also devotes a lot of time to "Faculty Views of Accommodation" which are not on-point for this paper.

119. *Id.* at 13.

misstates the law. For example, “colleges and universities may be exempt from the new, looser definition of disability if they can show that applying it would alter the nature of their academic program and standards.”¹²⁰ As shown earlier in this paper, the fundamentally alters/undue burden analysis has always been part of the ADA. Further, Vickers invents the following: “Postsecondary institutions may seek exemptions under [the ADAAA, where the institution] can show that it would cause them to fundamentally alter the nature of the academic services involved. Such an exemption could keep schools from having to accommodate students under the new standards.”¹²¹ This is very, very inaccurate. It is not the aggregate accommodations for all disabled students that are “exempted,” but rather if a *particular* student’s accommodation would fundamentally alter the student’s course of study or the university’s program, the school can show that the requested accommodation is simply not reasonable.

During the interactive process by which a disabled student receives accommodations, a student might get an erroneous accommodation and thus have an unreasonable accommodation. Vickers’ solution, however, is no better than the problem she seeks to address. Vickers would have committees evaluate accommodations before accommodations are granted to the student, and she would have all schools have a “strict committee process.”¹²² There are significant problems with her proposal. First, this is not an efficient use of the school’s limited resources—faculty will happily tell you that they are bogged down with school-related duties without new committee requirements being created. Second, there is no reason to believe that the school will come to better decisions as a result of a “strict committee process,” and to the contrary, the groupthink decision-making model would suggest that the group will likely reach consensus quickly and without much concern for alternatives.¹²³

120. *Id.* at 14.

121. *Id.* at 3–4.

122. *Id.* at 9. There are obvious legal problems (disparate impact, disparate treatment, class actions, possibly even hostile environment claims) with *implementing* such a policy, but pointing out all the shortcomings is a bit too easy and a bit off-topic for this paper.

123. Patricia Cohen, *Thinking Cap: Preventing Groupthink*, N.Y. TIMES (Aug. 9, 2011) available at

Regarding Vickers's criticism of the ADAAA's broader scope of accommodations, it is of note that the ADAAA passed with unanimous consent in the Senate, and the vote was 402-17 in the House.¹²⁴ The mandate from Congress is clear; coverage for disabled persons under the ADA should be broad. Vickers' criticism of the ADAAA highlights the fundamental difference between Vickers' position and this paper, too. When given a choice between over-accommodating or under-accommodating a student, schools should err on the side of the student.

CONCLUSION

Accommodations for learning disabled students will likely always cause some controversy. When given a choice between granting an accommodation that is possibly an over-accommodation, denying that same accommodation, or going a third route, the third route should be explored. There is no reason why allowing all students to record their classes would conflict with the goals or law of the ADA. Similarly other common, *de minimus* accommodations should be evaluated to determine if an approach exists that is better and fairer to all students.

But, in situations where there is no practical third option, the school should grant the accommodation on behalf of the disabled student, even if that accommodation is arguably an over-accommodation. To the extent that the student is actually over-accommodated, this is unfair to the over-accommodated disabled student's classmates.¹²⁵ However, when extrapolated out, if the rule is "generally over-accommodate" versus "generally under-

<http://artsbeat.blogs.nytimes.com/2011/08/09/thinking-cap-preventing-groupthink/> (last visited Nov. 19, 2012). The first two paragraphs sufficiently describe the phenomenon.

124. Pub. L. No. 110—325, 122 Stat. 3553, (2008). The House vote information is available at <http://thomas.loc.gov/cgi-bin/bdquery/z?d110:HR03195:TOM:/bss/d110query.html> (last visited Nov. 19, 2012).

125. Vickers' own research suggests that students do not feel like others' accommodations are unfair. She has no explanation for her suggestion that accommodated students may experience a "backlash" other than that disability services offices seek to avoid that hypothetical backlash. Vickers, *supra* note 116, at 22.

accommodate” when accommodations are questionable, in order to fulfill Congress’s goals, the rule must be to over-accommodate.¹²⁶ If the rule in marginal cases is to under-accommodate students, then the school has discriminated against at least some students by failing to provide reasonable accommodations. This would expose the school to greater criticism and potentially litigation. The school is always protected by the fundamentally alters/undue burden language, especially where the accommodation requested is not a fairly small one, or in cases where the school has already given many other accommodations.

Insofar as that there is a conflict between the interests of the school, professors, or other students and the disabled student, most of these concerns can be dealt with by simple codes of behavior and on-point contracts, and subsequent enforcement of both. At the end of the day, there will always be bad actors of one variety or another. But when a university creates impediments to learning based because of fears of how bad actors will behave, the university gives up its most important role—educating all its students, as they come to it.

126. The Congressional findings are discussed *supra* p. 4.