ORAL ARGUMENT NOT YET SCHEDULED

No. 19-7057

IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA

MARKELLE SETH

Plaintiff- Appellant.

v.

DISTRICT OF COLUMBIA, *et al.*,

Defendants-Appellees.

On Appeal from the United States District Court
for the District of Columbia, No.18-cv-1034 (Howell, J.)

BRIEF OF DISABILITY SERVICES EXPERTS AS *AMICI CURIAE* IN SUPPORT OF APPELLANT MARKELLE SETH AND REVERSAL

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CERTIFICATE OF PARTIES, RULINGS, RELATED CASES, FILING OF SEPARATE BRIEF

As required by 28(a)(1) and 29(d), counsel for amici curiae, Prianka Nair and Sarah Lorr of the Disability and Civil Rights Clinic at Brooklyn Law School and Brian Wolfman, hereby certify as follows:

A. Parties, Intervenors, and Amici Curiae

All parties and amici curiae who appeared before the district court appear in Plaintiff-Appellant's brief. The parties appearing in this Court include those listed in Plaintiff-Appellant's brief and the amici curiae listed in Defendants-Appellees' brief.

B. Ruling Under Review

An accurate reference to the ruling at issue appears in Plaintiff-Appellant's brief.

C. Related Cases

Counsel is aware of no currently pending related case.

D. Separate Brief

All parties have consented to the filing of this brief.[1] Pursuant to D.C. Circuit Rule 29(d), amici curiae certify that a separate brief is necessary to provide the perspective of experts in the provision of community-based services to individuals with intellectual and developmental disability concerning (1) the rights of individuals with disabilities

[1] No counsel for a party authored this brief in whole or in part, and no person other than the amici curiae, their members, or their counsel contributed money that was intended to fund the preparation or submission of this brief. *See* Fed. R. App. P. 29(a)(4)(E).

who face discrimination in the legal system; (2) the importance of continuing to remove obstacles that interfere with access to government programs and services; and (3) the rights of people with disabilities to live successfully in community-based settings.

/s/Brian Wolfman
Prianka Nair
Sarah Lorr
Brian Wolfman

Counsel for amici curiae

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GLOSSARY

ADA	Americans with Disabilities Act of 1990, 42 U.S.C. §§ 12101-12213
ATSA	Association for the Treatment of Sexual Abusers
I/DD	Intellectual and Development Disability

STATUTES AND REGULATIONS

Applicable statutes and regulations are listed in the Brief of Plaintiff-Appellant.

INTEREST OF THE AMICI CURIAE

Amici curiae are experts in the delivery of services to people with intellectual and developmental disability (I/DD). They have a wealth of knowledge regarding best practices in the provision of supports and services for individuals with I/DD to live successfully in community-based settings. Amici curiae include

- Steven Eidelman, H. Rodney Sharp Professor of Human Services Policy and Leadership and Faculty Director of The National Leadership Consortium on Developmental Disabilities at the University of Delaware;
- Beverly Frantz, Ph.D., Criminal Justice and Healthy Sexuality Project Director, Temple University;
- David Rotholz, Ph.D., BCBA-D, a national expert on positive behavior support for persons with I/DD, past President of the American Association on Intellectual and Developmental Disabilities;
- Nancy Thaler, Special Assistant to the Secretary of Pennsylvania's Department of Human Services, past Executive Director of the National Association of State Directors of Developmental Disability Services and Deputy Secretary of what is now the Pennsylvania Office of Developmental Programs.

INTRODUCTION AND SUMMARY OF ARGUMENT

In this lawsuit, Markelle Seth challenges the failure of the District of Columbia to provide him with supports and services in the most integrated setting appropriate. There is strong evidence that Mr. Seth, like many individuals with I/DD, can be safely treated in the community.[2] Amici submit this brief to provide relevant information concerning the professional consensus regarding the occurrence of inappropriate sexual behavior among individuals with I/DD and the successful treatment of these individuals through individualized, community-based treatment programs.[3]

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[2] "Intellectual disability is characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills. This disability originates before age 18." *See* Am. Ass'n on Intellectual and Developmental Disabilities, *Intellectual Disability: Definition, Classification, and Systems of Support* 5 (11th ed. 2010). Amici curiae use the term "intellectual disability" in place of "mental retardation" except when directly quoting or referencing names of organizations. *See* Rosa's Law, Pub. L. No. 111-256, 124 Stat. 2643 (2010) (changing entries in the U.S. Code from "mental retardation" to "intellectual disability").

[3] The term "inappropriate sexual behavior" is used in this brief to discuss sexual behavior that is "unacceptably impinging on others, such as sexual offenses or abuse" as well as "sexualized challenging behavior." The latter refers to behavior that "will subject a person to ridicule, legal risk, or would be deemed unacceptable by the community." *See* Casey J. Clay et al., *Behavioral Interventions for Inappropriate Sexual Behavior in Individuals with Developmental Disabilities and Acquired Brain Injury: A Review*, 123 Am. J. on Intell. and Developmental Disabilities 245, 245 (2018). Experts and authors writing in this field also use phrases such as "problematic sexual behaviors" to describe this continuum of behavior. *See, e.g.*, Dorothy M. Griffiths & Paul Fedoroff, *Persons with Intellectual Disabilities and Problematic Sexual Behaviors*, 37 Psychiatr. Clin. N. Am. 195 (2014). Unless specifically noted, we use these terms largely coextensively.

ARGUMENT

I. Individuals with I/DD who exhibit sexually inappropriate behavior are most effectively treated in the community.

A. Understanding individuals with I/DD who engage in inappropriate sexual behavior requires understanding the context.

Experts understand incidents of inappropriate sexual behavior among the community of adults with I/DD to be a nuanced issue, and there is broad recognition that individuals with I/DD who engage in sexually inappropriate behavior are not necessarily "sexually deviant." Instead, experts have developed and studied the concept of "counterfeit deviance." *See, e.g.*, Dorothy Griffiths et al., *Counterfeit Deviance Revisited,* 26 J. of Applied Research. in Intell. Disabilities 471, 480 (2013) ("The primary concept involved in 'counterfeit deviance,' then, is that people with intellectual disabilities, because of their unique histories and unique living situations may engage in deviant behavior for reasons other than deviance.").

Unique challenges associated with developing and building interpersonal relationships are believed to be one of the primary causes of inappropriate sexual behavior by individuals with I/DD. "It has long been known that people with intellectual disabilities . . . often have difficulty negotiating relationships, and that these difficulties extend to sexual conduct." Robin J. Wilson et al., *People with Special Needs and Sexual Behavior Problems: Balancing Community and Client Interests While Ensuring Effective Risk Management*, 21 J. of Sexual Aggression 86, 89 (2015). These difficulties may be related to a misunderstanding of social boundaries and rules. *See id.* People with intellectual

disability "may have diminished capacities regarding age discrimination, ability to give or receive consent for sexual activities, experience sexual impulsivity or demonstrate poor sexual problem-solving." *Id.* Likewise, "[s]ex offenders with [I/DD] may lack the skills necessary to effectively modulate emotions, endure distress, tolerate frustration, communicate feelings, process new information, comprehend social norms and accurately interpret socio-sexual cues." Phillip L. Marotta, *A Systematic Review of Behavioral Health Interventions for Sex Offenders with Intellectual Disabilities*, 29 Sexual Abuse: A J. of Res. and Treatment 148, 151 (2017) (*A Systematic Review*); (citations omitted); *see also* The Arc Nat'l Ctr. on Crim. Just. & Disability, *Sex Offenders with Intellectual/Developmental Disabilities: A Call to Action for the Criminal Justice Community*, 3 (2015), http://thearc.org/wp-content/uploads/2019/07/NCCJD-White-Paper-2_Sex-Offenders-FINAL.pdf (NCCJD Report) (describing barriers in communication that individuals with I/DD may experience, including understanding consequences and expressing emotions, which can lead to inappropriate sexual behavior).

Other experts and scholars have recognized the related and "well documented problem of identification of emotion in people with intellectual disability." William R. Lindsay & A.H.W. Smith, *Responses to Treatment for Sex Offenders with Intellectual Disabilities: A Comparison of Men with 1-and 2-year Probation Sentences*, 42 J. of Intell. Disability Res. 346, 352 (1998). As explained by Lindsay and Smith, "[i]f there is difficulty in recognizing emotions in oneself, then there may also be difficulty in recognizing sexual arousal. There will be correspondingly greater problems in identifying emotions in

others (e.g., victims)." *Id.* Studies have also noted sexual naivety and difficulty understanding "normal sexual relationships, lack of relationship skills, difficulty in mixing with the opposite sex, poor impulse control and susceptibility to the influence of others." William R. Lindsay, et al., *A Treatment Service for Sex Offenders and Abusers with Intellectual Disability: Characteristics of Referrals and Evaluation*, 15 J. of Applied Res. in Intell. Disabilities, 166, 167 (2002) (*Treatment Service*) (citations omitted).

Lack of education about sexuality and sexual interactions are also a reason that individuals with I/DD may engage in inappropriate sexual behavior. *See* G.D. Blasingame, et al., Ass'n for the Treatment of Sexual Abusers, *Assessment, Treatment, and Supervision of Individuals with Intellectual Disabilities and Problematic Sexual Behaviors*, 4-5 (2014) ("ATSA Report") ("[A] number of studies have shown that persons with [I/DD] have low levels of knowledge about sexuality . . . and experience greater problems negotiating consent for sexual interactions than persons without [I/DD] (although these issues can improve with appropriate interventions—see Dukes & McGuire, 2009)."). This lack of education—combined with a lack of opportunity to learn and practice appropriate sexual expression and intimacy—can create significant and lasting confusion. *See* NCCJD Report, 6 ("Individuals with [I/DD] may act improperly due to having poor social skills, poor impulse control, a lack of formal sex education, as well as a lack of opportunity to experiment sexually with peers"); *id.* at 7-8 (noting that the failure to receive sex education at home or at school can lead to inappropriate sexual behavior).

Research also suggests that individuals with I/DD who engage in sexually inappropriate behavior may "come from chaotic, violent and neglectful families where parents often have criminal histories themselves." *See* Glynis Murphy et al., *Cognitive-Behavioural Treatment for Men with Intellectual Disabilities and Sexually Abusive Behavior: A Pilot Study,* 51 J. of Intell. Disability Res. 902, 903 (2007) (citations omitted) (*Cognitive-Behavioural Treatment*). Research indicates that a "significant proportion of cases" involve intra-family conflict, parental separation, and marital discord. *See A Treatment Service*, 167. Likewise, they often have a history of sexual abuse as victims themselves. *See Cognitive-Behavioural Treatment* at 903; *see also* Joseph Shapiro, *Abused and Betrayed*, National Public Radio (Jan. 2018), https://www.npr.org/series/575502633/abused-and-betrayed (reporting that individuals with ID/D are seven times more likely to experience sexual abuse than people without disabilities).

Mr. Seth fits the profile of a person with I/DD who has offended for reasons other than "deviance." Mr. Seth was abused and neglected as a child and was placed in foster care and lived in homeless shelters. In addition to broad deficits in cognitive skills, assessments of Mr. Seth reveal extremely low adaptive functioning, notably in the areas of communication, health and safety, and social skills. *See* Risk Assessment Report of Dr. Matthew Mason, PhD, BC-BA-D, LBA, 2-4, Feb. 24, 2017, Ex. 13 to the Am. Compl. ("Mason Report"). He exhibited "basic and inconsistent knowledge" with respect to sexuality and lacked comprehensive knowledge of biological functions related to sexual development. *Id.* at 10.

However, Dr. Mason noted that factors that may reduce Mr. Seth's risk of reoffending include "lack of sexual misconduct and sexual preoccupation when in a supervised setting." *Id.* at 13. While in prison, Mr. Seth has not taken advantage of others to gain a sexual favor or acted in a predatory manner. *Id.* 12-13. Dr. Mason noted that Mr. Seth's sexually inappropriate behavior was more opportunistic than predatory and was influenced by his limitations in cognition and self-management. *Id.* at 14. Dr. Mason further noted that prison staff who work consistently with Mr. Seth described him as "more vulnerable and immature compared to other inmates." *Id.* at 12. *Id.* Dr. Mason noted "protective" factors that indicated that Mr. Seth would succeed in a community-based program included Mr. Seth's willingness to engage with responsible and supervising adults and his ability to develop therapeutic relations. *Id.* at 13. Dr. Mason concluded that Mr. Seth possesses traits that would enable him to develop lasting, useful relationships with community-based staff and other adults in his life, namely, "the capacity for establishing appropriate emotional ties, empathy and a desire to please others." *Id.* at 15.

B. Experts agree that individuals with I/DD who display sexually inappropriate behaviors are best treated in the community.

The professional literature demonstrates that most individuals with I/DD who display sexually inappropriate behaviors are most effectively—and safely—treated in the community. Though there is no single treatment model for sexual offenders with intellectual disabilities, the professional consensus is that treatment interventions

should be provided in the community to be effective. As noted by the Association for the Treatment of Sexual Abusers ("ATSA"):

> Commitment and active engagement in the community (work, play, and personal attachments) and societal norms and values are important treatment focuses for persons with [intellectual disability and problematic sexual behaviors] . . . . The focus needs to be on physical and material surroundings that increase quality of life and, most importantly, on prosocial influences and full community integration (citation omitted).

ATSA Report, 17.

Of particular relevance here, sex-offender treatment received in the community is recognized as more effective in preventing recidivism than sex-offender treatment in prisons. *See* Friedrich Losel et al., *On the Effectiveness of Sexual Offender Treatment in Prisons: A Comparison of Two Different Evaluation Designs in Routine Practice*, 17 (2019), https://journals.sagepub.com/doi/full/10.1177/1079063219871576. "[T]he core philosophy behind cognitive-behavioral skills-based treatment is diametrically opposed to treating offenders in a prison context." *A Systematic Review*, 151. To be rehabilitated, "[o]ffenders must have ample opportunity to practice and generalize skills, for contingency management, for stimulus aversion and for relapse prevention in real world contexts." *Id.* Research indicates that "treatment plans focusing on community involvement, successful employment and positive self-image are generally more effective than those that segregate and confine offenders and focus primarily on acknowledging and suppressing problematic behavior." *See* NCCJD Report, 1.

The results of a significant study also support community-based treatment. *See* Jerry A. Rea et al., *Assessing the Generalization of Relapse-Prevention Behaviors of Sexual Offenders Diagnosed with Intellectual Disability*, 38 Behav. Modification 25 (2014). The study assessed community-based programs for males aged 18-28 who have an intellectual disability and committed sexual crimes against children. It found that, with proper supervision and trained staff, individuals can maintain an "enriched quality of life" while ensuring public safety. *Id.* at 42.

Other components of best practice treatment interventions are the use of cognitive, skill-based behavioral treatment. ATSA Report, 16. Cognitive behavioral therapy has been found to be extremely effective in treating individuals with I/DD who have sexually offended. Daniel T. Wilcox, *Treatment of intellectually disabled individuals who have committed sexual offences: A review of literature*, 10 J. of Sexual Aggression 85, 90 (2004); *see also* Glynis Murphy et al., *Effectiveness of Group Cognitive-Behavioral Treatment for Men with Intellectual Disabilities at Risk of Sexual Offending*, 23 J. of Applied Res. in Intell. Disabilities, 537, 549 (2010) ("Certainly, [cognitive behavioral] treatment should be on offer to more men with intellectual disabilities and sexually abusive behavior, so that the men can choose active treatment, rather than just long periods of tight risk management and close supervision, as in the past."). In a study of a UK community-based program that used cognitive behavioral therapy to treat sex offenders with I/DD, participants demonstrated a significant increase in socialization skills, listening skills, sexual

knowledge, and social responsibility. Leam A. Craig, et al., *Treating Sexual Offenders with Learning Disabilities in the Community: A Critical Review*, 50 Int'l J. of Offender Therapy and Comp. Criminology 369, 384 (2016).[4]

Another best practice identified by ATSA is the individualization of services to meet the needs of each participant. ATSA Report, 16. Services must be tailored to address the risk factors or triggers that directly relate to the individual's likelihood of reoffending and should also include post release monitoring, life skills training, and community supports. *See* Karen M. Ward & Rebecca L. Bosek, *Behavioral Risk Management: Supporting Individuals with Developmental Disabilities Who Exhibit Inappropriate Sexual Behaviors*, 27 Res. & Prac. for Persons with Severe Disabilities 27, 27 (2002) (*Behavioral Risk Management*); *see also* Robert McGrath et al., The Safer Society, *Current Practices and Emerging Trends in Sexual Abuser Management: The Safer Society 2009 North American Survey* 91 (2009), http://robertmcgrath.us/files/6414/3204/5288/2009_Safer_Society_North_American_Survey.pdf ("Programs should design and deliver services to meet clients' special needs because doing so increases the effectiveness of interventions . . . . Services should

[4] In the United Kingdom, the term "learning disability" is the official term for "intellectual disability." *See* U. of Hertfordshire, *Intellectual Disability Policy in England*, Intellectual Disability and Health, http://www.intellectualdisability.info/historic-articles/articles/intellectual-disability-policy-in-england.

be delivered in a manner that matches an individual's motivation, ability, learning style and personality characteristics.").

A 2002 study demonstrates how, with enough support, "high risk" offenders with I/DD can be safely treated within the community. *Behavioral Risk Management*, 27, 39. The program involved 41 individuals, all high-risk sex offenders, who received wrap-around services within the community.[5] *Id.* at 28. Participants' behavioral patterns, adaptive and emotional functioning and sexual knowledge and interest were assessed. *Id.* at 29. For each participant, the program developed a risk management plan and arranged for support and supervision within the community. *Id.* Services included interventions such as cognitive-behavior therapy, the teaching of new skills and alternate behaviors, supervision and monitoring. *Id.* The goals of the program were "to ensure community safety, to increase the individual's ability to live successfully in the community, and to reduce the time and cost of external management." *Id.* Participants learned various skills, including coping strategies to avoid or self-manage risky situations (such as proximity to children) and social and sexual skills (including knowledge and attitudes and behaviors related to legal and safe sexual alternatives). *Id.* at 34-35. Over

[5] Of these 41, 15 stopped participating the program due to a variety of factors, including individuals moving to another community, care providers and support teams not supporting the program, one death and incarceration for non-sexual offences. *Behavioral Risk Management*, 28.

the ten-year course of development of the program, none of the participants committed a sexual offence. *Id.* at 39.

II. The service plan for Mr. Seth is safe, appropriate, and similar to those offered by many states that provide community-based treatment to individuals with I/DD who exhibit inappropriate sexual behavior.

A. States routinely serve individuals with I/DD who exhibit inappropriate sexual behavior.

States have increasingly shifted from more expensive, outmoded institutions to less expensive, more effective community-based treatment for individuals with I/DD, including for those who present a wide range of "challenging" behavior, which can include sexually inappropriate behavior as well as physical aggression, property destruction, self-injurious behavior, and risk of flight. As explained by expert Laura N. Nuss, who served as D.C.'s Director of the Department on Disability Services from 2010 to 2016, the District of Columbia has the expertise and the capacity to serve individuals with I/DD exhibiting problematic behavior (including sexual misbehavior). See Decl. of Laura N. Nuss, ¶¶ 14-21, Ex. 1 to the Am. Compl. ("Nuss Decl."). Nancy Thaler, who has 19 years' experience leading government agencies, including as Pennsylvania's Deputy Secretary of the Office of Developmental Programs and as a technical advisor to the District, agrees that "extensive research and experience across the country have led to the development and widespread implementation of safe and successful community-based treatment are not available in the District of Columbia and across the country." Decl. of Nancy Thaler, ¶ 19, Ex. 2 to the Am. Compl. ("Thaler

Decl.”). In Pennsylvania alone, over 300 individuals with I/DD and a history of sexual offenses are successfully supported by more than ten community provider agencies across the state. Id. ¶ 26.

Further, numerous nonprofit organizations working throughout the country also provide safe, structured, and supportive community-based services to individuals who, like Mr. Seth, have an I/DD and a history of inappropriate sexual behavior.

Resources for Human Development (“RHD”) is a national nonprofit that currently supports programs in fourteen states. *See* Resources for Human Development, Our Programs, https://www.rhd.org/our-programs. As of October 2019, RHD supports over 100 participants with I/DD who have histories of problematic sexual behavior, including the commission of serious sexual offenses. Participants in RHD programing are typically supported in community living arrangements: they live in neighborhood residences with other participants and staff support. These living arrangements are designed to encourage and facilitate increasing independent living skills acquisition and community engagement. *Id.* The risk of recidivism of these participants is assessed using evidence-based risk assessment tools that have been widely researched and used in accordance with ATSA standards. Participants are supervised as appropriate, which may involve 1:1 or 2:1 staffing ratios, if necessary for community safety. Participants also receive treatment with qualified and trained practitioners using evidence-based treatment models including cognitive behavioral

therapy. *See* E-mail from David K. Attryde, MS LPC, Clinical Director, Resources for Human Development to Beverly Frantz, Ph.D. (Oct. 25, 2019), http://bit.ly/RHDDavidAttryde.

Benchmark Human Services ("Benchmark") is another agency operating in more than a dozen states. Benchmark supports over 1,200 people in community-based residential programs, including people with I/DD who have engaged in inappropriate sexual behavior and serious assault. *See* Letter from Jeff Cross, President, Public Solutions, Benchmark Human Services to Dr. David. A. Rotholz, Ph.D., BCBA-D (Oct. 11, 2019), http://bit.ly/benchmarkJeffCross. In Indiana, Benchmark operates nine separate transitional homes, each with four residents. People with a history of sexually offenses make up 25-50% of the residents. In Missouri, Benchmark operates a community residential program that typically serves 25-30 individuals with "complex behavioral needs," including seven individuals with histories of inappropriate sexual behavior. Benchmark has developed an extensive assessment and training protocol, as well as operational procedures that enable these individuals to participate in planned outings, community access, work, and family visits. *Id.*

In Minnesota, 5.2% of the 7,022 individuals receiving home and community-based services exhibited severe inappropriate sexual behavior. *See* R.J. Stancliffe & K.C. Lakin, *Costs and Outcomes of Community Services for People with Intellectual Disabilities*, 100 (Paul H. Brookes, Ed.) (2005). In other words, more than 360 people with I/DD who

have a history of severe inappropriate sexual behavior are being served in the community.

Wholistic Home and Community Services ("Wholistic"), the agency identified to serve Mr. Seth in this case, also offers programing in line with best practices. *See* Proposal for Transition, Safety and Support Services for Markelle Seth, Wholistic Services, Inc., 3-4, Ex.15 to the Am. Compl. ("Wholistic Services Plan"). In the proposal for Mr. Seth's treatment, Wholistic described its experience effectively treating this population. For example, as Wholistic supported a 36-year-old man, A.F., with intellectual disability and an Axis I diagnosis of bipolar, who was found incompetent to stand trial on charges involving inappropriate and dangerous sexual relations with young children. *Id.* at 3. Under the structured support of Wholistic, he lives peacefully and safely in a two-bedroom apartment, participating in a job-readiness program and volunteering at a local foodbank. He has 24-hour 1:1 staff supervision. Since he started receiving services through Wholistic, he has had no interactions of any kind with the criminal-justice system. *Id.*

B. Wholistic's proposed plan has all the components to successfully and safely serve Mr. Seth in the community.

Dr. Mason conducted detailed and extensive assessments of the risk Mr. Seth might pose in the community and recommended that Mr. Seth participate in a highly structured, community-based residential program with 1:1 staffing on a 24-hour basis. *See* Mason Report, 15. Dr. Mason found that Mr. Seth would require counseling and

psychiatric supports, including sexual education and a behavior-management plan. Dr. Mason also recommended that Mr. Seth be provided with a daily schedule of employment and other meaningful activities. *Id.* at 16. With these supports, Dr. Mason stated that Mr. Seth "can be safely and successfully supported in the community." *Id.* at 15. Dr. Mason's recommendations were later endorsed by Dr. Stephen Hart—an internationally-renowned forensic psychologist. *See* Report from Stephen D. Hart, Ph.D, Protect Int'l Risk and Safety Servs. Inc, re: U.S. v. Markelle Seth, June 18, 2017, 9-10, Ex. 14 to the Am. Compl.

The plan Wholistic provides is precisely the kind of support recommended by Dr. Mason. Wholistic's plan for Mr. Seth is extensive and includes a plan for intensive residential supports, vocational programming, services for a psychiatrist, a therapist, and a behavioral specialist, safety and crisis management plans, sexuality education, and person-centered planning. *See W*holistic Services Plan, 4-11. Wholistic's plan for Mr. Seth includes 1:1 staffing in a single residence with no more than one additional resident. *Id.* at 8.

Experts who have reviewed Wholistic's plan for Mr. Seth have agreed that this plan would be effective in treating Mr. Seth while maintaining the safety of the community. Laura Nuss opined that the Wholistic plan provides "appropriate, closely supervised, residential, vocational and therapeutic services in a community setting … while assuring the safety of the community in the District," thereby "offer[ing] Mr. Seth

the opportunity for rehabilitation and freedom from further ongoing trauma." Nuss Decl. ¶ 25. Nancy Thaler described Wholistic's proposal as "a complete approach to supervision of Mr. Seth, assuring safety in the community and addressing crisis events such as elopements or behavioral incidents." Thaler Decl. ¶ 30. Board-certified neuropsychologist, Dr. Robert L. Denney, who has extensive experience in assessing court-involved individuals with I/DD, and conducted a comprehensive neuropsychologist assessment of Mr. Seth, stated that "There is every reason to believe that Mr. Seth would not pose a danger and would thrive if released to a program such as the one …proposed by Wholistic Services Inc." Decl. of Robert L. Denney, ¶ 10, Ex. 3 to the Am. Compl. ("Denney Decl.").

C. Individuals with I/DD are disproportionally harmed in prison.

The deficits in cognitive and adaptive functioning typical to a diagnosis of I/DD make life in prison excruciatingly difficult for a person with an I/DD. *See* Rebecca Vallas, Cntr. for Am. Progress, *Disabled Behind Bars: The Mass Incarceration of People with Disabilities in America's Jails and Prisons, Center for American Progress* 3 (2016), https://cdn.americanprogress.org/wp-content/uploads/2016/07/18000151/2CriminalJusticeDisability-report.pdf. Prisoners with I/DD are at a serious risk of harm due to their susceptibility to abuse, manipulation, and exploitation. Deprived of necessary supports, services, and accommodations, they may not be able to read, write, or understand myriad prison rules. *Id.* Prisoners with disabilities may exhibit challenging behaviors that disrupt the running of the correctional facility. For instance, prisoners

with I/DD are more likely to respond physically in threatening situations, rather than verbally. Joan Petersilia, California Pol'y Res. Cntr., *Doing Justice? Criminal Offenders with Developmental Disabilities*, 13 (2000). As a result of their behavioral challenges, and the lack of training for correctional officers to identify and interact with inmates with I/DD, inmates may be reclassified to a higher, more restrictive security level. *Id.* In fact, prisoners with I/DD are likely to incur more disciplinary sanctions, including a greater loss of privileges. *See* Margo Schlanger, *Prisoners with Disabilities*, in *Reforming Criminal Justice: Punishment, Incarceration, and Release* 295, 307-308 (E. Luna ed., 2017).

Mr. Seth's experience has been consistent with the experience of many inmates with I/DD in a correctional setting in that he has been continuously punished for behaviors related to his disability. During one portion of his confinement, Mr. Seth was held in a locked cell "due to his inability to function in general population" including his low frustration tolerance, anger/agitation, withdrawal, and intermittent compliance—all behaviors related to his disability. *See* Mason Report, 4. He suffered a skull fracture following an altercation with prison guards. *See* Amended Complaint, at 18. His difficulty with communication, self-care, social skills, and self-direction has led him to engage in problematic behaviors, like refusing to follow instruction, minor self-injury, impulsivity, and verbal abuse. *Id.* As noted by Dr. Denney, "[s]uch behaviors are disruptive in a correctional setting where conformity is required." Denney Decl. ¶ 9. Unsurprisingly, the response to these behaviors has been punitive and harsh rather

than therapeutic: Mr. Seth has spent the majority of his time in prison in solitary confinement with little connection to necessary programming or human contact. *Id.*

Placement in solitary confinement has a particularly debilitating effect on individuals with I/DD. Psychiatrist Dr. Stuart Grassian, whose observations and conclusions about solitary confinement have been cited by a number of federal courts, including *Madrid v Gomez*, 889 F. Supp. 1146 (N.D. Cal. 1995), states that individuals who are the most severely affected by solitary confinement are those with neurological disorders or some other form of intellectual disability, who may suffer from florid psychotic delirium, severe hallucinatory confusion, disorientation, incoherence, and intense agitation and paranoia. Stuart Grassian, *Psychiatric Effects of Solitary Confinement*, 22 Wash. U.J.L & Pol'y 235, 332 (2006).

Furthermore, the effects of solitary confinement are long lasting. Psychologist Dr. Craig Haney, who conducted research into the effect of the use of prolonged solitary confinement at California's Pelican Bay, noted that inmates develop adaptations that are "dysfunctional and problematic" to cope in solitary confinement. Craig Haney, *Mental Health Issues in Long-term Solitary and "Supermax" Confinemen*t, 49 Crime & Delinq. 124, 139 (2003). For some inmates, the lack of social contact means that they "are literally at risk of losing their grasp on who they are, of how and whether they are connected to a larger social world." *Id.* Others become disorientated and frightened by social contact. *Id.* at 140. These acutely dysfunctional responses to social contact

become internalized and persist long after the prisoner's time in isolation has ended, so that those without significant social and professional support "may never return to the free world and resume normal, healthy, productive social lives." *Id.* at 141.

The use of measures like solitary confinement, reduced mingling with other inmates, and reduced access to preferred activities or areas has further destabilized Mr. Seth's mental health and depriving him of the opportunity to develop the necessary communication and socialization skills that he requires. *See* Mason Report, 11. By contrast, community settings can be easily individualized and designed to avoid the specific triggers that cause an individual's challenging behaviors. Thaler Decl. ¶ 24. For instance, Mr. Seth has been punished for conduct that arose when Mr. Seth was prevented from watching his preferred program on television. Nancy Thaler has pointed out that this would not be a problem in a community setting. Not only would it be unlikely that Mr. Seth would be in a group setting sharing a television, but Wholistic has trained staff with "tools to de-escalate conflict and teach positive social behaviors without resorting to isolation." *Id.* ¶ 25.

Without access to appropriate rehabilitative programs or treatment, the continued confinement of Mr. Seth in a punitive environment that is unequipped to meet Mr. Seth's disability-related needs is pointless and cruel. As noted by Dr. Denney, "the design, service provision and staff models of the [Federal Bureau of Prisons] virtually ensure continuing failure and continuing incarceration." Denney Decl. ¶ 9. Dr.

Denney voices the concern that continued incarceration would worsen Mr. Seth's condition rather than improve in terms of potential risk of future violence upon release to the community. *Id.* ¶23. By contrast, in the community, services could be individualized to meet Mr. Seth's needs and behaviors. He could learn necessary and positive social skills and develop the ability to live safely in the community under the supervision of trained staff.

CONCLUSION

Amici curiae respectfully request that the Court vacate the district court's judgment and remand the case for further proceedings.

Dated: December 18, 2019

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

1. This brief complies with the type-volume limitations of Federal Rule of Appellate Procedure 32(a)(7)(B) because this brief contains 5,147 words, excluding the parts of the brief exempted by Federal Rule of Appellate Procedure 32(f).

2. This brief complies with the typeface requirements of Federal Rule of Appellate Procedure 32(a)(5) and the type-style requirements of Federal Rule of Appellate Procedure 32(a)(6) because this brief has been prepared in a proportionally spaced typeface using Microsoft Office Word 365 ProPlus in 14-point Garamond.

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CERTIFICATE OF SERVICE

I hereby certify that, on December 18, 2019, this Brief of Amicus Curiae in Support of the Plaintiffs-Appellant and Reversal was served through the Court's ECF system on counsel for all parties.

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