**Using Disability Accommodations at Sentencing   
to Divert Persons with Mental Illness Away from Prison**

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Mr. A was charged with attempted unarmed robbery. At arraignment, he behaves erratically—interrupting the judge, exclaiming that he wants a lawyer despite having one by his side, and ordering the bailiff to release him immediately. Concerned about her client’s mental health status, Mr. A’s lawyer moves for a competency evaluation, which the judge grants. After a comprehensive neuropsychiatric evaluation, Dr. B—the forensic psychiatrist tasked with assessing Mr. A’s present ability to cooperate with his lawyer and understand the legal proceedings against him—takes the stand. She testifies that, in her opinion, Mr. A is competent to stand trial. But she notes Mr. A’s serious memory deficits, his recent psychiatric involvement (Mr. A reported having been institutionalized for bipolar disorder), and his frequent heavy alcohol consumption to self-medicate mood swings that are otherwise poorly ameliorated by superficially monitored psychotropic medication. Satisfied with the expert opinion and the evidence presented, the judge orders the prosecutorial process to proceed. Mr. A ultimately pleads guilty.

Next, the judge must decide how Dr. B’s testimony regarding Mr. A’s neuropsychological deficits and history of psychiatric disability will affect the sentence, if at all. Her choices in this respect are many because U.S. law affords judges great discretion at the sentencing stage of criminal proceedings. That said, judges generally choose one of two routes when asked to weigh neuroscientific evidence of psychiatric disability as part of their sentencing decisions. *See* Hentry T. Greely & Nita A. Farahany, *Neuroscience and the Criminal Justice System,* 2 Ann. Rev. Crim. 451 (2019). Neuroscience and the criminal justice system. Annual Review of Criminology. They choose to disregard evidence of disability and punish based on statutory guidelines. Alternatively, they temper the punishment—for example, by decreasing the length of imprisonment—under the assumption that defendants’ disability may have impaired their decision-making ability at the time of the offense. In Mr. A’s case, however, both responses fail to account for and respond to the neuroscientific evidence of his condition. We propose a third and currently under-utilized pathway in U.S. criminal law and procedure: the leveraging of reasonable modifications as prescribed by Title II of the Americans with Disabilities Act (ADA).

ADA Title II prohibits state and local governments from discriminating against people with disabilities because of their disability. Both the U.S. Supreme Court and federal regulations recognize that Title II applies to non-federal carceral facilities, including prisons and jails. 42 U.S.C. § 12131. Although the ADA does not apply in federal criminal cases, the Rehabilitation Act of 1973 does, and the obligations that arise under it are analogous. Their prohibition against discrimination requires government entities, including prisons, to implement “reasonable modifications” to existing infrastructure as ex ante measures to prevent disability discrimination, and it extends to medical, recreational, educational, and vocational programming that excludes or does not equally benefit people with disabilities.

What is less recognized, however, is how judges can incorporate reasonable modifications directly into sentencing decisions and thereby prescribe steps to prevent discrimination against defendants with disabilities. In Mr. A’s case—or in similar criminal case involving neuropsychiatric evidence of disability—this judicial tool has the potential for positive impact in at least two critical ways. Each accounts for the scientific and public recognition that people with psychiatric disabilities are overrepresented in the nation’s jails and prisons, and that they are among the most vulnerable to violence, health and mental deterioration, and maltreatment in carceral settings.

First, judges could leverage Title II to prohibit the use of punitive practices like solitary confinement as a substitute for treatment due to their disproportionate and discriminatory impact on people with mental disabilities. Recent evidence shows that solitary confinement is an acute risk factor for post-traumatic stress disorder symptomology, psychotic episodes, hostility, self-harm behavior, suicidality, and mortality. *See* Mimosa Luigi, Laura Dellazizzo, Charles-Édouard Giguère, Marie-Hélène Goulet, & Alexandre Dumais, *Shedding Light on “the Hole”: A Systematic Review and Meta-Analysis on Adverse Psychological Effects and Mortality Following Solitary Confinement in Correctional Settings*, 11 Frontiers Psych. 840 (2020). Moreover, the frequent lack of access to treatment afforded to people with psychiatric disabilities in solitary confinement compound these problems. One federal investigation conducted in Massachusetts prisons found that people placed in “mental health watch”—shorthand for restrictive housing reserved for those in mental health crisis—suffer from chronic lack of care, a problem not least due to shortages in clinical staff. *See* Benjamin A. Barsky, *Ending Restrictive Housing in Prisons for People With Mental Disorders*, Psych. Serv. (Forthcoming). These findings are generalizable across other states and types of carceral facilities.  Concerning the monitoring of psychotropic medications, the situation is dire and often lacking in the appropriate level of biopsychosocial assessment. Even when a baseline of monitoring does occur for side effects (e.g., the metabolic toxicity associated with many psychotropics), inadequate monitoring of the interaction of the prescribed substance with the patient’s state of mind and psychosocial setting can persist.

Second, judges could require diverting defendants back into the community. Evidence shows that people with psychiatric disabilities are at higher risk of criminal justice involvement and recidivism than those without disabilities.  *See* Alene Kennedy-Hendricks, Haiden A. Huskamp, Lainie Rutkow, & Colleen L. Barry, *Improving Access to Care and Reducing Involvement in the Criminal Justice System for People with Mental Illness*, 35 Health Aff. 1076 (2016). This issue has prompted scholars, policymakers, and practitioners alike to recognize that incarceration has at best questionable deterrent or rehabilitative effect for this population. *See* Armita Adily et al., *Association Between Early Contact With Mental Health Services After an Offense and Reoffending in Individuals Diagnosed With Psychosis*, 77 JAMA Psych. 1137 (2020). What is more, in most jurisdictions, judges have access to a menu of diversionary strategies, including referring defendants to mental health courts, probation, and community service. Access to non-carceral resources and programs (e.g., integrated housing, health insurance, work supports) will often enable successful reintegration into the community. In other cases, a question for judges to consider is whether the benefits of adequately funded and implemented community supervision of individuals at low risk of re-offense in need of mental health treatment (and required by the ADA’s mandate of access to health care) outweigh those of institutionalized incarceration.

Two sources of law coalesce in making diversion a feasible strategy at sentencing. To ensure compliance with ADA Title II, the U.S. Department of Justice (DOJ) has promulgated regulations that require state and local governments to “ensure that inmates or detainees with disabilities are housed in the most integrated setting appropriate to the needs of the individuals.” 28 C,F.R. § 35.152. The DOJ has imposed similar requirements in the context of federal carceral facilities, an obligation that falls under the Rehabilitation Act as opposed to the parallel ADA. At the same time, in the 1999 case of *Olmstead v. L.C.*, the U.S. Supreme Court ruled that unjustified institutionalization constitutes the kind of discrimination proscribed under Title II—a ruling that has become known as the “integration mandate,” and that applies across federal, state, and local government services. These requirements allow judges to impose alternatives to incarceration when they deem carceral institutionalization to be an ineffective response to the defendant’s neuropsychiatric needs, or when such incarceration, given the lack of meaningful treatment, could lead to cruel and unusual punishment.

In cases like Mr. A’s—where neuropsychological evidence suggests that non-punitive and community-based interventions would be more appropriate than institutional punishment—judges should use their discretion at sentencing to minimize harm. By triggering protections under the ADA, defendants with histories of psychiatric disability should have the right to avoid unneeded suffering in solitary confinement, receive appropriate mental health services, and gain the chance to avoid incarceration altogether. As such, the use of neuroscientific evidence during criminal prosecutions—especially when it reveals evidence of psychiatric disability—can serve as a valuable harm-reduction, diversionary, and decarceral tool. By the same token, neuroscience can become a gateway through which lawyers and judges can secure more just outcomes for individuals with disabilities caught in the thrall of the criminal-legal system.