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Conditions of Confinement at Sentencing: The Case of Seriously Disordered Offenders

E. Lea Johnston

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Cover Page Footnote

Associate Professor of Law, University of Florida, Levin College of Law. I wish to thank Miriam Baer, Douglas Berman, Darryl Brown, Michael Cahill, Mary Anne Franks, Carissa Hessick, Jerold Israel, Elta Johnston, Wes Jones, Shani King, Jennifer Laurin, Gerald Leonard, Tom Lin, Dan Markel, Jason Nance, Sharon Rush, Christine Scott-Hayward, Michael Seigel, Christopher Slobogin, John Stinneford, and Scott Sundby for their valuable comments and suggestions. I also appreciate feedback from participants at the University of Alabama School of Law's faculty colloquium, the University of Florida Levin College of Law's Criminal Justice Center's Junior Scholars' Conference, the Law and Society 2013 Annual Meeting, and the Southeastern Association of Law Schools' 2013 Annual Meeting. I am grateful for the summer grant provided by the Levin College of Law. Finally, I thank Laura Beard, Stephen Carr, Rebecca Eikleberry, Jessie Ervolino, Chelsea Koester, Matt Michel, Patricia Morgan, Eric Pacifici, Erica Perdomo, Nerissa Robinson, Daniel Tullidge, Christopher Vallandingham, and Benjamin Wolf for their outstanding research assistance.

CONDITIONS OF CONFINEMENT AT SENTENCING:
THE CASE OF SERIOUSLY DISORDERED
OFFENDERS

E. Lea Johnston⁺

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⁺ Associate Professor of Law, University of Florida, Levin College of Law. I wish to thank Miriam Baer, Douglas Berman, Darryl Brown, Michael Cahill, Mary Anne Franks, Carissa Hessick, Jerold Israel, Elta Johnston, Wes Jones, Shani King, Jennifer Laurin, Gerald Leonard, Tom Lin, Dan Markel, Jason Nance, Sharon Rush, Christine Scott-Hayward, Michael Seigel, Christopher Slobogin, John Stinneford, and Scott Sundby for their valuable comments and suggestions. I also appreciate feedback from participants at the University of Alabama School of Law's faculty colloquium, the University of Florida Levin College of Law's Criminal Justice Center's Junior Scholars' Conference, the Law and Society 2013 Annual Meeting, and the Southeastern Association of Law Schools' 2013 Annual Meeting. I am grateful for the summer grant provided by the Levin College of Law. Finally, I thank Laura Beard, Stephen Carr, Rebecca Eikleberry, Jessie Ervolino, Chelsea Koester, Matt Michel, Patricia Morgan, Eric Pacifici, Erica Perdomo, Nerissa Robinson, Daniel Tullidge, Christopher Vallandingham, and Benjamin Wolf for their outstanding research assistance.

Sentencing law fails to provide judges with the tools necessary to prevent anticipated and unjustified harm to prisoners. Judges can foresee that certain individuals—often because of their mental or physical disabilities, sexual orientation, or diminutive size¹—will experience serious physical abuse or mental injury while imprisoned.² Currently, concerned judges may call these offenders' susceptibilities to harm or anticipated special needs to the attention of correctional officials or suggest certain housing or treatment in prison through their sentencing orders.³ However, these findings and recommendations are non-binding, and officials may not even notify judges when they choose to disregard such requests.⁴ Judges presently lack the authority to order any condition of confinement, or to prevent the imposition of a particular condition, even if they believe a condition is critical to the humaneness of an offender's carceral sentence or to the effectuation of its objectives. This Article builds the case for granting judges that authority within the context of one vulnerable population of prisoners: those with major mental disorders.⁵

Prisons are overwhelmed with inmates with schizophrenia, bipolar disorder, and other serious mental illnesses, conditions that leave inmates poorly equipped to navigate these dangerous environments.⁶ The hazards that seriously

1. See 28 C.F.R. § 115.41 (2013) (identifying risk factors for sexual assault in prison, which include mental illness; physical or developmental disability; youth; diminutive size; a history of victimization; first, nonviolent, or sexual offender status; and perception as gay, bisexual, transgender, or gender-nonconforming); see also NAT'L PRISON RAPE ELIMINATION COMM'N, NATIONAL PRISON RAPE ELIMINATION COMMISSION REPORT 7–8, 69–74 (2009), available at <https://www.ncjrs.gov/pdffiles1/226680.pdf> (discussing risk factors).

2. See E. Lea Johnston, *Vulnerability and Just Desert: A Theory of Sentencing and Mental Illness*, 103 J. CRIM. L. & CRIMINOLOGY 147, 181–82 & nn.172–75 (2013); Adam J. Kolber, *The Subjective Experience of Punishment*, 109 COLUM. L. REV. 182, 188–89 & n.11 (2009).

3. See *infra* notes 181, 302–06 and accompanying text (discussing the types of recommendations judges may make for vulnerable defendants).

4. See ALLAN ELLIS ET AL., FEDERAL PRISON GUIDEBOOK 27 (2012); see also *infra* note 305 and accompanying text (discussing the frequency with which Federal Bureau of Prisons officials adopt judicial recommendations).

5. See *infra* note 19 and accompanying text (defining the population at issue).

6. See HOLLY HILLS ET AL., U.S. DEP'T OF JUSTICE, EFFECTIVE PRISON MENTAL HEALTH SERVICES 2–3 (2004), available at <http://static.nicic.gov/Library/018604.pdf>. Experts estimate that around sixteen percent of prisoners have a mental disorder. *Id.* at 3; Kenneth Adams & Joseph Ferrandino, *Managing Mentally Ill Inmates in Prisons*, 35 CRIM. JUST. & BEHAV. 913, 913 (2008). This rate exceeds the incidence of mental disorder within the non-incarcerated community. DORIS J. JAMES & LAUREN E. GLAZE, U.S. DEP'T OF JUSTICE, MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES 3 (2006), available at <http://bjs.ojp.usdoj.gov/content/pub/pdf/mhppji.pdf> (reporting that around eleven percent of individuals age eighteen or older in the general population of the United States satisfies DSM-IV criteria for symptoms of a mental health disorder). Because male prisoners constitute ninety-three percent of the prisoner population in the United States, this Article will focus on male prisoners. See HEATHER C. WEST ET AL., U.S. DEP'T OF JUSTICE, PRISONERS IN 2009, at 2 (2010), available at <http://bjs.ojp.usdoj.gov/content/pub/pdf/p09.pdf>.

disordered inmates face are numerous and substantial.⁷ For instance, correctional officials may fail to detect an inmate's disorder⁸ or treat it effectively.⁹ Prisons typically house mentally ill offenders within the general prison population, where they are especially likely to suffer physical and sexual victimization.¹⁰ For disciplinary or protective reasons, correctional officials are disproportionately likely to transfer disordered inmates to solitary confinement, where they often experience serious psychological deterioration and acute distress.¹¹ These foreseeable harms may undermine the purposes of an offender's punishment and render his sentence disproportionate or even inhumane.

Cognizant of this reality, a number of jurisdictions factor offender vulnerability—a term used by this Article to include both substantial risks of serious harm and a need for treatment or protection—into sentencing to a limited extent. A handful of jurisdictions permit judges to commit certain individuals for mental health treatment in lieu of imprisonment.¹² A larger number of states allow trial courts to depart from presumptive sentences when offenders require specialized treatment or would face excessive hardship in prison.¹³ Many of these jurisdictions permit a finding of vulnerability to support a stayed sentence of incarceration with probation,¹⁴ while others authorize a reduction in the duration of an offender's carceral term upon a vulnerability determination.¹⁵ These efforts are laudable. However, they do not provide adequate relief for vulnerable offenders sentenced to imprisonment because they fail to authorize judges to alter an inmate's likely conditions of confinement.

7. See Johnston, *supra* note 2, at 181–82 & nn.172–75. This Article focuses on individuals with serious mental illnesses who are sentenced to prison. However, a defendant's mental disorder may not be his only source of vulnerability to serious harm in prison. See *supra* note 1 (identifying other sources of vulnerability). Any additional risk factors should also factor into a sentencing calculus to ensure that sentences are humane, proportionate, and serve the intended aims of punishment.

8. See *infra* Part I.B. (discussing the shortcomings of mental health evaluation procedures in prisons).

9. See *infra* Part I.C. (surveying and evaluating mental health treatment procedures in prisons).

10. See *infra* notes 88, 95 and accompanying text.

11. See *infra* notes 96–98 and accompanying text.

12. See *infra* Part III.A. (analyzing these jurisdictions).

13. See *infra* Part III.B. Specific authorization to factor vulnerability into sentencing is most critical in jurisdictions that limit sentencing judges' discretion. About half of all states employ indeterminate sentencing schemes that allow for wide judicial discretion, while the remaining jurisdictions limit judges' abilities to vary sentences according to offender characteristics through sentencing guidelines or a statutory determinate sentencing regime. See Kevin Reitz, *The "Traditional" Indeterminate Sentencing Model*, in THE OXFORD HANDBOOK OF SENTENCING AND CORRECTIONS 270, 270–71 (Joan Petersilia & Kevin R. Reitz eds., 2012).

14. See *infra* notes 195–97 and accompanying text (discussing these jurisdictions).

15. See *infra* notes 199–202 and accompanying text (discussing these jurisdictions).

To address that concern, this Article extends these statutory frameworks to the carceral context. In particular, it advocates for authorizing judges to tailor the conditions of confinement for seriously disordered, vulnerable offenders. With that authority, judges could design sentences to meet the needs of mentally ill prisoners, obviate unjustifiable hardships, and, hopefully, reduce the extent to which their disorders exacerbate the severity of their prison experiences. The Article considers a number of tailoring options that each affect correctional affairs to a different degree and offer unique efficiency benefits.

In arguing for an expansion of sentencing authority over conditions of confinement, this Article contributes to the ongoing conversation in the scholarly literature concerning whether and how sentencing should respond to foreseeable but unintended harm. The author's previous work has supported the efforts of Professor Adam Kolber and others, who have theorized that just punishment must consider foreseeable harm to offenders.¹⁶ One effective critique of those efforts has been the practical observation that recognizing susceptibility to harm in sentencing would entail giving lesser punishments (i.e., shorter carceral sentences) to sensitive, but equally culpable, offenders, which would undermine the value of parity in punishment and the predictability of the sentencing process.¹⁷ This Article suggests an alternative means of accounting for vulnerability that would avoid that pitfall: give equally culpable offenders the *same* basic punishment (i.e., terms of incarceration of the same duration), but tailor the sentences of vulnerable prisoners to remove the unacceptable hardships that flow from each individual's disability.¹⁸

16. See Adam J. Kolber, *Unintentional Punishment*, 18 LEGAL THEORY 1, 3–4 (2012) (arguing for a “justification-symmetry principle,” whereby state actors must justify harm purposely, knowingly, recklessly, or negligently caused in the name of just punishment); see also Johnston, *supra* note 2, at 190–91 (commending this theory).

17. See Dan Markel & Chad Flanders, *Bentham on Stilts: The Bare Relevance of Subjectivity to Retributive Justice*, 98 CALIF. L. REV. 907, 978–82 (2010).

18. Other scholars have also advocated for the consideration of correctional conditions in sentencing. See Myrna S. Raeder, *Gender-Related Issues in a Post-Booker Federal Guidelines World*, 37 MCGEORGE L. REV. 691, 741–42 (2006) (suggesting that courts consider women's health issues in sentencing); Ken Strutin, *The Realignment of Incarcerative Punishment: Sentencing Reform and the Conditions of Confinement*, 38 WM. MITCHELL L. REV. 1313, 1357–71 (2012) (suggesting that sentencing courts be permitted to consider the humaneness of treatment in prison under an Eighth Amendment analysis); cf. Adam J. Kolber, *Against Proportional Punishment*, 66 VAND. L. REV. 1141, 1143 (2013) (arguing that, “once we understand punishment severity in terms of harsh treatment rather than a more neatly bordered but inaccurate construct like days in prison, we must consider the actual amount of harsh treatment we inflict,” which will vary by an inmate's facility and how he experiences that facility, among other factors); Alexander A. Reinert, *Eighth Amendment Gaps: Can Conditions of Confinement Litigation Benefit from Proportionality Theory?*, 36 FORDHAM URB. L.J. 53, 85–86 (2009) (suggesting that the partial unification of the proportionality and conditions of confinement analyses under the Eighth Amendment could result in constitutional conditions of confinement that vary by offenders' crimes and characteristics).

For clarity of analysis, this Article limits its attention to defendants with clinical syndromes, such as schizophrenia, bipolar disorder, and major depression, which cause extreme distress and interfere with social and emotional adjustment.¹⁹ Although other risk factors exist and merit recognition,²⁰ major mental disorders pose unique difficulties within a prison environment. First, individuals with serious mental illnesses face the threat of declining cognitive function, which—because it implicates a person’s hold on reality, personality, and autonomy—constitutes a particularly grave danger. Second, mental disorder is often difficult to diagnose, and the screening systems that prison intake centers use overlook some disorders, which leads to a delay in treatment and possible placement in an unsuitable environment.²¹ Other vulnerabilities, such as physical disability, diminutive stature, and first-offender status, may be easier to identify (and harder to feign).²² Third, prisons commonly protect offenders susceptible to abuse by placing them in protective custody or solitary confinement, but the prolonged confinement of a mentally disordered offender in isolated and extremely restrictive conditions may result in severe psychological damage.²³ Thus, to the extent that isolation constitutes a prison’s primary protective mechanism, prisons may lack a means of protecting vulnerable, disordered offenders without further endangering their health. Judges may be able to compensate partially for these deficiencies through sentencing.

To be clear, this Article does not advocate for the full judicial assumption of responsibility for evaluating and placing mentally ill inmates in appropriate facilities, or for a diminution of correctional responsibility in these areas. Indeed, prisons are well positioned for, and should accelerate their progress in, developing and implementing objective, verified, reliable classification procedures and humane housing and treatment options for mentally ill offenders.²⁴ Rather, the Article merely examines whether a judge should be

19. The fourth edition of the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders* characterizes these disorders as Axis I disorders. See AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 13–24, 28 (4th ed. rev. 2000). The fifth, current edition of the DSM eliminates the Axis system. See AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 16–17 (5th ed. 2013) [hereinafter DSM-5]. This Article uses *serious mental illness*, *major mental illness*, and *major mental disorder* interchangeably and *mental illness* and *mental disorder* as shorthand for these serious conditions. A *disordered* individual is assumed to have one of these conditions.

20. See *supra* note 1 (detailing risk factors).

21. See *infra* Part I.B. (discussing the shortcomings of prison mental illness evaluations).

22. This observation does not apply to all vulnerabilities, such as gay or bisexual orientation. See *supra* note 1 (listing characteristics that contribute to vulnerability in prison).

23. See *infra* notes 95–97, 103–04 and accompanying text (explaining why disordered inmates are placed in segregated housing and discussing the effects of isolation).

24. See JAMES AUSTIN & KENNETH MCGINNIS, U.S. DEP’T OF JUSTICE, CLASSIFICATION OF HIGH-RISK AND SPECIAL MANAGEMENT PRISONERS 1 (2004), available at

authorized to shape the terms of a mentally ill offender's carceral sentence to minimize its potential for serious harm.

The adoption of this Article's proposal would carry three practical effects. First, it should ameliorate the harsh conditions experienced by a subset of offenders. Second, it would draw attention to the plight of mentally disordered prisoners and the insufficient provision of mental health care in prisons and perhaps spur legislative funding. Third, addressing vulnerability in sentencing could strengthen inmates' future Eighth Amendment claims. A judicial pronouncement that an inmate has a serious mental disorder and requires treatment or protective resources should help that inmate later establish that relevant prison officials were aware that certain conditions could pose a substantial risk of serious harm to the inmate, thus satisfying part of the "deliberate indifference" standard necessary to prove an Eighth Amendment violation.²⁵

This Article is organized in four parts. Part I identifies the potential perils that await offenders with serious mental illnesses in prison, including the shortcomings in the processes designed to detect offenders' mental disorders and to provide them with protective and therapeutic housing. Part II defends the premise that vulnerability is a legitimate concern for sentencing judges as they attempt to advance the various goals of punishment. Part III details the current approaches employed in some jurisdictions to recognize vulnerability in sentencing and explains why these measures are inadequate. Finally, Part IV extends these statutory frameworks to the carceral context and argues that judges should possess the authority to tailor the confinement conditions for vulnerable, seriously disordered offenders when they believe that a condition is critical to the humaneness or objectives of an offender's sentence. Part IV considers steps judges could take to accommodate this subset of offenders, including mandating comprehensive mental health examinations, disqualifying facilities particularly likely to exacerbate an individual's disorder, designating facilities with certain treatment or protective options, and directing that offenders receive—or not receive—certain treatment in prison.

I. IDENTIFICATION AND TREATMENT OF SERIOUS MENTAL ILLNESSES IN PRISON

Prison is physically and psychologically hazardous for inmates with major mental disorders. Recognizing the constitutional imperative to identify and treat

<http://static.nicic.gov/Library/019468.pdf> (noting that most prisons have implemented successful objective classification systems to assign custody levels to inmates).

25. See *Farmer v. Brennan*, 511 U.S. 825, 842–43 (1994) (“Whether a prison official had the requisite knowledge of a substantial risk is a question of fact subject to demonstration in the usual ways, including inference from circumstantial evidence, and a factfinder may conclude that a prison official knew of a substantial risk from the very fact that the risk was obvious.”); *infra* note 134 (delineating standard for Eighth Amendment violation for condition of confinement).

these offenders,²⁶ prisons have established procedures to detect serious mental health issues at intake and to factor an inmate's mental health needs into his facility and housing placements. Shortcomings exist in the current assessment and classification systems, however, that lead to the under-detection of mental disorders and unpredictable placement of mentally ill prisoners in protective housing. In addition, the protective housing options afforded within many prisons may actually exacerbate mental disorders.

A. Mental Health Screening

Prisons rely on a triage system to identify offenders with mental disorders who require treatment and special housing.²⁷ The initial mental health screen—sometimes the only assessment of an inmate's mental health—is typically part of the prison intake process.²⁸ The aims of this screen are to detect individuals with severe mental disorders who need immediate psychiatric attention, prevent suicide, continue individuals' psychotropic medications, and identify individuals with non-acute mental health needs that require further assessment and treatment.²⁹ In addition, the results of the mental health screen inform an inmate's classification, housing, job assignment, programming, and treatment.³⁰ The screen typically consists of a short interview regarding an inmate's current symptoms, past psychiatric history, suicide potential, social history, and level of education.³¹ The screen may also involve a review of available records and the administration of specialized instruments or tests.³²

26. See *infra* notes 75–79 and accompanying text.

27. See ALLEN J. BECK & LAURA M. MARUSCHAK, U.S. DEP'T OF JUSTICE, MENTAL HEALTH TREATMENT IN STATE PRISONS, 2000, at 1–2, 5 (2001), available at <http://www.bjs.gov/content/pub/pdf/mhtsp00.pdf>; see also NAT'L INST. OF CORR., U.S. DEP'T OF JUSTICE, PROVISION OF MENTAL HEALTH CARE IN PRISONS 2 (2001), available at <http://static.nicic.gov/Library/016724.pdf>; Humberto Temporini, *Conducting Mental Health Assessments in Correctional Settings*, in HANDBOOK OF CORRECTIONAL MENTAL HEALTH, 119, 129–39 (Charles L. Scott ed., 2d ed. 2010). For a description of the initial medical screen conducted at intake and subsequent medical examination in the federal prison system, see Ellis et al., *supra* note 4, at 67.

28. See BECK & MARUSCHAK, *supra* note 27, at 2. For a detailed discussion of the variety of approaches to the intake process that state correctional agencies employ, see PATRICIA L. HARDYMAN ET AL., NAT'L INST. OF CORR., PRISONER INTAKE SYSTEMS (2004), available at <http://static.nicic.gov/Library/019033.pdf>.

29. See Temporini, *supra* note 27, at 130, 135.

30. HARDYMAN ET AL., *supra* note 28, at 10–11.

31. See *id.* at 10; Temporini, *supra* note 27, at 135.

32. See HARDYMAN ET AL., *supra* note 28, at 10 (“Generally, the screen consists of a brief interview by mental health staff. Depending on the results, the mental health staff may complete one or more psychological tests, such as the Millon Clinical Multiaxial Inventory (MCMI), the Minnesota Multiphasic Personality Inventory (MMPI), and the Wechsler Adult Intelligence Scale (WAIS).”); see also HILLS ET AL., *supra* note 6, at 14.

If the evaluator believes that an inmate is likely to have one or more psychiatric disorders, she will refer the inmate to a mental health professional for further evaluation and testing.³³ According to the American Psychiatric Association's guidelines, this "second-level triage"³⁴ should take place within seventy-two hours of referral and consist of a "brief mental health assessment" tailored to "the particular, suspected level of services needed."³⁵ Finally, for inmates with serious treatment needs, a psychiatrist or other appropriately credentialed mental health professional should perform a comprehensive mental health evaluation within a time frame appropriate to the offender's level of urgency.³⁶ This thorough evaluation consists of a face-to-face interview and a review of the inmate's health care records and collateral information.³⁷ The evaluation usually concludes with a diagnostic formulation and an initial treatment plan.³⁸

While inmates who screen positive for mental disorder will undergo additional assessment, few safety nets exist for prisoners whose mental health problems are not recognized or cognizable at the initial screening point.³⁹ Legal commentators have urged prisons to conduct a subsequent screen to identify inmates whose disorders were not initially detected or who have developed mental health problems during the course of their confinement.⁴⁰ However, prisons typically do not conduct a second screen for all inmates,⁴¹ but instead rely on post-classification referrals to detect mental health disorders that manifest after admission.⁴² Regrettably, anecdotal evidence suggests that the

33. HARDYMAN ET AL., *supra* note 28, at 10; HILLS ET AL., *supra* note 6, at 14; NAT'L INST. OF CORR., *supra* note 27, at 2; Temporini, *supra* note 27, at 135–36.

34. Temporini, *supra* note 27, at 139.

35. AM. PSYCHIATRIC ASS'N, *PSYCHIATRIC SERVICES IN JAILS AND PRISONS* 43–44 (2d ed. 2000).

36. *Id.* at 44.

37. *Id.*

38. *Id.*

39. See HUMAN RIGHTS WATCH, *ILL-EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS* 102 (2003), available at <http://www.hrw.org/reports/2003/usa1003/usa1003.pdf> ("In many prisons, there is no routine monitoring of [the] mental health of prisoners who are not on [the] mental health caseload, even when the prisoners are in notoriously stressful settings such as segregation that can prompt mental health crises.").

40. See, e.g., Bonnie J. Sultan, *The Insanity of Incarceration and the Maddening Reentry Process: A Call for Change and Justice for Males with Mental Illness in United States Prisons*, 13 *GEO. J. ON POVERTY L. & POL'Y* 357, 374 (2006) (advocating for making treatment options available to inmates who develop mental illnesses while in prison).

41. See HUMAN RIGHTS WATCH, *supra* note 39, at 101–02; Temporini, *supra* note 27, at 137–38.

42. See Temporini, *supra* note 27, at 137–38.

referral process is woefully deficient⁴³ because seriously ill inmates often fail to self-report.⁴⁴ Further, correctional officers tend to misinterpret symptomatic illness as disorderly conduct, and thus only report inmates who pose security threats.⁴⁵ One court observed that “custody staff essentially make medical judgments that should be reserved for clinicians, and some inmates are not given appropriate early treatment that could prevent or alleviate a severe psychiatric disorder.”⁴⁶

B. Shortcomings in Initial Screening Procedures

Multiple shortcomings mar correctional agencies’ mental health screening processes. Some deficiencies involve failures in implementation, while other problems are structural in nature.

First, while the vast majority of prison facilities report administering mental health screens within a day of admission,⁴⁷ they do not necessarily do so in a comprehensive manner or under conditions likely to generate accurate results. For instance, in *Coleman v. Wilson*, the U.S. District Court for the Eastern District of California found that the California Department of Corrections’s mental health screening processes “are either used haphazardly, or depend for efficacy on incomplete or non-existent medical records, self-reporting, or the observations of custodial staff inadequately trained in the signs and symptoms of mental illness.”⁴⁸ According to the court, thousands of inmates suffer from

43. See, e.g., Richard L. Elliott, *Evaluating the Quality of Correctional Mental Health Services: An Approach to Surveying a Correctional Mental Health System*, 15 BEHAV. SCI. & L. 427, 435 (1997); HUMAN RIGHTS WATCH, *supra* note 39, at 101.

44. See *Madrid v. Gomez*, 889 F. Supp. 1146, 1218 (N.D. Cal. 1995) (noting that an individual’s mental illness may affect his ability to recognize his disorder or seek assistance).

45. See Jamie Fellner, *A Corrections Quandary: Mental Illness and Prison Rules*, 41 HARV. C.R.-C.L. L. REV. 391, 396–97 (2006) (explaining that correctional officers often cannot distinguish between the actions of a disgruntled inmate and a mentally ill inmate); see also HUMAN RIGHTS WATCH, *supra* note 39, at 75–76; W. David Ball, *Mentally Ill Prisoners in the California Department of Corrections and Rehabilitation: Strategies for Improving Treatment and Reducing Recidivism*, 24 J. CONTEMP. HEALTH L. & POL’Y 1, 16–17 (2007); Johnston, *supra* note 2, at 169–74.

46. *Madrid*, 889 F. Supp. at 1219.

47. See JAMES AUSTIN & KENNETH MCGINNIS, NAT’L INST. OF CORR., CLASSIFICATION OF HIGH-RISK AND SPECIAL MANAGEMENT PRISONERS 45 (2004), available at <http://static.nicic.gov/Library/019468.pdf>; HARDYMAN ET AL., *supra* note 28, at 10. The Bureau of Justice Statistics found that maximum and medium security facilities were more likely than minimum security facilities to screen inmates at intake and conduct psychiatric assessments. See BECK & MARUSCHAK, *supra* note 27, at 2 tbl.2. (finding that minimum security facilities conducted psychiatric assessments approximately sixty-two percent of the time, compared to eighty-four percent at medium security facilities and approximately eighty-eight percent at maximum security facilities).

48. *Coleman v. Wilson*, 912 F. Supp. 1282, 1305–06 (E.D. Cal. 1995).

undetected or untreated mental illnesses.⁴⁹ In 2005, despite a court order directing the Department to improve the assessment process,⁵⁰ the U.S. District Court for the Northern District of California concluded that the state's prisoner intake system "fails to adequately identify and treat the health care problems of new prisoners."⁵¹ The court observed that intake evaluators typically administered health screens in less than half of the amount of adequate time (seven minutes instead of fifteen minutes).⁵² Perhaps even more egregiously, screeners sometimes assessed inmates in groups, without regard to their confidentiality or unwillingness to share sensitive information in a group setting.⁵³

Second, the quality of screening instruments varies among facilities.⁵⁴ Federal reports warn that some prison facilities administer incomprehensive tests that have neither been verified nor tested on representative prisoner populations.⁵⁵ A 2007 report by the U.S. Department of Justice's National Institute of Justice observed that "screening procedures are highly variable; they may consist of anything from one or two questions about previous treatment to a detailed, structured mental status examination."⁵⁶ Additional studies show that the brief screening tests developed specifically for correctional settings fail to identify one out of every four offenders with a previously undetected mental disorder.⁵⁷ Other tests may yield even less impressive results.⁵⁸

Third, limitations inherent to the assessment process inhibit evaluators' abilities to accurately detect inmates with mental health needs. Initial mental health assessments may rely almost exclusively on information the inmate

49. *Id.* at 1306.

50. *See id.* at 1323–24.

51. *Plata v. Schwarzenegger*, No. C01-1351 TEH, 2005 WL 2932253, at *12 (N.D. Cal. Oct. 3, 2005). For an analysis of this case and deficiencies in California prisons' assessment processes, see Ball, *supra* note 45, at 7–10.

52. *Plata*, 2005 WL 2932253, at *12 (assessing the constitutional sufficiency of all health screens conducted at California prisons, not just mental health assessments).

53. *Id.* at *13.

54. *See HILLS ET AL.*, *supra* note 6, at 14 (recognizing that, although mental health screening is a legal and practical necessity, "[d]etermining how to screen and the methods to use remains challenging").

55. *See, e.g., HARDYMAN ET AL.*, *supra* note 28, at 14.

56. JULIAN FORD ET AL., U.S. DEP'T OF JUSTICE, MENTAL HEALTH SCREENS FOR CORRECTIONS 1–2 (2007), available at <https://www.ncjrs.gov/pdffiles1/nij/216152.pdf>.

57. Temporini, *supra* note 27, at 132 (reporting that standardized screening methods, such as the Correctional Mental Health Screen and the Brief Jail Mental Health Screen, are approximately seventy-five percent effective at accurately identifying individuals with previously undetected mental disorders).

58. *See, e.g., Linda A. Teplin, Detecting Disorder: The Treatment of Mental Illness Among Jail Detainees*, 58 J. OF CONSULTING & CLINICAL PSYCHOL. 233 (1990) (finding that 62.5% of inmates with acute mental illnesses were missed by routine screening and not treated).

communicates to the evaluator through speech or behavior.⁵⁹ However, inmates with serious mental disorders may be unwilling or unable to communicate accurate information about their mental health status or history. Many inmates are aware that individuals who manifest bizarre thoughts or behavior may face adverse consequences, such as being placed on suicide watch, sent to administrative lockdown, forcibly administered medication, or preyed upon by other inmates.⁶⁰ In addition, an inmate's mental illness, low intelligence, mental retardation, or lack of verbal skills may hamper his ability to communicate his symptoms effectively.⁶¹ Moreover, inmates who lack access to the psychiatric medication necessary to enable ordered thought or effective communication may not be able to remember or convey relevant information.⁶² Experts warn that evaluators may misinterpret an inmate's inability to communicate as intentional malingering or an attempt to be manipulative.⁶³ In addition, anosognosia, or refusal to acknowledge one's disorder,⁶⁴ is a common symptom of some serious mental illnesses,⁶⁵ and inmates may go to great lengths to hide their maladies as a manifestation of their disorders.⁶⁶ Finally, co-occurring substance abuse disorders, head injuries, and developmental disorders can complicate diagnoses and treatment.⁶⁷ In this setting, accurate detection of mental disorder may depend upon an evaluator's level of training. However, mental health professionals with extensive training in assessment and diagnosis, such as psychologists and psychiatrists, rarely conduct mental health screenings. Instead, the screens are often performed more economically—and perhaps less effectively⁶⁸—by nurses, counselors, or social workers.⁶⁹

Finally, intake evaluators often lack access to records or reports that could provide a more accurate picture of an inmate's mental health status. Evaluators

59. See Ball, *supra* note 45, at 8 (observing that mental health screens in California prisons “fail to incorporate objective factors alongside self-reporting”).

60. HILLS ET AL., *supra* note 6, at 14–15.

61. See *id.* at 15; Ball, *supra* note 45, at 8.

62. See Ball, *supra* note 45, at 7–8.

63. HILLS ET AL., *supra* note 6, at 15.

64. VESNA MILDNER, *THE COGNITIVE NEUROSCIENCE OF HUMAN COMMUNICATION* 253 (2008).

65. See, e.g., E. FULLER TORREY, *THE INSANITY OFFENSE* 112 (2012) (noting that approximately half of all individuals with schizophrenia and bipolar disorder have impaired awareness of their illness).

66. HILLS ET AL., *supra* note 6, at 5; *Anosognosia Keeps Patients From Realizing They're Ill*, *PSYCHIATRIC NEWS* (Sept. 7, 2001), <http://journals.psychiatryonline.org/newsarticle.aspx?articleid=103404>.

67. See HILLS ET AL., *supra* note 6, at 5.

68. *Madrid v. Gomez*, 889 F. Supp. 1146, 1219 (N.D. Cal. 1995) (“The [medical technical assistants] who briefly screen incoming inmates typically do not have the necessary training and background to recognize psychiatric illnesses.”).

69. NAT'L INST. OF CORR., *supra* note 27, at 3.

commonly do not have the results of prior psychiatric evaluations, even those conducted in connection with a competency examination, insanity proceeding, or pretrial detention.⁷⁰ Inmates usually do not bring medication containers, prescriptions, or copies of their medical records to a diagnostic center.⁷¹ In addition, mental health screens are often uninformed by jail evaluation and treatment records, even though state law may require that these records accompany an inmate upon transfer.⁷² An evaluator may even complete an initial assessment and classification without access to a presentence report.⁷³ Without this data, screeners must rely on inmates' willingness and ability to share information about their mental health. Consequently, prisoners' mental disorders can go undetected.⁷⁴

C. Treatment, Housing, and Vulnerability

Even when evaluators do detect a mental disorder, prisons often fail to provide the treatment and the protective environment necessary to prevent disordered offenders from experiencing serious harm. In 1976, the U.S. Supreme Court held that prisoners have an Eighth Amendment right to reasonably adequate medical care.⁷⁵ Although the Supreme Court has never addressed the issue, circuit courts of appeals have extended this holding to psychiatric and psychological care.⁷⁶ In *Ruiz v. Estelle*, the U.S. District Court for the Southern District of Texas outlined six guidelines that correctional institutions must meet to satisfy the Eighth Amendment.⁷⁷ Under these guidelines, prisons must maintain a systematic screening and evaluation program to identify inmates who

70. HUMAN RIGHTS WATCH, *supra* note 39, at 101. Electronic record-keeping may ameliorate this critical deficiency.

71. See Ball, *supra* note 45, at 7; Temporini, *supra* note 27, at 133–34.

72. See Ball, *supra* note 45, at 7.

73. HARDYMAN ET AL., *supra* note 28, at 13 (observing that, while “[i]nformation typically contained in a presentence investigation report is critical to conducting a comprehensive and complete initial assessment[,] . . . [m]any states reported . . . that these data are not received in a timely manner and sometimes arrive after the prisoner has been transferred from the intake facility to another prison”).

74. See JAMES & GLAZE, *supra* note 6, at 9 (reporting that, although most prisons provide mental health services, only thirty-four percent of state prisoners and twenty-four percent of federal prisoners who had a mental health problem actually received mental health treatment after admission).

75. *Estelle v. Gamble*, 429 U.S. 97, 103–04 (1976); see also *DeShaney v. Winnebago Dep't of Soc. Servs.*, 489 U.S. 189, 199–200 (1989) (recognizing that prisoners have a right to health care under both the Eighth Amendment and the Due Process Clause).

76. *Bowring v. Godwin*, 551 F.2d 44, 47–48 (4th Cir. 1977); cf. *Youngberg v. Romeo*, 457 U.S. 307, 324 (1982) (“[T]he State is under a duty to provide [an individual with mental retardation involuntarily confined to a mental institution] with such training as an appropriate professional would consider reasonable to ensure his safety and to facilitate his ability to function free from bodily restraints.”).

77. See *Ruiz v. Estelle*, 503 F. Supp. 1265, 1339 (S.D. Tex. 1980).

require mental health treatment, provide treatment beyond segregation or close supervision, employ a sufficient number of trained mental health professionals for individualized treatment, keep accurate and confidential records, properly administer medications, and identify and treat inmates at risk for suicide.⁷⁸ Several courts and correctional organizations have embraced the *Ruiz* criteria as the standard for constitutionally adequate mental health care in correctional settings.⁷⁹

Prisons generally apply the principle of least eligibility, deliberately maintaining the level of health care a step below the services that the government provides to the non-incarcerated population that relies on public assistance.⁸⁰ Under this principle, “the level of prison conditions should always compare unfavorably to the material living standards of the laboring poor,”⁸¹ because prisoners “are the least eligible or least deserving members of society for any free benefit from the government.”⁸² Given their cost, older psychiatric medications—which often have more side effects and lower rates of compliance than newer medications—are the treatment modality of choice inside prisons.⁸³ Additionally, although the vast majority of prisons report providing some form of psychotherapy or counseling,⁸⁴ they must limit their distribution of this

78. *Id.*

79. See Fred Cohen, *Legal Issues and the Mentally Disordered Inmate*, in NAT’L INST. OF CORR., SOURCE BOOK ON THE MENTALLY DISORDERED PRISONER 32, 48 (1985); Kim P. Turner, *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, 424 & n.66 (2008).

80. FRANK SCHMALLEGER & JOHN ORTIZ SMYKLA, CORRECTIONS IN THE 21ST CENTURY 205 (2001).

81. Richard Sparks, *Penal “Austerity”: The Doctrine of Less Eligibility Reborn?*, in PRISONS 2000, at 74 (R. Matthews & P. Francis eds., 1996).

82. Brandon K. Applegate, *Penal Austerity: Perceived Utility, Desert, and Public Attitudes Toward Prison Amenities*, 25 AM. J. CRIM. JUST. 253, 256 (2001).

83. See HUMAN RIGHTS WATCH, *supra* note 39, at 115–17, 121–25 (detailing the limited access to newer medications within some prison systems and examining the side effects of older antipsychotic medications, which some prisons fail to appropriately monitor); Adams & Ferrandino, *supra* note 6, at 922; see also NAT’L INST. OF CORR., *supra* note 27, at 4 (reporting that all forty-nine departments of corrections responding to the survey treat mentally ill inmates with psychotropic medication).

84. See BECK & MARUSCHAK, *supra* note 27, at 2 tbl.1 (reporting that eighty-four percent of state adult confinement facilities provide therapy).

expensive service.⁸⁵ Consequently, many inmates do not receive the therapy that they need to cope effectively in prison.⁸⁶

The default rule within many state correctional agencies, as well as the Federal Bureau of Prisons, is to house inmates with major mental disorders within the general prison population at the appropriate security level.⁸⁷ Inspired by the ideals epitomized in the Americans with Disabilities Act,⁸⁸ these jurisdictions “mainstream” inmates with serious mental illnesses.⁸⁹ Theoretically, this housing arrangement could facilitate equality of opportunity, full participation in programs, and independent living for disordered individuals.⁹⁰ However, because the general prison environment is antitherapeutic, this approach has engendered criticism.⁹¹

85. See NAT’L INST. OF CORR., *supra* note 27, at 4–5 (reporting that fourteen departments of corrections typically provide inmates with non-acute mental illnesses with less than one hour per week of counseling, ten departments typically provide these inmates with one hour of counseling per week, four departments provide more than one hour of counseling per week, and nine departments provide therapy based on an individual prisoner’s need).

86. See HUMAN RIGHTS WATCH, *supra* note 39, at 109–14 (detailing the limited provision of therapeutic interventions in many prison systems); Sally J. MacKain & Charles E. Messer, *Ending the Inmate Shuffle: An Intermediate Care Program for Inmates with a Chronic Mental Illness*, 4 J. FORENSIC PSYCHOL. PRAC. 87, 89 (2004) (observing that “few inmates receive care beyond the prescriptions of medication or assignments to separate housing”).

87. See BECK & MARUSCHAK, *supra* note 27, at 1, 4; HUMAN RIGHTS WATCH, *supra* note 39, at 128. For a detailed examination of placement decisions and treatment afforded in U.S. prisons, see ELLIS ET AL., *supra* note 4, at 28–29.

88. See Americans with Disabilities Act of 1990, Pub. L. No. 101-336, 104 Stat. 327 (1990) (codified as amended in scattered sections of 26 U.S.C.).

89. See Fellner, *supra* note 45, at 394 (“Apart from the mental health services that may or may not be provided, prisons typically treat prisoners with mental illness identically to all other inmates. There are no special allowances. Officials confine them in the same facilities, expect them to follow the same routines, and require them to comply with the same rules.”); see also U.S. Dep’t of Justice, Fed. Bureau of Prisons, Institution Management of Mentally Ill Inmates § 6, at 3 (Program Statement 5310.13) (1995), available at http://www.bop.gov/policy/progstat/5310_013.pdf (“To ensure consistent treatment throughout the system, each institution shall develop a comprehensive approach for managing mentally ill inmates which emphasizes the management of these cases in a regular correctional setting, rather than in a hospitalized setting, as the preferred treatment strategy whenever and wherever feasible.”).

90. See Judy Anderson, *Special Needs Offenders*, in PRISON AND JAIL ADMINISTRATION 219, 220 (Peter M. Carlson & Judith Simon Garrett eds., 1999).

91. See, e.g., CORR. ASS’N OF N.Y., MENTAL HEALTH IN THE HOUSE OF CORRECTIONS 43 (2004), available at <http://www.correctionalassociation.org/wp-content/uploads/2004/06/Mental-Health.pdf> (identifying “the overarching problem with the provision of mental health care in New York State prisons [as] the attempt of [the Office of Mental Health] to superimpose the community mental health model on the correctional system” and arguing that this model is inapt because “in the correctional system . . . not only is outpatient care sorely lacking in ‘the community’ of the general prison population, the violence and chaos of prison life itself can destabilize even mentally balanced individuals”); Shelia M. B. Holton, *Managing and Treating Mentally Disordered Offenders in Jails and Prisons*, in CORRECTIONAL MENTAL HEALTH HANDBOOK 101, 109–10 (Thomas J. Fagan & Robert K. Ax eds., 2003) (arguing that mentally ill inmates in a mainstreamed

Confinement within the general prison population can be seriously damaging for an inmate with a major mental disorder.⁹² As a preliminary matter, this high-stress environment exacerbates the symptoms of many serious mental illnesses and can cause cognitive degeneration.⁹³ Moreover, recent studies demonstrate that individuals with serious mental illnesses, unable to sufficiently assess danger and modify their behavior to ward off attacks, are more prone to physical and sexual victimization than non-disordered individuals.⁹⁴ In addition, strict compliance with prison rules can be difficult for individuals with mental and behavioral limitations, and prisoners with serious mental illnesses are more likely than non-disordered prisoners to violate prison rules.⁹⁵ As a result, mentally ill prisoners are disproportionately punished in solitary confinement,⁹⁶ where they may be especially susceptible to decompensation, psychotic break, and suicide ideation.⁹⁷

environment are likely to isolate themselves through withdrawal and enter the cycle of segregation); cf. HUMAN RIGHTS WATCH, *supra* note 39, at 133 (discussing why deinstitutionalization and the community mental health model are problematic in the prison context).

92. See HUMAN RIGHTS WATCH, *supra* note 39, at 53; Marshall T. Bewley & Robert D. Morgan, *A National Survey of Mental Health Services Available to Offenders with Mental Illness: Who is Doing What?*, 35 LAW & HUM. BEHAV. 351, 352 (2010); Richard C. McCorkle, *Gender, Psychopathology, and Institutional Behavior: A Comparison of Male and Female Mentally Ill Prison Inmates*, 23 J. CRIM. JUST. 53, 54 (1995).

93. See Jamie Fellner, *A Conundrum for Corrections, A Tragedy for Prisoners: Prisons as Facilities for the Mentally Ill*, 22 WASH. U. J.L. & POL'Y 135, 139–40 (2006) (explaining that the general prison environment can worsen a mental illness to the point at which hospitalization is necessary); Holton, *supra* note 91, at 108–10.

94. See Johnston, *supra* note 2, at 161–69 & nn.64–83, 91–103 (physical and sexual assault); ALLEN J. BECK ET AL., U.S. DEP'T OF JUSTICE, *SEXUAL VICTIMIZATION IN PRISONS AND JAILS REPORTED BY INMATES, 2011–12*, at 24–25, 27–29 (2013), available at <http://www.bjs.gov/content/pub/pdf/svpjri1112.pdf> (sexual victimization).

95. See Johnston, *supra* note 2, at 170–74 nn.114–34 (citing several studies reporting that mentally disordered inmates have trouble following prison rules).

96. See *id.* at 174–76 & nn.146–49. A 2004 report by the National Institute of Corrections found that forty-seven percent of states reported subjecting disruptive mentally ill inmates to the same maximum-custody policies as non-disordered inmates. AUSTIN & MCGINNIS, *supra* note 47, at 37.

97. See Johnston, *supra* note 2, at 176–78 & nn.150–55. Conversely, a recent study led in part by the Colorado Department of Corrections concluded that confinement in administrative segregation does not induce significant cognitive or psychological decline in inmates with or without pre-existing mental disorders. See Maureen O'Keefe et al., *A Longitudinal Study of Administrative Segregation*, 41 J. AM. ACAD. PSYCHIATRY L. 49, 54–59 (2013). However, other researchers have identified a number of methodological flaws in the study. See Stuart Grassian, *"Fatal Flaws" in the Colorado Solitary Confinement Study*, SOLITARY WATCH (Nov. 15, 2010), <http://solitarywatch.com/2010/11/15/fatal-flaws-in-the-colorado-solitary-confinement-study/>. More research is necessary to determine how variations in conditions of confinement—such as the physical layout of cells, access to personal effects, and programming opportunities—may affect the mental health of prisoners with and without preexisting serious mental illness. See Adams & Ferrandino, *supra* note 6, at 921; Carl B. Clements et al., *Systemic Issues and*

Because seriously disordered offenders are particularly vulnerable to predation, prisons may house these inmates in isolation as a means of protection. Through a process called *external classification*, correctional authorities—based largely on information collected at intake—determine a prisoner’s custody level (minimum, medium, or maximum) and his facility placement.⁹⁸ Once the prisoner is placed in a facility, correctional officials typically undertake the process of *internal classification*, which determines the appropriate housing for an individual of a particular custody level and the programming and resources he requires.⁹⁹ Although aspects of inmate classification have become increasingly objective over time,¹⁰⁰ facilities still base protective custody decisions on the subjective judgments of correctional officials.¹⁰¹ Prison classification experts recognize that these subjective assessments may yield arbitrary determinations with tragic results.¹⁰² Ironically, the housing arrangement designed to protect vulnerable inmates from general-population predators may introduce a different, but equally significant, danger. Protective custody places inmates in highly restrictive housing that resembles disciplinary isolation, in which offenders are secluded for twenty-one to twenty-four hours

Correctional Outcomes: Expanding the Scope of Correctional Psychology, 34 CRIM. JUST. & BEHAV. 919, 925–26 (2007).

98. AUSTIN & MCGINNIS, *supra* note 47, at 7. For an explanation of the Bureau of Prisons’s designation process, see ELLIS ET AL., *supra* note 4, at 29–37; *see also* Fed. Bureau of Prisons, U.S. Dep’t. of Justice, Inmate Security Designation and Custody Classification (2006) (Program Statement No. 5100.08), *available at* http://www.bop.gov/policy/progstat/5100_008.pdf (governing the designation of an inmate to a specific institution).

99. *See* PATRICIA L. HARDYMAN ET AL., DEP’T OF JUSTICE, INTERNAL PRISON CLASSIFICATION SYSTEMS 1–2 (2002), *available at* http://www.jfa-associates.com/publications/pcras/05_Internal.pdf.

100. *See* AUSTIN & MCGINNIS, *supra* note 47, at 1.

101. *See id.* at 7–8; HARDYMAN ET AL., *supra* note 28, at 11; NAT’L PRISON RAPE ELIMINATION COMM’N, *supra* note 1, at 76–77.

102. *See, e.g.,* AUSTIN & MCGINNIS, *supra* note 47, at 7–8 (“Unfortunately, professional judgment has been shown to be by far the least accurate risk assessment method.”); James Austin, *External and Internal Classification*, in NATIONAL INSTITUTE OF CORRECTIONS PRISON CLASSIFICATION PEER TRAINING AND STRATEGY SESSION 5, 7 (2001), *available at* <http://static.nicic.gov/Library/016707.pdf> (“Currently, most prisons systems have less structured internal classification systems which can often result in serious incidents or high-profile escapes. Often, inmates are inappropriately housed, programmed or improperly separated.”). However, under the Prison Rape Elimination Act, all facilities must assess prisoners with an objective screening instrument during an intake screening for their risk of sexual victimization by other inmates. *See* 28 C.F.R. § 115.41 (2013). For a description of several actuarial-based risk assessment instruments, *see* AUSTIN & MCGINNIS, *supra* note 47, at 15–23.

per day.¹⁰³ Evidence suggests that individuals with serious mental disorders often deteriorate in this restrictive environment.¹⁰⁴

If a prisoner reaches a state of crisis or an acute state of mental illness, prison authorities typically transfer him to an acute crisis unit for inpatient mental health services.¹⁰⁵ Stays in these units are temporary; the goal is to treat and stabilize the inmate for return to the general population or, perhaps, a residential treatment unit.¹⁰⁶ Criteria for admission match those required for involuntary civil commitment,¹⁰⁷ and treatment resembles that available in an inpatient psychiatric hospital, with significant psychotherapy and pharmaceutical regimens.¹⁰⁸

In addition, some states house mentally ill inmates in separate units or facilities for longer periods of time, especially when inmates cannot function adequately or cope within the general prison population.¹⁰⁹ One report, based on the 2000 Census of State and Federal Adult Correctional Facilities, revealed the existence of 155 facilities, located in forty-seven states, that provide mental health or psychiatric confinement as a “special function.”¹¹⁰ Facility administrators specified that mental health confinement was the primary function of twelve facilities and a secondary function of 143 facilities.¹¹¹ While some states restrict their use of these special accommodations to short-term

103. See HUMAN RIGHTS WATCH, NO ESCAPE: MALE RAPE IN U.S. PRISONS 31 (2001); Sharon Dolovich, *Strategic Segregation in the Modern Prison*, 48 AM. CRIM. L. REV. 1, 3–4 (2011); Craig Haney, *Mental Health Issues in Long-Term Solitary and ‘Supermax’ Confinement*, 49 CRIME & DELINQ. 124, 135 (2003); James E. Robertson, *The Constitution in Protective Custody: An Analysis of the Rights of Protective Custody Inmates*, 56 U. CIN. L. REV. 91, 91 (1987).

104. See Johnston, *supra* note 2, at 176–77.

105. See CORR. ASS’N OF N.Y., *supra* note 91, at 41; HUMAN RIGHTS WATCH, *supra* note 39, at 128.

106. HUMAN RIGHTS WATCH, *supra* note 39, at 128. For more information on residential treatment units, or intermediate care facilities, see *infra* Part IV.E.

107. See, e.g., VA. DEP’T OF CORR., OPERATING PROCEDURE 3 (2012), available at <http://www.vadoc.state.va.us/about/procedures/documents/700/730-3.pdf> (“Involuntary admission proceedings shall be initiated when the offender has a mental illness and there exists a substantial likelihood that, as a result of the mental illness, the offender will, in the near future: (i) Cause serious physical harm to himself or herself as evidenced by recent behavior causing, or attempting, or threatening harm and other relevant information or (ii) Cause serious physical harm to others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information or (iii) Suffer serious harm due to his/her lack of capacity to protect himself or herself from harm or to provide for his/her basic human needs, and (iv) Alternatives to involuntary admission have been investigated and deemed unsuitable and there is no less restrictive alternative to such an admission.”).

108. See HUMAN RIGHTS WATCH, *supra* note 39, at 128.

109. See NAT’L INST. OF CORR., *supra* note 27, at 5–6.

110. BECK & MARUSCHAK, *supra* note 27, at 2; see also NAT’L INST. OF CORR., *supra* note 27, at 6–7 (reporting that thirty-three states, the Bureau of Prisons, Puerto Rico, and Guam provide separate housing units for inmates with mental disorders in at least one institution).

111. BECK & MARUSCHAK, *supra* note 27, at 4 tbl.5.

housing for inmates suffering from acute episodes, others report utilizing facilities as long-term segregated housing for inmates with mental disorders.¹¹²

One increasingly popular correctional option involves the use of intermediate care facilities or residential treatment units, which are designed to assist mentally disordered inmates who are unable to function adequately in the general prison population. These units aim to provide prisoners with effective clinical care and coping skills.¹¹³ No recent report catalogues every state that maintains intermediate care units,¹¹⁴ but research reveals the existence of units in New York,¹¹⁵ Washington,¹¹⁶ Ohio,¹¹⁷ North Carolina,¹¹⁸ Virginia,¹¹⁹ Kansas,¹²⁰ New Mexico,¹²¹ Mississippi,¹²² Vermont,¹²³ Alabama,¹²⁴ California,¹²⁵ and Wyoming.¹²⁶ These units are associated with lower levels of mental disorder, disciplinary violations, and victimization, and may yield aggregate cost savings for prisons.¹²⁷ Given the widely touted success of these units, other states may

112. *Id.* at 4; *see also* Holton, *supra* note 91, at 115–16 (describing the conditions in mental health treatment units).

113. *See* BECK & MARUSCHAK, *supra* note 27, at 4.

114. *See* 1 NAT'L COMM'N ON CORR. HEALTH CARE, THE HEALTH STATUS OF SOON-TO-BE-RELEASED INMATES xii & xxi n.22 (2002), *available at* <https://www.ncjrs.gov/pdffiles1/nij/grants/189735.pdf> (reporting, based on a 1992 study, that only thirty-six percent of prisons have specialized housing for inmates with stable mental health conditions).

115. CORR. ASS'N OF N.Y., *supra* note 91, at 35.

116. WASH. DEP'T OF CORR., MENTAL HEALTH TREATMENT SERVICES 3 (2008), *available at* <http://www.doc.wa.gov/aboutdoc/docs/p351gmentalhealthtreatmentservicesfactsheet.pdf>.

117. OHIO DEP'T OF REHAB. & CORR., RESIDENTIAL TREATMENT UNITS 2 (2010) [hereinafter Ohio DRC], *available at* http://www.drc.ohio.gov/web/drc_policies/documents/67-MNH-23.pdf.

118. MacKain & Messer, *supra* note 86, at 91–92.

119. VA. DEP'T OF CORR., *supra* note 107, at 3, 5–6.

120. *Larned Correctional Mental Health Facility*, KANSAS DEPARTMENT OF CORRECTIONS, <http://www.doc.ks.gov/facilities/lcmhf> (last modified Dec. 7, 2012, 7:55 AM).

121. N.M. CORR. DEP'T, MENTAL HEALTH TREATMENT CENTER: PSYCHIATRY, MEDICAL, AND NURSING CARE 2, 4–7 (2012), *available at* <http://corrections.state.nm.us/policies/docs/CD-172300.pdf> (operating procedure).

122. Terry A. Kupers et al., *Beyond Supermax Administrative Segregation: Mississippi's Experience Rethinking Prison Classification and Creating Alternative Mental Health Programs*, 36 CRIM. JUST. & BEHAV. 1038 (2009).

123. VT. DEP'T OF CORR., RESIDENTIAL TREATMENT PROGRAMS 2 (1997), *available at* <http://www.doc.state.vt.us/about/policies/rpd/correctional-services-301-550/361-370-programs-treatment-programs/361.01.09%20Residential%20Tx%20Programs.pdf>.

124. ALA. DEP'T OF CORR., TREATMENT PLANNING 4 (2010), *available at* <http://www.doc.state.al.us/docs/AdminRegs/AR622.pdf>.

125. HUMAN RIGHTS WATCH, *supra* note 39, at 131.

126. WIS. DEP'T OF CORR. & DEP'T OF HEALTH SERV., AN EVALUATION: INMATE MENTAL HEALTH CARE 51–61 (2009), *available at* <http://legis.wisconsin.gov/lab/reports/09-4full.pdf> (Wisconsin Resource Center).

127. *See infra* notes 276–80 and accompanying text (discussing the benefits of intermediate care units).

choose to invest in this mode of treatment to the extent they have not done so already.¹²⁸

II. LEGITIMACY OF RECOGNIZING VULNERABILITY AT SENTENCING

Offender vulnerability is an appropriate consideration for sentencing. Allowing judges to tailor disordered offenders' prison sentences in light of their vulnerabilities would enable judges to better fulfill their institutional function and achieve the goals of punishment.¹²⁹ A sanction that is appropriate for an offender without a disability may be wholly excessive, criminogenic, or even inhumane for an offender lacking the cognitive or behavioral capabilities needed to cope within a given punitive environment. Traditional theories of punishment help to justify the consideration of an offender's susceptibility to serious harm or need for treatment at sentencing. Although additional justifications may exist,¹³⁰ consideration of offender vulnerability may be critical to effectuating the retributive or rehabilitative purposes of a criminal sentence. Collateral benefits would attend the accommodation of offender vulnerability as well.

A. Retributive Rationales

Two retributive rationales support the notion that a judge should have the authority to tailor an offender's carceral sentence to meet his mental health treatment needs or to mitigate hardship in prison. First, a retributive understanding of punishment suggests that a sentencing system should consider an offender's vulnerability to avoid imposing an inhumane punishment.

128. See HUMAN RIGHTS WATCH, *supra* note 39, at 130 (citing Dr. Jeffrey Metzner as stating that "Michigan, Ohio, Georgia, New York, Vermont, New Jersey, Puerto Rico, Colorado, and Kansas have all taken steps towards creating networks of sub-acute care facilities"). Correctional agencies do not employ consistent terminology for these units, and it can be difficult to discern the long- or short-term nature of mental health units included in government reports. See NAT'L INST. OF CORR., *supra* note 27, at 6–7 (listing ways in which mental health units may be characterized). Intermediate care facilities are detailed in Part IV.E below.

129. The U.S. Constitution does not assign the sentencing power to one branch of government, and all three branches may properly play a role in sentencing. See Kieran Riley, *Trial By Legislature: Why Statutory Mandatory Minimum Sentences Violate the Separation of Powers Doctrine*, 19 B.U. PUB. INT. L.J. 285, 302 (2010). Sentencing constitutes one of those "zones of twilight" in which the distribution of power between the separate branches of government overlaps and is uncertain. See Jordan Fried, Note, *The Constitutionality of the U.S. Sentencing Commission: An Analysis of the Role of the Judiciary*, 57 GEO. WASH. L. REV. 704, 712–13 (1989) (quoting *Youngstown Sheet & Tube Co. v. Sawyer*, 343 U.S. 579, 637 (1952) (Jackson, J., concurring)); see also *Mistretta v. United States*, 488 U.S. 361, 364 (1989).

130. Offender hardship would also factor into utilitarian proportionality conceptions. See, e.g., Richard S. Frase, *Excessive Prison Sentences, Punishment Goals, and the Eighth Amendment: "Proportionality" Relative to What?*, 89 MINN. L. REV. 571, 592–97 (2005); E. THOMAS SULLIVAN & RICHARD S. FRASE, *PROPORTIONALITY PRINCIPLES IN AMERICAN LAW* 161–66 (2009). It could also be relevant to theories of mercy.

Premised upon respect for the moral dignity and personhood of the offender,¹³¹ retributivism will not tolerate punishments that violate human dignity,¹³² fail to recognize the personality of offenders,¹³³ or “approximate a system of sheer terror in which human beings are treated as animals to be intimidated and prodded.”¹³⁴

Determining when, exactly, a mode of punishment or conditions associated with a particular sanction cross the line from harsh to inhumane is a difficult contextual question that ultimately reflects the sensitivities and values of a particular society.¹³⁵ While corporal punishment was once commonplace, much of the civilized world now rejects corporal sanctions, such as whipping and lashing, as inhumane.¹³⁶ The same holds true for sanctions intended to profoundly disrupt one’s personality or senses or to precipitate mental crisis.¹³⁷ Philosophers, legal scholars, and courts distinguish incarceration from corporal sanctions by emphasizing the former’s primary function as a deprivation of

131. See BARBARA A. HUDSON, UNDERSTANDING JUSTICE 51 (2003) (characterizing Immanuel Kant’s moral theory as resting “on a model of the human as someone whose actions are the result of moral choices”); Jeffrie G. Murphy, *Marxism and Retribution*, 2 PHIL. & PUB. AFF. 217–20, 229–31 (1973) (outlining Immanuel Kant’s theory of punishment, with an emphasis on its manifestation of respect for dignity, autonomy, rationality, and rights).

132. See JEFFRIE G. MURPHY, RETRIBUTION, JUSTICE, AND THERAPY 233 (1979).

133. See *id.* (decrying “a punishment which is in itself degrading, which treats the prisoner as an animal instead of a human being, which perhaps even is an attempt to *reduce* him to an animal or a mere thing” as inconsistent with human dignity).

134. Herbert Morris, *Persons and Punishment*, 52 MONIST 475, 488 (1968); see also Markel & Flanders, *supra* note 17, at 958 (“To literally or psychologically break or destroy a person under the aegis of retributive punishment would violate the offender’s dignity, and, in a democracy, our own.”).

135. See, e.g., JOHN KLEINIG, PUNISHMENT AND DESERT 123 (1973); David Garland, *Sociological Perspectives on Punishment*, 14 CRIME & JUST. 115, 143 (1991). This moral question parallels the legal inquiry of whether punishment is cruel and unusual under the Eighth Amendment. See *Farmer v. Brennan*, 511 U.S. 825, 834, 838–42 (1994) (holding that, to establish an Eighth Amendment claim for conditions of confinement, an inmate must demonstrate that the responsible prison official acted with “deliberate indifference” towards his health or safety by knowing of the existence of conditions that pose “a substantial risk of serious harm” and failing to take reasonable measures to abate the risk). Arguably, “retributive theory, with its focus on justice, morality, and the dignity of the offender can and should be more sensitive to risk of physical and psychological harm than current Eighth Amendment jurisprudence.” Johnston, *supra* note 2, at 213 n.314.

136. See Ruplekha Khullar, *Punishment and Human Rights*, in APPLIED ETHICS AND HUMAN RIGHTS 183, 187–88 (Shaski Motilal ed., 2010); Garland, *supra* note 135, at 143.

137. See Hernán Reyes, *The Worst Scars Are In the Mind: Psychological Torture*, 89 INT’L REV. RED CROSS 591, 594–616 (2007) (defining psychological torture, detailing various methods of psychological torture, and describing its effects); see also Jeffrey L. Metzner & Jamie Fellner, *Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics*, 38 J. AM. ACAD. PSYCHIATRY LAW 104, 104 (2010) (“Solitary confinement is recognized as difficult to withstand; indeed, psychological stressors such as isolation can be as clinically distressing as physical torture.”).

rights.¹³⁸ However, a sentence of incarceration that carries an unacceptably high likelihood of victimization or psychological harm for a vulnerable prisoner may more closely resemble an inhumane corporal penalty than an unobjectionable deprivation of rights.¹³⁹ If this is true, then, when the foreseeable risk of serious physical or psychological harm in prison surpasses an acceptable threshold, incarceration under a certain set of conditions should no longer be a permissible punishment option.¹⁴⁰ Thus, when a judge believes that incarceration under standard conditions would pose an unacceptable risk of serious harm to a particular offender, she should have the authority to select an alternative sanction of roughly equivalent punitive bite or to modify the conditions of the offender's confinement so that incarceration is a morally tolerable option.¹⁴¹

The second justification, as I have argued at length elsewhere, involves the application of the principle of equal impact.¹⁴² Under a just deserts theory, the severity of an offender's punishment should reflect his culpability and the harm that he effected through his criminal act.¹⁴³ While most scholars measure a punishment's severity by reference to an objective standard,¹⁴⁴ some commentators have recognized that sanctions such as incarceration have a

138. See, e.g., J.D. Mabbott, *Discussion: Professor Flew on Punishment*, 30 *PHILOSOPHY* 256, 257 (1955); Alexander A. Reinert, *Release as Remedy for Excessive Punishment*, 53 *WM. & MARY L. REV.* 1575, 1588–90 (2012) (observing that terms of incarceration will almost always survive scrutiny under the Eighth Amendment); Geoffrey Scarre, *Corporal Punishment*, 6 *ETHICAL THEORY & MORAL PRAC.* 295, 297 (2003).

139. See Sharon Dolovich, *Cruelty, Prison Conditions, and the Eighth Amendment*, 84 *N.Y.U. L. REV.* 881, 915–16 (2009); cf. Garland, *supra* note 135, at 149 (“The crucial difference between corporal punishments that are banned, and other punishments—such as long-term imprisonment that are routinely used—is not a matter of the intrinsic levels of pain and brutality involved. It is a matter of *the form* which that violence takes, and the extent to which it impinges on public sensibilities.”).

140. Whether an individual's risk of harm is intolerable will depend on the particularized risk of serious harm that prison poses to the offender. See Johnston, *supra* note 2, at 180 (“Statistical risk alone, however, may not merit a change in sentencing.”); cf. Kenneth W. Simons, *Statistical Knowledge Deconstructed*, 92 *B. U. L. REV.* 1, 6 (2012) (distinguishing between statistical and individualized knowledge for purposes of culpability determinations). Individuals with serious mental illnesses often will be able to prove that they face a particularized risk of serious harm from incarceration, beyond background statistical rates. In many instances an individualized showing will be possible given prior patterns of behavior, personal history of abuse, and additional risk factors that can be brought to a judge's attention at a sentencing hearing.

141. See Johnston, *supra* note 2, at 216–21.

142. See *id.* at 183–229.

143. See ANDREW VON HIRSCH & ANDREW ASHWORTH, *PROPORTIONATE SENTENCING* 4–5 (2005); cf. Meghan J. Ryan, *Proximate Retribution*, 48 *HOUS. L. REV.* 1049, 1062–64 (2011) (distinguishing between harm-based and intent-based means of evaluating an offender's desert and asserting that, “[t]o the extent that American sentencing systems are retribution-based, they are often harm-based systems in a number of respects”).

144. See, e.g., David Gray, *Punishment as Suffering*, 63 *VAND. L. REV.* 1619, 1658 & n.195 (2010) (“[R]etributivism defines punishment as a restraint on liberty or other consequence that is determined and justified objectively by reference to a culpable offense.”).

foreseeable, disparate impact on vulnerable classes of offenders, such as the elderly, young, physically disabled, and mentally ill.¹⁴⁵ In response, scholars, including Professors Andrew Ashworth and Andrew von Hirsch, have espoused a principle of *equal impact*, which dictates that, “when an offender suffers from certain handicaps that would make his punishment significantly more onerous, the sanction should be adjusted in order to avoid its having an undue differential impact on him.”¹⁴⁶ The equal impact principle thus acknowledges the foreseeable, typical, and serious side-effects that certain penalties hold for vulnerable populations and seeks to adjust ordered sanctions so that members of vulnerable classes receive penalties of roughly equivalent severity as non-vulnerable individuals.¹⁴⁷ Understood properly, the equal impact principle does not call for a *reduction* in punishment, but rather for equalizing the severity of penalties imposed on equally blameworthy offenders.¹⁴⁸ Therefore, recognition of the equal impact principle may be necessary, at least in extreme cases, to achieve proportionality in punishment.¹⁴⁹

145. See, e.g., Andrew Ashworth & Elaine Player, *Sentencing, Equal Treatment, and the Impact of Sanctions*, in *FUNDAMENTALS OF SENTENCING THEORY* 251, 259–60, 274–75 (Andrew Ashworth & Martin Wasik eds., 1998); Andrew Ashworth, *Sentencing Young Offenders*, in *PRINCIPLED SENTENCING* 294, 300 (Andrew von Hirsch et al. eds., 3d ed. 2009) (describing the disproportionate effects of punishment on young offenders); VON HIRSCH & ASHWORTH, *supra* note 143, at 42–43, 172–73, 176 (arguing that incarceration disproportionately affects the young, disabled, ill, and elderly); Barry C. Feld, *A Century of Juvenile Justice: A Work in Progress or a Revolution that Failed?*, 34 N. KY. L. REV. 189, 247–48 (2007) (discussing the punishment of young offenders); see also JEREMY BENTHAM, *PRINCIPLES OF MORALS AND LEGISLATION* 44 (Haffner Press 1948) (1789) (delineating “circumstances influencing sensibility”).

146. VON HIRSCH & ASHWORTH, *supra* note 143, at 172; see also Ashworth & Player, *supra* note 145, at 253 (advocating “a general principle of equal treatment, by which we mean that a sentencing system should strive to avoid its punishments having an unequal impact on different offenders or groups of offenders”). The roots of the equal impact theory can be traced to Jeremy Bentham. See BENTHAM, *supra* note 145, at 182.

147. See ANDREW ASHWORTH, *SENTENCING AND PENAL POLICY* 277 (1983); VON HIRSCH & ASHWORTH, *supra* note 143, at 172–73; see also Johnston, *supra* note 2, at 194–95 & nn.219–23, 221–29; Kolber, *Subjective Experience*, *supra* note 2, at 199–200. This stance may depend upon subscription to a definition of punishment that includes foreseeable, substantial risks of serious harm, proximately caused by the state during confinement. See Johnston, *supra* note 2, at 186–87. Traditionally, scholars have defined punishment to include only hardships or deprivations that a legitimate sentencing authority both intends and authorizes. See, e.g., Hugo Adam Bedau, *Feinberg’s Liberal Theory of Punishment*, 5 BUFF. CRIM. L. REV. 103, 111–12 (2001); Johnston, *supra* note 2, at 188 n.198 (collecting sources).

148. See VON HIRSCH & ASHWORTH, *supra* note 143, at 173.

149. See Ashworth & Player, *supra* note 145, at 255; cf. VON HIRSCH & ASHWORTH, *supra* note 143, at 172 (asserting that, although the “‘equal impact’ principle is connected with the proportionalist sentencing model, [it] is not part of it in standard cases” and that its use should be reserved for “unusual cases that diverge significantly from the norm”).

B. Rehabilitative Rationales

Two strains of rehabilitative thought could also inspire the consideration of mental disorder and vulnerability at sentencing. The first view echoes the understanding of punishment dominant in the United States from the World Wars through the 1970s: the state, through criminal punishment, should seek to identify and treat the underlying causes of an individual's criminality.¹⁵⁰ Professor Francis Allen described the "rehabilitative ideal" in this way:

It is assumed, first, that human behavior is the product of antecedent causes. These causes can be identified as part of the physical universe[,] and it is the obligation of the scientist to discover and to describe them with all possible exactitude. Knowledge of the antecedents of human behavior makes possible an approach to the scientific control of human behavior. Finally, . . . it is assumed that measures employed to treat the convicted offender should serve a therapeutic function, that such measures should be designed to effect changes in the behavior of the convicted person in the interest of his own happiness, health, and satisfaction and in the interest of social defense.¹⁵¹

While the rehabilitative ideal did not specify a single theory of crime causation,¹⁵² psychiatrists Karl Menninger¹⁵³ and Benjamin Karpman,¹⁵⁴ among others,¹⁵⁵ embraced a medical model of crime.¹⁵⁶ According to this theory, criminal behavior is symptomatic of mental illness or personality disorder.¹⁵⁷ In essence, offenders are considered "sick" and in need of a state-coerced "cure" to

150. See FRANCIS A. ALLEN, *THE DECLINE OF THE REHABILITATIVE IDEAL* 2 (1981); Richard C. Boldt, *Rehabilitative Punishment and the Drug Treatment Court Movement*, 76 WASH. U. L. Q. 1205, 1219–20 (1998).

151. Francis A. Allen, *Criminal Justice, Legal Values, and the Rehabilitative Ideal*, in PUNISHMENT AND REHABILITATION 172, 173 (Jeffrie G. Murphy ed., 1973).

152. ALLEN, *DECLINE OF THE REHABILITATIVE IDEAL*, *supra* note 150, at 3.

153. See, e.g., KARL MENNINGER, *THE CRIME OF PUNISHMENT* 4–5 (1968) (discussing the "science of criminology"); Karl Menninger, *Therapy, Not Punishment*, in PUNISHMENT AND REHABILITATION, *supra* note 150, at 132; Karl Menninger, *Medicolegal Proposals of the American Psychiatric Association*, 19 J. CRIM. L., CRIMINOLOGY & POLICE SCI. 367, 370–71 (1928) (detailing several medical and scientific explanations for criminal behavior).

154. See, e.g., BENJAMIN KARPMAN, *CASE STUDIES IN THE PSYCHOPATHOLOGY OF CRIME* vii (1944); BENJAMIN KARPMAN, *THE SEXUAL OFFENDER AND HIS OFFENSES* (1954); Benjamin Karpman, *Criminal Psychodynamics: A Platform*, in PUNISHMENT AND REHABILITATION, *supra* note 150, at 118.

155. See, e.g., BARBARA WOOTTON, *CRIME AND THE CRIMINAL LAW* (1963) (arguing that the criminal justice system should serve preventative, not punitive, ends and treat the origins of criminality).

156. For a description of the tenets and evolution of therapeutic rehabilitation, see E. ROTMAN, *BEYOND PUNISHMENT* 60–63 (1990).

157. See Jeffrie G. Murphy, *Introduction*, in PUNISHMENT AND REHABILITATION, *supra* note 151, at 1, 5; Karpman, *supra* note 154, at 119.

address their underlying sources of criminality.¹⁵⁸ Identification and treatment of an inmate's mental disorder, under this perspective, may be essential to restoring the offender to his status as a law-abiding citizen. Evidence suggests, however, that offenders with major mental disorders often retain the ability to make rational choices and that their criminal behavior often reflects varying motivations.¹⁵⁹ A less radical and perhaps more defensible view is that the treatment and control of symptoms associated with mental illnesses are necessary to allow a disordered individual to benefit from programming, which has been shown by some studies to hold rehabilitative potential.¹⁶⁰

C. Collateral Benefits

Finally, authorizing judges to consider and accommodate offender vulnerability at sentencing would carry collateral benefits. Expressing concern for offenders' actual prison experiences would serve as a means to honor their personhood and inherent worth.¹⁶¹ Further, permitting judges to acknowledge and respond to foreseeable, substantial risks of harm would hold prisons accountable and foster the reform of both prison conditions and correctional mental health programs.¹⁶² Sustained attention to the plight of vulnerable populations in prison could also increase the demand for alternative sentencing options, such as home detention with electronic monitoring, halfway houses, inpatient and outpatient mental health treatment, and mandatory community service. Many of these noncarceral penalties are much less expensive than prison and could offer welcome cost savings.¹⁶³ Finally, by recognizing vulnerability at sentencing, judges could make the criminal justice system more just and less cruel.

158. See ROTMAN, *supra* note 155, at 5.

159. See E. Lea Johnston, *Theorizing Mental Health Courts*, 89 WASH. U. L. REV. 519, 558–61 (2012) (discussing social scientists' views of the varying motivations of offenders with serious mental illnesses); *cf. infra* note 237 (citing research suggesting that mental illnesses may directly contribute to the criminality of only a small minority of the mentally disordered offending population).

160. See HILLS ET AL., *supra* note 6, at 8 (reviewing the rehabilitative benefits of treating mentally ill inmates while they are in prison).

161. See Johnston, *supra* note 2, at 195–97.

162. See Alice Ristroph, *Sexual Punishments*, 15 COLUM. J. GENDER & L. 139, 141 (2006) (“[T]o the extent that sexual coercion in prison cannot be eliminated, we should make that fact part of debates about the appropriate use of imprisonment as a penalty.”).

163. See LINH VUONG ET AL., NAT'L COUNCIL ON CRIME AND DELINQUENCY, *THE EXTRAVAGANCE OF IMPRISONMENT REVISITED 1–2* (2010), available at http://www.nccdglobal.org/sites/default/files/publication_pdf/specialreport-extravagance.pdf (analyzing the incarcerated populations of four states and the federal prison system to determine the percentage of non-serious offenders and concluding that imposing non-carceral sentences on these offenders would yield significant cost savings).

III. CURRENT STATUTORY FRAMEWORKS THAT FACTOR VULNERABILITY INTO SENTENCING

At least two statutory frameworks currently authorize sentencing courts to consider a disordered offender's need for treatment and susceptibility to harm in prison.¹⁶⁴ These statutory schemes permit judges to either replace incarceration with commitment for mental health treatment or treat offender vulnerability as a mitigating factor weighing in favor of probation or a reduced sentence of incarceration. The statutes reveal the legislative judgment that sentencing should reflect a sanction's foreseeable effects on an offender. They also suggest that judges are competent to evaluate both an offender's ability to cope within a typical prison environment and his likelihood of victimization and mental degeneration once he is incarcerated.¹⁶⁵ While these efforts are important, they are incomplete and ultimately fail to ensure that vulnerable prisoners receive proportionate, appropriate, and humane punishments.

A. Authority to Commit Defendants for Treatment

The federal government and a handful of states authorize trial courts to commit a defendant for mental health treatment in lieu of incarceration in certain circumstances.¹⁶⁶ Critically, these statutes apply to defendants who are

164. The sentencing of juveniles would provide another potential analog. Many states authorize judges to designate certain offenders below a certain age as "youthful offenders"—a designation that carries particular placement, programming, and treatment consequences—after considering their background, maturity, and prospects for rehabilitation in a juvenile facility versus prison. *See, e.g.*, KY. REV. STAT. ANN. § 640.010(2)(b)(1)–(8), (c) (2008); VA. CODE ANN. §§ 19.2-311–16 (2008 & Supp. 2013); *West Virginia v. Brewster*, 579 S.E.2d 715, 717 (W.Va. 2003) (discussing sentencing under West Virginia's Young Adult Offenders Act).

165. *See infra* notes 205–210 and accompanying text (discussing legislative confidence in judges' evaluations of criminal defendants).

166. *See* 18 U.S.C. § 4244 (2006); HAW. REV. STAT. ANN. § 706-607 (LexisNexis 2013) (authorizing the court to hospitalize and dismiss the prosecution of a defendant who is "suffering from mental abnormality and . . . is subject by law to involuntary hospitalization for medical, psychiatric, or other rehabilitative treatment," if the court "is of the view that it will substantially further the rehabilitation of the defendant and will not jeopardize the protection of the public"); 725 ILL. COMP. STAT. ANN. 5/104-26(c)(1)-(2) (West 2013) (providing that "[t]he court shall not impose a sentence of imprisonment upon [an offender rendered fit for trial through the provision of assistance to compensate for his disabilities] if the court believes that because of his disability a sentence of imprisonment would not serve the ends of justice and the interests of society and the offender or that because of his disability a sentence of imprisonment would subject the offender to excessive hardship" and authorizing hospitalization in lieu of incarceration); KAN. STAT. ANN. §§ 22-3429 to -3431 (2012) (authorizing a trial court to commit a defendant for psychiatric care if examination reveals "that the defendant is in need of psychiatric care and treatment, that such treatment may materially aid in the defendant's rehabilitation and that the defendant and society are not likely to be endangered by permitting the defendant to receive such psychiatric care and treatment, in lieu of confinement or imprisonment"); N.D. CENT. CODE § 12.1-32-02(1)(g) (2012) (authorizing, instead of incarceration, "commitment to an appropriate licensed public or private institution for treatment of . . . mental disease or defect"); 50 PA. STAT.

competent to stand trial or plead guilty and to be sentenced. The laws allow judges to identify defendants whose mental disorders require care outside of correctional facilities and to guarantee their placement in a suitable hospital or institution.

For example, 18 U.S.C. § 4244 provides that a trial court prior to sentencing shall order a hearing, on motion of counsel or *sua sponte*,¹⁶⁷ if it has “reasonable cause to believe that the defendant may presently be suffering from a mental disease or defect for the treatment of which he is in need of custody for care or treatment in a suitable facility.”¹⁶⁸ When the “reasonable cause” standard is met, the court *must* order a hearing.¹⁶⁹ After the hearing, if the court finds by a preponderance of the evidence that the defendant is presently suffering from a mental disease or defect and that he should, in lieu of imprisonment, be committed to a facility for care or treatment, the court must commit the defendant to the custody of the Attorney General.¹⁷⁰ The Attorney General will then hospitalize the defendant in a suitable facility.¹⁷¹ This commitment constitutes a provisional sentence for the maximum term authorized by the relevant criminal statute, which likely exceeds the sentence the defendant would have received under the U.S. Sentencing Guidelines.¹⁷² If the defendant

ANN. § 4410(c) (West 2001) (“Upon receipt of a report that the defendant is so mentally disabled that it is advisable for his welfare or the protection of the community that he be committed to a facility, the court may so commit him in lieu of sentence for such period, as may be appropriate until further order of the court; but in no event for a period longer than the maximum sentence authorized for the crime of which he was adjudged guilty.”); S.D. CODIFIED LAWS § 23A-27-45 (2004) (“If, after hearing, the court finds by a preponderance of the evidence that the defendant is presently suffering from a mental disease or defect and that he should, in lieu of being sentenced to imprisonment, be committed to a suitable facility for care or treatment, the court shall commit the defendant to the custody of the Human Services Center.”); *cf.* MINN. STAT. ANN. § 609.1055 (West 2009) (“When a court intends to commit an offender with a serious and persistent mental illness . . . to the custody of the commissioner of corrections for imprisonment at a state correctional facility [for a term of longer than one year], . . . the court, when consistent with public safety, may instead place the offender on probation or continue the offender’s probation and require as a condition of the probation that the offender successfully complete an appropriate supervised alternative living program having a mental health treatment component.”).

167. Either party may file a motion, within ten days of conviction and before sentencing, “if the motion is supported by substantial information indicating that the defendant may presently be suffering from a mental disease or defect for the treatment of which he is in need of custody for care or treatment in a suitable facility.” 18 U.S.C. § 4244(a).

168. *Id.* Before the hearing, the court may order a psychiatric examination of the defendant and the filing of a psychiatric report with the court, pursuant to the provisions of Sections 4247(b) and (c). *Id.* § 4244(b).

169. *See* *United States v. Chapman*, 902 F.2d 1331 (8th Cir. 1990) (quoting 18 U.S.C. § 4244).

170. 18 U.S.C. § 4244(d).

171. *Id.*

172. *See id.*; *see also* *United States v. Wood*, 459 F. Supp. 2d 451, 459–60 (E.D. Va. 2006) (noting that the recommended sentence under the Sentencing Guidelines would be “around one quarter of the time [the defendant] would receive under section 4244(d)”); *United States v. Moses*,

recovers from his mental disorder to the extent that his continued custody in a mental health facility is unnecessary, but he has not yet served the full length of his provisional sentence, the court will proceed to traditional sentencing.¹⁷³

A defendant's need for treatment, ability to cope within a typical correctional environment, and susceptibility to harm in prison are all appropriate factors for a court's consideration under § 4244. The Fifth Circuit has opined that § 4244 advances several legitimate governmental interests: "(1) protecting mentally ill prisoners who might be at substantial risk if placed in the general prison population; (2) ensuring the safety of other inmates; and (3) providing humanitarian treatment for mentally ill inmates."¹⁷⁴ Other courts have cited these purposes as animating the statute.¹⁷⁵ Accordingly, one forensic psychology text reflects that "[t]he main issue in [Section 4244] evaluations is not only the severity of the mental illness from which the defendant suffers, but also how well the mentally ill defendant can adapt to prison society at a standard federal prison facility. In essence, it is a question of the fit between the mentally ill defendant's needs, the prison's treatment abilities, and the prisoner's perceived coping abilities."¹⁷⁶

The statute anticipates that commitment will only be necessary for a fraction of offenders with mental disorders.¹⁷⁷ For example, a pre-hearing psychiatric or psychological report may conclude that a particular defendant suffers from a mental disease or defect "but that it is not such as to require his custody for care or treatment in a suitable facility."¹⁷⁸ In these cases, the report must include the expert's opinion regarding the sentencing alternatives available to the court.¹⁷⁹ If the court finds that a disordered offender does not require commitment outside

106 F.3d 1273, 1275 n.1 (6th Cir. 1997); *United States v. Roberts*, 915 F.2d 889, 892 (4th Cir. 1990).

173. 18 U.S.C. § 4244(e). The defendant will receive credit for time served under his provisional sentence. See *United States v. Abou-Kassem*, 78 F.3d 161, 164 (5th Cir. 1996); *Roberts*, 915 F.2d at 892. He will be released "upon expiration of the maximum term that could have been imposed for the offense of conviction." See 7A FED. PROC. FORMS § 20:981 (Lawyer's Ed., 2012).

174. *Abou-Kassem*, 78 F.3d at 165.

175. See, e.g., *United States v. Jensen*, 639 F.3d 802, 805–06 (8th Cir. 2011); *Moses*, 106 F.3d at 1277 n.2; cf. S. REP. NO. 98-225, at 245 (1984) (adding the provision "in order to assist the court in determining the proper facility for commitment of a convicted defendant," to "benefit . . . a convicted defendant who is mentally ill and who needs hospitalization," to "protect[] the public from mentally ill convicted defendants," and to "treat[] and hopefully cur[e] such a person").

176. Daniel A. Krauss & Alan M. Goldstein, *The Role of Forensic Mental Health Experts in Federal Sentencing Proceedings*, in FORENSIC PSYCHOLOGY 359, 377–78 (Alan M. Goldstein ed., 2007).

177. See *United States v. Buker*, 902 F.2d 769, 770 (9th Cir. 1990) (reasoning that Congress did not intend for every mentally ill defendant, without regard to the severity of their illnesses, to be committed under § 4244).

178. 18 U.S.C. § 4244(b) (2006).

179. *Id.*

the prison system, the sentencing judge may recommend the offender's placement in a correctional facility capable of providing for his mental health needs, such as a federal medical facility.¹⁸⁰ However, these recommendations are not binding on correctional authorities,¹⁸¹ and therefore do not ensure that a vulnerable, disordered prisoner will be housed in a facility with adequate treatment or protective resources.

Although this type of statute permits judges to commit some disordered offenders for treatment when confinement in a typical carceral environment would be intolerably injurious, these statutes are insufficient to protect mentally ill prisoners. First, they may expose defendants to longer terms of confinement than would have been probable under sentencing guidelines.¹⁸² Second, some state statutes include a requirement that placement in a mental health institution must be consistent with public safety, or restrict the application of the statute to low-level offenders.¹⁸³ Most importantly, none of these statutes reaches offenders who could function in a correctional environment with reasonable accommodations. For these offenders, judges can only *recommend* correctional placements, which correctional authorities are free to ignore.¹⁸⁴

B. Vulnerability as a Mitigating Factor

A greater number of states designate an offender's susceptibility to harm in prison or need for treatment as a mitigating factor at sentencing.¹⁸⁵ At least a dozen jurisdictions recognize excessive offender hardship as a mitigating factor.¹⁸⁶ Many state statutes frame the sentencing factor in general, source-neutral terms. Arkansas, Hawaii, Indiana, Louisiana, Montana, New Jersey, North Dakota, and Utah, for instance, authorize judges to consider when imprisonment would result in "undue" or "excessive" hardship for an

180. See, e.g., *Buker*, 902 F.2d at 769–70; *United States v. Chapman*, 902 F.2d 1331, 1333–34 (8th Cir. 1990); *United States v. Gigante*, 989 F. Supp. 436, 438, 443 (E.D.N.Y. 1998); Krauss & Goldstein, *supra* note 176, at 377.

181. See *infra* note 304 and accompanying text (discussing the frequency with which Federal Bureau of Prisons officials adopt judicial recommendations).

182. See *supra* note 172 and accompanying text.

183. See HAW. REV. STAT. ANN. § 706-607 (LexisNexis 2012); KAN. STAT. ANN. §§ 22-3429 to -3430 (2011); MINN. STAT. ANN. § 609.1055 (West 2013); N.D. CENT. CODE ANN. § 12.1-32-02(1)(g) (LexisNexis 2012).

184. See *infra* note 304 and accompanying text.

185. See *supra* note 13 (stressing that explicit authorization is most critical in jurisdictions with determinate sentencing regimes).

186. See *infra* notes 187–89, 199. In addition, states may have a "catch-all" provision, which allows courts to mitigate an individual's sentence when it feels that doing so is necessary for the ends of justice. See, e.g., ARIZ. REV. STAT. ANN. § 13-701(E)(6) (2012) (providing that the court shall consider "[a]ny other factor that is relevant to the defendant's character or background or to the nature or circumstances of the crime and that the court finds to be mitigating").

offender.¹⁸⁷ Other states specify that mitigation may be appropriate when the likely hardship stems from a specific source. One example is Illinois, which instructs a sentencing judge to consider, as a factor in favor of withholding or minimizing a sentence of imprisonment, whether “the imprisonment of the defendant would endanger his or her medical condition.”¹⁸⁸ The District of Columbia, on the other hand, allows a judge to sentence outside the voluntary sentencing guidelines if she “determines that the defendant, by reason of obvious and substantial mental or physical impairment or infirmity, cannot be adequately protected or treated in any available prison facility.”¹⁸⁹

In addition, at least a dozen jurisdictions classify an offender’s need for treatment as a valid consideration at sentencing. Some statutory provisions simply express concern for a defendant’s need for, and amenability to,

187. See ARK. CODE ANN. § 5-4-301(c)(11) (2012) (authorizing the trial court to consider, in favor of suspension or probation for most criminal offenses, whether “[t]he imprisonment of the defendant would entail excessive hardship to the defendant or to a dependent of the defendant”); HAW. REV. STAT. ANN. § 706-621(2)(i) (LexisNexis 2007) (“The court, in determining whether to impose a term of probation, shall consider [whether] . . . [t]he imprisonment of the defendant would entail excessive hardship to the defendant or the defendant’s dependents[.]”); IND. CODE ANN. 35-38-1-7.1(b)(10) (LexisNexis 2012) (“The court may consider the following factors as mitigating circumstances or as favoring suspending the sentence and imposing probation: . . . Imprisonment of the person will result in undue hardship to the person or the dependents of the person.”); LA. CODE. CRIM. PROC. ANN. art. 894.1.B(31) (2013) (providing that courts, when deciding whether to suspend a sentence and impose probation, should consider whether “[t]he imprisonment of the defendant would entail excessive hardship to himself or his dependents”); MONT. CODE ANN. § 46-18-225(2)(j) (West 2011) (“Prior to sentencing a nonviolent felony offender . . . to a term of imprisonment in a state prison, the sentencing judge shall take into account whether: . . . imprisonment of the offender would create an excessive hardship on the offender or the offender’s family.”); N.J. STAT. ANN. § 2C:44-1(b)(11) (West 2013) (listing, as a criterion for the appropriateness of imprisonment as a sanction, whether “imprisonment of the defendant would entail excessive hardship to himself or his dependents”); N.D. CENT. CODE § 12.1-32-04(11) (2012) (suggesting that the trial court should consider, in deciding whether to order imprisonment, whether “[t]he imprisonment of the defendant would entail undue hardship to himself or his dependents”); UTAH SENTENCING COMM’N, 2011 ADULT SENTENCING AND RELEASE GUIDELINES, at 12–13, available at <http://www.sentencing.utah.gov/Guidelines/Adult/2011%20Adult%20Sentencing%20and%20Release%20Guidelines.pdf> (specifying that “[i]mprisonment [that] would entail excessive hardship on offender or dependents” constitutes a mitigating factor that may “compel deviation from the guidelines”); see also 9 MINN. PRAC., CRIMINAL LAW & PROCEDURE § 36:41(F) (4th ed. 2013) (explaining that, under the Minnesota Sentencing Guidelines as interpreted through case law, a judge must consider a dispositional departure at sentencing if the defendant is vulnerable to victimization in a prison setting). See generally Carissa Byrne Hessick, *Ineffective Assistance at Sentencing*, 50 B.C. L. REV. 1069, 1119–20 & n.284 (2009) (characterizing the hardship of imprisonment as a mitigating factor that has been considered “particularly powerful in various jurisdictions”).

188. 730 ILL. COMP. STAT. ANN. § 5/5-5-3.1(a)(12) (West 2013).

189. D.C. SENTENCING & CRIM. CODE REVISION COMM’N, VOLUNTARY SENTENCING GUIDELINES MANUAL § 5.2.3(8) (2012).

specialized treatment.¹⁹⁰ Other statutes permit the judge to assess implications for public safety and a treatment program's likelihood of reducing offender recidivism.¹⁹¹ Still other statutes direct judges to determine whether a defendant has a greater need for treatment than carceral punishment.¹⁹²

190. See 18 U.S.C. § 3553(a) (2006) (“The court shall impose a sentence sufficient, but not greater than necessary, to comply with the purposes set forth The court, in determining the particular sentence to be imposed, shall consider . . . the need for the sentence imposed . . . to provide the defendant with needed educational or vocational training, medical care, or other correctional treatment in the most effective manner”); FLA. STAT. ANN. § 921.0026(2)(d) (West 2012) (treating as a mitigating circumstance when “[t]he defendant requires specialized treatment for a mental disorder that is unrelated to substance abuse or addiction or for a physical disability, and the defendant is amenable to treatment”); HAW. REV. STAT. ANN. § 706-606(2)(d) (LexisNexis 2012) (requiring the court to consider, when imposing a sentence, the need “[t]o provide the defendant with needed educational or vocational training, medical care, or other correctional treatment in the most effective manner”); N.C. GEN. STAT. ANN. § 15A-1340.16 (West 2013) (permitting the court discretion to depart from the presumptive sentence range where a defendant proves, by a preponderance of the evidence, the existence of the mitigating factor that “[t]he defendant has a good treatment prognosis, and a workable treatment plan is available”); N.D. CENT. CODE § 12.1-32-04(10) (2012) (providing that, “while not controlling the discretion of the court” in its decision whether to order imprisonment, it “shall be accorded weight” whether “[t]he defendant is particularly likely to respond affirmatively to probationary treatment”); N.J. STAT. ANN. § 2C:44-1(b)(10) (West 2013) (allowing the court, in discerning whether a sentence of imprisonment is appropriate, to consider the mitigating circumstance of whether “[t]he defendant is particularly likely to respond affirmatively to probationary treatment”); VT. STAT. ANN. tit. 13, § 7030(a) (2012) (directing the court to consider the defendant’s need for treatment and his “risk to self” in determining his sentence); WIS. STAT. ANN. § 973.017(2) (West 2012) (“When a court makes a sentencing decision concerning a person convicted of a criminal offense . . . , the court shall consider . . . [t]he rehabilitative needs of the defendant.”); D.C. SENTENCING & CRIM. CODE REVISION COMM’N, VOLUNTARY SENTENCING GUIDELINES MANUAL § 5.2.3(8) (2013) (permitting a trial judge to depart from the voluntary sentencing guidelines upon a finding of the mitigating factor that “the defendant, by reason of obvious and substantial mental or physical impairment or infirmity, cannot be adequately . . . treated in any available prison facility”); see also *State v. Trog*, 323 N.W.2d 28, 31 (Minn. 1982) (“[A] defendant’s particular amenability to individualized treatment in a probationary setting will justify departure in the form of a stay of execution of a presumptively executed sentence.”); *infra* note 199 (noting possible departures under the U.S. Sentencing Guidelines).

191. See IDAHO CODE ANN. § 19-2523(1) (2012) (“In determining the sentence to be imposed . . . , if the defendant’s mental condition is a significant factor, the court shall consider such factors as: (a) The extent to which the defendant is mentally ill; (b) The degree of illness or defect and level of functional impairment; (c) The prognosis for improvement or rehabilitation; (d) The availability of treatment and level of care required; (e) Any risk of danger which the defendant may create for the public, if at large, or the absence of such risk. . . .”); OR. ADMIN. R. 213-008-0002(1)(a)(I) (2013) (listing, as a mitigating factor that may be considered in determining whether substantial and compelling reasons for a departure exist, whether “[t]he offender is amenable to treatment and an appropriate treatment program is available to which the offender can be admitted within a reasonable period of time; the treatment program is likely to be more effective than the presumptive prison term in reducing the risk of offender recidivism; and the probation sentence will serve community safety interests by promoting offender reformation”).

192. See DEL. SENTENCING ACCOUNTABILITY COMM’N, BENCHBOOK 2013, at 1, 123, 126–27 (2013), available at http://courts.delaware.gov/Superior/pdf/benchbook_2013.pdf

Currently, a judge's assessment of an offender's need for treatment and likely hardship in prison may affect his sentence in one of two ways.¹⁹³ First, offender vulnerability may militate towards a suspended sentence of incarceration with probation.¹⁹⁴ For example, the New Jersey statute authorizes judges to consider, among other mitigating factors, whether "imprisonment of the defendant would entail excessive hardship to himself" and whether "[t]he defendant is particularly likely to respond affirmatively to probationary treatment."¹⁹⁵ Case law suggests that the mitigating factors typically result in probation only for those offenders who have limited aggravating factors, have no prior criminal history, or would otherwise be amenable to probation.¹⁹⁶ In states that limit the use of these mitigating factors to the probation/incarceration calculus, courts lack the means to mitigate the vulnerability of prisoners who fall outside this narrow band.¹⁹⁷

(authorizing the court to depart from the prescribed sentence range when mitigating factor(s) are found, including whether "the offender is in greater need of an available treatment program than of punishment through incarceration," and whether, "before detection, the defendant . . . voluntarily sought professional help for drug/alcohol treatment, or for any other recognized compulsive behavioral disorders related to the offense").

193. In addition, some states permit courts to commit offenders for treatment in lieu of incarceration. *See supra* Part III.A.

194. *See supra* notes 187–92 (citing state statutes that permit the judge to consider the hardship an offender may experience in prison or his need for treatment).

195. N.J. STAT. ANN § 2C:44-1(b)(10)–(11) (West 2013).

196. *See, e.g.,* State v. Evers, 815 A.2d 432, 451–55 (N.J. 2003) (representing that it is only an "extraordinary or extremely unusual case where the human cost of imprisoning a defendant for the sake of deterrence constitutes a serious injustice" and reviewing relevant case law); State v. Jarbath, 555 A.2d 559, 561, 569 (N.J. 1989) (finding that the extreme hardship of an offender with mental retardation, who had suffered almost daily severe abuse in prison and had attempted suicide, and her likelihood of responding to conditional probationary treatment outweighed the deterrent value of her carceral sentence, where no aggravating factors applied and the defendant was unlikely to commit future violent acts); State v. E.R., 641 A.2d 1072, 1073, 1077–78 (N.J. Super. Ct. App. Div. 1994) (approving a probationary sentence upon resentencing for an offender who was amenable to probation, would suffer extreme hardship in prison, was not at risk of committing another offense, and was likely to die within a few months from AIDS); *see also* State v. Wright, 310 N.W.2d 461, 462–63 (Minn. 1981) (upholding the dispositional departure where the defendant was "more child than man" and would be victimized easily in prison, no appropriate psychiatric institution was available, the defendant was amenable to individualized treatment in a probationary setting, and he would pose a minimal threat to society if supervised through out-patient treatment); State v. Hitz, No. C6-90-1168, 1990 WL 115108, at *2 (Minn. Ct. App. Aug. 14, 1990) (affirming a dispositional departure based on reports that a mentally disordered defendant would become suicidal in prison and that he was more amenable to probation and treatment than prison); Rachel Konforty, *Efforts to Control Judicial Discretion: The Problem of AIDS and Sentencing*, 1998 ANN. SURV. AM. L. 49, 64–65, 92–94 (1998) (describing New Jersey's statutory framework and its application within the context of AIDS and HIV).

197. *See, e.g.,* State v. Behl, 573 N.W.2d 711, 713–14 (Minn. Ct. App. 1998) (holding that offender-related factors, such as post-offense conduct and new psychological evidence, may justify a dispositional departure but not a durational departure, while offense-related factors can support both dispositional and durational departures).

Other jurisdictions, including the federal government,¹⁹⁸ allow courts to shorten the prison terms of offenders likely to suffer extreme hardship while incarcerated.¹⁹⁹ These jurisdictions, in effect, allow a sentencing “discount” for the increased severity of a vulnerable offender’s carceral sentence, as compared to the anticipated prison experience of a standard offender.²⁰⁰ However, judges in these jurisdictions cannot tailor the conditions of confinement in order to reduce a vulnerable offender’s risk of harm. This predicament has led to charges, such as those raised by Professor Mary Sigler, that reducing an offender’s prison term on the basis of extreme vulnerability to victimization is functionally equivalent to sentencing him to a prison term “at rape” or to a term involving another form of cruelty.²⁰¹

Although these statutes are preferable to sentencing systems that discourage judges from modifying presumptive carceral sentences due to their likely injurious effect, they do not go far enough. Intermediate sanctions such as weekends in jail and laborious community service may provide appropriate (and cost-effective) penalties for many offenders.²⁰² However, imprisonment will likely remain a necessary sanction for the most serious offenses.²⁰³ While some

198. See Mary Sigler, *Just Deserts, Prison Rape, and the Pleasing Fiction of Guideline Sentencing*, 38 ARIZ. ST. L.J. 561, 571–74 (2006). Under the U.S. Sentencing Guidelines, mental and emotional conditions are ordinarily irrelevant to the judge’s determination of whether a sentence should fall outside of the suggested range established by the Guidelines for a criminal offense. See U.S. SENTENCING GUIDELINES MANUAL § 5H1.3 (2010). However, under Federal Sentencing Guidelines section 5H1.3, an offender’s vulnerability due to mental or emotional conditions may justify a downward departure so long as such conditions “are present to an unusual degree and distinguish the case from the typical cases covered by the guidelines.” *Id.* Some courts have also relied on sections 5K2.0, 5H1.4, and 5K2.13 to grant downward departures on the basis of suspected or demonstrated hardship in prison. See Johnston, *supra* note 2, at 181–82 & nn. 172–75.

199. See, e.g., Kern v. State, No. 47A01–0706–CR–277, 2008 WL 1746704, at *2 (Ind. Ct. App. Apr. 17, 2008) (holding that the trial court afforded sufficient weight to defendant’s back pain and pleurisy as a mitigating factor when it sentenced her to less than the maximum sentence of incarceration); Moyer v. State, 796 N.E.2d 309, 314 (Ind. Ct. App. 2003) (finding that the sentencing court abused its discretion in failing to consider the defendant’s history of lymphoma, malignancy of the larynx, recurring tumors, pulmonary disease, reliance on a breathing apparatus, and need for frequent tracheal cleanings and sterile catheters and, consequently, reducing the defendant’s sentence from forty years in prison to twenty-four years).

200. See Johnston, *Vulnerability*, *supra* note 2, at 201–03.

201. Sigler, *supra* note 198, at 573.

202. See MICHAEL TONRY, SENTENCING MATTERS 127–28 (1996); Robert E. Harlow et al., *The Severity of Intermediate Penal Sanctions: A Psychophysical Scaling Approach for Obtaining Community Perceptions*, 11 J. QUANTITATIVE CRIMINOLOGY 71, 72 (1995); Paul H. Robinson & John M. Darley, *The Role of Deterrence in the Formulation of Criminal Law Rules: At Its Worst When Doing Its Best*, 91 GEO L.J. 949, 996 (2003); *supra* note 163.

203. Some commentators have opined that incarceration is the only sanction severe enough to communicate the degree of censure warranted for commission of serious offenses. See, e.g., VON HIRSCH, *supra* note 136, at 111; Harlow et al., *supra* note 202, at 86. In addition, incarceration

statutes allow a sentencing court to recognize the likely harshness of a vulnerable offender's sentence by shortening his term of imprisonment, none grants courts the authority to ensure that a prison sentence will be carried out under conditions that are humane and that approximate, as closely as possible, the conditions that a non-vulnerable person would experience if confined.²⁰⁴ Indeed, the shortened terms appear to condone the harsher treatment experienced by the vulnerable inmate.

In jurisdictions that permit judges to weigh vulnerability as a mitigating factor at sentencing, judges may consider the offender's need for treatment or the potential hardships he may face in prison. While existing statutory schemes do not permit judges to dictate conditions of incarceration, these approaches demonstrate the legislative judgment that offender vulnerability is a valid and important sentencing factor. They also establish legislatures' confidence in judges' abilities to accurately and fairly evaluate a defendant's current mental health status, future treatment needs, ability to cope within a traditional correctional environment, and likelihood of experiencing excessive or undue harm if incarcerated.²⁰⁵

That legislatures entrust judges with these important tasks should not be surprising, because fact-finding and individualized risk assessment are routine

may be the only sanction likely to serve as an effective general or specific deterrent in specific instances. See DAVID C. ANDERSON, *SENSIBLE JUSTICE* 144 (1998).

204. See Bonnie P. Tucker, *Deaf Prison Inmates: Time to Be Heard*, 22 *LOY. L.A. L. REV.* 1, 14 (1988) (arguing that the solution to the problem of harsher prison experiences of deaf prisoners "lies in equalizing—to the extent practicable—the conditions of confinement for deaf and hearing prisoners").

205. See *Woodall v. Fed. Bureau of Prisons*, 452 F.3d 235, 245–49 (3d Cir. 2005) (observing that Congress demonstrated its confidence in sentencing judges by requiring the Federal Bureau of Prisons to consider any court statements regarding the reasoning behind a sentencing recommendation). This legislative confidence, and judges' history of sentencing under these statutes, may offer a partial response to commentators such as Judge Marvin Frankel, who have questioned judges' abilities to individualize sentences. See MARVIN E. FRANKEL, *CRIMINAL SENTENCES* 12–25 (1972); Marvin E. Frankel, *Lawlessness in Sentencing*, 41 *U. CIN. L. REV.* 1, 4–8 (1972). Frankel criticized judges' broad sentencing discretion within indeterminate sentencing schemes, which he characterized as a state of "lawlessness" that afforded the opportunity to express personal bias and prejudice. See Frankel, *Lawlessness in Sentencing*, *supra*, at 6–9. Those concerns would have less purchase in the context of the reforms suggested by this Article, which would permit the consideration of offender vulnerability as a sentencing factor, see *infra* Part IV.A., and would allow for explicit, reasoned sentencing decisions susceptible to review. But see Michael M. O'Hear, *Appellate Review of Sentences: Reconsidering Deference*, 51 *WM. & MARY L. REV.* 2123, 2135–52 (2010) (identifying reasons as to why trial courts may be less inclined to make high quality, fine-grained sentencing decisions than is often assumed and thus why their decisions may be less worthy of deference). The fact that the Bureau of Prisons follows most judicial recommendations suggests the reasonableness and feasibility of judicial suggestions for placement, programming, and treatment. See *infra* notes 304–306 and accompanying text.

aspects of judging.²⁰⁶ Crimes typically include a mens rea component, for instance, and sentencing often involves an assessment of an offender's likelihood of recidivism. Judges weigh analogous considerations and engage in similar fact-finding pursuits when they consider information gathered by probation staff in presentence reports, adjudicate civil commitment hearings, quantify future loss, and decide custody cases.²⁰⁷ Moreover, by the time a mentally disordered offender appears for sentencing, the judge is likely familiar with his mental health history and status and is therefore in a good position to structure the sentence to meet his particular needs.²⁰⁸ While correctional officials will also assess an offender's mental health and susceptibility to harm,²⁰⁹ the assessment of a sentencing judge may enjoy a higher likelihood of accuracy, given a defendant's rights at sentencing to an attorney's assistance in gathering evidence of mental disorder and vulnerability (including medical records and, potentially, expert opinions), in bringing this information to the judge's attention, and in arguing that it warrants mitigation (if supported by law).²¹⁰

IV. EXTENSION OF JUDGES' CONSIDERATION OF VULNERABILITY TO CONDITIONS OF CONFINEMENT

Legislatures typically permit judges to specify conditions of probation but limit judges to establishing the duration of terms of confinement. A number of compelling reasons support withholding judicial authority from conditions of

206. See, e.g., CYNTHIA A. MAMALIAN, U.S. DEP'T OF JUSTICE, STATE OF THE SCIENCE OF PRETRIAL RISK ASSESSMENT 6, 9 (2011), available at [http://www.pretrial.org/download/risk-assessment/PJI%20State%20of%20the%20Science%20Pretrial%20Risk%20Assessment%20\(2011\).pdf](http://www.pretrial.org/download/risk-assessment/PJI%20State%20of%20the%20Science%20Pretrial%20Risk%20Assessment%20(2011).pdf); Jonathan Simon, *Reversal of Fortune: The Resurgence of Individual Risk Assessment in Criminal Justice*, 1 ANN. REV. L. & SOC. SCI. 397, 398 (2005).

207. See, e.g., Kolber, *supra* note 18, at 1165–66 (discussing various institutional actors' experiences of measuring the actual or anticipated experiences of offenders and victims). But see O'Hear, *supra* note 205, at 2137–40 (arguing that an accumulation of experience does not necessarily warrant an assumption of competence).

208. Judges have the opportunity to consider and receive information concerning a defendant's mental illness at multiple stages in the criminal justice process, including bail determinations, competency proceedings, and defense to criminal charges. Additionally, many state statutes require probation officers to include an offender's mental health history in the presentencing report, and others permit the inclusion of this information if relevant to the appropriateness of sentencing options. Johnston, *supra* note 2, at 159. Judges likely have less information about defendants who plead guilty than those who go to trial. However, sentencing judges still have the benefit of presentence reports for defendants who plead guilty. See Gabriel J. Chin, *Taking Plea Bargaining Seriously: Reforming Pre-Sentence Reports After Padilla v. Kentucky*, 31 ST. LOUIS U. PUB. L. REV. 61, 63 & n.13 (2011).

209. See *supra* Part I.

210. See Hessick, *supra* note 187, at 1101–02 (listing defendants' rights at sentencing); Alan C. Michaels, *Trial Rights at Sentencing*, 81 N.C. L. REV. 1771, 1787–88 (2003) (exploring which constitutional trial rights apply at sentencing).

confinement. As the U.S. Supreme Court stressed in *Turner v. Safley*, “[r]unning a prison is an inordinately difficult undertaking that requires expertise, planning, and the commitment of resources, all of which are peculiarly within the province of the legislative and executive branches of government.”²¹¹ Correctional officials, not judges, have the best sense of available resources, know which offenders are most in need of these resources, and are best able to track offenders’ evolving treatment needs. Moreover, judges’ micromanagement of prison affairs can adversely affect prison security.²¹²

These objections apply, to a varied extent, to all of the reforms proposed below. However, there are several advantages to the judicial tailoring of conditions of confinement for vulnerable offenders. First, specific conditions of confinement may be integral to a judge’s sentencing goals and to the humaneness of the sentence.²¹³ Legislatures should authorize judges to order any condition integral to the purpose or legitimacy of a sentence so that they may fulfill their institutional roles as arbiters of proportional and appropriate punishment. Second, the pretrial, adjudication, and sentencing processes will often yield relevant information about offenders’ mental health histories and needs.²¹⁴ Allowing this information to factor into placement, programming, and treatment decisions could result in more appropriate and efficient inmate designations.

211. 482 U.S. 78, 84–85 (1987); see also *Jones v. N.C. Prisoners’ Labor Union, Inc.*, 433 U.S. 119, 126 (1977) (“Because the realities of running a penal institution are complex and difficult, we have . . . recognized the wide-ranging deference to be accorded the decisions of prison administrators.”); *Procunier v. Martinez*, 416 U.S. 396, 404–05 (1974) (observing that overcoming the “Herculean obstacles” to effectively maintaining order and discipline, preventing unauthorized access or escape, and rehabilitating prisoners “require[s] expertise, comprehensive planning, and the commitment of resources, all of which are peculiarly within the province of the legislative and executive branches of government”) (quoting *Turner*, 482 U.S. at 85).

212. See *Bell v. Wolfish*, 441 U.S. 520, 547 (1979) (“Prison officials must be free to take appropriate action to ensure the safety of inmates and corrections personnel and to prevent escape or unauthorized entry” and therefore should be afforded “wide-ranging deference in the adoption and execution of policies and practices that in their judgment are needed to preserve internal order and discipline and to maintain institutional security”); *Turner*, 482 U.S. at 89 (“Subjecting the day-to-day judgments of prison officials to an inflexible strict scrutiny analysis would seriously hamper their ability to anticipate security problems and to adopt innovative solutions to the intractable problems of prison administration.”).

213. See Am. Bar Ass’n, *Criminal Justice System, Project on Standards Relating to the Legal Status of Prisoners*, 14 AM. CRIM. L. REV. 377, 408–09 (1977) (advocating that, as a means to ensure that prisoners’ sentences are carried out consistently with the purposes and intents of their sentences, “[j]udges should not sentence defendants to confinement unless correctional authorities have certified in writing that facilities, programs, and personnel are available to reasonably carry out the purpose and intent of each sentence,” and “[s]entencing courts should be authorized . . . to reduce a sentence or modify its terms whenever the court finds after an open hearing that the treatment of the prisoner or the conditions under which he lives are not related to the purpose of the sentence.”).

214. See *Johnston*, *supra* note 2, at 158–59.

Third, judicial input could help to counter the tendency of correctional officials to prioritize the mental health treatment of prisoners who pose security threats. Prisons arguably operate under a conflict of interest: they have a moral and legal obligation to detect and treat inmates' serious mental disorders, but under-detecting and under-treating mental illness may conserve valuable financial, medical, staff, and therapeutic housing resources, at least in the short term. Indeed, commentators have long complained that correctional officials tend to overlook the mental disorders of offenders who slip through the mental health screening process at intake and who do not pose a security threat.²¹⁵

Fourth, few checks exist to ensure that prison conditions are humane and appropriate. Prisoners have limited tools with which to demand better conditions,²¹⁶ and judges have limited power to alter conditions of confinement after sentencing.²¹⁷ Fifth, the public nature of the sentencing proceeding would impart a degree of transparency and accountability to the assessment and treatment of seriously disordered prisoners.²¹⁸ Currently, prisons conduct mental health and vulnerability assessments behind closed doors, so decisions regarding assessment, treatment, and housing receive little scrutiny.²¹⁹ Permitting judges to consider an individual's mental disorder, treatment needs, and susceptibility to harm at sentencing would bring these assessments and underlying prison conditions to light and would subject them to public review and debate.

Finally, encouraging judges to consult and collaborate with correctional officials in the reaching and imposing of conditions would help to protect important correctional interests. Generally, judges should seek input from affected correctional agencies before ordering any condition that implicates correctional affairs.²²⁰ In addition, though alternative models of judicial

215. See *supra* note 45 and accompanying text.

216. See, e.g., *Simmat v. U.S. Bureau of Prisons*, 413 F.3d 1225, 1231–40 (10th Cir. 2005) (detailing hurdles to inmates' challenges of federal prison conditions under a variety of theories); *ELLIS ET AL.*, *supra* note 4, at 69–70 (discussing the administrative remedy process within the Federal Bureau of Prisons); Russell, *supra* note 2, at 808–17 (assessing means of state and federal offenders to secure adequate care in prison or release from confinement).

217. For thoughtful elucidations of Eighth Amendment conditions-of-confinement claims and available remedies, see Alice Ristroph, *State Intentions and the Law of Punishment*, 98 J. CRIM. L. & CRIMINOLOGY 1353, 1380–84 (2008); Reinert, *supra* note 138, at 1595–1602.

218. See Kay A. Knapp, *Allocation of Discretion and Accountability Within Sentencing Structures*, 64 U. COLO. L. REV. 679, 689 (1993) (“[T]he judiciary is the discretionary point that is most accountable. Compared to any other discretionary point—prosecutors, corrections administrators, or parole boards—judicial decisions are public, as is the information on which they base their decisions (open at least to those involved with the case, if not to the public at large). Judges are expected to provide reasons for their decisions and there is a strong tradition of review for most decisions—although not for sentencing decisions.”).

219. See *supra* Part I (discussing aspects of mental health screens, treatment, and housing decisions in prison).

220. See *supra* note 213; *infra* note 254.

authority are possible,²²¹ allowing the government to move to reopen a sentence if it believes that an ordered condition is inappropriate, unreasonable, or infeasible would allow for judicial reconsideration of those conditions that create security risks, are unnecessary in light of an offender's evolving mental health needs, or are impracticable due to resource constraints.

A. *Permissive or Mandatory Sentencing Factor*

Legislatures seeking to give greater sentencing discretion to judges must determine whether the consideration of mentally disordered offenders' vulnerability should be mandatory or permissive. A legislature could dictate that judges *must* consider certain offenders' vulnerability and take necessary actions to ensure humane, proportionate, and appropriate punishment. Alternatively, a legislature could *authorize* judges to consider offender vulnerability and take necessary actions to prevent foreseeable and substantial harm.

The statutory approaches detailed in Part III reflect varying legislative judgments on this issue. Statutes authorizing judges to commit defendants for treatment in lieu of incarceration differ both in the extent to which judges must consider a defendant's need for treatment and the level of discretion afforded to judges in choosing whether to commit the offender.²²² Similarly, states that classify vulnerability as a mitigating factor may or may not require judges to consider vulnerability at sentencing. Some states require courts to consider the likelihood that an offender will experience undue hardship if incarcerated,²²³

221. At least two other models are possible for how judges could respond to a finding of offender vulnerability. First, a judge could order a correctional agency to take some mandatory action, such as disqualifying a particular facility as a possible housing option. At the other end of the spectrum, a judge could identify an offender as having a serious mental disorder and likely vulnerable to harm, and simply order the correctional agency to report back to the judge after intake with its classification and housing plan for the offender. At this point, the court would have the option of resentencing the offender if his punishment, in light of the department's housing and treatment plan, appears disproportionate, excessive, or otherwise inappropriate. While the first option would allow for too little input from correctional officials, the latter would provide judges too little control over those conditions that they feel are necessary, over the length of a prisoner's term, for the effectuation of the purposes of punishment or to ensure the humaneness of an offender's sentence.

222. Compare 18 U.S.C. § 4244(a), (d) (2006), and S.D. CODIFIED LAWS § 23A-27-45 (2004) (directing the court to consider a defendant's mental health status and need for commitment and mandating commitment if he meets certain criteria), with HAW. REV. STAT. ANN. § 706-607 (LexisNexis 2007); 725 ILL. COMP. STAT. ANN. 5/104-26(c) (West 2006); KAN. STAT. ANN. §§ 22-3429, 22-3430 (2007); N.D. CENT. CODE ANN. § 12.1-32-02(1)(g) (West 2012); and 50 PA. STAT. ANN. § 4410(a), (c) (West 2001) (granting discretion to the judge to determine whether to order a mental examination or hearing and whether to commit the offender).

223. See, e.g., ARK. CODE ANN. § 5-4-301(c)(11) (2006); HAW. REV. STAT. ANN. § 706-621(2)(i); 730 ILL. COMP. STAT. ANN. § 5/5-5-3.1(a)(12); LA. CODE CRIM. PROC. ANN. art. 894.1.B(31) (2008); MONT. CODE ANN. § 46-18-225(j) (2011); N.D. CENT. CODE ANN. § 12.1-32-04(11).

while others treat susceptibility to harm as a permissive sentencing factor.²²⁴ Likewise, some states require courts to consider a mentally disordered offender's treatment needs at sentencing,²²⁵ while others merely permit courts to do so.²²⁶

Vulnerability should *at least* be a permissive factor at sentencing, and legislatures that already permit sentencing judges to accommodate vulnerability should consider extending that authority to conditions of carceral confinement. While strong arguments support designating offender vulnerability as an obligatory factor, countervailing considerations exist. The decision to classify vulnerability as a permissive or a mandatory sentencing consideration holds important systemic ramifications.

A number of negative consequences could flow from assigning vulnerability as a discretionary factor. Permitting judges to disregard vulnerability ensures disparity in treatment. Some judges will be more interested in recognizing vulnerability in sentencing than others, and such discretion will allow the expression of bias or favoritism or otherwise exacerbate discriminatory tendencies.²²⁷ These are not new problems: uneven administration has always been a hallmark of probation with conditions, and disparate treatment is a feature of indeterminate sentencing systems and jurisdictions with voluntary sentencing guidelines.²²⁸ Relatedly, designating vulnerability as a discretionary factor

224. See, e.g., IND. CODE ANN. 35-38-1-7.1(b)(10) (LexisNexis 2012); N.J. STAT. ANN. § 2C:44-1(b)(11) (West 2013); D.C. SENTENCING & CRIM. CODE REVISION COMM'N, VOLUNTARY SENTENCING GUIDELINES MANUAL §5.2.3(8) (2013); UTAH SENTENCING COMM'N, 2011 ADULT SENTENCING AND RELEASE GUIDELINES, at 15, *available at* <http://www.sentencing.utah.gov/Guidelines/Adult/2011%20Adult%20Sentencing%20and%20Release%20Guidelines.pdf>.

225. See, e.g., 18 U.S.C. § 3553(a) (2006); HAW. REV. STAT. ANN. § 706-606(2)(d); IDAHO CODE ANN. § 19-2523; N.D. CENT. CODE ANN. § 12.1-32-04(12); VT. STAT. ANN. tit. 13, § 7030 (2009); WIS. STAT. ANN. § 973.017(2) (West 2007).

226. See, e.g., FLA. STAT. ANN. § 921.0026(2)(d) (West 2006); N.J. STAT. ANN. § 2C:44-1(b)(10) (West 2005); N.C. GEN. STAT. ANN. § 15A-1340.16 (West 2011); OR. ADMIN. R. 213-008-0002(1)(a)(I) (2013); DEL. SENTENCING ACCOUNTABILITY COMM'N, *supra* note 193, at 123, 127; DIST. OF COLUMBIA SENTENCING & CRIM. CODE REVISION COMM'N, VOLUNTARY SENTENCING GUIDELINES MANUAL §5.2.3(8) (2013).

227. See NORVAL MORRIS & MICHAEL TONRY, BETWEEN PRISON AND PROBATION 207 (1990) (observing that some judges reserve alternative sentencing options for white, middle- or upper-class offenders). Thus, the exercise of discretion may exacerbate the unfortunate and intolerable gap in addressing the mental health needs of whites versus those of African Americans. See Jennifer M. Keys, *When They Need Us Most: The Unaddressed Crisis of Mentally Ill African American Children in the Juvenile Justice System*, 2 DEPAUL J. FOR SOC. JUST. 289, 301-10 (2009) (discussing racial disparities in recognizing and treating the mental illnesses of juveniles).

228. See, e.g., FRANKEL, *supra* note 205, at 21-23; ANDREW VON HIRSCH, DOING JUSTICE 23-30 (reprint ed. 1986); Gary L. Mason, *Indeterminate Sentencing: Cruel and Unusual Punishment, or Just Plain Cruel?*, 16 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 89, 100, 120 n.69 (1990); Dean J. Spader, *Megatrends in Criminal Justice Theory*, 13 AM. J. CRIM. L. 157, 189

contributes to the uncertainty and opacity of the sentencing process because an offender will seldom know before sentencing whether the judge will consider his mental health needs and susceptibility to harm. This type of inconsistency and lack of transparency currently exist in the federal system as a consequence of *United States v. Booker*.²²⁹

Conversely, mandating the consideration of disordered offenders' vulnerability carries both substantial benefits and significant disadvantages.²³⁰ In some instances, judges may have more and better information than correctional officials, and thus may identify some disordered and vulnerable offenders whom correctional officials may miss.²³¹ Over time, judicial decisions concerning vulnerability would become more predictable and transparent. Moreover, treating vulnerability as a mandatory sentencing factor could prompt legislatures to develop regulatory regimes and allocate resources to aid judges in the accuracy of their determinations. Upstream and downstream actors would become attentive to the mental health of offenders as a matter of law.²³² For example, law enforcement would be more likely to note the mental status of a suspect and to perform some sort of mental health assessment at intake. Prosecutors would consider the mental health of a defendant and affirmatively differentiate between prison environments when considering sentencing options. Defense counsel would also investigate the defendant's mental health and vulnerability under various sentencing options,²³³ and the failure to recognize an

(1986) ("Whenever discretion exists, especially in the difficult and value-laden tasks of sentencing, vast disparities exist between sentencing decisionmakers.").

229. 543 U.S. 220 (2005) (holding that mandatory sentencing guidelines are unconstitutional and, therefore, granting judges greater discretion in sentencing); see Kolber, *supra* note 2, at 194–95; cf. Raeder, *supra* note 18, at 741–43 (urging judges to use their discretion under *Booker* to consider correctional conditions in sentencing).

230. The observations of, and conversations with, Professors Miriam Baer, Douglas Berman, Jerold Israel, and Scott Sundby enriched this section.

231. See *supra* notes 208–10 and accompanying text.

232. Training and education would be useful to facilitate the consideration of mental disorder by actors in criminal justice system. See, e.g., JACKIE MASSARO, GAINS TECHNICAL ASSIST. & POLICY ANALYSIS CTR. FOR JAIL DIVERSION, OVERVIEW OF THE MENTAL HEALTH SERVICE SYSTEM FOR CRIMINAL JUSTICE PROFESSIONALS 4 (2005), available at http://gainscenter.samhsa.gov/pdfs/jail_diversion/MassarosII.pdf (describing the training of police and correctional officers to identify and respond appropriately to mental health problems); *Mental Health on the Bench: Empowering Judges to Change the Way the Criminal Justice System Responds to Mental Illness and Substance Abuse*, NAT'L ALLIANCE ON MENTAL ILLNESS, <http://www.nami.org/Template.cfm?Section=CIT&Template=/ContentManagement/ContentDisplay.cfm&ContentID=148027> (last visited May 15, 2014) (describing training programs on mental disorders for judges, attorneys, and court personnel). I am grateful to Professors Miriam Baer and Jennifer Laurin for these points.

233. Expert assistance may be necessary for these assessments, raising important issues under *Ake v. Oklahoma*, 470 U.S. 68, 77–83 (1985), which held that indigent defendants are entitled to expert psychiatric assistance when necessary for a fair trial.

offender's mental illness and notify the court could serve as the basis for a Sixth Amendment ineffective assistance of counsel claim.²³⁴

However, requiring judges to consider an offender's vulnerability could yield negative consequences as well. Guaranteeing consideration of vulnerability, particularly if it would necessitate a hearing, ultimately may not result in judicially tailored sentences. Instead, a defendant's right to a hearing, if waivable, may simply offer another "bargaining chip" for plea negotiations.²³⁵ Further, mandatory consideration may result in a more complicated and expensive sentencing process that requires more preparation time, longer hearings, and possibly opinions from and examinations of mental health witnesses. On the other hand, increasing the attention of institutional players to the existence and plight of mentally ill offenders could result in overall savings from the diversion of low-level offenders with mental illnesses, higher rates of plea bargaining, and the increased use of less costly, alternative sanctions. Moreover, savings may result from reductions in hospital days,²³⁶ and possibly reduced rates of recidivism,²³⁷ resulting from better treatment in prison. Because this analysis is so complex, further evaluation is necessary before recommending that legislatures require or merely permit judges to consider disordered offenders' vulnerability at sentencing.

234. See *Glover v. United States*, 531 U.S. 198, 203–04 (2001) (holding that the failure by defense counsel to object to an error of law that could affect sentencing is deficient performance for purposes of ineffective assistance of counsel, and that this deficient performance could suffice to show prejudice); Hessick, *supra* note 187, at 1080–86 (examining the standard for ineffective assistance of counsel in mandatory sentencing systems under *Glover*).

235. See WILLIAM J. STUNTZ, *THE COLLAPSE OF AMERICAN CRIMINAL JUSTICE* 224–27 (2011); Stephanos Bibas, *Incompetent Plea Bargaining and Extrajudicial Reforms*, 126 HARV. L. REV. 150, 172 (2012) (reflecting that often "new rights have had unintended consequences, encouraging legislatures to broaden criminal laws and give prosecutors more bargaining chips, diverting attention from innocence, favoring well-off defendants with well-funded counsel, and increasing the hydraulic pressures to plead guilty and waive rights"); cf. Talia Fisher, *The Boundaries of Plea Bargaining: Negotiating the Standard of Proof*, 97 J. CRIM. L. & CRIMINOLOGY 943, 944–45 (2007) (observing that many features of the criminal process have turned into "bargaining chips" and arguing that permitting defendants to waive their rights results in the efficient resolution of criminal cases and may advance the defendant's autonomy).

236. See *infra* notes 276–80 and accompanying text (citing the cost savings resulting from treatment in intermediate care facilities).

237. See, e.g., JOHN MONAHAN ET AL., *RETHINKING RISK ASSESSMENT* 136–38 (2001) (finding that patients who attended mental health or substance abuse treatment sessions were less likely to commit violent acts after hospital discharge than those who attended fewer sessions or did not receive any treatment); Johnston, *supra* note 159, at 558–61, 566 (reporting that mental illnesses may directly contribute to the criminality of approximately ten percent of the mentally disordered offender population and suggesting that treating this population's mental illnesses and any co-occurring substance abuse may be effective in reducing recidivism); *supra* note 160 and accompanying text.

The remainder of this Article explores some of the conditions that judges could order under a procedure allowing a reopening of an offender's sentence.²³⁸ These proposals build upon the statutory frameworks presented in Part III and extend the principles illustrated there to terms of confinement. The sections below list possibilities by degree of intrusiveness into correctional affairs and first profile reforms that would infringe upon correctional affairs the least. Efficiency benefits and disadvantages associated with each option are explored.

B. Authority to Order Mental Health Evaluations

One way in which judges could improve the prison experiences of vulnerable, disordered defendants would be to ensure that they receive comprehensive mental health evaluations by qualified mental health professionals at intake. At the very least, this requirement would accelerate the timing of the assessment and eliminate the uncertainty of the screening process.²³⁹

Authorizing judges to order a comprehensive mental health examination would hold a number of benefits, but is not without risk. Its primary benefit would be to increase the likelihood that vulnerable, disordered offenders would receive necessary treatment and appropriate housing assignments. Because the sentencing judge's assessment of a defendant's mental health may be more accurate than an intake evaluator's assessment,²⁴⁰ allowing a judge to trigger a comprehensive mental health evaluation could result in a more thorough, accurate, and efficient correctional evaluation process that identifies a greater proportion of disordered individuals.²⁴¹ However, one potential disadvantage of this option is that judges could order evaluations that ultimately prove to be unnecessary, resulting in wasted resources. In addition, permitting judges to order comprehensive evaluations for specific offenders may delay the assessments of other deserving individuals.

Notably, a judge's finding of mental disorder could serve as a more appropriate mechanism for securing the primary benefit of a guilty but mentally ill verdict. While statutes differ, one common formulation allows a jury to find a defendant who has asserted an insanity defense "guilty but mentally ill," thus exposing him to any sentence appropriate for his offense but specifying the

238. See *supra* text accompanying note 221.

239. See *supra* Part I.A–B.

240. See *supra* note 208 (listing steps in the criminal justice process that allow for the consideration of a defendant's mental disorder and observing that judges will likely have less information about defendants who plead guilty than those who proceed to trial); *supra* note 210 (listing rights afforded to defendants at sentencing).

241. Intake evaluators typically consider information concerning a defendant's mental health history and needs that is included in a presentencing report, and judges can play an important role in ensuring the completeness and accuracy of this information. Evidence suggests, however, that intake evaluators may perform evaluations without the benefit of these reports. See *supra* note 73.

defendant's eligibility for mental health treatment while incarcerated.²⁴² Typically, offenders found guilty but mentally ill do not actually obtain better treatment than other mentally ill prisoners.²⁴³ In some states, however, the verdict has increased offenders' likelihood of receiving psychiatric evaluations, thereby improving the odds that their illnesses will be detected and that they will ultimately receive mental health treatment in prison.²⁴⁴ A judge's finding at sentencing could operate in a similar fashion.

Moreover, a sentencing judge's finding of mental disorder would be more probative, and more appropriate, than the finding of mental disorder communicated through a guilty but mentally ill verdict. Commentators have criticized these verdicts on the basis that assessments of mental disorder at the time of the crime are largely irrelevant to a prisoner's mental health needs during confinement.²⁴⁵ This objection has less purchase in the context of sentencing, however, because the sentencing judge's concerns rightfully extend to an inmate's anticipated mental health needs in prison and because this assessment occurs closer to the time of incarceration.²⁴⁶

242. Christopher Slobogin, *The Guilty But Mentally Ill Verdict: An Idea Whose Time Should Not Have Come*, 53 GEO. WASH. L. REV. 494, 494–95 (1985).

243. See Lisa A. Callahan et al., *Measuring the Effects of the Guilty But Mentally Ill (GBMI) Verdict*, 16 LAW & HUM. BEHAV. 447, 460 (1992); Ingo Keilitz, *Researching and Reforming the Insanity Defense*, 39 RUTGERS L. REV. 289, 319 (1987); John Q. La Fond & Mary L. Durham, *Cognitive Dissonance: Have Insanity Defense and Civil Commitment Reforms Made a Difference?*, 39 VILL. L. REV. 71, 103 (1994); Slobogin, *supra* note 242, at 513–14 (identifying legal and fiscal constraints that minimize differences in the treatment afforded to guilty and guilty but mentally ill prisoners).

244. Slobogin, *supra* note 242, at 514 n.95 (observing that, “[i]n many states, guilty but mentally ill offenders receive post-conviction evaluation more often than do other offenders; therefore, their treatment needs are more likely to be identified”); see also Keilitz, *supra* note 244, at 319 (concluding, based on a review of records from Georgia, Illinois, and Michigan, that at least ninety percent of guilty but mentally ill inmates received a post-conviction mental health evaluation and that treatment was recommended in sixty-four to seventy-two percent of those cases).

245. Slobogin, *supra* note 242, at 518; cf. Mark A. Woodmansee, *The Guilty But Mentally Ill Verdict: Political Expediency at the Expense of Moral Principle*, 10 NOTRE DAME J.L. ETHICS & PUB. POL’Y 341, 385 (1996) (“Although the jury [in a guilty but not mentally ill case] found evidence of mental illness, this indicates only that the defendant suffered from mental illness at the time of the offense. Such a determination is not dispositive of whether the defendant should receive mental health treatment at the time he is sentenced.”).

246. A defendant's mental disorder may impact sentencing in several ways. For instance, his mental impairment at the time of the crime may serve as a mitigating factor to the extent that it reduces his culpability. Conversely, mental illness may aggravate a defendant's sentence, as sentencing bodies often assume that mental disorder correlates with dangerousness. See Ellen F. Berkman, *Mental Illness as an Aggravating Circumstance in Capital Sentencing*, 89 COLUM. L. REV. 291, 298–300 (1989) (discussing the use of mental disorder, typically a mitigating factor, as an aggravating circumstance in capital sentencing).

C. Authority to Disqualify Certain Facilities

Another option to reduce a vulnerable, disordered prisoner's risk of harm would be to authorize judges to disqualify certain facilities for placement. A judge may find a facility unacceptable for a particular offender for a number of reasons, including the facility's thin mental health staffing, inadequate mental health services,²⁴⁷ lack of specialized housing for individuals with serious but non-acute mental disorders,²⁴⁸ dearth of protective housing, high rates of violence, or overcrowding. A facility may also be objectionable because of its regular practice of disciplining, protecting, or maintaining offenders in isolation.²⁴⁹ Many prisons place vulnerable inmates in protective custody in extremely restrictive conditions, which may cause acute psychological deterioration and distress.²⁵⁰ Offenders with serious mental disorders are both vulnerable to abuse and likely to experience difficulty complying with prison rules.²⁵¹ Thus, disqualifying facilities that respond to these foreseeable

247. See, e.g., BECK & MARUSCHAK, *supra* note 27, at 1–2, 5; Ronald W. Manderscheid et al., *Growth of Mental Health Services in State Correctional Facilities 1988 to 2000*, 55 PSYCHIATRIC SERVICES 869, 871 tbl.1 (2004) (reporting the number and percentage of adult correctional facilities that provide twenty-four-hour mental health care, therapy, and medication in each state).

248. See *infra* Part IV.E (discussing the existence of and benefits offered by intermediate care facilities).

249. See *supra* notes 96–97 and accompanying text. Several courts have held that the prolonged isolation of offenders with serious mental illnesses constitutes cruel and unusual punishment. See Thomas L. Hafemeister & Jeff George, *The Ninth Circle of Hell: An Eighth Amendment Analysis of Imposing Prolonged Supermax Solitary Confinement on Inmates with a Mental Illness*, 90 DENV. U. L. REV. 1, 25–31 (2012); Johnston, *supra* note 2, at 178 & n.156. Many professional organizations now recommend that penal institutions avoid the prolonged segregation of inmates with serious mental illnesses. See AM. BAR. ASS'N, TREATMENT OF PRISONERS: AMERICAN BAR ASSOCIATION STANDARDS FOR CRIMINAL JUSTICE Standard 23-2.8(a), at 55–56 (3d ed. 2010), (“No prisoner diagnosed with serious mental illness should be placed in long-term segregated housing.”); AM. PSYCHIATRIC ASS'N, POSITION STATEMENT ON SEGREGATION OF PRISONERS WITH MENTAL ILLNESS 35 (2013), available at http://www.dhcs.ca.gov/services/MH/Documents/2013_04_AC_06c_APA_ps2012_PrizSeg.pdf (“Prolonged segregation of adult inmates with serious mental illness, with rare exceptions, should be avoided due to the potential for harm to such inmates.”); Restricted Housing of Mentally Ill Inmates, SOC'Y OF CORRECTIONAL PHYSICIANS (July 9, 2013), <http://societyofcorrectionalphysicians.org/resources/position-statements/restricted-housing-of-mentally-ill-inmates> (acknowledging “that prolonged segregation of inmates with serious mental illness, with rare exceptions, violates basic tenets of mental health treatment” and that “[i]nmates who are seriously mentally ill should be either excluded from prolonged segregation status (i.e. beyond 4 weeks) or the conditions of their confinement should be modified in a manner that allows for adequate out-of-cell structured therapeutic activities and adequate time in an appropriately designed outdoor exercise area”); *Solitary Confinement as a Public Health Issue*, AM. PUB. HEALTH ASS'N (Nov. 5, 2013), <http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1462> (calling on correctional authorities to “[e]xclude from solitary confinement prisoners with serious mental illnesses”).

250. See Johnston, *supra* note 2, at 202 nn.257–59.

251. See *supra* notes 93–95 and accompanying text.

predicaments in ways that imperil disordered inmates could serve as an important means to excise those sources of harm most likely to render an offender's sentence excessive or inhumane.

However, this option has several practical limitations. While disqualifying a facility for a given prisoner could, in theory, pose minimal difficulty for a correctional agency, that outcome would depend upon the number of available facilities and the security levels present within each one.²⁵² Additionally, ruling out a particular facility does not guarantee that the offender will be confined in humane or appropriate conditions. Consequently, whether this method will actually improve conditions of confinement remains to be seen. Disqualifying certain facilities could even result in greater hardship for an offender if, for example, he were placed in a facility farther away from his family or support network.

D. Authority to Designate Certain Kinds of Facilities

Alternatively, legislatures could grant trial courts the authority to order a vulnerable, disordered offender to serve—or at least start²⁵³—his sentence in a particular level or kind of facility, such as one with certain mental health, programming, or protective resources, assuming that a facility within that class is capable of managing an offender's security risks.²⁵⁴ For example, the Federal Bureau of Prisons has designated facilities as CARE Level 1, 2, 3, or 4 institutions.²⁵⁵ Facilities at each level are capable of responding to a different degree of medical need, either directly or through their proximity to community medical centers or major regional treatment centers.²⁵⁶ Only Level 4 institutions, which include federal medical centers, supply limited inpatient care and may offer inpatient mental health units.²⁵⁷ Thus, if Congress were to sanction this option, a federal judge could require a vulnerable, disordered

252. See *infra* note 254.

253. See *infra* text accompanying note 287. Multiple considerations militate toward allowing prison officials to transfer prisoners among facilities, such as prisoners' evolving mental health statuses, the need to protect prisoners from emergent dangers within a particular facility, changes in prisoners' security classifications, and institutional priorities and resource needs.

254. See *infra* notes 271–73 and accompanying text (detailing the benefits of an intermediate care unit). Before imposing a condition that affects a defendant's facility or housing placement, a judge should be aware of an inmate's likely security level and ensure that correctional officials anticipate being able to satisfy the condition without unduly compromising the institution's legitimate security needs. See Am. Bar Ass'n, *supra* note 213, at 408–09. Indeed, experts report that, when the Federal Bureau of Prisons fails to follow a judicial recommendation regarding inmate placement, "it is usually because the judge has recommended a facility incompatible with the defendant's security level." ELLIS ET AL., *supra* note 4, at 26–27.

255. See ELLIS ET AL., *supra* note 4, at 102–03.

256. See *id.*

257. *Id.* at 102.

offender to complete at least part of his sentence in a federal medical center with inpatient mental health services.

This proposal is similar to, but would provide broader authority than that granted under, 18 U.S.C. § 4244. Section 4244, as discussed in Part III.A, authorizes a trial court to commit certain mentally disordered offenders for hospitalization as part of a provisional sentence.²⁵⁸ If a court finds that an individual has a mental disorder under the first prong of § 4244 but does not require commitment for treatment under the second prong, it may recommend his placement in a correctional facility capable of providing a certain level of mental health treatment.²⁵⁹ The instant proposal would make these recommendations presumptively binding.²⁶⁰ The approach would also eliminate a major disadvantage of 18 U.S.C. § 4244: the requirement that judges order provisional sentences for the maximum statutory term.²⁶¹

E. Authority to Designate a Particular Facility

Another, more intrusive option would involve authorizing courts to choose the particular facility in which an offender will begin his sentence, assuming that the facility is capable of managing his security risk level.²⁶² For example, a legislature could establish that seriously disordered offenders who would face unacceptable levels of hardship in a typical prison environment should serve their sentences in facilities capable of offering an appropriate therapeutic environment. The legislature could then grant sentencing judges the authority to identify qualifying individuals and to select available facilities that comply with this directive. One attractive option for vulnerable, mentally disordered offenders would be a prison with an intermediate care facility or residential treatment units. Treatment in these units has been shown to “dramatically improve the quality of life” of mentally ill inmates who have difficulty coping with the stresses of prison, especially those who are vulnerable to victimization or who struggle with medication compliance.²⁶³

258. See *supra* notes 167–79 and accompanying text (discussing the requirements and application of § 4244).

259. See *United States v. Chapman*, 902 F.2d 1331, 1333–34 (8th Cir. 1990); *United States v. Gigante*, 989 F. Supp. 436, 438, 443 (E.D.N.Y. 1998).

260. This placement would be subject to modification by reopening the sentence. See text accompanying *supra* note 221.

261. See *supra* note 172 and accompanying text. Many of the possible objections to allowing trial courts to designate a type of facility also apply to authorizing judges to assign an offender to a specific facility. For this reason, the next section will consider objections to both proposals.

262. See *supra* note 254.

263. Fred Cohen & Joel Dvoskin, *Inmates with Mental Disorders: A Guide to Law and Practice*, 16 MENTAL & PHYSICAL DISABILITY L. REP. 462, 465 (1992).

Although many commentators have characterized prison as a toxic environment for individuals with serious mental illnesses,²⁶⁴ an exception seems to exist for many individuals housed in intermediate care facilities. Intermediate care facilities, found in an increasing number of states,²⁶⁵ are designed to provide a stable and therapeutic environment for mentally ill prisoners²⁶⁶ who are unable to cope effectively in the general prison population but do not require hospital-level care.²⁶⁷ Modeled on the “therapeutic community” and “therapeutic milieu” concepts advanced by Professor Hans Toch and his colleagues,²⁶⁸ intermediate care facilities provide inmates with a therapeutic environment that reduces the stressors and conditions that cause psychological degeneration and threaten victimization.²⁶⁹ These programs assume that, although most mental illnesses cannot be cured, with appropriate treatment mentally ill individuals can cope with their disorders.²⁷⁰ Many treatment modalities and programming options are typically available within these units or facilities.²⁷¹ Through individual or group therapy, prisoners may learn symptom recognition, anger management, medical compliance strategies, communication techniques, and vocational

264. See *supra* note 92.

265. See *supra* notes 115–26 (listing states with intermediate care facilities).

266. Many intermediate care programs focus on treating prisoners with severe mental illnesses. See, e.g., Ohio DRC, *supra* note 117; David Lovell et al., *Evaluating the Effectiveness of Residential Treatment for Prisoners with Mental Illness*, 28 CRIM. JUST. & BEHAV. 83, 86 (2001). Inmates with less serious disorders but significant coping problems are also eligible in some states. See, e.g., Ohio DRC, *supra* note 117; Ward S. Condelli et al., *Intermediate Care Programs for Inmates with Psychiatric Disorders*, 22 BULL. AM. ACAD. PSYCHIATRY L. 63, 67 tbl.2 (1994).

267. See CORR. ASS'N OF N.Y., *supra* note 93, at 35; HUMAN RIGHTS WATCH, *supra* note 40, at 130; Ohio DRC, *supra* note 118; Va. Dep't of Corr., *supra* note 107, at 2; WASH. DEP'T OF CORR., *supra* note 115, at 3.

268. See generally THERAPEUTIC COMMUNITIES IN CORRECTIONS (Hans Toch ed., 1984).

269. Lovell et al., *supra* note 266, at 86.

270. *Id.*

271. See CORR. ASS'N OF N.Y., *supra* note 91, at 35 (providing group therapy, individual counseling, and medication); Condelli et al., *supra* note 266, at 64 (noting that New York's intermediate care facilities provide “milieu therapy, individual and group therapy, chemotherapy, recreation therapy, task and skills training, educational instruction, vocational instruction, and crisis intervention”); Lovell et al., *supra* note 266, at 86 (providing psychoeducational classes, counseling, and medication); see also Kupers et al., *supra* note 122, at 1042–43 (describing various programs provided by several different facilities). Intermediate care facilities may be located within separate correctional mental health facilities or in separate wards or units within individual prisons. For example, New York operates intermediate beds within eleven of its maximum security prisons. CORR. ASS'N OF N.Y., *supra* note 91, at 35. Washington provides residential treatment in three facilities, including the McNeil State Prison. WASH. DEP'T OF CORR., *supra* note 116, at 4. Kansas maintains a separate mental health facility. See *Larned Correctional Mental Health Facility*, *supra* note 120. Additionally, security levels vary among institutions, and even within individual programs. See, e.g., Ohio DRC, *supra* note 117, at 4–5; VT. DEP'T OF CORR., *supra* note 123, at 2; Kupers et al., *supra* note 122, at 1042 (describing Mississippi's program).

skills.²⁷² Rates of medication compliance are high in intermediate care facilities as a result of patient education, symptom management, frequent psychiatric consultations, and the increased privacy and decreased stigma surrounding psychotropic medication.²⁷³ Much like a halfway house or community care center outside of prison, these units are intended as short- or mid-term safe-havens where inmates learn strategies for living in the general prison population.²⁷⁴ Although programs encourage reentry into the general population, some administrators allow inmates to remain in residential treatment units if reentry is not feasible given an inmate's risk of victimization, self-harm, or medication noncompliance.²⁷⁵

Several studies demonstrate that treatment in intermediate care facilities results in lower levels of mental disorder, disciplinary violations, and victimization, and may yield aggregate cost savings for prisons.²⁷⁶ A study by Professor David Lovell and his colleagues at the University of Washington reported:

Inmates [who were treated in the intermediate care facility] were significantly more stable in terms of psychiatric symptoms when they left than when they arrived. Inmates had better infraction records and consumed less of the department's management resources, . . . and were able to maintain themselves in [the] general population setting.²⁷⁷

The study also found that inmates consumed fewer prison resources after completing treatment in the intermediate care program.²⁷⁸ Other studies have

272. See CORR. ASS'N OF N.Y., *supra* note 91, at 35; Kupers et al., *supra* note 122, at 1042–42; Lovell et al., *supra* note 266, at 86; MacKain & Messer, *supra* note 86, at 92, 96.

273. See CORR. ASS'N OF N.Y., *supra* note 91, at 36.

274. *Id.* at 36–37; VT. DEP'T OF CORR., *supra* note 123, at 2; WASH. DEP'T OF CORR., *supra* note 116, at 3; Kupers et al., *supra* note 122, at 1042–43.

275. Intermediate care programs vary in duration. In Washington, inmates spend a median of seven months in the McNeil mental health program. Lovell et al., *supra* note 266, at 88. Prison rules specify that prisoners may stay a maximum of eighteen months, but staff allow some inmates to stay longer if they believe no other situation is suitable. *Id.* at 88–89. In New York, inmates may stay in intermediate care programs for years, and “many” never leave. CORR. ASS'N OF N.Y., *supra* note 91, at 38; see Condelli et al., *supra* note 266, at 65. In North Carolina, most offenders complete the Social Skills Training Day Program in six to eight months, but offenders may remain in the program indefinitely if they are “not yet ready for transfer to a less restrictive environment.” MacKain & Messer, *supra* note 86, at 94.

276. See MacKain & Messer, *supra* note 86, at 91–92 (describing studies of the benefits of intermediate care facilities).

277. Lovell et al., *supra* note 266, at 100. This study measured the number of disciplinary infractions that program participants received before and after completion and related that figure to a cost index. *Id.* at 90–91.

278. *Id.* at 95 tbl.4. The finding that intermediate care facilities may convey cost savings might be counterintuitive because these units typically require more mental health professionals, nurses, and counselors per inmate than units in the general population. See, e.g., ALA. DEP'T OF CORR., *supra* note 124, at 4 (listing members of an inmate's treatment team).

reached similar conclusions.²⁷⁹ Social scientists have speculated that intermediate care programs may help disordered inmates “generalize the skills they will need post-release and, therefore, offer promise in reducing stress and cost in a larger sphere of mental health treatment.”²⁸⁰

These studies suggest that intermediate care facilities and residential treatment units offer a humane and affordable means of confining vulnerable offenders with serious mental illnesses.²⁸¹ Legislatures should consider authorizing judges to sentence vulnerable, disordered offenders to confinement in a facility with residential treatment units, assuming that such a placement is consistent with an offender’s security and management needs.²⁸² While laws in every jurisdiction currently provide for the treatment of prisoners with serious mental disorders,²⁸³ correctional authorities may not transfer an offender to a specialized correctional facility or mental hospital until an offender is in acute distress.²⁸⁴ Admittedly, ordering the confinement of an offender in a particular facility with certain treatment or protective resources would not guarantee access to those services for the duration of his sentence.²⁸⁵ However, the proximity of these resources may increase the likelihood that an offender will benefit from them if the need arises, so long as they are available at the offender’s security level.²⁸⁶ In essence, it is easier to move an offender within a facility than between facilities, and authorities may be more likely to use intermediate care if it would not require transfer to another facility.

279. See, e.g., CORR. ASS’N OF N.Y., *supra* note 91, at 37–39 (finding that intermediate care programs in New York successfully protected vulnerable prisoners from aggressive inmates and significantly reduced the rate of disciplinary infractions); Condelli et al., *supra* note 266, at 67–68 (finding, in an earlier study of New York programs, significant reductions in mental health services received by program inmates, including crisis care, seclusion, and hospitalization, and reporting significant reductions in very serious infractions and suicide attempts but not in merely serious infractions, during the six months after admission to the program); Kupers et al., *supra* note 122, at 1046 (finding, in a study of Mississippi’s step-down program, that rates of disciplinary infractions dropped significantly when inmates entered the program, as compared to rates six months prior to entry, and remained low six months after the program ended).

280. MacKain & Messer, *supra* note 86, at 89.

281. See *supra* notes 276–79 and accompanying text.

282. See *supra* note 254.

283. CHRISTOPHER SLOBOGIN ET AL., LAW AND THE MENTAL HEALTH SYSTEM 640 (5th ed. 2009).

284. Such a result may follow from application of the least restrictive alternative doctrine. See, e.g., *Lake v. Cameron*, 364 F.2d 657, 660 (D.C. Cir. 1966) (“Deprivations of liberty solely because of dangers to the ill persons themselves should not go beyond what is necessary for their protection.”).

285. Intermediate care “facilities” are often units within larger facilities. See *supra* note 271.

286. See Holton, *supra* note 91, at 105 (observing that “some treatment modalities may not be available at all security levels, so an inmate may be unable to receive optimal care due to his or her security rating”).

A more intrusive option would involve allowing judges to designate initial presumptive placements in particular units. Permitting a judge to order a vulnerable, disordered offender to start his carceral term in a residential treatment unit, for instance, would ensure that he receives a comprehensive evaluation, diagnosis, and treatment plan. In addition, residing in an intermediate care facility for a few months would allow the inmate to acclimate to any new psychotropic medication, receive greater monitoring of his medication, benefit from individual and group therapy, and develop skills and strategies for living in the general prison population, such as symptom recognition, anger management, medical compliance, and interpersonal skills.²⁸⁷ The inmate would thus be better equipped to cope successfully in the general prison population when (and if) he is transferred out of the unit. The inmate may also be less likely to fall through the cracks of the prison's mental health care docket if his mental health later deteriorates. Because this placement would be presumptive, the offender could begin his term in another unit if a qualified mental health professional believes that another environment could satisfy his treatment and protection needs.²⁸⁸

Despite the benefits of initial placement designation, there are valid objections to allowing judges to tailor sentences in this way. Placing individuals first in line for residential treatment slots could result in inequity and a misallocation of resources because correctional officials may be unable to assign the neediest and most vulnerable offenders to these units. Judicial placement authority may also result in designated offenders' receiving more costly housing than is necessary given their post-sentencing mental health statuses. However, allowing the government to move to reopen a sentence if an ordered placement becomes unnecessary, infeasible, or unreasonable may respond adequately to these concerns.²⁸⁹

Other objections are more difficult to diffuse. Allowing judges to make facility designations would impede the ability of correctional authorities to forecast prison housing and resource needs. Given the number of offenders with serious mental illnesses entering the prison system,²⁹⁰ permitting judges to order a subset of these offenders to begin their sentences in residential treatment units may require an expansion of those units.²⁹¹ Furthermore, this option would

287. See *supra* note 272 and accompanying text. Over a third of inmates in North Carolina's Social Skills Day Training Program arrive directly after entering the prison system. See MacKain & Messer, *supra* note 86, at 93, 96.

288. See text accompanying *supra* note 221 (describing the proposed process to reopen sentences).

289. See *id.*

290. See *supra* note 6.

291. Many mental health experts, organizations, and advocates have urged states to expand the number and capacities of intermediate care facilities. See, e.g., CORR. ASS'N OF N.Y., *supra* note 91, at 40; HUMAN RIGHTS WATCH, *supra* note 39, at 133–34; Holton, *supra* note 91, at 116.

provide only temporary relief to vulnerable, disordered offenders, since correctional officials would be free to transfer inmates out of the therapeutic environments after some period of time.²⁹² As an alternative, legislatures could authorize judges to order that vulnerable, disordered offenders presumptively spend the entirety of their carceral terms in protective, therapeutic units, at least in states in which such a long-term option exists.²⁹³ This alternative could be structured similarly to the commitment measures detailed in Part III.A. However, judicial decisions pursuant to this authority would compound forecasting and resource allocation problems.

F. Authority to Mandate Certain Treatment Consequences

A final option would permit courts to attach certain treatment conditions to the carceral sentences of vulnerable, disordered individuals.²⁹⁴ Under this proposal, correctional officials would retain authority over housing decisions, but judicial qualifications could govern the treatment of particular offenders. A number of conditions are possible. For example, assuming an offender's mental health problems continue to merit treatment,²⁹⁵ a judge could order that the offender receive an individualized treatment plan within a designated period of time and treatment in accordance with that plan, plus additional treatment as necessary, over the course of his confinement. The court could require periodic assessments of the nature and extent of the defendant's mental illness and updates regarding his mental health, housing, and treatment.²⁹⁶

Further, to mitigate the risk of serious harm to a disordered prisoner, a judge could attach additional conditions to his sentencing order. The judge could direct correctional officials to consider the offender's mental disorder, and its possible contribution to a disciplinary violation, in any disciplinary proceeding.²⁹⁷ A judge could order that, in responding to future rule violations,

292. See *supra* note 275 (discussing the average length of stay in intermediate care facilities).

293. But see *supra* note 253 (listing considerations that support maintaining correctional officials' abilities to transfer inmates among facilities).

294. See Am. Bar Ass'n, *supra* note 213, at 408–09 (outlining practices that would aid judges in crafting realistic sentences that would achieve their intended purposes).

295. While a court could impose a presumptive need for treatment based on its assessment of an offender's current and projected mental health needs, correctional mental health professionals must assess (and respond to) an offender's treatment needs over time.

296. In this way, sentencing conditions could mimic the requirements of some guilty but mentally ill statutes. See, e.g., 730 ILL. COMP. STAT. ANN. 5/5-2-6 (West 2013).

297. For example, a judge could mandate that a clinician review any disciplinary reports to discern whether mental disorder contributed to the infraction. Cf. Ball, *supra* note 45, at 38–39 (noting that, in California, a clinician must review the disciplinary report of every prisoner receiving mental health treatment to determine whether the prisoner's mental disorder contributed to the infraction); AM. PSYCHIATRIC ASS'N, *supra* note 35, at 26 (discussing the importance of clinical input in disciplinary issues). Prisons vary in the extent to which they consider mental disorder in disciplinary proceedings. See HUMAN RIGHTS WATCH, *supra* note 39, at 62–64; Michael Krelstein,

officials use their best efforts to avoid imposing sanctions, such as prolonged isolation, likely to exacerbate an offender's disorder.²⁹⁸ The sentencing order could provide that, if isolation is deemed necessary, any period spent in segregation must take place under conditions recommended by the American Psychiatric Association.²⁹⁹ These conditions include maximal access to structured, clinically indicated, out-of-cell programming and therapeutic activities (i.e., mental health/ psychiatric treatment) in appropriate, out-of-cell programming space, as well as regular, unstructured, out-of-cell recreation.³⁰⁰

Allowing judges to affect correctional placement and treatment conditions, when those conditions are integral to their sentencing aims or the humaneness of a punishment, would merely increase the weight given to their current recommendations. Federal law requires the Bureau of Prisons to consider judicial recommendations when assigning an offender to a particular facility.³⁰¹ Evidence demonstrates that federal judges offer recommendations regarding an offender's placement, programming, or treatment in over forty percent of cases

The Role of Mental Health in the Inmate Disciplinary Process: A National Survey, 30 J. AM. ACAD. PSYCHIATRY L. 488, 494 (2002).

298. See *supra* notes 96–97 and accompanying text (noting that mentally ill prisoners are disproportionately punished in solitary confinement, where they may be especially susceptible to a number of ill effects); *supra* note 249 (observing that some courts have held that the prolonged isolation of offenders with serious mental illnesses constitutes cruel and unusual punishment and that some professional organizations recommend that penal institutions avoid prolonged segregation of inmates with serious mental illnesses).

299. AM. PSYCHIATRIC ASS'N, *supra* note 249, at 36.

300. *Id.*

301. See 18 U.S.C. § 3621(b)(4) (2006) (providing that the Bureau of Prisons, when designating the place of a prisoner's imprisonment, must consider "any statement by the court that imposed the sentence (A) concerning the purposes for which the sentence to imprisonment was determined to be warranted; or (B) recommending a type of penal or correctional facility as appropriate"); see also Fed. Bureau of Prisons, *supra* note 98, at 1, 4 (describing the Bureau's placement system, providing guidelines for addressing judicial recommendations, and directing its designators to "make every effort to accommodate recommendations from the courts"). States also authorize and afford deference to judicial recommendations. See, e.g., CAL. R. CT. 4.480.

involving imprisonment.³⁰² Estimates of accommodation differ,³⁰³ but recent evidence suggests that the Bureau fully or partially accommodates between sixty-six and seventy-three percent of judicial requests.³⁰⁴ This degree of deference is telling and reflects, as the Third Circuit has recognized, that “[j]udges take their sentencing responsibilities very seriously and are familiar with the various [Bureau of Prisons] institutions and programs. Their recommendations as to the execution of sentences are carefully thought out and are important to them.”³⁰⁵ The degree of accommodation also demonstrates that the Bureau of Prisons usually finds judicial requests to be both reasonable and feasible to implement.

V. CONCLUSION AND ISSUES FOR FURTHER EXPLORATION

At sentencing, a judge can often foresee that an individual, because of his major mental disorder and other vulnerabilities, will experience serious psychological or physical harm in prison. These harms may include psychological deterioration and mental distress, attempted suicide, and victimization by staff or other inmates. In response, some jurisdictions allow a judge to commit a disordered offender for treatment in lieu of incarceration, and others designate the defendant’s need for treatment and likely undue hardship in prison as mitigating factors at sentencing. However, these measures do not go far enough to protect vulnerable prisoners. To prevent anticipated and unjust harms, legislatures should authorize judges to tailor the conditions of vulnerable,

302. See Todd Bussert, “Real Time” Designation, Proximity to Home and the Importance of Judicial Recommendations, FED. PRISON & POST-CONVICTION BLOG (July 12, 2012), <http://www.federalprisonblog.com/2012/07/real-time-designation-proximity-to-home-the-importance-of-judicial-recommendations.html> (reporting that, between June 2011 and March 2012, there were 40,563 judicial recommendations and 94,621 initial designations, meaning that judges offered recommendations for approximately forty-three percent of sentences during that period); Sonya Cole & Todd A. Bussert, BOP Presentation at United States Sentencing Commission’s Annual Federal Sentencing Guidelines Seminar (June 12, 2009), available at http://www.ussc.gov/Education_and_Training/Annual_National_Training_Seminar/2009/014a_BOP_Issues.pdf (noting that requests for specific programming (such as vocational training, drug abuse treatment, or work assignments), confinement in a specific facility or medical center, and sentence calculation are common recommendations).

303. See, e.g., ELLIS ET AL., *supra* note 4, at 27 (citing unspecified Bureau statistics showing that the Bureau honored about eighty-five percent of judicial recommendations for facility placements in cases in which the defendant qualified for the recommended institution).

304. See Bussert, *supra* note 302 (reporting that the Bureau followed or partially followed sixty-six percent of judicial recommendations made between June 2011 and March 2012); Cole & Bussert, *supra* note 302 (reporting that the Bureau completely followed sixty-two percent, and partially followed eleven percent, of judicial recommendations). Correctional facilities may not accommodate a judicial request because of conflicts between the recommended facility and the inmate’s security level, the inmate’s ineligibility for the recommended program, security concerns, or the unavailability of the requested program at the recommended facility. Cole & Bussert, *supra* note 302, at 3.

305. *Woodall v. Fed. Bureau of Prisons*, 432 F.3d 235, 247 (3d Cir. 2005).

disordered offenders' sentences when specific conditions of confinement are integral to the judge's sentencing aims or the humaneness of the punishment. Under one possible model, if correctional officials find a condition to be inappropriate, unnecessary, or infeasible, the government could move to reopen the sentence.

A number of important practical issues remain for exploration.³⁰⁶ First, these proposals hold important budgetary implications. Assessment of the costs or savings associated with allowing judges to tailor offenders' sentences is necessary. For instance, judges' findings of mental disorder and vulnerability may save money for correctional departments by streamlining their assessment processes and reducing the need for initial mental health screenings. Moreover, ensuring that vulnerable, disordered offenders receive adequate treatment and reside in protective environments may reduce these offenders' hospitalization rates, disciplinary infractions, and rates of recidivism upon release.³⁰⁷ Judicially imposed conditions could also result in fewer suits alleging deprivations of civil rights under 42 U.S.C. § 1983. Each of these possibilities requires further study.

Second, it is important to assess when formal judicial hearings would be necessary and what conditions would trigger such hearings. A hearing may be necessary to discern the degree of a defendant's mental illness and his level of vulnerability. In addition, legislatures could require a hearing for any defendant with a history of institutionalization or in any case in which a claim of mental illness (such as that relating to incompetency, insanity, or diminished capacity) was raised during a defendant's trial or in pretrial proceedings. Furthermore, a hearing may aid sentencing judges in deciding whether to order conditions affecting a prisoner's housing, discipline, or treatment.

Third, legislatures should establish protections to ensure that conditions of confinement for vulnerable offenders are actually humane and appropriate.³⁰⁸ One possibility is to require defense counsel to monitor the mental health and conditions of confinement of their vulnerable, disordered clients at regular intervals. Attorneys possibly could request funds for monitoring under the Criminal Justice Act.³⁰⁹

Finally, it is vital to consider how defense counsel's limited resources and competing strategic considerations may affect the utilization of the measures proposed in this Article. Defense counsel are often woefully underfunded and lack access to the investigative and expert resources necessary to prepare

306. This section, in particular, benefited from conversations with participants at the University of Florida Levin College of Law's Criminal Justice Center's Junior Scholars' Conference.

307. *See supra* notes 276–80.

308. I am grateful to Professor Douglas Berman for this observation.

309. *See* 18 U.S.C. § 3006A(d) (2012) (authorizing reimbursement of reasonable out-of-pocket expenses necessary to provide an adequate defense for indigent defendants).

adequate defenses and effective mitigation cases at sentencing.³¹⁰ Their access to expert assistance will likely be vital to effect the reforms this Article proposes.³¹¹ Furthermore, while mental disorder is associated with heightened vulnerability, its potential correlation with increased dangerousness may justify its use as an aggravating factor,³¹² such that its emphasis creates the risk of a longer sentence.³¹³ How defense counsel should balance these competing strategic and moral concerns is an important topic for another day.

310. See, e.g., Am. Bar Ass'n, Standing Comm. on Legal Aid & Indigent Defendants, Gideon's Broken Promise: America's Continuing Quest for Equal Justice 36–41 (2004), available at http://www.americanbar.org/content/dam/aba/administrative/legal_aid_indigent_defendants/ls_sc_laid_def_bp_right_to_counsel_in_criminal_proceedings.authcheckdam.pdf.

311. See *supra* note 233 (recognizing important issues under *Ake v. Oklahoma*).

312. For a discussion of the relationship between mental disorder and crime, including crimes of violence, see Johnston, *supra* note 159, at 564–75.

313. See, e.g., Berkman, *supra* note 246, at 299–300 (discussing the use of mental disorder, a mitigating factor, as an aggravating circumstance in capital sentencing).