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Severe Mental Illness and the Death Penalty

American Bar Association
Death Penalty Due Process Review Project
December 2016

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Executive Summary

Introduction

“Individuals with severe mental disorders or disabilities – present either at the time a capital crime is committed or as they are facing execution – should not be subject to capital punishment.”

In recent years, our society’s improved understanding of mental illness has led to a growing recognition that, to ensure fairness, the American justice system should treat those with mental disorders and disabilities differently. Advocates, professional organizations, and many others are troubled by the overrepresentation of people with mental illness in the criminal justice system, and agree that these conditions need to be better taken into account by prosecutors and courts because of their relevance to culpability, sentencing, and meaningful participation in the legal process. This consideration is particularly critical in capital cases, when the stakes are the highest. For these reasons, among many others that will be discussed in this Paper, individuals with severe mental illness should not be subject to the death penalty.

It has now been 10 years since the American Bar Association (ABA), in conjunction with the American Psychiatric Association, American Psychological Association and National Alliance on Mental Illness (NAMI) adopted a policy opposing the death penalty for individuals with severe mental disorders or disabilities present at the time a crime is committed; and five years since Mental Health America adopted a similar position. As we reflect on these anniversaries, it is significant to note that, since 2006, none of the jurisdictions that use capital punishment have passed statutes to categorically prevent the execution of individuals with severe mental illness. Despite broader efforts to reform the criminal justice system’s approach to mental illness, individuals with these types of conditions can still be sentenced to death and executed. It is, therefore, now time to convert the ABA’s policy into a meaningful tool to help states pass laws that will establish clear standards and processes to prevent the execution of those with severe mental illness.

Definition of Severe Mental Illness and its Relevance to Criminal Justice

The American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), defines mental disorder as: “a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning...usually associated with significant distress in social, occupational, or other important activities.”

Severe mental illness refers to a narrower set of diagnoses. According to the American Psychological Association, it includes “mental disorders that carry certain diagnoses, such as schizophrenia, bipolar disorder, and major depression; that are relatively persistent (e.g., lasting at least a year); and that result in comparatively severe impairment in major areas of functioning.”

Although not an exhaustive list, the most recognized and common severe mental illnesses include schizophrenia and schizoaffective disorder, bipolar disorders, major depressive disorder, and post-traumatic stress disorder (PTSD).

Inadequacy of Existing Legal Mechanisms to Address Severe Mental Illness in Capital Cases

None of the existing legal procedures afford complete or sufficient protection against death sentences and execution for individuals who had severe mental illness at the time of their crime.

Competency to Stand Trial. The competency standard is used to ensure that a defendant can adequately partake in his or her own defense. It is focused on a defendant's present mental abilities at the time of trial and does not address the question of state of mind at the time of the alleged offense, or legal culpability. If a defendant is found incompetent, he or she is moved to a medical facility to receive treatment to be restored, if possible, to competency so he or she can eventually face the charges against him or her. While mental illness often plays a role in a court's determination of a defendant's competence to stand trial, a history of mental illness "does not render the defendant mentally incompetent per se." The competency standard does not take into account a defendant's mental state at the time of crime, and does not preclude the death penalty for those with severe mental illness, unlike the ABA's proposed exemption.

The Insanity Defense. The insanity defense is an affirmative defense to a crime, intended to relieve a defendant of legal responsibility. A defendant found insane will be found not guilty of the crime and most likely sent to a psychiatric institution. However, the insanity defense is used in a very small number of cases, and is successful in even fewer. Indeed, it only applies to a narrow category of individuals with very particular manifestations of mental illness. The exemption endorsed by the ABA provides a middle ground protection for individuals who do not fit the extremely narrow insanity defense requirements, but who have significant mental impairments that make them undeserving of the death penalty.

Mitigating Factors. While jurors' consideration of mitigating factors related to mental illness is permitted in a death penalty sentencing phase, this has proven to be an unreliable method to ensure that a defendant's severe mental illness will be fully considered and given its proper weight. Significant jury research has shown that jurors frequently hold widespread and erroneous prejudices about mental illness and future dangerousness, and may make life or death decisions based on them. The Supreme Court expressed similar concerns with juries' consideration of defendants with intellectual disability or who are juveniles in capital cases, and found that categorical bars to the death penalty were the only appropriate protections. The proposed ABA exemption would provide a similar protection to those with severe mental illness.

Competency to be Executed. When looking at a defendant's competency to be executed, courts look at that person's mental state at the time near the execution date, which can occur many years after the crime. It is focused on whether defendants understand the reasons for their execution, and not on whether they were suffering from a severe mental disorder or disability that significantly impairs their understanding of reality and ability to control behavior at the time of the crime. Thus, this standard, like the other current mechanisms in the law, provides inadequate legal protection.

Constitutional Challenges to the Execution of Defendants with Severe Mental Illness

No Penological Justification. The U.S. Supreme Court has identified two purposes served by capital punishment: retribution and deterrence. Neither of these purposes justifies the execution of individuals with severe mental illness.

To warrant the death penalty, a defendant must be more morally culpable than the average murderer – as capital punishment is intended for the "worst of the worst." Executing people with severe mental illness does not further the retributive goals of the punishment, as this population simply does not have the requisite moral culpability. Their illnesses can impair the ability to interpret reality accurately, comprehend fully the consequences of their actions, and control their actions. In addition, the theory that the death penalty can deter potential murderers is controversial and unsupported by conclusive evidence. Any possible deterrent effects are

further diminished among people who suffer from impairments that affect their cognition, emotion regulation, or behavior.

A Violation of the Eighth Amendment Ban on Cruel and Unusual Punishment. The Supreme Court's jurisprudence has created categorical bars on the death penalty for individuals with intellectual disabilities (in *Atkins v. Virginia*) and juvenile defendants (in *Roper v. Simmons*). In both cases, the Court noted that the Eighth Amendment's ban on cruel and unusual punishment must be interpreted through the standards of the time and should reflect contemporary society's view on punishment. Most significantly, the Court conducted independent analyses in which it listed the impairments that characterize intellectual disability and youth and concluded: "These deficiencies do not warrant an exemption from criminal sanctions, but diminish their personal culpability."

The impairments described by the Court in *Atkins* include "diminished capacity to understand and process information, to communicate, to engage in logical reasoning, to control impulses, and to understand others' reactions" and are very similar to impairments frequently caused by severe mental illness. Indeed, hallucinations, delusions, grossly disorganized thinking – among other symptoms of mental illness – also significantly interfere with an individual's thinking, behavior, and emotion regulation.

The "Unreliability Principle." The Supreme Court has consistently affirmed that capital punishment requires individualized sentencing because of its gravity and finality. The death penalty cannot be automatically applied for specific categories of crime, and jurors must make sentencing decisions based on unique considerations and facts in the case before them. The Supreme Court and many states' laws specify that mental illness can be part of that individualized consideration as a mitigating factor.

However, in practice, severe mental illness can end up being a significant impediment to the presentation of effective, individualized mitigation. It can strongly affect defendants' decision-making about their defense, leading them to refuse to cooperate with their attorneys or reject the presentation of any mitigating evidence related to their illness. Worse, research has shown that mental illness can be erroneously interpreted by jurors as an aggravating factor, and it is worsened when a defendant has a bizarre or flat affect in the courtroom. Plus, jurors hold many of the same unwarranted prejudices present in the general population about violence and mental illness, and may view people with mental illness as intrinsically dangerous – a view completely unsupported by empirical evidence.

Thus, there is a significant risk that a death sentence may be imposed because of – not simply in spite of – a defendant's mental illness. This is unconstitutional and unacceptable. Because mitigation may not be reliably assessed in cases involving these defendants, the constitutional requirement of an individualized sentencing may not be met. Only a categorical exemption can ensure that a defendant's severe mental illness does not hinder individualized sentencing.

A Violation of the Equal Protection Clause. The Fourteenth Amendment's requirement of equal protection guards against the differential treatment of similarly situated individuals under the law and, therefore, there is no constitutional justification for permitting the execution of defendants with severe mental illness while defendants with similar impairments are exempted from the ultimate punishment. This principle is arguably violated by continuing to allow the death penalty for these defendants while individuals with intellectual disabilities and juveniles have been constitutionally exempted.

Significant Public Policy Concerns

Higher Risk of Executing an Innocent Person. One of the most persistent concerns with capital punishment is the risk of its imposition on the innocent, and individuals with severe mental illness are especially vulnerable to erroneous convictions. First, they are at a relatively higher risk of making false confessions. Second, once in court, the stigma of mental illness, including popular and unwarranted beliefs that they are inherently

dangerous, contributes to assumptions of guilt and more punitive sentencing. Finally, defendants with severe mental illness are less able to participate in their own defense because of their limited or impaired abilities. A ban on the execution of the individuals with severe mental illness would not prevent wrongful accusations or even convictions, but it would prevent the justice system from “committing the irreparable” against a more at-risk population.

Opposition of Professional Organizations, Some Murder Victims’ Families, International Institutions, and a Majority of the American Public. The ABA, the American Psychiatric Association, the American Psychological Association, NAMI and Mental Health America have all called for jurisdictions that impose capital punishment to exempt defendants suffering from severe mental illness from the death penalty. In 2009, Murder Victims’ Families for Human Rights and NAMI co-published “Double Tragedies,” a report addressing the urgent need for treatment and prevention to diminish the likelihood that tragic events like murders by people with severe mental illness occur. Both groups believe that seeking the death penalty in those cases diverts resources and energy that could be used to address mental health issues in the community, decrease the likelihood of violence, and help murder victims’ families heal through psychological and material support.

Additionally, major international institutions also oppose capital punishment in cases of defendants with severe mental illness. The United Nations, the European Union, the Council of Europe and the Inter-American Commission on Human Rights all urge countries that continue to use the death penalty not to impose it on defendants with mental illness. Finally, Americans are strongly in favor of a severe mental illness exemption. A 2015 multi-state poll found that 66% of Americans oppose the death penalty for persons with severe mental illness and this consensus follows across party lines. Support for the exemption rises to 72% after voters hear details about how it would work in practice.

Conclusion

The death penalty is the ultimate punishment that should be reserved for the most blameworthy individuals who commit the worst crimes – and it does not serve any effective or appropriate purpose when it is applied to individuals with severe mental illness. The Supreme Court has already recognized that there are two other categories of individuals who have similar functional impairments to people with severe mental illness that are inherently “less culpable” to the point that it is unconstitutional to apply the death penalty in their cases. In light of this constitutional landscape, the growing consensus against this practice, and the fact that none of the current legal mechanisms afford adequate protection against the death penalty to those diagnosed with serious mental disorders or disabilities, it is time for the laws in U.S. capital jurisdictions to change.

About the Project

The ABA Death Penalty Due Process Review Project (Project) conducts research and educates the public and decision-makers on the operation of capital jurisdictions' death penalty laws and processes in order to promote fairness and accuracy in death penalty systems. The Project encourages adoption of the ABA's Protocols on the Fair Administration of the Death Penalty; assists state, federal, and international stakeholders on death penalty issues; and develops new initiatives to support reform of death penalty processes.

The Project created the Mental Illness Initiative in 2015 to educate legal professionals, policy makers, and the public on the subject of severe mental illness and the death penalty and to support policy reform efforts to exempt individuals with severe mental illness from the death penalty. To further this mission, the Initiative seeks to: 1) serve as a national resource for lawyers, organizations, and policy makers interested in learning more about the issues surrounding severe mental illness and capital punishment; 2) provide policy materials to advocates and lawmakers who want to advance legislation to exempt individuals with severe mental illness from the death penalty; and 3) and support state coalitions that seek to end the execution of defendants with severe mental illness.

You can learn more about the work of the Project by visiting <http://www.americanbar.org/dueprocess>.

Severe Mental Illness and the Death Penalty

Introduction¹

Individuals with severe mental disorders or disabilities – present either at the time a capital crime is committed or as they are facing execution – should not be subject to capital punishment. This is one part of a comprehensive position that the American Bar Association (ABA) has supported since 2006, when, in conjunction with the American Psychiatric Association, American Psychological Association, National Alliance on Mental Illness (NAMI), and other experts, it adopted a detailed Resolution opposing the use of the death penalty for individuals with severe mental illness.²

Although the ABA does not take a position supporting or opposing the death penalty generally, its policy is based largely on the rationale that the execution of people with severe mental illness is inconsistent with our existing legal prohibitions on executing people with intellectual disabilities or children under the age of 18 (often referred to as “juveniles” in the case law). The U.S. Supreme Court held in 2002 and 2005 respectively that executing defendants belonging to either of these two groups is unconstitutional. Indeed, our society considers these groups less morally culpable than the most blameworthy murderers for whom the death penalty is ostensibly intended. The legal system and science recognize that they are less able to appreciate the consequences of their actions and less able to participate fully in their own defense – characteristics that apply to certain people with mental illness, as well.

Executing people whose disorders or disabilities significantly impair their ability to appreciate the nature of their conduct, exercise rational judgment, or conform their behavior to the requirements of the law is fundamentally inconsistent with the retributive and deterrent goals of the death penalty. Furthermore, as a matter of public policy, our society is learning more about the too-frequent fallibility and high costs of the death penalty, the impacts of mental illness on our veterans and other citizens, and the scarcity of affordable and accessible psychological and psychiatric treatment. All of these issues are not lost on the people of the United States: 66% of them oppose the death penalty for people with mental illness, based on a 2015 multi-state poll.³ After hearing further details about how a severe mental illness exemption would work in practice, voter support for the severe mental illness exemption rises to 72%.⁴

Despite increased awareness of the impacts of mental illness and growing public support for an exemption, almost none of the jurisdictions that use capital punishment have yet adopted policies to categorically prevent the execution of individuals whose severe mental illness was present at the time of their crime. Therefore, 10 years after these major organizations called for a severe mental illness exemption, now is the time to convert their policy positions into meaningful public education and advocacy tools to help establish clear standards and workable processes to prevent the execution of individuals with severe mental illness.

This Paper aims to provide readers with a complete explanation of the rationale behind the proposed exemption, as well as provide policy makers, legal professionals, and the public with all the information needed to comprehend this issue and work towards reform in state legislatures.

¹ The statements and analysis contained in this White Paper are the work of the American Bar Association Death Penalty Due Process Review Project, which is solely responsible for its content. The Board of Governors and House of Delegates of the American Bar Association have neither reviewed nor sanctioned its contents, with exception to its references to 2006 ABA Mental Illness Resolution 122-A. Accordingly, the views expressed herein should not be construed as representing the policy of the ABA. In addition, this White Paper is intended as background information. It is not intended as legal advice on particular cases.

² We chose to use “severe mental illness” as it is the most commonly used term in past and current bills attempting to exempt individuals with mental illness from the death penalty. There is no intent to conceptually distinguish “severe mental illness” from “serious mental illness” or “severe mental disorder.”

³ *Multi-State Voter Survey: Death Penalty and Mental Illness*, Survey conducted: November 30th – December 7th, 2015, DAVID BINDER RESEARCH (2015).

⁴ Additionally, a 2014 poll found that 58% of Americans supported a severe mental illness exemption. See National Survey Results, PUBLIC POLICY POLLING (Nov. 2014) (https://drive.google.com/file/d/0B1LFfr8Iqz_7R3dCM2VJbTJiTjVYVVDVodjVVSTNjBhgXZWIB/view).

The American Bar Association's Position on Mental Illness and the Death Penalty

The ABA has done extensive work to improve the fairness and accuracy of the American death penalty and has closely followed developments of many aspects of capital punishment law. As part of this work, the ABA has reflected about and adopted several policies expressing its concerns about the application of the death penalty to more vulnerable populations.⁵ Its policy on mental illness and the death penalty is part of that long history.

In 2002, the U.S. Supreme Court held in *Atkins v. Virginia*⁶ that the execution of people with mental retardation (now referred to as “intellectual disability”)⁷ violates the Eighth Amendment’s ban on cruel and unusual punishment. The ABA’s Section of Individual Rights and Responsibilities (now called “Section of Civil Rights and Social Justice”)⁸ recognized that this decision offered “a timely opportunity to consider the extent, if any, to which other types of impaired mental conditions ought to lead to exemption from the death penalty.”⁹

To do so, the Section convened the Task Force on Mental Disability and the Death Penalty, composed of 24 attorneys and mental health professionals, both practitioners and academics with diverse expertise, from across the country.¹⁰ This group deliberated between April 2003 and March 2005 and proposed a resolution that was adopted by the ABA’s House of Delegates in 2006.

ABA Resolution 122-A contains three sections: the first recommends that individuals with significant limitations in both intellectual functioning and adaptive skills be exempt from the death penalty. This section’s primary purpose is to suggest practical standards to implement the *Atkins* decision, in particular by providing a medically based definition of “mental retardation” as a disability originating before the age of 18 that is “characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills.”¹¹ The language in this part of the Resolution was also meant to encompass dementia and traumatic brain injury, disabilities also characterized by significant limitations in intellectual functioning and adaptive behavior, but which may not be present before the age of 18.

The second section of the Resolution is the most relevant to this Paper and to the current work of the Death Penalty Due Process Review Project’s Mental Illness Initiative. In this section, the ABA urges each jurisdiction that imposes capital punishment to implement the following policy:

Defendants should not be executed or sentenced to death if, at the time of the offense, they had a severe mental disorder or disability that significantly impaired their capacity (a) to appreciate the nature, consequences or wrongfulness of their conduct, (b) to exercise rational judgment in relation to conduct, or (c) to conform their conduct to the requirements of the law. A disorder manifested primarily by repeated criminal conduct

⁵ See *ABA Death Penalty Policies*, ABA DEATH PENALTY DUE PROCESS REVIEW PROJECT, http://www.americanbar.org/groups/crsj/projects/death_penalty_due_process_review_project/resources/policy.html (last visited Nov. 21, 2016) (For a full list of ABA positions related to the death penalty).

⁶ *Atkins v. Virginia*, 536 U.S. 304 (2002).

⁷ “Intellectual disability” has been increasingly used by professional organizations, journals, agencies and published research as the preferred term for the disability historically referred to as mental retardation. Individuals with intellectual disability and others have advocated for this change as the term “mental retardation” does not communicate dignity or respect, and frequently results in the devaluation of such persons. In 2010, President Obama signed “Rosa’s Law” requiring the federal government to replace the term “mental retardation” with “intellectual disability” in many areas of government, following a trend already established in many states and federal agencies. Rosa’s Law, S.2781, 111th Cong. (2010).

⁸ For more information about the activities of the ABA’s Civil Rights and Social Justice Section, see *Civil Rights and Social Justice*, ABA, <http://www.americanbar.org/groups/crsj.html> (last visited Nov. 22, 2016).

⁹ ABA, RECOMMENDATION 122-A, 2006 Ann. Mtg. (adopted Aug. 7-8, 2006), http://www.americanbar.org/content/dam/aba/migrated/2011_build/death_penalty_moratorium/mental_illness_policies.authcheckdam.pdf.

¹⁰ *Id.* at 3, n.1 (includes a list of the Task Force’s members).

¹¹ This definition was, at the time of the ABA’s resolution, the most recently endorsed by the American Association of Mental Retardation (now American Association on Intellectual and Developmental Disabilities or AAIDD). The definition was also consistent with the most recent edition of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders. See AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL 49, (text rev. 4th ed. 2000) (hereafter DSM-IV-TR). The AAIDD currently uses a similar definition. *Definition of Intellectual Disability*, AAIDD, <https://aaidd.org/intellectual-disability/definition#.WDNjzP6QzDc> (last visited Nov. 21, 2016).

or attributable solely to the acute effects of voluntary use of alcohol or other drugs does not, standing alone, constitute a mental disorder or disability for purposes of this provision.¹²

The Resolution’s accompanying report specifically notes that this paragraph is only meant to apply to those with “severe” mental disorders and disabilities, and specifically excludes from this exemption those whose conditions are manifested primarily by criminal behavior or voluntary substance use. That report explains that the rationale for recommending this exemption is based on the recognition that, similarly to individuals with intellectual disability and juveniles, those with severe mental illness are less morally culpable than the “average offender.”

The third section of the Resolution addresses three different circumstances in which concerns about a defendant’s mental competence and suitability for execution arise after a defendant is sentenced to death. The section provides in its first sub-paragraph that:

(a) Grounds for Precluding Execution. A sentence of death should not be carried out if the prisoner has a mental disorder or disability that significantly impairs his or her capacity (i) to make a rational decision to forgo or terminate post-conviction proceedings available to challenge the validity of the conviction or sentence; (ii) to understand or communicate pertinent information, or otherwise assist counsel, in relation to specific claims bearing on the validity of the conviction or sentence that cannot be fairly resolved without the prisoner’s participation; or (iii) to understand the nature and purpose of the punishment, or to appreciate the reason for its imposition in the prisoner’s own case.¹³

Within a few months of the ABA’s adoption of Resolution 122-A, the American Psychiatric Association and American Psychological Association, and the National Alliance on Mental Illness also adopted almost identical resolutions.¹⁴ One of the Task Force on Mental Disability and the Death Penalty members, forensic psychologist and American Psychological Association representative Dr. Joel Dvoskin, noted that “to my knowledge, this is

“The rationale for recommending this exemption is based on the recognition that, similarly to individuals with intellectual disability and juveniles, those with severe mental illness are less morally culpable than the ‘average offender.’”

the very first time in history that those four organizations have adopted the same position on anything.”¹⁵ As noted by the American Psychological Association, “the task force members also hope that the policy will eventually influence state legislation on whether to execute mentally ill offenders.”¹⁶

However, since these Resolutions have passed, no jurisdiction that retains a capital punishment statute has adopted policies to prevent the execution of those with severe mental illness. In light of that inaction and the Death Penalty Due Process Review Project’s mission, we conducted significant research and created this comprehensive White Paper about the complex issue of severe mental illness and the death penalty.

Part I: Severe Mental Illness and Its Relevance to Criminal Justice

What exactly is meant by severe mental illness and why does it matter in the context of criminal behavior? This Part will provide elements of a definition of severe mental illness according to medical professionals and experts, descriptions of some of the mental illness diagnoses that constitute “severe mental illness,” and explanations of how severe mental illnesses affect individuals in ways relevant to criminal behavior and culpability. Finally, it will discuss some of the current issues regarding the intersection of mental health with the criminal justice system beyond the death penalty, to place the reform effort in its broader context.

¹² ABA, RECOMMENDATION 122-A, 2006, *supra*, note 9.

¹³ *Id.*

¹⁴ *Associations concur on mental disability and death penalty policy*, 38 MONITOR ON PSYCHOLOGY 14 (Jan. 2007), <http://www.apa.org/monitor/jan07/associations.aspx> (last visited Nov. 21, 2016).

¹⁵ *Id.*

¹⁶ *Id.*

Definition of Mental Illness and Severe Mental Illness

The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, (DSM) is one of the most authoritative classification and diagnostic guides for mental disorders. Its fifth edition (DSM-5), published in 2013, defines mental disorder as follows:

“A mental disorder is a syndrome characterized by **clinically significant disturbance** in an individual's **cognition, emotion regulation, or behavior** that reflects a **dysfunction in the psychological, biological, or developmental processes underlying mental functioning**. Mental disorders are usually associated with **significant distress in social, occupational, or other important activities**. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above.”¹⁷

NAMI, a nationwide grassroots advocate group representing families and people affected by mental illness, uses the following definition:

“A mental illness is a condition that impacts a person's **thinking, feeling or mood** and may affect his or her ability to **relate to others** and **function on a daily basis**. Each person will have different experiences, even people with the same diagnosis.”¹⁸

Prevalence of mental illness in the U.S.¹⁹

Approximately 1 in 5 adults in the U.S.—43.7 million, or 18.6%—experiences mental illness in a given year. Approximately 1 in 25 adults in the U.S.—13.6 million, or 4.1%—experiences a severe mental illness in a given year that substantially interferes with or limits one or more major life activities.

People do not choose to have a mental illness, and no single cause has been identified for the disorders mentioned above. Rather, “research suggests multiple, interlinking causes. Genetics, environment and lifestyle combine to influence whether someone develops a mental health condition.”²⁰ It is important to remember that, as expressed in a report by Amnesty International, “[m]ental illnesses cannot be overcome through “will power” and are not related to a person's “character” or “intelligence.”²¹

Severe mental illness refers to a narrower set of diagnoses than mental illness. According to the American Psychological Association, it “refers to mental disorders that carry certain diagnoses, such as schizophrenia, bipolar disorder, and major depression; that are relatively persistent (e.g., lasting at least a year); and that result in comparatively severe impairment in major areas of functioning.”²² Severe mental illness can thus have a significant negative impact on a person's ability to function in a multitude of life spheres. This means that an individual with severe mental illness may have, for example, difficulty completing instrumental activities of

¹⁷ Eric R. Maisel, *The New Definition of a Mental Disorder*, PSYCHOLOGY TODAY (July 23, 2013), <https://www.psychologytoday.com/blog/rethinking-psychology/201307/the-new-definition-mental-disorder> (Emphasis added).

¹⁸ *Mental Health Conditions*, NATIONAL ALLIANCE ON MENTAL ILLNESS, <http://www.nami.org/Learn-More/Mental-Health-Conditions> (last visited Nov. 21, 2016) (Emphasis added).

¹⁹ *Mental Health by the Numbers*, NATIONAL ALLIANCE ON MENTAL ILLNESS, <http://www.nami.org/Learn-More/Mental-Health-By-the-Numbers> (last visited Nov. 21, 2016) (Emphasis added).

²⁰ *Mental Health Conditions*, NATIONAL ALLIANCE ON MENTAL ILLNESS, <http://www.nami.org/Learn-More/Mental-Health-Conditions> (last visited Nov. 21, 2016).

²¹ *USA: The Execution of Mentally Ill Offenders*, AMNESTY INTERNATIONAL, at 17 (Jan. 31 2006), <https://www.amnesty.org/en/documents/AMR51/003/2006/en/>.

²² *Assessment and Treatment of Serious Mental Illness*, AMERICAN PSYCHOLOGICAL ASSOCIATION, at 5 (Aug. 2009), <https://www.apa.org/practice/resources/smi-proficiency.pdf>. The term “serious mental illness,” or severe mental illness, came from a request by Congress to the Secretary of Health and Human Services to develop a federal definition of severe mental illness: “See Federal Definition of Severe Mental Illness, 58 Fed. Reg. 96, 29422-29425 (May 20, 1993). See also Thomas Insel, *Getting Serious About Mental Illness*, NATIONAL INSTITUTE OF MENTAL HEALTH (July 31, 2013), <https://www.nimh.nih.gov/about/directors/thomas-insel/blog/2013/getting-serious-about-mental-illnesses.shtml>.

daily life such as eating, dressing, bathing, or driving,²³ and may have difficulty communicating coherently²⁴ or difficulty maintaining full-time employment.²⁵

Below are descriptions of some of the most common severe mental illnesses. Significantly, this is not an exclusive or comprehensive list of all diagnoses that could be considered “severe mental illness.” Further, because many people can have dual diagnoses or co-occurring disorders,²⁶ and can have different experiences even within the same diagnosis, someone who has not been diagnosed with one of the following illnesses may still suffer from severe disturbance in their cognition, emotion regulation, and behavior.

Schizophrenia and Schizoaffective Disorder

According to the American Psychiatric Association, **schizophrenia** is a “chronic brain disorder that affects about one percent of the population.”²⁷ For a diagnosis of schizophrenia, the DSM-5 requires the presence of two of the five key symptoms listed in Criterion A, and that at least one symptom must be one of the first three (delusions, hallucinations, disorganized speech).²⁸

Symptoms of schizophrenia – Criterion A, DSM-5:²⁹

1. Delusions are fixed beliefs that are not amenable to change in light of conflicting evidence. Their content may include a variety of themes (e.g. persecutory, referential, somatic, religious, or grandiosity). Delusions are deemed bizarre if they are clearly implausible and not understandable to same-culture peers and do not derive from ordinary life experiences.
2. Hallucinations are perceptual experiences that occur even when there is no stimulus in the outside world generating the experiences. They can be auditory, visual, olfactory (smell), gustatory (taste), or somatic (touch).
3. Disorganized speech can include frequent derailment or incoherence.
4. Disorganized or catatonic behavior includes bizarre behavior or abnormal movements, and can include catatonia, which refers to a variety of behaviors that seem to reflect a reduction in responsiveness to the external environment
5. Negative symptoms are characterized by a loss of or a decrease in the ability to initiate plans, speak, express emotion, or find pleasure.

²³ Jennifer Sanchez et al., *Predicting quality of life in adults with severe mental illness: Extending the International Classification of Functioning, Disability, and Health*, 61 REHABILITATION PSYCHOL. 19, 19 (Feb. 2016).

²⁴ Thomas L. Patterson & Brent T. Mausbackh, *Measurement of Functional Capacity: A New Approach to Understanding Functional Differences and Real-world Behavioral Adaptation in Those with Mental Illness*, 6 ANN. REV. CLINICAL PSYCHOL. 139, 150 (Apr. 27, 2010), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3160788>.

²⁵ *Getting to work, Promoting Employment of People with Mental Illness*, JUDGE DAVID L. BAZELON CENTER FOR MENTAL HEALTH LAW (Sept. 2014), <http://www.bazelon.org/LinkClick.aspx?fileticket=TGW5AEIvqjs%3D&tabid=738>.

²⁶ See *Co-occurring Disorders*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, <http://www.samhsa.gov/disorders/co-occurring> (last visited Nov. 21, 2016); *Dual Diagnosis*, NATIONAL ALLIANCE ON MENTAL ILLNESS, <http://www.nami.org/Learn-More/Mental-Health-Conditions/Related-Conditions/Dual-Diagnosis> (last visited Nov. 21, 2016).

²⁷ *What is Schizophrenia?*, AMERICAN PSYCHIATRIC ASSOCIATION, <https://www.psychiatry.org/patients-families/schizophrenia/what-is-schizophrenia> (last visited Nov. 21, 2016).

²⁸ *About Schizophrenia*, SCHIZOPHRENIA AND RELATED DISORDER ALLIANCE OF AMERICA, <http://www.sardaa.org/resources/about-schizophrenia/> (last visited Nov. 21, 2016); Deanna M. Barch, NOBA TEXTBOOK SERIES, <http://nobaproject.com/modules/schizophrenia-spectrum-disorders> (last visited Nov. 21, 2016).

²⁹ Rajiv Tandon et al., *Definition and description of schizophrenia in the DSM-5*, SCHIZOPHR. RES. (2013), <https://pdfs.semanticscholar.org/b6df/6b113345da78988d707d753feb44bf50683d.pdf>.

In addition, people with schizophrenia commonly have “anosognosia,” which means “lack of insight,” and are unaware of their illness.³⁰ What appears to observers as delusions are strongly held beliefs for a person with schizophrenia, and those affected by the illness may view the people around them as delusional for not having the same beliefs. This can make treatment significantly more complicated.

The typical age of onset for men is in their early twenties and for women in their late twenties to early thirties, although some signs of the illness may appear earlier in what is called the “prodromal period” (usually in the teenage years). Although there is no cure, drug treatment can greatly reduce the symptoms and reduce future relapses. However, according to the National Institute of Mental Health (NIMH), only 60% of adults with schizophrenia have received or sought treatment, leaving 40% of those living with this illness untreated.³¹

Lack of treatment is explained by many factors, which can vary depending on the individual and the illness. One reason may be the lack of insight into one’s own illness, which, as noted above, is one of the symptoms of illnesses like schizophrenia. People convinced that they do not have an illness will not see why undergoing treatment is necessary or helpful. Other reasons that lead people to stop, avoid, or be denied treatment may include uncomfortable side effects, financial or other barriers to treatment, decisions to discontinue medications when the person seems to have improved or disordered thinking, a consequence of the illness itself that can, for example, cause the person to forget or deliberately stop taking prescribed medications.

Schizoaffective disorder is a chronic mental health condition characterized primarily by symptoms of schizophrenia and symptoms of a mood disorder, such as mania and depression.³² Many people suffering from schizoaffective disorder are incorrectly diagnosed with bipolar disorder or schizophrenia because it shares symptoms of multiple mental health conditions.

The DSM-5 diagnostic criteria for schizoaffective disorder require:

1. An uninterrupted period of illness during which there is a major mood episode (major depressive or manic) concurrent with Criterion A of schizophrenia (the major depressive episode must include Criterion A1: Depressed mood.)
2. Delusions or hallucinations for two or more weeks in the absence of a major mood episode (depressive or manic) during the lifetime duration of the illness.
3. Symptoms that meet criteria for a major mood episode are present for the majority of the total duration of the active and residual portions of the illness.
4. The disturbance is not attributable to the effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.³³

Bipolar Disorders

Bipolar disorders are brain disorders that cause changes in a person’s mood, energy, and ability to function. This is a category that includes three different conditions – bipolar I, bipolar II and cyclothymic disorder.³⁴

³⁰ *Schizophrenia*, NATIONAL ALLIANCE IN MENTAL ILLNESS, <http://www.nami.org/Learn-More/Mental-Health-Conditions/Schizophrenia> (last visited Nov. 22, 2016).

³¹ *Schizophrenia*, NATIONAL INSTITUTE OF MENTAL HEALTH <https://www.nimh.nih.gov/health/statistics/prevalence/schizophrenia.shtml> (last visited Nov. 22, 2016).

³² *Schizoaffective Disorder*, NATIONAL INSTITUTE OF MENTAL HEALTH, <http://www.nami.org/Learn-More/Mental-Health-Conditions/Schizoaffective-Disorder#sthash.GKewlQIV.dpuf> (last visited Nov. 22, 2016).

³³ Dolores Melaspina et al., *Schizoaffective Disorder in the DSM-5*, 150 SCHIZOPHRENIA RES. 21 (2013), <http://dx.doi.org/10.1016/j.schres.2013.04.026>.

³⁴ Ranna Parekh, *What are Bipolar Disorders?*, AMERICAN PSYCHIATRIC ASSOCIATION (July 2015), <https://www.psychiatry.org/patients-families/bipolar-disorders/what-are-bipolar-disorders>.

For the purposes of this Paper, we will only focus on bipolar I, as bipolar II and cyclothymic disorder are considered less severe versions of the disorder. Although bipolar disorder can occur at any point in life, the average age of onset is 25 for both genders.³⁵ Every year, 2.9% of the U.S. population is diagnosed with bipolar disorder, with nearly 83% of cases being classified as severe.³⁶

In bipolar I, a person can experience dramatic mood swings and alternate between manic episodes and depressive episodes, with periods of normal mood between the episodes.

A **manic episode** is a period of at least one week when a person is very high spirited or irritable in an extreme way most of the day and for most days, has more energy than usual and shows changes such as: exaggerated self-esteem or grandiosity, less need for sleep, increased risky behavior, easy distractibility, doing many activities at once, scheduling more events in a day than can be accomplished, or uncontrollable racing thoughts.³⁷

During a **depressive episode**, a person will experience intense sadness or despair; feeling helpless, hopeless, or worthless and loss of interest in activities once enjoyed. The person may also experience some of the following: sleep problems, feeling restless or agitated, frequent thoughts of death or suicide, loss of energy, difficulty concentrating, feeling worthless or guilty.³⁸

Bipolar disorder can be treated and managed, although not cured, in several ways: medications, psychotherapy, or self-management education and strategies. NIMH estimates that only 55.5% of individuals with this condition are receiving treatment,³⁹ for the reasons discussed above.

Major Depressive Disorder

Although we hear the term depression frequently and sometimes casually, **Major Depressive Disorder** is a serious and distinct mental health disorder that negatively affects how a person feels (emotion regulation), thinks (cognition) and acts (behavior). It is more than just feeling sad or ‘going through a rough patch.’ According to the DSM-5, “an expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder,” no matter how painful it may feel.⁴⁰ To meet the DSM-5 criteria of a Major Depressive Episode, five or more of the following symptoms must be present nearly every day during the same two-week period (and for at least two years for Persistent Depressive Disorder):

1. Depressed mood most of the day;
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day;
3. Significant weight loss when not dieting or weight, or decrease or increase in appetite;
4. Insomnia or hypersomnia;
5. Psychomotor agitation or retardation;
6. Fatigue or loss of energy;

³⁵ *Bipolar Disorder*; NATIONAL ALLIANCE ON MENTAL ILLNESS, <http://www.nami.org/Learn-More/Mental-Health-Conditions/Bipolar-Disorder> (last visited Nov. 22, 2016).

³⁶ *Id.*

³⁷ Parekh, *supra* note 34.

³⁸ *Id.*

³⁹ *Bipolar Disorder Among Adults*, NATIONAL INSTITUTE OF MENTAL HEALTH, https://www.nimh.nih.gov/health/statistics/prevalence/file_148124.pdf (last visited Nov. 22, 2016).

⁴⁰ Maisel, *supra* note 17.

7. Feelings of worthlessness or excessive or inappropriate guilt;
8. Diminished ability to think or concentrate, or indecisiveness;
9. Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.⁴¹

These symptoms must cause clinically significant distress or impairment in social, occupational or other important areas of functioning, and must not be attributable to the physiological effects of a substance or to another medical condition.⁴² Sixteen million – or 6.9% of adults in the U.S. – had at least one major depressive episode in 2015.⁴³

Post-traumatic Stress Disorder

Post-traumatic stress disorder (PTSD) is a psychiatric disorder that can occur in people who have experienced or witnessed a traumatic event.⁴⁴ PTSD has been known by many names in the past, such as “shell shock” during the years of World War I and “combat fatigue” after World War II. In 1980, the DSM-III classified PTSD as an anxiety disorder, recognizing it as a legitimate psychological ailment.⁴⁵ Although PTSD is

often associated with combat veterans, it does not apply only to them. It can occur after a variety of distressing or catastrophic events in which a person experiences extreme trauma.

When in danger, the natural “fight-or-flight” response which typically takes place in life or body threatening circumstances is a healthy reaction meant to protect people from harm. But for those with PTSD, this reaction is changed or damaged. People who have PTSD may feel stressed or frightened even when they are no longer in danger.

Diagnostic criteria for PTSD in the DSM-5 include:⁴⁶

1. A history of exposure to a traumatic event: the person was directly exposed to, witnessed, or learned that a close relative or friend was threatened with or experienced death, serious injury, or sexual violence.
2. Intrusion symptoms: the traumatic event is persistently re-experienced through recurrent, intrusive memories, traumatic nightmares, dissociative reactions (such as flashbacks), intense or prolonged distress after exposure to traumatic reminders or marked physiologic activity after exposure to trauma-related stimuli.
3. Avoidance: persistent effortful avoidance of distressing trauma-related stimuli (thoughts, feelings or external reminders) after the traumatic event.

⁴¹ CECIL R. REYNOLDS & RANDY W. KAMPHAUS, *BASICS 3 MAJOR DEPRESSIVE DISORDER*, (Pearson 5th ed. 2013).

⁴² Diagnose and Characterize Major Depression/Persistent Depressive Disorder with Clinical Interview, INSTITUTE FOR CLINICAL SYSTEMS IMPROVEMENT, https://www.icsi.org/guideline_sub-pages/depression/diagnose_and_characterize_major_depressionpersistent_depressive_disorder_with_clinical_interview/ (last visited Nov. 22, 2016).

⁴³ *Major Depression Among Adults*, NATIONAL INSTITUTE OF MENTAL HEALTH, <https://www.nimh.nih.gov/health/statistics/prevalence/major-depression-among-adults.shtml> (last visited Nov. 22, 2016) (Finding that in 2015, an estimated 16.1 million adults aged 18 or older in the United States had at least one major depressive episode in the past year).

⁴⁴ *What is Posttraumatic Stress Disorder?*, AMERICAN PSYCHIATRIC ASSOCIATION, <https://www.psychiatry.org/patients-families/ptsd/what-is-ptsd> (last visited Nov. 22, 2016).

⁴⁵ Matthew J. Friedman, *PTSD History and Overview*, U.S. DEPARTMENT OF VETERANS AFFAIRS, <http://www.ptsd.va.gov/professional/PTSD-overview/ptsd-overview.asp> (last visited Nov. 22, 2016).

⁴⁶ *DSM-5 Criteria for PTSD*, BRAINLINEMILITARY, <http://www.brainlinemilitary.org/content/2014/06/dsm-v-tr-criteria-for-ptsd.html> (last visited Nov. 22, 2016); *Post-traumatic Stress Disorder*, AMERICAN PSYCHIATRIC ASSOCIATION (2013), <http://www.dsm5.org/Documents/PTSD%20Fact%20Sheet.pdf>.

4. Negative alterations in cognitions and mood: inability to recall key features of the traumatic event, persistent (and often distorted) negative beliefs and expectations about oneself or the world, persistent distorted blame of self or others, persistent negative trauma-related emotions, markedly diminished interest in significant activities, feeling alienated from others or persistent inability to experience positive emotions.

5. Alterations in arousal and reactivity: irritable or aggressive behavior, self-destructive or reckless behavior, hyper vigilance, exaggerated startle response, problems in concentration, or sleep disturbance.

In veterans, a review of combat-related PTSD found that the prevalence of the condition in U.S. military veterans since the Vietnam War to range from 2-17%.⁴⁷

Symptoms of PTSD usually begin within 3 months after a traumatic event, but occasionally emerge years afterward. It can be treated effectively through the use of medications, psychotherapy, self-management strategies or service animals.⁴⁸ Symptoms must last more than a month, and it is often accompanied by depression, substance abuse or another anxiety disorder.⁴⁹

Traumatic Brain Injury

Traumatic Brain Injury (TBI) occurs when a sudden trauma causes damage to the brain. It can result when the head suddenly and violently hits an object, or when an object pierces the skull and enters brain tissue.⁵⁰ The impacts of a moderate to severe brain injury can include, among others, cognitive deficits (including difficulties with executive functions, language processing, memory, speed of processing, etc.), speech, vision, hearing, and can also have social-emotional consequences such as dependent behaviors, aggression, depression, irritability, among others.⁵¹

Although, like PTSD, TBI is not specific to veterans, it is often associated with that population. This is due in particular to the fact the overall rate of TBI among active duty service members more than doubled from 2000 to 2011.⁵² Since 2000, 352,619 military personnel have been affected by TBI, according to the Department of Defense.⁵³

As mentioned above, this list includes the most common diagnoses considered severe mental illness, but is not exhaustive. In addition, the American Psychiatric Association regularly updates its Diagnostic and Statistical Manual, and some of the terminology may evolve in future years. However, it is clear that these disorders are all characterized by severe functional impairments for those who suffer from them, and that they are highly relevant to an individual's functioning and understanding of reality.

⁴⁷ Lisa K. Richardson et al., *Prevalence Estimates of Combat-Related PTSD: A Critical Review*, 44 AUSTL. N.Z. J. PSYCHIATRY 4, 4 (2010), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2891773/>. See also Richard C. Dieter, *Battles Scars: Military Veterans and the Death Penalty*, DEATH PENALTY INFORMATION CENTER (Nov. 11, 2015), <http://deathpenaltyinfo.org/files/pdf/BattleScars.pdf> (Includes a detailed discussion of PTSD prevalence rates for veterans of different wars, as well as a discussion of veterans on death row).

⁴⁸ *Post-Traumatic Stress Disorder*, NATIONAL ALLIANCE ON MENTAL ILLNESS, <https://www.nami.org/Learn-More/Mental-Health-Conditions/Posttraumatic-Stress-Disorder> (last visited Nov. 22, 2016).

⁴⁹ *Post-Traumatic Stress Disorder*, NATIONAL INSTITUTE OF MENTAL HEALTH (Feb. 2016), <https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml>.

⁵⁰ *NINDS Traumatic Brain Injury Information Page*, NATIONAL INSTITUTE OF NEUROLOGICAL DISORDER AND STROKE (Sept. 8, 2016), <http://www.ninds.nih.gov/disorders/tbi/tbi.htm>.

⁵¹ *Severe TBI Symptoms*, TRAUMATICBRAININJURY.COM, <http://www.traumaticbraininjury.com/symptoms-of-tbi/severe-tbi-symptoms> (last visited Nov. 22, 2016).

⁵² The CDC, NIH, DoD, and VA Leadership Panel, *Report to Congress on Traumatic Brain Injury in the United States: Understanding the Public Health Problem among Current and Former Military Personnel*. Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), the Department of Defense (DoD), and the Department of Veterans Affairs (VA) (2013), http://www.cdc.gov/traumaticbraininjury/pdf/report_to_congress_on_traumatic_brain_injury_2013-a.pdf.

⁵³ *DoD Worldwide Numbers for TBI*, DEFENSE AND VETERANS BRAIN INJURY CENTER (Aug. 12, 2016), http://dvbic.dcoe.mil/files/tbi-numbers/DoD-TBI-Worldwide-Totals_2000-2016_Q1-Q2_Aug-12-2016_v1.0_508_2016-09-20.pdf.

Mental Illness in the Broader Criminal Justice Context

While the ABA's 2006 Resolution and this Paper are focused on the application of the death penalty to those with severe mental illness at the time of their crime, it is important to place this discussion within the broader one surrounding the interactions between the criminal justice system and individuals with mental illness.

The U.S. Department of Justice estimated in 2006 that 10% of inmates in state prisons had a severe mental illness,⁵⁴ an estimate considered conservative by many.⁵⁵ A 2009 study found 14.5% of male jail inmates and 31% of female jail inmates had symptoms of a severe mental illness.⁵⁶ Coupling these with less serious illnesses, more than half of current U.S. inmates have a mental health diagnosis.⁵⁷ The proportion of people in the U.S. with mental illnesses in correctional institutions is three to six times greater than that of the general public.⁵⁸ The Sentencing Project calls this phenomenon the “criminalization of the mentally ill,” defined as “the increased likelihood of people with mental illness being processed through the criminal justice system instead of through the mental health system.”⁵⁹ Beyond a mere problem, the American Psychiatric Association has labeled this an American “crisis.”⁶⁰

This was not always the case. In 1959, U.S. mental hospitals housed nearly 560,000 patients. However, after the deinstitutionalization of the 1970s, this dropped to about 130,000 in 1980.⁶¹ Many of those expelled from the hospitals ended up behind bars.⁶² A 2010 study estimated that “there are now more than three times more seriously mentally ill persons in jails and prisons than in hospitals.”⁶³

Given the numerous societal costs associated with the increasing criminalization of mental illness, many scholars, professional organizations, attorneys, politicians, and activists are advocating for reform of how individuals with these conditions are treated in the context of their interactions with the criminal justice system. To help address the issue, both the American Psychiatric Association and the National Commission on Correctional Health Care have suggested that mental health screenings be conducted immediately upon an individual's arrival into a correctional facility, so that if the person has a mental health problem, he may be “referred for appropriate mental health evaluation (assessment) and housed in an appropriate level of care.”⁶⁴

After this initial screening, they recommend a second, “more detailed, thorough, and structured intake mental

⁵⁴ Doris J. James & Lauren E. Glaze, *Mental Health Problems of Prison and Jail Inmates*, Special Report NCJ 213600, US BUREAU OF JUSTICE STATISTICS (Sept. 2006), <http://bjs.gov/content/pub/pdf/mhppji.pdf>.

⁵⁵ *How Many Individuals with Serious Mental Illness are in Jails and Prisons?*, TREATMENT ADVOCACY CENTER (Nov. 2014), <http://www.treatmentadvocacycenter.org/storage/documents/backgrounders/how%20many%20individuals%20with%20serious%20mental%20illness%20are%20in%20jails%20and%20prisons%20final.pdf>.

⁵⁶ Henry J. Steadman et al., *Prevalence of serious mental illness among jail inmates*, 60 PSYCHIATRIC SERVICES 761, 761 (2009).

⁵⁷ James & Glaze, *supra* note 54.

⁵⁸ *Id.*

⁵⁹ Beth Carter et al., *Mentally Ill Offenders in the Criminal Justice System: An Analysis and Prescription*, THE SENTENCING PROJECT (Jan. 2002), <http://www.sentencingproject.org/wp-content/uploads/2016/01/Mentally-Ill-Offenders-in-the-Criminal-Justice-System.pdf>.

⁶⁰ *Stepping Up*, AMERICAN PSYCHIATRIC ASSOCIATION FOUNDATION <http://www.americanpsychiatricfoundation.org/what-we-do/public-education/stepping-up-initiative> (last visited Nov. 22, 2016). Several other studies have shown that individuals with severe mental illness are overrepresented in the criminal justice system. *See, e.g.*, Seena Fazel & John Danesh, *Serious Mental Disorder in 23,000 Prisoners: A Systematic Review of 62 Surveys*, 359 LANCET 545, 548 (2002); Linda Teplin, *The Prevalence of Severe Mental Disorder Among Urban Male Jail Detainees: Comparison with the Epidemiologic Catchment Area Program*, 80 AM. J. PUB. HEALTH 663, 665 (1990); Jillian Peterson & Kevin Heinz, *Understanding Offenders with Serious Mental Illness in the Criminal Justice System*, 42 MITCHELL HAMLINE LAW REVIEW 537 (2016).

⁶¹ *See, e.g.*, *Impact of Mentally Ill Offenders on the Criminal Justice System: Hearing Before the Subcomm. On Crime, H. Comm. On the Judiciary*, 106th Cong. 18 (Sept. 21, 2000); Timeline: Treatments for Mental Illness, PBS, <http://www.pbs.org/wgbh/amex/nash/timeline/timeline2.html> (last visited Nov. 23, 2016).

⁶² Sarah Varney, *By the Numbers: Mental Illness Behind Bars*, KAISER HEALTH NEWS (May 15, 2014), <http://khn.org/news/by-the-numbers-mental-illness-jail/>; *Stepping Up*, AMERICAN PSYCHIATRIC ASSOCIATION FOUNDATION, <http://www.americanpsychiatricfoundation.org/what-we-do/public-education/stepping-up-initiative> (last visited Nov. 22, 2016).

⁶³ Edwin Fuller Torrey et al., *More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of the States*, TREATMENT ADVOCACY CENTER & NATIONAL SHERIFFS' ASSOCIATION (May 2010), http://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf.

⁶⁴ *Psychiatric Services in Jails and Prisons: a task force report of the American Psychiatric Association*, American Psychiatric Association (2nd Ed. 2000).

health screening” to determine where to place the individual.⁶⁵

Another prominent national group, the Stepping Up Initiative, has formed to tackle the issue directly, and is “a collaboration between The Council of State Governments Justice Center, the National Association of Counties[,] and the American Psychiatric Foundation to help advance counties’ efforts to reduce the number of people with mental and co-occurring substance use disorders in jails.”⁶⁶ NAMI, the Major County Sheriff’s Association, and the U.S. Department of Justice’s Bureau of Justice Assistance also support the Initiative.⁶⁷ Stepping Up is highly concerned by the criminalization of individuals with mental illness, suggesting that the “human toll,” as well as the cost to taxpayers, put the issue’s resolution at the forefront of modern criminal justice reform efforts. As of June 2016, over 270 counties have issued resolutions in response to Stepping Up, calling for reform on behalf of this mental health and criminal justice crisis.⁶⁸

Conservative politician and writer Newt Gingrich and liberal political commentator, attorney, and author Van Jones have joined hands across the political aisle to speak out on the issue, jointly writing: “When governments closed state-run psychiatric facilities in the late 1970s, they didn’t replace them with community care, and by default, the mentally ill often ended up in jails.... Our system is unfair to those struggling with mental illness.... These people are sick, not bad.”⁶⁹ On the street, people with disabilities suffer considerable risk under law enforcement. They are more likely to be confronted by police or even shot – as shown in Virginia, for example, where 40% of the fatal police shootings since 2010 were of persons with disabilities.⁷⁰

In courtrooms, persons with disabilities, often falsely labeled “violent,” have “future dangerousness” risk assessments that can be biased by the “operative presumption that dangerousness is often a result of mental illness.”⁷¹ The stress of jail and prison often aggravates these individuals’ symptoms, in particular if they are placed in solitary confinement.⁷² With initiatives, researchers, activist groups, government officials, and politicians all joining together with the same conclusions, it is clear that this American crisis can no longer be ignored.

“Many agree that we need to readdress the way we deal with persons with mental illnesses in the context of the law and criminal justice.”

With the increasing recognition that the legal system should treat those with mental illness differently because of their conditions’ relevance to culpability, sentencing, and meaningful participation in the legal process, it also makes sense to extend these considerations to the area of capital punishment. When it comes to capital defendants, Mental Health America estimates that at least 20% of people on death row have a severe mental illness.⁷³ However, this is only an estimate, and precise statistics are not available, so it remains difficult to determine exactly how many capital defendants live with a severe mental illness.

⁶⁵ *Id.* See also, Holly Hills et al., *Effective Prison Mental Health Services: Guidelines to Expand and Improve Treatment*, U.S. DEP’T OF JUSTICE: NATIONAL INSTITUTE OF CORRECTIONS (2004), <http://static.nicic.gov/Library/018604.pdf>; *Receiving Screening*, NATIONAL COMMISSION ON CORRECTIONAL HEALTH CARE, <http://www.ncchc.org/spotlight-on-the-standards-25-1> (last visited Nov. 28, 2016).

⁶⁶ *The Stepping Up Initiative*, THE HUFFINGTON POST, <http://www.huffingtonpost.com/the-stepping-up-initiative/> (last visited Nov. 23, 2016).

⁶⁷ *The Stepping Up Initiative*, NATIONAL ASSOCIATION OF COUNTIES, <http://www.naco.org/resources/programs-and-initiatives/stepping-initiative> (last visited Nov. 23, 2016).

⁶⁸ *The Stepping Up Initiative*, *supra*, note 66; *Mental Health Services: Guidelines to Expand and Improve Treatment*, DEP’T OF JUSTICE: NATIONAL INSTITUTE OF CORRECTIONS (2004), <http://static.nicic.gov/Library/018604.pdf>; see also American Psychiatric Association, *Psychiatric Services in Jails and Prisons: a task force report of the American Psychiatric Association* (2nd Ed. 2000); *Receiving Screening*, NATIONAL COMMISSION ON CORRECTIONAL HEALTH CARE, <http://www.ncchc.org/spotlight-on-the-standards-25-1> (last visited Nov. 28, 2016).

⁶⁹ Newt Gingrich & Van Jones, *Mental Illness Is No Crime*, CNN.COM (May 27, 2015), <http://www.cnn.com/2015/05/27/opinions/gingrich-jones-mental-health>.

⁷⁰ Gary A. Harki, *Virginia Is Outpacing the Nation in Police Shootings of the Mentally Ill*, THE VIRGINIAN-PILOT (June 4, 2016), http://pilotonline.com/news/government/virginia/virginia-is-outpacing-the-nation-in-police-shootings-of-the/article_de1e5f1d-d893-51fb-9d9d-4c47f034ba66.html.

⁷¹ Robert M. Phillips, *Predicting the Risk of Future Dangerousness*, 14 Am. Med. Ass’n J. Ethics, 472, 473 (2012), <http://journalofethics.ama-assn.org/2012/06/pdf/hlaw1-1206.pdf>.

⁷² 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 (2010).

⁷³ *Position Statement 54: Death Penalty and People with Mental Illness*, MENTAL HEALTH AMERICA (June 14, 2016), <http://www.mentalhealthamerica.net/positions/death-penalty>.

Nonetheless, the exemption recommended in the 2006 ABA Resolution is a restrictive standard that only includes the most serious forms of mental illness, ensuring that this would remain a limited exclusion. Many mental health diagnoses – and many people with any given diagnosis – would not meet the requirements of the exemption supported by the ABA, American Psychological Association, American Psychiatric Association, and NAMI.

Prevalence of Violent Behavior and Being a Victim of Violence

While people with mental illness are overrepresented in the criminal justice system, there is little evidence that they are more violent than those without mental illness. Instead, other factors contribute to explain this overrepresentation, including: the higher than average prevalence of substance abuse, the inadequacy of community mental health services and lack of available treatment options, as well as a policy of zero tolerance in regards to drug crimes effective in many jurisdictions, among others.⁷⁴

In addition, the links between mental illness and violence are frequently misunderstood and mischaracterized, and people often face prejudices because of their disorders. This problem pervades the entire criminal justice system, where judges, prosecutors, correctional officers, law enforcement and defense attorneys often do not receive training on how to properly react to defendants with mental illness.⁷⁵ Mental disability law expert Professor Michael Perlin argues that “sanism,” or “an irrational prejudice against people with mental illness,” is present in the criminal justice system.⁷⁶

Popular conceptions of those suffering from severe mental illness trade on stereotypes of violence and dangerousness, which are perpetuated by the media. A new study found that “nearly four in 10 news stories about mental illness analyzed by Johns Hopkins Bloomberg School of Public Health researchers connect mental illness with violent behavior toward others, even though less than five percent of violence in the United States is directly related to mental illness.”⁷⁷ Similarly, 66% of television news stories about those with mental illness emphasized the dangerousness of the individual.⁷⁸

Overall, people with severe mental illness contribute very little to the rate of violence, and they are much more likely to be victims of violence than perpetrators. Less than 3 to 5% of crimes involve people with mental illness as defendants⁷⁹ while people with severe mental illness are 11 times more likely to be victims of a violent crime than the general population.⁸⁰ As David Kopel and Clayton Cramer explain in a 2015 article: “when we examine the data on serious mental illness and violent crime, it is clear that the problem of victimization is

⁷⁴ In a 2001 study of people with a mental illness in prison, two-thirds of their crimes were related to substance use and were usually non-violent. See Mark R. Munetz et al., *The Incarceration of Individuals with Severe Mental Disorders*, 37 COMMUNITY MENTAL HEALTH J., 361 (2001). Indeed, accompanying risks of mental illness like poverty, unemployment, and poor social skills, lead those with mental illness to situations with higher exposure to psychoactive substances. Corinne Henderson, *Why People with a Mental Illness are Over-represented in the Criminal Justice System*, RESEARCHGATE (Jul. 19, 2015), https://www.researchgate.net/publication/237568921_Why_people_with_a_mental_illness_are_Over-represented_in_the_Criminal_Justice_System.

⁷⁵ The ABA Death Penalty Due Process Review Project conducted Assessments on the death penalty in 12 states. Florida, Indiana, Ohio, Kentucky, Missouri, Texas, Virginia and Pennsylvania were found “partially in compliance” with the recommendation that “all actors in the criminal justice system, including police officers, court officers, prosecutors, defense attorneys, judges, and prison authorities, should be trained to recognize mental illness in capital defendants and death-row inmates” and Tennessee was found not in compliance. This evaluation is not available for Alabama, Arizona and Georgia. See American Bar Association Death Penalty Due Process Review Project, *State Death Penalty Assessments*, http://www.americanbar.org/groups/crsj/projects/death_penalty_due_process_review_project/state_death_penalty_assessments.html (last visited Nov. 27, 2016).

⁷⁶ Michael L. Perlin, *Sanism and the Law*, 15 AM. MED. ASS’N. J. ETHICS, 878, 878 (October 2013), <http://journalofethics.ama-assn.org/2013/10/msoc1-1310.html>.

⁷⁷ *Study: News Stories Often Link Violence With Mental Health Illness, Even Though People With Mental Health Illness Are Rarely Violent*, JOHN HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH (June, 6 2016), <http://www.jhsph.edu/news/news-releases/2016/study-news-stories-often-link-violence-with-mental-health-illness-even-though-people-with-mental-health-illness-are-rarely-violent.html/>.

⁷⁸ Peter Byrne, *Stigma of Mental Illness and Ways of Diminishing it*, 6 ADVANCES PSYCHIATRIC TREATMENT 65, 66 (2000). Also important is what is almost never portrayed in media accounts of mental illness—stories of rehabilitation or representations of individuals with mental illness as active, valuable members of a community. See Otto F. Wahl, *News Media Portrayal of Mental Illness*, 46 AM. BEHAV. SCIENTIST 1594, 1597 (2003).

⁷⁹ Jonathan M. Metz et al., *Mental Illness, Mass Shootings, and the Politics of American Firearms*, 105 AM. J. PSYCHIATRY 240, 241 (2015) (citing to Paul S. Appelbaum, *Violence and mental disorders: data and public policy*, 163 AM. J. PSYCHIATRY 1319, 1319 (2006)).

⁸⁰ Linda Teplin et al., *Crime victimization in adults with severe mental illness*, 62 ARCHIVES OF GENERAL PSYCHIATRY 911, 911 (2005).

far larger than the problem of perpetration.”⁸¹ Or, as Thomas Insel, former Director of NIMH, puts it: “Most people with severe mental illness are not violent, and most violent acts are not committed by people with severe mental illness.”⁸² Dr. Insel further notes that violence by individuals with mental illness is often directed towards themselves, notably in the form of suicide.⁸³

For a long time, studies found no link between increased risk of violence and severe mental illness.⁸⁴ However, a growing body of research is suggesting that there may be such a link when mental illness goes untreated and is associated with other risk factors.⁸⁵ Indeed, “understanding the link between violent acts and mental disorder requires consideration of its association with other variables such as substance abuse, environmental stressors, and history of violence.”⁸⁶ In their 2009 study, Eric Elbogen and Sally Johnson found that “severe mental illness alone did not predict future violence; it was associated instead with historical (past violence, juvenile detention, physical abuse, parental arrest record), clinical (substance abuse, perceived threats), dispositional (age, sex, income), and contextual (recent divorce, unemployment, victimization) factors.”⁸⁷ Even though under some circumstances, people with severe mental illness may be more likely to be violent than an average person without a mental health diagnosis, other elements need to be taken into account to fully understand the relationship between severe mental illness and violence, and “the relationship is much more complex than just the immediate effects of the disorder itself.”⁸⁸

NAMI’s position on the issue also reflects these research findings and recognizes “that acts of violence by people with mental illness are usually the result of lack of needed mental health services.”⁸⁹ This is why most mental health organizations advocate for early screening, diagnosis, and effective treatment as the best way to prevent violence by people with severe mental illness.

People on death row with severe mental illness have also frequently encountered the criminal justice system prior to being charged with a capital crime. According to the American Psychiatric Association, “[p]eople with serious mental illnesses who come into contact with the criminal justice system are often poor, uninsured, homeless, and living with co-occurring substance abuse and mental disorders. They are likely to continually recycle through the mental health, substance abuse, and criminal justice systems.”⁹⁰ This revolving door phenomenon highlights the current inadequacy of the response of the criminal justice system to individuals who suffer from severe impairments. Some defendants may eventually end up committing a capital crime and be sentenced to death. However, had they had access to and received treatment in a manner appropriate to their impairment, such deadly violence may have been much less likely, or avoided altogether.

⁸¹ David B. Kopel & Clayton E. Cramer, *Reforming Mental Health Law to Protect Public Safety and Help the Severely Mentally Ill*, 58 HOW. L.J. 715, 726 (2015).

⁸² Thomas Insel, *Understanding Severe Mental Illness*, NATIONAL INSTITUTE OF MENTAL HEALTH (Jan. 11, 2011), <http://www.nimh.nih.gov/about/director/2011/understanding-severe-mental-illness.shtml>.

⁸³ *Id.*

⁸⁴ Heather Stuart, *Violence and Mental Illness: An Overview*, 2 WORLD PSYCHIATRY 2, 121, 122 (2003) (“Prior to 1980, the dominant view was that the mentally ill were no more, and often less likely to be violent.”)

⁸⁵ See, e.g., Richard Van Dorn et al., *Mental Disorder and Violence: Is There a Relationship Beyond Substance Use?*, 47 SOC. PSYCHIATRY & PSYCHIATRIC EPIDEMIOLOGY, 487 (2012); Richard A. Friedman, *Violence and Mental Illness—How Strong Is the Link?*, 355 NEW ENG. J. MED 2064 (2006); Jeffrey Swanson et al., *The social-environmental context of violent behavior in persons treated for severe mental illness*, 92 AM. J. PUB. HEALTH 1523 (2002); Jeffrey W. Swanson et al., *Violence and Psychiatric Disorder in the Community: Evidence from Epidemiologic Catchment Area Surveys*, 41 HOSP. & COMMUNITY PSYCHIATRY 761 (1990).

⁸⁶ Epidemiologic Catchment Area Surveys, 41 HOSP. & COMMUNITY PSYCHIATRY 761 (1990). Eric B. Elbogen & Sally C. Johnson, *The Intricate Link Between Violence and Mental Disorder Results From the National Epidemiologic Survey on Alcohol and Related Conditions*, 66 ARCHIVES GEN. PSYCHIATRY 152, 152 (2009).

⁸⁷ *Id.*

⁸⁸ Kopel & Cramer, *supra* note 81, at 731.

⁸⁹ *Violence and Gun Reporting Laws*, NATIONAL ALLIANCE ON MENTAL ILLNESS <https://www.nami.org/Learn-More/Mental-Health-Public-Policy/Violence-and-Gun-Reporting-Laws> (last visited: Nov. 27, 2016). Mental Health America also states in its Policy Statement 72 that “While untreated or undertreated mental health conditions, when accompanied by untreated or undertreated substance use conditions, may be associated with an increased risk of violence, this does not justify discrimination against people with mental health conditions as a class.” *Position Statement 72: Violence: Community Mental Health Response*, MENTAL HEALTH AMERICA, <http://www.mentalhealthamerica.net/positions/violence> (last visited: Nov. 27, 2016).

⁹⁰ PSYCHIATRIC SERVICES IN JAILS AND PRISONS: TASK FORCE TO REVISE THE APA GUIDELINES ON PSYCHIATRIC SERVICES IN JAILS AND PRISONS (American Psychiatric Association ed., 2000).

Part II: Inadequacy of Existing Legal Mechanisms to Address Severe Mental Illness in Capital Cases

There are currently several points in a criminal trial at which a judge or jury may be asked to take a defendant's mental illness into account. However, these existing procedures do not adequately protect individuals with severe mental illness from being sentenced to death or executed, as they apply to very few cases and can (and do) allow people with profound impairments to slip through the cracks.

Competency to Stand Trial

All criminal defendants in the U.S. have a due process right to a fair trial under the Fifth and Fourteenth Amendments.⁹¹ This concept includes a right not to be tried if they are “incompetent to stand trial” – in other words, if they suffer from a mental disability such that they lack the present ability to consult with their lawyer

with a reasonable degree of rational understanding or lack a rational as well as factual understanding of the proceedings against them.⁹² The justification for this protection “has been viewed as a byproduct of the ban against trials in absentia, as the mentally incompetent defendant, although physically present in the courtroom, is in reality afforded no opportunity to defend himself.”⁹³

The competency standard is used to ensure that a defendant can adequately participate in his own defense before and at trial, and is focused on a defendant's present mental abilities. It does not in any way address the question of a defendant's state of mind at the time of the alleged offense, or his legal culpability for the crime committed. If a defendant is found incompetent, he or she is typically moved to a medical facility to receive treatment to help him or her be restored, if possible, to legal competency and eventually face the charges against him or her. Many times competency is legally restored through psychotropic medications. However, some defendants cannot ever be restored to competency, even with medication. In those instances, depending on the charges and the circumstances, it is possible for an incompetent person to be hospitalized indefinitely and never face trial for the crime that he or she is accused of committing.⁹⁴

As articulated above, the standard for competency is very low and only requires a defendant to have “sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding” and a “rational as well as factual understanding of the proceedings against him.”⁹⁵ A person can have a severe mental illness and yet still possess the necessary attributes to be considered legally competent to stand trial. While mental illness often plays a role in a court's determination of a defendant's competence to stand trial and can be a factor in the competency determination, “[a] defendant's history of mental illness does not render the defendant mentally incompetent *per se*.”⁹⁶

The exemption endorsed by the ABA differs from the competency to stand trial standard in several ways. First, the competency to stand trial standard looks at the defendant's mental state at the time of trial – and not at the time of the offense. The ABA exemption would apply to defendants who had significant impairments due to a severe mental disorder at the time of the crime. In addition, competency to stand trial does not address the question of the penalty that a defendant should receive – like the exemption does – but looks at whether a defendant can partake in his own defense. A defendant could be found incompetent to stand trial, have his or her competency restored, and again be eligible for the death penalty. The competency standard does not allow the sentencer to take into account a defendant's mental state at the time of crime, and does not preclude the death penalty for those with mental illness.

⁹¹ *Pate v. Robinson*, 383 U.S. 375 (1966).

⁹² *Dusky v. United States*, 362 U.S. 402 (1960).

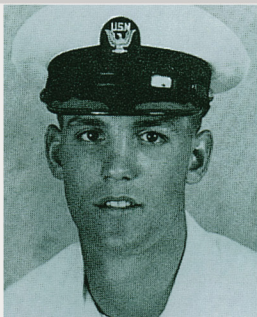
⁹³ 40 AM. JUR. 2D *Proof of Facts* § 171 (1984).

⁹⁴ Bruce J. Winick, *Restructuring Competency to Stand Trial*, 32 UCLA L. REV. 921, 924 (1985).

⁹⁵ *Dusky v. United States*, 362 U.S. 402, 402 (1960).

⁹⁶ Haleigh Reisman, *Competency of the Mentally Ill and Intellectually Disabled in the Courts*, 11 J. HEALTH & BIOMEDICAL L. 199, 212 (2015).

CASE EXAMPLE: Scott Panetti



Scott Panetti
Texas

- Hospitalized 14 times in 11 years due to symptoms of his paranoid schizophrenia.
- Represented himself at his 1995 trial, dressed in a purple cowboy outfit.
- Currently on Texas death row, appeals pending.

Scott Panetti, a man with severe mental illness currently on Texas death row, was found to be competent to stand trial after a second competency hearing. Prior to his arrest, Mr. Panetti was hospitalized more than a dozen times for mental health related reasons. He was diagnosed with schizophrenia and suffered severe hallucinations. After a judge declared him competent to stand trial, Mr. Panetti waived his right to counsel, and decided to represent himself. At his trial, Mr. Panetti wore a cowboy costume and attempted to subpoena the Pope, John F. Kennedy, and Jesus Christ. A jury sentenced Mr. Panetti to death in 1995.

In the subsequent years that Mr. Panetti has been on death row it has become clear that he continues to suffer from severe mental illness, which includes schizophrenic delusions, hallucinations and a steadfast belief that he is being persecuted for preaching the gospel. Although Mr. Panetti has a severe mental illness, the competency standard did not prevent him from getting a death sentence. His case is just one example of why the competency standard alone does not effectively prevent individuals with severe mental illness from receiving a death sentence.

Information about Scott Panetti's case can be found at: Scott Panetti, TEXAS DEFENDER SERVICES, <http://texasdefender.org/scott-panetti/> (last visited Nov. 27, 2016).

The Insanity Defense

In contrast to the question of competency to stand trial, the insanity defense does focus on a defendant's mental state at the time of the alleged offense, rather than on his or her ability to rationally understand the proceedings and case against him. Not Guilty by Reason of Insanity (NGRI), or the insanity defense, is an affirmative defense to a crime, intended to allow a "not guilty" verdict at the end of a trial and relieve the defendant of responsibility for the crime based on mental illness.⁹⁷

The current standard for the insanity defense in the majority of states is based on the *M'Naghten* Rule, which holds that a person is not criminally liable if "at the time of the committing of the act, the party accused was labouring under such a defect of reason, from disease of mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong."⁹⁸ Other states follow the Model Penal Code test for insanity, which states that a person is not responsible if at the time of the crime, "as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality [wrongfulness] of his conduct or to conform his conduct to the requirements of law."⁹⁹ A small number of states adhere to the "irresistible impulse" test for legal insanity, which requires a showing that the defendant was so lacking in volition due to a mental defect or illness that he could not have controlled his actions.¹⁰⁰

⁹⁷ See, e.g., Michael L. Perlin, *Unpacking the Myths: The Symbolism Mythology of Insanity Defense Jurisprudence*, 40 CASE W. RES. L. REV. 599 (1989).

⁹⁸ *M'Naghten's Case*, 10 Cl. & Fin. 200, 210, 8 Eng. Rep. 718, 722 (1843); see also Michael J. Shoptaw, *M'Naughten is a Fundamental Right: Why Abolishing the Traditional Insanity Defense Violates Due Process*, 84 MISS. L.J. 1101 (2015).

⁹⁹ Model Penal Code, § 4.01.

¹⁰⁰ Emanuel Francone, *Insanity Defense*, LEGAL INFORMATION INSTITUTE (Jul. 2016), https://www.law.cornell.edu/wex/insanity_defense. For a list of the insanity defense legal standards used in each of the 50 U.S. states see *The Insanity Defense Among the States*, FINDLAW, <http://criminal.findlaw.com/criminal-procedure/the-insanity-defense-among-the-states.html> (last visited Nov. 27, 2016).

While many of us have heard about this concept, the reality is that the insanity defense is asserted in an extremely small number of cases, and is successful in an even smaller number. Nationally, it is raised in approximately 1% of all criminal cases and successful only 25% of the time.¹⁰¹ In Virginia, for example, this translates into 35 NGRI acquittals on average per year.¹⁰²

While the test for legal insanity varies by state, in most jurisdictions the definition is so narrow that it excludes many individuals with severe mental illness. Even if a defendant indisputably suffered from severe mental illness at the time of the crime, a defendant still does not qualify as legally insane in a jurisdiction that adheres to the *M’Naghten* standard unless his mental illness also rendered him completely unable to appreciate that what he was doing was wrong. So, for example, that standard would exclude from the insanity defense people “who have a mood disorder with psychotic features [and who] might understand the wrongfulness of their acts, but nonetheless feel impervious to punishment because of delusion-inspired grandiosity.”¹⁰³

Moreover, because the legal definition of insanity is so narrow in most jurisdictions, and because jurors are often inherently skeptical of the defense, many defendants with severe mental illness and their lawyers elect not to assert the defense at trial knowing it is either inapplicable or unlikely to succeed. This may be in part because jurors in capital cases must be “death-qualified,” or capable of considering both life and death as potential punishments upon conviction.¹⁰⁴ Research shows that death-qualified jurors are “more likely to endorse certain insanity myths.”¹⁰⁵ These myths include the idea “that the insanity defense is used on a frequent basis, that the insanity defense is a “legal loophole,” and that if a person is found NGRI, he or she is released immediately back into society.”¹⁰⁶ This is another reason why the insanity defense cannot reliably protect many individuals with severe mental illness who are prosecuted capitally.

Returning to the example of Scott Panetti, highlighted earlier, it is easy to see how the insanity defense can fail. After being found competent to stand trial, Mr. Panetti waived his right to counsel and represented himself at trial. Although he has severe schizophrenia and attempted to assert the insanity defense amid his bizarre trial presentation, he was unsuccessful and sentenced to death.

A defendant found not guilty by reason of insanity is not convicted of the crime and is typically sent to a psychiatric institution. With the exemption endorsed by the ABA, a defendant could be prosecuted, convicted and sentenced to life without parole if found guilty. In addition, the insanity defense only applies to a very narrow category of individuals with severe mental illness. This exclusion provides a middle ground protection for individuals with severe mental illness who do not fit the extremely narrow insanity defense, but have significant mental impairments that make them undeserving of the death penalty.

¹⁰¹ *Not Guilty by Reason of Insanity: Reference Manual for Community Services Boards & Behavioral Health*, VIRGINIA DEPARTMENT OF BEHAVIORAL HEALTH & DEVELOPMENTAL SERVICES (2016), <http://www.dbhds.virginia.gov/professionals-and-service-providers/forensic-services/ngri-manual>.

¹⁰² *Id.*

¹⁰³ ABA, RECOMMENDATION 122-A, 2006, *supra*, note 9.

¹⁰⁴ Jurors in capital trials must undergo a process called death qualification. Death qualification is a part of *voir dire* during which prospective jurors are questioned regarding their beliefs about capital punishment. This process serves to eliminate jurors whose attitudes toward the death penalty would prevent them from being fair and impartial in deciding the fate of a defendant. In order to sit on a capital jury, a person must not feel so strongly about the death penalty that his or her belief would “prevent or substantially impair the performance of [his or her] duties as a juror” Brooke J. Butler, *The Role of Death Qualification in Jurors’ Susceptibility to Pretrial Publicity*, 37 J. APPLIED SOC. PSYCHOL., 1744, 1744 (2007).

¹⁰⁵ Brooke J. Butler & Adina Wasserman, *The Role of Death Qualification in Venirepersons’ Attitudes Toward the Insanity Defense*, 36 J. APPLIED SOC. PSYCHOL., 1744, 1752 (2006).

¹⁰⁶ *Id.*

CASE EXAMPLE: Kelsey Patterson



Kelsey Patterson
Texas

- Diagnosed with paranoid schizophrenia in 1981. Found incompetent to stand trial and deemed insane in prior assaults.
- Believed he had a “permanent stay of execution.”
- Executed in 2004.

This case provides another striking example of how the insanity defense is insufficient to ensure adequate consideration of a defendant’s mental illness in capital proceedings. Mr. Patterson had a long history of mental illness, and was diagnosed with paranoid schizophrenia in 1981. He spent much of the 1980s in and out of mental hospitals. In three separate occurrences in 1980, 1983 and 1986, Mr. Patterson assaulted a co-worker and was later found either incompetent to stand trial or no charges were filed because of his mental health status.

However, in 1992, Kelsey Patterson randomly shot and killed a local business owner, Louis Oates, and his secretary, Dorothy Kay Harris. After the shooting, he put down the gun, stripped to his socks, and paced at the scene, shouting incomprehensibly until the police arrived. But at his subsequent competency hearing in this case, two physicians (who did not dispute the existence of his mental illness) found him competent to stand trial. The controversial doctor who had diagnosed him with schizophrenia 12 years earlier testified that Mr. Patterson had been sane at the time of the 1992 crime. Despite Mr. Patterson’s incoherent ramblings to the jury about the conspiracies against him, the jury rejected his insanity defense and sentenced him to death. Mr. Patterson’s mental illness continued throughout his time on death row, where he believed he had a “permanent stay of execution.”

On May 17, 2004, the Texas Board of Pardons and Paroles issued an extremely rare recommendation of clemency for Mr. Patterson because of his mental illness; the vote was 5-1 and was only the second such recommendation in the board’s history. Then Governor of Texas Rick Perry rejected the recommendation and the execution took place the next day.

USA: *The Execution of Mentally Ill Offenders*, AMNESTY INTERNATIONAL, at 74 (Jan. 31 2006), <https://www.amnesty.org/en/documents/AMR51/003/2006/en/>. (Additionally, the controversial doctor in Mr. Patterson’s case, psychiatrist Dr. Grigson, was known as “Dr. Death” because his testimony was instrumental in sending so many people to death row. He later was expelled from the American Psychiatric Association and Texas Society of Psychiatric Physicians because of his unethical, unscientific testimony in such cases.)

Mitigating Factors

While jurors are permitted to consider evidence presented by the defense related to mental illness in a death penalty sentencing phase, this use of “mitigation” has proven to be an unreliable method to ensure that a defendant’s severe mental illness will be fully considered and given its proper weight. Although some have argued that this sufficiently protects those with severe mental illness from receiving a death sentence, practice has shown that this is untrue, and that individuals with severe mental illness are still regularly sentenced to death.

In fact, jurors often treat mental illness as an aggravating factor rather than a mitigating factor in capital cases.¹⁰⁷ They may view defendants with severe mental illness as inherently dangerous or may lack enough expert understanding of the ways mental illness can impair an individual and change their behavior. A study conducted by David Baldus revealed that in fact, a defendant’s insanity or incompetence claim was one of the strongest correlates with a death sentence, suggesting that most jurors view mental illness as aggravating rather than mitigating.¹⁰⁸ A jury’s misinterpretation of a defendant’s actions might also extend to a failure to recognize that severe mental illness is a mitigating, and not an aggravating, factor. In a case cited by Professor Scott Sundby, in which all parties and experts, including the state’s psychiatrist, agreed that the defendant suffered from severe mental illness, a “juror summarized the jury’s decision in the case [...] when asked about the strongest factor

¹⁰⁷ See e.g. Stephen P. Garvey, *The Emotional Economy of Capital Sentencing*, 75 N.Y.U. L. REV. 26, 57 (2000); Ellen F. Berkman, *Mental Illness as an Aggravating Circumstance in Capital Sentencing*, 89 COLUM. L. REV. 291, 299 (1989).

¹⁰⁸ DAVID BALDUS ET AL., *EQUAL JUSTICE AND THE DEATH PENALTY* (Northeastern University Press ed., 1990).

for and against the death penalty: ‘For: His incurability. Against: ‘His illness.’”¹⁰⁹ Moreover, if jurors are simply provided with a list of mitigating factors related to mental illness without further explanation, they may be left confused and uninformed about the sentencing implications of those factors.¹¹⁰ These biases interfere with jurors’ ability to appropriately assess the weight to be given to the mitigating factor of a defendant’s mental illness, which is unacceptable when a defendant’s life is at stake.

In addition, severe mental illness may significantly interfere with a defendant’s ability to effectively participate in his defense. The illnesses that are characterized by a lack of insight can make it extremely complicated for a lawyer to present mitigating evidence about a mental disorder that the defendant him or herself denies. Persons with schizophrenia, for instance, are often forgetful, have difficulty organizing thoughts and struggle to make decisions. They may also suffer from paranoid delusions that make them distrustful of their attorneys and their motives.

Persons with schizophrenia are often extremely concrete thinkers and have limited insight; they may also exhibit alogia, or diminished speech output, and may be relatively unhelpful or inaccurate historians about their lives.¹¹¹ Difficulty communicating, disorganized thoughts, and psychotic symptoms all get in the way of effective representation, and put defendants with severe mental illness at a significant disadvantage when defending themselves from a death sentence: “The very characteristic that diminishes the mentally ill defendants’ culpability jeopardizes his attorney’s ability to prepare and present the case that would persuade the jury to return a life sentence.”¹¹² The stigma of mental illness can also lead defendants to refuse any mitigating evidence to be presented about their illness. Furthermore, in cases where trauma is mingled with the severe mental illness, defendants will want to avoid reliving the traumatizing evidence and thus try to avoid the presentation of potentially life-saving evidence about the trauma they suffered.

Another way in which a defendant’s severe mental illness may interfere with an effective presentation of mitigating evidence is that the symptoms may create “an unwarranted impression of lack of remorse.”¹¹³ Indeed, while suffering from a psychotic episode, they may become agitated, unable to control their movements, or make inappropriate comments – all of which can be interpreted by jurors as dangerous, impulsive behavior and thus increase the likelihood of jurors finding the death sentence appropriate.¹¹⁴ Conversely, when heavily medicated, defendants may not exhibit such florid symptoms but may instead display a flat demeanor or look (and even fall) asleep as a side-effect of the medication, all of which gives the impression that he or she is remorseless, another element to which jurors give a strong weight.¹¹⁵ It is often difficult for jurors to reconcile the defendant’s behavior during a crime with their demeanor in court when they are heavily medicated.

Indeed, the U.S. Supreme Court found in *Atkins* and *Roper* that the mitigation phase did not effectively protect individuals with intellectual disability or juveniles from receiving the death penalty: “reliance on mental retardation as a mitigating factor can be a two-edged sword that may enhance the likelihood that the aggravating factor of future dangerousness will be found by the jury.”¹¹⁶

Likewise, it is not possible to rely on this stage of the capital sentencing process to fully protect individuals with severe mental illness. While jurors’ consideration of mitigating factors related to mental illness is permitted, this is not an absolute guarantee that it will be fully considered and given its proper weight. Research has shown that jurors may hold widespread and erroneous prejudices about mental illness and future dangerousness, and may make life or death decisions based on those. The Supreme Court expressed similar concerns in the case of

¹⁰⁹ Scott Sundby, *The True Legacy of Atkins and Roper: The Unreliability Principle, Mentally Ill Defendants, and the Death Penalty’s Unraveling*, 23 WM. & MARY BILL RTS. J. 487, 519 (2014).

¹¹⁰ Garvey, *supra* note 107.

¹¹¹ Joe Hennell, *Mental Illness on Appeal and the Right to Assist Counsel* 29 J. CONTEMP. HEALTH L. & POL’Y 350, 354 (2013).

¹¹² Sundby, *supra* note 109, at 514.

¹¹³ *Atkins* at 321.

¹¹⁴ Stephen P. Garvey, *Aggravation and Mitigation in Capital Cases: What Do Jurors Think?*, 98 COLUM. L. REV. 1538, 1599 (1998).

¹¹⁵ Ronald S. Honberg, *The Injustice of Imposing Death Sentences on People With Severe Mental Illness*, 54 CATH. U. L. REV. 1153 (2005).

¹¹⁶ *Atkins* at 321.

defendants with intellectual disability and juveniles, and found that a categorical bar was the only appropriate protection. The proposed ABA exemption would provide a similar protection to those with severe mental illness.

Competency to be Executed

Finally, in *Ford v. Wainwright*, the U.S. Supreme Court held that the Eighth Amendment forbids states from executing prisoners if they are “insane.”¹¹⁷ In reaching this decision, the Court noted the lack of “retributive value of executing a person who has no comprehension of why he has been singled out and stripped of his fundamental right to life.”¹¹⁸ In 2007, the Court clarified that the determination of whether an inmate is “insane” such that he or she is incompetent to be executed requires an analysis of whether the inmate has a rational understanding of the government’s reason for executing him or her, noting, “[a] prisoner’s awareness of the State’s rationale for an execution is not the same as a rational understanding of it.”¹¹⁹ This “competency to be executed” standard requires an assessment of an inmate’s mental state at the time of the impending execution, rather than at the time of the offense or at the time of trial.

Ford further held that defendants must have an opportunity to litigate the issue of their competency to be executed. While declining to set forth a specific procedure that states must follow, the Court noted that “the lodestar of any effort to devise [such a] procedure must be the overriding dual imperative of providing redress for those with substantial claims and of encouraging accuracy in the fact-finding determination.”¹²⁰ Within this framework, the competency assessment varies in administration from state to state. As with the competency to stand trial standard, the competency to be executed standard sets a very high bar, leaving it entirely possible to have severe mental illness and still purportedly have a rational understanding of the reason for one’s pending execution, proving that this standard does not provide adequate safeguards to protect individuals with severe mental illness against execution.

The case of Kelsey Patterson, noted above, who was executed despite the fact that he believed he had a “permanent stay of execution,” provides one example demonstrating that it can be extremely difficult for defendants to establish that they are incompetent to be executed, despite ample evidence of severe mental illness.

In addition to failing to provide adequate safeguards against execution for inmates with severe mental illness, the competency to be executed standard also often creates significant ethical dilemmas for mental health professionals asked to evaluate such inmates.¹²¹ On one hand, a physician’s first duty is to their patients, and “typically, the only effective means of treatment for the inmate’s symptoms of a serious mental illness is to provide appropriate medications.”¹²² On the other hand, “[m]ost mental health professionals believe it is unethical to provide treatment for the purpose of restoring a person’s competence to enable a state to carry out an execution.”¹²³ Thus, this requirement creates an ethical quandary for mental health professionals to provide treatment to an inmate in order to facilitate their execution. Yet it may also be problematic for such a professional to refuse to treat an inmate’s severe mental illness, when such treatment would be in the inmate’s best medical interest and would alleviate the person’s symptoms and degree of suffering.¹²⁴

When looking at a defendant’s competency to be executed, courts look at that individual’s mental state at the time near the execution date – which can occur many years after the crime. The standard is focused on whether defendants understand the rationale for their execution, and not on whether they were suffering from a severe

¹¹⁷ *Ford v. Wainwright*, 477 U.S. 399, 399 (1986).

¹¹⁸ *Id.* at 409.

¹¹⁹ *Panetti v. Quarterman*, 551 U.S. 930, 933 (2007).

¹²⁰ *Ford* at 417.

¹²¹ Rochelle Graff Salguero, *Medical Ethics and Competency to be Executed*, 96 *YALE L.J.* 167 (1986).

¹²² Brian D. Shannon & Victor R. Scarano, *Incompetency to Be Executed: Continuing Ethical Challenges & Time for A Change in Texas*, 45 *TEX.*

TECH L. REV. 419, 425 (2013).

¹²³ *Id.* at 424.

¹²⁴ *Id.* at 425.

mental disorder or disability that significantly impairs their understanding of reality and ability to control behavior at the time of the crime. Thus, this standard, like the other current mechanisms in the law, provides inadequate legal protection.

“These existing procedures do not adequately protect individuals with severe mental illness from being sentenced to death or executed as they apply to very few cases and allow people with profound impairments to slip through the cracks”

Clearly, each of the current legal mechanisms that attempt to account for a defendant’s mental illness at various stages in the criminal justice process is limited in scope and applicability. Even taken together, these mechanisms do not and cannot provide meaningful protection against death sentences and execution for individuals with severe mental illness. The ABA Resolution’s proposed exemption would better ensure that defendants with severe mental illness are protected from the death penalty and given the proportional and appropriate punishment.

Part III: Constitutional Challenges to the Execution of Defendants with Severe Mental Illness

No Penological Justification

The Supreme Court has identified “two principal social purposes” served by capital punishment: retribution and deterrence.¹²⁵ However, neither of them justifies the execution of individuals with severe mental illnesses.

First, the retributive rationale for the death penalty is conditioned on an offender’s level of responsibility, a question that goes beyond whether he or she committed the crime. A defendant can be found guilty of first degree murder beyond a reasonable doubt, but may not possess the level of personal moral culpability that makes him or her deserving of the death penalty. Indeed, the vast majority of murders in this country do not result in a death sentence.¹²⁶ As the Supreme Court noted in *Atkins*, “[w]ith respect to retribution—the interest in seeing that the offender gets his ‘just desserts’—the severity of the appropriate punishment necessarily depends on the culpability of the offender.”¹²⁷ As well, the Court’s analysis of whether a death sentence is excessive has always been based on the idea that “punishment should be directly related to the personal culpability of the criminal defendant.”¹²⁸ In other words, the individual’s culpability and the punishment must be proportional.

To warrant the death penalty, a defendant must be more morally culpable than the average murderer. As Laurie Izutsu puts it, “the reality that not every defendant in a capital case is sentenced to death reflects the attitude that ‘only the most deserving’ should be executed.”¹²⁹

Punishing people with severe mental illness does not further the retributive goals of the punishment because this population simply does not have the requisite moral culpability as their illness can impair their ability to interpret reality accurately, to comprehend fully the consequences of their actions, and to control their actions.¹³⁰ As such, it is contradictory that a person belonging to a more vulnerable group in society, would also, at the same time, be among the most culpable individuals who possess the highest level of culpability. As U.S. District

Judge William Wayne Justice noted in another context, “[i]f we reject the moral necessity to distinguish between those who willingly do evil, and those who do dreadful acts on account of unbalanced minds, we will do injury

¹²⁵ *Gregg v. Georgia*, 428 U.S. 153, 183 (1976).

¹²⁶ *Publications & Products: Felony Sentences in State Courts*, U.S. DEP’T OF JUSTICE, BUREAU OF JUSTICE STATISTICS, <http://www.bjs.gov/index.cfm?ty=pbse&sid=28> (last visited Nov. 27, 2016).

¹²⁷ *Atkins* at 319.

¹²⁸ *Thompson v. Oklahoma*, 487 U.S. 815, 834 (citing *California v. Brown*, 479 U.S. 538, 545 (1987)).

¹²⁹ Laurie Izutsu, *Applying Atkins v. Virginia to Capital Defendants with Severe Mental Illness*, 70 BROOK. L. REV. 995, 999 (2005).

¹³⁰ ABA, RECOMMENDATION 122-A, 2006, *supra*, note 9.

to these people.”¹³¹

Second, the theory that the death penalty in general deters potential murderers is controversial and unsupported by conclusive evidence.¹³² However, any possible deterrent effect is necessarily further diminished among people who, as with people intellectual disability, have a “diminished ability to understand and process information, to learn from experience, to engage in logical reasoning, or to control impulses.”¹³³ As the Supreme Court observed, “the death penalty has little deterrent force against defendants who have reduced capacity for considered choice.”¹³⁴

“The death penalty has little deterrent force against defendants who have reduced capacity for considered choice.”

People with mental illness did not choose their condition. In addition, impairments like hallucinations, delusions, impaired cognition, or disorganized thinking create a “reduced capacity for considered choice,” as detailed in Part I of this Paper. In light of this, defendants with severe mental illness have little in common with the offenders the death penalty is intended to target and likely could not have been deterred from committing a crime that occurred while they were experiencing symptoms of their condition.

A Violation of the Eighth Amendment Ban on Cruel and Unusual Punishment

As noted earlier, the U.S. Supreme Court has recognized categorical constitutional bars on the death penalty for individuals with intellectual disability and juvenile defendants, noting significant mental similarities and rationales between these two vulnerable groups.

The constitutional bar on the execution of defendants with intellectual disability

In *Atkins v. Virginia*, the Court concluded that “death is not a suitable punishment for a mentally retarded criminal.”¹³⁵ With *Atkins*, the Court “announced a rule of *per se* diminished responsibility required by the Constitution” – the execution of people with intellectual disability was unconstitutional “based upon their diagnosis alone.”¹³⁶ The bar to execution rests solely on the fact that defendants have intellectual disability, which is enough in itself to justify a sentence other than death. However, defendants with intellectual disability can still be found guilty of murder and sentenced to life without parole.

In explaining its reasoning, the Court first noted that the Eighth Amendment’s ban on cruel and unusual punishment must be interpreted through the standards of the time, and reflect contemporary society’s view on punishment. As far back as 1910, the Supreme Court had stated that the Amendment “is progressive and does not prohibit merely the cruel and unusual punishments known in 1689 and 1787, but may acquire meaning as public opinion becomes enlightened by humane justice.”¹³⁷ In 1958, the Court confirmed this line of reasoning by affirming that the definition of cruel and unusual punishment must draw its meaning from “the evolving standards of decency that mark the progress of a maturing society.”¹³⁸

¹³¹ James Kimberly, *Judge Defends Mentally Ill in Speech*, HOUSTON CHRONICLE (Sept. 26, 2002), <http://www.chron.com/news/houston-texas/article/Judge-defends-mentally-ill-in-speech-2122274.php>.

¹³² See generally, *Discussion of Recent Deterrence Studies*, DEATH PENALTY INFORMATION CENTER, <http://www.deathpenaltyinfo.org/discussion-recent-deterrence-studies> (last visited Nov. 27, 2016) (“A report released on April 18, 2012, by the prestigious National Research Council of the National Academies based on a review of more than three decades of research concluded that studies claiming a deterrent effect on murder rates from the death penalty are fundamentally flawed [...] The committee concludes that research to date on the effect of capital punishment on homicide is not informative about whether capital punishment decreases, increases, or has no effect on homicide rates.”).

¹³³ *Atkins* at 320.

¹³⁴ *Skipper v. South Carolina*, 476 U.S. 1, 13 (1986) (Powell, J., concurring).

¹³⁵ *Atkins* at 321.

¹³⁶ Bruce Winick, *The Supreme Court’s Emerging Death Penalty Jurisprudence: Severe Mental Illness as the Next Frontier*, 50 B. C. L. REV. 785, 786 (2009).

¹³⁷ *Weems v. United States*, 217 U.S. 349, 378 (1910).

¹³⁸ *Trop v. Dulles*, 356 U.S. 86, 101 (1958).

Next, the *Atkins* Court observed that a significant number of states had outlawed the execution of individuals with intellectual disability in the 13 years that had passed since it had previously upheld the execution of these individuals in *Penry v. Lynaugh* in 1989. The Court specifically noted “the consistency of the [legislative] change” (particularly significant in a context that generally favors anticrime legislation rather than the protection of violent criminals) and the fact that even in the states where the practice was not illegal, executing offenders with intellectual disability was uncommon.¹³⁹

The Court also conducted an “independent evaluation” and concluded that:

Mentally retarded persons frequently know the difference between right and wrong and are competent to stand trial, but, by definition, they have **diminished capacities to understand and process information, to communicate, to abstract from mistakes and learn from experience, to engage in logical reasoning, to control impulses, and to understand others’ reactions.** Their deficiencies **do not warrant an exemption from criminal sanctions, but diminish their personal culpability.**¹⁴⁰

The Court found that, in light of these deficiencies, “there is a serious question whether either justification underpinning the death penalty – retribution and deterrence of capital crimes – applies to mentally retarded offenders.” It continued:

Mentally retarded defendants in the aggregate face a special risk of wrongful execution because of the possibility that they will **unwittingly confess to crimes they did not commit**, their **lesser ability to give their counsel meaningful assistance**, and the facts that **they are typically poor witnesses** and that **their demeanor may create an unwarranted impression of lack of remorse** for their crimes.¹⁴¹

Twelve years after *Atkins*, the Court later strengthened the protection for individuals with intellectual disability in *Hall v. Florida*.¹⁴² In *Hall*, the Court struck down a Florida statute that strictly foreclosed further exploration of a capital defendant’s intellectual disability if his or her IQ score was higher than 70. The Court relied on “established medical practice” and the expertise of professionals who have “long agreed that IQ test scores should be read as a range” to rule that the Florida statute was unconstitutional.¹⁴³ It further relied on the fact that the majority of states reject a strict 70-point cutoff, stating that “in summary, every state legislature to have considered the issue after *Atkins*, save Virginia’s – and whose law has been interpreted by its courts has taken a position contrary to that of Florida.”¹⁴⁴

In *Hall*, the Court recognized the complexity of intellectual disability and the fact that no definitive scientific measurement can be used as a cutoff:

Florida’s rule disregards established medical practice in two interrelated ways. It takes an IQ score as final and conclusive evidence of a defendant’s intellectual capacity, when experts in the field would consider other evidence. It also relies on a purportedly scientific measurement of the defendant’s abilities, his IQ score, while refusing to recognize that the score is, on its own terms, imprecise.¹⁴⁵

While some may argue that it is easier to protect those with intellectual disability from execution than those with severe mental illness because the impairment is easier to diagnose, this shows the Court itself recognizes that the complexity of a diagnosis should not be an impediment to protection from execution. As the Court summarized, “Intellectual disability is a condition, not a number.”¹⁴⁶

¹³⁹ *Atkins* at 315.

¹⁴⁰ *Id.* at 318 (emphasis added).

¹⁴¹ *Id.* at 321 (emphasis added).

¹⁴² *Hall v. Florida*, 134 S.Ct. 1986 (2014).

¹⁴³ *Id.* at 1988 (2014).

¹⁴⁴ *Hall* at 1998.

¹⁴⁵ *Id.* at 1995.

¹⁴⁶ *Id.* at 2001.

Importantly, the Court reiterated in *Hall* that “no legitimate penological purpose is served by executing a person with intellectual disability” because “those with intellectual disability are, by reason of their condition, likely unable to make the calculated judgments that are the premise of the deterrence rationale” and “retributive values are also ill-served by executing those with intellectual disability.”¹⁴⁷ Likewise, and as discussed earlier, the goals of retribution and deterrence are not met by executing a person with severe mental illness.

The constitutional bar on the execution of juveniles

Three years after *Atkins*, the U.S. Supreme Court recognized another important categorical exemption from the death penalty by ruling that the execution of children under the age of 18 is unconstitutional in *Roper v. Simmons*.¹⁴⁸ Again, the Court reiterated the necessity of taking into account “the evolving standards of decency that mark the progress of a maturing society” and directly relied on the reasoning in *Atkins*. The Court again found that in the case of juveniles, the “indicia of national consensus” – in this case 30 states outlawing the execution of juveniles – supported a finding of unconstitutionality.¹⁴⁹ As in *Atkins*, the Court also conducted an independent analysis, discussing the intrinsic characteristics of juveniles that show that they “cannot with reliability be classified among the worst offenders.”¹⁵⁰

First, the Court found that juveniles’ **susceptibility to immature and irresponsible behavior** means “their irresponsible conduct is not as morally reprehensible as that of an adult.”¹⁵¹ In addition, the Court continued: “their own **vulnerability and comparative lack of control** over their immediate surroundings mean juveniles have a **greater claim than adults to be forgiven for failing to escape negative influences** in their whole environment”¹⁵² and “the reality that juveniles **still struggle to define their identity** means it is less supportable to conclude that even a heinous crime committed by a juvenile is evidence of irretrievably depraved character.”¹⁵³

The *Roper* Court also noted the “overwhelming weight of international opinion” against the juvenile death penalty, which “although not controlling,” “provides respected and significant confirmation for the Court’s determination.”¹⁵⁴

Extending the constitutional bar on execution to those with severe mental illness

Much of the reasoning in *Atkins* and *Roper* can be applied virtually word-for-word to defendants with severe mental illness. Indeed, “[m]ental illness bears striking similarities to both mental retardation and juvenile status.”¹⁵⁵ As many scholars agree, “the parallels between the severely mentally ill and the individuals protected by *Atkins* and *Roper* are remarkable.”¹⁵⁶

“Much of the reasoning in *Atkins* and *Roper* can be applied virtually word-for-word to defendants with severe mental illness.”

While it is important to make clear that “mental illness” and “intellectual disability” are two separate diagnoses, it does not mean that they are always mutually exclusive. While a diagnosis of intellectual disability requires an inquiry into a person’s intelligence, mental illness can strike a person of any intelligence level. In addition, intellectual disability is a permanent,

¹⁴⁷ *Id.* at 1993.

¹⁴⁸ *Roper v. Simmons*, 543 U.S. 551, 551 (2005).

¹⁴⁹ *Roper* at 553. (These 30 states include 12 that had abolished the death penalty at the time, and 18 that retained it. The Court notes also that “even in the 20 States without a formal prohibition, the execution of juveniles is infrequent.”)

¹⁵⁰ *Roper* at 553.

¹⁵¹ *Roper* at 553. (Emphasis added.)

¹⁵² *Id.* at 553. (Emphasis added.)

¹⁵³ *Id.* (Emphasis added.)

¹⁵⁴ *Id.* at 554.

¹⁵⁵ Winick, *supra* note 136, at 788.

¹⁵⁶ Lyn Entzeroth, *The Challenge and Dilemma of Charting A Course to Constitutionally Protect the Severely Mentally Ill Capital Defendant From the Death Penalty*, 44 AKRON L. REV. 529, 559 (2011).

life-long condition that typically becomes evident in infancy and must be established by the age of 18. Conversely, mental illness can manifest at any age, with many of the more severe mental illnesses (e.g., bipolar disorder and schizophrenia) first appearing in adulthood and is potentially treatable. It can be a temporary condition, be experienced in cycles, or episodes may recur throughout life.

However, a careful comparison of the language used in *Atkins* to describe the characteristics of intellectual disability that lower a defendant's culpability and the symptoms characteristic of severe mental illness, shows how much the reasoning of the Court applies with equal force to defendants with mental illness. For example, consider the following similar traits:¹⁵⁷

- **“Diminished capacity to understand and process information:”** The American Psychiatric Association refers to mental illness as health conditions involving significant changes in thinking, among others.¹⁵⁸ For example, symptoms of schizophrenia include confused and disordered thinking, trouble with logical thinking, problems with attention and declining educational performance. People with bipolar disorder can have “uncontrollable racing thoughts” when in a manic episode, and difficulty concentrating when in a depressive episode. PTSD also affects the capacity to understand and process information, making people hyper-vigilant and over-react to perceived threats. They may also experience dissociative thoughts and experiences of reliving trauma, all of which interfere with a person's capacity to understand and process information.
- **“Diminished capacity to communicate:”** Many individuals with severe mental illness also have an impaired capacity to communicate. For example, symptoms of schizophrenia can include a loss or a decrease in the ability to initiate plans, speak or express emotion. Delusional disorders and extreme paranoia can also interfere with the ability to communicate, as persons with such an illness may not trust those around them with important information. In certain cases, defendants with those types of disorders refuse to speak about their disorder altogether, including to their attorney or close family members.
- **“Diminished capacity to abstract from mistakes and learn from experiences:”** People with severe mental illness may exhibit delusional or paranoid thinking. As a result, they are less able to logically analyze past mistakes and experiences and draw appropriate conclusions. Those exhibiting symptoms of mania have a heightened and often unrealistic sense of their capacities which can lead to risky behavior.
- **“Diminished capacity to engage in logical reasoning:”** Mental illness can impair an individual's capacity to engage in logical reasoning in a variety of ways. Delusions and paranoid thinking can obviously interfere with a person's ability to engage in logical thought. In addition, a person going through a depressive episode, a person may be overwhelmed by his or her feelings of hopelessness and worthlessness, hindering logical reasoning. The hyper vigilance characteristic of PTSD also leads to an assessment of risks not based in logical reasoning.
- **“Diminished capacity to control impulses:”** Many mental illnesses can result in poor impulse control. Schizophrenia symptoms can include bizarre behavior or abnormal movements, while bipolar disorder, especially when manifested through a manic episode can lead to increased risky behavior. PTSD can include being startled very easily, feeling tense, or having outbursts of anger, which can in turn lead a person to overreact to perceived threats
- **“Diminished capacity to understand others' reactions:”** For the same reasons that severe mental illness impairs understanding and processing of information as well as logical reasoning and learning from mistakes, mental illness also impairs the capacity to understand others' reactions and respond appropriately to them. Anosognosia, the lack of insight into one's own illness, can only reinforce this diminished capacity to understand others' reactions.

¹⁵⁷ *Atkins* at 318.

¹⁵⁸ *What is Mental Illness*, AMERICAN PSYCHIATRIC ASSOCIATION (Nov. 2015), <https://www.psychiatry.org/patients-families/what-is-mental-illness>.

This is only a limited, and certainly non-exhaustive, list of examples that illustrate how the functional impairments brought about by mental illness create the same kind of diminished capacities that *Atkins* relied on to find the execution of those with intellectual disability unconstitutional.

In *Atkins*, the Court also wrote: “[m]entally retarded defendants in the aggregate face a special risk of wrongful execution because of the possibility that they will unwittingly confess to crimes they did not commit, their lesser ability to give their counsel meaningful assistance, and the facts that they are typically poor witnesses and that their demeanor may create an unwarranted impression of lack of remorse for their crimes.”¹⁵⁹ As will be discussed in Part IV, defendants with severe mental illness are similarly more vulnerable to giving false confessions, less able to meaningfully assist their counsel, less likely to be good witnesses and their behavior may be interpreted to their detriment by a jury.

Indeed, several state and federal court judges have already noted the similarity between impairments due to intellectual disability and mental illness, and have concluded that there is no justification for failing to categorically exempt individuals with severe mental illness from the death penalty while providing such an exemption for individuals with intellectual disability.

For example, Indiana Supreme Court Justice Robert D. Rucker asserted in a 2002 dissent that the “underlying rationale for prohibiting executions of the mentally retarded is just as compelling for prohibiting the executions of the seriously mentally ill, namely evolving standards of decency.”¹⁶⁰ Justice Rucker reiterated that position in further separate concurrences in 2005 and 2007.¹⁶¹ Similarly, Justice James Zazzali of the New Jersey Supreme Court wrote in *State v. Nelson* that “if the culpability of the average murderer is insufficient to evoke the death penalty as our most extreme sanction, then the lesser culpability of Nelson, given her history of mental illness and its connection to her crimes, ‘surely does not merit that form of retribution.’”¹⁶² In 2003, Judge Robert Henry of the U.S. Court of Appeals for the Tenth Circuit that the imposition of the death penalty against mentally ill Oklahoma death row inmate Robert Bryan, “contributes nothing” to the goals of retribution and deterrence, noting *Atkins*.¹⁶³ Although Judge Henry was joined by three other judges on the court, it was not enough to stop Robert Bryan from being executed in June 2004.¹⁶⁴

In 2001 in *State v. Scott*, Ohio Supreme Court Justice Paul Pfeifer dissented from a majority opinion affirming the death sentence of man with schizophrenia:

I cannot get past one simple irrefutable fact: he has chronic, undifferentiated schizophrenia, a severe mental illness. Mental illness is a medical disease. Every year we learn more about it and the way it manifests itself in the mind of the sufferer. At this time, we do not and cannot know what is going on in the mind of a person with mental illness. As a society, we have always treated those with mental illness differently from those without. In the interest of human dignity, we must continue to do so.¹⁶⁵

While Justice Pfeifer recognized that the defendant was not “a sympathetic man” but rather a “twice-convicted murder who does not appear to express remorse for his crimes,” he strongly affirmed that “[e]xecuting Jay Scott says more about our society than it says about him.”¹⁶⁶ Mr. Scott was nevertheless executed in June 2001.¹⁶⁷

In 2011, former Ohio Supreme Court Justice Evelyn Stratton wrote a separate concurrence in *State v. Lang*, explaining that: “[i]f executing persons with mental retardation/developmental disabilities or executing

¹⁵⁹ *Atkins* at 317-321.

¹⁶⁰ *Corcoran v. State*, 774 N.E. 2d 495, 502 (Ind. 2002).

¹⁶¹ *Overstreet v. State*, 877 N.E.2d 144 (Ind. 2007) (Rucker J., concurring); *Matheney v. State*, 834 N.E.2d 658 (Ind. 2005) (Rucker J., concurring).

¹⁶² *State v. Nelson*, 803 A.2d 1, 47 (N.J. 2002) (Zazzali J., concurring).

¹⁶³ *Bryan v. Mullin*, 335 F.3d 1207, 1228 (10th Cir. 2003) (Henry J., concurring in part and dissenting in part).

¹⁶⁴ *State inmate executed for aunt's death in 1993*, THE OKLAHOMAN (June 10, 2004), <http://newsok.com/article/1906240>.

¹⁶⁵ *State v. Scott*, 748 N.E. 2d 11, 20 (Ohio 2001) (Pfeifer, J., dissenting).

¹⁶⁶ *Id.* at 20.

¹⁶⁷ Spencer Hunt, *Killer Scott is Executed by Injection*, THE CINCINNATI ENQUIRER (June 15, 2001), http://enquirer.com/editions/2001/06/15/loc_killer_scott_is.html.

juveniles offends ‘evolving standards of decency,’ then I simply cannot comprehend why these same standards of decency have not yet evolved to also prohibit execution of persons with severe mental illness at the time of their crimes.”¹⁶⁸ Since then, she has reiterated that position in front of the Ohio Senate in October 2015,¹⁶⁹ and is one of the leading supporters of Ohio’s Senate Bill 162, a bill introduced in May 2015 that would exempt those with severe mental illness from the death penalty.¹⁷⁰

More recently, Judge Richard Teitelman of the Supreme Court of Missouri, wrote in a dissent: “I would hold that the reasoning in *Ford v. Wainwright*, *Atkins v. Virginia*, and *Roper v. Simmons*, applies to individuals who... were severely mentally ill at the time the offense was committed.”¹⁷¹

The “Unreliability Principle”

The U.S. Supreme Court has consistently affirmed that capital punishment requires individualized sentencing because of its gravity and finality. The same day that it reinstated the death penalty in *Gregg v. Georgia* in 1976 by approving guided discretion schemes, the Court also struck down mandatory death penalty statutes and made clear that jurors were required to make decisions about sentencing based on individualized consideration in *Roberts v. Louisiana* and *Woodson v. North Carolina*.¹⁷² The Court found that North Carolina and Louisiana’s laws, which would trigger an automatic imposition of capital punishment, did not resolve “the constitutional vice of mandatory death sentence statutes – lack of focus on the circumstances of the particular offense and the character and propensities of the offender.”¹⁷³

It is clear then that a death sentence can only be applied when full consideration and full weight have been given to the “diverse frailties of humankind” that may be found in a defendant.¹⁷⁴ But what happens when, as in the case of people with severe mental illness, these mitigating factors cannot be reliably weighed and taken into account?

As noted earlier, all death penalty states and the federal government allow a defendant to present mitigating evidence of mental illness as a reason not to impose death.¹⁷⁵ Many of these provisions specifically refer to

impairment due to a “mental disease or defect” or “mental illness.” However, severe mental illness is sometimes an impediment to the efficient presentation of mitigation, or, worse, is interpreted as an aggravating factor.

As Professor Scott Sundby puts it, “where mitigation defied reliable assessment, the only constitutional answer was a categorical removal of those cases from the death penalty.”¹⁷⁶ Professor Sundby analyzes factors used by the Court for “flagging ‘special difficulties’ that might place a mitigating factor beyond a sentencer’s reliable evaluation” and how these factors apply in the case of severe mental illness.¹⁷⁷

¹⁶⁸ *State v. Lang*, 954 N.E.2d 596, 649 (Ohio 2011) (Lundberg Stratton J., concurring).

¹⁶⁹ Alan Johnson, *Don’t execute mentally ill, lawmakers told*, THE COLUMBUS DISPATCH (Oct. 14, 2015), http://www.dispatch.com/content/stories/local/2015/10/14/death_penalty_bill.html.

¹⁷⁰ See S.B. 162, 131st Gen. Assemb., Reg. Sess. (Ohio 2015), <https://www.legislature.ohio.gov/legislation/legislation-summary?id=GA131-SB-162>. As of November 27, 2016, the bill is still being considered by the committee.

¹⁷¹ *State ex rel. Strong v. Griffith*, 462 S.W.3d 732, 739 (Mo. 2015) (Teitelman, J., dissenting). Further dissents of state supreme court judges on the issue of severe mental illness and the death penalty include: *Com. v. Baumhammers*, 960 A.2d 59 (Pa. 2008) (Todd J., concurring); *State v. Ketterer*, 855 N.E.2d 48 (Ohio 2006) (Lundberg Stratton, J., concurring); *Baird v. State*, 833 N.E.2d 28 (Ind. 2005) (Boehm, J., dissenting).

¹⁷² *Roberts v. Louisiana*, 428 U.S. 325 (1976); *Woodson v. North Carolina*, 428 U.S. 280 (1976).

¹⁷³ *Roberts* at 333.

¹⁷⁴ *Woodson v. North Carolina*, 428 U.S. 280, 304 (1976). In *Lockett v. Ohio*, 438 U.S. 586 (1978), the Court further reinforced this trend, when it ruled unconstitutional an Ohio “guided discretion” statute that limited the capital sentencer’s consideration of mitigating factors to a list of only three factors. The court held that the constitutional mandate of individualized sentencing required that “any aspect of a defendant’s character or record and any of the circumstances of the offense that the defendant proffers as a basis for a sentence less than death” may be considered by the sentence. See also *Eddings v. Oklahoma*, 455 U.S. 104 (1982); *Williams v. Taylor* 529 U.S. 362 (2000), *Tennard v. Dretke* 542 U.S. 274 (2004).

¹⁷⁵ Lyn Entzeroth, *The Challenge and Dilemma of Charting A Course to Constitutionally Protect the Severely Mentally Ill Capital Defendant From the Death Penalty*, 44 AKRON L. REV. 529, 568 (2011).

¹⁷⁶ Sundby, *supra* note 109, at 506.

¹⁷⁷ *Id.*

They include the following concerns:

- Severe mental illness can impair the defendant’s cooperation with his lawyer and the lawyer’s ability to prepare a defense.

In *Atkins*, the Court directly mentioned the lesser ability of people with intellectual disabilities to effectively assist their counsel. In *Graham v. Florida*, a case in which the Court held that juveniles could not be sentenced to life in prison without parole for a non-homicide crime, the Court wrote: “[j]uveniles mistrust adults and have limited understanding of the criminal justice system and the roles of the institutional actors within it.”¹⁷⁸ The same reasoning can be applied with equal, if not stronger force to defendants with mental illness.

- Severe mental illness can interfere with the defendant’s decision-making.

In addition to interfering with a defendant’s ability to make informed decisions regarding presentation of mitigating evidence related to mental illness (as discussed in Part II of this Paper), severe mental illness also strongly affects decision-making about other aspects of the case. For example, depressive episodes can lead defendants to waive their appeals, which some consider akin to making the death penalty a “state-assisted suicide.”¹⁷⁹ Our legal system should not accept the likelihood that a severe mental illness will interfere with a defendant’s decision-making in a way that is detrimental to him or her at some point in the proceedings – for example, deciding to waive *Miranda* rights,¹⁸⁰ to plead guilty or not, to cooperate with defense attorneys, to represent themselves. These decisions could result in the perverse effect that a defendant’s mental illness itself increases the risk of getting a death sentence, when it is legally intended to be a mitigating factor only.

- Mental illness can make defendants poor witnesses.

The fact that severe mental illness may create “an unwarranted impression of lack of remorse” due to the defendant’s psychotic behavior and/or the side effects of psychotropic medication, as discussed earlier, creates an additional risk that the mitigating value of mental illness will be misunderstood by jurors.

- Mental illness is a double-edged sword when it acts as both a mitigating and aggravating factor.

Jurors’ sentencing decisions are often based on their assessment of future dangerousness and lack of remorse, while mitigation evidence is ignored.¹⁸¹ This poses a problem for defendants with severe mental illness, who might, even without corroborating evidence, appear to pose a threat of future dangerousness.

- Mental illness may play a role in the perception of the defendant’s dangerousness and the brutality of their crime.

Finally, the brutality of a crime often plays an important role in the defendant’s perceived future dangerousness and may overpower mitigation. “The danger is especially acute for a mentally ill defendant, because the illness sometimes will sometimes result in crimes being committed in a particularly bizarre, brutal or sadistic manner.”¹⁸² Crimes committed by individuals with mental illness might also appear to lack a clear motive, which may generate fear in jurors of similar acts in the future, especially when the state highlights that possibility.¹⁸³

“There is a strong risk that mitigation will not be reliably assessed in cases involving defendants with severe mental illness.”

¹⁷⁸ *Graham v. Florida*, 560 U.S. 48, 78 (2010).

¹⁷⁹ John H. Blume, *Killing the Willing: “Volunteers,” Suicide and Competency*, 103 MICH. L. REV. 939, 942 (2005).

¹⁸⁰ William C. Follette et al., *Mental Health Status and Vulnerability to Police Interrogation Tactics*, 22 CRIM. JUST. (2007), available at http://www.americanbar.org/content/dam/aba/publishing/criminal_justice_section_newsletter/crimjust_cjmag_22_3_mentalhealthstatus.authcheckdam.pdf.

¹⁸¹ Marla Sandys et al., *Aggravation and Mitigation: Findings and Implications*, 37 J. PSYCHIATRY & L. 189 (2009).

¹⁸² Sundby, *supra* note 109, at 522.

¹⁸³ *USA: The Execution of Mentally Ill Offenders, supra*, note 21, at 74.

All of these elements show how and why there is a strong risk that mitigation will not be reliably assessed in cases involving defendants with severe mental illness, and thus that the constitutional requirement of an individualized sentencing will not be met. As in the case of defendants with intellectual disability, the more effective and fairer remedy is a categorical ban on execution of those with severe mental illness.

A Violation of the Equal Protection Clause

In his article *Mental Illness and the Death Penalty*, Professor Christopher Slobogin, a member of the Task Force on Mental Disability and the Death Penalty, explains that “[i]n sharp contrast with the immunity from execution granted children and people with mental retardation, no state prohibits execution of a person who was mentally ill at the time of offense. The Fourteenth Amendment’s injunction requiring equal protection under the law is violated by this difference in treatment because there is no good reason for it.”¹⁸⁴

Professor Slobogin additionally anticipates counter-arguments to this conclusion. One of them is that youth and intellectual disability are easier to identify than mental illness. He argues that SMI is actually easier to diagnose reliably than intellectual disability, but that if courts disagree, the correct response is to place a higher burden on the party alleging that condition.¹⁸⁵ With respect to concern about malingering, he notes that many studies prove that it is difficult to convincingly pretend to have a mental illness.¹⁸⁶ To the argument that severe mental illness can be successfully treated, whereas people with intellectual disability and juveniles do not have that option, Slobogin explains that, as noted earlier, treatment options for those with severe mental illness are limited, and that in any event in all but rare circumstances people with SMI should be held responsible for failing to pursue them. Finally, Slobogin notes that “the base rate for violence among those with mental illness is no greater than the violence base rate for those with mental retardation and is much lower than the violence base rate for youthful offenders,”¹⁸⁷ which renders void the argument that defendants with severe mental illness are more dangerous than the two exempt categories and therefore do not deserve a categorical ban from execution.

In light of all of this, there is no sound constitutional justification for permitting the execution of defendants with severe mental illness while defendants with similar impairments are exempted from capital punishment.

Part IV: Significant Public Policy Concerns

In addition to the legal and constitutional arguments that support the concept of a severe mental illness exemption from the death penalty, there are also additional public policy concerns regarding the use of capital punishment for people with mental illness that should be considered. Some of these issues have been raised by legal and mental health professional organizations, the international community, and some murder victim family members, among others.

Higher Risk of Executing an Innocent Person

One of the most persistent concerns with capital punishment is the imposition of the death penalty on the innocent. Individuals with severe mental illness are especially vulnerable to erroneous convictions. First, they are at a relatively higher risk of making false confessions. Second, once in court, the stigma of mental illness, including popular and unwarranted beliefs that individuals with mental illness are inherently dangerous contribute to assumptions of guilt and more punitive sentencing. Finally, defendants with severe mental illness

¹⁸⁴ Christopher Slobogin, *Mental Illness and the Death Penalty*, 1 CAL. CRIM. L. REV. 3, 7 (2000) (Article provides a detailed analysis of Supreme Court cases dealing with differences of treatment between intellectually disabled and mentally ill people.).

¹⁸⁵ See Christopher Slobogin, *What Atkins Could Mean for People with Mental Illness*, 33 N. M. L. REV. 293, 303-305, 307 (2003) (“When focused solely on gross impairment related to psychosis, studies show a much higher rate of reliability (i.e., agreement between diagnosticians) despite the softness of the criteria, and other research indicates that successful malingering is very difficult.”)

¹⁸⁶ See, e.g., MICHAEL PERLIN, *THE JURISPRUDENCE OF INSANITY*, 238-241 (Carolina Academic Press ed., 1994).

¹⁸⁷ Slobogin, *supra* note 184, at 14.

are less able to participate in their own defense because of their limited abilities, which magnifies the impact of that stigma. This confluence of factors generates an intolerable risk that those suffering from severe mental illness will be convicted and, where the death penalty is an option, sentenced to death and executed.

False confessions are a well-documented phenomenon in general interrogations.¹⁸⁸ Those suffering from mental illness, however, are especially susceptible to confessing to crimes they did not commit, a claim borne out in empirical study. Even more than those without mental illness, they might be unable to appreciate their *Miranda* rights.¹⁸⁹ A 2007 study found that only 10% of individuals with mental illness had a good understanding of *Miranda*.¹⁹⁰ They could therefore be incapable of asking for a lawyer or might feel as though they have no choice but to comply with what officers want. Moreover, because individuals suffering from mental illness frequently are unable to be assertive, they might lack the capacity to invoke their constitutional rights, even if they understand that those rights exist. Abundant empirical evidence demonstrates the increased vulnerability of those with mental illness to false confessions. A 2010 study found that 22% of those with mental illness reported giving a false confession.¹⁹¹ Other measures have demonstrated that persons with mental illness or intellectual disability account for nearly a third of false confessions.¹⁹² While a consistent measure of false confessions in individuals without mental illness in the United States is lacking, a study of European prisoners suggests that this number is between 3 and 14%, far below that of those with mental illness.¹⁹³

Those with mental illness also risk wrongful conviction and execution because their disorder impairs their ability to assist in their own defense, as mentioned earlier. They might be generally unassertive and unwilling to provide vigorous objection to the prosecution's claims. Mental illness can make them poor witnesses in their own case, as they may forget or confuse exculpatory evidence. Their symptoms could also render communication with counsel very difficult, complicating their attorneys' already challenging task of securing an innocent verdict.

Defendants with severe mental illness are more vulnerable to being wrongfully accused and convicted because of their diminished ability to accurately perceive reality and to rationally express their thoughts. A ban on the execution of the individuals with severe mental illness would not prevent wrongful accusations or even convictions, but it would prevent the justice system from "committing the irreparable" against a vulnerable population.

Opposition of Professional Organizations, International Institutions and a Majority of the American Public

The leading legal and mental health professional organizations recommend a ban on the use of capital punishment for those with severe mental illness

As noted earlier, after the U.S. Supreme Court ruled that people with intellectual disability are categorically exempt from the death penalty in 2002, the ABA took an interest in helping ensure there were logical processes for how to actually implement that ruling in the courts. The ABA also recognized that similar legal rationales for excluding those with intellectual disability also equally applied to people with severe mental disorders. The ABA ultimately adopted Resolution 122-A in 2006, urging jurisdictions that impose capital punishment to

¹⁸⁸ See, e.g., Saul M. Kassir, *False Confessions: Causes, Consequences, and Implications for Reform*, 17 CURRENT DIRECTIONS IN PSYCHOL. SCI. 249 (2008).

¹⁸⁹ See Jodi L. Viljoen et al., *An Examination of the Relationship Between Competency to Stand Trial, Competency to Waive Interrogation Rights, and Psychopathology*, 26 LAW & HUM. BEHAV. 481 (2002).

¹⁹⁰ Richard Rogers et al., *Knowing and Intelligent: A Study of Miranda Warnings in Mentally Disordered Defendants*, 31 LAW & HUM. BEHAV. 401 (2007).

¹⁹¹ Allison D. Redlich et al., *Self-Reported False Confessions and False Guilty Pleas Among Offenders with Mental Illness*, 34 LAW & HUM. BEHAV. 79 (2010).

¹⁹² Steven A. Drizin, S. & Richard A. Leo, *The Problem of False Confessions in the Post-DNA World*, 82 N. C. L. REV. 891 (2004).

¹⁹³ Redlich et al., *supra* note 191, at 80.

exempt defendants suffering from severe mental illness from the death penalty.¹⁹⁴ An almost identical policy was adopted within a few months by the American Psychiatric Association, the American Psychological Association and NAMI.¹⁹⁵ In 2011, Mental Health America adopted a similar position.¹⁹⁶ All of these organizations share a common belief that the penological purposes of capital punishment are not met in the case of defendants with severe mental illness, and that these individuals' diminished personal moral culpability should preclude them from being eligible for a death sentence.

Major international institutions and foreign countries that use the death penalty oppose its use in cases of defendants with severe mental illness

Additionally, there is a strong international consensus against the execution of individuals with mental illness. The United Nations (U.N.) Commission on Human Rights has long called for all states that maintain the death penalty “not to impose it on a person suffering from any form of mental disorder; not to execute any such person.”¹⁹⁷ Most recently, the U.N. General Assembly called for those countries that continue to apply the death penalty not to impose it on “persons with mental or intellectual disabilities.”¹⁹⁸

In 2014, two U.N. Human Rights experts urged the U.S. and Texas authorities to halt the execution of Scott Panetti, arguing that, “[i]t is a violation of death penalty safeguards to impose capital punishment on individuals suffering from psychosocial disabilities.”¹⁹⁹ They added that implementing the sentence “may amount to arbitrary execution.”²⁰⁰

For the same occasion, U.N. Special Rapporteur on torture and other cruel, inhuman and degrading treatment or punishment Juan E. Méndez reminded the U.S. that “international law considers the imposition and enforcement of the death penalty on persons with mental disabilities a violation of the prohibition of torture and other cruel, inhuman and degrading treatment or punishment.”²⁰¹

The European Union (E.U.), which condemns the use of the death penalty in general, calls for countries that still maintain executions to comply with certain “minimum standards,” which include a requirement that capital punishment not be imposed on “persons suffering from any mental illness.”²⁰² The reaffirmed this position in a letter to the Texas Board of Pardons and Parole regarding the case of Scott Panetti, discussed earlier.²⁰³ The E.U. wrote that it strongly believes that “the execution of persons suffering from a mental disorder is contrary to widely accepted human rights norms and in contradiction to the minimum standards of human rights set forth in several international human rights instruments”, including U.N. Economic and Social Council resolution 1989/64 and Resolution 2004/94.

¹⁹⁴ *Supra*, note 9.

¹⁹⁵ *Mental Disability and the Death Penalty* (2006), AMERICAN PSYCHOLOGICAL ASSOCIATION COUNCIL POLICY MANUAL, Chapter: IV, <http://www.apa.org/about/policy/chapter-4b.aspx>; *Death Penalty*, NATIONAL ALLIANCE ON MENTAL ILLNESS, <https://www.nami.org/Learn-More/Mental-Health-Public-Policy/Death-Penalty> (last visited Nov. 28, 2016).

¹⁹⁶ *Position Statement 54: Death Penalty and People with Mental Illness*, *supra* note 73.

¹⁹⁷ *Commission on Human Rights Resolution 2000/65 The question of the death penalty*, UN COMMISSION ON HUMAN RIGHTS (Apr. 27, 2000), <http://www.refworld.org/docid/3b00f29a14.html> (last visited Nov. 28, 2016), this was reiterated in two further resolutions in 2004 and 2005:

Commission on Human Rights Resolution 2004/67 The question of the death penalty, UN COMMISSION ON HUMAN RIGHTS (Apr. 21, 2004) and *Human Rights Resolution 2005/59 The question of the Death Penalty*, UN COMMISSION ON HUMAN RIGHTS (Apr. 20, 2005).

¹⁹⁸ G.A. Res. 69/186, ¶ 5(d) (Feb. 4, 2015), http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/69/186 (last visited Nov. 28, 2016).

¹⁹⁹ *Death row: UN expert urge US authorities to stop execution of Scott Panetti, a mentally ill prisoner*, UNITED NATIONAL HUMAN RIGHTS OFFICE OF THE HIGH COMMISSIONER (Dec. 2, 2014), <http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=15369&LangID=E> (last visited Nov. 28, 2016).

²⁰⁰ *Id.*

²⁰¹ *Id.*

²⁰² See Council Common Guidelines on Death Penalty (EU). No.8416/13 Annex of 12 Apr.2013 at 5, <http://data.consilium.europa.eu/doc/document/ST-8416-2013-INIT/en/pdf> (stating the European Union's policy on the death penalty).

²⁰³ *Letter from EU Presidency to Texas Board of Pardons and Parole*, DELEGATION OF THE EUROPEAN UNION TO THE UNITED STATES (Jan. 15, 2004), <http://www.euintheus.org/what-we-do/policy-areas/democracy-and-human-rights/torture-and-capital-punishment/death-penalty/death-penalty-archive-2004/> (last visited Nov. 28, 2016).

The Council of Europe, an organization independent from the E.U. and comprised of 45 member states, has also expressed its opposition to the use of capital punishment for people with severe mental illness. In welcoming the decision of a U.S. federal court of appeal to stay Scott Panetti's execution, the Council of Europe's General rapporteur declared: "While the Council of Europe is against the death penalty in all circumstances, it must be underlined that executing persons suffering from severe mental illnesses constitutes a violation of international human rights law, and it is also a breach of the Eighth Amendment to the United States Constitution."²⁰⁴

In 2014, the World and European Day Against the Death Penalty was specifically focused on ensuring that all states using the death penalty prohibit it for persons with mental health issues.²⁰⁵ The World Coalition Against the Death Penalty recommended at this occasion that there be an "immediate implementation of existing standards barring the imposition of death sentences or executions on [...] who are seriously mentally ill" and called for renewed efforts to "(i) ensure that all states have laws that embed international protections in their domestic legislation; (ii) extend protection to those with serious mental illness not covered by existing proscriptions against executing persons affected by 'insanity.'"²⁰⁶

The Inter-American Commission on Human Rights (IACHR), a principal and autonomous human rights body representing the thirty-five countries making up the Organization of American States, also stated in deciding the case of *Lackey v. United States*, that "[i]t is a principle of international law that persons with mental disabilities, either at the time of the commission of the crime or during trial, cannot be sentenced to the death penalty."²⁰⁷

The general public favors a severe mental illness exemption

Finally, the people in the United States are also strongly in favor of an exemption from the death penalty for those with severe mental illness. A 2015 national poll found that 66% of voters support such a severe mental illness exemption.²⁰⁸ After hearing further details about how the proposed exemption would work, support for the exemption rises to 72%. The poll also shows that support for the exemption is consistent across party lines: indeed, 62% of Republicans, 72% of Democrats and 67% of Independents oppose the use of the death penalty for persons with mental illness. While Americans remains divided on the issue of the death penalty as a whole, they agree by a wide margin that our society should not execute those with severe mental illness.

The United States' continued sanctioning of the execution of those with severe mental illness is out of step with the consensus of many important and relevant stakeholders: legal and mental health professional organizations, major international institutions and even a majority of the American public.

Perspectives of Some Murder Victims' Families

In 2009, Murder Victims' Families for Human Rights (MVFHR) and NAMI co-published "Double Tragedies," a report of a group of "families of victims killed by persons suffering from severe mental illness, who oppose the death penalty in these cases...[and whose] reasons for opposing the death penalty should be part of the public

²⁰⁴ *General rapporteur welcomes the decision to stay the execution of Scott Panetti*, PARLIAMENTARY ASSEMBLY (Dec. 5, 2014), <http://assembly.coe.int/nw/xml/News/News-View-en.asp?newsid=5334&lang=2>.

²⁰⁵ *12th World Day Against the Death Penalty: Mental Health*, WORLD COALITION AGAINST THE DEATH PENALTY, <http://www.worldcoalition.org/worldday2014.html> (last visited Nov. 28, 2016).

²⁰⁶ *Id.*

²⁰⁷ See Cases 11.575, 12.333 & 12.341, INTER-AM. C.H.R., Report No. 52/13 (2013). For further discussion of the death penalty and mental illness in international human rights law, see Richard J. Wilson, *The Death Penalty and Mental Illness in International Human Rights Law: Toward Abolition*, 73 (2) WASHINGTON AND LEE LAW REVIEW (Summer 2016).

²⁰⁸ *Multi-State Voter Survey: Death Penalty and Mental Illness*, Survey conducted: November 30th – December 7th, 2015, DAVID BINDER RESEARCH (2015).

conversation.”²⁰⁹ The report also aimed to include the families of individuals with mental illness who were executed, to allow them to share their “repeated, and thwarted, efforts to get treatment for their relatives with mental illnesses” and to show that “prevention, not execution” is an effective way of addressing violence.

The report argues that “the death penalty is not only inappropriate and unwarranted for persons with severe mental illness but that it also serves as a distraction from problems within the mental health system that contributed or even led directly to tragic violence.”²¹⁰ Both groups believe that seeking or imposing the death penalty diverts resources and energy that could be better used to address mental health issues in the community, to decrease the likelihood of violence, or help families heal through psychological and material support.

Murder victims’ families have many questions when they lose a loved one to the violence of a person with severe mental illness, including whether the crime could have been prevented. As Amnesty International reported, “[i]n some cases involving mentally impaired defendants, there are indications that individuals within wider society failed to heed warnings that could have averted a tragedy. This is not to suggest that crimes committed by mentally impaired people are to be condoned or excused. It is, however, to ask whether society could devote its energies and resources more constructively.”²¹¹

The MVFHR/NAMI report highlights the stories of family members who lost loved ones to murders committed by a person with severe mental illness. For example, one mother, Pat Webdale, lost her daughter Kendra as she was pushed under New York subway tracks by Andrew Goldstein, a man diagnosed with schizophrenia. They later learned that he had been convicted of assault 13 times prior to this fatal assault and wondered why nothing was done to stop this pattern.²¹² In another case in Florida, Linda Gregory, the wife of Deputy Sheriff Gene Gregory, recalls first learning about mental illness after her husband was murdered by Alan Singletary, a man with a mental health disorder.²¹³ That defendant’s family wrote her a letter explaining how they had not been able to get the help they wanted and how they knew something like this would eventually happen. The warning signs had been numerous, but ignored.

This unique report also takes into account the point of view of family members of capital defendants with mental illness. Tina Morris recalls how her brother James Colburn suffered from very severe hallucinations throughout his life, and how despite the family using all of their savings and trying to get all the help they could for him, he never got sufficient treatment and attention, largely because his family could not afford it anymore. Lois Robison, the mother of Larry Robison, a man with mental illness recalls how her son would be discharged from each hospital after 30 days because he was not determined to be violent. The options for care eventually ran out, and he murdered five people. He went from being discharged from the hospital for not being violent directly to death row.²¹⁴

“His last statement was, ‘I won’t be a part of the problem no more.’ He looked over at the victim’s family and apologized. I sat there and watched him take his last breath, and that will be a memory that I’ll never forget. Watching my brother be executed was the hardest thing I ever, ever had to do in my life. ... I don’t understand how they can execute mentally ill people when they don’t try to treat them first.”

Tina Morris, James Colburn’s sister

The murder victims’ families and families of individuals with severe mental illness on death row whose experiences were highlighted in the MVFHR/NAMI report agree that

²⁰⁹ *Double Tragedies, Victims Speak Out Against the Death Penalty For People with Severe Mental Illness*, MURDER VICTIM’S FAMILIES FOR HUMAN RIGHTS, NATIONAL ALLIANCE ON MENTAL ILLNESS, at 2 (2009), <http://www.deathpenaltyinfo.org/files/DoubleTragedies.pdf>. It is important to note here that the views of murder victims’ families on the death penalty are extremely varied, and that the view expressed in “Double Tragedies” only reflects the opinion of some of them.

²¹⁰ *Id.* at 3.

²¹¹ *USA: The Execution of Mentally Ill Offenders*, *supra*, note 21 at 56.

²¹² *Double Tragedies, Victims Speak out Against the Death Penalty for People with Severe Mental Illness*, *supra* note 209 at 4.

²¹³ *Id.* at 5.

²¹⁴ *Id.* at 9.

treatment and prevention are urgently required to diminish the likelihood that such tragic events occur. Although they cannot and do not purport to speak for all victims' families, for them, the death penalty does nothing to address this need, it even diverts resources from it. Further, capital punishment is inadequate for people who are paranoid, delusional, suffer from hallucinations or consequences of war trauma or other symptoms of severe mental illness.

Conclusion

The death penalty, the ultimate punishment reserved for the most blameworthy who commit the worst actions, does not serve any purpose when it is applied to individuals with severe mental illness. Capital punishment is unlikely to deter individuals with severe mental illness, and it does not serve any retributive purpose for those whose impairments significantly interfere with their ability to appreciate the nature, consequences or wrongfulness of their conduct, to exercise rational judgment in relation to conduct, or to conform their conduct to the requirements of the law. The Supreme Court has already recognized that there are categories of individuals – individuals with intellectual disability and juveniles – that are inherently “less culpable” to the point that it is unconstitutional to apply the death penalty in their cases. The Court based its reasoning on an “independent analysis” of these individuals’ impairments, which are strikingly similar to the impairments brought about by severe mental illness.

In addition, and contrary to popular belief, current mechanisms in the criminal justice process do not adequately protect defendants with severe mental illness against death sentences and executions. While mental illness may be a factor in various respects before, during and after trial, none of the current mechanisms afford complete protection against the death penalty to those diagnosed with serious mental disorders or disabilities. Examples such as those of Scott Panetti and Kelsey Patterson, two individuals diagnosed with paranoid schizophrenia sentenced to death, demonstrate that individuals who have a severe mental illness and whose capacity to appreciate the wrongfulness of their actions is significantly impaired are still capable of being executed in the United States.

However, a growing consensus is emerging against this practice. The general public, major legal and mental health organizations, some state appellate judges, some murder victim’s family members, and international institutions have all made their voice heard in opposition to the death penalty for individuals with severe mental illness. The American Bar Association’s Mental Illness Initiative will continue to work to educate legal professionals, policy makers, and the public on this important and timely subject and to support policy reform efforts to exempt individuals with severe mental illness from the death penalty.

Acknowledgements

The Death Penalty Due Process Review Project would like to thank Mental Illness Initiative Fellow Aurélie Tabuteau Mangels for her primary authorship of this paper.

The Project also extends its sincere appreciation to Vincent Atchity, Lauren Beebe King, Tanya Greene, Kirk Heilbrun, Kristin Houlé, Alli Kielsgard, Kristen Nelson, Kimberly Rosenfeld, Meredith Martin Rountree, Christopher Slobogin, Russell Stetler, Ronald Tabak, and Misty Thomas for their careful reviews and helpful feedback. Additionally, the Project would also like to recognize former ABA interns and law clerks Anissa Badea, Anthony Sampson, Gretchen Shumaker, Ash Smith, and Alexandra Stephens for their varied contributions to the paper. Finally, we thank the Proteus Fund and the Eighth Amendment Project for their continued support of the Project's work on mental illness and the death penalty.

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