Mental Illness and the Death Penalty in North Carolina

A DIAGNOSTIC APPROACH

"If your office and the court need something constructive to do, aid the Attorney Generals Office in preparing my settlement of two hundred and fifty million dollars and then contact me when you actually have something meaningful to discuss... I honestly don't know who's or what kind of fool you people take me for but hang around and receive some of my rath... I am the brick wall which doesn't crumble for cornballs, have a nice day... Close your eyes and repeat three times: Beetlejuice, Beetlejuice, Beetlejuice... In the courtroom... I will bring you to your knees and make you proclaim me Lord and Master... The longer you elude me the more fire I set under your feet... Lucifer"

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COVER | *Excerpts written by Guy T. LeGrande in multiple correspondences with his attorneys, court officials, and the North Carolina Supreme Court.*

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STATE ROAD 63
JUSTICE DRIVE

Introduction by Dean Gene Clark

Significant numbers of individuals with serious mental illnesses are housed in North Carolina jails and prisons today. This is so despite the accepted fact that people with severe and debilitating mental illness are considered to be less responsible for their actions than those without such impairments, even when those actions violate the basic tenets of civil society. This acknowledged truth has been as true for those who commit murders as for those who behave inappropriately without committing violent crimes. Drawing from precedents that date back to the ancient Greeks and have been reinforced through the centuries, state and federal laws in the United States have consistently recognized that people who have less capacity to control their behavior by virtue of serious mental disabilities should not be subject to the same sanctions as those without such impairments.

The concept of treating individuals with serious mental illnesses differently under the law also carries over to our nation's death penalty laws, at least to a limited extent. Most states categorically exempt the execution of people who are considered legally insane at the time of the crime. Other laws prohibit the execution of mentally ill defendants who are deemed incompetent under specific criteria that have been developed over the years, both legislatively and by the courts.

Although mental illness has long been considered a factor in determining the ultimate sanction imposed, and despite safeguards designed to prevent the execution of a defendant deemed insane, severe mental illness among prisoners on death row is pervasive. Though definitive statistics have not been compiled, the National Mental Health Association has estimated that 5 to 10 percent of the U.S. death row population has serious mental illness.[1] The Dallas Morning News reported in 1997 that one-third of the 602 death row inmates nationwide who responded to the newspaper's questionnaire had been treated for psychiatric problems. International studies of people convicted of murder support these figures.[2]

In an effort to engender further debate about mental illness and the death penalty in North Carolina, and with an eye toward working on practicable solutions, the Charlotte School of Law convened a symposium on October 20, 2006 called *Mental Illness and the Death Penalty: Seeking a 'Reasoned Moral Response' to an Unavoidable Condition*. [APPENDIX 5] The symposium brought together judges, mental health experts, attorneys, prosecutors and other experts in a series of panel discussions that covered an array of legal and mental health topics. This report both draws from and supplements the information and ideas presented at the symposium. By assembling both the concerns and promising ideas offered at the symposium, this report is intended to provide a foundation for future discussions.

While no comprehensive analysis presently exists in North Carolina, court records and other evidence conclusively show that severely mentally ill people are currently on death row and have been executed in North Carolina. For example, James David Rich received multiple diagnoses of mental illness dating back to his child-

hood. These diagnoses included bipolar disorder with psychotic features, major depression, and schizoaffective disorder. Rich was involuntarily committed to state mental hospitals on several occasions, attempted suicide a number of times, and was prescribed more than 20 different psychotropic medications over the years. Notwithstanding this tortured mental health history, Rich was executed in 1999.

Another death row inmate, Guy LeGrande, was committed to a state hospital before his 1995 death penalty trial after exhibiting behavior that pointed to serious mental and emotional disturbances. Despite these disturbances, LeGrande was allowed to represent himself during his capital trial. LeGrande's jury never heard the extensive evidence of his psychosis, which manifested itself during his trial in bizarre and self-destructive ways. LeGrande was sentenced to death, although his execution was stayed by the courts in November 2006 until his mental health condition could be further evaluated.

Other examples of serious mental illness affecting those who have wound up on North Carolina's death row are both numerous and well documented. Former North Carolina Supreme Court Chief Justice Burley Mitchell — currently a valued member of the Charlotte School of Law Board of Directors — agrees that the high number of mentally ill prisoners on death row should be of concern to policy makers. Justice Mitchell, who reviewed numerous death penalty cases during more than 30 years as a prosecutor and jurist, notes

> I have had a chance to watch the interplay between mental illness, violence and the death penalty, and in most cases, all three elements are present [and] there is some form of mental problem on the defendant's part. And it is a true problem for a state that is going to impose the extreme punishment.[3]

This report seeks to examine the "true problem" that Justice Mitchell identifies — mental illness and the death penalty — and provide a foundation for constructive dialogue on this fiercely contested topic.

The challenging issue of mental illness in the criminal justice system has been confronted repeatedly over many years by courts, legislators, mental health professionals, corrections officials and others, both in North Carolina as well as throughout the United States. Balancing the state's legitimate interests in public safety, punishment, and deterrence, on the one hand, with a comprehensive understanding of mental illness, its effect on individual behavior, and the particular needs of those with mental disabilities, on the other, has been at the crux of this struggle. Political considerations as well as public misperceptions about the nature of mental illness have compounded the inability of stakeholders to reach agreement on how to address this issue fairly and consistently, especially when it comes to the highly charged topic of capital punishment.

As this report lays bare, entrenched obstacles within the criminal justice system impede efforts to recognize those with severe mental illness and to treat them fairly. As detailed in this report, these obstacles include the fact that:

• mentally ill offenders, because of their impairments, often undermine their own defenses in a variety of ways that contribute directly to their convictions, death sentences and executions.

• although state law exclusively defines mental illness as a mitigating factor for sentencing purposes, juries often perceive mental illness as an aggravating (rather than mitigating) factor.

• the law governing mental illness in the context of the death penalty does not often align itself with clinical realities; thus mental health experts must often answer legal questions that do not conform to their medical analyses.

The debate over whether to rethink the imposition of the death penalty for severely mentally ill offenders has been engaged nationally and is escalating. The American Bar Association (ABA) convened a committee to address the issue in 2003, which included representatives from the major mental health organizations in the United States, such as the American Psychological Association, the American Psychiatric Association and the National Alliance on Mental Illness. The committee's subsequent report recommended that those with severe mental illness be exempted from the death penalty, and included a resolution which was adopted in 2006 by the ABA House of Delegates, and in almost identical form by various mental health organizations. The report also included model reform legislation. [APPENDICES 1–4] Based on the ABA resolution, legislation has been introduced in North Carolina, as well as Indiana and Washington, to bar the execution of those with severe mental illness.

Recognition of this issue has also manifested within the executive and judicial branches of our government. Over the past several years, a handful of death sentences have been commuted due to concerns about executing mentally ill offenders.[4] Most recently, in December 2006, Virginia Governor Timothy Kaine delayed the execution of Percy Walton for 18 months due to his concerns about Walton's mental status.[5] Numerous courts have also stayed executions pending additional mental health evaluations, just as in North Carolina in the case of Guy LeGrande in November 2006. And on April 18, 2007, the United States Supreme Court heard oral argument in *Panetti v. Quarterman*, a case to determine whether executing an indisputably delusional and schizophrenic Texas inmate would be unconstitutional.[6]

FOLLOWING NUMEROUS STUDIES AND EXTENDED DEBATE, THE ABA AND LEADING MENTAL HEALTH ORGANIZATIONS HAVE ADOPTED RESOLUTIONS TO BAR THE EXECUTION OF THOSE WITH SEVERE MENTAL ILLNESS.

Perhaps most significantly, the debate concerning whether to exclude individuals with severe mental illnesses from eligibility for the death penalty centers on the fact that the two primary justifications explicitly recognized by the United States Supreme Court for applying the death penalty — retribution and deterrence — are arguably not furthered by executing people with severe mental illness. Aspects of these considerations are found in two recent Supreme Court decisions which banned the death penalty for mentally retarded defendants and those who were under the age of 18 at the time of their crimes.[7] Those decisions may offer a compelling rationale for expanding exemptions to include the class of defendants with severe mental illness.

Additionally, in certain narrow respects, new approaches toward understanding the intersection between mental illness and crime have evolved to match a growing scientific and social consensus. The creation in some locales of diversion programs for mentally ill offenders of lesser crimes, community- and institution-based treatment options, and other advances have improved the ability of the criminal justice system to protect the public

while enhancing the element of fairness that is so fundamental to American jurisprudence. These changes, though not yet widespread, have come in response to an appreciation of the fact that mentally ill offenders, by virtue of their impairments, deserve special consideration when assessing culpability and determining an appropriate punishment.

The Charlotte School of Law considers this correlation between serious mental illness and the ultimate criminal punishment an important and pressing issue of public policy for North Carolina and for the nation. Charlotte Law was motivated by the importance of this topic to make it the subject of the first substantive symposium during the school's inaugural year. It is our hope that this report will continue the dialogue initiated by the symposium.

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Conceptualizing Mental Illness

DEFINING SEVERE MENTAL ILLNESS

Although the essential characteristics of severe mental illness have been recorded and dissected in the annals of social and medical science for centuries, defining mental illness is a complex business, and the science of mental illness is an evolving field with many significant advances in recent decades.

Most mental illnesses cannot be identified physiologically, *i.e.*, with blood tests or brain scans (though some associations are now being made between structural brain abnormalities and mental disabilities). Instead, mental health professionals consider a host of observable and testable criteria when rendering their opinions.

According to the *Diagnostic and Statistical Manual of Mental Disorders*, which is the manual used most often in diagnosing mental illness, a mental disorder is defined as

> a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significant increased risk of suffering death, pain, disability, or an important loss of freedom. . . . Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual.[8]

The *Diagnostic and Statistical Manual of Mental Disorders*, presently in its fourth revised edition (hereinafter referred to as DSM-IV-TR), organizes psychiatric diagnosis into five axes:

AXIS I clinical disorders, including major mental disorders, as well as developmental and learning disorders
AXIS II underlying pervasive or personality conditions, as well as mental retardation
AXIS III medical conditions which may be relevant to the understanding and treatment of the mental disorder
AXIS IV psychosocial and environmental factors contributing to the disorder
AXIS V Global Assessment of Functioning (on a scale from 100 to 0)

The DSM-IV-TR's multi-axial system attempts to yield a more complete and holistic picture of the patient, rather than just a simple diagnosis. A more fulsome analytical system is needed because people sharing the same diagnosis may not have the same etiology (cause) or require the same treatment. Indeed, it is for this reason that the DSM-IV-TR contains no information on treatment or cause.

Common Axis I disorders include depression, anxiety disorders, bipolar disorder, attention deficit hyper-

PHILLIP LEE INGLE

Phillip Ingle was executed in 1995 for the murders of Fred and Margaret Davis in Rutherford County and E.Z. and Sarah Willis in Gaston County. Beset by frequent hallucinations, Ingle saw his victims as demons with red skin, horns and tails. Though a State's expert declared him competent, three other psychiatrists diagnosed him as a paranoid schizophrenic prone to psychotic breaks who did not know the difference between right and wrong at the time of the murders.

Between the two crimes, Ingle was committed to a state mental institution after he was found lying down at night in the middle of a highway wearing dark clothes. An emergency room physician noted that Ingle "says he will kill himself somehow" and was "wanting treatment and willing to do anything to get it." Ingle was discharged that same day.

Ingle had a well-documented history of suicide attempts and debilitating mental illness dating to his childhood. His first suicide attempt occurred at age five when he attempted to hang himself and had to be cut down. Beginning at age 15, various medical reports chronicle such delusions as hearing flowers talking to him, communicating with flying saucers and believing that others could read his mind. At age 19, he shot himself in the stomach with a .22 caliber rifle; several years later, he drove his car into a parked vehicle at 50 miles an hour. Ingle was committed to several institutions in the 1980s; he left one state facility against medical advice. His diagnoses included schizoaffective disorder, schizophrenia with bipolar features and dysthymia.

Mental illness ran in Ingle's family. Both his parents were diagnosed with paranoid schizophrenia, and Ingle's mother repeatedly attempted suicide. Once, she held a gun to her head, threatening to kill herself and her children while Ingle's father was passed out drunk in another room. Another time, Ingle came home from school and found his mother on the living room floor, covered with blood, her wrists slashed.

While in prison, Ingle frequently heard voices and reported that he heard a television admonishing him for being bad. His recollection of the crimes was vague, though he said that demons "had been after me for awhile," and that he had heard them saying "I got you" in low, slow voices emanating from a television. Ingle frequently invoked Lucifer and believed that the devil was out to get him. On one psychological test he took three different times, Ingle's answers were so extreme that a psychiatrist noted such results "are generally assumed to be invalid because anyone so disturbed would be unable to take the test." Ingle's profile, he wrote, "indicates a very significant psychosis."

Though trial counsel mounted an insanity defense, it hinged entirely on the testimony of a single doctor. The jury never heard the bulk of Ingle's mental health history, and sentenced him to death.

After his conviction, Ingle alternated between pursuing and rejecting post-conviction remedies, but ultimately fired his attorneys, waived further appeals and volunteered for execution. Though the State argued that he was acting rationally and was not exercising a death wish, Ingle himself stated in court during his competency hearing on the matter that he was seeking a "State-assisted suicide." The court obliged, and Ingle was executed on September 22, 1995.

activity disorder, and schizophrenia. Common Axis II disorders include borderline personality disorder, schizotypal personality disorder, antisocial personality disorder, narcissistic personality disorder, and mild mental retardation.

Both Axis I and Axis II include disorders that are the most debilitating. Among the symptoms the DSM-IV-TR associates with schizophrenia (Axis I), for example, are delusions, hallucinations, grossly disorganized behavior and structural brain abnormalities.

THE LINK BETWEEN MENTAL ILLNESS AND VIOLENCE

Mental health advocates have long fought to destigmatize mental illness, in particular to dispel the misperception that people with mental disabilities are, individually and collectively, more violent and "dangerous" than those who are not mentally ill. If anything, studies consistently demonstrate that mentally ill individuals are more likely to be the victims rather than the perpetrators of violence.[9]

Nevertheless, a growing body of research indicates that a relationship between violence and mental illness does exist. A study released in November 2006, for example, showed that patients with one of three identified serious mental illnesses—those with schizophrenia, major depression, or bipolar disorder—were two to three times as likely as people without such an illness to be assaultive.[10] The study noted that not all types of psychiatric illness are associated with violence, and that most people with the disorders associated with assault do not commit assaultive acts. But the presence of those disorders was significantly associated with an increased risk of violence.[11]

The correlation between violence and mental illness does not boil down to a particular diagnosis. Rather, it depends on a combination of interrelated elements, both organic and environmental, and what mental health professionals call "risk factors." Dr. Peter Barboriak, Medical Director of Forensic Psychiatric Services at Dorothea Dix Hospital in Raleigh, says that research on the link between violence and people with mental illness reveals "a very complex situation with a lot of factors being involved.... The more [risk factors] they have, the higher the risk of violence."[12] One Duke University study of violent behavior in people with schizophrenia, for example, found that violent behavior among the subjects was closely associated with factors such as psychotic and depressive symptoms, victimization and childhood conduct problems.[13] Co-occurring substance abuse has also been frequently associated with increasing the risk of violence among the mentally ill population.[14]

Research shows that combinations of risk factors are commonly found among death row inmates or those who have committed murder. A widely cited 1986 study of 15 death-row inmates in the United States reported that each of the inmates had experienced a severe head injury in childhood, and that their diagnoses included schizophrenia, chronic psychosis and bipolar disorder. The study's authors concluded that many condemned individuals probably suffer unrecognized severe psychiatric, neurological, and cognitive disorders.[15]

Anecdotal evidence from mental health professionals and the legal community further bolsters these findings. "In my experience, an overwhelming majority of the people that we see on various death rows around the country really don't have a psychiatric disorder," says Dr. Richard Dudley, a clinical and forensic psychiatrist who has evaluated numerous capital defendants. "They have *multiple* problems that are coming into play at the same time."[16]

Dr. Dudley's observations are echoed by former North Carolina Superior Court Judge Shirley L. Fulton. "The overwhelming number of people on death row have multiple risk factors," Judge Fulton says. "They generally have not had one psychiatric disorder, but have multiple disorders."[17]

Impeding efforts to examine the intersection between mental illness and violent crimes is the fact that most people who commit violent crimes have a history of mental illness that was undiagnosed and/or untreated. The failure of the mental health and criminal justice systems to deal appropriately with mental health problems (resulting in large measure from a chronic and overwhelming lack of resources) is well documented. The President's New Freedom Commission on Mental Health, one of the many authorities which has investigated the mental health care system in America, has called the nation's mental health system a badly fragmented "system in shambles."[18]

The consequences of failing to address severe mental illness proactively are graphically illustrated by the case of David Lynch, who was convicted and sentenced to death in North Carolina in 1993. Several months prior to the crimes, Lynch, a Navy veteran and devout Christian with no prior criminal record, voluntarily admitted himself to a psychiatric hospital following a suicide attempt. He told his examiners that he had considered killing himself and others, that he heard persistent sounds that others did not, and that he felt persecuted by his neighbors. Doctors concluded that he was merely depressed, prescribed Prozac and discharged him after two weeks.[19] Lynch subsequently committed a double murder in Gaston County and remains on North Carolina's death row.

Further, it should be no surprise that a dysfunctional system disproportionately affects society's most marginalized citizens. According to the American Psychiatric Association, "People 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."[20]

Judge Fulton saw this revolving door in action during more than 20 years as a prosecutor and judge. "Courts would put a Band-Aid on the problem, and send [mentally ill offenders] back into the community," she says. "Somebody comes in, you send them back out, then they come back again and again and again until we get a crime like murder. And by then it's almost too late to address the real issue, which has been some kind of mental illness all along."[21]

SEVERE MENTAL ILLNESS IN THE LEGAL CONTEXT

The prevalence of mental illness in the nation's prisons and jails has confounded the ability of stakeholders to manage the issue consistently and equitably. Various estimates have suggested the total number of U.S. inmates with severe mental illness to be as high as 285,000.[22] A 1999 Bureau of Justice Statistics report revealed that 16 percent of all inmates in state and federal jails and prisons have schizophrenia, manic depressive illness (bipolar disorder), major depression, or another severe mental illness.[23] In North Carolina, an estimated 23,000 adults with mental illness are under the supervision of the Department of Corrections: about 5,000 incarcerated in state prisons and 18,000 on probation or parole.[24]

Effectively explaining the relevance (not to mention the many aspects) of mental illness in a criminal jus-

tice proceeding can be challenging even for professionals charged with the task. Dr. Faye Sultan, a clinical psychologist who directs University Psychological Associates in Charlotte, accurately summarizes the problem: "The reality is, when I appear as an expert witness, my job is to try to explain how the mental illness of the person on trial actually might have affected him or her. It's not easy to explain, and it's certainly not easy for me to communicate to a jury."[25]

This communication challenge results, in part at least, from the fact that the criminal justice system asks mental health experts to discuss mental illness in ways that do not always align with clinical realities. Legal standards that demand "factual understanding" by the defendant or "capacity to form intent" do not necessarily fit well into a clinical model. "These legal questions are not scientific," says Dr. Barboriak. "The way the law looks at [mental illness] may be based on 18th century concepts, or concepts that don't jibe very well with science. In general, the law wants things to be very straightforward, black and white."[26]

"COURTS WOULD PUT A BAND-AID ON THE PROBLEM, AND SEND [MENTALLY ILL OFFENDERS] BACK INTO THE COMMUNITY," SAYS JUDGE SHIRLEY FULTON. "SOMEBODY COMES IN, YOU SEND THEM BACK OUT, THEN THEY COME BACK AGAIN AND AGAIN AND AGAIN UNTIL WE GET A CRIME LIKE MURDER."

Dr. Dudley agrees that the law often asks mental health professionals to "say things that have no reality in the world of people who are actually treating, evaluating and working with people who are mentally ill. There's a certain disconnect between the mental health system and the criminal justice system that makes addressing some of these issues more difficult. It's a challenge for mental health professionals to hone things down and fit things into the boxes that we're given."[27]

One clear example of this can be found in the concept of insanity, a defense available in most states to criminal defendants with mental disorders. As many observers have noted, insanity is a purely legal construct based on individualistic and subjective assessments, not scientific criteria.[28] And that construct varies from state to state; different standards are used to define insanity in different jurisdictions. Thus, insanity is defined not by a nationally accepted set of criteria (*e.g.*, DSM-IV-TR), but rather how a particular jurisdiction legislated its insanity law. As one mental health professional explains, "As a result, a defendant may be considered insane in one jurisdiction but not in another even though she or he performed the same action with the same mental condition."[29]

In a cautionary disclaimer, the DSM-IV-TR explicitly recognizes this disconnect in its introduction: "The purpose of DSM-IV-TR is to provide clear descriptions of diagnostic categories in order to enable clinicians and investigators to diagnose, communicate about, study, and treat people with various mental disorders. It is to be understood that inclusion here, for clinical and research purposes, of a diagnostic category . . . does not imply that the condition meets legal or other non-medical criteria for what constitutes mental disease, mental disorder, or mental disability."

From a practical standpoint, this divergence between science and the law means that judges, juries, prose-

cutors and defense lawyers are at a disadvantage from the outset of any criminal proceeding that involves a defendant with a mental disability. The chances that each party will fully grasp the many issues that attend mental illness are slim, yet they all must make decisions at each step of the process based on what are often imperfect translations of, and connections between, medical concepts and the law.

This is particularly troublesome in a matter of life and death, when a single misinterpretation of data or misapplication of the law can result in an irreversible injustice. "We know a lot about how a combination of disabilities can contribute to very horrible behavior," says Dr. Dudley. "Whether that ever really gets understood in the context of any particular case is often something that I don't think ever really happens."[30]

The National Mental Health Association highlighted this concern in its position statement on the death penalty and mental illness. Given the vagaries of the law, the statement concludes, "our current system of fact-finding in capital cases [sometimes] fails to identify who among those convicted and sentenced to death has a mental illness."[31]

Legal Considerations of Mental Illness in North Carolina Capital Cases

Public perception of mental illness in the criminal justice system has been shaped primarily by infamous high-profile cases, such as the case of John Hinckley, who was acquitted in 1982 by reason of insanity of shooting President Ronald Reagan, press secretary James Brady, secret service agent Timothy McCarthy and police officer Thomas Delahanty.[32] Such cases, in which the defendants are often viewed as "getting off" for their crimes, have resulted in public outrage, as well as actions by legislators to limit or even eliminate the ability of defendants to claim insanity as a defense.[33]

Public antipathy toward the insanity defense is based partly on the misperception that someone found insane will promptly be returned to the community to endanger the public. As one study noted, "This deeply held notion is usually incorrect, because defendants found insane, especially those who commit violent crimes, often spend more time behind walls than if they had been tried and found guilty and given a standard sentence with a length predetermined by statute."[34]

Moreover, the insanity defense is rarely used in criminal cases: Less than four percent of defendants nationwide raise the insanity defense, and the defense is successful in less than one percent of those cases. The same study concluded, "The amount of public outcry is thus vastly out of proportion to the actual volume of such cases relative to all criminal cases."[35]

To be sure, the insanity defense is merely one way that a defendant's mental illness is relevant to a criminal case. Indeed, considerations of a defendant's mental condition can occur throughout the criminal justice process and in a variety of ways:

THE INSANITY DEFENSE

Insanity is an affirmative criminal defense in North Carolina, as in most states, meaning that a defendant's culpability can be excused or limited even if the factual allegations of the crime are admitted or proved. Pleas of insanity must be filed in a timely manner, pursuant to applicable state statutes. A possible verdict of Not Guilty by Reason of Insanity (NGRI) may be rendered by either a judge or a jury.

The foundation of the insanity defense in North Carolina dates back to 1843 and the case of Daniel M'Naghten, a paranoid schizophrenic who murdered the Secretary to the British Prime Minister. M'Naghten was acquitted on the grounds that he was insane at the time of the crime. Public outrage over the verdict spurred the English House of Lords to establish a new standard for insanity, which became known as the *M'Naghten Rule*. According to this standard, "every man is presumed to be sane, and to possess a sufficient degree of reason to be responsible for his crimes, until the contrary be proved to [the court's] satisfaction… [T]o establish a defense on

the grounds of insanity, it must be clearly proved that at the time of committing the act, the party (accused) was laboring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing, or as not to know that what he was doing was wrong."

Though there is no statutory definition of insanity, North Carolina case law has firmly established the *M'Naghten Rule* as the standard by which insanity is judged in this state. The North Carolina Court of Appeals, for example, reaffirmed the *M'Naghten Rule* in 1996: "A defendant in North Carolina can be exempt from criminal responsibility for an act by reason of insanity, if he is able to prove that at the time of the offense, 'he was laboring under such a defect of reason from disease or deficiency of mind as to be incapable of knowing the nature and quality of his act or, if he did know this, of distinguishing between right and wrong in relation to the act.'"[36]

"THEY MADE A STANDARD THAT WAS ACTUALLY FAIRLY DIFFICULT FOR PEOPLE TO MEET," SAYS DR. PETER BARBORIAK. "THAT HAS NOTHING TO DO WITH PSYCHIATRY, IT HAS NOTHING TO DO WITH PSYCHOLOGY. THAT'S NOT SCIENCE."

The *M'Naghten Rule*, and the test it articulates, has often been criticized by mental health professionals because its narrowness and inflexibility makes obtaining legitimate NGRI verdicts nearly impossible. More importantly, however, the test is divorced from the actual study of mental illness. "They made a standard that was actually fairly difficult for people to meet," says Dr. Barboriak. "That has nothing to do with psychiatry, it has nothing to do with psychology. That's not science. That's just a social, political decision that's made."[37]

For example, the *M'Naghten Rule* fails to recognize elements such as compulsion or other volitional factors that may contribute to a defendant's mental incapacity. To address these shortcomings, some jurisdictions, including federal courts, adopted what is generally known as the Irresistible Impulse Test in the late 19th century. The Irresistible Impulse Test absolves defendants who know their acts are wrong but cannot control their impulses to commit them. The Irresistible Impulse Test was eliminated from federal law, as well as that of many states, in the wake of the Hinckley trial.[38]

Recognizing the narrowness of the *M'Naghten Rule*, the American Law Institute (ALI) designed a more comprehensive insanity test for its Model Penal Code that incorporated both cognitive and volitional standards, and required that the underlying disability constitute a medical diagnosis. The test states that "a person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirements of law."[39] The ALI test was adopted by the federal courts as well as a majority of state courts. Today, however, largely in response to the Hinckley verdict, only 18 states (not including North Carolina) still use the ALI test.

The burden of proof with an insanity defense differs from state to state. Prior to the Hinckley case, the majority of states placed the burden of proof on the prosecution to disprove insanity "beyond a reasonable doubt." After the Hinckley verdict, however, most states switched the burden of proof to the defendant. North Carolina requires the defense to prove insanity "by a preponderance of the evidence"; in some other states, the standard is "clear and convincing evidence." Only eleven states still require the prosecution to prove sanity once

a defendant has raised an insanity claim.

Because of the limitations noted above, capital and other criminal defendants in North Carolina rarely invoke an insanity defense, and it is rarely successful when they do. Though statistics are unofficial, Dr. Barboriak states that 34 individuals who received NGRI verdicts in North Carolina are currently committed to state hospitals; more than 70 percent of those were diagnosed with schizophrenia or schizophrenic disorder. Notably, only three of those verdicts were delivered by juries. As Dr. Barboriak confirms, "Juries in North Carolina do not like to give NGRI verdicts."[40]

Philip Ingle was one of the few capital defendants in North Carolina who raised an insanity defense. However, the entire defense presented by Ingle's trial attorneys consisted of testimony from a single doctor. The jury never heard the bulk of Ingle's mental health history, which included several commitments to psychiatric institutions, frequent hallucinations and multiple diagnoses of severe and debilitating mental illness. Ingle, who asked the court in one competency hearing to grant his wish for a "state-assisted suicide," was executed in 1995.[41]

THE DIMINISHED CAPACITY DEFENSE

A second way in which the mental illness of a criminal defendant in North Carolina might affect punishment is the diminished capacity defense. In essence, diminished capacity is raised by defendants whose mental disabilities are not severe enough to serve as the basis for an insanity defense but may be sufficient to raise questions about their ability to form the requisite specific intent necessary to commit particular crimes.

Diminished capacity, unlike insanity, does not exculpate a defendant. For example, when the diminished capacity defense is successful in a capital case, a defendant may be found guilty of a lesser offense (such as second-degree murder) that requires only general intent (*e.g.*, malice) as opposed to specific intent (*e.g.*, intent to kill). Thus, the difference between insanity and diminished capacity is that "defendants may be found insane in North Carolina if, at the time of the offense, they were incapable of knowing the nature and quality of their actions or that their actions were wrong. In contrast, diminished capacity means only that the defendant lacked the capacity to form the state of mind necessary for conviction."[42]

As one commentator explains, "diminished capacity acts as a 'negating' defense, meaning that it prevents the state from proving its case. If the defendant lacks the capacity to premeditate [for example], the prosecution cannot establish an element of first-degree murder. On the other hand, if the prosecution proves that the defendant acted with the state of mind required for conviction of first-degree murder, the defendant cannot use the diminished capacity defense as a basis for avoiding liability."[43]

The standard for determining diminished capacity in North Carolina is reasonable doubt, *e.g.*, "whether the evidence of defendant's mental condition is sufficient to cause a reasonable doubt in the mind of a rational trier of fact as to whether the defendant was capable of forming the specific intent to kill the victim at the time of the killing."[44]

The concept of diminished capacity as a defense dates back to Scottish Common Law and was first adopted in the United States in 1949.[45] North Carolina explicitly recognized diminished capacity in 1988 and has continued to accept it as evidence in first-degree murder cases.[46] As with insanity, a diminished capacity claim must be introduced by the defense in a timely way as prescribed by law.

JAMES HUTCHINS

The first person executed under North Carolina's current death penalty law was James Hutchins. Suffering from a "bizarre delusional system" that controlled his life, Hutchins believed he was being persecuted by law enforcement officers. Convicted and sentenced to death in 1979 for killing a McDowell County deputy sheriff and a N.C. Highway Patrol officer, Hutchins suffered from paranoid psychosis that not only caused him to commit the offense, but also substantially interfered with his counsel's ability to present a defense at his capital trial and sentencing hearing. Over the dissent of two justices of the N.C. Supreme Court, Hutchins was executed in March of 1984.

In the months leading up to Hutchins' death penalty trial, his attorneys repeatedly sought to withdraw from the case and have different lawyers appointed. Counsel explained that, fueled by his mental illness, Hutchins had so lost confidence in them and harbored such animosity against them that the communication between counsel and client essential to proper trial preparation was impossible. Indeed, former Chief Justice James G. Exum, Jr., wrote that there was "as severe a breakdown in communication between counsel and client as can be."

One of Hutchins' attorneys had previously worked as an assistant prosecutor. Hutchins was particularly distrustful of this attorney and at one point accused him of colluding with the prosecutor to read Hutchins' mail. In a typical letter to his attorneys, Hutchins wrote: **"I am fire you from my case. I'll not to court with you as my Lawyer. You have lie to my mother in other worlds I don't need you any more at all. that is that. good bye."**

Although counsel had retained a psychiatrist, they were unable to talk with Hutchins about his background and state of mind at the time of the crime. Hutchins met with a psychiatrist once before his trial but refused to speak to him in detail. He did tell the psychiatrist that he had killed in self-defense and that law enforcement authorities "had been tormenting me since 1956, trying to force me to sell dope." Hutchins said he had lost several jobs and been kicked off the Volunteer Fire Department in Spindale because he would not sell drugs. He also claimed that the local sheriff was a very wealthy man because he was the head of a "dope ring." Hutchins' attorneys described him as radically changeable: taking one position one day and, a short time later, taking a diametrically opposite view on the same issue. As a result of Hutchins' inability to cooperate, his attorneys were ultimately unable to explore any mental health defense.

The trial judge denied the request to appoint new lawyers and ordered the trial to go forward as scheduled. During the trial, counsel asked the judge to delay the case, arguing that Hutchins was "swinging so intensely from one to another pole in this matter that it is difficult, if not impossible . . . to anticipate where he is going to be on any given time." The judge declined to delay the trial.

Hutchins' attorneys presented no evidence of insanity or any other evidence of mental illness at his trial. Hutchins was convicted of first-degree murder and, although the jury found he was suffering from a mental or emotional disturbance at the time of the crime, he was sentenced to death.

In later appeals, new counsel presented evidence that, in fact, Hutchins was insane and was experiencing hallucinations and suffering from gross distortions of reality at the time of the crimes for which he was sentenced to death. A full psychiatric evaluation of Hutchins revealed him to be suffering from a severe paranoid disorder characterized by paranoid delusions, disturbed judgment, and hallucinations. Although one federal judge found his case "heartrending," Hutchins' appeals for relief were denied and he was executed on March 16, 1984.

PENALTY PHASE MITIGATION

A third way in which North Carolina takes into consideration a criminal defendant's mental illness is during the sentencing phase of a capital trial. When defendants are convicted of capital crimes, juries must determine in a separate sentencing proceeding whether to impose the death penalty or life without the possibility of parole. In order to sentence the defendant to death, the jury must determine whether sufficient aggravating circumstances exist to warrant execution and, if so, whether mitigating circumstances also exist. Capital juries must then determine beyond a reasonable doubt whether the mitigating circumstances outweigh the aggravating circumstances.[47]

North Carolina law recognizes eleven aggravating circumstances, including that the crime was "especially heinous, atrocious, or cruel," that the defendant had a history of violent crimes, and that the crime in question was committed in conjunction with another felony.[48]

For mitigation purposes, the statute lists nine circumstances that a jury may consider.[49] Two of these directly pertain to the defendant's mental or emotional state at the time of the crime:

> **N.C.G.S. §15A–2000 (f)(2): The capital felony was committed while the defendant was under the influence of mental or emotional disturbance.**

> **N.C.G.S. §15A–2000 (f)(6): The capacity of the defendant to appreciate the criminality of his conduct or to conform his conduct to the requirements of law was impaired.**

The last mitigating factor in the statute is open-ended — "Any other circumstance arising from the evidence which the jury deems to have mitigating value" — and could conceivably include evidence of mental disability not covered by the more specific mitigating factors.

How juries weigh mental illness in the context of balancing aggravating and mitigating factors is discussed below. Numerous studies suggest, however, that juries not only give insufficient weight to evidence of mental disabilities, but often, contrary to the law, consider those disabilities as aggravating factors. For this reason, defense attorneys can be reluctant even to present such evidence. University of Florida law and psychiatry professor Christopher Slobogin, who has compiled and referenced this research, has concluded that "contrary to statutory command and empirical reality, mental illness is seen as a stigmatizing sign of violence proneness, not as a mitigating factor. Consequently, death sentences imposed in cases where mental illness is clearly evident are suspect."[50]

QUESTIONS OF COMPETENCE

Both the insanity and diminished capacity defenses depend on the defendant's state of mind at the time of the crime. A defendant's mental state during a capital proceeding itself, however, may also become an issue. In North Carolina, as in most jurisdictions, the issue is defined as one of "capacity to proceed" (or "competence") which may be adjudicated at various points in the following contexts:

1 Competence of a defendant to waive interrogation rights, such as the right to have the assistance of a lawyer or to remain silent;

2 Competence of a defendant to stand trial;

3 Competence of a defendant to waive his right to counsel and to act as his own lawyer;

4 Competence of a defendant to plead guilty;

5 Competence of a defendant to proceed during post-conviction appeals;

6 Competence of a defendant to drop his appeals against his conviction and death sentence; and

7 Competence of a defendant to be executed.

Legal determinations of competence are guided by *Dusky v. United States*, in which the United States Supreme Court articulated two primary criteria for competency to stand trial. First, a defendant must have a rational as well as factual understanding of the charges against him and the penalties associated with those charges. Second, the defendant must have the ability to consult and cooperate with an attorney in his own defense.[51]

Though federal and state courts have periodically modified the competency standard,[52] North Carolina criminal statutes adhere to the *Dusky* language in barring legal proceedings against incompetent defendants: "No person may be tried, convicted, sentenced, or punished for a crime when by reason of mental illness or defect he is unable to understand the nature and object of the proceedings against him, to comprehend his own situation in reference to the proceedings, or to assist in his defense in a rational or reasonable manner. This condition is hereinafter referred to as 'incapacity to proceed.'"[53]

In lay terms, competence can be summarized as follows: "To be fair to a defendant who is facing such a formidable adversary as the state, the defendant should be in good and alert mental shape to grasp the complexities of the situation of being on trial; to understand the charges, the possible penalties, and the options; to answer questions meaningfully; to detect lies or errors by witnesses; and to keep the defense attorney continually informed about relevant facts as the trial progresses."[54]

The process for determining incapacity to proceed is governed by statute.[55] A capacity challenge may be raised in a motion at any time during a criminal proceeding by the defense, the court, or the prosecutor, and is subject to a court hearing as well as evaluations by mental health experts. If a defendant cannot meet any of the statutory conditions for capacity to proceed, the proceedings must be put on hold.[56]

A separate, much-debated test is used to determine a defendant's competency to be executed. In *Ford v. Wainwright*, the United States Supreme Court ruled that executing insane defendants violates the constitutional proscription against cruel and unusual punishment, though it declined to define insanity. In his concurring opinion, Justice Lewis Powell suggested that "the Eighth Amendment forbids the execution only of those who are unaware of the punishment they are about to suffer and why they are to suffer it."[57] Though many judges have subsequently adopted Justice Powell's language, mental health advocates and other commentators have often expressed concern that the standard for preventing the execution of an insane defendant is so high that even the most severely mentally ill offenders cannot meet it.[58] As noted above, the United States Supreme Court may revisit the *Ford* standard in its consideration of the *Panetti* case.

In North Carolina the burden of showing incapacity to proceed, as with insanity, rests with the defendant and is based on "a preponderance of the evidence."[59]

Application: Practice vs. Theory

As described above, North Carolina and federal law would appear to offer reasonable protections for capital defendants with mental disabilities. In actual practice, however, full and fair consideration of those disabilities during capital proceedings — or any criminal proceeding, for that matter — is often hindered by one or more well documented systemic deficiencies. "Although in the laws we have what looks like the possibility of taking [mental illness] into account," says Dr. Faye Sultan, "really that's not what happens."[60]

The inherent inability of severely mentally ill defendants to operate effectively in a criminal justice setting is the overarching explanation for the disconnect between the current theoretical and statutory protections of those with mental illness and what actually takes place. As one study summarized, "Misperceptions, suspicions, hopelessness and despair, common symptoms of mental illness, added to ease of intimidation, distrust of authorities, difficulties in communicating and errors of judgment, may affect how a defendant presents him or herself to the lawyer, the judge and the jury. Even when counsel is effective and the forms of due process are scrupulously followed, these problems infect every stage of a capital trial. The implication is not only that the defendant may not be able to cooperate in putting on the best defense, but that the process itself, despite our best efforts, will not produce an accurate or just result."[61]

ASSISTING COUNSEL

As mentioned above, defendants must be able to "assist in [their] defense in a rational or reasonable manner," namely, consult and cooperate with their attorneys in their own defense.[62] Whether mentally ill defendants are "able" to do this is a matter for the courts to decide. However, that determination often fails to take into account how mental illness plays a significant role in what are often described as a defendant's "willful" decisions to obstruct the efforts of lawyers, mental health experts or others working on his behalf. Indeed, many defendants may want to work with their attorneys but are unable to do so effectively because of their disabilities. One thing is clear in this regard, however: many mentally ill defendants do not fully assist their attorneys, with predictable results.

North Carolina courts expressly recognize that defendants must be able to cooperate with their attorneys so that all possible defenses may be raised.[63] Nevertheless, North Carolina courts have permitted mentally ill defendants to refuse psychological evaluations and to instruct their counsel not to introduce evidence pertaining to mental illness at trial. A particular concern is that the defendant's mental illness might interfere with counsel's ability to prove the defendant's innocence (a concern highlighted by recent stories of exonerations of persons on death row). Even when guilt is not in question, however, impediments to the defense due to a defendant's mental disability can improperly and unjustly skew the results of a trial.

Prior to his 1979 capital murder trial, James Hutchins refused to cooperate with his court-appointed attorneys or the psychiatrist they retained. Suffering from what would eventually be diagnosed as a severe mental disorder characterized by paranoid delusions, disturbed judgment, and hallucinations, Hutchins accused his attorneys of colluding with the prosecution and wrote incoherent letters to that effect in an effort to "fire" them. The attorneys tried repeatedly to withdraw from the case, but their efforts were denied by the court. Having little to work with, the lawyers presented a skeletal defense, and Hutchins was convicted and sentenced to death. Former North Carolina Supreme Court Chief Justice James G. Exum, Jr., later wrote that there was "as severe a breakdown in communication between counsel and client as can be."[64]

As the Hutchins case and many others illustrate, even when severe mental illness manifests acutely and dramatically in ways that render defendants unable to assist in their own defense, prosecutions continue unimpeded. To be sure, when a capital case proceeds under these circumstances, the fallout is subsequently compounded at each phase of the proceeding.

SELF-REPRESENTATION AT TRIAL

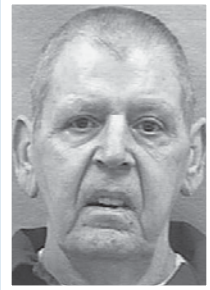
Mentally ill defendants have a difficult enough time cooperating with their attorneys even when they are able and inclined to do so. When they choose to exercise their legal right to waive counsel and represent themselves at trial, however, a "choice" that is inextricably intertwined with their disabilities, they face insurmountable obstacles. Any outcome other than a guilty verdict and death sentence is rare indeed.

Guy LeGrande invoked his right to represent himself over the objections of his court-appointed attorneys, who were not allowed to tell the court of his delusions and intense hostility toward them. The court deemed him competent based on the assessment of a single doctor, who briefly examined LeGrande but nonetheless concluded that he had "narcissistic, grandiose and hypomanic traits." Another competency hearing was denied by the judge because LeGrande rejected it.

LeGrande appeared at trial wearing a Superman t-shirt, periodically became visibly agitated (and was told to calm down by the judge), and repeatedly undermined himself because of his ignorance of the rules. Unsurprisingly, LeGrande presented none of his extensive history of mental illness to the capital jury. In a statement to the jury during his sentencing hearing, LeGrande called them Antichrists and said they'd worship him in Hell. "All you so-called good folks can kiss my natural black ass in the showroom window of Heilig-Myers," he told them. "Pull the damn switch and shake that groove thing." The jury quickly returned a death sentence.[65]

In the intervening years, LeGrande has continued to sabotage his own defense, including efforts by his standby counsel and family members to explore and expose his mental illness. And even though the disabilities he exhibited at trial have been confirmed by subsequent medical diagnoses,[66] the damage LeGrande did to himself at trial is perhaps impossible to repair.

Former North Carolina Chief Justice Burley Mitchell notes that allowing mentally ill defendants to represent themselves at trial poses an unacceptable impediment to justice. If North Carolina is to use the death penalty, Justice Mitchell says, the state has an "absolute obligation" to ensure that capital defendants get a fair trial. "That means with some of them, we have to protect them from themselves," he stated. "Just saying [a defendant] has a constitutional right [to represent himself] doesn't answer it for me."[67]



GEORGE PAGE

N.C. death row prisoner George Page served 16 years in the military and is a Vietnam War Veteran with a long history of mental illness. For the last 20 years, he has been treated with numerous psychotropic drugs for Post-Traumatic Stress Disorder (PTSD) and bipolar disorder by doctors and mental health professionals in hospitals and in the North Carolina Department of Correction.

On February 27, 1995, Page was suffering from a manic, flashback episode and began randomly shooting out of the windows of his Winston-Salem apartment at other apartments, vehicles, and law enforcement officers who arrived on the scene. In the chaos, Page fatally wounded police officer Stephen Amos. Page told others at the time that he was surrounded by soldiers who were shooting at him. Page was sentenced to death in 1996, and remains on death row.

Page has a documented mental health history which includes attempts at suicide, hospitalization for overdoses on rubbing alcohol and lighter fluid, and treatment for major depression. Despite this history, Page's attorneys at trial were denied the opportunity to hire an independent, qualified forensic psychiatrist to fully evaluate Page before his trial.

The State psychiatrist who examined Page after his arrest told the jury that Page did not have PTSD because his military records showed he was a truck mechanic in Vietnam and was not in combat. But those records actually show Page was stationed in Pleiku, Vietnam, the scene of numerous skirmishes and bombings in 1968. Page arrived in Vietnam just after the Tet Offensive, a time of heavy fighting and mounting disillusionment among U.S. troops.

Despite the testimony of the State's mental health expert, jurors recognized that Page was mentally ill, and found the mitigating circumstances that Page was under the influence of a mental or emotional disturbance and that his capacity to appreciate the criminality of his conduct or to conform his conduct to the requirements of the law was impaired. Nonetheless, the jury sentenced him to death.

Disturbingly, much of the evidence supporting Page's PTSD was never heard by the jury that sentenced him to death, including statements from family members who witnessed Page's Vietnam flashbacks. Had she been called as a witness at trial, Page's former wife, Gay Lynch, could have described for the jury how Page changed dramatically after his service in Vietnam. Many times she would find Page in the middle of the night sitting on the kitchen floor crying. Other times, he would disappear for days, and have no memory of it. No one from Page's defense team ever contacted Lynch about her experiences.

Other family members also say Page suffered from his war experience, once becoming violent and yelling, "I got him, Charlie. I got him, Charlie." Another time Page shot a hole in the ceiling of his living room and appeared to be in a trance.

In addition to testimony from people who knew Page, there was dramatic evidence of Page's mental illness that the jury never heard. Before the tragic murder of Officer Amos, Page had undergone a brain scan. The scan showed evidence of brain damage. Although prosecutors had the medical records of this scan, they never shared this evidence with the psychiatrist who testified for the State at trial. Page's lawyers were also apparently unaware of the brain scan. When the psychiatrist learned of it, many years after Page's trial, she said the scan significantly altered her opinions.

Recently, Page underwent a full psychological evaluation that showed he suffers from symptoms of PSTD as well as bipolar disorder. Additionally, the evaluation confirmed that Page has neurological damage. Unfortunately, although the evidence is clear that George Page is a deeply disturbed and mentally ill man who was suffering from a manic episode when he began shooting out his window in 1995, no court has been willing to consider the significant evidence of his mental illness.

WAIVER OF APPEALS

The phenomenon of "volunteering" — death row inmates giving up their post-conviction appeals to hasten their executions — has been widely reported and studied in recent years. Many of these inmates offer seemingly rational reasons for their decisions to forego appeals, such as remorse for their crimes or a preference for death over life in prison, thereby satisfying the demands of a competency evaluation. But these reasons may in fact be grounded more in suicidal impulses, depression or other mental illness than in any rational thought process.

Since the United States Supreme Court reinstated the death penalty in 1976, a majority of the death row inmates who have volunteered for execution had histories or symptoms of severe mental illness: 77 percent of the total number of "volunteers", according to one study, had recorded diagnoses of schizophrenia, bipolar disorder, depression and post-traumatic stress disorder. At least 28 percent had previously attempted suicide.[68]

Dr. Dorothy Lewis, a Yale University psychiatry professor whose research on mental illness, violence and the death penalty has been cited by the United States Supreme Court, has been studying the link between mental illness and death row "volunteers" for the past four years. "Preliminary data indicate that every subject had severe mental illness of which he was unaware and which adversely affected his (singular) reasoning and judgment," Dr. Lewis says. "In fact, these very mental diseases influenced the defendants' decisions to represent themselves."[69]

"THE ISSUE [OF MENTAL ILLNESS] IS IMPORTANT NOT ONLY AT TRIAL AND SENTENCING, BUT ALSO IN THE ABILITY OF THE ACCUSED TO ADEQUATELY ASSIST HIS LAWYER ON APPEAL," SAYS JUDGE SHIRLEY FULTON. "MANY SERIOUSLY MENTALLY ILL DEFENDANTS, WITHOUT UNDERSTANDING, WAIVE THEIR RIGHT [TO APPEAL], FURTHER EXACERBATING THEIR DISADVANTAGE."

The research supports what former Superior Court Judge Shirley Fulton has observed over the years: "The issue [of mental illness] is important not only at trial and sentencing, but also in the ability of the accused to adequately assist his lawyer on appeal," Judge Fulton explains. "Many seriously mentally ill defendants, without understanding, waive their right [to appeal], further exacerbating their disadvantage."[70]

James Rich fit that description. Rich represented himself at trial, pled guilty and was sentenced to death for a 1994 murder he committed while in prison. In concluding that Rich was mentally ill, a state-conducted mitigation evaluation documented Rich's long history of mental disability, which included ten separate diagnoses of severe mental illness, several involuntary commitments in state hospitals and multiple suicide attempts. After his court-appointed post-conviction attorneys filed his appeal, Rich sought to have it withdrawn and his lawyers dismissed, asserting that "I have been found and diagnosed with two or three mental disorders, but what I want to say, your Honor, is neither one of these — and any psychiatrist or psychologist will tell you the same thing — that

neither one that I have affects a person's ability to understand or intellectual level in any kind of way."[71] The court granted his request, and Rich was executed.

MENTAL ILLNESS AS "AGGRAVATING"

North Carolina law is clear that mental illness should be considered a mitigating factor at sentencing to be weighed against aggravating factors as described above. But research overwhelmingly shows that, in fact, the opposite may be true: Juries tend to see mental illness as an aggravating factor.[72]

Even when juries do consider mental disability as a mitigating factor, they tend to devalue that information in relation to aggravating evidence.[73] The American Psychiatric Association has stated that "many observers of capital sentencing proceedings, including participating psychiatrists, believe that juries tend to give too little weight to mitigating evidence of severe mental disorder, leading to inappropriate execution of offenders whose responsibility was significantly diminished by mental retardation or mental illness."[74]

The United States Supreme Court has recognized these facts in several cases, including the decision to ban the death penalty for mentally retarded offenders. The Court notes that "mentally retarded persons have a 'lesser ability . . . to make a persuasive showing of mitigation in the face of prosecutorial evidence of one or more aggravating factors,' in part because they 'are typically poor witnesses, and their demeanor may create an unwarranted impression of lack of remorse for their crimes.'"[75]

In some states, the question of "future dangerousness" can be weighed by the jury when considering whether to impose death or a lesser sentence. Notably, as the Supreme Court has stressed, mentally impaired defendants are often perceived by juries as dangerous: "[R]eliance 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."[76] While North Carolina law does not list future dangerousness as an aggravating factor, the tendency of juries to see severely mentally ill defendants as dangerous doubtless plays into their deliberations.

Partly because of these concerns, in 2002 the Supreme Court ruled, "Mentally retarded defendants in the aggregate face a special risk of wrongful execution."[77] Though the Court was speaking of mentally retarded defendants, that risk is equally applicable to mentally ill defendants. This in part explains why some defense attorneys choose not to present any mitigating evidence related to mental disability at sentencing, even though it would seem obligatory to do so. Even in the face of credible evidence of a defendant's mental illness, an attorney's decision *not* to present the information has been approved by the courts for the very reason that juries might misinterpret it.[78]

STRATEGIC IMPEDIMENTS

An accurate picture of a defendant's mental illness depends on a comprehensive investigation of his or her history, as well as interviews and assessments by mental health professionals. Because this information is gathered within the context of an adversarial proceeding, the respective findings by defense counsel and prosecution often create a scattered and incomplete picture—and unsurprisingly can result in conflicting conclusions.

Strategic decisions by attorneys and prosecutors to withhold key information mean that the experts may be

lacking what they need to make a thorough analysis. "We'd like to see everything," but that's not always the case, says Dorothea Dix psychiatrist Dr. Peter Barboriak, who has testified for both the defense and prosecution in capital cases. "A lot of times it's because one side feels the other side will get an advantage if that information comes out in a report."

In George Page's case, one such omission may have been catastrophic. Currently on death row for a murder committed during a random shooting spree from his apartment window in 1995, Page has been diagnosed with bipolar disorder as well as post-traumatic stress disorder stemming from his experience as a soldier in Vietnam. Prior to the crime, Page had undergone a brain scan that showed significant neurological damage. The prosecution had medical records of the scan but did not share them with the defense or the psychiatrist who testified for the prosecution at trial. Several years later, after seeing the evidence, the prosecution's psychiatrist said that the results changed her opinions.[79]

For obvious strategic reasons, capital defense lawyers sometimes do not reveal their mental health claims until late in a capital proceeding. When this happens, relevant and crucial information may not be presented until trial or at sentencing, which leaves each side little or no opportunity to digest it. Mecklenburg County prosecutor Marsha Goodenow identifies this process as a major source of frustration. In some instances, Ms. Goodenow says, "the first time I hear what the [defense] expert's opinion is, is after the defendant has been convicted of first degree murder and that expert is on the witness stand. I can't talk to them before trial because of their patient privilege. The first time I get their written report is while they're on the stand and I'm sitting there literally sometimes with 400 pages of documents that I'm trying to read while that expert is testifying. I'm sort of stuck in an adversarial position where I have none of the information beforehand and no reason to necessarily believe it's true or not true."[80]

And when the absolute objective of both sides is to win, the nuances of how mental disabilities affected a defendant's behavior often get lost in the battle to discredit expert witnesses and otherwise undermine the opposition arguments. Dr. Faye Sultan sums up this dynamic: "What really happens in the courtroom is that I do my very best to explain mental illness and the impact of mental illness on this person's behavior, and the state does its best to tell me how I'm wrong and to minimize the mental disability of my client. And so we get into a tug of war, where really understanding the person from a psychological sense or a psychiatric sense is not the goal. The goal is somehow either to negate the very existence of a mental illness, or to have somebody so blatantly mentally ill that everybody somehow gets it eventually. Most of the defendants that you see don't fall into that category."[81]

OTHER SYSTEMIC PROBLEMS

In addition to these obstacles that mentally ill capital defendants face in actual practice, other impediments have been identified by researchers, judges, attorneys and other observers. Juries, for example, do not always grasp the fine points of the law when it comes to interpreting instructions from the bench. In one study, jurors "demonstrated high confusion with the trial instructions, little improvement with revised instructions... and a strong relationship between miscomprehension and willingness to impose death."[82]

In addition, the process used in North Carolina for determining competence or insanity often results in

judges and juries having to make their decisions based entirely on expert evaluations that may have been conducted using different methods and criteria, and at different times. This is partly a matter of the experts needing a better legal framework to make determinations that are more consistent with medical opinion, so they can answer questions based on standard professional criteria rather than purely legal constructs. Solutions might include revisions to the language governing competency and other standards, and a better mechanism for the prosecution and defense to share and discuss information; both are outlined below.

In summary, while the legal protections afforded defendants with mental illness may be adequate in some specific cases, the combination of deficiencies in those protections greatly increases the probability that those deserving a lesser sentence based on their mental disabilities will nonetheless receive the death penalty.

JAMES DAVID RICH

James David Rich was sentenced to die for the stabbing death of fellow inmate Paul Gwyn at Eastern Correctional Center in Greene County in 1994. Rich fired his trial attorneys, was permitted to represent himself in the trial for his life, and pled guilty. After his death sentence, Rich forfeited his appeals in state and federal court and was executed on March 26, 1999.

Rich had a long, documented history of serious mental illness, beginning in childhood. At age 11, Rich shot himself in the stomach in front of his 5th grade class. He was involuntarily committed to state mental hospitals on several occasions and attempted suicide a number of times. Rich received more than ten different mental health diagnoses over the years, including bipolar disorder with psychotic features, major depression, and schizoaffective disorder. He was prescribed more than 20 different psychotropic medications over the years, including Haldol, Thorazine, Lithium, and Prozac.

Rich's original trial attorneys raised the issue of his competency to the court, and Rich subsequently fired them. The "standby attorney" who was appointed also raised the issue of Rich's competency in a motion, which the Court denied. Rich was never evaluated by a mental health professional to determine his competency.

Rich pled guilty to first degree murder and consented to a mitigation evaluation by Dr. Bob Rollins of Dorothea Dix State Hospital. Rollins testified that Rich's family had a history of mental illness, that his father was abusive towards him and his mother, and that Rich had made several suicide attempts. He concluded that Rich was mentally ill. After a brief sentencing hearing, Rich was sentenced to death in August, 1995.

Despite clear documentation of severe, lifelong mental illness, Rich was allowed to represent himself at trial and to give up his appeals and be executed before his mental illness was fully presented and evaluated in a court of law.

Rationale for Reform

The morally questionable prospect of executing severely mentally ill offenders despite the protections currently afforded under the law is reason enough for some in the mental health and legal communities to call for reform. But arguments for reform go beyond moral questions and steady their focus on questions of how to best achieve the goals of a criminal justice system. Many of these arguments are grounded in existing federal and state case law, including from the United States Supreme Court.

REASONS FOR CAPITAL PUNISHMENT NOT FURTHERED BY EXECUTING THE MENTALLY ILL

The United States Supreme Court has identified "two principal social purposes" served by capital punishment: retribution and deterrence.[83] The Court has also held that "unless the death penalty when applied to those in [the defendant's] position measurably contributes to one or both of these goals, it 'is nothing more than the purposeless and needless imposition of pain and suffering,' and hence an unconstitutional punishment."[84]

The retributive rationale for the death penalty is conditioned on an offender's level of responsibility, a question that goes well beyond whether he or she committed the crime. According to the Supreme Court: "Retribution as a justification for executing [offenders] very much depends on the degree of [their] culpability.... [F]or purposes of imposing the death penalty . . . punishment must be tailored to [a defendant's] personal responsibility and moral guilt."[85] Restating that proposition in *Atkins v. Virginia*, its landmark 2002 opinion banning the death penalty for mentally retarded offenders, the Court noted that "[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."[86]

The Court has also held on numerous occasions that the death penalty is to be reserved for the "worst of the worst" offenders,[87] stating that "our jurisprudence has consistently confined the imposition of the death penalty to a narrow category of the most serious crimes."[88] Relative culpability is a key determinant of what falls into this category: in one case, for example, the Supreme Court set aside a death sentence because the defendant's crimes did not reflect "a consciousness materially more 'depraved' than that of any person guilty of murder."[89]

As case law vividly demonstrates, however, the emotional impact of murder, particularly an especially brutal or senseless crime, can often sway juries and distract from the question of culpability that the Supreme Court has identified as paramount. "Decisions often to seek the death penalty have to do with the horribleness of the crime itself," says Dr. Richard Dudley. "Is that really the issue? Because if you're considering the role of mental retardation or mental illness or any other disability, then you're really not talking so much about whether the crime was more horrible than somebody else's crime, but whether the person who committed it is more culpable than any other person."[90]

Jim Ellis, a University of New Mexico law professor and former president of the American Association on Mental Retardation, stresses that a death sentence for mentally retarded offenders cannot rationally be justified. "To permit the execution of a person with mental retardation," Ellis says, "requires concluding that such an individual is both in the bottom 2 percent of the population in intelligence and also in the top 1 or 2 percent of the population in his appreciation and understanding of the wrongfulness of his actions."[91]

The same contradictory reasoning attends the practice of executing those with severe mental illness. If mentally retarded offenders are by definition less culpable for their crimes, then severely mentally ill defendants whose impairments profoundly affect their ability to function within the boundaries of the law also do not qualify as the most morally culpable or number among the "worst of the worst."

Applying the Supreme Court's logic, executing the severely mentally ill therefore does not advance the retributive function of the death penalty.

Regarding deterrence, the United States Supreme Court has been consistent in its pronouncements that the death penalty does not deter specific classes of defendants. As Justice Lewis Powell stated, "The death penalty has little deterrent force against defendants who have reduced capacity for considered choice."[92] Expanding on this idea, the Court has asserted that "capital punishment can serve as a deterrent only when murder is the result of premeditation and deliberation."[93]

As the Supreme Court explained in *Atkins*, the deterrent effect of capital punishment is unlikely to be a factor for those defendants who have "the diminished ability to understand and process information, to learn from experience, to engage in logical reasoning, or to control impulses."[94] Such a description unequivocally matches that of individuals with severe mental illness.

Indeed, former North Carolina Chief Justice Burley Mitchell places mentally ill defendants in the group that is not deterred from criminal behavior by the possibility of execution. "The truth is, the death penalty prevents some murders directly," says Justice Mitchell. "But it's not going to deter the mentally ill, and it's a waste of time [for them]."[95]

EXEMPTIONS UNDER *ATKINS* AND *ROPER*

Mental illness differs from mental retardation in fundamental ways, but in certain cognitive and behavioral respects they have similar features. The same is true when comparing the cognitive and behavioral capacities of physically and emotionally immature individuals (*i.e.*, juveniles) and the mentally ill. It is in these similarities that the United States Supreme Court's decisions to bar the death penalty for the mentally retarded and juveniles are grounded.

In *Atkins v. Virginia*, the Court specifically restated why the culpability of mentally retarded offenders is reduced: "Because of their impairments… [mentally retarded persons] 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 the reactions of others…. Their deficiencies do not warrant an exemption from criminal sanctions, but they do diminish their personal culpability."[96]

The *Atkins* Court continued: "If the culpability of the average murderer is insufficient to justify the most extreme sanction available to the State…the lesser culpability of the mentally retarded offender surely does not

merit that form of retribution. Thus, pursuant to our narrowing jurisprudence, which seeks to ensure that only the most deserving of execution are put to death, an exclusion for the mentally retarded is appropriate."[97]

In *Roper v. Simmons*, the Court reiterated this principle in concluding that it is disproportionate, and therefore unconstitutional, to impose the law's most severe penalty on those who were under the age of 18 at the time of their crimes: "As in *Atkins*, the objective indicia of consensus in this case…provide sufficient evidence that today our society views juveniles, in the words *Atkins* used respecting the mentally retarded, as 'categorically less culpable than the average criminal.'"[98]

The Court has applied the same rationale in observing that both mentally retarded and juvenile offenders are unlikely to be deterred from committing a capital crime by a possible death sentence. "Exempting the mentally retarded from that punishment will not affect the 'cold calculus that precedes the decision' of other potential murderers. Indeed, that sort of calculus is at the opposite end of the spectrum from behavior of mentally retarded offenders. The theory of deterrence in capital sentencing is predicated upon the notion that the increased severity of the punishment will inhibit criminal actors from carrying out murderous conduct. Yet it is the same cognitive and behavioral impairments that make these defendants less morally culpable….that also make it less likely that they can process the information of the possibility of execution as a penalty and, as a result, control their conduct based upon that information."[99]

"THE TRUTH IS, THE DEATH PENALTY PREVENTS SOME MURDERS DIRECTLY," SAYS JUSTICE BURLEY MITCHELL. "BUT IT'S NOT GOING TO DETER THE MENTALLY ILL, AND IT'S A WASTE OF TIME [FOR THEM]."

In *Roper*, the Court stated that "the absence of evidence of deterrent effect is of special concern because the same characteristics that render juveniles less culpable than adults suggest as well that juveniles will be less susceptible to deterrence."[100] And in a separate case, the Court concluded that "[t]he likelihood that the teenage offender has made the kind of cost-benefit analysis that attaches any weight to the possibility of execution is so remote as to be virtually nonexistent."[101]

That these facts apply equally to persons with mental illness has been increasingly acknowledged by the courts. Citing the *Atkins* language concerning the diminished capacities of mentally retarded offenders, for example, a California court stated in 2004 that "[t]he same mental capacities are impaired in a person suffering from paranoid schizophrenia, and the impairment may be equally grave."[102] In a more recent opinion, Ohio Supreme Court Justice Lundberg Stratton wrote, "There seems to be little distinction between executing offenders with mental retardation and offenders with severe mental illness, as they share many of the same characteristics…. [T]he time has come for our society to add persons with severe mental illness to the category of those excluded from application of the death penalty."[103]

The inherent logic of extending the exemption from capital punishment to the mentally ill has also been noted repeatedly by mental health experts and other observers. As the *Washington Post* editorialized in 2005, for example, "The Supreme Court has held that it is unconstitutional to execute the mentally retarded or those who

were not of age at the time of their crimes. That it is still somehow okay to put to death a florid psychotic is a strange and amoral anomaly of contemporary American law, one that cries out for reform."[104]

PRIORITY OF RESOURCES

Because of major deficiencies in the nation's mental health system, United States prisons and jails have become warehouses for the mentally ill. Duke University psychiatry and behavioral sciences professor Dr. Jeffrey Swanson, who has extensively studied mental illness in the criminal justice context, notes that the social and economic costs of this predicament are enormous: "Employing the criminal justice system to deal wholesale with the problematic behavior of people with untreated psychiatric disorders is not only unfortunate and misguided—it is also hugely expensive."[105]

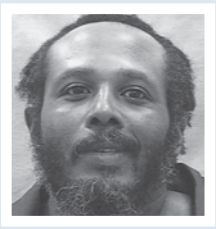
The outlays multiply exponentially when capital cases are part of the mix. As is well documented, the aggregate costs of prosecuting and executing an offender vastly exceed the aggregate costs of a life sentence and create a heavy financial burden on states and counties.[106] Justice Burley Mitchell references this burden in his observation that the money might be better spent elsewhere, such as on mental health treatment and prevention. "I've never had a great problem with the death penalty," Justice Mitchell says, "but it is terribly expensive, it is terribly inefficient, and we really need those resources for mental health work in the class of people who commit these violent crimes."[107]

The state's prisons and jails remain poorly equipped to manage the constant influx of mentally ill prisoners. A North Carolina study released in 2007 catalogued a litany of concerns about inadequate staffing levels and training as well as the lack of basic mental health services.[108] Regarding mental health care in the state's jails, Dr. Peter Barboriak agrees that services are generally quite limited. "That used to be something that was done by the local mental health centers," he says. "It's not so clear that there's actually anybody doing that all the time in all the jails. Some places like Durham and Mecklenburg counties actually have very good mental health care delivered to their prisoners. Other places, it's not that good."[109]

The repercussions of this cumulative state of affairs are both negative and unavoidable absent changes in policy, and can manifest themselves after a mentally ill inmate, incarcerated for a less serious offense than first degree murder, is released from incarceration (as most eventually are). As one national analysis noted, "It is well recognized that in the majority of cases, jailing or imprisoning seriously mentally ill individuals worsens their psychiatric symptoms."[110]

The benefits of redirecting resources to the mental health system are not just theoretical—just as a relationship between violence and mental illness has been scientifically established, so too is it accepted that this potential for violence can be reduced with intervention and treatment. As the National Alliance on Mental Illness has stated, "treating individuals with major psychiatric disorders markedly reduces episodes of violent behavior.... In recent years, increasing evidence has accumulated that individuals with major psychiatric disorders, such as schizophrenia and manic-depressive disorder, are more likely to be violent if they do not receive the medications and other treatments needed to prevent the recurrence of their illness."[111]

"The disorders that afflict these thousands of North Carolinians currently in prison and jail are effectively treatable, with success rates of 60–85 percent," concurs Dr. Swanson. "That's better than for heart disease. Giv-



GUY LEGRANDE

Guy Tobias LeGrande was sentenced to death in 1996 in Stanly County for the murder of Ellen Munford. LeGrande fired his court-appointed attorneys and was permitted to represent himself at trial. The judge appointed "standby counsel" who sat in the courtroom, but were not allowed to do anything without LeGrande's permission.

Standby counsel filed a motion suggesting that LeGrande was severely mentally ill and not competent to represent himself, but they were not allowed to be heard. They wanted, but were not allowed, to tell the court that LeGrande believed that he was receiving signals from Oprah Winfrey and Dan Rather over the television; that he suffered from delusions of grandeur and extreme mood swings; and that he believed he would receive a large monetary settlement after his acquittal. The judge asked LeGrande, who was wearing a Superman t-shirt, if he wanted him to disregard the motion; LeGrande's response was to tear the document in half. The judge allowed the trial to proceed.

At one point in the trial, the judge was moved to comment on LeGrande's increasing agitation and urged him to take time to calm himself. LeGrande's testimony and arguments culminated in incoherent ramblings, and the jury recommended a sentence of death.

After the North Carolina Supreme Court affirmed the conviction and death sentence, LeGrande continued to represent himself, and refused to properly preserve his legal issues in state court because he did not trust the state of North Carolina and believed he would prevail in federal court.

After his death sentence, experts evaluated LeGrande and concluded that he suffers from psychosis; specifically, a delusional disorder with grandiose and persecutory delusions. His delusions make it impossible for him to participate in a meaningful way in the defense of his life, and his thinking is very disorganized and rambling. LeGrande has refused to see his lawyers for several years. In prior conversations with his counsel, he has said that he can see other people's thoughts and true desires. He also obsessively discusses the prospects for settling his multi-billion dollar lawsuits against various government agencies. In one conversation, LeGrande insisted he could see a "circle of smoke" around his lawyer's head.

LeGrande is a prolific letter writer. Most of his letters focus on the pending settlement of his multi-billion dollar lawsuit against the State of North Carolina, while others detail such fantastical events as anvils falling from the skies.

After LeGrande filed scores of frivolous documents in court on his own, a federal judge finally appointed two lawyers to represent him. But the lawyers had little to present in federal court, since courts will not hear issues that are not first raised properly in state court. LeGrande was scheduled to be executed in December 2006, but the execution has been stayed several times and is still on hold pending an additional mental health evaluation. His status is in doubt, mostly because LeGrande continues to obstruct the efforts of his attorneys and mental health experts, making an accurate and reliable evaluation virtually impossible.

en timely intervention with community-based mental health services — including medication, supportive therapy, or substance abuse treatment as appropriate — many of these persons might never have committed the offenses that landed them behind bars."[112] Put simply, as former Judge Shirley Fulton says, "The more treatment a person receives, the less violence is reported."[113]

To look at this from another angle, estimates suggest that approximately 1,000 homicides annually in the United States are carried out by individuals with major psychiatric disorders who are not being treated.[114] There is little debate that if just one, if not many, of those homicides could have been prevented by intervention and treatment, the resources would have been better spent in those areas rather than in capital trials and executions of the mentally ill.

OBJECTIONS TO REFORM DISPELLED BY DATA, LEGAL SAFEGUARDS

Some observers have noted that efforts to exempt the severely mentally ill from the death penalty will be confounded in practice by the complexity of mental illness and consequential difficulty in obtaining reliable and consistent diagnoses. Studies show, however, that mental health experts agree the vast majority of the time when looking at gross impairment related to psychosis.[115] Placing the burden on defendants to prove that they suffer from severe mental illness would further alleviate this concern.

Besides, as University of Florida law and psychiatry professor Christopher Slobogin contends, "The state is not acting reasonably if it justifies executing people with mitigating mental illness simply on the ground that it has difficulty identifying who they are."[116]

Others have objected that defendants will feign mental illness in order to avoid a death sentence. This concern, however, appears overstated. Michael Perlin, who directs the Mental Disability Law Program at New York Law School, notes, "There is virtually no evidence that feigned insanity has ever been a remotely significant problem of criminal procedure.... A survey of the case law reveals no more than a handful of cases in which a defendant free of mental disorder 'bamboozled' a court or jury into a spurious insanity acquittal." Perlin further remarks that advances in the detection of malingering can discern someone who is faking mental illness in more than 90 percent of the few cases in which it does occur. In fact, research suggests that mentally ill defendants are far more likely to feign sanity, that is, resist categorization as mentally ill, in order to avoid stigmatization.[117]

Though the retributive and deterrent functions of the death penalty are not furthered by executing the mentally ill, advocates for reform recognize that criminal justice and public safety considerations are still paramount in dealing with any violent crimes committed by mentally ill offenders. For those first-degree murder defendants not declared legally insane but still determined to be mentally ill, proposals for reform (much like the current law on diminished capacity) would only preclude the death penalty but still allow for life without parole. "We're not talking about letting people go," says Ken Rose, attorney with the Center for Death Penalty Litigation in Durham. "We're not even talking about finding them guilty and putting them in the hospital for life. And we're only talking about those people with serious, serious mental illness, which is very narrowly defined. We're talking about life without parole as the alternative to executing someone with severe mental illness."[118]

Solutions: Building a Scientific and Legal Consensus

Today, a critical mass of leading mental health organizations have recommended exempting the seriously mentally ill from the death penalty. Indeed, the American Psychological Association,[119] American Psychiatric Association[120] and the National Alliance on Mental Illness[121] have all passed virtually identical resolutions on the issue. [APPENDICES 2–4] In the wake of the Supreme Court decision in *Atkins v. Virginia*, the American Bar Association (ABA) convened a Task Force on Mental Disability and the Death Penalty, comprising 24 mental health professionals and attorneys, to explore the question of which, if any, other types of mental conditions ought to be considered sufficiently serious for a similar exemption from the death penalty. After two years of deliberations, the task force came up with a set of recommendations that were adopted by the ABA in 2006.[122]

The ABA recommendations, which are intended to resolve many of the current ambiguities and deficiencies that have led (and continue to lead) to the execution of severely mentally ill defendants, read as follows:

1 Defendants should not be executed or sentenced to death if, at the time of the offense, they had significant limitations in both their intellectual functioning and adaptive behavior, as expressed in conceptual, social, and practical adaptive skills, resulting from mental retardation, dementia, or a traumatic brain injury.

2 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 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.

3 Mental Disorder or Disability after Sentencing

(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.

(b) *Procedure in Cases Involving Prisoners Seeking to Forgo or Terminate Post-conviction Proceedings*. If a court

finds that a prisoner under sentence of death who wishes to forgo or terminate post-conviction proceedings has a mental disorder or disability that significantly impairs his or her capacity to make a rational decision, the court should permit a next friend acting on the prisoner's behalf to initiate or pursue available remedies to set aside the conviction or death sentence.

(c) *Procedure in Cases Involving Prisoners Unable to Assist Counsel in Post-Conviction Proceedings*. If a court finds at any time that a prisoner under sentence of death has a mental disorder or disability that significantly impairs his or her capacity to understand or communicate pertinent information, or otherwise to assist counsel, in connection with post-conviction proceedings, and that the prisoner's participation is necessary for a fair resolution of specific claims bearing on the validity of the conviction or death sentence, the court should suspend the proceedings. If the court finds that there is no significant likelihood of restoring the prisoner's capacity to participate in post-conviction proceedings in the foreseeable future, it should reduce the prisoner's sentence to the sentence imposed in capital cases when execution is not an option.

(d) *Procedure in Cases Involving Prisoners Unable to Understand the Punishment or its Purpose*. If, after challenges to the validity of the conviction and death sentence have been exhausted and execution has been scheduled, a court finds that a prisoner has a mental disorder or disability that significantly impairs his or her capacity to understand the nature and purpose of the punishment, or to appreciate the reason for its imposition in the prisoner's own case, the sentence of death should be reduced to the sentence imposed in capital cases when execution is not an option.

The ABA report issued in conjunction with the recommendations offers a complete analysis and explanation of each component.[123] But a few elements are worth noting here:

The language in Part 1 of the recommendations defines mental retardation (which the Supreme Court in *Atkins* failed to do) in a manner consistent with that endorsed by the American Association of Mental Retardation.[124] That paragraph is also meant to address the question of organic brain injury and dementia, whose symptoms can mirror those of mental retardation in their impact on intellectual and adaptive functioning. The primary distinction is that while mental retardation is always manifested before age 18, the others either always (dementia) or sometimes (brain injury) occur after that age.

The use of the term "severe" is key to Part 2 of the recommendations and is intended to encompass the most significant mental disabilities, conforming roughly to the Axis I, and some Axis II, diagnoses as defined in the *Diagnostic and Statistical Manual of Mental Disorders*. The ABA report notes that "these disorders include schizophrenia and other psychotic disorders, mania, major depressive disorder . . . with schizophrenia being by far the most common disorder seen in capital defendants. In their acute state, all of these disorders are typically associated with delusions (fixed, clearly false beliefs), hallucinations (clearly erroneous perceptions of reality), extremely disorganized thinking, or very significant disruption of consciousness, memory and perception of the environment."[125]

The point of defining the impairment in Part 2, rather than relying on a simple diagnosis, is to ensure that only those less culpable and deterrable than the average murderer are exempted from the death penalty. The lan-

guage also takes into account the medical reality that symptoms of different illnesses can be more or less severe in order not to create too broad an exclusion. "[T]he purely diagnostic exclusion utilized by the Supreme Court in *Atkins* is not a plausible approach for dealing with mental illness," the American Psychiatric Association explains. "Even among persons with major mental disorders, such as schizophrenia, symptoms vary widely in severity, as does the impact of the disorder on the person's behavior. Thus, a mere diagnosis of a major mental disorder does not identify a narrow class of cases in which a death sentence would virtually always be disproportionate to the offenders' culpability. Instead, the category must be further narrowed to include only those defendants whose severe mental disorders are characterized by significant impairments of responsibility-related capacities."[126]

Both Parts 1 and 2 require that any severe mental illness that would qualify for a death penalty exemption must be manifested at the time of the crime. "We did not feel that we could say that a simple diagnosis of the condition at some point in life, or after the crime, or before the crime, is sufficient," says Ronald Tabak, a member of the ABA task force, "because there needs to be a nexus to the crime in order for us to be able to say, as they did in *Atkins* and *Roper*, that this person's conduct in committing a capital offense makes them substantially less morally culpable than even the average murderer."[127]

The exception regarding substance abuse is consistent with North Carolina court decisions, which have held, for example, that "in order for the requested insanity instruction to be submitted to the jury, evidence of chronic or permanent insanity not induced by the voluntary ingestion of alcohol or drugs must exist."[128]

"WE'RE NOT EVEN TALKING ABOUT FINDING THEM GUILTY AND PUTTING THEM IN THE HOSPITAL FOR LIFE. AND WE'RE ONLY TALKING ABOUT THOSE PEOPLE WITH SERIOUS, SERIOUS MENTAL ILLNESS, WHICH IS VERY NARROWLY DEFINED. WE'RE TALKING ABOUT LIFE WITHOUT PAROLE AS THE ALTERNATIVE TO EXECUTING SOMEONE WITH SEVERE MENTAL ILLNESS."

Part 3 seeks to refine the concept of competence in order to match medical realities with legal considerations, offer remedies for those who cannot properly assist their attorneys, and deal with the troubling phenomenon of "volunteerism". The use of the term "significantly impairs" may seem subjective and thus open the door to endless dispute over degree, but the functional capacities that are identified in each provision are the operative determinants, and actually would offer more explicit evaluative guidance to mental health professionals (and, in turn, judges and juries) than current federal and state competency standards.

The final provision in Part 3 would again better align medical realities with the standard for determining competency to be executed, distinguishing between a "factual understanding" of the reason for execution (which even the most severely mentally ill individuals may have) and a "rational understanding" (which their disabilities may prevent).

The particular proposal to exempt the mentally ill from the death penalty, crafted over a period of years by

the ABA and the most prominent national mental health organizations, has been embraced by the mental health community at large, including in North Carolina. The list of state groups that support legislation modeled after the ABA proposal includes the North Carolina Psychological Association, the North Carolina Psychiatric Association, the Governor's Council on Persons with Disabilities, the Coalition of Persons Disabled by Mental Illness-N.C., Carolina Legal Assistance, NAMI-N.C., the National Association of Social Workers-N.C., the Alliance of Disability Advocates—Center for Independent Living, Disability Rights and Resources, and the North Carolina Centers for Independent Living Directors Association. Dr. Peter Barboriak suggests that front-line practitioners would likely be amenable to reform as well. "I would say that most of the clinicians that I work with would be totally in agreement with both positions, ABA and APA," Dr Barboriak says.[129]

While the ABA proposal does not suggest procedural measures that might be employed in implementing its recommendations, a solid procedural foundation already exists in the North Carolina law that exempts mentally retarded defendants from the death penalty.[130] Upon the request of the defendant, for example, a judge has the discretion to order a pre-trial hearing on whether a defendant is mentally retarded and thus qualifies for the exemption. The state and defense then conduct evaluations and present their findings, which offers an opportunity to lay all the relevant information on the table pretrial.

That and other mechanisms in the law seem to be working well since the law was implemented in 2002. In the eight pretrial mental retardation hearings that have been conducted, seven resulted in determinations that the cases should be non-capital. Just as importantly, the law has helped preclude the need for a capital trial in 45 additional cases: mental retardation issues led directly to or influenced plea agreements with 22 defendants, and 23 other cases were declared non-capital without a pretrial hearing.[131] "I have no doubt that the mental retardation bill has helped reduce the number of capital trials and reduced taxpayer spending in those cases," says Tye Hunter, who directs the state's Office of Indigent Defense Services.[132]

Conclusion

Given the demonstrably accurate premise that severely mentally ill offenders are not more culpable or deterrable than the average murderer, a mechanism to exempt them from the death penalty is justified on both moral and legal grounds. This is especially true given the collectively inadequate protections currently afforded under law. As the National Mental Health Association has concluded, "Our current system of justice does not adequately address the complexity of cases involving defendants with mental illness. Therefore, NMHA calls upon states to suspend use of the death penalty until more just, accurate and systematic ways of determining a defendant's mental status are developed."[133]

The calls for reform are coming not just from mental health professionals, academics and the legal bar, but from the courts as well. In a 2006 opinion upholding a death sentence for a mentally ill man, Ohio Supreme Court Justice Evelyn Lundberg Stratton wrote that the time has come for the legislature to enact an exemption: "I urge our General Assembly to consider legislation setting the criteria for determining when a person with a severe mental illness should be excluded from the penalty of death. Unlike mental retardation, which can be determined by a number on an IQ test and other basic criteria, mental illnesses vary widely in severity. The General Assembly would be the proper body to examine these variations, take public testimony, hear from experts in the field, and fashion criteria for the judicial system to apply."[134]

The proposals adopted almost identically by the American Bar Association, the American Psychiatric Association, American Psychological Association, the National Alliance for the Mentally Ill and others create an effective model that is narrow in its scope but calibrates clinical and legal assessments where they presently conflict. Were this mechanism in place in North Carolina, the cases of Guy LeGrande, George Page, James Rich, Philip Ingle, James Hutchins and other severely mentally ill offenders might have been resolved in a manner consistent with justice and public safety, but without the shameful prospect of executing individuals whose severe mental impairments render them clearly less culpable and less deterrable than other murderers who receive life without parole or a lesser sentence.

And it most certainly would have altered the case of David Crespi. Prosecutors sought a death sentence for Crespi, who killed two of his children, despite his family's wishes for a non-capital prosecution based on their understanding that his crime was profoundly affected by his mental illness. Faced with the tremendous cost of a capital trial, both in terms of resources and on his family, as well as the risk of a death sentence, Crespi, with the urging of his family, pleaded guilty in exchange for a sentence of life without parole. "To take David to trial for his life, when [his crime] was mental-health related, seemed so absurd," says Crespi's wife, Kim. "Taking him to trial would only cause more harm. I'm completely convinced that putting him on death row would have caused the ultimate harm to our family."[135]

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20. American Psychiatric Association, *Psychiatric Services in Jails and Prisons: Task Force to Revise the APA Guidelines on Psychiatric Services in Jails and Prisons* (Rep. No. 2) (2000).

21. Hon. Shirley L. Fulton, *supra*.

22. *See*, *e.g.*, Bureau of Justice Statistics Special Report, *Mental Health Problems of Prison and Jail Inmates* (Sept. 2006) (finding that more than two fifths of state prisoners (43 percent) and more than half of jail inmates (54 percent) reported symptoms that met the criteria for mania; about 23 percent of state prisoners and 30 percent of jail inmates reported symptoms of major depression; and an estimated 15 percent of state prisoners and 24 percent of jail inmates reported symptoms that met the criteria for a psychotic disorder); *The Impact of the Mentally Ill on the Criminal Justice System: Hearing Before the House Judiciary Subcomm. on Crime*, 106th Cong. (2000) (testimony of Congressman Ted Strickland); Kessler, R.C. *et al.*, "A Methodology for Estimating the 12-Month Prevalence of Serious Mental Illness," in MENTAL HEALTH UNITED STATES 1999 (eds. Manderscheid & Henderson) (finding that somewhere between 8 and 19 percent of prisoners have significant psychiatric or functional disabilities, and another 15 to 20 percent will require some form of psychiatric intervention during their incarceration); American Psychiatric Association, *Psychiatric Services in Jails and Prisons* XIX (2d ed. 2000) (finding that perhaps as many as one in five prisoners were seriously mentally ill, with up to 5 percent actively psychotic at any given moment).

23. Bureau of Justice Statistics, *Mental Health and Treatment of Inmates and Probationers*, NCJ–174463 (1999).

24. Jeffrey Swanson, *Correctional Health in NC—An Expensive Non-Solution*, J. COMMON SENSE, Vol. 6, No. 3 (2000/2001).

25. Dr. Faye Sultan, speaking at *Mental Illness and the Death Penalty*, *supra*.

26. Dr. Peter Barboriak, *supra*.

27. Dr. Richard Dudley, *supra*.

28. *See*, *e.g.*, Rogers, R., *et al.*, *Evaluating Insanity: A Study of Construct Validity*, LAW & HUM. BEHAV. 8: 293–303 (1984).

29. John R. Chamberlain, M.D., *Beyond the Twinkie Defense: Criminal Culpability and Mental Illness*, San Francisco Medical Society (2005).

30. Dr. Richard Dudley, *supra*.

31. National Mental Health Association, *Position Statement 45: Death Penalty and People with Mental Illness* (2006).

32. *United States v. Hinckley*, 525 F. Supp. 1342 (D.D.C. 1981), *clarified*, 529 F. Supp. 520 (D.D.C.), *aff'd* 672 F.2d 115 (D.C. Cir. 1982).

33. Four states—Idaho, Kansas, Montana and Utah—have abolished the insanity defense. Arizona eliminated the cognitive incapacity element of its insanity test and added restrictions to expert testimony; the changes were upheld by the U.S. Supreme Court in *Clark v. Arizona*, 126 S. Ct. 2709 (2006).

34. Thomas Gutheil, M.D., *A Confusion of Tongues: Competence, Insanity, Psychiatry, and the Law*, PSYCHIATRIC SERV. 50:767–73 (June 1999) (citing Steadman, H.J., *Empirical research on the insanity defense*, ANNALS AM. ACAD. POL. & SOC. SCI. 477:58–64 (1985)).

35. *Id*.

36. *State v. Myers*, 123 N.C. App 189, 198, 472 S.E.2d 598, 604 (1996) (citing *State v. Bonney*, 329 N.C. 61, 78, 405 S.E.2d 145, 155 (1991) and *State v. Franks*, 300 N.C. 1, 265 S.E.2d 177 (1980)).

37. Dr. Peter Barboriak, *supra*.

38. The Federal Insanity Defense Reform Act (1984), 18 U.S.C. § 17 (1984).

39. The American Law Institute Model Penal Code, Section 4.01(1) (1962).

40. Dr. Peter Barboriak, *supra*.

41. *See* Case Summary: Phillip Lee Ingle at 10.

42. John Rubin, *The Diminished Capacity Defense*, Administration of Justice Memorandum No. 92/01, Institute of Government, UNC Chapel Hill (September 1992).

43. *Id*.

44. *Id*. (citing *State v. Clark*, 324 N.C. 163, 377 S.E.2d 64 (1989)).

45. *People v. Wells*, 33 Cal. 2nd 330, 202 P.2d 53 (1949).

46. *State v. Shank*, 322 N.C. 243, 367 S.E.2d 639 (1988). *See also State v. Rose*, 323 N.C. 455, 458–59, 373 S.E.2d 426, 429 (1988).

47. N.C.G.S § 15A–2000(b).

48. N.C.G.S § 15A–2000(e).

49. N.C.G.S § 15A–2000(f).

50. CHRISTOPHER SLOBOGIN, MINDING JUSTICE: LAWS THAT DEPRIVE PEOPLE WITH MENTAL DISABILITY OF LIFE AND LIBERTY (2006).

51. *Dusky v. United States*, 363 U.S. 402 (1960).

52. *See*, *e.g.*, *Godinez v. Moran*, 509 U.S. 389 (1993); *Rees v. Peyton*, 384 U.S. 312 (1966); *Hauser v. Moore*, 223 F.3d 1316, 1322 (11th Cir. 2000); *Rumbaugh v. Procunier*, 753 F.2d 395, 398–99 (5th Cir. 1985); *State v. Carter*, 338 N.C. 569, 581, 451 S.E.2d 157, 163 (1994); *State v. Thomas*, 331 N.C. 671, 673, 417 S.E.2d 473, 475 (1992).

53. N.C.G.S. § 15A–1001(a).

54. Thomas G. Gutheil, M.D., *A Confusion of Tongues: Competence, Insanity, Psychiatry, and the Law*, PSYCHIATRIC SERV. 50:767–73 (1999).

55. N.C.G.S. § 15A–1002.

56. *See State v. Shytle*, 323 N.C. 684, 374 S.E.2d 573 (1989).

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

58. For example, in its brief urging the Supreme Court to grant *certiorari* in *Panetti v. Quarterman*, the National Alliance on Mental Illness argued that "this case exemplifies why mere 'awareness'... is not a meaningful requirement for determining whether to execute prisoners who are severely mentally ill." *Brief of Amicus Curiae in Support of Petitioner on Behalf of National Alliance for the Mentally Ill* at 13.

59. *See State v. O'Neal*, 116 N.C. App. 390, 448 S.E.2d 306 (1994).

60. Dr. Faye Sultan, *supra*.

61. The League of Women Voters of New Jersey, *Facts and Issues About the Death Penalty: A Study of New Jersey's Death Penalty Statute and Its Application* (Jan. 2004).

62. N.C.G.S. § 15A–1001(a).

63. *See*, *e.g.*, *State v. Jackson*, 302 N.C. 101, 273 S.E.2d 666 (1981); *State v. O'Neal*, 116 N.C. App. 390, 448 S.E.2d 306 (1994).

64. *See* Case Summary: James Hutchins at 18.

65. *See* Case Summary: Guy LeGrande at 33.

66. *Id*.

67. Hon. Burley Mitchell, *supra*.

68. John Blume, *Killing the Willing: "Volunteers," Suicide and Competency*, 103 MICH. L. REV. 939 (2005). *See also* Cunningham & Vigen, *Without Appointed Counsel in Capital Postconviction Proceedings; The Self-Representation Competency of Mississippi Death Row Inmates*, CRIM. JUST. & BEHAV. 26: 293–321 (1999) (finding that "Mississippi death row inmates exhibited a pattern of broad deficits in requisite verbal intellectual ability, reading comprehension, legal aptitude, knowledge specific to postconviction practice, and psychological well-being. These deficits raise grave concerns regarding the self-representation competency of Mississippi death row prisoners.")

69. E-mail from Dr. Dorothy Lewis, Feb. 7, 2007 (on file with the Charlotte School of Law).

70. Hon. Shirley L. Fulton, *supra*.

71. *"Next Friend" Petition for Writ of Certiorari* (filed with N.C. Supreme Court) (Sept. 16, 1998) (quoting transcript from July 20, 1998 hearing).

72. *See* Stephen P. Garvey, *Aggravation and Mitigation in Capital Cases: What Do Jurors Think?* 98 COLUM. L. REV. 1538 (1998); Stephen P. Garvey, *The Emotional Economy of Capital Sentencing*, 75 N.Y.U. L. REV. 26 (2000); Christopher Slobogin, *Mental Illness and the Death Penalty*, 24 MENTAL & PHYSICAL DISABILITY L. REP. 667, 669–70 (2000) (describing studies that show juries treat mental disability as an aggravating circumstance); John Parry, *The Death Penalty and Persons with Mental Disabilities: A Lethal Dose of Stigma, Sanism, Fear of Violence, and Faulty Predictions of Dangerousness*, 29 MENTAL & PHYSICAL DISABILITY L. REP. 667, 667 n.7 (2005) (criticizing the "misconception that persons with mental illness are inherently violent and generally dangerous to themselves or

others"); Phyllis Crocker, *Concepts of Culpability and Deathworthiness: Differentiating between Guilt and Punishment in Death Penalty Cases*, 22 FORDHAM L. REV. 21 (1997); Richard J. Bonnie & C. Robert Showalter, *Psychiatrists and Capital Sentencing: Risks and Responsibilities in a Unique Legal Setting*, 12 BULL. AM. ACAD. PSYCHIATRY & LAW 159–67 (1984); Joshua N. Sondheimer, *A Continuing Source of Aggravation: The Improper Consideration of Factors in Death Penalty Sentencing*, 41 HASTINGS L.J. 409, 420 (1990).

73. *See*, *e.g.*, Phyllis Crocker, *Concepts of Culpability and Deathworthiness: Differentiating Between Guilt and Punishment in Death Penalty Cases*, 22 FORDHAM L. REV. 21 (1997).

74. American Psychiatric Association Position Statement, *Diminished Responsibility In Capital Sentencing* (2004).

75. *Atkins v. Virginia*, 536 U.S. at 320, 321 (2002) (citing *Penry v. Lynaugh*, 492 U.S. 302, 323–325 (1989)).

76. *Id*. at 318 (citing *Penry*, 492 U.S. at 323—325).

77. *Id*.

78. *See*, *e.g.*, *Boyle v. Johnson*, 93 F.3d 180, 187–188 (5th Cir. 1996).

79. *See* Case Summary: George Page at 23.

80. Marsha Goodenow, speaking at *Mental Illness and the Death Penalty*, *supra*.

81. Dr. Faye Sultan, *supra*.

82. Wiener, R., *et al.*, *Comprehensibility of approved jury instructions in capital cases*, J. APPLIED PSYCHOL., 80: 455–467 (1995).

83. *See*, *e.g.*, *Penry v. Lynaugh*, 492 U.S. 302, 335–36 (1989) (quoting *Gregg v. Georgia*, 428 U.S. 153, 183 (1976)).

84. *Enmund v. Florida*, 458 U.S. 782, 798 (1982) (quoting *Coker v. Georgia*, 433 U.S. 584, 592 (1977)).

85. *Id*. at 800, 801.

86. *Atkins*, 536 U.S. at 318.

87. *See*, *e.g.*, *Marsh v. Kansas*, 126 S. Ct. 2156, 2543 (2006) (Souter, J., dissenting).

88. *Atkins*, 536 U.S. at 318.

89. *Godfrey v. Georgia*, 446 U.S. 420, 433 (1980).

90. Dr. Richard Dudley, *supra*.

91. Diane Suchetka, *IQ in 60s doesn't change fate*, CHARLOTTE OBSERVER, Sept. 14, 2000.

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

93. *Enmund*, 458 U.S. at 799.

94. *Atkins*, 536 U.S. at 318.

95. Hon. Burley Mitchell, *supra*.

96. *Atkins*, 536 U.S. at 318.

97. *Id*.

98. *Roper v. Simmons*, 543 U.S. 551, 567 (2004) (quoting *Atkins*, 536 U.S. at 316).

99. *Roper*, 543 U.S. at 567 (citing *Gregg v. Georgia*, 428 U.S. 153, 186 (1976)).

100. *Roper*, 543 U.S. at 571.

101. *Thompson v. Oklahoma*, 487 U.S. 815, 837 (1988).

102. *California v. Danks*, 32 Cal. 4th 269, 82 P.3d 1249, 1285 (2004) (Kennard, J., concurring and dissenting).

103. *State v. Ketterer*, 111 Ohio St.3d 70, 855 N.E.2d 48 (2006) (Lundberg Stratton, J., concurring).

104. Editorial, *Hoosier Mercy*, WASH. POST (Sept. 1, 2005) (commenting on the commutation of mentally ill death row inmate Arthur Baird by the Governor of Indiana). *See also Testimony of Philip Coons, M.D.*, Hearing Before the Indiana Senate Corrections, Criminal and Civil Matters Committee (Jan. 30, 2007) (stating that "because of their illness, these people are simply not the worst of the worst"); Robert C. Goodwin, M.D., *Too Ill For Execution*, HARTFORD COURANT (Jan. 16, 2005); Editorial, *Mad moms, insane law*, HOUS. CHRON. (Dec. 19, 2004); Alan A. Stone, M.D., *Condemned Prisoner Treated and Executed*, PSYCHIATRIC TIMES, 21:3 (Mar. 2004); Editorial, *Executing the mentally ill*, SAN ANTONIO EXPRESS-NEWS (Apr. 6, 2003); Editorial, *It's Wrong to Execute Murderer Who Is Mentally Ill*, NEWSDAY (Nov. 6, 2002).

105. Dr. Jeffrey Swanson, *Correctional Health in NC—An Expensive Non-Solution*, *supra* (noting that "[n]ot counting capital expenditures, our state's Department of Corrections spent an estimated $117 million [in FY 1999/2000] solely for the incarceration of persons with mental illness (excluding substance abuse)").

106. Philip Cook *et al.*, *supra*. *See also* Mary E. Forsberg, *Money for Nothing? The financial cost of New Jersey's Death Penalty*, NEW JERSEY POLICY PERSPECTIVE (Nov. 2005) (estimating that since 1983, New Jersey's death penalty had cost state taxpayers $253 million above the amount that would have been incurred had the offenders been sentenced to life without parole); State of Tennessee Comptroller of the Treasury, Office of Research, *Tennessee's Death Penalty: Costs and Consequences* (July 2004) (estimating that death penalty trials cost 48 percent more than non-capital trials); Kansas Legislative Division of Post Audit, *Overview of Costs Incurred for Death Penalty Cases: A K-GOAL Audit of the Department of Corrections* (Dec. 2003) (finding that the median cost of death penalty cases through execution was $1.26 million, compared to the median cost of $740,000 for non-capital cases through the end of sentence); National Bureau of Economic Research, *The Budgetary Repercussions of Capital Convictions*, NBER Working Paper No. s8382 (July 2001) (estimating that the extra cost of capital trials between 1982–1997 was $1.6 billion, and that "counties manage these high costs by decreasing funding for highways and police and by increasing taxes").

107. Hon. Burley Mitchell, *supra*.

108. Jennie Vaughn & Anna Scheyett, *Identification and Treatment of Individuals with Mental Illness and Mental Retardation/Developmental Disability in North Carolina Jails*, N.C. GOVERNOR'S ADVOCACY COUNCIL FOR PERSONS WITH DISABILITIES (Jan. 2007) (concerns included the increase in staffing and fiscal demands on jails when housing individuals with mental illness; that jails are not screening for mental illness effectively, and that screening is done primarily by jail officials who do not receive adequate and ongoing training in identifying and working with individuals with mental illness; that suicide protocols vary; that inmates often must wait for medications or do not receive their usual medications; that getting consumers mental health care while in jail is difficult; and that jail personnel are concerned about the inadequacy of the mental health system).

109. Dr. Peter Barboriak, *supra*.

110. Joint Report of the National Alliance for the Mentally Ill

and Public Citizen's Health Research Group, *Criminalizing the Seriously Mentally Ill: The Abuse of Jails as Mental Hospitals* at 62 (1992).

111. National Alliance on Mental Illness, *New Study Confirms Treatment Reduces Violence in Individuals with Major Psychiatric Disorders by Half* (May 14, 1998) (responding to a study by Steadman *et al.*, *Violence by People Discharged from Acute Psychiatric Inpatient Facilities and by Others in the Same Neighborhoods*, ARCH GEN PSYCHIATRY 55(5):393–401 (May 1998)).

112. Dr. Jeffrey Swanson, *Correctional Health in NC—An Expensive Non-Solution*, *supra*.

113. Hon. Shirley Fulton, *supra*.

114. E. FULLER TORREY, M.D., OUT OF THE SHADOWS: CONFRONTING AMERICA'S MENTAL ILLNESS CRISIS (1997) (citing Dawson & Langan, *Murder in Families*, U.S. Department of Justice (1994)).

115. *See*, *e.g.*, Fukunaga *et al.*, *Insanity Plea: Inter-Examiner Agreement and Concordance of Psychiatric Opinion and Court Verdict*, 5 LAW & HUM. BEHAV. 325 (1981) (finding 92 percent interrater agreement on gross impairment), Phillips *et al.*, *Psychiatry and the Criminal Justice System: Testing the Myths*, AM. J. PSYCHIATRY 145: 605 (1988) (finding 76 percent agreement on psychosis).

116. SLOBOGIN, MINDING JUSTICE, *supra*.

117. MICHAEL PERLIN, THE JURISPRUDENCE OF THE INSANITY DEFENSE 238–242 (1994).

118. Ken Rose, speaking at *Mental Illness and the Death Penalty*, *supra*.

119. *See* American Psychological Association, *Excerpt from the Council of Representatives 2005 Meeting Minutes* (Feb. 18–20, 2005); *Excerpt from the Council of Representatives 2006 Meeting Minutes* (Feb. 17–19, 2006).

120. *See* American Psychiatric Association Position Statement, *Diminished Responsibility In Capital Sentencing* (2004); American Psychiatric Association Position Statement, *Death Sentences for Persons with Dementia or Traumatic Brain Injury* (2005); American Psychiatric Association Position Statement, *Mentally Ill Prisoners on Death Row* (2005).

121. Public Policy Platform of The National Alliance on Mental Illness, Sec. 10.9 (Nov. 2006).

122. American Bar Association, Recommendation 122A and Report (adopted by the ABA House of Delegates, Aug. 8, 2006).

123. *See* American Bar Association, Recommendation 122A and Report, *supra*.

124. MANUAL OF THE AMERICAN ASSOCIATION OF MENTAL RETARDATION 13 (10th ed., 2002) (mental retardation defined as a disability originating before the age of 18 and "characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills").

125. American Bar Association Recommendation 122A and Report, *supra*.

126. American Psychiatric Association Position Statement, *Diminished Responsibility In Capital Sentencing*, *supra*.

127. Ronald Tabak, speaking at *Mental Illness and the Death Penalty*, *supra*.

128. *State v. Austin*, 320 N.C. 276, 357 S.E.2d 641, *cert. denied*, 484 U.S. 916, 98 L. Ed. 2d 224 (1987).

129. Dr. Peter Barboriak, *supra*.

130. N.C.G.S. § 15A–2005.

131. Figures provided by the Center for Death Penalty Litigation.

132. E-mail from Tye Hunter, Mar. 13, 2007 (on file with the Charlotte School of Law).

133. National Mental Health Association Fact Sheet, *supra*.

134. *State v. Ketterer*, 111 Ohio St.3d 70, 855 N.E.2d 48 (2006) (Lundberg Stratton, J., concurring).

135. Kim Crespi, speaking at *Mental Illness and the Death Penalty*, *supra*.

APPENDICES

APPENDIX 1

American Bar Association: Resolution 122A

Adopted by the House of Delegates | August 7–8, 2006

RESOLVED, That the American Bar Association, without taking a position supporting or opposing the death penalty, urges each jurisdiction that imposes capital punishment to implement the following policies and procedures:

1 Defendants should not be executed or sentenced to death if, at the time of the offense, they had significant limitations in both their intellectual functioning and adaptive behavior, as expressed in conceptual, social, and practical adaptive skills, resulting from mental retardation, dementia, or a traumatic brain injury.

2 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 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.

3 Mental Disorder or Disability after Sentencing

(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. Procedures to be followed in each of these categories of cases are specified in (b) through (d) below.

(b) *Procedure in Cases Involving Prisoners Seeking to Forgo or Terminate Post-Conviction Proceedings.* If a court finds that a prisoner under sentence of death who wishes to forgo or terminate post-conviction proceedings has a mental disorder or disability that significantly impairs his or her capacity to make a rational decision, the court should permit a next friend acting on the prisoner's behalf to initiate or pursue available remedies to set aside the conviction or death sentence.

(c) *Procedure in Cases Involving Prisoners Unable to Assist Counsel in Post-Conviction Proceedings.* If a court finds

at any time that a prisoner under sentence of death has a mental disorder or disability that significantly impairs his or her capacity to understand or communicate pertinent information, or otherwise to assist counsel, in connection with post-conviction proceedings, and that the prisoner's participation is necessary for a fair resolution of specific claims bearing on the validity of the conviction or death sentence, the court should suspend the proceedings. If the court finds that there is no significant likelihood of restoring the prisoner's capacity to participate in post-conviction proceedings in the foreseeable future, it should reduce the prisoner's sentence to the sentence imposed in capital cases when execution is not an option.

(d) *Procedure in Cases Involving Prisoners Unable to Understand the Punishment or its Purpose.* If, after challenges to the validity of the conviction and death sentence have been exhausted and execution has been scheduled, a court finds that a prisoner has a mental disorder or disability that significantly impairs his or her capacity to understand the nature and purpose of the punishment, or to appreciate the reason for its imposition in the prisoner's own case, the sentence of death should be reduced to the sentence imposed in capital cases when execution is not an option.

RECOMMENDATION REPORT

Preamble

In *Atkins v. Virginia*, 536 U.S. 304 (2002), the United States Supreme Court held that execution of people with mental retardation violates the Eighth Amendment's ban on cruel and unusual punishment. The Individual Rights and Responsibilities Section of the American Bar Association recognized that *Atkins* 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. To achieve that objective, the Section established a Task Force on Mental Disability and the Death Penalty. The Task Force, which carried out its deliberations from April, 2003 to March, 2005, was composed of 24 lawyers and mental health professionals (both practitioners and academics), and included members of the American Psychiatric Association and the American Psychological Association.[1] The American Psychiatric Association[2] and the American Psychological Association[3] have officially endorsed the Task Force's proposal.[4] The following commentary discusses the three paragraphs of the proposal.

1 The Task Force's members are Dr. Michael Abramsky; Dr. Xavier F. Amador; Michael Allen, Esq.; Donna Beavers; Professor John H. Blume; Professor Richard J. Bonnie; Colleen Quinn Brady, Esq.; Richard Burr, Esq.; Dr. Joel A. Dvoskin; Dr. James R. Eisenberg; Professor I. Michael Greenberger; Dr. Kirk S. Heilbrun; Ronald Honberg, Esq.; Ralph Ibson; Dr. Matthew B. Johnson; Professor Dorean M. Koenig; Dr. Diane T. Marsh; Hazel Moran; John Parry, Esq.; Professor Jennifer Radden; Professor Laura Lee Rovner; Robyn S. Shapiro, Esq.; Professor Christopher Slobogin; and Ronald J. Tabak, Esq. Drs. Paul S. Appelbaum, Howard V. Zonana and Jeffrey Metzner also contributed significantly to the Task Force's deliberations and recommendations.

2 *See* Am. Psychiatric Ass'n, Diminished Responsibility in Capital Sentencing; Death Sentences for Persons with Dementia or Traumatic Brain Injury; Mentally Ill Prisoners on Death Row: *available at* http://www.psych.org/edu/other_res/lib_archives/archives/200406.pdf, 200508.pdf, 200505.pdf.

3 *See* American Psychological Association, Excerpt from the Council of Representatives 2005 Meeting Minutes (Feb. 18–20, 2005); Excerpt from the Council of Representatives 2006 Meeting Minutes (Feb. 17–19, 2006).

4 The recommendation being presented to the House of Delegates is identical to the wording approved by these other groups, except that minor changes have been made to paragraph 3(c) and 3(d) to remove any potential doubt that, where either provision applies, the sentence would be the one that would be applicable in a capital case in situations in which the death penalty is not a sentencing option.

Paragraph 1

Paragraph 1 of the Recommendation is meant to exempt from the death penalty persons charged with capital offenses who have significant limitations in both intellectual functioning and adaptive skills. Its primary purpose is to implement the United States Supreme Court's holding in *Atkins v. Virginia*,[5] which declared that execution of offenders with mental retardation violates the cruel and unusual punishment prohibition in the Eighth Amendment. The Court based this decision both on a determination that a "national consensus" had been reached that people with mental retardation should not be executed,[6] and on its own conclusion that people with retardation who kill are not as culpable or deterrable as the "average murderer," much less the type of murderer for whom the death penalty may be viewed as justifiable.[7]

While the *Atkins* Court clearly prohibited execution of people with mental retardation, it did not define that term. The Recommendation embraces the language most recently endorsed by the American Association of Mental Retardation, which defines mental retardation as a disability originating before the age of eighteen that is "characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills."[8] The language of the Recommendation is also consistent with the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, which defines a person as mentally retarded if, before the age of 18, he or she exhibits "significantly subaverage intellectual functioning" (defined as "an IQ of approximately 70 or below") and "concurrent deficits or impairments in present adaptive functioning . . . in at least two of the following areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety."[9] Both of these definitions were referenced (albeit not explicitly endorsed) by the Supreme Court in *Atkins*, and both have been models for states that have defined retardation for purposes of the death penalty exemption.[10] Both capture the universe of people who, if involved in crime, *Atkins* describes as less culpable and less deterrable than the "average murderer." As the APA's Diagnostic and Statistical Manual indicates, even a person with only "mild" mental retardation, as that term is defined in the Manual, has a mental age below that of a teenager.[11]

The language in this part of the Recommendation is also meant to encompass dementia and traumatic brain injury, disabilities very similar to mental retardation in their impact on intellectual and adaptive functioning

5 536 U.S. 304 (2002).

6 *Id*. at 313–17.

7 *Id*. at 318–20.

8 MANUAL OF THE AMERICAN ASSOCIATION OF MENTAL RETARDATION 13 (10th ed., 2002).

9 See AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL 49 (text rev. 4th ed. 2000) (hereafter DSM-IV-TR).

10 536 U.S. at 308 n.3. DEATH PENALTY INFO. CTR., STATE STATUTES PROHIBITING THE DEATH PENALTY FOR PEOPLE WITH MENTAL RETARDATION, www.deathpenaltyinfo.org/article.php?scid (describing state laws).

11 DSM-IV-TR, *supra* note 9, at 43 (stating that people with "mild" mental retardation develop academic skills up to the sixth grade level, amounting to the maturity of a twelve year old). For more on the definition of retardation, see James W. Ellis, *Mental Retardation and the Death Penalty: A Guide to State Legislative Issues*, 27 MEN. & PHYS. DIS. L. REP. 11–24 (2003); Richard J. Bonnie, *The APA's Resource Document on Mental Retardation and Capital Sentencing: Implementing Atkins v. Virginia*, 32 J. AM. ACAD. PSYCHIAT. & L. 304, 308 (2004).

except that they always (in the case of dementia) or often (in the case of head injury) are manifested after age eighteen. Dementia resulting from the aging process is generally progressive and irreversible, and is associated with a number of deficits in intellectual and adaptive functioning, such as agnosia (failure to recognize or identify objects) and disturbances in executive functioning connected with planning, organizing, sequencing, and abstracting.[12] The same symptoms can be experienced by people with serious brain injury. Of course, people with dementia or a traumatic head injury severe enough to result in "significant limitations in both intellectual functioning or adaptive behavior" rarely commit capital offenses. If they do, however, the reasoning in *Atkins* should apply and an exemption from the death penalty is warranted, because the only significant characteristic that differentiates these severe disabilities from mental retardation is the age of onset.[13]

Paragraph 2

Paragraph 2 of the Recommendation is meant to prohibit execution of persons with severe mental disabilities whose demonstrated impairments of mental and emotional functioning at the time of the offense would render a death sentence disproportionate to their culpability. The Recommendation uses the phrase "disorder or disability" because, even though those words are often used interchangeably, some prefer one over the other. The Recommendation indicates that only those individuals with "severe" disorders or disabilities are to be exempted from the death penalty, and it specifically excludes from the exemption those diagnosed with conditions that are primarily manifested by criminal behavior and those whose abuse of psychoactive substances, standing alone, renders them impaired at the time of the offense.

Rationale

This part of the Recommendation is based on long-established principles of Anglo-American law that the Supreme Court recognized and embraced in *Atkins* and recently affirmed in *Roper v. Simmons*,[14] in which it held that the execution of juveniles who commit crimes while under the age of eighteen is prohibited by the Eighth Amendment. In reaching its holding in *Atkins*, the Court emphasized that execution of people with mental retardation is inconsistent with both the retributive and deterrent functions of the death penalty. More specifically, as noted above, it held that people with mental retardation who kill are both less culpable and less deterrable than the average murderer, because of their "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 the reactions of others."[15] As the Court noted, "[i]f the culpability of the average murderer is insufficient to justify the most extreme sanction available to the State, the lesser culpability of the mentally retarded offender surely does not merit that form of retribution."[16] Similarly, with respect to deterrence, the Court stated, "[e]xempting the mentally retarded from [the death penalty] will not affect the 'cold calculus that precedes the

12 DSM-IV-TR, *supra* note 9, at 135 (describing symptoms of dementia).
13 *Compare id.* at 135 (describing symptoms of dementia) *with id.* at 46 (symptoms of mental retardation).
14 125 S.Ct. 1183 (2005).
15 536 U.S. at 318.
16 *Id.* at 319.

decision' of other potential murderers."[17]

The Court made analogous observations in *Simmons*. With respect to culpability, the Court stated:

> Whether viewed as an attempt to express the community's moral outrage or as an attempt to right the balance for the wrong to the victim, the case for retribution is not as strong with a minor as with an adult. Retribution is not proportional if the law's most severe penalty is imposed on one whose culpability or blameworthiness is diminished, to a substantial degree, by reason of youth and immaturity.[18]

On the deterrence issue it said, "'[t]he likelihood that the teenage offender has made the kind of cost-benefit analysis that attaches any weight to the possibility of execution is so remote as to be virtually nonexistent.'"[19]

The same reasoning applies to people who, in the words of the Recommendation, have a "severe mental disorder or disability" that, at the time of the offense: "significantly impaired their capacity" (1) "to appreciate the nature, consequences, or wrongfulness of their conduct"; (2) "to exercise rational judgment in relation to the conduct"; or (3) "to conform their conduct to the requirements of law." Offenders who meet these requirements, even if found sane at trial, are not as culpable or deterrable as the average offender. A close examination of this part of the Recommendation makes clear why this is so.

The Severe Mental Disorder or Disability Requirement

First, the predicate for exclusion from capital punishment under this part of the Recommendation is that offenders have a "severe" disorder or disability, which is meant to signify a disorder that is roughly equivalent to disorders that mental health professionals would consider the most serious "Axis I diagnoses."[20] These disorders include schizophrenia and other psychotic disorders, mania, major depressive disorder, and dissociative disorders—with schizophrenia being by far the most common disorder seen in capital defendants. In their acute state, all of these disorders are typically associated with delusions (fixed, clearly false beliefs), hallucinations (clearly erroneous perceptions of reality), extremely disorganized thinking, or very significant disruption of consciousness, memory and perception of the environment.[21] Some conditions that are not considered an Axis I condition might also, on rare occasions, become "severe" as that word is used in this Recommendation. For instance, some persons whose predominant diagnosis is a personality disorder, which is an Axis II disorder, may at times experience more significant dysfunction. Thus, people with borderline personality disorder can experience "psychotic-like symptoms ... during times of stress."[22] However, only if these more serious symptoms occur at the time of the capital offense would the predicate for this Recommendation's exemption be present.

17 *Id.*

18 125 S.Ct. at 1196.

19 *Id.* (quoting *Thompson v. Oklahoma*, 487 U.S. 815, 837 (1988)).

20 *See* DSM-IV-TR, *supra* note 9, at 25–26 (distinguishing Axis I diagnoses from Axis II diagnoses).

21 *See id.* at 275–76 (schizophrenia); 301 (delusional disorders); 332–33 (mood disorder with psychotic features); 125 (delirium); 477 (dissociative disorders).

22 *See id.* at 652. Other Axis II diagnoses that might produce psychotic-like symptoms include Autistic Disorder, *id.* at 75, and Asperger's Disorder. *Id.* at 84.

The Significant Impairment Requirement

To ensure that the exemption only applies to offenders less culpable and less deterrable than the average murderer, this part of the Recommendation further requires that the disorder significantly impair cognitive or volitional functioning at the time of the offense. *Atkins* held the death penalty excessive for *every* person with mental retardation, and the Supreme Court therefore dispensed with a case-by-case assessment of responsibility. However, for the disorders covered by this second part of the Recommendation, preclusion of a death sentence based on diagnosis alone would not be sensible, because the symptoms of these disorders are much more variable than those associated with retardation or the other disabilities covered by the Recommendation's first paragraph.

The first specific type of impairment that this part of the Recommendation recognizes as a basis for exemption from the death penalty (if there was a severe disorder at the time of the offense) is a significant incapacity "to appreciate the nature, consequences, or wrongfulness" of the conduct associated with the offense (section (a)). This provision is meant to encompass those individuals with severe disorder who have serious difficulty appreciating the wrongfulness of their criminal conduct. For instance, people who, because of psychosis, erroneously perceived their victims to be threatening them with serious harm would be covered by this language,[23] as would delusional offenders who believed that God had ordered them to commit the offense.[24]

Section (a) also refers to offenders who fail to appreciate the "nature and consequences" of the crime. This language would clearly apply to offenders who, because of severe disorder or disability, did not intend to engage in the conduct constituting the crime or were unaware they were committing it.[25] It would also apply to delusional offenders who intended to commit the crime and knew that the conduct was wrongful, but experienced confusion and self-referential thinking that prevented them from recognizing its full ramifications. For example, a person who experiences delusional beliefs that electric power lines are implanting demonic curses, and thus comes to believe that he or she must blow up a city's power station, might understand that destruction of property and taking the law into one's own hands is wrong but might nonetheless fail to appreciate that the act would harm and perhaps kill those who relied on the electricity.

The second type of impairment recognized as a basis for exemption from the death penalty under this part of the Recommendation (in section (b)) is a significant incapacity "to exercise rational judgment in relation to the conduct" at the time of the crime. Numerous commentators have argued that irrationality is the core determinant of diminished responsibility.[26] As used by these commentators, and as made clear by the Recommendation's threshold requirement of severe mental disability, "irrational" judgment in this context does not mean

23 This is a fairly common perception of people with schizophrenia who commit violent acts. *See* Dale E. McNiel, *The Relationship Between Aggressive Attributional Style and Violence by Psychiatric Patients*, 71 J. CONSULTING & CLINICAL PSYCHOLOGY 404, 405 (2003).

24 *Cf. People v. Schmidt*, 216 N.Y. 324, 110 N.E. 945 (1915) (stating that if a person has "an insane delusion that God has appeared to [him] and ordained the commission of a crime, we think it cannot be said of the offender that he knows the act to be wrong").

25 These offenders would not have the *mens rea* for murder, and perhaps not even meet the voluntary act requirement for crime. *See* Wayne LaFave, Criminal Law 405 (3d ed. 2000) (describing the voluntary act requirement under the common law).

26 *See, e.g.*, HERBERT FINGARETTE & ANN FINGARETTE HASSE, MENTAL DISABILITIES AND CRIMINAL RESPONSIBILITY 218 (1979); MICHAEL MOORE, LAW AND PSYCHIATRY: RETHINKING THE RELATIONSHIP 244–245 (1985); Stephen J. Morse, *Immaturity and Irresponsibility*, 88 J. Crim. L. & Criminology 15, 24 (1997); ROBERT F. SCHOPP, AUTOMATISM, INSANITY AND THE PSYCHOLOGY OF CRIMINAL RESPONSIBILITY: A PHILOSOPHICAL INQUIRY 215 (1991).

"inaccurate," "unusual" or "bad" judgment. Rather, it refers to the type of disoriented, incoherent and delusional thinking that only people with serious mental disability experience. Furthermore, as noted above, the Recommendation requires that the irrationality occur in connection with the offense, rather than simply have existed prior to the criminal conduct.

Under these conditions, offenders who come within section (b) would often also fail to appreciate the "nature, consequences, or wrongfulness" of their conduct. But there is a subset of severely impaired individuals who may not meet the latter test and yet who should still be exempted from the death penalty because they are clearly not as culpable or deterrable as the average murderer. For instance, a jury rejected Andrea Yates' insanity defense despite strong evidence of psychosis at the time she drowned her five children. Apparently, the jury believed that, even though her delusions existed at the time of the offense, she could still appreciate the wrongfulness (and maybe even the fatal consequences) of her acts. Yet that same jury spared Yates the death penalty, probably because it believed her serious mental disorder significantly impaired her ability to exercise rational judgment in relation to the conduct.[27]

The third and final type of offense-related impairment recognized as a basis for exemption from the death penalty by this part of the Recommendation is a significant incapacity "to conform [one's] conduct to the requirements of law" (section (c)). Most people who meet this definition will probably also experience significant cognitive impairment at the time of the crime. However, some may not. For example, people who have a mood disorder with psychotic features might understand the wrongfulness of their acts and their consequences, but nonetheless feel impervious to punishment because of delusion-inspired grandiosity.[28] Because a large number of offenders can make plausible claims that they felt compelled to commit their crime, however, enforcement of the Recommendation's requirement that impairment arise from a "severe" disorder is especially important here.

Exclusions

In addition to the severe disability threshold and the requirement of significant cognitive or volitional impairment at the time of the offense, a third way this part of the Recommendation assures that those it exempts from the death penalty are less culpable and deterrable than the average murderer is to exclude explicitly from its coverage those offenders whose disorder is "manifested primarily by repeated criminal conduct or attributable solely to the acute effects of voluntary use of alcohol or other drugs." The Recommendation's reference to mental disorders "manifested primarily by repeated criminal conduct" is meant to deny the death penalty exemption to those offenders whose only diagnosis is Antisocial Personality Disorder.[29] This language is virtually identical to language in the Model Penal Code's insanity formulation, which was designed to achieve the same purpose.[30]

27 For a description of the Yates case, see Deborah W. Denno, *Who is Andrea Yates? A Short Story About Insanity*, 10 Duke J. Gender L. & Pol'y 37 (2003).

28 DSM-IV-TR, *supra* note 9, at 332–33.

29 *Id.* at 650 et. seq. (defining as a symptom of antisocial personality disorder "failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest).

30 *See* AMERICAN LAW INSTITUTE, MODEL PENAL CODE § 4.01(2) and commentary (draft, 1962) (stating that "mental disease or defect as used in the insanity formulation does not include "abnormality manifested only by repeated or otherwise anti-social conduct).

However, the Recommendation uses the word "primarily" where the MPC uses the word "solely" because Antisocial Personality Disorder consists of a number of symptom traits in addition to antisocial behavior, and therefore the MPC language does not achieve its intended effect. Compared to the MPC's provision, then, the Recommendation's language broadens the category of offenders whose responsibility is not considered sufficiently diminished to warrant exemption from capital punishment.

Similarly, the Recommendation denies the death penalty exemption to those offenders who lack appreciation or control of their actions at the time of the offense due "solely to the acute effects of voluntary use of alcohol or other drugs." Substance abuse often plays a role in crime. When voluntary ingestion of psychoactive substances compromises an offender's cognitive or volitional capacities, the law sometimes is willing to reduce the grade of offense at trial, especially in murder cases,[31] and evidence of intoxication should certainly be taken into account if it is offered in mitigation in a capital sentencing proceeding.[32] However, in light of the wide variability in the effects of alcohol and other drugs on mental and emotional functioning, voluntary intoxication alone does not warrant an automatic exclusion from the death penalty.[33] At the same time, this Recommendation is not meant to prevent exemption from the death penalty for those offenders whose substance abuse has caused organic brain disorders or who have other serious disorders that, in combination with the acute effects of substance abuse, significantly impaired appreciation or control at the time of the offense.[34]

How This Recommendation Relates to the Insanity Defense

The language proposed in this part of the Recommendation is similar to modern formulations of the insanity defense.[35] Nonetheless, in light of the narrow reach of the defense in most states (and its abolition in a few),[36] many offenders who meet these criteria will still be convicted rather than acquitted by reason of insanity. Even in those states with insanity formulations that are very similar to the Recommendation's language, these individuals might be convicted, for a whole host of reasons;[37] in such cases, the Recommendation would require juries and judges to consider whether cognitive and volitional impairment removes the defendant from being among

31 *See generally* LAFAVE, *supra* note 25, at 415–16.

32 *See* Jeffrey L. Kirchmeier, *A Tear in the Eye of the Law: Mitigating Factors and the Progression Toward a Disease Model of Criminal Justice*, 83 OREGON L. REV. 631, 679 n.237 (2004) (listing statutes and judicial decisions from over a dozen states that have recognized intoxication as a mitigating circumstance).

33 In Montana v. Egelhoff, 518 U.S. 37 (1996), a plurality of the Supreme Court held that the voluntary intoxication defense is not constitutionally required. Id. at 38. At least 13 states now reject the voluntary intoxication defense. *See* Molly McDonough, *Sobering Up*, 88 A.B.A. J. 28 (2002).

34 *See, e.g.*, DSM-IV-TR, *supra* note 9, at 170 (describing dementia due to prolonged substance abuse).

35 The language in 2(a) and 2(c), for instance, is almost identical to the language in the Model Penal Code's insanity formulation. *See* MODEL PENAL CODE, *supra* note 30, at § 4.01(1).

36 Today, five states do not have an insanity defense, another twenty-five do not recognize volitional impairment as a basis for the defense, and many states define the cognitive prong in terms of an inability to "know" (as opposed to "appreciate") the wrongfulness of the act or, as is true in federal court, leave out the word "substantial" in the phrase "lack of substantial capacity to appreciate" in the Model Penal Code formulation. *See* RALPH REISNER ET AL., LAW AND THE MENTAL HEALTH SYSTEM: CIVIL AND CRIMINAL ASPECTS 534–36 (4th ed. 2004).

37 *See generally* Michael L. Perlin, *"The Borderline Which Separated You from Me": The Insanity Defense, the Authoritarian Spirit, the Fear of Faking, and the Culture of Punishment*, 82 IOWA L. REV. 1375 (1997) (exploring reasons for hostility to the insanity defense).

the most morally culpable offenders. This approach rests on the traditional understanding that significant cognitive or volitional impairment attributable to a severe disorder or disability often renders the death penalty disproportionate to the defendant's culpability, even though the offender may still be held accountable for the crime.[38] It also underlies the various formulations of diminished responsibility that predated the contemporary generation of capital sentencing statutes.[39]

How This Recommendation Relates to Mitigating Factors

This part of the Recommendation sets up, in effect, a conclusive "defense" against the death penalty for capital defendants who can demonstrate the requisite level of impairment due to severe disorder at the time of the offense. However, the criteria in the Recommendation do not exhaust the relevance of mental disorder or disability in capital sentencing. Those offenders whose mental disorder or disability at the time of the offense was not severe or did not cause one of the enumerated impairments would still be entitled to argue that their mental dysfunction is a mitigating factor, to be considered with aggravating factors and other mitigating factors in determining whether capital punishment should be imposed.[40]

Paragraph 3

This paragraph of the Recommendation is meant to address three different circumstances under which concerns about a prisoner's mental competence and suitability for execution arise after the prisoner has been sentenced to death. Subpart (a) states that execution should be precluded when a prisoner lacks the capacity (i) to make a rational decision regarding whether to pursue post-conviction proceedings, (ii) to assist counsel in post-conviction adjudication, or (iii) to appreciate the meaning or purpose of an impending execution. The succeeding subparts spell out the conditions under which execution should be barred in these three situations.

Prisoners Seeking to Forgo or Terminate Post-Conviction Proceedings

The United States Supreme Court has ruled that a competent prisoner is entitled to forgo available appeals.[41] If the prisoner is not competent, the standard procedure is to allow a so-called "next friend" (including the attorney) to pursue direct appeal and collateral proceedings aiming to set aside the conviction or sentence. Subpart 3(b) of the Recommendation addresses the definition of competence in such cases, providing that a next friend petition should be allowed when the prisoner has a mental disorder or disability "that significantly impairs his or her capacity to make a rational decision."

38 *See* Ellen Fels Berkman, *Mental Illness as an Aggravating Circumstance in Capital Sentencing*, 89 COLUM. L. REV. 291, 297 (1989) (noting that "nearly two dozen jurisdictions list as a statutory mitigating circumstance the fact that the defendant's capacity to appreciate the criminality of her conduct was substantially impaired, often as a result of mental defect or disease" and that "[a]n equally high number of states includes 'extreme mental or emotional disturbance' as a mitigating factor").

39 *See generally* SHELDON GLUECK, MENTAL DISORDER AND THE CRIMINAL LAW (1925).

40 *See, e.g.*, MODEL PENAL CODE, *supra* note 30, at § 210.6.

41 *See, e.g.*, *Gilmore v. Utah*, 429 U.S.1012 (1977).

Reportedly, 13 percent of the prisoners executed in the post-*Gregg* era have been so-called "volunteers."[42] Any meaningful competence inquiry in this context must focus not only on the prisoner's understanding of the consequences of the decision, but also on his or her *reasons* for wanting to surrender, and on the rationality of the prisoner's thinking and reasoning. In *Rees v. Peyton*,[43] the U.S. Supreme Court instructed the lower court to determine whether the prisoner had the "capacity to appreciate his position and make a rational choice with respect to continuing or abandoning further litigation or on the other hand whether the prisoner is suffering from a mental disease, disorder or defect which may substantially affect his capacity in the premises."[44] Unfortunately, the two alternative findings mentioned by the Court are not mutually exclusive—a person with a mental disorder that "affects" his or her decision-making may nonetheless be able to appreciate his or her position and make a "rational" choice. For this reason, the lower courts have integrated the *Rees* formula into a three-step test: (1) does the prisoner have a mental disorder? (2) if so, does this condition prevent the prisoner from understanding his or her legal position and the options available to the prisoner? (3) even if understanding is unimpaired, does the condition nonetheless prevent the prisoner from making a rational choice among the options?[45]

Because the courts have adopted a fairly broad conception of mental disorder (the first step) and the prisoner's understanding of his or her "legal position" (the second step) is hardly ever in doubt in these cases, virtually all the work under the *Rees* test is done by the third step.[46] Conceptually, the question is relatively straightforward—is the prisoner's decision attributable to the mental disorder or to "rational choice"?

Unequivocal cases of irrationality rarely arise. For example, if an offender suffering from schizophrenia tells his or her attorney to forgo appeals because the future of civilization depends upon the offender's death,[47] the "reason" for the prisoner's choice can comfortably be attributed to the psychotic symptom. However, decisions rooted in delusions are atypical in these cases. The usual case involves articulated reasons that may seem "rational" under the circumstances, such as (a) a desire to take responsibility for one's actions and a belief that one deserves the death penalty or (b) a preference for the death penalty over life imprisonment. The cases that give the courts the most trouble are those in which such apparently "rational" reasons are intertwined with emotional distress (especially depression), feelings of guilt and remorse, and hopelessness. In many cases, choices that may otherwise seem "rational" may be rooted in suicidal motivations. Assuming, for example, that the prisoner is depressed and suicidal but has a genuine desire to take responsibility, how is one to say which motivation "predominates"?

John Blume has studied the prevalence of significant mental disorder among the 106 prisoners who have volunteered for execution. According to Blume, 14 of the "volunteers" had recorded diagnoses of schizophrenia, 23 had recorded diagnoses of depression or bipolar disorder, 10 had records of PTSD, 4 had diagnoses of

42 John Blume, *Killing the Willing: Volunteers, Suicide and Competency*, 103 MICH. L. REV. 939, 959 (2005).

43 384 U.S. 312 (1966) (case remanded for competency determination after condemned prisoner directed attorney to withdraw petition for certiorari).

44 *Id*. at 314.

45 *See, e.g.*, *Hauser v. Moore*, 223 F.3d 1316, 1322 (11th Cir. 2000); *Rumbaugh v. Procunier*, 753 F.2d 395 (5th Cir 1985).

46 Richard J. Bonnie, *Mentally Ill Prisoners on Death Row: Unsolved Puzzles for Courts and Legislatures*, 54 CATH. UNIV. L. REV.1169 (2005).

47 Cf. *Illinois v. Haynes*, 737 N.E.2d 169, 178 (Ill. 2000); *In re Heidnick*, 720 A. 2d 1016 (Pa. 1998).

borderline personality disorder and 2 had been diagnosed with multiple personality disorder. Another 12 had unspecified histories of "mental illness."[48] Given this high prevalence of mental illness, the courts should be more willing than they now are to acknowledge suicidal motivations when they are evident and should be more inclined than they are now to attribute suicidal motivations to mental illness when the clinical evidence of such a link is convincing. The third step of the *Rees* test would then amount to the following: Is the prisoner who seeks execution able to give plausible reasons for doing so that are clearly *not* grounded in symptoms of mental disorder?[49] Given the stakes of the decision, a relatively high degree of rationality ought to be required in order to find people competent to make decisions to abandon proceedings concerning the validity of a death sentence.[50]

Prisoners Unable to Assist Counsel in Post-Conviction Proceedings

Subpart 3(c) of the Recommendation addresses the circumstances under which impaired competence to participate in adjudication should affect the initiation or continuation of post-conviction proceedings. The law in this area is both undeveloped and uncertain in many respects. However, some principles have begun to emerge.

Under the laws of many states and the federal Anti-Terrorism and Effective Death Penalty Act (AEDPA), collateral proceedings are barred if they are not initiated within a specified period of time. However, it is undisputed that a prisoner's failure to file within the specified time must be excused if such failure was attributable to a mental disability that impaired the prisoner's ability to recognize the basis for, or to take advantage of, possible collateral remedies. Similarly, the prisoner should be able to lodge new claims, or re-litigate previously raised claims, if the newly available evidence upon which the claim would have been based, or that would have been presented during the earlier proceeding relating to the claim, was unavailable to counsel due to the prisoner's mental disorder or disability.[51]

Assuming, however, that collateral proceedings have been initiated in a timely fashion, the more difficult question is whether, and under what circumstances, a prisoner's mental disability should require suspension of the proceedings. Subpart 3(c) provides that courts should suspend post-conviction proceedings upon proof that a prisoner is incompetent to assist counsel in such proceedings and that the prisoner's participation is necessary for fair resolution of a specific claim.

Thorough post-conviction review of the legality of death sentences has become an integral component of modern death penalty law, analogous in some respects to direct review. Any impediment to thorough collateral review undermines the integrity of the review process and therefore of the death sentence itself. Many issues raised in collateral proceedings can be adjudicated without the prisoner's participation, and these matters should

48 Blume, *supra* note 41, Appendix B, at 989–96. The text refers only to significant mental disorders that could have distorted the prisoner's reasoning process and impaired capacity for "rational choice." In addition to these cases, Blume reports that 20 of these prisoners had histories of substance abuse unaccompanied by any other mental disorder diagnosis, another 6 had personality disorders (with or without substance abuse) and 4 had sexual impulse disorders.

49 *See* Bonnie, *supra* note 46, at 1187–88. A more demanding approach would ask whether the prisoner is able to give plausible reasons that reflect authentic values and enduring preferences.

50 *See* Richard J. Bonnie, *The Dignity of the Condemned*, 74 VA.L. REV. 1363, 1388–89 (1988); *Cf.* Richard J. Bonnie, *The Competence of Criminal Defendants: Beyond Dusky and Drope*, 47 UNIV. MIAMI L. REV. 539, 579–80 (1993).

51 *See, e.g.*, *Council v. Catoe*, 359 S.C. 120, 597 S.E.2d 782, 787 (2004); *Commonwealth v. Haag*, 809 A.2d 271, 285 (Pa. 2001).

be litigated according to customary practice. However, collateral proceedings should be suspended if the prisoner's counsel makes a substantial and particularized showing that the prisoner's impairment would prevent a fair and accurate resolution of specific claims,[52] and subpart 3(c) so provides.

Where the prisoner's incapacity to assist counsel warrants suspension of the collateral proceedings, it should bar execution as well, just as ABA Standards recommend. ABA Standard 7–5.6 provides that prisoners should not be executed if they cannot understand the nature of the pending proceedings or if they "[lack] sufficient capacity to recognize or understand any fact which might exist which would make the punishment unjust or unlawful, or [lack] the ability to convey such information to counsel or to the court."[53] As the commentary to Standard 7–5.6 indicates, this rule "rests less on sympathy for the sentenced convict than on concern for the integrity of the criminal justice system."[54] Scores of people on death row have been exonerated based on claims of factual innocence, and many more offenders have been removed from death row and given sentences less than death because of subsequent discovery of mitigating evidence. The possibility, however slim, that incompetent individuals may not be able to assist counsel in reconstructing a viable factual or legal claim requires that executions be barred under these circumstances.

Once the post-conviction proceedings have been suspended on grounds of the prisoner's incompetence to assist counsel, should the death sentence remain under an indefinite stay? The situation is analogous to the suspension of criminal proceedings before trial; in that context, the proceedings are typically terminated (and charges are dismissed) after a specified period if a court has found that competence for adjudication is not likely to be restored in the foreseeable future. In the present context, it would be unfair to hold the death sentence in perpetual suspension. A judicial finding that the prisoner's competence to assist counsel is not likely to be restored in the foreseeable future should trigger an automatic reduction of the sentence to the disposition the relevant law imposes on capital offenders when execution is not an option.

Prisoners Unable to Understand the Punishment or Its Purpose

In *Ford v. Wainwright* (1986),[55] the U.S. Supreme Court held that execution of an incompetent prisoner constitutes cruel and unusual punishment proscribed by the Eighth Amendment. Unfortunately, the Court failed to specify a constitutional definition of incompetence or to prescribe the constitutionally required procedures for adjudicating the issue.[56] The Court also failed to set forth a definitive rationale for its holding that might have

52 *Council v. Catoe*, 359 S.C. 120, 597 S.E.2d 782, 787 ("[T]he default rule is that [post-conviction review] hearings must proceed even though a petitioner is incompetent. For issues requiring the petitioner's competence to assist his [post-conviction] counsel, such as a fact-based challenge to his defense counsel's conduct at trial, the [post-conviction] judge may grant a continuance, staying review of these issues until petitioner regains his competence."); *Carter v. State*, 706 So.2d 873, 875–77 (Fla. 1997); *State v. Debra*, 523 N.W.2d 727 (Wisc. 1994) (non-capital case); *People v. Kelly*, 822 P.2d 385, 413 (Cal. 1992).

53 *ABA Criminal Justice Mental Health Standards 290* (1989).

54 *Id*. at 291.

55 477 U.S. 399.

56 State courts have disagreed about the procedures required to make *Ford* competence determinations. This Recommendation does not deal with such procedural issues. For a treatment of this topic, see ABA Standard 7.5–7 and *Coe v. Bell*, 209 F.3d 815 (6th Cir. 2000), which should be read in conjunction with the ABA Guidelines for Appointment and Performance of Defense Counsel in Death Penalty Cases http://www.abanet.org/deathpenalty/publications/2005/2003Guidelines.pdf.

helped resolve these open questions. Rather it listed, without indicating their relative importance, a number of possible reasons for the competence requirement. These rationales included the need to ensure that the offenders could provide counsel with information that might lead to vacation of sentence; the view that, in the words of Lord Coke, execution of "mad" people is a "miserable spectacle . . . of extream inhumanity and cruelty [that] can be no example to others"; and the notion that retribution cannot be exacted from people who do not understand why they are being executed.[57] Apparently based on the latter rationale, Justice Powell, in his concurring opinion in *Ford*, stated: "I would hold that the Eighth Amendment forbids the execution only of those who are unaware of the punishment they are about to suffer and why they are to suffer it."[58] Justice Powell pointed out that states are free to preclude execution on other grounds (particularly inability to assist counsel), but most courts and commentators have assumed that the Eighth Amendment requirement is limited to the test stated by Justice Powell. Most commentators have also agreed with Justice Powell's view that the *Ford* competence requirement is grounded in the retributive purpose of punishment.[59]

There has been some confusion about the meaning of the idea that the prisoner must be able to understand (or be aware of) the nature and purpose for (reasons for) the execution. In *Barnard v. Collins*,[60] decided by the Fifth Circuit in 1994, the state habeas court had found that Barnard's "perception of the reason for his conviction and impending execution is at times distorted by a delusional system in which he attributes anything negative that happens to him to a conspiracy of Asians, Jews, Blacks, homosexuals and the Mafia."[61] Despite the fact that Barnard's understanding of the reason for his execution was impaired by delusions, the Fifth Circuit concluded that his awareness that "his pending execution was because he had been found guilty of the crime" was sufficient to support the state habeas court's legal conclusion that he was competent to be executed.[62]

In order to emphasize the need for a deeper understanding of the state's justifying purpose for the execution, subpart 3(d) of the Recommendation would require that an offender not only must be "aware" of the nature and purpose of punishment but also must "appreciate" its personal application in the offender's own case—that is, why it is being imposed *on the offender*. This formulation is analogous to the distinction often drawn between a "factual understanding" and a "rational understanding" of the reason for the execution.[63] If, as is generally assumed, the primary purpose of the competence-to-be-executed requirement is to vindicate the retributive aim of punishment, then offenders should have more than a shallow understanding of why they are being executed. Similarly, the offender should also have a meaningful understanding of what it means to be dead—in the sense that life is terminated and that the prisoner will not be "waking up" or otherwise continuing his existence. Deficient understanding of what it means to be dead can be associated with mental retardation and with delusional beliefs symptomatic of severe mental illness. These profound deficiencies in understanding asso-

57 *Id*. at 406–08.

58 *Id*. at 422 (Powell, J., concurring).

59 *See* Barbara Ward, *Competency for Execution: Problems in Law and Psychiatry*, 14 FLA. ST. UNIV. L. REV. 35, 49–56 (1986); Christopher Slobogin, *Mental Illness and the Death Penalty*, 24 MEN. & PHYS. L. REP. 667, 675–77 (2000).

60 13 F.3d 871 (5th Cir. 1994).

61 *Id*. at 876.

62 *Id*.

63 *See Martin v. Florida*, 515 So. 2d 189, 190 (Fla. 1987).

ciated with mental disability should not be trivialized or ignored by analogizing them to widely shared uncertainty among normal persons about the existence of some form of spiritual "life" after death or about the possibility of resurrection.

The underlying point here is that the retributive purpose of capital punishment is not served by executing an offender who lacks a meaningful understanding that the state is taking his life in order to hold him accountable for taking the life of one or more people. Holding a person accountable is intended to be an affirmation of personal responsibility. Executing someone who lacks a meaningful understanding of the nature of this awesome punishment and its retributive purpose offends the concept of personal responsibility rather than affirming it.

Whether a person found incompetent to be executed should be treated to restore competence implicates not only the prisoner's constitutional right to refuse treatment but also the ethical integrity of the mental health professions.[64] Some courts have decided that the government may forcibly medicate incompetent individuals if necessary to render them competent to be executed, on the ground that once an individual is fairly convicted and sentenced to death, the state's interest in carrying out the sentence outweighs any individual interest in avoiding medication.[65] However, treating a condemned prisoner, especially over his or her objection, for the purpose of enabling the state to execute the prisoner strikes many observers as barbaric and also violates fundamental ethical norms of the mental health professions.

Mental health professionals are nearly unanimous in the view that treatment with the purpose or likely effect of enabling the state to carry out an execution of a person who has been found incompetent for execution is unethical, whether or not the prisoner objects, except in two highly restricted circumstances (an advance directive by the prisoner while competent requesting such treatment or a compelling need to alleviate extreme suffering).[66] Because treatment is unethical, it is not "medically appropriate" and is therefore constitutionally impermissible when a prisoner objects under the criteria enunciated by the Supreme Court in *Sell v. United States*[67] and *Washington v. Harper*.[68] As the Louisiana Supreme Court observed in *Perry v. Louisiana*,[69] medical treatment to restore execution competence "is antithetical to the basic principles of the healing arts," fails to "measurably contribute to the social goals of capital punishment," and "is apt to be administered erroneously, arbitrarily or capriciously."[70]

There is only one sensible policy here: a death sentence should be automatically commuted to a lesser punishment (the precise nature of which will be governed by the jurisdiction's death penalty jurisprudence) after a

64 Kirk S. Heilbrun, Michael L. Radelet, Joel A. Dvoskin, *The Debate on Treating Individuals Incompetent for Execution*, 149 AMERICAN JOURNAL OF PSYCHIATRY 596 (1992); Richard J. Bonnie, *Dilemmas in Administering the Death Penalty: Conscientious Abstention, Professional Ethics and the Needs of the Legal System*, 14 LAW & HUMAN BEHAVIOR 67 (1990).

65 *Singleton v. Norris*, 319 F.3d 1018 (8th Cir.) (*en banc*), *cert denied*, 124 S. Ct. 74 (2003).

66 *See* Council on Ethical and Judicial Affairs, American Medical Association, Physician Participation in Capital Punishment, 270 JAMA365 (1993); American Psychiatric Association and American Medical Association, Amicus Brief in Support of Petitioner in *Perry v. Louisiana*, 498 U.S. 38 (1990); Richard J. Bonnie, *Medical Ethics and the Death Penalty*, 20 HASTINGS CENTER REPORT, MAY/JUNE, 1990, 12, 15–17.

67 539 U.S. 166 (2003).

68 494 U.S. 210 (1990).

69 610 So.2d 746 (La. 1992).

70 *Id*. at 751.

prisoner has been found incompetent for execution.[71] Maryland has so prescribed,[72] and subpart 3(d) of the Recommendation embraces this view. Once an offender is found incompetent to be executed, execution should no longer be a permissible punishment.

The current judicial practice is to entertain *Ford* claims only when execution is genuinely imminent. Should courts be willing to adjudicate these claims at an earlier time? Assuming that a judicial finding of incompetence — whenever rendered — would permanently bar execution (as proposed above), subpart 3(d) provides that *Ford* adjudications should be available only when legal challenges to the validity of the conviction and sentence have been exhausted, and execution has been scheduled.[73]

Procedures

While this paragraph contemplates that hearings will have to be held to determine competency to proceed and competency to be executed, it does not make any recommendations with respect to procedures. Federal constitutional principles and state law will govern whether the necessary decisions must be made by a judge or a jury, what burdens and standards of proof apply, and the scope of other rights to be accorded offenders. Additionally, in any proceedings necessary to make these determinations, the victim's next-of-kin should be accorded rights recognized by law, which may include the right to be present during the proceedings, the right to be heard, and the right to confer with the government's attorney. Victim's next-of-kin should be treated with fairness and respect throughout the process.

RESPECTFULLY SUBMITTED,

Paul M. Igasaki, Chair, Section of Individual Rights and Responsibilities
Michael S. Pasano, Chair, Criminal Justice Section
Scott C. LaBarre, Chair, Commission on Mental and Physical Disability Law
James E. Coleman, Jr., Chair, Death Penalty Moratorium Implementation Project
Terri Lynn Mascherin, Chair, Death Penalty Representation Project

August 2006

71 A state could try to restore a prisoner's competence without medical treatment, but the prospects of an enduring change in the prisoner's condition are slight.

72 Md. Code of Correctional Services, 3–904(a)(2), (d)(1).

73 This does not mean that no litigation challenging the validity of the sentence can be simultaneously occurring. For all practical purposes, "exhaustion" means that one full sequence of state post-conviction review and federal habeas review have occurred where, as in most jurisdictions, no execution date set during the initial round of collateral review is a "real" date. Given the many procedural barriers to successive petitions for collateral review, an execution date set after the completion of the initial round may be a "real" date, even if a successive petition has been filed or is being planned. In such a case, the state may contest the prisoner's request for a stay of execution. A *Ford* claim should be considered on its merits in such a case, and it should be considered earlier on in a jurisdiction where a "real" execution date is set during the initial round of collateral review.

APPENDIX 2

Resolution of the American Psychological Association: The Death Penalty in the United States

Adopted | August 2001

WHEREAS recent empirical research reviewing all death penalty cases in the United States concluded that two thirds of the death penalty cases from 1973 to 1995 were overturned on appeal with the most common reasons cited as incompetent counsel, inadequate investigative services, or the police and prosecutors withholding exculpatory evidence. (Liebman, Fagan, & West, 2000); and

WHEREAS the recent application of DNA technology has resulted in, as of June 2000, 62 post-conviction determinations of actual innocence, with eight of these having been for persons sentenced to death at trial. (Scheck, Neufeld, Weyer, 2000; Wells, Malpass, Lindsay, Fisher, Turtle, & Fulero, 2000); and

WHEREAS research on the process of qualifying jurors for service on death penalty cases shows that jurors who survive the qualification process ("death-qualified jurors") are more conviction-prone than jurors who have reservations about the death penalty and are therefore disqualified from service. (Bersoff, 1987; Cowan, Thompson and Ellsworth, 1984; Ellsworth, 1988; Bersoff & Ogden, 1987; Haney, 1984); and

WHEREAS recent social science research reveals strong inconsistencies in prosecutors' decisions to seek the death penalty in particular cases, based on factors other than the severity of the crime. The "prosecutor is more likely to ask for a death sentence when the victim is European-American, of high social status, a stranger to the offender, and when counsel is appointed." (Beck & Shumsky, 1997, p. 534); and

WHEREAS race and ethnicity have been shown to affect the likelihood of being charged with a capital crime by prosecutors (e.g., Beck & Shumsky, 1997; Bowers, 1983; Paternoster, 1991; Paternoster & Kazyaka, 1988; Sorensen & Wallace, 1995) and therefore of being sentenced to die by the jury. Those who kill European-American victims are more likely to receive the death penalty, even after differences such as the heinousness of the crime, prior convictions, and the relationship between the victim and the perpetrator are considered. This is especially true for African-Americans. (e.g., Keil & Vito, 1995; Thomson, 1997) and Hispanic-Americans who kill European-Americans. (Thomson, 1997); and

WHEREAS psychological research consistently demonstrates that juries often misunderstand the concept of mitigation and its intended application (e.g., Haney & Lynch, 1994, 1997; Wiener, Pritchard, & Weston, 1995; Wiener, Hurt, Thomas, Sadler, Bauer & Sargent, 1998), so that mitigation factors, e.g., the defendant's previous life circumstances, mental and emotional difficulties and age, have little or no relation to penalty phase verdicts. (Beck & Shumsky, 1997; Costanzo & Costanzo, 1994); and

WHEREAS death penalty prosecutions may involve persons with serious mental illness or mental retardation. Procedural problems, such as assessing competency, take on particular importance in cases where the death penalty is applied to such populations. (Skeem, Golding, Berge & Cohn, 1998; Rosenfeld & Wall, 1988; Hoge, Poythress, Bonnie, Monahan, Eisenberg & Feucht-Haviar, 1997; Cooper & Grisso, 1997); and

WHEREAS death penalty prosecutions may involve persons under 18 (sometimes as young as 14). Procedural problems, such as assessing competency, take on particular importance in cases where the death penalty is applied to juveniles. (Grisso & Schwartz, 2000; Lewis et al., 1988); and

WHEREAS capital punishment appears statistically neither to exert a deterrent effect (e.g., Bailey, 1983; 1990; Bailey & Peterson, 1994; Cheatwood, 1993; Costanzo, 1997; Decker & Kohfeld, 1984; Radelet & Akers, 1996; Stack, 1993) nor save a significant number of lives through the prevention of repeat offenses. (Vito, Koester, & Wilson, 1991; Vito, Wilson, & Latessa, 1991): Further, research shows that the murder rate increases just after state-sanctioned executions. (Bowers, 1988; Costanzo, 1998; Phillips, 1983; Phillips & Hensley, 1984);

THEREFORE, BE IT RESOLVED, that the American Psychological Association:
Calls upon each jurisdiction in the United States that imposes capital punishment not to carry out the death penalty until the jurisdiction implements policies and procedures that can be shown through psychological and other social science research to ameliorate the deficiencies identified above.

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APPENDIX 3

Public Policy Platform of The National Alliance on Mental Illness (NAMI)

Adopted by the Public Policy Committee of the Board of Directors and the NAMI Department of Public Policy and Legal Affairs | March 2007

10. CRIMINAL JUSTICE/FORENSIC ISSUES

10.1 Ultimate Responsibility of Mental Health Systems

10.2 Therapeutic Jurisprudence

10.3 Education at all levels of Judicial and Legal Systems

10.4 Collaboration

10.5 Boot Camps

10.6 Right to Treatment (Regardless of Criminal Status)

10.7 Jail Diversion

10.8 Violence

10.9 Death Penalty

10.10 Insanity Defense

10.9 DEATH PENALTY

NAMI opposes the death penalty for persons with brain disorders.

(10.9.1) NAMI urges jurisdictions that impose capital punishment not to execute persons with mental disabilities under the following circumstances:

(10.9.1.1) Defendants shall not be sentenced to death or executed if they have a persistent mental disability, with onset before the offense, characterized by significant limitations in both intellectual functioning and adaptive behavior as expressed in their conceptual, social, and practical adaptive skills.

(10.9.1.2) Defendants shall not be sentenced to death or executed if, at the time of theiroffense, 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 or attributable solely to the acute effects of alcohol or other drugs does not, standing alone, constitute a mental disorder or disability, for purposes of this provision.

(10.9.1.3) Sentences of death shall be reduced to lesser punishment if prisoners under such sentences are found at any time subsequent to sentencing to have a mental disorder or disability that significantly impairs their ability (a) to understand and appreciate the nature of the punishment or its purpose, (b) to understand and communicate information relating the death sentence and any proceedings brought to set it aside, or (c) to make rational choices about such proceedings.

10.10 INSANITY DEFENSE

NAMI supports the retention of the "insanity defense" and favors the two-prong ("ALI")[1] test that includes the volitional as well as the cognitive standard.

(9.10.1) "Guilty but Mentally Ill"

NAMI opposes "guilty but mentally ill" statutes as presently applied because they are used to punish rather than to treat persons with brain disorders who have committed crimes as a consequence of their brain disorders.

(9.10.2) "Guilty except for insanity" and other alternative terminology for the insanity defense

NAMI supports systems that provide comprehensive, long-term care and supervision to individuals who are found "not guilty by reason of insanity," "guilty except for insanity," and any other similar terminology used in state statutes.[2]

(9.10.3) "Informing Juries about the Consequences of Insanity Verdicts"

NAMI Believes that juries in cases where the insanity defense is at issue should be informed about the likely consequences of an insanity verdict to enable them to make a fair decision.

1 The "ALI test" refers to the rule for insanity adopted in Section 4.01(1) of the American Law Institute Model Penal Code. The Code states that "a person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality (or alternatively, wrongfulness) of his conduct (cognitive standard) or to conform his conduct to the requirements of law (volitional standard)."

2 States currently apply three different terms to verdicts incorporating a formal finding or acknowledgement of mental illness.
"Not guilty by reason of insanity" is the traditional term used when a person is determined as not criminally responsible due to mental illness. Individuals found "not guilty by reason of insanity" are typically sentenced to secure psychiatric treatment facilities instead of prison.
"Guilty but mentally ill" (GBMI) statutes have been adopted in the criminal codes of a number of states. These statutes currently function very similarly to "guilty" verdicts. An individual found GBMI could be sentenced to life in prison or even to death. Additionally, a verdict of GBMI does not guarantee psychiatric treatment.
"Guilty except for insanity" statutes have been adopted in several states such as Oregon and Arizona as substitutes for "not guilty by reason of insanity." These states have developed effective systems for providing long-term treatment and supervision to individuals who are found "guilty except for insanity."

APPENDIX 4

Resolution of American Psychiatric Association: Diminished Responsibility in Capital Sentencing

Approved by the Assembly | November 2004
Approved by the Board of Trustees | December 2004

"Policy documents are approved by the APA Assembly and Board of Trustees...These are... position statements that define APA official policy on specific subjects..." — *APA Operations Manual*.

Defendants shall not be sentenced to death or executed 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 their conduct, or (c) to conform their conduct to the requirements of the law. A disorder manifested primarily by repeated criminal conduct 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.

COMMENTARY

Anglo-American law has long recognized that serious mental disorder diminishes a person's responsibility for criminal conduct and that execution is often a cruel and excessive punishment for offenders who were severely disturbed at the time of the offense. The insanity defense itself originally served primarily to prevent execution of mentally ill offenders, especially when the death penalty was mandatory for murder and other felonies. During the 20th century, even after the death penalty was no longer a mandatory punishment for murder, many states allowed evidence of mental disorder to be used to reduce a first-degree murder charge to second-degree murder, thereby precluding a death sentence.

Under the current generation of capital sentencing statutes upheld by the Supreme Court in 1976, a defendant convicted of a capital crime is entitled to introduce evidence of mental disorder in mitigation at the sentencing phase of the trial, where it is weighed by the jury, together with the prosecution's evidence in aggravation, in deciding whether the death penalty is justified. However, many observers of capital sentencing proceedings, including participating psychiatrists, believe that juries tend to give too little weight to mitigating evidence of severe mental disorder, leading to inappropriate execution of offenders whose responsibility was significantly diminished by mental retardation or mental illness.

The important decision in *Atkins v. Virginia*, 536 U.S. 304 (2002), shows that this concern is shared by the Supreme Court. The Court recognized in *Atkins* that the ordinary practice of capital adjudication does not prevent persons with severely diminished responsibility due to mental retardation from being sentenced to death and thereby being punished in a manner grossly disproportionate to their culpability. The remedy adopted by the Supreme Court in Atkins was to preclude death sentences for defendants diagnosed with mental retardation. This categorical remedy was based on the judgment that virtually all defendants with mental retardation lack the morally requisite capacities for capital punishment.

A systematic risk of disproportionate punishment also arises in cases involving defendants with severe mental illness. Even though defendants with mental illness are entitled to introduce mental health evidence in mitigation of sentence, commentators on capital sentencing have often observed that juries tend to devalue undisputed and strong evidence of diminished responsibility in the face of strong evidence in aggravation. *See, e.g.*, Phyllis Crocker, *Concepts of Culpability and Deathworthiness: Differentiating Between Guilt and Punishment in Death Penalty Cases*, 22 Fordham L. Rev. 21 (1997). Indeed, such evidence is often a double-edged sword, tending to show both impaired capacity as well as future dangerousness. *See, e.g.*, Richard J. Bonnie and C. Robert Showalter, *Psychiatrists and Capital Sentencing: Risks and Responsibilities in a Unique Legal Setting*, 12 Bulletin of the American Academy of Psychiatry and Law 159–67 (1984).

As the Supreme Court observed in *Zant v Stephens*, treating evidence of mental illness as an aggravating factor would violate the due process clause:

> [In this case, Georgia did not attach] the "aggravating" label to ... conduct that actually should militate in favor of a lesser penalty, such as perhaps the defendant's mental illness. *Cf. Miller v. Florida*, 373 So.2d 882, 885–886 (Fla.1979). If the aggravating circumstance at issue in this case had been invalid for reasons such as these, due process of law would require that the jury's decision to impose death be set aside. (462 U.S. at 885).

Similarly, one of the problems with the Texas capital sentencing statute that has been before the Court repeatedly is that juries were instructed for three decades to consider the aggravating force of the evidence (in proving future dangerousness) without being told to consider its potentially mitigating weight. (See, e.g., *Penry v. Johnson*, 121 S.Ct 1910 (2001) and *Penry v. Lynaugh*, 492 U.S. 302 (1989)).

Strong evidence of diminished responsibility due to mental illness should preclude a death sentence and should not be weighed against evidence in aggravation. The core rationale for precluding death sentences for defendants with mental retardation is equally applicable to defendants with severe mental illness. However, the purely diagnostic exclusion utilized by the Supreme Court in *Atkins* is not a plausible approach for dealing with mental illness. Even among persons with major mental disorders, such as schizophrenia, symptoms vary widely in severity, as does the impact of the disorder on the person's behavior. Thus, a mere diagnosis of a major mental disorder does not identify a narrow class of cases in which a death sentence would virtually always be disproportionate to the offenders' culpability. Instead, the category must be further narrowed to include only those defendants whose severe mental dis-

orders are characterized by significant impairments of responsibility related capacities.

The task of defining criteria of diminished responsibility must start with the criteria for the insanity defense—the goal is to specify a degree of impairment that significantly reduces responsibility even though it does not foreclose conviction and punishment. The most widely accepted formula for defining diminished responsibility is found in the capital sentencing provisions in the Model Penal Code. Section 210.6 (4) includes among mitigating circumstances the following:

> "(g) At the time of the murder, the capacity of the defendant to appreciate the criminality [wrongfulness] of his conduct or to conform his conduct to the requirements of law was impaired as a result of mental disease or defect or intoxication."

This provision, which appears in the capital sentencing laws of a great majority of death penalty states, was designed to identify conditions of strong mitigation that should be balanced against aggravating circumstances. Because the task at hand is to identify an *exclusionary* criterion, the best approach is to tighten and narrow the Model Penal Code's language to require a *significant* impairment of the relevant responsibility-related capacities (ability to appreciate and conform) resulting from *severe mental disorder*. Impairments associated with other disorders or with intoxication should not be given preclusive force, although they should continue to be taken into account in determining the suitability of a death sentence.

The Position Statement language supplements the Model Penal Code criteria of impaired capacity with an additional phrase (impaired capacity "to exercise rational judgment in relation to conduct") in order to encompass what many people intuitively regard as the most basic prerequisite for moral agency—a capacity for rationality. This language is also designed to correct for unduly narrow interpretations of what it means to lack "appreciation." Some expert witnesses and courts have said that "appreciation" refers only to cognitive functioning, thereby failing to include affective disturbance that can distort a person's understanding and judgment.

mental illness and the death penalty

SEEKING A "REASONED MORAL RESPONSE" TO AN UNAVOIDABLE CONDITION

October 20, 2006 | 8.30 am–5.30 pm | Charlotte School of Law
1211 E. Morehead Street | Charlotte, NC 28204

THE CHARLOTTE SCHOOL OF LAW, the Z. SMITH REYNOLDS FOUNDATION, the JOHN S. LEARY BAR ASSOCIATION, and the CHARLOTTE COALITION FOR A MORATORIUM NOW welcome you to this groundbreaking symposium that will explore, develop, and communicate ideas, opinions, and scholarship about one of the most controversial aspects of the death penalty: mental illness. In addition to debating whether the imposition of the death penalty for a person suffering a serious mental illness reflects a "reasoned moral response" to that particular defendant's background, CALIFORNIA V. BROWN, 479 U.S. 538, 545 (1987) (O'Connor, J., concurring), the symposium will also explore whether more responsible treatment of mental illness by society generally, and the criminal justice system more particularly, can further the degree to which our court system provides the level of restorative justice that our communities demand and deserve.

A number of factors lay bare the critical importance and timeliness of this symposium:

FIRST | Developments in the United States Supreme Court's Eight Amendment jurisprudence indicate the possible merits of an Eighth Amendment-based categorical exclusion of the mentally ill from the system of capital punishment, similar to the exclusions of juveniles and the mentally retarded.

SECOND | A host of influential mental health and legal associations, including the American Psychiatric Association, the American Psychological Association, and the American Bar Association, have taken the position that the death penalty should not be applied to those with serious mental illnesses.

THIRD | The administration of North Carolina's death penalty is currently undergoing a comprehensive examination by state legislators. On November 9, 2005, the North Carolina House of Representatives created the House Select Study Committee on Capital Punishment. The Committee's charge was to study all aspects of North Carolina's administration of the death penalty and submit by December 31, 2006, a final written report of its findings and recommendations. In light of the active statewide debate over the

death penalty and whether or not to impose a moratorium on executions, the Committee's report is expected to significantly shape the future of the death penalty in North Carolina. The symposium is designed to inform the Committee's final report.

FOURTH | The intersection of mental illness, violence, and the legal system's corresponding response is something experienced within our communities nearly every day. This fact compels us to constantly reexamine and reassess what values and priorities are being served by our criminal justice system when dealing with the unavoidable condition of mental illness.

Two cases, separated by ten years but only a few miles, illustrate the pressing need to improve how our criminal justice system responds to serious crimes involving mental illness and the potential imposition of the death penalty:

In 1996, an African-American man was sentenced to death in Stanly County for killing a woman after being recruited by another man in a "murder-for-hire" scheme. The man who sought the killing of his estranged wife received a life sentence. The defendant, who believed that he was receiving signals from Oprah Winfrey and Dan Rather over the television, wore a Superman t-shirt in court, and was permitted to fire his court-appointed attorneys and represent himself at trial. The defendant testified and argued to the jury in incoherent ramblings. The prosecutor, who wore a gold lapel pin shaped like a noose, and awarded similar nooses to assistants who secured death sentences, secured an all-white jury that returned the death sentence. The defendant, who has been diagnosed with psychosis, specifically a delusional disorder, is expected to have an execution date set before 2007.

In 2006, less than one hour away in Mecklenburg County, a white corporate executive was sentenced to life in prison after stabbing to death his twin 5-year-old daughters in their Charlotte home. While the entire city was understandably shocked and horrified, there was an immediate sensitivity to the defendant's severe depression and psychiatric condition. Following the defendant's family's efforts to raise awarness about mental illness and their desire to seek understanding rather than retribution, as well as significant public support for a sentence other than death, the Mecklenburg County District Attorney's Office extended a plea offer to life.

SYMPOSIUM PROGRAM

Following INTRODUCTORY REMARKS by Dean Eugene Clark, Ph.D., of the Charlotte School of Law, OPENING SPEAKERS, Honorable Burley B. Mitchell, Jr., and Professor James E. Coleman, Jr. will discuss "The State of Mental Illness and the Courts." PANEL ONE will then address how the law decides what guilty people we can or cannot kill (e.g., juveniles, the mentally retarded) and the challenging task of defining and differentiating among mental illnesses.

Following a KEYNOTE ADDRESS by renowned capital defense attorney Bryan Stevenson, PANEL TWO ("Mental Illness on Trial") will discuss resources available to identify and assess mental illness among criminal offenders, and the challenges presented by implementing the proposals by the American Psychiatric Association, the American Psychological Association, and the American Bar Association to exclude offenders with "severe" mental illness from eligibility for the death penalty. PANEL THREE ("Mental Illness and Restorative Justice") will discuss how families and communities respond in the wake of a tragedy caused by mental illness, and whether imposing the ultimate punishment of death does more harm then good. This panel will also discuss the clinical and experiential effect of wrestling with mental illness and tragic loss. PANEL FOUR ("Improving Justice") will discuss whether North Carolina can improve the manner in which the criminal justice system deals with mentally ill individuals charged with serious crimes, and if so, then how. This panel will bring to bear the experience of different professionals to wrestle with the question of how North Carolina can improve its handling of serious criminal cases that have a significant mental illness component. The Honorable Shirley L. Fulton will then conclude the symposium with CLOSING REMARKS.

Special thanks to Ferguson, Stein, Chambers, Gresham & Sumter, P.A., and the Law Firm of Julie Fosbinder for their generous contributions of attorney and staff time, office resources, and assistance in producing this symposium.

Contributions are greatly appreciated and will be distributed to the following organizations:

CAPITAL RESTORATIVE JUSTICE PROJECT | Durham, North Carolina | The mission of Capital Restorative Justice Project (CRJP) is to promote healing and nonviolent responses within North Carolina communities torn apart by capital murder and execution. The CRJP is organized into four Healing Circles: one for families of murder victims, one for families of offenders, one for professionals who work on capital cases (attorneys, mitigation specialists, clergy, victim advocates, etc.), and one for others traumatized by the cycle of violence. The Circles provide space and community through which murder victim families and those traumatized by death sentences can find healing.

CENTER FOR CHILD & FAMILY HEALTH | Durham, North Carolina | The Center for Child & Family Health provides a comprehensive and integrated approach to the problems of child abuse and neglect, domestic violence, adolescent pregnancy, maternal depression, and related issues. The Center for Child & Family Health offers services in parent /child relationships, strengthening families, mental health evaluation and treatment, child sexual abuse, trauma treatment, and legal services. The Center for Child & Family Health seeks to stop the cycle of hurting and start the cycle of healing.

EQUAL JUSTICE INITIATIVE | Montgomery, Alabama | The Equal Justice Initiative (EJI) is a private, non-profit organization committed to addressing the problems of the Alabama criminal justice system, especially as they relate to the poor, the despised, and the disadvantaged. EJI provides legal assistance to the imprisoned and condemned, works with low-income communities and people of color, and educates lawyers, law students, and the public about those problems while pursuing reforms that create hope.

Contributions should be made to the Charlotte Coalition for a Moratorium Now (CCMN), which will distribute 100% of all donations to these three organizations.

8.30 am – 9.00 am	REGISTRATION AND COFFEE
9.00 am – 9.10 am	INTRODUCTORY REMARKS **Eugene Clark, Ph.D.,** Dean, Charlotte School of Law
9.10 am – 10.10 am	OPENING SPEAKERS THE STATE OF MENTAL ILLNESS AND THE COURTS **Hon. Burley B. Mitchell, Jr.,** Former Chief Justice, North Carolina Supreme Court **James E. Coleman, Jr.,** Professor, Duke University Law School REPORTER | **Malik Edwards,** Assistant Professor, Charlotte School of Law
10.15 am – 11.15 am	PANEL ONE | CATEGORIES OF GUILTY PEOPLE WE CHOOSE NOT TO KILL: HOW DOES THE LAW DECIDE? **Ken Rose, Lao E. Rubert** (facilitator), **Ronald Tabak** REPORTER | **Eugene Clark, Ph.D.,** Dean, Charlotte School of Law
11.15 am – 11.30 am	MID-MORNING BREAK
11.30 am – 12.30 pm	KEYNOTE ADDRESS **Bryan Stevenson,** Executive Director of the Equal Justice Initiative of Alabama, and Professor of Law at the New York University School of Law
12.30 pm – 1.15 pm	LUNCH
1.15 pm – 2.45 pm	PANEL TWO | MENTAL ILLNESS ON TRIAL **Peter Barboriak, M.D., Ph.D, James P. Cooney, III, Richard G. Dudley, Jr., M.D.** (facilitator), **Marsha L. Goodenow, Alyson Kuroski, M.D., Faye E. Sultan, Ph.D** REPORTER | **Renee F. Hill,** Associate Dean, Charlotte School of Law
2.45 pm – 3.00 pm	MID-AFTERNOON BREAK
3.00 pm – 4.00 pm	PANEL THREE | MENTAL ILLNESS AND RESTORATIVE JUSTICE: HOW HEALING REQUIRES UNDERSTANDING WHICH THE DEATH PENALTY CANNOT PROVIDE **Kim Crespi, Gretchen M. Engel, Robert Murphy, Ph.D., Russell F. Sizemore, Bryan Stevenson, Julian H. Wright, Jr.** (facilitator) REPORTER | **Malik Edwards,** Assistant Professor, Charlotte School of Law
4.05 pm – 5.10 pm	PANEL FOUR | IMPROVING JUSTICE: MENTAL ILLNESS AND THE CRIMINAL JUSTICE SYSTEM **Richard G. Dudley, Jr., M.D., Malcolm Ray Hunter, Jr., Wilhelmenia Rembert, Ph.D** (facilitator), **Dave Richard** REPORTER | **Victoria Clark,** Director of Admissions, Charlotte School of Law
5.10 pm – 5.30 pm	SYMPOSIUM REPORT AND CLOSING REMARKS **Hon. Shirley L. Fulton,** Former Superior Court Judge, Mecklenburg County
5.30 pm – 7.00 pm	RECEPTION | ATRIUM, CHARLOTTE SCHOOL OF LAW

SYMPOSIUM BIOS

PETER NEAL BARBORIAK, M.D., PH.D, is Training Director for the Forensic Psychiatric Residency Program at the UNC-Chapel Hill, School of Medicine, and Medical Director, Forensic Psychiatric Service, at Dorothea Dix Hospital in Raleigh, NC. He completed his residency in psychiatry at Duke University Medical Center and his Forensic Psychiatry Fellowship at the Federal Correctional Institution in Butner, NC.

EUGENE CLARK, PH.D, is Dean and Professor of Law at Charlotte School of Law. He holds five degrees that include post graduate qualifications in law and education from both the United States and Australia. He is the author or co-author of twenty books and hundreds of law review articles and professional journals. Prior to coming to Charlotte, Dr. Clark was Emeritus Professor at the University of Canberra where he served as Head of the Law School and Pro Vice-Chancellor.

JAMES E. COLEMAN, JR., is Professor of Law at Duke University School of Law, where he teaches courses on criminal law, legal ethics, negotiation and mediation, capital punishment and wrongful convictions. Professor Coleman, who received his J.D. from Harvard University, is Chair of the ABA Moratorium Implementation Project Steering Committee and a member of the NC Joint Legislative Capital Punishment Commission on mental retardation and racial discrimination.

JAMES P. COONEY, III, is a partner with Womble Carlyle Sandridge & Rice, PLLC, in Charlotte. A graduate of Duke University and the University of Virginia School of Law, Mr. Cooney is on the Board of Directors for the Center for Death Penalty Litigation, and is one of the most widely-respected defense lawyers in the state specializing in medical malpractice and death penalty defense.

KIM CRESPI is the wife of David Crespi and mother of five-year-old twins Samantha and Tessara. The Crespi family worshipped together at St. Matthew's Catholic Church, and enjoyed a loving and supportive family relationship. On January 20, 2006, David Crespi killed his twin daughters, called 911, and in a state of bewilderment reported his tragic actions and awaited the police arrival and his arrest. Mr. Crespi, though a successful business executive, had suffered for many years with severe mental illness (depression) and was under psychiatric care. He ultimately pleaded guilty to two counts of first degree murder and was sentenced to life without parole. Kim Crespi, who is also mother to three older children, two of them from her husband's earlier marriage, hopes that her family tragedy can help the community better understand mental illness and better respond to the needs of the many individuals and families affected.

RICHARD G. DUDLEY, JR., M.D., is a clinical and forensic psychiatrist, as well as Adjunct Associate Professor, City University of New York Medical School and Adjunct Assistant Professor of Law at the New York University School of Law. He is a graduate of the Temple University School of Medicine in Philadelphia and completed his fellowship in Psychiatry at Northwestern University Institute of Psychiatry in Chicago. Dr. Dudley regularly appears as a psychiatric expert in various types of legal proceedings throughout the United States, and is a presenter of continuing medical education programs for health professionals, attorneys and the public. He is the author of numerous publications.

GRETCHEN M. ENGEL is Director of Post-Conviction Litigation at the Center for Death Penalty Litigation in Durham, and is on the Board of Directors of the Capital Restorative Justice Project. In 2003, Ms. Engel received the Paul Green Award bestowed by the North Carolina Chapter of the ACLU for her work against the death penalty. She is a graduate of Oberlin College and Northeastern University School of Law.

HON. SHIRLEY L. FULTON served over 20 years in the Mecklenburg County court system as a judge and prosecutor. Judge Fulton is currently in private practice in Charlotte, and is the Chair of the Board of Trustees for Charlotte School of Law. A recent President of the Mecklenburg County Bar, she graduated from NC A&T, Duke University Law School, and the McColl School of Business at Queens University. Judge Fulton continues her lifelong commitment to active leadership in community-based programs and is the owner of the Wadsworth House.

MARSHA GOODENOW is a graduate of Myers Park High School, Queens College and the University of Akron Law School. She has been practicing law since 1984. She served on active duty with the United States Air Force and is currently a lieutenant colonel with the North Carolina Air National Guard. She is the head of the homicide unit with the Mecklenburg County District Attorney's Office. She has been with that office for over 16 years. Ms. Goodenow has a 14 year old daughter.

MALCOLM RAY HUNTER, JR. ("Tye") is Executive Director of the NC Office of Indigent Defense Services (IDS). A graduate of UNC-School of Law, Mr. Hunter served for 15 years as the Appellate Defender before becoming the first director of IDS. Mr. Hunter is a member of the North Carolina Innocence Commission, and has taught at NC Central University School of Law and UNC-School of Law.

ALYSON KUROSKI, M.D. is the Director of Forensic Psychiatry, University of North Carolina at Chapel Hill, School of Medicine.

CHIEF JUSTICE BURLEY B. MITCHELL, JR., served as the twenty-fourth Chief Justice of North Carolina until he retired in 1999 to head the appellate advocacy and government relations groups at Womble Carlyle Sandridge & Rice, PLLC, in Charlotte. As a judge, he authored 484 appellate decisions for the North Carolina Supreme Court and Court of Appeals. Prior to taking the bench, Chief Justice Mitchell served as District Attorney for the Tenth Judicial District (Wake County) from 1972 to 1977. He graduated from NC State University and UNC-School of Law. Chief Justice Mitchell currently serves as a member of numerous boards and commissions.

ROBERT A. MURPHY, PH.D., is a clinical psychologist and Executive Director of the Center for Child and Family Health in Durham, NC. Dr. Murphy's organization promotes healthy child development by enhancing family and supportive relationships critical to physical, social and mental health; and by preventing and minimizing the effects of abuse, trauma and other disruptions of healthy development. Dr. Murphy graduated from the University of Massachusetts in Amherst, where he received his M.S. and Ph.D. He is Adjunct Associate Professor at the Department of Maternal and Child Health at the School of Public Health at UNC-Chapel Hill and is Senior Research Fellow in the Health Inequalities Program at the Center for Health Policy, Law and Management, at Duke University.

WILHELMENIA REMBERT, PH.D., is Professor of Social Work at Winthrop University in Rock Hill, SC, and Vice Chairperson of the Mecklenburg County Board of Commissioners. Dr. Rembert is a veteran educator and licensed clinical social worker in both North Carolina and South Carolina, with practice experience in outpatient mental health and rehabilitation. She is an active community volunteer, serving on numerous local boards. Dr. Rembert received her Ph.D. in child development at the UNC-Greensboro and completed the Management Development Program at Harvard University.

DAVID RICHARD is Executive Director of The Arc of North Carolina, which is an Advocacy and Service organization of over 5,000 members and 41 affiliate chapters throughout North Carolina, with a primary mission of improving the lives of people with developmental disabilities and their families. Mr. Richard is responsible for the administration of The Arc's service programs and advocacy efforts. He is a graduate of Louisiana State University.

KENNETH J. ROSE was Executive Director of the Center for Death Penalty Litigation from 1996 until July 2006, when he transitioned into a staff attorney position. The Center for Death Penalty Litigation is a non-profit organization dedicated to representing capital defendants and to assisting attorneys representing persons charged or convicted in capital cases. Mr. Rose, who graduated from Boston University Law School, has dedicated his professional life to capital defense work.

(CONTINUED NEXT PAGE)

LAO E. RUBERT is Executive Director of the Durham-based Carolina Justice Policy Center, and has spent over two decades working on death penalty and community corrections reform. Among her many accomplishments, Ms. Rubert helped lead successful North Carolina efforts to repeal the death penalty for juveniles and for mentally retarded persons. She has also been involved at some level in nearly every clemency campaign in North Carolina since 1984, and has worked closely with the campaign to enact a moratorium on the death penalty. Ms. Rubert has also worked to develop and implement the state's community-based corrections program; managed a community-based corrections program; and helped coordinate the statewide Community Sentencing Association. She currently serves on the NC Sentencing and Policy Advisory Commission, and chairs the Durham County Criminal Justice Partnership Program. Ms. Rubert received her B.A. from the University of Missouri and her M.A. from Duke University.

RUSSELL F. SIZEMORE is a partner with Kennedy Covington Lobdell & Hickman, LLP, in Charlotte, and Chairman of the Board of the Council for Children's Rights. He graduated with a Ph.D. from Harvard and received his law degree from Yale University. Mr. Sizemore represented the children of Elias and Teresa Syriani in the family's ultimately unsuccessful campaign to prevent the State of North Carolina from taking their father's life in response to his conviction for the murder of their mother.

BRYAN A. STEVENSON is Executive Director of the Equal Justice Initiative of Alabama, and Professor of Law at the New York University School of Law. His representation of poor people and death row prisoners in the deep south has won him national recognition and dozens of national awards, including the National Public Interest Lawyer of the Year, the ABA Wisdom Award for Public Service, the ACLU National Medal of Liberty, the Reebok Human Rights Award, the Olaf Palme Prize for International Human Rights, and the prestigious MacArthur Foundation Fellowship Award Prize. He is a graduate of Harvard Law School and the Harvard School of Government. Mr. Stevenson has published articles on race and poverty and the criminal justice system, and manuals on capital litigation and habeas corpus.

RONALD J. TABAK is Special Counsel at Skadden Arps Slate Meagher & Flom LLP He has been a leader in the ABA's efforts to recruit and train lawyers for indigent death row inmates. As Co-Chair of the Death Penalty Committee of the ABA's Section of Individual Rights and Responsibilities, Mr. Tabak spearheaded the successful effort to get the ABA to call for a moratorium on executions until various due process concerns are resolved. He is also Chair of the Section's Task Force on Mental Disability and the Death Penalty, whose proposals have been adopted as policies by the ABA, the American Psychological Association, and the American Psychiatric Association.

FAYE E. SULTAN, PH.D., is Director and Clinical Psychologist at University Psychological Associates, P.A., a clinical psychology and forensic consulting practice in Charlotte. She graduated from UNC-Chapel Hill, and is a clinical consultant for the Western Carolinians for Criminal Justice in Asheville, NC. Dr. Sultan is also a consulting evaluator for the NC Child Forensic Mental Health Evaluation Program and is on the NC State Board of Directors for Summit House, Inc.

JULIAN H. WRIGHT, JR., is a member of Robinson Bradshaw & Hinson. P.A., in Charlotte. He works primarily in the areas of employment, commercial and securities litigation. Mr. Wright also maintains an active pro bono practice, particularly in the areas of domestic violence protection, landlord-tenant disputes, and criminal appellate and post-conviction work. He is a Board Member of the Charlotte Coalition for a Moratorium Now. Mr. Wright graduated from Vanderbilt Divinity School and Vanderbilt University, where he received his J.D. Most recently, Mr. Wright represented the Crespi family in their struggle to spare Mr. Crespi's life.