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Laurie T. Izutsu

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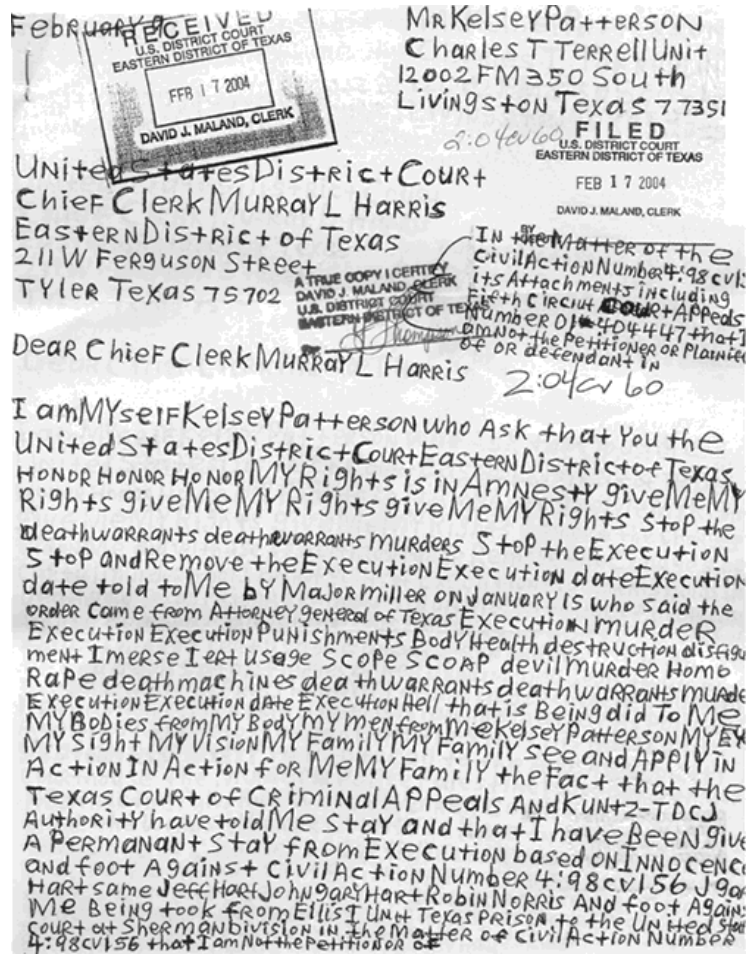
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# Applying *Atkins v. Virginia* to Capital Defendants with Severe Mental Illness



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<sup>1</sup> AMNESTY INTERNATIONAL UNITED STATES OF AMERICA (AIUSA), *Another Texas Injustice: The Case of Kelsey Patterson, Mentally Ill Man Facing Execution*, at 5 (Mar. 2004) (letter from Kelsey Patterson to a federal court), available at <http://web.amnesty.org/library/Index/ENGAMR510472004> (last visited Jan. 27, 2005) [hereinafter AIUSA, *Another Texas Injustice*].

## INTRODUCTION

On May 18, 2004, the State of Texas executed Kelsey Patterson, a man long diagnosed with paranoid schizophrenia, for the murders of Louis Oates and Dorothy Harris.<sup>2</sup> Twelve years earlier, Patterson had gone to the loading dock of Oates Oil Company and shot Oates with a .38-caliber Pistol.<sup>3</sup> Patterson then killed Oates' secretary when she walked out of her office and screamed at finding Oates' body on the ground.<sup>4</sup> Patterson made no effort to conceal the crimes. Instead, he returned home, informed his roommate of what he had done,<sup>5</sup> undressed to his socks, and began pacing and shouting in the street.<sup>6</sup>

After Patterson was found competent to stand trial,<sup>7</sup> his lawyers raised the insanity defense.<sup>8</sup> Patterson never asserted a motive for the killings.<sup>9</sup> Throughout his legal proceedings, he claimed to be controlled by outside forces through implants and to be a victim of conspiracy and poisoning.<sup>10</sup> Though Patterson

<sup>2</sup> David Carson, Texas Execution Information Center, *Kelsey Patterson*, at <http://www.txexecutions.org/reports/322.asp> (last visited Dec. 19, 2004).

<sup>3</sup> *Patterson v. Cockrell*, 69 Fed.Appx. 658, 2003 WL 21355999, at \*\*1 (5<sup>th</sup> Cir. May 23, 2003).

<sup>4</sup> Carson, *supra* note 2.

<sup>5</sup> *Patterson*, 2003 WL 21355999, at \*\*1.

<sup>6</sup> AIUSA, *Another Texas Injustice*, *supra* note 1, at 1.

<sup>7</sup> *Patterson*, 2003 WL 21355999, at \*\*1. At Patterson's competency hearing before a jury, defense counsel had relied on the cross-examination of the state's witnesses, clinical psychologist Walter Quijano and forensic psychiatrist James Grigson. AIUSA, *Another Texas Injustice*, *supra* note 1, at 6. Neither of these expert witnesses evaluated Patterson in person. *Patterson*, 2003 WL 21355999, at \*\*5. Based on his records alone, Dr. Quijano diagnosed Patterson with schizophrenia and Dr. Grigson proposed that Patterson had learned to fake psychosis. *Id.* Both doctors believed Patterson was competent to stand trial. *Id.*

<sup>8</sup> The contemporary notion of insanity in American criminal law has its roots in the famed *M'Naghten* case of 1843. See Cynthia G. Hawkins-Leon, "Literature as Law": *The History of the Insanity Plea and a Fictional Application Within the Law & Literature Canon*, 72 TEMP. L. REV. 381 (1999). Daniel M'Naghten was found not guilty by reason of insanity in England after shooting to death Edward Drummond while in the grip of extreme paranoia and believing Drummond to be the prime minister. *Id.* at 390-92. This verdict caused Queen Victoria to question the rationale behind the decision of the House of Lords, prompting a series of questions that resulted in the M'Naghten Rule:

[T]o establish a defence on the ground of insanity, it must be clearly proved that, at the time of the committing of the act, the party accused was labouring 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 if he did know it, that he did not know he was doing what was wrong.

*Id.* at 392.

<sup>9</sup> *Patterson*, 2003 WL 21355999, at \*\*1. See also AIUSA, *Another Texas Injustice*, at 1.

<sup>10</sup> AIUSA, *Another Texas Injustice*, *supra* note 1, at 1, 6.

continually interrupted trial proceedings to insist that he was a victim of conspiracy,<sup>11</sup> the judge did not return to the issue of competency.<sup>12</sup> Further, the prosecution elicited testimony that it was feasible to feign psychotic symptoms.<sup>13</sup> Even more significantly, the prosecution intermittently punctuated the trial with statements that encouraged the jury to treat Patterson's schizophrenia as an indicator of future dangerousness.<sup>14</sup> The jury deliberated about four hours before recommending the death penalty.<sup>15</sup>

The low standard for competence, the effects of severe mental illness on the defendant's courtroom behavior, and the tendency for the prosecutor to present a mental disorder as an aggravating factor instead of a mitigating factor exemplify the serious disadvantages a severely mentally ill defendant faces in capital proceedings. Such circumstances have led state lawmakers to consider adding a sentence of life without the possibility of parole in Texas.<sup>16</sup> Public outcry over Patterson's execution,<sup>17</sup> and the execution of others with a similar psychiatric background,<sup>18</sup> reflect the burgeoning controversy over whether individuals with severe mental illness should be excluded from capital punishment.

In June of 2002, the Supreme Court in *Atkins v. Virginia*<sup>19</sup> found it unconstitutional to execute people with mental retardation.<sup>20</sup> The Court convincingly demonstrated that the execution of criminals with mental retardation

<sup>11</sup> *Id.* at 10-11.

<sup>12</sup> *Id.* at 11.

<sup>13</sup> *Patterson*, 2003 WL 21355999, at \*\*5.

<sup>14</sup> See text accompanying footnote 209, *infra*.

<sup>15</sup> AIUSA, *Another Texas Injustice*, *supra* note 1, at 13.

<sup>16</sup> Scott Gold, *The Nation*; *Texas Weighs Its Life or Death Decisions; The Execution of A Schizophrenic Man Helps Build Support for A New Sentencing Option in Capital Cases: Life without Parole*. L.A. TIMES, Aug. 15, 2004, at A17. See also Mary Alice Robbins, *A Preview of the Action the 79<sup>th</sup> Texas Legislature Will See*, 20 TEXAS LAWYER 14, Jan. 10, 2005.

<sup>17</sup> See Gold, *supra* note 16. See also Editorial, *Our View: Two More Death Penalty Inequities*, SPRINGFIELD NEWS-LEADER, May 21, 2004, at 8A; Cato Meador, Editorial, *Letter Regarding Kelsey Patterson*, DALLAS MORNING NEWS, May 30, 2004, at 2H. Dr. Maria Felix-Ortiz, *In Texas, Mental-Health Spending Is Down, Executions Continue*, SAN ANTONIO EXPRESS-NEWS, June 9, 2004, at 9G.

<sup>18</sup> See generally Editorial, *Executing the Mentally Ill; The Execution of a Person Who Has Suffers [sic] from Mental Illness is Cruel and Unusual and Should Be Outlawed*, SAN ANTONIO EXPRESS, Apr. 6, 2003, at 02H; Editorial, *Genuine Justice Calls for Sparing Severely Mentally Ill*, HOUSTON CHRONICLE, Nov. 6, 2002, at 42.

<sup>19</sup> 536 U.S. 304 (2002).

<sup>20</sup> *Id.* Because mental retardation and other mental disorders classify disorders and not the people themselves, this author attempts to avoid expressions such as "mentally retarded" or "schizophrenic."

amounts to cruel and unusual punishment prohibited by the Eighth Amendment, given their diminished culpability due to factors ranging from subaverage intellect to impaired social functioning.<sup>21</sup> The *Atkins* rationale compels the conclusion that the death penalty should likewise be found unconstitutional as imposed on defendants with a severe mental disorder who suffer from similar disabling effects.

This Note proposes a categorical exemption from capital punishment for individuals with severe mental disorders. To provide necessary context for the analysis, this Note first discusses the Eighth Amendment's mandate that capital punishment be commensurate with the character of the defendant and his or her criminal offense, and the Supreme Court's corresponding emphasis on proportionality review and moral culpability. Part Two looks closely at the Supreme Court's discussion of reduced moral culpability in capital defendants with mental retardation in *Atkins*. Part Three reviews state death penalty statute provisions that have a bearing on mental illness and the viewpoints of various justices and communities towards the execution of the mentally ill to demonstrate that people with severe mental illness should also be considered less morally culpable. Part Four examines the nature of severe mental disorders and compares how mental retardation and severe mental illness impact the individual. In Part Five, the cases of Kelsey Patterson, James Colburn, and Charles Walker illustrate how the experiences of defendants with severe mental disorders in capital proceedings implicate the exact concerns expressed by the Supreme Court in *Atkins*. Finally, Part Six cautions against limiting the scope of severe mental illness as a mitigator and addresses the implications of applying *Atkins* to offenders with severe mental disorders. Part Seven concludes this Note with comments on the evolving standards of decency in the United States.

#### I. THE EIGHTH AMENDMENT, PERSONAL CULPABILITY, AND THE PENOLOGICAL JUSTIFICATIONS OF THE DEATH PENALTY

The Eighth Amendment of the United States Constitution prohibits the use of "cruel and unusual punishments."<sup>22</sup> In capital cases, the Supreme Court has

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<sup>21</sup> *Id.*

<sup>22</sup> U.S. CONST. amend. VIII.

generally construed this prohibition to mean that a sentence of death must not be excessive and must serve some penological justification, such as retribution or deterrence, so as not to result in the “gratuitous infliction of suffering.”<sup>23</sup> The Court has further held that certain crimes that do not involve the taking of human life are *per se* ineligible for the death penalty because such a sentence would be excessive.<sup>24</sup> Certain individuals might also be ineligible regardless of the crime committed.<sup>25</sup> This bar might occur when, taking into account the individual’s character and background, the death penalty would offend “currently prevailing standards of decency.”<sup>26</sup>

The idea that “punishment should be directly related to the personal culpability of the criminal defendant”<sup>27</sup> has been central to the Court’s analysis of whether the death sentence is excessive.<sup>28</sup> Indeed, the reality that not every defendant in a capital case is sentenced to death reflects the attitude that “only the most deserving” should be executed.<sup>29</sup> Proportionality review implies that some capital defendants may not be culpable enough to warrant the death penalty.<sup>30</sup> The fact that the individual’s level of culpability lies on a continuum is reflected by state statutes that provide for the assessment of mitigating and aggravating circumstances in capital trials. It is only at the extreme end of this continuum that the public will deem the criminal deserving of execution.<sup>31</sup> In this way, the death penalty becomes “an expression of society’s moral outrage at particularly offensive conduct.”<sup>32</sup>

Deterrence also plays a role in considerations of capital sentencing. The Court has found that “the death penalty has little deterrent force against defendants who have reduced

<sup>23</sup> *Gregg v. Georgia*, 428 U.S. 153, 182-83 (1976).

<sup>24</sup> *See, e.g., Coker v. Georgia*, 433 U.S. 584 (1977) (holding that the death penalty was a disproportionate punishment for rape).

<sup>25</sup> Alyssa C. Lareau & Grant H. Willis, *Thirty-First Annual Review of Criminal Procedure IV. Sentencing, Capital Punishment*, 90 GEO. L.J. 1838, 1842 (2002).

<sup>26</sup> *See Thompson v. Oklahoma*, 487 U.S. 815 (1988).

<sup>27</sup> *Thompson*, 487 U.S. at 834 (quoting *California v. Brown*, 479 U.S. 538, 545 (1987)).

<sup>28</sup> Van W. Ellis, Note, *Guilty but Mentally Ill and the Death Penalty: Punishment Full of Sound and Fury, Signifying Nothing*, 43 DUKE L.J. 87, 90 (1994).

<sup>29</sup> *Atkins v. Virginia*, 536 U.S. 304, 319 (2002).

<sup>30</sup> Ellis, *supra* note 28, at 90.

<sup>31</sup> Joseph A. Nese, *The Fate of Mentally Retarded Criminals: An Examination of the Propriety of Their Execution Under the Eighth Amendment*, 40 DUQ. L. REV. 373, 401 (2002).

<sup>32</sup> *Gregg v. Georgia*, 428 U.S. 153, 183 (1976).

capacity for considered choice.”<sup>33</sup> When the death penalty does not serve either the goal of retribution *or* that of deterrence, it purposelessly imposes pain and suffering.<sup>34</sup>

Accordingly, the Court has held that the provisions of the Eighth Amendment require an analysis of the defendant’s personal culpability in capital sentencing and an assessment of whether the aims of retribution or deterrence are met. These requirements come to bear significantly on the Supreme Court holding in *Atkins*.

## II. THE SUPREME COURT FINDINGS ON MENTAL RETARDATION IN *ATKINS V. VIRGINIA*

In *Atkins*, the Supreme Court barred the execution of individuals with mental retardation finding that although the deficiencies of mental retardation did not exempt a defendant from criminal responsibility, they did diminish his or her moral culpability.<sup>35</sup> The Court premised its holding on the Eighth Amendment’s bar against excessive punishment and the accompanying need for proportionality review.<sup>36</sup> As the Court had pointed out in *Penry v. Lynaugh*,<sup>37</sup> such proportionality review is best informed by the actions of state legislatures.<sup>38</sup> Hence, the Court reviewed state death penalty statutes, examined the evidence of a national consensus against capital punishment for persons with mental retardation, and noted the impact of mental retardation on these defendants.

The *Atkins* Court evaluated whether society regards people with mental retardation less culpable than the average criminal by observing the changes in state death penalty laws that had been enacted since 1986.<sup>39</sup> That year marked the execution of Jerome Bowden, a Georgia death row inmate said to have an IQ of 65.<sup>40</sup> Bowden’s execution led to the first state statute bar against execution of offenders with mental retardation.<sup>41</sup> In the next few years, Georgia and Maryland enacted death penalty legislation prohibiting capital

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<sup>33</sup> *Skipper v. South Carolina*, 476 U.S. 1, 13 (1986).

<sup>34</sup> *Coker v. Georgia*, 433 U.S. 584, 592 (1977).

<sup>35</sup> *Atkins v. Virginia*, 536 U.S. 304, 320 (2002).

<sup>36</sup> *Id.* at 311.

<sup>37</sup> 492 U.S. 302 (1989).

<sup>38</sup> *Id.* at 330-31.

<sup>39</sup> *Id.* at 313-14.

<sup>40</sup> *Id.* at 313 n.8.

<sup>41</sup> *Id.* at 313-14.

punishment for people with mental retardation.<sup>42</sup> The decision in *Penry* followed in 1989, in which the Court found that the defendant's mental retardation alone did not exempt him from capital punishment under the Eighth Amendment.<sup>43</sup> The Court later reversed *Penry*'s death sentence, however, on the ground that the statute deprived the sentencer of an adequate means of giving mitigating effect to *Penry*'s mental retardation.<sup>44</sup> In response to *Bowden*'s execution and *Penry*, many state legislatures enacted death penalty statutes similar to the laws of Georgia and Maryland. The *Atkins* Court noted that the State trend<sup>45</sup> of barring execution of persons with mental retardation indicated that society has come to regard such people as less culpable.<sup>46</sup>

In further support of its finding of a national consensus, the Court noted that professional organizations such as the American Psychological Association and the American Association on Mental Retardation (AAMR), recognized for their expertise in mental health, had officially taken a stance against imposing the death penalty on criminal offenders with mental retardation.<sup>47</sup> Additionally, the Court reported that various religious groups had together filed an *amicus curiae* brief on behalf of a petitioner with mental retardation, because despite their differences, these *amici* "share a conviction that the execution of persons with mental retardation cannot be morally justified."<sup>48</sup> The Court then acknowledged the widespread disapproval within the world community of executing offenders with mental retardation.<sup>49</sup> The Court found this consensus to reflect a "widespread judgment about the relative culpability of mentally retarded offenders, and the relationship between mental retardation and the penological purposes served by the death penalty."<sup>50</sup>

Moreover, the Court noted that "some characteristics of mental retardation undermine the strength of the procedural

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<sup>42</sup> *Penry*, 492 U.S. at 314.

<sup>43</sup> *Id.* at 340.

<sup>44</sup> See *Penry v. Johnson*, 532 U.S. 782, 804 (2001).

<sup>45</sup> As the Court specifically stated: "It is not so much the number of these States that is significant, but the consistency of the direction of change." *Atkins v. Virginia*, 536 U.S. 304, 315 (2002).

<sup>46</sup> *Id.* at 314-16.

<sup>47</sup> *Id.* at 316 n.21 (citation omitted).

<sup>48</sup> *Id.*

<sup>49</sup> *Id.*

<sup>50</sup> *Atkins*, 536 U.S. at 317.



protections that our capital jurisprudence steadfastly guards.”<sup>51</sup> According to the AAMR, a person considered to have mental retardation exhibits an intelligence quotient (IQ) of somewhere around 70 to 75 at the highest, as well as deficits manifested by problems with self-care, social interaction, employment, education, and health.<sup>52</sup> A person is diagnosed with mental retardation if subaverage intelligence and limitations in adaptive functioning are present before the individual turns eighteen years old.<sup>53</sup> Discussing the impact of mental retardation on the offender’s thought processes, the Court acknowledged that people with mental retardation are paradoxically often found competent to stand trial, despite reduced capacities to analyze information, think logically, articulate, learn from mistakes, and comprehend human behavior.<sup>54</sup> The Court noted that even given these deficiencies, “[t]here is no evidence that they are more likely to engage in criminal conduct than others, but there is abundant evidence that they often act on impulse rather than pursuant to a premeditated plan.”<sup>55</sup>

The Court found these cognitive and behavioral defects to reduce the moral culpability of defendants with mental retardation.<sup>56</sup> Consequently, where the death penalty is typically not appropriate retribution for crimes committed by a person of average intelligence, it offends contemporary standards of decency in the case of defendants with mental retardation.<sup>57</sup> Furthermore, deterrence is not measurably served by executing individuals who are unable to see that certain acts might result in the death penalty, and so cannot adjust their conduct accordingly.<sup>58</sup>

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<sup>51</sup> *Id.* at 318.

<sup>52</sup> *Id.* at 308 n.3. *See also* AMERICAN ASSOCIATION ON MENTAL RETARDATION (AAMR), *Definition of Mental Retardation*, available at [http://www.aamr.org/Policies/faq\\_mental\\_retardation.shtml](http://www.aamr.org/Policies/faq_mental_retardation.shtml) (last visited Feb. 28, 2005).

<sup>53</sup> AAMR, *supra* note 52. The American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV) criteria parallel that of AAMR. *See* AM. PSYCHIATRIC ASS’N, DSM-IV 39-46 (1994). Adaptive functioning or behavior refers to “the collection of conceptual, social, and practical skills that people have learned so they can function in their everyday lives. Significant limitations in adaptive behavior impact a person’s daily life and affect the ability to respond to a particular situation or to the environment.” AAMR, *Fact Sheet: Frequently Asked Questions about Mental Retardation*, available at [http://www.aamr.org/Policies/faq\\_mental\\_retardation.shtml](http://www.aamr.org/Policies/faq_mental_retardation.shtml) (last visited Dec. 23, 2004).

<sup>54</sup> *See Atkins*, 536 U.S. at 318.

<sup>55</sup> *Id.*

<sup>56</sup> *Id.* at 320.

<sup>57</sup> *Id.* at 319.

<sup>58</sup> *Id.* at 320.

In addition to recognizing that retribution and deterrence are not furthered by imposing the death penalty on people with mental retardation, the Court determined that such individuals suffer significant disadvantages during legal proceedings.<sup>59</sup> Because of the reduced capacity that mental retardation causes, defendants are more vulnerable to situations generating false confessions and they are sometimes unable to assist counsel or provide adequate testimony.<sup>60</sup> Equally as crucial, jurors might misperceive the attitudes of the defendants towards their crimes based on their outward appearance, which “may create an unwarranted impression of lack of remorse for their crimes.”<sup>61</sup> Perhaps even more important, evidence of mental retardation as a mitigating factor can act as a “two-edged sword” that jurors also regard as an indicator of future dangerousness.<sup>62</sup> Given all these encumbrances, the Court concluded that defendants with mental retardation “face a special risk of wrongful execution.”<sup>63</sup>

The weight the Court gives to functional and cognitive impairment in assessing both culpability and vulnerability in legal proceedings casts serious doubt on the constitutionality of imposing the death penalty on individuals with severe mental illness. Thus, where defendants experience impaired cognitive and adaptive functioning that reduce culpability and lead to vulnerabilities during legal proceedings, and where evidence exists that society denounces capital punishment for such persons, the Supreme Court should exempt severely mentally ill offenders from the death penalty.

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<sup>59</sup> *Atkins*, 536 U.S. at 320-21.

<sup>60</sup> *Id.*

<sup>61</sup> *Id.* at 321.

<sup>62</sup> *Id.* at 320-21.

<sup>63</sup> *Id.* at 321.

### III. APPLYING THE RATIONALE OF *ATKINS* TO OFFENDERS WITH SEVERE MENTAL DISORDERS

#### A. *State Death Penalty Statutes<sup>64</sup> and Severe Mental Illness as a Mitigating Factor*

The overwhelming majority of state statutes contain mitigating factors that implicate mental illness.<sup>65</sup> Many capital statutes, like the Model Penal Code, permit the defendant to proffer evidence that the offense was committed “under the influence of extreme *mental* or emotional disturbance” as a mitigating circumstance relevant to determination of a sentence less than death.<sup>66</sup> Some states do not even require that such mental or emotional disturbance be “extreme,” but only that the condition had an “influence” on the defendant’s conduct at the time of the offense.<sup>67</sup>

<sup>64</sup> Currently, over one-fifth of state jurisdictions do not have death penalty statutes. Alaska, Hawaii, Iowa, Maine, Massachusetts, Michigan, Minnesota, North Dakota, Rhode Island, Vermont, West Virginia, Wisconsin. Deborah Fins, *Death Row U.S.A. Summer 2004, A Quarterly Report by the Criminal Justice Project of the NAACP Legal Defense and Educational Fund, Inc.*, at 1, 3, available at [http://www.naacpldf.org/content/pdf/pubs/drusa/DRUSA\\_Summer\\_2004.pdf](http://www.naacpldf.org/content/pdf/pubs/drusa/DRUSA_Summer_2004.pdf) (last visited Feb. 27, 2005). This absence automatically excludes individuals with severe mental illness from capital punishment in twelve states, as well as the District of Columbia. *Id.*

<sup>65</sup> See Kyron Huigens, *Homicide in Aretaic Terms*, 6 BUFF. CRIM. L. REV. 97, n.108 (2002). See also Ellen F. Berkman, *Mental Illness as an Aggravating Circumstance in Capital Sentencing*, 89 COLUM. L. REV. 291, 297-98 (1989). See also AMERICAN BAR ASSOCIATION SECTION OF INDIVIDUAL RIGHTS AND RESPONSIBILITIES, *Death without Justice: A Guide for Examining the Administration of the Death Penalty in the United States*, 63 OHIO ST. L.J. 487, 529 (2002) (noting that those death penalty statutes following the Model Penal Code implicate mental illness).

<sup>66</sup> See Ellen Fels Berkman, *Mental Illness as an Aggravating Circumstance in Capital Sentencing*, 89 COLUM. L. REV. 291, 296-98 (1989) (emphasis added). See also MPC 210.6(4)(b). See, e.g., ARK. CODE ANN. § 5-4-605(1) (2004); CAL. PENAL CODE § 190.3(d) (2005); FLA. STAT. ANN. § 921.141(6)(b) (2004); 720 ILL. COMP. STAT. ANN. 5/9-1(c)(2) (2004); IND. CODE § 35-50-2-9(c)(2) (2005); KAN. STAT. ANN. § 21-4626(2) (2003); KY. REV. STAT. ANN. § 532.025 (2004)(2)(b)(2); LA. CODE CRIM. PROC. ANN. art. 905.5(b) (2004); MISS. CODE ANN. § 99-19-101(6)(b) (2004); MO. ANN. STAT. § 565.032(3)(2) (2004); MONT. CODE ANN. § 46-18-304(b) (2004); NEB. REV. STAT. ANN. § 29-2523(2)(c) (2004); NEV. REV. STAT. ANN. 200.035(2) (2004); N.H. REV. STAT. ANN. § 630:5(VI)(f) (2004) (refers to an offense committed under “severe mental or emotional disturbance”); N.J. STAT. ANN. § 2C:11-3(5)(a) (2004); 42 PA. CONS. STAT. § 9711(e)(2) (2004); TENN. CODE ANN. § 39-13-204(j)(2) (2004); VA. CODE ANN. § 19.2-264.4(B)(i)-(ii) (2004); WYO. STAT. ANN. § 6-2-102(j)(ii)-(iii) (2004).

<sup>67</sup> See NM Stat. Ann. § 31-20A-6; N.C. GEN. STAT. § 15A-2000(f)(2) (2005); NY CPL § 400.27 (9)(e). See also S.C. CODE ANN. § 16-3-20(C)(b)(2) (1976); Utah Criminal Code § 76-3-207. In June of 2004, the State of New York Court of Appeals struck down the state’s death penalty statute as unconstitutional due to a problematic jury instruction requirement in the penalty phase. 783 N.Y.S.2d 485 (N.Y. 2004). At the time of publication, New York State Assembly members remain undecided as to whether or not to correct this flaw and reinstate the death penalty. Patrick D. Healy, *Death Penalty Seems Unlikely to Be Revived*, N.Y. TIMES, Feb. 11, 2005, at B1.

In addition to mental or emotional disturbance, twenty-eight states—well over half of those jurisdictions that have death penalty statutes—give mental illness mitigating impact by allowing the jury to consider the defendant’s capacity.<sup>68</sup> These states commonly refer to “the capacity of the defendant to appreciate the criminality [or wrongfulness] of his conduct or to conform his conduct to the requirements of law” as being “impaired” or “significantly” or “substantially impaired.”<sup>69</sup> Many of these provisions expressly stipulate that this impairment be due to “mental disease or defect” or “mental illness.”<sup>70</sup> Connecticut has gone so far as to bar the death penalty when such incapacity is found.<sup>71</sup>

Death penalty statutes may also implicate severe mental illness as a mitigating factor with other language. Oregon, for instance, instructs jurors to consider “the extent of *mental or emotional pressure* under which the defendant was acting at the time the offense was committed.”<sup>72</sup> Illinois, on the other hand, looks more broadly at whether the defendant

<sup>68</sup> See ARIZ. REV. STAT. § 13-703 (2004); ARK. CODE ANN. § 5-4-605 (Michie 2004); CAL. PENAL CODE § 190.3 (West 2005); COLO. REV. STAT. ANN. § 18-1.3-1201(4)(b) (2003); CONN. GEN. STAT. ANN. § 53a-46a (West 2005); FLA. STAT. ANN. § 921.141 (West 2004); IND. CODE § 35-50-2-9(c)(2) (2005); KAN. STAT. ANN. § 21-4626 (2004); KY. REV. STAT. ANN. § 532.025 (Banks-Baldwin 2004); LA. CODE CRIM. PROC. ANN. art. 905.5 (West 2005); MD. CODE ANN., CRIMINAL CAUSES § 4-343 (2005); MISS. CODE ANN. § 99-19-101 (2005); MO. ANN. STAT. § 565.032 (West 2005); MONT. CODE ANN. § 46-18-304 (2005); NEB. REV. ST. § 29-2523 (2005); N.H. REV. STAT. ANN. § 630:5 (2005); N.J. STAT. ANN. § 2C:11-3 (West 2004); N.M. STAT. ANN. § 31-20A-6 (Michie 2004); N.Y. CRIMINAL PROCEDURE LAW § 400.27 (McKinney 2004); N.C. GEN. STAT. § 15A-2000(f)(2) (2005); OHIO REV. CODE ANN. § 2929.04 (West 2005); 42 PA. CONS. STAT. § 9711 (2005); S.C. CODE ANN. § 16-3-20 (Law. Co-op. 2005); TEX. CODE ANN. § 39-13-204 (2005); UTAH CODE ANN. § 76-3-207 (2004); VA. CODE ANN. § 19.2-264.4 (Michie 2004); WASH. REV. CODE § 10.95.070 (2005); WYO. STAT. ANN. § 6-2-102 (Michie 2005).

<sup>69</sup> See statutes cited *supra* note 66.

<sup>70</sup> See ARK. CODE ANN. § 5-4-605 (3) (2004); CAL. PENAL CODE § 190.3(h) (1978); IND. CODE ANN. § 35-50-2-9(c)(6) (2004); LA. CODE CRIM. PROC. ANN. art. 905.5(e) (2004); N.J. STAT. ANN. 2C:11-3(i)(5)(d) (2002); OHIO REV. CODE ANN. § 2929.04(B)(3) (2002); TENN. CODE ANN. § 39-13-204(j)(8) (2002); WASH. REV. CODE ANN. 10.95.070. Kentucky and Nebraska specifically refer to the term “mental illness.” KY. REV. STAT. ANN. § 532.025 (2)(b)7 (2002); NEB. REV. ST. § 29-2523(2)g (2004). Maryland refers to “mental incapacity” and “mental disorder.” MD. R. CR. PROC. § 4-343 (4).

<sup>71</sup> CONN. GEN. STAT. ANN. § 53a-46a(h) (2001). The statute states:

The court shall not impose the sentence of death on the defendant if the jury or, if there is no jury, the court finds by a special verdict . . . that at the time of the offense . . . the defendant’s mental capacity was significantly impaired or the defendant’s ability to conform the defendant’s conduct to the requirements of law was significantly impaired but not so impaired in either case as to constitute a defense to prosecution.

*Id.* This mitigating circumstance is listed separately from that of mental retardation. *Id.*

<sup>72</sup> OR. REV. STAT. § 163.150(1)(c)(A) (2005) (emphasis added).

“suffers from a reduced *mental capacity*.”<sup>73</sup> Finally, South Carolina asks jurors to consider the “*mentality* of the defendant at the time of the crime.”<sup>74</sup>

The consistent inclusion of a mental illness component in death penalty statutes indicates that some degree of mental illness falling short of insanity must be weighed during sentencing. While the provisions do not explain exactly what is meant by “mental disturbance” or impairment of capacity, such criteria would surely embrace a person suffering from a severe mental disorder.<sup>75</sup> This pattern among death penalty statutes of considering the defendant’s mental condition and corresponding inability to act within the law suggests that a majority of legislatures recognize the potential of mental illness to mitigate a person’s culpability.<sup>76</sup>

*B. Views of State Justices, Experts and Religious and World Communities*

The codification of mental illness in numerous state death penalty statutes reflects agreement amongst professional, religious and world communities that defendants with severe mental disorders should be excluded from capital punishment. While this codification may not be as clearly laid out as statutes prohibiting execution of criminal offenders with mental retardation, it does appear to indicate “a much broader social and professional consensus.”<sup>77</sup> Many justices presiding over capital cases have cast doubt over the appropriateness of

<sup>73</sup> ILL. COMP. STAT. ANN. 5/9-1(c)(7) (2004) (emphasis added).

<sup>74</sup> S.C. CODE ANN. § 16-3-20(C)(b)(7) (2004) (emphasis added). This factor is noted separately from the circumstance of mental retardation. *Id.* § 16-3-20(C)(b)(10).

<sup>75</sup> See *infra* Part IV.

<sup>76</sup> Judges have certainly understood these statutes to give effect in this manner. For example, in vacating an order dismissing a capital defendant’s petition for post-conviction relief, a Pennsylvania Supreme Court judge deemed that evidence of a defendant’s chronic schizophrenia “would have been sufficient to implicate the mental-health mitigators, namely that Appellant was under the influence of an extreme mental or emotional disturbance, and that his capacity to appreciate the criminality of his conduct or conform it to the requirements of the law was substantially impaired.” *Commonwealth v. Hughes*, 2004 WL 3050831, at \*37 (Pa. 2004). In another instance, a Seventh Circuit judge referred to the Indiana death penalty statute as having two mitigating factors “to which mental illness can be relevant” and cited the following provisions: “was under the influence of extreme mental or emotional disturbance when the murders were committed” and “the defendant’s capacity to appreciate the criminality of the defendant’s conduct or to conform that conduct to the requirements of law was substantially impaired as a result of mental disease or defect or of intoxication.” *Baird v. David*, 388 F.3d 1110, 1115 (7th Cir. 2004) (citing IND. CODE § 35-502-9(C)(2) (2004)).

<sup>77</sup> *Atkins v. Virginia*, 536 U.S. 304, 316 n.21 (2002).

excluding people with severe mental disorders from the death penalty. In *State v. Scott*,<sup>78</sup> Justice Pfeifer dissented from the majority's opinion which had affirmed a death sentence for a man with schizophrenia.<sup>79</sup> Arguing that evolving standards of decency prohibited the man's execution, Pfeifer wrote:

I cannot get past one simple irrefutable fact: he has chronic, undifferentiated schizophrenia, a severe mental illness. Mental illness is a medical disease. Every year we learn more about it and the way it manifests itself in the mind of the sufferer. At this time, we do not and cannot know what is going on in the mind of a person with mental illness. As a society, we have always treated those with mental illness differently from those without. In the interest of human dignity, we must continue to do so.<sup>80</sup>

Another justice, dissenting in *Corcoran v. State*,<sup>81</sup> cited *Atkins* to propose that the death penalty should not be imposed on an individual with severe mental illness. Acknowledging that the defendant in this case who received a death sentence did not have mental retardation, Justice Rucker asserted that "the underlying rationale for prohibiting executions of the mentally retarded is just as compelling for prohibiting executions of the seriously mentally ill, namely evolving standards of decency."<sup>82</sup> Still another justice, in *State v. Nelson*,<sup>83</sup> relied heavily on *Atkins* in his concurrence.<sup>84</sup> Contending that the defendant's "irrationalities" lessened her culpability, Justice Zazzali opined that "if the culpability of the average murderer is insufficient to invoke the death penalty as our most extreme sanction, then the lesser culpability of Nelson, given her history of mental illness and its connection to her crimes, 'surely does not merit that form of retribution.'"<sup>85</sup>

Additionally, a number of justices have questioned the imposition of the death penalty on individuals with mental illness in other contexts. For example, in December of 2004, two former North Carolina Supreme Court justices urged Governor Mike Easley to commute the sentence of Charles Walker, a death row inmate who suffers from a severe mental

<sup>78</sup> 748 N.E.2d 11 (Ohio 2001).

<sup>79</sup> *Id.*

<sup>80</sup> *Id.* at 20.

<sup>81</sup> 774 N.E.2d 495 (Ind. 2002).

<sup>82</sup> *Id.* at 502.

<sup>83</sup> 803 A.2d 1, 47 (N.J. 2002).

<sup>84</sup> *Id.*

<sup>85</sup> *Id.* (quoting *Godfrey v. Georgia*, 446 U.S. 420, 433 (1980)) (Zazzali, J., dissenting).

disorder.<sup>86</sup> “To spare Walker’s life and impose a sentence of life imprisonment without parole is particularly appropriate,” wrote Exum in a letter to the Governor, “because of the role Walker’s long-standing mental illness—paranoid schizophrenia—played in the proceeding leading to his sentence of death.”<sup>87</sup> In 2002, a group of twenty-one retired state and federal judges in Illinois wrote an open letter to then Governor George Ryan, urging him to commute the death sentences to life without parole in cases where the fairness and accuracy of the conviction or sentence was in doubt.<sup>88</sup> They referred to mental illness as one of the legitimate bases for granting clemency.<sup>89</sup> In that same year, United States District Judge William Wayne Justice openly criticized the Texas criminal justice system for approaching the mentally ill with “a spirit of vengeance.”<sup>90</sup> He referred to Andrea Yates, a woman diagnosed with schizophrenia who had drowned her children, to illustrate one who could not be “justly blame[d].”<sup>91</sup> The federal judge alluded to the notion of moral culpability, stating, “If we reject the moral necessity to distinguish between those who willingly do evil, and those who do dreadful acts on account of unbalanced minds, we will do injury to these people.”<sup>92</sup> Other judges, despite their affirmation of death sentences, have made critical remarks about the outcome of death penalty cases involving the severely mentally ill, perhaps hinting at an inconsistency between what is considered legally appropriate and what punishment they feel a capital defendant morally deserves.<sup>93</sup>

Organizations with germane expertise in the realm of mental health and religious and world communities agree with this sentiment to evaluate criminal offenders with severe

<sup>86</sup> Andrea Weigl, *Former Justices Urge Mercy*, NEWS & OBSERVER, Nov. 24, 2004, at B5. See also *infra* Part V.C.

<sup>87</sup> Weigl, *supra* note 86.

<sup>88</sup> John F. Cirricone et al., *An Open Letter from Retired Judges to Governor George Ryan* (Dec. 1, 2002), available at <http://www.law.northwestern.edu/depts/clinic/wrongful/documents/JudgeLet1.pdf> (last visited Feb. 2, 2005).

<sup>89</sup> *Id.*

<sup>90</sup> James Kimberly, *Justice Defends Mentally Ill/U.S. Judge Chides Texas Law’s “Spirit of Vengeance”*, HOUSTON CHRON., Sept. 26, 2002, at 29.

<sup>91</sup> *Id.*

<sup>92</sup> *Id.*

<sup>93</sup> Fifth Circuit Justice Edith H. Jones apparently expressed frustration about Kelsey Patterson’s case and asked, “What are we doing here?” She then reportedly said to Assistant Attorney General Gina Bunn, “This is a very sick man.” Mike Tolson, *Mentally Ill Killer’s Life on the Line*, HOUST. CHRON., Aug. 11, 2002, at A37. Justice Fortunato Benavides spoke out more strongly, evidently blaming Texas’s mental health system for continually discharging Patterson back into the community where he eventually committed the two murders. *Id.*

mental disorders in capital sentencing proceedings more like offenders with mental retardation. For instance, organizations such as the National Alliance for the Mentally Ill, the American Psychological Association (APA) and the National Mental Health Association (NMHA) have taken an official stance against capital punishment as imposed on persons with severe mental illness.<sup>94</sup> In the same vein, four of the twelve religious group *amici* supporting the petitioner in *Atkins* believe that the death penalty is never a legitimate punishment when it is aimed at persons who are more “vulnerable” than the average person or who suffer from a mental illness or disability.<sup>95</sup> Two of the other groups similarly emphasized that it is the *decreased culpability* of people with mental retardation that renders the death penalty particularly inappropriate for this population.<sup>96</sup> These religious *amici*’s concerns about vulnerability and decreased culpability readily apply to individuals with severe mental disorders.<sup>97</sup>

In addition to American professional and religious communities, world communities have expressed strong opposition to the execution of people with severe mental

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<sup>94</sup> See National Mental Health Association, News Release, NMHA Announces Position on Death Penalty (Apr. 3, 2001), available at <http://www.nmha.org/newsroom/system/news.vw.cfm?do=vw&rid=276> (last visited Dec. 23, 2004); National Alliance for the Mentally Ill, Press Release, No Death Penalty for Persons with Severe Mental Illnesses (Jan. 12, 1998), available at [http://www.nami.org/Content/ContentGroups/Press\\_Room1/1998/January\\_1998/No\\_Death\\_Penalty\\_For\\_Persons\\_With\\_Severe\\_Mental\\_Illnesses\\_hr\\_i\\_Statement\\_By\\_Laurie\\_M\\_Flynn\\_Execut.htm](http://www.nami.org/Content/ContentGroups/Press_Room1/1998/January_1998/No_Death_Penalty_For_Persons_With_Severe_Mental_Illnesses_hr_i_Statement_By_Laurie_M_Flynn_Execut.htm) (last visited Jan. 25, 2005); American Psychiatric Association Online, *Resolution on the Death Penalty in the United States* (Aug. 2001), available at <http://www.apa.org/pi/deathpenalty.html?CFID=2646048&CFTOKEN=67528764> (last visited Jan. 25, 2005).

<sup>95</sup> Brief of Amici Curiae, *McCarver v. North Carolina*, 533 U.S. 975 (2000), available at <http://www.usccb.org/ogo/amicuscuriae3.shtml> (last visited Jan. 25, 2005). The General Board of Church and Society and the General Board of Global Ministries of the United Methodist Church specifically call on society to “protect the civil rights of persons with *disabilities*” and refer to the “the well-established principle that diminished mental capacity also reduces moral culpability.” The General Synod of The United Church of Christ reports “an immediate focus on ending the execution of juvenile offenders and persons with mental retardation *or mental illness*.” Clifton Kirkpatrick, as Stated Clerk of the General Assembly of the Presbyterian Church, U.S.A., indicates that “those who are ‘most *vulnerable*, most likely to be forgotten, exploited or oppressed, most unable to defend’ are entitled to “special protection.” The Mennonite Central Committee, U.S. Washington Office emphasizes “God’s special concern for those who are weak, neglected and *vulnerable*.” *Id.* (emphasis added).

<sup>96</sup> *Id.* (emphasis added). The Evangelical Lutheran Church in America “believes the execution of persons with mental retardation is particularly inappropriate because of their diminished culpability,” while the Foundation for the Preservation of the Mahayana Tradition, Inc. believes that because people with mental retardation are “less culpable than would otherwise be the case . . . it behooves us to treat these individuals with care and compassion.” *Id.*

<sup>97</sup> See discussion *infra* Part IV. C.



disorders. The European Union (EU), whose brief the Court cited in *Atkins* when noting that the world community “overwhelmingly disapprove[s]” of capital punishment for individuals with mental retardation,<sup>98</sup> has specifically spoken out against inflicting the death penalty on any person with a serious mental illness.<sup>99</sup> In a letter written to urge the commutation of Kelsey Patterson’s death sentence, representatives of the EU Presidency stated, “The EU strongly believes that the execution of persons suffering from a mental disorder is contrary to widely accepted human rights norms and in contradiction to the minimum standards of human rights set forth in several international human rights instruments.”<sup>100</sup> This view reflects that of the Office of the United Nations Commission for Human Rights (OHCHR).<sup>101</sup> The provisions of the OHCHR Resolution 2002/77 urge that all non-abolitionist States refrain from imposing the death penalty “on a person suffering from any form of mental disorder or to execute any such person.”<sup>102</sup> Certainly “any form of mental disorder” includes severe mental illness.<sup>103</sup>

While international communities tend to oppose capital punishment in general and for individuals with mental disorders in particular,<sup>104</sup> national polls suggest that the United States public also opposes the death penalty for individuals

<sup>98</sup> *Atkins v. Virginia*, 536 U.S. 304, 316 n.21 (2002).

<sup>99</sup> European Union, Delegation of the European Commission to the United States, *EU Policy on the Death Penalty*, Letter to Governor of Georgia (Feb. 2002), available at <http://www.eurunion.org/legislat/DeathPenalty/WilliamsGAGovLett.htm> (last visited Dec. 23, 2004). The EU is a treaty-based international organization comprised of fifteen countries working towards forging strong ties between European peoples. *Id.*

<sup>100</sup> Letter from European Union to Governor of Texas (April 26, 2004), available at <http://www.internationaljusticeproject.org/pdfs/DEMARIAPatterson.pdf> (last visited on Jan. 3, 2005).

<sup>101</sup> The OHCHR is composed of 53 member states spanning several continents that strive to defend human rights and promote implementation of agreed upon international standards. See UNITED NATIONS CYBER SCHOOL BUS, *Human Rights and the United Nations*, available at <http://www.un.org/cyberschoolbus/humanrights/about/history.asp> (last visited March 26, 2005). See also OFFICE OF THE UNITED NATIONS HIGH COMMISSIONER FOR HUMAN RIGHTS, Brochure, Preface, available at <http://www.unhchr.ch/html/enu6/OHCHR.pdf> (last visited Feb. 27, 2005).

<sup>102</sup> UNITED NATIONS HIGH COMMISSIONER FOR HUMAN RIGHTS, *The Question of the Death Penalty, Commission on Human Rights Resolution 2002/77*, available at <http://www.unhchr.ch/Huridocda/Huridoca.nsf/TestFrame/e93443efabf7a6c4c1256bab00500ef6?Opendocument> (last visited Dec. 23, 2004).

<sup>103</sup> See discussion *supra* Part III.B.

<sup>104</sup> *Id.* See also EUROPEAN UNION IN THE US, *EU Memorandum on the Death Penalty*, available at <http://www.eurunion.org/legislat/deathpenalty/eumemorandum.htm> (last visited Dec. 23, 2004).

with severe mental disorders. Varying reports on a Gallup Poll conducted in May of 2002 found that when asked whether they favored or opposed the death penalty for “the mentally ill,” between seventy-three and seventy-five percent of Americans responded that they opposed it.<sup>105</sup> This number approaches the eighty-two percent of respondents who said they opposed the death penalty for “the mentally retarded.”<sup>106</sup> Additionally, in the appendix to Chief Justice Rehnquist’s opinion in *Atkins*, poll results showed that 63.8% of Americans nationwide do not support execution of the “mentally impaired.”<sup>107</sup> Although the Court interpreted the term “mentally impaired” to refer to the mentally retarded, there is nothing to indicate that the poll respondents excluded the severely mentally ill from consideration. While the terms “mentally ill” and “mentally impaired” may seem undefined, individuals with severe mental disorders undeniably fit within either description. Thus, the polling data strongly suggests that a significant segment of the United States disapproves of executing the mentally ill, a population that would encompass at the very least those persons with severe mental disorders. These national polls, combined with state statutes, court opinions, and the views of world communities, reveal an overwhelming consensus opposing imposition of capital punishment on defendants with severe mental disorders.

#### IV. SEVERE MENTAL ILLNESS AND ITS IMPACT ON THE DEFENDANT: A COMPARISON WITH THE DECREASED CULPABILITY AND VULNERABILITIES OF DEFENDANTS WITH MENTAL RETARDATION

##### A. *Criteria for Mental Illness in General*

Severe mental disorders comprise a narrow category under the catch-all mental illness grouping and can arguably be characterized as involving impaired mental functioning.<sup>108</sup>

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<sup>105</sup> See DEATH PENALTY INFORMATION CENTER, *Summaries of Recent Poll Findings, National Polls*, available at <http://deathpenaltyinfo.org/article.php?scid=23&did=210#Gallup3/30/00> (last visited Dec. 23, 2004). See also Death Penalty, The Gallup Poll, available at <http://www.pollingreport.com/crime.htm> (last visited Dec. 23, 2004).

<sup>106</sup> See Death Penalty Information Center, *supra* note 105; Gallup Poll, *supra* note 105.

<sup>107</sup> *Atkins*, 536 U.S. at Appendix to Opinion of Rehnquist, C.J. (2002).

<sup>108</sup> See discussion *infra* Part IV.A.

Mental illness itself is generally thought of as encompassing distinct categories of mental disorders marked by impairment in cognition, mood, and behavior stemming from abnormal brain function.<sup>109</sup> People diagnosed with these disorders experience symptoms that vary in degree of severity, duration, and disturbance of daily performance.<sup>110</sup> As with other medical illnesses, these symptoms lie on a continuum.<sup>111</sup> At one end, the less severe disorders respond to outpatient psychotherapy and medication monitoring.<sup>112</sup> At the other end, severe mental disorders involve gross functional impairment and psychosis which often incapacitate the individual to the point that hospitalization is required.<sup>113</sup>

*B. Severe Mental Illness, Prognosis and Lack of Insight*

Severe mental illness is usually restricted to categories of schizophrenia, schizoaffective disorder and bipolar disorder (i.e. manic depression).<sup>114</sup> The symptoms associated with these disorders, such as hallucinations and delusions, are principally treated with antipsychotic medication<sup>115</sup> and increase the need

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<sup>109</sup> OFFICE OF THE SURGEON GENERAL, MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL, CH. 2, THE FUNDAMENTALS OF MENTAL HEALTH AND MENTAL ILLNESS, OVERVIEW OF MENTAL ILLNESS 39 (1999), available at <http://www.surgeon-general.gov/library/mentalhealth/chapter2/sec2.html> (last visited Feb. 2, 2005) [hereinafter FUNDAMENTALS].

<sup>110</sup> *Id.*

<sup>111</sup> *Id.*

<sup>112</sup> *Id.* at 65-70.

<sup>113</sup> See AMERICAN PSYCHIATRIC ASSOCIATION, DEFINITION OF SEVERE MENTAL ILLNESS, at <http://www.psych.org/aids/modules/illness/sld005.htm> (last visited Dec. 23, 2004). See also TREATMENT ADVOCACY CENTER, FREQUENTLY ASKED QUESTIONS, FAQ: SEVERE MENTAL ILLNESS, available at [http://www.psychlaws.org/PressRoom/presskits/AboutTACPressKit/abouttadoc2.htm#AA\\_SMI](http://www.psychlaws.org/PressRoom/presskits/AboutTACPressKit/abouttadoc2.htm#AA_SMI) (last visited March 20, 2005) [hereinafter FAQ].

<sup>114</sup> FAQ, *supra* note 113. For a description of schizophrenia see discussion *infra* Part IV. C.1. Bipolar disorder is an illness causing fluctuations in mood and is characterized by depressive and/or manic episodes. DSM-IV, *supra* note 53, at 350-51. A manic episode may entail grandiose ideas, decreased sleep, rapid speech, tangential thinking, and excessive, impulsive behavior, and is often accompanied by psychotic symptoms. *Id.* A depressive episode is marked by depressed mood throughout the day, apathy, sleep and appetite disturbances, restlessness or loss of energy, distractibility, feelings of worthlessness, and suicidal thoughts. *Id.* at 327. Individuals diagnosed with schizoaffective disorder exhibit symptoms of both schizophrenia and a mood disorder. *Id.* at 292. See generally A. Benabarre et al., *Bipolar Disorder, Schizoaffective Disorder and Schizophrenia: Epidemiologic, Clinical and Prognostic Differences*, 16 EUR. PSYCHIATRY, 167 (2001).

<sup>115</sup> See also NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH), *Schizophrenia*, at 13-15, available at <http://www.nimh.nih.gov/publicat/schizoph.pdf> (last visited Jan. 28, 2005) [hereinafter NIMH].

for hospitalization during acute episodes.<sup>116</sup> Like mental retardation, these conditions are not “curable,” although they may be treatable with medication.<sup>117</sup> Because there are several types of severe mental disorders with variations in symptoms, there is no definite course of illness.<sup>118</sup> For instance, while advocates and practitioners remain optimistic, statistics reveal that about half the people diagnosed with schizophrenia will experience only modest improvement, no improvement, or death.<sup>119</sup> Even taking their medications, about a third will relapse within a one year time period.<sup>120</sup>

A person with severe mental illness may be unsuccessful in seeking treatment or following through with medication management due to lack of awareness or “insight” caused by irregularities in brain function.<sup>121</sup> This deficiency is commonly found in both patients with schizophrenia and patients with bipolar disorder.<sup>122</sup> When a person lacks insight, he or she does not have the ability to *realize* that he or she is sick.<sup>123</sup> Therefore, when psychotic symptoms cause afflicted

<sup>116</sup> AMERICAN PSYCHIATRIC ASSOCIATION, Public Information, *Schizophrenia*, available at [http://www.psych.rg/public\\_info/chizo.cfm](http://www.psych.rg/public_info/chizo.cfm) (last visited Jan. 25, 2005) [hereinafter *Schizophrenia*]. The APA reports that “Schizophrenia fills more hospital beds than almost any other illness, and Federal figures reflect the cost of schizophrenia to be from \$30 billion to \$48 billion in direct medical costs, lost productivity and Social Security pensions.” *Id.* at 4.

<sup>117</sup> FAQ, *supra* note 113. See also NIMH, *supra* note 115, at 13.

<sup>118</sup> OFFICE OF THE SURGEON GENERAL, MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL, CH. 4, ADULTS AND MENTAL HEALTH, SCHIZOPHRENIA, COURSE AND RECOVERY, at 274 (1999), available at [http://www.surgeongeneral.gov/library/entalhealth/chapter4/sec4\\_1.html](http://www.surgeongeneral.gov/library/entalhealth/chapter4/sec4_1.html) (last visited Dec. 23, 2004) (“Most individuals experience periods of symptom exacerbation and remission, while others maintain a steady level of symptoms and disability which can range from moderate to severe.”). *Id.*

<sup>119</sup> FAQ, *supra* note 113. See also SURGEON GENERAL, SCHIZOPHRENIA, COURSE AND RECOVERY, *supra* note 118, at 274 (“Most do not return to their prior state of mental function.”). The course of illness is influenced by factors such as the individual’s biological vulnerabilities, personal motivation, family or other social support, and socioeconomic status. *Id.*

<sup>120</sup> FAQ, *supra* note 113.

<sup>121</sup> See Stefano Pallanti, et al., *Awareness of Illness and Subjective Experience of Cognitive Complaints in Patients with Bipolar I and Bipolar II Disorder*, 156 AM. J. PSYCHIATRY 1094 (July 1999). “Poor awareness of one’s own mental illness is an established feature in schizophrenia.” Celso Arango, et al., *Relationship of Awareness of Dyskinesia in Schizophrenia to Insight into Mental Illness*, 156 AM. J. PSYCHIATRY 1097 (July 1999). The medical term for lack of insight is “anosognosia,” which literally means “to not know a disease.” TREATMENT ADVOCACY CENTER, Briefing Paper, *Impaired Awareness of Illness (Anosognosia): A Major Problem for Individuals with Schizophrenia and Bipolar Disorder*, available at <http://www.psychlaws.org/BriefingPapers/BP14.htm> (last visited Dec. 23, 2004).

<sup>122</sup> See Pallanti, *supra* note 121, at 1094. See also Arango, *supra* note 121, at 1097.

<sup>123</sup> TREATMENT ADVOCACY CENTER, MEDICAL RESOURCES, INSIGHT, available at <http://www.psychlaws.org/MedicalResources/index.htm> (last visited Dec. 23, 2004).

persons to erroneously think “that a neighbor is controlling their behavior with magnetic waves; that people on television are directing special messages to them; or that their thoughts are being broadcast aloud to others,” those persons believe such thoughts to be based in reality.<sup>124</sup>

Lack of insight differs from denial of one’s illness in that the former is caused by actual damage to the right hemisphere of the brain.<sup>125</sup> Research indicates that “approximately half of all patients with schizophrenia and mania have markedly impaired awareness of their illness as measured by tests of insight.”<sup>126</sup> In some ways, lack of insight renders people with schizophrenia comparable to patients who have experienced a stroke or who suffer from Alzheimer’s disease.<sup>127</sup> Such individuals consistently refuse to take medication because they do not believe they are sick. In most cases they will take medication only under some form of assisted treatment.<sup>128</sup>

Apart from lack of insight, patients stop complying with treatment because of uncomfortable side effects, barriers to treatment, misguided advice to discontinue medications when the person seems to have improved, and disordered thinking which causes the person to forget to take medications.<sup>129</sup> The inability or refusal to comply with treatment tends to lead to exacerbation of symptoms and coinciding disturbances in behavior.<sup>130</sup> These disturbances can be manifested by psychiatric hospitalization, suicide attempts, homelessness, incarceration, and violent acts.<sup>131</sup>

Although non-adherence to treatment increases the risk of relapse into acute illness, lay persons frequently do not understand that individuals with severe mental disorders may experience a recurrence of psychosis even when compliant with medications.<sup>132</sup> This reality is especially important to consider when gauging a defendant’s culpability, where jurors might

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<sup>124</sup> NIMH, *supra* note 115, at 5-6.

<sup>125</sup> See TREATMENT ADVOCACY CENTER, *supra* note 123.

<sup>126</sup> *Id.*

<sup>127</sup> *Id.*

<sup>128</sup> *Id.*

<sup>129</sup> See Diana O. Perkins, *Predictors of Noncompliance in Patients with Schizophrenia*, 63 J. CLINICAL PSYCHIATRY 1121, 1123 (Dec. 2002). See also NIMH, *supra* note 115, at 16.

<sup>130</sup> NIMH, *supra* note 115, at 7, 9; FAQ, *supra* note 113.

<sup>131</sup> TREATMENT ADVOCACY CENTER, *supra* note 123.

<sup>132</sup> NIMH, *supra* note 115, at 15.

erroneously believe that a person has both insight into and control over his or her illness.<sup>133</sup>

Severe mental disorders have a clear detrimental impact on cognition and function, with relatively poor prognosis for the individual. Therefore, courts should recognize that such illness affects the criminal offender's moral culpability and susceptibility to disadvantage in legal proceedings, just as the Supreme Court acknowledged the impact of subaverage intelligence on death row inmates with mental retardation.

C. *A Comparison of the Impact of the Severe Mental Disorder of Schizophrenia with the Impact of Mental Retardation on the Defendant*

In order to compare the impact of mental retardation on capital defendants with the impact of severe mental illness on the offender, it may be helpful to address their commonalities by way of example. These next four sections will thus discuss the range of impairment that individuals with schizophrenia experience and the effects that psychological and functional deficiencies have on their moral culpability and vulnerability in legal proceedings.

1. Schizophrenia as a severe mental disorder by which to compare mental retardation

A person with schizophrenia tends to continually experience either positive or negative symptoms and at baseline might only be able to minimally care for his or her needs.<sup>134</sup> Positive symptoms involve an exaggeration or distortion of normal consciousness,<sup>135</sup> while negative symptoms involve blunted personality and emotions, impoverished thinking, and inability to act in a goal-directed manner.<sup>136</sup>

<sup>133</sup> See Christopher Slobogin, *Mental Illness and the Death Penalty*, 24 MENT. PHYS. DIS. L. REP. 667, 670 (2000) (citing a study involving mock jurors who reasoned that "mental illness is no excuse . . . he should have sought help for his problems.").

<sup>134</sup> "Complete remission (i.e., a return to full premorbid functioning) is probably not common in this disorder. Of those who remain ill, some appear to have a relatively stable course, whereas others show a progressive worsening associated with severe disability." DSM-IV, *supra* note 53, at 282.

<sup>135</sup> *Id.* at 53, at 274-75; FUNDAMENTALS, *supra* note 109.

<sup>136</sup> JOURNAL OF CLINICAL PSYCHIATRY, Academic Proceedings Monograph, II, *Negative Symptoms in Schizophrenia*, 16 J. CLIN. PSYCH. MONOGRAPH 9 (Feb. 1998). People with negative symptoms appear to have "a diminution of thoughts that is

People with psychotic disorders like schizophrenia frequently have disturbed thought processes.<sup>137</sup> Because of these limitations in functioning and thinking, people with schizophrenia logically provide a group with which to compare individuals with mental retardation.

While there are different types of schizophrenia, each form must have at least two of the following symptoms: delusions; hallucinations; disorganized speech; disorganized or catatonic behavior; or negative symptoms.<sup>138</sup> A person must also experience a demonstrably lower level of social and occupational functioning.<sup>139</sup> None of these features can be caused by substance abuse or another medical condition.<sup>140</sup> While a diagnosis of schizophrenia requires manifest psychotic symptoms for at least one month, signs of the disturbance overall must last at least six months.<sup>141</sup>

Schizophrenia as a rule and mental retardation in general involve known biological components. Scientific research supports the theory that certain individuals have a genetic predisposition to schizophrenia, that certain parts of the brain in these people are structurally abnormal, that excessive levels of certain chemicals are present in particular brain pathways, and that these conditions combine with environmental stressors to produce this disorder.<sup>142</sup> According to the Centers for Disease Control and prevention, mental retardation can be caused by defects in chromosomes, brain

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reflected in decreased fluency and productivity of speech. This must be differentiated from an unwillingness to speak . . .” DSM-IV, *supra* note 53, at 277.

<sup>137</sup> SURGEON GENERAL, *Schizophrenia*, *supra* note 118.

<sup>138</sup> DSM-IV, *supra* note 53, at 285. If one of these symptoms is particularly pronounced, for example, the individual has auditory hallucinations in which he or she hears two or more voices carrying on a conversation, then only one symptom is required. *Id.* at 285.

<sup>139</sup> *Id.*

<sup>140</sup> *Id.* at 286.

<sup>141</sup> DSM-IV, *supra* note 53, at 285.

<sup>142</sup> See Jae-Jin Kim et al., *Regional Neural Dysfunctions in Chronic Schizophrenia Studied with Positron Emission Tomography*, 157 AM. J. PSYCHIATRY 542 (Apr. 2000); James J. Levitt, et al., *Quantitative Volumetric MRI Study of the Cerebellum and Vermis in Schizophrenia: Clinical and Cognitive Correlates*, 156 AM. J. PSYCHIATRY 1105 (July 1999); Brendan McDonald et al., *Anomalous Asymmetry of Fusiform and Parahippocampal Gyri Gray Matter in Schizophrenia: A Postmortem Study*, 157 AM. J. PSYCHIATRY 40 (Jan. 2000); Kai Vogetley et al., *Disturbed Gyration of the Prefrontal Region in Male Schizophrenic Patients: A Morphometric Postmortem Study*, 157 AM. J. PSYCHIATRY 34 (July 2000). See also OFFICE OF THE SURGEON GENERAL, MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL, CH. 4, ADULTS AND MENTAL HEALTH, ETIOLOGY OF SCHIZOPHRENIA, at 276 (1999), available at [http://www.surgeongeneral.gov/library/mentalhealth/chapter4/sec4\\_1.html#etiology](http://www.surgeongeneral.gov/library/mentalhealth/chapter4/sec4_1.html#etiology) (last visited Dec. 23, 2004).

abnormalities, stroke, or childhood infections.<sup>143</sup> It can also be caused by complications at birth such as lack of oxygen to the baby's brain.<sup>144</sup> Additionally, the mother's compromised health and environmental factors might create biological conditions that place the fetus, baby or child at risk for mental retardation. For instance, mental retardation might result from a pregnant woman who is chemically addicted, malnourished, or prescribed certain medications.<sup>145</sup> It may also result from abuse of the child or head injury.<sup>146</sup>

The etiologies of schizophrenia and mental retardation differ in that on the one hand, a first psychotic episode related to schizophrenia generally occurs in the early to mid-twenties for males, the later twenties for females.<sup>147</sup> In contrast, mental retardation can arise in infancy and must generally be present before a child turns 18 years old.<sup>148</sup> Yet whether caused by genetic factors alone or influenced by the environment, both schizophrenia and mental retardation involve conditions which indicate that the brain has been affected in a way that produces significant vulnerabilities in the individual.

## 2. Decreased moral culpability in criminal offenders with schizophrenia

Although people with schizophrenia might not be of subaverage intelligence as are people with mental retardation, many people with schizophrenia actively experience cognitive disturbances.<sup>149</sup> These problems can include difficulties in: remembering, orienting oneself to time and place, concentrating, processing information, and thinking abstractly or in a goal-directed way.<sup>150</sup> As a result, people with schizophrenia often exhibit behavior marked by impulsiveness

<sup>143</sup> CENTERS FOR DISEASE CONTROL AND PREVENTION, NATIONAL CENTER ON BIRTH DEFECTS AND DEVELOPMENTAL DISABILITIES, MENTAL RETARDATION, *available at* <http://www.cdc.gov/ncbddd/dd/ddmr.htm> (last visited Dec. 23, 2004).

<sup>144</sup> *Id.*

<sup>145</sup> *Id.*

<sup>146</sup> *Id.*

<sup>147</sup> DSM-IV, *supra* note 53, at 282.

<sup>148</sup> *Id.* at 44.

<sup>149</sup> *See* DSM-IV, *supra* note 53, at 274; OFFICE OF THE SURGEON GENERAL, MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL, CH. 4, ADULTS AND MENTAL HEALTH, SCHIZOPHRENIA, OVERVIEW, (1999), *available at* [http://www.surgeongeneral.gov/library/mentalhealth/chapter4/sec4\\_1.html#etiology](http://www.surgeongeneral.gov/library/mentalhealth/chapter4/sec4_1.html#etiology) (last visited Dec. 23, 2004) [hereinafter *Adults and Mental Health*].

<sup>150</sup> *Id.* *See also* DSM-IV, *supra* note 53, at 279.



and “chaotic or imprecise planning.”<sup>151</sup> These disturbances could exist in addition to psychotic symptoms that might distort the person’s perception of reality and cause illogical thinking.<sup>152</sup> For instance:

[P]atients suffering from paranoid-type symptoms—roughly one-third of people with schizophrenia—often have delusions of persecution, or false and irrational beliefs that they are being cheated, harassed, poisoned, or conspired against. These patients may believe that they, or a member of the family or someone close to them, are the focus of this persecution.<sup>153</sup>

Such thought disorders diminish the culpability of defendants with schizophrenia just as do the cognitive limitations of defendants with mental retardation.

People with schizophrenia similarly are not necessarily found to be more likely to engage in violence than others.<sup>154</sup> Studies that formerly found a link between violence and disorders such as schizophrenia have since become controversial, if not outdated.<sup>155</sup> Researchers have asserted that “Mental disorders—in sharp contrast to alcohol and drug abuse—account for a miniscule portion of the violence that afflicts American society.”<sup>156</sup> The only segment of the population

<sup>151</sup> See Gerard E. Hogarty et al., *Cognitive Enhancement Therapy for Schizophrenia, Effects of a 2-Year Randomized Trial on Cognition and Behavior*, 61 ARCHIVES GEN. PSYCHIATRY, 866, tbl. 1 (Sept. 2004). See also *infra* Part IV.C.3.

<sup>152</sup> *Schizophrenia*, *supra* note 116.

<sup>153</sup> NIMH, *supra* note 115, at 5.

<sup>154</sup> While the Court in *Atkins* referred to the likelihood of people with mental retardation to engage in “crime” in general, medical research of individuals with severe mental disorders tends to focus specifically on violence. *Atkins v. Virginia*, 536 U.S. 350-51 (2002). Thus, the following discussion of research findings pertains only to violence.

<sup>155</sup> Cameron Wallace et al., *Criminal Offending in Schizophrenia Over a 25-Year Period Marked by Deinstitutionalization and Increasing Prevalence of Comorbid Substance Use Disorders*, 161 AM. J. PSYCHIATRY 716 (2004). A noteworthy British national clinical survey found that “There [were] substantial rates of mental disorder in people convicted of homicide. Most [did] not have severe mental illness or a history of contact with mental health services.” Jenny Shaw et al., *Mental Disorder and Clinical Care in People Convicted of Homicide: National Clinical Survey*, 318 BRIT. MED. J. 1240 (May 8, 1999). Some studies have also found that offenders with schizophrenia are less likely to reoffend than offenders without schizophrenia, given the same opportunity. Marnie E. Rice & Grant T. Harris, *The Treatment of Mentally Disordered Offenders*, 3 PSYCH. PUB. POL. L. 126, 131 (1997). Another study found that “in the combined sample of offenders as well as among the insanity acquittees alone, recidivism rates (both general and violent) were lower for those diagnosed as psychotic than for nonpsychotic offenders.” *Id.*

<sup>156</sup> John W. Parry, *Criminal Mental Health Jurisprudence*, 24 MENTAL & PHYSICAL DISABILITY L. REP. 538, 542 (2000) (citing John Monahan & J. Arnold, *Violence by People with Mental Illness: A Consensus Statement by Advocates and Researchers*, 19 PSYCHIATRIC REHABILITATION J. 67 (1996)).

with schizophrenia that seems to *definitively* demonstrate a strong correlation with increased violence is that which abuses substances.<sup>157</sup> These findings comport with the acknowledgement that individuals with severe mental disorders *who receive sufficient treatment* are no more dangerous than the general population.<sup>158</sup>

In addition to cognitive disturbances and the finding that “the total amount of violence in society attributable to psychotic patients is small,”<sup>159</sup> individuals with schizophrenia also share with persons with mental retardation difficulties

<sup>157</sup> These substances range from alcohol and marijuana to stimulants and sedatives. Michael Soyka, *Substance Misuse, Psychiatric Disorder and Violent and Disturbed Behaviour*, 176 BRIT. J. PSYCHIATRY 345 (April 2000).

<sup>158</sup> APA Fact Sheet, *Violence and Mental Illness*, at 3 (Jan. 1998), available at [http://www.psych.org/public\\_info/violence.pdf](http://www.psych.org/public_info/violence.pdf) (last visited Jan. 30, 2005) [hereinafter *Violence*]. See also Treatment Advocacy Center, *Consequences of Lack of Treatment, Are People with Mental Illness Dangerous?*, available at [http://www.psychlaws.org/PressRoom/presskits/abouttadoc2.htm#lot\\_danger](http://www.psychlaws.org/PressRoom/presskits/abouttadoc2.htm#lot_danger) (last visited Feb. 24, 2005). Studies have shown that persons diagnosed with schizophrenia, bipolar disorder and other mood disorders were more likely than persons without a mental disorder to report having been violent within a specific time frame and that this behavior was related to the presence of psychotic symptoms. Rice & Harris, *supra* note 155, at 130. However, persons with substance abuse disorders had a greater likelihood of engaging in violence or other criminal behavior than persons with severe mental disorders. *Id.* at 130-31. The American Psychiatric Association points out that the factors associated with increased risk for violence are the same for those persons with mental illness as for those persons without such a diagnosis. AMERICAN PSYCHIATRIC ASSOCIATION, *Violence and Mental Illness, Conditions that Increase the Risk of Violence*, available at [http://www.psych.org/public\\_info/VIOLLEN~1.cfm](http://www.psych.org/public_info/VIOLLEN~1.cfm) (last visited Feb. 24, 2005). These factors include: history of violence among family members; lack of family or community support; stressful, chaotic living situation; and exposure to an environment in which substance abuse is common. *Id.* One body of research asserts that there is a significant correlation between schizophrenia and violence. However, some researchers qualify this finding by stating that:

[N]o sizeable body of evidence clearly indicates the relative strength of schizophrenia or mental illness in general as a risk factor for violence compared with other risk factors. Indeed, compared with the magnitude of risk associated with the combination of male gender, young age and lower socio-economic status, the risk of violence presented by mental disorder is modest.

Elizabeth Walsh et al., *Violence and Schizophrenia: Examining the Evidence*, 180 BRIT. J. PSYCHIATRY 490 (2002) (citations omitted). Furthermore, the evidence points to substance abuse and psychotic symptoms as being factors distinguishing people with schizophrenia who are at increased risk for violence. *Id.* Such findings are again consistent with the understanding that untreated individuals with schizophrenia and or those who abuse substances are more prone to violence.

<sup>159</sup> Dale E. McNeil, *Correlates of Violence in Psychotic Patients*, 27 PSYCHIATRIC ANNALS 683, 684 (1997). McNeil refers to a study which later concluded:

[M]ajor mental disorder is a statistically significant but modest risk factor for violence . . . . [T]he total amount of violence in society attributable to psychotic patients is small (in part because serious mental illness itself is rare), and that the level of risk posed by psychotic disorders is much less than that of substance use.

*Id.*

functioning in major life areas. Essential to a diagnosis of schizophrenia are social and occupational dysfunction in which “one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset. . . .”<sup>160</sup> Individuals so diagnosed frequently suffer from “unemployment, disrupted education, limited social relationships, isolation, legal involvement, family stress, and substance abuse.”<sup>161</sup> These elements of schizophrenia are analogous to the adaptive behavior deficits that form part of the definition of mental retardation. A person with mental retardation is limited in the level of academic skills that he or she can acquire and may or may not be able to develop the social and vocational skills necessary to be self-sufficient, depending on the level of mental retardation.<sup>162</sup>

When individuals with schizophrenia suffer an acute phase, their level of functioning becomes more comparable to that of people with moderate to severe mental retardation. Although the conditions take on noticeably different appearances, the capacity of either population to communicate, think coherently and behave appropriately is similarly substantially impaired. The psychotic symptoms tend to influence the person to behave bizarrely, become agitated, and speak nonsense.<sup>163</sup> He or she might also be unable to bathe and dress appropriately.<sup>164</sup> Individuals with schizophrenia who lack awareness of their illness also typically do not take their medications.<sup>165</sup>

In sum, offenders with severe mental illness, although not intellectually impaired, suffer from cognitive and behavioral impairments analogous to the deficiencies experienced by defendants with mental retardation found less culpable in *Atkins*.

### 3. Individuals with schizophrenia and the penal justifications for the death penalty.

In keeping with the *Atkins* Court rationale, the two penal goals of retribution and deterrence are not furthered by

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<sup>160</sup> DSM-IV, *supra* note 53, at 285.

<sup>161</sup> FUNDAMENTALS, *supra* note 109.

<sup>162</sup> DSM-IV, *supra* note 53, at 41.

<sup>163</sup> *Id.* at 276.

<sup>164</sup> *Schizophrenia*, *supra* note 116, at 276.

<sup>165</sup> See text accompanying footnotes 122, 124.

the execution of individuals with severe mental illness. In *Atkins*, the Court weighed heavily the concern that:

[I]t is the same cognitive and behavioral impairments that make these [defendants with mental retardation] less morally culpable—for example, the diminished ability to understand and process information, to learn from experience, to engage in logical reasoning, or to control impulses—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.<sup>166</sup>

Likewise, the Court should consider that the deficiencies suffered by defendants with schizophrenia that render them less culpable also impede their ability to refrain from conduct based on a possible penalty of death. Indeed, recent research has found that “[p]atients with schizophrenia who commit violent acts have insight deficits, including lack of awareness of the legal implications of their behavior.”<sup>167</sup>

The failure to make the critical connection between conduct and legal consequences directly affects the capacity of the defendant with schizophrenia to be deterred. Whereas someone with mental retardation might not refrain from committing an offense because his or her intellectual functioning does not allow that person to see beyond the act to the possibility of penalty, the individual with schizophrenia might also not refrain from committing an offense because of cognitive dysfunction or firmly held erroneous beliefs that lead the defendant to think that he or she is acting in accordance with reality.<sup>168</sup>

Justice is also not advanced in terms of retribution, because a person with schizophrenia who commits a capital crime is less morally culpable than a person without schizophrenia.<sup>169</sup> Retribution entails punishing the offender in proportion to his or her culpability.<sup>170</sup> The Supreme Court has asserted that “[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.”<sup>171</sup> Accordingly, the death penalty is certainly a disproportionate

<sup>166</sup> *Atkins v. Virginia*, 536 U.S. 304, 320 (2002).

<sup>167</sup> Peter F. Buckley et al., *Insight and Its Relationship to Violent Behavior in Patients with Schizophrenia*, 161 AM. J. PSYCHIATRY 1712 (2004).

<sup>168</sup> See *Violence*, *supra* note 158, at 2. See also DSM-IV, *supra* note 53, at 275.

<sup>169</sup> See discussion *supra* Part IV.C.3.

<sup>170</sup> *Atkins*, 536 U.S. at 319.

<sup>171</sup> *Id.*

punishment to inflict on an offender with schizophrenia, who by definition has experienced “profound disruption in cognition and emotion, affecting the most fundamental human attributes: language, thought, perception, affect, and sense of self.”<sup>172</sup>

4. Disadvantages in criminal proceedings associated with severe mental illnesses such as schizophrenia

Apart from the limited applicability of the normal penal justifications, greater potential for vulnerabilities in legal proceedings present disadvantages to severely mentally ill defendants that are similar to those faced by defendants with mental retardation. One attorney’s statement that “[i]f the defendant knows he is in a courtroom and can tell the difference between a judge and a grapefruit, he is deemed competent to stand trial,” albeit hyperbolic, alludes to the concern that defendants who are mentally ill are assessed as competent by low standards and are therefore often inappropriately propelled into court.<sup>173</sup> Defendants may understand the role that each person plays in the legal process, but because of delusions or impaired judgment, may distrust or refuse to cooperate with defense counsel, or believe that a defense is somehow unnecessary.<sup>174</sup>

Like persons with mental retardation, defendants with schizophrenia might still be found competent to stand trial. Their symptoms do not necessarily sever them completely from reality.<sup>175</sup> They might be aware, for example, that “people eat three times a day, sleep at night and use the streets for driving vehicles. For that reason, their behavior *may* appear quite

<sup>172</sup> FUNDAMENTALS, *supra* note 109, at 269.

<sup>173</sup> Ronald L. Kuby & William M. Kunstler, *So Crazy He Thinks He Is Sane: The Colin Ferguson Trial and the Competency Standard*, 5 CORNELL J.L. & PUB. POL’Y 19, 25 (1995).

<sup>174</sup> See Press Release, American Civil Liberties Union, ACLU Opposes Death Sentence for Mentally Ill Inmate, First Ohio Execution in 35 Years (Feb. 11, 1999), available at <http://www.aclu.org/news/NewsPrint.cfm?ID=8403&c=17> (last visited Jan. 24, 2004). See also Martin Sabelli & Stacey Leyton, *Train Wrecks and Freeway Crashes: An Argument for Fairness and Against Self Representation in the Criminal Justice System*, 91 J. CRIM. L. & CRIMINOLOGY 161, 185-86 (2000). Situations in which severely mentally ill defendants insist on self representation and refuse mental illness defenses raise the issue of whether assistance of counsel should be mandatory to serve the defendants’ best interests in capital cases. *Id.* at 186, 197-98.

<sup>175</sup> *Schizophrenia*, *supra* note 116.

normal much of the time.”<sup>176</sup> On the other hand, once inside the courtroom, people with schizophrenia may not be able to keep up the appearance of normalcy because of their outward responses to underlying symptoms. As in the case of an individual with mental retardation, a defendant with schizophrenia might also be a poor witness whose demeanor “may create an unwarranted impression of lack of remorse.”<sup>177</sup> Because a schizophrenic individual tends to “not show the signs of normal emotion, perhaps may speak in a monotonous voice, have diminished facial expressions, and appear extremely apathetic,”<sup>178</sup> his or her appearance in the courtroom might have a similar adverse effect on the jury.

Perhaps most significantly, just as with mental retardation, severe mental illness “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.”<sup>179</sup> While most death penalty statute provisions create the potential for severe mental illness to be a mitigating factor,<sup>180</sup> studies have demonstrated that the factfinder often treats such illness as an aggravator.<sup>181</sup> For example, research into 128 Georgia capital cases in 1990 revealed that an unsuccessful insanity defense strongly correlated with a sentence of death.<sup>182</sup> Given that defendants who raise the insanity defense generally present evidence of mental illness,<sup>183</sup> this correlation suggests that juries and judges may be influenced to impose the death penalty even when mitigating evidence exists. This result is not necessarily inconsistent with a finding of lesser culpability in a severely mentally ill offender.<sup>184</sup> Though studies using mock jurors offer a range of theories to explain why the insanity defense may fail for the afflicted defendant,<sup>185</sup> it is the jurors’

<sup>176</sup> *Id.* (emphasis added).

<sup>177</sup> *Atkins v. Virginia*, 536 U.S. 304, 320-21 (2002).

<sup>178</sup> NIMH, *supra* note 115, at 6.

<sup>179</sup> *Atkins*, 536 U.S. at 321.

<sup>180</sup> See discussion *supra* Part IV.A. See also Christopher Slobogin, *Mental Illness and the Death Penalty*, 24 MENT. PHYS. DIS. L. REP. 667, 669 (2000).

<sup>181</sup> Slobogin, *supra* note 180, at 669-70.

<sup>182</sup> *Id.* at 669 (citing David Baldus et al., EQUAL JUSTICE AND THE DEATH PENALTY, 644-45 (1990)).

<sup>183</sup> FRONTLINE, *Insanity Defense FAQs*, at <http://www.pbs.org/wgbh/pages/frontline/shows/crime/trial/faqs.html> (last visited March 1, 2005).

<sup>184</sup> Aletha M. Claussen-Schulz et al., *Dangerousness, Risk Assessment, and Capital Sentencing*, 10 PSYCHOL. PUB. POL’Y & L. 471, 475-476, 481 (2004).

<sup>185</sup> Slobogin, *supra* note 180, at 670 (citing Lawrence T. White, *Juror Decision Making in the Capital Penalty Trial: An Analysis of Crimes and Defense Strategies*, 11 L. HUM. BEHAV. 113, 125 (1987); Phoebe C. Ellsworth et al., *The Death-Qualified Jury*

perception of the defendant's future dangerousness at sentencing that appears to be the decisive factor in the decision to impose the death penalty, regardless of the level of the defendant's culpability.<sup>186</sup>

The impact of a severe mental disorder such as schizophrenia on a defendant is all-encompassing. When a psychiatrist or other mental health expert diagnoses an individual as severely mentally ill, that individual has been evaluated as having vulnerabilities that ordinary people do not share. These vulnerabilities span difficulties in obtaining adequate treatment to the inability to meaningfully participate in one's legal defense. Professionals in the field of mental health, such as members of the American Psychological Association, recognize that these liabilities place the severely mentally ill in a category of persons who should be spared from the death penalty.<sup>187</sup> As discussed in the next Part, Kelsey

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*and the Defense of Insanity*, 8 L. HUM. BEHAV. 81, 90 (1984)).

<sup>186</sup> Slobogin, *supra* note 180, at 670.

<sup>187</sup> AMERICAN PSYCHOLOGICAL ASSOCIATION ONLINE, *The Death Penalty in the United States, Resolution*, available at <http://www.apa.org/pi/deathpenalty.html?CFID=2646048&CFTOKEN=67528764> (last visited Dec. 23, 2004). People with bipolar disorder and schizoaffective disorder have characteristics that impact them in a manner sufficiently similar to individuals with mental retardation to the extent that they, too, should be treated in the same way during capital sentencing. Both of these illnesses entail impediments experienced by anyone with a severe mental disorder, including: psychosis and other psychiatric symptoms induced by brain disorder; recurrent need for hospitalization; lack of insight; complications with receiving adequate treatment; and the risk of being perceived as a future threat to society due to their psychiatric illness. See discussion *supra* Part IV.B. Additionally, people with bipolar disorder experience alternating episodes of mania and depression throughout their lifetimes. See NIMH, *Bipolar Disorder: What is the Course of Bipolar Disorder?* available at <http://www.nimh.nih.gov/publicat/NIMHbipolar.pdf> (last visited March 20, 2005) [hereinafter NIMH, *Bipolar Disorder*]. While some individuals might experience asymptomatic interludes, "as many as one-third of people [with bipolar disorder] have some residual symptoms." *Id.* Moreover, "a small percentage of people experience chronic unremitting symptoms despite treatment." *Id.* A diagnosis of schizoaffective disorder, on the other hand, features symptoms of schizophrenia concurrent with symptoms of either depression, mania, or both. DSM-IV, *supra* note 53, at 292-96. This complexity of symptoms leads to challenges in diagnosis of this disorder. See NATIONAL ALLIANCE FOR THE MENTALLY ILL, *Schizoaffective Disorder*, available at [http://www.nami.org/Content/ContentGroups/Helpline1/Schizoaffective\\_Disorder.htm](http://www.nami.org/Content/ContentGroups/Helpline1/Schizoaffective_Disorder.htm) (last visited Jan. 25, 2004); see also NMHA, *Schizoaffective disorder*, available at <http://www.nmha.org/infoctr/factsheets/52.cfm> (last visited Jan. 25, 2004) [hereinafter NMHA, *Schizoaffective Disorder*]. People with schizophrenia might appear to have deficiencies that lay persons more readily compare to people with mental retardation. In the absence of full appreciation for the consequences of enduring longstanding severe psychiatric illness by people with bipolar disorder or schizoaffective disorder, the public might understandably be hesitant to group these individuals within a category that includes offenders with mental retardation or schizophrenia. Yet given that people with bipolar disorder or schizoaffective disorder share the same core features of severe mental illness as those individuals with schizophrenia, they must certainly be deemed less culpable than the average murderer. Accordingly, they too

Patterson and James Colburn were, and Charles Walker is, among such persons.

## V. CASE ILLUSTRATIONS

### A. *Kelsey Patterson*

Kelsey Patterson grew up in Palestine, Texas, raised by his grandmother after his mother died when he was four years old.<sup>188</sup> He appeared to have a normal childhood and joined the military following high school.<sup>189</sup> He received an honorable discharge after two years of service in order to care for his grandmother who had become terminally ill.<sup>190</sup> Patterson's half-sister reports that his mental health began to deteriorate when his grandmother died, that he became withdrawn and began to talk and laugh to himself.<sup>191</sup> When he was about twenty-four-years old, the time period associated with a first psychotic break in males, Patterson was arrested for aggravated assault on a police officer.<sup>192</sup>

In the ensuing years, Patterson was charged with the attempted murders of co-workers on two separate occasions.<sup>193</sup> Psychiatrists diagnosed him with paranoid schizophrenia and both times determined that he had been suffering from a mental disease or defect at the time of the crimes and could not conform his behavior to the law.<sup>194</sup> Patterson was also arrested for assault.<sup>195</sup> The episodes of violence were accompanied by paranoid ideation of being poisoned and raped.<sup>196</sup> Patterson spent months at inpatient psychiatric centers, including a state hospital.<sup>197</sup>

Despite a pattern of extremely violent and paranoid behavior, Patterson was evidently not receiving any significant treatment at the time he shot Louis Oates and Dorothy Harris

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should be excluded from the death penalty.

<sup>188</sup> INTERNATIONAL JUSTICE PROJECT, *Kelsey Patterson*, available at <http://www.internationaljusticeproject.org/illnessKPatterson.cfm> (last visited Dec. 20, 2004) [hereinafter IJP, *Kelsely Patterson*].

<sup>189</sup> *Id.*

<sup>190</sup> *Id.*

<sup>191</sup> AIUSA, *Another Texas Injustice*, supra note 1, at 3.

<sup>192</sup> *Id.* See also DSM-IV, supra note 53, at 282.

<sup>193</sup> Patterson, 2003 WL 21355999, at \*\*1. See also IJP, *Kelsey Patteron*, supra note 190.

<sup>194</sup> IJP, *Kelsey Patteron*, supra note 188.

<sup>195</sup> *Id.*

<sup>196</sup> *Id.*

<sup>197</sup> *Id.*



in 1992.<sup>198</sup> Although his half-brother had attempted to seek help for him prior to the murders,<sup>199</sup> there is no mandatory treatment (i.e. involuntary commitment) for a person who is not imminently a danger to himself or others.<sup>200</sup> It may be particularly difficult to obtain help even under ordinary circumstances in the State of Texas, which recently ranked 47th in the United States for funding of treatment for the mentally ill.<sup>201</sup>

Consistent with his psychiatric history, Patterson continued to exhibit symptoms of schizophrenia during his competency hearing and throughout his trial. The judge repeatedly ordered Patterson out of the courtroom due to outbursts during which he would claim that electrical devices had been inserted to his body or that he had been poisoned.<sup>202</sup> Yet the mental health experts involved did not seem to seriously consider these signs of severe mental illness.<sup>203</sup> Grigson, the state forensic psychiatrist who had previously found Patterson incompetent in 1980, undermined Patterson's claims of being a victim of ongoing conspiracy, food poisoning, and inner ear implantation by suggesting that he had since learned how to fake psychotic symptoms in order to manipulate the judicial system.<sup>204</sup> In contravention to professional medical standards, neither Grigson nor the state clinical psychologist Quijano had examined Patterson before declaring him to be competent.<sup>205</sup>

<sup>198</sup> AIUSA, *Another Texas Injustice*, *supra* note 1, at 3-4.

<sup>199</sup> *Id.* at 3.

<sup>200</sup> See Amy E. Lansing et al., *The Treatment of Dangerous Patients in Managed Care: Psychiatric Hospital Utilization and Outcome*, 19 GEN. HOSP. PSYCHIATRY, 112, 112 (1997); Harriet P. Lefley, *Cultural Perspectives on Families, Mental Illness, and the Law*, 23 INT'L J.L. & PSYCHIATRY 229, 237 (2000). See also AIUSA, *Another Texas Injustice*, *supra* note 1, at 3.

<sup>201</sup> AIUSA, *Another Texas Injustice*, *supra* note 1, at 3. Fifth Circuit Judge Fortunato Benavides placed blame for the deaths on Texas' mental health system. Mike Tolson, *Mentally Ill Killer's Life on the Line*, HOUS. CHRON., Aug. 11, 2002, at A37.

<sup>202</sup> *Patterson*, 2003 WL 21355999, at \*\*2. The AIUSA report states that at one point the judge went so far as to order Patterson to be gagged with tape. AIUSA, *Another Texas Injustice*, *supra* note 1, at 11.

<sup>203</sup> AIUSA, *Another Texas Injustice*, *supra* note 1, at 6-7.

<sup>204</sup> *Patterson*, 2003 WL 21355999, at \*\*5. See also AIUSA, *Another Texas Injustice*, *supra* note 1, at 7.

<sup>205</sup> Indeed, Grigson, nicknamed "Dr. Death" because of his frequent testimony for the prosecution in capital murder cases, was later expelled by the American Psychiatric Association for making predictions about a defendant's future dangerousness without having examined them. Pat Gillespie, *James Grigson Expert Psychiatric Witness Was Nicknamed Dr. Death*, DALLAS MORNING NEWS, June 14, 2004, at 4B. Apparently, Grigson and Quijano had only reviewed the medical files

In addition to this questionable assessment of his competence, Patterson himself further compromised his case through disruptive behavior during his state post-conviction hearing and imprudent decision-making in general. Despite the damning evidence against him, Patterson rejected the prosecution's offer of a life sentence in exchange for a guilty plea, chose to testify during the guilt phase of his trial, and tried to fire his lawyers.<sup>206</sup> Moreover, Patterson refused to submit to examination by mental health professionals.<sup>207</sup> Like other mentally ill defendants before him, Patterson continually made decisions against counsel's advice and disobeyed the judge's orders in such a way as to demonstrate gross impairment of judgment and lack of self-control.<sup>208</sup>

The prosecution, for its part, attempted to persuade the jury to treat Patterson's schizophrenia only as an indicator of future dangerousness. "If you ever diagnose schizophrenia," said the prosecutor, "what that is going to do is give that person a licence [sic] to kill anybody, anywhere, anytime, and they come in and say, 15 years ago some psychologist said I was schizophrenic. So, because of that I just blew two holes in two people's heads. You can't hold me responsible for it."<sup>209</sup> Ultimately, Patterson's rejection of a plea forced the jury to choose between the permanent penalty of death and a prison term which allowed for parole.

Despite the senselessness of the murders and the prosecutor's efforts to present evidence that Patterson had been malingering or at the least would prove dangerous, the jury nevertheless seemed to contemplate that he might not be deserving of capital punishment, as evidenced by their request for a dictionary to look up the meaning of "mitigating circumstances."<sup>210</sup> In the end, the jury found Patterson to be a future danger to society and that there was not sufficient

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related to a 1984 hospitalization. AIUSA, *Another Texas Injustice*, *supra* note 1, at 7.

<sup>206</sup> AIUSA, *Another Texas Injustice*, *supra* note 1, at 9-11.

<sup>207</sup> *Id.* at 14.

<sup>208</sup> See, e.g., Kuby & Kunstler, *supra* note 173, at 23 (positing that a man who suffered from delusional disorder, although deemed competent, should not have been tried, because he "was clearly incapable of assisting in his own defense in any meaningful way" and "lacked the capacity to trust any attorney enough to actually and rationally evaluate the advice the attorney provided.").

<sup>209</sup> AIUSA, *Another Texas Injustice*, *supra* note 1, at 12.

<sup>210</sup> *Id.* at 13. According to the AIUSA report, the judge denied the request and instead had the Charge reread which instructed that "[t]he jury shall consider mitigating evidence to be evidence that a juror might regard as reducing the defendant's moral blameworthiness." *Id.* at 13 n.16.

mitigating evidence to warrant a life sentence,<sup>211</sup> which allows for the possibility of parole after forty years.<sup>212</sup>

Patterson experienced insurmountable vulnerabilities as a severely mentally ill defendant. Much like a person with mental retardation, he displayed cognitive and behavioral defects that reduced his moral culpability. Furthermore, Patterson's severe mental disorder diminished his ability to contain himself in the courtroom, or to participate adequately in his defense. Most significant, the jury considered Patterson to be at risk of future dangerousness, given his history of paranoia culminating in violence. This factor was dispositive of Governor Perry's decision to deny clemency, despite the Texas Board of Pardons and Paroles' 5-1 vote to recommend a life sentence on the eve of Patterson's execution.<sup>213</sup> Patterson's 2004 execution stirred debate over Texas's lack of life without parole option for capital defendants whose circumstances call for mercy.<sup>214</sup>

### B. *James Colburn*

The 2003 execution of James Colburn perhaps even more specifically highlighted the need to be conscious of the deficiencies of severely mentally ill individuals and to approach them with the same mindset as in the case of people with mental retardation. James Colburn was executed on March 26, 2003 for the murder and attempted rape of Peggy Murphy.<sup>215</sup> Colburn, a man with an extensive psychiatric history, presents another apt example of an individual whose life might have been spared, if not for the impairments caused by his severe mental disorder.

Colburn first saw a psychiatrist at age fourteen.<sup>216</sup> By the time he reached seventeen in 1977 doctors had diagnosed

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<sup>211</sup> *Id.* at 13.

<sup>212</sup> TEX. CRIM. PROC. CODE ANN. § 37.071(2)(e)(2)(B) (2005) (describing procedure in capital case).

<sup>213</sup> Editorial, *Our Turn: Perry Ignores Facts to Allow Execution*, SAN ANTONIO EXPRESS NEWS, May 20, 2004, at 6B.

<sup>214</sup> See Editorial, *supra* note 213. See also, Editorial, *Our View: Two More Death Penalty Inequities*, SPRINGFIELD NEWS LEADER, May 21, 2004, at 8A; Associated Press, *Senator Urges Sentencing Options*, HOUS. CHRON., May 21, 2004, at 22; Scott Gold, *The Nation: Texas Weighs Its Life or Death Decisions*, L.A. TIMES, Aug. 15, 2004, at A17.

<sup>215</sup> David Carson, TEXAS EXECUTION INFORMATION CENTER, *James Colburn*, at <http://www.txexecutions.org/reports/301.asp> (last visited Jan. 24, 2004).

<sup>216</sup> *Id.*

him as having paranoid schizophrenia.<sup>217</sup> Colburn suffered not only from hallucinations, delusions and suicidal thoughts, but also exhibited symptoms of posttraumatic stress disorder as a result of being raped while hitchhiking.<sup>218</sup> Throughout his late teens, Colburn received psychiatric treatment for his condition, which included state hospitalization in 1979.<sup>219</sup> His behavior was marked by suicide attempts, self-mutilation, enuresis,<sup>220</sup> and substance abuse attributed to his psychiatric disorder.<sup>221</sup> From 1977 to 1991, he incurred six felony convictions, including for aggravated robbery and arson, and served prison time.<sup>222</sup>

During the week before the capital offense occurred, Colburn had allegedly experienced increased psychosis, eventually leading him to attempt an overdose on valium in response to hearing voices telling him to commit suicide.<sup>223</sup> The next day he awoke to continued command auditory hallucinations and later met Murphy on the street outside his home.<sup>224</sup> Colburn apparently invited Murphy into his home for a drink of water.<sup>225</sup> After she resisted his sexual advances, he strangled her and stabbed her in the neck, killing her.<sup>226</sup> Colburn immediately reported the crime to his neighbor who phoned the police.<sup>227</sup> Accounts of his videotaped confession described how Colburn rocked back and forth, lost control of his bladder, and shook uncontrollably.<sup>228</sup>

<sup>217</sup> *Id.* This fact speaks to the longevity of Colburn's illness, given that schizophrenia normally has an age of onset in the early to mid-20s for males. DSM-IV, *supra* note 53, at 282.

<sup>218</sup> INTERNATIONAL JUSTICE PROJECT, *Mental Illness, James Blake Colburn*, at <http://www.internationaljusticeproject.org/illnessJColburn.cfm> (last visited Dec. 30, 2003) [hereinafter IJP, *James Blake Colburn*].

<sup>219</sup> *Id.*

<sup>220</sup> Enuresis is repeated urination during the course of the day into bed or clothing, not due to a general medical condition. DSM-IV, *supra* note 53, at 108.

<sup>221</sup> IJP, *James Blake Colburn*, *supra* note 218.

<sup>222</sup> Carson, *supra* note 215.

<sup>223</sup> AIUSA, *James Colburn: Mentally Ill Man Scheduled for Execution in Texas*, at 3, at [http://web.amnesty.org/aidoc/aidoc\\_pdf.nsf/Index/AMR511582002ENGLISH/\\$File/AMR115802.pdf](http://web.amnesty.org/aidoc/aidoc_pdf.nsf/Index/AMR511582002ENGLISH/$File/AMR115802.pdf) (last visited Jan. 29, 2005) [hereinafter AIUSA, *James Colburn*]. In the months prior to Murphy's murder, records indicate that Colburn had been receiving only sporadic outpatient treatment. *Id.* at 3.

<sup>224</sup> *Id.*

<sup>225</sup> *Colburn v. Cockrell*, 37 Fed.Appx. 90, 2002 WL 1021891, at \*\*1 (5th Cir. May 9, 2002).

<sup>226</sup> *Id.*

<sup>227</sup> *Id.* One account reports that Colburn stated he killed Murphy in order to return to prison. Carson, *supra* note 215.

<sup>228</sup> AIUSA, *James Colburn*, *supra* note 223, at 2.

While being detained prior to trial, Colburn apparently received insufficient mental health treatment.<sup>229</sup> Although Colburn was indigent, the Texas county jail that housed him required that he pay for medication from his inmate account.<sup>230</sup> Revealing of his complete lack of insight, Colburn instead chose to use his money towards small things like candy and soda.<sup>231</sup> Without the psychiatric care and structure of an adequate mental health regimen, Colburn's condition during this period deteriorated to the point of ongoing suicidal ideation, urination and defecation on himself, auditory hallucinations, agitation, and need for physical restraint.<sup>232</sup>

When a person such as Colburn suffers from a severe mental disorder, they require medication to control their symptoms.<sup>233</sup> Throughout the course of the trial, Colburn exhibited signs of heavy sedation as a result of receiving regular injections of Haldol, a strong anti-psychotic drug.<sup>234</sup> He at times was sufficiently drowsy or asleep as to snore loudly in court, prompting a recess in order for his lawyers to rouse him.<sup>235</sup> His lawyers argued that the sedative effects of the medication prevented Colburn from effectively communicating with counsel or understanding the proceedings against him.<sup>236</sup> Although on appeal Colburn's sedation was found not to impact his competency, certainly repeated lapses into unconsciousness placed Colburn at a disadvantage not normally experienced by the average defendant at trial. At the least, his demeanor may have caused him to come across as being disinterested in the proceedings around him.

In addition to difficulties produced by the side effects of Haldol, Colburn's case was also compromised by use of only the testimony of Walter Quijano, the court-appointed psychologist. Colburn's lawyers during postconviction proceedings argued that his trial attorney should have hired a psychiatrist who could explain the pharmacological and medical evidence to the jury.<sup>237</sup> Instead they relied on a psychologist who specialized in

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<sup>229</sup> *Id.* at 3.

<sup>230</sup> *Id.*

<sup>231</sup> *Id.*

<sup>232</sup> *Id.*

<sup>233</sup> See text accompanying footnote 117.

<sup>234</sup> AIUSA, *James Colburn*, *supra* note 223, at 4. See also Patty Reinert, *High Court Refuses Death Row Case, Mentally Ill Texas Man Will Seek Clemency from Perry, Lawyers Say*, HOUS. CHRON., Jan. 2, 2003, at 5.

<sup>235</sup> AIUSA, *James Colburn*, *supra* note 223, at 4.

<sup>236</sup> Reinert, *supra* note 234.

<sup>237</sup> *Colburn v. Cockrell*, 37 Fed.Appx. 90, 2002 WL 1021891, at \*\*11 (5th Cir.

sex crimes<sup>238</sup> and on Dr. Quijano, who, while finding that Colburn's schizophrenia was "intractable," "chronic," "not expected to disappear," and "difficult to treat," determined that he was sane because Colburn knew at the time he committed the crime that his actions were wrong.<sup>239</sup> It is possible that a more lucid defendant might have urged the use of the more favorable or informed testimony at his trial or played a more active role in his defense.<sup>240</sup> Yet drowsy from medication during the course of the proceedings and "chronically mentally ill" as diagnosed by the court-appointed psychologist,<sup>241</sup> Colburn did not appear to have had that opportunity.

Despite the prosecutor's efforts to convince jurors to consider solely the death penalty,<sup>242</sup> they initially contemplated a life sentence. While in deliberation, the foreman specifically asked the judge whether a life sentence would entail the possibility of parole for Colburn.<sup>243</sup> Afterwards, one juror was quoted as saying, "Had I realized that he would not finish serving his prison time until he was over 70 years of age, I sincerely believe that I would have voted to give him a life sentence."<sup>244</sup> Without this knowledge, and believing that Colburn presented a future danger to society, the jury eventually inflicted a sentence of death on Colburn.<sup>245</sup>

### C. Charles Walker

While the involvement of Patterson and Colburn in their respective crimes is without question, Charles Walker's role in the murder for which he was convicted is in dispute. Similar to Patterson, Walker refused to plea-bargain. His case stands apart from Patterson's, however, in that Walker

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May 9, 2002).

<sup>238</sup> *Id.*

<sup>239</sup> AIUSA, *James Colburn*, *supra* note 223, at 3-4.

<sup>240</sup> While trial preparation and witness selection are normally within the lawyer's control, the lawyer has a duty to "reasonably consult with the client about the means by which the client's objectives are to be accomplished." AMERICAN BAR ASSOCIATION, *Model Rules of Professional Conduct, Rule 1.4, Communication*. Here, there is no indication that Colburn's trial attorney effectively communicated any strategies to Colburn, or that Colburn had even expressed his objectives.

<sup>241</sup> AIUSA, *James Colburn*, *supra* note 223, at 4-5.

<sup>242</sup> *Id.* at 5.

<sup>243</sup> *Id.* The judge reportedly responded that issues of parole were not the jury's concern. *Id.*

<sup>244</sup> *Id.*

<sup>245</sup> See IJP, *James Colburn*, *supra* note 218.

exposed himself to the death penalty when there were, and still remain, questions about his guilt.

Like Patterson and Colburn before him, Charles Walker has been diagnosed with severe mental illness. Initially diagnosed with schizophrenia during childhood, he was later evaluated during his prosecution as having bipolar disorder with psychotic features.<sup>246</sup> In 1995, he was convicted of the first degree murder of Tito Davidson.<sup>247</sup> In December of 2004, he received a stay of execution pending further examination of claims that he is constitutionally ineligible for the death penalty and may in fact be innocent.<sup>248</sup>

A glimpse of Walker's background reveals an extensive history of mental illness compounded by extreme childhood abuse. Walker was born in Brooklyn, New York in 1965, to a "mentally unstable" father and a mother addicted to alcohol and cocaine.<sup>249</sup> At age two, his father left and his mother remarried an abusive man who later shot and stabbed her.<sup>250</sup> His mother is said to have punished Walker repeatedly, including whipping him with electrical cords and a dog leash, denying him food, and burning his penis with an iron.<sup>251</sup> Walker was first diagnosed with paranoid schizophrenia at age ten when he received inpatient psychiatric treatment due to his bizarre and violent behavior, paranoia, auditory hallucinations,

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<sup>246</sup> See INTERNATIONAL JUSTICE PROJECT, *Mental Illness: Charles Walker*, at <http://www.internationaljusticeproject.org/illnessCWalker.cfm> (last visited Jan. 29, 2005) [hereinafter IJP, *Charles Walker*]. "People with bipolar disorder who have these symptoms are sometimes incorrectly diagnosed as having schizophrenia." NIMH, *Bipolar Disorder*, *supra* note 187. The mental health expert who examined Walker most recently found him to be "understandably depressed and anxious" and that his mental condition was currently in "remission." State's Answer to Defendant's Motion for Appropriate Relief and Application for Stay at 27, *State v. Walker*, 469 S.E.2d 919 (4th Cir. 1996), *cert. denied*, 519 U.S. 901 (1996) (Nos. 92CR 520762, 70920). The finding that Walker's symptoms appear to be "in remission" is consistent with the general course of a severe mental disorder, which may include periods of exacerbation and remission. See *supra* notes 118 and 134.

<sup>247</sup> See Motion for Appropriate Relief with Application for Stay of Execution at 1, *Walker* (Nos. 92CR 520762, 70920) [hereinafter MAR] (on file with author).

<sup>248</sup> Order Regarding Claims I and VI at 5, *Walker* (Nos. 92CRS 20762, 70920) (on file with author).

<sup>249</sup> MAR, *supra* note 247, at 8, 20.

<sup>250</sup> *Id.* at 9. Walker's cousin reports that Walker witnessed his mother's boyfriend stab her, possibly describing the same incident. *Id.* at 20. Walker's mother survived the attack and died in 1994 of acute and chronic cocaine intoxication. *Id.*

<sup>251</sup> See IJP, *Charles Walker*, *supra* note 246. See also AIUSA, *Urgent Action, Charles Anthony Walker*, at <http://web.amnesty.org/library/Index/ENGAMR511652004?open&of=ENG-USA> (last visited Jan. 29, 2005) [hereinafter AIUSA, *Charles Anthony Walker*]; MAR, *supra* note 247, at 9, 20, 21-22.

and incoherent thought processes.<sup>252</sup> His second hospitalization in 1976 at age eleven lasted about four months.<sup>253</sup>

Accounts of his conduct during adolescence coincide with a diagnosis of schizophrenia.<sup>254</sup> By age twelve, he lived on the streets of New York City.<sup>255</sup> When in school, he attended a special education program, but his attendance was at best sporadic.<sup>256</sup> At seventeen years old, Walker went to prison for shooting a man he claimed had been following him around to hurt him.<sup>257</sup> He did not receive treatment during the approximately six years of his incarceration.<sup>258</sup> Less than two years after his release, Walker's parole was revoked and he returned to prison for another year until his release in 1991 when he was twenty-five years old.<sup>259</sup> On August 11, 1992, Tito Davidson, the young man Walker is alleged to have murdered, disappeared in Greensboro, North Carolina.<sup>260</sup>

The circumstances surrounding Davidson's disappearance are vague. On August 13, 1992, an anonymous informant relayed to police that a body had been placed in the dumpster of a particular apartment.<sup>261</sup> Police searched through the trash, and, finding nothing, looked through tons of landfill refuse as well, without finding a body.<sup>262</sup> The statements of Antonio Wrenn, a suspect in an unrelated shooting, eventually led authorities to six other alleged participants in Davidson's suspected murder: Rahshar Darden; Pamela Haizlip; Jesse Thompson; Sabrina Wilson; Nickie Summers; and Charles Walker.<sup>263</sup>

As in the cases of Patterson and Colburn, the outcome of the legal proceedings demonstrate that Walker, as a person with a severe mental disorder, was enormously disadvantaged. Walker's co-participants, Darden, Thompson, Wrenn, and Haizlip each had the wherewithal to accept plea arrangements, while Wilson and Summers cooperated with the State in

<sup>252</sup> IJP, *Charles Walker*, *supra* note 246. MAR, *supra* note 247, at 9.

<sup>253</sup> MAR, *supra* note 247, at 9.

<sup>254</sup> IJP, *Charles Walker*, *supra* note 246. *See also* AIUSA, *Charles Anthony Walker*, *supra* note 251.

<sup>255</sup> AIUSA, *Charles Anthony Walker*, *supra* note 251.

<sup>256</sup> MAR, *supra* note 247, at 20-21.

<sup>257</sup> *Id.* At 9-10. Walker had been living in an abandoned building at the time. AIUSA, *Charles Anthony Walker*, *supra* note 251.

<sup>258</sup> AIUSA, *Charles Anthony Walker*, *supra* note 251.

<sup>259</sup> *Id.*

<sup>260</sup> MAR, *supra* note 247, at 2.

<sup>261</sup> AIUSA, *Charles Anthony Walker*, *supra* note 251.

<sup>262</sup> *Id.*

<sup>263</sup> *Id.* *See also* MAR, *supra* note 247, at 2-3.



providing testimony and were never charged.<sup>264</sup> Walker, on the other hand, described by the psychiatrist who evaluated him during this period as paranoid that the defense counsel was assisting the prosecution,<sup>265</sup> refused the state's offer of a second-degree murder plea.<sup>266</sup> Dr. Billy Royal noted Walker to be not only "extremely paranoid," but also "highly grandiose [with] profound difficulties in distinguishing fantasy from reality."<sup>267</sup> Just as Patterson and Colburn had been found competent to stand trial, Dr. Royal found Walker to be legally competent.<sup>268</sup> Yet Dr. Royal qualified his evaluation with the following statement:

Mr. Walker throughout the interviews had an inability to deal with the reality of what was going on in terms of his legal status, trial options that he had. There was a consistent view of himself that was different from what the facts of life showed, in terms of his behaviour [sic] and functioning. He was never able to come to grips or deal adequately in a major way with his attorneys, or with myself, or with other persons who tried to deal with him in terms of his legal status, the evidence that appeared to be related to his crime or what his potential was for the future.<sup>269</sup>

Walker's decision converted the proceedings into a capital case. Although the state of North Carolina now allows

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<sup>264</sup> MAR, *supra* note 247, at 2-3. Haizlip admitted proximity and pled to accessory to murder with time served in exchange for testimony. *Id.* at 3. Darden admitted shooting Davidson in the chest four times and once between the eyes. He served a total of six years for murder 2. Wrenn pled to accessory to murder 1 and served seven years. *Id.* Thompson admitted slashing Davidson's throat and bragged about firing the shot that killed him. He pled to murder 2 and received a life sentence. He is now eligible for parole. *Id.* See IJP, *Charles Walker*, *supra* note 246. See also Danica Coto, *Inmate on Death Row Spared in Final Hours*, CHARLOTTE OBSERVER, Dec. 3, 2004, at 1A; AIUSA, *Charles Anthony Walker*, *supra* note 251; Lisa Hoppenjans, *Judge Stays Friday's Execution of a Greensboro Man*, WINSTON SALEM J., Nov. 30, 2004, at B1.

<sup>265</sup> See IJP, *Charles Walker*, *supra* note 246; MAR, *supra* note 247, at 21.

<sup>266</sup> See IJP, *Charles Walker*, *supra* note 246. Forensic psychiatrist Dr. Seymour Halleck made a thorough review of this case, including school and prison records, and interviewed Walker in person. Dr. Halleck expressed particular concern about "the severe limitation upon Walker's ability to cooperate with his trial attorneys due to his paranoid belief that they were helping the prosecutor." MAR, *supra* note 247, at 21.

<sup>267</sup> IJP, *Charles Walker*, *supra* note 246. It should be noted that although Dr. Royal interviewed Walker and his family and reviewed certain records, the psychiatrist was impeached because he had not reviewed Walker's school or prison records and he was unaware of Walker's extreme childhood abuse history. MAR, *supra* note 247, at 10-11, 21. However, Dr. Royal had first-hand knowledge of Walker's behavior during the legal proceedings and it is for this reason that Dr. Royal's perceptions of Walker at that time are included.

<sup>268</sup> *Id.*

<sup>269</sup> *Id.*

for prosecutorial discretion in trying a defendant capitally for first degree murder when an aggravating circumstance is present, this option did not exist until 2001.<sup>270</sup> Due to the especially cruel nature of the murder allegations and because Walker had a prior violent felony conviction, the state had no recourse at that time but to seek the death penalty for Walker.<sup>271</sup> Without adequate consultation with defense counsel and by his own impaired judgment, Walker had placed his life at stake.

The trial contained a number of weaknesses that Walker might have been able to challenge if he had been free of severe mental illness. The prosecution relied solely on the uncorroborated testimony of co-participants who had reached plea agreements with the State. There was no physical evidence linking Walker to the crime.<sup>272</sup> The testimony provided by the participants contained numerous inconsistencies.<sup>273</sup> Additionally, because Walker refused to provide information about his history of mental illness and severe childhood abuse to Dr. Royal,<sup>274</sup> the jury did not hear all relevant mitigating evidence.<sup>275</sup>

The magnitude and complexity of a capital trial under “ideal” circumstances would seem to require that a defendant, at a minimum, collaborate with defense counsel. Walker’s apparent paranoia towards his own attorneys can be analogized to the lapse in procedural protections that could occur due to the mental retardation of a defendant, which caused the Court significant concern in *Atkins*.<sup>276</sup> Being at extreme odds with defense counsel undoubtedly decreases the communication between attorney and defendant. In Walker’s

<sup>270</sup> State v. Ward, 555 S.E.2d 251, 260 (N.C. 2001).

<sup>271</sup> AIUSA, *Charles Anthony Walker*, *supra* note 251, at 1. *See also* N.C. GEN. STAT. § 15A-2000(a)(1) (2004).

<sup>272</sup> MAR, *supra* note 247, at 12-15.

<sup>273</sup> Darden testified that Walker had hit Davidson on the knee with a hammer, but Haizlip testified that it was Thompson who had hit Davidson with the hammer. *Id.* at 6. Darden also testified that Walker had fired the fatal shot at Davidson’s neck, but this testimony was contradicted by accounts that Thompson had bragged about fatally shooting Davidson in the chest. *Id.* at 16.

<sup>274</sup> *Id.* at 30.

<sup>275</sup> Review of an Amnesty International report and *State v. Walker*, suggests that Walker’s relatives came forth sometime after his conviction to provide further illumination of his background. 469 S.E.2d 919 (N.C. 1996); AIUSA, *Charles Anthony Walker*, *supra* note 251. The additional information referred to has been brought up on appeal. MAR, *supra* note 247, at 19-22. Walker was able to share details about his past with Dr. Seymour Halleck, the psychiatrist who examined him most recently. *Id.* at 21.

<sup>276</sup> *Atkins v. Virginia*, 536 U.S. 304, 317 (2002).

case, at the least his mitigation evidence could have been more thoroughly developed in a timely manner. The combined effect of Walker's compromised mental state, the nature of the testimony presented at trial, and the deficient mitigation evidence possibly jeopardized the fairness of his proceedings.

Although the jury acquitted Walker of delivering the fatal gunshot wound, the jurors recommended a sentence of death after four days of deliberations.<sup>277</sup> Based on the testimony of witnesses, albeit uncorroborated, the jury found that Walker had "acted in concert with others with the intent to kill Davidson."<sup>278</sup> Again the issue of future dangerousness appears to have played a key role in the sentencing. The jury recommended the death penalty *despite* finding that Walker had been mentally or emotionally disturbed at the time of the crime and that his disturbances were caused by childhood trauma and mental illness.<sup>279</sup> The jurors considered the possibility that Walker would be paroled under a life sentence influential to their decision.<sup>280</sup> Two jurors suggested that they would have found the additional mitigating evidence brought up on appeal to be significant.<sup>281</sup> Further, some of the jurors later expressed that life without parole was the appropriate sentence for Walker, but it had not been available at that time.<sup>282</sup> Not only did Walker's rejection of a plea agreement turn the proceedings into a capital case, but his failure to cooperate with defense counsel may have prevented the jury's access to the complete mitigation evidence, evidence which had the potential to outweigh concerns about future dangerousness.

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<sup>277</sup> AIUSA, *Charles Anthony Walker*, *supra* note 251. This recommendation was controversial, because no person has ever been executed in North Carolina in a case in which the body was never found. *See* Estes Thompson, *Condemned Man's Lawyers Say Case Lacks Evidence: Inmate to Be Executed for Slaying in Which Body Was Never Found*, CHARLOTTE OBSERVER, Nov. 30, 2004, at 3B.

<sup>278</sup> MAR, *supra* note 247, at 11.

<sup>279</sup> *State v. Walker*, 469 S.E.2d at 924 (N.C. 1996).

<sup>280</sup> North Carolina adopted a life without parole option in October of 1994 which did not apply retrospectively. For offenses occurring prior to that date, a sentencer had to choose between death or life imprisonment with the possibility of parole after twenty years. *See* N.C. GEN. STAT. § 15A-2002(a) (2004). *See also* MAR, *supra* note 247, at 24.

<sup>281</sup> One specifically stated that she would not have voted for the death penalty. *See* MAR, *supra* note 247, at 22. The mitigating evidence described in *State v. Walker*, while in itself troubling, does not convey the full breadth of Walker's history of psychiatric illness or trauma and thus suggests that the jury could not have had a full appreciation for the severity of the abuse or mental illness experienced by Walker. *Id.* at 19-22.

<sup>282</sup> *Id.* at 24.

Patterson and Colburn's lives were marked, and Walker's life has been marked, by a history of psychiatric symptoms, sporadic, reactive attempts to treat them, and coinciding maladaptation to normal life activities. While their intelligence levels may not have been subaverage, their severe mental disorders rendered them both less culpable and more vulnerable during legal proceedings. These same attributes were sufficient to convince the Supreme Court to constitutionalize the consensus that defendants with mental retardation should not be executed. Although jurors appeared to recognize that Patterson, Colburn, and Walker suffered from severe mental disorders, the defendants' illnesses were not considered as mitigating factors. The sentencers in Patterson and Colburn's cases ultimately chose to view the mental disorders as aggravators, and in Walker's case this vital information was simply unavailable. But as discussed above, a complete picture of the impact of severe mental illness on the individual reveals that execution was and is a disproportionate punishment for each of these three defendants.

VI. *TENNARD V. DRETKE*, SEVERE MENTAL ILLNESS AS AN AGGRAVATOR, AND THE IMPLICATIONS OF EXTENDING *ATKINS* TO DEFENDANTS WITH SEVERE MENTAL ILLNESS

A. *Tennard v. Dretke*<sup>283</sup>

If severe mental illness is accepted as comparable to mental retardation in its impact on the individual, it must also have comparable mitigating effect. As explained in *Tennard*, the mitigating effect of mental retardation under *Atkins* is broad.

*Tennard* involved a man described as "gullible" with an I.Q. of 67 who was convicted of capital murder in Texas.<sup>284</sup> *Tennard* had sought postconviction relief, claiming that the jury instructions did not allow the sentencer to give mitigating effect to *Tennard's* low I.Q. and gullibility.<sup>285</sup> After *Tennard* lost his appeals in the lower courts, the Fifth Circuit held that he was not entitled to a certificate of appealability because his I.Q. score did not establish mental retardation, and that even if it

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<sup>283</sup> 124 S. Ct. 2562 (2004).

<sup>284</sup> *Id.* at 2565-66.

<sup>285</sup> *Id.* at 2566-67.

did, “[Tennard] did not show that the crime he committed was attributable to his low I.Q.”<sup>286</sup>

The Supreme Court rejected the Fifth Circuit’s requirement that a nexus exist between low I.Q. and the capital crime in order to consider mental retardation as a mitigator.<sup>287</sup> In the Court’s holding, Justice O’Connor clarified that “[i]mpaired intellectual functioning has mitigating dimension beyond the impact it has on the individual’s ability to act deliberately.”<sup>288</sup> Indeed, *Atkins* had explained that “impaired intellectual functioning is *inherently* mitigating.”<sup>289</sup> Likewise, just as the issue in the case of a defendant with mental retardation would not be whether that defendant’s low I.Q. caused the crime, the issue in the case of a person with severe mental illness would not be limited to whether that person was actively psychotic at the time the capital crime was committed. In this respect, any concerns about a lack of nexus between a severe mental disorder and the crime would be entirely at odds with the *Tennard* holding.<sup>290</sup> “The question is

<sup>286</sup> *Id.* at 2568.

<sup>287</sup> *Id.* at 2570.

<sup>288</sup> *Tennard*, 124 S. Ct. at 2572 (emphasis added).

<sup>289</sup> *Id.* at 2571.

<sup>290</sup> The American Psychiatric Association (APA) appears to erroneously raise a parallel concern in a statement advocating the exclusion of defendants with severe mental illness from capital punishment. Although the APA states that “[T]he core rationale for precluding death sentences for defendants with mental retardation is equally applicable to defendants with severe mental illness,” the APA retreats from this position. The APA proposes modifying the language of the Model Penal Code to include prohibiting the execution of defendants if, at the time of the offense, they had a “severe mental disorder” that “significantly impaired” their capacity “to exercise rational judgment in relation to their conduct.” In doing so, the APA uses legal provisions to narrow a medical classification of mental disorders. AMERICAN PSYCHIATRIC ASSOCIATION, *Position Statement, Diminished Responsibility in Capital Sentencing*, Nov. 2004. By tying the definition of severe mental disorders to the insanity defense, the APA clearly does not incorporate the substance of *Tennard* into its suggested changes. The APA bases its proposed changes on its concern that “[E]ven 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.” *Id.* Yet among persons with mental retardation, the level of impairment of intelligence also varies widely, so much so that the APA has divided the levels into four categories, in addition to a general category where mental retardation is strongly presumed, but the person’s intelligence is not testable. DSM-IV, *supra* note 53, at 40. The limitations in adaptive skills, too, vary widely among individuals with mental retardation. Indeed, in their definitions of mental retardation, both the AAMR and APA require limitations in as few as two areas of adaptive skills which include: communication, self-care, home living, and social skills. *See* DSM-IV, *supra* note 53, at 46. *See also* AAMR, *supra* note 52. Despite this variation, the *Atkins* Court did not deem it necessary to narrow the category of individuals with mental retardation, where this condition reduces their moral culpability in general. *See supra* text accompanying note 56. In light of the argument that a death sentence would essentially be disproportionate to the culpability of the offender with severe mental illness for the reasons set forth in this

simply whether the evidence is of such a character that it 'might serve as a basis for a sentence less than death.'<sup>291</sup>

By clarifying the expansive role mental retardation plays in mitigation, the Court in *Tennard* acknowledged and cautioned against the tendency to give a low IQ aggravating effect in considering future dangerousness, but to dismiss mental retardation as irrelevant in mitigation.<sup>292</sup> As described above, this problematic interpretation occurs frequently in cases of severely mentally ill defendants, in which the prosecutor is all too ready to instill jurors with a sense that the defendant before them is dangerous and will kill again, thereby urging them to disregard the mitigating effects of the mental disorder and recommend a sentence of death.<sup>293</sup>

### B. *Severe Mental Illness as an Aggravator*

The factfinder's tendency to consider severe mental illness an aggravator is aptly illustrated by the sentencing of Patterson and Colburn. The Texas capital sentencing scheme gained much attention after *Penry* for its cumbersome jury instructions, which even after revision remain confusing, and the statute continues to raise controversy for its lack of a life without parole option.<sup>294</sup> In a discussion addressing this issue, Amnesty International, a human rights organization, notes:

Even today, there is public fear and ignorance around the subject of mental illness. Under the Texas capital sentencing scheme, even if the defence [sic] attorneys put on a persuasive case that their client's mental illness demands compassion, it may not be enough to overcome jurors' fears of the individual in front of them, whom they have just convicted of a violent crime . . . a prosecutor's bid for a death sentence may lead such officials to play on juror fears and make a death sentence more likely under Texas's capital sentencing scheme.<sup>295</sup>

A defendant like Kelsey Patterson with an unequivocal history of violent behavior would arouse understandable

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Note, the Court, and certainly the APA, should not narrow the category of capital defendants with severe mental illness by requiring a nexus between the defendants' severe mental illness and the capital crime or the capacity to commit it.

<sup>291</sup> *Tennard*, 124 S. Ct. at 2571 (internal citations omitted).

<sup>292</sup> *Id.* at 2572.

<sup>293</sup> See AIUSA, *Another Texas Injustice*, *supra* note 1, at 11-12. See also *Tennard*, 124 S. Ct. at 2572-73.

<sup>294</sup> TEX. CRIM. PROC. CODE ANN. § 37.071(2)(e)(2)(B), *supra* note 212 (describing procedure in a capital case).

<sup>295</sup> AIUSA, *James Colburn*, *supra* note 223, at 5.

concerns for the jury. However, the circumstances surrounding the sentencing of James Colburn make it clear that at least some jurors feel a compassion for defendants with severe mental illness that conflicts with their desire to prevent harm to society. These jurors must be given a “vehicle for expressing [their] ‘reasoned moral response’ to that [mitigating] evidence in rendering its sentencing decision.”<sup>296</sup> The function of mitigation provisions in state death penalty statutes otherwise becomes meaningless when the factfinder is not able to acknowledge the qualities of a defendant that reduce culpability. Furthermore, to disregard a defendant’s severe mental disorder is to treat that defendant as an average murderer and neglect to make a distinction between offenders who are more deserving of capital punishment than others.<sup>297</sup>

C. *The Implications of Extending Atkins to Defendants with Severe Mental Illness*

A categorical exclusion of the severely mentally ill would put to rest apprehensions about executing individuals whose mitigating circumstances make them less culpable than the average murderer. Still, such an exclusion may be difficult for lay persons and the legal community to embrace, in part because it opens up the probability that psychiatry (i.e. the medical profession) will have a greater hand in determining who can be disqualified from a death sentence.<sup>298</sup> Whereas defendants with schizophrenia, schizoaffective disorder or bipolar disorder who failed to successfully plead insanity were previously executed, under the proposed exemption they would no longer be eligible for the death penalty as individuals diagnosed as suffering from severe mental disorders. As in the

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<sup>296</sup> *Penry v. Lynaugh*, 492 U.S. 302, 328 (1989) (quoting *Franklin v. Lynaugh*, 487 U.S. 164, 184 (1988)).

<sup>297</sup> Berkman, *supra* note 65, at 293.

<sup>298</sup> Concerns of inconsistency of diagnoses by physicians should be quashed. It is the similar presentation of the individuals with schizophrenia, schizoaffective disorder and bipolar disorder in terms of symptoms, behavioral deficits, and disadvantages in criminal proceedings that substantively matter, not the *names* of their conditions. Because these severe mental illnesses share common traits that make it difficult to differentiate between the disorders, it is not unusual for physicians, mental health professionals, and researchers to discuss them in tandem. See DSM-IV, *supra* note 53, at 283-84; NIMH, *Bipolar Disorder*, *supra* note 187, at 4; NMHA, *Schizoaffective Disorder*, *supra* note 187; Benabarre, *supra* note 114; Martin Harrow et al., *Ten-Year Outcome: Patients with Schizoaffective Disorders, Schizophrenia, Affective Disorders and Mood-Incongruent Psychotic Symptoms*, 177 BRIT. J. PSYCHIATRY 421 (2000).

*Atkins* case and *Ford v. Wainwright* before it, each State must develop “appropriate ways” to carry out this categorical exclusion,<sup>299</sup> particularly when the prosecution disputes that a defendant is severely mentally ill. When a person is diagnosed with a severe mental disorder *after* sentencing, that death sentence would thereafter be commuted in order to comply with the Eighth Amendment. Additionally, in order to ensure due process and avert wrongful execution, the issue of mandatory evaluation might be raised where defendants suspected to have mental health issues refuse psychiatric examination.<sup>300</sup>

The *Atkins* court did not express concern that a categorical exclusion of people with mental retardation from the death penalty would increase the number of capital offenses committed by that population, nor should this worry exist with respect to individuals with a severe mental disorder. Persons with severe mental disorders comprise a very small portion of society to begin with and the prevalence of violence associated with them is modest.<sup>301</sup> Moreover, an exemption would not exculpate the severely mentally ill from punishment for serious crimes they in fact perpetrate. Rather, such an exemption would recognize that the experiences of persons afflicted with a severe mental disorder in developing a chronic illness over time and dealing with its impact emotionally, socially and in the courtroom, are accompanied by vulnerabilities that may be unfathomable to the ordinary person.

Creating a categorical exclusion of the severely mentally ill from the death penalty requires offering alternative sentences that adhere to the Eighth Amendment’s proscription

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<sup>299</sup> *Atkins v. Virginia*, 536 U.S. 304, 317 (2002).

<sup>300</sup> The desire to protect client autonomy at times conflicts with the criminal defense attorney’s role of providing effective representation. For a framework with which to address this dilemma, see Christopher Slobogin, *The Criminal Defense Lawyer’s Fiduciary Duty to Clients with Mental Disability*, 68 *FORDHAM L. REV.* 1581 (1999).

<sup>301</sup> Mental retardation affects between 1.5% to 2.5% of the population. AAMR, *Fact Sheet: The Death Penalty*, at [http://www.aamr.org/Policies/faq\\_death\\_penalty.shtml](http://www.aamr.org/Policies/faq_death_penalty.shtml) (last visited Feb. 1, 2005). Approximately 1.2% of American adults develop schizophrenia. This estimate may also include those persons with schizoaffective disorder. William E. Narrow et al., *Revised Prevalence Estimates of Mental Disorders in the United States*, 59 *ARCH. GEN. PSYCHIATRY*, 115, 121, Table 4 (Feb. 2002). Bipolar disorder affects roughly 1.2% of the population. NAMI, *Bipolar Disorder*, at [http://www.nami.org/Template.cfm?Section=By\\_Illness&template=/ContentManagement/ContentDisplay.cfm&ContentID=10442](http://www.nami.org/Template.cfm?Section=By_Illness&template=/ContentManagement/ContentDisplay.cfm&ContentID=10442) (last visited Feb. 1, 2005). See also Elizabeth Walsh et al., *Violence and Schizophrenia: Examining the Evidence*, 180 *BRIT. J. PSYCHIATRY* 490 (June 2002).



against cruel and unusual punishment. There will be instances when a life sentence without parole may be appropriate, but effort should be made to explore institutionalization in a psychiatric setting where a defendant who is diagnosed with chronic schizophrenia, schizoaffective disorder or bipolar disorder may receive sufficient, ongoing treatment. More importantly, given that the larger societal concern appears to be the fear of future dangerousness, policymakers within the criminal justice system should combine their efforts with mental health experts to work towards violence prevention in identified high-risk individuals.

Based on the literature,<sup>302</sup> resources should be concentrated on increasing treatment compliance, reducing substance abuse, and working with health care bodies such as managed care companies to ensure adequate length of inpatient psychiatric stays, or comprehensive outpatient programs. A monitoring program should be required for any severely mentally ill person with a *known history of violent behavior who refuses treatment*, particularly if that person has a co-existing substance abuse disorder. The potential benefits of tracking these patients, perhaps through daily, face-to-face contact with case managers, should outweigh any disquiet over expenses incurred to supervise individuals who might not currently appear in need of care. The cornerstone of implementing these improvements would lie in educating the public about mental illness and the need for a comprehensive mental health system that addresses all facets of the afflicted individual's life, not simply treatment. Lawmakers should be urged to invest in preventive measures rather than merely fund the expansion of the penal system.

## VII. CONCLUSION

The concept of "evolving standards of decency" suggests a movement towards a more sensitive and informed morality that analyzes the developmental, functional, and cognitive makeup of offenders when assessing culpability. Indeed, in an opinion that echoed the *Atkins* rationale, the Supreme Court recently determined that the death penalty is disproportionate punishment for juveniles.<sup>303</sup> Although current legislation and case law may suggest that American society is not yet at the

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<sup>302</sup> See *supra* text accompanying note 158.

<sup>303</sup> *Roper v. Simmons*, 125 S.Ct. 1183 (2005).

same point that the Supreme Court found it to be when it decided *Atkins* in favor of individuals with mental retardation, existing statutory provisions, the views of justices and religious communities, national polls, and official statements by professional bodies indicate that at least a significant segment of the American public agrees with the widely held international belief that people with severe mental disorders should be spared from capital punishment.

It may be that society's moral compass will someday mature in a way that execution of the severely mentally ill will be deemed unconstitutional. This maturity is likely to be bolstered by a conscious effort to create an informed citizenry, legislature, and criminal justice system which address and incorporate the realities of mental illness into their decision-making, rather than shun the lessons of medical and mental health professionals. In the interim, Justice Stevens' opinion in *Atkins* serves as a highly applicable rationale for courts to consider in capital sentencing proceedings for defendants with severe mental disorders.

*Laurie T. Izutsu*<sup>†</sup>

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<sup>†</sup> J.D. Candidate, 2005, Brooklyn Law School; M.S.W., 1996, University of Washington. I would like to thank Professor Ursula Bentele for her unfailing guidance and inspiration. Many thanks also to Jason Cade for his insightful editing and to the diligent *Brooklyn Law Review* staff.