

Mental Illness and the Death Penalty Resource Guide

Prepared by
Kristin Houlé
Soros Justice Fellow

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Introduction

In 1986, the U.S. Supreme Court ruled in the case of *Ford v. Wainwright* that it is unconstitutional to execute someone who does not understand the reason for, or the reality of, his or her punishment. The *Ford* decision left the determination of insanity and competency for execution up to each state, however, and it has not prevented the execution of scores of offenders with severe and persistent mental illnesses, such as schizophrenia or bipolar disorder. In Texas, the state legislature did not establish a statute governing the process to determine competency to be executed until 1999, and the U.S. Fifth Circuit Court of Appeals, which considers cases from Texas, Louisiana, and Mississippi, has never found a death row inmate incompetent for execution.

While state and federal courts have wrangled with issues of competency and sanity, at least 25 individuals with documented histories of paranoid schizophrenia, bipolar disorder, and other persistent and severe mental illnesses have been executed by the State of Texas. Countless others continue to languish on death row, waiting to be found “competent to be executed.” During this same time period, state funding for mental healthcare has not kept pace with the demand for services, and persons suffering from severe mental disorders increasingly have been incarcerated in jails or prisons rather than placed in treatment facilities. Many of those sentenced to death and executed in Texas had sought treatment before the commission of their crimes, but were denied long-term care.

In the last six years, the U.S. Supreme Court has outlawed the death penalty for juvenile offenders and for persons with mental retardation. It considered these offenders to be less morally culpable and determined that their diminished capacity might impact their ability to appreciate the consequences of their actions or to participate fully in their own defense. Advocates now are addressing the fact that it is profoundly inconsistent for juveniles and people with mental retardation to be ineligible for the death penalty while offenders with severe and persistent mental illnesses are held to a higher standard of culpability.

The national effort on this issue is grounded in a recommendation crafted by the American Bar Association’s (ABA) Task Force on Mental Disability and the Death Penalty, which consisted of legal and mental health experts and called for a prohibition on the death penalty for persons with mental disabilities or disorders. It sets forth standards for determining competency under which offenders whose severe mental illness impairs their capacity to participate in their own defense, exercise rational judgment, or understand the nature and purpose of their punishment no longer are subject to the death penalty. The American Psychiatric Association, the American Psychological Association, and the National Alliance on Mental Illness have endorsed this recommendation, and the ABA House of Delegates passed it unanimously in 2006.

It now falls upon individual states to ensure that the ABA recommendation becomes reality. This effort will require close collaboration with mental health advocates, as well as a significant investment in public education. Texas is leading the way in this arena, as it currently is the only state in the nation with a specific campaign related to mental illness and the death penalty as well as dedicated staff to support it.

The materials in this organizing packet have been developed to help you educate yourself and the public at large about mental illness and how it intersects with the death penalty/ criminal justice systems in Texas. You can use these resources to reduce the stigmas

associated with mental illness in this country, to launch a broader dialogue about the death penalty in Texas, and to take action in your community.

In this Mental Illness and the Death Penalty Resource Guide, you will find the following materials:

- Talking Points on Mental Illness and the Death Penalty
- Key Terms and Legal Statutes Related to Mental Illness
- Ideas for Action
- Discussion Guide for “Executing the Insane: The Case of Scott Panetti”
- Available Speakers on Mental Illness and the Death Penalty
- Executions of Offenders with Severe Mental Illness in Texas (synopses of all known cases)
- Resources on Mental Illness and the Death Penalty

Elsewhere in the packet, you will find these resources:

- Mental Illness and the Death Penalty in Texas: Know the Facts
- In-Depth Case Studies on James Colburn, Monty Delk, Scott Panetti, Kelsey Patterson, and Larry Robison
- “Executing the Insane: The Case of Scott Panetti” DVD
- Mental Illness and the Death Penalty Postcards (10 to get you started; you can request more)
- American Bar Association Recommendation on the Death Penalty and Persons with Mental Disabilities

Please feel free to copy and distribute any of the resources enclosed in this packet. Contact Kristin Houlé at khouletx@gmail.com or 512-441-1808 if you have any questions or would like to receive additional information or materials.

You can stay up-to-date on current developments and news related to mental illness and the death penalty by visiting the *Prevention Not Punishment* blog - <http://preventionnotpunishment.blogspot.com/> - and posting comments about how this issue is impacting your community.

Thank you for your interest and commitment to improving our state’s criminal justice system. With your active participation, Texas will serve as a model in the effort to prohibit the death penalty for offenders with severe mental illness.

Talking Points on Mental Illness and the Death Penalty

These talking points are intended to provide you with information on how mental illness intersects with the death penalty and the impact it can have on the entire legal process – from trial to execution. The case studies and synopses included in this packet help to illustrate these points.¹

1. Persons suffering from a severe mental illness at the time they commit a capital offense are significantly less culpable than the “average murderer.”

- It is profoundly inconsistent to exempt people with mental retardation from the death penalty yet hold offenders with severe mental illness to a higher standard, particularly when there is significant reason to believe that the crime would not have been committed but for the symptoms of that disorder.

2. The recognized purposes of the death penalty - deterrence (to stop people from committing capital offenses out of fear of being executed) and retribution (punishment that is proportionate to, and warranted by, the crime) - are not served by executing offenders with severe mental illness.

- People do not choose to develop mental illness. The existence of the death penalty cannot deter people from becoming psychotic or from behaving in a manner that stems from their disorder(s).
- The retributive purpose of the death penalty is not served when an offender lacks a meaningful understanding that the state is taking his life in order to hold him accountable for his crime. It offends the concept of personal responsibility.
- Early identification and the availability of community-based mental-health services (and follow-up care) that are affordable, appropriate, and consumer-centered are the most effective ways to ensure public safety and deter crime.
- Prosecuting a capital case involving a defendant with severe mental illness is expensive and diverts valuable resources away from effective crime prevention measures and mental health treatment programs.

3. Mental illness can have a significant impact on the legal proceedings at every stage in the process and can play a large role in determining whether or not a defendant receives a death sentence.

¹ These talking points have been modeled on and adapted from three sources: Amnesty International USA’s Program to Abolish the Death Penalty, January 2006; a collaboration by Judith G. Storaandt, J.D., National Disability Rights Network ; Ronald Tabak, J.D., Co-chair, Death Penalty Committee, ABA Section of Individual Rights & Responsibilities; Ron Honberg, J.D., National Alliance on Mental Illness; and David Kaczynski, Executive Director, New Yorkers Against the Death Penalty, March 2007; and the Criminal Justice/Mental Health Consensus Project.

- Defendants with mental illness often lack the capacity to communicate with or effectively assist their attorney.
- Court-appointed attorneys, employed in the vast majority of capital cases, might have no experience with offenders with mental illness and might not conduct a proper investigation into their clients' medical history and its impact on their behavior.
- Defendants might not share information related to their mental illness with their attorney or might not allow this information to be presented to a jury. This means that important mitigating evidence that might be persuasive to a jury is not presented during the sentencing phase of a trial.
- Evidence of a defendant's mental illness might be used as an aggravating factor rather than a mitigating circumstance – prosecutors might use it to convince the jury that the defendant poses a "future danger."
- Defendants with mental illness might not have the capacity to testify on their own behalf (though some might insist on doing so anyway).
- Defendants with mental illness might seek to represent themselves or otherwise not cooperate with legal counsel as a result of delusions about their attorneys or a belief that they are part of a conspiracy against them.
- Jurors might not interpret unusual courtroom behaviors, such as frequent outbursts or uncontrolled talking, as manifestations of mental illness. They also might be unaware of the side effects of anti-psychotic medications, which might render the defendant emotionless or without affect.
- Death row inmates with severe mental illness might not be competent to assist their attorneys in post-conviction proceedings (appeals). They might not consent to or cooperate with psychiatric evaluations or sign the release forms necessary to provide their attorneys with critical information about their medical history.
- Some death row inmates with severe mental illness might choose to give up their appeals and "volunteer" for execution.

4. People with mental illness are not more likely to be violent than the general population.

- Several large-scale research projects have found a weak statistical association between violent behavior and mental illness.
- People with mental illness are more likely to be the victims of violence than the perpetrators.
- Nearly half of prison inmates with a mental illness were incarcerated for committing nonviolent crimes.
- Serious violence among people with mental illness is concentrated in a small subset of the population – namely those who abuse drugs or alcohol or who have inadequate access to effective mental health services.

5. Both state and federal courts have been too narrow in their interpretation of the U.S. Supreme Court decision *Ford v. Wainwright* regarding competency to be executed.

- While death row inmates with severe mental illness might be aware of their impending execution and the state's given reason for it, they might not appreciate the reality of their impending death and often harbor delusions about how they will survive the execution process.
- The U.S. Fifth Circuit Court of Appeals, which considers cases from Texas, Louisiana, and Mississippi, has never found a death row inmate incompetent for execution.
- The Texas Legislature did not establish a statute governing hearings to determine competency to be executed until 1999. By that time, at least 11 individuals with histories of mental illness had been executed by the state.

Key Terms and Legal Statutes Related to Mental Illness

Bipolar Disorder: Bipolar disorder, or manic depression, is a medical illness that causes extreme shifts in mood, energy, and functioning. These changes may be subtle or dramatic and typically vary greatly from person to person. Over 10 million people in America have bipolar disorder; the illness affects men and women equally. Bipolar disorder is a chronic and generally lifelong condition with recurring episodes of mania and depression that can last from days to months; the condition may vary over the course of an individual's life. It often emerges in adolescence or early adulthood and can occasionally occur in children. Most people generally require some sort of lifelong treatment, including medication and psychotherapy. Support and education about the illness are also essential components of the treatment process.²

Competency to Stand Trial: According to Chapter 46B, Texas Code of Criminal Procedure: Article 46B.003. Incompetency; Presumptions:

- “(a) A person is incompetent to stand trial if the person does not have:
 1. sufficient present ability to consult with the person's lawyer with a reasonable degree of rational understanding; or
 2. a rational as well as factual understanding of the proceedings against the person.
- (b) A defendant is presumed competent to stand trial and shall be found competent to stand trial unless proved incompetent by a preponderance of the evidence.”

Competency relates to a defendant's mental state *at the time of trial*, not at the time of the alleged crime. Either the defense or prosecution may suggest by motion, or the trial court may suggest on its own, that the defendant may be incompetent to stand trial. Once such a suggestion has been made, the court determines by informal inquiry whether there is evidence from any source (a family member, mental health professional, etc.) to support a finding that the defendant may be incompetent to stand trial. Evidence that a defendant is suffering from a mental illness is not enough to establish that he or she is incompetent to stand trial.

All other proceedings in the case must be halted once the judge determines that there is some evidence of incompetency. The court may raise the issue of competency at any point during the proceedings, before a sentence is pronounced.

A finding of incompetency to stand trial is not a defense to the crime charged. If a defendant is deemed incompetent to stand trial (either by a jury trial or an agreement by all parties), the court typically will commit him/her to a treatment facility (such as a state mental hospital) for up to 120 days. Once committed to a facility, a defendant will be treated so as to “restore” him or her to competency so that the case can proceed.³

Competency to Be Executed: In *Ford v. Wainwright* (1986), the U.S. Supreme Court held that it is unconstitutional to execute someone who does not understand the reason for or the reality of his punishment.

² National Alliance on Mental Illness: www.nami.org

³ Shannon, Brian and, Daniel Benson, Professors. [Texas Criminal Procedure and the Offender with Mental Illness: An Analysis and Guide](#). Third Edition. National Alliance on Mental Illness – Texas, 2005. pp. 41-53 and 75-77.

When the Texas legislature rewrote the state's criminal code in 1975, it "inexplicably omitted the section dealing with execution competency." In 1988, the Texas Court of Criminal Appeals recommended that the legislature resolve this issue "at the earliest opportunity," but legislators did not act for another 11 years.⁴ In 1999, Texas finally established a statute governing the process to determine competency to be executed. Article 46.05 in the Texas Code of Criminal Procedure states that:

- "(a) A person who is incompetent to be executed may not be executed.
- (b) The trial court retains jurisdiction over motions filed by or for a defendant under this article. ...
- (h) A defendant is incompetent to be executed if the defendant does not understand:
 - (1) that he or she is to be executed and that the execution is imminent; and
 - (2) the reason he or she is being executed."

It requires a preponderance of the evidence to determine that someone is incompetent to be executed.⁵

Consumers: Those who seek, receive, and become eligible for mental health services.

Insanity: According to Section 8.01 of the Texas Penal Code, "insanity is an affirmative defense to prosecution that, at the time of the conduct charged, the actor, as a result of severe mental disease or defect, did not know that his conduct was wrong. The term 'mental disease or defect' does not include an abnormality manifested by repeated criminal or otherwise antisocial conduct." Although it does not specify, the "wrong" referred to in the statute means *legal* wrong.

Insanity must be proved by a preponderance of the evidence. Texas juries are not informed of the consequences to the defendant if they return a verdict of not guilty by reason of insanity.⁶

According to a 1991 eight-state study funded by the National Institute of Mental Health, the insanity defense was used in less than *one percent* of the cases in a representative sampling of cases argued before those states' county courts. The study showed that only 26 percent of those insanity pleas were argued successfully. In approximately 80 percent of the cases where a defendant has been found "not guilty by reason of insanity," the prosecution and defense have agreed on the appropriateness of the plea before trial. Other studies over the past two decades report similar findings.⁷

Major Depression: Major depression is a serious medical illness affecting 15 million American adults, or approximately 5 to 8 percent of the adult population in a given year. Unlike normal emotional experiences of sadness, loss, or passing mood states, major depression is persistent and can significantly interfere with an individual's thoughts, behavior, mood, activity, and physical health. Among all medical illnesses, major depression is the leading cause of disability in the U.S. and many other developed countries.⁸

⁴ *Austin American-Statesmen*, January 14, 1996.

⁵ Shannon, Brian and Daniel Benson, Professors. pp. 138-141.

⁶ *Ibid*, pp. 145-152 and 156-157.

⁷ American Psychiatric Association: www.healthyminds.org/insanitydefense.cfm

⁸ www.nami.org

Malingering: According to the American Psychiatric Association, malingering is the deliberate fabrication or gross exaggeration of psychological or physical symptoms for personal gain or to achieve a tangible goal.

Dr. Richard Rogers, one of the leading experts on the issue of malingering, has stated that "A critical issue is that the presence of malingering does not preclude the presence of a genuine disorder. It is common for both malingering and a genuine disorder to be observed in the same person. When a person is formally classified with malingering, a thorough evaluation still must be conducted regarding the presence of a genuine disorder."⁹

Mental Retardation: According to the American Association on Mental Retardation (AAMR), mental retardation is a disability that occurs before age 18. It is characterized by significant limitations in intellectual functioning and adaptive behavior as expressed in conceptual, social, and practical adaptive skills. It is diagnosed through the use of standardized tests of intelligence and adaptive behavior.

Although the U.S. Supreme Court prohibited the application of the death penalty to persons with mental retardation in *Atkins v. Virginia* (2002), the Texas Legislature still has not enacted statutory provisions governing the standards and procedures to be followed in these cases.

In contrast to those with mental retardation, people with mental illnesses have varied intellectual functioning, just like the general population.¹⁰

Post-Traumatic Stress Disorder (PTSD): PTSD is a psychiatric disorder that can occur in people who have experienced or witnessed life-threatening events such as natural disasters, serious accidents, terrorist incidents, war, or violent personal assaults like rape. People who suffer from PTSD often relive the experience through flashbacks or nightmares, have difficulty sleeping, and feel detached or estranged. Although researchers once thought PTSD was primarily a disorder of war veterans who had been involved in heavy combat, they now know that it also affects both female and male civilians, and that it strikes more females than males. In some cases the symptoms of PTSD disappear with time, whereas in others they persist for many years. PTSD often occurs with - or may contribute to - other related disorders, such as depression, substance abuse, problems with memory, and other problems of physical and mental health.¹¹

Psychosis: In the general sense, psychosis is a mental illness that markedly interferes with a person's capacity to meet life's everyday demands. It is a severe mental condition characterized by a loss of contact with reality. Symptoms can include seeing, hearing, smelling, or tasting things that are not there; paranoia; and delusional thoughts. Depending on the condition underlying the psychosis, symptoms may be constant or intermittent. Psychosis can occur as a result of brain injury, disease, or mental health condition, and is seen particularly in schizophrenia and bipolar disorders.¹²

Schizophrenia: Schizophrenia is an illness that affects more than 2 million American adults (about one percent of the adult population). It often interferes with a person's ability to think clearly, to distinguish reality from fantasy, to manage emotions, to make decisions, and to relate to others. The first signs of schizophrenia typically emerge in the late teens or

⁹ Rogers, R. Ed., *Clinical Assessment of Malingering and Deception*, 2nd edition, 1997. p. 48.

¹⁰ Substance Abuse and Mental Health Services Administration: www.allmentalhealth.samhsa.gov/myths_facts.html

¹¹ American Psychiatric Association: www.healthyminds.org/factsheets/LTF-PTSD.pdf

¹² www.medterms.com

early twenties (though often later for females). Most people with schizophrenia contend with the illness chronically or episodically throughout their lives. A person with schizophrenia does not have a "split personality," and almost all people with schizophrenia are not dangerous or violent towards others while they are receiving treatment. The World Health Organization has identified schizophrenia as one of the ten most debilitating diseases affecting human beings.

The symptoms of schizophrenia generally are divided into three categories - Positive, Negative, and Cognitive:

- Positive Symptoms, or "psychotic" symptoms, include delusions and hallucinations. Delusions cause individuals to believe that people are reading their thoughts or plotting against them, that others are secretly monitoring and threatening them, or that they can control other people's minds. Hallucinations cause people to hear or see things that are not present. Auditory hallucinations are much more prevalent than visual hallucinations.
- Negative Symptoms include emotional flatness or lack of expression, an inability to start and follow through with activities, speech that is brief and devoid of content, and a lack of pleasure or interest in life.
- Cognitive Symptoms pertain to thinking processes. For example, people may have difficulty with prioritizing tasks, with certain kinds of memory functions, or with organizing their thoughts. A common problem associated with schizophrenia is the lack of insight into the condition itself. This is not a willful denial but rather a part of the mental illness itself.

Schizophrenia also affects mood. While many individuals affected with schizophrenia become depressed, some also have apparent mood swings and even bipolar-like states. When mood instability is a major feature of the illness, it is called **schizoaffective disorder**, meaning that elements of schizophrenia and mood disorders are prominently displayed by the same individual. It is not clear whether schizoaffective disorder is a distinct condition or a subtype of schizophrenia.

While there is no cure for schizophrenia, it can be treated and managed. People sometimes stop treatment, however, because of the side effects of the medication, the lack of insight noted above, disorganized thinking, or because they feel the medication is no longer working. Others may self-medicate with drugs and/or alcohol, which often can increase their propensity to commit crimes or acts of violence. People with schizophrenia who stop taking prescribed medication are at risk of relapsing into an acute psychotic episode.¹³

Serious Mental Illness (SMI): A term defined by federal regulations that generally applies to diagnosable mental disorders characterized by alterations in thinking, mood, or behavior and associated with distress and/or impaired functioning. Approximately 5.4 percent of the adult population in the United States is affected by SMI.¹⁴

¹³ www.nami.org

¹⁴ U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*: www.surgeongeneral.gov/library/mentalhealth/chapter2/sec2_1.html

For a mental illness to be diagnosable, its symptoms must meet the criteria specified in the Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition (DSM-IV), which is published by the American Psychiatric Association.¹⁵

Severe and Persistent Mental Illness (SPMI): A diagnosis that includes schizophrenia, major depression, and bipolar disorder. Approximately 2.6 percent of the U.S. population is affected with SPMI.¹⁶

A note about language: Consumers of mental health services generally prefer consumer-centered language; that is, it is preferable to refer to “persons or offenders with severe mental illness” rather than “severely mentally ill offenders.” Presented in this way, mental illness is a condition, not an identity.

¹⁵ www.heritage.org/Research/HealthCare/BG1522.cfm

¹⁶ U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*: www.surgeongeneral.gov/library/mentalhealth/chapter2/sec2_1.html

Ideas for Action

Please consider taking one (or more) of these actions to help educate others about the intersection of mental illness and the death penalty:

1. Collect signatures on the **Mental Illness and the Death Penalty Postcards**, which call for a prohibition on the death penalty for offenders with severe mental illness and for increased funding for the mental health system in Texas. Those who sign should keep the top half of the card, which contains facts and quotes about this issue; they should sign and return the bottom half to TCADP. You either can encourage people to send the cards directly to TCADP themselves or collect and send them to the office as a batch.

Postcards will be gathered by TCADP, and the names/contact information of those who sign will be compiled in a database of supporters to be mobilized around specific cases, clemency campaigns, and other relevant issues. Names will not be shared with any other organizations.
2. Organize a **literature table**. Make copies of the Mental Illness and the Death Penalty Fact Sheet and the case studies (Kelsey Patterson, James Colburn, Larry Robison, etc.), and collect signatures on the postcards.
3. Show the film **“Executing the Insane: The Case of Scott Panetti”** and facilitate a discussion (see the discussion guide on pages 13-14 of this resource guide).
4. **Host a speaker** on the topic of mental illness and the death penalty. (See pages 15-16 for a list of available speakers; contact Kristin Houlé to make arrangements.)
5. Be alert to **death penalty cases** in your community that involve issues related to mental illness - either when prosecutors announce their intention to seek the death penalty for someone who may have a severe mental illness or when a severely mentally ill offender on death row receives an execution date. Please notify Kristin immediately at khouletx@gmail.com if you learn of such cases.
6. Become involved with **clemency campaigns** on relevant death penalty cases in Texas as they arise. This entails contacting the Board of Pardons and Paroles and the Governor, writing letters to the editor of your local newspaper, and mobilizing others in your community to take action.
7. *(For students)* **Reach out to professors** in the psychology or social work departments at your college/university or to those at your law school. Encourage them to view the Scott Panetti film in one of their classes or to host a speaker who has worked on the case of an offender with severe mental illness.
8. Write **letters to the editor** in response to articles about mental illness and the criminal justice system.

We want to hear from you! If you or your group organizes an event or activity – or otherwise uses the materials in this organizing packet - please let Kristin know so that she can post it on the **Prevention Not Punishment** blog!

9. Reach out to **mental health advocacy organizations** in your area, such as local affiliates of the National Alliance on Mental Illness-Texas or Mental Health America-Texas (see pages 31-32 for contact information). Ask for a meeting to discuss opportunities for collaboration or invite them to participate in local events (marches, vigils, conferences, local chapter meetings, etc.). Learn how you might support their advocacy efforts on behalf of mental health consumers.
10. Provide mental health organizations, legal organizations, and criminal justice reform organizations in your area with a copy of the **American Bar Association (ABA) recommendation** calling for a prohibition on the death penalty for offenders with severe mental disorders and disabilities. Ask these organizations to secure an endorsement of the recommendation from their boards or governing bodies.

You can find a copy of the ABA recommendation in this packet; it also is available online at www.abanet.org/disability/docs/DP122A.pdf. Please contact Kristin to discuss this action in more detail.

Discussion Guide for “Executing the Insane: The Case of Scott Panetti”

On June 28, 2007, in a 5-4 decision in the case of *Panetti v. Quarterman*, the U.S. Supreme Court ruled in favor of Texas death row inmate Scott Panetti and blocked his execution. Panetti was sentenced to death in 1995 despite his long, documented history of paranoid schizophrenia. The Court questioned the value of executing someone who does not comprehend why he is being put to death; Panetti believes that the state intends to execute him in order to prevent him from preaching the gospel in prison.

The Justices found that the 5th U.S. Circuit Court of Appeals used “an improperly restrictive test” in deciding that Panetti was competent to be executed. The 5th Circuit had said that it did not matter what Panetti believed as long as he could acknowledge the murders as well as the stated purpose of his execution. The Supreme Court decision sent the case back to a federal district judge, who conducted a hearing in February 2008 as to whether Panetti’s delusions are indeed so severe that he cannot make a rational connection between his crime and punishment and should be spared from execution. Panetti remains on death row.

The following discussion questions accompany the DVD “Executing the Insane: The Case of Scott Panetti,” enclosed in this packet. The film also is available on the Texas Defender Service website at www.texasdefender.org/.

1. What feelings or reactions did you have while viewing this film?
2. What scenes or images in the film stand out for you?
3. What new information about the death penalty did you learn from viewing this film?
4. What does this film reveal about the mental health system in Texas?
5. What does this film reveal about the criminal justice system’s treatment of people with severe mental illness?
6. How do you feel about the judge’s decision to allow Scott Panetti to represent himself during the trial?
7. Do you feel that Scott Panetti received a fair trial? Why or why not?
8. Do you feel that the death penalty was an appropriate punishment for Scott Panetti? Why or why not? Is it an appropriate punishment for other people with documented histories of severe mental illness?
9. Someone in the film says that the death penalty is supposed to be reserved for the “worst of the worst.” What does that concept mean to you? Does it apply in cases like that of Scott Panetti?
10. The legal system has essentially recognized two main purposes for the death penalty: retribution and deterrence. Scott Panetti’s attorneys have argued that his execution would not serve either of these purposes. What are your thoughts about retribution and deterrence? Are these valid reasons to have the death penalty? Is there a difference between retribution and vengeance?

11. What does this film reveal about the impact of the death penalty on the families of those sentenced to die?
12. How do the media typically portray the families of those who are incarcerated or on death row? How are they treated in society?
13. How has the story of Scott Panetti affected your own feelings about the death penalty in Texas?
14. What do you think should be the outcome of Scott Panetti's case?

For more information on Scott Panetti, please see the case study included in this packet or visit these websites:

- www.thejusticeproject.org/press/releases/panetti-briefs.html
- www.texasdefender.org/

Available Speakers on Mental Illness and the Death Penalty

Please contact Kristin Houlé at khouletx@gmail.com or 512-441-1808 to arrange a speaking event with any of the individuals listed below. We will continue to add names to this list.

Mike Halligan

Mike Halligan is the Executive Director of Texas Mental Health Consumers, a non-profit agency based in Austin that is designed to encourage, educate, train, and organize persons with mental illness to advocate for themselves and support each other. Mike is a consumer of mental health services, but does not consider himself disabled. He earned a master's degree in counseling psychology, after spending 14 years in the oil field. Mike has worked as a direct care provider for mentally ill and mentally retarded consumers, both adults and children. He has also worked as a volunteer for several victim programs including Rape Crisis Services, the Child Assault Prevention Project, Building Bridges, People Against Violent Crime, Williamson County Victim's Assistance Program, State School Volunteer Organization, and Court Appointed Special Advocate (CASA).

Mike is currently the Chairman of the Texas Mental Health Planning and Advisory Council and serves on the board for the National Association of Mental Health Planning and Advisory Councils. He serves on numerous state committees dealing with issues relating to mental illness. He is a Licensed Professional Counselor in Texas.

Genevieve Tarlton Hearon

Genevieve Tarlton Hearon has served on the Austin Travis County Mental Health Mental Retardation Center's Board of Trustees since 1993. She is the founder and president of *Capacity* FOR JUSTICE, a non-profit organization which promotes the fair, just, and humane treatment of people with mental disabilities in the criminal justice system. Years ago, Genevieve spearheaded the formation of the Texas Alliance for the Mentally III (TxAMI) and the Austin Alliance for the Mentally III (AAMI), both affiliates of the National Alliance for the Mentally III (now the National Alliance on Mental Illness [NAMI]). She is the parent of a daughter with schizophrenia and a son with mental retardation.

John Larson

John Larson has served as a pen pal and visitor for Texas death row inmate Scott Panetti for numerous years. He lives part of the year in Minnesota and part in Livingston, Texas.

Walter Long

Walter Long is a criminal defense attorney practicing in Austin, Texas. He is licensed to practice in state and federal courts, the Fifth Circuit Court of Appeals, and the U.S. Supreme Court. For approximately a decade, he has represented Texas death row inmates in post-conviction appeals in courts at all levels. He is particularly interested in the relationship between international human rights law and the death penalty and was involved in the litigation process that ultimately led to the elimination of the juvenile death penalty in the United States. Walter worked on two capital cases involving death row inmates with severe mental illness: Kenneth Granviel and Harold Barnard.

Lois Robison

Lois Robison is the mother of Larry Robison, who was executed by the State of Texas in 2000 despite evidence of his long history of mental illness. Mrs. Robison lives in Fort Worth.

Brian Shannon

Professor Brian Shannon is a faculty member at Texas Tech University School of Law in Lubbock. In addition to his teaching duties, Professor Shannon serves on the Governor's Committee on People with Disabilities, having been appointed in 2003. He also serves as board chair of the Lubbock Regional Mental Health & Mental Retardation Center and is the Lubbock County delegate to the Dispute Resolution Center Advisory Board. Professor Shannon is an elected member of the American Law Institute and the President-Elect of the Lubbock County Bar Association. He has served on the boards of directors of Advocacy, Inc., the Lubbock County Bar Association, NAMI-Texas, and the Texas Council of Community Mental Health & Mental Retardation Centers. He is also a past chair of the State Bar of Texas Disability Issues Committee and a former Council member of the State Bar ADR Section. He and Professor Dan Benson have co-authored three editions of the book, Texas Criminal Procedure and the Offender with Mental Illness. He served through appointment by the Lt. Governor on a task force in 2002-03 that re-wrote the state's criminal competency statutes. In 2002 he received the Outstanding Law Review Article Award from the Texas Bar Foundation, and he received the 2001 Mary Holdsworth Butt Award from the Texas Department of Mental Health & Mental Retardation for outstanding volunteer service.

Executions of Offenders with Severe Mental Illness in Texas

This is a comprehensive compilation of all known executions to date involving offenders with severe mental illness in Texas. All of these individuals have been executed or died while on death row; their cases are presented in chronological order according to year of death. More in-depth case studies on select individuals appear elsewhere in the packet.

1985

Charles Rumbaugh¹⁷

Shortly before murdering Michael Fiorillo during a robbery in 1975, Charles Rumbaugh escaped from a mental hospital where he was being treated for bipolar disorder. He had spent most of his life in jails, reform schools, and mental hospitals. He twice attempted suicide in the Potter County Jail while awaiting trial.¹⁸ Rumbaugh, who was 17 at the time of the crime, gave up his appeals. In a dissenting opinion regarding his competency to waive his appeals, two U.S. Supreme Court Justices wrote that "Rumbaugh seeks death because he knows himself to be mentally ill and has lost hope of obtaining treatment. If not for his illness and his pessimism regarding access to treatment, he would probably continue to challenge his death sentence; but faced with his vision of life without treatment for severe mental illness, Rumbaugh chooses to die... a choice of a desperate man seeking to use the State's machinery of death as a tool of suicide."¹⁹

¹⁷ Unless otherwise noted, the primary source for all synopses is *USA: The Execution of Mentally Ill Offenders*. Amnesty International, January 2006.

www.amnestyusa.org/document.php?lang=e&id=ENGAMR510022006

¹⁸ www.tdcj.state.tx.us/statistics/deathrow/executed/rumbaugh.jpg

¹⁹ Justices Marshall and Brennan dissented:

<http://caselaw.lp.findlaw.com/scripts/getcase.pl?court=us&vol=473&invol=919>

1988

Robert Streetman

Robert Streetman sustained a serious head injury as a child and thereafter suffered from numerous mental problems, including persistent delusions and hallucinations. He started taking drugs when he was 8 and dropped out of school at 14. His court-appointed attorney failed to raise issues of his mental impairment at his brief 1983 trial. Streetman sought to forego his appeals, but later changed his mind. Twenty-two at the time of the crime, he was sentenced to death for the murder of a woman during a burglary of her home. Two of his three accomplices served no prison time at all in return for their cooperation with the prosecution.

1990

James Smith

James Smith had a long history of mental illness. In 1978 he was found not guilty by reason of insanity in a Florida case. In 1981, he attempted suicide and was placed under psychiatric care. He was sentenced to death in Texas for a crime committed in 1983. In 1985, a Texas court found him not competent to handle his appeal. A psychiatrist concluded that he suffered from paranoid schizophrenia, "marked by suicidal tendencies and religious delusions." Two U.S. Supreme Court Justices dissented from the decision to allow his execution to go ahead "when serious doubts remain concerning his mental competence" to waive his appeals. Smith "volunteered" for execution in 1990.

1992

Johnny Frank Garrett

Johnny Frank Garrett was executed for the 1981 murder of a nun, a crime committed when he was 17 years old. The execution proceeded despite his long history of severe mental illness and childhood abuse. One expert called him “one of the most profoundly and pervasively disabled people I’ve encountered in the last 25, 28 years of practice.”²⁰

As a youth, Garrett was subjected to horrific sexual abuse by his stepfather and other men. He was introduced to alcohol and other drugs by family members at the age of ten and subsequently indulged in brain-damaging substances such as paint-thinner and amphetamines. Garrett was beaten regularly and had a history of blackouts.²¹

Information on Garrett's abusive upbringing and mental health problems was not presented to the jury. According to three mental health experts who examined him between 1986 and 1992, Garrett was extremely mentally impaired, chronically psychotic, and brain-damaged as the result of the severe head injuries he sustained as a child. He suffered from delusions, including a belief that the lethal injection would not kill him. He also experienced audio hallucinations about his deceased aunt and reported seeing and communicating with her regularly. Diagnosed as paranoid schizophrenic, he was under psychiatric care and medicated throughout his time on death row.²²

Garrett’s attorneys argued that he was incompetent to be executed because he could not comprehend his own

²⁰ Testimony of Dr. Windel Dickerson, State Habeas Hearing, February 2, 1989.

²¹ *The Death Penalty in Texas: Lethal Injustice*. Amnesty International, March 1988. <http://web.amnesty.org/library/Index/engAMR510101998>.

²² Ibid.

mortality – instead, he believed that he would be saved from the toxic effect of poisons injected into his body by the supernatural intervention of his long-dead aunt. According to one appeal, “every expert to examine Mr. Garrett in this case has reported this firmly held delusion.”²³

The U.S. Court of Appeals for the Fifth Circuit upheld a state court finding that Garrett’s belief that his dead aunt would protect him from the lethal chemicals did not render him incompetent to be executed. Following appeals for clemency from Pope John Paul II and the nuns from the victim's convent, then-Governor Ann Richards granted Garrett a rare 30-day reprieve. After a grossly inadequate clemency hearing, however, the Texas Board of Pardons and Paroles voted unanimously to allow his execution to proceed.

1992

Robert Black

Robert Black was diagnosed with Post-Traumatic Stress Disorder (PTSD) as a result of his experiences in the Vietnam War. He was twice hospitalized in mental institutions.

1994

Harold Barnard

Several months before committing the murder that sent him to death row, Harold Barnard sustained severe head injuries that went largely untreated. According to his mother, his personality and ability to function changed dramatically after this incident. During his 13 years on death row, Barnard’s serious mental illness became increasingly pronounced. By the time his execution date was set in early 1994, all the mental health professionals (including

²³ *Petitioner’s Opposition to Respondent’s Motion to Vacate*, in the U.S. Court of Appeals for the Fifth Circuit. January 6, 1992.

five prison doctors) who had examined, diagnosed, and treated him over the years agreed that he could not understand the reason for or reality of his execution and therefore was incompetent to be executed. Their records indicated that he had a long-standing history of auditory hallucinations and delusions, which centered on members of the mafia who were trying to have him killed. He was diagnosed as paranoid schizophrenic.

Two additional forensic experts retained by his attorneys also concluded that Barnard was profoundly psychotic and that his delusional thinking prevented him from understanding why he was to be put to death. His attorneys argued that Barnard's mental illness prevented him from rationally communicating with them or assisting in his own defense.

The state produced one expert, Dr. Edward Gripon, who contradicted the testimony of seven different psychiatrists and psychologists. After a cursory examination, he concluded that Barnard was mentally ill but still competent to be executed. The state court sided with Dr. Gripon and denied relief. The federal courts refused to stop the execution.

1995

John Fearance

John Fearance's claim that he was incompetent to be executed was unsuccessful. There was evidence that he suffered from paranoid schizophrenia. He also claimed that his rights had been violated when he was forcibly medicated to render him competent for execution, but this also was rejected on the basis that the claim should have been raised earlier. He tried to make amends in his last statement: "I would like to say that I have no animosity toward anyone. I made a mistake 18 years ago – I lost control of my mind but I didn't mean to hurt anyone. I have no hate toward

humanity. I hope He will forgive me for what I done. I didn't mean to."²⁴

1995

Karl Hammond²⁵

As a child, Karl Hammond was severely abused by his parents and witnessed his father sexual abuse his sisters. When he was 9, he witnessed his older brother kill and mutilate their father after a confrontation about this abuse. From the age of 10, Hammond experienced frequent visual and auditory hallucinations, which apparently commanded him to commit "bad acts." He began using drugs around this same time. He was examined by several doctors who concluded he suffered from severe mental illness, including Post-Traumatic Stress Disorder and schizophrenia, and who prescribed numerous anti-psychotic medications to help control his psychotic episodes. In addition, experts determined that Hammond had borderline mental retardation and suffered from moderate organic brain impairment. Upon his release from prison in Bexar County for an earlier offense, Hammond sought to obtain medication and to contact a psychiatrist who had treated him within the Texas Department of Corrections, but he was unable to receive treatment.

None of this substantial mitigating evidence was presented to the jury that sentenced him to death in 1986. His attorneys failed to investigate his childhood or review his psychiatric history. Post-trial records revealed that they spent less than \$500 on their entire investigation.

²⁴ www.tdcj.state.tx.us/stat/fearancejohnlast.htm

²⁵ *Application for Reprieve/Clemency and Memorandum in Support Thereof*, Filed with Governor George Bush, 1995.

1996

Kenneth Granviel²⁶

Kenneth Granviel experienced his first psychotic episode at the age of 16, when he attempted to assault his mother. He was transported to a psychiatric ward at John Peter Smith Hospital in Fort Worth and then placed in the custody of the Texas Youth Commission. He later joined the army and was sent to Vietnam, where he went A.W.O.L; somehow he obtained an early honorable discharge.

Granviel committed several brutal, senseless murders of female acquaintances in 1975. At his trial, his attorneys presented an insanity defense. They retained Dr. John Holbrook to assess his sanity; although his findings were meant to be confidential, the state petitioned the judge to order Dr. Holbrook to prepare a report for the prosecution. The state then called him as a witness, where he testified that in his opinion, Granviel was sane at the time of offense. Dr. Holbrook died after the first trial.²⁷

Subsequently, the 5th Circuit reversed the conviction and sentence and the case returned to the original trial judge. At that time, Granviel's mental illness prevented him from providing his attorneys with meaningful assistance. They petitioned for appointment of a forensic psychologist in order to determine his competency to stand trial. The state moved for a complete competency and sanity evaluation. In 1983, the trial court granted the motion and moved Granviel to Rusk State Hospital.²⁸

Two treating psychiatrists and one treating psychologist at Rusk State Hospital testified at his competency hearing that Granviel was schizophrenic and incompetent to stand trial.

²⁶ *Clemency Petition to Governor George Bush*, February 27, 1996.

²⁷ *Suggestion for Reconsideration and Motion for Stay of Execution*, Filed in the Texas Court of Criminal Appeals. February 1996.

²⁸ *Clemency Petition*

They reached their conclusions independently after 23 days of close observation. The prosecution then introduced two state psychiatrists (including Dr. James Grigson – “Dr. Death”²⁹) who had never interviewed Granviel but rather testified on the basis of hypothetical questions. The jury sided with the state and found Granviel competent.³⁰ During his second trial, his attorneys again presented an insanity defense, but it was rejected. The state had been allowed to introduce the original testimony of Dr. Holbrook, even though there was no opportunity for the defense to question him or rebut his evaluation.

All of the treating psychiatrists during his 21 years on death row agreed that Granviel was mentally debilitated by schizophrenia. He subsisted on regular doses of Haldol, a powerful anti-psychotic medication. According to his treating physicians, he suffered stages of acute decompensation, when he lapsed into delusional, paranoid states; his speech became incoherent and he experienced auditory hallucinations. During those times, his doctors found Granviel to be so out of touch with reality as to have lost all comprehension of why he was on death row.

1997

Robert Madden

Robert Madden suffered from brain damage and was diagnosed with schizophrenia, as a result of his substantial thought disorder and delusions. According to his medical records, he first saw a psychiatrist at age 3 (and again at

²⁹ Dr. Grigson was known as “Dr. Death” because his testimony was instrumental in sending so many people to death row. He later was expelled from the American Psychiatric Association and Texas Society of Psychiatric Physicians because of his unethical, unscientific testimony in such cases.

³⁰ Sydnor, Rev. Jon Paul. *How Many Innocent People Did He Execute? The Texas Death Penalty Under Governor George W. Bush. Chapter Four.* www2.bc.edu/~sydnor/4.html.

ages 7 and 15).³¹ There is strong evidence to suggest that he was not capable of assisting his attorney, for whom Madden's trial was his first capital case as lead counsel (and only his second capital murder case ever). In an apparent conflict of interest, this attorney previously had represented the state's key witness against Madden in divorce proceedings.³²

At his trial, a clinical psychologist testified that as a result of his long-term substance abuse, combined with his mental illness, Madden suffered from "permanently clinically diminished capacity." This condition limited his ability to reason, communicate, deliberate, or weigh the consequences of his actions.³³

Reports suggest that Madden's mental state deteriorated while he was on death row. Both his original trial and appellate attorneys questioned his understanding of his pending execution.³⁴ A psychiatrist who examined Madden 12 days before his execution reported that he was incompetent for execution. Madden believed that he would not be executed because his "will" was stronger than that of those who would put him to death. He also believed his "will" could make him pass through brick walls and that the poison they would give him during the execution would not work.³⁵ He claimed innocence in his final statement, and his last sentences before being put to death were recorded by the Texas Department of Criminal Justice as "unintelligible."³⁶

³¹ *Report of Allen Childs, M.D., F.A.P.A.*, May 17, 1997.

³² *Affidavit of William F. Carter*, May 21, 1997.

³³ *Application for Post-Conviction Writ of Habeas Corpus* in the 12th Judicial District Court of Leon County, Texas. May 21, 1997.

³⁴ *Affidavit of William F. Carter*.

³⁵ *Report of Allen Childs*.

³⁶ www.tdcj.state.tx.us/stat/maddenrobertlast.htm

1998

Joseph John Cannon

Joseph Cannon was executed for a crime committed when he was 17. A post-conviction examination resulted in a diagnosis of organic brain syndrome. At the age of four he was hit by a truck and suffered a fractured skull and other injuries. He was in the hospital for 11 months and unconscious for part of that time. His head injury left him hyperactive and uncontrollable. He suffered from a speech impediment and did not learn to speak clearly until he was six. He was expelled from school in first grade and received no further formal education. He drank and sniffed gasoline and at the age of 10 was diagnosed as suffering from organic brain damage as a result of the solvent abuse. Cannon also was diagnosed as suffering from childhood schizophrenia and treated in mental and psychiatric hospitals from an early age. He was sexually abused by his stepfather (his mother's fourth husband) from ages seven to eight, and between the ages of ten and seventeen he was regularly sexually assaulted by his grandfather.³⁷ Psychologists, psychiatrists, and educational diagnosticians repeatedly confirmed Cannon's mental impairments and recommended intensive, long-term help. Instead, he was sent to a youth camp, where he tried to commit suicide by drinking a bottle of insecticide.³⁸

At his murder trial in 1980, the jury rejected Cannon's plea of not guilty by reason of insanity and sentenced him to death. His conviction was overturned on procedural grounds in 1981 and he was re-tried in 1982. At his second trial he pleaded not guilty. This time, his lawyers offered no mitigating testimony concerning his mental health or disturbed upbringing. They feared that while his history might help explain his behavior, it also would show he was a continuing danger. Provided with no information on his

³⁷ Sydnor, Rev. Jon Paul. www2.bc.edu/~sydnor/1.html#_ftn5.

³⁸ Editorial, *Dallas Morning News*, April 19, 1998.

shockingly depraved background, the jury sentenced Cannon to death.³⁹

A psychologist who later examined Cannon considered his case history “exceptional” in the extent of the brutality and abuse he had suffered as a child. He concluded that such was the “depravity and oppressiveness” of his upbringing that Cannon thrived more on death row than he ever did in his home environment.

1998

Emile Duhamel⁴⁰

Emile Duhamel was sentenced to death in 1985 despite a diagnosis of schizophrenia, major depression, dementia, and an IQ of 56. During a hearing to determine his competency to stand trial, a court-appointed psychologist testified that Duhamel was not aware of the proceedings against him, was not able to assist his court-appointed attorney, and was not competent to stand trial. For the prosecution, two jail guards and a jail nurse testified that Duhamel “seemed normal” to them. After 39 minutes of deliberation, the jury found him competent to stand trial. During his capital murder trial, his attorney presented no mitigating evidence of his mental illness.

Once transferred to death row, he was placed on the psych unit and treated with psychotropic drugs. His mental health progressively deteriorated, and he experienced severe and persistent auditory and visual hallucinations. He also was diagnosed with permanent organic brain damage. Duhamel repeatedly refused to meet with his attorneys, because he thought they were conspiring against him. He believed that

³⁹ Ibid.

⁴⁰ Information about this case, including court filings and transcript of an interview conducted with Duhamel by his attorneys, is available at <http://lonestar.texas.net/~acohen/>.

he had died already, that prison officials in Brownsville had put a machine in him to keep an eye on him, that he was winning millions of dollars from slot machines, that he was a woman, and that crystals would give him four more lives.

Despite his multiple mental incapacities, Duhamel was declared competent to be executed after a 14-minute hearing at which he was not represented by a lawyer and presented no mental health expert. The courts ultimately stayed his 1996 execution date to reconsider his competency to be executed. Before his case could be resolved, however, Emile Pierre Duhamel was found dead in his cell on July 9, 1998 in the midst of a record-breaking heat wave. Although the cause of death was officially listed as complications from diabetes, the heat appeared to be a major factor, as psychotropic medications can heighten body temperature. Except for certain special units and hospitals, none of the cells in Texas prisons are air conditioned. Duhamel did not have a fan in his cell.⁴¹

2000

Larry Robison⁴²

Larry Robison was diagnosed with paranoid schizophrenia at the age of 21, three years before the murders for which he was sentenced to die. He began hearing voices and acting strangely as a teenager, claiming to have secret paranormal mental powers and the ability to read people’s minds and move objects from a distance. He joined the Army but was discharged after only a year. Robison’s parents sought help and warned mental health authorities of their son’s erratic and increasingly aggressive behavior, but were told that the state could offer no resources unless he turned violent. He was shuffled in and out of mental hospitals, admitted after

⁴¹ Sydnor, Rev. Jon Paul. www2.bc.edu/~sydnor/4.html.

⁴² For more information, see *Time for Humanitarian Intervention: The Imminent Execution of Larry Robison*. Amnesty International, 1999. <http://web.amnesty.org/library/print/ENGAMR511071999>

aggressive behavior and released after a period of medicated passivity. He received no regular, ongoing treatment. Robison was not covered by his parents' insurance, nor did he have his own.⁴³

Robison claimed that voices in his head, which came through the clocks in his room, spewed out warnings about Old Testament prophecies of the Apocalypse and told him to murder, behead, and mutilate his roommate, Bruce Gardner. Robison then went next door and murdered four of his neighbors. When authorities arrested him, he told them that he had committed the murders in order to "find God."⁴⁴

The four prosecutors developing the case against Larry Robison recognized his past history of mental illness and were willing to accept an insanity plea in exchange for life in a mental institution. The Tarrant County district attorney overruled them, however, and ordered them to seek a death sentence. In the courtroom, most evidence of Robison's mental illness was ruled inadmissible, so the jury heard little of it.⁴⁵ None of the three doctors who had diagnosed Robison before the crime as suffering from paranoid schizophrenia were called to testify at his trial.⁴⁶ The jury rejected his plea of not guilty by reason of insanity.

Once in prison, evidence of Robison's mental illness continued to accumulate. The Texas Court of Criminal Appeals stayed his execution at one point, doubtful as to whether or not he was competent to be executed. When asked what the execution would be like, Robison replied that he felt like "a little kid at Christmas time waiting for Santa Claus to come." Eventually, he demanded that his

lawyers cease filing appeals based on his mental illness, but only if the state agreed to execute him on the night of a full moon.⁴⁷ Despite protests from mental health organizations and concerned citizens throughout the world, the state complied.⁴⁸

2000

Ramon Mata

Ramon Mata vacillated between appealing his death sentence and asking to be executed as soon as possible. He had a long history of mental illness, received medication in prison, and attempted suicide several times while on death row. A court-appointed psychologist and a psychiatrist both concluded that Mata was not competent to drop his appeals. The psychiatrist had determined that he was suffering from a paranoid delusional disorder and that his suicide attempts and his delusions of seeing and talking with his murder victim were genuine. His attorneys urged a federal judge to declare Mata incompetent to waive his appeals or to hold a hearing to determine the issue. The federal judge described the defense motion as "trendy and trashy psycho-analytical analysis" and dismissed it without ruling on Mata's competency.

In 1999, after further vacillation by Mata, the judge ruled him competent, without having held any hearings or ordered any further examination. The court based its decision on the fact that Mata had been found competent to stand trial 13 years earlier. On July 6, 2000, Ramon Mata died on death row; his cause of death was listed as "natural causes (septic shock)."⁴⁹

⁴³ Sydnor, Rev. Jon Paul. www2.bc.edu/~sydnor/4.html.

⁴⁴ "Just Another Night on Texas' Death Row," *National Catholic Reporter*, February 4, 2000.

⁴⁵ *Texas Observer*, August 6, 1999.

⁴⁶ *Ibid.*

⁴⁷ Sydnor, Rev. Jon Paul. www2.bc.edu/~sydnor/4.html.

⁴⁸ See "Texas Executed Our Mentally Ill Son" by Lois Robison in the packet for more details about this case.

⁴⁹ www.tdcj.state.tx.us/stat/permanentout.htm

2000

Juan Soria

Last-minute appeals to stay Juan Soria's execution on the grounds that he was incompetent to be executed were unsuccessful. He had a history of self-mutilation and suicide attempts, including one a few days before his execution. On the eve of his execution, a psychologist employed by the defense to examine Soria concluded that he was not competent. A judge rejected the claim. Local reports of the execution noted that as he was strapped to the gurney, he was "covered with sheets to conceal numerous self-inflicted wounds." Soria concluded his rambling final statement with the comment that "They say I'm going to have surgery, so I guess I will see everyone after this surgery is performed."⁵⁰

2000

John Satterwhite

John Satterwhite's first conviction was overturned because he was forced to meet with a psychiatrist, James "Dr. Death" Grigson, without his lawyer. The juries for two subsequent competency hearings were unable to decide whether Satterwhite was mentally fit to stand trial. A third jury decided he was competent enough to understand the proceedings against him. At his 1989 retrial, a psychiatrist formerly employed by the state prison system testified for the defense that Satterwhite had suffered from chronic paranoid schizophrenia since his teens. He also concluded that Satterwhite had borderline mental retardation. A second expert endorsed this diagnosis.

A psychiatrist testified for the state, however, that he believed Satterwhite was neither mentally ill nor mentally retarded. After the trial, two state medical documents came to light which had been suppressed prior to trial, both of

⁵⁰ www.tdcj.state.tx.us/stat/soriajuanlast.htm

which supported the defense's claim that Satterwhite was mentally ill.⁵¹ Regardless, he was executed in 2000.

2001

Dennis Dowthitt

Dennis Dowthitt suffered from mental illness from the time he was a teenager. His original trial lawyers did not investigate this issue or the abuse he suffered as a child. One of several mental health experts who assessed Dowthitt after his conviction concluded that his profile was "consistent with paranoid and schizophrenic features." A second expert stated that the tapes of Dowthitt's interrogation showed his "severe mental problems." None of this information was presented to the jury that sentenced him to death.

2001

Miguel Richardson

Miguel Richardson was diagnosed with bipolar disorder and medicated on death row. A psychiatrist who examined him and reviewed his history concluded that he was likely suffering from a manic episode at the time of his offense. The jury at his 1981 trial never heard mitigating evidence that Richardson suffered extreme physical and sexual abuse as a child; it also was not aware of his bipolar disorder, since it was diagnosed later in life. This evidence could have provided strong mitigating grounds for deciding upon a life sentence, rather than death.⁵²

His appeals focused primarily on his mental competency and whether he should be given anti-psychotic drugs by prison officials to keep him competent. A state trial court rejected his claims that he was incompetent to be executed or was

⁵¹ Syndor, Rev. Jon Paul. www2.bc.edu/~sydnor/4.html.

⁵² ACLU: *Miguel Richardson Clemency Letter*. June 25, 2001. www.aclu.org/capital/clemency/103791g120010625.html

forcibly medicated to be rendered competent. Federal courts also denied his appeals on these grounds.⁵³

2001

Jeffrey Tucker

As a child, Jeffrey Tucker was physically, sexually, and emotionally abused. By the age of 5, he had sustained a number of serious head injuries and had been molested. By the age of 8, he had been physically abused by a number of adults and older children, had suffered further head injuries, had been raped, and had been introduced to marijuana. By the time Tucker was 11, a state psychiatrist concluded that he would not be mentally stable unless he stayed on anti-psychotic medication for the rest of his life. He reportedly responded well to the medication, but his mother failed to refill his prescription.⁵⁴

In 1997, a psychiatrist concluded that Tucker suffered from brain damage and Post-Traumatic Stress Disorder. His trial lawyers did not present evidence of his mental illness to the jury and presented only minimal mitigating evidence about his horrific childhood. They later admitted that “it was certainly not due to any legal strategy, tactic or plan that we neglected to pursue and introduce documents or testimony regarding Mr. Tucker’s mental illness at either phase of the trial. In fact, such evidence would have helped us immeasurably. The idea of investigating a client’s childhood and mental health history was new to us.” According to the ACLU, the state had ample records both of the diagnoses issued to Tucker as a child and his mother’s failure to administer the medications, but it failed to turn these records over to Tucker’s trial attorney.⁵⁵

⁵³ www.oag.state.tx.us/newspubs/newsarchive/2001/20010625richardsonfact.s.htm

⁵⁴ www.clarkprosecutor.org/html/death/US/tucker742.htm

⁵⁵ *ACLU: Jeffrey Tucker Clemency Letter*. September 7, 2001. www.aclu.org/capital/clemency/104581g120010907.html

In 2001, the U.S. Court of Appeals for the Fifth Circuit stated that “we do not profess to be unmoved by the dreadful circumstances of Tucker’s childhood, and we understand the relevance of such evidence to the jury’s determination of Tucker’s moral culpability at the time he committed the murder.” Nevertheless, the Court upheld his death sentence and allowed his execution to proceed.

2002

Monty Delk⁵⁶

Sentenced to death in 1988 for a crime committed at the age of 19, Monty Delk displayed a pattern of disturbed behavior during his years on death row. In 1990, the prison medical authorities diagnosed him with bipolar disorder with psychotic features; they also raised the possibility that he was suffering from schizoaffective disorder. Delk repeatedly expressed delusional beliefs - that he was a submarine captain, a CIA or FBI agent, or a member of the military (among countless others). At a court hearing in 1993, he responded to the judge in prolonged streams of unbroken gibberish. At another hearing in 1997 to determine his competency to proceed with state habeas appeals, Delk was gagged and then removed from the courtroom after repeatedly interrupting the court with nonsensical utterances.

While prison officials later declared that Delk was “malingering to avoid execution,”⁵⁷ a former chief mental health officer with the Texas prison system said that his review of the prison records and his own contact with Delk suggested that he suffered from a severe mental illness that was progressive in nature. Delk’s execution was allowed to proceed on the basis of a determination by a trial judge in

⁵⁶ See the in-depth case study for more information.

⁵⁷ This was based on a single incident where a prison “psych tech” claimed to overhear Delk say to another inmate that he was “playing the crazy fool” and would not be executed.

1998 (four years before his actual execution date) that he was competent to be executed. The courts refused to conduct a thorough mental health examination at the time of his execution.⁵⁸ Strapped down for execution, Delk shouted gibberish and obscenities:

"I've got one thing to say, get your Warden off this gurney and shut up. I am from the island of Barbados. I am the Warden of this unit. People are seeing you do this."⁵⁹

2002 Rodolfo Hernandez

Rodolfo Hernandez's medical records revealed that he had been diagnosed with chronic paranoid schizophrenia and treated with anti-psychotic medication and electro-shock therapy in the 15 years before his capital conviction. Before his 1985 trial, there were doubts about his sanity at the time of the crime and his competence to stand trial. The court-appointed expert who examined Hernandez, Dr. John Sparks, did not review his extensive psychiatric or medical records, except for a single 1974 report indicating that Hernandez suffered from schizophrenia. He concluded that Hernandez had an anti-social personality disorder, was not mentally ill, and was competent to stand trial.

During the sentencing phase of Hernandez's trial, the prosecution used Dr. Sparks' diagnosis of anti-social personality disorder to imply that Hernandez would commit future acts of criminal violence and hence pose a continuing threat to society. Under questioning, Dr. Sparks testified that if he had reviewed Hernandez's records, he would have diagnosed him with paranoid schizophrenia in remission as well as anti-social personality disorder. The damage was

⁵⁸ *Clemency Petition to the Texas Board of Pardons and Paroles*, Filed by John Wright, February 5, 2002.

⁵⁹ www.tdcj.state.tx.us/stat/delkmontylast.htm

already done, however, and Hernandez's death sentence survived the appeals process with minimal dissent.

2002 Jermarr Arnold

To the best of his recollection, Jermarr Arnold spent all but 15 months of his adult life behind bars or in psychiatric institutions. He was diagnosed with schizophrenia in 1978 and again in 1983, months before the crime for which he was sentenced to death. In fact, he murdered Christine Sanchez during a robbery in Corpus Christi just two months after escaping from the Colorado State Hospital where he was being treated for severe schizophrenia.⁶⁰

After fleeing to California, Arnold carried out an armed robbery in 1984 for which he was sentenced to five years in prison. He served some time at Folsom State Penitentiary but then was transferred to the California Medical Facility, where he was charged with several assaults. One of his treating psychiatrists indicated that when off his medication, Arnold was highly dangerous; even with medication, he continued to be severely mentally ill. Another psychologist found him to be chronically mentally ill and recommended that he be placed in a secure inpatient psychiatric facility. He was considered suicidal and engaged in self-mutilation.⁶¹ In August 1987, a California court found him not guilty by reason of insanity of pending charges and ordered that he be committed to Atascadero State Hospital.⁶²

In 1988, the Nueces County District Attorney in Texas received a letter from Arnold, which claimed to have information about the Sanchez murder in Corpus Christi.

⁶⁰ www.ccadp.org/jermarrarnold.htm

⁶¹ Placement Evaluation by Mental Health Services of California, August 13, 1987.

⁶² *California v. Arnold. Order Committing Defendant to Department of Health*, Superior Court of California, County of Solano. August 14, 1987.

Texas Rangers interviewed Arnold in California, where he confessed to the crime. He was transferred to Texas to stand trial.⁶³

Evidence suggests that Arnold's mental illness affected his ability to assist his lawyers during the trial and interfered with the fairness of the proceedings in general.⁶⁴ He often insisted on directing his own defense and demanded jurors that would be likely to impose a death sentence. He did not allow his attorneys to present mitigating evidence, cross-examine witnesses, ask for mercy, or make a closing argument.⁶⁵ The jury quickly convicted him and sentenced him to death.

2003

James Colburn⁶⁶

James Colburn was diagnosed with schizophrenia as a teenager and spent time in and out of mental health institutions, crisis centers, and prison. In the week leading up to the murder of Peggy Murphy, he was allegedly experiencing auditory and visual hallucinations, some of which commanded him to commit suicide. Colburn turned himself in to the police and gave a videotaped confession in which he could be seen rocking back and forth and shaking uncontrollably. While in jail awaiting trial, he was placed on suicide watch on several occasions.

During his 1995 trial, Colburn received injections of Haldol, an anti-psychotic drug which caused him to sleep throughout the proceedings and to appear emotionless.

⁶³ Carson, David. *Texas Execution Information – Report: Jermarr Arnold*. January 16, 2002. www.txexecutions.org/reports/258.asp.

⁶⁴ *ACLU: Jermarr Arnold Clemency Letter*. January 15, 2002. www.aclu.org/capital/clemency/104631g120020115.html

⁶⁵ Carson, David. *Texas Execution Information – Report: Jermarr Arnold*.

⁶⁶ See the in-depth case study for more information.

Numerous experts later questioned whether Colburn had been competent to stand trial.

2004

Kevin Zimmerman

Kevin Zimmerman was charged originally with murder, not capital murder. He was appointed a succession of lawyers who all withdrew from the case for various reasons, having done little or no work on it. After a year, Zimmerman wrote letters to the prosecutor and court, effectively daring them to charge him with capital murder. They complied. A doctor who later reviewed the case stated in an affidavit that the claims in Zimmerman's letters were "patently absurd" and that the records indicate that at the time he was "psychotic", "potentially suicidal and required suicide prevention measures."

His trial lawyers, who had no capital trial experience, failed to have Zimmerman evaluated for his competency to stand trial, even though there was evidence that he might not be able to assist in his own defense. They did not investigate his family background and did not learn that he had a history of mental problems beginning after a serious bicycle accident at the age of 11. They did not contact any of the relatives and neighbors who could have testified that his personality and behavior changed after the accident. They also failed to present expert psychiatric evidence that could support his claim of self-defense or serve as mitigating evidence against the death penalty. In 1997, an expert who evaluated Zimmerman found that his childhood brain injury had "materially affected his behavioral control, both as an adolescent and at the time of the stabbing". In 1995 another doctor had concluded that Zimmerman showed signs of a mental disorder characterized by impaired impulse control and judgment. In 2003, a psychologist concluded that Zimmerman's "behavior at the time of the crime and around the time of his trial raises the strong

probability that he was suffering from a separate mental illness or disorder” at those times.

2004

Kelsey Patterson⁶⁷

Kelsey Patterson was hospitalized on numerous occasions and diagnosed with chronic paranoid schizophrenia in 1981. Before committing the murders that sent him to death row, he carried out several irrational and motiveless assaults on co-workers. In those instances, he was found incompetent to stand trial and later deemed insane, because he was unable to conform his conduct to the law. Prosecutors dropped the charges against him, but the state did nothing to prevent him from committing future acts of violence or ensure that he received long-term treatment for his mental illness.

Patterson developed an elaborate system of delusions and conspiracy theories. He believed that people were trying to poison him and that he had devices implanted in his body that tried to control him. After shooting Louis Oates and Dorothy Harris in 1992 - two people with whom he was only casually acquainted - Patterson put down the gun, stripped to his socks, and paced, shouting incomprehensibly, until the police arrived. He constantly disrupted both his competency hearing and trial and generally refused to assist his attorneys, believing that they were involved in the evil plot against him.

During his time on death row, he refused to meet with mental health professionals or his lawyers, which made it impossible to formally assess his competence. After learning of his execution date, Patterson wrote rambling letters to various officials, in which he referred to a “permanent stay of execution” that he had received on

⁶⁷ See the in-depth case study for more information.

grounds of innocence. Although Patterson received an extremely rare recommendation of clemency from the Texas Board of Pardons and Paroles, Governor Rick Perry allowed his execution to proceed, “in the interests of justice and public safety.”

2005

Troy Kunkle

At the time of the crime, Troy Kunkle was just over 18 years old, had no criminal record, and had survived a childhood of deprivation and abuse. At times, his parents suffered from mental illness. When Kunkle was 12, his father’s mental condition deteriorated, resulting in severe mood swings during which he would physically abuse his son. It was during this time that Kunkle’s problems at school escalated - conduct that later would be used by the state to persuade the jury to vote for his execution.

In post-conviction evaluations, a psychologist concluded that Kunkle was suffering from schizophrenia, a diagnosis that was substantiated by prison records. The psychologist concluded that an expert evaluation at the time of the trial would likely have shown Kunkle’s emerging mental disorder and the exacerbating effect of his substance abuse (late teens is typically the age of onset for schizophrenia). The jury heard no expert testimony, however.

2006

Angel Maturino Reséndiz⁶⁸

There was compelling evidence that Angel Maturino Reséndiz suffered from serious mental illness. His childhood in Mexico was marked by mental illness in his family and by appalling deprivation and abuse. At his 2000 trial, the

⁶⁸ Amnesty International. Urgent Action 136/06 (AMR 51/077/2006). May 16, 2006.

defense argued that Reséndiz was not guilty by reason of insanity because he did not know right from wrong at the time of the murder. An expert for the defense testified that Reséndiz was suffering from chronic paranoid schizophrenia and had the delusion that he was an angel of God with a duty to destroy "evil people." The prosecution's experts did not dispute that he was mentally ill – and their tests found evidence of brain damage – but they testified that, in their opinion, he was not legally insane at the time of the crime.

The courts did not determine his competency to stand trial. However, a pre-trial psychological evaluation reported that Reséndiz "stated with great vehemence that he wanted to be his own attorney, that he wanted to plead guilty and that he wanted to be put to death. He explained that if this course of events occurred, he would be victorious because he would return to live on this earth whereas the judge, the jury and the executioner would all die instantly when he was put to death." Throughout the trial proceedings, he received anti-psychotic drugs in order to subdue the symptoms of his mental illness. After the jury rejected the insanity defense and found him guilty, Reséndiz asked to be sentenced to death. He would not permit his court-appointed attorneys to make an opening statement at the penalty phase of his trial, to cross-examine the state's witnesses, or to present testimony on his behalf.

His first appellate lawyer filed a petition raising a single generic claim, which failed to make any reference to Reséndiz's mental illness and did not even mention him by name. It later was discovered that this petition was identical, word-for-word, to a brief filed by the same lawyer in the appeal of another death row prisoner. The appeal lawyer also missed a crucial filing deadline, and as a result, under federal law Reséndiz forfeited his right to further review of case-specific issues, such as his mental illness.

In the six years that Reséndiz spent on death row, his mental condition continued to deteriorate. He was transferred to an inpatient psychiatric unit on 8 different occasions, mutilated himself more than 30 times, and was placed on anti-psychotic medication to control his auditory hallucinations and delusions. Before his execution, a psychiatrist found that Reséndiz was completely delusional, convinced that as a "man-angel" he was immune from lethal injection and would awaken unharmed with a "renovated body" on the third day following his execution. A psychologist also concluded that he suffered from schizophrenia and that he did not believe he would die as a result of execution. His lawyers argued that he was incompetent for execution – that he did not understand the reason for, or reality of, his punishment – but the courts disagreed.

2007

Jonathan Bryant Moore⁶⁹

At his trial, Jonathan Moore pleaded not guilty by reason of insanity to the shooting death of San Antonio Police Officer Fabian Dominguez. His defense lawyers argued that Moore had not realized his conduct was wrong at the time of the crime and had feared that Officer Dominguez was going to shoot him. His behavior stemmed from his mental illness, particularly his paranoid delusions that authority figures, especially the police, were trying to kill him. Upon the request of Moore's court-appointed lawyers, the judge appointed a mental health expert, Dr. Michael Arambula, to examine him. Dr. Arambula and his colleague Dr. Margot Zuelzer concluded that Moore was suffering from schizoaffective disorder, a serious mental illness combining symptoms of schizophrenia such as delusions or hallucinations with a mood disorder such as depression.

⁶⁹ Amnesty International. Urgent Action 07/07 (AMR 51/005/2007). January 5, 2007.

They were not asked to report to the court on the question of Moore's competence to stand trial.

Drs. Arambula and Zuelzer testified at the trial that in their opinion, Moore had been suffering from serious mental illness at the time of the crime and had been legally insane as a result. The defense also presented lay witnesses who detailed Moore's difficult family life, his commitment to a mental hospital and treatment with psychotropic medication during his adolescence, and his increasing paranoia as a young adult. The prosecution's experts rebutted this testimony in its entirety. The jury rejected the insanity defense and convicted Moore of capital murder.

According to a 2005 brief, by the time of the trial, Moore had begun "to suspect that his own lawyers were part of the larger conspiracy to kill him, and eventually refused to cooperate with them at all." He became variously withdrawn or disruptive and sought to represent himself. At a post-conviction hearing, his lawyers recalled that they had suspected that Moore was mentally ill from the time they first met him and that it had become increasingly difficult during the trial to communicate with him.

At the sentencing phase of his trial, Moore again sought to discharge his lawyers and represented himself for the first two days of proceedings. His lawyers sought a competency hearing, but did not recall the mental health experts, who therefore never testified at any stage of the process on the question of Moore's competence to stand trial. The judge rejected the motion, the sentencing continued, and Moore was sentenced to death.

Resources on Mental Illness and the Death Penalty

Organizations in Texas

Mental Health Organizations

Advocacy, Inc.

7800 Shoal Creek Blvd. Suite 171-E
Austin, Texas 78757
www.advocacyinc.org

Contact: Beth Mitchell, Senior Managing Attorney
512-454-4816
bmitchell@advocacyinc.org

Advocacy, Inc. is the federally funded and authorized protection and advocacy system for Texans with disabilities. It works to advance their legal, human and service rights.

Capacity FOR JUSTICE

3 Clarendon Lane
Austin, Texas 78746
www.capacityforjustice.org

Contact: Genevieve Tarlton Hearon
512-327-2501
ghearon@capacityforjustice.org

Capacity FOR JUSTICE (C4J) is a non-profit organization which promotes the fair, just, and humane treatment of people with mental disabilities in the criminal justice system. C4J offers courses several times per year on mental health professional reliability and on the legal and mental health professional roles in judicial procedures involving mental health issues. It also maintains the Texas Registry of Forensic Experts for Competency, Sanity and Capacity Determinations in Adult and Juvenile Proceedings.

Hogg Foundation for Mental Health

The University of Texas at Austin
P. O. Box 7998
Austin, Texas 78713-7998
www.hogg.utexas.edu/index.html

The Hogg Foundation for Mental Health is an administrative unit of the University of Texas at Austin. It provides grants to mental health service, research, public education, and policy projects in Texas. The Foundation also tracks state legislation related to mental health issues and operates internal programs, including mental health services research, public policy analysis, public education, and conferences.

Mental Health America of Texas

1210 San Antonio Street, Suite 200
Austin, Texas 78701
512-454-3706
www.mhatexas.org

Mental Health America of Texas is an affiliate of Mental Health America (formerly the National Mental Health Association) and is the state's leading source for mental health information, education and advocacy. MHA Texas has seven affiliate offices:

Abilene: www.abilenementalhealth.org/
Greater Houston: www.mhahouston.org/
Beaumont and Jefferson County: no website available

Greater San Antonio: www.healthymindconnection.org/
Greater Dallas: www.mhadallas.org/
Tarrant County: www.mhatc.org
Fort Bend County: www.mhafbc.org/

See <http://mhatexas.org/AffiliateList.htm> for additional affiliate contact information.

National Alliance on Mental Illness of Texas

Fountain Park Plaza III
2800 S. I-35, Suite 140
Austin, Texas 78704
512-693-2000
www.namitexas.org/

The National Alliance on Mental Illness of Texas (NAMI Texas) has nearly 10,000 members, including mental health consumers, family members, friends, and professionals. It is affiliated with the National Alliance on Mental Illness (NAMI) and has 45 local affiliates throughout Texas. Its purpose is to help improve the lives of people affected by mental illness through education, support, and advocacy.

Visit www.namitexas.org/affiliates/ for a list of local affiliates.

Texas Mental Health Consumers

608 Morrow Street, Suite 103
Austin, Texas 78752
www.tmhc.org

Contact: Mike Halligan, Executive Director
512-451-3191
tmhc@tmhc.org

Texas Mental Health Consumers is a non-profit agency designed to encourage, educate, train, and organize persons with mental illness to advocate for themselves and support each other. Visit the website for information on local chapters and other consumer groups.

Legal and Criminal Justice Reform Organizations

StandDown Texas Project

PO Box 13475
Austin, Texas 78711-3475
www.standdown.org

Contact: Steve Hall, Project Director
512-879-1675
shall@standdown.org

The StandDown Texas Project advocates for a moratorium on executions and calls for a state-sponsored review of Texas' application of the death penalty. Its website provides up-to-date information on the death penalty in Texas and nationwide.

Texas Appleseed

1609 Shoal Creek Suite #201
Austin, Texas 78701
www.texasappleseed.net

Contact: Deborah Fowler, Legal Director
512-473-2800 x 105
dfowler@texasappleseed.net

Texas Appleseed is a non-profit, public interest law organization that focuses on systemic reform. Among other issues, it works to improve representation of persons with mental illness in the criminal justice system. (See Publications below for more information.)

Texas Coalition to Abolish the Death Penalty

2709 S. Lamar Blvd.
Austin, Texas 78704
512-441-1808
www.tcadp.org

The Texas Coalition to Abolish the Death Penalty (TCADP) is a grassroots organization that works to end the death penalty through education and action. It has members and chapters throughout the state.

Texas Defender Service

510 S. Congress #304
Austin, Texas 78704
512-320-8300
www.texasdefender.org/

412 Main St. #1150
Houston, Texas 77002
713-222-7788

Texas Defender Service (TDS) works to promote a fair and just criminal justice system in Texas, with an emphasis on improving the quality of representation in death penalty cases. Its staff has worked tirelessly on the case of Scott Panetti and other death row inmates with severe mental illness. Visit the website to learn more.

National Organizations

American Bar Association

www.abanet.org/dch/committee.cfm?com=IR504000&edit=1&new=1

The Death Penalty Committee of the American Bar Association's (ABA) Section on Individual Rights and Responsibilities has spearheaded a national coalition effort aimed at prohibiting the death penalty for persons with mental disabilities or disorders. In August 2006, the ABA House of Delegates passed a recommendation calling for such a prohibition, which was developed by a Task Force on Mental Disability and the Death Penalty (consisting of legal and mental health experts). Read the recommendation and background report at www.abanet.org/leadership/2006/annual/dailyjournal/hundredtwentytwoa.doc.

American Psychiatric Association

www.psych.org

The American Psychiatric Association (APA) is a medical specialty society. Its 38,000 U.S. and international members work together to ensure humane care and effective treatment for all persons with mental disorders, including mental retardation and substance-related disorders. The APA is the voice and conscience of modern psychiatry. It envisions a society with available, accessible quality psychiatric diagnosis and treatment. Visit <http://www.healthyminds.org/> - the APA's online resource for mental health information, including fact sheets and testimonials.

The APA's position statement on Mentally Ill Prisoners on Death Row (a slightly modified version of the ABA recommendation) is available at http://archive.psych.org/edu/other_res/lib_archives/archives/200505.pdf.

Amnesty International USA

www.amnestyusa.org/abolish

Amnesty International released a comprehensive report on the execution of mentally ill offenders in the United States in January 2006 (see Publications below for more information). Amnesty International USA's Program to Abolish the Death Penalty has worked on numerous cases involving death row inmates with severe mental illness in Texas and around the country, and it strives to fulfill the key recommendations of the report. You can find both summary and full versions of the report, as well as other information on this topic, by clicking on the link to "The Execution of Mentally Ill Offenders" from the web address above.

Bazelon Center for Mental Health Law

www.bazelon.org/index.html

The Bazelon Center for Mental Health Law is a national legal advocate for people with mental disabilities. It envisions an America where people who have mental illnesses or developmental disabilities exercise their own life choices and have access to the resources that enable them to participate fully in their communities. The Bazelon Center uses a coordinated approach of litigation, policy analysis, coalition-building, and public information, and it provides technical support on mental health law issues, policy advocacy, and public education to local advocates. Resources and fact sheets on the criminalization of people with mental illness are available at www.bazelon.org/issues/criminalization/index.htm.

Criminal Justice/Mental Health Consensus Project

<http://consensusproject.org/>

The Criminal Justice/Mental Health Consensus Project, coordinated by the Council of State Governments Justice Center, is a national effort aimed at helping local, state, and federal policymakers and criminal justice and mental health professionals improve their response to people with mental illness who come into contact with the criminal justice system.

The landmark *Consensus Project Report*, which was written by Justice Center staff and representatives of leading criminal justice and mental health organizations, was released in June 2002. Since then, the Consensus Project has supported the implementation of practical, flexible criminal justice/mental health strategies through on-site technical assistance; the dissemination of information about programs, research, and policy developments in the field; continued development of policy recommendations; and educational presentations.

Visit the website for fact sheets, research initiatives, and current developments related to the intersection of mental health and criminal justice issues. See Publications below for more information.

Death Penalty Information Center

www.deathpenaltyinfo.org

The Death Penalty Information Center is a non-profit organization serving the media and the public with analysis and information on issues concerning capital punishment. It prepares in-depth reports, issues press releases, conducts briefings for journalists, and serves as a resource to those working on this issue. Click on "Mental Illness" (under Issues) for current and past developments, articles, and recent cases.

The Justice Project

www.thejusticeproject.org/

The Justice Project (TJP) is a nonpartisan organization dedicated to fighting injustice and to creating a more humane and just world. It has two current programs: the Campaign for Criminal Justice Reform and Veterans for America.

The mission of the Criminal Justice Reform Campaign is to address unfairness and inaccuracy in the American criminal justice system. TJP develops, coordinates, and implements integrated national and state-based campaigns involving public education, litigation and legislation to reform the criminal justice system, with a particular focus on capital punishment. As part of this campaign, TJP worked closely with litigators on the case of Scott Panetti, a Texas death row inmate with severe mental illness. More information is available at www.thejusticeproject.org/press/releases/panetti-briefs.html.

Mental Health America

www.mentalhealthamerica.net/

Mental Health America (MHA), formerly the National Mental Health Association, is the country's oldest and largest nonprofit organization addressing all aspects of mental health and mental illness. With more than 320 affiliates nationwide, MHA works to improve the mental health of all Americans, especially the 54 million individuals with mental disorders, through advocacy, education, research and service. It opposes the use of the death penalty as a form of punishment for individuals with mental illness.

Go to <http://www1.nmha.org/position/deathPenalty/index.cfm> for MHA's position statement on the death penalty, as well as an issue brief, a case study featuring Texan Larry Robison, talking points, a sample letter opposing the execution of an offender with mental illness, and a sample news release.

National Alliance on Mental Illness

www.nami.org/

The National Alliance on Mental Illness (NAMI) is the nation's largest grassroots mental health organization. It is dedicated to improving the lives of persons living with serious mental illness and their families. Founded in 1979, NAMI has organizations in every state and in over 1100 local communities across the country who join together to support its mission through advocacy, research, support, and public education. The national office supports affiliates by serving as a clearinghouse and coordinator of state and local activities and providing resources and technical assistance as needed.

In 2006, NAMI released "Grading the States: A Report on America's Mental Health Care System for Serious Mental Illness." Click on individual states to see how they fared on a variety of grading criteria. Texas received a 'C' overall; NAMI identified funding and inpatient beds as urgent needs.

NAMI has endorsed the ABA recommendation calling for a prohibition on the death penalty for persons with severe mental illness, and it has played an active role in numerous cases and legislative efforts.

Read NAMI's recent press release on the U.S. Supreme Court decision in the case of Scott Panetti at www.nami.org/Content/ContentGroups/Press_Room1/20076/June6/Supreme_Court_Decision_Mental_Illness_and_Death_Penalty.htm and visit the website to learn more about mental illness.

National Disability Rights Network

www.ndrn.org

The National Disability Rights Network (NDRN) is the non-profit membership organization for the federally-mandated Protection and Advocacy (P&A) Systems and Client Assistance Programs (CAP) for individuals with disabilities. Collectively, the P&A/CAP network is the largest provider of legally-based advocacy services to people with disabilities in the United States. Through training and technical assistance, legal support, and legislative advocacy, the NDRN works to create a society in which people with disabilities are afforded equal opportunities and are able to participate fully by exercising choice and self-determination.

Go to www.ndrn.org/issues/cj/default.htm for a comprehensive list of resources on criminal justice issues, including talking points on mental disabilities and the death penalty and position statements from other mental health organizations.

Treatment Advocacy Center

www.psychlaws.org/

The Treatment Advocacy Center (TAC) is a national non-profit organization dedicated to eliminating barriers to the timely and effective treatment of severe mental illnesses. TAC promotes laws, policies, and practices for the delivery of psychiatric care, and it supports the development of innovative treatments for and research into the causes of severe and persistent psychiatric illnesses, such as schizophrenia and bipolar disorder.

The TAC website contains information on state mental health laws, as well as medical resources. It also contains a "Preventable Tragedies" database, which provides information on incidents involving individuals with mental illness who have been the victim or perpetrator of a violent episode. The episodes are drawn from news articles, ranging roughly from 1987 to the present. The database allows searches according to a variety of criteria, such as state, year, and whether law enforcement was involved in the incident. It provides compelling examples of how many of the crimes committed by those with mental illness could have been avoided with enhanced treatment programs.

Books

Earley, Pete. *Crazy: A Father's Search Through America's Mental Health Madness*. G.P. Putnam's Sons, 2006. Author and journalist Pete Earley tells the story of his son's struggle with bipolar disorder and his interactions with the criminal justice system. He also traces the origins of deinstitutionalization in this country and the shift to community-based treatment centers, and he documents the growing trend toward incarcerating offenders with mental illness. Earley spent a year investigating the Miami-Dade County jail, where he shadowed inmates and interviewed correctional officers, prosecutors, judges, psychiatrists, family members, and others whose lives have been impacted by the increased criminalization of those with mental illness. Go to www.petearley.com/ for more information.

Kupers, Terry. Prison Madness: The Mental Health Crisis Behind Bars and What We Must Do About It. Jossey-Bass Inc., 1999. Kupers, a forensic psychiatrist and psychology professor, exposes current prison policies and the treatment of prisoners with mental disorders. Calling for immediate reform, he outlines successful programs throughout the United States and around the world and makes practical recommendations for the development of comprehensive mental health services.

Pfeiffer, Mary Beth. Crazy in America: The Hidden Tragedy of Our Criminalized Mentally Ill. Carroll & Graf Publishers, 2007. Mary Beth Pfeiffer presents six case studies (including one from Texas) to illustrate the devastating impact that incarceration, particularly solitary confinement, can have on those with severe mental disorders. Go to www.crazyinamerica.com/ for more details.

Shannon, Brian D. and Daniel H. Benson. Texas Criminal Procedure and the Offender with Mental Illness: An Analysis & Guide. Third Edition. NAMI-Texas, 2005. Brian Shannon and Daniel Benson, Professors of Law at Texas Tech University School of Law, examine Texas laws relating to offenders suffering from mental illness. This book includes information related to competency to be executed, and it analyzes recent changes to Texas Criminal Procedure as enacted by the State Legislature. Available for order from NAMI-Texas: www.namitexas.org/resources/.

Publications

The Advocacy Handbook: A Guide for Implementing Recommendations of the Criminal Justice / Mental Health Consensus Project. A joint effort of NAMI, MHA, the National Association of State Mental Health Program Directors, the Bazelon Center for Mental Health Law, and the Criminal Justice / Mental Health Consensus Project. This how-to guide explains the extent to which people with mental illness are overrepresented in the criminal justice system, discusses the origins and repercussions of this problem, and summarizes the keys to improving outcomes for this population. It examines the issue from the perspective of various stakeholders – law enforcement, the courts, corrections agencies, mental health advocates, and elected officials – with the aim of facilitating collaboration. The handbook presents examples of successful efforts throughout the country and provides guidance for communities seeking to forge partnerships between criminal justice and mental health advocates. Download at <http://consensusproject.org/advocacy/>.

Finding Help When You're In Trouble with the Law: A Handbook for Persons with Mental Illness and Their Families. Third Edition. Texas Appleseed, 2005. This handbook provides information for individuals and their families and answers questions such as how to retain a lawyer and how to ensure that someone receives medication while in jail. Download at www.texasappleseed.net/pdf/hbook_MH_family_FindingHelp.pdf. Also available in Spanish.

Ill-Equipped: U.S. Prisons and Offenders with Mental Illness. Human Rights Watch, 2003. This report explores such topics as rates of incarceration of those with mental illness, difficulties faced by prisoners with mental illness, and mental health treatment in prisons. It includes several case studies. Download at www.hrw.org/reports/2003/usa1003/.

“Mental Health Problems of Prison and Jail Inmates.” U.S. Department of Justice - Bureau of Justice Statistics, 2006. This study presents estimates of the prevalence of mental health problems among prison and jail inmates using self-reported data on recent history and symptoms of mental disorders. More than half of all prison and jail inmates, including 56 percent of state prisoners, 45 percent of federal prisoners, and 64 percent of local jail inmates, were found to have a mental health problem. The report compares the characteristics of offenders with mental health problems to those without on such factors as current offense, criminal record, sentence length, time expected to be served, co-occurring substance dependence or abuse, family background, and conduct since current incarceration. It presents measures of mental health problems by gender, race, and age and describes mental health treatment among inmates since admission to jail or prison. Findings are based on the Survey of Inmates in State and Federal Correctional Facilities, 2004, and the Survey of Inmates in Local Jails, 2002. Download at www.ojp.usdoj.gov/bjs/abstract/mhppji.htm.

Mental Illness, Your Client, and the Criminal Law: A Handbook for Attorneys Who Represent Persons with Mental Illness. Texas Appleseed, 2005. This handbook includes information on competency evaluations, pretrial options, expert mental health witnesses, and mental impairment as a defense. Download at www.texasappleseed.net/pdf/hbook_MH_attorney_MentalIllness.pdf.

“Recommendation and Report on the Death Penalty and Persons with Mental Disabilities.” *Mental and Physical Disabilities Law Reporter*. September/October 2006. This article provides background information on and the rationale behind the ABA recommendation to prohibit the death penalty for persons with mental disabilities and disorders. Download at www.ndrn.org/issues/cj/ABA%20Resolution-%20feature%20article305.pdf.

Talking Points: Mental Disabilities and the Death Penalty. Judith G. Storandt, J.D., National Disability Rights Network; Ronald Tabak, J.D., Co-chair, Death Penalty Committee, ABA Section of Individual Rights & Responsibilities; Ron Honberg, J.D., National Alliance on Mental Illness; and David Kaczynski, Executive Director, New Yorkers Against the Death Penalty. March 2007. These comprehensive talking points address various issues related to the intersection of the death penalty and mental illness. Available at www.ndrn.org/issues/cj/Talking%20Points.pdf.

The United States of America: The Execution of Mentally Ill Offenders. Amnesty International, 2006. This comprehensive report illustrates how current legal safeguards have failed to protect offenders with severe mental illness from being sentenced to death and executed in this country. It includes numerous case studies, as well as an appendix of 100 individuals with mental illness who have been executed since 1977. Download at <http://web.amnesty.org/library/Index/ENGAMR510032006>.

Films

“Executing the Insane: The Case of Scott Panetti.” This documentary was produced by Texas Defender Service, in association with Off Center Media. It chronicles the case of Scott Panetti, who was sentenced to death in Texas despite a long, documented history of paranoid schizophrenia. It is a compelling illustration of the impact that Panetti’s mental illness – and his death sentence – has had on his family. 2007. 27 minutes. Available on DVD or online at www.texasdefender.org/panettidocumentary.asp. See the discussion guide on pages 13-14.

Blogs

Grits for Breakfast: <http://gritsforbreakfast.blogspot.com/>. This blog covers all aspects of the criminal justice system in Texas and includes valuable information related to mental health issues.

Prevention Not Punishment: <http://preventionnotpunishment.blogspot.com/>. Visit for current news and developments related to mental illness and the death penalty in Texas and around the country. The blog includes links to local, state, and national organizations and other resources.

StandDown Texas Project: <http://standdown.typepad.com/weblog/>. Visit daily for updates on the death penalty and other criminal justice issues in Texas and around the country.

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Kristin Houlé
Soros Justice Fellow
Texas Coalition to Abolish the Death Penalty
2709 S. Lamar Blvd.
Austin, Texas 78704
512-441-1808 (work)
202-494-3578 (cell)
khouletx@gmail.com
www.tcadp.org
<http://preventionnotpunishment.blogspot.com/>