MVFHR
2161 Massachusetts Avenue
Cambridge, MA 02140 USA
www.mvfhr.org • 617-491-9600

NAMI
2107 Wilson Blvd., Suite 300
Arlington, VA 22201-3042
703-524-7600 • www.nami.org

Double Tragedies

Victims Speak Out Against the Death Penalty For People with Severe Mental Illness

Murder Victims' Families for Human Rights
The National Alliance on Mental Illness

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Double Tragedies was written by Susannah Sheffer
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All photographs are by Scott Langley except those on pages 5, 10, 17, and 18, which are from the subjects' private family collections.

The cover photo is of participants sharing a moment after the launch of the Prevention, Not Execution project in San Antonio, Texas, October 2008.

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Foreword

Kelsey Patterson spent much of the 1980s in and out of mental hospitals in Texas. No one questioned that he had a severe mental illness – paranoid schizophrenia – that often caused him to become violent.

In 1980, he shot and seriously wounded a co-worker. Patterson believed his food was being poisoned by the man even though they'd only met that morning. Three years later, Patterson wounded another man during a delusional assault. In 1986, Patterson assaulted yet a third victim. Finally, on September 25, 1992, just days after his brother had tried unsuccessfully to get him committed to a psychiatric facility, Patterson fatally shot a businessman and his secretary. He then put his gun down, stripped to his socks, and paced, shouting incomprehensibly until the police arrived.

There was no doubt that Patterson had committed two murders. A judge also ruled that Patterson met the razor-thin criteria that the U.S. Supreme Court has established to decide when someone can be held legally accountable for their actions even though they have a mental disorder. Psychiatrists said Patterson knew he had done something wrong at the time of the killings.

In a rare move – only the second time in its history - the Texas Board of Pardon and Paroles sent a recommendation to the governor asking that Patterson's life be spared. By a 5 to 1 vote, the panel said Patterson deserved mercy because he was simply too sick to be punished.

The governor ignored that recommendation and on May 18, 2004, a clearly delusional Patterson, still rambling incoherently, was put to death.

How could a civilized society execute someone who was so obviously psychotic? Was society culpable in the murders because it permitted Kelsey Patterson's mental state to deteriorate despite nearly a decade of warning signs? Would sparing his life have been fair to the families of his two victims? Where should the line be drawn between mental acuity and responsibility for criminal acts? Should someone who is in the midst of a psychotic breakdown be treated differently from a person with mental retardation – a class of individuals whom the Supreme Court has exempted from execution because of their obvious diminished culpability?

As the father of a son with a severe mental illness, the Patterson case outraged me.

This was a preventable tragedy.

In the past two years, I have visited 43 states speaking about the need to reform our mental health system. I've toured nearly a hundred mental health treatment programs and my travels have convinced me that we know how to help most people who have mental illnesses. This is not a case of us being ignorant.

Housing First programs, when teamed with Assertive Community

Treatment teams, have proven successful in helping even the most chronically mentally ill persons, certainly those as sick as Kelsey Patterson. Innovative job programs, such as New York's Fountain House, have given persons with mental illnesses opportunities to recover. Medications, cognitive behavioral training, peer-to-peer counseling, clubhouses, drop-in centers, outpatient treatment – the list of recovery tools at our disposal is extensive.

And yet, at least 100 persons known to have been severely mentally ill have been executed in our country and another couple of hundred are currently awaiting execution. Meanwhile, more than 300,000 persons with severe mental illnesses are currently being warehoused in U.S. jails and prisons. Another half million languish on probation and the largest public mental facility in America is not a hospital but the Los Angeles jail.

This is shameful.

I am outraged that the U.S. Supreme Court has adopted such a simplistic formula for punishing persons with brain disorders that are anything but simple.

I am outraged that states have adopted involuntary commitment standards that focus exclusively on imminent danger and do not consider other signs of deterioration that clearly signal that a person, such as Kelsey Patterson, needs help.

I am outraged that even though we spend billions of dollars per year on mental health care in this country we still have a system that, according to the President's New Freedom Commission, is in "disarray."

I am outraged that the public does not understand that mental illnesses, such as schizophrenia, bipolar disorder, and major and persistent depression, are, in fact, illnesses that can strike anyone.

I am outraged that families try desperately to get help for their loved ones with mental illness, and instead innocent people end up getting murdered by persons who could and should have been helped.

And I am outraged that states are willing to put money and effort into medicating someone so they competent enough to be executed, but not willing to put money into medication earlier, when they could help the person become well and avoid a senseless murder.

Thankfully, the National Alliance on Mental Illness and Murder Victims' Families for Human Rights have chosen through this report to raise difficult questions that need to be asked about the death penalty and mental illness. By discussing these questions, the two groups open the door to an even larger issue: how can we correct our flawed system?

What makes the union of NAMI and MVFHR powerful is that it brings together advocates for persons with mental illnesses and advocates for families of murder victims. This union gives both groups' statements credibility and power. I greatly admire the people quoted here because many of them are victims, yet rather than demanding revenge, they see the need for mental health reform.

I hope that NAMI and MVFHR can help us turn our outrage into constructive dialogue and political action that can bring about changes, which will stop lives from being lost – both on our streets and in execution chambers.

— Pete Earley, author of *CRAZY: A Father's Search Through America's Mental Health Madness*

Introduction: Why This Report

In October 2008, a group of people gathered around a table in San Antonio, Texas to begin an unprecedented conversation. Among the group were families of victims killed by persons with severe mental illness and families of persons with severe mental illness who have been executed. They had traveled from all over the U.S. to participate in this gathering. They had brought photographs of their loved ones to show one another: the daughter shot to death by a man with paranoid schizophrenia; the son diagnosed with paranoid schizophrenia and executed by lethal injection. The photos showed parents, children, brothers, cousins. Along with these visual images, the family members had brought newspaper clippings, legal briefs, medical records. Most powerfully, they had brought stories from their own experience, each giving a specific window into the horrors of murder and execution.

Some of the participants were uncertain about whether members of the other group could be open to their distinct experience. Could families of victims, whose loved ones' lives had been taken by someone with mental illness, be open to hearing about the pain of the families of offenders? Could families of offenders, full of the shame and isolation that accompanies a loved one's execution, bear to confront the pain of families who had been directly victimized by people with mental illness? Not actually present at the table, but very much part of the conversation both implicitly and explicitly, were the individuals whose illnesses, crimes, and eventual punishment had brought this group together. How would *their* experience be represented and understood?

The San Antonio gathering marked the official launch of a project that had been in the making for several months. The project was conceived when two organizations joined forces to bring a new perspective to the debate about whether persons with severe mental illness should be exempt from capital punishment. The National Alliance on Mental Illness (NAMI), the nation's largest grassroots organization for people with mental illness and their families, had in 2004 issued a public statement against the death penalty for people with mental illnesses, saying that the execution of these individuals compounds the tragedy of violent crimes and serves no purpose in deterring similar crimes.[1] Murder Victims' Families for Human Rights (MVFHR), an organization of relatives of homicide victims and relatives of people who have been executed, all of whom oppose the death penalty in all cases, had since the time of its founding in 2004 been amplifying the voices of victims' families and challenging the idea that all victims' families want and need the death penalty. The two groups agreed to launch a collaborative project, titled "Prevention, Not Execution," with the goal of opposing the death penalty for persons with severe mental illness.

The argument for exempting persons with severe mental illness from the death penalty is that the death penalty – the harshest of punishments – does not deter, serves no retributive function for, and is a disproportionate punishment for individuals who are less culpable for their crime than the average person. In the United States Supreme Court's 2002 *Atkins v. Virginia*[2] decision, which ruled the execution of defendants with mental retardation unconstitutional, and the 2005 *Roper v. Simmons*[3] decision, which did the same regarding juvenile defendants, the Court recognized that society's "evolving standards of decency" made executions of such defendants inappropriate. The Court ruled that because of their reduced judgment, understanding, and self-control (compared to others convicted of murder), defendants with mental retardation and defendants under the age of 18 lack the level of culpability that would warrant the most severe sanction, and so should be exempt from the death penalty. Since then, some members of the legal and mental health professions have proposed that the same reasoning applies to those with mental illnesses so severe that their crimes were committed while they were in the grip of psychotic delusions or other equally disabling psychological conditions.

The Court has not yet taken up the constitutionality of sentencing offenders with severe mental illness to death. Among the states, only Connecticut has passed legislation

[1] NAMI had opposed the execution of people with severe mental illnesses long before 2004, but issued the policy statement with this specific wording at that time.

[2] *Atkins v. Virginia*, 536 U.S. 304 (2002)

[3] *Roper v. Simmons*, 543 U.S. 551 (2005)

exempting certain individuals with impaired mental capacity from the death penalty, but this legislative exemption has been rarely applied.[4] Yet the *Atkins v. Virginia* and *Roper v. Simmons* rulings suggest a trend in this direction, and several states have begun to spearhead legislative and public education campaigns in this area. The time has come for a public debate on the question of exempting certain persons with severe mental illness from the death penalty.

It is within this public debate that the voices represented at the San Antonio gathering become so important. Skeptics of the idea of exempting offenders with certain severe mental illnesses from the death penalty might say that it is an insult to victims' families to claim that someone with mental illness who commits a murder is less than fully culpable for that act and therefore should not face the death penalty. In terms of the traumatic impact on a victim's family, murders committed by people with severe mental illness are no less devastating than any other murders. What message does it send to victims' families when such offenders are described as less culpable for what they have done than are others who commit murder? Does this in any way deprive victims' families of an adequate societal acknowledgment of what occurred? This question arises for victims' families not only in the context of the death penalty but also in the context of a broader inquiry about what the appropriate response should be when an individual with severe mental illness commits murder.

Politically, supporting the death penalty for persons with severe mental illness, or at least opposing the idea of exempting them from this penalty, would seem to be a pro-victim stance. Yet not all victims see it this way. Families of victims killed by persons suffering from severe mental illness, who oppose the death penalty in these cases, have an important statement to make on the issue. Their experience and their reasons for opposing the death penalty should be part of the public conversation.

Families of victims killed by persons suffering from severe mental illness who oppose the death penalty can help shape societal response in ways that MVFHR and NAMI believe are of unique value. But in designing the joint project that came to be titled "Prevention, Not Execution," MVFHR and NAMI also believed it essential to include another group of stakeholders: the families of people with mental illness who have been executed. Questions about what might have been done to prevent the crime are their questions, too, made achingly specific by their (in many cases) years of frustrated attempts to get help for their ill family member. These family members' narratives of repeated, and thwarted, efforts to get treatment for their relatives with mental illnesses infuse the "prevention, not execution" phrase with an urgency grounded in direct experience.[5]

In joining together to draw attention to the intersection of mental illness, murder, and the death penalty, NAMI and MVFHR are highlighting a nexus of suffering between two groups of families whose opposition to the death penalty is grounded in personal tragedy. From the start, we have recognized a risk inherent in framing a project in this way. Even with recent advances in both medical and public understanding of mental illness, those who live with these illnesses still face enormous stigma. A risk inherent in a project such as this one is that it will exacerbate the negative portrayal of people with mental illness that many who live with these illnesses and their advocates can quite rightly claim is already all too prevalent. The project is not arguing that people with mental illnesses are inherently violent and dangerous. Indeed, we recognize that people with severe mental illnesses are more often the victims than the perpetrators of violence.[6]

We also recognize that the question of how to prevent people with severe mental illness from committing violent crimes is complicated tremendously by the very real need to respect the personal autonomy and civil liberties of such individuals. But in addition to a discussion of rights, this issue also demands a discussion of obligations – specifically, a consideration of the obligations that a society has both toward its members who live with mental illness and toward the victims of the crimes some have committed.

The initial wariness felt by the families who came together in San Antonio was soon transformed into a profound

[4] Connecticut General Statutes § 53(a)-46(a) exempts a defendant from capital prosecution if "his mental capacity was significantly impaired or his ability to conform his conduct to the requirements of law was significantly impaired but not so impaired in either case as to constitute a defense to prosecution."

[5] Amnesty International's 2006 report, "The Execution of Mentally Ill Offenders," (see our List of Resources in Appendix C of this document) lists 100 individuals with mental illness who have been executed in the United States since 1977. Amnesty writes, "This list represents about 10 per cent of those put to death in the country during this period, and is for illustrative purposes only. It does not claim to be exhaustive – cases of others who have been executed have also raised serious questions relating to their mental health." As well, according to Mental Health America, an estimated 5-10% of inmates currently on death row in the United States have a serious mental illness. (See Mental Health America's "Position Statement 54: Death Penalty and People with Mental Illnesses.")

[6] The National Alliance on Mental Illness's 2008 report on schizophrenia says, "The U.S. Surgeon General reported ten years ago that although some research exists to support public concern, 'the overall likelihood of violence is low' and the 'overall contribution of mental disorders to the total level of violence in society is exceptionally small.' The 'greatest risk' is from persons dually diagnosed with both a mental illness and a substance abuse disorder. There is also a 'small elevation of risk' for persons with severe disorders such as psychosis, 'especially if they are noncompliant with their medication.'
Other studies support the U.S. Surgeon General's basic assessment and the National Institute of Mental Health (NIMH) has noted that substance abuse 'always increases violent behavior, regardless of the presence of schizophrenia.' Meanwhile, people with serious mental illnesses are as many as ten times more likely to be victims of violence than the general public." "Schizophrenia: Public Attitudes, Personal Needs; Views From People Living with Schizophrenia, Caregivers, and the General Public,"
National Alliance on Mental Illness, June 2008.. See www.nami.org/schizophreniasurvey. For another useful summary, see "Increased Symptoms Lead Mentally Disordered To Become Victims Of Violence" in *Science Daily*, April 14, 2009, which opens by saying: "Contrary to common stereotypes, individuals with major mental disorders are more likely to become victims of violent crimes when they are experiencing an increase in symptoms than they are to commit crime, according to a new study by Brent Teasdale, an assistant professor of criminal justice at Georgia State University." See also V.A. Hiday, M.S. Swartz, et al, "Criminal Victimization of Persons with Severe Mental Illness," *Psychiatric Services* 50: 62-68, January 1999.

sense of common cause. What the families gathered around the table overwhelmingly found was a shared understanding and shared longing to address, at the root, the problem that had brought them all together.

This report[7] now gives public voice to this shared commitment by asserting that the death penalty is not only inappropriate and unwarranted for persons with severe mental illness but that it also serves as a distraction from problems within the mental health system that contributed or even led directly to tragic violence. Families of murder victims and families of people with mental illness who have committed murder have a cascade of questions and needs. It is to these questions, rather than to the death penalty, that as a society we must turn our attention and our collective energies if we are truly to address the problem of untreated mental illness and the lethal violence that can result.

To legislative and public education campaigns, this report adds voices from a distinct constituency that is otherwise missing from advocacy efforts on the issue. Without this testimony, advocacy in favor of exempting offenders with severe mental illness from the death penalty is open to the charge of being unconcerned with victims. Specifically, policymakers may fear that a vote in favor of exempting offenders with severe mental illness from the death penalty will be viewed as a vote against the interests of victims. Testimony from families of victims directly refutes this charge.

Victims' opposition to the death penalty for offenders with certain severe mental illnesses is rooted in their own experience of traumatic loss and in their effort to understand how their loved one came to be murdered. For this reason, a victim-oriented discussion of exempting offenders with severe mental illness from the death penalty is inextricably tied to a discussion of the circumstances surrounding the murder and the need for greater mental health intervention in order to reduce the likelihood of violence. A victim-oriented examination of the issue of the death penalty and mental illness cannot look only at the specific question of whether offenders with severe mental illness should be exempt from the death penalty but must also give serious consideration to victims' questions about intervention, prevention, and how the notion of diminished culpability relates to accountability and to victims' right to information and participation in the proceedings. Thus, the discussion that follows will encompass these considerations, as will the recommendations for policy reform that are presented at the end of the report.

[7] See Appendix B for a description of methodology, including how the interviewees were found. The report is based on interviews with (and supplemental material from) 21 family members who meet the above criteria. Other similar stories from family members whom we were not able to interview directly have also informed our thinking on the issue.

On October 3, 2008, in San Antonio, Texas, a private gathering followed by a public ceremony marked the official launch of the NAMI/MVFHR "Prevention, Not Execution" Project. Victims' families and families of the executed, all of whom had been affected by mental illness, murder, and the death penalty, traveled from Florida, Georgia, Tennessee, North Carolina, California, Maine, Massachusetts, and elsewhere in Texas to participate. During the two-and-a-half hour morning gathering, participants sat around a table and shared their stories. The event later that afternoon, attended by supporters and members of the press, featured brief public statements and then a ceremony in which participants placed roses in a vase in memory of the losses represented at the gathering.

In addition to making a public statement against the death penalty for people with mental illness who have committed murder, the gathering had a profound effect on those who participated. People who had not previously met one another found themselves sharing their most painful memories; Julie Nelson referred to it later as an experience of being among people who had been "broken open" - made open to personal revelation by what they had undergone. As well, the gathering yielded some unexpected feelings of affinity between families of victims and families of the executed.

Joe Bruce reflected on the experience with these words: "The San Antonio experience was one of the most extraordinary things that I have ever had the privilege of being a part of. To see the effect that executions had on the [family members of the executed] who had committed no crime whatsoever, who had already struggled for years to get help for [their family member] – I saw that and said that [the death penalty] is just absolutely a practice that should be ended."

Bonnie Stawski, whose brother Robert Coe had been executed in Tennessee eight years prior to the gathering, said, "I cannot describe the peace I felt sitting around that table in San Antonio. Everybody's pain was different, everybody's situation was different, but I felt a bond with everyone that was like good medicine."

The Death Penalty: The Wrong Direction

In its 2006 report "The Execution of Mentally Ill Offenders," Amnesty International suggests that murders committed by people with severe mental illness raise questions of societal responsibility – and failure of responsibility – in a particularly vivid way. In a section titled "Burying Society's Mistakes," Amnesty's report suggests that

> In some cases involving mentally impaired defendants, there are indications that individuals within wider society failed to heed warnings that could have averted a tragedy. This is not to suggest that crimes committed by mentally impaired people are to be condoned or excused. It is, however, to ask whether society could devote its energies and resources more constructively.

In the aftermath of their incomparable loss, murder victims' families find themselves thrust into the complex territory between not condoning or excusing an individual act and being forced to understand that the individual may be in some sense less than fully responsible for that act. The territory is complicated further when victims' families grasp the possibility that others might have been able to foresee and even prevent the act. What were the warning signs? Who or what agency failed to heed them? What might have been done differently?

For some, the pursuit of answers to these questions eventually coalesces into a determined advocacy for specific ways in which society might better dedicate its resources to help people with mental illness, thereby preventing further loss of life. But at the outset, the focus of these shocked and grieving family members is simply on trying to make sense of what had happened.

When Pat Webdale got a frantic phone call from her daughter Kim saying that the younger Webdale sister, Kendra, had been killed in the New York City subway, Pat struggled to absorb what she was hearing. At first the family thought Kendra had fallen accidentally onto the subway tracks. Then they learned that she had been pushed and they guessed that she was the victim of an attempted mugging. Finally the news came that Kendra had been pushed by a man named Andrew Goldstein who was quickly revealed to be suffering from schizophrenia.

"I didn't really know anything about real mental illness," Pat recalls. "My family went to Barnes and Noble almost immediately [after getting the news], and that's when we started learning." Right away Pat struggled with the tension between "needing a consequence," as she summarized it, and believing that Andrew Goldstein "didn't know what he was doing." She didn't want to see Goldstein out on the street again, and as she learned that he had assaulted 13 people prior to his fatal assault on Kendra, she "felt like, why didn't somebody see what he needed 13 times ago?"

Like Pat Webdale, Linda Gregory knew little about mental illness before its effects invaded her life. Linda's husband Gene Gregory, a deputy sheriff in Seminole County, Florida, had occasionally been called in to try to defuse a potentially volatile situation involving someone with mental illness. Linda remembers that after those encounters he "would come home and say something about inadequate services and how somebody should do something to help law enforcement be able to do more." Linda sometimes worried for her husband's safety; her only experience with mental illness was of a friend of her brother's when they were all growing up. "I remember us just calling him 'crazy.' Truthfully, other than that, I was ignorant, I knew nothing else about mental illness."

On the day of his murder in 1998, Deputy Gregory had been called in to assist when Alan Singletary, diagnosed years earlier with paranoid schizophrenia, pulled a gun on the landlord who had threatened to evict him. During a 13-hour standoff, Alan Singletary shot and killed Deputy Gregory and wounded two other deputies. Alan Singletary himself was then killed by gunfire from the other deputies who had come to assist.

Linda remembers the long night of waiting for news:

PAT WEBDALE'S 32-year-old daughter Kendra was killed in 1999 when Andrew Goldstein, who had been diagnosed with schizophrenia a decade earlier, pushed her onto the New York City subway tracks. Andrew Goldstein was convicted of second-degree murder and sentenced to 25 years to life; that conviction was overturned on appeal and he then pled guilty to manslaughter and was sentenced to 23 years in prison followed by five years of post-release supervision.

Pat says, "[Kendra's murder has] affected us in lasting ways. Everybody in the family seems to have PTSD, and there's been some depression. For myself, I feel gratitude that I was her mother, but I will never get over the pain of living without my daughter. I feel terrible about the horrific physical way that she died. If we were educated and aware and had more resources maybe we could stop some of the killing."

> They had come to get me to take me to the hospital – they knew my husband was down but they didn't know how badly he was injured. On the way, they learned that they weren't able to get in to him, so they took me to the sheriff's office. Friends came and we had a vigil there and prayer and that kind of thing. Nothing was said at that time about the man's mental illness. In the wee hours the sheriff came in. He never had to tell me [that Gene was dead] because when I saw him coming in the door I knew.

Initially, Linda's main concern was reaching her grown children quickly so that they wouldn't have to learn of their father's death from a news report. In the midst of the family's fresh shock and grief, the seeds of Linda's later activism were already being sown:

> Early the next morning, Sheriff Eslinger came to see me and he told me a little about Alan because he had talked to Alice, his sister. He told me, "I've been so concerned about mental illness and there's been nothing much we could do, but I promise you today that we're going to make a difference."

In the ensuing weeks, Linda learned that, after the murder, Alan Singletary's sister had sent a letter to the sheriff describing how the family had tried for years to get help for her brother. "They couldn't get much help for him," Linda says, summarizing the letter, "and they knew something like this would eventually happen."

Alan Singletary's history of mental illness was reported in the early news coverage of the standoff. Similarly, news coverage of the murder of Laura Wilcox, in California, immediately focused on the issue of mental illness because the murder took place at a behavioral health clinic where Laura, a college student, was working as a receptionist during her winter break in 2001. Laura was killed when Scott Thorpe, a patient of the clinic, approached the glass window separating the receptionist from the waiting room and fired four shots at close range.[8]

Laura's mother Amanda Wilcox describes herself as "in shock, numb, practically non-functional" when the family first got the news of Laura's murder. But the tragedy "turned very soon to issues of mental health," recalls Laura's father, Nick Wilcox. If Scott Thorpe was a patient of the clinic, did that mean he was under supervised treatment? How did it happen that his family's warning calls to the clinic weren't returned, or that the psychiatrist had written six months earlier that he was dangerous and should be hospitalized but Scott Thorpe was still living alone in a house full of assault weapons?

"We had an ongoing need for information and we couldn't get it," Amanda recalls of the period immediately after Laura's murder. "I thought after something like this, someone comes and tells you what happened. It's like we didn't exist for the county. We had made an initial claim [against the county] and that's how we got the police report, which had a lot in it relating to the mental health of Scott Thorpe. It was obvious to us that there was a problem."

These families eventually became activists on the issue of mental health reform, and their activism grew out of what they learned from looking back to the period before the tragedy to try to determine how it had come to happen, and then looking forward to what policy reforms seemed to be needed. The possibility of the death penalty as a response to their losses struck these families as not only inappropriate but, even more specifically, as a way of bypassing any attempt to understand what had led to the murder.

In the period immediately following Laura Wilcox's murder, a newspaper article quoted the district attorney stating that he would seek the death penalty for Scott

[8] He also shot two others at the clinic, killing one and critically injuring the other, and shortly afterward killed the manager at a nearby restaurant and seriously wounded the cook.

LINDA GREGORY'S husband, Seminole County (Florida) Deputy Sheriff Gene Gregory, was killed in 1998 by Alan Singletary, who was then killed himself during the police standoff that resulted. A few weeks afterward, the Sheriff arranged a meeting between Linda and Alan Singletary's sister, Alice Petree.

"I remember shaking as I walked into the meeting," Linda says. "I didn't know how any of us would react and I was even frightened of how I would feel. When I saw her I just held out my arms and we just hugged each other and started crying. She shared their history and I told her mine and we decided that we wanted to do together whatever we could to stop this kind of thing from happening again."

Thorpe. Shortly thereafter, the Wilcoxes publicly expressed their opposition to the death penalty. Nick recalls the eventual conversation that he and Amanda had with the DA:

> We met with the district attorney about six months later and affirmed that we don't seek the death penalty in our name. He said, "You know, I was really upset when I made my initial statement to the paper," but he went on to say that he would not pursue the death penalty now.

The Wilcoxes' opposition to the death penalty was part moral – as they later said in several public statements, "To execute him for an act he committed while delusional with a severe disease is, to us, simply wrong" – and part driven by their desire to keep the focus on "policy, not vengeance," as Nick says now.

It is common for victims' families to be called upon to state their position on the death penalty to prosecutors or to members of the press. Charlie Strobel, whose mother was killed in Tennessee by an escapee from a prison mental health ward, remembers his family's meeting with the DA:

> The DA's office contacted us and said, "We want to seek the death penalty." I said, "As a family we would not want to seek the death penalty." Our public statement had already said that we agree society needs to be protected from his doing any further harm but we do not wish to seek the death penalty in this matter; it would not be in keeping with the spirit of our mother or with our own wishes. We had said clearly that we were not asking for his release – we had to say that so people wouldn't be out there thinking, "Well, they just want to let him go." So I said to the DA, "As you know, this is what our position is, and I just want to state that again." I said I would do whatever it took, though I don't think I knew what I would do or how I would follow through on that.

Barbara McNally, whose husband Jim was killed in Illinois by a childhood friend who was later diagnosed with delusional disorder, would have liked an opportunity to express her opinion on the death penalty directly to the District Attorney, but because the man responsible for the murder was never deemed competent to stand trial, the issue of the death penalty was dropped. Initially, however, when Barbara was told that the death penalty was a possibility, she was forced to evaluate where she stood on the issue:

> Early on, shortly following the arraignment, the state did tell me that the charges in the case were severe enough that it comes under the death penalty eligibility. They had 120 days to decide whether they were going to proceed down that path. They did tell me that they were going to talk to me before they made a decision. My feeling was no, I did not want to go down that path. However, I never even got a chance to give that opinion. They just called me and said they weren't going to go for it. I was fine with that, but still [it bothered me that] my opinion didn't matter.
>
> I was opposed to the death penalty because of my faith, my belief that just because he murdered my husband, it is not OK to then go and take his life. But the other main reason was that, let's say, ok, the state goes and kills him, so our family's safe from that one person. How many others are out there? I just didn't see any huge benefit or value, I didn't see that it would really address the problem.

Linda Gregory discovered through direct experience that the death of the person responsible for her husband's murder didn't make her feel better and didn't, in her view, get to the core of the problem. "I never felt good that Alan Singletary was dead," she said, referring to the fact that the

AMANDA AND NICK WILCOX'S 19-year-old daughter Laura was killed in California in 2001 by a patient at a behavioral health clinic where she was filling in as a receptionist during her college's winter break. The man who committed the murder, Scott Thorpe, was later diagnosed with paranoid schizophrenia and was found not guilty by reason of insanity and committed to a psychiatric hospital.

In their public statement at the launch of the NAMI/MVFHR "Prevention, Not Execution" project, the Wilcoxes said, "Our prisons are now filled with the mentally ill and in many instances the only way a person can receive proper mental health care is by committing a crime. The financial resources now spent on implementing the death penalty would be better spent if redirected to treatment of those with serious mental illness, thereby preventing future acts of violence. We had no control over what happened to our daughter, but we can choose how we respond. For us, part of that response involves speaking out for violence prevention and against the death penalty for people with mental illness."

man responsible for her husband's murder had been killed during the same standoff. "I just thought, what a tragedy that might have been prevented. It was a heartbreak for everybody." Years later, Linda's greater understanding of mental illness only underscores for her the futility of executions in such cases:

> I wish people who were ignorant like [I was before this happened] would understand that mental illness is an illness; people don't [commit crimes] because they want to. When people aren't able to get the treatment or the services that they need, they can become violent. What good is it going to do to kill someone who is not really responsible for the death? Some people don't understand why I see it this way. They say, "Well, they still did it." Yes, they did it, but they were ill. That's what did it, the illness, so if we combat the illness, and educate the public, then we'll be able to help someone instead of killing them.

Victims' families who did not directly confront the issue of the death penalty in their loved one's case may still find themselves called upon to express an opinion about the issue. Art Laffin, whose brother Paul Laffin was stabbed to death in 1999 by a homeless man as he was leaving the shelter where he had worked for a decade, explains that although the man responsible for the murder was deemed mentally incompetent to stand trial, "It was a very high-profile case and if he had been deemed competent to stand trial, he could have faced the death penalty. My mother said clearly that she would be against such a thing, and I made that clear in my eulogy, too." The Laffins learned that Dennis Soutar had been diagnosed with paranoid schizophrenia years before the murder, and had bounced from shelter to shelter after being released from the hospital. "He fell through the cracks," is how Art describes it.

Hearing or reading a blanket statement assuming that *all* victims' family members support the death penalty can be the lever that propels a survivor to express publicly what had previously been a quietly held belief. Julie Nelson, whose father was murdered by a man who had been diagnosed with schizophrenia, recalls that she wrote a letter to her city's newspaper in response to such an article, and she summarizes her beliefs now by saying, "For me, more killing wouldn't make it any better. To think that one is somehow going to cancel out the other or bring some kind of closure to a tragic event that's already happened doesn't make sense to me and seems to go in the wrong direction."

Tom Lowenstein was 10 years old when his father, Congressman Al Lowenstein, was shot and killed in his office by Dennis Sweeney, who had been diagnosed with paranoid schizophrenia. Tom recalls that he felt compelled to express his opposition to the death penalty publicly when an opinion piece in a Boston newspaper asserted that if you oppose the death penalty, you don't care about victims. Tom disagreed, and he thought, "I can't be the only victim's family member who feels this way, but someone's got to respond to this."

Pat Webdale puts it this way: "Killing another person never brings back the person you lost, and it's like double-doing the crime." Pat traveled to testify against the death penalty in her home state of New York, believing "that they shouldn't be killed, and especially not if they're mentally ill; there are extenuating circumstances and I want treatment in those cases, not an eye for an eye."

The Broken Mental Health System

While victims' family members ask whether there were indications that the murder of their loved one could have been foreseen and prevented, families of persons with mental illness who end up committing murder have parallel tales of foreboding and helplessness. These families are tormented by a dual remorse: that they were unable to overcome the obstacles to proper treatment of their loved one's mental illness, and that a member of their family was responsible for the murder of another human being.

"My family has lived in guilt about [my brother's crime] for a long time," says Tina Duroy, whose brother, James Colburn, was executed in Texas in 2003 after being convicted of the murder of Peggy Murphy. "I'm not saying 'My brother was mentally ill and that was his excuse.' But if he could've gotten the help that he deserved, things would've been different."

Tina remembers her older brother, as early as 14 years old, showing symptoms of what would later be diagnosed as paranoid schizophrenia. The family tried repeatedly to get him help, and James was in and out of mental hospitals as a teenager. When he turned 18 and was no longer covered by the family's medical insurance, "our grandparents literally drained their savings," Tina recalls, "but eventually we couldn't afford it." Out of the hospital and only sporadically taking medication, James got in various kinds of trouble, the most serious being an armed robbery conviction for which he served seven and a half years in prison.

After his release from prison, his mother continued to try to have him committed to a psychiatric treatment facility, but he would spend three days there and then be discharged because he was not determined to be an immediate danger to himself or others, a common standard used in determining whether an individual can or ought to remain hospitalized. Still, Tina recalls, "We knew something could happen, and we all walked on eggshells." James talked in such a way about the symptoms he was experiencing that the family grew increasingly frightened. Tina remembers:

> He would have command hallucinations telling him to do things. He would tell us that a little devil would eat his way out of his stomach and the devil would sit there and talk to him and tell him what to do. One time the devil told him to kill my brother or my mother.

That brother, Billy, underscores Tina's observation, saying, "That's why James committed the murder, because the voices were telling him if he didn't go back to prison he was going to hurt me or my mother. He didn't want to hurt us. He wanted to go back to prison and never get out."

Though James was frightened of his own potential violence, his family had a hard time convincing him to take medication regularly. "Six months is probably the longest that we saw him on his medication at one time," Tina remembers. Billy continues:

> Yes, there were times when I felt like he was on his medication and doing good, but I don't know how familiar you are with schizophrenia – they get on their meds, they're doing good, and then they think they're doing so good that they don't need their medication anymore. That's the way their mind works. If someone could administer his medication every day, he could have lived a normal life. Not give him a month's supply and say, "Take it."

In addition to his fears, James, says Tina, "felt terrible guilt about his mental illness." Remembering her last moments with her brother, Tina says

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

CHARLIE STROBEL'S mother, Mary Catherine Strobel, was abducted and killed in Nashville, Tennessee in 1986 by a man who had escaped from a prison mental health ward. Hers was the first of six murders committed before the man was arrested at the Mexican border three weeks later. After his arrest, the Strobel family released a statement saying they did not support the death penalty. "We knew it could be an issue, and we got out of in front of it," Charlie explains. "We said we do not want to see this person put to death, it was not in the spirit of the way that our mother looked at life nor the way that we look at life."

Charlie, a Catholic priest and longtime social justice activist, opposes the death penalty on both spiritual and political grounds. He remembers testifying against the death penalty before the Tennessee legislature in the 1970s, at least a decade before his mother's murder. Now that the issue has touched him personally, he feels an even greater urgency to speak out. He says, "Given that I am now a family member of a victim, perhaps it falls to me to speak out more so than to someone else."

The man responsible for the murders was sentenced to prison for three consecutive life terms and died in prison of natural causes in 2006.

Lois Robison's question is similar. Her firstborn son, Larry, began exhibiting strange behavior when he was a teenager. By the time he was talking about seeing hallucinations and hearing voices, Lois and her husband Ken knew something was seriously wrong, and they brought him to the hospital emergency room.

> The emergency room physician came out [after] about 30 minutes and told us, "Paranoid schizophrenia." They called our family doctor and had Larry admitted. They called in a psychiatrist the next day who talked to us and said it was the worst case of paranoid schizophrenia he'd ever seen. The psychiatrist said, 'He's going to need long-term care. Who's your insurance with?" I told him, but I said that Larry had just turned 21 and wasn't covered anymore. When they found that out, they couldn't wait to get him out of there.

Lois was called in to sit with her son in his hospital room while he watched television and thought he was being laughed at, or being sent secret messages, through the programs. Eventually a doctor advised her to take Larry to the county hospital. He spent about three weeks there, and

> Finally they called up one day and said they were going to discharge him in a few days. I said, "You can't do that," and they said, "We can't keep him any longer. We can only keep him for thirty days, because he's not violent." They kept asking us if he'd ever been violent. No, he's never been violent. His whole life he's never been violent. So finally I begged and I pleaded with everybody. I called downtown, you know, to where they commit people. They wouldn't do anything; they all kept asking, "Is he violent?"

Lois finally asked if Larry, having served time in the U.S. Air Force before his breakdown, could be admitted to a Veteran's Hospital. She took him there, where he again spent a few weeks before Lois got another, now all-too-familiar call from a doctor:

> He said, "We're discharging Larry and we're sending him on the bus to [the Robisons' home town]." I said, "You're kidding. Discharging him? Is he well?" "Oh no, he's not well, and if he doesn't get help he'll get worse. But we can't keep him anymore because he's not violent, and we can't keep him more than 30 days." So they sent him home, and about an hour later I got another call from the same doctor, and he said, "We made a small mistake. We forgot to get Larry to sign a release of records."
>
> This small mistake ended up having big consequences. Because they hadn't gotten Larry to sign the release of records, we couldn't get medication for him at the local Mental Health/Mental Retardation office. I asked the doctor what to do, and he said, "Take him to MHMR, get him to sign a release of records there, they'll send it to us, and we'll send them his records." In the meantime, they sent him a two-week supply of medication. But it took six weeks to get an appointment at MHMR, and by that time he'd left home. When MHMR called and said they could see him now, I said, "Well, he's left home, he's not here."

While out on his own, Larry tried to rent a truck, and drove off with one in the rental lot that had keys inside. He was charged with auto theft and spent six months in jail, during which time Lois called every agency and group she could find, trying to hit upon one that would take Larry. She managed to get him into a rehab facility for people with drug addictions, where he spent several months, but his underlying mental illness still went untreated. "I couldn't get any-

BARBARA MCNALLY'S husband, Jim, was shot and killed in Illinois in 2006 by James Masino, a childhood friend who was later diagnosed with delusional disorder. Found incompetent to stand trial, James Masino was committed to a psychiatric hospital.

Barbara remembers the shock of learning that her husband had been killed: "I was at work and my HR people came in and told me my husband had died. I said he's 44 years old, what do you mean? I ended up having to talk to the detective before I found out he was shot." She then had the terrible task of breaking the news to their three children. "There was no making sense of it," Barbara remembers. "Today, the kids are doing OK. They miss their father terribly, but they're not letting it consume them. Still, I do feel, the way this case has gone, that we're the ones who got a life sentence."

body, anybody, anybody to help me get any kind of treatment for him," Lois recalls.

Months and then years passed. Larry left his parents' home and Lois and Ken didn't always know where he was. For a period, he moved in with a girlfriend and their child. Frightened by his peculiar behavior, Larry's girlfriend ended up leaving Texas with the child. Larry continued to live on his own, still untreated, while his parents grew increasingly worried and frustrated by their helplessness; as the Robisons had initially been told, if their son was not violent he could not be held in a mental hospital for longer than 30 days. It felt to Lois and Ken as if they were running out of options.

Larry was 25, four years after his initial diagnosis of paranoid schizophrenia, when Lois and Ken heard the terrible news: their son had just been arrested for killing five people, brutally. He had decapitated the man whose home he had moved into about a month before, and shot or stabbed four other neighbors.

"Everybody said they couldn't help him, because he wasn't violent, and if he ever got violent, then they would commit him to a mental hospital," Lois says now, "and instead they committed him to death row." Larry was executed in 2000.

The nightmarish absurdity of this sequence of events has turned Lois and Ken Robison into determined public speakers who beg audiences to consider the devastation that comes from waiting until *after* a person with mental illness has committed violence before taking any meaningful action. Ken says:

> The thought that Larry was responsible for five people being murdered was more than we could handle. But immediately, with the media coming in and asking questions, we talked about it with each other and we said, "Look, we can either back off and just crawl into a hole or we can be forthright and talk about it."

Bill Babbitt, too, has decided to talk about the mental illness and execution in his family. When Bill's brother Manny joined the U.S. Marines at age 18, he had already suffered a head injury as a child, after which his family remembers that his behavior changed and his memory became unreliable.[9] Manny was sent to Vietnam, where he fought in five major battles, including the siege at Khe Sanh, where he was wounded and then medevaced out in a helicopter, forced to ride on top of a pile of dead soldiers.

He returned home, and in 1973 he was arrested for the armed robbery of two gas stations and sent to Bridgewater State Hospital, the mental hospital within Massachusetts's prison system, where he was diagnosed with paranoid schizophrenia. Bill remembers:

> My family looked at it as, Manny's in the crazy house. That's how we thought of Bridgewater. The doctors warned that if Manny was released he would need further treatment. They cautioned that without further treatment his condition would only worsen. I don't think my family had ever heard the word schizophrenia – all they knew was the word crazy. My family had no idea of the seriousness of Manny's mental illness, and no idea about post-traumatic stress disorder – we only learned about that much later.

After getting out of Bridgewater, Manny lived in Rhode Island, where he fathered two children with his common-law wife. Although the family hadn't heard the term "post-traumatic stress disorder," they saw that Manny would frequently be overtaken by memories of the war, almost as if he were reliving the experience, hearing sounds of bombs inaudible to the others around him. In hindsight, the family now understands that Manny was living with severe PTSD in addition to the paranoid schizophrenia that had been diagnosed at Bridgewater.

In 1980, Manny came out to California, where Bill

[9] Manny Babbitt repeated several grades in elementary school and never went past the seventh. When he tried to enter the Marines, he failed the test several times until, as Bill recalls it, "the recruiters gave him the answers."

ART LAFFIN'S brother, Paul Laffin, was stabbed to death in 1999 by a mentally ill homeless man, Dennis Soutar, as he was leaving the shelter in Hartford, Connecticut where he had worked for ten years. Dennis Soutar was found mentally incompetent to stand trial and was committed to sixty years in a state mental hospital.

"When it happens to you, it's earthshattering," says Art of the experience of losing a family member to murder. "It took me to a place that I'd never been before, emotionally and spiritually."

Shortly after the murder, Art and his mother had the opportunity to meet with Dennis Soutar's sister-in-law and then, later, with his brother. Art describes the meeting with the sister-in-law: "She was very, very nervous but very grateful that we were willing to meet with her. She began to tell us about Dennis; we began to learn about his history. The family had made such an effort to try to be of help to him, driving around trying to find him. You could see the pain that they were going through." Art recognizes that what happened to his brother is "not uncommon. It is a societal disgrace that some of the mentally ill homeless, who fall through the cracks and are not properly cared for, end up committing violent lethal acts."

was living with his wife Linda.

> We didn't know ahead of time what shape he was in. I knew something was wrong with Manny, but I didn't realize there was this thing called PTSD and how it manifested itself. No one told us. All I knew was that he was hyped up. He was so combative in his mind. It almost seemed like you could see his temper escalating. I noticed that he would get surly with people, and he was always talking about the war.

Manny's behavior continued to deteriorate over the next weeks. Bill remembers that Manny complained about hearing voices and had trouble sleeping. In late December, Bill read in the newspaper that a 78-year-old woman named Leah Schendel had died of a heart attack during an intrusion into her home. When he found belongings with Leah Schendel's initials in the house among Manny's things, he began to suspect that Manny might have been responsible for the crime. Horrified, he agonized about what to do. Part of him was tempted to put Manny on a bus and just get him out of there. "As his older brother who loved him, I did think about that option," Bill recalls, "but if I did that, I'd have blood on my hands too. I couldn't live with that. I couldn't live with the risk that there was someone else out there who could become a victim of my brother and his war demons."

Bill went to the police, told them what he suspected, and agreed to help lead them to Manny. He remembers vividly that after they arrested Manny, an officer said to him, "You're not going to go to the gas chamber or anything like that." But Manny was given an inexperienced attorney who had never tried a death case, and jurors were presented with very little information about Manny's history of mental illness. Bill remembers:

> They didn't say much about the war during the trial, how the war impacts mental conditions or any conditions that might have existed prior. Two members of the jury came out later, during the clemency process, and said that if they had known Manny was in such terrible psychiatric shape, they never would have voted for the death penalty. But clemency was denied. The governor said thousands of people have been through calamities and don't murder old ladies. In 1980, when Manny committed his crime, people thought PTSD was hogwash, an excuse. In 1999, when we were pleading for clemency, a lot more evidence about it had come out by then, but still it was a political thing.

Ironically, Bill says, Manny's condition stabilized in prison:

> In prison, he had a sergeant telling him what to do again. Prison was a quasi-military situation without the bombs coming in. On the streets, Manny had always needed somebody to take care of him. In prison, he would stand in the cell saying "Sir, yes sir" to the warden. There's my brother, the condemned man, telling the person who's going to strap him down and kill him, "Sir, yes sir." Manny never left the war.

Bill remains haunted by the paradoxical feeling that he both did the right thing and did something that led to his brother's execution. "For the rest of my life I have to live with the fact that I turned my mentally ill brother in and that led to his death," he says now.

Foreboding and helplessness are perhaps especially acute in those whose loved ones ended up committing violence against someone in their own families. When Joe Bruce describes his son William's worsening illness and his own growing fear for others, particularly for his wife, William's mother Amy, the feeling is of listening to some-

TINA DUROY'S brother, James Colburn, was executed in Texas in 2003 after being convicted of the murder of Peggy Murphy. Tina recalls that her brother had struggled with mental illness for years – he was diagnosed with paranoid schizophrenia as a teenager – but "there was no one we could turn to when we were trying to get help for James. No one talked about mental illness."

Tina vividly remembers the difficult period leading up to James's execution, particularly "the anticipation of knowing my brother is going to die on this day." She wishes that "more people would be open and honest about the mental illness in their family" and that those within the criminal justice system who are asked to respond to crimes committed by people with mental illness would have a greater understanding of the problem. "Our police, our lawyers, our judges need to be educated about mental illness before they make the decisions they do," she says.

one describe a nightmare scenario: seeing danger approach and being unable to intervene and stop it from coming. Willy had begun exhibiting disturbing behavior as early as age 15, when a psychiatrist diagnosed him with bipolar disorder and prescribed an anti-psychotic drug that Joe remembers as having a positive effect. "He settled down and was able to focus, and we could talk to him about things," Joe recalls. "We had no idea what bipolar disorder was. I asked, 'Do they grow out of this?'" Willy's life was up and down for the next few years, but by the time he was 21, Joe knew that something was seriously wrong:

> I went out with him for a ride in the car and he started talking about how the CIA had planted stuff under his skin and people were following him. It made the hair stand up on the back of my neck. It was the first time that I went *uh oh, now I know what the problem is.* That was the first time that I had any inkling that he was mentally ill. Even though we had been told by that one doctor that Willy was bipolar, it had no significance to us, I didn't understand. But there's a certain point at which you don't need any background in the field to know that somebody's sick. He had moved into the beginning of severe, persistent mental illness.

Joe talked to Amy about what he'd seen, and they immediately focused on trying to convince Willy that he needed help. "When people have anosognosia, which means that they either don't realize they're ill or they refuse to acknowledge they're ill, you're really up against it, if they're an adult," Joe explains. "We couldn't convince him to go for help, and we just didn't know what to do at that point." The Bruces couldn't convince their son to go for help, and legally they were unable to force him to go. Living in a remote rural area of Maine and unfamiliar with the mental health system, the Bruces struggled to figure out what step to take.

> It isn't exactly like, when something like this gets dropped on you, you say, "Oh, I know, I'll go to this agency or that agency." You ask people and most of them don't have any idea. It's better in some places than others, but we just kind of kept waiting and hoping that we'd see our way through it. We couldn't get him to a doctor. We would've taken him anywhere. I worked for the state of Maine, I had an excellent health insurance program, though actually I don't know if it covered Willy, but if we could have gotten him in somewhere, we would have, but there was no way. If you suggested it, he would get extremely agitated. Willy was always a very powerful kid, strong, not big but strong and fast. In his illness, he began showing more anger and he began to get scarier.

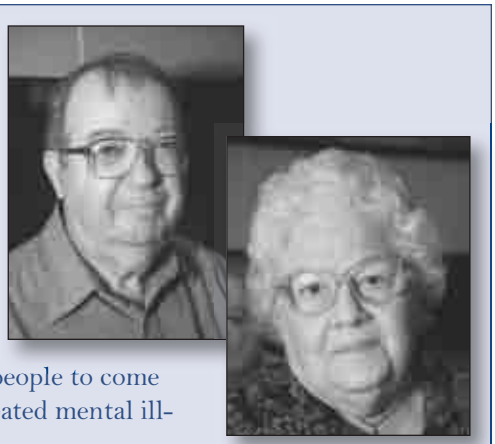
Willy lived with his parents for the next year as they struggled with his deteriorating condition. Finally, after a frightening incident during which Willy pointed a firearm at two family friends, Joe's call to a Crisis Counseling Line led to Willy's being transported to a state hospital for evaluation. Joe remembers how horrifying it was to see his son threatening the two friends.

> That was the first time that I'd ever seen somebody who was truly psychotic. When I looked at my own son, I knew that his body was there but he was somewhere else. When you see it, you understand how it's been described in some cultures at some points in time as a demon entered their body, like they're possessed. It was the most terrifying thing I ever saw.

At the state hospital, Willy agreed to commit himself voluntarily, and the medication he received calmed him down and stabilized him so that, as Joe again describes it, "you could talk to him." Meanwhile, as the date approached for a

LOIS AND KEN ROBISON'S son, Larry, was executed in Texas in 2000 after being convicted of the murders of five people. Larry had previously been diagnosed with paranoid schizophrenia. In her public statement at the launch of the NAMI/MVFHR "Prevention, Not Execution" project, Lois said,

"We were horrified, and terribly distressed for the victims and their families. We thought Larry would finally be committed to a mental institution, probably for life. We were wrong. Despite his medical history, he was found sane, guilty and sentenced to death. How can a modern, civilized society choose to exterminate its mentally ill citizens rather than treat them? When I was invited by MVFHR and NAMI to participate in the project that we are embarking on today, I said, 'I've been waiting 25 years for this.' I have been waiting for people to come together and say that the death penalty is not the answer to the problem of untreated mental illness in our country."



hearing at which a judge would decide about the need for longer-term commitment, "the hospital lawyer called the psychiatrist who said we're not going to send him [to the hearing], we don't think we have a case." Joe continues:

> We were flabbergasted. We said, "You've got to be kidding – a couple of weeks ago he almost shot two guys to death." They said "Yes, but that was then, this is now." Their interpretation of the law was that he had to be an imminent threat to himself or someone else. They said, "Well, he's on medication now; how can we honestly go before a judge and say that he's a threat?" But they also said, "As soon as we let him out of here, he'll go off his meds." I go, "Well, isn't it logical to argue that if he goes off his meds there's a good chance that he's going to be an imminent threat to himself or someone else?" They said, "Sorry, Mr. Bruce, there's nothing we can do."

Released from the hospital, Willy "got worse and worse – it started getting really scary." Joe left for work every day worried about Amy. After Willy attacked his father, who again called the Crisis Line, Willy was committed to another mental hospital, where he stayed for three months. He was released back to his parents' home and at that point he was, in Joe's words, "the worst he'd ever been – we had never seen anything like it. He was completely psychotic by this point. People in town were locking their doors." Joe remembers his increasing panic and helplessness: "I had told the doctor at [the first hospital], 'He is going to hurt or kill someone, and in all likelihood it is going to be her,' and I pointed at Amy."

Joe and Amy's frustration increased tremendously when they were prohibited from receiving any information about Willy's treatment. They later learned that patient advocates had persuaded Willy that his parents were working against his own interests and that he should cut them out of his treatment. Only much later, after Joe's worst fears had been realized, did he get access to Willy's medical records, where he learned that

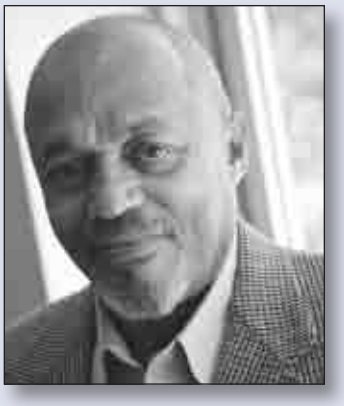
> [the doctor] whom Willy had during his commitment repeatedly stated in his progress notes, "This young man is a high risk for violent behavior if released into the community without pharmacotherapy." He was so concerned about it that he more or less said in his last notes, "Don't drop the ball on this." He wrote that Willy has a pattern of concealing his illness but is a serious threat for violent behavior if released without medication.

At just this juncture, a new doctor took over at that hospital and – influenced, Joe believes, by pressure from patient advocates - downgraded the assessment from "high risk" to "moderate risk." Willy was released in April 2006, unmedicated, and two months later, alone with his mother, he used a hatchet to take her life. Joe was the one who found her, and he "knew immediately that Willy had done it."

Willy was found not guilty by reason of insanity and remanded to a psychiatric hospital, where he is a patient today. "Now that he is getting the treatment he should have gotten back in 2005," Joe reports, "he has a long way to go but he has not been in a state of psychosis for months and months. He is doing well, but his life is ruined. He has a deep awareness of what happened. He has to live with what he did."[10]

Living in Maine, a state that does not have the death penalty, the Bruces did not directly face the threat of a death sentence, but Joe is able to imagine the way that such an out-

[10] In April 2009, William submitted written testimony to Maine lawmakers in support of a bill that would provide Assisted Outpatient Treatment (AOT). He opens the letter by explaining that he is in a psychiatric facility because he killed his mother, and then he writes, "I have been living in sorrow since." William then goes on to summarize the events leading up to his mother's murder: "Before the crime happened I was hospitalized but I refused medication. If I had been on medication and in an outpatient treatment program I would not be writing you this letter today. I struggle with this on a daily basis. At the time everything seemed clear to me. I was a clandestine operative and I believed my mother was an Al Qaeda operative and I was being ordered to kill her. I did not realize how distorted my mind was and how much the delusions had taken over. My dad tells me everyone could see there was something wrong with me but I couldn't. This is when I should have been treated."



BILL BABBITT'S brother Manny, who was diagnosed with paranoid schizophrenia and post-traumatic stress disorder after serving two tours of duty in Vietnam, was executed in California in 1999 after being convicted of the murder of Leah Schendel.

"I wish we had been able to get my brother the help he needed long ago," Bill says. Manny's death sentence and eventual execution took a toll on the entire Babbitt family. "We never really thought he would be executed, right up until the last half hour when I watched my brother be put to death at San Quentin Prison," Bill remembers, adding that he will never forget the look on his mother's face that night. "My mother suffers to this day from the effect of losing her son to execution. Manny's children suffer too. These are innocent people who have been harmed by the death penalty."

come would have felt like a compounding of the tragedy. "To have lost my wife and then to spend years going through appeal after appeal and death watches – adding that to the scenario would be degrading to our family and to the memory of my wife and the love that she had for Will. It would be a constant reminder of the worst thing that happened in our lives, over and over again."

Others who experienced a murder within the family expressed similar sentiments about the inappropriateness or futility of the death penalty for such cases. Speaking of her sister-in-law, Carla Jacobs said, "The threat of the death penalty did not deter Bette from killing her mother. In her mind, what she was doing was just and right. To then execute her would not have served any purpose. You would be murdering a mental illness with a body attached, if you will."

The threat of the death penalty may not deter someone who is operating under significant delusions, but, as the Crespi family's story illustrates, the threat of a death sentence can have other consequences once a murder has been committed. Kim Crespi's husband David killed the couple's 5-year-old twins, Samantha and Tessara, during a psychotic episode that the family now believes was caused by a toxic reaction to anti-depressant medication. He was sentenced to two life sentences in prison. As Kim recounts it now, David was offered the choice of pleading guilty and accepting the two life sentences or going to trial and risking a death sentence:

> We were backed up against a wall and couldn't gamble on his life. The defenders said to David, "You will lose your family through a death penalty trial; they will not support you." Well, that was not their call. Lawyers also came to see me and said, "You have no good options, this is the only way to save his life."[11]

In shock about what had happened, and struggling to care for the family's surviving children, Kim had initially not even considered the possibility that David could be facing a capital trial. "It had never occurred to me," she explains. "I didn't even know we had the death penalty in North Carolina! And I thought David would go to a psych ward. I remember thinking, he's clearly sick, how can this even be a criminal matter?"

The prospect of a death sentence for David, on top of the tragedy the family had already experienced, added an unthinkable possibility to what was already beyond their understanding:

> Executing David would only make things worse for me and our children. It is hard enough for them to understand that their loving father, in an uncontrolled psychotic state, killed their baby sisters. Trying to understand how reasonable, non-psychotic people would now choose to take their father's life would create another layer of distrust and tragedy that certainly would do nothing to aid in their healing.

[11]David Crespi's brother, John Crespi, also felt that the threat of the death penalty was a huge factor in David's agreeing to forego a trial. Three years later, John, like Kim, wishes that they had encouraged David to risk going to trial so that they might have had the opportunity to learn more about the psychosis that led to his killing the twin girls. Now suspecting that the psychosis was caused by a toxic reaction to anti-depressant medication, John Crespi says, "I personally believe the drugs caused the tragedy, but I know we never got a chance to see that taken up in court because this case was wrapped up so fast. At the time, I think his lawyers thought it was best for David to forego a trial. I know I thought so, because a death penalty would have added one more meaningless death to an already grieving family. We had been told that a mental institute was worse than prison. For so many reasons, we encouraged a decision that I now believe we were in no position to make because we still did not know all the facts."

Knowing Right from Wrong: Victims' Perspectives

The legal process makes determinations about an offender's degree of culpability and makes its own kinds of judgments about an offender's mental capacity at the time of a crime. Victims' families and families of offenders, thrust in the midst of shock and loss into the world of legal distinctions, quickly learn the meaning of phrases like "diminished culpability" and "not guilty by reason of insanity," but their own attempts at inquiry and understanding go beyond the legal realm. As they try to comprehend the actual story of what happened to their loved one, they have before them, in some sense, a dual reality. One human being took the life of another, and thus – in the vernacular if not always in the language of the law – was responsible for the act and is guilty of having done it. Yet if the person committed the act while operating within a profoundly delusional and disordered thought process, can he be said to have the same level of responsibility as someone without those impairments?

An examination of families' reactions to legal determinations regarding a defendant's level of culpability may seem to be a departure from the topic of the death penalty. But for victims' families and families of offenders who are directly affected by these issues, the questions are all tied up together: what should be done about murder committed by someone with severe mental illness? How are we to understand such crimes, how should we as a society respond to them, and how do victims' perceptions or reactions factor into this?

The distinction between insanity as a legal concept and mental illness as a psychiatric diagnosis is frequently the first juncture at which families confront a discrepancy between the legal arena and their own understanding or experience. The legal concept of "insanity" derives from the 19th century "M'Naghten Rule"[12] that to be considered insane a defendant must have been "laboring under such a defect of reason, from disease of mind, as not to know the nature and quality of the act he was doing; or if he did know it, that he did not know he was doing what was wrong." Families of defendants, and perhaps especially those who are related to both the victim and the offender, have had to consider very carefully this question of what it means to say that an individual "didn't know what he was doing" or "didn't know right from wrong."

Jacqueline Stuart[13] came to understand that "a person can know the difference between right and wrong in certain instances if it has nothing to do with their delusion. But if there's a delusional system that's taken over, that wipes it out. The legal definition sees this in a very simplistic context, whereas what's going on in the brain is a lot more complicated."

Jacqueline dates the beginning of her son's illness back to the mid-1970s, when he was a college student. Like so many others, she "knew very little about mental illness before this happened to our family." Jacqueline and her husband tried for four years to get help for their son, who was diagnosed with paranoid schizophrenia, but "everywhere we turned, it became some kind of dead end." Their first attempt to get help, at a local mental health clinic, had yielded a mistaken diagnosis and thus the wrong medication. In another attempt, on the recommendation of a local psychologist, Jacqueline and her husband sent their son to a live-in "farm" for psychiatric patients. He received no medication there, and came home after six months "in pretty bad shape," as Jacqueline recalls it, but "tried to hide his symptoms." He next went to a psychiatric hospital a couple of hours away from the family's home and spent five days there without being treated. Jacqueline remembers that she

> tried several times to call and talk to the doctor to explain that my son had been sick for nearly four years and they really needed to move fast at this point. I wanted to suggest that by now we were in a crisis situation. My son had even asked for medication by this time. But I was not once able to talk to the doctor. Then someone called from the hospital and said, "Your son wants to leave." He had been there for five days and they had done nothing

[12] Daniel M'Naghten, a man with paranoid schizophrenia who shot and killed the Secretary to the British Prime Minister in 1843, was found not guilty on the grounds that he was "insane" at the time of the crime. The British House of Lords then used this case as a basis for establishing legal standards for a defense of insanity.

[13] At the interviewee's request, this name is a pseudonym.

JOE BRUCE'S wife, Amy, was killed in 2006 by their son William, who had been suffering from mental illness for several years. William was found not criminally responsible by reason of insanity and was committed to a Maine psychiatric hospital – the very hospital from which he had been released just two months prior to murdering his mother. In a 2008 newspaper article about the case, Joe speaks of obtaining William's medical records from the hospital eight months after the family's tragedy: "I read through the records and I just remember crying all the way through. My God, these people knew exactly what they were sending home to us."[1]

In the immediate aftermath of the tragedy, Joe made a decision to speak publicly about what had happened in his family. "I made up my mind that there were no secrets in the Bruce family," he explains. "I decided that people had to see this, people had to understand. When a reporter from the local newspaper called me the day afterward, I told him about how sick Willy was and how we had tried to get him help and that they had sent him home and that his mother just couldn't abandon him. I told him that his mother and I forgive him."

[1] Elizabeth Bernstein and Nathan Koppel, "A Death in the Family," *The Wall Street Journal*, August 16, 2008.

> and I guess he got fed up and wanted to come home. We weren't going to say, "Turn him out on the street," so he came home on the bus by himself. He later told me that as he was walking home from the bus stop, there were these voices talking to him.

At home, Jacqueline's son's condition deteriorated further. His parents tried to determine what their next step should be. At one point he disappeared from his parents' house without telling them where he was going. Only later did Jacqueline find out that he was living on the streets on the opposite end of the country, deteriorating into acute psychosis and becoming emaciated because he wasn't getting enough to eat. "He had developed the delusion that his father was somehow taking food away from him and he was going to die of hunger," Jacqueline explains now. After several months of this, he showed up at his parents' house unexpectedly, took out a knife, and killed his father with a single stab. Jacqueline came into the room minutes later, when it was already too late to save her husband.

Jacqueline believes that imposing the death penalty on her son would have been "barbaric" and would have only added to the agony that the family was already experiencing. Convicted in a state that only rarely sentenced people to death, Jacqueline's son did not face a capital prosecution and was sentenced to a prison term rather than to death. Wishing that he had been found Not Guilty by Reason of Insanity so that he could be committed to a psychiatric hospital and at long last receive treatment, the family struggled with what they believed was an inappropriately narrow definition of insanity, which did not encompass her son's longstanding diagnosis of schizophrenia. The family also suffered from the additional stigma placed on them because they were related not only to the murder victim but also to the person responsible for the murder. It was as if "the fact that I was a victim's family member disappeared," Jacqueline says now, referring to the fact that she was advised that the district attorney wouldn't speak with her and that the newspaper headlines characterized her only as the "murderer's mother" and not also as the widow of the victim.

The distinction between knowing and not knowing right from wrong can blur when an individual behaves in ways that suggest recognition of the wrongness of his actions, but at the same time has taken those actions in the context of delusional thinking. Kim Crespi recalls that her husband's call to 911 after he had stabbed the twin girls to death was viewed as an indication that he knew what he did was wrong, "but the lawn sprinklers told him to [make that call]," she explains now. "He was hallucinating." (Kim recalls that David also believed that the children would be able to be brought back to life.)

Carla Jacobs, who was quoted earlier as saying that the threat of the death penalty did not deter her sister-in-law, Bette, from murdering her own mother, Roma Jacobs, sees it this way:

> Let's face it, most people know that it is wrong to murder somebody. However, people with mental illness like Bette are being driven by their demons. They are victims of an illness that causes them to believe that what they are doing is of more moral purpose than the law itself. Bette planned the murder. She actually, we found out later, tried to hire hit men to do it for her. So there was a lot of planning that went into the murder. Not effective planning, or she would have gotten away with it, but it was not just a case of "Oh, I'm going to murder my mother right now." It was very definitely a calculated murder, but the calculation was based upon delusions and illness.

This paradox - that an individual can have the cognitive ability to know that something is wrong but, in the grip of a delusion or series of delusions, believe that a specific act falls outside that general rule – can be challenging for victims' families to accept. It's one thing if the delusions and

CARLA JACOBS'S sister-in-law, Bette Madeira, was found not guilty by reason of insanity after murdering her own mother, Roma Jacobs, in California in 1990. Bette was committed to a psychiatric hospital.

"You can't punish mental illness out of a person; the only way you can defend society is to provide individuals with treatment, " Carla says now. "Bette had in the past responded to medication and treatment. If she had been allowed access to the hospital originally, if she had received treatment commensurate to the fact that she had no recognition of her illness and therefore was incompetent to make those decisions herself, the crime wouldn't have occurred. It's very simple: waiting for danger is too late."

the acts that follow from them seem to have little or nothing to do with the *specific* victim who is tragically in the wrong place at the wrong time. For example, Julie Nelson's father George Nelson, a Lutheran minister, was shot and killed by the son of an elderly parishioner whom he was visiting:

> One of the doctors who [later] evaluated Peter Thorpe said that he'd been hearing voices that he was characterizing as demons, malevolent voices, and he'd been fearing them which is why he'd gone out and gotten the gun. Then when he was in the back room of the apartment, he thought my dad's voice was the voice of one of those demons in his head. We understood that he was sick, that it was not premeditated against my dad.

But when the act appears to have been premeditated and the individual victim specifically chosen and targeted, the victim's family can view the offender as more directly culpable, even if also suffering from mental illness.

"I'm not questioning that this guy's mentally ill," says Barbara McNally, "but I do believe that he knew what he was doing." As we described earlier, Barbara's husband Jim was killed by a childhood friend who was later diagnosed with delusional disorder. "When I first learned that they had found nine shots, I recoiled in my chair," Barbara remembers. "I thought, 'that's an assassination.'" She continues, "While I knew that surely there was something wrong with him, I didn't feel that he was insane because of the cold calculation before and after the murder. Mentally ill yes, but I do believe that he understood the criminality of what he was doing."

As quoted earlier, Barbara was against the death penalty for the man who killed her husband, but she was also upset by the "not guilty by reason of insanity" finding that resulted in his being sent to a psychiatric hospital rather than to prison. "My feeling is that he certainly is guilty. The 'not guilty by reason of insanity' really grates on me."

Similarly, Tom Lowenstein felt that "to have the state of New York say 'not responsible' was just a huge smack in the face." Tom, who as we noted earlier was 10 years old when his father, Congressman Al Lowenstein, was shot and killed in his office by Dennis Sweeney, who had been diagnosed with paranoid schizophrenia, said, "It's not that I thought [Dennis Sweeney] wasn't sick, but he was well enough to plan this out, to get the gun where he needed it, and go and track my father down. I thought he was *both*: sick in the head, but clearly able to control his actions, to figure things out."

However victims' family members come to interpret the state of mind of the person responsible for their loved one's murder, the phrase "not guilty by reason of insanity" can feel insulting, insufficient, or at best imprecise. The difficulty here is not only with the discrepancy between the legal and the psychiatric definitions of insanity but also with the implications of the words "not guilty."

Significantly, families of the executed, too, struggle to find a way of understanding and telling what had happened that adequately acknowledges their loved one's guilt. Conceptually, the words "guilty but mentally ill," or even "guilty *and* mentally ill," sit better with both victims' families and families of the executed than "not responsible" or "not guilty by reason of insanity." Julie Nelson said that she would like to see

> language that goes more toward, it's not that you didn't do it, it's not that you're excused from doing it, but we don't think we can punish you because you didn't know what you were doing. I think "guilty but mentally ill" would bring less rankling.

While the families interviewed for this report were unanimously opposed to sentencing mentally ill defendants to death, their views on what form of punishment *would* be appropriate, or whether it was appropriate to think in terms

KIM CRESPI'S 5-year-old twin daughters, Samantha and Tessara, were killed by their father, David Crespi, during a psychotic episode that the family now suspects was caused by a toxic reaction to anti-depressant medication. Kim explains that David had been dealing with recurring episodes of severe insomnia, anxiety, and depression.

"Each time," Kim remembers, "we sought help, listened to advice, went to therapy, and followed the prescribed medication. We were not warned about potential side effects of medication, particularly the possibility of mania and psychosis."

Rather than face the possibility of a death sentence, David Crespi pled guilty, and he is now serving two consecutive life sentences in North Carolina prison.

In her public statement at the launch of the NAMI/MVFHR "Prevention, Not Execution" project, Kim said, "I am here today with other family members of murder victims, feeling our shared losses. I am here today with family members of people who have been executed, deeply aware of how close our family came to suffering that additional loss too. And I am here with others who are family members of both the victim and the person responsible for the crime, saying that the death penalty is not the way to respond to tragedies like ours."

of punishment as opposed to treatment, definitely varied. That diversity of opinion derives from the varying details of each specific story and from the victims' family members' range of personal responses and views. Collectively, their remarks highlight the questions with which victims' families grapple and demonstrate that opposition to the death penalty is not synonymous with a belief in complete absolution of responsibility.

Pat Webdale vividly remembers struggling with the question of how to view the culpability of Andrew Goldstein, who pushed Pat's daughter Kendra to her death in the New York City subway: "I was tortured by the question – I wrote an essay for myself, should the mentally ill be held accountable? I used to lie awake at night thinking about it. I definitely didn't want him killed, but I definitely needed a consequence. That's the guts of it."

The idea of a legal outcome that acknowledges the defendant's guilt while also taking the exigencies of his or her mental illness into account was compelling to some of the family members interviewed for this report, making the phrase "guilty but mentally ill" conceptually attractive. But in practice, a "guilty but mentally ill" verdict, which is an option for jurors in several states, does not differ significantly (or at all) from an ordinary "guilty" verdict. One professor of law and psychiatry called the "guilty but mentally ill" verdict "a sham," adding that "it is nothing more or less than another guilty verdict."[14] Particularly significant for our discussion is that a "guilty but mentally ill" verdict does *not* prohibit a death sentence, and, though it is not common, it has happened that a defendant has been found "guilty but mentally ill" and then sentenced to death.

In theory, a "guilty but mentally ill" verdict would seem to offer a compromise between the extremes of punishment-without-treatment and treatment-without-accountability. But just as jurors can misunderstand (or, in some states, fail to be told) the consequences of a "not guilty by reason of insanity" finding, believing that it will result in a defendant's "getting off" entirely, so can they misunderstand the consequences of a guilty but mentally ill finding, believing that it will result in the defendant's getting mental health treatment in prison (or being rendered ineligible for the death penalty). Says Amnesty International:

> In theory, defendants found guilty but mentally ill were supposed to be guaranteed mental health care during their incarceration. However this has largely proved illusory and the "guilty but mentally ill" verdict has been widely criticized. It appears to have been a legislative response aimed at assuaging public outrage following particular high-profile cases, rather than a more preventive and treatment approach to people with mental illness who commit serious crimes.

And, as we can infer from this summary, the question of victims' family members' response to this verdict has not been given much, if any, consideration. It may be tempting to assume that victims' families fall under the rubric of a general public outraged by policies that are insufficiently tough on crime; if that were so, victims' families, too, might be assuaged by a "guilty but mentally ill" option that didn't actually differ from "guilty" in any meaningful way. But victims' families are both less monolithic and more nuanced in their attempts to wrestle with questions of criminal responsibility in offenders with mental illness than this assumption allows.

A couple of states[15] also offer a "guilty except for insanity" option, which is essentially another term for "not guilty by reason of insanity," as the defendant who receives such a verdict will be committed to a psychiatric hospital rather than sent to prison. But with "guilty except for insanity," the individual is then placed under the supervision of an independent Psychiatric Security Review Board for as long as the maximum sentence that could have been imposed had the person been found guilty. These PSRBs, much like parole boards, take administrative responsibility for those

[14] Ralph Slovenko, Physician's Weekly, October 27, 1997, Vol. XIV, No. 40.

[15] Specifically, Oregon, Connecticut, and Arizona.

JACQUELINE STUART'S[1] husband was killed when their 24-year-old son, who had been diagnosed with schizophrenia, stabbed him in their family home. Jacqueline's son was found guilty of manslaughter and sentenced to a prison term of 8-25 years. "Mental illness," says Jacqueline, "is very isolating and very, very frightening, both to the person who is experiencing it and to the family." She has come to understand that "serious mental illness is brain disease; it's a misfortune, not a disgrace."

Now receiving medication that, as Jacqueline describes it, "controls some of the worst symptoms – the hallucinations, the delusions," her son's condition has improved, but with that improvement comes an awareness of what his actions led to years ago. "I think that shortly after the tragedy, he had no awareness that he had done something that he would consider wrong," says Jacqueline today. "Later, one of the psychiatrists who examined him told me that my son had come to the realization that he had done something terrible and that he felt terrible about it. Now, today, he doesn't need to look at me and say 'I'm sorry for what I did.' This is understood between us."

Jacqueline concludes, "If my son had received anti-psychotic medication when he needed it, I think the whole tragedy could have been averted.

[1] At the interviewee's request, this name is a pseudonym.

who have come to institutions after a successful insanity plea. They oversee the individual's treatment and can set conditions for release or for return to a hospital.

We have seen that both victims' family members and families of the executed, each from their own perspectives, try to make sense of the question, "How do we define criminal responsibility?" In other words, how can we acknowledge and account for the fact that someone *did* an act but did it in the throes of an illness so severe that the "doing it" did not necessarily occur within the context of a shared reality or with full awareness of the act's ramifications? In and among the many considerations, both political and practical, that may influence a legal outcome in a case of murder committed by an individual with severe mental illness, we can view the options now available as imperfect attempts to reckon with this question. Any societal effort to improve upon the current situation must manage to acknowledge and address the harm done to the victim and his or her family, the mental illness of the person responsible for the act, and the legitimate public safety interest in trying to protect others from becoming victims.

Tom Lowenstein reflects on the inadequacy of the existing options this way:

> The way the system is working now is bad for [people with mental illness] *and* bad for victims' families. Either the person is declared "not responsible," which is a huge insult to the victim's family, or you go to trial and the jury is presented with two options: in one, the guy could really be out in a few years, or you send him to prison where he gets no treatment.

Any option that tilts too far toward either of the extremes – punishment without treatment or treatment without acknowledgment and accountability – will be at least somewhat unsatisfying to victims' families who want their own experiences, their own losses, adequately recognized and who also want the underlying circumstances surrounding their loved one's murder – untreated mental illness – to be addressed. In light of this difficult and as yet unresolved challenge, the death penalty strikes these families as profoundly beside the point. It fails to address the heart of the matter, whether in terms of recognizing the harm done to victims' families, understanding the effects of severe mental illness, or reducing the chances of similar tragedies occurring in the future.

TOM LOWENSTEIN'S father, Congressman Al Lowenstein, was murdered by Dennis Sweeney, who had been diagnosed with paranoid schizophrenia. Dennis Sweeney was found not guilty by reason of insanity and committed to a psychiatric hospital.

Tom describes himself as always having been opposed to the death penalty. He explains, "I mean, as a child I wanted to kill the guy myself; I didn't think the state could do it fairly. The inequalities in the system were always too much for me. Later I'd have arguments with people about the death penalty [as a social issue] and they would say, 'If you'd been through it, if someone in your family had been murdered, you'd feel differently.' I'd sit there weighing whether to tell them that I had been through it."

When Tom decided to become active in opposing reinstatement of the death penalty in Massachusetts, where he lived in the 1990s, he met other victims' family members who shared his views for the first time. "It was amazing," he says of that experience. "It was the first time I had ever talked about my dad with someone who had been through something similar."

Giving Victims a Voice

The case's legal outcome is not victims' family members' only concern. Other considerations, such as access to information and the opportunity to testify to or otherwise receive recognition for the impact of the crime, factor heavily into victims' family members' feelings about the societal response to their tragedy. An additional reason for dissatisfaction with the "not guilty by reason of insanity" verdict, among some victims' family members, is that once a case is under the jurisdiction of the mental health system rather than the criminal justice system, the rights of victims are less clearly delineated. In some instances, when a defendant is deemed incompetent to stand trial or when the case results in a "not guilty by reason of insanity" verdict, the victim is plainly deprived of a right that he or she would have retained had the defendant been found criminally responsible and the case adjudicated within the criminal justice system.

A defendant found "not guilty by reason of insanity" may spend more time in confinement (in a psychiatric facility) than one found guilty and sentenced to prison.[16] From the standpoint of public safety and even of a victim's family member's own desire to know that the defendant is securely removed from society, a guilty verdict is not necessarily preferable to not guilty by reason of insanity. But when it comes to access to information, and the right to be notified about developments in the case, and the right to testify to the impact of the crime, a not guilty by reason of insanity ruling may offer a victim's family much less than a guilty verdict.

"Victims of crimes committed by individuals with mental illnesses are less likely to receive information, services, and protection than other crime victims," says a 2008 report from the Council of State Governments Justice Center.[17] The report, undertaken with support from the federal Office for Victims of Crime and titled "Responding to People Who Have Been Victimized by Individuals with Mental Illnesses," asserts that "The relatively small number of cases in which an individual with a mental illness is ordered into the care of a state mental health forensic facility should not diminish the importance of this issue."

Because federal victims' rights law does not address the specific issue of victims' rights in cases where a defendant is found "not guilty by reason of insanity" and committed to a psychiatric facility rather than to a prison, it has been left to individual states to figure out how to respond to victims in these cases and, in particular, how to navigate the conflict between the rights of victims and the legally mandated privacy rights of those who enter the mental health system. At present, according to the Council of State Governments report, this territory remains largely undefined:

> No prosecutor or victim advocate interviewed [for the Council of State Governments report] had received instructions or training about how to protect and serve this group of crime victims. In addition, no prosecutor or victim advocate had designated personnel within his or her office for managing cases involving victims of crimes committed by individuals with mental illnesses. Finally, most individuals surveyed said there was not (or they were not aware of) an individual assigned in either the mental health system or criminal justice system to serve as the point of contact between the forensic facility and the prosecutor's office or victim advocate.

When the man who shot Julie Nelson's father to death was released from the psychiatric facility to which he had been committed after being found incompetent to stand trial, the Nelson family was not notified and indeed only learned about it by seeing mention of it in the newspaper. Living at the opposite end of the country and not anticipating being directly affected by his release, Julie says she wasn't personally disturbed by the news but she does think it would have been preferable if the family had been officially notified. Her state's victims' rights law, which would have been applicable had the defendant been found guilty, mandates that the fam-

[16] See, for example, E. Silver, "Punishment or Treatment? Comparing the Lengths of Confinement of Successful and Unsuccessful Insanity Defendants", Law and Human Behavior, Vol. 19, No. 4, 1995.

[17] Monica Anzaldi Ward and Hope Glassberg (2008). *Responding to People Who Have Been Victimized by Individuals with Mental Illnesses.* New York: Council of State Governments Justice Center.

JULIE NELSON was 22 when her father, George Nelson, a Lutheran minister, was shot by the son of an elderly parishioner whom he was visiting. Julie remembers her mother telephoning her with the news: "I was standing up when I answered the phone. I'd never understood why people say, 'Sit down, I've got bad news,' but I just collapsed on the floor."

Julie and her family learned that her father had been sitting on the couch talking with his parishioner, Chester Thorpe, when Chester's son Peter suddenly came out of the bedroom with a rifle and shot at them both, killing George Nelson and wounding Chester Thorpe. "My mom and I went and visited Chester in the hospital, where he was just in agony with remorse that his son could have done this to his friend," Julie remembers.

Peter Thorpe was found incompetent to stand trial and was committed to a psychiatric hospital in California.

ily receive such a notification. Had they not received it under those circumstances, they would at least have had grounds to object that a right was not being enforced.

For Barbara McNally, one reason a guilty verdict would have been preferable to "not guilty by reason of insanity" was that she would have been entitled to deliver a victim impact statement during the sentencing phase of the trial. "I wanted my kids to be heard," she explains. Barbara's children were 7, 10, and 12 when their father was murdered, and the impact on them is foremost in Barbara's mind. Barbara wanted it "recognized that yes, you are a victim, that is recognized by the court." She wanted to be able to deliver a statement that would say, "This is how we've been harmed, this is what this did to us," as she would have been able to do had the case been criminally adjudicated.[18]

"I want victims to be able to give a statement even if it goes this way," she says now, explaining that she is working with her state legislator to craft a bill that would allow victims' families to be able to deliver an impact statement regardless of the defendant's eventual legal status.[19] "I feel like we're blazing a trail here," she says.

[18] The defendant in this case was never deemed competent to stand trial.

[19] At the time of this writing, Senate Bill 0042 was working its way through the Illinois legislature. The bill "Provides that if a criminal defendant has been found not guilty by reason of insanity of a violent crime and a hearing has been ordered by the court under the Mental Health and Developmental Disabilities Code to determine if the defendant is: (1) in need of mental health services on an inpatient basis; (2) in need of mental health services on an outpatient basis; or (3) not in need of mental health services, the victim or the victim's spouse, guardian, parent, grandparent, or other immediate family or household member shall have the right to present a victim's impact statement at the commitment hearing."

Turning Grief into Action

Amanda and Nick Wilcox actively sought an admission of guilt and acknowledgment of harm done, but they pursued this primarily within the mental health, rather than criminal justice, arena. After their daughter Laura's murder, the Wilcoxes filed a wrongful death suit against the county, on the basis that the murders (of Laura, and of Scott Thorpe's other victims) were "predictable and preventable" and that "the county had failed in both those things," as Nick explains now. Nick continues, "We wanted the county to deliver an acknowledgment of harm and an apology to us, and we wanted to deliver a victim impact statement."

In their eventual settlement,[20] the Wilcoxes did receive a public apology, read at the county Board of Supervisors meeting, and they delivered their own impact statements at that same meeting. Amanda's statement began by describing how she had learned of Laura's murder:

> I remember becoming numb, feeling as if I were underwater with my senses diminished. My knees buckled, I sat down. Our two tall teenage sons crawled into my lap, and for my family, life as we knew it was over. … I spent the next months in a state of shock, disbelief, pain and physical illness. I could not sleep. I slowly adjusted to my new life as a grieving mother. Now the hurt is not as raw, but it runs deep. The grief and heartache come in unexpected, overwhelming waves.
>
> As parents of a murdered child, we had, and still have, three great needs: information, accountability, and most importantly, recognition of the harm we have endured. We have had difficulty with all three.[21]

This is at the heart of the phrase "victim impact statement": an opportunity to describe, and be heard describing, the devastation that murder causes. But the Wilcoxes' pursuit was also of an acknowledgment that Scott Thorpe's mental health treatment prior to the murders had been inadequate and – critical to their argument – truly could have been better. Just as Joe Bruce, quoted earlier, learned later that medical records included a psychiatrist's note saying that his son William Bruce presented a high risk for violence if released from the hospital, so did the Wilcoxes learn that a psychiatrist's evaluation had characterized Scott Thorpe as "potentially dangerous and on the verge of needing hospitalization."[22]

The Wilcoxes had actually *wanted* a finding of "not guilty by reason of insanity," because they viewed that finding as a way of pursuing accountability from another angle. "We actually had the same view as the public defender," Nick recalls. "We both wanted to show the lack of mental health care. He wanted "not guilty by reason of insanity" for his client and we wanted that too because we wanted to get knowledge and change."

The Wilcoxes soon advocated for the legislation that became known as "Laura's Law," which allows for court-ordered outpatient treatment for people with mental illness who pose a risk for violence and have refused voluntary treatment.[23] It was modeled on similar legislation in New York, "Kendra's Law," named for Pat Webdale's daughter Kendra.

Families who advocate for this kind of policy change do not necessarily view it as an airtight solution to the problem of violence committed by persons with mental illness; in an interview with his local newspaper, Nick Wilcox said of the legislation, "We recognize it was less than a perfect bill, but

[20] The settlement also included (1) Nevada County's commitment to implementing Laura's Law if Prop 63, the "Mental Health Services Act," passed at the state level, (2) a meeting between the Wilcoxes and Scott Thorpe's psychiatrist, in a restorative justice setting, (3) naming the new county facility for children's mental health and other children's services the "Laura Wilcox Building," (4) a cash payment of $150,000, and (5) the County's agreeing to be responsible for paying the full cost of the Wilcoxes' grief counseling. The Wilcoxes donated the cash settlement (which, after discovery costs and attorney fees, came to about $55,000) to the Prop 63 campaign, to child advocacy and mental health advocacy organizations, and for scholarships. Amanda says, "We never planned to, and will not, keep any of the settlement money."

[21] Amanda Wilcox testimony before the Nevada County Board of Supervisors, September 28, 2004.

[22] Nick Wilcox testimony before the Nevada County Board of Supervisors, September 28, 2004.

[23] The legislation, which originally passed in 2002, did not include a funding stipulation, and the decision about whether to implement the bill's "assisted outpatient treatment" program was left to each county. When California's Proposition 63, the Mental Health Services Act, passed in 2004, the Wilcoxes were among those who hoped that now counties would have the funds they needed to implement Laura's Law more widely.

PAT SEABORN'S cousin, Ron Spivey, was executed in Georgia in 2002 after being convicted of the murder of Billy Watson. Pat recalls that her cousin had a long history of mental illness, and spent a couple of weeks in a psychiatric hospital as early as age 15. "At that time, mental illness was something you didn't talk about," Pat says, referring to the 1950s when Ron was a boy. "It was hushed up."

Today, Pat says of her cousin and others with mental illness who have been convicted of murder, "These people that are committing these crimes, don't just assume that they're monsters. Don't forget that they have families, people that love them. I wish people would understand that [a claim of] mental illness is not a cop-out; it's not about trying to get them off. I wish it could be recognized that serious mental illness exists and if it is treated, a person can be saved – that one ill person and the people who come in contact with them."

you have to start somewhere."[24] What families hope to do through their advocacy is draw attention to the kinds of problems that, in their analysis and understanding, led or contributed to their loved one's murders.

Pat Webdale recalls that the morning after her daughter Kendra's murder, she was "standing in my kitchen and yelling, 'Why wasn't he taking his medicine? I am going to do something about this!'" She goes on to recall that as she began to learn more about mental illness, she came to a richer understanding of why an individual might refuse to take his medication, which in turn led to her involvement with the National Alliance on Mental Illness and to a range of public speaking and advocacy work.

Linda Gregory, similarly, became an advocate for assisted outpatient treatment and was instrumental in working for reform of Florida's Baker Act, which, like the other laws described here, allows court-ordered outpatient treatment for people with severe mental illnesses who have refused voluntary treatment and have had multiple involuntary commitments or a history of violence. Linda now trains members of law enforcement in crisis intervention, and has worked to increase the availability of mental health screenings when individuals are arrested for misdemeanors. "If they can catch it there and divert them into treatment rather than to jail, we can prevent worse crimes from happening," she explains.

Her involvement in this kind of advocacy work has put Linda into contact with many who live with mental illness and their families. Linda, who by her own description knew "next to nothing" about mental illness before her husband's murder, now has a more nuanced understanding of both the challenges and the possibilities that exist for people faced with such diseases. One of her closest colleagues in this advocacy work is the sister of the man who was responsible for Linda's husband's murder. "My biggest concern was to protect law enforcement from being hurt," Linda explains of her initial motivation for engaging in advocacy work. She continues:

> For [Alan Singletary's sister], her major concern was trying to get treatment for people like her brother. As we worked together and as I became more educated, I realized it's about this total person who's ill, who needs help, and if we can get them help, all the rest of this is going to fall into line. And she began to realize that it wasn't just the person themselves, it was the whole community that was involved, including law enforcement. So we came from a different angle but ended up at the same place.

Barbara McNally, who, as we noted earlier, has been advocating for the application of victims' rights in cases that result in a "not guilty by reason of insanity" finding or those in which a defendant is deemed incompetent to stand trial, says, "My motivation is to make it better for the next person. I keep thinking, we can't have been the first. If I can make it better for some future victims, that's what I'm going to do."

Those who have not been through the experience of losing a loved one to murder may find such altruism mystifying or dismiss it as exceptional, but victims' families' subjective experience of advocacy work is more complex and multi-layered than this dismissal assumes. Along with a genuine desire to prevent others from experiencing similar tragedies, a family member's activism can be motivated by a reclamation of their own sense of power and agency. Explains Amanda Wilcox, "I felt stripped of control after Laura was killed. This awful thing was done to us, and we needed to gain control of our lives. Working on legislation has been and continues to be empowering."

Of course, a victim's family member who viewed advocacy and policy change as a magical solution to their pain would likely be disappointed. Julie Nelson observes, "I don't believe we can legislate or medicate ourselves to a perfect world." Nevertheless, for many families, working for prevention of the kind of violence that so devastated their own

[24] Dave Moller, "Laura's Law May Be Extended," The Union newspaper, April 24, 2006.

BONNIE STAWSKI AND BILLIE JEAN MAYBERRY'S brother, Robert Coe, was executed in Tennessee in 2000 after being convicted of the murder of Cary Ann Medlin. Robert had had a long history of mental illness, and had been diagnosed with schizophrenia and psychosis. "Mama tried to get him help when we were growing up, but she couldn't," Bonnie recalls. The period leading up to her brother's execution is still vivid in Bonnie's mind. She remembers sitting alone in her kitchen with the Bible open beside her and the day's newspapers with their articles about Robert's case. Of the experience of witnessing the execution, Bonnie says, "I'm so glad that they let me be in there, but it's the most horrible thing to go through." Billie Jean echoes the thought, saying, "I don't think people understand what executions do to the family of the person being executed."

Bonnie wonders now what kind of message it sends that the state would kill someone with mental illness. "Robert's mental illness was in all the records and they went ahead and killed him anyway," she says. "It just seems so cruel."

lives is, in its way, a pursuit of accountability, as well as a way to honor their loved ones' lives.

Families of the executed, too, can be motivated toward activism and public speaking by a desire to spare other families the distinct kinds of losses they themselves have experienced, and perhaps in some way to redress the harm both caused and suffered by their loved ones. We have referred to the Robisons' and Bill Babbitt's expressed commitment to speaking out about the obstacles they faced in trying to get help for their family member. Like them, Pat Seaborn, whose cousin Ron Spivey was executed in Georgia in 2002, continues to work against the death penalty and toward a greater understanding of mental illness – an area in which she sees progress since the 1950s when her cousin was first diagnosed with mental illness. "If enough of us speak out and tell our stories and can get the understanding out there, maybe we can turn this thing around," she says now.

Bonnie Stawski still struggles with the stigma that she feels is associated with her and her siblings because of their relationship to their brother Robert Coe, who was executed in Tennessee in 2000 for the murder of Cary Ann Medlin, after a long history of mental illness. "When they find out who you are, it does make a difference in how they treat you, even now," she explains. But despite this, she is determined to try to prevent other families from going through what hers did. "I know what it does to the family. It's like they were killing us, a part of us."

In addition to struggling against the stigma that is associated with being related to someone who has been executed, families have to manage the repeated re-engagement with painful and even traumatic memories that public speaking and activism requires. As Tina Duroy says, "I try to do as much as I can, and there's probably more that I could do, but I can't relive it every day. I wish I could, because I could probably help more people, but I just can't." Despite this, Tina, like the other family members of the executed quoted here, has on several occasions spoken publicly about the challenges involved in trying to get help for her brother and the toll that an execution takes on the surviving family members.

Conclusion

In cases of murders committed by individuals with severe mental illness, the available legal outcomes, though all imperfect in the various ways we have outlined here, have one thing in common: they all offer more caution, more mental health intervention, supervision, and scrutiny, and greater protections against further violence than existed regarding the same individuals before they committed a crime. Several of the stories detailed here contain the cruelest of ironies: an individual with mental illness is only now, after committing a murder, receiving the mental health treatment that was so desperately needed in the first place. *Why is this what it took?* the victims' families wonder. In cases that result in an execution, rather than psychiatric commitment or imprisonment, the cruelty of the irony is only compounded: now another life has been taken, and the executed person's family, too, is desperately asking why nothing was done earlier.

We recognize the critical distinction between having committed a crime and being at high risk for committing a crime. The civil liberties of an individual with mental illness are not to be taken lightly, and none of the family members interviewed here would suggest otherwise. But the discrepancy between the response to mental illness before and after a murder is committed should not be so stark. If we put the concerns of victims' families *and* of people suffering from severe mental illness and their families at the forefront of our collective consideration, we can see that no one is served by failure to try – at least as hard as we can – to prevent the tragedy of murder committed by an individual in the grip of a psychotic delusion.

By working for prevention (treatment of the mental illness prior to a murder's being committed) rather than execution (responding with the ultimate punishment after the crime has been committed), the family members quoted throughout this report are making a powerful statement not only about their personal beliefs but also about where they think societal priorities should lie: address the cause, the illness; acknowledge the harm to victims and their families; take real and meaningful steps to reduce the likelihood of such a tragedy recurring, by this individual and by others in similar circumstances.

The death penalty is not the answer to the problem of violence committed by persons with severe mental illness. Society's "evolving standards of decency" render the death penalty an inappropriate and disproportionate response to such crimes, as the recent trend in U.S. Supreme Court rulings shows. Moreover, as the testimony of victims' families and families of offenders so vividly demonstrates, executions do not address the central concerns engendered by their incomparable losses. As a society, we owe it to them to do better.

Appendix A: Recommendations

In bringing together the voices of victims' families and of families of the executed, all of whom have been affected by issues of severe mental illness, murder, and the death penalty, *Double Tragedies* has created an intersection of relevant considerations: the inappropriateness of the death penalty as a response to homicides committed by persons with severe mental illness, how to prevent or minimize the risk of such homicides before they occur, and how to recognize and address the needs of families of victims of people with severe mental illness and families of offenders with severe mental illness.

The core recommendations that grow out of our foregoing discussion are these:

- Individuals who committed crimes as a result of impairments caused by severe mental illnesses should not be sentenced to death or executed
- Everything possible should be done to reform and improve the mental health system so that individuals with severe mental illnesses can receive affordable and appropriate treatment they need, thus preventing, or at least minimizing to a far greater degree than we now do, the risk of violence committed by some individuals who experience acute psychotic symptoms of mental illness
- Families of victims killed by persons with severe mental illnesses should be treated with respect and dignity throughout the criminal or mental health proceedings, and their rights to information and participation should not be denied
- Families of the executed should be recognized as victims and given the assistance due to any victims of traumatic loss

In bringing together these multiple considerations, we are entering a conversation that has already been going on. Much good work has already been done to develop policy recommendations in each of these areas. Our goal here is therefore to summarize and refer readers to the recommendations that colleague organizations have devised in these four areas and to add our endorsement of those recommendations.

We are entering an existing conversation, but entering it with a unique voice – the voice of victims fitting these specific profiles. As a result, our goal is to encourage an integrated understanding and advocacy by urging readers to become familiar with aspects of the issue, and with specific policy analyses and recommendations, that may have up to now lain outside their own direct area of involvement. To address the very difficult problem of murders committed by individuals with severe mental illness and the resulting questions about appropriate response – including the question of death penalty or no death penalty – it will be essential to encompass the variety of perspectives of those who have a stake in the issue.

What follows is a summary of what we believe are the key recommendations that have been developed in each area. We strongly encourage readers to seek out the full text of each of the reports referenced here. For links to those reports, and suggestions of further reading and resources on the issue of mental illness and the death penalty, see Appendix C.

Prohibiting the Death Penalty for Persons with Severe Mental Illness

In 2006, the American Bar Association's House of Delegates adopted a Recommendation developed by a Task Force on Mental Disability and the Death Penalty and officially endorsed by the American Psychiatric Association, the American Psychological Association, and the National Alliance on Mental Illness. The Recommendation states that the ABA, "without taking a position supporting or opposing the death penalty," urges jurisdictions that currently make use of the death penalty to exempt people with mental disorders and disabilities.

The ABA Task Force was created in the aftermath of the U.S. Supreme Court's *Atkins v. Virginia* ruling, which, as we noted at the start of our discussion, ruled the execution of defendants with mental retardation unconstitutional. The ABA, as their report states, "recognized that *Atkins* offered a timely opportunity to consider the extent, if any, to which other types of impaired mental conditions ought to lead to exemption from the death penalty." The *Atkins* and then the 2005 *Roper v. Simmons* decisions were based on the principle that the death penalty, if it is to be used at all, ought to serve either a deterrent or a retributive purpose, and that in the case of people with reduced capacity for understanding, judgment, and self-control, it serves neither purpose.

Determining that a given defendant was a juvenile (under the age of 18) at the time of the crime is a straightforward matter. Determining whether the defendant has mental retardation is somewhat more difficult; it has generally been defined as having an IQ of 70 or below, deficits in adaptive functioning, and age of onset prior to 18. Determining exactly what is meant by mental illness requires still more guidance, and the ABA Recommendation defines mental illness fairly narrowly and precisely, refuting the concern that any defendant charged with capital murder would easily be able to claim mental illness. The ABA's report says that their

> predicate for exclusion from capital punishment under this part of the Recommendation is that offenders have a "severe" disorder or disability, which is meant to signify a disorder that is roughly equivalent to disorders that mental health professionals would consider the most serious "Axis I diagnoses." These disorders include schizophrenia and other psychotic disorders, mania, major depressive disorder, and dissociative disorders—with schizophrenia being by far the most common disorder seen in capital defendants. In their acute state, all of

these disorders are typically associated with delusions (fixed, clearly false beliefs), hallucinations (clearly erroneous perceptions of reality), extremely disorganized thinking, or very significant disruption of consciousness, memory and perception of the environment.

Some conditions that are not considered an Axis I condition might also, on rare occasions, become "severe" as that word is used in this Recommendation. For instance, some persons whose predominant diagnosis is a personality disorder, which is an Axis II disorder, may at times experience more significant dysfunction. Thus, people with borderline personality disorder can experience "psychotic-like symptoms . . . during times of stress." However, only if these more serious symptoms occur at the time of the capital offense would the predicate for this Recommendation's exemption be present.

We note that legislation modeled to varying degrees on the ABA Recommendation, exempting from the death penalty certain persons who committed crimes as a result of impairments caused by severe mental illness, was introduced during the 2009 legislative session in North Carolina, Tennessee, Indiana, and Kentucky.

Focus on Treatment: Reform of the Mental Health System

The 2009 *Grading the States* report, produced by the National Alliance on Mental Illness, is a comprehensive and detailed look at how states are or are not managing to provide necessary care to individuals with mental illness, and an analysis of what needs to change. The report's introductory statement includes this call to action:

> The nation can sit idly no longer. It is time to break down the barriers in government that have led to the abandonment of people with serious mental illness and to undo years of bad policies that have increased the burdens on emergency rooms, the criminal justice system, families, and others who have been left to respond to people in crisis. We must invest adequate resources in mental health services *that work* and finally end the pervasive fragmentation in America's system of care.

Grading the States offers "10 Pillars of a High-Quality State Mental Health System" and explains what good mental health care looks like and how to put it into practice. Particularly relevant to the stories put forth here in *Double Tragedies* is the finding that many people with severe mental illnesses do not have access to long-term or sustained treatment and services. As with any other medical disorder, lack of appropriate treatment can exacerbate the symptoms of severe mental illnesses and lead to negative outcomes such as homelessness, suicide, and criminal behavior.

Equally relevant is the section on "non-adherence to treatment," which looks at the challenging issue of individuals who "discontinue their own treatment, in particular, their use of prescribed medications." *Grading the States* lists several possible reasons for this:

- They have a neurological syndrome called Anosognosia that leaves them unaware that they are ill. As many as 50 percent of people with schizophrenia are affected by this condition, and it is the most significant reason why people with illnesses characterized by psychosis refuse treatment;
- Their medications have uncomfortable or even debilitating side effects;
- They experience little or inadequate symptom relief;
- They perceive stigma about having a mental illness; and/or
- They have had negative experiences in the mental health system, ranging from indifference and disrespect to abusive and inhumane treatment.

Other possible reasons for discontinuing treatment are that the individual does not have access to affordable health care, and cannot afford the medications/treatments prescribed, or that the individual has been prescribed the wrong medications and/or the wrong dosages – especially when the provider is under pressure to save on costs by using the cheapest medication, not necessarily the one most appropriate to the individual.

The consequences of non-adherence or lack of access to treatment can sometimes be devastating, both to individuals with severe mental illness and, as we have seen, to victims and their families. *Grading the States* offers a detailed look at what strategies have been shown to be effective and what reforms to the existing mental health system are needed.

For example, to address non-adherence to treatment, the report recommends that states "should implement a full set of strategies tailored to individuals whose symptoms may preclude them from recognizing that they are ill and thus participating in treatment. These strategies (which are described in Chapter 1 [of *Grading the States*]) should include Assertive Community Treatment (ACT) programs, peer supports, Psychiatric Advance Directives (PADs), motivational strategies such as the LEAP program, treatment guardianships, and, as a last resort, court-ordered assisted outpatient treatment (AOT)."

Recognizing Victims' Needs

At the conclusion of the American Bar Association Task Force's report, the writers note that

> in any proceedings necessary to make these determinations, the victim's next-of-kin should be accorded rights recognized by law, which may include the right to be present during the proceedings, the right to be heard, and the right to confer with the government's attorney. Victim's next-of-kin should be treated with fairness and respect throughout the process.

The proceedings the ABA refers to here are those that are meant to determine whether an offender meets the test for competency to proceed with a trial or to be executed. As we have seen, the rights of victims' families when a defendant with men-

tal illness is found *not* competent to stand trial, or is found not guilty by reason of insanity – in other words, when the case shifts to a mental health rather than criminal jurisdiction – are far less clearly defined. In 2008, with support from the federal Office for Victims of Crime, the Council of State Governments Justice Center released a much-needed guide titled *Responding to People Who Have Been Victimized by Individuals with Mental Illnesses.* In its introduction, this guide says

> The enactment of state statutes and passage of state constitutional amendments establishing legal rights for crime victims have been among the most important and heralded improvements to crime policy during the past two decades. During this same period, a growing number of people with mental illnesses have been arrested, detained, and incarcerated, which has attracted widespread attention among local and state elected officials. Despite the significance of both trends, there has been little, if any discussion, about the rights of victims when the person who committed the crime has a mental illness.

Of special relevance to several of those profiled here in *Double Tragedies*, the Council of State Governments guide acknowledges the particular needs of victims in which the crime was committed by a member of the same family.

The guide offers a helpful overview of current policy and practice, discusses the barriers that can make it difficult for victims' rights to be enforced in these cases, and provides a series of useful "action items" for collaboration between the criminal justice and mental health systems regarding response to victims, developing better systems for cross-training and availability of information between these systems, much better clarity and information for victims and for those assigned to assist victims, especially regarding notification and participation.

We note that the guide does not dismiss, but instead carefully discusses, the challenge inherent in balancing these rights with the privacy rights of individuals with mental illness, especially those covered under the Health Insurance Portability and Accountability Act (HIPAA).

Legislation allowing victims to participate in the proceedings by delivering a victim impact statement in cases where the defendant was found not competent to stand trial or not guilty by reason of insanity was introduced in Illinois during the 2009 session. (see page 21 of this document.) As well, the Council of State Governments report suggests that Missouri serves as a model in this area:

> The Missouri victims' bill of rights contains several provisions specific to victims of crime committed by individuals who are found not guilty by reason of mental illness. Victims are granted the right to confer with and be informed by the prosecutor regarding pleas of "not guilty by reason of mental disease or defect." In addition, victims have the right to be informed by the custodial mental health facility of any release-related court hearings for an individual committed as not guilty by reason of mental disease or defect; such court hearings could relate to temporary, unescorted visits to the community or longer-term releases. Victims have the right to be present and heard at such hearings or to offer a written statement or video/audio recording in lieu of a personal appearance. Victims also have a right to be notified of the individual's escape from mental health facility within 24 hours.

In addition to encouraging other states to follow these models, we encourage efforts to develop model legislation that improves upon the current "guilty but mentally ill" or "not guilty by reason of insanity" options by acknowledging and addressing both the harm done to victims and the mental illness of the person responsible for that harm.

Recognizing Families of the Executed as Victims

In 2006, as part of the "No Silence, No Shame" project, which aims to draw attention to the ways in which executions harm the surviving family members of the person executed, Murder Victims' Families for Human Rights released a report called *Creating More Victims: How Executions Hurt the Families Left Behind.* Based on the testimony of three dozen family members of the executed within the United States, this report argued that families of the executed ought to be considered victims under the United Nations Universal Declaration of the Principles of Justice for Victims of Crime and Abuse of Power, and ought to be given the recognition and assistance accorded to other victims of traumatic loss.

The report offered specific recommendations for lawmakers, religious leaders and counselors, victim advocates and victim assistants, educators, child welfare advocates, mental health professionals, and academic scholars. For example, for victim advocates and victim assistants, the report urged

> that family members of the executed be recognized as victims who may be in need of advocacy and assistance, and we encourage the development of a protocol for making programs, services, and other forms of help available to these families. Although advocates and assistants may need to interact with the criminal justice system in order to identify and reach out to families of the defendant in capital cases, we recommend that such advocates and assistants be independent rather than under the auspices of either the prosecutor's or the defender's offices.

And for mental health professionals:, the report recommended "that the short- and long-term psychological effects of an execution in the family be included in literature and training directed at social workers, clinical psychologists, trauma specialists, and others who might come in contact with such families."

Appendix B: Methodology

Criteria for participation in the project

Participation in the "Prevention, Not Execution" project requires that an individual be opposed to the death penalty for persons with severe mental illness and be

- a family member of a victim who was killed by a person outside their family who had been diagnosed with severe mental illness;
- a family member of a victim who was killed by a person within the same family who had been diagnosed with severe mental illness; or
- a family member of a person diagnosed with severe mental illness who has been executed

For persons in the first two groups, the legal outcome of the defendant's case may vary. Participation in the project does not require the case to have resulted in the death penalty – only that the individual accused of the killing had been diagnosed with severe mental illness at the time of the offense.

Family members of individuals diagnosed with severe mental illness and currently in prison or on death row – but not yet executed — may be involved in the project as supporters and allies, but are not direct participants and were not interviewed for this report.

How the participants were found

Some participants were members of Murder Victims' Families for Human Rights and/or the National Alliance on Mental Illness prior to the development of this project, and they participated in early discussions about its form, direction, and scope. Others were found through research and direct outreach, and were invited to participate if they met the above criteria.

The report is based on interviews with (and supplemental material from) 21 family members who meet the above criteria. The majority but not all of those interviewed for the report also participated in the private gathering and public event in San Antonio on October 3, 2008 that marked the official launch of the project. Interviewees quoted in this report are from ten states: California, Florida, Georgia, Illinois, Louisiana, Maine, Massachusetts, New York, North Carolina, Tennessee, Texas. Other similar stories from family members whom we were not able to interview directly have also informed our thinking on the issue.

How the interviews were conducted

Most of the interviews were conducted via telephone by MVFHR staff member Susannah Sheffer. Interviews were recorded and transcribed with the subjects' permission. Two of the interviews were conducted in person by the staff of the Texas After Violence Project. (The Texas After Violence Project conducts oral history interviews with people who have been affected by the death penalty in Texas, including families of victims and families of the executed).

Definition of "severe mental illness"

The project has from the start used as its guideline the Recommendation adopted by the American Bar Association House of Delegates in 2006 regarding exempting mentally ill defendants from the death penalty. The recommendation was developed by a Task Force on Mental Disability and the Death Penalty, which, according to the description in the ABA document, "carried out its deliberations from April, 2003 to March, 2005, [and] was composed of 24 lawyers and mental health professionals (both practitioners and academics), and included members of the American Psychiatric Association and the American Psychological Association. The American Psychiatric Association and the American Psychological Association have officially endorsed the Task Force's proposal."

See the relevant excerpt from the Recommendation, about the definition of mental illness for these purposes, in our Appendix A, pages 26-27.

Appendix C: Further Reading and Resources

REPORTS AND ARTICLES

Reports mentioned in Appendix B:

American Bar Association Recommendation and Report on the Death Penalty and Persons with Mental Disabilities
http://www.ndrn.org/issues/cj/ABA%20Resolution-%20feature%20article305.pdf

Grading the States 2009: A Report on America's Health Care System for Adults with Serious Mental Illness
http://www.nami.org/Content/NavigationMenu/Grading_the_States_2009/Full_Report1/Full_Report.htm

Responding to People Who Have Been Victimized by Individuals with Mental Illnesses
http://consensusproject.org/downloads/responding.pdf

Creating More Victims: How Executions Hurt the Families Left Behind http://www.mvfhr.org (click on "Publications")

Other useful reading:

Honberg, Ronald S. "The Death Penalty and Mental Illness: The Injustice of Imposing Death Sentences on People with Severe Mental Illness," Catholic University Law Review, Summer 2005 (54 Cath. U.L. Rev. 1153)

Mental Illness and the Death Penalty Resource Guide, by Kristin Houle. Includes talking points, case studies, ideas for action, and lists of further resources. http://www.tcadp.org/uploads/documents/mental%20illness/MIDP%20Resource%20Guide-second%20edition.pdf

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. http://web.amnesty.org/library/Index/ENGAMR510032006.

"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. 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. www.ndrn.org/issues/cj/Talking%20Points.pdf.

ORGANIZATIONAL WEBSITES

American Bar Association www.abanet.org
Amnesty International USA www.aiusa.org
Death Penalty Information Center www.deathpenaltyinfo.org
Mental Health America www.mentalhealthamerica.net
Murder Victims' Families for Human Rights www.mvfhr.org
National Alliance on Mental Illness www.nami.org
National Coalition to Abolish the Death Penalty
www.ncadp.org
National Disability Rights Network www.ndrn.org
Office for Victims of Crime www.ojp.usdoj.gov/ovc/
Texas After Violence Project www.texasafterviolence.org
Treatment Advocacy Center
www.treatmentadvocacycenter.org/

BLOGS

For Victims, Against the Death Penalty. Visit for updates about the work of Murder Victims' Families for Human Rights and news and examples of victim opposition to the death penalty. http://www.mvfhr.blogspot.com

Prevention Not Punishment. 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.
http://preventionnotpunishment.blogspot.com/

FILM

"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/panetti-documentary.asp.

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About the Organizations

The National Alliance on Mental Illness (NAMI) is the nation's largest grassroots organization for people with mental illness and their families. Founded in 1979, NAMI has affiliates in every state and in more than 1,100 local communities across the country. NAMI's members and friends work to fulfill its mission through support, education, and advocacy for better mental health treatment and services.

NAMI
2107 Wilson Blvd., Suite 300
Arlington, VA 22201-3042
703-524-7600
www.nami.org

Murder Victims' Families for Human rights (MVFHR) is an international organization of relatives of homicide victims and relatives of people who have been executed, all of whom oppose the death penalty. MVFHR opposes the death penalty from a victim perspective (asserting that executions do not help victims achieve justice or closure) and from a human rights perspective (asserting that executions violate the most basic of human rights). MVFHR is a member of the World Coalition Against the Death Penalty, the National Coalition to Abolish the Death Penalty, the U.S. Human Rights Network, the National Center for Victims of Crime, and the Asia Death Penalty Abolition Network.

MVFHR
2161 Massachusetts Avenue
Cambridge MA 02140
617-491-9600
www.mvfhr.org
info@murdervictimsfamilies.org

ABOUT THE AUTHOR
Susannah Sheffer has developed numerous written materials about victim opposition to the death penalty, including (with Renny Cushing) *Dignity Denied: The Experience of Murder Victims' Family Members Who Oppose the Death Penalty*, *"I Don't Want Another Kid to Die": Families of Victims Murdered by Juveniles Oppose the Juvenile Death Penalty*, and *Creating More Victims: How Executions Hurt the Families Left Behind.* She is the author of four books, including *In a Dark Time: A Prisoner's Struggle for Healing and Change*, and in her work with MVFHR she draws upon two decades of experience interviewing, writing, and editing.